Dogfennau Ategol - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Ystafell Bwyllgora 4 - Tŷ Hywel

Dyddiad: Dydd Iau, 13 Hydref 2016

Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:

Sarah Beasley

Committee Clerk

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

Ymatebion i'r Ymgynghoriad

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol: Ymatebion i'r Ymgynghoriad

(Tudalennau 1 - 266)

Dogfennau atodol:

Consultation cover template

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WF 03 Cymorth Canser Macmillan (Saesneg yn unig)

WF 04 Cŵn Tywys Cymru (Saesneg yn unig)

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WF 13 UNSAIN (Saesneg yn unig)

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WF 15 Coleg Brenhinol y Bydwragedd (Saesneg yn unig)

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WF 18 Bwrdd Iechyd Prifysgol Hywel Dda (Saesneg yn unig)

WF 19 Cyfarwyddwyr Therapïau a Gwyddorau Iechyd (Saesneg yn unig)

WF 20 Multiple Sclerosis Society Cymru (Saesneg yn unig)

WF 21 Cymorth Cymru (Saesneg yn unig)

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WF 34 Bwrdd Iechyd Prifysgol Betsi Cadwaladr (Saesneg yn unig)

WF 35 Leonard Cheshire Disability (Saesneg yn unig)

WF 36 RNIB Cymru (Saesneg yn unig)

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Ymatebion i'r Ymgynghoriad

Medi 2016

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Health, Social Care and Sport Committee

Inquiry into the sustainability of the health and social care workforce

Consultation Responses

September 2016

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04	Cŵn Tywys Cymru	Guide Dogs Cymru
05	Coleg Nrysio Brenhinol	Royal College of Nursing
06	Fferylliaeth Gymunedol Cymru	Community Pharmacy Wales
07	Coleg Brenhinol y Meddygon (Cymru)	Royal College of Physicians (Wales)
08	Association of Independent Healthcare Organisations	Association of Independent Healthcare Organisations
09	Coleg Brenhinol y Meddygon o Caeredin	Royal College of Physicians of Edinburgh
10	Coleg Brenhinol y Seiciatryddion	Royal College of Psychiatrists
11	Coleg y Therapyddion Galwedigaethol	College of Occupational Therapists
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WF 01

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Age Cymru

Response from: Age Cymru

Consultation Response

Sustainability of the health and social care workforce

August 2016

Introduction

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

We are pleased to respond to the Health, Social Care and Sport Committee's inquiry into the sustainability of the health and social care workforce. The proportion of the population aged 65 and over in Wales has been growing at a faster rate than the proportion of the population aged between 18 and 64 and this is a trend that will continue in coming decades. The number of individuals aged 65 and above in Wales is expected to increase from around 600 000 in 2013 to almost 900 000 in 2037[1]. The need for social care increases with age, and the number of those aged 85 or over is growing at an even faster rate than those aged 65 plus. In order to meet the health and social care needs of this population, we need to ensure that the relevant workforce is suitably trained and integrated, with the appropriate skills mix available.

General comments

- We are aware that in some places older people's services in secondary care, for example mental health services, are not always available 24/7 whereas they are available 24/7 for what is known as the working age population. It is imperative that training and recruitment (as well as funding) are able to address such gaps in the current provision. A lack of such a service can, for example, be problematic if a person living with dementia or a cognitive impairment is admitted outside those service hours.
- There will be a greater demand for health and social care from an increasingly frail older population, many of whom may have co-morbidities. It is essential that the workforce is able to treat the person holistically. We are aware of issues that have arisen due to people living with dementia being treated for other conditions by staff who are not trained to deal with symptoms and behaviour that may arise from their dementia.
- As a consequence, we believe that dementia care training is fundamental for all specialisms apart from paediatrics for both the health and social care workforce. For example, growing numbers of people in receipt of domiciliary care are living with dementia and there is an urgent need for domiciliary care workers to understand how best to support them. Around two-thirds of people living with dementia live in the community, and one-third of these live alone in their own homes[2]. It is thus highly probable that domiciliary care workers regularly encounter people who may have difficulty in communicating their needs, may be confused, frustrated or even on occasions aggressive. Knowing how to

[1] LE Wales (April 2014): *Future of Paying for Social Care in Wales. First report to the Welsh Government*.
[2] Alzheimer's Society (2014): *Dementia 2014: Opportunity for change*: p18

communicate and respond appropriately is therefore essential to the delivery of quality care[3]. Appropriate support can have a significant impact upon quality of life.

- We would also argue that there is a need for more geriatric specialists in light of the ageing demographic profile of the Welsh population. For example, we know from data collected by the Wales Cancer Intelligence and Surveillance Unit (February 2016) that the rate of new cancer cases generally increases with age, as does the rate of cancer deaths. We are therefore concerned that more attention should be given to the provision of geriatric oncology services and ensuring that all patients are treated equally, irrespective of age. This would require further training and recruitment of staff specialising in providing care and treatment to older people within their area, for example oncology.

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

[3] *Ibid: p28*

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

☎ 029 2044 5030
08442 64 06 80
www.olderpeoplewales.com

Cambrian Buildings
Mount Stuart Square
Cardiff CF10 5FL

Adeiladau Cambrian
Sqwâr Mount Stuart
Caerdydd CF10 5FL

WF 02

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Comisiynydd Pobl Hŷn Cymru
Response from: Older People's Commissioner for Wales

Dai Lloyd AM
Cadeirydd
Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Caerdydd
CF99 1NA

26 Awst 2016

Annwyl Gadeirydd,

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

1. Mae gweithlu iechyd a gofal cymdeithasol sydd wedi ei hyfforddi'n briodol ac yn cael ei werthfawrogi'n hanfodol i sicrhau gwasanaethau o ansawdd uchel yng Nghymru. Felly rwy'n croesawu'r cyfle hwn i gynnig sylwadau ynglŷn â chynaliadwyedd y gweithlu iechyd a gofal cymdeithasol fel rhan o ymchwiliad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon.
2. Rwy'n croesawu'r meysydd ffocws a nodwyd gan y Pwyllgor fel rhan o'r ymchwiliad hwn, meysydd y mae llawer o fy ngwaith hyd yma wedi rhoi sylw iddynt. Mae fy nhystiolaeth isod yn crynhoi nifer o'r pryderon yr wyf wedi eu codi drwy fy ngwaith parhaus:

Adolygiad o Gartrefi Gofal:[1]

3. Mae staff gofal yn chwarae rhan hanfodol o safbwynt p'un ai a yw pobl hŷn sy'n byw mewn cartrefi gofal yn mwynhau bywyd o ansawdd da. Yn fy Adolygiad tynnwyd sylw at y pwysau presennol sydd ar y gweithlu gofal cymdeithasol mewn cartrefi gofal yng Nghymru. Roedd y rhain yn cynnwys:

[1] Lle i'w Alw'n Gartref?
http://www.olderpeoplewales.com/wl/Reviews/Residential_Care_Review/ReviewReport.aspx

- Diffyg capasiti staff, a hynny'n creu dull seiliedig ar dasgau tuag at ofal;
- Diffyg hyfforddiant, yn cynnwys hyfforddiant addas i staff sy'n gweithio'n agos gyda phobl sy'n byw gyda dementia a/neu sydd wedi colli eu golwg neu eu clyw;
- Arweinyddiaeth a chefnogaeth annigonol ar gyfer rheolwyr cartrefi gofal, sy'n hanfodol er mwyn creu'r diwylliant priodol o fewn cartref gofal;
- Bod gweithlu ar gael (yn cynnwys prinder staff nyrsio)
- Telerau ac amodau staff

4. Roedd Fy Adolygiad yn cynnwys nifer o Ofynion i'w Gweithredu mewn perthynas â gweithlu cartrefi gofal. Gellir eu gweld yma. Ar hyn o bryd rwy'n mapio'r gwaith sydd ar y gweill i sicrhau'r canlyniadau y mae pobl hŷn eisiau eu gweld ac rwy'n bwriadu rhannu'r gwaith hwn gyda'r Pwyllgor yn fuan.

Gofal Cymdeithasol Cymru:

5. Mae'r Pwyllgor yn nodi'r angen i fesur i ba raddau y mae gan Gymru weithlu dra chymwys i ddiwallu anghenion iechyd a gofal yn y dyfodol, a ddatblygir drwy nifer o ffyrdd.
6. Yn y dyfodol bydd y gweithlu gofal yn y cartref a gofal preswyl oedolion yn cael ei reoleiddio drwy Ddeddf Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru) gan sicrhau hyfforddiant gorfodol i'r gweithlu gofal cymdeithasol. Gan ddefnyddio'r canfyddiadau yn fy Adolygiad o Gatrtefi gofal, nodais yn ddiweddar fy nisgwyliadau ar gyfer sicrhau gweithlu gofal cartref, wedi ei hyfforddi'n briodol mewn ymateb i'r ymgynghoriad diweddar ar y blaenoriaethau ar gyfer deddf newydd Gofal Cymdeithasol Cymru. Gellir eu gweld yma.

Gofal yn y Cartref:

7. Roedd recriwtio a chadw staff iechyd a gofal cymdeithasol drwy Gymru, a'r ffactorau sy'n dylanwadu ar hyn, yn faes y tynnwyd sylw ato yn fy Adolygiad o Gartrefi Gofal. Yn fwy diweddar, ymatebais i ymgynghoriad Llywodraeth Cymru ar wella'r broses o recriwtio a

chadw gweithwyr gofal yn y cartref yng Nghymru, a oedd yn amlinellu'r angen i'r gweithlu gael ei ystyried fel proffesiwn o bwysigrwydd strategol allweddol. Gellir gweld fy ymateb i'r ymgynghoriad hwn yma.

Gofal Sylfaenol:

8. Mae cynllun gofal sylfaenol Llywodraeth Cymru a GIG Cymru[1] yn dangos yn glir symudiad tuag at ddarparu mwy o ofal a chefnogaeth o fewn y gymuned ac yn agos at gartrefi pobl, lle y bo hynny'n bosibl.
9. Mae'n hanfodol bod staff iechyd sydd wedi eu hyfforddi'n briodol ar gael i wireddu'r bwriad hwn. Er enghraifft, tra bod ymrwymiadau i lefelau staff nyrsio mewn wardiau ysbytai, a nodir yn Neddf Lefelau Staff Nyrsio 2016, i'w croesawu, rhaid cynllunio a hyfforddi'r gweithlu'n ddigonol er mwyn sicrhau na fydd yr ymdrech i gyflawni hyn yn amharu ar lefelau staff nyrsio o fewn gofal sylfaenol a'r gymuned.
10. Ar hyn o bryd rwy'n ymgymryd â gwaith i ddeall profiadau a mynediad pobl hŷn at wasanaethau meddygon teulu, gan gasglu tystiolaeth drwy sesiynau trafodaethau grŵp a holiadur. Byddaf yn cyhoeddi fy nghanfyddiadau yn gynnar yn 2017.
11. Nid wyf am ragfarnu canfyddiadau a chasgliadau'r gwaith hwn, ond mae'r dystiolaeth yr wyf eisoes wedi ei chasglu'n dangos bod pobl hŷn yn ymwybodol o heriau presennol y gweithlu ym maes gofal sylfaenol ac o'r anhawster i recriwtio meddygon teulu'n benodol, ac yn gallu cael trafferth ar hyn o bryd i wneud apwyntiad o fewn amserlen resymol.
12. Gallaf eich briffio ymhellach ynglŷn â'r gwaith hwn os hoffech gael rhagor o wybodaeth.

[1] Llywodraeth Cymru a GIG Cymru, Ein cynllun ar gyfer gwasanaeth gofal sylfaenol i Gymru hyd at fis Mawrth 2015

Deddf Lefelau Staff Nyrsio (Cymru):

13. Roedd fy Adolygiad o Gartrefi Gofal yn cynnwys tystiolaeth sylweddol ynglŷn â'r rôl allweddol y mae GIG Cymru'n a'i nyrsys yn ei chwarae o safbwynt ansawdd gofal a diogelwch pobl hŷn mewn cartrefi gofal preswyl a nyrsio. Yn ogystal â chartrefi gofal nyrsio, mae nifer fawr o nyrsys sy'n gweithio drwy Gymru yn gweithio yn y gymuned.

14. Gyda'r polisi a gynlluniwyd yn symud oddi wrth driniaeth ac aros am hir mewn wardiau aciwt a thuag at ofal a thriniaeth yn y gymuned, a hefyd yr angen i integreiddio gwasanaethau iechyd a gofal cymdeithasol yn well, mae angen cynllunio gweithlu a sicrhau lefelau staff nyrsio diogel yn y lleoliadau hynny er mwyn sicrhau bod pobl hŷn sydd efallai'n fregus a diamddiffyn yn derbyn gofal diogel a phriodol ym mhob sefyllfa. Gellir gweld fy ngwaith craffu cyn deddfu yma:

15. Byddaf yn gwneud gwaith dilynol i fy Adolygiad o Gartrefi Gofal yn ystod y flwyddyn nesaf ac edrychaf ymlaen at weithio gyda'r Pwyllgor a'i aelodau yn ein rolau craffu.

Os hoffech gael unrhyw wybodaeth bellach, mae croeso i chi gysylltu â mi.

Cofion gorau,

Sarah Rochira

Sarah Rochira

Comisiynydd Pobl Hŷn Cymru

WF 03
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Cymorth Canser Macmillan
Response from: Macmillan Cancer Support

Purpose:	**Macmillan's response to inform the NAfW Health, Social Care & Sport inquiry into the sustainability of the health and social care workforce**
Contact:	**Lowri Griffiths, Policy & Public Affairs Manager (Wales)** [redacted] **Tel:** [redacted]
Date created:	**17 August 2016**

1. Introduction

1. 1 Macmillan Cancer Support welcomes the opportunity to contribute to this inquiry focussing on the sustainability of the health and social care workforce in Wales. We believe this inquiry at the beginning of the committee's lifespan is timely. The number of people affected by cancer is rising. We must ensure that in-line with this increase in demand; we have a well resourced, well motivated, highly trained and skilled workforce with the appropriate specialist and generalist balance to meet needs in a holistic way.

1.2 In Wales, 19,000 (WCISU Feb 2015) people are diagnosed with cancer every year and more than 130,000 people are currently living with or beyond cancer, almost 4.5 percent of the population. By 2030 it is expected that 250,000, almost eight percent of the Welsh population, will have been affected by a cancer diagnosis and one in two of us will be affected by cancer at some point in our lives.

1.3 The good news is that survival rates are steadily improving and many people recover. On average 70 percent[1] of Welsh residents diagnosed with cancer can expect to survive at least one year. However, improving survival rates in Wales need to be considered in the context of even better survival rates in many other European countries.

1.4 There should be no doubt that in order to close the gap in outcomes with our European counterparts the workforce both now and in the future will need to be one that has a broad mix of skills capable of addressing the holistic needs of the patient, family member or carer. We believe that this discussion is about more than staffing numbers. Whilst understanding where there is a lack of staff both now and in the future is an important part of the task at hand, there are broader developments required in culture and approach to working with patients.

[1] Welsh Cancer Intelligence and Surveillance Unit Official Statistics 2012 data. Published 10 April 2014

2. Person centred care

2.1 Macmillan believes that to achieve the best outcome following a cancer diagnosis, person-centred care must be at the heart of service delivery. Only by focussing on the whole person, can the patient's experience during their cancer journey be as good as it can possibly be. This is true for those who survive cancer, are living with cancer or someone who is nearing the end of life.

2.2 Person-centred care means that the needs of the person living with cancer are always at the heart of how services are planned, not the needs of the service providers. It means treating people with sensitivity and compassion and ensuring that their care is holistic in its planning and delivery. This care goes beyond the clinical to also address wider social, financial, emotional, practical, psychological and spiritual concerns.

2.3 There are a number of factors required in order to deliver person-centred care consistently and to a high quality. These are:

- Personalised and holistic needs assessments and written care planning
- Coordinated and continuity of care
- Good communication
- Information and support
- Signposting to financial, practical and emotional support

2.4 Person centred care requires coordination throughout the cancer pathway and a range of professionals may be require to deliver holistic care. This could for example include speech and language therapists, welfare benefit advisers and physiotherapists.

3. The impact of the Specialist Cancer workforce

3.1 Specialist nurses are key members of the cancer multidisciplinary team and are normally recognised as the patient's key worker.[8] They manage a clinical caseload, assess people's clinical and non clinical needs and co-ordinate patients treatment and care throughout the clinical pathway. They promote an individual's health and wellbeing in collaboration with the patients they care for from diagnosis onwards.

3.2 Ahead of the 2016 Welsh Assembly Elections, we were calling on all political parties to commit to ensuring **everyone who is given a cancer diagnosis is assigned and has access to a specialist cancer nurse who is also their key worker whilst in the acute stages of treatment**. We continue to strongly believe that this should be the case to deliver the best possible clinical outcomes and patient experience.

3.3 Specialist cancer nurses possess advanced clinical skills, expert knowledge and strong leadership qualities. They use this skill set to ensure that people with cancer receive the best possible care and support throughout the cancer pathway.

3.4 Further evidence can be found in the results of the Wales Cancer Patient Experience Survey (2013), produced in partnership between Macmillan and Welsh Government. The survey found that on 59 questions in the survey, patients who had a CNS were more likely to be positive about their care and treatments than patients who did not. For example the overall rating of care of respondents who had a CNS was 91% satisfaction, for those without a CNS this satisfaction rate fell to 77%.

3.5 The second Wales Cancer Patient Experience was launched in July 2016. The second survey will build on the strong evidence base produced through the first survey and provide invaluable insight in identifying where progress has been made, and where further work is required in improving patient experience. The published analysis of the results is expected in Spring 2017 and we look forward to informing the Committee on the outcomes of this work.

3.6 There is also a wealth of evidence which demonstrates that specialist cancer nurses represent good value for money. They can reduce the number of emergency admissions, the length of hospital stays, the number of follow-up appointments, and the number of medical consultations and provide support at end of life to enable people to be cared for and to die in their place of choice.

4. **Macmillan Specialist Adult Cancer Nurse Census**

4.1 Macmillan has concerns about the numbers of specialist cancer nurses. The first specialist adult cancer nurse census in Wales in 2014[17] revealed that the number of specialist nurses employed across Wales varied both geographically and by cancer site, leading to inequalities in patient experience. On average there is only one urology nurse to 181 people diagnosed with an urological cancer; one lung cancer nurse for every 113 people diagnosed with lung cancer, compared to 70 people per breast cancer nurse in Wales contributing to inequalities in experience. Care needs to be tailored and delivered according to pathways which are stratified on the basis of cancer type and treatments received, as well as individual needs, preferences and circumstances.

4.2 Data from the survey suggests that as many as half of the adult specialist cancer nurses providing cancer care are over 50, and it is likely the majority of these will retire in the next 5-10 years.[2]

4.3 With this insight Macmillan responded to the NHS Wales Workforce Review in September 2015 and, in our response, we outlined our understanding of the rationale behind "professional substitution". However, we urge caution within any prudent healthcare application, to ensure that healthcare professionals operate at the top of their licence, but do not delegate care responsibilities to those who are not qualified to deliver those aspects of care. Macmillan believes that the term "complimentary roles" would better describe the desired outcome from staff supporting each other whilst operating at the peak of their expertise.

4.4 In our response to the inform the refresh of Welsh Government's Cancer Delivery Plan we have highlighted that a commitment must be made to building and supporting a cancer workforce that meets the changing needs of people affected by cancer and address the significant challenges facing the health and social care system by delivering:

- Clear national-level assessment of the workforce – bringing together current data on levels of supply and demand in the health and social care workforce and improving national data collection and use to aid long-term planning

- Strong national leadership – a strategic approach to workforce planning, training and education to develop the right workforce for now and the future

- Address immediate gaps in key areas – increasing the capacity of the cancer specialist workforce needed to support current and redesigned service models

- Improve recruitment and retention of staff – identify the skills needed by current and future staff, provide increased education and training to build those skills and clear professional development pathways

- Break down the barriers in how care is provided to improve coordination of care across sectors, professions and conditions

- Enable people to take greater control of their own care – supporting self-management through a skilled workforce

- Value informal carers and volunteers as part of cancer care teams, making the most of their contribution and ensuring they have the skills, knowledge and support to provide care and support

[2] "Specialist Adult Cancer Nurses in Wales" Macmillan Cancer Support (2014)

5. Linking Staff Satisfaction & Patient Satisfaction

5.1 We believe that key to delivering positive outcomes for patients is by building and maintaining high levels of staff satisfaction. That is, staff who feel empowered, trusted and expert in their role, operating at the top of their licence to utilise their full range of skills. Echoing the point that an exercise involving workforce reorganisation should not be solely focussed on numbers that are needed now and in the future, we would further encourage recognition of the role that staff development has in motivating and equipping the workforce for modern-day challenges.

5.2 A Macmillan funded analysis, "The People Behind Cancer Care" (2015), showed that where staff experience high levels of discrimination, cancer patients are up to 18 times more likely to receive poor care. Other research has shown links of management style and patient experience,[3] and the impact of work-related stress on staff.[4]

6. Conclusion

6.1 The cancer specialist workforce is and will continue to be pivotal in delivering person centred care and consistency for patients. There is overwhelming evidence that having a CNS is a powerful positive factor in patient experience and leads to joined-up care. Therefore, maintaining, utilising and, where needed, increasing the specialist workforce is essential.

6.2 Person centred care is a primary mechanism to empowering patients to jointly own their treatment and improve their experience of care. The workforce is a vital component of consistently delivering person centred care that is well served by the use of holistic needs assessment and written care plans offered to the patient.

6.3 We believe that whilst data on workforce gaps are important, parity should be given to a focus around quality of the workforce. Ensuring changes in culture to reflect a person centred approach should be considered as important to meeting demand and improving quality.

For any further information regarding this response, please contact Lowri Griffiths, Policy & Public Affairs Manager, Wales – [redacted]

[3] Point of Care Foundation (2014) Staff care: How to engage staff in the NHS and why it matters London: The point of care foundation. Available at: http://www.pointofcarefoundation.org.uk/Downloads/Staff-Report-2014.pdf (accessed September 2015)

[4] Maben J, Adams M, Robert G, Peccei R, Murrells T. (2012) Poppets and Parcels: the links between staff experience of work and acutely ill older peoples' experience of hospital care International Journal of Older People Nursing: Special Issue: Acute Care. 7(2):83-94.

WF 04
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Cŵn Tywys Cymru
Response from: Guide Dogs Cymru

[Via email]

Consultation

Inquiry into the sustainability of the health and social care workforce

Guide Dogs Cymru welcomes the Committee's inquiry into the sustainability of the health and social care workforce in Wales.

The Committee will wish to note that we have recently published the attached research study of habilitation service provision for children and young people with a vision impairment in Wales.

This study provides an up-to-date picture of the declining workforce that is supporting children and young people in Wales who are visually impaired.

The study does suggest that Local Authorities in Wales are not providing the levels of service that match the expectations of the Social Services and Well-being (Wales) Act Codes of Practice. Across the whole of Wales there are only 8.6 FTE children's habilitation specialists with 10 Local Authorities not employing any. We estimate the number employed, directly or indirectly, should be between 15-19 FTE to meet need. Our view is that the current workforce is unable to meet the needs of visually impaired children and young people and this is something the Committee should urgently investigate.

A particular concern is that 50 per cent of Local Authorities provide no service or a reduced service in school holiday time.

The Welsh Government needs to be held to account about these matters. Unless things improve children and young people in Wales with

visual impairment will fail to achieve their full potential and will be unable to take advantage of life chances.

Guide Dogs Cymru are happy to provide any further information that the Committee may require.

Guide Dogs Cymru
5 September 2016.

Tel [redacted]

Email [redacted]

Astudiaeth Ymchwil O Ddarpariaeth Gwasanaeth Cymhwyso Ar Gyfer Plant A Phobl Ifainc Sydd Â Nam Ar Y Golwg Yng Nghymru Mai 2016

Peter R Jones
Blind Children UK Cymru, Adeilad 3, Parc Busnes Dwyreiniol, Llaneirwg, Caerdydd, CF3 5EA

1. Crynodeb Gweithredol

Daeth Blind Children UK Cymru yn rhan o deulu Guide Dogs yn 2013. Mae Blind Children UK Cymru yn cefnogi plant a phobl ifainc sy’n ddall a gwan eu golwg a’u teuluoedd, trwy gynni hyfforddiant cymhwyso a gwasanaethau cefnogi. Caiff hyfforddiant a chefnogaeth mewn medrau symudoldeb, cyfeiriadedd ac annibyniaeth eu cyflenwi ar hyn o bryd trwy gyfrwng rhaglen “Movement Matters” (gwelir crynodeb o’r rhaglen hon yn Atodiad G).

Argymhella Blind Children UK Cymru y dylai’r holl blant a phobl ifainc sydd â nam ar y golwg yng Nghymru gael mynediad at hyfforddiant cymhwyso sy’n glynu wrth y ‘Quality Standar in the Delivery of Habilitation Training’1 yn ôl y galw. (Mae’r ‘Quality Standards’ yn rhoi llinell sylfaen ar gyfer ymarfer cymhwyso ac yn rhagnodi’r medrau, yr wybodaeth a’r dealltwriaeth sydd eu hangen gan y rhai sy’n cyflwyno hyfforddiant o’r fath a beth y gallesid disgwyl iddynt ei gyflwyno; maent hefyd yn cynnwys y deilliannau dysgu disgwyliedig ar gyfer y plant a’r bobl ifainc dan hyfforddiant sy’n colli golwg) (Miller. Et al, 2012). Yn 2012, datgelodd adroddia o’r enw “Growing up and Moving On” 2 bod darpariaeth gwasanaethau cymhwyso ar draws Cymru yn anghyson iawn gyda deg Awdurdod Lleol yn darparu dim gwasanaethau o gwbl (Kelleher 2012). Comisiynwyd yr astudiaeth bresennol gan Blind Children UK Cymru gyda’r nod o ymchwilio’r lefelau presennol o gymhwyso ar gyfer plant a phobl ifainc dall a gwan eu golwg yng Nghymru yn ôl fel y crybwyllir gan Awdurdodau Lleol, er mwyn adeiladu cysylltiadau ychwanegol gyda Phenaethiaid Gwasanaethau Cymdeithasol a chomisiynwyr gwasanaethau ac i hysbysu mudiadau partner yn y sector colli golwg a Llywodraeth Cymru. Wrth wraidd y nodau hyn y mae awydd cryf gan Blind Children UK Cymru i wella

gwasanaethau yng Nghymru i blant a phobl ifainc sydd â nam ar y golwg.

Y darganfyddiadau allweddol yw bod bylchau yn narpariaeth gwasanaeth wedi cynyddu ers 2012 sy’n meddwl bod dirywiad cyson wedi bod yn lefel y gefnogaeth a ddarperir gan Awdurdodau Lleol i blant a phobl ifainc yng Nghymru sydd â nam ar y golwg. Mae’r dystiolaeth a gasglwyd yn cefnogi’r darganfyddiadau allweddol hyn:

- Mae’n achos pryder nad yw Awdurdodau Lleol yn adnabod pob plentyn a pherson ifanc sydd â nam ar y golwg yn iawn, o gymharu’r data a grybwyllwyd ganddynt â data cyffredinolrwydd y Swyddfa Ystadegau Gwladol.
- Ar draws Cymru gyfan does dim ond 8.6 o arbenigwyr cymhwyso i blant sy’n gyfwerth ag amser llawn ar gael gydag 10 Awdurod Lleol yn cyflogi dim un. Amcangyfrifwn y dylai’r nifer a gyflogir, yn uniongyrchol neu’n anuniongyrchol, fod rhwng 15 a 19 sy’n gyfwerth ag amser llawn i ddiwallu’r angen.
- Mae nifer athrawon arbenigol y rhai sydd â nam ar y golwg wedi gostwng gan 12 y cant ers 2012 tra bo’r baich achosion o blant wedi dangos cynnydd bychan.
- Mae gweithwyr cymdeithasol arbenigol (nam ar y golwg) bron wedi diflannu o Gymru gyda dim on 3.2 sy’n gyfwerth ag amser llawn ar ôl ac mae’r rhain wedi’u neilltuo’n bennaf ar gyfer timau oedolion.
- Mae’r mwyafrif llethol o swyddogion ailgymhwyso sy’n cefnogi plant yn gweithio’n bennaf mewn gwasanaethau i oedolion.
- Dim ond 55 y cant o Awdurdodau Lleol sy’n defnyddio’r fframwaith ansawdd er penderfynu cymhwyster i wasanaethau, sef y ‘National Sensory Impairment Partnership’. Dim ond Gwent a Chaerdydd sy’n crybwyll cynnwys rhieni a phlant yn y broses o wneud penderfyniadau.
- Dylai gweithredu mewn dull sy’n canolbwyntio ar unigolion gan gynnwys plant a phobl ifainc fod wrth galon y penderfyniadau a wneir gan bob awdurdod lleol.
- Nid yw 50 y cant o Awdurdodau Lleol yn darparu gwasanaeth na gwasanaeth wedi’i leihau yn ystod gwyliau’r ysgol.
- Dangosodd y gwaith o gasglu data bod diffyg cysylltiad yn aml rhwng addysg a gwasanaethau cymdeithasol o ran cydweithio a chyd-drefnu gwasanaethau cymhwyso.
- Yn gyffredinol nid yw’n ymddangos bod lefelau gwasanaeth yn cyd-fynd â Chodau Ymarfer Deddf Gwasanaethau

Cymdeithasol a Llesiant (Cymru) o ran gwasanaethau cymhwyso plant.

2. Cyflwyniad

Amcangyfrifir bod 40,000 (plant a phobl ifainc) hyd at 25 oed sydd â nam ar y golwg digon difrifol i fod angen cefnogaeth arbenigol yn y DU. O’r rhain mae oddeutu 25,000 dan 16 oed:

- Lloegr – 34,000 (oddeutu 21,400 dan 16 oed)
- Yr Alban – 3,235 (oddeutu 1,970 dan 16 oed)
- **Cymru – 1,935 (oddeutu 1,180 dan 16)**
- Gogledd Iwerddon – 1,260 (oddeutu 810 dan 16 oed)

Ffynhonnell: RNIB 2013[3]

Mae’r ateb i alluogi a chefnogi plant a phobl ifainc sydd â nam ar y golwg i gyrraedd eu llawn botensial i’w gael yng nghyflenwad hyfforddiant cymhwyso a gwasanaethau cefnogi cynhwysfawr yn ôl y Safonau Ansawdd gyda phwyslais arbennig ar ymyriad ar ôl diagnosis yn y blynyddoedd cynnar. Mae rhoi amser i’r blynyddoedd cynnar a chynnal cefnogaeth nes tyfu’n oedolion yn hanfodol os yw plant a phobl ifainc i gael y cyfle gorau i fod yn oedolion annibynnol, ymreolus a chyflogadwy. Cyfeirnodir cymhwyso yn yr Ymarfer Codau newydd a rhoddir arweiniad ar ymarfer swyddogaethau’r gwasanaethau cymdeithasol a threfniadau partneriaeth mewn perthynas â rhan 2 (Swyddogaethau Cyffredinol) Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014. Mae paragraffau185-186 y Cod yn dweud:

Mae cymhwyso yn ganolog o ran galluogi plant ac oedolion ag anabledd i fyw mor annibynnol â phosibl fel ag y mae’n allweddol i feithrin a datblygu medrau a fyddai fel arall yn cael eu dysgu’n ddamweiniol. Mae’n hanfodol os yw’r unigolyn wedi methu datblygu’r medrau hynny neu’n hwyr yn gwneud hynny. Mae adnabod gwasanaethau ataliol sy’n helpu pobl i ddysgu, cadw neu wella medrau a gallu swyddogaethol yn hanfodol er hyrwyddo lles. Fel gydag ailalluogi, dylai cymhwyso effeithiol gefnogi anghenion corfforol, synhwyraidd, cymdeithasol ac emosiynol a chael ei gyflwyno mewn partneriaeth rhwng yr awdurdod lleol a’r Bwrdd Iechyd Lleol. Gall cefnogaeth gymhwyso fod yn wahanol i wasanaethau ailalluogi safonol a bydd gofyn dull gweithredu gwahanol; gall un sy’n canolbwyntio ar gefnogaeth benodol fod yn wahanol i wasanaethau ailalluogi safonol ac anghenion yr unigolyn a’i deulu. O ganlyniad, bydd gofyn am raglen cefnogaeth mwy adeiledig am gyfnod hwy. Dylai ailalluogi a chymhwyso effeithiol

gael eu cyflwyno mewn partneriaeth rhwng yr awdurdod lleol a’r GIG.

Mae Blind Children UK Cymru yn cefnogi safbwynt Llywodraeth Cymru’n gryf ynghylch pwysigrwydd cyflenwi cymhwyso yn ôl fel y’i gwelir yn eu Cod Statudol newydd.

3. Dulliau

Cafodd Arolwg Cymhwyso Plant ei weithredu gan dîm Blind Children UK Cymru gyda chymorth gan Strategaeth Cŵn Tywys a Nicola Crews, Cynghorwr Ymgynghorol ac Addysgol RNIB Cymru. Gwnaed arolwg i gael ciplun o wasanaethau cymhwyso o 22 o Awdurdodau Lleol yn Nghymru ym Mehefin/Hydref 2015. Roedd yr arolwg dwyieithog yn wirfoddol ac fe’i gweithredwyd trwy gyfrwng holiadur drwy’r post a ddilynwyd gan nodyn atgoffa drwy’r post. Anfonwyd yr arolwg at y Prif Weithredwr ym mhob Awdurdod Lleol yn y gobaith y byddai hyn yn annog ymatebion ar y cyd gan addysg a gwasanaethau cymdeithasol (o ystyried bod y ddau yn gallu darparu gwasanaethau cymhwyso). Roedd hefyd waith atodol helaeth un ai dros y ffôn, trwy e-bost neu gyfarfodydd wyneb yn wyneb gyda’r person a gwblhaodd yr arolwg i geisio sicrhau bod y data a ddychwelwyd mor gywir â phosibl. Digwyddodd y gwaith maes rhwng Mehefin 2015 a Thachwedd 2015. Gellir cael copïau o’r holiadur gan Peter Jones o Blind Children UK Cymru (01189 838 746).

Roedd yr ymateb terfynol gant y cant er bod nifer o Awdurdodau Lleol wedi cyflwyno dychweliadau ar y cyd a ddatgelai drefniadau gweithio lleol partneriaethol. Mae hwn yn raddfa ymateb eithriadol i arolwg gwirfoddol ac fe hoffem fynegi ein diolchgarwch llwyr am hyn i’r holl Awdurdodau Lleol yng Nghymru.

4. Canlyniadau

Nifer y plant sydd â nam ar y golwg a’r nifer sy’n cael mynediad at wasanaethau cymhwyso – Atodiad A

Mae cyfanswm y plant a’r bobl ifainc sydd â nam ar y golwg yng Nghymru a adnabyddir yn yr arolwg hwn fwy neu lai yr un fath â’r nifer a adroddwyd yn adroddiad 2012 Kelleher, sef oddeutu 1,500. Mae’n achos pryder bod data cyffredinolrwydd Swyddfa’r Ystadegau Gwladol yn amcangyfrif y dylai’r nifer fod yn 1,935. Mae hyn yn ddiffyg o 22 y cant ac efallai’n awgrymu nad yw’r Awdurdodau Lleol yn adnabod yr holl blant a’r bobl ifainc sydd â nam ar y golwg. Aeth 23 y cant o blant a phobl ifainc sydd â nam ar y golwg at wasanaethau cymhwyso yn y chwe mis cyn i’r ffurflen arolwg gael ei chwblhau. Roedd y canran uchaf

o blant a phobl ifainc a gafodd wasanaeth, o fewn yr amrediad oedran 5-11, yn 33 y cant a’r canran isaf, o fewn yr amrediad oedran 17-19, yn 14 y cant. I’r rhai rhwng 0 a 4 mlwydd oed roedd yn nifer yn 24 y cant. Mae’r amrediadau oedran eraill i gyd o fewn amrediad 19-29 y cant sy’n agos at y cyfartaledd cyffredinol o 29 y cant. Mae’r dystiolaeth yn amhendant pa un a oes unrhyw gefnogaeth arbennig yn cael ei ddarparu i roi cymorth trwy gefnogaeth ychwanegol pan fydd plant a phobl ifainc yn gwneud trawsnewid rhwng gwahanol leoliadau neu ysgolion. Yr hyn sy’n eglur yw na chafodd oddeutu dri chwarter y plant a’r bobl ifainc yng Nghymru sydd â nam ar y golwg unrhyw gefnogaeth cymhwyso yn y chwe mis cyn i’r ffurflen arolwg gael ei chwblhau.

Roedd gan fwy na hanner y plant a’r bobl ifainc oedd yn cael cefnogaeth ddatganiad anghenion addysgol arbennig. Bydd ar Lywodraeth Cymru angen ystyried hyn os byddant yn cyflwyno’r ddeddfwriaeth ADY arfaethedig fydd yn rhoi cynlluniau datblygu unigolion yn lle’r datganiadau. Ar gyfer plant a phobl ifainc sydd â nam ar y golwg bydd angen i gefnogaeth arbenigol allanol gael ei ddarparu bob amser o’r tu allan i’r ysgol a byddem yn awgrymu bod yn rhaid i unrhyw ddeddfwriaeth ADY Cymreig newydd wneud hyn yn glir.

A yw gwasanaethau cymhwyso ar gael i blant a phobl ifainc sydd â nam ar y golwg mewn Awdurdodau Lleol? – Atodiad B

Hawliodd pob Awdurdod Lleol eu bod yn darparu gwasanaethau cymhwyso. Nid yw wyth o’r Awdurdodau Lleol yn darparu dim gwasanaeth neu wasanaeth cyfyngedig yn unig yn ystod gwyliau ysgol. Mynegodd un Awdurdod Lleol, Ceredigion, nad oedd gwasanaeth ar gael oherwydd absenoldeb swyddog symudoldeb. Nid yw Awdurdod Lleol arall, sef Gwynedd, yn darparu ‘darpariaeth o fewn gwasanaeth’ ond mae’n prynu gwasanaethau gan bartneriaid allanol.

Y nifer o arbenigwyr plant – Atodiad C

Yn ôl ymatebion yr arolwg y mae 8.6 (cyfwerth ag amser llawn) o arbenigwyr cymhwyso ar gyfer plant yn cael eu cyflogi gan Awdurdodau Lleol yng Nghymru. Nid oes gan wyth Awdurdod Lleol arbenigwyr cymhwyso i blant, ond, o’r rhain, mae Gwynedd yn prynu gwasanaethau yn ôl y galw gan Blind Children UK Cymru a Chymdeithas Deillion Gogledd Cymru. Mae hyn yn fwlch brawychus mewn darpariaeth gwasanaeth o ystyried Canllawiau Cod Ymarfer statudol y Gwasanaethau Cymdeithasol a gyhoeddwyd gan Lywodraeth Cymru (gweler uchod). Ni fentrodd yr arolwg chwilio i weld a oedd arbenigwyr cymhwyso’r plant y sonwyd amdanynt â chymwysterau digonol. Fodd

bynnag, dengys ciplun o aelodau o ‘Habilitation VI UK’ yng Nghymru a gymerwyd yn Hydref 2015 bod un ar bymtheg o bobl yn gweithio yn yr Awdurdodau Lleol Cymreig. Mae hyn fwy neu lai yr un fath â’r 8.6 cyfwerth ag amser llawn a adroddwyd yn ein harolwg ac awgrymir bod y nifer a adroddir â chymwysterau digonol. Credwn hefyd, o ganlyniad i’n gwaith data atodol, bod pob arbenigwr cymhwyso plant â chymwysterau digonol.

Mae’r nifer o arbenigwyr symudoldeb sy’n gyfwerth ag amser llawn yn hyd yn oed is, sef 7.1 sy’n gyfwerth ag amser llawn. Nid yw 50 y cant o Awdurdodau Lleol yn cyflogi arbenigwyr symudoldeb.

Mae pob Awdurdod Lleol yn cyflogi athrawon arbenigol y rhai sydd â nam ar y golwg. Mae’r nifer a adroddir yn 36.5 sy’n gyfwerth ag amser llawn, sy’n ostyngiad o 12 y cant ers adroddiad Elaine Kelleher yn 2012. Mae grŵp o bobl yn ymroddi i’r gwaith o wella’r argyfwng staffio parhaus hwn. Mae ‘All Wales Sensory Group’ wedi ei sefydlu i ddelio â rhai o’r problemau staffio / hyfforddiant / ymarfer cyffredin. Mae hwn yn grŵp newydd wedi’i sefydlu dan / sy’n atebol i CCAC (Cymdeithas Cyfarwyddwyr Addysg yng Nghymru). Mae’n cynnwys cynrychiolwyr o RNIB Cymru, Sense Cymru, NDCS Cymru, Llywodraeth Cymru (Rhwydwaith Mewnol, Cwricwlwm, Cymwysterau a Bwrdd Cyfarwyddwyr Cefnogi Dysgu) a chynrychiolwyr a ddewiswyd o holl sector Nam Synhwyraidd yr Awdurdodau Lleol. Mae cefnogaeth i’r grŵp wedi bod yn dda, gan amlygu’r gydnabyddiaeth o’r argyfwng staffio presennol a’r awydd i weithio ar y cyd i chwilio am atebion.

Nifer y gweithwyr cymdeithasol arbenigol (nam ar y golwg) – Atodiad CH

Nid yw’r mwyafrif o Awdurdodau Lleol, 82 y cant, yn cyflogi gweithwyr cymdeithasol arbenigol ar gyfer pobl sydd â nam ar y golwg.

Mae lleihad sylweddol wedi bod yn nifer y staff sy’n gyfwerth ag amser llawn ar y cyfan yn y categori hwn ers 2012, yn disgyn o 8.7 i 3.2 o’r rhai sy’n gyfwerth ag amser llawn.

Nifer y swyddogion ailgymhwyso (nam ar y golwg) – a gyflogir gan Awdurdod Lleol neu a brynir gan asiantaeth nad yw’n Awdurdod Lleol – Atodiadau D ac Dd

Cofnodir cyfanswm y swyddogion ailgymhwyso, sy’n gyfwerth ag amser llawn, a gyflogir yng Nghymru i weithio gyda phlant a phobl ifainc yn 15. Mae hyn yn cymharu ag 16.9 a adroddwyd yn 2012 sydd fwy neu lai yr

un fath. Adroddir bod y mwyafrif llethol o’r swyddogion ailgymhwyso hyn yn gweithio’n bennaf mewn gwasanaethau i oedolion.

Meini prawf cymhwyster a phwy sy’n penderfynu a fydd gwasanaeth yn cael ei ddarparu – Atodiad E

Mae 55 y cant o Awdurdodau Lleol yn defnyddio fframwaith y ‘National Sensory Impairment Partnership’ i benderfynu cymhwyster ar gyfer gwasanaethau. Mae pob Awdurdod Lleol arall yn defnyddio rhyw fath o asesiad sy’n dibynnu ar angen.

Mae darlun cymysg ar draws yr Awdurdodau Lleol o ran pwy sy’n penderfynu a fydd gwasanaeth yn cael ei ddarparu. Cadarnha naw Awdurdod Lleol bod yr Athro Cymwysedig Disgyblion â Nam ar eu Golwg, ACDNG, yn chwarae rôl sylweddol yn y broses o wneud penderfyniad. Enwir swyddogion ailgymhwyso ac arbenigwyr cymhwyso hefyd fel rhai sy’n cymryd rhan yn y broses o wneud y penderfyniad. Mae llawer o dystiolaeth o asesu ar y cyd rhwng y gwasanaethau cymdeithasol ac addysg. Dim ond gwasanaeth Gwent, sy’n cynnwys pum Awdurdod Lleol, a Chaerdydd sy’n crybwyll trafodaethau â defnyddwyr gwasanaeth (plant, pobl ifainc a rhieni) yn y broses o wneud penderfyniad.

Lleoliadau ar gyfer gwasanaethau cymhwyso - Atodiad F

Darpara’r mwyafrif o Awdurdodau Lleol wasanaethau cymhwyso ar gyfer plant a phobl ifainc ym mhob lleoliad yn ôl fel y diffinnir gan y Safonau Ansawdd. Yr eithriad yw Ceredigion sy’n mynegi mai dim ond mewn lleoliadau addysg y maent yn darparu gwasanaeth.

Yr adegau y bydd gwasanaethau cymhwyso ar gael i blant a phobl ifainc – Atodiad Ff

Mae pob Awdurdod Lleol yn darparu gwasanaethau cymhwyso yn ystod y tymor. Nid yw chwech o’r Awdurdodau Lleol yn darparu unrhyw wasanaeth yn ystod y gwyliau ac mae pump arall yn darparu gwasanaeth wedi’i leihau. Golyga hyn bod hanner cant y cant o Awdurdodau Lleol yn darparu dim gwasanaeth neu wasanaeth llai yn ystod gwyliau’r ysgol.

5. Trafodaeth

Anfonwyd yr arolwg i’r Prif Weithredwr ym mhob Awdurdod Lleol yn y gobaith y byddai hyn yn annog ymatebion ar y cyd gan addysg a gwasanaethau cymdeithasol (a derbyn bod y ddau yn medru darparu gwasanaethau cymhwyso). Digwyddodd hyn mewn rhai achosion ond gyda llawer cafwyd effaith blwyfol gyda dim ond un gwasanaeth yn

darparu data. Awgryma’r ymatebion o’r gwaith casglu data bod diffyg cysylltiad yn aml rhwng addysg a gwasanaethau cymdeithasol a amlygir gan ddiffyg eglurder rhwng gwasanaethau mewn perthynas â phwy oedd yn darparu pa wasanaethau i’r plant a’r bobl ifainc sydd â nam ar y golwg. Gwnaeth arbenigwr ar addysg mewn un awdurdod y sylw canlynol, sy’n crynhoi’r diffyg cysylltiad – “Buasai gen i ddiddordeb mawr mewn cysylltiad pellach â chydweithwyr ynghylch cefnogaeth gwasanaethau cymdeithasol i blant sydd â nam ar y golwg ar hyn o bryd, gan fod hwn yn faes sydd yn heriol iawn i ni – clywais fod arnon ni angen cyfeirio plant trwy broses Plant mewn Angen safonol a dim ond os oedd pryderon yn ymwneud â phroblemau Plant mewn Angen yn ogystal â’u hanabledd.” **Ni ddylai** plant a phobl ifainc sydd â nam ar y golwg orfod dibynnu ar atgyfeiriad plentyn mewn angen er mwyn cael mynediad at wasanaethau cymhwyso.

Gweithredwyd yr arolwg yng nghanol heriau difrifol a pharhaus i gyllidebau Awdurdodau Lleol yng Nghymru. O ran gwasanaethau cymhwyso i blant a phobl ifainc, ymddengys bod y dystiolaeth a gasglwyd yn ddigalon.

Amlyga’r data a gasglwyd trwy gyfrwng yr arolwg bod Awdurdodau Lleol yn annhebygol o fod yn adnabod pob plentyn a pherson ifanc sydd â nam ar y golwg yn iawn o’i gymharu â ffynonellau data eraill, e.e. data cyffredinolrwydd y Swyddfa Ystadegau Gwladol. Yr hyn sy’n amlwg yw bod dirywiad sylweddol wedi bod ers 2012 yn y lefelau cefnogaeth a ddarperir gan Awdurdodau Lleol i blant a phobl ifainc sydd â nam ar y golwg**.**

Mae pob Awdurdod Lleol yn dweud eu bod yn darparu gwasanaethau cymhwyso, er bod wyth yn cyfaddef nad ydynt yn darparu unrhyw wasanaeth neu’n darparu gwasanaeth cyfyngedig yn ystod gwyliau’r ysgol. Ochr yn ochr â hyn mae’n rhaid i ni ystyried nad oes ond 8.6 o arbenigwyr cymhwyso i blant sy’n gyfwerth ag amser llawn yn gweithio yng Nghymru. Yn ei dro, rhaid ystyried hyn ochr yn ochr a’r ffaith ei bod hi’n bosibl bod 1,500 o blant a phobl ifainc sydd angen y gwasanaeth hwn. Nid yw wyth Awdurdod Lleol yn cyflogi arbenigwr cymhwyso i blant er bod un o’r rhain yn prynu yn ôl y galw gan ddarparwyr o’r trydydd sector. Ni chasglwyd data i weld a oedd y staff hyn â chymwysterau digonol ond roedd ein gwaith atodol yn awgrymu hynny.

Fe ŵyr Blind Children UK Cymru trwy flynyddoedd lawer o brofiad o ddarparu gwasanaeth bod arbenigwr cymhwyso hollol gymwys mewn cytundeb o bum diwrnod yr wythnos yn medru gweithio gydag oddeutu 40-50 plentyn y flwyddyn (cymysgedd o ymyriadau byr, canolig a mwy

hirdymor). Y casgliad a geir o feini prawf estynedig NatSIP, sydd ar ddod, ar gyfer dosbarthu cefnogaeth cymhwyso yw y dylai pob plentyn sydd â nam ar y golwg gael asesiad gan arbenigwr cymhwyso cymwysedig. Ar sail hynny awgryma Blind Children UK Cymru y dylai Awdurdodau Lleol Cymreig, yn ddelfrydol, weithio tuag at gael 1 arbenigwr cymhwyso cymwysedig i bob cant o blant a phobl ifainc sydd â nam ar y golwg neu o bosibl 1 arbenigwr cymhwyso cymwysedig ac un cynorthwy-ydd cymhwyso cymwysedig i bob cant a hanner o blant a phobl ifainc. Mae’r Awdurdodau Lleol Cymreig yn adnabod oddeutu 1,500 o blant a phobl ifainc sydd â nam ar y golwg (o’i gymharu â 1,900 a amcangyfrifir gan y Swyddfa Ystadegau Gwladol). Ni all y lefel bresennol o 8.6 o arbenigwyr cymhwyso cymwysedig sy’n gyfwerth ag amser llawn a gyflogir gan Awdurdodau Lleol Cymreig ddiwallu anghenion 1,500-1,900 o blant a phobl ifainc. Un ai mae angen ar i lefelau staffio gynyddu neu dylid trefnu gwell partneriaethau gweithio â darparwyr addas o’r trydydd sector.

Dim ond 7.1 sy’n gyfwerth ag amser llawn yw’r nifer o arbenigwyr symudoldeb ac nid yw hanner cant y cant o Awdurdodau Lleol yn cyflogi yr un. Mae’r darlun yn waeth hyd yn oed ar gyfer gweithwyr cymdeithasol arbenigol ar gyfer y rhai sydd â nam ar y golwg gyda dim ond 3.2 bellach sy’n gyfwerth ag amser llawn yn gweithio yng Nghymru. Ymddengys bod heriau i gyllidebau’r gwasanaethau cymdeithasol yn meddwl bod gwasanaethau arbenigol ar gyfer plant a phobl ifainc sydd â nam ar y golwg ar fin diflannu. Mae ar blant a phobl ifainc sydd â nam ar y golwg angen cael mynediad at wasanaethau a staff proffesiynol, cymwysedig sydd â’r wybodaeth arbenigol berthnasol, sy’n deall yr anghenion ac yn gallu rheoli asesiadau cynhwysfawr a darparu’r gefnogaeth sydd ei hangen.

Ochr yn ochr â hyn mae nifer yr Athrawon Cymwysedig Disgyblion â Nam ar eu Golwg yn dal i ostwng ond mae’r ‘All Wales Sensory Group’ newydd yn edrych ar hyn. Mae nifer y swyddogion ailgymhwyso yng Nghymru sy’n gweithio gyda phlant a phobl ifainc wedi aros yn gymharol sefydlog ers 2012 er bod y staff sy’n ymrwymo i wneud y gwaith hwn yn gweithio yn bennaf o fewn gwasanaethau i oedolion.

Mae’r gostyngiad amlwg hwn mewn lefelau staffio’n gyffredinol ers 2012 yn awgrymu bod yr heriau mewn cyllidebau Awdurdodau Lleol yn cael effaith gref ar y gwasanaethau sydd ar gael i gefnogi plant a phobl ifainc dall a gwan eu golwg. Ni ellir pwysleisio’n ddigon cryf bod gwasanaethau yn methu dal llawer mwy a rhaid gwneud rhywbeth o ddifrif i wella comisiynu a darparu gwasanaethau.

Roedd yn galonogol gweld bod mwy na hanner yr Awdurdodau Lleol yn defnyddio rhyw fath o feini prawf asesu, fel fframwaith y NatSIP, i benderfynu cymhwyster a cheir tystiolaeth o weithio ar y cyd rhwng arbenigaethau yn y broses o wneud y penderfyniad. Roedd yn siomedig mai dim ond gwasanaeth Gwent a Chaerdydd sy’n crybwyll bod cwsmeriaid (rhieni a phlant) yn cymryd rhan y broses asesu. Mae hyn yn groes i reoliadau Llywodraeth Cymru sy’n disgwyl proses asesu sy’n canolbwyntio ar y plant a’r bobl ifainc, yn cefnogi hawliau plant a phobl ifainc i gael sgyrsiau llawn parch am eu lles ac ymarfer llais cryf a rheolaeth yn y penderfyniadau am y gwasanaethau maent yn eu derbyn.

Yn y mwyafrif o’r ardaloedd yng Nghymru darperir gwasanaethau cymhwyso yn y cartref, yn yr ysgol ac yn yr amgylchedd cyhoeddus yn ôl y Safonau Ansawdd. Fodd bynnag, mae gwasanaeth yn wael ar draws Cymru yn ystod gwyliau’r ysgol sy’n achos pryder mawr. Rhaid i gefnogaeth y mae ar blant ei angen i ddatblygu, a dod yn feistri ar fedrau byw’n annibynnol, fod yn gyson ac nid yn ddibynnol ar galendr yr ysgol. Mae angen mynd i’r afael â’r diffyg gwasanaeth hwn sy’n bodoli am 25 y cant o’r flwyddyn galendr.

6. Diweddglo

O ran y nod cyntaf mae canlyniadau’r arolwg yn rhoi ciplun manwl o lefelau cymhwyso ar gyfer y deillion a’r rhai gwan eu golwg ym Medi/Tachwedd 2015 yng Nghymru. Effaith ychwanegol o weithredu’r arolwg yw ei fod wedi codi proffil gwasanaeth ‘Movement Matters’ a ddarperir gan Blind Children UK Cymru ac wedi agor sgwrs rhwng llawer o’r Awdurdodau Lleol yng Nghymru. Bydd yr adroddiad yn darparu cyfle i Awdurdodau Lleol brisio gwerth eu gallu presennol o ran arbenigwyr cymhwyso plant gyda’r bwriad o adnabod cyfleoedd ar gyfer cydweithredu i ddarparu’r gwasanaethau hyn.

