Cynnws | Contents

*Ar gael yn ddwyieithog | Available bilingually

Rhif | Number	Sefydliad	Organisation
PCWL 01	Fferylliaeth Gymunedol Cymru	Community Pharmacy Wales
PCWL 02	Coleg Brenhinol yr Ymarferwyr Cyffredinol	Royal College of General Practitioners
PCWL 03	Coleg Brenhinol Pediatreg ac Iechyd Plant	Royal College of Paediatrics and Child Health
PCWL 04	Mind Cymru	Mind Cymru
PCWL 05	Coleg Brenhinol y Therapyddion Galwedigaethol	Royal College of Occupational Therapists
PCWL 06	Coleg Brenhinol Podiatreg	Royal College of Podiatry
PCWL 07	Coleg Brenhinol y Therapyddion Lleferydd ac Iaith	Royal College of Speech and Language Therapists
PCWL 08	Tenovus Cancer Care	Tenovus Cancer Care
PCWL 09	Y Groes Goch Brydeinig	British Red Cross
PCWL 10	BMS Consultation	BMS Consultation
PCWL 11	Cymorth Canser Macmillan	Macmillan Cancer Support
PCWL 12	Age Cymru	Age Cymru
PCWL 13	Y Gymdeithas Feddygol Brydeinig Cymru	British Medical Association Cymru
PCWL 14	Ombwdsmon Gwasanaethau Cyhoeddus Cymru*	Public Services Ombudsman for Wales
PCWL 15*	Crohn's & Colitis UK	Crohn's & Colitis UK
PCWL 16	Coleg Brenhinol Llawfeddygon Lloegr*	Royal College of Surgeons of England
PCWL 17	Cymdeithas Genedlaethol Plant Byddar Cymru	National Deaf Children's Society Cymru
PCWL 18	RNIB Cymru	RNIB Cymru
PCWL 19	Coleg Brenhinol y Seiciatryddion	Royal College of Psychiatrists
PCWL 20	Company Chemists Association	Company Chemists Association
PCWL 21	Parkinsons UK Cymru	Parkinsons UK Cymru
PCWL 22	Cymdeithas Fferyllol Frenhinol Cymru*	Royal Pharmaceutical Society Wales
PCWL 23	Cymdeithas Orthopedig Prydain	British Orthopaedic Association
PCWL 24	Coleg Nyrsio Brenhinol Cymru	Royal College of Nursing Wales
PCWL 25*	Cancer Research UK	Endometriosis UK
PCWL 26	Fair Treatment for the Women of Wales	Fair Treatment for the Women of Wales
PCWL 27	Cancer Research UK	Cancer Research UK
PCWL 28	Conffederasiwn GIG Cymru	Welsh NHS Confederation
PCWL 29	Coleg Brenhinol y Meddygon Cymru	Royal College of Physicians
PCWL 30*	Bwrdd Cyngor Iechyd Cymuned	Board of Community Health Councils
PCWL 31	Diabetes UK Cymru	Diabetes UK Cymru
PCWL 32	Cymru vs Arthritis	Cymru vs Arthritis

PCWL 33	Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	Cardiff and Vale University Health Board

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 01
Ymateb gan: | Response from: Fferylliaeth Gymunedol Cymru | Community Pharmacy Wales

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Community Pharmacy Wales response to the
Health and Social Care Committee's

Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Date: May 2022

Contact Details
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Part 1: Introduction

Community Pharmacy Wales (CPW) represents community pharmacy on NHS matters and seeks to ensure that the best possible services, provided by pharmacy contractors in Wales, are available through NHS Wales. It is the body recognised by the Welsh Government in accordance with *Sections 83 and 85 National Health Service (Wales) Act 2006* as 'representative of persons providing pharmaceutical services'.

Community Pharmacy Wales is the only organisation that represents every community pharmacy in Wales. It works with Government and its agencies, such as local Health Boards, to protect and develop high quality community pharmacy-based NHS services and to shape the community pharmacy contract and its associated regulations, in order to achieve the highest standards of public health and the best possible patient outcomes. CPW represents all 712 community pharmacies in Wales. Pharmacies are located in high streets, town centres and villages across Wales as well as in the major metropolitan centres and edge of town retail parks.

In addition to the dispensing of prescriptions, Welsh community pharmacies provide a broad range of patient services on behalf of NHS Wales. These face-to-face NHS Wales services, available from qualified pharmacists 6 and occasionally 7 days a week, include, Pharmacist Independent Prescribing Services, Emergency Contraception, Discharge Medicines Reviews, Smoking Cessation, Influenza Vaccination, Palliative Care Medicines Supply, Emergency Supply, Substance Misuse and the Common Ailments services.

CPW is supportive of the narrative and intentions within the Welsh Government's *plan for transforming and modernising planned care and reducing waiting lists*. The plan is pragmatic and coordinated and takes account of the current backlog situation. CPW was heartened to see the recognition in the paper that '*The primary care workforce adapted very quickly in response to the pandemic and adopted a new clinical model at pace to support those in need of care.*

CPW is pleased to have the opportunity to respond to this important consultation which is part of the committee's inquiry into the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment. CPW believes that the community pharmacy network can help to relieve pressure in key parts of the health service, and in doing so, to help create a degree of headroom to reduce the backlog.

Community pharmacy can help to acheive the key objective of '*increasing health service capacity by providing better access to healthcare closer to home – to*

doctors, nurses, dentists, optometrists and other healthcare professionals who work together so people receive the right care from the right professional.

CPW is also fully supportive of the statement that '*community pharmacy services will continue to be promoted as an alternative to visits to urgent care services. They will play a vital role in supporting patients who may be already on a waiting list or require onward referral*

While CPW is pleased with the recognition of community pharmacy in the paper, CPW feel that the community pharmacy network across Wales is perfectly placed to make a more significant contribution to the delivery of the plan.

Part 2: Observations on the plan for transforming and modernising planned care and reducing waiting times.

Within the paper there are many areas which CPW feel community pharmacies across Wales can make a significant contribution.

The key opportunities include :-

Moving some diagnostic tests into community pharmacies: CPW is fully supportive of the statement in the plan that: *diagnostic services need to be planned and delivered differently. Currently, these services are predominantly based in our main hospitals, serving urgent as well as routine planned care. The need to increase capacity provides an opportunity to deliver services in a different way, for example diagnostic hubs and community provision.* With improvements in technology many tests can be accurately undertaken using Point of Care Testing (finger prick testing). Provision of an extended range of diagnostic services through community pharmacies will be extremely convenient for patients and will release much needed capacity in diagnostic services. It would be helpful to also remove any existing barriers for example, community pharmacy cannot currently request blood tests, even when undertaking a prescribing role, and have instead have to refer to a GP.
The plan aims to '*develop regional treatment and diagnostic centres to further increase capacity. Provide local access to diagnostic procedures, with more tests undertaken at the same time'*. The community pharmacy network stands ready to take on this role.

Move some routine monitoring of stable patients into community pharmacies: The majority of patients with stable long-term conditions visit their pharmacy on a routine basis to obtain a supply of their medication. These same people, who are in regular contact with a capable healthcare professional, visit another part of the NHS and another healthcare professional for their annual monitoring and assessment. This is not good use of NHS resources and CPW would recommend that we look to move routine monitoring of people, who are

living with diabetes and respiratory conditions, into community pharmacy. This will provide headroom in GP practices to manage more complex cases and could reduce admissions due to exacerbations. The plan states that '*we will build on established self-management models as a core component of person-centred care providing information and education to support and empower people with long-term health conditions to understand and manage their own health and wellbeing effectively'.* CPW is confident that community pharmacies can take on more of this role.

Using community pharmacy to reduce health inequalities: The plan states that '*the Welsh Government is committed to reducing health inequalities. The pandemic has highlighted and worsened health inequalities and poor population health. Reducing health inequalities will enable more people to live longer, healthier and more productive lives'*. Evidence from public health Wales shows that community pharmacy is one of the areas of the NHS where the *Inverse Care Law* does not apply, in that there are a greater number of community pharmacies in areas of deprivation. CPW would suggest that this is leveraged to improve health outcomes in these areas.

Give community pharmacies a greater role in health improvement: The plan recognises that *'two of the biggest causes of avoidable ill health and death, and drivers of health inequality, are smoking and obesity. To tackle these and other health inequities, health bodies in Wales working with Public Health Wales will continue to promote healthier lifestyles including encouraging people to achieve and maintain a healthy weight'.* Community pharmacies are the most accessible part of NHS Wales and have, through their stop smoking outcomes, a proven record in change management. With over 700 pharmacies across Wales, located where people live, work and shop there is no other part of the NHS that can deliver health improvement support of the required nature at scale. Currently even the successful community pharmacy smoking cessation is subject to the vagaries of local commissioning and should be part of a suite of services available from every community pharmacy. There is also a significant opportunity to engage the network in the delivery of the *All-Wales Weight Management Pathway* and to allow community pharmacies to the National Exercise Referral Scheme and other services.

Provide more routine vaccinations in community pharmacies: Routine vaccination is a key weapon in preventing disease and demands for hospital care. Community pharmacies have clearly demonstrated their competence in vaccination through flu and Covid vaccination services and consideration should be given to expanding their vaccination role especially now that the public have shown their willingness and confidence to receive vaccinations in their local pharmacy.

Grow the Independent Prescribing role: Welsh Government has recognised the potential for community pharmacists to prescribe and have provided the

support needed to significantly grow the number of prescribers across the network. CPW would recommend that thought is now given to how we can best use this growing prescribing resource, for example to reduce demands on out of hours prescribing, to release capacity in other areas of the NHS.

Supporting hospital discharge: For the majority of patients returning home, or back into community care, following a period of time in hospital, ensuring that they receive, understand and can effectively use the medicines they were intended to receive is a key element of their continued care.

Welsh Government has previously fully recognised the importance of this part of the discharge process and the high level of errors that occur in practice. They responded pragmatically to this challenge by putting in place the Community Pharmacy Discharge Medicines Review (DMR) service following independent evidence on the value of the service. This is a home-grown service of which Welsh Government should feel justly proud however it is unfortunately a service that has not been leveraged and there remains a significant underutilisation of the service.

It is well recognised that errors occur in the hospital discharge process leading to inefficiencies and an unnecessary impact on patient care. The DMR remains a highly effective service which fully utilises the skills and expertise of community pharmacy teams and produces significant benefits to patients through the identification and resolution of medicines issues around discharge.

The current data on the performance of the service clearly shows that too many unnecessary medication errors still occur following discharge. These errors, if not spotted and addressed, could result in less-than-optimal treatment and affect the patient's condition, bringing harm to the patient and in a small number of cases resulted in the patient being readmitted into hospital. It also identifies that patients receiving the support of the DMR service were significantly less likely to have problems with their prescribed medicines following discharge than those patients that did not receive a DMR.

CPW recognise that the use of the service remains suboptimal and this needs to be addressed as a matter of urgency. This can be improved significantly by ensuring that when patients are discharged from hospital there is an automatic notification to their community pharmacy via the Choose Pharmacy platform.

Driving work into community pharmacy: The recent Pharmaceutical Needs Assessments conducted by health boards across Wales identified that the majority of patients are not aware of many of the services offered in community pharmacies. CPW feel that lessons can be learned from the excellent and coordinated effort made each year to make people aware of the benefits of flu vaccination with a campaign of a similar nature put in place to raise awareness of community pharmacy services. This would significantly help the people of

Wales to choose the best provider in support of the *Help Us Help You* principles and reduce pressure on many parts of the NHS.

Speed up hospital discharge processes: As part of the (E – Early Discharge) element of the SAFER guidance CPW is aware of the delay to discharge that can occur while patients wait to receive their discharge medicines from the hospital. We believe, following feedback from our contractors, that this is an unnecessary delay and can be removed by allowing the medicines to be provided by the patient's local community pharmacy and delivered to the patient's home if required with the minimum of delay. CPW would recommend that a community pharmacy Enhanced Service is put in place to address this unnecessary delay to hospital discharge.

Addressing the long-standing issue of medicines compliance aids: Some of the patients discharged from hospital will require the support of a compliance aid such as a monitored dosage system (MDS) or a MAR Chart. As the provision of MDS or MAR Chart support for carers is not an NHS service and is provided as a gesture of goodwill by the pharmacy contractors, patients are often held up in hospital while hospital pharmacy teams ring around to try to secure the support required by the patient. This is another unnecessary delay in discharge processes that can be easily addressed. CPW feels that we should have long ago resolved this issue as this is placing unnecessary pressure on social care, community and hospital pharmacy teams and delaying discharge. CPW would recommend that a national community pharmacy Enhanced Service covering the provision of MDS or MAR Chart support following discharge, where this is required, is put in place with the minimum of delay.

Providing speedy access to key information: To ensure that all elements of the community pharmacy services offer operate as effectively as possible it is essential that any remaining restrictions to community pharmacy routine access to the GP Medical Record in Wales are removed. A community pharmacist should be able to access a GP Medical Record at any time that they feel it is appropriate.

Part 3: Conclusion

The plan is clear in its desire to ensure that '*more care and support will be available from a wider range of local services and healthcare professionals to help you stay well and remain at home'.*

CPW is fully supportive of this aim and has laid out above several ways in which the community pharmacy network in Wales can help deliver the plan and release headroom in other parts of the service to tackle the challenge of the current waiting list.

CPW is happy to explore any of the elements touched on and will be a willing partner in instigating change.

CPW agree that the content of this response can be made public.

CPW welcomes communication in either English or Welsh.

For acknowledgement and further Contact:

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Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 02

Ymateb gan: | Response from: Coleg Brenhinol yr Ymarferwyr Cyffredinol | Royal College of General Practitioners

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Royal College of GPs Cymru Wales **May 2022**	**Response to Health and Social Care Committee's request for written evidence** **Welsh Government's programme for transforming and modernising planned care and reducing waiting lists- Royal College of GPs Cymru Wales**

Background

In May 2022 the Welsh Government released its programme for 'transforming and modernising planned care and reducing waiting lists'. The programme notes that lengthy waiting lists are an historic issue. However, the challenge has been exacerbated by the suspension of planned care services due to COVID -19. This has caused approximately 500,000 referrals not to be received in a timely manner for secondary care treatment.