Bydd yr adroddiad yn cael ei rannu â holl fudiadau’r trydydd sector sy’n gweithio gyda phobl sydd wedi colli eu golwg yng Nghymru. Ni fydd y dirywiad parhaus mewn gwasanaethau i blant a phobl ifainc yn syndod o gwbl iddynt. Mae’r adroddiad yn darparu tystiolaeth wedi’i ddiweddaru i gefnogi ymgyrchoedd er mwyn sicrhau bod gan blant a phobl ifainc sydd wedi colli eu golwg fynediad at wasanaethau sydd eu hangen arnynt i hyrwyddo annibyniaeth ac ansawdd bywyd. Mae’r adroddiad hefyd yn amlygu stad argyfyngus gwasanaethau cymhwyso. Mewn rhannau o Gymru mae arwyddion clir bod staff sydd â medrau arbenigol yn cael eu colli a dangosir ei bod yn anodd iawn cael rhai yn eu lle.

Yn olaf, mae canlyniadau’r arolwg yn galw ar Lywodraeth Cymru a’r Awdurdodau Lleol i ddeffro. Mae Deddf y Gwasanaethau Cymdeithasol

a Llesiant (Cymru) 2014 a’r Ymarferion Cod cysylltiedig yn ymwneud llawer â mynd i’r afael â phroblemau yn gynnar i’w rhwystro rhag gwaethygu a bygwth lles ac annibyniaeth unigolyn. Os na fydd rhywbeth yn cael ei wneud i fynd i’r afael â’r diffygion argyfyngus sy’n cael eu nodi mewn darpariaeth gwasanaeth, wedi’u seilio ar ddata’r Awdurdodau Lleol eu hunain, bydd llawer o blant a phobl ifainc yn Nghymru yn methau â chyrraedd eu llawn botensial ac ni fyddant yn gallu cymryd mantais o gyfleoedd bywyd.

7. Cyfeiriadau

1 Miller, O., Wall, K., a Garner, M. (2011), *‘Quality Standards: Delivery of Habilitation training (Mobility and Independent Living Skills) for Children and Young People with Visual Impairment.* London: Institute of Education, University of London and RNIB
2 Growing Up and Moving On – Service Provision for Children and Young People with Vision Impairment in Wales, Elaine Kelleher, sponsored by Sight Support (September 2012)
3 http://www.rnib.org.uk/knowledge-and-research-hub-research-reports/evidence-based-reviews

Atodiad A – Nifer y plant sydd â nam ar y golwg a’r nifer sy’n cael mynediad at wasanaethau cymhwyso

Awdurdodau Lleol	Plant a Phobl Ifainc sydd â nam ar y golwg sydd â datganiad	Plant a Phobl Ifainc sydd â nam ar y golwg sydd heb ddatganiad	Yn y chwe mis diwethaf faint o blant a phobl ifainc sydd wedi cael mynediad at wasanaethau cymhwyso?	Canran y plant a’r bobl ifainc sydd wedi cael hyfforddiant cymhwyso yn ystod y chwe mis diwethaf.
Sir Fôn a Gwynedd				
0-4 blynedd	0	6	0	0
5-11 mlynedd	28	17	0	0
12-16 mlynedd	6	16	4	18
17-18 mlynedd	2	0	1	50
19-25 mlynedd	1	0	0	0
Pen-y-bont ar Ogwr				
0-4 blynedd	0	13	5	38
5-11 mlynedd	10	26	9	25
12-16 mlynedd	11	36	2	4
17-18 mlynedd	5	0	2	40
19-25 mlynedd	0	18	2	11
Caerdydd				
0-4 blynedd	0	18	7	39
5-11 mlynedd	63	34	51	53
12-16 mlynedd	34	11	26	58
17-18 mlynedd	11	0	3	27
19-25 mlynedd	0	0	0	0
Caerfyrddin				
0-4 blynedd	3	7	1	10
5-11 mlynedd	47	38	16	19
12-16 mlynedd	16	21	4	11
17-18 mlynedd	10	1	1	9
19-25 mlynedd	10	0	3	30

Ceredigion				
0-4 blynedd	0	0	0	0
5-11 mlynedd	0	2	0	0
12-16 mlynedd	2	1	0	0
17-18 mlynedd	0	1	0	0
19-25 mlynedd	0	0	0	0
Conwy				
0-4 blynedd	0	0	0	0
5-11 mlynedd	3	2	0	0
12-16 mlynedd	2	0	0	0
17-18 mlynedd	1	4	0	0
19-25 mlynedd	0	15	0	0
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)				
0-4 blynedd	25*	0	13	52
5-11 mlynedd	131*	0	94	72
12-16 mlynedd	84*	0	49	58
17-18 mlynedd	18*	0	2	11
19-25 mlynedd	0*	0	0	0
Merthyr Tudful				
0-4 blynedd				
5-11 mlynedd	0	2	0	0
12-16 mlynedd	4	4	2	25
17-18 mlynedd	2	4	1	17
19-25 mlynedd	2	0	1	50
	0	0	0	0
CNPT				
0-4 blynedd	3	9	3	25
5-11 mlynedd	27	31	10	17
12-16 mlynedd	10	14	8	33
17-18 mlynedd	6	0	0	0
19-25 mlynedd	0	0	0	0

Sir Benfro				
0-4 blynedd	2	4	5	83
5-11 mlynedd	4	12	4	25
12-16 mlynedd	2	13	0	0
17-18 mlynedd	1	2	0	0
19-25 mlynedd	2	0	2	100
Powys				
0-4 blynedd	0	1	0	0
5-11 mlynedd	5	0	3	60
12-16 mlynedd	4	0	3	75
17-18 mlynedd	5	0	3	60
19-25 mlynedd	24	0	3	13
RhCT				
0-4 blynedd	3	19	2	9
5-11 mlynedd	16	27	7	16
12-16 mlynedd	9	16	8	32
17-18 mlynedd	2	2	0	0
19-25 mlynedd	0	0	0	0
Abertawe				
0-4 blynedd	6	10	3	19
5-11 mlynedd	32	24	18	32
12-16 mlynedd	25	24	14	29
17-18 mlynedd	0	2	0	0
19-25 mlynedd	0	0	0	0
Bro Morgannwg				
0-4 blynedd	0	2	0	0
5-11 mlynedd	37	0	0	0
12-16 mlynedd	20	0	2	10
17-18 mlynedd	25	0	0	0
19-25 mlynedd	0	0	0	0
Wrecsam, Sir Ddinbych a Sir y Fflint				
0-4 blynedd	7	15	4	18
5-11 mlynedd	30	42	16	22
12-16 mlynedd	43	24	11	16
17-18 mlynedd	8	2	1	10
19-25 mlynedd	4	0	4	100

Cyfanswm				
0-4 blynedd	49	106	43	28
5-11 mlynedd	437	259	230	33
12-16 mlynedd	270	180	132	29
17-18 mlynedd	96	14	14	14
19-25 mlynedd	41	33	14	19
Cyfanswm cyfan	**893**	**592**	**433**	**29**

*****methu â darparu manylion rhwng datganiad a rhai nad ydynt yn ddatganiad

Atodiad B - A yw gwasanaethau cymhwyso ar gael i blant a phobl ifainc sydd â nam ar y golwg mewn Awdurdodau Lleol?

Awdurdodau Lleol	Ydynt	Nac ydynt - gyda rhesymau
Sir Fôn/Gwynedd	Dim darpariaeth ‘mewn gwasanaeth’. Symudoldeb yn cael ei ddarparu gan Swyddog Symudoldeb o Gymdeithas Deillion Gogledd Cymru wedi’i leoli yng Ngwasanaethau Cymdeithasol Sir Fôn. Gwynedd – comisiynir gwasanaethau gan Gymdeithas Deillion Gogledd Cymru ar gyfer plant hŷn neu Blind Children UK Cymru ar gyfer y plant ifainc. Trefnir hyn gan wasanaethau plant arbenigol Derwen.	-
Pen-y-bont ar Ogwr	Yn gyffredinol ydynt. Mae’r ddarpariaeth trwy gyfrwng Addysg a/neu Wasanaethau Cymdeithasol gan ddibynnu ar wasanaethau unigol. Does dim cytundeb ffurfiol. Roedd gan Addysg ei Arbenigwyr Symudoldeb ei hun tan yn ddiweddar – byddai arnoch angen cadarnhau ag Addysg beth yw ei ddarpariaeth ar hyn o bryd. O ran plant ifainc, mae Addysg fel arfer yn arwain y ffordd ynghylch unrhyw gymhwyso ond efallai ein bod ni’n ymwneud â medrau byw bob dydd/symudoldeb ar gyfer plant hŷn. Bydd Addysg yn cyfeirio atom ni ynghylch pob plentyn os bydd angen asesiad addasiadau/goleuo.	-
Caerdydd	Gwasanaethau Cymdeithasol – mae dau swyddog symudoldeb. Gwneir atgyfeiriad trwy gyfrwng Athro nam ar y golwg. Addysg – mae dau arbenigwr cymhwyso plant ac arbenigwr symudoldeb cymwysedig sydd, gyda’i gilydd, yn ffurfio swydd llawn amser.	-

Sir Gaerfyrddin	Ydynt	-
Ceredigion	Ydynt ond mae’r swyddog symudoldeb ar seibiant salwch hirdymor ar hyn o bryd.	-
Conwy	Ydynt, un ai trwy gymhwyso a gynigir yn yr ysgol neu yn y gymuned ac mewn rhai achosion trwy leoliad coleg arbennig.	-
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	Ydynt. Gwasanaethau cyfyngedig yn ystod gwyliau’r ysgol. Dywedodd Casnewydd eu bod nhw'n "derbyn atgyfeiriadau eithriadol o gyfyngedig am blant sydd â nam ar y golwg". Byddai hyn yn awgrymu efallai nad yw'r llwybr atgyfeirio yng Nghasnewydd - yn enwedig trwy gyfrwng pobl broffesiynol y maes iechyd - yn gweithio.	-
Merthyr Tudful	Ydynt. Yn cael eu darparu trwy gytundeb lefel gwasanaeth gyda RhCT.	-
CNPT	Ydynt. Yn ystod y tymor mae pob plentyn sydd eu hangen yn cael hyfforddiant symudoldeb a chyfeiriadedd. Y tymor hwn rydyn ni hefyd wedi dechrau cynnig rhaglen o annibyniaeth a medrau byw bob dydd. Eto, dim ond yn ystod y tymor y darperir hon gan ein bod yn gweithio mewn lleoliadau addysg.	-
Sir Benfro	Ydynt	-
Powys	Ydynt. Gall atgyfeiriadau fod yn uniongyrchol, gan ymarferwyr addysg a iechyd neu drwy’r Tîm Plant ag Anableddau neu swyddog cymhwyso Oedolion sydd â Nam ar y Golwg.	-
RhCT	Mae pedwar o Swyddogion Ailgymhwyso (Nam ar y Golwg) wedi’u lleoli yn Nhîm y Gwasanaethau Synhwyraidd yn y Gwasanaethau i Oedolion. Ein rôl gyda phlant a phobl ifainc yw ymgymryd â’r cofrestru (nam ar y golwg difrifol/nam ar y golwg) yn dilyn derbyn Tystysgrif Nam yr y Golwg gan Wasanaeth Llygaid yr Ysbyty. Mae hyn yn ddyletswydd statudol. Rydym ni’n ymgymryd ag	-

	asesu ac yn darparu gwybodaeth a chyngor. Rydym ni’n cysylltu â chydweithwyr yn yr Adran Addysg oherwydd, er ein bod ni’n gallu darparu hyfforddiant symudoldeb ac annibyniaeth, mae gan y staff o fewn Addysg y cymwysterau a llawer mwy o wybodaeth arbenigol i weithio gyda phlant a phobl ifainc. Ein dull ni yw cydweithio ac fe allem ddarparu hyfforddiant yn ystod gwyliau’r ysgol, er enghraifft, petai ein cydweithwyr ym myd Addysg yn gofyn am hyn.	
Abertawe	Ydynt.	-
Bro Morgannwg	Ydynt.	-
Wrecsam, Sir Ddinbych a Sir y Fflint	Ydynt.	-

Atodiad C – Y nifer o arbenigwyr plant

Awdurdodau Lleol	Nifer (cyfwerth ag amser llawn) yr arbenigwyr cymhwyso plant	Nifer (cyfwerth ag amser llawn) yr Arbenigwyr Symudoldeb	Nifer Athrawon Arbeingol Disgyblion â Nam ar y Golwg
Sir Fôn/Gwynedd	0	0	2
Pen-y-bont ar Ogwr	1	0	2
Caerdydd	1	1	6.5*
Sir Gaerfyrddin	0.6	0	2
Ceredigion	0	0.6	0**
Conwy	1	0	2.5
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	1	0	5
Merthyr Tudful	0	0	2
CNPT	0	0.5	1.6
Sir Benfro	0	0	0.9
Powys	1	1	3
RhCT	2	1.5	2.5
Abertawe	1	0	2
Bro Morgannwg	0	1	1.5
Wrecsam, Sir Dinbych a Sir y Fflint		1.5	3
Cyfanswm	**8.6**	**7.1**	**36.5**

*Maent hefyd yn cyflogi 4.6 o gynorthwy-wyr addysgu nam ar y golwg sydd â chymwysterau Braille – nid yw’r rhain wedi’u cysylltu â phlant penodol mewn ysgol ond yn gweithio ar draws y gwasanaeth i gefnogi mynediad at y gwasanaeth a’i adeiladu o fewn ysgolion. Mae arnynt hefyd angen cefnogaeth â symudoldeb a chymhwyso pan fydd angen.
**yn rhannu oddeutu 0.2, cyfwerth ag amser llawn, o gefnogaeth athrawon arbenigol o Sir Gaerfyrddin.

Atodiad CH – Nifer y gweithwyr cymdeithasol arbenigol sy’n gweithio gyda phlant a phobl ifainc

Awdurdodau Lleol	Nifer (cyfwerth ag amser llawn) y gweithwyr cymdeithasol arbenigol (nam ar y golwg)	Gwasanaethau i oedolion	Gwasanaethau i blant
Sir Fôn/Gwynedd	0	0	0
Pen-y-bont ar Ogwr	1	1	0
Caerdydd	0	0	0
Sir Gaerfyrddin	0	0	0
Ceredigion	0	0	0
Conwy	0.7	0.7	0
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	0	0	0
Merthyr Tudful	1	0.5*	0.5*
CNPT	0	0	0
Sir Benfro	0	0	0
Powys	0	0	0
RhCT	0	0	0
Abertawe	0	0	0
Bro Morgannwg	0.5	*	0.5
Wrecsam, Sir Ddinbych a Sir y Fflint	0	0	0
Cyfanswm	**3.2**	**2.2**	**1**

*1 cyfwerth ag amser llawn yn gyfrifol am wasanaethau plant ac oedolion – ni ddarperir manylion amseroedd.

Atodiad D – Nifer y Swyddogion Ailgymhwyso (nam ar y golwg) – sy’n gweithio gyda phlant a phobl ifainc a gyflogir gan Awdurdodau Lleol

Awdurdodau Lleol	Nifer y swyddogion ailgymhwyso (nam ar y golwg) – a gyflogir gan yr ALl	Gwasanaethau i oedolion	Gwasanaethau i blant
Sir Fôn/Gwynedd	0	0	0
Pen-y-bont ar Ogwr	2	2	0
Caerdydd	0	0	0
Sir Gaerfyrddin	4*	4*	0
Ceredigion	0	0	0
Conwy	0	0	0
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	0	0	0
Merthyr Tudful	0	0	0
CNPT	0	0	0
Sir Benfro	2	1**	1**
Powys	3	3	0
RhCT	0	0	0
Abertawe	0	0	0
Bro Morgannwg	0	0	0
Wrecsam, Sir Ddinbych a Sir y Fflint	0	0	0
Cyfanswm	**11**	**10**	**1**

*yn cynnwys cynorthwy-ydd sy’n gwneud asesiadau lefel isel
**dwy swydd cyfwerth ag amser llawn yn gweithio gyda phlant ac oedolion – ni ddarperir manylion ar wahân

Atodiad Dd – Nifer y Swyddogion Ailgymhwyso (nam ar y golwg) – trefniadau prynu gydag asiantaeth sydd ddim yn Awdurdod Lleol sy’n gweithio gyda phlant a phobl ifainc

Awdurdodau Lleol	Nifer y swyddogion ailgymhwyso (nam ar y golwg) – trefniadau prynu gydag asiantaeth sydd ddim yn Awdurdod Lleol	Gwasanaethau i oedolion	Gwasanaethau i blant
Sir Fôn/Gwynedd	0	0	0
Pen-y-bont ar Ogwr	0	0	0
Caerdydd	0	0	0
Sir Gaerfyrddin	0	0	0
Ceredigion	0	0	0
Conwy	1	1	0
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	0	0	0
Merthyr Tudful	0	0	0
CNPT	0	0	0
Sir Benfro	0	0	0
Powys	3	3	0
RhCT	0	0	0
Abertawe	0	0	0
Bro Morgannwg	*	0	*
Wrecsam, Sir Ddinbych a Sir y Fflint	0	0	0
Cyfanswm	**4**	**4**	*

*yn crybwyll peth prynu gwasanaethau plant yn ôl y galw ond ni nodir faint.

Atodiad E - Meini prawf cymhwyster a weithredir a phwy sy’n penderfynu a fydd gwasanaeth yn cael ei ddarparu

Awdurdodau Lleol	Meini prawf cymhwyster	Pwy sy’n penderfynu a fydd gwasanaeth yn cael ei ddarparu
Sir Fôn/Gwynedd	Tystysgrif cofrestru nam ar y golwg; defnydd gwael o olwg swyddogaethol, meysydd gweledol, canfyddiad pellter a chydsymudiad deulygadog fel ag y nodir mewn adroddiadau arbenigol meddygol; cymhwyster ar gyfer darpariaeth yn dilyn asesu priodol gan asiantaethau perthnasol.	Darperir gwasanaeth yn ôl yr angen.
Pen-y-bont ar Ogwr	O fewn gwasanaethau cymdeithasol ‘nam synhwyraidd sylweddol’ ond mae popeth yn dibynnu ar yr wybodaeth wrth atgyfeirio ac wrth gyflwyno problemau; meini prawf NatSIP ochr yn ochr ag asesu golwg swyddogaethol. Hefyd asesu symudoldeb/cymhwyso.	Byddai unrhyw ymholiadau ynghylch darpariaeth gwasanaeth yn mynd at reolwr tîm Annibyniaeth/Lles y gymuned ar gyfer penderfyniad; asesu swyddogaethol Athro Cymwysedig Disgyblion â Nam ar eu Golwg, asesu gan swyddog symudoldeb/cymhwyso.
Caerdydd	Wedi’i seilio ar y prif angen. Mae pob plentyn sy’n gymwys i gael gwasanaeth nam	Arbenigwyr cymhwyso, mewn ymgynghoriad â rhieni, Athrawon Cymwysedig Disgyblion

	ar y golwg yn gymwys i gael yr elfen gymhwyso o’r ddarpariaeth hon. Mae maint y cyflenwi a’r amseru yn dibynnu ar ddymuniadau’r rhieni, dymuniadau’r plentyn, adeg trawsnewid, angen, asesu gan arbenigwyr cymhwyso.	â Nam ar y Golwg, yr ysgol a’r plentyn.
Sir Gaerfyrddin	Mae gwasanaethau i oedolion yn gweithio gydag unrhyw oedolyn dros 18 sydd â nam ar y golwg sy’n dymuno defnyddio’r gwasanaeth. Nid oes rhaid iddynt o reidrwydd fod â nam ar y golwg neu nam difrifol ar y golwg. Bydd Gwasanaethau Plant yn gwneud asesiad o anghenion Cymhwyso ar unrhyw blant a phobl ifainc sydd â nam ar y golwg (gan gyfeirio at Safonau Ansawdd Gwasanaethau Cymhwyso i blant a phobl ifainc sydd â nam ar y golwg; Safonau Ansawdd i Blant a Phobl Ifainc sydd â Nam Synhwyraidd (WAG 2005); Safonau Ansawdd i Blant a Phobl Ifainc sydd â Nam ar y Golwg: Gwybodaeth i Gomisiynwyr a Chynllunwyr	Penderfynir ar ddarpariaeth gwasanaeth ar ôl i’r Swyddog Cymhwyso/Swyddog Ailgymhwyso asesu angen. Pan nodir y byddai plentyn neu berson ifainc yn manteisio o ddarpariaeth ar eu cyfer, mae Rheolwr y Gwasanaeth (plant), neu’r Swyddog Uwch Ailgymhwyso (Oedolion) yn trafod natur/lefel y ddarpariaeth.

	Gwasanaethau.	
Ceredigion	NatSIP	Ar ôl asesiad yn ôl angen meini prawf y cymhwyster
Conwy	-	-
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	Safonau NatSIP	Sgorio ar asesiad meini prawf y cymhwyster a thrafodaeth ag Athro Cymwysedig Disgyblion â Nam ar y Golwg, y rhieni a’r ysgol.
Merthyr Tudful	Fframwaith NatSIP	Rheolwr ADY mewn ymgynghoriad â chydlynydd nam ar y golwg
CNPT	Rydym yn defnyddio Meini Prawf Cymhwyster NatSIP i benderfynu a yw plant i gael cefnogaeth gan ein gwasanaeth. Mae unrhyw blant sydd wedi cael eu hasesu gan Athro Cymwysedig Disgyblion â Nam ar y Golwg ac sy’n cael eu cadw ar ein llwyth gwaith, yna’n cael eu hasesu gan ein Harbenigwr Symudoldeb, sy’n penderfynu a oes angen medrau symudoldeb/byw bob dydd.	Rydym yn defnyddio Meini Prawf Cymhwyster NatSIP i benderfynu a yw plant i gael cefnogaeth gan ein gwasanaeth. Mae unrhyw blant sydd wedi cael eu hasesu gan Athro Cymwysedig Disgyblion â Nam ar y Golwg ac sy’n cael eu cadw ar ein llwyth gwaith, yna’n cael eu hasesu gan ein Harbenigwr Symudoldeb, sy’n penderfynu a oes angen medrau symudoldeb/byw bob dydd.
Sir Benfro	Mae’n rhaid i’r plentyn/person ifanc fod â nam parhaol a sylweddol ar y golwg sy’n effeithio ar ei fedrau byw bob dydd, ei fedrau cyfathrebu a/neu ei fedrau	Swyddog Synhwyraidd Uwch (Swyddog Ailgymhwyso Cymwysedig)

	symudoldeb.	
Powys	Mae nam ar y golwg anghywiradwy yn cael ei atgyfeirio’n uniongyrchol. Ar gyfer Tîm y Plant sydd ag Anableddau, nam synhwyraidd canolig i ddifrifol.	Yn dilyn asesiad nam ar y golwg gan swyddog cymhwyso. Mae’r Tîm Plant ag Anableddau yn penderfynu ar asesiad sy’n eilradd i nam ar y golwg ar gyfer cael asesiad arbenigol a chefnogaeth.
RhCT	Meini prawf cymhwyster NatSIP	Mae’r panel synhwyraidd yn penderfynu gan ddefnyddio meini prawf cymhwyster ac unrhyw wybodaeth ychwanegol berthnasol i’r disgybl.
Abertawe	Mae’r arbenigwyr cymhwyso wedi datblygu eu meini prawf cymhwysedd eu hunain wedi’i seilio ar NatSIP.	Yr arbenigwr cymhwyso
Bro Morgannwg	Asesu yn ôl angen gan Athro Nam ar y Golwg. Os yw’r plentyn yn hysbys i Dîm Iechyd ac Anabledd Plant, bydd asesiad cychwynnol yn cael ei gwblhau.	Bydd un ai yr Athro Nam ar y Golwg neu, os yw o ganlyniad i asesiad cychwynnol, bydd Rheolwr Tîm y Tîm Iechyd ac Anabledd Plant yn awdurdodi.
Wrecsam, Sir Ddinbych a Sir y Fflint	Meini prawf cymhwyster yr Awdurdod Lleol wedi’i seilio ar NatSIP	Awdurdodau Lleol o fewn darpariaeth ranbarthol

Atodiad F – Lleoliadau ar gyfer gwasanaethau cymhwyso

Awdurdodau Lleol	O fewn y cartref a’r amgylchedd	Lleoliadau addysgol (ysgol feithrin/ ysgol/coleg/ prifysgol)	Amgylcheddau cyhoeddus (strydoedd/ siopau lleol/trefi/ defnyddio cludiant cyhoeddus)
Sir Fôn/ Gwynedd	oes	oes	oes
Pen-y-bont ar Ogwr	oes	oes	oes
Caerdydd	oes	oes	oes
Sir Gaerfyrddin	oes	oes (prifysgol – gwasanaeth i oedolion yn unig)	oes
Ceredigion	nac oes	oes	nac oes
Conwy	oes	oes	oes
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen	oes	oes	oes
Merthyr Tudful	oes	oes	oes
CNPT	oes	oes	oes
Sir Benfro	oes	oes	oes
Powys	oes	oes	oes
RhCT	oes	oes	oes
Abertawe	oes	oes	oes
Bro Morgannwg	oes	oes	oes
Wrecsam, Sir Ddinbych a Sir y Fflint	oes	oes	oes

Atodiad Ff – Yr adegau y bydd gwasanaethau cymhwyso ar gael i blant a phobl ifainc

Awdurdodau Lleol	Yn Ystod y Tymor	Gwyliau’r ysgol/coleg/prifysgol	Y ddau
Sir Fôn/Gwynedd	oes	oes	oes
Pen-y-bont ar Ogwr	oes	oes	oes
Caerdydd	oes	oes	oes
Sir Gaerfyrddin	oes	oes (prifysgol – gwasanaeth i oedolion yn unig)	na
Ceredigion	oes	nac oes	nac oes
Conwy	oes	oes	oes
Gwent (Caerffili, Sir Fynwy, Casnewydd, Blaenau Gwent a Thorfaen)	oes	oes (gwasanaeth cyfyngedig)	oes
Merthyr Tudful	oes	nac oes	nac oes
CNPT	oes	nac oes	nac oes
Sir Benfro	oes	oes	oes
Powys	oes	oes	oes
Abertawe	oes	nac oes	nac oes
Bro Morgannwg	oes (trwy gyfrwng addysg)	oes (trwy gyfrwng y gwasanaethau cymdeithasol)	oes
Wrecsam, Sir Ddinbych a Sir y Fflint	oes	nac oes	nac oes

Atodiad G – Arolwg o Wasanaeth ‘Movement Matters Blind Children UK Cymru’

Mae gwasanaeth ‘Movement Matters Blind Children UK Cymru’ yn darparu hyfforddiant i helpu plant a phobl ifainc dall yng Nghymru i symud o gwmpas yn ddiogel ac annibynnol. Mae ‘Movement Matters’ hefyd yn dysgu medrau byw pwysig fel trin arian a pharatoi bwyd. Ar gyfer plant sydd ag anghenion cymhleth ac ychwanegol, gall ‘Movement Matters’ ddarparu rhaglen wedi’i haddasu gan gynnwys ymwybyddiaeth gorfforol, symudoldeb cadair olwyn, defnyddio’r golwg sydd ar ôl a mwy.

Mae plant sydd yn gweld yn dysgu trwy wylio pobl eraill; yn aml mae plant sydd â nam ar y golwg angen dysgu medrau a chysyniadau na fuasent yn gwybod sut i’w gwneud fel arall. Mae ‘Movement Matters’ yn darparu hyfforddiant a chefnogaeth wedi’i bersonoli mewn symudoldeb, medrau cyfeiriadedd ac annibyniaeth o fabandod hyd at gyrraedd oed oedolyn. Y rhain yw’r medrau fydd yn helpu plentyn dall i wneud pethau fel ymestyn am degan, gwneud byrbryd a datblygu eu medrau gwrando.

Mae hyfforddiant ‘Movement Matters yn datgloi posibiliadau – gan helpu plant a’u teuluoedd i ddeall nad yw colli golwg yn gorfod bod yn rhwystr i gyrraedd eu potensial.

Mae gwasanaethau ‘Movement Matters’ yn cynnwys:

- asesiad i weld beth yw anghenion y plentyn neu’r person ifanc
- hyfforddiant medrau symudoldeb ac annibyniaeth
- gweithdai cyngor a chefnogaeth i rieni a gofalwyr
- gwaith ymarferol gyda ffrindiau, teulu a phobl broffesiynol i gefnogi plant a phobl ifainc sydd â nam ar y golwg.

Mae’r gwasanaethau hanfodol hyn yn cael eu cyflenwi gan Arbenigwyr Cymhwyso cymwysedig sy’n gweithio ysgwydd wrth ysgwydd â phobl broffesiynol eraill, er enghraifft: Therapyddion Iaith a Lleferydd, Ffysiotherapyddion, Therapyddion Galwedigaethol a mudiadau eraill gan gynnwys awdurdodau lleol.

Diweddarwyd yr adroddiad hwn fis Mai'r 13eg 2016, dylid darllen y fersiwn hon fel adroddiad terfynol. Elusen Gofrestredig yng Nghymru a Lloegr 1051607 a'r Alban SC042089. Wedi'i chofrestru yng Nghymru a Lloegr Rhif 31330. Rhif TAW 879717554 0234 05/16.

WF 05
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Nyrsio Brenhinol
Response from: Royal College of Nursing

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

Inquiry of the National Assembly for Wales Health, Social Care and Sport into the sustainability of the Health and Social Care Workforce September 2016

Submission from the Royal College of Nursing, Wales

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

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

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Inquiry of the National Assembly for Wales Health, Social Care and Sport into the sustainability of the Health and Social Care Workforce
Submission from the Royal College of Nursing, Wales

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Executive Summary of RCN response to Committee Questions

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

At a National and Local Health Board level the numbers of the nursing workforce working for the NHS can be seen. However the overall skill mix of that workforce and the ratio of registered nurses to healthcare support workers is unclear.

The level of nursing activity undertaken or the nursing need required (i.e. the number of nurses and healthcare support workers for the number and complexity of patients) is unclear in the acute (hospital sector) and completely unknown in the community sector (at national level).

There is little to no published data at national level on nursing in the independent sector or in care homes despite CSSIW inspecting the sector.

This means it is very difficult to plan the provision of nurses and nursing on the basis of health and social need across the full spectrum of providers.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

There is a clear understanding by the nursing profession of the Welsh Government's vision for specific health services. Often high standards are set out in service plans. These plans can engender frustration in the profession at the apparent lack of workforce planning to meet the demand created. There appears often a considerable gap between the Welsh Government's vision and Health Board service plans. The RCN would wish each new strategy to be accompanied by a workforce plan.

The Nurse Staffing Levels (Wales) Act became law in March 2016. This historic new law is the first of its kind in Europe and will protect patients by requiring that in adult acute care settings, an appropriate nurse staffing level must be calculated and maintained. The RCN remains committed to working with politicians of all parties to ensure the implementation of the legislation and see it extended to other areas such as community and mental health care.

How well-equipped is the workforce to meet future health and care needs?

Nursing as a profession is well equipped to meet the future health and social care needs of the population in terms of knowledge and skills.

However there are areas in which the Welsh Government needs to act to develop the profession. In primary and community care nursing as a profession needs to be included in the strategic planning of services. Support is needed to develop advanced and extended nursing skills amongst practice nurses.

Action to develop and support the Welsh language skills of the profession is also required.

Specifically the RCN is calling for an increase in Children's Nurses. Demand for Children's Nurses has increased in recent years particularly in the community and in neonatal nursing.

In addition the RCN is highlighting the prospective demise of the District Nurse unless action is taken by the Welsh Government and calling for urgent action to remedy this.

What are the factors that influence recruitment and retention of staff across Wales?

It is vitally important for the Welsh Government to maintain the sustainability of the nursing workforce though a sustainable education commissioning process. It may be possible to examine ways to widen access to the nursing profession but the high quality of nursing higher education (including high quality educational placements) in Wales must be safeguarded.

In this paper the RCN also sets out our views on the importance of valuing nursing as a profession through fair pay and fair terms and conditions of work. Access to Continuous Professional Development is a particular issue for the nursing profession.

Whether there are particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

Throughout the paper we have highlighted areas of specific concern in the nursing workforce. One such example is the nursing shortage in the care home sector which is causing significant problems in meeting current standards and maintaining patient care. There is a need for increased investment in primary and community care and there is also a need to improve the provision of care in the Welsh language.

Although these are all national issues impacting in every geographical area they will have differential impacts depending on the nature of the area e.g. low numbers of district nurses will have a particular impact in areas of sparse and older population.

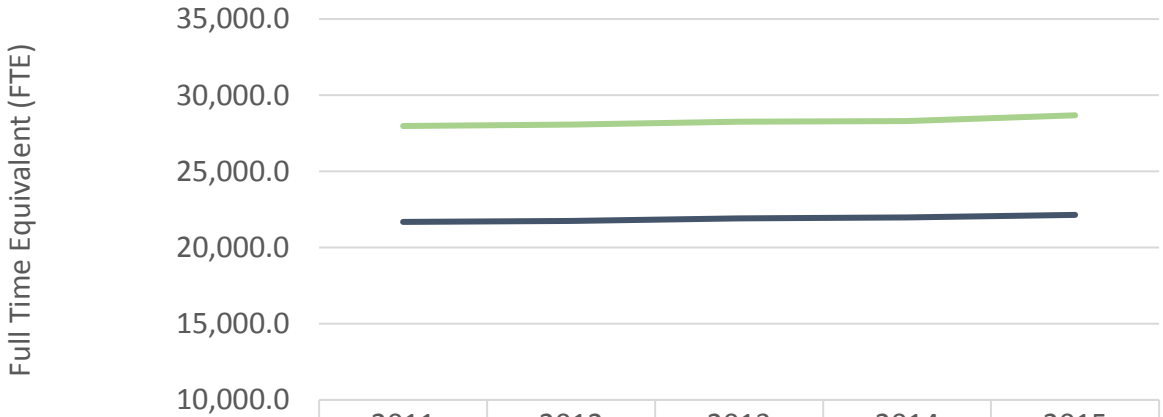
Section 1 The picture of the NHS nursing workforce & identifying data gaps

1.1 The workforce planning process

1. Currently each Health Board endeavours to produce an Integrated Medium Term Plan (IMTP) which requires Welsh Government approval. These plans cover service and workforce planning for a 3 year period. These workforce plans (which are not in the public domain) feed into the annual commissioning of student nurse places by the Welsh Government. The Committee will be aware that Abertawe Bro Morgannwg, Betsi Cadwaldr, Hywel Dda and Cardiff and the Vale Health Board all have not had these plans approved in 2016[1].

2. The RCN would welcome the publication of these IMTPS for scrutiny from the National Assembly or public. This could be done at draft stage to ensure a constructive process. In addition the RCN would welcome a National Workforce strategy from the Welsh Government with an annually updated statement clearly stating the objectives and priorities of the Government to add context to the IMTPs.

Fig. 1 NHS Nursing staff and Registered Nurses in Wales (Statistics Wales)



	2011	2012	2013	2014	2015
Nursing staff	27,979.7	28,068.30	28254.3	28,300.20	28683.5
Registered Nurses	21686	21754.8	21922.7	21987.4	22146.3

[1] http://gov.wales/about/cabinet/cabinetstatements/2016-new/mediumtermplanning/?lang=en

3. The figures above demonstrate that registered nurse numbers employed by the NHS in Wales have remained generally static since 2011. There have been real improvements in NHS workforce planning in Wales in the last few years and the Nurse Staffing Levels (Wales) Act 2016 should safeguard this process.

4. **However the number of nursing posts in the NHS still does not reflect the need of people receiving care.** There is little recorded data on nursing activity in the NHS at national level and there is no coordinated effort to examine what patient need might be. Available data from Statistics Wales on general hospital activity might include admissions and number of outpatients and also bed occupancy.

5. Patient throughput in hospitals has risen sharply as has bed occupancy. An 85% bed occupancy rate in hospital is generally recommended[2]. The 2014/15 figures from Statistics Wales[3] show a Welsh average of 86.7% rising above 90% in general medicine, geriatric medicine and rehabilitation. A recent report from Welsh Government into critical care[4] gave a January 2015 bed occupancy rate of 107% in this speciality (where the recommendation is lower at 70%).

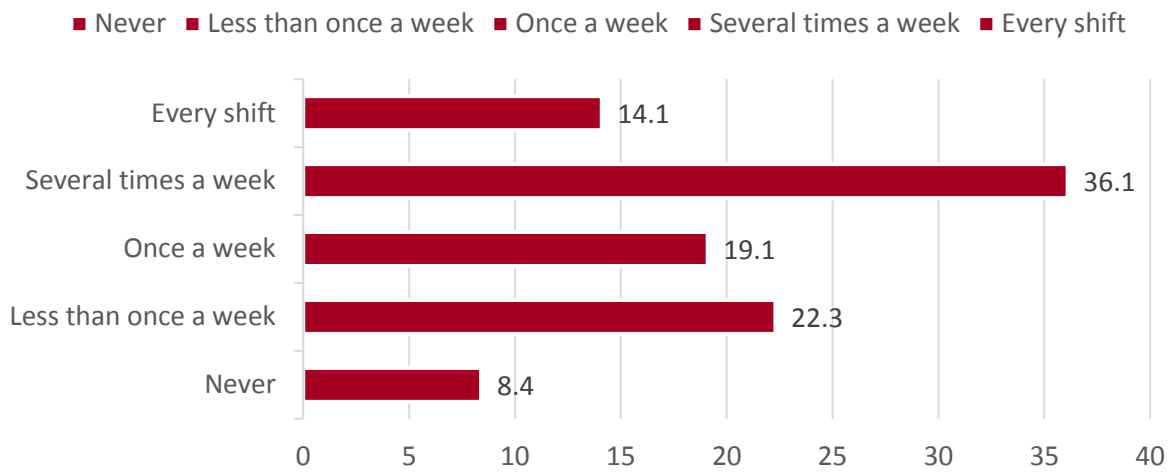
6. There is an increased nursing workload in caring for an ageing population with increased dependency and co-morbidities. The average age of an NHS patient is now over 80[5]. Put very simply it takes a higher number of nursing staff with a greater level of knowledge and skill to care for a person with a broken hip if they are also physically frail, and living with dementia, diabetes, a heart condition and respiratory illness. This is even more the case if this person is being cared for at home, alone or in poor housing.

7. The Welsh NHS also continues to demonstrate a heavy reliance on overtime. 69% of nurses work overtime at least once a week. There are 22,146 nurses employed

[2] "hospitals with average occupancy levels above 85 per cent can expect to have regular bed shortages, periodic bed crises and increased numbers of hospital‐acquired infections." P. 22 of National Audit Office Report (2013) Emergency admissions to hospital: managing the demand
[3] http://gov.wales/statistics-and-research/nhs-beds/?lang=en
[4] http://gov.wales/topics/health/nhswales/plans/delivery-plan/?lang=en
[5] http://www.kingsfund.org.uk/

in the NHS (Stats Wales 2015). 69% of this figure would represent 15,281 nurses. If each of these worked just two hours more in one week the NHS would be receiving 30,562 additional hours of work in that week. **Every week nurses in Wales give the NHS extra hours to the value of 815 full-time nursing staff.**

Fig. 2 How often do you work in excess of contracted hours? (%)
(2015 RCN Employment Survey)



1.2 Skill Mix in nursing - a data gap

8. The overall numbers can mask what it sometimes referred to as “skill mix”. A nursing team should be comprised of experienced senior Registered Nurses who lead the team and provide clinical supervision, Registered Nurses and health care support workers. The RCN recommends that (allowing for variation according to patient need) the ratio of Registered Nurses to Health Care Support Workers in acute areas should generally be 65:35.

9. Nurses” or “Registered Nurses” are healthcare professionals educated to degree level (education though practice and study) on registration with the Nursing and Midwifery Council (NMC). Nurses are a regulated profession and the NMC is the regulator. Regulation means nurses have a consistent level of education and skill, are subject to revalidation and can be formerly removed (‘struck off’) from registration at a UK level. Registered Nurses are employed in the NHS from Band

5 of Agenda for Change[6] up to a Band 8 or higher. After 3 years full time education and practice a newly graduated and Registered Nurse will enter NHS employment at Band 5.

10. The term "nursing staff" or "nursing" means Registered Nurses and also includes Health Care Support Workers (HCSW). Health Care Support Workers are sometimes known as healthcare assistants or 'nursing auxiliaries'.[7] HCSWs are an important part of the nursing team and eligible to be members of the Royal College of Nursing. However HCSW are not a regulated profession and there is considerable variation in the experience, competencies and qualifications they may possess.

11. The RCN has concerns that some NHS nursing teams do not have sufficient numbers of senior Registered Nurses to provide quality clinical leadership, or the appropriate ratio of healthcare support workers to Registered Nurses to ensure excellence in patient care. **The RCN would welcome nationally published nursing data by Agenda for Change Pay Band.**

1.3 Bank & agency, vacancy, and migration - data gaps

12. In 2014 the cost of agency nursing in Wales to the NHS was £23,035,785. This cost is the equivalent value of an extra 1062 newly qualified nurses[8].

13. There will always be a need for a flexible nursing workforce able to take on temporary roles. Sickness, maternity and annual leave alongside sudden variations in patient numbers and dependency ensure this. However a consistent reliance on temporary nursing staff is not desirable. Nurses unfamiliar with the ward layout, equipment or inexperienced with the particular patients will need more support than NHS directly employed colleagues who can deliver a consistency of

[6] Agenda for Change is the UK wide payment framework for nursing in the NHS. "Bands" reflect the Knowledge and Skills required by the post.
[7] In England the titles 'nursing associate' or 'nursing apprentice" are also used.
[8] The cost of agency nursing is not regularly published by the Welsh Government. Instead these figures are from a response to an FOI request in February 2015. In 2015/16 the salary of a newly qualified registered nurse in the NHS was £21,692.

care. Extra time also has to be allocated for supervision. It is not a financially effective strategy and the resulting instability in staffing levels and subsequent stress for ward sisters/charge nurses is not conducive to best patient care.

14. The RCN would recommend that reliance on agency nursing in the NHS is monitored at a national level. Quite apart from the financial implications, in the absence of more effective data, expenditure and usage rates for Bank and Agency Nursing represent a useful proxy measure of additional nursing need.

15. There are no national figures on vacancies in registered nurse posts and no meaningful figures by Local Health Board either. Newcomers to health policy are often confused by the apparent contradiction between reports of 'nursing shortages' and reports of 'no nursing vacancies'. The NHS 'sustains' vacancies by holding or suspending the existence of posts once the post holder has retired or moved to another post. It is almost impossible to penetrate the bureaucratic labyrinth that allows brisk movement of nurses around the NHS thus obscuring shortages of particular nursing skills and shortages on registered as a whole.

16. Nurses and nursing staff sometimes retire or leave the profession prematurely. They may also leave the NHS to work in the independent sector. Nurses may also move abroad to practice. There is a considerable amount of movement across the border with England. This information could be very useful to plan for recruitment and retention.

17. It would also be helpful to have information on nurses recruited to the NHS internationally both outside and within the EU. The 2015 Employment Survey of RCN members tells us that 3.7% of our respondents in Wales were first registered as nurses outside the UK and of these 35.9% were directly recruited to work in the NHS. This gives an estimate of 925 internationally recruited nurses in Wales and around 300 working in the NHS.

The RCN calls for clearer national data on:

- **Bank and agency nursing cost and usage**
- **NHS nursing vacancies**

- **movement of nurses within the NHS**
- **movement of nurses to the independent care sector**
- **nurses leaving (or returning to) health and social care**
- **nursing in prison services**
- **nursing in education establishments**
- **International recruitment & nurses leaving Wales to practice abroad**
- **cross border migration with England**

1.4 The Independent Sector – a data gap

18. Little is still known about the numbers of nurses employed outside the NHS in sectors such as nursing and residential homes, prisons, educational establishments, independent hospitals and clinics, independent hospices, respite and voluntary agencies and commercial nursing agencies. Between a quarter to a third of the RCN membership work in the independent sector in Wales.

19. Despite the fact that care homes providing nursing care beds are regulated by Care Standards Inspectorate Wales and the Care Council for Wales (soon to be the Social Care Council) neither body can provide a nationally published figure (or broken down by Health Board) of registered nurses employed.

20. This data gap is critical. The services this workforce provide are essential to patient care. Nurses in care home provide preventative and palliative care to older people which reduces hospital admissions, they administer medication and provide rehabilitative care which maximises independence. If a particular area is vulnerable (e.g. a large proportion of nurses due for retirement at the same time or emigrating) it is important to forecast this.

21. **Care Forum Wales have recently warned of a critical shortage of nurses[9] in the care home sector and RCN members are similarly reporting that nursing shortages are critically beginning to negatively affect patient care.** We have report of single handed agency nurse handing over to other agency nurses in

[9] http://www.bbc.co.uk/news/uk-wales-politics-37157515

homes with no continuity of nursing care. Alternatively nursing care beds are being 'downgraded' to care beds to reflect the lack of staff and patients inappropriately placed. This shortage of nursing care places is delaying patient discharge from hospital emergency care which in turn is impacting on A&E departments.

22. Several countries, including the United States and Canada, have commissioned extensive surveys of this sector using their equivalent of the Nursing & Midwifery Council's Register in order to inform their workforce planning processes and we would recommend this option to the Welsh Government.

Section 2 The Welsh Government's vision for health and care services and the workforce needed to deliver this

23. There is a clear understanding by the nursing profession of the Welsh Government's vision for specific health services. Often high standards are set out in service plans. These plans can engender frustration in the profession at the apparent lack of workforce planning to meet the demand created. There appears often a considerable gap between the Welsh Government's vision and Health Board service plans. The RCN would wish each new strategy to be accompanied by a workforce plan.

24. It would certainly be helpful for the Welsh Government to clarify their vision for the NHS and social care. What is the intended mechanism of support for closer relationships and/or the integration of health and social care services?

25. The Nurse Staffing Levels (Wales) Act became law in March 2016. This historic new law is the first of its kind in Europe and will protect patients by requiring that in adult acute care settings, an appropriate nurse staffing level must be calculated and maintained. The nursing profession internationally has recognised this new legislation as visionary, ambitious in intention and practical in scope.

26. Poor outcomes also associated with low levels of nursing care include adverse events after surgery; increased accident rates and patient injuries; increased cross-infection rates; higher rates of pneumonia and increased morbidity and mortality.

27. In 2007 Professor Rafferty surveyed nearly four thousand nurses across England and Scotland and looked at 118,752 patient episodes of care in 30 hospital trusts in England. She found that wards with lower nurse to patient ratios had a 26% higher patient mortality rate. An international meta study in 2007 estimated that each additional full time nurse per patient day saved five lives per 1,000 medical patients, and six per 1,000 surgical patients. Another study in 2014 found that when a nurse is required to work with more than seven patients per day the risk of the patient dying within 30 days increases by 7 per cent[10].

28. RCN members in Wales have consistently rated staffing levels as a top concern, and the RCN remains committed to working with politicians of all parties to ensure the implementation of the legislation and see it extended to other areas such as community and mental health care.

Section 3 Equipping the Future Nursing Workforce

3.1 Nursing in Primary and Community Care

29. Nursing as a profession is well equipped to meet the future health and social care needs of the population. However the Royal College of Nursing believes that developing the profession in the community and primary care should be a priority for the Welsh Government.

30. For the last decade in Wales Health Boards have been reconfiguring acute hospital services, reducing bed numbers, encouraging shorter patients stays and enabling more complex treatments and care to be delivered at home. People prefer to receive care at home. This allows people to maintain greater independence. When excellent care is provided in the home it is also often of a nature that prevents future illness or accidents.

[10] Rafferty, Anne Marie et al. 2007. Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records. International Journal of Nursing Studies 44 (2), pp. 175 - 182 Kane, RL et al. 2007. Nurse Staffing and Quality of Patient Care. Rockville: Agency for Healthcare Research and Quality (US) Aiken, Linda et al. 2014. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. The Lancet 383 (9931) , pp. 1824 - 1830

31. The Royal College of Nursing is supportive of this move in principle but has concerns over whether there is sufficient investment in the workforce to ensure high quality of care. There is a paucity of statistical data and performance information on care provided in community settings.

32. Numbers of nurses employed by the NHS are known at a national level but the number of people receiving care (and their needs) are not. Therefore it is difficult to judge the level of nursing need and improve workforce planning to meet this need. The skill mix of community nursing teams within a Health Board is also not published at a national level. Most importantly there is no information on the outcomes for the patients.

33. As more health care is delivered in the community and more of the health budget is spent on this, it is even more important that this lack of national information be rectified to improve workforce and service planning.

34. The nursing workforce based in the community and employed by the NHS is a large and diverse group of specialised nursing areas of practice. It may include Learning Disability nurses, palliative care nurses, school nurses and occupational health nurses. It may include Specialist Nurses and Nurse Consultants who may lead diagnostic clinics with the ability to admit directly to hospitals. It may include nurses working in specific teams such as ‘rapid response teams’ working to maintain people’s independence and deliver care in the community. Figures indicate there has been an increase in the numbers of registered nurses working in NHS community services. Health Visitors in particular have increased in numbers.

35. Nurses in different roles provide the bulk of NHS care in the community, yet despite this they are often overlooked as a profession when primary and community care services are planned and the workforce considered. **Directors of Primary Care Local Health Board levels should always include senior nurses in service and workforce community planning alongside other professions.**

36. Within the GP surgery it is often the Practice Nurse, supported by the healthcare support worker that will see, advise and treat people appropriately. Practice Nurses undertake a huge range of assessments and interventions, immunisation and vaccination, the management of long-term conditions and cervical cytology.

37. Nurses undertake a further two years of learning to become Nurse Practitioners and then can be responsible for nurse led clinics, minor illness, triage, supplementary or independent prescribing. Nurses who can independently prescribe can speed up patient care considerably and also strengthen the clinical accountability for prescription.

38. The Welsh Government should, together with the Local Health Boards and NHS Trusts, ensure that Advanced Nurse Practitioner posts are created across Wales to strengthen the primary care team and there is provision for Extended Nursing skills.

3.2 Patient Care in the Welsh Language

39. The language that care is delivered in is integral both to the experience of care that patients receive (e.g. respect and compassion) but also to the quality of the care patients receive (e.g. the effectiveness of assessment and of treatment). The importance of the language of care is easy to identify in key fields such as speech therapy and counselling but it is equally important where healthcare professionals are relying on speech with the patient and family to make an assessment, explain a treatment or medication regime or seeking to gain consent for a course of action.

40. Ensuring that health and social care services can increasingly deliver care in the Welsh Language is therefore an important objective in ensuring improved health outcomes for the people of Wales. **The Royal College of Nursing strongly supports the Welsh Government strategy for the Welsh language in health and social care More Than Just Words.** In particular it would draw the Committee's attention to the specific recommendations in workforce planning and education commissioning.

41. Health Boards must understand the linguistic skills of the workforce they employ and the needs of the areas they serve as priority. The need for welsh language skills should be clearly identified by professional grouping in each Health Board's IMTPS. This in turn should be reflected by the Welsh Government in the education commissioning process.

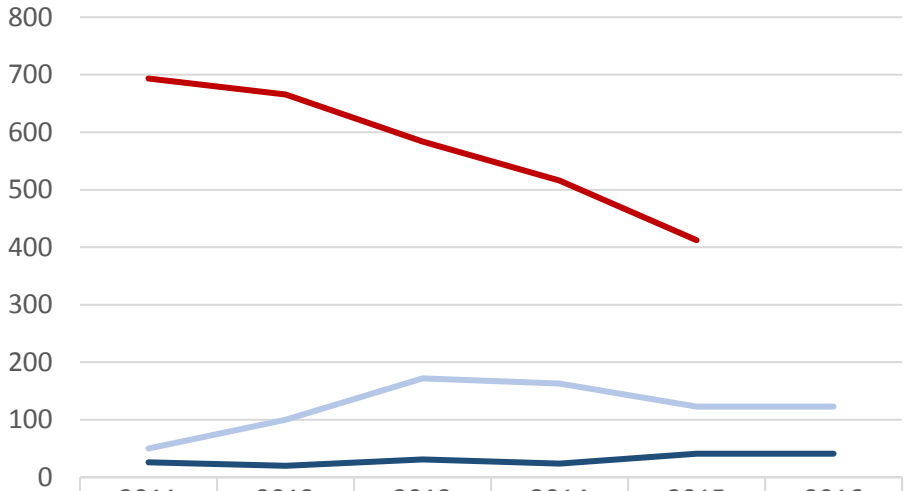
42. **Education is the key to the future delivery of the service.** The development of modules and courses in the Welsh language in higher education nursing would encourage the development and the production of a linguistically confident and competent workforce. Also important is the development of general awareness of bilingual care practice for all healthcare professionals at university and in NHS induction processes.

43. Strengthening Welsh language services in healthcare will improve patient outcomes. It will improve the patient experience. It will ensure that nursing services in Wales are at the forefront of best practice and innovative research with intentional application for our profession.

3.3 The urgent need for District Nurses

44. The numbers of registered nurses working in NHS community settings has increased in recent years. Despite this general increase the numbers of District Nurses have not only failed to increase but are sharply falling.

Fig. 3 District Nurses and Welsh Government Commssioned District Nursing Education (Statistics Wales and Welsh Government)



	2011	2012	2013	2014	2015	2016
Full DN Qualification	26	20	31	24	41	41
DN modules	50	100	172	163	123	123
District Nurses	693.4	665.8	583.5	516	412.3	

45. The graph above also shows the sharp and rapid drop in the numbers of District Nurses in Wales. In 2015 there were only 412 recorded at a national level as working in Community Services in Wales. **This is alarming and should be of <u>serious</u> concern to the Welsh Government.**

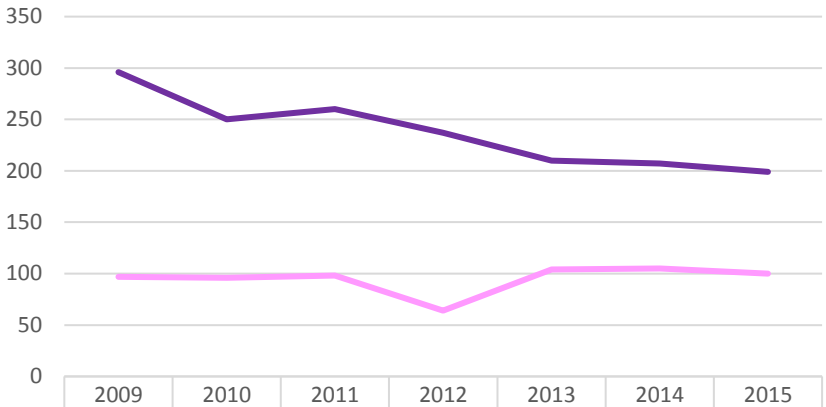
46. In 2008 the model of education for the specialist nursing qualification in district nursing switched from full-time to 6 modules which could be studied separately. This arrangement was more flexible both for the nurse and the needs of the NHS. However the RCN was sceptical that nurses would not be supported to take all 6 modules and so to achieve the full qualification. This concern has proven justified.

47. The District Nurse qualification recognises a very high level of knowledge, skill and practice in a generalist field. It is a specialism in general community nursing. These nurses are the experienced pinnacle of a community nursing team providing clinical supervision and leadership.

48. Some leading voices in the nursing profession have expressed a desire to modernise the educational curriculum for this qualification. The Royal College of Nursing would welcome discussion on this point but it cannot be used as an excuse for this decline. **The RCN believes the Welsh Government should strengthen the District Nursing service in Wales.**

3.4 The need for Children's Nurses

Fig. 4 Childrens Nurses (Statistics Wales)



	2009	2010	2011	2012	2013	2014	2015
FTE Childrens Nurses in NHS	296	250	260	237	210	207	199
No of Welsh Government Commissioned Student Places for Chilrens's Nurses	97	96	98	64	104	105	100

49. Children's Nurses are one of the four fields of nursing (adult, child, mental health and learning disability). Children's nurses work with people from birth to the age of 16, or 18 if the young person has a disability. Children's nurses work in a variety of areas including neonatal units, acute children's wards, emergency units, out-patient departments, safeguarding, looked after children, child and adolescent mental health services, school nursing, community settings which include special schools and continuing care teams. Children's nurses are a small group within the wider fields of nursing and often it is assumed that any registered nurse is sufficiently prepared to care for children and young people.

50. **There are now historical low numbers of children's nurses in Wales.** While adult nursing, mental health nursing and other health professions have seen

welcome increases in pre-registration training places in Wales, children's nursing education has remained static and does not support the future workforce requirements. Current workforce planning for children's nursing across Wales does not take into account the number of potential registrants due to retire or the reconfiguration of services.

51. This shortage of children's nurses is particularly damaging in neonatal nursing and in the community. Traditionally children's nurses worked in the hospital on children's wards. When children were very sick they were cared for in the hospital environment. Today advances in technology and medicine allow more children to be cared for in the home and for children and young people to live more independently with chronic conditions. This requires support from children's nurses based in the community yet very few children's nurses are based in community nursing teams.

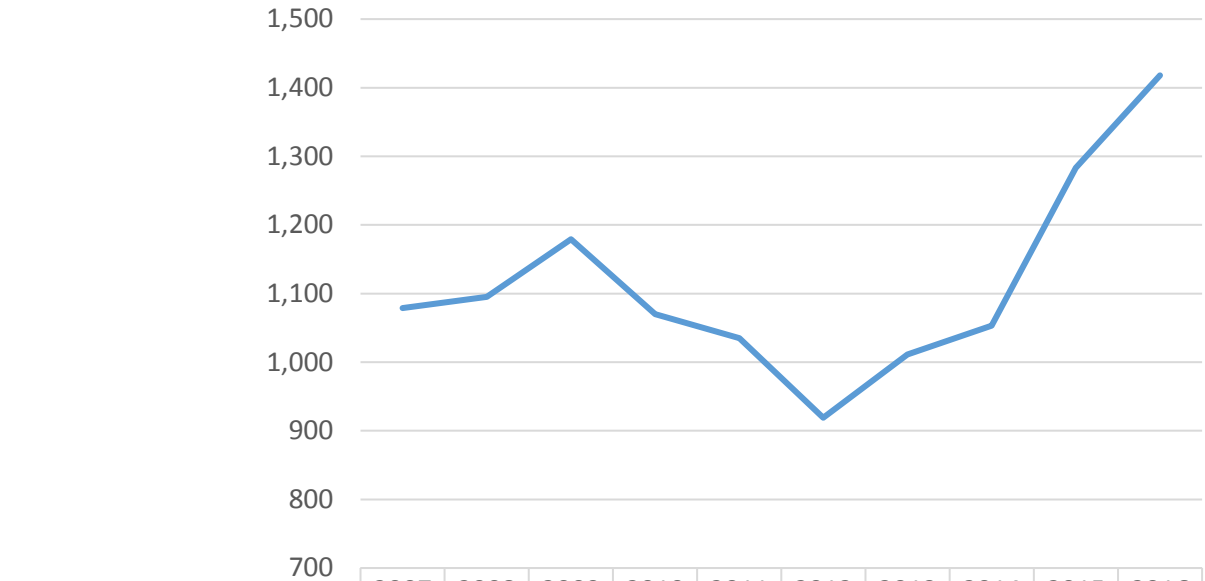
52. Children's Nurses, rather than midwives are also increasingly making up the neonatal nursing workforce. (Neonatal nursing qualifications are post registration specialist qualifications). In July 2016 Bliss published a report in Welsh neonatal services in Wales. 2016: time for change[11] Bliss' research shows that services for premature and sick babies in Wales are facing critical staffing shortages, leaving many neonatal units unable to meet national standards for safe, high quality care. Eight out of ten units did not have enough nurses to staff all of their cots, leading to nearly a quarter of all emergency transfers taking place due to a shortage of staffed cots rather than health need, putting babies at unnecessary risk and adding to families' stress and worry.

53. Investment and leadership from the Welsh Government will be essential to tackle the staffing shortages that have left neonatal units falling far short of the All Wales Neonatal Standards. This must be directed towards a significant increase in the number of child branch nurses, which is essential to close the neonatal nursing gap that exists in Wales.

[11] http://www.bliss.org.uk/News/services-for-waless-sickest-babies-under-pressure

Section 4 Nursing Recruitment and Education

Fig. 5 Commissioned Nursing Student Numbers (Welsh Government)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Pre-registration Nursing Students	1,079	1095	1,179	1,070	1,035	919	1011	1053	1283	1418

54. In order to provide the future workforce needed for the NHS in Wales, it is crucial that there are sufficient numbers of nursing students entering the profession. The graph above shows a sharp decline in nursing student numbers between 2009 and 2012. This shortfall subsequently caused great pressure on the NHS in Wales between 2012 and 2015. There was additional expenditure on international recruitment for nurses and a marked increase in spending on agency nursing (see section 1.3 for more information). The graph also shows a sharp increase in the number of student nurses places commissioned by the Welsh Government in 2015 and 2016. This increase is much needed ad welcomed.

55. It would be helpful if the Welsh Government would ensure the numbers of pre-registration student nurses commissioned is maintained at the right level to meet workforce requirements rather than the 'boom and bust' cycles previously seen.

56. There has been some discussion in recent years of moving the education commissioning function to an external body to some degree 'independent' of Welsh

Government. The Royal College of Nursing has a cautious response to this proposal and a number of concerns. Unlike the situation in England with highly autonomous Trusts, 'health devolution' in regions and the commissioning of services form various providers, the Welsh NHS remains at the moment a nationally consistent service with the majority of services directly provided by the NHS. One of the purposes of a democratically elected Welsh Government is to set national health policy and ensure high standards in a nationally run and nationally accountable health service. Without control of the workforce planning process it is difficult to see how the Welsh Government can be accountable for either or deliver on either.

57. Secondly although improvements in scrutiny and wider input of advice are needed into the current system of workforce planning it must not be forgotten that this system is vastly improved from the last Committee Inquiry of 2007 nearly a decade ago. The Welsh Government has driven this improvement, attempting to make workforce, service and financial planning integrated, longer term and compatible with national policy whilst dramatically improving the quality of the data available.

58. There is no indication that any of these improvements would have taken place if workforce planning for health care had remained solely the domain of the NHS in Wales.

59. Student nurses spend three years (and these years consist of 42 working weeks and not the traditional academic calendar year) undertaking the nursing degree course (fields of practice are Adult, Child, Learning Disability and Mental Health) spending 50% of their time on practical placements often on an NHS ward. On these placements student nurses are working full-time but with no income.

60. Finding sufficient high quality educational placements for nursing students, particularly when there is a need to increase numbers, is always a challenge. Placements require mentors who can teach and supervise students and students must not be counted as part of the regular workforce team – they are 'supernummery'.

61. The Royal College of Nursing is keen to work with the Welsh Government, NHS and Universities, to increase the number of educational placements in the community. More imaginative placements could be in community teams, particularly in care homes, the independent sector or even directly supporting carers in their home. As well as expanding the number of placements and thus student numbers, this type of placement would meet the need to provide students with encouragement and experience in the sector where most of the future care will be delivered.

62. Research in 2014, conducted across nine European countries, found that a better educated nursing workforce reduced unnecessary deaths. Every 10% increase in the number of Bachelor's degree educated nurses within a hospital is associated with a 7% decline in patient mortality.[12]

63. The average age of a nursing student in the UK is 29 and they are far more likely to have caring responsibilities. An RCN survey found that 31% had dependent children, 10% were single parents and 23% were caring for a sick, disabled or elderly relative.[13]

64. Nursing students in Wales currently receive a bursary from the Government to allow them to pursue their studies. The UK Government recently announced the abolition of the student nurse bursary in England. This increases the risk of poverty for nursing students and may discourage people from this career option. Wales currently has the lowest attrition rate for nursing students in the UK. It seems foolish to jeopardise this.

65. In addition removing the bursary destabilizes the funding of higher education nursing funding and removes the ability of the Government to nationally plan the workforce. Serious questions remain about this option – e.g. nursing students spend the last 3 months of their degree rostered on to the NHS working full-time. How will this be paid or is the Government seriously expecting students to pay for

[12] http://www.kcl.ac.uk/nursing/newsevents/news/2014/degree-educated-nurses-can-reduce-hospital-deaths.aspx
[13] RCN response to the UK Department of Health consultation Changing how healthcare education is funded

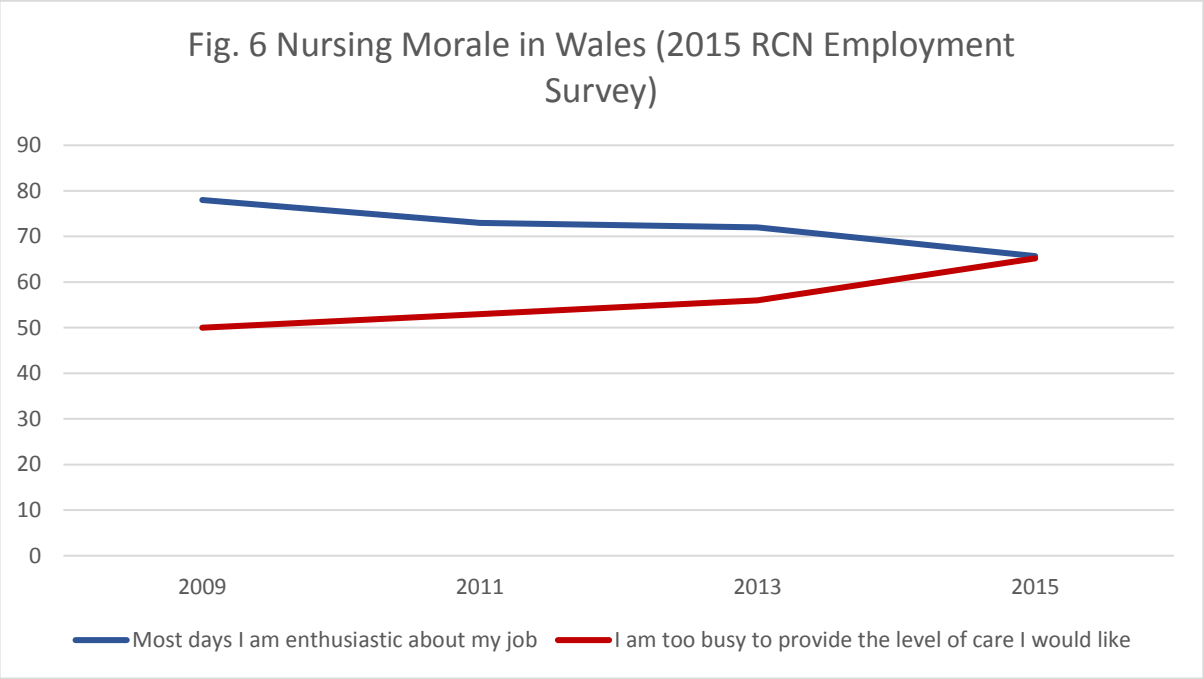
the privilege of working 12 hours shifts with little control over hours? Will universities still be expected to arrange placements? The administration of this is one of the many reasons why nursing education is costly to provide.

66. In contrast the Scottish Government has announced its intention to keep the student nursing bursary.

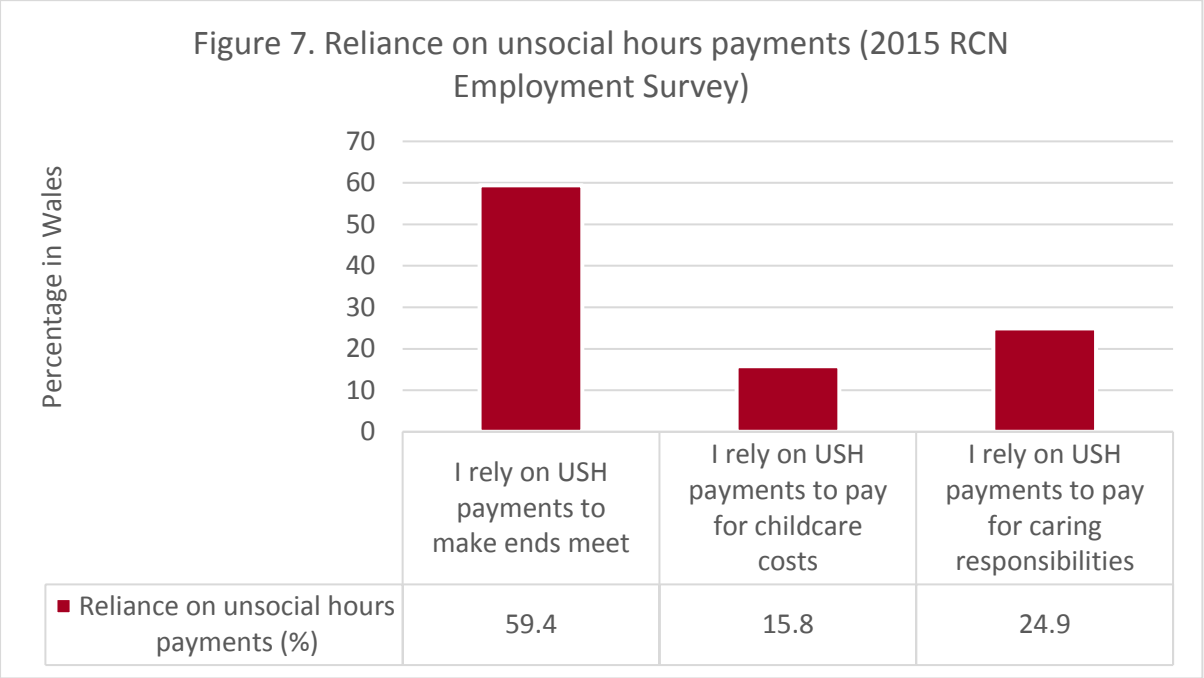
67. The RCN believes that Wales should examine ways to widen access to the nursing profession. Other objectives should be to ensure that national workforce planning can continue and that the high quality of nursing education in Wales remains. **RCN Wales has recently published <u>The Future of Nursing Education in Wales</u> This document outlines a strategic vison for widening access equitably and sustainably to nursing education in Wales.**

Section 5 Nursing Retention

68. Nurses in Wales often do not feel valued by the NHS or Government. This is partly related to pay (which has not kept pace with inflation in recent years) but also other factors including long hours or hours over which nurses have little control and poor access to continuous professional development. However nothing impacts more negatively on the nursing profession than feeling unable to provide a high standard of care. The graph below shows the relationship between nursing morale and being '*too busy to provide the level of care I would like'.*

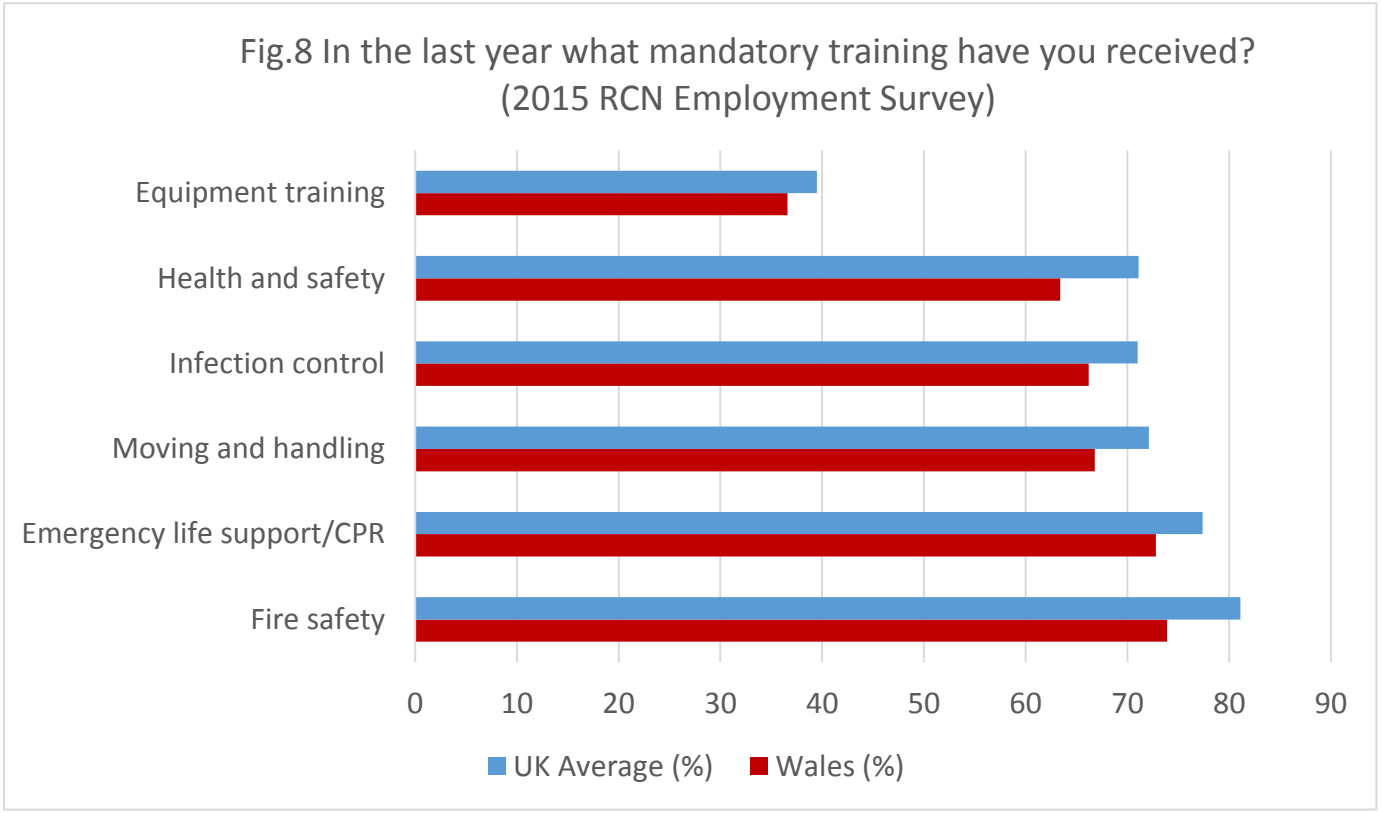


69. There has been a 14% real terms fall in nursing pay since 2010. **A newly qualified nurse in Wales currently earns £21,909. This is £8091 less than the UK median graduate salary.** 20% of Nurses and HCSWs have taken another job to make ends meet. Many rely on additional unsocial hours payments for income or to cover caring responsibilities.



70. Professional development and learning does not and must not stop at registration. It is a fundamental career-long requirement for every nurse. It is a requirement for successful revalidation by the Nursing and Midwifery Council. Continuing Professional Development (CPD) is essential for patient safety and clinical effectiveness, and is one tool used by the nursing profession to ensure that the highest standards of practice are promoted and maintained.

71. Improving access to CPD is also an important way of showing how the nursing profession is valued and improving morale. Doctors, for example, have access to CPD as part of their contracts. Yet many nurses and midwives in the NHS find it very difficult to take time out from the clinical environment to develop their skills – or even to complete mandatory training.



72. **Investing in nursing, through a fair pay agreement, good terms and conditions and access to continuous professional development will benefit people receiving care**

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WF 06
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Fferylliaeth Gymunedol Cymru
Response from: Community Pharmacy Wales

Community Pharmacy Wales
Fferylliaeth Gymunedol Cymru

A Response

Health, Social Care & Sport Committee's inquiry into the sustainability of the health and social care workforce

9 September 2016

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

Part 1: Introduction

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

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

Part 2: Priorities for the Committee

3. CPW believes community pharmacies have a major role to play in contributing to a sustainable health service in the future. Despite widespread recognition of the massive potential of the community pharmacy network across the political and health professional spectrum, for reasons unknown it remains a hugely under-exploited healthcare asset, with a wide variation in commissioning of community pharmacy based services across Wales. Although CPW understands the need for planning care locally, we feel there is a need for the development of core services available from every community pharmacy in Wales in order to increase the awareness and confidence of the general public in relation to the full range of community pharmacy based services in order to reduce pressures elsewhere in the primary and secondary care sectors.

Chronic Conditions Support:

Respiratory disease is the cause of one in seven deaths in Wales. Studies have shown that the majority of patients prescribed inhalers have poor inhaler technique and are therefore not getting the full benefit of their medication. A community pharmacy based Respiratory Enhanced service has been developed in several Health Board Areas. These services support patients to understand their medication and how to use it and have been shown to improve patient's disease control, thereby reducing additional costs to the NHS as well as the patient's quality of life.

An additional service has also been developed and piloted in Powys where COPD patients were supported through a community pharmacy to self manage their condition, this service led to a 77% reduction in GP appointments compared to the previous year and a 24% reduction in steroid and antibiotic usage over the same period.

Similar services could be developed to support patients with other chronic conditions to self care and self manage their conditions.

4. Community pharmacies could make a significant contribution to releasing GP colleagues to focus on those patients that really do need to be seen by a doctor. For example, community pharmacy based common ailments services and emergency supply services can reduce the pressure on GP practices by releasing the need for these patients to otherwise require appointments. Chronic conditions management services and associated medicines management services can support people to live with a condition which could otherwise result in the requirement of hospital admission and treatment. This will also help to reduce the number of expensive hospital beds and secondary care treatments needed to support an ageing population. An important part of the development of these services would also be a relaunch and re-focus of the under-utilised "batch" prescribing service which forms part of the current community pharmacy contract as the Repeat Dispensing Essential Service. Taken together, these measures could have a significant impact on the GP practice workload.

Repeat Dispensing Implementation:

Two thirds of prescriptions issued in primary care are repeat prescriptions. These repeat prescriptions account for nearly 80 per cent of NHS medicine costs for primary care. The management of these prescriptions and the time involved in processing them can be significant.

There are over 30 million repeat prescriptions generated every year – equivalent to an average of more than 200 per GP per week. It is estimated that approx. 24 million, or 80 per cent, of all repeat prescriptions could eventually be replaced with repeat dispensing or "batch" prescribing; this could save 0.2 million hours of GP and practice time.

5. Community pharmacy services could be further transformed by utilising community pharmacist's skills in medication adherence and reducing polypharmacy.

> ***Community Pharmacy Independent Prescribers:***
>
> *Each day numerous GP appointments are taken up by patients with uncomplicated minor acute conditions and minor ailments. In addition, a number of these appointments have already been signposted to the GP surgery from the local pharmacy, for patients needing to obtain a Prescription Only Medicine for a minor ailment.*
>
> *This multiple step process means that the patient may have seen a healthcare professional on 3 or 4 occasions to finally obtain a single treatment for a minor ailment or acute condition.*
>
> *By training a local community pharmacist to assess and prescribe treatment for minor ailments and acute conditions, a patient could be dealt with at first contact with the pharmacy. In addition, it would be possible for the surgery or other healthcare professionals to signpost straight to the local pharmacy thereby reducing the demand for GP appointments. This would release significant GP time, reduce GP and practice workload and enable GPs to see other and higher priority patients. Patients would have improved access and service, but would also benefit from preventative advice and potentially wider services that could eventually be offered through local pharmacy.*

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

7. CPW welcomes the integration of health and social care services and would like to seek to understand what opportunities there are for community pharmacies to work closer with social care to support the development of domiciliary care medication support to preserve a patient's independence and allow them to remain in their own home. Community pharmacy services are currently only commissioned through Local Health Boards but local authorities too could benefit from the support that community pharmacy could provide to those in receipt of social services care.

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

9. CPW understands the importance that primary care clusters have in transforming primary care. CPW would like to see the role of all primary

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

Integration with other Health Care professionals:

Patients requiring treatment for eye conditions that are seen by an optometrist require referral from the optometrist to the GP to obtain a prescription that will then require to be taken to the pharmacist for dispensing. CPW believe that this doesn't fit with prudent healthcare objectives and is working with an LHB to develop a service that will allow the community pharmacy to provide treatment under the NHS following a request from an optometrist.

The development of the Common Ailments service (CAS) has also developed closer working relationships between health care professionals and has seen GPs and optometrists both referring to community pharmacy and vice versa. An example given by a pharmacist in Gwynedd is of a patient referred by the GP surgery to the pharmacy for treatment for an eye condition under CAS where it became clear that the condition wasn't a simple condition, the patient was referred to an optician through the Wales Eye Care Service, who then referred direct to hospital as the patient was suffering a serious eye infection.

10. CPW is aware of the various on-going work streams currently being undertaken across Welsh Government and NHS Wales and in particular regarding the recruitment and retention of healthcare professionals. CPW believes that there is an urgent need to explore how the existing capacity of the Wales based community pharmacy network might contribute to the delivery of NHS services to inform the scale of the recruitment and retention challenges across the NHS. To that end CPW would seek representation on all the working groups to help inform their discussions and deliberations.

Part 3: Conclusion

11. CPW is pleased that the Committee is seeking to understand the challenges facing NHS Wales in securing a sustainable workforce across all sectors. The report produced by the committee in the fourth Assembly set out a series of recommendations which, if implemented in full, would increase the contribution that community pharmacy could make to the NHS and which would impact upon the workload of other healthcare professionals which could have a significant and positive influence on achieving the sustainable workforce to which all NHS service providers aspire.

WF 07

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Brenhinol y Meddygon (Cymru)
Response from: Royal College of Physicians (Wales)

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

Inquiry into the sustainability of the health and social care workforce

RCP Wales response

Key points

The RCP has identified several key priorities for the NHS workforce in Wales:

- Develop a national medical workforce and training strategy.
- Show national leadership on the balance between service and training.
- Focus on addressing recruitment and training challenges.
- Increase the number of medical school places offered to Welsh domiciled students.
- Improve the support available to junior doctors in rural areas.
- Encourage health boards to implement the RCP Future Hospital workforce model.
- Legislate on safe staffing levels.
- Ensure that future changes to medical training are reflective of the needs of patients.
- Develop and embed other clinical roles in the NHS workforce.
- Invest in research and innovation, locally and nationally.
- Invest in data collection about the health and social care workforce.
- Make staff health and wellbeing a national priority.

For more information, please contact:

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09 September 2016

Inquiry into the sustainability of the health and social care workforce

1. Thank you for the opportunity to respond to your consultation on the National Assembly for Wales committee inquiry into the sustainability of the health and social care workforce. Our response is based on the experiences of our fellows and members.

2. The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,100 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions. Involving patients and carers at every step, the RCP works to ensure that physicians are educated and trained to provide high-quality care.

3. Good care in the future depends on good training now, and medical education and training must be prioritised when designing health services. The Welsh Government must work with NHS bodies and the Wales Deanery to develop a national medical workforce and training strategy which ensures that staff are deployed and trained effectively, now and in the future.

> *We need to state what a catastrophic place we are in with regard to workforce in the NHS in Wales at present. Medical staff recruitment problems are threatening the existence of many hospitals and general practices in Wales. We need to train more doctors and nurses in Wales with the aim of retaining them to work in Wales. The tension between service and training needs to be addressed by developing a national workforce strategy.*
>
> [Consultant physician in Wales]

4. Workforce planning must be a key priority during the entire process of service reconfiguration. Internal medicine must be valued and urgent action taken to ensure that more physicians contribute to the acute take. Trainee and medical undergraduate numbers must be increased, and junior doctors and medical students must be supported and encouraged to stay in Wales by offering them innovative new training pathways, an improved workload, and more opportunities to take part in clinical leadership and quality improvement programmes.

5. Wales needs a mature conversation about a future vision and a new way of working for the NHS in Wales. It is important that future investment into the health service does not go towards propping up the old, broken system. The Welsh Government must promote innovative models of integration and introduce shared budgets that establish shared outcomes across the local health and care sector. Spending money on the existing system will not change anything in the long term; health boards must invest in prevention and treatment of chronic conditions and allow clinicians to innovate.

6. Those living in rural and remote areas must not be forgotten either; it is these areas where the crisis in primary care is hitting hardest, and where a new ambitious model of care has the most potential. All of this will need a drastic change in mind-set, stronger clinical leadership and engagement, and more joined-up thinking between primary, secondary, community and social care teams.

7. The RCP has identified several key priorities for the NHS workforce in Wales:

- **Develop a national medical workforce and training strategy.** Good care in the future depends on good training now. Service planners must make medical education and training a priority when designing health services. Health boards should review existing service planning arrangements to ensure that they do not threaten the sustainability of the medical workforce, especially in rural and remote areas.

> *I do not think that the Welsh Government has a vision for service or workforce. There are quite a lot of meetings and working parties but no clear vision that everyone can articulate and support.* [Consultant physician in Wales]

- **Show national leadership on the balance between service and training.** The Welsh Government, health boards and the Wales Deanery must acknowledge the delicate balance between service needs and training issues. Every hospital in Wales depends on its trainees and there are huge implications when a unit loses its training status. Physicians working in rural and remote hospitals should be supported by colleagues working in other hospitals, not only with service provision, but also with teaching time. Hospitals across Wales should work as a collection of formal, structured alliances operating hub-and-spoke, or integrated care, networks. Politicians must show national leadership and support innovative solutions to keep these units sustainable.

> *There is too much pressure on front line staff so people leave. This is currently made worse by increasing demand – population growth, people getting older. The other major problem is fewer staff, due to vacant posts which we cannot fill. It is not exactly lack of funding – more that we lack people coming out of training that we could employ.* [Consultant physician in Wales]

- **Focus on addressing recruitment and training challenges**, particularly in north and west Wales. The number of medical undergraduate and core medical training (CMT) posts in Wales should be increased. Rota changes should allow trainees to work within the same teams for a block of time, to improve continuity of care and enhance training and learning on the job. For those hospitals with poor trainee feedback, CMT roles should be timetabled to ensure clinic time and dedicated teaching time. Health boards must also recognise the risk to the service of losing those consultants who are nearing retirement, and act to retain these senior physicians and their knowledge and experience for as long as possible, especially in more remote hospitals.

The main [problem] is the lack of training places in nursing and medicine.
[Consultant physician in Wales]

- **Increase the number of undergraduate medical school places offered to Welsh domiciled students.** It is also crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea. These students are more likely to stay in Wales for their postgraduate training, and if they do leave, they are more likely to return home afterwards. Only 30% of students in Welsh medical schools are Welsh domiciled. This compares to 55% in Scotland, 80% in England and 85% in Northern Ireland.[1] Medical schools must offer more undergraduate places to Welsh domiciled students in order to grow and retain a home-grown workforce, and they should invest in outreach programmes which encourage applications from rural, remote and Welsh speaking communities.

- **Improve the support available to junior doctors in rural areas.** The rota gaps in many smaller, rural hospitals in Wales can result in isolated working for junior doctors. They also mean that there is not enough face-to-face consultant teaching time for some trainees. Training pathways specialising in rural and remote healthcare should be developed in Wales and advertised across the UK to encourage the best trainees to apply. To recognise how healthcare will change in the coming years, these rural training jobs should be built around the integrated patient journey, and made more attractive through new opportunities to gain postgraduate qualifications or formal experience in service improvement or leadership roles.

- **Encourage health boards to implement the RCP Future Hospital workforce model.** Hospitals should move towards a 7-day consultant presence – this will require a more even distribution of the acute take between the medical specialties, as well as an increase in the number of internal and acute physicians working in Wales. Integrated working and shared outcomes with health and social care partners should be the norm; physicians and medical teams should spend part of their time working in the community in order to deliver more specialist care in, or close to, the patient's home.

- **Legislate on safe staffing levels.** The RCP has supported safe nursing staffing legislation in the National Assembly for Wales, and we would support this legislation being extended to other health professionals, where appropriate. Nursing and medical staffing data must be made publicly available and easily accessible, and should be displayed in every ward on a daily basis.

- **Ensure that future changes to medical training are reflective of the needs of patients**. In the future, we will need more doctors with general medical skills to care for the increasing numbers of patients coming to hospital with multiple medical conditions, particularly frail older patients. However, training a good doctor who can provide generalist care as well as specialist expertise will require adequate time. This is why the RCP supports the expansion of general medicine, the dual accreditation of physicians at Certificate of Specialty Training (CST) level, and an increase of flexibility in training, and we urge action in these areas. We will oppose any shortening of training time for physicians, which would compromise both the quality and the safety of care.

- **Develop and embed other clinical roles in the NHS workforce.** Excellent patient care depends on cohesive, organised and well-resourced team working. Staff and associate specialist grade posts in Welsh hospitals should be encouraged, and these doctors should be supported in their career progression. The roles of advanced nurse practitioner and physician associate should be

[1] NHS Education for Scotland. *Domicile of UK undergraduate medical students*. March 2013

developed as core members of the clinical team. However, any increase in staffing numbers for these posts should not be at the expense of consultant expansion.

- **Invest in research and innovation, locally and nationally.** There should be national investment in innovation and new technologies, which have the potential to revolutionise care and to position Wales as a world leader. Academic research should be considered when planning and delivering health services. All health boards should receive a regular report of research activity, and hospitals should be publicly supported to build a culture of research and allow their staff time out of service for research. Mandatory reporting of research findings should be established to share intelligence. Patients should be given the opportunity to participate in ongoing research activity and should also be involved in setting research priorities.

> *We do not have any accurate picture of the NHS workforce in Wales. Whatever data there is does not seem to be shared.* [Consultant physician in Wales]

- **Invest in data collection about the health and social care workforce** which would provide a robust evidence base for future medical recruitment strategies and campaigns. We need to better understand the drivers for recruitment and retention. Not enough research has been done so far, and too many decisions are based solely on anecdotal evidence about why we cannot recruit trainees and consultants to work in the Welsh NHS.

> *As for having enough data about the workforce – despite making lots of assumptions and interventions, I don't feel we know both why trainees make decisions about specialty and location in Wales, plus why the perceived morale among junior doctors is so low.* [Trainee physician in Wales]

- **Make staff health and wellbeing a national priority.** The Welsh Government should invest in the health and wellbeing of its NHS workforce by implementing National Institute for Health and Care Excellence (NICE) public health guidance for employers on obesity, smoking cessation, physical activity, mental wellbeing and the management of long-term sickness. Staff engagement and wellbeing are associated with improved patient care and better patient experience.[16–19] The Welsh Government should consider staff health and wellbeing as part of the proposed national medical workforce and training strategy, and promote national sharing of good practice on staff health and wellbeing.

If you have any questions about this response, or the work of the RCP in Wales, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted].

With best wishes,

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RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
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Cofrestrydd yr RCP

WF 08

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Association of Independent Healthcare Organisations

Response from: Association of Independent Healthcare Organisations

Priorities for the Health, Social Care and Sport Committee

Inquiry into the sustainability of the health and social care workforce.

Introduction

WIHA (the Welsh Independent Healthcare Association) is the representative association of the majority of independent acute, mental health and learning disability hospitals/units in Wales.

WIHA is pleased to contribute to the Committee's initial, broad piece of evidence-gathering to help understand what the key workforce issues are across the health and care sector. We recognise that planning around workforce issues is a critical consideration if Wales is to be able to provide prudent and efficient health services to its population in the decades ahead. WIHA was pleased to note that the Committee is obtaining evidence of the sustainability of the workforce.

Responses

- **Do we have an accurate picture of the current health and care workforce? Are there any data gaps?**
    - There is a potential gap as current Independent Sector workforce data may not have been taken into account. The WIHA members submit annual workforce data projections to the workforce team at the Welsh Government and are represented on the wider stakeholder Strategic Education Development Group.
    - WIHA will be happy to submit more detailed aggregated workforce data and would welcome an opportunity to work with the Committee.

- **How well-equipped is the workforce to meet future health and care needs?**
    - Independent Sector providers are carrying out their own workforce planning exercise and it is clear that the aging workforce is going to have a detrimental effect within health care within the next 5 to 10 years unless more student nurses are trained, specifically within the theatre environment. The area which is experiencing continuous difficulty are theatres and this will continue unless attention is given to this specialised area.

      WIHA has a constructive relationship with parts of the Welsh Government, in particular the Chief Nursing Officer, with whom we have twice yearly meetings. On the whole, the Welsh Government understands the contribution of independent mental health, learning disabilities and acute hospitals. However, WIHA has experienced some difficulties in engaging with certain sections of the Welsh Government in terms of workforce issues.

- **What are the factors that influence recruitment and retention of staff across Wales? This might include for example:**
  1. **the opportunities for young people to find out about/experience the range of NHS and social care careers;**
  2. **education and training (commissioning and/or delivery);**
  3. **pay and terms of employment/contract;**

     WIHA members already offer clinical placements to student nurses and allied health professionals and would welcome the opportunity to develop more places.

     - Independent hospitals also offer a range of education and career development opportunities for staff. The booklet *Career Opportunities in Independent Hospitals*, produced by the UK-wide Association of Independent Healthcare Organisations (AIHO) highlights these.

9 September 2016

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WF 09
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Brenhinol y Meddygon o Caeredin
Response from: Royal College of Physicians of Edinburgh

The National Assembly for Wales

Inquiry into the sustainability of the health and social care workforce

Response from the Royal College of Physicians of Edinburgh

1. The Royal College of Physicians of Edinburgh (RCPE) is an independent clinical standard setting body and professional membership organisation, which continually aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout the UK and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties.

2. Workforce planning: The RCPE supports increased availability of consultant-delivered care, including at evenings and weekends, where there is potential to improve quality of care for patients with the appropriate staff and services in place. It is essential that an evidence-based approach to extended working is taken, recognising the importance of a multi-professional approach and an appropriately phased implementation. This cannot be delivered without additional resource, increased medical staffing, clinical time, and increased support from services such as radiology; pathology and allied health professionals (AHPs).

3. Collaboration is vital between the Government and clinicians to build upon the emerging evidence in this area, such as the findings of the RCPE's expert workshop on extended working. The medical workforce faces a number of challenges and the RCPE recognises the need for safe and sustainable staffing levels throughout the NHS. We need to ensure that we continue to recruit and retain a world class workforce to deliver the best possible patient care (1). The RCPE is committed to working with the Welsh Government and other allied organisations to address issues around recruitment and retention such as consultant vacancies, rota gaps and trainee attrition rates, as a matter of priority. We are also committed to working with partner organisations to promote innovative ways of working in the NHS. The roles of Physician Associates, Advanced Nurse Practitioners and other examples of physician extenders should be further examined to create a workforce fit for the future.

4. Political parties must commit to developing and implementing minimum staffing levels for all professions within hospital settings, based upon best evidence (2), along with improved workforce planning which reassesses the size and structure of the consultant workforce taking account of such changes as the rise of part-time working, extended working, and the needs of an ageing population.

5. The College is committed to promoting the highest clinical standards and implementation of robust, evidence-based medical practice. Standards must be measurable and the associated scrutiny proportionate in order to be effective. Improving patient flow across health and social care remains vital in this regard, both in terms of patient safety and quality improvement (3). Patients must be treated in the right place, and as quickly as possible. This requires the right numbers of staff and mix of skills across health and social care.

6. Training: Excellent training is essential to provide excellent patient care. Doctors in training provide a significant level of core hospital services and care, and are key in identifying concerns in service provision and standards of patient care. Our trainees will become future NHS leaders and the RCPE is committed to supporting them throughout their careers.

7. The RCPE calls for the incoming Government to ensure that: UK wide training standards, as regulated by the GMC, must be met throughout Wales; development of Shape of Training should be conducted in Wales with input from the RCPE and implementation must be appropriately evaluated;

medical Royal Colleges need to be able to devise curricula according to patient need, independent of government involvement; training and service are inherently linked and both must be supported in order to deliver high quality patient care. Full adoption of the RCPE's Charter for Medical Training (4) provides this environment.

8. All medical units admitting acutely ill patients must be staffed by doctors in training at registrar level possessing the MRCP (UK) examination, or equivalent Staff, Associate Specialist and Specialty (SAS) grade doctors, working under the direct supervision of consultant staff, all on robust and sustainable rotas. A healthy working environment must also be ensured by, for example, a zero tolerance approach to bullying, harassment or undermining behaviour.

References

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4 RCPE Charter for Medical Training.
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WF 10
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Brenhinol y Seiciatryddion
Response from: Royal College of Psychiatrists

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DATE: 09 September 2016
RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS IN WALES

RESPONSE TO: National Assembly for Wales Inquiry into the Sustainability of the Health and Social Care Workforce

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

This evidence was prepared by the Royal College of Psychiatrists in Wales.

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RCPsych in Wales - Previous workforce consultation responses

The RCPsych in Wales has previously submitted responses to Welsh Government consultations on workforce. These include:

- Welsh Government – Health Professional Education Investment review
- Welsh Government (commissioned) - review into the NHS Workforce

RCPsych Workforce Census

- The RCPsych has recently published the results of its Workforce Census

NHS ten- year plan on workforce

In March 2015, the minister announced that a 10-year national workforce plan for the NHS will be developed, bringing together work already underway, including prudent healthcare principles. It will be informed by two areas of work – the primary care workforce plan and the independent review of the NHS Wales workforce (see above).

The RCPsych in Wales is pleased to respond to this inquiry by the National Assembly for Wales.

1. **Do we have an accurate picture of the current Health and Care Workforce? Are there any data gaps?**

The RCPsych conducts Psychiatry workforce censuses for Consultants and Staff and Associate Specialist Grade Psychiatrists every two years (link above).

The Royal College of Psychiatrists census was conducted at the end of 2015 and gives a snapshot of staffing as of 30 September 2015. We are pleased that nearly 90% of NHS trusts/Health Boards responded to the workforce census, up from 79% in 2013.

Summary of findings

The detailed findings are set out in the report of the workforce census for 2015 but the headlines are:

- A reported increase in filled consultant posts (up 5.9% from 2013).
- A gradual and continuing shift towards gender parity in consultant staffing.
- An ongoing rise in the number of vacant or unfilled consultant posts, concentrated in General, CAMHS and Old Age psychiatry, and in the London area.
- A decrease in the number of filled SASG posts, a reflection of the ongoing recruitment difficulties at that grade.

Trusts/Health Boards continue to report job plans of above 10PAs as very much the exception – this almost certainly represents a hidden cut in manpower, taking account of the number of vacant posts.

The long anticipated increase in retirement numbers as a result of pension changes has not yet become an eventuality – this is an area that the College, along with others such as Health Education England, will continue to monitor and gather intelligence on, to ensure that the supply of psychiatrists is sufficient to meet the demand for high quality services.

Feedback from College Assessors attending Advisory Appointment Committees indicates that competition ratios for consultant posts is lower than in other parts of the UK, though competition for posts appears to be declining nationally.

Competition rates for consultant posts – by applications – by region, since January 2014

Region	Competition
London	**6.7**
South East	**4.4**
Eastern	**4.2**
AVERAGE	**4.1**
W Midlands	**3.8**
N Ireland	**3.3**
Trent	**2.9**
North & Yorks	**2.7**
South West	**2.6**
North West	**2.4**
Wales	**1.7**

(*Source: RCPsych workforce 2015*)

2. **Is there a clear understanding of the Welsh Government's vision for Health and Care Services and the workforce needed to deliver this?**

The RCPsych in Wales was encouraged by the announcement in March 2016 by the then Minister of Health and Social Services that a 10- year national workforce NHS plan for Wales would be developed. We responded accordingly to the consultation process that lead to this announcement (links above).

Within its manifesto document, the RCPsych in Wales calls upon Welsh Government for development of a National Workforce and Training Strategy which places greater emphasis on medical professions that are in recruitment and retention crisis such as psychiatry.

Together for Health (2011) is the Welsh Government's five- year strategy for the NHS in Wales. It aims to address financial problems and other pressures, including a rising elderly population, changes in clinical practice, enduring health inequalities, an increase in the number of people with chronic illnesses, and poor organisational performance.[2]One of the main plans of the Welsh Government outlined in the strategy is 'Workforce Development'.

[2] Welsh Government (2011), *Together for Health*, Cardiff: Welsh Government, p.1

The RCPsych in Wales would again stress that the rising elderly population in Wales will impact significantly on future services in Older Adult Psychiatry. There is a trend indicating a shortfall of Older Adult and General Adult Psychiatrists in Wales. Historical low numbers of Core trainees are now leaving gaps in higher training rotations in Wales. Demand forecasts for Consultant Psychiatrists until 2026 are available in the RCPsych in Wales response to the Review into the NHS Workforce 2015.

3. **How well-equipped is the workforce to meet future healthcare needs?**

The RCPsych in Wales thinks the current workforce is not well enough equipped to meet future healthcare needs.

In 2011, the NHS in Wales responded to the Strategy by commissioning Marcus Longley, Professor of Applied Health Policy and Director of Welsh Institute for Health and Social Care, to review the state of NHS. The purpose was to determine what factors were influencing changes in service provision, and to provide possible solutions. One of the main findings of the report was that 'Unless action is taken quickly, the shortage of medical staff in some services is likely to lead to the unplanned closure of those services'.

There are also barriers to workforce planning within the current Health Board structures. These include relatively small numbers of psychiatrists employed by each health board especially in smaller psychiatric sub-specialities, limited connections between health boards and deanery structures.

Psychiatry has one of the highest number of locum posts of any specialty in the Wales. This is not sustainable and does not fit the principles of the Prudent Healthcare Agenda.

4. **What are the factors that influence recruitment and retention of staff across Wales?**

The RCPsych (UK) has recently revised its recruitment and retention action plan. This document provides a detailed set of initiatives developed to improve recruitment and retention across the UK.

The RCPsych in Wales believes that in order to improve rates of recruitment, young people should be targeted at secondary school age and medical schools to be well informed of NHS careers. Work experience, careers fairs and Young People's debates on Mental Health provide young people the experience and knowledge to make an informed decision about their future career.

The RCPsych in Wales has published its Recruitment and Retention Action Plan 2015 - 2017 and works constantly to improve the rates of recruitment and retention in Wales. We strive to:

- Reduce stigma and promote good mental health within secondary schools in Wales.
- Reduce stigma and promote psychiatry within medical schools in Wales.
- Ensure high quality and supported training at core and higher level within psychiatry in Wales.

Retention of Psychiatrists and trainee psychiatrists is a major issue. Factors that influence this include lack of good quality training experience in some areas,

stigma within the medical profession and pressures on services. Wales specifically has issues with rurality and some Health Boards find it difficult to recruit to rural posts. Discussions with members in Wales have highlighted that pay is not *the* major factor in recruitment. Quality of service provision, support services, work-life balance and job satisfaction are seen as priorities.

The RCPsych in Wales is aware of the impact that the new junior doctor contract is having in England. We are encouraged that no plans to implement such a contract have been announced in Wales. This would lead to a further reduction in Recruitment and Retention of psychiatry doctors in Wales.

It remains to be seen what impact leaving the EU will have on Recruitment and Retention in Wales. The College in Wales will not speculate on this issue.

5. **Are there any particular issues in some geographical areas, rural or urban areas, or areas of deprivation?**

It has long been documented that there are issues recruiting into some of the more rural parts of Wales. Problems that include, for example, training posts that require the post holder to travel for 2 hours between appointments. This is most apparent in Powys Teaching Health Board and Hywel Dda Health Board. Betsi Cadwaladr University Health Board also covers a large rural area with lengthy distances between hospitals.

The use of telemedicine has been discussed and is considered a possible solution. The Mid Wales Collaborative published 'A review of telehealth, telecare and telemedicine' in January of this year. This method would be extremely useful in the delivery of training and education between health professionals. However, within the specialty of psychiatry, this form of communication between doctor and patient should be approached with caution due to the nature of illness.

Areas of deprivation (urban and rural) have historically been difficult to recruit to.

Additionally, the RCPsych in Wales believes that Welsh Language provision should be provided for patients where this is requested. There is a current lack of Welsh speaking Psychiatrists in Wales.

Professor Keith Lloyd

Chair, RCPsych in Wales/President, RCPsych

WF 11

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Coleg y Therapyddion Galwedigaethol

Response from: College of Occupational Therapists

Response from the College of Occupational Therapists: Health, Social Care and Sport Committee Inquiry into the sustainability of the health and social care workforce

1. Introduction

1.1. The College of Occupational Therapists is the professional body for occupational therapists and represents around 30,000 occupational therapists, support workers and students from across the United Kingdom and 1,600 in Wales. Occupational therapists work in the NHS, local authority housing and social services departments, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services. Occupational therapists are regulated by the Health and Care Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

1.2. The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, living independent lives in their own homes, caring for themselves and others, working, and learning, playing and interacting with others. Being deprived of or having limited access to occupation can affect physical and psychological health.

2. **Do we have an accurate picture of the current health and care workforce? Are there any data gaps**?

2.1. Yes, the separation of health and social care workforce data, planning, education commissioning and professional development activities prevents full data gathering and understanding for the current workforce position. For example, are joint or integrated services captured in both NHS and local government) data sets? In the local government data (annex 1, below) it is unclear whether data for local government includes those in housing departments or is solely from social services. The inclusion of figures under social *work* implies they are social services only, but it is not clear if they are only adult social care or if they capture the children's workforce.

2.2. It is also not possible to identify in which services the occupational therapy workforce is delivering. For example, how many occupational therapists work in mental health, or with children and young people, in CAMHs, learning disabilities or primary care?

2.3. There is no way to identify occupational therapists in posts which are not titled occupational therapist. The local government data does not show the occupational therapy team managers we know exist. In the NHS we cannot identify the many occupational therapists in reablement, management, primary mental health practitioner posts etc. This lack of clarity limits accurate understanding of the workforce.

2.4. There appears to be no data capture of the workforce employed as part of the Department of Work and Pensions schemes. Welsh government should consider requiring this data to be provided as part of the commissioning of schemes such as employment support and personal independence assessments in order to match up the numbers of graduates to the real workforce requirements.

2.5. A third of the occupational therapy workforce is aged over 50 and could be lost over the next 15 years due to retirement. This needs to be taken into account to ensure a stable workforce for the future.

2.6. The data shows the very small number of occupational therapists within the health & social care workforce compared to other groups. (1,254 full time equivalent occupational therapists in NHS Wales in September 2015 https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/Scientific-Therapeutic-and-Technical/staff-by-areaofwork-year (accessed 17.8.16)) (See also separately attached Appendix A: workforce statistics briefing). When percentage figures are used to consider commissioning cuts or

increases in workforce figures this can be very misleading when compared with large groups such as, for example, nursing.

2.7. Workforce planning and development and service improvement should be integrated across health and social care. The development of a single strategic body for commissioning education and workforce planning, as recommended in the recent Health Professional Investment Review, would be an excellent development. This should also be integrated with social care commissioning and workforce planning. The College response to the Review is here: https://www.cot.co.uk/consultation/wales/health-professional-education-investment-review-21-14-15). Many occupational therapy services already span the boundary and staff are either jointly employed or work across multi agency teams. Workforce planning needs to reflect this reality.

3. Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

3.1. Occupational therapists are the key Allied Health Professionals that work in the health, social care and housing sectors with expertise navigating across these boundaries. The College welcomes increased integration of services. The Welsh Government's vision for health and social care is closely aligned to the philosophy and principles of occupational therapy. The profession has an influential and pivotal role to play in delivering this vision and already embraces the skills needed to work in an integrated, person centred and outcome focussed way. The Occupational Therapy Advisory Forum (the occupational therapy health and social care managers in Wales) have produced an excellent report describing many of the innovations already being delivered throughout Wales. See: http://gov.wales/docs/phhs/publications/150529guidanceen.pdf.

3.2. A clear workforce plan is needed to ensure that innovation is strategic and the workforce is used to best effect. There are many areas where occupational therapy can offer significant workforce skill to modernise services. Changes in the funding, location and use of the profession will be needed. For example, by increasing the proportion of posts located in primary and community care. Managers report that although there are have some challenges for recruitment overall there is a positive picture. Where primary, community and integrated posts are created they are easy to recruit to.

3.3. General Practitioner (GP) practices are under significant pressure; providing significantly more consultations in Wales than they did five years ago. Urgent attention must be paid to considering how to free up GPs to do what only do GPs can do and how some of their other tasks could be undertaken by other healthcare professionals. The Primary Care Plan has identified the need for increasing the wider primary care workforce and occupational therapy is an important member of that wider workforce.

4. How well-equipped is the workforce to meet future health and care needs?

4.1. The workforce is well equipped as the following paragraphs show. However, there is concern that unless current levels of occupational therapy commissions are protected, there will be insufficient capacity to meet future needs. The implications of increasing complexity of conditions; greater numbers of frail older people and the high age of one third of the current available workforce need to be recognised in future commissioning.

4.2. Pre-registration occupational therapy education in Wales is already preparing students for person centred services and practical prudent intervention. The focus of occupational therapy on enabling occupation provides practical and outcome orientated interventions which are particularly relevant for those with long term complex, multiple conditions or sets of needs. There are three pre-registration B.Sc. programmes across Wales, but no Master's level pre-registration courses in Wales as there are in the rest of the UK.