Request for written evidence

The Health and Social Care Committee has requested overall views from relevant parties. It has also asked for specific input in response to several supplementary questions which will be addressed below.

Overall views:

1. *Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits?*

2. *Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?*

RCGP response:

The College is encouraged by the themes demonstrated in this Programme. It demonstrates an understanding of the challenges GPs are facing as they deal with the impact of long waiting lists, frequent follow-ups by patients on those waiting lists and the inevitable deterioration of patients' symptoms while they await a referral. This was described in 'Waiting Well?' [1] where Professor Peter Saul of RCGP Wales is cited as saying that *'backlogs had resulted in the prescription of drugs such as antidepressants, when other treatment approaches might have been more appropriate.'* However, the Programme does not explain the steps to be taken

[1] Waiting Well paragraph 42 https://senedd.wales/media/dfqbafj1/cr-ld15079-e.pdf

which will lead to these changes, nor does it give clear targets to measure what a resilient and sustainable social care system looks like.

The College is concerned by the lack of targets in the sections of the plan entitled 'what do we want to achieve?'. This provides broad ideas as to the desired outcomes, but data and a clear framework for measuring these outcomes will be vital before we can comment on the efficacy of the Programme. For example, the College looks forward to the workforce plan, which we hope will provide further staffing to decrease GP workloads, which are currently neither sustainable nor safe.

While digital consultations and virtual tools are a great help in alleviating some of the pressure, it is important that the investment in digital infrastructure keeps pace with patient need. It is also important to note that remote consultation can improve convenience from the patient perspective, but it does not reduce the amount of time a GP needs to spend in the consultation and has been known to extend that timeframe as for questions that need to be asked in a virtual setting, the answers to which might be implicitly obvious in a face to face environment. The College notes that many GP surgeries are using the telephone as the primary tool for remote consultations and there is scope to expand use of online video consultation.

The College supports making full use of the multi-disciplinary team where clinically appropriate. Seeing the right person at the right time is the most important factor in a patient's treatment and rehabilitation.

The focus on health inequalities is welcome and we are working with Welsh Government on a project to help tackle this long-standing problem. To properly address the challenge of health inequalities, Government needs to look beyond just the health remit to consider how poverty and exclusion across the board impact on health outcomes.

The College draws the Committee's attention to its 8 Point Plan[2], and is encouraged to see some similar themes in the Programme, particularly the focus on improving communication with the public to support improved health literacy, and the increased use of digital tools which we hope will include sensibly managed online appointment booking and video consultation in practice.

We would urge the Welsh Government to consider improving the clarity of triage by upscaling the role of Care Navigator as highlighted in the plan.

Supplementary Questions

Meeting people's needs

3. *Whether the plan includes sufficient focus on:*

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[2] RCGP 8 Point Plan, October 2021 https://www.rcgp.org.uk/about-us/news/2021/october/rcgp-cymru-wales.asp

a. Ensuring that people who have health needs come forward.
b. Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management.
c. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time.
d. Improving patient outcomes and experience of NHS services?

As in 'Overall Views' above, the College is encouraged to see consideration of all patients currently on the waiting list and the beginnings of a communication strategy to encourage those in need to come forward. However, as has been mentioned above and will be detailed below, the Programme lacks the specifics which would allow us to accurately predict its efficacy in terms of patient need.

We note that the idea of digital tools to facilitate commination between healthcare providers is being broached, however we feel that clear communication to both staff and patients is vital to ensure this is used effectively. We also highlight the potential of the introduction of Care Navigators as in our 8 Point Plan.[3]

As above, we support the use of multidisciplinary teams and look forward to seeing further detail on the application of these. As Professor Peter Saul is quoted in 'Waiting Well'' *'the embedding of specialist staff, such as diabetic nurses or pain management specialists, into primary care practices was a key development'* [4] The Programme would also benefit from the further detail on the plan for estates as there is currently not space to house multiple disciplines and 'community hubs' within the infrastructure of GP practices. Furthermore, this lack of capacity results in a lack of training space for new members of the practice team entering the profession.

Detail is needed regarding the workforce plan, which we understand is forthcoming. We need to understand how digital consultations are going to be rolled out given that the current norm for GP practices is to hold a remote consultation via telephone. We do not yet know how or where the funding discussed in the report will be allocated.

The Programme implies that much of the practical application of these broad themes will be left to health boards. This is not unreasonable, but it will be important to ensure safeguards exist to measure a consistency of service and to identify areas of additional need due to existing inequality. As Professor Saul noted in Waiting Well '*I think it will deliver for some of them, but we've identified perhaps people in deprived areas who are less vociferous, who have less access, and I think there may be difficulties there. And I think the timescale is going to be longer than stated'.*

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[3] RCGP 8 Point Plan, October 2021 https://www.rcgp.org.uk/about-us/news/2021/october/rcgp-cymru-wales.asp
[4] Waiting Well? paragraph 248 https://senedd.wales/media/dfqbafj1/cr-ld15079-e.pdf

Leadership and national direction

4. *Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?*

5. *Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?*

The College supports the idea of collaboration between NHS and Social Services with the introduction of a Diagnostic Board as on page 19 of the Programme. However, the College feels far greater detail is required as to who will facilitate the introduction of the new systems discussed. There is an implication throughout the Programme that much of the detail of 'how' the processes will be put in place will be left to health boards, which leaves room for inconsistency and inequality through the system that we wish to improve, if not eradicate.

Targets and timescales

6. *Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?*

7. *Is it sufficiently clear which specialties will be prioritised/included in the targets?*

8. *Do you anticipate any variation across health boards in the achievement of the targets by specialty?*

As mentioned above, the Programme lacks targets. The Programme highlights that 691,885 are currently on waiting lists with 251,647 waiting over 36 months (an increase of 223,353 on March 2020).

Under the sections entitled *'What do we want to achieve?*', themes and ideal outcomes are listed such as *'We will plan for planned care to be managed on a 52 weeks, seven days and 15 hours a day basis'* (page 30), and *'we want to support people to make informed decisions about their healthcare'* (page 32), it will be exceedingly difficult to measure the success of this project without a measurable target.

On page 23 of the Programme which discusses cancer diagnoses, there is an assertion that the first outpatient appointment should take place within 10 days of suspicion. However, there is no indication of when we are likely to get to that point and given the 251,647 patients waiting for over three years, this does not seem like a realistic goal for the near future.

Furthermore, page 18 describes how the Welsh Government intends to *'build capacity'*. As stated above, we look forward to the workforce plan, and hope that it will be available as swiftly as practicable, and will provide the much needed detail of how that capacity will be built.

Financial resources

9. *Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?*

10. *Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?*

The College notes that Welsh Government has given a recurrent £170m to support planned care recovery and that £20m a year has been invested to support recovery in the medium term. However, without clear indication of what new services, if any, will be created, where they will be housed and the staffing capacity, it is impossible to state whether there is sufficient revenue and funding to deliver the plan.

On page 28 the Programme notes *'Health board estates are no longer the sole resource for seeing and treating our patients. We will need to ensure that we use the physical estate as efficiently as possible,'* However, it is well documented that the estates are not sufficient for the multidisciplinary teams discussed elsewhere in the Programme and we need to be confident that while virtual consultations are available and are useful, there must be the facility for a patient to be seen in person should they require it.

Workforce

11. *Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?*

The Programme discusses community hubs (page 20) bringing together health, social care and other services, which if properly staffed would make a considerable difference to the backlog and waiting lists. It also discusses the leasing of staffed scanners, outsourcing and insourcing of staff members from outside and from different parts of the health service. However, it does not discuss the staff numbers which will be needed to bring the plan into fruition. We look forward to seeing the workforce plan as well as the planning on general practice estates.

Digital tools and data

12. Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?

The College notes that the Welsh Government plans to ensure that 35% of new appointments and 50% of follow up appointments are virtually delivered (page 16). These are reasonable indicative figures, but we should ensure flexibility in the system so that the patient is seen in the most appropriate way for their condition. There is also likely to be variation across Wales, including by age of patient and access to reliable technology.

We would like to emphasise again that many remote appointments within GP practices are carried out using the telephone, rather than any video conferencing software.

We believe that for video conferencing software to be widely used in the health sector there needs to be funding, communication and training with a clear plan to deliver the same being vital if we are to ensure that digital delivery becomes a reliable and trusted method of consultation.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 03

Ymateb gan: | Response from: Coleg Brenhinol Pediatreg ac Iechyd Plant | Royal College of Paediatrics and Child Health

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June 2022

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

RCPCH response to Health and Social Care Committee request for evidence on Welsh Government Plan to Transform Planned Care and Reduce Waiting Lists

About the Royal College of Paediatrics and Child Health (RCPCH)

The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 500 members in Wales, 14,000 across the UK and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

We are grateful to the Health and Social Care Committee for the opportunity to help inform scrutiny of the Welsh Government's plan to Transform Planned Care Service and Reduce Waiting Times.

For further information please contact Gethin Matthews-Jones, Head of Devolved Nations via

Overall views

As a College, we have welcomed the aims and ambitions set out in the Plan to Transform Planned Care and Reduce Waiting Lists (hereafter 'the plan'); and in particular the recognition that delays can have a particularly significant impact on children as many treatments are age or developmental stage critical. We're pleased that the Welsh Government recognises this and has now sent a clear statement that children and young people must be prioritised; with their needs and services considered and measured separately to adult services.

However, some of our members have questioned how all of this will be delivered. One member said that in their opinion, it would take an increase in the workforce including administrative support along with significant investment and improvement in IT and technology to achieve the stated aims. They noted that "this will require significant financial investment from the Welsh Government and will take time to allow for the additional clinicians to be trained... In terms of paediatrics and child health... there will need to be significant financial investment into children's services". The member questioned whether there would be dedicated or ringfenced additional funding for child health services, noting that when funding is delivered through existing budgets, it can be difficult for paediatrics to compete with adult services for additional funding.

The Royal College of Paediatrics and Child Health is a registered charity in England and Wales (105774) and in Scotland (SCO38299)

Meeting people's needs

We very much welcomed the recognition in this plan that:

"Waiting times for children must be considered differently to waiting times for an adult, as the illness will represent a higher proportion of a child's whole life and potentially have permanent long term impact on growth and development"[1].

We agree with this assessment and welcome the commitment to act accordingly: "we will ensure that children's elective care is prioritised, as we respond to the needs of each child"[2].

We also note the following in the plan:

"Waiting lists can now be measured by age allowing the recovery of children's health services to be managed effectively with their needs considered separately from those of adults"[3].

Waiting lists should be measured by age for the reasons identified by the Welsh Government. To ensure transparency and to make the most of this opportunity to effectively manage children's services and understand where resources need to be focussed and action taken, these data should be regularly published and communicated externally. They should also be broken down by Health Board area to mitigate against geographical inequity within Wales. Finally, Welsh Government should consider how these data should be broken down to understand and take action on health inequalities. It would be helpful for the Welsh Government to set out how and when waiting times data will be published and communicated as part of this plan and its operationalisation.

We note the following in the plan:

"We will work towards accelerating the embedding of virtual approaches and offer telephone and video appointments so that 35% of new appointments and 50% of follow up appointments are delivered virtually"[4].

We strongly recommend that in operationalising this commitment, that the Welsh Government and NHS services are mindful of our Principles for Conducting Virtual Consultations with Children and Young People[5]. Children and young people have different needs to adults with potential risks including safeguarding, confidentiality and digital exclusion. The principles described in our guidance aim to support clinicians who are consulting virtually with patients to provide care in a way that is in the best interests of children and young people, whilst protecting both from the risks associated with virtual consultations.

[1] Welsh Government (2022). *Our programme for transforming and modernising planned care and reducing waiting lists in Wales*, p23. Available at: https://gov.wales/sites/default/files/publications/2022-04/our-programme-for-transforming--and-modernising-planned-care-and-reducing-waiting-lists-in-wales.pdf
[2] Welsh Government (2022), p.23.
[3] Welsh Government (2022), p.23.
[4] Welsh Government (2022), p.14.
[5] RCPCH (2020). *Principles for conducting virtual consultations with children and young people*. Available at: https://www.rcpch.ac.uk/resources/principles-conducting-virtual-consultations-children-young-people

Targets and timescales

This is a top line plan setting out principles and a vision. We accept that detailed targets and timescales for each service may be beyond its scope. However, this does then raise the question of where such detailed planning will be located and whether we should expect further documents sitting under this one to operationalise these principles.

There are also areas within that plan that are particularly top line, where further detail is needed. For example, on dentistry and oral health, we note the following from the plan:

"We are making steady progress with recovery of dental services and as dentists respond to new ways of working, activity is still 50% compared to the same period pre-pandemic…Priority is being placed on those with highest risk and needs, this includes children who are in high risk groups, particularly those from disadvantaged socioeconomic backgrounds. More routine care will be provided as we move through recovery phases where throughput is able to increase safely and provide services in the community to support people's needs closer to home"[6].

Despite tooth decay being largely preventable, it is the leading reason why children aged five to nine require admission to hospital. Multiple tooth extractions can also result in the need for a child to go under general anaesthetic[7]. In pre-pandemic years, our State of Child Health data showed that children from lower socioeconomic groups are more likely to be at risk of tooth decay prevalence and severity. The good news is that between 2008 and 2016, prevalence of visually obvious tooth decay among 5 year old children in Wales fell from 47.6% to 35.4%. From 2014/15 to 2017/18, among 0 to 2 year olds in Wales, the rate of general anaesthetics performed for dental reasons fell from 2.8 to 1.7 per 1,000[8]. Given school closures and disruption to the Designed to Smile programme, which the Welsh Government says has driven much of this improvement[9], it is important that we have up-to-date data on the prevalence of tooth decay on children in Wales and what this means for hospital admission and waiting lists for children requiring dental extractions and other treatment.

There is much in the statement on dentistry in the plan that we welcome, including the focus on children and young people; and on heath inequalities. However, given the ongoing disruption to dentistry services, the Welsh Government should provide a more detailed explanation of these 'recovery phases' and set out a plan for ensuring that its own targets and ambitions for children being seen by dentists are being met.