4.3. The inquiry should consider how students can access placements in modern services and access community-based and often rural services. Placements are easier to access

in hospitals and other centres where there is a concentration of staff able to support student learning: no need for cars (and many students are unable to claim support for travel on placement): and the existence of hospital accommodation (when students need to pay for accommodation both at university and on placement). Students must undertake approximately one third of their course time in practice. This requires services to support students' practise based learning in the right models of care.

4.4. Access to Post Registration development needs to improve. There are significant challenges in supporting the existing workforce to develop, improve and maintain their skills and ensure they can deliver the services needed in the future. The Advanced Practitioner Framework and forthcoming AHP career framework (modernising AHP Careers) will help. The staff employed in the NHS haver access to a range of personal development processes including funding and release from work. This is not the same for those employed in local government where access is severely limited.

4.5. There is a lack of post registration career pathway and continuing professional education and learning (CPEL) for occupational therapists in local government. This inequity is increasingly impacting on the ability to recruit and retain occupational therapists in social care and as more and more services are integrated this places significant pressures where two occupational therapists are employed in the same (integrated) team, by different employers with different opportunities for career development, support, supervision and opportunities for career progression. Such a lack of continuing development impacts on service outcomes and workforce retention. This is described in more detail under the next question (5)

4.6. Support workers are an essential part of our workforce. The profession is pleased to support our vital support workforce via the new Diploma in Occupational Therapy Support (http://www.agored.cymru/Units-and-Qualifications/Qualification/127254). The Diploma offers opportunities for support workers wherever they work. It is accredited by Agored Cymru, approved by Skills for Health on the QCF and in an apprenticeship framework: It is recognised by the College of Occupational Therapists and endorsed by the Care Council for Wales. This helps staff move across the sector taking their qualification with them. It is an excellent example of how Wales needs to develop to integrate workforce qualifications to meet the Welsh Government's vision for health and social care.

5. **What are the factors that influence recruitment and retention of staff across Wales?**

5.1. There is not a significant problem filling current posts. However, demand is increasing without equivalent increase in posts. The numbers of occupational therapists employed in health have shown an 18% decrease from the figures from StatsWales between 2013 -14. There has also been a small decrease in the numbers of occupational therapists in social care over a five year period of time. This means the existing workforce is facing increasing pressure in their workloads, increasing stress levels and staff turnover.

5.2. There is insufficient information available to reflect fully the exciting opportunities for a person entering the profession, whether by a professional or a support worker route. This is true across health, social care and housing. It is particularly difficult for young people to find out about a career in social care occupational therapy and there is an opportunity for Social Care Wales, with a new role for the whole social care workforce to promote occupational therapy as a social care career.

5.3. 'Mature' (over 21 years) students also seek to make a career change into occupational therapy alongside those who already have a first degree and seek to change direction. There are no master's entry level programmes, distance learning or part time routes into occupational therapy in Wales even though these exist in other UK nations. A thorough workforce review including examination of the types of people applying to the profession might indicate whether these routes would help attract applicants from a wider population.

5.4. Occupational therapy workforce planning and education commissioning is currently part of the Workforce and Education Commissioning Service (WEDS) remit, funded wholly via the NHS budget. The profession is grateful that the 2008 Health, Wellbeing and Local Government Committee Inquiry into Workforce Planning in the Health Service and in Social Care March 2008 identified (recommendation 28) the need to take into account the social care workforce needs for the profession. Since this time, the Care Council has collected workforce numbers for occupational therapy which have been incorporated into the commissioning numbers for the profession. (http://www.weds.wales.nhs.uk/sitesplus/documents/1076/Inquiry%20into%20workforce%20planning.pdf). This lack of scrutiny of the social care workforce is reflected in the poor post registration and career pathway opportunities for occupational therapists. Wales also does not capture the workforce in other employers, including the DWP employment schemes, third sector and independent employers.

5.5. The current lack of promotion, career development and CPD opportunities for occupational therapists in local government is having a significant impact on the recruitment, retention and development of occupational therapy there. We are pleased that Welsh Government and the Association of Directors of Social Care (ADSS) are supporting the development of new career framework for occupational therapists in social care to fit alongside the one available for occupational therapists in the NHS. This will be vital to recruit and retain skilled staff.

5.6. The College is acutely aware of the differentials in pay and reward between staff in the two sectors, particularly in respect of training opportunities and the principle of equal pay for work of equal value. As more services are integrated these differences in pay, terms and conditions within integrated services will need to be considered to ensure there is parity between responsibilities and their grade and pay and equal opportunities for career development. There are already situations where two occupational therapists in an integrated team may be doing the same job for different pay, different hours of work and amount of annual leave, with different career prospects, different levels of support, development /training and supervision.

6. Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

6.1. There is a clear indication that access to a service on placement during the programme raises interest in a post there once qualified. This adds to the importance of considering access to rural and community placements for students.

6.2. It remains more difficult for services in rural and remote areas to attract applicants for posts than those in the cities, particularly those near the universities where students have already established themselves. There is a need for workforce planning to consider how new configurations of occupational therapy services in primary and community services can be achieved to meet future needs.

The College would be pleased to offer any further information or provide oral evidence to the committee. Please do not hesitate to contact the Wales Policy Officer at the address below

Julia Skelton, Director of Professional Operations, College of Occupational Therapists
Ruth Crowder, Wales Policy Officer, College of Occupational Therapists
ruth.crowder@cot.co.uk 029 2076 2834 / 07585 606385

(See annex 1 overleaf for data on local government and the separately attached Appendix 1 for workforce statistics in occupational therapy)

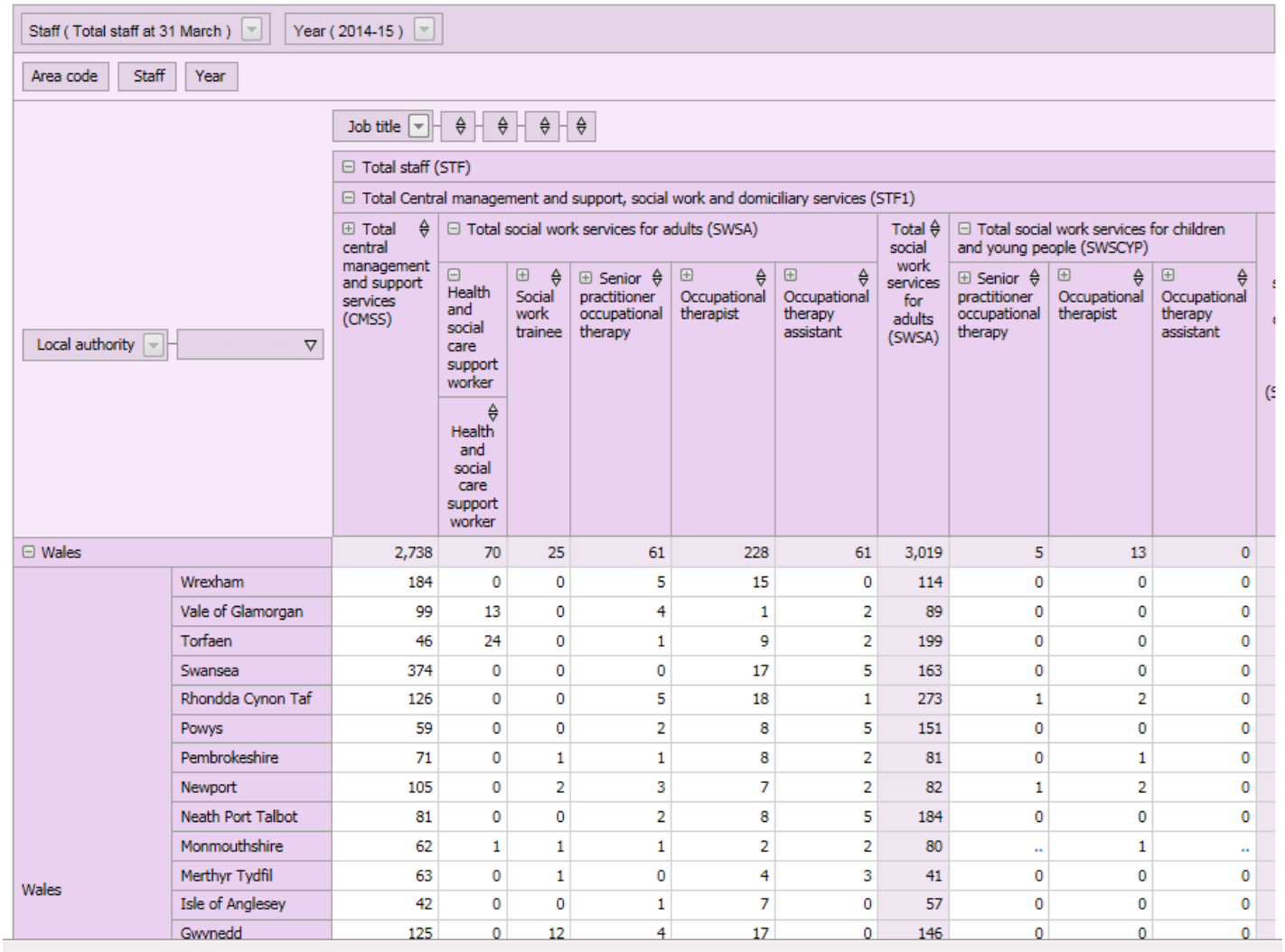
Annex 1: StatsWales Local Government data March 2015 (NB lacks Carmarthenshire)

At 31 March 2015

Occupational therapist - Staff structure (Headcount)

	Establishment	Full time in post	Part time in post	Total staff	Vacancies	Other agency workers
Isle of Anglesey	8	4	4	8	-	-
Gwynedd	21	13	8	21	-	-
Conwy	14	8	6	14	-	-
Denbighshire	23	13	8	21	2	1
Flintshire	35	31	4	35	-	-
Wrexham	21	14	6	20	1	-
Powys	11	3	7	10	1	2
Ceredigion	16	12	2	14	2	-
Pembrokeshire	11	7	3	10	1	-
Carmarthenshire						
Swansea	17	13	4	17	-	-
Neath Port Talbot	11	8	2	10	1	-
Bridgend	11	10	1	11	-	-
The Vale of Glamorgan	8	5	3	8	-	2
Cardiff	21	8	13	21	-	3
Rhondda Cynon Taf	27	15	11	26	1	-
Merthyr Tydfil	4	4	-	4	-	-
Caerphilly	27	21	5	26	1	-
Blaenau Gwent	4	2	-	2	2	-
Torfaen	10	9	1	10	-	-
Monmouthshire	5	3	1	4	1	3
Newport	13	9	4	13	-	-
Wales	**318**	**212**	**93**	**305**	**13**	**11**
North Wales	**122**	**83**	**36**	**119**	**3**	**1**
Mid & West Wales	**66**	**43**	**18**	**61**	**5**	**2**
South East Wales	**130**	**86**	**39**	**125**	**5**	**8**

The Screenshot below of the StatsWales page shows the lack of detailed data for occupational therapists in local government. The College is aware of Team Managers and staff in Reablement Teams, of Joint funded and integrated service posts, there are also occupational therapists in Local Government housing departments but it is not clear how or if any of those posts are included in the data captured by StatsWales which sits under 'total social work services'. A search for social workers shows a completed career hierarchy for members of that profession. This further demonstrates the lack of a career framework for occupational therapists wishing to make a career in social care in Wales.



Staff (Total staff at 31 March) | Year (2014-15)

Area code | Staff | Year

Job title

Total staff (STF)

Total Central management and support, social work and domiciliary services (STF1)

Local authority		Total central management and support services (CMSS)	Total social work services for adults (SWSA)					Total social work services for adults (SWSA)	Total social work services for children and young people (SWSCYP)			
			Health and social care support worker	Social work trainee	Senior practitioner occupational therapy	Occupational therapist	Occupational therapy assistant		Senior practitioner occupational therapy	Occupational therapist	Occupational therapy assistant	
			Health and social care support worker									
Wales		2,738	70	25	61	228	61	3,019	5	13	0	
Wales	Wrexham	184	0	0	5	15	0	114	0	0	0	
	Vale of Glamorgan	99	13	0	4	1	2	89	0	0	0	
	Torfaen	46	24	0	1	9	2	199	0	0	0	
	Swansea	374	0	0	0	17	5	163	0	0	0	
	Rhondda Cynon Taf	126	0	0	5	18	1	273	1	2	0	
	Powys	59	0	0	2	8	5	151	0	0	0	
	Pembrokeshire	71	0	1	1	8	2	81	0	1	0	
	Newport	105	0	2	3	7	2	82	1	2	0	
	Neath Port Talbot	81	0	0	2	8	5	184	0	0	0	
	Monmouthshire	62	1	1	1	2	2	80	..	1	..	
	Merthyr Tydfil	63	0	1	0	4	3	41	0	0	0	
	Isle of Anglesey	42	0	0	1	7	0	57	0	0	0	
	Gwynedd	125	0	12	4	17	0	146	0	0	0	

https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Staffing/StaffOfLocalAuthoritySocialServicesDepartments-by-LocalAuthority-PostTitle

WF 12

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Conffederasiwn GIG Cymru

Response from: Welsh NHS Confederation

	The Welsh NHS Confederation and NHS Wales Employers response to the Health, Social Care and Sport Committee inquiry into the sustainability of the health and social care workforce.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted] Richard Tompkins, Director, NHS Wales Employers. [redacted] Tel: [redacted] Jayne Dando, Head of Workforce Strategy & Planning, Workforce, Education & Development Services (WEDS).
Date:	8 September 2016

Introduction

1. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee inquiry. We hope that our response, which has been developed with our members, including Directors of Workforce and Organisational Development (OD), highlights the key issues and challenges that we face in Wales. The Welsh NHS Confederation and Directors of Workforce and OD would be more than happy to provide further information to Members of the Committee.

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

3. NHS Wales Employers is hosted by and operates as a part of the Welsh NHS Confederation. NHS Wales Employers supports the strategic workforce agenda of the NHS in Wales from an NHS employers' perspective. NHS Wales Employers support the employers with workforce policy development, practical advice and information, and enables the NHS Wales Workforce and OD community to network, and share knowledge and best practice.

Key points

4. The health service is Wales' biggest employer, currently employing around 86,500[i] staff and providing a significant contribution to both the national and local economy. As changes in demographics and our lifestyles have resulted in a dramatic rise in demand on the health and care services, it has become increasingly clear that a transformation in the way treatment is delivered is required if the NHS is to meet the needs of a future population. A sea-change in the way services are designed is vital. A key aspect to driving this, and successfully putting NHS Wales on a sustainable footing, is the workforce.

5. With an ageing population and a rising number of people with complex and chronic conditions, the workforce must be ready to evolve and respond to the challenges ahead. As well as meeting the future needs of the population, the workforce must also develop new ways of working to

address concerns about an expected shortfall in the future NHS workforce, especially for certain types of jobs and in different regions of Wales.

6. The Welsh Government (WG), through cross-party support, must help facilitate sustainable long-term workforce planning according to the needs of local communities. Future demand for health and social care will not be met unless we plan, develop and use the health and social care workforce differently. The Welsh NHS Confederation Policy Forum, consisting of health and social care organisation from across Wales, have recently developed the "One workforce: Ten actions to support the health and social care workforce in Wales"[ii] document which has been endorsed by nearly 40 organisations. The document, which is included as part of our submission, considers the ten key areas to ensure a sustainable health and social care workforce in the future. Members of the Policy Forum will be highlighting these key areas, including having a long term vision for health and social care, with all Assembly Members in the coming months.

7. We now have an opportunity in the fifth Assembly to put forward a long term vision for the health and social care workforce, acknowledging that the workforce needs to change to deliver integrated, personalised care closer to home.

1. Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

8. Overall we have an accurate picture of the current health and care workforce working in secondary and community care services (Health Boards and Trusts). There are, however, significant challenges in accessing comprehensive data for primary care as well as being able to develop a comprehensive picture of the social care workforce. As we move to different models of delivery, primary care will no longer be a sector in isolation and increasingly Health Boards are taking on primary care functions or working with practices to deliver innovative workforce solutions. This changing landscape will increase the importance of needing to have comprehensive data available, gathered through reliable systems.

9. Workforce information for the NHS Wales employed workforce is provided through the Electronic Staff Record (ESR). All Health Boards and Trusts in Wales use the system and centrally there is a Data Warehouse that is accessed by analysts employed by Workforce, Education and Development Services (WEDS) and NHS Wales Shared Services Partnership (NWSSP) who can access data on a Wales basis to support workforce planning, workforce performance and pay modelling. Whilst this data set is comprehensive ESR does not currently hold information on skills and competences. Maintaining accurate data systems is always a challenge as well as ensuring that reporting can be accurate and as "real time" as possible. These systems will always require significant support and funding to enable the service to be accurately informed about trends and areas for action.

10. The NHS ESR Programme provides NHS Wales with an integrated HR, Payroll and learning management system and service. The system is undergoing a wide programme of development to deliver enhancements identified following user consultation. These developments will include enhanced user interfaces. NHS Wales has embarked on a programme of work "ESR Hire to Retire" aiming to fully roll out ESR self-service to managers across NHS Wales and to maximise opportunities to drive efficiency and benefits realisation through the following key areas:

a. Reducing recruitment timescales through full deployment of ESR functionality and workforce interfaces;

b. Supporting the reduction of sickness absence through improved data reporting and use of real time Business Intelligence reporting;
c. Full deployment of ESR Self Service;
d. Payroll paper free systems;
e. Single data entry; and
f. Real time accurate information.

11. While we have data systems available in the NHS there are some areas where there are data gaps, for example primary care. To develop a complete picture of the workforce NHS Wales also needs to have a clear picture of primary care. Currently this data is not readily available in the following areas:

a. For practice based staff, other than manual trawls for information from health boards, there is no easily accessible information on a Wales wide basis. NHS Wales supports WG consideration of the Primary Care Web based tool currently being rolled out by NHS England. It is understood that over 85% of practices in England now use this system. Use of this tool would provide NHS Wales with comprehensive practice based staff workforce information and would also provide access to a Data Warehouse facility similar to that provided for ESR. This would support workforce planning at both a local and national/strategic level. NWSSP has been working with WG to understand the detail of the PC Web Based system and to assess the implementation requirements.
b. For other primary care staff there is limited available data e.g. Community Pharmacy, Optometry, etc. NWSSP and WEDS were provided with funding by WG for a period of 6 months to undertake work into what primary care workforce data is available and this is being developed further.

12. The WG has indicated that it would like to access information about social care staff who work "at the interface" between health and social care. A mechanism to identify such staff is being considered.

2. Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

13. It is important for the development of the workforce that there is a clear strategic direction to build on or replace "Together for Health" which supported the last Government's programme. It is expected that any new vision/strategy will present new workforce challenges and therefore the sooner that this vision is agreed and published the sooner the service can focus and align its programmes of work around its priorities.

14. Notwithstanding the above, in ensuring a clear and shared understanding of WG's vision for health and care services the focus and emphasis of any new vision/strategy will, it is expected, follow many of the current themes and priorities. As such the following themes are being taken forward by the service:

a. Developing the prudent workforce for the future;
b. Developing effective care and support models (primary, community, secondary and social) to best meet the needs of an ageing population and increasing complex diseases;
c. Delivering high quality, safe and prudent healthcare to optimise outcomes for patients;
d. Adopting innovation and technology to transform health, care and well-being;
e. Establishing more responsive, open, usable, inter-operable and accessible data resources to best deliver effective health and care;

f. Using resources effectively and efficiently to enable and deliver up-to-date health and care (including financial, infrastructure, digital and estates);

g. Embedding prevention and early intervention to improve population health;

h. Focusing on early years to optimise health and well-being for present and future generations;

i. Embedding the Well-being of Future Generations (Wales) Act 2015, with health as a leading partner and through effective collaboration; and

j. Making the best of ourselves for Wales – embedding effective, modern-day leadership for current and future leaders.

15. How these themes translate into workforce strategy and plans is challenging and is underpinned by:

a. Changing the way that the workforce is engaged, educated and trained to enable more flexible working across a range of settings to reflect changing patient needs and service delivery models – includes technological change;

b. Redesigning workforce models and jobs to avoid rigid demarcation and building smooth handovers at key points of contact so that from a patient perspective care is delivered seamlessly by an effective multi-disciplinary team;

c. Service users are increasingly developing more multiple and complex conditions requiring a holistic care approach. The development of increasing sub specialisation of professional staff militates against this. For the future a focus on generalist as well as specialist skills will be essential;

d. The need to examine work content and engage staff in redesigning work that delivers prudent outcomes;

e. Ongoing development of whole system workforce planning based on population based planning systems;

f. Joining up understanding of workforce supply and demand risk (e.g. projected undersupply of some medical specialties) with opportunities to develop the wider multi-disciplinary team;

g. Evaluation of developing workforce models in primary care. The Nuffield Trust[iii] has suggested that the greatest opportunities for skill-mix lie in primary care services; and

h. Aligning workforce skill mix across patient pathways from primary, secondary and tertiary care.

16. In the Workforce and Organisational Development Directors "Shape of Workforce" work programme the following key actions have been identified:

a. Redesign across the whole workforce by patient pathway / service - prioritising areas for redesign linked to population based planning;

b. Identify scope for band 4 development and in which areas. Maximised use of Wales Delegation Guidance e.g. Modernising Scientific Careers in restructuring Pathology;

c. Driving workforce changes "at scale" underpinned by education and training;

d. Further development of bespoke training to extend clinical skills;

e. Extend facilitated approaches to redesign for to support managers in workforce transformation;

f. Identify scope for workforce development of multi-disciplinary team: e.g. Pharmacy, Paramedics, Extended skills Nurses and Allied Health Professionals;

g. Identify scope for medical workforce transformation e.g. Shape of Training; and

h. Greater use of modular programmes to support skill-development and re-visiting of the concept of the skills escalator.

17. NHS Wales is also exploring appropriate models that support integration, such as the:

- Spread of evaluated workforce models that support delivery of a social model of health;
- Use of mechanisms to address and mitigate against barriers to workforce integration;

- Health and social care working as a single, whole system; and
- Workforce that is skilled to care for people with multi-morbidities that span mental and physical health and skills to act as a 'partner' and 'facilitator', rather than an 'authority'.

18. The change needed in this regard is summarised below:

Current view	Evolving model of care
• Geared towards acute conditions	• Geared towards long term conditions
• Hospital centred	• Embedded in communities
• Doctor dependent	• Team based
• Episodic care	• Continuous care
• Disjointed care	• Integrated care
• Reactive care	• Preventative care
• Patient as passive recipient	• Patient as partner
• Self-care infrequent	• Self-care encouraged and facilitated
• Carers undervalued	• Carers supported as partners
• Low Tech	• High Tech

3. How well-equipped is the workforce to meet future health and care needs?

19. The Centre for Workforce Intelligence (which was disbanded in March 2016) undertook a major study of NHS workforce skills and developed the Horizon 2035 skills framework. The framework provided two "lenses" through which skills and competencies of the workforce and the demand drivers could be viewed. Consideration of the future workforce in such terms is helpful in focusing attention more on skills and competencies matched to patient need rather than professional staff groups. Such work has identified that the future skills deficit is likely to be at "lower" skill levels as the population ages. In the short term for NHS Wales there needs to be a focus on the fact that NHS Wales invests circa £350m to support 15000 students and trainees undertaking health related education programmes. It is estimated that circa 60% of this funding is spent on doctors (9% of workforce) and around 31% on nurses (30% of workforce). As little as 5% of the central funding is invested in the clinical support workforce.

Apprenticeship Review and Levy:

20. The review of apprenticeship is in the purview of the Education and Skills Department, and will have a major impact on both the health and social care sectors. However, neither sector has any input into, or influence, over the decisions made by this WG department. It is not known if discussions have been held at an interdepartmental level in WG, as to the impact on, and implications for the health and social sectors with regards to the review or the Levy. If the new model of apprenticeships follows the English model then any new apprenticeships will be employer led. This could reduce the transferability of apprenticeships across employers both within and between the sectors unless a collaborative approach is taken.

21. The formal WG response to the review has been delayed pending the impact of the UK apprenticeship Levy, and the loss of EU funding supporting apprenticeships. The Levy will impact NHS Wales, Local Authorities and any private or third sector organisations with a pay bill in excess of £3million. This will impact on the affordability of accredited training programmes. If the decision is made to return the NHS / Local Authority Levy to the health and social care sectors as ring fenced

training monies, then the sectors would be in a good position to deliver all required accredited support worker training and education, but capacity to scale up quickly may be an issue.

22. In spite of the issues with the process, there are significant opportunities for apprenticeships within the NHS and the service will want to embrace an approach which helps to deliver skills in health and social care through this route. Apprenticeships can also be a valuable way to widen access to health services from candidates within our local communities and to support the development of a shared skill sets across health and social care.

The Health and Social Care Integration Agenda

23. The Social Services and Well-being Act (2014) has put a legal requirement on all public sector bodies to work together to identify population needs, and use pooled budgets to develop and deliver services to meet these needs. The Care Council for Wales (CCW), as Social Care Wales (SCW), is being given the statutory lead in this area. The Well-being of Future Generations (Wales) Act 2015 places corresponding legal requirements on public sector bodies, with NHS Wales as the statutory lead.

24. The Regulation and Inspection of Social Care (Wales) Act (2016) puts a statutory requirement in place to register all domiciliary care and residential care home workers with SCW by 2022, with the Register for domiciliary care workers opening in April 2018.

25. NWSSP, WEDS are working in partnership with CCW to develop joint approaches or resources to support the development of integrated roles. The policy direction for creating joint roles can however impede development and progress. For example regulating social care support workers is a policy decision, regulating Healthcare Support Worker in health is not. Where staff working at the interface and employed by health, with different or better terms and conditions but required as part of a joint role to work within the social care setting i.e. the home of a service user, the issue of regulation becomes significant.

4. What are the factors that influence recruitment and retention of staff across Wales?

i. the opportunities for young people to find out about/experience the range of NHS and social care careers;

26. Health Boards undertake significant engagement with their local communities by supporting work experience, attending careers fairs, encouraging and facilitating volunteering and offering specific insight into working in health through targeted taster days. NWSSP and WEDS have a remit within its work programme for providing a Career's Service for NHS Wales. The resource to support this function is limited (1 Whole Time Equivalent Band 5) with responsibility for on-going management, development and updating of the Careers website. In addition this resource supports one off campaigns required, such as the Core Medical Recruitment campaign which ran during December 2015.

27. The careers service also includes managing the All Wales Careers Network which brings together key partners such as Jobcentre Plus, Careers Wales, education and NHS Wales organisations to share and work collaboratively. In 2015 WEDS managed the hosting of three regional events across Wales to update Jobcentre Plus Careers advisors on the range of professional and vocational job roles available in the health sector. This initiative will be repeated in 2016 to support staff in partner organisations to gain current and accurate information for people seeking

careers advice, both adults and children. There are initiatives in place on widening access to jobs in health and social care such as engaging with schools at an early stage to raise awareness of the number of different roles. A workshop on Widening Access was held in June 2016 to share learning and to explore where opportunities exist to expand on work in this area.

28. The landscape for recruitment campaigns or promotion of NHS Wales has previously been fragmented. There is currently significant work progressing on joint co-ordination of a national campaign to promote working in Wales which is being developed by WG and the service. In addition, many of the Health Boards and Trusts have developed local campaigns, however, these by necessity are often University/professionally focussed and don't take a whole workforce approach despite the fact that there are shortages in many clinical roles. Health Boards and Trusts are working jointly on nursing recruitment and on promoting medical jobs in Wales and most organisations will be represented, together with WG, at a major careers event in October. A targeted GP recruitment campaign will also be launched shortly by the WG as part of the Programme for Government commitment.

ii. Education and training (commissioning and/or delivery);

29. There are a range of issues which need to be considered within the context of education and training, these include:

University provision

30. NWSSP, on behalf of the Welsh Government, will invest over £85m in 2016/17 in the education and training of the next generation of health care professionals. This includes initial education for nurses, midwives, health visitors, allied health professionals, scientists and pharmacists. The funding also supports:

- Some post graduate education for advanced practice;
- Community nursing roles;
- Non-medical prescribing; and
- Education to support health care support worker meet the requirements of the health care support worker career framework.

31. Welsh Universities are part of a larger UK education system and as such cross boarder flow is inevitable and has a positive influence. However in 2015/16 academic year NWSSP commissioned over 2,100 student places in Welsh universities of which:

- 21% of students identified themselves as either fluent in Welsh or as having a basic understanding of Welsh (this needs to be built upon in order to ensure that there is an effective pipeline of students graduating who can undertake NHS roles through the medium of Welsh);
- 62% of students were over the age of 21 with 20% of the total number of students being over 30 years of age;
- 76% of all students were Welsh resident, and one nurse education provider recruited 94% of its students from Wales;
- Of the students recruited onto NWSSP commissioned programmes only 35% enter their education programme with 'A' levels as their highest qualification. However 30% of students in 2014/15 graduated with a 1st class honours degree and 71% of students graduated with a 2:1 or better (up from 58% in 2012/13); and
- Student destination data, as provided by universities in Wales (as of May 2016), identifies that:

- 65% of students are working in Wales;
- 9.5% are working in the NHS in other parts of the UK;
- 3% are working in the private sector; and

- We do not know where 22.5% of the graduates are currently working, this could be in Wales or elsewhere.

32. The removal of the bursary system in England will have implications on Wales as the current bursary system is aligned to the University rather than the area of origin of the student. There is a risk that now the bursary has been removed in England, applications to train in Wales will increase but that the students, on graduating, will not necessarily stay in Wales.

33. It is essential that the commissioned educational places at Welsh Universities, maintains a strong workforce pipeline for the future. A response will therefore need to be developed to the bursary changes in England which actively supports the translation of education commissioning numbers into employees in the Welsh health and social care system.

Workforce supply and demand

34. NWSSP and WEDS has also undertaken modelling work to identify the key variables impacting on the overall nursing workforce. These are:

- Course attrition rate – in Wales course attrition is extremely low when benchmarked against other UK and international programmes – there is little gain to be achieved in this area;
- Welsh student employment rate – during the past 4 years this has ranged from 66% -88% and has the largest impact on the supply of the workforce into the Welsh NHS, it is therefore a key area to target;
- Workforce attrition (leaver & joiner rates) – this has the second largest impact on the FTE numbers. This variable is made up from how many staff NHS Wales is able to attract from other countries and sectors, and how well NHS Wales can retain its' workforce. Managing workforce attrition makes a significant difference to the workforce numbers but this alone will not meet the anticipated demand of the nursing workforce; and
- Non Welsh graduates numbers & new overseas joiners

Qualifications Wales (QW)

35. QW was established through the Qualifications Wales Act 2015 as the regulator of non-degree qualifications, (such as apprenticeships and GCSEs), and the qualifications system in Wales. It is a WG sponsored body, independent of Government, but accountable to WG.

36. Part of its remit includes reviewing vocational qualifications. Their first review focused on the health and social care qualifications suite, concentrating on the 10 most commonly used health and social care qualifications available for public funding, all of which were found to require further development for application in Wales.

37. As a result of the review, QW stated they will create a "*new suite of qualifications for Health and Social Care for learners in Wales, with a target date for first teaching in September 2019*". These qualifications will then replace the qualifications currently underpinning the Health and Social Apprenticeships in Wales.

38. This review will impact on at least 19 of the qualifications that share common mandatory and optional units used by the health and social care sectors.

iii. Pay and terms of employment/contract;

39. The Nuffield Trust research report "A decade of austerity in Wales?"[iv] highlighted the challenge for the NHS workforce pay policy as the economy recovers following the recession. In the post-election summer budget of 2015, the previous Chancellor of the Exchequer stated that public sector pay increases would be restricted to 1% in each of the next four years. In addition the statement also noted that the "*the Government expects pay awards to be applied in a targeted manner within workforces to support the delivery of public services*" adding that "*as part of the forthcoming Spending Review, the Government will continue to examine pay reforms and modernise the terms and conditions of public sector workers. This will include a renewed focus on reforming progression pay, and considering legislation where necessary to achieve the Government's objectives*".

40. The rate of inflation in the economy and the rate at which pay inflation exceeds NHS cost of living increases will have a bearing on how the NHS workforce responds and NHS Wales organisations will not be divorced from the wider impacts and affects that public sector pay restraint will have throughout the UK. This position is now more uncertain given the indications of a slowing of the UK economy following the EU referendum and the potential impact on the UK Government's spending plans.

41. The Pay Review Body (PRB) and the Doctors and Dentists Review Body (DDRB) both have a remit to advise and make recommendations on NHS pay and in normal circumstances they would be able to address any wider impacts in the economy and across NHS professions and specific roles. Whilst the PRB may be given remits to consider pay reform over the next 4 pay cycles, the 1% "pay cap" will restrict any recommendations which may need to be made to respond and/or address any observed movement in the NHS labour market. It is however, expected that the PRB will continue to recommend that employers and trade unions explore how the current system is operating, so as to ensure that pay and associated terms and conditions are appropriately aligned to the areas where pay and reward can have the optimal impact.

42. In addition, having a common NHS pension scheme with England provides for a seamless transition of staff into and out of Wales where benefits are carried forward within the single scheme arrangements.

43. The Agenda for Change structure of common pay bands underpinned by the Job Evaluation Scheme provides consistency across Wales, as well as the other three UK nations comprising the UK NHS Staff Council. This is an important feature for recruitment and retention of NHS Staff in Wales. The terms and conditions are also common to all NHS employers and an employee's continuous previous service with any NHS employer counts as reckonable service in respect of NHS agreements on redundancy, maternity, sick pay and annual leave.

44. Wider reform of public services in Wales are set to develop further with greater integration of health and social care. The Workforce Partnership Council is addressing many of the areas of common interest in respect of the workforce but for health it is essential that the discrete system within which the NHS operates, as a public service, is acknowledged as having many features where NHS solutions will continue to be the most appropriate ones for the healthcare workforce.

45. There is a requirement to consider the interconnected nature of doctors in training across the UK and the need to ensure parity and consistency in employment so as to ensure that there is a seamless flow of doctors in training within/ in and out of Wales. A pressing challenge is addressing

the outcome of the junior doctors' contract dispute in England and its implications for Wales. This has, for the first time, established separate arrangements for doctors in training in England. Enabling and facilitating the flow of doctors in training across the NHS is an important feature which will need to be maintained whatever approach is taken in Wales in relation to a new contract for these staff.

46. As the consultant medical workforce continues to develop there will be a need to ensure an appropriate linkage of the progression from training into a consultant grade. Currently Wales has a separate Consultant Contract which developed (amended) from the previous contract in 2003. Reform of this contract is being considered and any development will need to mirror or match the arrangements operating across the UK. Employers have emphasised that their preferred approach is to for these contracts to be consistent across the UK.

47. The Nuffield Trust research report[v] also estimated that there will be a funding gap of £2.5b for NHS Wales by 2025/26 assuming that funding is held flat in real terms. This would require efficiency savings worth 3.7% per annum. The report stated that "*beyond 2015/16 it will be very difficult to continue to hold down real terms pay"* and that *"further reductions would be difficult to implement without impacting on recruitment and retention*".

48. For NHS Wales the issue of the affordability and sustainability of the current workforce is critical and the extent to which the gap can be closed by pay bargaining and the potential contribution of redesign needs to be realistic. Accordingly, it is essential that developments around the medical workforce and associated terms and conditions are considered alongside developments with Agenda for Change terms and conditions. Whist this is important, there are limitations and this needs to be viewed in the context of the constraints on the ability to reduce and change workforce size and configuration without major service change and redesign.

49. Limited pay awards set against inflation and recent pension contribution increases has made having conversations difficult when there is a, not unreasonable, expectation from staff and trade unions of an inflationary increase. However employers do not consider that conversations in this area should be mutually exclusive and within any investment in pay, however small, it is legitimate to discuss other elements of the total reward package and how they might adapt or change. These issues were explored in detail in the NHS Wales Workforce Review[vi] which reported in March 2016.

50. The increases in demand, complexity and acuity of patients and service users have added pressure to front-line staff which can influence people leaving sooner than they otherwise would. In addition changes to the NHS pension arrangements as well as the pension taxation regime are having an impact on the retention of staff in their 50's. These two issues working together are providing a significant retention challenge.

5. Whether there are particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

51. There are significant challenges recruiting into some of our rural and deprived communities as well as those services provided away from the main population centres. Whilst there are different factors at play, bespoke interventions are required to support the delivery of health and social care in these communities The "Focus on Sickness Absence Trends in NHS Wales"[vii] report highlights that populations with high deprivation have poorer staff health. It is an area which individual health boards are addressing. Overall the challenge is one of providing jobs and working

environments which are attractive through the recruitment process but also with continuing support in order that we can provide consistent and sustainable services for these communities.

52. As discussed in our briefing, "From Rhetoric to Reality - NHS Wales in 10 years' time: The NHS Wales Workforce",[viii] included as part of our submission, highlighted the employed workforce in Wales is ageing. More than 40% are now aged 45 or over, and the numbers of those over 64 in employment has grown by almost 60% in four years, though the age composition of different sectors does differ. The retention and management of the health and well-being of older staff will be a key issue in developing workforce strategy with the age profile of staff being different across Health Boards. There will be a need to consider those parts of the workforce which have an older profile than the Wales average and to understand the implications of working longer.

Conclusion

53. People working within the NHS and social care are our biggest asset. Without their hard work and dedication the health and care service would collapse. We need to think about the workforce we have today for our current service delivery requirements but also focus on creating a pipeline for the future, which will include many of today's health and social care employees. This will require innovation and perhaps new regulation mechanisms for new roles. We now have an opportunity in the fifth Assembly to put forward a long term vision for the health and social care workforce, acknowledging that the workforce should change to deliver integrated, personalised care closer to home.

Attachments included in our submission:

- Welsh NHS Confederation Policy Forum, September 2016. One workforce: Ten actions to support the health and social care workforce in Wales.
- Welsh NHS Confederation, January 2015. From Rhetoric to Reality - NHS Wales in 10 years' time: The NHS Wales Workforce.

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[i] Stats Wales, May 2016. NHS staff by staff group and year 2015.
[ii] Welsh NHS Confederation Policy Forum, September 2016. One workforce: Ten actions to support the health and social care workforce in Wales.
[iii] The King's Fund and Nuffield Trust, July 2013. Securing the future of general Practice: New models of primary care.
[iv] Nuffield Trust, June 2014. A Decade of Austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26.
[v] Nuffield Trust, June 2014. A Decade of Austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26.
[vi] Welsh Government, March 2016. NHS Wales Workforce Review.
[vii] WEDS, Shared Services: Jan 2015. Focus on Sickness Absence Trends in NHS Wales.
[viii] Welsh NHS Confederation, January 2015. From Rhetoric to Reality - NHS Wales in 10 years' time: The NHS Wales Workforce.

WF 13
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: UNSAIN
Response from: UNISON

UNISON Cymru/Wales response: Inquiry into the sustainability of the health and social care workforce

Introduction

1.1 UNISON Cymru/Wales is Wales' largest public sector trade union. UNISON has 100,000 members working in public services across Wales. We welcome the opportunity to feed into the National Assembly Wales priorities for the Health, Social Care and Sport Committee.

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

1.3 UNISON's health care members are from all non-medical occupational groups including: nurses and health care assistants; midwives; health visitors; administrative, finance and HR staff; ambulance staff including paramedics, technicians, control room and maintenance staff, therapy and healthcare science staff; estates and housekeeping staff; technicians and maintenance staff; commissioning staff; allied health professionals; scientific staff; healthcare managers.

1.4 UNISON's social care members include social workers and social care workers working across residential, non-residential and domiciliary care services. Our members undertake roles in early years and childcare; mental healthcare; care for older people; disabled people's care; caring for people with learning disabilities.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

2.1 The principles of the NHS in Wales are clear. UNISON welcomes the ongoing commitment of the Welsh Government to keep the Welsh NHS free from privatisation and marketisation.

2.2 However, there are fundamental questions about what the NHS should be expected to deliver. Is the NHS sustainable in its' current state? Can we afford to sustain all of the services that are currently delivered by the NHS?

2.3 More widely, the direction of travel is towards the integration of health and social care and there is a greater emphasis on health services being delivered in the community. This is only plausible if services within communities are adequately funded.

2.4 Taking homecare services as an example, we have regularly seen homecare services being outsourced to the private sector. This has not increased the quality of care for all patients. It has created an unregulated sector where there is little incentive for employers to invest in training, a high reliance on casual and zero hour contracts, and poor terms and conditions, including low pay.

2.5 Whilst we believe the integration of health and social care would be beneficial, there is a clear need to address the disparity between the culture in the NHS and the culture in social care. In particular, ending the two-tier workforce and raising the generally inferior social care employment conditions should be a priority. In a social care setting, it is often those responsible for providing direct care who experience the lowest pay – this clearly presents problems with regards to recruitment and retention.

2.6 UNISON recommends that one approach the committee could consider is for the Welsh Government to enforce and Ethical Care Charter across the sector in order to unify the culture across the NHS and social care.

2.7 The Charter would place the needs of care users, dignity of patients and investment in the care workforce above profit-making considerations. This wouldn't "short-change" clients and would allow for the recruitment and retention of a more stable workforce through good working conditions, sustainable pay and high training levels across the board.

2.8 Furthermore, it is clear the marketisation of social care has failed. Any moves to outsource social care, in any form, should be strongly opposed. Care services need to be delivered directly by the local authority. The terms and conditions of social care workers employed directly by a local authority are far more favourable than their counterparts in the third or private sector. It is worth noting that where staff are employed directly by a local authority, staff turnover is far lower.

2.9 The Welsh Government's vision for both health and social care should include a concerted effort to bring outsourced care services back under public control.

How well equipped is the workforce to meet future health and care needs?

3.1 The Safe Nurse Staffing Levels legislation, and its ratio of no more than seven patients in Wales to one nurse, is very positive.

3.2 UNISON wants to see safe minimum staffing levels extended to all staff groups in all settings and advocate that this is a key element of ensuring that the workforce is able to meet future health and care needs.

3.3 It is a concern that some health boards have reduced ward cleaning standards to save money on the appointment of the appropriate level of domestic and housekeeping staff.

3.4 The amount spent on agency staff in the NHS is unacceptable and is an indication of poor workforce planning. UNISON believes there should be caps on fees agencies can charge and greater use of existing staff on overtime at enhanced rates.

3.5 The key to cutting agency costs however is to fill vacancies and reduce sickness across the service. Making bank rates of pay more competitive would encourage staff to use the bank rather than going to agencies for additional shifts.

3.6 Welsh Government has funded additional nurse training places, which is a positive step, but the benefits will not be realised for three years.

3.7 One solution could be the reinstatement and extension of in-service, fast-track training of healthcare support workers to attain professional qualifications whilst continuing to receive full salary. This would provide an additional pool of staff and a preferable option to agencies.

3.8 Access to professional development must be a priority in order to ensure the workforce is well equipped. As a part of this, a meaningful personal development review process needs to be in place. UNISON is aware of many scenarios where members of NHS Wales staff have not undergone a personal development review for a significant period and this is unacceptable. Without a robust development review process in place, it will be impossible to establish whether the workforce is truly equipped to meet future health and care needs.

3.9 It is well documented that the NHS workforce is an aging workforce. Much needs to be done to ensure that working for the NHS is an attractive option for young people as the current situation is unsustainable in the long term.

3.10 It is essential that workforce succession planning builds in the use of long-standing and experienced members of the workforce, but there must be a concerted focus on bringing new people into the workforce.

3.11 In addition, it must be noted that there are a significant number of EU workers from outside of the UK who work for the NHS in Wales. It is essential that these workers are protected post-Brexit and these protections must be offered as soon as possible. The vote to leave the EU could prove to be a hugely destabilising factor for the NHS Wales workforce and efforts must be made to safeguard against this.

3.12 The issue of an aging population is particularly relevant for both health and social care. The issue of staff turnover is clear concern in social care settings – including both home and residential care. As the population ages and the focus is more heavily on care in the community, demand on these services is inevitably going to grow.

3.13 There is a clear lack of funding available for domiciliary and residential care. Without appropriate funding it will be impossible to ensure the workforce is able to meet future demand. More money must be made available for the sector.

3.14 A series of prominent providers in Wales have said highlighted that there is no slack built into the system and they simply do not have enough money to meet the terms of their care contracts and the introduction of the national living wage.

3.15 Local authorities have refused to release additional funding on the basis that the care contracts have already been awarded. Two third sector companies have reduced sick pay benefits as a direct result of the national living wage.

3.16 It is a scandal that low paid care workers are caught in the middle and their conditions attacked in this manner. In addition to sick pay, payment for shift enhancements and weekend working is under threat. Gains made on the basis rate of pay are lost elsewhere.

3.17 Furthermore, there is no clear career structure for the social care workforce. UNISON remains of the view that healthcare workers across the board should be registered. A professional register would allow the healthcare support role to be underpinned by professional standards, clear role definitions and expectations, stronger links to qualifications, and a more defined career structure. We believe that this, in turn, would allow for the greater fluidity of workers between NHS and local authority and so work towards the Welsh Government's 'one public service Wales' ethos.

What are the factors that influence recruitment and retention of staff across Wales?

4.1 Decent levels of pay and fair terms and conditions of employment are obviously key factors that influence recruitment and retention of staff in Wales. Workers delivering essential services need to be adequately rewarded for the important work they do.

4.2 UNISON is supportive of degree based nursing. Wales took a decision to move nursing towards an all degree profession in 2004, this was followed in 2010 by the Nursing and Midwifery Council taking this approach across the UK. There is no doubt that there is a need for degree level thinking when caring for complex cases and in responding to rapidly changing conditions. This coupled with the pace of science requires staff to be able to practise within ever-changing environments.

4.3 However as important we need to maintain a wide entry route into nursing and midwifery across the country. Wales has a rich history of recruiting prospective staff from some of the most socially deprived communities. If they aspire to enter into professional training we need to make it easier for them to gain accreditation of their prior learning, this would enable them to be credited for their learning and not automatically have to start a programme of learning at the beginning. This approach would be benefit them and the public purse as it could see them graduating and entering the work environment quicker.

4.4 We must ensure that those staff who wish to remain in their role - loving their part in delivering compassionate care – are not treated as poor cousins. They should have access to learning and development with comparable career pathways as those who go onto train as nurses, or occupational therapists.

4.5 The need for Masters level thinking in particular in specialist and senior roles also plays an important part in the delivery of care. To achieve this support staff need access to financial support and time to learn and complete studies.

4.6 Within the NHS there needs to be a better utilisation of band 3 and 4 roles. This would allow a better skills mix across the sector and allow for more suitable delegation. It is important that staff are operating appropriately within their job band in order for the NHS to run as efficiently as possible. In addition, people should be paid appropriately for the work they undertake. A better use of these bands 3 and 4 would allow for a more efficient distribution of work as well as a clearer career pathway for those working on lower bands. In addition, the workforce is being deskilled if opportunities are not provided for progression.

4.7 Wales is a low income nation. People should not be expected to pay for their own training to enable them to work in the health and social care sector. We welcome the Welsh Government's commitment to continue to fund bursaries for nurses and urge this practice to keep on. However, whilst nursing and midwifery is an extremely important element of the healthcare workforce, it is only one element.

4.8 The success of health and social care across Wales depends on the entire workforce and so it is essential there is access to training and development opportunities across the board. Arguably, those in or working towards lower paid roles are in greater need of financial aid.

4.9 UNISON is seeking the formal registration of care workers, paid for by the Welsh Government. We believe this would provide an opportunity to ensure care workers have professional support and consistency. A professional body would provide the opportunity to produce role descriptions and expectations across the care sector as a whole, as well as professional standards.

4.10 This is a key issue when we consider care workers who work in a social care environment, particularly in a home care setting. The expectations on staff employed within a homecare environment, compared to those who work for the NHS, can be vastly different – even where both of those provisions are delivered in the community.

4.11 There are countless situations where homecare workers, who often have limited training and receive minimal pay, are expected to undertake involved levels of personal care which may be inappropriate for their role, but there is no benchmarking mechanism to allow us to measure this effectively. There is a vast difference between this environment and the experiences of NHS employed care workers, and this is reflected in the retention rates of the workforce.

4.12 There is also much greater clarity around the boundaries of different job roles when we compare the NHS and homecare. There appears to be a much clearer career path available to those who work for publically delivered public services – including the NHS and local authorities – compared to those who have been outsourced. For many homecare workers, there is no apparent career path at all. In addition, workers who are employed directly by local authorities or the NHS

have a better sense of how they contribute to the overall care service – they feel a greater sense of empowerment and confidence when undertaking their roles. Many homecare workers in the third and private sector are isolated from the wider workforce and this has an impact on morale and confidence.

4.13 In fact, for many homecare workers in particular, there is a sense of stigma attached to their work. Clearly, the work homecarers undertake is extremely valuable, but is not recognised by the employment standards they experience. How can we realistically expect people to take on such high levels of responsibility for such low employment standards?

4.14 The poor state of homecare is well documented. In order for there to be a true integration of health and social care services there needs to be parity across the sector both in a cultural and practical sense. We believe that this will have a positive influence on the recruitment and retention of care staff across the board. Without a wholehearted commitment to full integration, we are likely to see more problems than solutions. UNISON remains committed to working towards a one-public service Wales and view this as a positive approach in ensuring the long term sustainability of the health and social care workforce.

4.15 Quality of care must always factor as a higher priority than financial savings. The workforce is at the heart of ensuring quality services and they must be appropriately rewarded for the essential work they undertake. Furthermore, it is imperative that the entire workforce is recognised for the value they provide – the safe and effective delivery of healthcare in Wales is very much a team effort and each member of the healthcare workforce contributes to that team work.

Conclusion

5.1 UNISON Cymru/Wales welcomes the opportunity to feed into the inquiry into the sustainability of the health and social care workforce.

5.2 We would welcome the opportunity to feed in further detail and evidence to this inquiry as the committee deems fit.

WF 14
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Ysgol Feddygaeth Prifysgol Caerdydd
Response from: Cardiff University School of Medicine

School of Medicine, Cardiff University

Responses to Consultative questions - Inquiry into the sustainability of the health and social care workforce

1. **Do we have an accurate picture of the current health and care workforce? Are there any data gaps?**

   Focusing on the Welsh Language data, we note it is currently very difficult to find accurate data of the Welsh speaking ability of the workforce, even with ESR – this is a clear data gap. Self-reporting of language ability can mean skills are hidden due to lack of confidence to use Welsh in the workplace. Whilst this clearly has an impact on the delivery of the aims of the Strategic Framework for Welsh Language services in Health and Social Services (More than Just Words), it also has an impact on finding Welsh speaking mentors and academic supervisors in the workplace for Welsh speaking students. This is threatening the sustainability of Welsh medium education in medicine and other healthcare courses chosen by students keen to continue their bilingual education and develop their clinical communication skills in both languages.

2. **Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?**

   We are still unclear re: policy/vision for health (but appreciate that this is partially due to new administration etc. and will become clearer).

3. **How well-equipped is the workforce to meet future health and care needs?**
   Please see response below

4. **What are the factors that influence recruitment and retention of staff across Wales? This might include for example:**
   - **the opportunities for young people to find out about/experience the range of NHS and social care careers;**
   - **education and training (commissioning and/or delivery);**
   - **pay and terms of employment/contract;**

   We believe it is important to ensure consideration is given to academic Medicine and the role of clinical academics when focusing on recruitment and retention in Wales. The relationship between Universities and the Health Boards is critical here. There is an important requirement to ensure parity and fairness between academic and non-academic medicine (financial and in job-planning). There must be appropriate levels of

funding to ensure this can continue.

The pipeline for health care professionals in Wales from school through Further and Higher Education and onto the career itself is critical. We aim to attract and retain the best Doctors in Wales, but must be equipped to achieve this. There are a number of important factors that must be addressed in order to achieve this including:

- Adequate funding and a clear financial strategy
- A workforce with the ability to deliver (particularly with the training elements)
- Facilities – particularly within the communities of Wales.

In a recent Teacher Advisory Panel at Cardiff University School of Medicine, teachers responded to a question about the reason why the numbers of young people from Wales applying to undergraduate medicine courses across the UK has fallen according to 2015 UCAS data. The teachers suggested that there was a lack of unbiased information about careers in the NHS, and that young people are being influenced by the negative media about working in the NHS in Wales and possibly outdated information from family connections. They also cited the success of recent campaigns by STEM organisations such as STEMnet in making other careers in Science more accessible and attractive. They believed that potential medics were being swayed away from the demands of medicine to study other degree programmes.

5. **Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.**

From the Medical Education perspective, we ensure clinical placements take place across the breadth of Wales. This includes rural and urban areas and ensures a clear understanding of the specific requirements and nuances of each situation. By ensuring an awareness at early career points we aim to provide the tools and training to provide an equipped workforce in the future.

Furthermore, work is currently ongoing to identify future potential “community-based” centres (building on the achievements and learnings from the Kier Hardy Health Park) – by enabling the training of students to take place in community-based facilities ensures an understanding and appreciation of the requirements of the full social (and geographical) spectrum across Wales.

WF 15
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Brenhinol y Bydwragedd
Response from: Royal College of Midwives

The Royal College of Midwives
8th Floor, Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB

The Royal College of Midwives' response to Welsh Assembly Inquiry on the sustainability of the health and social care workforce

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1. The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

2. The RCM welcomes the opportunity to respond to this consultation and our answers to the consultation topics are set out below.

3. **Q: Do we have an accurate picture of the current health and care workforce? Are there any data gaps?**

4. Successive Welsh governments have supported a midwifery specific workforce planning tool (Birthrate Plus) and have maintained midwife numbers which has helped to prevent a serious shortage of midwives. The principles of prudent healthcare provide numerous opportunities for midwives and midwifery services. They support a focus on normality and a decrease in unnecessary intervention.

5. However, many challenges remain. The RCM has remained concerned for some time about the age profile of our workforce. Looking at midwifery numbers alone, the picture looks rosy: There were more midwives working in the NHS in Wales in 2015 than there have been since at least 2009. The increase during that time was around eight per cent. This has outpaced the changed in the number of births, helping to reduce the ratio of births per midwife.[1]

6. However, this situation is under threat. 37 per cent of midwives working in the NHS in Wales are in their fifties or sixties. Without investment in our workforce, before too long we could see a dwindling number of midwives available to staff our maternity units, with an insufficient number of younger midwives in place to replace those set to retire. So while we have an accurate picture of our workforce, we need to take action on the basis of that picture.

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1 Royal College of Midwives. State of Maternity Services Report 2015. https://www.rcm.org.uk/sites/default/files/RCM%20State%20of%20Maternity%20Services%20Report%202015.pdf

7. Q: Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

8. There are three key documents used by Health Boards across Wales to describe the vision for health care given to women and families: the *Maternity Strategy*, *Midwifery 20:20* and the Birthplace study. Between them these documents spell out what needs to happen in order for us to have a maternity service that promotes pregnancy and childbirth as an event of social and emotional significance, where women and families are treated with dignity and respect. All Health Boards are currently required to report on progress made in relation to the targets set out in the Maternity Strategy. And we now have a huge raft of evidence from the Birthplace study which suggests that lower-intensity birth locations (such as midwifery-led units and women's own homes) are safe and sustainable options for many women.[2] In addition the adoption of the principles of Prudent Health care has meant that there are opportunities for less unnecessary intervention, lower caesarean section rates and fewer low risk women receiving care in obstetric units unnecessarily. The RCM was a key player in the development of the Maternity Strategy and Midwifery 20:20 and supports their aims. We believe that the evidence provided in the Birthplace study can radically change the way that care is provided and contribute hugely to the prudent health care agenda.

9. What is less clearly articulated in national policy is the workforce needed to realise these ambitions. The RCM has made our views clear in our Welsh election manifesto, our *Caring For You Charter* and our response to the NHS workforce review in 2014. We support the recommendations coming from the *Prudent Healthcare* resource.[3]

10. Unlike other parts of the UK, Wales is fortunate in that it appears to currently have enough midwives to meet its birth rate. However this is only in relation to birth rate numbers. It is our view that the current structures do not support a cohesive approach to workforce planning, development and commissioning of training across NHS Wales. We would like to see a long-term commitment to continuing to have the required number of midwives, especially as this will be prerequisite to meeting the requirement of having 45% of births taking place in midwifery-led units. Further, we believe that in order to meet the public health challenges above, we must strengthen community midwifery, and there is an opportunity for further development of maternity support workers (MSWs).

11. Q: How well-equipped is the workforce to meet future health and care needs?

12. The maternity workforce has changed to meet the changes in service demand. Whilst the number of Consultant Midwives had remained static there is now a move to have at least one Consultant Midwife in each Health Board. The RCM supports this move and

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[2] Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, McCourt C, Marlow N, Miller A, Newburn M, Petrou S, Puddicombe D, Redshaw M, Rowe R, Sandall J, Silverton L, Stewart M. 'Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study'. *British Medical Journal*. 2011;343.

[3] '*Design the future workforce* – ensuring that the future workforce is in line with service and financial planning; *Develop the future workforce* – includes education commissioning, staff development, and recruitment and retention process; *Deliver the future workforce* – ensuring plans are delivered, processes are effective, clinicians are engaged and best practice is shared'. See Making Prudent Healthcare Happen. http://www.prudenthealthcare.org.uk/workforce/

welcomes the recognition of the contribution that these roles bring to maternity services, especially in areas such as normality and public health. There has also been an acknowledgement of the vital role that Maternity Support Workers can play in Maternity services. The development of the Maternity Support Worker Curriculum has meant that the role and responsibilities of MSW's are clearly defined.

13. We would also support the establishment of systems whereby on going training and development and continuous improvements become the norm. We support a greater emphasis on the use of multi-disciplinary teams in the planning and delivery of healthcare and believe that multi professional training programmes have a role to play in encouraging respect and understanding for other roles in the provision of service. As before, effective team-working across disciplines is vital to quality maternity care.

14. The role of the Midwife in delivering the public health agenda is now well established. The 2011 Strategic Vision for Maternity Services in Wales stated, 'Pregnancy is a powerful motivator for change. It is a time when women and their partners, often for the first time, make positive lifestyle changes and choices in order to provide the optimal conditions to ensure the health and wellbeing of their unborn baby'.[4] Each contact with a midwife is an opportunity to improve the health not only of the woman and her baby but that of her wider family. Midwives are also the frontline professionals who can signpost women to other specialist services, such as for smoking, weight loss, domestic violence and drug abuse. They are also involved in cases of safeguarding and mandatory reporting of FGM.

15. Q: What are the factors that influence recruitment and retention of staff across Wales? This might include for example:

- **a. the opportunities for young people to find out about/experience the range of NHS and social care careers;**
- **b. education and training (commissioning and/or delivery);**
- **c. pay and terms of employment/contract**

16. In 2016 the RCM launched a major campaign to improve RCM members' health, safety and wellbeing at work so they are able to provide high quality maternity care for women and their families. The asks of *Caring For You* are based on the startling results of a survey of RCM midwife, student and maternity support worker (MSW) members.[5]

17. The results from the survey show that maternity units are overworked and understaffed and many midwives, maternity support workers and student midwives are feeling under intense pressure to be able to meet the demands of the service. This is creating high levels of stress and burn out which is impacting on the care that is provided to women and their families.

18. RCM members' shift working has a negative impact on their health, safety and wellbeing, in particular restrictions to work flexibly; working long shifts; shift patterns; missing breaks; and working beyond hours cause frequent problems. Some workplaces have

[4] Welsh Government (2011). A Strategic Vision for Maternity Services in Wales. http://wales.gov.uk/docs/dhss/publications/110919matstrategyen.pdf

[5] The RCM's Caring for You survey was conducted during March 2016 with RCM members using Survey Monkey. In total there were 1,361 responses. The survey asked questions about midwives', maternity support workers' and student midwives' health, safety and wellbeing at work.

dysfunctional cultures, resulting in workplaces that have high levels of bullying, harassment and undermining behaviours.

19. The following quotes are from welsh midwives and we urge the committee to think about retention and recruitment in the context of these experiences:

20. *"The organisation runs on goodwill, staff working extra shifts on top of their contracted hours, staying on after shift end-times etc. Not a great deal of appreciation for this apparent from senior management".*

21. *"Short staffed and made to feel guilty about this, therefore struggle to go to work when unwell. Currently pregnant, awful morning sickness and sciatica. No support and no sickness absence as feel guilty".*

22. *"If things go wrong we do not feel supported even though management say there is a no blame culture. We are also expected to attend people* [in the community] *even if there are health and safety concerns and management do not want to pay two midwives to attend for the whole labour* [at home] *due to paying overtime. Some colleagues are scared to be called because they do not want to be out alone at night in a strange environment".*

23. The research also found that 69% of our members said they had caring responsibilities. This gives us a good indication about the balance that many members (and NHS staff overall) have to find in their daily lives. While 35% of respondents had made a request to change their shifts in the last two years, unfortunately 37% of these said their request to change their hours was rejected. Many respondents reported that they were not given the reason for why their request was rejected but many said it was due to staffing and workload.

24. Part time work is common and clinical midwives are experiencing a higher level of stress and burnout than ever before. Service demands can make higher-banded positions less attractive, which means the talent pool can shrink. We must focus not only on ensuring raw numbers of midwives are sustainable but also think about how to support midwifery careers for life and support emerging leaders.

25. While at times this report makes for troubling reading about the level of burn out and stress amongst midwives and maternity support workers it does offer solutions too. The evidence we present shows that when Heads of Midwifery and RCM Health and Safety Representatives work in partnership and take action on health, safety and wellbeing it does make a difference. Stress levels are lower, health and wellbeing is better and importantly, care for women and their families improves.[6] We are thrilled that Powys Teaching Health Board was the first health board in Wales to sign up to the RCM's *Caring for You* Charter and they have been joined by three other boards in recent weeks. We hope all the boards will sign up to the Charter to improve health and wellbeing of staff which will help create happier and healthier workplaces, with positive working cultures that always deliver quality care for women and families.

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[6] Royal College of Midwives. *Caring for You Campaign: Survey Results*. May 2006. https://www.rcm.org.uk/sites/default/files/Caring%20for%20You%20-%20Survey%20Results%202016%20A5%2084pp_5%20spd.pdf

26. In regards to pay and terms and conditions, the Royal College of Midwives is committed to UK wide pay bargaining, through the NHS Staff Council, and the independent Pay Review Body. We believe that Agenda for Change is the most transparent, fair and equal system as it is underpinned by the job evaluation system which is based on equal pay for work of equal value. Our expectation is that this will continue.

27. The independent NHS pay review body makes recommendations to the Welsh Government on the pay of midwives, nurses and other staff employed by the NHS, with the exception of doctors, dentists and very senior managers. Unlike the Scottish Government, which has consistently followed the pay body's recommendations, the Welsh Government has failed in the past to honour them in full. This is a shame, and has left midwives in Wales out of pocket and they continue to be paid less than their Scottish equivalents.

28. Midwives are drawn into the profession for many reasons, they may have had children themselves, they may follow family members into the profession but mostly they are driven by a desire to work with women and families and to provide the best care possible. Financial reward is frequently not the primary driver; however, it is unrealistic to expect them to work without adequate financial reward. Midwives have bills to pay just like everyone else. That is why it is important that they are paid a fair salary for the work they do, and the fairest way of determining that salary is through an independent process like the one we have. It is so important that all sides honour the pay review body's recommendations even when midwives might think it is too low or employers think it is too high.

29. Q: Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

30. The latest statistics on breastfeeding in Wales show the massive variation between areas which the RCM believes must urgently be addressed to tackle life-long health inequalities.

31. The highest breastfeeding rates were seen for babies of women resident in Powys Teaching Local Health Board (72%) and lowest for those in Cwm Taf University Local Health Board (50%). There is a clear need for more breastfeeding support, especially for young mothers, and midwives must be able to have the time to work with women to enable them to breastfeed safety and comfortably. Breastfeeding lays the foundations for an individual's future health and wellbeing. It brings great benefits for society as a whole in terms of reduced spending on ill health. Previous surveys into our members views on postnatal care found there is not usually enough time our resources to support new mothers with important aspects of breastfeeding, according to 25% of our members.[7] With the increase in complex care needs the labour ward has often been seen as the priority for midwifery staffing with the result that post natal care has not been given the value/attention that it should have had.

The Royal College of Midwives
August 2016

[7] Royal College of Midwives. *Pressure Points: Infant feeding, Supporting parent's choice.* May 2014.

WF 16
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Brenhinol Pediatreg ac Iechyd Plant
Response from: Royal College of Paediatrics and Child Health

Consultation response from the Royal College of Paediatrics and Child Health (RCPCH):
Inquiry into the sustainability of the health and social care workforce

1. Who we are

1.1 The Royal College of Paediatrics and Child Health (RCPCH) works to transform child health through knowledge, innovation and expertise. We have over 550 members in Wales and over 17,000 worldwide. The College 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.

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

2. Our priorities for child health in Wales

2.1 Infants, children and young people (ICYP) aged 0 to 18 make up around 20% of the UK population[1] and they are high users of healthcare services; accounting for around a quarter of a typical GP's workload[2] and more than a quarter of emergency department attendances. Yet services for ICYP appear to be a low priority. ICYP must be considered equitably to adults in all aspects of healthcare. Under Article 24 of the UN Convention on the Rights of the Child (UNCRC), all ICYP have the right to be as healthy as they can be and to access health services.

2.2 While children's health has improved greatly in the UK over the last 30 years, the UK lags behind much of Western Europe on key measures of child health and wellbeing and continues to have one of the highest mortality rates in Western Europe for under-fives[3]. UNICEF places the UK 16th out of 29 rich countries in measures of child wellbeing[4].

2.3 Since the founding of the NHS in 1948, there has been a strong shift in the burden of disease in childhood away from infectious diseases to more chronic, long term conditions. One in seven (15%) of 11 to 15 year olds now have a long term condition or disability[5]. The increased long-term survival of children with complex disabilities, in part due to better survival rates for low birth weight and improvements in care, means that appropriate care needs to be in place to support these ICYP from infancy through to adulthood.

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[1] 2011 Census, ONS

[2] 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.

[3] Royal College of Paediatrics and Child Health, 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

[4] UNICEF Report Card 11, 2013

[5] Association for Young People's Health Key Data on Adolescence 2013

2.4 Wales has the opportunity to deliver better models of care for infants, children and young people.

2.5 The RCPCH's Why Children Die report highlights a need to better manage sick ICYP and recommends that measures are taken to improve recognition and management of serious illness across the healthcare service.

2.6 Last year we published Child Health Matters: A Vision for 2016 in Wales. Following a consultation with our members in Wales, this document set out a series of policy calls that we believe would have the most positive impact on the health and wellbeing of children and young people in Wales.

2.7 RCPCH's Facing the Future (FtF): Standards for Acute General Paediatric Services makes the case for whole system change in paediatrics to more effectively meet the needs of ICYP. The model recommends fewer, larger inpatient units which provide consultant delivered care and which are better equipped to provide safe and sustainable care. These units must 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.

2.8 RCPCH, Royal College of General Practitioners (RCGP) and Royal College of Nursing (RCN) have also worked together to develop a new set of standards in the Facing the Future suite, Facing the Future: Together for Child Health. These standards apply across the unscheduled care pathway to improve healthcare and outcomes for ICYP. They aim to ensure there is always high-quality diagnosis and care early in the pathway, providing care closer to home where appropriate (right care, right time and right place). The standards will ensure specialist child health expertise and support are available directly into primary care services where the needs of the child and their family are known and will build good connectivity between hospital and community settings; primary and secondary care; and paediatrics and general practice.

2.9 We can provide hard copies of these publications upon request.

3. *Do we have an accurate picture of the current health and care workforce? Are there any data gaps?*

3.1 RCPCH carries out a biennial census of the UK paediatric workforce and child health services, from which we produce figures for Wales. The report to be disseminated late in 2016 will be a comprehensive picture of the paediatric workforce and services in Wales.

3.2 It is important for the Welsh Government to recognise the importance of the Workforce Census (see references) and support RCPCH to achieve a 100% completion rate so that we have a complete picture of the paediatric workforce and avoid the need for additional projects that risk duplicating this work.

3.3 From our previous census in 2013 (see references), we reported that there were 153 wte (whole time equivalent) 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 College estimate that across the UK as a whole approximately 800-1000 wte consultants are needed to meet its standards for acute care such as 12 hour consultant presence in hospital 7 days a week (FtF) and British Association for Perinatal Medicine (BAPM) standards for neonatal care. This demand increases if there is to be greater integration between primary and secondary care for child health or an increase to 24 hour consultant presence.

3.4 From the data received to date from our 2015 census (2 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 15/16 winter period. These figures are slightly higher than elsewhere in the UK. Most tier 1 rotas are made up of 10 wte or more posts in line with College standard (FtF) whereas the average wte of slots on tier 2 rotas is 8.4 doctors.

3.5 It is important to note that while we have a good picture of the number of paediatricians and gaps in paediatric units, we need a better picture of the paediatric workforce overall – in particular GPs, children's nurses, health visitors and CAMHS. This is crucial in order to deliver the models set out in the Facing the Future suite and we would urge the Welsh Government to ensure that we have a comprehensive picture of the child health workforce.

4. *Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?*

4.1 Dealing with pressures in the paediatric and child health workforce will help child health services achieve the care standards set out by RCPCH and ensure safe and sustainable services for children across Wales.

4.2 We would welcome Welsh Government support for our vision. We have called on the Welsh Government to work with the Wales Deanery, RCPCH, other stakeholders and UK Government to develop a strategic workforce plan, which should include measures to address the child health and paediatric workforce.

4.3 Other medical royal colleges have also called for a workforce strategy. Royal College of Physicians Wales has called for "a national medical workforce and training strategy which ensures that staff are deployed and trained effectively, now and in the future."[6]

4.4 For the paediatric element of the strategy and plan RCPCH recommends the workforce requirements are designed around the introduction of new service models:

[6] RCP Wales, Focus on the future, June 2015

4.5 More effective paediatric care in hospital settings:

- Increased number of paediatric consultants to provide consultant cover to meet the RCPCH standards. In general paediatrics (assuming the same number of units) an additional 35 consultants would be needed plus community child health and subspecialty consultants.
- Increased number of trainees to fill rota vacancies and meet RCPCH standards of ten trainees on a training rota
- Development of new rota models including the role of Advanced Nurse Practitioners on paediatric tier one rotas and resident consultants.
- Increased number of registered children's nurses

4.6 Better management of the health of infants, children and young people in primary care and the wider community

- Delivery of more care in the community, including increased training and development of community children's nursing teams and increased numbers of GPs trained in paediatrics.
- Greater paediatric support for the delivering of care in the community e.g. consultant hot phones, rapid access, outreach clinics
- Development of safer staffing arrangements and transport infrastructure for remote and rural units.
- Increased number of registered children's nurses

4.7 Increased use of associate professionals

- Physician Associates. There have been very few working in paediatrics to date but RCPCH expects the numbers will increase, which will enable effective evaluation.
- Advanced Paediatric Nurse Practitioners.
- Resident consultants.

4.8 We do not therefore have a clear understanding of the Welsh Government's plan to deliver the health and social care workforce we need.

4.9 We ask the Welsh Government to support our vision and develop the comprehensive health and social care workforce strategy that would give us a clear understanding of how the Welsh Government will deliver this.

5. How well-equipped is the workforce to meet future health and care needs?

5.1 As mentioned above, to meet future demands of College standards and to provide safe care, consultant numbers need to increase, which means the number of new Certificate of Completion of Training (CCT) holders in Wales should be appropriate to meet this demand.

5.2 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 would impact the number of new CCT holders who qualify as future consultants. In 2014 only 13 doctors achieved CCT in paediatrics and its subspecialties in Wales, 5 of whom had worked less than full time as trainees.

5.3 Again, we would call for a comprehensive health and social care workforce strategy to address these issues.

6. *What are the factors that influence recruitment and retention of staff across Wales? This might include for example:*

- *the opportunities for young people to find out about/experience the range of NHS and social care careers;*
- *education and training (commissioning and/or delivery);*
- *pay and terms of employment/contract;*
- *Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.*

6.1 When paediatricians resign early or take up posts elsewhere, they are given an exit interview. RCPCH does not hold this information but we would recommend that the data is anonymised and headlines made available to the Welsh Government to inform its strategy to retain paediatric and child health staff in Wales.

6.2 36 consultant appointment committees were reported to the College in Wales in 2014 and 2015. For 10 of those (27.7%) an appointment was not made. This data may be incomplete if not all appointment committees are reported to us, but we are obviously concerned that the available data suggests over a quarter of consultant posts advertised in Wales are not filled.

6.3 We asked a panel of RCPCH members representing each region in Wales whether they could identify factors relating to geography, rural or urban areas, or areas of deprivation. The feedback we received included the following statements from RCPCH members:

6.4 On urban and rural areas:

6.5 “Often the adverts say you will be based at one hospital but you may be expected to travel all over the Health Board if necessary (or words to that effect) As travel times in rural areas are not as simple as judging it on the mileage this is a factor.”

6.6 “Whilst most hospital services in the UK are experiencing difficulties with the recruitment of junior doctors it is especially challenging for those hospitals in rural areas. Many junior doctors perceive rural DGH’s to be too small and therefore less attractive for training purposes and many prefer to settle with their families in larger urban/city areas where the density of hospitals is greater

and the chances of employment at more academic/tertiary institutions greater… Doctors and their families will settle in the larger cities closer to the hospitals that provide the majority of their specialist training (ie tertiary centres) and as a result will be very reluctant to move away to more rural locations for work."

6.7 On larger and smaller hospitals:

6.8 "Acute/on-call rotas for Consultants in smaller hospitals are more onerous than in the teaching hospitals (appreciate different intensity but the frequency of on-call is a big factor for many when considering a job)."

6.9 Other issues:

6.10 "Too often it is the clinical staff (mainly consultants) who are spending significant period of time during their working week attempting to fill rotas, contacting locums, persuading doctors to change their shifts to plug gaps etc. In my view this is very poor use of consultant time but has resulted mostly due cutbacks within the administrative workforce who should provide the practical support for recruitment."

References

Facing the Future: Standards for Acute General Paediatric Services http://www.rcpch.ac.uk/facingthefuture

Facing the Future: Together for Child Health http://www.rcpch.ac.uk/facing-future-together-child-health

RCPCH Workforce Census 2013 http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/workforce-planning/workforce-census-2015/previous-censuse

RCPCH Workforce Census 2015 http://www.rcpch.ac.uk/census

Why Children Die report http://www.rcpch.ac.uk/news-campaigns/campaigns/why-children-die/why-children-die-rcpch-campaign

WF 17
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Cymdeithas Gweithwyr Cymdeithasol Prydain Cymru
Response from: British Association of Social Workers Cymru

Consultation response from BASW Cymru.

Inquiry into the sustainability of the health and social care workforce.

The British Association of Social Workers is a UK wide organisation with a membership of over 20,000 social workers. Since the Association was established in 1970, it has focussed on developing excellent social work practice with a Code of Ethics that reflects both British and International good practice. BASW recognised the need for the Association to be part of developments in each of the four countries as devolution brought in different paths. After nearly twenty years, BASW Cymru is well-established with an increasing membership.

1. **Do we have an accurate picture of the current health and care workforce?**

   The Care Council for Wales publishes reports based on information supplied by social workers on the Register. At June 1st 2015 there were 4189 people registered on Part 1 of the Register who had the necessary social work qualification, although not all were working in social work directly. The majority of social workers are employed by Local Authorities. Although the numbers are small, independent social workers have had a stronger profile in BASW in recent years which may predict a changing pattern in employment in the future. The social work profession remains predominantly female with an increase in registrants over the age of 50.

   The Welsh Government also reports on the work force drawn from returns made by local authorities. In the year 2013/14 there were 4922 people working in what are described as social work services for adults or for children and a small number in clinic services. In 2014/15 the number of people working in these services had risen by 1929 to 6851. However, the number of local authority social workers on the Care Council for Wales register rose by 55. The statistics are broad but they suggest that in 2013 80% of people described as working in social work services were registered social workers but this had declined to only 60% by the following year. The possibility is that services are now being delivered by people who are less well trained and not subject to regulation by the Care Council for Wales. As the Care Council for Wales data relates to registered social care workers and the Stats Wales data is not detailed, it is not possible to judge whether this is the case. It would be unfortunate if the investment made by the Welsh Government in improved education at both undergraduate level and in post qualifying training and in regulating the workforce to provide assurance to the public were undermined by employers redirecting work to unqualified and unregulated workers.

2. **Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver his?**

The principal aims of the Social Services and Well-being (Wales) Act 2014 fit well with social work practice. Giving individuals voice and choice, promoting well-being, intervening at an early stage and collaborating with others to improve individual outcomes are the daily work of social workers.

The vision is clear. However, the detail of how some parts of the Act will was not in place when the Act was implemented which, despite awareness raising sessions, left practitioners unclear about how they could change their working practices. In particular, the messages about the assistance people could expect to improve their well-being and the reality of working in services with diminishing budgets caused considerable concern.

Achieving the vision of the Act will require a workforce who are both knowledgeable and have the ability to enable people to develop their own solutions. People often approach local authorities with a service solution in mind. Assisting them to look at other options, using their strengths and own resources takes skill and often more time than either slotting them into the service or telling them they are ineligible for the service. At a time of budgetary pressure, managing the tension between the available resource and the workforce required will be challenging.

The Act has provided for the establishment of a national Adoption Service to implement best practice across Wales. BASW members have highlighted the importance of post adoption support, particularly for those families who adopt children with complex needs. There is a concern that funding for these services will be reduced or withdrawn altogether. This could result in an increase in adoption breakdown. It is vital that families who experience difficulties caring for children they have adopted have access to skilled practitioners who can help them through what are often extremely challenging circumstances.

Person-centred services are at the heart of the Welsh Government's vision for social care services. This includes the right of Welsh speakers to receive services in their chosen language. BASW is in full agreement with his aspiration. However, of the 76% of social workers registered with the Care Council for Wales in 2014/5 who provided details of their ability to speak Welsh, 65.5% could not speak any Welsh and only 13.5% were fluent. While there was a slight increase in the previous year from 20.4% to 21% in social workers who could speak some Welsh, the percentage of fluent workers did not increase. The tension between providing a service through the medium of Welsh and ensuring the social worker has the appropriate skill set will need to be managed to ensure the best outcome for individuals and families.

How well equipped is the workforce to meet future health and care needs?

Since 2004 new entrants have required either a Bachelors or a Master's degree in social work. More than a quarter of registered social workers in Wales now hold this qualification.

The introduction in 2005 of protection of title for social workers and the requirement to register with the Care Council for Wales was welcomed by BASW, following years of advocating for the introduction of a professional framework. Registration requires social workers to demonstrate that they have undertaken a minimum of five days learning and development in a year.

The development of a Continuing Professional Education and Learning Framework for Social Workers has given further impetus to ensure that social workers continue to develop their skills. The implementation of the advanced levels of the Framework is relatively recent but the impact will be demonstrable with time.

Learning and development has been strong in the fields of child care and mental health but weaker in that of work with older people. Historically older people have been viewed as requiring practical services that can be arranged by people who do not need to be qualified. Social work degree programmes and post qualifying learning have not provided robust training on the role of social work in protecting the rights of older people and enabling them to make their own choices. Incorporating the multi-disciplinary approaches required for positive outcomes for older people has also been problematic. Older people access services in larger numbers than in other service areas so the lack of emphasis on appropriate training could be viewed as somewhat perverse. However, the recent publication by the Care Council for Wales of a Dementia Learning and Development Framework for Wales is a welcome development. There needs to be further work to ensure that social workers providing services to older people have an appropriate knowledge base to achieve the best outcomes.

BASW is focussing on providing comprehensive resources for social workers to continue their Continuing Professional Development. The online content is available to members and is of particular benefit to social workers who are restricted by rurality and other factors from accessing other learning opportunities.

3. **What are the factors that influence recruitment and retention of staff across Wales? This might include for example: the opportunities for young people to find out about/experience the range of NHS and social care careers; education and training (commissioning and/or delivery); pay and terms of employment/contract.**

The factors influencing recruitment and retention of staff are multi-faceted. A survey conducted by the results of a survey by the Guardian newspaper in December 2015 recorded the positive job satisfaction that social workers expressed but also some of the negative aspects of increasing workload, lack of management support, poor work environments and the persistence of hostile media coverage.

The findings from the Guardian survey are congruent with anecdotal and survey findings among the BASW membership. The results of a survey published in December 2015 in Professional Social Work were reported to show that 'Cramped, noisy, vermin infested, poorly lit, badly heated, dirty and crumbling buildings that lack privacy or quiet places to concentrate appear to be typical working environments for social workers.' The move to accommodating staff in large open plan offices with high levels of noise that make sensitive or confidential phone calls with service users problematic. Hot desking can make it impossible to derive the benefits of team working.

BASW has received concerns from some social workers that they will lose their jobs if they fail to learn Welsh to level 2 standard. Achieving this level enables people to have engage in a simple conversation. It is not sufficient to provide a service through the medium of Welsh. It would be unfortunate if competent social workers were deterred from working in Wales because of a perception that the ability to speak Welsh was a requirement.

Despite these negative aspects, 87% of respondents from Wales to the Guardian survey reported they enjoy their jobs. This was higher than the 79% across the UK. One factor behind this may have been because the scale of cuts to local authority budgets was much greater in England at that time. However, the positive reasons are that social workers feel that their contribution is more valued in Wales, workloads are better managed, there is more support from managers and the integration of health and social care works well.

4. **Whether there are particular issues in some geographic areas, rural or urban areas or areas of deprivation for example.**

Recruitment of social workers in areas further away from urban centres can be difficult. Social workers can find the challenges of working in an environment where services are limited or are only available at a considerable distance and the time spent travelling in a rural area to be unattractive. However, generally there are no specific geographical issues associated with the social worker workforce.

Dr C. Poulter

BASW Cymru Ambassador

WF 18
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Bwrdd Iechyd Prifysgol Hywel Dda
Response from: Hywel Dda University Health Board

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

The UHB has a detailed analysis by profession of the workforce risks and sustainability which sits within the Workforce Plan in the IMTP submitted to WG this year. There are particular challenges associated with primary/community care clinical workforce , the age profile, national recruitment issues for G.P's across the UK. The same applies to registered nurses across both acute and community services and the UHB has been leading the way in the development of the HCSW role and its value in supporting patient outcomes within integrated community teams.
Whilst the NHS workforce analysis is detailed the knowledge of the social care workforce challenges are broadly understood and we have developed strong integrated working to be in a position prospectively to reflect the sustainability across community and social care workforce within fully integrated workforce plans which is piloted currently.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

The UHB IMTP reflects the strategic plan for integrated community services and the likely workforce model. The detail has yet to be mapped, however there are likely to more integrated HCSW roles across services and professions to make best use of the workforce skills across sectors.

How well-equipped is the workforce to meet future health and care needs?
The UHB has a wide range of development programmes for registered and un registered professions with well defined career pathways some examples include:

- HCSW development from band 2-4 then able to access RGN training
- Apprenticeship programmes
- Post registration modules to develop specific skills to support clinical practice within community services

What are the factors that influence recruitment and retention of staff across Wales? This might include for example:
the opportunities for young people to find out about/experience the range of NHS and social care careers; education and training (commissioning and/or delivery);
pay and terms of employment/contract;
Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for
example.
The Health Board continues to work towards being the Employer of Choice not only within the local community, but also to retain existing staff, therefore reducing turnover for non retirement related reasons and in doing so attracting a highly skilled workforce to join the organisation from across the UK. To achieve this there are a range of initiatives currently in place as well as new work to strengthen our position. This includes staff benefits, health and well-being support and thank you events. We are supporting our staff with education and development including leadership development programmes for our medical staff and a consultant mentoring scheme.

Good staff health, well-being and sustainable engagement is proven to impact on organisational performance and is therefore vital for ensuring that the Health Board can meet the challenges of delivering comprehensive and consistent high-quality patient care, continuing to improve services within resource and financial restraints, reinforcing and supporting public health promotion and prevention initiatives, attracting and retaining staff.

Recognising the importance of retaining current staff and undertaking effective succession planning is key to sustaining our workforce.

Some actions underway currently include:

- continue work to publicise good practice and raise the profile of HB using social media and clinical networks to reflect best practices /service developments

- establishing a mechanism to follow up all staff appointed a year after induction to get feedback on their experience over their 12 months in the HB to inform local induction, culture, development opportunities etc
- Actively inviting experienced staff to retire and return as appropriate to support key work , where identified e.g. supporting mentorship of new starters
- Maintain and actively seek to expand staff benefits available to staff
- Develop staff to access career pathways
- Actively support CPD for all professionals
- Encourage innovation and encourage staff to contribute to development of teams and services

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Good staff health, well-being and sustainable engagement is proven to impact on organisational performance and is therefore vital for ensuring that the Health Board can meet the challenges of delivering comprehensive and consistent high-quality patient care, continuing to improve services within resource and financial restraints, reinforcing and supporting public health promotion and prevention initiatives, attracting and retaining staff.

Recognising the importance of retaining current staff and undertaking effective succession planning is key to sustaining our workforce. Some of the current work streams include:

- Continuing to work to publicise good practice and raise the profile of HB using social media and clinical networks to reflect best practices /service developments
- establishing a mechanism to follow up all staff appointed a year after induction to get feedback on their experience over their 12 months in the HB to inform local induction, culture, development opportunities etc
- Actively inviting experienced staff to retire and return as appropriate to support key work , where identified e.g. supporting mentorship of new starters
- Maintaining and actively seeking to expand staff benefits available to staff
- Developing staff to access career pathways
- Actively supporting CPD for all professionals
- Encouraging innovation and encourage staff to contribute to development of teams and services

The rurality of the UHB and geographic spread of the services does have an impact upon our recruitment as a UHB and our recruitment campaigns have focussed upon highlighting the benefits of working within rural healthcare and the associated lifestyle benefits.

WF 19
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Cyfarwyddwyr Therapïau a Gwyddorau Iechyd
Response from: Directors of Therapies and Health Science

Inquiry into the sustainability of the health and social care workforce

Consultation Response from Executive Directors of Therapies and Health Science

1. **Do we have an accurate picture of the current health and care workforce? Are there any data gaps?**

The data available on the current health and social care workforce across Wales covering professionally registered and unregistered staff is not joined up. Whilst there are certainly gaps, because the workforce intelligence is incomplete is difficult to accurately say where the gaps are.

Form must follow function and it would be helpful if there was a nationally described service specification for an integrated health and social care system. If we can accurately describe the outputs required to meet the needs of the people of Wales, we could then describe the workforce as an input to deliver the required system level outputs. The health and social care workforce must be described in terms of tasks and competencies rather than solely professional roles to enable the development of a truly integrated workforce. We could then benchmark our existing workforce against the required workforce and develop a workforce plan to bridge the gaps

The future health and social care workforce will certainly have portfolio careers with supporting skill sets and knowledge bases to allow them to flex to support areas of need across the entire health and social care system. This would provide an element of system level resilience and support the continued migration of care from secondary care settings into settings closer to people's homes.

Care pathways must seamlessly join up public, private and third sector provider care delivery. To make this a reality the health and social care workforce must straddle traditional sectoral and organisational interfaces to ensure that individual care is joined up and effective.

There is a significant degree of unwarranted variation in practice across the whole health and social care system. The role of the hybrid/multi-competency support worker is not defined, nor are national competencies in place. We've got clear delegation guidelines and examples of competencies e.g. Occupational Therapy and Physiotherapy Level 3 diplomas but these are not routinely utilised across Social Care and in residential care other than in in a few discrete localities. NHS Wales CEOs have recently commissioned a piece of work to develop a multi-competent support worker workforce. There are numbers of roles in the community already undertaking this function but they differ across Wales, some more effective than others, and assurance of governance is not always robust.

2. **Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?**

The information is out there but it may benefit from further streamlining or finessing to improve clarity and reduce ambiguity. The triple integration agenda described in England (primary: secondary, mental: physical health and health and social care) does not appear to be articulated at all in Wales in an easily digestible way. A workforce that is competent to operate across all three domains of integration should be a fundamental tenet of our vision in Wales.

However it would appear there is a fundamental lack of understanding by existing professional groups on what they are required to do, to make this step change happen. Professional groups are not always motivated to work in new ways when it is perceived that the change will undermine their professional standing, and ways of engaging them in a collaborative manner is required.

3. **How well-equipped is the workforce to meet future health and care needs?**

The focus on RTT and patient flow has shaped the secondary care workforce, making it difficult to respond to the necessary paradigm shift required to continue to deliver safe and sustainable high quality care. Largely workforce is planned in sectoral, organisational and professional silos with impermeable boundaries. This has been further strengthened by the "Nurse safe staffing Act", which has looked at a profession in isolation, rather than the needs of patients which may be better met by a truly integrated workforce approach, which would also make it more sustainable. The vast majority of our current health workforce is designed to meet secondary care challenges, and not the challenges of delivering coproduced, patient activated care in non-traditional healthcare settings. We have a workforce which requires re- configuring to deal with the challenges we face going forwards.

The Career Framework 2-4 healthcare support worker workforce will be critical to successfully integrating the existing fragmented workforce across, and within, health and social care. The move to portfolio skill sets based on competence rather than professional affiliation will enable the required integration of the workforce across the 3 domains. It is important that these roles are not just seen as part of the nursing workforce. Enablement and rehabilitation are therapeutic activities and require therapist direction and supervision.

This will require a significant shift of thinking from existing professional groups. Workforce models must include a support worker cohort which can maximise their input into a broad range of professional services. We will need to create bespoke training and competence frameworks and apprenticeships to support the development of support workers aligned to pathways rather than professional groups. Already we have examples of professions creating associate roles, with proposals to develop more, rather than boundary spanning multiprofessional re-ablement roles.

The medical model needs to be refocused in many areas to a social model of healthcare. Medicine as a profession has not been subject to the paradigm shift that is required, at the scale that is required. There are pockets of change, but integrated workforce planning and service provision that includes all professions,, including medicine is required.

4. **What are the factors that influence recruitment and retention of staff across Wales?**

Recruitment and retention are significantly impacted by job satisfaction, including access to and funding for training, access to peers with specialist knowledge, career progression, R&D opportunities as well as remuneration and terms and conditions of employment.

The Primary care workforce plan did not go far enough in defining the new models due differential incentives for private and public care providers. Safe staffing levels for particular professional groups are not helpful as it prevents diversification in the workforce and is a barrier to integration. Safe staffing levels are essential in some areas but this should not be prescriptive about the profession but more about the availability of service and the supply of tasks based on competence.

Funding in all sectors is going to be a constraint to change. Strategic budget setting, integrated training and development budgets and integrated service modelling and commissioning will start to unpick these issues. However without pump priming it may be difficult envisage how the move from the current state to the desired state will happen at the pace required.

4.1 The opportunities for young people to find out about/experience the range of NHS and social care careers;

Career events tend to be profession specific. It is difficult to promote new ways of working and supporting roles with confidence when they are poorly understood and may not be universally supported by traditional professional groups.

4.2 Education and training (commissioning and/or delivery);

Organisational Workforce and OD functions should be linked across organisations and sectors and able to respond to WG directives. Again existing local governance frameworks inhibit this and there is a requirement for a simplified national system level governance framework. This will allow all organisations to interpret the 'rules of engagement' in similar ways.

An integrated training and education budget will be essential to allow tasks to be transferred safely from one professional group to another in services where shortage profession are creating bottlenecks in care.

An effective integrated workforce commissioning model will be fundamental, as will access to an integrated staff budget for training and development. The workforce will have to be commissioned at a national system level and deployed locally based on need rather than organisational budgets and boundaries. Outreach models and 'push and pull' workforce models will need to be considered along with the supporting integrated governance framework required to enable this change to happen

4.3 Pay and terms of employment/contract;

There will be requirements for staff to work across public, private, third sector and even industry sectors. These types of appointments and developments are not easily enabled by the current configuration of healthcare providers in Wales. Agenda for Change banding lacks consistency of application across Health Boards and can be demotivating for staff. In addition delays in the banding approach often delay recruitment. A consistent national approach would be welcomed. Social care staff are on different terms and conditions which can cause tension between front line staff working side by side – the same system for health and social care would be beneficial. The different terms, conditions and pay scales across health and social care can be a barrier and greater integration of education and training departments would be welcomed.

Professional regulatory issues are not consistently understood and therefore interpreted. This leads to inconsistencies in workforce models and de facto barriers to integration. Further work on a standard multi-sectoral and multi-professional scheme of delegation will be required to enable better integration of cross-sectoral workforce and adoption of standard workforce practices.

4.4 Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

Having stated that there is a pressing need to create an integrated workforce with a broad range of multi-professional skills particularly at career framework 2 - 4 there will also be a requirement for highly specialised workforce with expert knowledge bases and skill sets. There are particular therapies and healthcare science skills gaps such as MRI expertise which need to be addressed on a national networked level rather than by an individual healthcare organisations. Also many highly specialist workforce groups face acute recruitment, training and retention issues when managing risks associated with an aging workforce.

A greater focus on intermediate care and the potential this offers at undergraduate level would probably be helpful. All therapy staff should have a community clinical placement at undergraduate level.

We need to work harder to raise the profile of the support workers and to make it a career of choice and alternative to nursing for some of the students at our local schools/colleges undertaking Diplomas in health and social care who don't wish to pursue the professional route. Apprenticeships appear to provide an ideal opportunity to recruit and develop a local workforce in some of the most deprived areas in Wales.

WF 20

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Multiple Sclerosis Society Cymru

Response from: Multiple Sclerosis Society Wales

Response to Health, Social Care and Sport Committee Inquiry into the sustainability of the health and social care workforce.

9th September 2016

1. Introduction

1.1.1. MS Society Cymru welcomes the opportunity to respond to the Health, Social Care and Sport Committee Inquiry into the sustainability of the health and social care workforce.

1.1.2. In particular we would like to respond to the particular question 'How well equipped is the workforce to meet future health and care needs?' The MS Society initially undertook a 'My MS My Needs in 2013 and found a postcode lottery of treatment, care and support, with apparent shortcomings and disparities in the services offered both across the UK and within Wales. This year, the MS Society conducted a survey of 11,024 people across the UK with MS making it the largest collection of patient-reported data from the UK MS community to date. The data presented here is from the 575 respondents who live in Wales. A section of the survey asked respondents to indicate their need for and access to support from various health professionals over the past 12 months, and as such this response only focuses on the health workforce, particularly those working in neurology.

2. Access to Disease Modifying Treatments

2.1.1. There are now 11 DMTs licensed for relapsing forms of MS, all with different efficacies, side effects and methods of administration. They can decrease the number and severity of relapses and slow the progression of disability. Added to this, there is now consensus among the MS and clinical community that early treatment with a DMT can improve long-term outcomes.

2.1.2. The recently revised Association of British Neurologists guidelines for prescribing DMTs recommends that decisions about treatment should be jointly taken by the person with MS and their neurologist, with treatment starting as early as appropriate after diagnosis. For people living with relapsing forms of MS, treating it early and effectively can suppress the disease and presents the best chance of preserving brain and spinal cord tissue during the course of the condition.

2.1.3. With the increasing number of treatments options, it's more important than ever that people living with MS are supported to make choices about their treatment, and can access the best treatment for them, regardless of where in Wales they live. In 2013 our survey found that access to DMTs in the UK was low (40% across the

UK) with Wales having the lowest rate - just 30% of people with relapsing forms of MS taking a DMT. It is encouraging to see that the number of people receiving DMTs in Wales has risen to 49% in 2016. This increase in DMT uptake demonstrates a significant positive improvement in MS healthcare in Wales. This is likely to be linked to the newer treatments that have become available on the NHS, which are judged to be more effective and easier to take. However compared to the rest of the UK; England (56%), Scotland (57%) and Northern Ireland (77%), access to DMTs among those who could benefit in Wales remains the lowest in the UK.

2.1.4. There are several drivers that make it more likely that a person will be taking a DMT. Access to health professionals and the right information are key; 81% of people who had access to MS Specialists and the right information in the last twelve months are taking a DMT, whereas only 20% of those who haven't accessed any of these services in the last twelve months are.

2.1.5. With an increasing number of treatments available, each with different support and monitoring requirements, it is vital that people with MS are fully supported to make an informed choice about their treatment. Conversations about treatment options, including DMTs, should begin close to diagnosis, with follow-up after diagnosis with a specialist within six weeks and again within six months. However, feedback from the MS community and clinicians in Wales suggest that timely follow up is becoming more and more difficult resulting in less time to assess people effectively, discuss treatment options and manage risks. With this added pressure on MS Neurologist and Specialist Nurse case-loads, people living with progressive MS tell us they feel they are being pushed further down the waiting lists with little or no support.

3. NICE Quality Standard for MS

3.1.1. People living with MS require access to professionals from all parts of the health and social care systems to best manage their condition. We believe that people with MS should have timely access to professionals and be at the centre of decision-making about their care. Published earlier in 2016, the NICE Quality Standard for MS recommends that people with MS have access to care from a multidisciplinary team with expertise in MS, and access to a comprehensive review of their treatment and care annually. This team should consist of a range of professionals including neurologists, MS specialist nurses, physiotherapists and occupational therapists, speech and language therapists, psychologists, dietitians, social care, continence specialists and GPs.

3.1.2. MS specialist nurses play a crucial role in the care and support of people with MS. Their role and responsibilities can be wide-ranging and varied but typically include providing information and support on how to best manage the condition and on DMTs, initiating and monitoring treatment for people with relapsing forms of MS, providing psychological support and co-ordinating care. 88% of people who needed to see an MS nurse were able to in the past twelve months, which is comparable to

the other nations of the UK. 11% of respondents had not seen an MS nurse but felt they had needed to. Given that people living with MS regularly cite their MS nurse as their key contact for treatment, care and support. (54% of respondents identified their MS Nurse compared to 14% who listed their GP) it is vital that this lack of access for some people with MS is addressed urgently.

3.1.3. NICE recommends that all people living with MS have a comprehensive review of all aspects of their care at least once a year, and that this review is carried out by healthcare professionals with expertise in MS. If a person is on a treatment, a comprehensive review could also be used to assess how that is working, typically including an MRI scan. There are only four neurologists who specialise in MS in Wales and all four are based along the M4 corridor in South Wales. The only other provision is provided by an MS specialist neurologist based at the Walton Centre in Liverpool who covers North Wales. Only 75% of respondents reported that they had their need to see their neurologist met. 17% had not seen a neurologist in the past twelve months but felt that they needed to.

3.1.4. Many people living with MS experience bladder and urinary problems, including incontinence and infections. Continence advisers can provide people living with the condition with information, for example about products and treatments for bladder problems, and confidential advice. In Wales 75% of respondents to our survey who had required specialist continence advice had received it. However, more than one in 10 (14%) people had not received this support despite needing to.

3.1.5. 48% of respondents had seen a physiotherapist in relation to their MS within the last year, but nearly 1 in 5 people (18%) had not seen a physiotherapist and felt that they needed to. Physiotherapy can have a significant impact on a person's rehabilitation after a relapse, or can improve movement and mobility for someone living with disability as a result of MS. Timely access to evidence based and appropriate physiotherapy should be a basic entitlement, available for everyone living with MS in Wales who could benefit.

3.1.6. Half the number of people living with MS experience anxiety and half experience depression, with many experiencing both. Moreover, there is a strong link between mental and physical health – in 2012, £1 in every £8 spent on long-term conditions was linked to poor mental health. Ensuring people living with MS can access emotional support is vital, however 28% of respondents said that they had needed emotional support in the last twelve months but hadn't received any/enough help or support.

3.1.7. NICE guidelines state that people living with MS should have access to a single point of contact who acts as a care and treatment coordinator and that care and treatment should be made available through multi-disciplinary teams. Care planning and care co-ordination has a vital role to play in ensuring that people living with MS can access the full suite of support they require to best manage their condition. Our survey found that overwhelmingly people in Wales reported that they had not been offered a care plan or a review of their care plan by their health

professional in the last 12 months (86%) For people to feel fully supported and empowered in their care, the MS multidisciplinary team must consist of health and social care professionals working with the person living with MS to achieve the best outcomes. When asked if they felt that the professionals who help plan their care worked well together, 18% of our survey respondents answered "not at all" meanwhile 15% responded "completely" and 34% "to some extent

4. Treatment Options for People with progressive forms of MS

4.1.1. All the DMTs we have at the moment only work with types of MS that have relapses. New drugs are being tested to see if they work against progressive (non-relapsing) types of MS. We hope that the first one that works against primary progressive MS, ocrelizumab, will be available in 2017 or 2018.

4.1.2. People with primary progressive forms of MS make up approximately 15% of people diagnosed with MS. Of the 85% of people diagnosed with relapsing forms of MS, 65% will have moved onto secondary progressive MS after 15 years.

4.1.3 As highlighted earlier, as more treatments become available feedback from the MS community and clinicians in Wales suggest that timely follow up is becoming more and more difficult resulting in less time to assess people effectively, discuss treatment options and manage risks. Given that the system is already under pressure and understaffed (Public Health Wales Neurological Conditions Needs Assessment 2015 identified that there is a significant shortage of consultant neurologists in Wales and that this is compounded by a severe shortage of neurology clinical nurse specialists [an overall shortage of between 7.1 and 9.5 multiple sclerosis nurses]when only 49% of those with relapsing forms of MS who could benefit from taking currently available treatment taking them, we are very concerned about the workforce capacity to ensure that all those who are eligible for currently NICE/ AWMSG approved medicines and future NICE/ AWMSG medicines are able to access these treatments equitably across Wales.

WF 21
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Cymorth Cymru
Response from: Help Wales

Inquiry into the sustainability of the health and social care workforce

Cymorth Cymru welcomes the opportunity to respond The Health and Social Care Committee, regarding forthcoming priorities. The committee oversees a broad variety of areas that are of great importance to our organisation and to our sector, some of which are outlined below

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

The current health and care workforce in Wales spans several different forms of care, all possessing different needs but sharing similar core needs. As suggested in John Kennedy's workforce work for adult social care from 2014, introducing a single assessment instrument (providing real data on quality indicators, dependency profile and resource needs) could give an understanding of the care home sector, as well as valuable data to measure quality. It could provide a national statistical database to inform strategic planning for the future of health and social care.

While at times it can feel like the care sector often suffers from the amount of paperwork, in Wales we still have very little objective statistical data on care and the way in which people work within it. As Kennedy pointed out in 2014 we have no cross-sector way of measuring case mix, age profile, prevalence, conditions, complexity, and length of stay. Lacking this kind of information makes it difficult to strategically plan, as we have little knowledge of the workforce.

As well as finding a way of capturing the basic information mentioned above, we need to look at ways to remedy the lack of robust data about the economic benefits of the care workforce.

Areas we feel need immediate data attention are:

- Morale trend changes
- Economic contributions of the care workforce
- Hours worked by individuals
- Training given to individuals
- Requirements for sustainable funding for the sector, based on the market analysis pilot due to be extended further

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

The Welsh Government's vision includes the Social Services and Wellbeing (Wales) Act. This Act recently came into force in April 2016 outlining the vision for the delivery of health and social care. However we believe more work needs to be done with organisations and employers to ensure they are fully informed about what that Act means for their organisation and any changes that will need to be made to comply with the Act.

The increase in the National Minimum Wage and subsequent progression towards a National Living Wage has shown that there have been efforts made by the Westminster Government to place more value on a lower-paid workforce. It is certainly welcomed as a broad policy, and will go some way to appropriately paying staff that our communities are increasingly reliant on.

However, the financial consequences of this remain unresolved and pose a major risk to the social care market. The consequences of provider / market failure will be felt far more widely than simply in local authorities and providers, with major consequences for the National Health Service in Wales. This policy change in the National Living Wage is a clear signifier of the lack of importance paid to the social care workforce as part of the wider economy as a whole (by Westminster policymakers) – the change in the National Living Wage will have a huge impact on social care and other publicly funded services, and it does not appear to have been fully thought through.

Getting the balance between paying the workforce what it is due and the financial sustainability of the sector is vital.

How well-equipped is the workforce to meet future health and care needs?

When it comes to domiciliary care, social work and wider health and social care roles, training can be inadequate – or, if adequate, there is a risk that little institutional good practice can be engendered due to the rapid turnover of staff. Beyond mandatory health and safety training such as 'manual handling' and 'fire safety', there are concerns that other training is limited. Training could be offered that would increase a team member's career progression or understanding of the wider issues outside of personal care that they are working with every day.

What are the factors that influence recruitment and retention of staff across Wales?

One of the biggest influences on recruitment is people's initial draw to and interest in the profession. A large factor in this is a parity of esteem in comparison to other professions. Roles in wider health and social care are often perceived as 'bottom rung' jobs, under-skilled with no opportunities for personal development. People who work within these roles are assumed to know little about the sector they are working in, when in actual fact they possess more practical insight and knowledge about their client group than many others within the sector and certainly those outside it.

A way to increase the amount of people showing an interest in these roles is to publically celebrate and value the knowledge and skill held by this workforce and add to this by offering more useful opportunities to develop and build on these skills and knowledge. This will raise the opinion of the profession and the esteem of those working within it.

The health care sector and social care sector has a reputation for high turnover of staff (The Welsh Government estimates the domiciliary care sector has a turnover of around 32% and a vacancy rate of 6%). A potential reason for this is that the care workforce are often required to work long hours with irregular shift patterns and sometimes very low contracted hours. We feel that hiring people on decent contracts (e.g. with a promised 30 hours a week) and assigning people consistent working hours will increase retention of staff across the sector. A feeling of security and direction within an individual's working life will lower the amount of people viewing care as a temporary job and more of a long term career.

Another way to retain workforce is to give clear differentials in pay between roles, enabling providers to offer a career path within care that currently does not exist. Knowing there is a pay increase will not only motivate people to take on extra responsibilities within their roll but also a feeling of value that these new responsibilities show a progression from a past roll.

As important as we believe the above points to be, one of the largest reasons for high turnover in health and social care is the low wage. A fully trained support worker is worth more in value to an organisation than the national minimum wage most are being paid. As stated above we believe there needs to be a proper salary scale compensating for experience and qualifications. When properly valued, care work is an extremely rewarding career. However, whilst relatively low stress jobs, such as those in named supermarkets offer over £1.50 per hour more in pay, people are not naturally going to migrate towards a career as mentally and physically demanding as care.

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

The impact of loneliness on people using services in rural areas is an issue. If elderly or living with physical or mental disability that increases travel barriers, an individual living in a rural area without good travel links to public areas or long distances between loved ones then isolation is a real possibility. If the workforce caring for these individuals are overworked, only being afforded 15 – 30 minutes per house visit, this allows little time for the care worker to build up a relationship with their client and curb this loneliness by affording the individual more time to effectively signpost to community initiatives, re-establish connection with family members and generally check on their personal wellbeing.

The Campaign to End Loneliness argues that loneliness and isolation are as harmful as smoking 15 cigarettes a day and that 41 per cent of those who feel lonely saying transport is a barrier to seeing people. These statistics point to there being a need for more services in rural areas.

However these same rural areas may also experience the effects of 'brain drain' to urban areas, leaving the areas they have left underqualified for the needs that need to be catered for.

A properly remunerated social care workforce has a huge potential for positively impacting both on the quality of care provided and on the sustainability of often rural communities where jobs are scarce. As people requiring social care are scattered

throughout communities so are the employment opportunities provided by supporting them.

Conclusion

Whilst we welcome the effort to improve the sustainability of the workforce, we and our members are concerned about costs rising and funding falling within the care sector. There is the inescapable challenge of how the care sector itself is funded and sustained. As it stands, any action to support the workforce or to address challenges would be weakened by the ever-present scramble for resources amongst local authorities and providers.

For queries please contact:

Oliver Townsend / Policy Manager / Cymorth Cymru:

[redacted] / [redacted]

9/9/2016

ENDS

WF 22

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Cymdeithas Fferyllol Frenhinol Cymru

Response from: Royal Pharmaceutical Society Wales

Patron: Her Majesty The Queen Chief Executive: Helen Gordon Member enquiries T 0845 257 2570 E support@rpharms.com

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8th of August 2016

Dear Sir / Madam

RE: Inquiry into the sustainability of the health and social care workforce

The Royal Pharmaceutical Society (RPS) Wales welcomes the opportunity to respond to the Inquiry into the sustainability of the health and social care workforce.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

We are pleased that the Welsh Government's national plan for primary care includes using the skills and expertise of the wider primary care team, including pharmacists. Welsh Government's Efficiency Through Technology Fund investment in choose pharmacy will see Community pharmacies in Wales will be fully integrated with GPs and hospitals. We hope that this investment will be fully utilized with the development of more services through community pharmacy to better support patients with their medication and health needs including long term conditions. In order to make prudent healthcare happen in Wales it is essential that our highly-educated and skilled health professionals are used appropriately, spending time on work that cannot be undertaken by other, less expensive members of staff

There is a clear vision for a seven day health service, particularly in the managed sector. Traditionally hospital pharmacies have operated a full week day service supplemented by limited services and on-call arrangements at weekends. It is necessary to remodel pharmacy services to provide the required seven day health provision for patients, this will increase the number of pharmacists and pharmacy technicians required.