In 2018, the Welsh Government's [Dental care and treatment for very young children][10] guidance stated that "we want all children to be taken to the dentist before the age of 1 - ideally as soon as deciduous teeth erupt. We want dental teams to see children routinely before there is a problem, provide preventive care and advice and support parents to keep their child's teeth sound" while the Welsh Government's 'A Healthier Wales: The oral health and dental services response' identified as a key priority for 2018-2021, a "year-on-year

[6] Welsh Government (2022), p.9.

[7] For pre-pandemic evidence on the need for anaesthetic in England (we are not aware of recent or comparable Wales data), see Royal College of Surgeons of England; 2019. *Hospital admissions for 5-9 year olds with tooth decay more than double those for tonsillitis*, available at: https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/dental-decay-hosp-admissions/

[8] RCPCH (2020). *State of Child Health: Oral Health*. Available at: https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/oral-health/

[9] See Welsh Government (2019) *Welsh Government scheme puts a smile on Children's faces*, available at: https://gov.wales/welsh-government-scheme-puts-smile-childrens-faces

[10] Welsh Government (2018) *Preventive dental advice, care and treatment for children from 0-3 Years*. Available at: https://gov.wales/sites/default/files/publications/2019-03/preventive-dental-advice-care-and-treatment-for-children-from-0-3-years.pdf

increase in the proportion of people who have seen an NHS dental practitioner in the last 2 years (1 year for children) in all Health Boards"[11]. We are unclear as to whether these commitments are being met and if not, what actions are being taken to ensure they are met as quickly as possible.

Given the scale and impact of tooth decay; and the extent to which it is preventable, it is also surprising that there is little in the plan on preventing tooth decay in children in the sections of the plan dealing with prevention of ill health. In State of Child Health and elsewhere we recommended ensuring sufficient funding and resource for Designed to Smile; and that Welsh Government should resource and support fluoridation of public water supplies, particularly for areas where there is a high prevalence of tooth decay[12].

Is it sufficiently clear which specialties will be prioritised/included in the targets?

One member expressed concern to us that such a top line plan could be seen as setting priorities to the exclusion of others.

One service area that isn't given much prominence in the plan is around services for neurodivergent children and young people. One member expressed concern that funding for ND could fall between the cracks as their experience was that increased mental health funding isn't being made available to ND services.

We were pleased to note that the Minister for Social Services has confirmed that she will publish the findings of the demand and capacity review of neurodevelopmental (ND) services and announce a series of actions to support medium to long term service improvements[13]. It is our hope that these actions will be designed in partnership with clinicians enabling their views to be taken onboard. Member feedback suggests that there are very long waiting lists now in children's ND services and that addressing these will require new funding here and now to find immediate solutions; including enhanced administrative support, improving IT and infrastructure development.

We are not clear that ND services are prioritised and included in new targets, but hope that publication of the demand and capacity review, which we would urge the Welsh Government to do as quickly as possible, will provide an opportunity to develop the plan for children and young people's ND services.

Financial resources

Members have fed back to us that to make short term progress in tackling waiting lists, immediate investment is required by child health services including IT and digital infrastructure and estates. We have elaborated elsewhere in this response. The need to specifically allocate or ringfence this funding for child health services has been fed back my members.

[11] Welsh Government (2018). A Healthier Wales: *The oral health and dental services response*. Available at: https://gov.wales/sites/default/files/publications/2019-03/the-oral-health-and-dental-services-response.pdf
[12] RCPCH (2020), see: https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/oral-health/#page-section-12
[13] See Deputy Minister for Social Services in Senedd Cymru (2022), *Plenary, 11/05/22*. Available at: https://record.assembly.wales/Plenary/12840#C424129

The Royal College of Paediatrics and Child Health is a registered charity in England and Wales (105774) and in Scotland (SCO38299)

Workforce

Before the pandemic, we made the following recommendations in State of Child Health, responding to the need for greater workforce planning:

"The strategy should:

- Consider the breadth of the child health workforce including medical, midwifery, nursing, allied health professionals, pharmacists, health visitors and school nurses.
- Address the recruitment and retention of the healthcare workforce.
- Ensure their healthcare workforce data is robust, reliable and comprehensive.
- Be based around robust and proactive modelling, to better match the changing needs of children and young people with the training and recruitment of our future child health workforce.[14]"

We were encouraged to hear that the Health Education and Improvement Wales (HEIW) workforce strategy, part of the response to A Healthier Wales, made commitments to deliver the capability to provide reliable and comprehensive data; and robust modelling based on that data. That strategy commits to creating "a centre of excellence for workforce intelligence for health and social care in Wales. This will use high quality standardised data sets, analytical methods and sophisticated modelling techniques to support workforce planning, development and productivity". Its success criteria include "Intelligence led workforce planning enabling us to change our workforce to meet our population need"[15].

This will be needed if we are to develop a workforce that will be able to deliver the Welsh Government's plan to transform planned care and tackle waiting lists. Therefore, we are glad that the plan builds on that HEIW strategy. We note that the Workforce Strategy for Health and Care in Wales sets the vision and direction for the plan, but its implementation and delivery has to be prioritised.

The Welsh Government plan signals a further strategic document in development: "We will develop in social partnership a Workforce Delivery Plan for Wales which incorporates these commitments and will enable the delivery of this plan as it is implemented". If this is the document that sets out how the HEIW strategy will become a reality, this would be welcomed. However, the important thing will be the end result and the material reality of whether we have sufficient numbers of paediatricians along with the wider child health workforce in midwifery, nursing, allied health professionals, pharmacists, health visitors and school nurses.

There is one other important document planned in this increasingly busy strategic landscape being developed by HEIW. In March 2022 we responded to the HEIW Mental Health Workforce Plan. The plan needs to be able to deliver the workforce required to support agreed and emerging models of care for children and young people, a number of which are outlined in the Welsh Government's Children and Young People's Plan[16], also published in March 2022.

[14] RCPCH (2020). See https://stateofchildhealth.rcpch.ac.uk/evidence/workforce/child-health-workforce/#page-section-22

[15] Health Education and Improvement Wales (2020). *A Healthier Wales: Our Workforce Strategy for Health and Social Care.* Available at: https://heiw.nhs.wales/files/workforce-strategy/

[16] Welsh Government (2022). *Children and young people's plan: What we will do to support children and young people who are growing up, living and working in Wales*. Available at: https://gov.wales/children-and-young-peoples-plan-html#section-90948

Recommendations we put forward in our response included[17]:

- Modelling and scenario planning to account for the emerging political and strategic framework for children and young people's mental health. These may require upskilling groups of people other than those considered within the adult mental health frameworks identified in order to deliver the Whole School Approach, specialist in-reach programmes and the Nyth/Nest framework.
- Modelling and scenario planning engages with and builds upon the review of demand and capacity within ND services in Wales. It needs to consider whether there needs to be longer term intelligence gathering around demand and capacity within ND services.

In short, there is an increasingly busy strategic landscape around the health and social care workforce in Wales and we welcome this focus by the Welsh Government and HEIW. However, for the Welsh Government to reach the aspirations and meet the commitments made in the transformation plan, these will have to translate into appropriately staffed children's services. The Workforce Delivery Plan for Wales will need to be consulted upon and delivered quickly; and will need to set out in detail how and when workforce commitments will be realised. It will also need to integrate seamlessly with HEIW's mental health workforce plan, to set out how and when a mental health workforce to deliver the Welsh Government's commitments in this space will be achieved.

[17] RCPCH (2022). *Mental Health Workforce Plan for Health and Social Care (Wales) consultation response.* Available at: https://www.rcpch.ac.uk/resources/mental-health-workforce-plan-health-social-care-wales-consultation-response

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 04
Ymateb gan: | Response from: Mind Cymru

Mind Cymru

Mind Cymru's response to the Welsh Government's plan for transforming and moderning planned care and reducing waiting lists.

About Mind Cymru

We're Mind Cymru, the mental health charity. We work nationally and locally.

Nationally, we campaign to raise awareness, promote understanding and drive change. We're also the first point of call for information and advice, providing mental health information to people in Wales over a million times every year. Locally, in communities across Wales, independent local Minds provide life-changing face-to-face support to more than 25,000 people each year.

Together, we won't give up until everyone experiencing a mental health problem gets support and respect.

We welcome the opportunity to respond to the Health and Social Care Committee's call for evidence on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

Overall view

We are concerned that the Welsh Government's plan (the plan) for transforming and modernising planned care and reducing waiting lists does not sufficiently consider mental health services. The plan focuses on, and establishes long-term targets against, waiting times statistics which do not include mental health services. The executive summary makes clear that while mental health interventions are included within the definition of planned care, the plan does not cover all areas and "focuses on the planned care which is predominantly linked to waiting lists". This is despite the

mind cymru

plan recognising that waiting lists in mental health services – as in physical health services - have grown significantly and are likely to continue growing in the coming months.

Our view is that the plan contains lots of commitments which would significantly improve people's experiences of accessing mental health services, particularly in terms of improving the provision of appropriate information, building planned care capacity, and eliminating long-waiters at all stages. Similarly, we support the five goals for planned care transformation, outlined on page 5 of the plan, and would like to see further information on what actions are being undertaken to achieve these goals in mental health services. We believe the Welsh Government should urgently clarify whether the commitments outlined within the plan apply to mental health services and outline specific targets to measure progress toward reducing waiting times therein.

Waiting times within mental health services

We share the Welsh Government's view, as outlined in the plan, of the impact of the (COVID-19) pandemic on people's mental health. We have previously highlighted to this Committee the negative and unequal impact the pandemic has had on people's mental health and how pre-existing inequalities and service-challenges have been compounded.[1]

We also share the Welsh Government's view that the pandemic is likely to have longer-term impacts on waiting lists for mental health services. However, as we highlighted in our written evidence to this Committee's inquiry into the impact of the waiting times backlog, it is important to recognise that mental health services were under considerable pressure before the pandemic, with many people facing unacceptably long waits for support, including hundreds of people waiting longer than a year for specialist psychological therapies and thousands of people waiting longer than the 26-week target.[2] This underpins the need to go beyond resetting mental health services to their pre-pandemic performance.

The plan notes that demand for mental health services surged post lockdown which added to waiting times and service pressures. Specifically, the plan highlights increased referrals to specialist mental health services, particularly those supporting young people with eating disorders (though it is worth noting that figures on referrals or waiting times for eating disorder specific services are not published by the Welsh Government). The plan goes on to highlight the Welsh Government's expenditure on mental health services and commitment to increased investment, which we

[1] https://business.senedd.wales/documents/s123799/MHI%2047%20-%20Mind%20Cymru.pdf
[2] https://business.senedd.wales/documents/s122255/WT%2025%20-%20Mind%20Cymru.pdf

welcome, but does not adequately seek to set-out a plan for reducing waiting times within mental health services.

Waiting times targets

In stark contrast with the sub-speciality referral-to-treatment waiting time statistics available for most physical health secondary care services, little information is available for mental health services. Statistics on waiting times for mental health services are only published for two parts of the system, Local Primary Mental Health Support Services and Specialist Child and Adolescent Mental Health Services. The equivalent waiting times figures for adults accessing secondary care, or adult mental health services, are not reported. This is despite clear waiting times standards being set, for example, for community mental health teams, "that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request."[3] We would question the relevance of waiting times standards that are not reported.

Where data on mental health services is collected it is not always published, for example, waiting times for access to specialist psychological therapies are not currently published despite a commitment from the Welsh Government to do so from the first year of the Together for Mental Health 2019-22 delivery plan.[4] Additionally, improving the access, quality and range of psychological therapies and delivering a significant reduction in waiting times by the end of this Government, is one of six key priorities for the lifetime of the 2019-22 delivery plan. Clearly, it is not possible to measure progress toward this priority whilst waiting times information remains unpublished. This issue is further compounded by a lack of annual reporting of progress by the Welsh Government on the delivery of the Together for Mental Health Strategy. Despite a commitment to do so, no progress reports have been published against the Together for Mental Health 2019-22 delivery plan and so it is not clear why the commitment to publishing waiting times statistics, alongside other actions, have not been delivered.

The gap between the level of data and insights available into performance and waiting times within physical health and mental health services serves as a reminder of the significant efforts still required to deliver genuine parity and modernise mental health services. Understanding access, demand, outcomes and waiting times within mental health services has long been a significant

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[3] https://senedd.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf

[4] Action 04 (ii), https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf

challenge due to limited access to and availability of services-data, these issues have been raised in several inquiries by Senedd Committees in recent years yet remain an ongoing issue.

The Welsh Government is committed to developing a Mental Health Core Dataset (MHCDS) for Wales for implementation this year (2022).[5] However, whilst Mind Cymru has supported the Welsh Government in developing the MHCDS we remain significantly concerned at the ongoing delays in its delivery. The original Together for Mental Health Delivery Plan (2012-16) committed to ensuring the MHCDS was operational by 2015. The Welsh Government need to ensure there are no further delays in delivery of the Mental Health Core Dataset and that a full range of protected characteristics data is collected and published. Additionally, we believe the Welsh Government should urgently review what data is currently collected, alongside clarifying waiting times targets across the mental health services system, and ensure these figures are collected and published.

Mental health support for people waiting for physical health treatment

The plan rightly recognises that 'long waits for health interventions are resulting in increased emotional and mental health concerns amongst those waiting' and that 'people report that uncertainty about diagnosis is adding to the stress of waiting times.' We wholeheartedly agree with this view and believe the plan could be strengthened by further commitments to improving mental health support for people facing long-waits. Specifically, we would want to see considerations of mental health support embedded across patient pathways and service-design to ensure timely access to appropriate support. For example, where a person is likely to face a long wait to access surgery or other treatment, information and or signposting should be provided to access support for their mental health.

In our written submission to this inquiry, we highlighted the contribution that third sector commissioned services can make in supporting the wider health and social care system. The sector plays an important role in the provision of support and information to people, including those waiting for specialist treatment for their physical and/or mental health. For example, Active Monitoring, which is delivered by Mind Cymru nationally in partnership with Local Mind's across Wales and funded by the Welsh Government. The service offers a 6-week guided self-help course for a range of mental health concerns. It is open to all on a self-referral basis and delivers timely and short-term interventions for people experiencing a range of mental health problems. This can include people facing long waiting lists for more specialist mental health support but may also be

[5] Action 04 (ii), https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf

beneficial for people experiencing physical health problems that are impacting on their mental health.

Such services could provide a means for mitigating the negative mental health impact of waiting-times backlogs by providing short-term support to those who need it. This will require improved links and referral processes between third-sector support and other health services. We believe the plan would be strengthened by further considering how the third sector, like allied health professionals, can contribute to a wider whole system approach that ensures timely care and support for people to manage their health and stay well, at every level.

Primary, secondary and tertiary prevention

Tackling the current backlog whilst building sustainable capacity in the long-term needs to ensure that prevention is delivered at every level of the service. This approach needs to be underpinned by a commitment to primary, secondary and tertiary prevention. Whilst upstreaming prevention to tackle mental health problems before they occur is a widely supported long-term ambition, priority must also be given to ensuring that people currently waiting for support are able to access it in the short and medium-term. This will ensure that people who need support are able to access it in a timely way and will help prevent their mental health deteriorating further.

Financial resources

We welcome the increased funding for mental health support announced in the Welsh Government's 2022-23 draft budget, including targeted funding for preventative and acute services for children and young people. However, linked to the above, the way that expenditure on mental health services is reported makes it difficult to assess whether funding is being utilised in the most effective way or is sufficient to tackle waiting times. The plan notes that the Welsh Government spends more on mental health services than any other aspect of the health service. However, whilst technically correct, this is largely down to the way in which expenditure on health services are categorised. Whilst physical health services are broken down into multiple expenditure categories, mental health expenditure forms only a single category. Additionally, it is not clear what formula is used to decide mental health ring-fence allocations or overall expenditure. In our evidence to this Committee's inquiry into mental health inequalities we highlighted our view that the Welsh Government the Welsh Government should re-join the Adult Psychiatric Morbidity Survey (APMS) which 'provides data on the prevalence of both treated and untreated psychiatric disorder in the adult population (aged 16 and over)'.[6] Wales last participated in the study in 2000. Alongside

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[6] https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014#highlights

measuring prevalence, the survey also provides insights on access to mental health services and unmet need which would ensure adequate and appropriate resources are allocated based on local need.

Issues around transparency of funding for mental health services have also previously been raised by the Senedd's Health Committee. In the Committee's scrutiny report of the Welsh Government's draft budget for 2020-21, it recommended that the Welsh Government provides a breakdown of the £745m ring-fenced allocation for mental health. We support this recommendation as a vital step to understanding funding for different aspects of the mental health services system. For example, how much funding is currently attached to the delivery of specialist psychological therapies?

Conclusion

Our view is that, despite the plan recognising increasing waiting times and demand for mental health support, the plan does not adequately consider mental health services. We would like to see urgent clarity on whether the commitments outlined within the plan apply to mental health services. If not, we would question why secondary care mental health services have been excluded in a plan that ostensibly focuses on tackling backlogs and building capacity within secondary care.

The executive summary suggests the plan focuses on 'planned care that is predominantly linked to waiting times.' It is unfortunate that, a lack of clear waiting times statistics and data more generally for mental health services – which itself is a disservice – seemingly means that mental health services have been excluded from the plan, despite a recognition of growing waiting lists and demand for support. Our view is that mental health services should receive parity with physical health services and that reducing waiting times, building capacity and improving data collection across the system should be prioritised by the Welsh Government with clear a plan, timescales and targets for delivery.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 05
Ymateb gan: Response from: Coleg Brenhinol y Therapyddion Galwedigaethol | Royal College of Occupational Therapists

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Royal College of Occupational Therapists
Coleg Brenhinol Therapyddion Galwedigaethol

Consultation response - Transforming and modernising planned care and reducing waiting lists in Wales

8 June 2022

About us

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 80 years; and today, we are thriving with over 35,000 members. Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole. Occupational therapists in Wales work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapy helps you live your best life at home, at work – and everywhere else. It's about being able to do the things you want and must do. That could mean helping you overcome challenges of learning at school, going to work, playing sport or simply doing the dishes. Everything is focused on increasing independence and wellbeing.

It's science-based, health and social care profession that's regulated by the Health and Care Professions Council.

An occupational therapist helps people of all ages overcome challenges completing everyday tasks or activities – what we call 'occupations'. Occupational therapists see beyond diagnoses and limitations to hopes and aspirations. They look at relationships between the activities you do every day – your occupations – alongside the challenges you face and your environment.

Then, they create a plan of goals and adjustments targeted at achieving a specific set of activities. The plan is practical, realistic and personal to you as an individual, to help you achieve the breakthroughs you need to elevate your everyday life.

This support can give people a renewed sense of purpose. It can also open new opportunities and change the way people feel about the future.

Our response

Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic and reduce long waits.

Our members report that on the current levels of service that they will struggle to meet the requirements of this report. Our managers state they have not yet heard when the extra funding will be made available.

Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?

The plan is heavily influenced by the Welsh Government's previous policy direction especially *"A Healthier Wales",* which we as a Royal College supported. Our members see slow progress towards those goals, especially moving more services closer to home with an increased focus on primary care. We have several great services that focus on rehabilitation in community settings, but these are often short term funded and patchy throughout Wales. There needs to be an acceleration of the delivery of programmes that have proved to be successful.

Whether the plan includes sufficient focus on:

- **Ensuring that people who have health needs come forward;**
- **Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**
- **Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**
- **Improving patient outcomes and their experience of NHS services?**

Occupational therapy is still predominantly accessed through secondary and tertiary services and tends to focus on individuals, rather than on populations. Access to occupational therapy services needs to be early and easy, across the lifespan, preventing the development of long-term difficulties and addressing some of the wider social determinants of health. The plan talks about access to Allied Health Professions (AHP) and wanting people to have more opportunity for direct access to a wider range of AHPs in the community, without the need to be referred by another health professional. However, there is no plan to achieve this or outcomes to measure this. Occupational therapists and AHPs are highly skilled in providing self-management support but we need to be positioned in the right areas to deliver. Again, we have excellent examples throughout Wales of occupational therapists actively targeting waiting list reduction and providing excellent treatment. These need to be upscaled and delivered across the country.

Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?

Our members are fully aware of the pressure of waiting lists and the current crisis in patient flow and discharge that is affecting hospital capacity. RCOT have had several meetings with senior managers and there appears to little awareness of the plan at operational level in terms of concrete actions or funding

Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?

No, it does not.

Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?

No, there is a lack of targets within the plan and measurable outcomes.

Is it sufficiently clear which specialties will be prioritised/included in the targets?

AHP and rehabilitation is mentioned in the plan but there are no clear details of how this will be prioritised. Cancer rehabilitation/prehabilitation is particularly time sensitive and there appears to be no priority in the report targeting this area

Do you anticipate any variation across health boards in the achievement of the targets by specialty?

There is variation throughout Wales currently and there is nothing in this plan that addresses this issue.

Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?

Our members report significant problems accessing the infrastructure that is already in place and there is no clear direction on how facilities and estate will be expanded.

Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?

Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?

No, the plan doesn't provide anything new in staff workforce planning or how to increase staff numbers to meet demand.

Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?

We believe that for video conferencing software to be widely used in the health sector there needs to be funding, communication, and training with a clear plan to deliver the same being vital if we are to ensure that digital delivery becomes a reliable and trusted method of consultation.

Contact

For further information on this submission, please contact:

Dai Davies
Royal College of Occupational Therapists

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 06
Ymateb gan: | Response from: Coleg Brenhinol Podiatreg | Royal College of Podiatry

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The Royal College of Podiatry's written evidence to the Health and Social Care Committee on Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

The Royal College of Podiatry is the professional organisation and trade union for podiatrists in the UK. The College represents qualified, regulated podiatrists across the UK and supports them to deliver high-quality foot and lower limb care and to continue to develop their skills.

Podiatrists are highly skilled healthcare professionals trained to diagnose, treat, rehabilitate, and prevent complications of the foot and lower limb. They enable people to manage foot and ankle pain, skin conditions of the legs and feet, treat foot and leg infections and assess and manage lower limb neurological and circulatory disorders. Podiatrists are unique in working across conditions rather than a disease specific area.

A podiatrist's training and expertise extends across population groups to those who have multiple chronic long term conditions, which place a high burden upon NHS resources (diabetes, arthritis, obesity, and peripheral arterial disease). In addition to delivering wider public health messages in order to minimise isolation, promote physical activity, support weight loss strategies and healthy lifestyle choices, podiatrists keep people mobile, in work and active throughout their life course.

1. Introduction

1.1 We welcome the Committee's inquiry into the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists. Given the urgency of

the situation it is vital that there is scrutiny of this plan to ensure it can deliver better experiences for patients, saving limbs and lives.

1.2 There is much to welcome in the Welsh Government's commitments in the plan – for example, to ensure that more care and support is available from a wider range of local health care professionals to help people stay well and stay at home. However, there is a lack of detail about how this will be delivered and where accountability will lie. While the plan anticipates a significant uncovering of late presentations as we emerge from the pandemic, there is insufficient explanation as to how the NHS will meet these needs, which are likely to be more complex and require higher levels of intervention and therapeutic time.

1.3 The coronavirus pandemic and the impact of COVID-19 means that a significant number of people require access to specialist rehabilitation services, including podiatry. Podiatrists work across a variety of specialisms including diabetic foot ulceration, vascular disease, musculoskeletal management, diabetes care, falls prevention and dermatology. Following the COVID-19 outbreak, podiatrists working across all these settings in Wales will be integral to the four groups of people requiring rehabilitation support as set out by the four nations paper on rehabilitation post COVID-19.[1]

1.4 Our comments highlight the unique position of podiatry to alleviate the care burden on NHS services in Wales through a combination of prevention, early intervention and salvage procedures. If the NHS is to reduce the care backlog and prevent avoidable loss of limbs and lives, then podiatry must be at the heart of its efforts to do so. Podiatry also has a huge amount to offer within public health, including easing pain, increasing mobility, and improving physical and mental health. The Royal College of Podiatry is working to ensure that the critical role which the podiatry profession has to play in this agenda is understood and implemented at all levels.

2. Overall views

2.1 The Royal College of Podiatry believe that there is a lack of detail in the plan as to how a more resilient and sustainable health and social care system will be built for the long term. In particular, there is a lack of detail about how services will be shifted, so that greater weight can be given to working to prevent complications within community health services. As highlighted in the Auditor General's recent report, "using existing resources to best effect should be a key priority. This will mean doing things differently by improving existing processes and systems. It will also mean doing things different and rethinking how, where and from whom patients get the advice and treatment they need". [2] We believe that podiatrists have a key role in achieving this.

2.2 As the experts in lower limb health and disease, podiatrists have the requisite knowledge, skills and training to work as First Contact Practitioners (FCPs) in primary care. Podiatrists in FCP roles have the potential to improve patient outcomes, reduce activity limitation, prevent further declines in sedentary related health conditions, reduce hospital admissions and positively contribute to the national health economy.

2.3 Podiatrists are trained to work autonomously and as part of multidisciplinary teams to safely diagnose, risk assess and triage, and provide advice and initiate treatment for

complications of the foot and lower limb. Podiatrists working as FCPs have the skills and competence to:

- Request and use diagnostic imaging or other tests such as blood screening or urine analysis
- Refer to or liaise with other health professionals across care settings, ensuring the patient is seen by the right person, at the right time, in the right place
- Supply or administer a range of medicinal products, and independently prescribe medicines.

2.4 Podiatrists also have a significant role in the public health and prevention agenda specifically around falls prevention, dermatology (malignant melanoma detection), diabetes prevention, arrythmia detection, cardiovascular risk reduction, medicines management, antibiotic stewardship and keeping people mobile and active.

2.5 Podiatrists fulfilling FCP roles will not only enhance the foot and lower limb health of patients but will also improve their overall health and wellbeing. People should be able to access podiatric diagnostics and first line treatment in primary care, so they are able to remain active, socially connected and in work. It is only by having podiatrists placed within primary care settings as FCPs that these multiple needs will be met.

3. Meeting people's needs

3.1 The Royal College of Podiatry believes there is insufficient detail in the plan to demonstrate how people's needs will be met. As an example, podiatrists play a significant role in diabetes foot care. 80% of toe, foot and leg amputations are preventable with the right preventative care, at the right time. There is significant concern that the drop in routine appointments over the past two years will lead to a record level of foot ulceration and lower limb amputations out of the pandemic.[3] Given that routine diabetic foot screening halved in 2021 and that 4.9 million people in the UK have diabetes, tens of thousands of people inevitably will be suffering from delayed diagnoses for diabetic foot conditions with many suffering potentially deadly consequences.[4] Estimates show that by 2025, 1.2 million people with diabetes in the UK will - if they are to remain ulcer and amputation free[5] - require regular podiatry appointments. Despite the potential scale of this problem, there is no reference to diabetes or to foot screening within the plan.

4. Leadership

4.1 We note that the only reference to leadership in the plan is to the establishment of the Diagnostics Board. We strongly agree with the Auditor General that "the national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose". [6] Much of the implementation of the plan will rely on the actions of individual Health Boards, and leadership within these bodies. Yet there is little within the plan to identify or support leadership of delivery, or to identify accountability for delivery.

5. Workforce

5.1 The Auditor General has highlighted that the national plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions.[7] It is shocking that of the £200m funding from Welsh Government in 2021-22 to tackle waiting lists in planned care only £146m could be allocated to health boards – with the Welsh NHS Confederation identifying the workforce as "the number one limiting factor for NHS capacity". [8]

5.2 The Royal College of Podiatry is extremely concerned that not enough podiatrists are being trained in Wales to meet the future podiatric needs of the Welsh population. Within podiatry there is an ageing workforce. Over 55% of the podiatry workforce in Wales are aged 50+. This workforce is a lot older than for other Allied Health Professions. It is imperative for the sustainability of the profession that we have adequate numbers of podiatrists being trained to replace those who are retiring. In addition, the number of people living in Wales with long term conditions which can affect the feet and lower limbs, such as rheumatoid arthritis, vascular disease and diabetes is rising. It is vital that the podiatry workforce is of sufficient size to meet the podiatric needs of the population both now and in the future as demand for podiatric intervention increases.