How well-equipped is the workforce to meet future health and care needs?

As the third largest professional group in the NHS, the pharmacy profession has a significant and unique contribution in the healthcare of the people of Wales. With the recognition and development of extended clinical roles for pharmacists and medicines management roles for pharmacy technicians and their inclusion in primary and secondary care multi-disciplinary teams (MDT) there is a need to allow these MDT teams to train and develop together and embrace and support the individual expertise that each member contributes to better patient care.

Expertise and resource is required to model the current pharmacy workforce and the future need. Such baseline data would allow a coherent workforce strategy to be developed with

other healthcare professionals to ensure that the potential role of pharmacy is maximised, and the Government's aspirations for primary care are achieved.

Medicines are the most common interventions in the NHS today. It is essential for patients that their medicines and pharmaceutical needs are overseen and coordinated at all points of the health and social care pathway to ensure they can benefit from their medicines and suffer no harm. Patients must be able to benefit from wider access to the pharmacy team in Wales, with the pharmacy profession taking greater responsibility for the outcomes of medication and working in partnership with patients to coach them to achieve their health goals at all points of their care journey.

Medicines are relevant to all healthcare journeys and patients must benefit from ease of access to pharmacy services that can provide:
• Public health advice and interventions
• Early detection of health problems, pharmaceutical interventions and referral to appropriate services
• Safe supply of medicines 7 days a week to reduce harm and improve outcomes
• Access to advice and support on medicines
• Support for patients in all care environments including their own homes

The full integration of the pharmacy team into NHS models of care will also help to:
• Improve the quality of patient care
• Improve the coordination of medicines when care is transferred
• Ensure the cost-effective and prudent use of medicines
• Reduce medicines waste

Current educational funding streams from WEDS are available only to managed sector for both pharmacists and pharmacy technicians and there is no investment in up skilling the community pharmacy team to enable new professional services to be offered to patients. Educational funds currently placed within primary care clusters are not being made available to pharmacy. Consider either a directive to ring fence monies or re-allocate the funds to WEDS or similar body. There is currently no central funding for foundation programmes for community pharmacists to further develop their skills and to provide protected time to support them in offering new clinical services for patients. There is also a lack of multi-disciplinary educational funds to facilitate learning programmes across healthcare teams which we envisage would encourage multidisciplinary working.

What are the factors that influence recruitment and retention of staff across Wales?

New work and services models that enable pharmacists to better utilise their clinical and consultation skills for patient benefit is essential to retain and recruit pharmacists in Wales.

As with other professions, pharmacy does face recruitment challenges, particularly in rural parts of Wales. This year, North Wales is piloting a new approach to the Pre-registration year for pharmacists which includes a split between community, hospital and primary care pharmacy in order to better equip individuals for a career in pharmacy rather than a sector specific career. We are supportive of new and innovative approaches such as this to attract high caliber future pharmacists to Wales

Patron: Her Majesty The Queen Chief Executive: Helen Gordon Member enquiries T 0845 257 2570 E support@rpharms.com

We consider there to be an opportunity to paint a positive picture of the opportunities for pharmacy in Wales that will encourage more pharmacy professionals to relocate to Wales, this would also help ensure we recruited the best professionals to work in Wales. This might include:

- Developing pharmacist and technician 'stories' which describe how pharmacy professionals are working in Wales today. These would focus not only on new roles (pharmacists in OOHs, GP practices etc) but also the extension of roles in traditional sectors (e.g. Additional community pharmacy roles such as the common ailment service and influenza vaccination).
- Describing the opportunities from Wales' integrated NHS including examples of pharmacists with portfolio careers.
- Describing new developments such as the agreement to allow all pharmacists in all sectors and pharmacy technicians in hospitals access to the Welsh GP Record to support delivering care.
- Describing integrated pre-registration training programmes for pharmacists staring in North Wales this year.
- Subject to Ministerial agreement, describing the proposals for pharmacy pre-registration training recommended by the Modernising Pharmacy Careers Programme Board.

I trust this information is helpful. Please do not hesitate to get in touch if you require any further information.

Yours sincerely

Mair Davies, Director RPS Wales

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including 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.

Patron: Her Majesty The Queen Chief Executive: Helen Gordon Member enquiries T 0845 257 2570 E support@rpharms.com

WF 23

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: The British Psychological Society

Response from: The British Psychological Society

The British Psychological Society
Promoting excellence in psychology

British Psychological Society response to the National Assembly for Wales

Inquiry into the sustainability of the health and social care workforce

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000 and have over 1,500 members in Wales.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the Assembly to contact us in the future in relation to this inquiry.

Please direct all queries to:-
Joe Liardet, Policy Advice Administrator (Consultations)
The British Psychological Society, 48 Princess Road East, Leicester, LE1 7DR
Email: [redacted] Tel: [redacted]

About this Response

The response was jointly led on behalf of the Society by:
Dr Adrian Neal, Consultant Clinical Psychologist, ABUHB
Dr Julie Highfield, Consultant Clinical Psychologist, CAVUHB

With contributions from:
Dr Debbie Rees-Adams, Consultant Clinical Psychologist, ABMU

We hope you find our comments useful.

Dr Ian J Gargan CPsychol AFBPsS
Chair, Professional Practice Board

Dr Paul Hutchings CPsychol AFBPsS
Chair, Welsh Branch

British Psychological Society response to the National Assembly for Wales

Inquiry into the sustainability of the health and social care workforce

	Do we have an accurate picture of the current health and care workforce? Are there any data gaps?
1.	Comments: The Society believes that reliance on traditional metrics for health and wellbeing including sickness absence, seasonal flu inoculation uptake, and staff survey give only a very limited sense of what the real picture is. We recommend that attention and value be given to a broader set of metrics to better understand the actual experience of work. These might include: retention / turnover, data from exit interviews, internal complaints and HR dignity at work processes, pulse surveys including satisfaction, morale, 'happiness at work', quality of relationships (peer to peer and towards the organisation), and lastly ways of assessing how safe do you feel at work.
	Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?
2.	Comments: The Together for Health document is a five year vision that was published in 2011. This document noted issues in recruitment and retention of medical staffing. The Delivering a Five Year Service document is also outdated, but highlighted the projected demands on NHS Wales. It outlined a vision of a workforce that is coordinated, motivated and professional. It linked the need for workforce allocation to healthcare population analysis. These documents did not link to research or evidence regarding important factors to the workforce e.g. factors impacting retention and recruitment, motivation, wellbeing at work, and other psychologically underpinned factors. There is no analysis and understanding of the complexities of the NHS and Social Care workforce. The Society believes the Welsh Government might benefit from such an analysis. Documents such as NICE Guidelines for Wellbeing at Work are useful

	guides. We also believe that there is currently too much emphasis on physical health, and not enough on psychological health & well-being. By creating systems that promote psychological well-being at work preventatively we may make progress towards a more sustainable workforce, and thus Welsh NHS.
	How well-equipped is the workforce to meet future health and care needs?
3.	Comments: Given the context which is characterised by hospitals that are already struggling with patient "flow", sizable pressures in both acute and longer stay settings, the predicted increase in age (85+) in the general population along with increased numbers of people living with chronic conditions (often lifestyle related – obesity, diabetes, CHD, mobility – orthopaedic problems etc) over the next few decades, the workforce are going to be significantly challenged. There is a general opinion that the current workforce and the systemic infrastructure that supports them are not currently equipped for these challenges. There seem to be two key factors to consider: 1. The supply and retention of a workforce to meet growing demand of an ageing population. 2. The sustainability of a high quality, compassionate, and productive workforce. Recent publications (e.g. CAVUHB Investigation into A&E services; The Andrews Report; Berwick report; Francis Report) indicate that there are systemic failings in the support of the workforce and undermine workforce sustainability and patient safety. A detailed understanding of these factors in relation to health and social care in Wales has not to our knowledge been undertaken.
	What are the factors that influence recruitment and retention of staff across Wales? This might include for example: • **the opportunities for young people to find out about/experience the range of NHS and social care careers;** • **education and training (commissioning and/or delivery);** • **pay and terms of employment/contract;**
4.	Comments:

	Additional psychological factors that may impact include: • The psychological contract between employer and employee. • Organisational justice, and how employees experience fairness at work. • At a macro level the compassion gap between how an organisation expects its staff to relate to patients, and how the organisation treats its staff. E.g. congruent utilisation of vision and values such as "kindness"; how this reflects in policies such as sickness absence; grievance; staff wellbeing. • History of organisational trauma; the NHS in particular has experienced several re-structures, poor press, and the ever present sense of threat from Welsh Government down the chain of command. • The evidence base suggests the relationship between management and employee is predictive of morale, satisfaction, and therefore retention (Guest, 2004). • Perception of the Welsh NHS from outside of Wales - not all potential employees will be aware that NHS England and NHS Wales are different organisations with varying policies, values and opportunities. This is not well publicised in England if Wales wished to recruit from England. Wider issues to consider also include: • It is not unusual for HBs to have hundreds of vacancies at any given time despite recruitment trips abroad (for nurses in particular). It's possible that nurses think the NHS is a difficult place to work and this can be off-putting. • Staff stress – there are areas of work where staff do not want to work which compounds the ongoing stress and pressure in those areas. • CPD restricted in recent years due to cost cutting, leading to some staff feeling frustrated and unable to progress. • In terms of psychology – few opportunities for progression in some specialities (e.g. MH), particularly above 8a level. • Restructure and organisational change have a traumatic impact on the workforce, leading to low morale. • Many staff counting down the days until retirement. Also changes to pension age and scheme (staff feeling they are being forced to work longer).
	Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

5.	Comments: The geography of Wales is such that there are more hospitals to cover the population. Recent documents (e.g. Faculty of Intensive Care Medicine, 2016) give examples of the lack of economies of scale of the number of hospitals required to meet the geographical spread of the Welsh population. Staffing might be adequate for the population, but the geography of the population is such that typical staffing estimations derived from English hospitals are not appropriate. There is only one medical Deanery and one school of Physiotherapy for Wales, which impacts the experience of Wales as staff in training will be asked to uproot themselves for placements across the whole of Wales Staff will vary in their attraction to bigger cities with better housing and cultural opportunities vs a more rural setting. In areas where Welsh language predominates may be a barrier to non-Welsh speakers.
	References
	• NICE (2009) Promoting Mental Wellbeing at Work • NICE (2015) Workplace policy and management practices to improve the health and wellbeing of employees • Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry • The Andrews Report (2015) - "Trusted to Care" – An independent • Review of the Princess of Wales Hospital and Neath Port Talbot • Hospital at ABMU Health Board • Department of Health (2013) Berwick review into patient safety • Faculty of Intensive Care Medicine (2016) Regional Workforce Engagement Report: Wales • Guest, D.E. (2004) The Psychology of the Employment Relationship: An Analysis Based on the Psychological Contract. Applied Psychology. **53(4)**, 541–555

End.

WF 24
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Gofal Canser Marie Curie
Response from: Marie Curie Cancer Care

Marie Curie response to the Health, Social Care and Sport Committee's inquiry into the sustainability of the health and social care workforce.

Marie Curie welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into the sustainability of the health and social care workforce.

Introduction

In Marie Curie we believe that everyone should have the right to the palliative care they need.

Yet we know from our research that, even with all the care and support the NHS and its partners provide, 6,200 people across Wales who need palliative care miss out on it each year because their needs are not recognised and they are not referred on to the right services.[1]

Marie Curie provides a range of services across of Wales, including:

- A nursing service providing hands on care day and night for people at the end of their lives in their own homes.
- A care home support service in west Wales enabling people to avoid being admitted to hospital who are living in supported accommodation.
- A Freephone advice line offering practical advice and support for patients and their loved ones.
- A 30 bed hospice providing in patient clinical care and day services for people across Cardiff and the Vale and beyond.
- A discharge liaison service in Velindre Trust which supports people returning to their own homes.

In providing all of these and the other services across Wales, Marie Curie makes a financial contribution (usually at least a matching one) out of its own charitable funds to augment those provided by NHS commissioning bodies. All of the clinical services in Wales are provided as a result of being commissioned by the NHS in Wales and all of them would be regarded as core services by the public.

Workforce sustainability

We know from our research that too many people miss out on the care they need for a variety of factors. Marie Curie firmly believes that everyone who needs Palliative Care should have access to it. There are still too many people nearing the end of their lives not getting the palliative care they need[1]. Seven out of 10 carers say people with a terminal illness do not get the care and support they need.

The health and social care sector as a whole recruits both British nationals and non-British nationals to make up its workforce.

The recent referendum on EU membership and the uncertainty over exactly what 'Brexit' has the potential to impact on the number of EU nationals seeking work in the health and care sector across the UK.

The health and social care workforce relies heavily on EU nationals not just for medical and clinical staff but also for vital support services including health care assistants.

Estimates suggest that 1 in 10 NHS Doctors are from elsewhere in the EU and around 4% of nurses. This clearly shows both the attractiveness of working in the UK to non-British Nationals as well as the vital role they play in our health and care services.

The uncertainty over the UK's exit strategy from the EU will inevitably be discussed at great length by both the National Assembly as a whole and also many individual committees. Marie Curie feels that this is an important topic and one that the committee should not shy away from discussing.

We feel this is something that could easily be over looked and would encourage the committee to consider how Wales can prepare itself for this in the future.

We would encourage the committee to consider a recommendation that LHBs should produce a forward plan identifying what contingency plans they have in place to manage any reduction in their current workforce and their forward recruitment plans across all roles. LHBs should be required to consult with other healthcare providers such as the charitable and nursing home sectors to establish the implications beyond the NHS of substantial changes to the existing workforce and future recruitment environment.

We very much hope that the Health, Social Care and Sport Committee will consider these topics.

Marie Curie
September 2016

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WF 25
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: The Delivery Unit
Response from: The Delivery Unit

Health Social Care and Sports Committee Consultation

Inquiry into the sustainability of the health and social care workforce

The Delivery Unit welcomes the inquiry into the health and social care workforce and the opportunity to provide a response to the Committee's consultation.

The Delivery Unit (DU) is responsible for the functions of assurance, improvement of performance and supporting delivery within the NHS. In order to achieve this it works in partnership with statutory and non-statutory health and social care agencies. The health and social care workforce are therefore of significant interest to the DU.

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

Data on the workforce within Health and social care have improved and are likely to have become more standardised as a result of initiatives such as the Knowledge and Skills Framework. However, ensuring that steps are taken to maintain accurate records of the workforce, its age profile, skill-base and geographical deployment will help to ensure that the picture is accurate and that the data can inform workforce planning.

Among the issues that need to be considered to improve workforce intelligence are the number and nature of posts being held by staff approaching retirement. This will allow improved business continuity planning and the potential for skill deficits in particular specialisms and geographical locations to be addressed.

Whilst health and social care may be keeping improved data on their individual workforces the necessity to draw these data together to provide a more coherent picture of the total workforce is not well developed. Furthermore within local authorities they have services outside formal social care services that impact very considerably upon the work of the health and social care sectors. For example; education services, in their health care support and pastoral care functions will employ schools based counsellors and teaching staff specialising in special educational needs. Housing services play a very significant role in supporting people to remain at home whilst receiving significant packages of support. Communities First programmes undertake important work to make communities more sustainable and create the environment necessary to enable communities to support people with long term conditions including dementia.

The third and independent sectors continue to provide a very significant part in the mixed economy of health and social care services. The workforce within these sectors needs to be considered. If these sectors are unable to staff their services the impact upon statutory services is considerable. It is

likely that the full picture of the workforce of these sectors is not fully understood particularly given the likely fluidity of this workforce and the nature of the contracts held by staff for example the greater prevalence of part time working and zero hours contracts.

These difficulties are exacerbated by the different sectors recruiting from the same workforce. This can have the effect of "robbing Peter to pay Paul" within and between agencies, especially when new services are designed or one sector has a recruitment drive.

- Continuing to build intelligence on the current workforce and future workforce needs is required using a cross-sector and more integrated approach.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

A significant number of health and social care policy documents have been produced by Welsh Government which have workforce implications. These documents frequently set out a vision for a more community based model of care, with greater integration of health and social care services and a reduction in the reliance upon hospital and other care settings and sustaining people within their own homes and communities. This policy has in recent years been encapsulated within legislation with the same intent

It is not clear that this vision has translated into the undergraduate and vocational training of health and social care professionals and support staff. Nor has it been adequately integrated into workforce plans.

- It will be necessary to provide vocational qualifications to undertake sensitive roles within this workforce.

How well-equipped is the workforce to meet future health and care needs?

The ageing population within Wales means that more people are living longer with increased numbers living into their 90s and beyond. This ageing population is more likely to have a number of co-morbid conditions. This will include long term conditions such as diabetes, cardiac heart disease complicated by obesity and for many an accompanying mental health condition such as anxiety, depression and/or dementia.

In order to build sustainability into health and social care services these people's needs will need to be met within the community, but with likely periodic hospital admissions.

The current arrangements in the delivery, planning and training of the workforce do not currently reflect this changing need. The workforce tends

to be “siloed” into community services hospital, services and a separation between physical and mental health divisions. Training the future workforce to work across community and hospital settings meeting people’s complex needs will be vital in building a workforce with the skill set required to meet existing and future challenges. Increased specialism can lead to the unintended consequence of a fragmented approach to delivery.

Unfortunately the expertise of genericism is not as highly valued as the more apparent expertise of the specialist. Working with frailty in older people and greater complexity more generally will require expertise across a number of fields.

- There is a need therefore to recognise and promote the value the role of the “expert generalist” and to develop a workforce drawn from a range of backgrounds.

What are the factors that influence recruitment and retention of staff across Wales? This might include for example:

The opportunities for young people to find out about/experience the range of NHS and social care careers;

Encouraging people to seek a career in the health and social care sectors is vital if we are to grow the workforce required in the future. Importantly this may be enhanced by identifying the transferability of skills acquired within these sectors into other areas of work. Recent trends suggest that it is less likely that those people who come into the workforce will remain within it throughout their lifetime. People will work for longer and will be more likely to be more mobile moving between sectors throughout their careers. This movement will need to be planned for but may well bring benefits as people bring fresh ideas and experience into the health and social care sectors. Engaging pupils in school and colleges of higher education and further education will be critical in stimulating people to gain the skills required.

It is not just children and young people that need to see the potential of working within these sectors. The extension of people’s working lives into their 70s and the mobility of the labour market provides opportunities for middle aged and older people to consider career transition into the health and social care sectors. This is likely to become more important due to the increasing pressure to reduce immigration and the potential to attract qualified and unqualified staff into these sectors from the EU and beyond.

- There is a need to stimulate interest in a working in health and social care settings among young people but also in older people with an interest in making a career change

Education and training (commissioning and/or delivery);

Developing more appropriate services requires a well-educated and well trained workforce with the range of skills necessary to meet the future needs of people using services and the sectors providing them. This will require education in a range of settings in preparation for work within the statutory, third and independent sectors. There will also be a need for continuing professional development within the workforce with staff being trained and provided with other opportunities to acquire the skills and competencies necessary to care and treat patients and clients most effectively. Particular attention should be paid to training which enables career development. For example health and social care support staff could, through training, be enabled to develop their careers qualifying within relevant professions. This will enable a greater commitment to the service. Furthermore it will not mean that those people who may feel they have reached a career ceiling have to leave services to progress, and the consequent loss of their knowledge, skills and experience.

It may provide a more diverse workforce better representing the needs of minority groups and people from socially deprived communities. People from these communities may find it difficult to enter health and social care professions through traditional routes but may have specialist skills such as cultural awareness or language skills including British Sign language that can tailor service provision to local community need.

- Different delivery models and entry levels to training may be required to develop diversity and flexibility in the workforce.

Pay and terms of employment/contract;

In order to develop and sustain the necessary workforce a more flexible approach to work with terms and conditions that better reflect the way that families meet employment and caring responsibilities determine the manner in which this balance is struck. This is not always embraced by organisations in spite of policy frameworks seeking to achieve greater flexibility. The results of staff surveys should be used on a National level to inform how the workplace needs to adapt to improve staff retention.

Enabling 7 day services reaching into the evenings and night as required may be attractive to some families with child care and other family care commitments. However if flexible working does not generate a sufficient workforce which prefers to work in this way services may need to consider creating incentives for people to work “anti-social” hours.

- Greater flexibility in terms and conditions may be required. Considerations may need to be given to financial or other incentives to attract the workforce required.

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

Addressing the needs of particular geographical areas is critical. Rural communities are ageing with many young people leaving to find work and many older people retiring to rural and coastal locations. There are disincentives for people to commute to rural areas to work including the cost of commuting, frequently by car as a necessity, the addition of commuting time to the working day etc.

This has led to a depletion of the workforce required. Strategically planned steps should be taken to attract people, young and older, into the health and social care workforce from within these communities.

It may also be necessary to create a rural weighting to incentivise people to work in these settings. This could include enhanced travel and subsistence and a formal rural weighting being applied to jobs in very rural settings or in deprived communities with a history of recruitment and retention problems.

- Particular focus is required to ensure that rural areas and deprived communities are adequately served.

Once again the DU welcomes the opportunity to contribute to this consultation and would ask the committee to accept its comments above as part of this consultation.

WF 26
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Institute of Physics and Engineering in Medicine
Response from: Institute of Physics and Engineering in Medicine

National Assembly for Wales Consultation: Inquiry into the sustainability of the health and social care workforce

The Committee welcomes views on any or all of the following points:

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

How well-equipped is the workforce to meet future health and care needs?

What are the factors that influence recruitment and retention of staff across Wales? This might include for example:

- the opportunities for young people to find out about/experience the range of NHS and social care careers
- education and training (commissioning and/or delivery)
- pay and terms of employment/contract

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation.

Background

The Institute of Physics and Engineering in Medicine (IPEM)

IPEM is a professional association and Learned Society with 4,300 members across the UK who are physicists, engineers and technologists working with applications of physics and engineering applied to medicine and biology. Our members work in hospitals, academia and industry, and IPEM has a unique role in linking the three areas.

As a charity, IPEM's aim is to advance the application of physics and engineering to medicine for the public benefit and to advance public education in this field. We do so by supporting and publishing research, and supporting the dissemination of knowledge and innovation through project funding and scientific meetings; and by setting standards for education, training and continuing professional development for healthcare scientists and clinical engineers.

IPEM's Welsh members were circulated with consultation documents and asked to provide their views to IPEM. The response is based on the feedback received and specifically addresses the following questions posed by the Committee, namely: Do we have an accurate picture of the current health and care workforce? Are there any data gaps? How well-equipped is the workforce to meet future health and care needs? What are the factors that influence recruitment and retention of staff across Wales?

IPEM response

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

1. In response to these particular questions, IPEM carried out a census of the Radiotherapy Physics workforce in November, 2015. All three radiotherapy centres (North Wales Cancer Treatment Centre, South West Wales Cancer Centre, and Velindre Cancer Centre) responded to the census, and the results are shown in the table below:

	Workforce/Whole Time Equivalent (WTE)	Vacancies	Vacancy Rate
Clinical Scientists	36.55	0	0%
Clinical Technologists (Physics)	25.56	3	11.7%
Clinical Technologists (Engineering)	19	2	10.5%

2. In terms of the Rehabilitation Engineering workforce, insufficient responses were received to produce a table as above. Some issues that were highlighted included difficulties in recruiting trained staff and retention concerns. In order to increase the service as required, more staff will be needed.

3. A 2014 survey of Diagnostic Radiology found that no department had adequate workforce resources in terms of establishment and some suffered from on-going vacancy issues. There is very limited MRI physics expertise in Wales (0.3 WTE).

4. IPEM holds no data on the following areas: Radiation Protection, Nuclear Medicine, Clinical Engineering (including Electro-biomedical Engineering) and Physiological Measurement.

How well-equipped is the workforce to meet future health and care needs? What are the factors that influence recruitment and retention of staff across Wales? The following forms IPEM's response to these particular questions.

5. Medical Physics and Clinical Engineering (MPCE) training capability exists but capacity is stretched; some training schemes (for example, imaging with ionising radiation at Scientist Training Programme level) are not offered locally due to resource limitations.

6. Where numbers of staff are very small, accurate workforce planning is difficult and the availability of vacancies to match training course outputs is unpredictable. This is a major issue. Some good staff are 'lost' and Health Boards should be encouraged to provide flexibility. Nevertheless, recruitment to vacancies for Clinical Scientist posts, suitable for newly-qualified Clinical Scientists, remains challenging as graduating trainees return to England, undertake PhD study etc. A 'lock-in' for both trainee and health board/trust might be explored.

7. Innovative solutions to recruitment are developing, for example, recruitment of Assistant Physicists (not yet qualified as Clinical Scientists) to support the scientific service and subsequently pursuing 'Route 2' training schemes to Health and Care

Professions Council (HCPC) Registration; but this is not a universal solution and has limited capacity.

8. Outreach activities to schools and work experience for students are activities supported by departments as an aid to advertising and recruiting the best students but it is too little and needs formal support. Unfortunately it is an activity that is under severe pressure as the working schedules of staff become ever more crowded.

9. Some engineering disciplines are stretched, for example, linear accelerator engineering, and in-service training schemes to 'grow-your-own' need to be available at Career Framework Level 3-5. Fully qualified engineers are in increasing demand.

10. Extending roles into previously 'medical functions' (for example, radiotherapy treatment volume and Organ At Risk outlining, nuclear medicine scan reporting). This extends the role of staff and follows prudent healthcare principles. This has particular promise for medical disciplines with recruitment shortages (for example, radiology, oncology).

11. Need for supporting newer modalities, for example, the provision of MRI safety expert advice, which remains a particular challenge in Wales.

12. Need to respond to the evolving technology of healthcare (for example, CT scanning on linear accelerators, diagnostic systems vastly more complex than just a few years ago etc.) where MPCE has the knowledge and skills to optimise safe and effective use but has limited resources with which to develop, advise and implement evolving technologies.

13. The growth of private healthcare providers in Wales, and particularly the recent X-ray and Proton Radiotherapy Centre under construction in Newport, has potential to impact on the NHS especially where highly specialist staff are scarce e.g. radiotherapy physicists. The Newport Centre has already recruited staff from the NHS. It would be good to encourage private providers to have a stake in the formal training of scientists and practitioners.

14. Some disciplines are working extended hours and thus staff presence during normal clinical hours can be limited with potential compromise in the service. The impact of extended hour working, and particularly if weekend services are to be provided, needs to be recognised as additional work and supported through an appropriate change to the Whole Time Equivalent (reliance on overtime payment is not a viable long term solution).

15. The workforce can be equipped for the future given the opportunity for development through protected time; the time available for training has become increasingly short in order to accommodate greater clinical workloads.

16. Further ideas being considered by the Clinical Engineering Profession Specific Group include:

    16.1 To develop and strengthen the clinical engineering Assistants and Associates workforce by providing centrally funded supernumerary apprenticeships aimed at attracting school leavers and those seeking career changes to clinical engineering within the NHS.

16.2 To establish readily accessible in-service clinical engineering Practitioner training across Wales based upon the following:

16.2.1 Top up routes for those already employed as Healthcare Science Assistants and Associates specialising in clinical engineering

16.2.2 Fast track conversion routes for graduates from non-Practitioner Training Programme medical engineering degree courses such as those offered by Cardiff and Swansea universities.

17. Consultant Clinical Scientists specialising in Clinical Biomedical Engineering to be based in every Health Board in Wales and to lead the adoption of medical technologies and the associated development of innovative practice within each Health Board. As such, each will provide the expert link with the Wales Health Technology Hub on behalf of that Health Board. This will be achieved via:

17.1 Strategic commissioning of Higher Specialist Scientific Training (HSST) Clinical Biomedical Engineering on an all Wales basis.

17.2 Centrally funded consultant level Continuing Personal and Professional Development (CPPD) to support in-service equivalence routes to registration on the Academy for Healthcare Science (AHCS) Higher Specialist Scientist Register (HSSR).

Ends

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Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Cymdeithas Llywodraeth Leol Cymru a Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol

Response from: Welsh Local Government Association and Association of Directors of Social Services

Inquiry into the sustainability of the health and social care workforce

Introduction

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. The challenges facing social care have been well documented. As a result of demographic changes primary and community care services are facing increasing and more complex demands; more people are diagnosed with one or more preventable health condition; and frail, older people increasingly have more complex needs. This comes at a time when we will continue to experience severe austerity in funding for public services across the UK. Given the challenges being faced by public services it is appropriate that there is serious reflection on the impact these issues have on the health and social care workforce and how we support and develop the workforce to meet future health and care needs.

5. One of the conclusions drawn from NHS workforce review undertaken last year was that, *"the widely held view across the service is that we currently lack an agreed strategic vision of what the NHS is intended to look like in Wales in ten years' time…and that this inhibits the planning of new workforce models, new skill mixes and new roles. If this is true with regard to the health service it is even more the case with regard to an integrated health and social care service.* "We would endorse

this statement. From the outset we need to be clear on what the vision for the workforce is – what are the expectations for the services that the workforce will be delivering. Without this direction it is hard to say how well-equipped the workforce is to meet future health and care needs.

6. We need to ensure that we have a workforce that will enable us to deliver high quality and where appropriate integrated care within the context of increasing demand. However, we also need to ensure that the system we have in place is sustainable. Local authorities and health boards are facing significant financial and demand pressures which will have long standing implications. In 2012 the Institute for Fiscal Studies report on local government expenditure in Wales showed that, until 2009-10, spend had been increasing in real terms by around 5% each year. This kept pace with inflation and service pressures. From 2009-10, spend has been reducing in real terms, but if expenditure had kept pace with general inflation, it would now be over £7bn. The resulting gap of £720m represents a conservative estimate of the cuts and efficiency savings achieved so far by local government. From April, councils in Wales face budget pressures of just over £200m due to inflation, demography and unavoidable financial pressures, e.g. the introduction of the single tier pension. It is likely that by 2019-20 there will be a cumulative budget shortfall of around £800m. The submission by WLGA and ADSS Cymru to Welsh Government on Social Services budget pressures last year indicated that social services departments in Wales faced unavoidable cost and demand pressures that will increase from £68m in 2016/17 to £234m by 2019/20. Clearly the ability to absorb any additional costs is virtually non-existent. At the same time we have seen significant investment into the NHS by the Welsh Government, however this has also not kept pace with demand.

7. In light of this, we believe that a more radical approach to integration is needed, 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. However, 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.

Current Issues

8. In Wales, we do not currently have an online National Minimum Data Set (NMDS) which records accurately the state of our social care workforce. Lots of data is

collected in a variety of different places but, unlike in England, we have no up to the minute coherent information system that can inform social care workforce planning about important issues such as regional and national vacancy rates, wage rates, levels of training, employment gaps, education levels, etc. Certain registers like the Care Council for Wales Social Worker register has accurate information about registered social workers but it is not a dynamic system and the annual social worker survey carried out with local authorities is only accurate at a point in time. Whilst these are essential in the absence of a NMDS, it is limited in the assistance it gives to decision makers.

9. Investment in an online NMDS system is required to enable Social Care Wales, CSSIW, employers, workforce planners and decision makers to work together on the basis of solid facts. This would help reduce duplication for employers completing a variety of information requests from different sources and provide confidence to make the right decisions about the future investment.

10. We have seen a number of recent studies focused on the social care workforce which have highlighted some of the significant challenges related to recruitment and retention particularly for domiciliary and residential care staff. One particular issue highlighted is in relation to pay and terms of conditions. The NHS workforce review, for example, heard evidence of what was seen as inferior terms and conditions of employment for social care staff carrying out direct care. Recent research undertaken by Manchester University, on behalf of Welsh Government, on the domiciliary care workforce identified that outside of local authorities, care workers uniformly expressed dissatisfaction with low pay and were also of the view that it did not reflect the levels of responsibility in the role.

11. The NHS introduced a living wage for staff in 2015 and whilst the announcement of a 'National Living Wage' by the UK Government may go some way to improving the offer to social care staff many social care providers are small, third and private sector agencies, who will find it extremely difficult to increase the wages of staff at a time when local authorities and health boards continue to look for efficiencies in response to their own financial constraints. Ultimately the risks will rest with local authorities if social care providers are unable to meet these requirements and assistance is not provided.

12. The phased introduction of a National Living Wage may help to improve recruitment and retention but this will be dependent upon funding to meet that funding gap. We also need to be mindful of the fact that the National Living Wage will apply to all sectors including retail and hospitality which the social care sector has reported losing staff to in recent times. Its implementation will significantly increases costs (by also causing a ripple effect in terms of pay differentials for supervisors and

managers) without any improvement in recruitment and retention if there is no increase in relative pay for the role.

13. The recent Welsh Government consultation on the domiciliary care workforce was focussed on how best to recognise the important work done by domiciliary care workers, how to raise their profile and improve the quality of domiciliary care in Wales by having a positive impact on the recruitment and retention of domiciliary care workers. The proposals touch upon areas such as zero hours contracts, call clipping and payment for travel time. WLGA and ADSS Cymru submitted a joint response to this consultation which can be found here

14. The social care provider market has been fragile for some time and all the signs are that the difficulties will increase. For example, UKHCA have indicated that 71% of their members across England and Wales turned down local authority funded packages of care over the last 12 months. For some areas of Wales it can be very difficult to access home care to respond to complex cases or because of the rurality of the area, with the local authority provision having to fill the gap, often with difficulty.

15. In some areas of Wales we are also experiencing small family run providers who are deciding to retire from the sector. Younger family members are not choosing to take over the business due to the smaller profit margins, higher acuity of service users and requirements and future anticipated requirements of the inspectorate, all of which add further challenges to the sector.

16. Recent research on the domiciliary care workforce has highlighted some of the significant challenges related to recruitment and retention for this section of the workforce. The research by Manchester University concluded that a well-trained, well-paid and secure workforce with appropriate working patterns is required to recruit and retain care workers and to deliver high quality care. However the research findings suggest these are not conditions widely experienced outside of local authority employment in the domiciliary care workforce. With the majority of social care provision provided by the independent sector in Wales this has major implications for having a well paid, secure workforce.

17. Some of the conclusions drawn from this research support work undertaken by the Older People's Commissioner for Wales looking into Care Homes. The Commissioner received evidence that low staffing levels are often the result of difficulties in the recruitment and retention of care staff. A number of reasons were stated for this, including poor levels of pay, low morale, long working hours that can include 12 hour shifts as part of a 60-70 hour week and the role of a care worker not being seen as a desirable and viable professional career option. This is a particular issue

in rural areas and areas where the need for Welsh language speakers is high, as the number of potential care workers with the right skills can be especially limited. The review also concluded:

- Workforce planning is challenging due to a lack of demographic projections about future demand for, and acuity levels within, care homes. It is therefore not possible to quantify the right number of care staff needed in the future.
- The unregulated nature of the care home workforce in Wales, which means that data is not held on the number of care home staff in Wales, can also lead to difficulties around effective workforce planning.
- In relation to nursing staff, workforce planning is not effective as it is based only on the needs of Health Boards and does not consider the needs of residential care. This can cause particular issues around the recruitment of qualified and competent nurses to work in EMI (Elderly Mentally Infirm) settings as reported by several local authorities.
- There are issues around the recruitment of qualified and competent Care Home Managers and there is a lack of effective planning for current and future needs.

18. CSSIW and Care Council for Wales have also undertaken research into the recruitment and retention of adult care home managers in response to concerns over the high turnover and possible recruitment difficulties for registered managers of care homes for older adults in Wales. The study looked at what influences the recruitment and retention of managers of care homes for older adults, with and without nursing provision, across all sectors and identified some key influencing factors, including:
    - The size of care homes and the complexity of residents' needs
    - The lack of a common set of data for the social care workforce
    - Significant differences between the roles and responsibilities of adult care home managers, as well as their pay and other terms and conditions
    - Negative publicity for care homes.

    The overview report notes that the Independent providers spoken with acknowledged that the direction of travel in commissioning was a move from residential care to services that help people remain at home, but questioned the availability of the workforce to meet the future needs.

19. During the review, providers and managers were concerned that there were not enough nurses across the board and that recruitment efforts within the NHS are likely to exacerbate the problem for care homes with nursing. There were fears that the NHS will actively recruit the best nurses and that attempts to improve nurse to patient ratios within the NHS will leave the care sector even more vulnerable.

20. The pressures on the social care sector have been well documented and there is increasing evidence on the impact that this is having on providers in particular. It is important to recognise that many of these challenges will also impact on local authorities, particularly where there is in-house provision of services such as domiciliary care and care homes. Workforce stability is critical to the delivery of consistent, reliable services. Some local authorities have faced real challenges in both children's and adult services particularly in light of growing demand for services and increasing caseloads. Across Wales we have seen a significant increase in numbers of looked after children and this has had a major impact on the caseloads within Children's Services. Whilst many authorities have stable, resilient workforces many have also had to make progress in stabilising their front line workforce, particularly across Children's Services. Despite reducing resources, local authorities have continued to invest in training and developing the workforce and with the implementation of the Social Services and Well-being (Wales) Act this will be key to ensure that we have an appropriately trained and competent workforce that is able to deliver the ambitious agenda set out in the Act.

Future Mix of Workforce and Services

21. We need to ensure that we take a whole sector approach to the health and social care workforce, which needs to apply to developing new roles and career progression. We need to be able to support a mobile workforce that can move between sectors, underpinned by training, qualification and progression opportunities. Career pathways are vital and we need to be able to support the workforce to be able to follow easy routes within and between health and social care, recognising the value of experience and not just simply qualifications. This includes the need to further develop joint training sessions across professional training programmes, supporting joint working and mutual understanding across different professional groups. The whole workforce includes the statutory, independent and third sector, but importantly needs to include unpaid carers and how they can be supported to access information, advice and training alongside the paid workforce. The SSIA have recently undertaken research looking to identify the improvement priorities for Social Care Wales and the findings re-inforce this view, with a need for a cross sector approach to training in order to build a mobile, flexible workforce with opportunities for career progression.

22. The new Social Services and Well-being (Wales) Act demands that we think differently about service provision otherwise if we keep doing the same thing we will continue to get the same results. We know that the current health and social care system is unsustainable. Apart from ensuring the paid workforce is up to speed and working together effectively, there has to be a massive transformation of attitudes and contributions made by communities and the support they are able to provide. We need a transformation of attitude in the health and social care sector to

developing and supporting carers and volunteers otherwise our paid professional workforce will simply not cope. It is vital we tap into the enormous bank of knowledge, energy and experience of people in communities to support vulnerable people and we have to invest in this to make it happen. Preventative, early intervention and community based support have to be developed and we need to invest in this unpaid workforce to release that capacity.

23. Career development is a critical feature of sustainability. There is a need to ensure that people are encouraged to develop their skills, not simply to aid personal progression, but to enable a better skilled workforce. This includes a need to ensure that supervision and support is provided to the whole workforce. This can make a critical difference, allowing workers to reflect on their experiences and practice and being supported in their own personal development.

24. Changes in service provision have not shifted at the pace of changes in people's needs and wants, so we are still left with some service responses to policies and needs that were identified in late 1940s and 1950s, at the start of 'the welfare state'. In addition there has been insufficient development of services that will still be relevant in 20 years time, in particular recognising the way that digital technology is changing many people's lives. Telecare and telehealth are still relatively under-developed in Wales and this means that we are not exploiting the opportunities that they afford to people to have much greater control over their own health and well-being and this requires a workforce that is comfortable in recommending and demonstrating the benefits of new technology.

25. There have been moves in some parts of Wales to introduce generic health and social care workers, as a way of avoiding wasting time and energy on defining what is a health task and what is a social care task. However there remains a need to deal with the issue of medicine-administration, as this often turns out to be an issue on which a more generic role falls down. There are examples where staff have been suitably trained to administer medicine and these should serve as evidence that it is possible to find a way through some of the unhelpful professional boundaries.

26. Whilst advocating the development of generic health and social care workers, we are not suggesting the dilution of professional expertise. Actually the outcome should be a better trained workforce, both competent and confident to provide a greater sense of holistic care to people. There are now regular examples of care coordinators from a variety of professional backgrounds, e.g. Occupational Therapist, Social worker, nurse, physiotherapist. Each will still have some degree of specialist knowledge, but the difference should continue to be a care coordinator

not looking to transfer responsibility to others, but bringing in others who can add value to their coordinating role.

27. Whilst there are examples of really good community-based services, they are still in the minority and still fewer that reflect shared responsibility between health and social care and NHS and local government. In Wales most health and social provision is sitting in private and third sector agencies and they have to be brought into the debate about planning for the future workforce.

28. There is a need for a stronger pool of consultant social workers and advanced practitioners amongst nurses and occupational therapists to carry out the developing number of leadership roles as well as offering coaching and mentoring, modelling best practice. The front-line workforce would, as a result, be better valued and better prepared, for the challenging nature of the tasks that they have to carry out. This does not replace the need for ensuring that they are properly rewarded for the demands of their job and that goes beyond the debate about a minimum or living wage.

29. In Wales, working with Social Services Improvement Agency (SSIA), Care Council for Wales and Universities, local authorities have invested in well established national social services management development programmes at first, middle and senior management levels as well as a sophisticated Continuing Professional and Education Programme (CPEL) for social work practitioners to ensure we continue to develop our social workers and their managers to meet the challenges of the future. This is essential in the sustainability for those elements of the workforce.

30. We need to give thought to how best to ensure access to services in the language of need and how to support front-line staff with language skills. This may include recognising and supporting those who have English as a second language, as well as securing adherence to the standards within "More than Just Words".

31. In addition this review needs to consider how best to fully engage with housing associations (and local authority landlords who retain stock), with an overall workforce in Wales of 8,000, many of whom will have worked in public sector agencies, bringing shared values and yet key additional knowledge and skills into the mix of a whole system approach to the workforce. Housing associations make a vital contribution to the health of the population and many housing association staff are able to offer community work and community development skills, so essential to rebuilding mature and co-productive relationships with local people and their communities.

32. We have been clear in responses to the SSWB Act that the workforce will be fundamental to the successful implementation of the Act – requiring a workforce

that is multi-agency and multi-disciplinary. The Act requires a very different way of working, particularly around the new approaches to assessment and eligibility, that will not be simple to apply and will challenge some of the existing practice and training. The right kind of staff training and development will be essential, in order to support staff to be able to meet the expectations set out in the Act, with realistic timescales for the changes to become embedded into people's everyday practice. Some of this work has already started, for example having an increasing focus on outcomes, however the size of the changes required and the new expectations cannot be under-estimated.

Cadeirydd/Chair: Arwel Ellis Owen
Prif Weithredwr/Chief Executive: Sue Evans

Cyngor Gofal Cymru
Care Council for Wales

Hyder mewn Gofal - Confidence in Care

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WF 28

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Cyngor Gofal Cymru

Response from: Care Council for Wales

Noddir gan Lywodraeth Cynulliad Cymru
Sponsored by Welsh Assembly Government

Sarah Beasley
Clerk to the Committee
Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff
CF99 1NA

9 September 2016

Dear Ms Beasley,

Please find attached the Care Council for Wales' response to the Assembly's Health, Social Care and Sport's
Inquiry into the sustainability of the health and social care workforce. We are grateful for the opportunity to respond.

The Care Council is a Welsh Government sponsored body which has a leading role in making sure the workforce delivering social services and childcare in Wales is operating to a high professional standard. We have legal powers to set the standards workers need to meet, and to take action where that doesn't happen. We help develop the professionalism of managers and workers through qualifications, training, knowledge sharing and continuous professional development. In April 2017 we will be renamed Social Care Wales and receive a wider remit for research and service improvement.

Yours sincerely,

Sarah McCarty
Director of Learning and Development

Care Council for Wales' response to the Assembly's Health, Social Care and Sport's Inquiry into the sustainability of the health and social care workforce

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

1. The care sector in Wales is characterised by its fragmented nature. There are over 3,700 registered social care providers in Wales in the public, private and third sectors who are organised locally and nationally. This reflects the complexity of the social care market and estimating the current workforce is difficult and relies on a range of different approaches.

2. General information about the numbers of people working in social care is collected by the Welsh government and the Local Government Data Unit. The first collates data on staff working for local authority social services departments[i]. The second collates data on staff working for services commissioned by local authorities[ii].

3. In terms of data gaps, these figures do not include workers employed by people who fully fund their own care. Nor do these figures include unpaid carers. Welsh Government data on local authority staff does not include important demographic data such as age, gender and ethnicity.

4. Comprehensive information is available on those workers registered by the Care Council, namely social workers, adult care home managers, domiciliary care mangers and residential child care managers and workers[iii]. For these staff we can describe work and employment patterns, career pathways and turnover. This is information is not currently available on the unregistered workforce.

5. In co-operation with the Data Unit, we have produced social worker workforce planning data which looks at looks at the trends of the workforce over time, staff turnover and the projected workforce over the next three years[iv]. A similar document has been prepared on occupational therapists.

6. By combining data from the Welsh Government and the Data Unit we find there are an estimated total of 79,000 people working for local authority social services departments of for organisations commissioned by them. The social care workforce is overwhelmingly female. 81 per cent of the staff who for services commissioned by local authorities are female. As the table below notes, social care staff work in a range of settings. Around 26,000 work in residential care and 23,000 work in domiciliary care.

7. In future we will be working with the Welsh Government and other partners to improve the quality and reach of this data. We are working with the Care and Social Services Inspectorate Wales (CSSIW) who plan to gather more data on the workforce in regulated services.

8. The plan to register domiciliary care workers and adult care home workers will increase the amount of data held and provide an opportunity to carry out more comprehensive workforce planning.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

9. The Welsh Government's vision for social care is reflected in the Social Services and Well-being (Wales) Act, 2014 which places an emphasis on person-centred care, early intervention and

prevention. The vision recognises a growth in both the demand and the complexity of the care that will be required. This will mean more care workers and more highly skilled workers. In addition there will be a requirement for: a. care staff that are able to provide both personal and health care; b. staff capable of applying professional judgement rather than only following prescribed procedures; c. more Welsh speaking staff. The requirement for additional staff with specific skills will prove a challenge, particularly in rural areas.

10. New statutory regional partnership boards have been established to plan and deliver social care and health services in each part of Wales. They are required to produce joint population assessments to better understand the care and health needs of people and strategic action plans to meet the needs of citizens within their locality. These assessments will provide the opportunity to better plan the workforce in future. The regional partnership boards are developing workforce sub-groups who will be able to contribute to this work.

11. Regulations under part 9 of the Social Services and Well-being (Wales) Act, 2014 require greater partnership working between social services departments and local health boards. For example, the regulations require the establishment of pooled funds for the exercise of care home accommodation functions and the exercise of family support functions. The legal requirement for partnership working between strategic authorities creates the opportunity for joint workforce planning and training.

12. We understand that the Welsh Government will be publishing a NHS Workforce Strategy, there is an opportunity to align this strategy with a workforce strategy for social care to ensure a complementary approach across the workforce. There is a clear interdependence between social care and health support to enable individuals to receive care in their own community.

How well-equipped is the workforce to meet future health and care needs?

13. The Care Council is working with partners across Wales to equip the workforce to meet future health and social care needs.

14. 53% of people employed in services commissioned by local authorities have the required or recommended qualifications for their job[v], leaving 47% to become qualified. In general the majority of these workers currently require a level 2 health and social care qualification (QCF Diploma).

15. The Care Council will be working with partners in the sector to encourage greater take up of qualifications to the sector. Providing a stronger professional ethos for the sector through training, registration and the development of career pathways will be central to this drive.

16. Under the Regulation and Inspection of Social Care (Wales) Act, 2014, almost all social care workers will need to be registered in order to practice by 2022. A key element of registration will be the attainment of a minimum level of qualification. The Care Council is embarking on a five year strategy for Care and Support at home, this will include preparations for the domiciliary care workforce for this change. From 2018 they will be the first main new group which will need to register. In 2020 they will be joined by adult care home managers.

17. Currently the following groups of workers are registered and are required to meet minimum standards of qualification: social workers; adult care home managers; domiciliary care managers; children's residential care home managers and workers. It is estimated that there are around

79,000 workers currently employed in the formal social care sector in Wales, of which approximately 11,000 are registered with the Care Council. The domiciliary care workforce and the adult care home workforce comprise a significant part of the remainder.

18. There is evidence that in future, an increasing number of people will be living for longer with more complex needs. For example, people with learning disabilities are now living longer with associated health care needs presenting new challenges for the people providing care and support to them. The likelihood is that higher levels of skills, knowledge and therefore qualifications will be demanded.

19. There is also a greater demand to receive care and support and home and to design services around the needs of the person. These changes will require new and enhanced skills for social care workers. The Social Services and Well-being Act, 2014 provides a legal framework for councils and their partners to deliver services in accordance with these demands. The Care Council has commissioned extensive material for the social care workforce to train them in new ways of working. These can be found on the Act's Information and Learning Hub[vi].

20. The way in which health care tasks are delegated from health workers to care workers is a barrier to achieving effective services. Unless there is a clear clinical governance framework in place with good quality training and support from health professionals it can present a risk for people who use services and workers themselves. The way in which health care tasks are delegated is inconsistent. There are concerns from local authorities that they are being asked, in some cases, to undertake duties that are an NHS responsibility, which may be ultra vires and with no additional funding to do so.

21. An All-Wales Framework for the delegation of health care tasks is needed to ensure that there is: a. clarity about the tasks that can be delegated; b. a clear clinical and corporate governance framework in place which facilitates the safe and legal delegation of tasks; c. appropriately training for those involved in both delegating and undertaking tasks; d. adequate funding agreed between health and social care to ensure that there is no additional financial burden placed upon local authorities, as functions transfer from one workforce or setting to another.

22. The Care Council is responsible for promoting learning and development in social care. In partnership with the social care and training sectors we have developed a qualification framework for the social care sector in Wales, which is a first in the UK[vii]. The qualification framework has been developed to define the minimum qualification required for each role in social care. The qualifications are regularly reviewed.

23. The Care Council publishes a Social Care Induction Framework for Wales which aims to support the workforce by providing a structure upon which induction can be based. It supports a common understanding to induction in social care in Wales by outlining the knowledge and competence workers need to demonstrate in their first 12 weeks of employment, whether they are new to social care or new to an organisation or role.

24. Retaining staff is a major challenge for the care sector. For example, the turnover rate for domiciliary care staff is 35 per cent, compared to 15 per cent for most workers across the economy. Care employers have provided consistent feedback that an important factor in retaining a care worker is whether they have the appropriate values for the sector. These values include empathy and patience, which demonstrate a person centred approach. In order to help Job

Centre Plus and others to recruit people with the appropriate values to the sector we have produced 'A Question of Care' which is a free online resource which aims to raise awareness of careers in the care sector[viii]. It helps people find out what work in social care and childcare is really like, and tests them on their suitability as potential recruits.

25. The Care Council is responsible for the Code of Professional Practice for Social Care[ix] which sets out the standards for the registered workforce. All applicants have to agree to abide by it when they register and may go before fitness to practise hearings if there are allegations over whether they have upheld its standards.

26. In 2015, the Code was reviewed to reflect the significant changes in social care since it was published in 2002, and to ensure it would support the workforce to deliver the expectations of Social Services and Well-being (Wales) Act 2014.

27. In January 2016 we launched our Caring with Pride initiative to promote the Code. It provides employers and managers with the tools and information to promote and embed the Code in their workplace, and encourages workers – whether registered or not – to take a proactive approach to show they support and share the values outlined by the Act.

28. The Care Council has developed a continuing professional education and learning framework for social workers. The framework equips social workers with the advanced knowledge, skills and qualifications they need as they progress from newly qualified to experienced practitioners and more senior practice roles. The Care Council has also developed a continuing professional development toolkit for social care, early years and child care managers and workers.

What are the factors that influence recruitment and retention of staff across Wales?

29. At present, there is no overall strategic approach to recruitment to social care. As a result, social care careers promotion is often undertaken in silos and in an ad hoc way without a joined up, coherent approach.

30. Therefore the Care Council, along with its partners is proposing a holistic careers recruitment and retention framework. It will provide a clear vision for supporting the sector in recruiting high quality individuals. It will encourage continuing professional development within the existing workforce to facilitate sustainability and quality. Values-based recruitment and retention is key to this. The emphasis will be placed on promoting social care as a viable and rewarding career option, offering support to address the new legislative requirements.

31. The negative portrayal of social workers in the media creates a barrier to recruitment. It is important that steps are taken to promote the excellent work that social workers do in child protection and other areas in order to overcome this.

32. The Care Council is responsible for working with partners to set the educational and training standards for social care. We are currently responsible for the regulation of social work training. In future, in our new guise as Social Care Wales, we will be given the authority to regulate all social care training.

33. We supported an independent review by Qualifications Wales which identified that the qualifications and learning landscape for social care and child care sector in Wales is complex, crowded and dynamic. The key findings questioned: a. the effectiveness of the present models of assessment in determining the knowledge, skills and understanding of learners; b. the

currency of some qualifications, particularly those qualifications taken by learners aged 14-16; c. the extent to which qualifications prepared learners for progression to higher education; d. the coverage of certain key aspects of learning for different areas of work, for example in relation to dementia care, domiciliary care and play work in the context of childcare; e. the extent to which qualifications prepared learners effectively for working in a bilingual nation

34. We are working with Qualifications Wales and others to address these issues with learning providers and social care employers. This is long term project which will run from now until 2019.

35. It is well documented that pay and terms and conditions are a serious barrier to achieving a sustainable care workforce. Pay and terms and conditions are not as favourable in social care as they are in other sectors. Employers report that they frequently lose staff to other sectors such as retail which offer more favourable terms.

36. It is a particular problem that there is lack of parity between the social care and health sectors. Staff often move from social care to health where they are paid more for undertaking similar roles. This reflects the funding protection afforded to the NHS as a government and public priority, relative to the budget cuts faced by local authorities.

37. The Welsh Government has published research which highlights the impact of poor pay and terms and conditions on the workforce and people receiving domiciliary care[x]. The introduction of the statutory National Living Wage for the over-25s at £7.20 an hour has led to a substantial increase in wages for low paid workers in the care sector. However, there are concerns about the impact on the costs of a sector which is already under significant financial pressure.

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

38. There is a particular concern around the sustainability of the social care workforce in rural areas. These centre around the affordability of providing care in these areas and the distances required to travel to provide care.

39. There is a case to made for developing new approaches to delivering services in rural areas which makes the best use of community and public assets, as well as technology, and the potential to recruit more people locally. There are good examples of rural service provision. However, more could be done to share learning, so that it is built into the system.