5.3 We are therefore surprised that the plan makes no reference to the NHS Wales Bursary Scheme or the opportunity to explore alternative routes to qualification, such as the podiatry apprenticeship route which is already available in England.

6. Digital tools and data

6.1 Welsh Government's plan acknowledges that during the pandemic Allied Health Professionals have adopted new digital ways of working to deliver the highest quality of care and improve health outcomes. There is no further reference to how these AHPs might be supported to continue to use these digital tools or how further innovation could occur. Given the importance of digital tools and data we believe that this is an oversight which fails to reflect the needs of those working in the NHS and could result in local variations in service delivery that does not provide equitable access for patients.

For further information, please contact:

Tess Saunders, Policy and Public Affairs Officer (Wales)

Royal College of Podiatry

June 2022

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[2] Audit Wales, 2022, Tackling the Planned Care Backlog in Wales. Available at: https://www.audit.wales/publication/tackling-planned-care-backlog-wales [Accessed 31/05/2022].

[3] Kennedy, K. and Donnelly, L., 2022. Drop in health checks during Covid puts diabetics 'at greater risk of amputation'. [online] The Telegraph. Available at: https://www.telegraph.co.uk/ news/2022/02/09/drop-health-checks-covidputs-diabetics-greater-risk-amputation/ [Accessed 15 March 2022].

[4] Donnelly, L & Taylor, R (2021) 'Quarter of diabetes cases missed over lockdown as obesity soars' [online] The Telegraph. Available at Quarter of diabetes cases missed over lockdown as obesity soars (telegraph.co.uk) [Accessed 15 March 2022].

[5] Royal College of Podiatry, 2021. Saks Report. London: Royal College of Podiatry, p.11. Available at: [Accessed 15 March 2022].

[6] Audit Wales, 2022, Tackling the Planned Care Backlog in Wales. Available at: https://www.audit.wales/publication/tackling-planned-care-backlog-wales [Accessed 31/05/2022].

[7] Audit Wales, 2022, Tackling the Planned Care Backlog in Wales. Available at: https://www.audit.wales/publication/tackling-planned-care-backlog-wales [Accessed 31/05/2022].

[8] https://www.bbc.co.uk/news/uk-wales-61634380. Accessed on 31.05.22.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 07

Ymateb gan: | Response from: Coleg Brenhinol y Therapyddion Lleferydd ac Iaith | Royal College of Speech and Language Therapists

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Senedd Cymru Health and Social Care Committee consultation on The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Executive summary

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the Welsh Government's Plan for transforming and modernising planned care and reducing waiting lists and the opportunity to provide written evidence as part of the Committee's inquiry on the same. Our response is based on discussions with our members and follows broadly the terms of reference.

Key points

- We welcome the notion of 'waiting well' which pervades through the Plan. However, there will need to be a continued investment in sufficient resources into patient information and communication and an enhanced approach to communicating with patients while they wait to help them manage their condition and know what to do if their condition gets worse.
- It is imperative that the necessary detail is provided that will support health boards to ensure they have sufficient workforce capacity to deliver the Programme's ambitions. There should be collaborative working with relevant NHS bodies and involving professional bodies' expertise like the RCSLT to develop the workforce plan at local, regional, and national level.
- We know that in some cases technological innovations have been positive. However, this is not the solution in every situation. For this reason, we would like to emphasise that there

should be flexibility in meeting the Programmes targets around digital approaches so that the patient is seen in the most appropriate way for their condition. There is also likely to be variation across Wales, including by age of patient and access to reliable technology.

- The RSCLT believes that for there to be real sustained improvements in digital delivery, there will be a need to ensure that physical estates are used as efficiently as possible.
- We welcome the prioritisation of children within the Plan. COVID-19 has had a huge impact on children's development with SLT services experiencing a significant backlog of demand with growing waiting lists. We have been encouraged by recent positive investment via the Child Development Fund and Flying Start Capital Funding. However, the RCSLT believes it is crucial that the prioritisation of children's services continues to be supported with substantial and sustained investment to both manage the consequences of the pandemic in the short term but also in the long-term to mitigate against further negative outcomes caused by a lack of services.
- There is a need to be more sophisticated in regards waiting times targets so that the whole pathway is timely.
- The national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose.[1]
- The Programme should come with a clear finance strategy. This should include determining the longer-term capital investment that will be required, as well as processes to assure that revenue sources will be sufficient to finance long-term service transformation.

About the Royal College of Speech and Language Therapists

1. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RCSLT has 17,500 members in the UK (650 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.

2. Speech and language therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/ or swallowing difficulties.

Meeting people's needs

3. The RCSLT is an agreeance with the themes highlighted in the Programme as it demonstrates an understanding of the challenges faced by speech and language therapists as they deal with the scale of backlog, unmet needs and increased demand post Covid. We particularly welcome the notion of 'waiting well' which pervades through the Plan. This has been evidenced well in relation to children as SLT Services have experienced a significant backlog of demand, with growing waiting lists, and late referrals for children with a high level of need, hence the developments in the Welsh Government Talk with Me: Speech, Language and Communication (SLC) Delivery Plan[2], has come at an opportune time, with a greater focus on better universal provision for children and families by promoting and supporting children's SLC needs via introduction of the Talk with Me campaign,[3] by strengthening information available to people on websites, the introduction of a toolkit and a number of health boards developing helplines.

[1] https://senedd.wales/media/3pjhrcie/agr-ld15132-e.pdf
[2] https://gov.wales/talk-me-speech-language-and-communication-slc-delivery-plan
[3] https://gov.wales/talk-with-me

4. However, the RCSLT would like to emphasise that building on existing mechanisms, given the numbers of patients waiting, NHS bodies will need to ensure that they are investing sufficient resources into patient information and communication. The Programme refers to the need for health boards to develop a communication strategy which is very welcomed, however there is a lack of detail in the Programme which would make it difficult to comment on its efficacy in relation to patient needs.

5. Further, Surveillance of patients whilst they are on the waiting list also needs to be carefully managed to minimise and ideally avoid them coming to harm as a result of long waits for treatment. To help achieve the action within the Programme of *seeking to identify and prioritise the clinical needs of those waiting and focus on those in greatest need*, performance measures need to have a greater focus on patients' clinical needs rather than simply how long they have been waiting.[4]

Workforce

The RCSLT welcomes that the Programme is due to be underpinned by a 'coordinated and focused' workforce plan as we believe that a sustainable workforce is a crucial element for the success of the Plan. Further we are pleased to see reference to the importance of rehabilitation.

Recruitment and retention

6. The RCSLT believes that the plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions. The Welsh Government should work with relevant NHS bodies and involving professional bodies' expertise like the RCSLT to develop the workforce plan at local, regional, and national level. The plan should be based on a robust assessment of current capacity gaps and realistic plans to fill them. Understanding the vacancy rate and subsequent recruitment need is difficult. NHS Wales does not collect this information which is thought to impact the quality of workforce planning.[5] The RCSLT also await details of how or where the funding discussed in the programme will be allocated.

7. In relation to SLT services, SLT teams are dealing with increasing numbers of people needing the service without a fundamental change in capacity, which may impact on the intervention offered. Our members report that ensuring a sustainable workforce to respond to growing pressures is of concern. There will need to be a consideration of the number of speech and language therapists trained and the support that is put in place e.g. opportunities for blended working and crucially interlinked with this, the consideration of SLT training in Wales as we believe we need to see an urgent step change in training places to meet future demand given our workforce profile. This is especially pressing given recent policy initiatives such as the Flying Start expansion, changes to mental capacity legislation to include speech and language therapists as approved mental capacity practitioners, the potential and actual demand due to the implementation of the Additional Learning Needs and Educational Tribunal (Wales) Act 2018, an increase in demand for SLT services in certain clinical areas such as Gender Services and potential new roles within youth justice.

[4] https://senedd.wales/media/3pjhrcie/agr-ld15132-e.pdf
[5] https://www.wcpp.org.uk/wp-content/uploads/2021/12/Challenges-and-Priorities-for-Health-and-Social-Care-Wales-Briefing-Note-.pdf

8. It is also important to note that not all SLTs work in the NHS, many work in schools, in community settings, in justice and in the independent sector. We are seeing increased demand for SLTs across these areas too, for example, in prisons and Youth Offending Teams, and as registered intermediaries for the Ministry of Justice. Not all new SLTs will enter the NHS so it is important to factor this in to planning.

9. Retention of existing staff is a further problem, partially due to poor wellbeing but we have also seen a number of staff take early retirement over the last two years. Combined with such recruitment issues, this means the health and social care sector are struggling to maintain their current staffing levels, let alone increase them. Some health boards have reported more younger speech and language therapists are leaving to join the private sector due to workload pressures and stress and there is a sense that it will be easy to return to the NHS at a later date, mitigating the risk of leaving. The RCSLT believes that there needs to be a greater focus on retention and the development of existing professionals. We wish to see far greater clarity on routes for AHP progression from support worker roles through to advanced practitioner and consultant roles. The development of advanced practitioners in particular presents significant opportunities for role development and service innovation for AHPs.[6]

Wellbeing

10. The SLT workforce itself has not been immune to the impact of COVID-19 and the continual burden of the pandemic for now over 2 years has meant they continue to experience profound personal effects.[7] The pandemic has left a legacy of a tired workforce which fundamentally threatens the ability of the NHS to function. Interventions aimed to support the mental and emotional wellbeing of health and social care workers were reported during the pandemic, however the impact of these is not yet known.[8] The availability of funding also calls into question the sustainability of these initiatives. The Programme cites as a priority - *to engage the workforce as Welsh government plan the recovery and reset to and understand the long-term workforce capacity, development and support needed both to recuperate and rebuild for the future*. The RCSLT looks forward to further details to this important action.

11. We would also like to highlight the tendency for and the impact of mixed messaging from Welsh government and health boards. On one hand, the message is one of commending staff for their resilience and hard work and acknowledgement of being overstretched and exhausted, however on the other, there is strong messaging around working to clear the backlog and reduce waiting lists, being creative and utilising new ways of working. There is a mismatch between the two which is causing anxiousness and leading to high stress levels.

Multidisciplinary working

12. COVID-19 patients are presenting in the community with a range of complex needs, requiring a multidisciplinary approach to care management and longer-term rehabilitation.

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[6] For further details, please see RCSLT Wales submission - https://www.rcslt.org/wp-content/uploads/2021/12/RCSLT-Wales-response-to-the-HSC-Committee-inquiry-on-workforce-003.docx

[7] Royal College of Speech and Language Therapists, 2021. Speech and language therapy services after COVID-19. RCSLT. URL https://www.rcslt.org/get-involved/building-back-better-speech-and-language-therapy-services-after-covid-19/

[8] (Swansea University, 2021)

Any national policies or strategies need to reflect both the rehabilitation needs of COVID-19 patients and the ongoing support of existing patients. The programme mentions *access to rehabilitation and recovery services as being essential……... and that Welsh government will build capacity through new ways of working and expansion and utilisation of the AHP workforce* and further the commitment in the Programme of *developing multidisciplinary 'teams around the patient'.* The RCSLT fully supports these actions as we believe collaboration will be essential to the effective delivery of the plan. However, we have concerns *over the* lack of detail of how this will be achieved.

Digital services and data

13. The SLT workforce has responded rapidly to changing circumstances which has included the adoption of new ways of working, including greater utilisation of technology and digital in-service delivery. For example, the SLT workforce quickly moved to using Attend Anywhere[9] and many services are offering a blended approach with a combination of video and face to face appointments. The RCSLT notes that the Welsh Government plans to ensure that *35% of new appointments and 50% of follow up appointments are virtually delivered.* In relation to this our members have voiced concerns as in some cases the utilisation of technologies has been positive, however, this not the solution in every situation, digital poverty and a lack of digital literacy are factors. The adoption of technologies may also not be suitable for a particular condition a person has or the age of the person with a communication or swallowing need, at both ends of the age range. Consideration also needs to be given to the challenges presented around school based services and adult services where the majority of service continues to be hospital based. For these reasons there will need to be flexibility around the targets for virtual approaches.

14. The RSCLT believes that for there to be real sustained improvements in digital delivery, there will be a need to ensure that physical estate are used as efficiently as possible, for example by maximising community and primary care premises to enable care close to home, maximising space in care homes and in other settings such as schools. The programme cites an investment into infrastructure and estates but there is no detail as to how this will be achieved. It will be important to ensure that patient outcomes and patient experience are considered alongside any gains from a productivity perspective.

15. We would also like to highlight that we believe the success of the plan will depend on investment in digital technology for example, electronic patient records which would support the outcome of waiting well. Also more sophisticated systems to support validating of waiting lists. Presently Therapy Manager systems do not distinguish between different types of waits. We welcome the recent positive response by Welsh government to the report on the Waiting times backlog inquiry regarding shared patient records and the plans to introduce a new digital interface to ensure data can be shared across organisational and system boundaries. We look forward to seeing details and timeframes for this single national health and care record.[10]

Children's services

[9] https://digitalhealth.wales/tec-cymru/vc-service/i-am-clinician/what-nhs-wales-video-consulting-service

[10] Pagehttps://business.senedd.wales/documents/s125743/Response%20from%20Welsh%20Government%20to%20the%20report%20Waiting%20Well%20-%20the%20impact%20of%20the%20waiting%20times%20backlog.pdf

16. The RCSLT particularly welcome the focus on children's services within the plan as we know that COVID-19 has had a huge impact on children's development. Many children and young people have not received the same level of speech and language therapy during the pandemic. The RCSLT's Build Back Better report published in March 2021, found that during the first UK-wide lockdown, across the UK, 81% of children and young people who had been receiving speech and language therapy before the pandemic received less during lockdown and 62% did not receive any. A number of other factors have also contributed to an increased level of need in children and young people, resulting in increased pressures on children's SLT services. In some cases, specialist input from speech and language therapists is required in order to meet the higher needs of these children. For example, children who did not receive the 2.5 year health visitor check during the early stages of the pandemic are now rising 4 and could have significantly delayed language development[11] and an increase in the number of children starting school with delayed language, because they have not benefited from the language-rich environment and opportunities for social interaction that are provided by early years settings. We welcome the investment via the Child Development Fund in recent years as a result of the Welsh government 'Talk with Me' plan[12] and Flying Start Capital Funding. However, the RCSLT would like to emphasise that there needs to be substantial and sustained investment in children's services and where SLTs are part of multi-agency teams to both manage the consequences of the pandemic in the short term but also in the long-term to mitigate against further negative outcomes caused by a lack of services. Short term funding is not adequate often regarding successful recruitment.

17. SLT services need to work with stakeholders to ensure that needs are met closest to the children and by the right person in the right place. This may mean that the SLT is not the best person to address needs. There will be many examples where ensuring that the wider workforce, e.g. in childcare settings and educational settings, is able to support children appropriately in their own environments for learning and development. Additionally, SLTs work in multi-disciplinary and multi-agency teams where children and young people need this, such as, where they have selective mutism and where they are known to Youth Justice Services. This will depend on how services are structured and funded. We look forward to seeing the detail to the actions on the prioritisation of this important area before we can comment on the Programmes efficacy.

Targets and Timescales

18. The national Plan sets out high level ambitions to reduce waiting times. It includes target milestones to reduce the number of people waiting for treatment but lacks detail especially in the sections entitled 'what do we want to achieve?' The Programme provides broad ideas as to the desired outcomes, but it will be difficult to measure the success of the plan without data and a clear framework for measuring these outcomes. For example, as mentioned above the RCSLT looks forward to the forthcoming workforce plan, which we hope will address the demand in SLT services and SLT workforce capacity issues.

19. The RCSLT has some concerns around the Welsh Government ambition of *increasing the speed of diagnostic testing and reporting to 14 weeks for therapy interventions by spring 2024.* Our members felt that this target may be too crude and that there was a need for

[11] https://www.rcslt.org/wp-content/uploads/2021/12/Supporting-children-and-young-people-with-communication-and-swallowing-needs_December-2021.pdf
[12] https://gov.wales/talk-me-speech-language-and-communication-slc-delivery-plan

more sophistication in regards waiting times targets. For example, there would need to be a consideration of follow up appointments and how technology may support meeting the target. Fundamentally there is a need for the whole pathway to be timely.

Leadership and national direction

20. The challenge of the planned care backlog is huge, and it will require the NHS to transform at a scale and pace not seen before. The national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose.[13] The RCSLT is concerned that the Programme implies that much of the detail of how processes will be put in place will be left to health boards, which leaves room for inconsistency and inequality through the system which needs to be improved, if not eradicated.

21. The RCSLT was disappointed to hear the recent announcement that the NHS executive will be set up as a hybrid model rather than its own organisation. We believe that this is a huge opportunity missed by Welsh government as more now than ever we believe there needs to be a clearer distinction between the strategic management of NHS Wales and the delivery of Welsh government priorities. Looking forward, we hope that the new NHS executive membership will be diverse to include AHP representation.

22. We would also like to highlight that the Welsh government should make sure that its national plan comes with a clear finance strategy. This should include determining the longer-term capital investment that will be required, as well as processes to assure that revenue sources will be sufficient to finance long-term service transformation.

Further information

We hope this paper will be helpful in supporting the committee discussions around the Programme for planned care and reducing waiting lists. We would be happy to provide further information if this would be of benefit. Please see below our contact details.

Naila Noori, External Affairs Officer (Wales), Royal College of Speech and Language Therapists

Confirmation

This response is submitted on behalf of The Royal College of Speech and Language Therapists in Wales. We confirm that we are happy for this response to be made public.

[13] https://senedd.wales/media/3pjhrcie/agr-ld15132-e.pdf

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 08
Ymateb gan: | Response from: Tenovus Cancer Care

Tenovus Cancer Care Response to the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

This response is formed by Tenovus Cancer Care, using the views and feedback of staff across the organisation, including those that work directly with people affected by cancer.

It is also formed by the opinions of those on our All-Wales Cancer Community – a community of people affected by cancer who are part of a community through Tenovus Cancer Care. Part of their involvement in this community is to contribute to policy consultations and support Tenovus Cancer Care to raise awareness of issues that affect them directly.

Overall, Tenovus Cancer Care welcome the focus of Welsh Government's proposal for planned care. This is a much-needed strategy to help the NHS and its partners tackle the backlog of planned care appointments, which has impacted greatly on people affected by cancer. This plan gives an overarching view of the approach that will be taken. In order for it to be successful, detail on how this will be implemented and achieved should be outlined in the new Cancer Services Action Plan, which is due to be published in the Autumn. The publication of this action plan cannot be delayed as it is vital if lives are to be saved and we at Tenovus Cancer Care are keen to work with the Welsh Government and the Wales Cancer Network Board to develop this.

We understand that the COVID-19 pandemic had a significant impact on the NHS and that there is catching up to do to get services running as they were before 2020. In May 2020, the *British Journal of Cancer* found that over a thousand fewer new cases of three common cancers were diagnosed in Wales in 2020 compared to 2019, equivalent to a reduction of 15 percent.[1] Extensive alterations to healthcare routes to diagnosis, increases in later-stage diagnoses and an increase in the number of undiagnosed patients with new cancers have and will continue to occur as a result of the pandemic. We therefore understand that managing expectations of what can be achieved needs to be considered and communicated effectively to people across Wales. However, we also believe that there should be a strong focus on finding solutions to both quickly and effectively address the backlog of people waiting to be seen, whilst ensuring that those newly coming into the system are not delayed by this. Clear messaging is essential in reassuring people where they are in the system and what they can expect next.

Tenovus Cancer Care welcomes using innovation to tackle the backlog and establish more efficient ways of working going forwards. Whilst we feel that using approaches such as digital and telephone appointments is a positive step forwards, this could cause concern and confusion for some people accessing the NHS. Many people struggled with mixed messaging during the pandemic about whether they should come forward to get checked. The Welsh Government and NHS must clearly communicate with people that any approach will be assessed against people's needs and is not one size fits all, but something that will be used for the benefit of both the NHS and patient. People should continue to receive person-centred care that meets their needs, no matter how long they wait.

The suggestion of patient initiated follow up needs careful consideration. The COVID-19 pandemic has proved that in Wales, people tend to not want to bother their doctor and now that people know how much pressure the NHS is under post-pandemic, they may be hesitant to initiate such follow ups. Not everyone is equally comfortable to chase up these appointments. The suggestion of patient initiated follow ups also does not fit in with the theme of regular communication for people on

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[1] https://phw.nhs.wales/news/study-finds-significant-reductions-in-cancer-diagnoses-in-wales-during-the-covid-19-pandemic/

where they are on the referral pathway and next steps. The messaging needs to be clear.

Tenovus Cancer Care Recommends:

Welsh Government should devise a campaign to communicate with the public what they are doing to address planned care in Wales. This should cover:

- How they will address the backlog for planned care
- Plans for ways of being more efficient such as by using digital technology, but not at the expense of receiving quality, person-centred care
- How they will ensure that new people coming through the NHS system are not delayed by addressing the backlog
- Highlighting that communication between the pathway and the person is one of Welsh Government's points in the care plan so that people should be better informed of where they are on a pathway and what the next steps are
- What people can do if they feel they are not getting the communication or care that they need, including information on the Community Health Councils and planned changes going forwards
- Supporting people to wait well by signposting to services that could support them whilst they are waiting for the next steps in the NHS referral pathway. This could include referral/signposting to other NHS services, community-based services or the third sector.

We also recommend that the Welsh Government should utilise and build upon the support it has from the Third Sector to significantly broaden its messaging reach. For example, by developing joint campaigns on promoting the signs and symptoms of cancer and on preventative behaviours such as the use of sun cream, stopping smoking, maintaining a healthy weight as well as promoting screening and encouraging people to attend appointments; highlighting that cancer is not necessarily a death sentence and that if caught early it is treatable.

We are one amongst many charities working in Wales who could support with the efforts to reduce the backlog of planned care through alleviating pressure on existing NHS services.

For example, Tenovus Cancer Care will seek to work with the Wales Cancer Network as it starts to review provision of Systemic Anti-Cancer Therapy (SACT) support as our Tenovus Cancer Care call back service is a vital lifeline to patients who have just started treatment and a well-regarded service by Clinicians.

In addition, Tenovus Cancer Care have a newly launched counselling service for people across Wales who are affected by cancer. There will be many people going through this who are anxious and would like to speak with someone about their

experiences, to gain some reassurance and support or simply for a listening ear. Mental health and wellbeing support will be critical for the recovery of the NHS in Wales and is particularly important for people who have been affected by cancer during the COVID-19 pandemic and the difficulties that they faced during this period.

Tenovus Cancer Care welcomes Welsh Government's plans to develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into referral pathways. Sing With Us' choirs are an initiative established in Wales by Tenovus Cancer Care to provide social support and improve mental wellbeing amongst those affected by cancer, whether patients, the bereaved, family member, carers or health care staff. Research has already demonstrated that these choirs can reduce depression and anxiety amongst participants and improve social support networks and quality of life. Whilst they do not cure disease, there is some evidence that participating in these activities can reduce levels of stress hormones and enhance immune activity.[2]

Moving care closer to home

Moving care closer to home is a theme throughout and is an approach that Tenovus Cancer Care supports, but there are some concerns about the feasibility of achieving this.

Over a period of many years many local hospitals and health facilities have been closed across Wales, with diagnosis, treatment and care being centralised in bigger hospitals in towns and cities. General hospitals have become increasingly under threat; for example, the repeated threat of closure of Withybush Hospital in Pembrokeshire. Powys no longer has a general hospital, forcing people to travel long distances to access the care that they need. For some, this care is often far over the border into England. For example, people affected by cancer often travel from Powys to Cheltenham or Birmingham and back every day for cancer treatment because they are unable to access this closer to home. This places additional financial, physical and emotional stress on these people compared with those that don't have to travel so far to access the same care. People affected by cancer who are eligible to claim money back on travel and parking for hospital appointments have told Tenovus Cancer Care that they have not seen their travel claim amount increase during the cost of living increase in 2022; leaving those travelling by car to pick up the price difference. The NHS is free at the point of use, but the distance people must travel (and decide to mitigate for missing work and other arrangements etc.) means that this is a hidden cost for people.

Moving care closer to home not only provides immediate benefits for the local population, but it also provides the opportunity to gather data and information to

[2] Tenovus Cancer Choirs Study: the Benefits of Singing for Those Affected by Cancer - Full Text View - ClinicalTrials.gov

assess the needs of that population. Tenovus Cancer Care recently undertook work to assess lung cancer and inequalities across Wales and were unable to include Powys in this assessment due to the lack of information available. This is because people must travel out of area to receive the care and support that they need. We are therefore not getting a clear and accurate picture of the health needs of the population to effectively design services and support people in this area and in other areas of Wales where access to healthcare is also difficult.

By enabling people to access care closer to home we will have a more accurate picture of the different inequalities that exist across the country and how we can address people's needs in a more targeted way.

Tenovus Cancer Care welcome using innovation in order to help bring care closer to home and one of our many offers is mobile cancer support in the community. Cancer patients in Wales can travel up to 150 miles for treatment. Every round trip to hospital can cost nearly £70 and if someone relies on public transport, these journeys can take many hours. Our mobile support units cut journey times to hospital, making receiving treatment less stressful and less expensive for cancer patients. Despite this, our offer of mobile support units is often not taken up by health boards. Tenovus Cancer Care encourage Welsh Government to support health boards to actively seek out and utilise such available support to ensure cost savings and benefits for people that need to access those services. This joint working is something that is desired by both sectors, as stated in the article published on NFP Research: 75% of healthcare professionals see the potential of developing closer working relationships with charities since the COVID-19 pandemic.[3]

Prioritisation of diagnostic services/Diagnosing cancer early

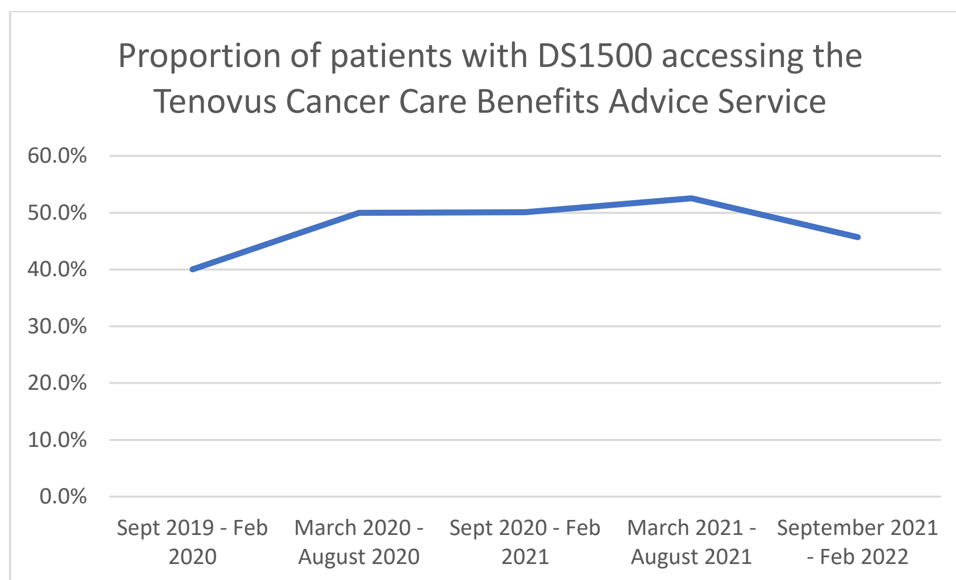
Tenovus Cancer Care welcome the formation of a Diagnostics Board. However, for this to be meaningful, it should be for more than "input" as is outlined in this plan. In order to achieve outcomes for people across Wales, the Diagnostics Board should have a programme of work and evidence that this is aligned with other agendas, such as the National Endoscopy Programme.

The disruption caused to people affected by cancer during the pandemic[4] may mean an increase in emergency presentations of cancer. From our own service provision, we saw a large increase in the proportion of patients with DS1500 accessing our benefits advice service.

In the 6 months immediately prior to COVID-19, 40% of the patients accessing our benefits advice service were in possession of a DS1500 (indicating that they were unlikely to survive beyond the next 6 months). This increased to 50% in the first 6 months of the pandemic and peaked at 52.5% in the March – August 2021 period.