Conclusion

40. There is a great deal of pressure on the care workforce in Wales. There is an increasing demand for social care provision. At the same time, the needs of those receiving social care are becoming increasingly complex. The workforce will be expected to focus on prevention, reablement, and focusing on the needs of individuals and families as part of communities.

41. There is an opportunity to provide greater employment in the sector. In order to achieve this more people will need to be recruited to the care sector and more effective steps will need to be taken to improve retention rates. The Care Council and its successor, Social Care Wales will work with the sector to improve levels of training and professionalism.

Appendix

Table 1: Summary of the main sources of data on the social care workforce

Data	Source
Staff working for local authority social services departments	Welsh Government
Staff working for organisations commissioned by local authority social services departments	Local Government Data Unit
Profiles of the registered workforce	Care Council for Wales

Table 2: Estimate of total staff working for local authority social services departments and in organisations commissioned by them, listed by workplace setting

Work place setting	Total number of workers
Central management and support	2,738
Social work	6,664
Hospital	187
Domiciliary care	22,836
Residential care	25,736
Day and community services	10,601
Mixed (services are organisations commissioned by local authorities who offer a mixture of domiciliary, residential and day care)	10,060
Total	**78,822**

[i] Staff working for local authority social services departments, Welsh Government
[ii] Staff working for organisations commissioned by local authority social services departments, Local Government Data Unit
[iii] Profiles of the registered workforce, Care Council for Wales
[iv] Social worker workforce planning 2014-15, Local Government Data Unit
[v] Staff working for organisations commissioned by local authority social services departments, Local Government Data Unit
[vi] Social Services and Well-being Act Information and Learning Hub, Care Council for Wales
[vii] Qualification Framework for the Social Care Sector in Wales, Care Council for Wales
[viii] A Question of Care, Care Council for Wales and partners
[ix] Code of Professional Practice for Social Care, Care Council for Wales
[x] Factors that affect the recruitment and retention of domiciliary care workers, Welsh Government, 2016

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Cymru Wales

WF 29

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Y Gymdeithas Feddygol Brydeinig Cymru
Response from: British Medical Association Cymru Wales

BMA

SUSTAINABILITY OF HEALTH AND SOCIAL CARE WORKFORCE

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

Response from BMA Cymru Wales

9 September 2016

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the Health, Social Care and Sport Committee on the sustainability of the health and social care workforce in Wales.

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

RESPONSE

In October last year, BMA Cymru Wales provided a comprehensive evidence submission to the *NHS Wales Workforce Review*[1] that was commissioned by the previous Welsh Government and chaired by David Jenkins. That review clearly has a significant cross-over in terms of its remit with this current committee inquiry. Given that there has been little change in the issues in hand in the intervening period, we would therefore ask the committee to accept our earlier submission – attached as Appendix 1 – as a key part of our response to this inquiry.

Similarly, the committee will be aware that its predecessor committee in the Fourth Assembly also undertook an inquiry last year into the GP workforce. Our comprehensive responses to that inquiry which was submitted in January 2015 should also be accepted as part of our response to this new inquiry. It is attached at Appendix 2.

In undertaking this current inquiry, we feel that committee could benefit from looking at the findings of the *NHS Wales Workforce Review*, including by looking at what is now being proposed should be done to address its recommendations. Given that such a major, and comparatively recent, piece of work has been undertaken, such an approach could prove more beneficial that starting to look again at many of the same issues in isolation. We would similarly suggest that the committee should look at what progress is being made in implementing the Welsh Government's workforce strategy for primary care, *A Planned Primary Care Workforce for Wales*[2], which was also published last year.

The timescale and timing of the call for evidence for this inquiry has presented us with a number of challenges. For member-based organisations like us, we need sufficient time, for instance, to effectively gather evidence from amongst our members. This is understandably difficult when undertaken at a time of year when many of our members are on annual leave, when a time-period of just over a month is offered for evidence to be submitted and when three inquiries of interest are launched by the committee concurrently. This has therefore limited our ability to respond to this call for evidence as effectively and as comprehensively as we might have wished, but we hope this contribution is helpful nonetheless.

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[1] Jenkins D, Phillips C, Cole S & Mansfield M (2016) *NHS Wales Workforce Review*. Available at: http://gov.wales/topics/health/publications/health/reports/workforce/?lang=en

[2] Welsh Government (2015) *A Planned Primary Care Workforce for Wales*. Available at: http://gov.wales/topics/health/nhswales/plans/care/?lang=en

In relation to the specific questions posed as part of the terms of reference for this inquiry, we would wish make the following additional points for the committee's consideration:

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

This issue is already touched upon within our response to the Jenkins Review. There are a number of factors, in our view, which prevent us from seeing an accurate picture. For instance, headcount numbers which are often quoted can mask a reduction in the workforce resulting from an increasing prevalence of less than full-time working. At the same time, it is not always possible to easily provide accurate whole time equivalent (WTE) figures. For instance, in the case of GPs, particularly those who are independent contractors, there can be much variety in the number of hours a full-time partner might actually work in a given week, with many working hours in excess of those that would otherwise be regarded as constituting full-time working. We know that the Welsh Government has been looking to identify a suitable methodology for arriving at an acceptable definition for a WTE GP but we are not aware that this work has yet reached a satisfactory conclusion due to the difficulties involved.

Another issue that we believe needs to be addressed to assist in effective workforce planning is the current lack of collection and publication of meaningful data on vacancies. We understand that such data has not been routinely published since 2011. As such, we have had to resort in more recent times to the use of Freedom of Information Act requests in order to obtain such data. Even then, the responses we received would appear to be highly inaccurate – largely due to the use of a fundamentally flawed definition which means a vacancy is only counted as such when an active process is underway to fill it. In addition, there is a lack of consistency in the definitions used for vacancies between different health boards and trusts making comparisons difficult. We fail to understand how health boards and trusts can undertake effective workforce planning when those in charge don't appear to be effectively monitoring the extent to which vacancies are impacting on workforce provision. Not only do we feel that this needs to be addressed by returning to a system whereby data on vacancies is routinely and regularly published, but steps also need to be taken to ensure that workforce data is meaningful and therefore able to be used for effective comparison.

In relation to secondary care, the committee might also wish to look at the extent to which effective job planning is often not properly undertaken by health boards and trusts. With reference to consultants, this issue has previously been the subject of investigations undertaken by the Wales Audit Office. We are also aware that this issue is a concern amongst staff and associate specialist grades.

We regularly hear from members that stress-related illnesses are becoming increasingly common. Burnout is a very serious threat to the sustainability of services, not to mention to individual doctors' health. We believe that an all-Wales comprehensive occupational health service for all NHS staff is required, and that action is needed to recruit more consultants in this specialty (some health board areas have less than one). Data collection is needed in this area beyond sickness absence recording, and should include capturing workloads and the impact of vacancies. Conducting exit interviews for employees leaving health boards (including GPs handing back their contracts) should also be formally collected and routinely analysed.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

Whilst we have previously expressed a number of concerns regarding the findings contained within the 2015 report of the Welsh Government-commissioned *Health Professional Education Investment Review*, carried out by a review panel chaired by Mel Evans, one of the report's key findings with which we did certainly agree is that there is a need for '*a refreshed strategic vision for NHS Wales which provides the longer term context for shaping the workforce of the future*'.

Given that there is already broad acceptance of that view amongst stakeholders across the sector, there may therefore be little need for the committee to pursue this particular question in further depth. Instead we would welcome a concentration on how this current lack of a strategic vision for the service, and its impact on effective and sustainable workforce planning, might now be addressed.

Regarding physician associates, there has been no detail or strategy about what role they are intended to play – i.e how they would contribute to the more effective delivery of care, or to alleviating the workload of existing staff, in addition to that which existing professions already provide. We would therefore welcome details of the training, regulation and career development options for such roles. We remain concerned that physician associates may be sold as the 'holy grail' of workforce planning, but will not have been adequately thought through for the longer-term, and that there is a danger that such roles would be filled by staff who would have otherwise entered existing shortage professions (such as healthcare assistants).That said, we are not opposed to such roles, and believe that the teams of professionals needed to meet local population health is best identified and determined locally (we hold hopes for GP clusters networks in this regard).

How well-equipped is the workforce to meet future health and care needs?

This is a very broad question which could be interpreted in a number of different ways. It is clear to us that, in many regards, the capacity of the workforce is failing to keep pace with increasing demand and is already therefore under strain in relation to current demand. This is particularly the case within primary care where there is an increasingly recognised recruitment and retention crisis amongst GPs against a backdrop where demand is continually increasing as a result of an ageing population and an increasing prevalence of chronic disease. There are also increasing recruitment and retention challenges amongst certain specialties within secondary care which have been the driver for various service reconfiguration proposals in recent years across different health board areas. Increasing use of locum doctors, and increasing overtime costs being reported by health boards amongst medical staff, are also signs that the current workforce provision is under severe strain. Taken in the round, these indicators suggest that the workforce is struggling in many regards to provide for current health and care needs, and these challenges will no doubt become greater in the medium- to long-term.

What are the factors that influence recruitment and retention of staff across Wales? This might include for example:

- *the opportunities for young people to find out about/experience the range of NHS and social care careers;*
- *education and training (commissioning and/or delivery);*
- *pay and terms of employment/contract.*

This question covers a number of issues already touched upon in the previous responses we have attached in the appendices to this response. We would therefore refer the committee to these earlier responses, but we also wish to make a few additional points which are outlined below.

In terms of opportunities for young people to find out about and/or experience the range of NHS and social care careers, we previously touched upon this issue in our response last year[3] to the report of the Welsh Government-commissioned *Health Professional Education Investment Review*.[4] Our responses to the following two questions posed in the Welsh Government's subsequent request for feedback are of relevance, and we have therefore reproduced them here:

[3] https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-walesreporthpeireview-01-06-2015.pdf?la=en

[4] Evans M, Phillips CJ, Roberts RN & Salter D (2015) *Health Professional Education Investment Review*. Available at: http://gov.wales/topics/health/publications/health/reports/education-investment-review/?lang=en

What are the barriers to providing wider work experience and apprenticeship opportunities and how can they be addressed?

In more deprived areas, local children may be more likely to lack personal links to health professionals. Another barrier that needs to be considered is how to identify the time for students to take up any work experience opportunities. We would suggest that consideration could be given to developing local NHS careers services with local NHS careers champions. Departments could also be established in each health board and university with a remit to promote NHS careers.

These suggestions could enable Wales to build upon the work that is currently undertaken by many hospitals and GP practices that already offer work experience opportunities through both formal schemes and informal arrangements, thereby providing scope to formalise and extend the links which already exist between the NHS and local schools in order to ensure wider access to such opportunities. They could also enable the NHS to go into schools at a stage much earlier than that at which pupils might be allowed into clinical areas, but early enough for them to consider aspiring to work in healthcare before their career choices have been narrowed by subject choices and exam results.

We would also suggest that work needs to be undertaken with schools to ensure opportunities can be provided for students to take up work experience opportunities in ways that will not disrupt teaching schedules. Some students may be willing to take time out of their holidays to undertake placements, but for others there may be a requirement to work with schools and colleges to ensure such opportunities can be taken up within term-time.

How can experience in the health care system be made more attractive to young people?

We would support greater opportunities for young people to gain work experience in all NHS settings, improved career information and guidance to be provided in schools from local NHS staff and organisations, and the development of stronger links between schools/colleges and local NHS establishments. Career days for students could be provided through which the benefits of working in healthcare can be advocated.

Consideration should also be given to the benefit of using role models to promote the merits of a career within the NHS. Health boards and universities should identify staff who can facilitate work experience, as well as visiting local schools to talk about their roles in healthcare.

We note the suggestion in paragraph 84 for a targeted approach to increase the quota of Welsh-domiciled students. This is something we would support but we also note the concerns raised in paragraph 80 regarding legal constraints which might preclude certain financial incentives being offered. This may similarly be the case in relation to the suggestion in paragraph 107 of the need to incentivise children from Welsh medium education to consider careers within NHS Wales. The suggestion of increasing the quota of students from lower socio-economic groups referred to in paragraph 84 is also something we would certainly support.

Attention clearly needs to be given, in our view, to both recruitment and retention of the medical workforce. It needs to be recognised that medicine is very much a global workforce and Wales is therefore competing within a global marketplace. Consideration must therefore be given to what can be done both to attract doctors to Wales and encourage them to remain here at subsequent stages throughout their careers.

As well as looking at how we might train more doctors here in Wales, we should also consider how we can attract more doctors who have been educated and/or trained elsewhere, including overseas. It should be noted that attracting more doctors who have been already trained elsewhere could be a

cheaper solution to plugging recruitment gaps than increasing the number of doctors trained here (who might then go on to work elsewhere), although both elements clearly have a role to play.

It should indeed be recognised that Wales has long-since depended on recruiting doctors from overseas. However, we would also point out that current immigration rules in the UK act as a barrier to such recruitment. For instance, we have previously argued that GPs should be added to the Home Office's occupation shortage list – but, much to our frustration, this suggestion has not been agreed by the Migration Advisory Committee which considers such matters on the Home Office's behalf. We have also argued that Wales should have its own shortage occupation list, as Scotland has.

In seeking to attract doctors at different stages in their careers, we should also be aware of the many and wide-ranging factors that will influence where they may choose to locate. These include: high quality training; access to funded study leave; evidence of exam success; research opportunities; access to a good social life and quality of living; availability of good career opportunities for their spouses or partners; and access to good schools for their children.

In many ways retaining existing staff may be seen as more of a concern than recruiting new staff. Recruitment initiatives can only contribute so far to addressing existing challenges if too many doctors are subsequently choosing to leave Wales, reduce their working hours, leave the profession or retire. We therefore need to consider the impact of the various factors which impact on retention. Amongst other factors, these include: workload pressures; working conditions; the extent to which doctors feel valued and empowered to influence decisions or be listened to and able to raise concerns without fear of recrimination; the bureaucracy around processes such as revalidation; pension changes, including the impact on pensions of those doctors continuing to work beyond a certain stage in their careers; and worsening sustainability challenges for many GP practices.

A clear strategy is also needed to support older workers in general within the NHS in Wales, particularly as the state pension age continues to rise towards 68.

In terms of the impact of issues such as pay, terms and conditions, and contracts, you would expect this is an area in which we would have much to contribute as a trade union. Although we have touched on some relevant issues – such as the impact of operating within a global marketplace – it has been difficult to provide a comprehensive and evidence-based response on the impact of all these factors within the timeframe offered. We would therefore suggest that this topic might warrant a more-focussed inquiry of its own. These issues clearly impact on recruitment and retention as well as upon the wider morale of the workforce. This includes the impact of an ongoing erosion of salaries in real terms for a number of years and there is clearly an impact with pay rises across the public sector no longer keeping pace with those in the private sector at present.

Pay erosion has had a particular impact amongst independent contractor GPs as it has been accepted by the pay review body for doctors and dentists that many recent funding increases for GP practices have failed to keep pace with the rising costs of GP practice expenses due to the failure of the formula previously employed to accurately calculate the costs incurred over a number of successive years.[5] This has led to GP earnings falling significantly in actual cash terms, and not just in real terms when adjusted for inflation. Indeed, figures show that there was a drop of over £11,000 a year in average GP earnings in Wales between 2005-06 and 2012-13.[6]

[5] Review Body on Doctors' and Dentists' Remuneration *43rd Report* (2015). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412151/DDRB_47332_Accessible.pdf

[6] NHS Digital *GP Earnings and Expenses - 2013-14*. Available at: http://digital.nhs.uk/article/2021/Website-Search?productid=18736&q=GP+earnings+and+expenses&sort=Relevance&size=10&page=1&area=both#top

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

There is clear evidence that recruitment and retention challenges are being felt more acutely in more rural parts of Wales as well as in some of our more deprived communities. Many of the factors we have referred to above – such as access to the availability of good career opportunities for doctor's spouses or partners – may be more of an issue in some rural parts of Wales. Perceptions, whether right or wrong, that a suitable command of the Welsh language may be required to work in certain parts of Wales can also hamper recruitment to certain geographic areas. We have previously raised concerns that training rotations that cover both north and south Wales can also deter junior doctors from undertaking their training in Wales, particularly if they have partners or children they may have to be located four or five hours' travel distance away from for long periods of time during their training. Greater use of training rotas which are more geographically concentrated, including those which operate across the border to nearby areas of England, can help to address this concern.

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CALL FOR EVIDENCE BY THE NHS WALES WORKFORCE REVIEW

Response from BMA Cymru Wales

The British Medical Association (BMA) is an independent professional association and trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 150,000 across the UK, which continues to grow every year. In Wales, we have a membership of over 7,000 from every branch of the medical profession.

The association welcomes the opportunity to respond to the NHS Wales Workforce Review call for evidence. We look forward to providing oral evidence to the pane later this month.

As set out in the Nuffield Trust report *'A decade of austerity in Wales'*, an ageing population combined with a difficult public spending environment poses a major challenge for the provision of health and social care. A co-ordinated system is required that can cope with the range of needs associated with demographic and epidemiology changes; this needs to cover community, residential and hospital health and social care, as well as public health.

We welcome the review panel's statement on fully engaging with all those who have an interest in the future of the NHS in Wales. The medical profession, as a significant constituency of the NHS workforce, will not only be affected by the implementation of any recommendations proposed by the review, but will also be key to their realisation. Therefore full engagement with the profession and its representatives is fundamental to the success and sustainability of any proposals. We were surprised, however, that the Review Panel did not include any trainee doctors, secondary care doctors, public health doctors or clinical academics. BMA Cymru Wales recommends that the lack of medical representation on the Review Panel is addressed; for instance a professional medical reference group might be established to advise the Panel as it begins to draw together its conclusions. We would hope that the views of medical students have also been sufficiently sought by the panel.

There is mounting evidence of the medical workforce crisis that has grown increasingly dire in the NHS in Wales - with frequent reports of failures to recruit to medical posts; unfilled training positions; GP practices closing; long-term medical vacancies; an aging workforce, morale at rock bottom and worryingly excessive workloads. This is not a new phenomenon, as we have been pressing for action by Government and employers for several years, to little effect. Urgent action is needed to address this, given the obvious ramifications on the provision of timely and appropriate care to patients.

It is clear that the solution to this crisis is multifactorial; there is no magic silver bullet or flicking of a switch. BMA Cymru Wales has previously put forward numerous suggestions as to how the current situation may begin to be turned around, and how the medical workforce can be placed on a more sustainable footing. These have included both long and short/medium term measures. Enclosed at the end of this paper are copies of recent papers we have put together outlining some of these solutions – we would of course be happy to discuss these further.

How future of NHS Wales's services, i.e. what, how and where services are to be delivered to best address patient and population need, will determine the make-up of the workforce. Therefore in this response we have reflected our views on the current medical workforce in NHS Wales and medical students, who are the future workforce, and what needs to be done so that appropriate and responsive services can be delivered, alongside overarching themes that should be considered for future workforce planning.

We note the lack of consideration in the consultation document on cross-border health provision. Any structural changes, such as health and social care integration, as well as policy developments, including efficiency and workforce changes, will need to consider the implications of well-established, as well as emerging, cross-border health provision. The review panel should ensure that any recommendations take account and explain the implications on cross border health care.

Fundamentally, in order to place the medical workforce across Wales, on a more secure longterm footing, it is absolutely essential that decisions are made with the full engagement of the profession, across all branches of medical practice. This full and open engagement should be established early on to the satisfaction of all parties, so as to create true ownership of the solutions. It should of course be a permanent feature of NHS Wales moving forward, and is essential in order to move away from the reports of an isolated, devalued and demoralised profession. It is also vital in making the NHS Wales environment an attractive place to train (which is key to addressing the current workforce problems), be employed, and develop a satisfying professional career.

Below is BMA Cymru Wales' response, to the questions set out in the consultation document.

<u>Integration of health and social care</u>

Questions:

- *How have other countries/health systems adapted to meet exponential increases in demand for health and social care provision?*
- *What factors have led to the increases in demand for provision within these countries/systems?*
- *What criteria have been used to assess degree to which integration of services has contributed to effective management of demand?*
- *To what extent can these models be replicated in Welsh system of health and social care?*
- *What barriers have been identified in inhibiting successful implementation of such models?*
- *How might such barriers be overcome within Welsh context?*

These questions are extremely wide-reaching and complex. We do not attempt to respond to them all here; we do, however, highlight our key points and considerations on health and social care integration and would be happy to discuss them further at the forthcoming oral evidence session.

The closer integration of health and social care has been a goal of successive UK governments for a number of years. Various different methods have been suggested and tried, ranging from measures to facilitate joint working and sharing of resources to enabling full structural integration. Thus integration is a nebulous term, but one best defined through the eyes of the service user - rather than structures,

organisations or pathways in place, or the way services are commissioned or funded. This is because integration is about individuals and communities having better care and support; therefore the individual must be the organising principle for services.

To many, the case for integration is clear. Across the UK there are increasing pressures on health and social care. Demographic and epidemiology changes combined with a difficult public spending environment pose major challenges for health and social care. As evidenced in the Nuffield Trust report '*A decade of austerity in Wales*', the population in Wales is ageing; many of these people will live with significant, often complex, health and social care needs. These pressure are likely to grow and intensify. The evidence demonstrates the need for health and social care to work with a common aim to address these challenges.

We agree with the approach and language used in the report from the National Collaboration for Integrated Care and Support headline definition of integration, from the patient's perspective:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"*

Yet, it is accepted that the current system does not always deliver the integrated care that people need and want, with gaps between different services and sectors, inefficient and unreliable transitions resulting in duplication, delays and missed opportunities.

The BMA does not believe that the full integration of health and social care (structures, budgets and staff) is either necessary or desirable. We believe that coordination is best achieved by creating longterm stability across the NHS and local authorities and allowing integrated care to become a priority, not by further reorganisation. Indeed, given the above definition, integration does not necessarily require high-level budgetary or structural integration, and results from membership surveys[1] do not find that rearranging organisational structures through mergers to be absolutely necessary or even sufficient to produce genuine joint working and more coordinated care. Instead, the emphasis is often placed on good information sharing and effective, professional relationships across disciplines and organisations.

Social care has significant crossover with healthcare; there is an obvious synergy with services such as nursing and care homes and end of life care for instance. There is often contention about whether an individual should be in receipt of health or social care and consequentially who should fund their care; the NHS or local authorities. The body responsible largely depends on the patient's condition and there are many examples of disagreements between local authorities and health providers about who should be caring for a patient. This puts finance, rather that the patient's need, front and centre – and can cause the patient and their relatives a great amount of distress (not least because of the huge sums a patient may be require to pay if their care falls under the remit of social care).

BMA Cymru Wales believes that patients should not perceive or experience any organisational barriers or restrictions while interacting with the various providers of their package of care. Our members place strong emphasis on improved clinical outcomes and better patient experience as the most important measures of success for integration. As such, a clear evidence base that demonstrates the longer-term clinical benefits would be necessary for doctors to support efforts to integrate.

[1] BMA Membership Surveys, HPERU, August and October 2011

Across the UK, integration of health and social care is variable. Northern Ireland has had an integrated structure for health and social care services since 1973. An important theme of the 2011 independent '*Transforming your Care*' review was integration[2]. The review identified a number of recommendations about what a future model of integrated health and social care in Northern Ireland should look like. In Scotland, the Public Bodies (Joint Working) (Scotland) Act 2014 introduced integrated adult health and social care. Full integration of services across Scotland is expected by April 2016. An example of why engagement and involvement of the medical profession is so important can be found in the Audit Scotland report[3] into CHPs (Community Health Partnerships)[4]. Audit Scotland reported that a failure to engage GPs was a fundamental factor in the failure of CHPs to perform as intended. In England, the integration of health and social care has also been a key policy focus for Government and NHS England. The Five Year Forward View vanguard sites are pursuing a range of approaches to integration, both horizontal and vertical, alongside the ongoing work of the BCF (better care fund)[5]. In addition, plans to devolve health spend and integrate with social care in Greater Manchester, will make the conurbation the holder of the largest single budget for health and social care in England. Clinical engagement and ownership from primary, secondary and community care, with significant public health input, will be essential in order for the new models of care to be successful[6].

If health and social care integration is going to be successful, any changes need to be evidence based. We have identified three important areas which should be addressed in planning for integration:

- Effective meaningful engagement and involvement of primary, secondary, community care doctors, as well as public health specialists. This will be an important factor in the success of an integration plan.
- Investment in building capacity in health, community and social care services. We have concerns about a single budget for health and social care. Also it cannot be assumed that funding can be solely found through the transfer of resources from secondary care. No matter how well primary or community based services are planned and delivered, many patients will still require hospital assessment and treatment. Consideration should be given to the overall cost envelope.
- Medical leadership and influence is an important factor in the success of an integrated plan. It will enable problems to be identified and efficiently resolved at a local level, as well as allowing best practice to develop. We believe that clusters hold potential to facilitate greater integration and local needs assessments – however that is a long-term consideration. It should be recognised that medical leadership is not constrained to those in health board hierarchies.

Doctors are an influential component of the NHS workforce. They are equipped with a unique and diverse range of knowledge and skills, whilst being ethically bound to act in their patients' best interests. They have a deep understanding of the needs of the local community and their patients and, as such, can make a valuable contribution to improving and developing more integrated services, in the wider management and leadership of their organisations and in the NHS generally. Furthermore, doctors'

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[2] John Crompton (December 2011) *Transforming Your Care* http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

[3] Audit Scotland (June 2011) *Review of Community Health Partnerships* Audit Scotland: Edinburgh http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf

[4] The NHS Reform (Scotland) Act 2004 required NHS boards to establish one or more CHPs in their area. The aim was to bridge the gap between primary and secondary healthcare as well as coordinate the planning and provision of a wide range of health services in the area.

[5] The BCF requires CCGs (clinical commissioning groups) and local authorities to pool a portion of their respective health and social care budgets to jointly plan and deliver services. It is intended to join up care more effectively for older and disabled people, develop community services and prevent unnecessary hospital usage/stays. BCF programme began in April 2015.

[6] More information on BMA's views for England can be found at http://bma.org.uk/news-views-analysis/the-bma-blog/2015/july/five-ways-the-five-year-forward-view-must-meet-doctors-concerns

concern with clinical standards, outcomes, effectiveness and audit mean they can be relied upon to lead the drive to improve quality and are central to its assurance.

In conclusion
BMA Cymru Wales holds that collaborative cultures with shared values, good professional relationships and effective leadership are essential if integration is to get off the ground. As confirmed by doctors in our surveys, these elements are also vital to securing what should be the key measures of success of efforts to integrate - improved clinical outcomes and better patient experiences. Therefore the individual must be the organising principle for any changes. We believe that integration is best achieved through better integration of services where there is evidence to support change, rather than a top-down reconfiguration. Given the obvious attributes doctors bring to the health service and to the care and support of patients and communities, it is reasonable to suggest that gaining doctors' support for a scheme to integrate would be beneficial to securing success.

Future workforce skill and skills mix

Questions:

- *To what extent has service provision changed within NHS Wales and across social care in Wales over past 10 years?*
- *How has the composition of workforce changed within the same time period – numbers, type, location, etc?*
- *What are the key strategic drivers that will influence trends in service provision over next 10 years?*
- *What structural/organisational changes may be required to address such changes?*
- *What are the likely workforce requirements to meet such demands on service provision over next 10 years?*
- *What are the likely deficits in workforce supply over next decade?*
- *How can such workforce supply deficits be addressed?*
- *What policies are in place to address such deficits?*
- *What new professional groupings and roles will be required? e.g physician assistants, advanced practitioners.*
- *What is the evidence for the effectiveness of such groups and roles in meeting supply deficits?*

Over the last 10 years, the demographic and epidemiology changes combined with the difficult public spending environment has put increasing pressures on the NHS in Wales. Delivering high quality and flexible healthcare is heavily reliant on a well-resourced and high performing workforce.

Doctors are at the heart of healthcare delivery, but to date, the medical workforce has not been adequately resourced to adapt to these changes and is now facing a recruitment and retention crisis, to the inevitable detriment of patient care.

Evidence around the number of doctors in Wales can be misleading. The number of doctors, by headcount and WTE (whole time equivalent) has increased, yet to clearly different extents. Workforce figures are often expressed in headcount terms which not does give a wholly accurate picture since it does not take account of the increases in preferences for less than full-time time working. For instance, there has been an increase in GPs in absolute terms by 11% over the last ten years, yet when expressed in WTE terms this has in fact remained broadly static. In 2014 Wales had the lowest number of GPs per

1,000 population in the UK at 0.6 GPs per 1,000 patients[7]. Whist the number of directly employed doctors may have increased to a greater extent, this does not counteract the significant and increasing recruitment and retention problems, including a high number of unfilled vacancies, facing Wales.

Indeed, BMA Cymru Wales members have increasingly reported high vacancy rates. However, there is no official national data on vacancy rates in Wales[8] in order to verify this. In March 2015 BMA Cymru Wales undertook a FOI (freedom of information) request to obtain information on consultant vacancies in Wales. Responses from health boards and trusts demonstrated a high vacancy rate across Wales of 6.8 per cent. Some local health boards and trusts reported significantly higher rates, for example Hywel Dda University Local Health Board had a 15.9 per cent vacancy rate and Public Health Wales 15.6 per cent. Vacancy rates are likely to be higher still, due to the definition of what constitutes a vacancy being starkly geared towards under-reporting[9]. The FOI request also showed a high use of locum consultants. The results estimated 10.5 per cent of consultants in Wales, by headcount, were locums – with significantly higher reliance on locum and temporary staff in some areas. This is significantly higher than the number of consultant locums in England during the same period, which was reported to be around 4 per cent[10].

Furthermore, BMA members have reported increasing numbers of doctors planning for early retirement. A recent UK BMA survey recorded that 41 per cent of doctors have considered retiring early[11]. Between 2003 and 2013, the proportion of GPs aged 55 years and over in Wales increased by 42 per cent. While the number of GPs aged below 45 years also increased, the rate of increase was significantly slower at just 1.2 per cent throughout the same period[12]. When an aging workforce is considered alongside the difficulty of recruiting trainees to posts it points to a very real a recruitment crisis to which NHS Wales is currently ill-equipped to respond.

The Panel may also wish to consider the work of the NHS Working Longer Group; its preliminary findings were published last year[13] and included the need to gather more data from those retiring before normal retirement age in order to better explore the reasons for this.

Another area of concern is that moves to provide more care closer to home has not been made with a corresponding move of resources to primary care – in fact the share of NHS expenditure allocated to

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[7] BMA (May 2015) *2014 UK Medical Workforce Briefing* London: BMA

[8] The Welsh Government stopped collecting and publishing data on consultant vacancies in 2011 following a consultation. Local health boards and trusts continue to collect this information but it is not published.

[9] Local health boards and trusts across Wales use different definitions of a vacancy. This makes the data collected inconsistent. The majority use the definition agreed by the Welsh Government and Medical Workforce Managers in 2013, "*an established post which is currently unoccupied and despite actively taking steps to recruit to this post, no appointment has been made'.* There is however no agreed interpretation of this definition. For example how to record a role that is empty but is not under current active recruitment, or, a role that is vacant but temporarily occupied such as by a locum.

[10] Health & Social Care England (May 2015) *NHS Workforce Statistics March 2015, Provisional statistics* http://www.hscic.gov.uk/searchcatalogue?productid=18106&topics=2%2fWorkforce%2fStaff+numbers%2fMedical+and+dental+staff&sort=Relevance&size=10&page=1#top

[11] BMA (April 2015) *BMA quarterly tracker survey, current views across the medical profession* *http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey/omnibus-survey-april-2015*

[12] Julia McWatt (March 2014) *Fresh concerns raised about GP recruitment after figures showed more than a 40% rise in number of GPs over age of 55 in past decade* http://www.walesonline.co.uk/news/wales-news/fresh-concerns-raised-gp-recruitment-6882121

[13] NHS Working Longer Group. Preliminary findings and recommendations report for the health departments. 2014. Available at: http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group/preliminary-findings-and-recommendations-report-for-the-health-departments

General Medical Services in Wales has fallen from 10.3% in 2007 to 7.9% in 2014. Coupled with this, out-of-hours services are facing huge challenges and continue to be astonishingly under-resourced; to the obvious detriment of unscheduled care and the workload of practices during core daytime hours.

Doctors, in both primary and secondary care, are reporting increasing and unmanageable workloads. In a recent UK BMA survey, 30 per cent of junior doctors reported that their workload was unmanageable or unsustainable[14]. Over 70 per cent of GPs who responded stated increasing workloads and rising pressures were becoming unmanageable or unstainable all of the time[15]. This is the biggest issue reported to us by GPs. In addition, BMA members report that stress related illnesses are becoming increasingly commonplace amongst doctors. Burnout is a very serious threat to the sustainability of the NHS, not to mention the individual health of doctors. Along with other healthcare professionals we have called for a comprehensive occupational health service[16] to be established, run for and by the NHS in Wales – occupational health provision is an area that the panel should consider in its deliberations. Progress to date, where any can be identified, has been unacceptably slow, with obvious consequences.

BMA Cymru Wales recommends that NHS employers and the Welsh Government develop incentives to promote the retention of doctors in the NHS. For example, a national financial resettlement programme to incentivise and support doctors to return to work in Wales. For GPs, the existence of a separate performer lists for England and Wales has had a detrimental impact. GPs on the English performer list may not immediately be able to take up vacancies that may exist within practices in Wales. In the same way, the separate lists also limit the availability of locums for border practices. We understand that the Welsh Government is looking at ways to address this.

Work also needs to be undertaken to dispel a number of negative perceptions about training and working in Wales – this includes myths around mandatory use of the Welsh language. BMA Cymru Wales has put forward a number of suggested incentives options to the Welsh Government to help address shortages across the medical profession; we enclose relevant details. Only when the attractiveness of a career (or training) in Wales is addressed will we see long-term and sustainable improvements to the current and worsening problems.

Adequate numbers of new doctors in primary and secondary care need to be trained in Wales. For example, despite longstanding commitments to expand primary care, the overall number of training places for GPs in Wales remains static. The Welsh Government needs to urgently address this deficit so that existing NHS services can be maintained. In addition priority must also be given to providing high quality undergraduate education, postgraduate training and continuing professional development. The recent BMA paper, *Every Doctor a Scientist and a Scholar*[17], puts forward the case that every doctor needs to be engaged as a scholar and scientist. It is important that undergraduates and post graduate education should equip doctors not only with clinical skills but the scientific skills to enable lifelong learning and enquiry. This will enable doctors to provide their patients with excellent standards of care

[14] BMA (April 2015) *BMA quarterly tracker survey, current views across the medical profession* *http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey/omnibus-survey-april-2015*

[15] BMA (April 2015) *BMA quarterly tracker survey, current views across the medical profession* *http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey/omnibus-survey-april-2015*

[16] BMA Cymru Wales. Occupational Health Service in NHS Wales. 2015. Available at: http://bma.org.uk/working-for-change/policy-and-lobbying/welsh-assembly/policy-documents

[17] BMA (March 2015) *Every doctor a scientists and a scholar* London: BMA

throughout their careers. Our members consider that the WCAT scheme has been successful in attracting high quality doctors to Wales, although the numbers benefiting from it have been steadily eroded, which needs to be reversed. Retaining those who complete their medical academic training here would place Wales is a unique position through attracting those who bring high quality scientific work, research and innovation.

We have set out just some of the considerable evidence of the medical workforce crisis which is currently facing the NHS in Wales, and have enclosed copies of recent papers we have drafted on workforce issues (our responses to Welsh Government's Heath Professional Education Investment Review and the Health and Social Care Committee's inquiry into the GP workforce will both be of particular relevance and outline further recommendations). Ultimately, the NHS in Wales needs to create an attractive environment in which to work or train; fundamental to that is addressing the current workload pressures. We cannot fully comment on what a future workforce should look like until it is clear what services will be delivered and where. Therefore our recommendations regarding the future shape of the workforce are limited; instead we have focused on two overarching issues which should be a 'foundational' part of future workforce planning.

Firstly, BMA Cymru Wales calls for a whole-system approach to workforce planning across primary, community, secondary, public health and social care. Workforce planning needs to take account of the changing demands, current and projected future demands – and therefore needs to also look at training requirements as well as measures to support greater retention such as portfolio careers and mentorships. We welcome this review, as we hope it will help take a comprehensive approach to ensure the workforce plan is aligned to a strategic vision for the NHS in Wales; and in line with prudent healthcare will avoid duplication and deliver multi-professional teams working to the benefit of the clinical needs of patients and their experience of using healthcare services. It needs to move forward with the engagement of all healthcare professionals.

Secondly, the association recommends that NHS data collection is significantly improved. Adequate data on the medical workforce is necessary, not only for the effective delivery of current care, but also for sustainable planning, and in understanding the requirements for medical training provision. BMA Cymru Wales calls for improved availability, quality and accuracy of NHS data collection, particularly around workforce numbers and vacancies which are currently not collected. BMA Cymru Wales would welcome the opportunity to work with the Welsh Government so that accurate data is routinely collected and reported.

<u>Efficiency and prudent principles</u>

Questions:

- *How can the 'only do what only you can do' principle be translated into an estimate of workforce configuration in the future?*
- *How can the 'only do what only you can do' principle be factored into workforce planning mechanisms?*
- *What is the scope for professional substitution?*
- *What are the financial implications of professional substitution?*
- *What is the role of technology in compensating for time and distance?*
- *What are the financial implications of technological developments in this area?*

BMA Cymru Wales supports the philosophy and principles of prudent healthcare. We must ensure that each element of the workforce is complementary, working across the range of their professional competence and presenting an effective use of skill mix and, in line with the principles of prudential healthcare, does not duplicate or complicate other parts of care pathways or delivery.

We are not clear on what 'professional substitution' is in practice or why it is needed if every professional is working at the top of their clinical competence. There has been much talk of Physicians Assistants but again we are unclear as to what role they will play and how they would contribute to the more effective delivery of services or to alleviating the workload of existing staff. We would welcome details of training and regulation requirements for such roles. We remain concerned that this may be sold as the 'holy grail' of workforce planning, but will not have been adequately thought through for the longer-term.

Certainly there is a discrete range of activities being undertaken by some doctors, particularly GPs, which could be more appropriately delivered by other professionals and this would hopefully help to address a little of the medical capacity issue. However a one-size-fits-all approach should not be developed; we feel that the teams of professionals needed to meet local population health is best identified and determined locally.

We believe that there is a need to invest in those already working for NHS Wales to extend their skills, work flexibly, remain in work, or to work in different ways in order to deliver clinically appropriate care or treatment which is decided upon on the basis of clinical need. There is, for instance, potential to extend the professionals who can play a role in admission, discharge and putting in place care plans. Such moves would need to be supported by sound and responsive communication systems, that are clinically appropriate, between all partners and which provides all necessary safeguards in relation to data confidentiality. Secondary care IT systems certainly have a long way to go in this regard.

Pay and reward

Questions:

- *What are your expectations for the long term strategic direction for pay and rewards within the NHS and in relation to pay and rewards within the wider economy?*
- *What are your expectations with regard to the continuation of, or changes to, current pay and reward differentials?*
- *What are the existing arrangements for A4C staff, executives and senior posts and how have these operated in each of the past five years?*
- *To what extent does Wales have autonomy, authority and powers to be able to determine pay and reward mechanisms and to what extent does this vary as between A4C staff, executives and senior posts?*
- *To what extent can the long-term strategic direction for pay and reward for people currently covered by the UK Agenda for Change contract terms and conditions be considered separately from a similar consideration of pay and reward for staff covered by the Doctors and Dentists Review Body?.*
- *To what extent can pay and rewards be considered in isolation from all the other terms and conditions of employment?*

We have not answered questions in this section on the UK Agenda for Change contract terms and conditions as they do not apply to doctors. The BMA will submit evidence to the Review Body on Doctor and Dentist Remuneration at the end of September 2015.
It is important to note that the BMA believes that the determination of pay should be conducted separately for doctors and dentists and those members of NHS staff subject to the Agenda for Change agreement. The market for medical and dental staff is different in being more significantly international, the qualifications and skills expected of them more demanding and the range of work undertaken, including academic as well as clinical activities, significantly more extensive and at a greater level of

responsibility. Consequently, the pay comparators used by the Review Body on Doctor and Dentist Remuneration differ from those for other NHS staff.

Further information – Primary Care

For detailed information in relation to the workforce challenges, and solutions, in primary care specifically please refer to:

- Chapter 2 of the GPCW's document 'Prescription for a Healthy Future' available here: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-members/gpc-wales
- BMA Cymru Wales response to the National Assembly for Wales Health and Social Care Committees Inquiry into the GP workforce in January 2015, available here: http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-walesgpworkforceresponse-19-01-2015.pdf
- BMA Cymru Wales response to the Welsh Government Consultation 'A planned primary care workforce for Wales', available here: http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-primarycareworkforce-01-09-2015.pdf

Further information – wider workforce planning and training:

- BMA Cymru Wales response to the call for feedback by the Welsh Government on the Report of the Health Professional Education Investment Review, available here: http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-walesreporthpeireview-01-06-2015.pdf

Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
2 Pentir Caspian
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BMA

Cymru Wales

INQUIRY INTO THE GP WORKFORCE

National Assembly for Wales, Health and Social Care Committee

Response from BMA Cymru Wales

16 January 2015

INTRODUCTION

BMA Cymru Wales welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into the GP workforce in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents over 7,000 members in Wales from every branch of the medical profession.

OVERVIEW

In an ever-evolving healthcare environment the independent contractor model has been at the heart of general practice's flexibility and innovation, which has been vital for affordable NHS care. It is well

documented that high-quality primary care provides excellent value for money,[1,2,3,4,5] at around £23 per consultation.

Accessible and well-resourced general practices are essential if NHS Wales is to deliver good health outcomes to patients in all parts of Wales. Yet, general practice is facing unprecedented challenges; we recognise that there needs to be fundamental change to make the provision of general practice in Wales sustainable.

Last year, the BMA's General Practice Committee Wales published a strategy[6] intended to chart a way forward to a more certain future. Many of the recommendations in that document are replicated here.

MODERN GENERAL PRACTICE

There is a clear and increasing requirement for the GP workforce to be able to respond effectively to the growing demand for primary care services. This demand has been driven by a range of factors,[7] including:

- population growth, higher birth rates and an ageing population;
- increased prevalence of chronic conditions (e.g. diabetes, obesity, dementia) and multi-morbidity;
- patients with higher expectations;
- increasing non-clinical duties (for example, multiple inspections from QOF, CHC, HIW visits, post payment verification visits; adapting funding changes; engaging in GP clusters and with health board initiatives e.g. prescribing leads); and
- policy initiatives for better-quality care, delivered closer to home.

GPs have increasingly reported they have never known a time when the workload was so intense; many say that services are under immense strain. We regularly hear from members that stress related illnesses are becoming increasingly common. Burnout is a very serious threat to the sustainability of general practice, not to mention to individual doctor health.

In attempting to respond to rising demand, the role of the GP has evolved and individual GPs are more accustomed than ever to innovating in order to improve practice operations and be more effective – for example: reviewing skill-mix; reducing the number of missed appointments; taking a prudent approach to prescribing; increasing the use of new technology; and engaging in cluster networks.

Working pattern preferences have also changed. The younger generation of GPs have different expectations and lifestyle desires than their predecessors. Partnerships are no longer seen as the end point of a career for some in general practice, as they increasingly resemble an overburdened path due to increased workload, bureaucracy and financial responsibility. This needs to be urgently addressed; and the

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1 A Survey of Primary Care Physicians in 11 Countries, 2009. Perspectives on Care, Cost and Experiences. Schoen, Obsorn, Doty, Squires, Peugh, Applebaum: Commonwealth Fund 2009. Available at: http://www.commonwealthfund.org/Surveys/2009/Nov/2009-Commonwealth-Fund-International-Health-Policy-Survey.aspx

2 Barbara Starfield, Leiyu Shi, and James Macinko, 2005. Contribution of Primary Care to Health Systems and Health.

3 Pierard E. 2009. The effect of physician supply on health status as measured in the National Population Health Survey. Waterloo [Canada]: University of Waterloo. Available at: http://economics.uwaterloo.ca/documents/TheEffectPaperPierard_000.pdf

4 Oldham, et al. 2012. Primary Care – the central function and main focus: Report of the Primary care Working Group. The Global Health Policy Summit.

5 Kringos et al. 2013. Europe's strong primary care systems are linked to better population health but also higher health spending. Health Affairs:32(4),686-694 Available at: http://nvl002.nivel.nl/postprint/PPpp5128.pdf

6 BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales

7 CFWI GP in-depth review: Preliminary findings 2013. Available at: http://www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings/@@publication-detail

impossible pressures of GP partnership need to be removed to make it an attractive option – for new and existing GPs alike. The partnership model needs to be maintained, supported by flexible career options for both men and women. We feel this is essential for being able to attract and retain new doctors to the profession, but note that few such flexible opportunities exist.

In terms of the size of the existing workforce, Wales has 2,617 GPs. This represents 85 GPs per 100,000 patients – the lowest ratio of GPs to patients in the UK.[8] The number of GPs in Wales has risen in absolute terms by 11.2% over the last ten years, but this figure may be misleading because an increasing number of GPs are working less than full-time. When the number of GPs is expressed in terms of whole time equivalents, it has in fact has remained broadly static over this time period, whilst the overall number of health board staff has increased by 19.7% (with some staff groups up by 120%).[9]

A report by the Kings Fund[10] highlighted that the looming shortage of GPs, and the oversupply of hospital specialists, will undermine the drive to safeguard the NHS in the future. The think-tank said the workforce needs to be rebalanced to drive down future costs and prepare for the future needs of the NHS. The projected imbalances between different specialties will have serious implications for patient care and come on top of reports showing wider staff shortages in key areas such as emergency care.

Between 2003 and 2013, the proportion of GPs aged over 55 in Wales increased by 42.1%. While the number of practitioners below 45-years-old also increased, the rate of increase was significantly slower at just 1.2% throughout the same period[11,12]. At the same time, the number of GPs under 50 planning to leave the profession has reached an all-time high.[13] In 2014, 23.4% of all GPs were aged 55 and over – the figures are likely to be much higher in rural and more deprived areas.

The retirement bulge will occur over the next few years; but in combination with both poor recruitment, and concerns over a 'brain drain' with doctors choosing to leave the profession in the UK, the result will be a significant shortfall of GPs. This is a scenario that the BMA has previously warned about as a 'perfect storm'.

Vitally, the GP workforce in Wales needs to increase to more sustainable levels. We estimate that, in addition to other measures, Wales needs at least 200 GP specialty trainee places each year, a rise from the current number of 136. Welsh Government will need to take action to attract trainees to these posts. Since it will take a minimum of three years to train these individuals, it will not significantly mitigate any supply shortfall that exists currently, or could emerge in the next few years.

Other measures, alongside trainee expansion, are therefore required; these are discussed in the sections that follow. These other measures also recognise the fact that an increase in capacity alone may not provide a long term solution – i.e. more GPs working equally as hard while demand continues to rise.

The Welsh Government is planning for more work to be done in primary care and for care planning to be managed through GP cluster networks. Primary care needs the workforce, infrastructure and resources to do the job. Despite strong evidence to support further investment, the share of total NHS expenditure allocated to Welsh GMS has fallen from 10.3% in 2007 to 7.9 %.[14]

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[8] GMC State of Medical Education and Practice in the UK 2014

[9] BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales

[10] King's Fund report on NHS workforce development, 24 July 2013

[11] http://www.walesonline.co.uk/news/wales-news/fresh-concerns-raised-gp-recruitment-6882121

[12] https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services

[13] Centre for Health Economics, University of Manchester Seventh National GP Worklife Survey

[14] Figures supplied to GPC Wales by Welsh Government

The Shape of Training Review,[15] and the implementation of its recommendations, are likely to have a considerable impact on the GP training curriculum – the review correctly identifies the huge challenges faced by the NHS in delivering a high-quality health service to a changing patient population in the decades ahead. These challenges are real and serious but the remedies suggested by Shape of Training do not offer the right solutions for patients and could risk all that currently works well in high quality medical education; for that reason the BMA has called for a pause in the review.

As health and social care needs grow in both volume and complexity, and health budgets remain constrained, pressure on the current fragmented system will continue to build. The downward pressure on GP income and working conditions has reached a nadir where the very infrastructure of practices is under threat. When practices fail to recruit, they are often forced into reducing the services that they offer to their patients. This is in no one's best interests.

There needs to be a recognition that with improved resources, enhanced GP training, and a significant expansion of the workforce, general practice can help to address the pressures posed by changing demographics and rising co-morbidity.

In the sections that follow, we provide commentary and offer recommendations on each of the three terms of reference areas of the inquiry, namely:

1. barriers to GP recruitment and retention;
2. whether the commissioning and delivery of medical training currently supports a sustainable GP workforce; and
3. the actions needed to ensure the sustainability of the GP workforce.

Cutting across all of this is the need for a comprehensive workforce strategy for primary care in Wales; one which includes the whole practice team.

RESPONSE (TO TERMS OF REFERENCE)

1 - BARRIERS TO GP RECRUITMENT AND RETENTION

As noted in the preceding section there are a multitude of factors that are combining to negatively affect both the retention of existing GPs in Wales and the attractiveness of entering a career in general practice. These factors include:

Workload
Almost half of the GPs who responded to the recent General Practitioners' Committee UK (GPC UK) survey revealed that increasing workloads and rising pressures were becoming unmanageable or unsustainable all of the time,[16] with 89.4% of GPs indicating 'very high/high levels' of pressure at work.[17] This is the single biggest issue reported to us by general practitioners.

Stress and burnout
Many GPs report that they feel an unsustainable level of pressure in their work, and many are choosing to leave the profession altogether [18] or to move abroad.[19] The Lack of occupational health provision for primary care is a serious problem.

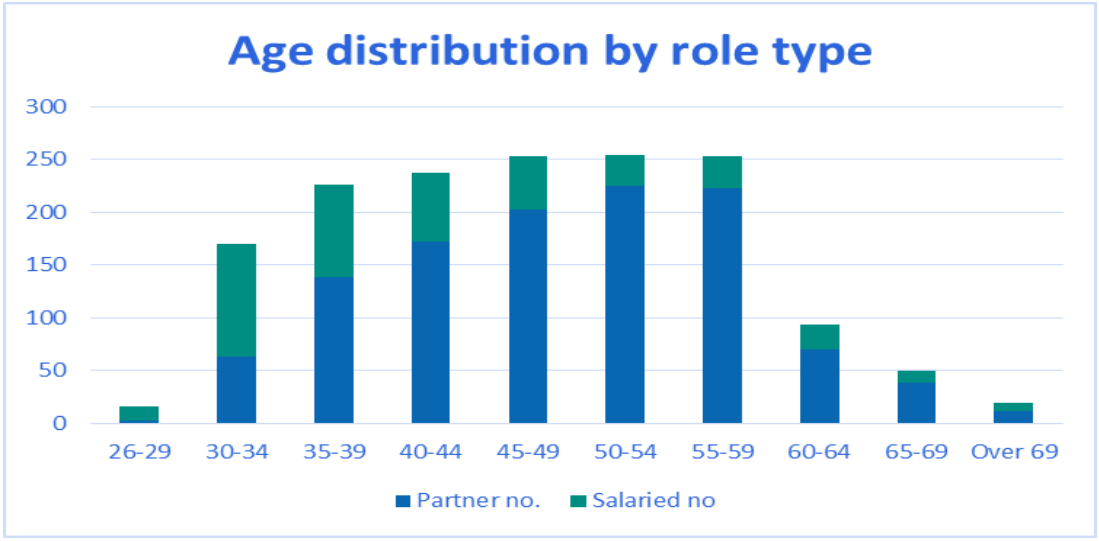
[15] http://www.shapeoftraining.co.uk/home.asp
[16] BMA GPC online workforce survey, 26 March 2014
[17] BMA UK 2013 Omnibus Survey
[18] CFWI, July 2014. In-depth review of the general practitioner workforce; and HEE Securing the Future GP Workforce, Delivering the Mandate on GP Expansion - GP Taskforce Report 2014
[19] GMC p57 State of medical education and practice in the UK 2014

Potential applicants to GP training are put off by well-documented reports of the stressful nature of working in general practice. In the most recent National Survey of GPs the level of overall job satisfaction reported was lower than in all surveys undertaken since 2001.[20] Of all BMA membership grades, GPs report the lowest average satisfaction with their work-life balance,[21] and GPs, by far, use 'Doctors for Doctors' (the BMA's 24/7 counselling and personal support service) the most.

GP training arrangements
Against the background of recruitment problems and an ageing workforce, it is imperative that adequate numbers of new GPs are trained – despite longstanding commitments to expand primary care, the overall number of training places in Wales has remained static. It is also imperative that they are trained appropriately to deal with the modern day pressures of general practice. Work also needs to be undertaken to dispel a number of negative perceptions about training and working in Wales – this includes myths around mandatory use of the Welsh language.

Partnerships and GP Principles
GP partnerships are increasingly being seen as unattractive, and therefore not sought after, due to the workload, bureaucracy and financial responsibility they involve – all for very little gain. In other circumstances, if such pressures are addressed, then many of the new generation of GPs have indicated that they would want to enter GP partnerships.

The graph below details the age profile of BMA GP members in Wales and their salaried/partnership split:



BMA GP members in Wales who work part-time comprise a quarter of those who are salaried GPs, compared to just 7% of those who are partners.

Lack of career flexibility
Flexible career schemes, for example posts that combine general practice partnership with an ability to undertake other roles within NHS Wales, are highly popular but very rarely supported.

Retainer and return-to-practice schemes
There is a lack of sufficient investment in making GP retainer and returner schemes accessible. The returner programmes are relatively inflexible in duration and content, regardless of the individual situation. They are costly, and the exit criteria often act as a deterrent for some individuals.

[20] http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf
[21] BMA Quarterly tracker survey, September 2014

Out-of-Hours (OOH)
There has been under investment in OOH services since 2004. This is irreconcilable with Welsh Government commitments to improve unscheduled care. Without adequate investment, it is impossible to attract and retain capacity – particularly at weekends and over public holiday periods.

We note that there is no mention of OOH services in the Welsh Government's proposed primary care plan, despite the fact they operate for more hours of the day than in-hours services.