[3] Charities during the pandemic: 5 observations from healthcare professionals | nfpResearch
[4] https://www.macmillan.org.uk/get-involved/campaigns/we-make-change-happen/we-shape-policy/covid-19-impact-cancer-report.html

This proportion has been decreasing since this peak but has yet to return to pre-pandemic levels.



Tenovus Cancer Care feel that it is important for the Welsh Government to take some responsibility for this, rather than laying the blame on "patients deciding not to come forward" as outlined in this action plan. People were told to 'stay at home, protect the NHS' and therefore it is inevitable that people would have stayed away and not sought advice.

Screening was paused for several months, which in the world of people affected by cancer is not a "very short time". This will have had an impact on the number of people being diagnosed with cancer at a later stage.[5] It is unfair to suggest that these delays are down to patient behaviours. Later diagnosis in these circumstances is a result of the system not being able to carry out diagnostics such as endoscopies and having to instead put in place hurried solutions around the use of sensitive FIT tests (FIT in symptomatic) in primary care. Tenovus Cancer Care feel that Wales should use this hindsight as a learning opportunity to now quickly adopt new and emerging technologies, which are backed by evidence from pilots. These radical and innovative solutions are important to get the NHS in Wales to a stage where it can build back better than before, not just to how things were pre-pandemic. The health system was fragile before the pandemic and Wales must be better prepared for possible similar disruptions in the future.

At the end of the forward (page 1) the plan states that during COVID "more people than ever have been checked and treated for cancer" yet official figures show that the number of patients referred for cancer treatment in April 2020 dropped by more than 51% compared to the previous month and at this stage charities had already warned of a cancer "timebomb" due to Covid-19 disruption.[6] In a separate release,

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[5] Millions in UK miss cancer screenings, tests and treatments due to Covid-19 | Cancer | The Guardian
[6] Coronavirus: Big drop in cancer referrals in Wales - BBC News

and as experienced by our own benefits team, Macmillan also stated that in 2021 the number of terminally ill people accessing end-of-life benefits has increased during the pandemic, with a warning of more evidence of a growing "cancer backlog"[7].

In addition, about 3,500 cancer patients had been reported as "missing" from treatment services since the start of the coronavirus pandemic.[8] Tenovus Cancer Care was one of many cancer charities that called for a recovery plan for cancer services back then and Wales is still waiting for this to be drawn up.

The new cancer recovery services plan must be drawn up with the third sector as soon as possible if Wales is to make its approach to planned care a success.

Less Survivable Cancers

Tenovus Cancer Care are pleased to see that cancer is being looked at as a whole disease area – that there is not a focus on high volume cancers at the expense of other cancers. Tenovus Cancer Care have been campaigning to raise awareness of the less survivable cancers, which are closely correlated with inequalities. The less-survivable cancers: Lung, liver, brain, oesophageal, pancreatic and stomach, have an average five-year survival rate of less than 20%. These six cancers account for over 69,000, and no less than 42% of the cancer deaths in the UK each year.[9]

Covid-19 has brought huge challenges to the health service, unlike anything we have previously experienced. This has had a serious and deeply concerning effect on people with cancer, with an alarming drop in cancer diagnoses and, in many places, backlogs building for vital diagnostic tests, treatments and surgery.[10]
For people who have one of these six less survivable cancers, early and fast diagnosis is critical to detecting the cancer at a stage when curative treatment is possible. However, these cancers often present with vague symptoms or are asymptomatic and are therefore hard to diagnose. As a result, three quarters of people with these cancers are diagnosed at a late stage and less than 16% of people diagnosed will survive five years or more. This was a serious problem before the pandemic. Covid-19 has now exacerbated this problem and we know that people will be diagnosed with cancer even later due to the disruption to health services.[11]
Urgent referrals for possible cancer were 25% of the normal rate at the peak of the pandemic and, even now (date), are only at 75% the expected rate.[12]

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[7] Covid: Cancer worry as claims for end-of-life help rise in Wales - BBC News
[8] Covid: 3,500 'missing' from cancer services in Wales - BBC News
[9] https://lesssurvivablecancers.org.uk/about-us-2/
[10] https://www.bbc.co.uk/news/uk-wales-54195580
[11] https://phw.nhs.wales/news/study-finds-significant-reductions-in-cancer-diagnoses-in-wales-during-the-covid-19-pandemic/
[12] https://www.pancreaticcancer.org.uk/wp-content/uploads/2021/04/APPG-report-The-Impact-of-Covid-19-on-Pancreatic-Cancer-Treatment-and-Care-in-England.pdf

Lung cancer is the biggest cancer killer in Wales.[13] One-year survival rates lag slightly behind those for England and Northern Ireland. In addition, five-year relative survival for lung cancer in women in Wales is 10%, which is below the average for Europe (16%). In men the survival rate is 5%, which is also below the average for Europe (12%)[14]

In August 2021 there were around 8,600 urgent referrals for suspected cancer in Wales, 9% fewer than the same time the previous year whereas lung cancer referrals were down 26% in August compared to the same time in 2019. During the lockdown in April, there was a 72% drop in lung cancer referrals compared to the previous year.[15]

Smoking cigarettes is the single biggest risk factor for lung cancer. It is responsible for more than 70% of cases.[16]

Of the most common cancer types, lung cancer has the widest cancer death inequality, with a gradient of higher mortality in increasingly deprived areas.[17] The size of the differences in mortality between more and less deprived areas has increased over time.

Whilst we welcome action being taken to address lung cancer survival in Wales, we feel that there is already enough evidence to justify the need for lung health checks and targeted screening, which is currently being consulted upon by the UK Screening Committee. If they make recommendations for nations to develop and implement a Lung Screening Programme, we expect Wales to move at pace to put in place a comprehensive and optimal framework to deliver this new programme which will save many lives across Wales.

Tenovus Cancer Care Recommends:

- The Welsh Government to support the implementation of the proposed Lung Health Check pilot in Cwm Taf Morgannwg and once the UK Screening Committee has made recommendations about a comprehensive lung cancer screening programme – for Welsh Government to work with its NHS partners to deliver this at pace. Rolling this intervention out will have a huge impact on cancer outcomes for people in Wales.

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[13] https://www.uklcc.org.uk/sites/default/files/2021-12/An-overview-of-the-impact-and-priorities-for-lung-cancer-in-Wales.pdf
[14] Lung cancer survival statistics | Cancer Research UK
[15] https://news.cancerresearchuk.org/2020/11/20/covid-19-referral-drop-fears-for-lung-cancer-patients-in-wales/
[16] https://www.nhs.uk/conditions/lung-cancer/causes/#:~:text=develop%20the%20condition.-,Smoking,carcinogenic%20(cancer%2Dproducing).
[17] https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/deprivation-gradient

Leadership and Patient Experience

The announcement regarding the establishment of the new NHS Executive has just been made[18]. This new function of NHS Wales will bring together senior teams within Welsh Government alongside key national NHS bodies which collectively should have the levers to drive improvement and put in place accountability structures for ongoing innovation and improvement in service delivery. Whilst the NHS in Wales has a difficult few years ahead to repair and rebuild, to be held to account on the care they deliver to their populations

Welsh Government itself has highlighted the role of the Executive as being essential in futureproofing the health system, stating that it's central purpose will be to support the NHS to deliver improved quality of care to people throughout Wales, resulting in better and more equitable outcomes, access and patient experience, reduced variation and improvements in population health[19].

There is now an expectation that we will see a step change in performance, especially in relation to cancer waiting times and access to diagnostics and screening.

We know that there were thousands of people who went undiagnosed with cancer in 2020 and 2021. This strategy is vital in ensuring that no matter what the prognosis of these people is, they must receive the best possible treatment, care and support to enable them to navigate their pathways and achieve the best possible outcomes.

Please contact:

Angie Contestabile

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[18] Written Statement: Update on setting up an NHS Executive for Wales (18 May 2022) | GOV.WALES
[19] ibid

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 09

Ymateb gan: | Response from: Y Groes Goch Brydeinig | British Red Cross

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British Red Cross

Y Groes Goch Brydeinig

British Red Cross written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

About the British Red Cross

For the last 150 years the British Red Cross has been putting kindness into action. We have been helping people in Wales get the support they need, when they need it most. The British Red Cross has more than 19,600 volunteers in the UK and nearly 3,900 staff. We are part of the world's most wide-reaching humanitarian network, the International Red Cross and Red Crescent Movement, which has 17 million volunteers across 192 countries. The Red Cross has decades of experience supporting people with health and care needs when they return home from hospital, responding to UK emergencies from house fires to terror attacks, and supporting refugees and people seeking asylum.

The British Red Cross has a long history of working in partnership with the NHS, and we have seen a lot of good practice through our work. We have been supporting in various emergency departments across Wales since 2018, providing non-clinical, emotional support to patients. As a part of this service, we may also take people home and provide a short intervention which focuses on things like referrals to social services for care needs assessment, to support for home adaptations, to befriending type services. We recognise how hard NHS staff and volunteers are working, especially during the Covid-19 pandemic.

We welcome the opportunity to respond to the Senedd Health and Social Care Committee's request for written evidence on Welsh Government's plan for transforming and modernising planned care and reducing waiting lists (this will be referred to in the below submission as 'the plan'). This submission draws on our extensive experience as a service provider, working in partnership with the NHS and our growing research and evidence base into people's needs.

Summary

The British Red Cross welcomes a plan to transform planned care services and reduce waiting times. The principles within the plan are common sense, however, it could benefit from a greater acknowledgement of the role of secondary preventative projects to ease pressures on planned care, and the role that the Voluntary and Community Sector (VCS) can provide in delivering such preventative services. There could also be greater emphasis on the role that the VCS can play in alleviating pressures on waiting times and the NHS workforce.

The plan also needs greater consideration of the wider context of life in Wales. In particular, the impact that the pandemic has had on existing health inequalities, but also the impact that other frameworks that Welsh Government are putting forward, such as the all-Wales framework for social prescribing will have on planned care. It is important that these areas are considered as avenues with which to alleviate pressures on the healthcare system.

The plan could also benefit from further detail on timescales and the planned use of digital tools.

Summary of recommendations

The British Red Cross recommends that in ensuring the plan supports the delivery of sustainable health and social care services:

- The Welsh Government should recognise the VCS as a key health and social care partner within the plan, particularly in:

  - Providing secondary preventative support in the community so that a person's health does not deteriorate.
  - Its ability to play a wider role in alleviating workforce pressures.
- The Welsh Government and other funding bodies commit to sustainable, long term funding sources in order to continuously fund integrated care programmes and preventative projects within the community.
- The Welsh Government recognise that services to address general lower-level needs[1] contribute to wider prevention efforts and that Welsh Government reference this more strongly in the plan.
- The Welsh Government should give further consideration to the role that hospital discharge plays in supporting sustainable health and social care services and patient flow within the plan.
- The Welsh Government should strengthen the commitment to address health inequalities within the plan through further detail on the socio-economic drivers of health inequalities.
- The Welsh Government develop a Cross-Governmental plan to address health inequalities which should outline the action being taken across all government departments, setting out how success will be measured and evaluated through shared performance measures and outcomes for all public bodies in Wales.
- The Welsh Government prioritises reform of social care to deliver high quality, more accessible services, and develop a long-term settlement to enable sustainable social care funding.

In order to meet people's needs, we recommend that:

- The Welsh Government use the plan on transforming care as a mechanism to ensure people receive one-to-one, tailored support through social prescribing services which are available to them until they regain their independence and are confident in accessing health services.

In relation to the timescales of the plan, we recommend that:

- The Welsh Government provides further information on timescales to deliver the plan.

In order to adequately reduce workforce pressures, we recommend that:

- The Welsh Government utilise 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' and the robust workforce plan to address gaps in the workforce and should include how people who are not registered as health and social care staff can assist with alleviating workforce pressures.
- The Welsh Government ensures that there is a blended approach to deliver planned services, including text, phone, video, email and in-person, to best meet all patients' varying needs and allow services to work efficiently and address inequality of access to services.

In providing information on the digital tools Welsh Government will use, we recommend:

[1] For the purposes of this consultation, lower-level needs refer to a situation where a person's condition is mild.

- The Welsh Government provides further detail on the ways in which digital tools and virtual wards, will be used to drive service delivery and efficiently manage waiting times while still ensuring those who are digitally excluded are supported.
- In developing the provision of digital tools, Welsh Government should make it clear in the plan that lead staff members that support information sharing in each health board should ensure that data sharing protocols and IT services support the flow of information between acute and community hospitals as well as key providers involved in discharge.

Overall views

Balance between tackling backlog and building sustainable health and social care system:

Prevention

We welcome the plan's reference to prevention as a way of tackling the backlog and building a sustainable health and social care system. The British Red Cross supports the commitment to shift the health and care system towards prevention and welcomed 'A Healthier Wales' which put forward a whole system approach to health and social care and emphasises the importance of prevention and early intervention. However, in discussing prevention within the plan, it is important that the role of the VCS is referenced.

We recognise that prevention also encompasses preventing deterioration and reoccurrence (secondary prevention), as well as the primary prevention of ill-health. This is often achieved through practical and emotional support at home after the initial health crisis has hit, such as social prescribing and community connector support. Within our services, we have seen the range of positive impacts that social prescribing has in not only addressing loneliness and isolation, but in preventing escalation to other services. For example, our service evaluations[2] from our social prescribing in Pembrokeshire have highlighted the impact that social prescribing has on preventing reliance on health services. Our services help people to manage their own health as well as helping people to develop their own coping strategies. The VCS are also able to tap into its knowledge of community-based assets and support services to help to build people's personal resilience so that they can cope better with future crises and challenges they may face. Demand for health and social care provisions is likely to increase due to the impacts of Covid-19, so prevention, including secondary prevention, and early intervention will be vital.

However, in order to advance secondary preventative services, long-term funding is of fundamental importance. Our operational experience demonstrates that there is a lack of long-term funding provision. Short-term funding contracts lead to high staff turnover drawing focus to recruitment and away from quality of service for users. Therefore, we welcome the document's reference to investment in care closer to home and recommend that this includes funding a range of preventative services within the community. In addition, we also welcome the introduction of a five-year revenue investment fund in April 2022 and hope this best practice will be reflected in other funding streams.