Barriers to recruitment and retention in specific areas
In more deprived areas poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas.[22] Current core GP funding arrangements do not properly recognise deprivation.[23]

Rurality causes similar recruitment difficulties. Issues in rural areas – such as limited choice of local schools, lack of career options for spouse or wider family members, lack of local amenities – act as disincentives, especially for younger GPs. Rural practices are also threatened by issues over their financial stability related to inadequate resourcing, threats to funding for dispensing practices and the forthcoming phasing out of Minimum Practice Income Guarantee (MPIG) funding.[24]

Hospital Waiting Times
The shift of work from secondary care to general practice has not been accompanied by resources moving in the same direction. This adversely affects the ability of GPs to do the job, puts services under immense strain, and further damages the morale of GPs.

This is further exacerbated by frustration over long secondary care waiting times, difficulties accessing some diagnostics, inadequate administrative systems within hospitals adding to GP workload (e.g. delayed clinic letters, poor discharge letters, chasing appointments), acute intakes regularly closing and the cancellation of routine surgery meaning that the patient's condition worsens in the interim and more GP appointments are required – often consuming more health resources, particularly around prescribing.

Successive adverse policies
Pension changes, a series of below-inflation pay increases, wide underinvestment (e.g. in premises) and the transfer of more work into primary care have added to the stresses on an already demoralised workforce, and pushed more and more GPs to consider leaving the profession. Government policies on extending GP access are unrealistic and irresponsible; there are not enough GPs to cover even core weekday hours let alone evenings and weekends.

Lack of incentives to work in Wales
There are no 'made in Wales' polices that act to attract GPs to Wales and which make Wales stand out as a positive place to work. We have put forward a number of suggested incentive options to Welsh Government to help address shortages across the medical profession – none of the ideas have, so far, been taken forward.

[22] Sibbald, B. (2005) Putting General Practitioners where they are needed: an overview of strategies to correct maldistribution. National Primary Care Research and Development Centre, University of Manchester. Available at: http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/archive/PublicationDetail.cfm/ID/139.htm
[23] http://www.gponline.com/why-gp-funding-linked-deprivation/article/1328431
[24] BMA General Practitioners Committee Wales. 2014. GPCW Chair's speech to the national LMC Conference. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales/lmc-conference-speech

For Welsh GPs, this is compounded by that fact that they earn less than English counterparts[25] which impacts on a GP's decision as to where to work – whilst this is not the only factor affecting recruitment, in light of the higher workload and the other factors noted, it does need to be acknowledged.

Separate medical performers lists
The existence of separate performers lists for England and Wales has a number of detrimental impacts. For instance GPs on the English performers list may not be immediately able to take up vacancies that may exist within practices in Wales. In border areas, having separate lists can prevent GP colleagues in nearby practices, on either side, from simply being able to cover for each other in the way that might often happen between practices on the same side of the border. In the same way, the separate lists also limit the availability of locums for border practices.

Lack of data
Assessment of the true performance of NHS Wales, and its workforce numbers or requirements, is difficult due to the inadequate availability and reliability of data.

2 - WHETHER THE COMMISSIONING AND DELIVERY OF MEDICAL TRAINING CURRENTLY SUPPORTS A SUSTAINABLE GP WORKFORCE

Improve the attractiveness of training in general practice
In 2014, across the UK only 5559 GP trainee applications were received during the first round of the selection process – the lowest number of applications since 2009.[26] General practice has become the least popular specialty, second only to psychiatry.

Unfilled training places are a problem across the UK – in Wales this is exacerbated by the fact that we have the lowest number of Foundation Level 2 (FY2) posts in general practice (24%[27] compared to a UK average of 55%). The Department of Health has committed to a 30% increase in training places in England.[28]

Whilst working to improve the image of general practice in medical schools, GP placements need to attract more doctors into general practice. 670 applicants who applied to general practice last year eventually chose other specialties.[29] Improving the attractiveness of training in general practice could include financial incentives, for example, and the provision of high quality accommodation for trainees and their families alongside adequate relocation expenses – this is especially needed in areas that are currently less popular.

The profession, the Welsh Deanery, medical schools and the Welsh Government need to work together to inspire and incentivise these applicants to choose a career in general practice. This will require new investment.

Increase exposure to general practice through foundation year placements
Consideration should be given to making foundation year GP placements mandatory for all doctors in training.

Increase the number of GP specialty trainee places
There needs to be a substantial increase in the commissioning of GP training numbers in Wales, phased in over several years. Based on an extrapolation of the data for England, which is not available in Wales, we estimate that Wales needs at least 200 GP speciality trainees each year, there are currently 136

[25] HSCIC GP Earnings and Expenses, 2012/13, p6
[26] General Practice National Recruitment Office & HEE MWAG Specialty Recruitment Update, Feb 2014
[27] note current 1 year increase to 34% in Wales
[28] DoH HEE Mandate 2013
[29] General Practice Recruitment Data, HEE, 2014

places. The numbers need to be reviewed regularly and against sound evidence/data (currently lacking). If demand on GPs increases at a faster pace than projected, additional measures should be considered. As we have noted, an increase in numbers alone will not solve the recruitment problem.

Ensure lead employer for GP trainees is implemented
This would ensure stability and, for example, would enable access to such things as childcare vouchers and mortgages – as the individual would not be moving employer every six months. It would also enable consistent human resources advice to be given.

Support training practices
Consideration should be given to an enhanced trainers' grant to recognise the impact that training has on the delivery of routine practice work. It is widely acknowledged that the workload involved, particularly the e-portfolio, is cumbersome and is becoming more onerous. The foundation placement fee and GP trainer's grant no longer reflect the current workload associated with training foundation and general practice trainees. An uplift proportionate to the workload is essential. The premises strategy also needs to ensure adequate space for GP training.

Extend GP Training
The RCGP makes a compelling case for extending GP training to four years[30] to prepare young doctors for the rigours of modern general practice. We recognise that this proposal would create a 'fallow' year where fewer GPs would exit training, temporarily compounding the already bleak environment of recruitment.

However, the GP specialty training programme needs to be planned to suit the challenges facing a 21st century GP, who is only part clinician, but also manager, commissioner, employer, negotiator, educator and book keeper. Many young GPs cite a lack of readiness as a reason they wish to defer joining partnerships following the completion of their training.

3 - THE ACTIONS NEEDED TO ENSURE THE SUSTAINABILITY OF THE GP WORKFORCE.

Increasing the GP workforce and training numbers should be a priority. However, as noted in the overview section above, we recognise that an increase in workforce numbers in isolation may not deliver better services to patients in the long-run.

In addition to supporting partnership working, we must also embrace new measures and ways of working to ensure the delivery of high quality, personalised and integrated care and to attract and retain GPs.

For instance we believe that a salaried service is valuable for supporting flexible careers and may help to retain doctors at the beginning and end of their careers, and thus plays an important role supporting the mainstream partnership model.

There are a number of measures that can be taken to support the partnership model and to help ensure the sustainability of general practice in Wales. It is important to realise that unless the attractiveness of general practice in Wales improves, and the working conditions for permanent staff are addressed, then the situation is only likely to worsen.

All of these have previously been put to Welsh Government, they include:

- ***Look at new models of care and practice viability, for example:***

  i. Support flexible career and training schemes:

[30] RCGP, 2012 'Preparing the Future GP: the case for enhanced GP training'

Wales needs to create environments where the new generations of both male and female GPs seeking different ways of working can flourish. Sessions spent in portfolio roles, for example, offers both variety and ways of preventing burnout.

More opportunities for flexibility are needed that combine general practice partnership with an ability to undertake other roles in NHS Wales. For example, where a GP works a certain amount of time in practice and then the rest of their contract time in a mix of out-of-hours work, or work on health board priorities (e.g. audit, network pathways, using or acquiring specialist skills).

The increase in the proportion of the medical school intake who are women has led to a more equal gender balance in GP training and has changed the composition of the profession – we celebrate the fact that there are more female doctors now than ever before; 48% of doctors on the GP Register in Wales are now female.[31] However, a dedicated piece of work needs to be commissioned to explore the multifactorial complexities behind why 40% of female GPs in the UK have left the profession by the age of 40.

Doctors in less than full-time training are expected to take at least five years to train, compared to three or four years for the majority of GPs in full-time training. This should be considered in workforce planning since it will reduce the rate of production of trained GPs.

ii. A salaried service

A salaried GP service is the most commonly promoted alternative to the independent contractor model and it remains attractive to some GPs. According to the King's Fund,[32] salaried GPs give flexibility, as they often have short-term contracts and do not have the financial commitment of GP partners.

Whilst having an important place in primary care provision, there is little reliable evidence to support the case for wholesale change. Evidence from health boards suggests that a salaried service is more expensive and requires a lot of management involvement.

iii. Encourage federations of practices where appropriate:

This could involve practices making informal arrangements to share staff or work collaboratively on the provision of services to patients, either in individual premises or in jointly-shared premises. It could, of course, also include practices formally merging or joining together.

The GPC UK paper 'Developing General Practice – providing health care solutions for the future' expands on the value and importance of the primary care health team working in collaboration with other health care providers, and the value of collaborative alliances and federations tailored to local population needs.[33]

iv. Develop opportunities for collaboration and innovation in primary care:

The expansion of the primary care team with pharmacists, health visitors, district nurses etc. can address some of the workload issues. There is currently a shortage of practice and district nurses, which has a knock on effect on GP workload. The King's Fund report on the future of general practice goes further by

[31] GMC State of Medical Education and Practice in the UK, 2014

[32] The King's Fund, 2011. Improving the quality of care in general practice: report of an independent enquiry commissioned by the King's Fund. Available at: http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice

[33] GPC UK Vision Document. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/improving-urgent-and-ooh-care

suggesting GPs, dentists and optometrists collaborate to create a much larger primary care team.[34] However, this is likely to be an option in the medium to long term rather than an immediate one.

GPs are part of a wider primary care workforce – we must ensure that each element is complimentary and presents an effective use of skill mix and, in line with the principles of prudent healthcare, [35] does not duplicate or complicate other parts of care pathways or delivery.

The GP Cluster Network also, if properly supported and operational, holds some potential to assist in the area of collaboration, the sharing of innovation and best practice.

v. Introduce an expanding practice allowance:

Currently practices have to see a significant rise in population numbers in order to have enough funding to take on additional partners. An expanding practice allowance would enable the development of staff and succession planning. It could for instance be paid for 24 months, after which the rising list would self-fund the practice expansion.

- ***Measures to retain existing GPs:***

i. Develop and invest in returner schemes:

Improving return-to-practice schemes should be a key area of consideration with regards to ways in which retention rates in Wales could be improved. It costs around £500K to train a GP[36] and around £30K to enable them to return. In addition, returners tend to be committed to the area in which they retrain. No matter how many individuals apply to the returner scheme, there should be sufficient funding available to enable them to return, and they should be supported to do so – in a flexible way if required.

We believe that for individuals who have been working in a country with a similar NHS system and doing general practice work, the 'returner scheme' should be of much shorter duration. We support the recent paper developed by the Welsh Government, the Royal College of General Practitioners (RCGP) Wales, the Wales Deanery and GPC Wales which proposes amendments to the current scheme and is currently with the Health Minister for consideration.

ii. Develop and invest in retainer schemes

Incentives and flexible working opportunities should be offered to retain older GPs, including perhaps to those approaching retirement age.

This would be designed to avoid performers in exceptional circumstances becoming returners and having to go through the associated formal processes. For example, there is a need to retain and develop GPs who are unable to work full-time for specified and short term reasons.

The Welsh Government must change its funding priorities and provide fully-funded retainer schemes. Work needs to be undertaken to discover why doctors choose to take early retirement or to leave the profession, and at the same time to ascertain if these doctors have any interest in alternative ways of remaining in practice – for example becoming mentors, or moving to part time working or flexible contracts/portfolio roles.

iii. Provide a full occupational health service

[34] Securing the future of general practice: new models of primary care, The King's Fund, July 2013
[35] http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en
[36] http://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/

GPs in Wales have access to Health 4 Health Professionals, but there is no complete occupational health and well-being service. It is widely acknowledged that burnout, stress, low morale and risks of mental health illness are becoming increasingly prevalent.[37]

BMA Cymru Wales has previously called for a comprehensive all-Wales occupational health service to be developed for all NHS employees. Given the significant cost of training a GP it makes complete economic sense to preserve and protect that investment – a comprehensive service is long overdue. It has been over five years since the recommendations of Sir Mansel Aylward's One Wales report into Occupational Health were accepted by the Welsh Government, and yet we are still only in the 'pilot' stages of projects.

- ***Additional enhancements***

Incentives, such as 'golden handcuffs', can be very effective in recruiting GPs to certain areas. For example, in exchange for working in an area for a set amount of time, contributions could be made towards student loan repayments, or to training and examination fees. Incentives should especially be considered for rural and more deprived areas. Such schemes also would help efforts towards widening access to medical education.

Wider incentive schemes also need to be considered to increase the number of applicants to GP training places. For example medical schools could be incentivised to increase the proportion of their graduates selecting General Practice (and other shortage specialties) as first choice careers.

- ***Review of Out-of-Hours (OOH) services***

Out of Hours (OOH) services have been underfunded since health boards took over in 2004; this has a serious knock on effect on the whole of unscheduled care. There is an urgent need to review the way in which OOH services are provided – while considering the introduction of the 111 service and ensuring its appropriate use – as in many areas there simply are not enough GPs to fill rosters.

GPs should be more involved in the planning and development of OOH services through strengthened GP clusters working arrangements. Competitive remuneration rates should be set to create attractive OOH GP salaried careers and to encourage the participation of local GPs.

Dedicated funding for continuous professional development (CPD) within OOH work should also be considered.

- ***Capitalise on local commissioning expertise***

GPs needs greater involvement (and a stronger voice) in local NHS management and commissioning, but they have limited capacity to engage in this currently given other pressures on workload.

We are very supportive of GP Cluster Networks, but in many areas they are no more than irregular meetings organised by the health board to administer the Quality and Outcomes Framework (QOF). They will only work if they are given adequate resources and real decision-making power.

- ***Leadership***

The management of primary care requires a very different skill set from running hospitals. The specialist nature of this work may not be well suited to delivery by seven small primary care teams based in each health board. We believe that primary care management expertise should be consolidated into a Primary Care Authority for Wales.

Wales would also benefit from the reinstatement of a Primary Care Directorate within Welsh Government. Given the emphasis on primary care in Welsh health policy, the lack of a dedicated director level post in Welsh Government is, in our view, a major oversight.

[37] http://www.pulsetoday.co.uk/your-practice/battling-burnout/one-in-eight-gps-have-sought-help-for-stress-in-past-year/20003871.article

- ***GP Premises***

There is no obvious funding stream for premises development; responsibility was handed to health boards in 2013 without a budget. A review of the condition of premises is required in order to identify a more affordable way of implementing the 2004 programme of development; it would need to take into account sufficient teaching and learning space. The requirement to sign leases with onerous terms and conditions is also a barrier to young GPs taking on partnerships.

This situation in Wales contrasts greatly with that in England, where £1.25 billion has been identified for investment in premises (£250 million a year for each of five years), meaning that Wales is now significantly lagging behind.

- ***Data availability***

There is a worrying lack of data available on service performance and on workforce numbers and workload – starkly portrayed by the fact that neither Welsh Government, nor Health Boards in Wales, hold data on vacancies.

Chapter seven of the General Practitioners' Committee Wales (GPCW) strategy[38] deals with data availability and continuous service improvement. It makes a series of recommendations as to how the paucity of data and evidence gathering can be turned around.

- ***Add General Practice to the Migration Advisory Committee (MAC) Shortage Occupation List***

The BMA has submitted evidence to the Migration Advisory Committee (MAC) in support of GPs being included on the shortage occupation list.

The MAC gives considerations to occupations within the UK suffering from workforce shortages on an annual basis. For shortage occupations on the list, individuals from outside of the European Economic Area (EEA) are then able to obtain a short term visa, i.e. two years, to enable them to apply for those vacancies in the UK.

The advantages of inviting non-EEA doctors to fill vacancies are twofold. First, it should alleviate some of the pressure on the overstretched workforce and, secondly, that will enable sufficient numbers of UK/EU GPs to train and qualify in the intervening period.

It is of note that there is a separate shortage occupation list for Scotland; while shortages in Wales and England are contained within the same list (which has the potential to skew specific shortage variations between the two).

- ***Retired GPs***

We need to look at avenues to enable retired GPs to return in the event of a major outbreak/emergency situation without having to go through the hurdles of the medical performers' list, GP returner scheme, revalidation etc.

- ***Patient Expectations***

Patient's expectations have changed over the last decade, as have the lifestyle factors affecting population health. As individuals we all need to take better responsibility for our health and well-being, and use health services appropriately.

Patients need to be able to access advice as to whether they need to see a health care professional or not; and where the most appropriate place to do so is. There are many advertising campaigns warning patients not to miss symptoms of illness and diseases. These campaigns have been introduced without taking into consideration the need to educate patients on the use of online and other resources to

[38] BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales

signpost them to relevant services, in line the Welsh Government-backed principles of prudent healthcare.[39] Although many patients are beginning to do this, it is poorly advertised at present.

Education (for example on first aid, CPR, and the role of healthy and active lifestyles in warning off a number of illnesses and diseases) should be a compulsory part of the curriculum. The lack of implementation in an effective self-help agenda encourages the inappropriate use of healthcare resources.

CONCLUSION/SUMMARY

We hope the recommendations in this paper, and those contained in our strategy document, will inform the committee's work in this area.

The BMA is currently undertaking a national survey of GP members, covering many of the areas touched upon in this paper – models of working, premises, opening hours, workload, morale, consultation times with patients, and career motivators. We would be happy to share the results for Wales when the survey has concluded.

In representing GPs in Wales, we are wholly committed to working with the Welsh Government, the Wales Deanery, RCGP and others to bring forward lasting change for primary care in Wales.

It is clear that the solution is not a simple turning on of a switch, but a complex, multifactorial change in culture and strategy within the NHS and government, to recognise the clear problem facing us all and to implement action with both immediate and longer-term effects.

A recent BMA survey found that a staggering six in ten GPs in the UK were 'actively considering' leaving the profession.[40] We are at a watershed moment, and the time to act really is now.

Thank you for the opportunity to respond to this inquiry.

[39] http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en
[40] BMA quarterly tracker survey, Quarter 4, 2014

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Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Coleg Brenhinol y Patholegwyr
Response from: Royal College of Pathologists

The Royal College of Pathologists
Pathology: the science behind the cure

Inquiry into the sustainability of the health and social care workforce

Response by Dr Esther Youd on behalf of the Royal College of Pathologists

1. Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

1.1 No. One of the roles of the Royal College of Pathologists Wales Regional Council is to monitor workforce issues. This is an ongoing work stream for the Council. As a small nation it is easier to compile this information, however there are significant difficulties in comparing across Wales and there is no uniform method of gathering data, no set criteria on which to draw comparisons on staffing numbers and skill mix for a given region/Health Board/population.

1.2 At Health Board or national levels there is no data gathering or monitoring, and no succession planning.

1.3 The Royal College of Pathologists produces guidance on staffing levels but in many cases these are not given appropriate weight when planning and delivering a service.

1.4 In many pathology specialties (histopathology, microbiology, haematology) this paucity of data and of forward planning is resulting in severe recruitment difficulties at consultant and clinical scientist level.

1.5 In many Health Boards locum staff (both at scientist and consultant level) are utilised. It is more difficult to capture data on the use of locums and this may give an inaccurate picture of the workforce employed and of the recruitment gaps.

2. Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

2.1 On the ground there is little understanding of the Welsh Government's vision.

2.2 Laboratory medicine and the pathology specialties are vital in delivering the vast majority of patient care, however, this delivery is often taken for granted. Workforce issues in direct patient facing areas tend to be the focus (eg. nurse recruitment, A&E doctors, ITU doctors, surgeons, GPs), but without pathology these healthcare professionals cannot provide patient care.

2.3 Concepts such as Prudent Healthcare can be delivered by an appropriately skilled and resourced workforce in pathology, saving money and time elsewhere.

3. How well-equipped is the workforce to meet future health and care needs?

3.1 Within pathology specialties there is a mixed picture. Advances in technology put pathology specialties at the forefront of changing patient care. For example genetic testing, identification of bacteria.

3.2 However, adoption of technology is often slow and changes in workforce are often difficult.

3.3 Demonstrating the impact of pathology investment in the savings made elsewhere in the healthcare provision is extremely complex, and therefore the required changes in workforce are difficult.

3.4 Specific challenges exist in histopathology, particularly around cancer care, as the incidence of cancer increases, and there is likely to be an increased requirement for consultant histopathologists. Yet recruitment of consultants is challenging across all of Wales and significant gaps exist in every Health Board.

4. What are the factors that influence recruitment and retention of staff across Wales?
   - opportunities for young people to find out about/experience the range of NHS and social care careers
   - education and training
   - pay and terms of employment/contract
   - are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation?

4.1 Pathologists and scientists across Wales offer informal opportunities for young people to gain work experience, promoting scientific and medical careers in pathology specialties.
4.2 There tends to be a focus on the obvious healthcare careers, nursing, physiotherapy, medicine (surgeons, GPs) rather than the smaller specialties.
4.3 The Royal College of Pathologists has an active programme of public engagement activity to promote careers.
4.4 There are significant problems with recruitment of consultants in pathology specialties including histopathology, haematology and microbiology.
4.5 Training programmes in Wales have a good reputation and produce excellent consultants.
4.6 In some areas there has developed a disconnect between the changes in medical training and the design of consultant posts, for example in microbiology changes in the curriculum have resulted in a change in the way that trainees work and the type of job they are interested in.
4.7 There are significant geographical difficulties with recruitment, especially in West Wales and North Wales. These challenges in recruitment threaten the viability of services and patient care.
4.8 Expansion of training schemes, to include an increase in numbers of training posts and their distribution across Health Boards, would be of benefit. As an example, in 2016 there were at least 6 excellent applicants for histopathology posts from Wales, but only one post available.
4.8 The Royal College of Pathologists has identified the training, recruitment and retention of the right workforce as a priority for Wales and looks forward to working with Welsh Government on this.

WF 31

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Fforwm Gofal Cymru

Response from: Care Forum Wales

Fforum Gofal Cymru . Ty Hillbury . 2 Ffordd Hillbury . Wrecsam . LL13 7ET
Care Forum Wales . Hillbury House . 2 Hillbury Road . Wrexham LL13 7ET
Ffon/Tel: 07805 152495 . Ebost/Email: mary:@careforumwales.co.uk

Consultation response –

Inquiry into the sustainability of the health and social care workforce

Care Forum Wales welcomes the opportunity to respond to this inquiry. We are a membership organisation for Health and Social Care Providers in Wales representing over 450 independent providers. Our response focuses on the workforce employed by our members, who include both private and third sector providers.

- **Do we have an accurate picture of the current health and care workforce? Are there any data gaps?**
  Data collected on an unregistered workforce is by its nature patchy but valuable work has been undertaken. This will by its nature become more comprehensive as we move into registering further parts of the workforce, i.e. domiciliary care workers and social care workers in care homes. In terms of information collected outside that process from providers we must concentrate on what we want the data for and the additional burden that would be placed on providers by gathering it.

- **Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?**
  We do not believe there is a sufficient understanding of the workforce needed to deliver Welsh Government's vision for health and social care. Not sufficient. We would highlight:

    - the lack of clear career pathways in social care, which contribute to the insufficiency of qualified managers to fill every position currently available in Wales;
    - qualifications not always being fit for purpose to meet the needs of employers in the sector;
    - a recognition of the terms and conditions needed to attract an increasingly professionalised workforce to the sector;
    - particular difficulties in recruiting nurses to work in nursing homes and ensuring that the needs of nursing homes are included in planning figures for nurse education. We would also likely to see greater use of nursing homes to provider pre-placement training;
    - There needs to be a clear commitment at a regional level to partnership working to make the vision work.

How well-equipped is the workforce to meet future health and care needs?
Care Forum Wales supports the need to train and further professionalise the social care workforce. However, we need to recognise that many existing staff have poor experiences of academic education and in order for training to work for them it needs to be highly practical and building in literacy and numeracy skills through practice rather than formal education. Training needs to be easily accessible to workers in the independent sector with improved processes for local authorities and the NHS making their

training available. Commissioners also need to recognise that time used for training is time when other staff members will have to cover caregiving and this needs to be built into costing models.

What are the factors that influence recruitment and retention of staff across Wales? This might include for example:

- the opportunities for young people to find out about/experience the range of NHS and social care careers;
- education and training (commissioning and/or delivery);
- pay and terms of employment/contract;

Regulations which have prevented those under 18 from working in a care home have presented a barrier. A number of current managers and senior works began their relationship with the care sector by taking on non-caring roles in care homes before they were 18. There is no substitute for this hands-on experience of the sector and we are pleased that this prohibition is being relaxed. That said we need to recognise that the majority of entrants to the sector are more mature often bringing voluntary caring experience to the role. The decision by the last Welsh Government to end funding for NVQs at levels 2 and 3 is causing significant problems to the sector. Experience indicates that older entrants are more likely to stay in the sector and their maturity and experience is appreciated by clients.

In terms of pay and terms and conditions we need to be realistic and recognise the increasing complexity of the work required by those in the sector. Ultimately providers can only pay rates that balance their books given what they are commissioned on. We know that commissioning at levels where care workers are able to deliver relationship based outcomes will create more job satisfaction (e.g. Raglan project in Monmouthshire has seen vastly improved staff morale). We were pleased to see Welsh Labour note the sector as one of national strategic importance in its manifesto and we believe more needs to be done to publicly recognise the value of the sector to encourage more applications and stop care workers feeling their role is not recognised.

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

Recruitment is a challenge everywhere – in more urban areas there are other competing offers for social care workers e.g. you can earn more stacking shelves in a supermarket. In more rural areas transport, ability to drive and access to a car are issues.

WF 32

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Ymddiriedolaeth Gofalwyr Cymru

Response from: Carers Trust Wales

Carers Trust

Health, Social Care and Sport Committee

Inquiry into the sustainability of the health and social care workforce

Your name: Kieron Rees

Organisation (if applicable): Carers Trust Wales

email / telephone number: [redacted] / [redacted]

Your address: Carers Trust Wales, 3rd Floor, 33 Cathedral Road, Cardiff, CF11 9HB

About Carers Trust Wales

Carers Trust Wales is part of Carers Trust, a major charity for, with and about carers. We work to improve support, services and recognition for the 370,000 people in Wales living with the challenges of caring, **unpaid**, for a family member or friend who is ill, frail, disabled or has mental health or addiction problems.

Our Mission is to identify, support and involve Wales' unpaid carers through the provision of action, help and advice.

Together with our locally-based network partners, we provide access to desperately-needed breaks, information and advice, education, training and employment opportunities – working with 20,000 carers a year in Wales. Our network partners benefit from the provision of grants, advice documents and reports to improve carers' services. We give carers and young carers opportunities to speak to someone and make their voices heard, offline via our carers' services and young carers' schemes, and via our online communities.

Our Strategic aims are

1. Championing carers – ensuring their voices heard and carers have a high profile across Wales including in the media, government
2. Delivering services for carers in Wales – researching and promoting solutions for carers across Wales
3. Building partnerships and delivering change – working meaningfully across sectors to reach more carers in all spheres of life
4. A strong Carers Trust Wales network – working closely with our network partners to increase sustainability and impact across Wales

Our Vision is a Caring Wales – where unpaid carers are recognised and able to get the support they need

Introduction

1. Carers Trust Wales works with our Network of 15 local services across Wales to support carers. Many of our Network Partners deliver regulated care including replacement care, short breaks and day services. All of our Network Partners are independently constituted charities whose purpose is to support carers.

2. A carer is anyone who cares, **unpaid**, for a friend or family member who would not cope without their support.

3. Wales is a caring country, according to the 2011 census we have the highest proportion of carers in the UK. The 2011 census also found that carers in Wales care for longer on average than carers anywhere else in the UK[1].

4. Officially, 12% of the population of Wales provide unpaid care to a friend or family member who would not cope without their support. In reality, this figure is likely to be much higher. The care provided by unpaid carers in Wales is the equivalent of £8.1billion worth of care every year[2].

5. Replacement care and short breaks play a vital role in protecting the well-being of both carers and those they care for. Similarly, there is a large evidence base that supports the economic case for investing in support for carers – doing so reduces demand upon both health and social service[3]. For example:

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1 http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/2011censusanalysisunpaidcareinenglandandwales2011andcomparisonwith2001/2013-02-15

2 http://www.sociology.leeds.ac.uk/assets/files/research/cuk-valuing-carers-2015-web.pdf

3 Much of the evidence is collated in our publication 'Investing in Carers, Investing to Save' (2016), https://carers.org/sites/files/carerstrust/media/commissioning_wales_finallo.pdf

i. One study found that when a person is readmitted to hospital, problems associated with the carer were the reason in 62% of cases[4].
ii. One report found that commissioning for carers could equate to a saving of £4 for every £1 spent[5]
iii. 35% of carers without good support experienced ill health compared to 15% of those with good support
iv. Fewer carers experience mental health problems if they have taken a break since beginning their caring role[6]

6. Over the past few years we have seen increasing pressure placed on our Network Partners from funders. This has led to significant difficulties in recruiting and retaining staff across Wales, as well as a wider issue about sustainability of these third sector, quality-focused services.

7. For example, the rates paid by commissioners are too low to pay staff a reasonable hourly rate, and in some cases too low to cover even the minimum costs associated with providing replacement care. Based on a sample collected from local authorities by the UKHCA in September 2014, the average rate paid by councils in Wales for care was £14.05 an hour[7]. The UKHCA calculates that to adequately cover National Living Wage, backend costs, travel time etc. a minimum of £16.70 is required[8].

8. Many of the factors that impact upon recruitment and retention amongst our Network Partners are a direct result of the lack of investment in social care by some local authorities. Furthermore, with the introduction of duties including automatic enrolment of pensions and the National Living Wage, the financial pressure on these services continues to increase while funding continues to decline.

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[4] Williams, E, Fitton, F (1991) 'Survey of Carers of Elderly Patients Discharged from Hospital', British Journal of General Practice, 41, 105–108.

[5] Conochie, G (2011), Supporting Carers: The Case for Change (The Princess Royal Trust for Carers and Crossroads Care).

[6] Singleton, N, Maung, NA, Cowie, A, Sparks, J, Bumpstead, R, Meltzer, H (2002) Mental Health of Carers (Office of National Statistics, The Stationery Office).

[7] http://www.ukhca.co.uk/rates/

[8] http://www.ukhca.co.uk/pdfs/AMPFHC_150719.pdf

9. Another factor in the recruitment and retention of staff is the working environment. In many cases, rotas and travel times are so tight that staff find that they are under pressure to get from one call to the next – it can be highly demanding and stressful. Many staff reported in exit interviews that they feel the quality of the care they are able to provide has been impinged on because of the time stress they are under, others that they are providing the services the public need *despite* the system they work under.

10. These issues arise from the continuing pressure to do 'more with less'. This has been the case for a number of years

11. Carers Trust Wales believes that the following are fundamental to tackling the issues faced in recruitment and retention of the social care workforce:

    a. Ensuring that commissioning is considered and adequate, and that it funds services in a sustainable way that fosters a good working environment
    b. Local health boards disproportionately benefit from the work of Wales' unpaid carers, and so should have a vested interest in ensuring unpaid carers receive the support they need. As such, local health boards should be involved in commissioning and funding social care in Wales.
    c. New models of funding replacement care and breaks for carers should be explored, for example looking at Scotland's Short Breaks Fund.

12. In the past year, Carers Trust Wales has been calling for the introduction of a national Carer Well-being Fund. The purpose of the fund would be to increase the availability of breaks to carers across Wales, easing pressure on health and social services and supporting the delivery of adequately funded social care in Wales.

13. Such a fund would take into account the lessons of Scotland's Short Breaks Fund which has delivered over £11 million worth of breaks to carers in Scotland since 2010[9].

14. A modest annual investment of £1.4 million in Wales would deliver around 53,000 hours of care at home at the new National Living Wage or provide 31,000 days of care at day centres across Wales. Alternatively, the same fund would secure 2,040 weeks of respite. These calculations include the cost of

[9] http://www.sharedcarescotland.org.uk/publications/short-breaks-fund-round-2-evaluation-report/

administrating the fund and are based on UKHCA calculations on the true cost of delivering care[10].

15. Carers Trust Wales strongly believes that without action to remedy the current counter-productive funding and commissioning environment for replacement care and breaks for carers, not only will the issues described in this response worsen, but we risk seeing the loss of high-quality, not-for-profit services that have the needs of unpaid carers at the heart of everything they do.

Contact

Kieron Rees

Policy and Public Affairs Manager, Carers Trust Wales

[redacted]

[redacted]

[10] Full proposal is available upon request

WF 33

Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol

Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Coleg Brenhinol y Therapyddion Iaith a Lleferydd

Response from: Royal College of Speech and Language Therapists

National Assembly for Wales Health, Social Care and Sport Committee Consultation on an inquiry into the Sustainability of the Health and Social Care Workforce

1. **Executive Summary**

1.1 The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to comment on the sustainability of the health and social care workforce**.** We are pleased to see that this issue of concern is being prioritized by the committee. Our response below provides brief background on the speech and language therapy (SLT) workforce in Wales and responds to the five key questions posed within the consultation document.

1.2 Our key points include;

- The pressing need to consider the impact of increased integration within health and social care on data collected to ensure effective strategic planning.
- The importance of fully utilizing the skills of the Allied Health professions, in particular SLTs.
- Concerns around band 8 posts and roles that support low incidence/high specialty roles.
- Issues with regard to recruitment in Pembrokeshire, Ceredigion, North West Wales and Powys.

1.3 We also wish to highlight that we are co-signatories of the 'One Workforce' document developed by the Policy Forum.

2. **About the Royal College of Speech and Language Therapists**

2.1 The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists (SLTs), SLT students and support workers working in the UK. The RCSLT has 15,000 members in the UK (450 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council). We promote excellence in practice and influence health, education, care and justice policies.

3. **About the Speech and Language Therapy Workforce in Wales**

3.1 SLTs provide life-improving treatment, support and care for people who have difficulties with speech, language or communication or eating, drinking or swallowing problems. SLTs are central to the provision of safe, value for money healthcare and supporting the delivery of NHS priorities. From helping babies with cleft lip and palate, to supporting people recovering from a stroke or older people living with dementia, speech and language therapy transforms lives.

3.2 Recent analysis of the SLT workforce in Wales employed by Local Health Boards (LHBs) across paediatric and adult services indicates 462 full time equivalent SLTs and Assistants. Ratio of the population to SLT and SLTA differ significantly between LHBs. From 1 member of the SLT support team to 8899 persons in Aneurin Bevan University Health Board to 1 member of the SLT support team to 5485 persons in Hywel Dda. SLTs are predominantly a female workforce. Part-time working is widespread and maternity leave cover is an ongoing consideration. The average age of the workforce in Wales is 39.

4. **Do we have an accurate picture of the current health and social care workforce? Are there any data gaps?**

4.1 Whilst NHS Workforce Education and Development Services are able to provide useful data on numbers of qualified staff, average age and staff retention figures, we have concerns with regards a number of data gaps which affect the ability of the SLT workforce to plan strategically at a national level. This is particularly an issue in areas of Speech and language therapy where we are working to a social care model. A significant amount of service provision within this area is delivered to 'care' staff (Social Services and third sector) e.g. training and support and there is an expectation that intervention is delegated. Due to the current separation of data between health and social services, we currently lack information at a national level on our input into social care which hinders the ability of staff to realistically plan and respond to need. Greater integration of health and social care will require a fundamental review of data collected.

5. **Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?**

5.1 RCSLT Wales believes that following the enactment of key legislation to support integration between health and social care such as the Social Services and Wellbeing Act and the Wellbeing of Future Generation Act, there is a pressing need to create a new vision for health and care services in Wales and the changing workforce required to deliver this. Such a vision must be co-designed by both those using the health and care system and those working within it and must address challenges such as sustainable funding, integration and the need to focus on wellbeing and prevention.

6. **How well equipped is the workforce to meet future health and care needs?**

6.1 RCSLT Wales believes that in order to respond to the dual challenge of budget pressures and a rising population with complex needs, it is vital that the skills of allied health professionals, and in particular SLTs are used more fully. As highlighted by the Nuffield Trust, there is a need to reshape the health workforce to deliver the care that patients need and alleviate pressures on the health system[1]. SLT as a profession has developed considerably over recent years to adopt a more consultative, collaborative approach. The profession has a vital role to play in the delivery of new models of care and shifting care from hospitals to community settings. The SLT workforce already provides preventative health care in local communities and is skilled in multidisciplinary team working and the delivery of integrated care. This is an increasing focus within the undergraduate training course.

6.2 SLTs are engaged in a number of roles as part of primary care teams, for example, SLTs provide telephone triage to care homes managing the communication and swallowing problems of those in their care, removing the need for a GP visit. They provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease, which reduces morbidity, mortality and prevent hospital admissions. SLT has been developing efficient and effective telehealth solutions in this regard. Published evidence already indicates that interventions delivered by SLTs can provide economic benefits. For example, social return on investment research has highlighted the value of the provision of speech and language therapy for post-acute stroke patients.[1] Evidence from a telehealth project in care homes has indicating savings of £60 on each tele swallowing assessment[2].

6.3 Our members have informed us that due to budgetary pressures, many band 8 specialist roles are under threat. Given the importance of these roles both to the preventative agenda and to the development of career progression routes for the profession in Wales, we would be keen to see acknowledgement of the key role of SLTs in the NHS workforce of the future. There is also a clear need to acknowledge the importance of development roles and building in research capacity to ensure the sustainability of services and effective succession planning.

6.4 We also have concerns about the current ability of the profession to respond to the need to provide 7 day services, given the relatively small SLT workforce across Wales and future recruitment of staff to low incidence, high speciality posts e.g. paediatric dysphagia

7. **What are the factors that influence recruitment and retention of staff across Wales?**

7.1 Feedback from our membership suggests that the following factors are key to the recruitment and retention of staff.

- Evidence that the workforce is valued and well supported by the employer. For example, posts banded appropriately, realistic capacity/demand,

[1] Nuffield Trust (2016) Reshaping the workforce to deliver the care patients need: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/reshaping_the_workforce_web_0.pdf

[2] University College London (2016) London Speech and Language Therapy workforce scoping project, phase 2: modelling workforce transformation example, report available upon request.

continuous professional development supported, robust personal appraisal development reviews and supervision processes, flexibility.

- Opportunities for varied clinical placements for students undertaking the speech and language therapy undergraduate course, including experience of multi-disciplinary team working to ensure education and training appropriately prepares students for the workplace.
- Appropriate skill mix.
- Good use of career fairs etc., particularly at the time when students are choosing A level subjects and seriously thinking about future careers.
- Pay and terms of employment.

8. **Are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation?**

8.1 The rurality of Wales presents a number of challenges to the delivery of high quality health and care services. SLTs in Wales are currently developing a range of telehealth projects to support access to specialist services within more rural communities. As an example, the Macmillan Telemedicine project is a joint project between Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board which enables people affected by head and neck cancers in sites across Hywel Dda University Health Board to access consultations via videoconference removing the need to travel to Singleton Hospital for appointments.

8.2 We have particular issues with regards recruitment to posts within Ceredigion, Pembrokeshire, and North Powys and Welsh speaking posts within North West Wales.

9. **Further Information**

9.1 We would be happy to provide any additional information required to support the Committee's decision making and scrutiny. For further information, please contact:

Dr Caroline Walters
Policy Officer, Wales
[redacted] / [redacted]

WF 34
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Bwrdd Iechyd Prifysgol Betsi Cadwaladr
Response from: Betsi Cadwaladr University Health Board

1.Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

Workforce planning returns from health boards should provide a reasonable picture of the workforce and education/training needs. However, as a small to medium sized scientific discipline there is benefit from central verification of nationally collated figures by advisory bodies (eg the Welsh Scientific Advisory Committee etc). This is important to ensure that local plans fully reflect and are coordinated with an up to date view of strategic developments (inc WG policy) and opportunities that may be apparent to the advisory bodies. Sometimes the view of health science staff re the workforce may be 'lost in translation' at health board level, where the bigger picture and opportunities may not be recognised – in this respect the process of developing workforce plans by healthboards is perceived to be variable. A second check at a national level is important.

2. Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

In current practice, pursuit of policy is often ahead of workforce planning and not necessarily coordinated in time. Eg a key action of the National ENT Planned Care Programme is to see a transfer of activity from medical ENT clinicians to healthcare science staff in audiology at health boards, yet this has not been coordinated with national workforce planning to commission the necessary numbers of Audiology staff to ensure that outcomes of the new policy can be realised.

3. How well-equipped is the workforce to meet future health and care needs?

Additional numbers of Audiology clinical staff are required to accommodate delivery of healthcare closer to patients homes through primary care roles.
One particular concern is the lack of responsiveness (time lag) in output from traditional education/training schemes (3 year duration at undergraduate and post-graduate level) to keep pace with evolving workforce demands (driven by policy). There should be facility within commisioning of education/training funding to support innovative fastrack schemes to more rapidly meet demand. Within Audiology proposals have been presented to this achieve this. Aside from new entrants, the development of the existing workforce (eg through support for Master level education/training) should also feature prominently in strategic workforce planning.

4. What are the factors that influence recruitment and retention of staff across Wales?

Opportunities for young people to find out about/experience the range of NHS and social care careers; Education and training (commissioning and/or delivery); Pay and terms of employment/contract;

There may be value in consulting recent graduates in the NHS workforce and other young people to help determine what they would regard as persuasive reasons to train and stay in Wales.

The cost effectiveness of education and training in Wales would be improved through targeted efforts to retain more trained staff. Suggested options/measures to achieve this are:

1.Provide education and training bursaries to individuals conditional on a period of commitment to employment in wales (eg for a minimum 3 years post graduation from training).
2.Limit bursaries to those already resident in Wales.
3.Favour Welsh applicants to education and training posts
4.Use monies currently allocated to bursaries to fund temporary first posts on employment with designated health boards across Wales (eg for 3-6 month period post graduation)
5.Use monies currently allocated to bursaries to fund on-going education and training allowances for individuals for their first few years in NHS Wales posts (to allow for further career progression).

Particular issues in some geographic areas, rural or urban areas, or areas of deprivation.

There are difficulties recruiting Audiologists in geographically remote areas eg N.Wales – in particular where remote from the national training centre (Swansea University). These could be mitigated by more effective local promotion of careers and education/training opportunities. Participation of local services in the recruitment process (eg at university entrance) may also be beneficial.

I hope this information is of use and I would be happy to expand on these points.

WF 35
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: Leonard Cheshire Disability
Response from: Leonard Cheshire Disability

Health, Social Care and Sport Committee
National Assembly for Wales
Pierhead Street
Cardiff
CF99 1NA

13th September 2016

Dear Health, Social Care and Sport Committee,

Thank you for the opportunity to contribute to your inquiry into the sustainability of the health and social care workforce.

Inquiry into the sustainability of the health and social care workforce

1. **Do we have an accurate picture of the current health and care workforce? Are there any data gaps?**

Without access to Welsh Government data collection exercises, it is difficult to be definitive in answering this question. Clearly, Leonard Cheshire Disability has an accurate picture of its own workforce, but there is no clear, publicly-accessible picture of the overall workforce in Wales. Our impression is that the overall workforce does not have sufficient numbers to accommodate demand.

It would be of great benefit to service providers such as Leonard Cheshire to have estimates on the number of people likely to come into the care system over the next decade. Ideally, such estimates would include all areas of care such as care at home, supported living, respite, residential, residential with nursing care, elderly care, specialist care. We would recommend that the Committee asks the Welsh Government whether it has mapped out the services required now, and year on year over the next decade. We would also recommend asking it whether it has a clear picture of what services it will need to commission to meet this demand over the near future.

Anecdotally, commissioners have indicated to us that supported living units are no longer being built, despite these units offering flexibility and independence for an individual in receipt of care. It would be helpful to have clarification on this from the Welsh Government.

Likewise, it would be helpful to know whether there have been impact assessments on the closing of day services by Local Authorities. In particular, it would be valuable to know whether the users of such services have taken up provision elsewhere, and whether such closures have impacted on their emotional and/or mental health impact.

There remain huge challenges around the delivery of health and social care in rural areas. Developing staff with a multi skill set (and potentially roles/job descriptions that would not be found in traditional models of health/social care) may deliver efficiencies and provide a more coherent service for users, by reducing the sheer number of people required in the delivery of services. If a nurse can spend an extra time on a visit combining tasks and performing duties that would traditionally be undertaken by a carer, not only is there a cost-saving, but the service user can build up more of a relationship with the person assisting them. Vice versa carers could be skilled up in additional nursing tasks similar to the nurse assistant role already established on NHS Wards to create a service which traditionally delivered by a nurse could in fact be delivered by a carer/nurse assistant.

We recognise also the need for there to be consistency across Wales and would recommend that the Committee presses Welsh Government to produce uniform clear guidance across Wales on delegated responsibility as currently different LHB delegate clinical responsibilities differently from one LHB to another.

In certain circumstances, it may also be appropriate to formalise (through payments) the informal care often already being given by neighbours and the wider community around a person receiving.

2. Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

Not yet.

There is a clear awareness of the need to professionalise the care sector and we have had some information as to what this would look like. But in some aspects there remains limited detail. The creation of Social Care Wales and the aspirations of the Social Services and Wellbeing Act 2014 clearly represent a significant step forward for the care sector. However, there remain risks around making a qualification part of the registration process. It is currently possible that training companies will spring up with an advertising emphasis on 'fast tracking' prospective carers through to an NVQ (so that they can start getting paid), rather than focus on actually providing meaningful learning. We do not yet have clarification on who will be delivering the training and accreditation for this QCF/NVQ, which will be critical and needs to be planned strategically. Qualifications need to be competency based as we have many good carers that are not academic but are excellent carers and for some the thought of a formal qualification will

distress some carers and act as a deterrent so formal qualifications need to be managed with this in mind and not create situation where carers leave the profession.

We would recommend that the Committee presses the Welsh Government on the issue of how training will be delivered, because the clock is ticking.

3. **How well-equipped is the workforce to meet future health and care needs?**

As noted above, we believe the overall workforce has insufficient numbers to accommodate the demands placed upon it.

This is not always obvious, because some agencies are able to fully recruit, while others cannot. An underlying driver behind this inconsistency is that Local Authority commissioned care staff are generally paid less than Health Board staff, and Health Board commissioning tends to be at better rates than Local Authority commissioning. A standardised pay rate would minimise the potential of staff jumping from employer to employer.

Not everything is about pay though. We believe providers should work with Social Care Wales to provide a pathway for those that want to get into management and senior management, and a pathway for those who want to be highly skilled carers, nurses or social workers. It is important to build a perception of care as a career and bring people into the sector. We should also be working with colleges and universities, looking at how to promote care as a career. At the moment it is very difficult, as the infrastructure and funding is not in place.

4. **What are the factors that influence recruitment and retention of staff across Wales? This might include for example:**

a) the opportunities for young people to find out about/experience the range of NHS and social care careers;

We believe secondments are an important element in developing opportunities.

Ideally, we could collaboratively work with other providers and promote the sharing of staff, to keep them interested in care. However, the competitive nature of tendering means that such collaborative working is often heavily dependent on individual relationships being fostered.

b) education and training (commissioning and/or delivery);

As noted above, it would be extremely valuable for the Committee to press the Welsh Government on who and how qualifications will be delivered.

As noted above, we need clear progression pathways and direction for staff, whether they are seeking to be a skilled carer, a nurse, a social worker, a manager or a senior manager. The training available to staff needs to match such pathways.

c) pay and terms of employment/contract;

As noted above, standardising pay and contracts would help to balance out staff across the sector. The Committee may wish to press for clarification on what the average pay of a carer currently is.

5) Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

As noted above, we are aware that there are particular issues around the delivery of care in rural areas. Further research into this question- perhaps commissioned by Social Care Wales- could provide illuminating answers.

Rhian Stangroom-Teel
Policy and Public Affairs Officer (Wales),
Leonard Cheshire Disability
Telephone: [redacted]
E-mail: [redacted]

WF 36
Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce
Ymateb gan: RNIB Cymru
Response from: RNIB Cymru

Inquiry into the sustainability of the health and social care workforce

Your contact details

Name	Rhian Nowell-Phillips
Are you responding as an individual or on behalf of an organisation?	Organisation
Organisation (and role if applicable)	RNIB Cymru, Policy and Campaigns Officer
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RNIB Cymru response to Health, Social Care and Sport Committee Inquiry into the sustainability of the health and social care workforce.

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1. About RNIB Cymru

RNIB Cymru welcomes this opportunity to contribute to the Health, Social care and Sport Committee inquiry into the sustainability of the health and social care workforce.

RNIB Cymru is Wales' largest sight loss charity We provide support, advice and information to people living with sight loss across Wales, as well as campaigning for improvements to services and raising awareness of the issues facing blind and partially sighted people.

About sight loss

There are around 106,000 people living with sight loss in Wales. (Access Economics 2009. Future Sight Loss UK: Economic Impact of Partial Sight and Blindness in the UK adult population. RNIB and Mid-2015 Population Estimates, Office for National Statistics (released 25/06/2015)).

This number is expected to double by 2050. Sight loss impacts on every aspect of a person's life: their physical and mental health, their ability to live independently, their ability to find or keep a job, their family and social life.

People with sight loss are significant users of health care services, spanning the spectrum of care, from primary to community to secondary care, as well as specialist and tertiary services. The prevalence of sight loss increases with age. Thus many people with sight loss are older and therefore have other health conditions, including chronic health conditions which are not linked to their sight loss.

2. Health and social care workforce

A sustainable health and care system has been defined within the NHS as one which "works within the available environmental and social resources protecting and improving health now and for future generations".

The NHS in Wales employs around 72,000 people which makes it Wales' biggest employer. Staff and the workforce are therefore the health and social care system's most valuable resource.

An engaged and empowered NHS workforce will be crucial for meeting the multiple challenges ahead for the health service, including the efficiency challenge and the move to prudent health care delivery.

Ensuring staff are highly motivated, trained and well-educated is key to the provision of high quality care and to improving standards in Wales.

Welsh Government's vision for an integrated health system will require a technology driven workforce where prudent healthcare principles are fully embedded into the system.

In 2014, RNIB Cymru commissioned a report into capacity at eye clinics. 'Real patients coming to real harm: Ophthalmology services in Wales', by Dr Tammy Boyce, this starkly highlighted that "Patients in Wales are spending so long on waiting lists that they are unnecessarily losing their sight."

We know that ophthalmology departments are working at full capacity, but they are still unable to meet the level of demand. There is a mismatch between demand and capacity – the number of ophthalmology patients is growing, however the capacity to treat them is not.

The current lack of capacity in the hospital eye services must be addressed through effective eye care pathways into *and out* of hospital, ensuring that available capacity in primary care is used where appropriate.

These pathways should maximise the professional skills currently available and patient safety and outcomes in these pathways should be safeguarded by good clinical governance and enhanced training for clinicians where necessary.

We believe that if the health and social care system is to attract and retain high quality staff in the future then there must be recognition that the current lack of connectivity between community eye health services and the rest of the NHS needs to be addressed to improve IT systems and link community and secondary care services.

This level of connectivity could allow electronic transfer of data and images, enabling primary and secondary care professionals to discuss patients in real time and decide whether a referral is needed.

Linking patient records also means that professionals can review a patient's eye health alongside any other long-term conditions that they might have. It could also help professionals identify non-adherence to treatments for chronic conditions. Linking patient records also improves access to treatment and thus could prevent avoidable sight loss. One of the most issues highlighted as needing attention within the Eye Health Delivery Plan was the need for an electronic patient record. This would save not only patient records going astray or being missed, but also saving time for overstretched staff.

3. Education and training (commissioning and/or delivery)

Achieving an appropriate staffing mix must also include consideration of how more patients could be dealt with in primary care and Ophthalmic Diagnostic and Treatment Centres – for example, as demonstrated in Cwm Taf UHB where patients were seen in a community hospital, rather than the eye clinic, for treatment of stable glaucoma or ocular hypertension.

The clinic was directly managed by an optometrist and overseen by a consultant. This is consistent with a prudent healthcare approach, that patients are treated in the appropriate place by the appropriate professional at the appropriate time, whether in the community or in the hospital. It is also consistent with the ‘only do what only you can do’ principle, where all people working for the NHS in Wales should operate at the top of their clinical competence. Nobody should be seen routinely by a consultant, for example, when their needs could be appropriately dealt with by an advanced nurse practitioner.

Results from the project showed that patients were extremely satisfied attending the community clinic as oppose to the main hospital eye clinic and waiting times between appointments were reduced. Also the community clinic increased capacity in the main hospital eye clinics.

Due to the success of the model further clinics have been implemented in other parts of Cwm Taf Health Board. Similar models are being implemented in other health boards across Wales as this is a priority within the Welsh Government Eye Care Delivery Plan 2013.

In addition to the provision of additional clinics in secondary care, Welsh Government under the Wales Eye Care Scheme has provided training and accreditation for community/high street optometrists to carry out glaucoma repeat readings and cataract referral refinement. They would normally be carried out in secondary care eye clinics, but enabling these to be carried out in primary care, reduces the burden on secondary care and also makes them much more accessible to patients, being closer to their homes. Currently, approximately 93% of practices are accredited to provide this service and this is another example of reorganizing services to reduce the burden on secondary hospital eye clinics.

Similarly, there are new models of care being put in place for the treatment of patients with Age Related Macular Degeneration, where nurses have been trained to give injections to patients, rather than consultants.

This steadily changing workforce and skillset must also be accompanied by good management and rigorous checks; the current system often means that patients aren’t always seen as timely as required by NICE guidelines, or by the right staff member which can lead to the principles of prudent healthcare being overlooked.

4. Pay and terms of employment contract

The above example of different models of the provision of services, demonstrate better use of resources for both professionals and patients. They would also suggest that in a time when capacity in secondary eye care is over-capacity and staff are stretched to the limit, that remodeling eye care services in this way would not only help reduce the load in secondary eye care but as long as staff are provided with any additional training required, would also enable staff to feel much happier in their roles, increasing the sustainability and retention of the workforce.

Integrated services could involve hospital based clinicians spending some of their time delivering and/or overseeing services in the community. This could apply not only to ophthalmologists, but also to clinicians such as orthoptists, ophthalmic nurses, opticians and optometrists with higher qualifications and specialist skills gained in the hospital environment.

The workforce becoming more skilled provides a great opportunity for the NHS to ensure that prudent healthcare is fully recognised, however there must be adequate opportunities for reward and recognition for these upskilled workers.