From our operational insight, we are aware that tackling lower-level care needs[3] acts as a long-term preventative measure. However, in looking for opportunities to develop services, we

[2] Evaluations from 2019/2020.
[3] Where a person's condition is mild.

have found that in practice there is a lack of investment in addressing low level care needs in Wales. In turn, this is likely to result in people accessing services once their need is higher, putting a strain on the health and social services system. In addition, it should be recognised that proper focus on preventative services is likely to be more cost effective as needs are addressed before they become more complex. While the plan references low complexity interventions, such as cataracts, these are very specific examples and may fail to acknowledge wider lower-level needs that can be treated in the community. Therefore, in order to achieve the ambitions of the Welsh Government's plan and help to create a sustainable health and social care system, the definition of prevention needs to account for a range of low-level needs to ensure adequate investment.

The British Red Cross recommends that

- **The Welsh Government should recognise the VCS as a key health and social care partner within the plan, particularly in providing secondary preventative support.**
- **The Welsh Government and other funding bodies commit to sustainable, long term funding sources in order to continuously fund integrated care programmes and preventative projects within the community.**
- **Welsh Government recognise that services to address general lower-level needs contribute to wider prevention efforts and that they reference this more strongly in the plan.**

The role of hospital discharge

Another element to ensuring that the plan supports the delivery of sustainable health and social care services is patient flow through hospital, including leaving hospital. Our operational experience in helping people home from hospital and research such as *Listening to what matters*[4] has emphasised the importance that leaving hospital at the right time with the right support in place has on maintaining independence. While the plan recognises the delays in discharge, its impact on bed availability and references the intention for discharge to become the default position post-treatment, the document does not acknowledge the role that effective and safe discharge has in helping patients to maintain independence and avoid readmittance. In addition, the plan does not acknowledge the community resources that will be needed to deliver on discharge as the default position. *Listening to what matters* highlights concerns raised by health and social care professionals that a seven-day service that exists in hospital does not exist in the community.[5] This links to the recommendations in the above section which reiterate the importance on investing in projects within the community.

The British Red Cross recommends that

- **The Welsh Government should give further consideration to the role that hospital discharge in supporting sustainable health and social care services within the plan.**

[4] British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales

[5] British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales

Addressing health inequalities

In order to deliver equitable health and social care, it is important to acknowledge the health inequalities that existed before the pandemic and have been brought into sharp focus by Covid-19. The references to reducing health inequalities within the plan are welcome, however, the plan would benefit from further detail on how Welsh Government will address health inequalities. For example, there is no mention to the socio-economic drivers of poor health outcomes and little detail on the work of Public Health Wales, who have acknowledged influencing the wider determinants of health as one of their (PHW'S) strategic priorities. In addition, while there are intentions to explore access varying between specific characteristics or where a person lives, the proposed research to explore this further does not detail any time frames of analysis.

Therefore, the commitment to address health inequalities within the plan should be strengthened through further detail on socio-economic drivers of health inequalities.

It is important to note that health status alone does not contribute to inequalities in accessing quality healthcare, experiences of care and health outcomes. There are a wealth of other factors[6], such as social connection, good work[7], and transport. In fact, a growing body of research has found that wider determinants can have a greater influence on health than health care.[8] Without concerted efforts to address these inequalities, the long-term social and economic impact of Covid-19 risks further exacerbating them. This is likely to have an adverse impact on building a sustainable health and social care system. A Cross-Governmental plan is needed to address health inequalities which should be introduced to complement other plans for health and social care such as the plan we are consulting on.

We support the joint call from over 30 organisations[9] in Wales for a Cross-Governmental plan to address health inequalities which should outline the action being taken across all government departments, setting out how success will be measured and evaluated through shared performance measures and outcomes for all public bodies in Wales.

Pressures on the social care system

The plan highlights the significant pressures of the social care system, with increasing wages as one of the solutions. While this may be part of the solution, more needs to be done to ensure that we have a sustainable social care system. For example, our report *Listening to what matters*[10] highlighted wider concerns around the ability of the health and social care system to deliver new hospital discharge practices which focus on home first principles that aim to free up bed capacity. In particular, concerns were raised around the availability of social care in the community which was seen to be as the result of insufficient resource in the social care sector to meet demand.

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6 Health Foundation (2018).'What makes us healthy? An introduction to the social determinants of health. Retrieved from: health.org.uk/publications/what-makes-us-healthy

7 Work which provides stable employment, pays a living wage, and offers fair working conditions, work-life balance and career progression.

8 Institute of Health Equity (2010). 'The Marmot Review: Fair Society, Healthy Lives.' Retrieved from: instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Future Generations Commissioner for Wales (2018). Advice to Welsh Government on taking account of the Well-being of Future Generations Act in the budget process. Retrieved from: futuregenerations.wales/wp-content/uploads/2018/12/2018-11-29-FGC-Budget-Recommendations-ENG.pdf

9 NHS Confederation (2021). 'Making the difference: tackling health inequalities in Wales.' Retrieved from: nhsconfed.org/publications/making-difference-tackling-health-inequalities-wales

10 British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales

Therefore, we recommend that Welsh Government prioritises reform of social care to deliver high quality, more accessible services, and develop a long-term settlement to enable sustainable social care funding.

Meeting people's needs

Ensuring that people who have needs come forward

As we adapt to Covid-19 longer-term, consideration should also be given to "hidden waiting lists", which will be made up of people who have a health condition but have avoided seeking care or have not yet been referred for treatment because of the disruption caused by the pandemic. Therefore, it is positive that the plan acknowledges that individuals are yet to come forward and emphasises that communications will focus on encouraging individuals to seek help if they feel unwell.

In order to ensure that people who have health needs come forward, the role of social prescribing will be beneficial. In particular, insights from our research, *Fulfilling the promise*[11], found that some of the loneliest people are completely isolated from not only other people but services too. Therefore, social prescribing is particularly important for people who are chronically lonely to help them to grow the confidence and independence they will need to reintegrate with services. Therefore, we welcome the references to social prescribing and the introduction of the all-Wales social prescribing framework in the plan.

We recommend that in recognising the importance of social prescribing services, Welsh Government use the plan to ensure people receive one-to-one, tailored support which is available to them until they regain their independence and are confident in accessing health services.

Supporting people who are waiting for treatment

A critical aspect of improving access to services is investment in patient-centred care and communication. Therefore, we welcome the plan's reference to targeted patient communication which also acknowledges the need to cater for those who are digitally excluded and those with language needs. These considerations are important to support people who typically fall through the gaps in the healthcare system. Given that these groups may fall through the gaps, communications should be monitored to ensure that these service users are receiving the communication that they need.

We believe patient-centred care involves taking a holistic approach to delivery of care, considering patients at all stages of their treatment journey and prioritising clear, two-way communication. This is important so that patients feel that they are listened to and seen, which in turn reduces the anxiety and stress associated with waiting.

As well as communications around waiting times, support to wait well is valuable.

[11] British Red Cross, Coop and Kaleidoscope (2018). 'Fulfilling the promise: How social prescribing can most effectively tackle loneliness.' Retrieved from: redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/fulfilling-the-promise-social-prescribing-and-loneliness.pdf

British Red Cross Waiting Well Service

The British Red Cross has been working with the Welsh Government to pilot a waiting well support service in three health boards in Wales. The service will involve an offer of pastoral care in the individuals' own homes, initially on a face-to-face basis for up to six weeks, followed by a further period of telephone support for up to six weeks, dependent upon the assessed need of the individual referred.

The service will contribute to the continued well-being of the individual awaiting treatment from their local hospital(s) and will comprise of health and well-being checks and will alert the referrer should there be any change or deterioration. The service will continue to be available during the wait for admission and/or treatment and will link with and signpost to other services which may be able to provide any ongoing support either prior to or following treatment.

It is expected that having someone who is dedicated to the individuals' well-being as they continue to wait for treatment will lessen anxiety and assist in their day-to-day ability to function.

When referencing supporting people to wait well, Welsh Government should continue to acknowledge the role that the VCS can contribute to provide non-clinical support.

Improving patient outcomes

Ensuring those with the greatest need are treated in a timely way is important. Therefore, it is reassuring to see that this is one of the objectives of the plan.

In addition, from our operational experience, we know that listening to people's needs and what matters to them can make all the difference. Therefore, we welcome the plan's reference to what matters to the patient and its commitment to engage with people waiting for treatment to discuss whether the planned intervention is still suitable. It is also positive to see a £20 million a year investment committed to implement a values-based approach which focuses on improving outcomes that matter to patients.

It is important that commitments to improve patient experience are consistently implemented across Wales, with Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) referenced in the plan being key to measuring patient experience.

Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system?

The national direction within the plan to drive collaboration is missing a few elements. In particular, collaboration with a range of sectors, including the VCS will be key in increasing capacity within the health and social care system. Reference to multi-disciplinary teams and the increasing development of the voluntary reservist NHS health support team within the document is welcome. However, when discussing outsourcing, the document does not mention the VCS. We believe there is an opportunity to harness the power of the VCS to create better outcomes for people, while also relieving pressure on the NHS and improving patient flow within and between health and social care providers across Wales. We do this through our direct work in health settings, but also through our wider preventative work which we have touched on in the above sections.

We recommend that when considering collaboration and collective effort to address waiting times, the Welsh Government acknowledges the work of the VCS within the plan.

Are the targets and timescales realistic?

While the plan states that it will take the whole of this Senedd term to deal with the backlog, with some key dates for ambitions, there is no clear timeline on when steps identified in the plan will take place.

Therefore, we recommend that the Welsh Government provide further information on timescales within the plan.

Anticipation of variation

When planning to address needs, it is important to consider this at a local level, to ensure services are delivered in a way that serves the local population. However, while assessing need at a local level, it is fundamental that approaches are streamlined to a minimum standard to ensure that there is not a postcode lottery in tackling the backlog. Therefore, we welcome the document's reference to regional approaches but looking to eliminate variation and are eager to see how this is implemented in practice.

Financial resources

It is difficult to assess whether there is sufficient funding to deliver the plan without further detail on the plan and its timescales. Without this, it is hard to ascertain if funds allocated for each year are suitable. However, as above, we would like to reiterate the importance of placing funding on long-term footing through long-term contracts, to ensure sustainability of services, as well as the importance of investment in community services.

Does the plan adequately address health and social care workforce pressures?

While the plan references multi-disciplinary teams, there is no explicit reference to. those who are not registered as health and social care staff, such as volunteers, which may aid capacity. This is also true of the 'Our Workforce Strategy for Health and Social Care' document which is mentioned in the plan.

We recommend that Welsh Government utilise 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' and the robust workforce plan to address gaps in the workforce and should include how people who are not registered as health and social care staff can assist with alleviating workforce pressures.

It is positive that the section on the current health infrastructure references that some services will be supported by the third sector.[12] However, when the plan discusses community services, this does not seem to include the VCS. As discussed above, we believe that the VCS can help to alleviate pressures in the health and social care space, including for the workforce itself, through the provision of additional capacity to complement the work by health and social care workers. For example, in our Emergency Department Well-being and Home Safe Services we provide emotional support to patients, alleviating pressures on medical staff who can focus on meeting patients' medical needs. We believe that this demonstrates the potential for the VCS to complement clinical treatment by providing pastoral support to people.

[12] Note that we have referred to the third sector in this document as the VCS.

We recommend that the Welsh Government should invest in and recognise the voluntary and community sector to enable it to play a wider role in alleviating workforce pressures.

Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?

It is positive that the plan references a balance between digital tools and provision for those digitally excluded. In particular, we welcome reference to the use of a range of formats to communicate with patients. However, discussions around setting up virtual centres in rural communities as referenced on page 15 may fail to consider the digital exclusion that many people face in rural areas.[13] Other groups, such as older people, also experience digital exclusion. For instance, 52 per cent of people over 75 do not have broadband access and many older people do not use computers and smart phones.[14] It is important that people who are unable to use digital technology are not excluded from treatment options. In addition, it is important to note that many patients value face-to-face appointments and feel that remote consultations can lead to a lack of a personal or consistent relationship with their clinician.[15]

Therefore, we recommend that the Welsh Government ensures that there is a blended approach to deliver planned services, including text, phone, video, email and in-person, to best meet all patients' needs and allow services to work efficiently and address inequality of access to services.

The plan currently provides some detail on the ways in which digital tools will be used, such as for virtual appointments. However, further detail could be provided on how the planned care portal will operate. For example, work in Scotland has made clear that patients will be given a date range for their treatment while waiting.[16] It would be useful to understand if Wales will be following a similar model.

Therefore, the Welsh Government should provide further detail on the ways in which digital tools and virtual wards, particularly the planned care portal, will be used to drive service delivery and efficiently manage waiting times while still ensuring those who are digitally excluded are supported.

While the plan discusses digital tools for patients, there is little reference to how digital tools will be used to aid communication between various health and social care staff involved in a patients care. In practice, we have found that communication between professionals could be improved. For example, in our report *Listening to what matters* some participants shared examples of situations where important medical information was not shared between

[13] Honeyman M, Maguire D, Evans H and Davies A. Cardiff: Public Health Wales NHS Trust, (2020). 'Digital technology and health inequalities: a scoping review.' Retrieved from: phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/

[14] Welsh Government, (2019) 'National Survey for Wales 2018-19: Internet use and digital skills.' Retrieved from: gov.wales/sites/default/files/statistics-and-research/2019-09/internet-use-and-digital-skills-national-survey-wales-april-2018-march-2019-207.pdf

[15] The Patients Association, 2020, 'Pandemic Patient Experience: UK patient experience of health, care and other support during the COVID-19 pandemic.' Retrieved from: patients-association.org.uk/Handlers/Download.ashx?IDMF=2fdaa424-8248-4743-a4d5-fe1d3f403d20.

[16] The Times (11 May 2022). 'Website to show NHS delays.' Retrieved from: https://www.thetimes.co.uk/article/website-to-show-nhs-delays-2d6m8fnl3

hospitals.[17] This is an area where the use of technology could help to support effective communication of patient information.

Therefore, in developing the provision of digital tools, we recommend that Welsh Government make it clear in the plan that lead staff members that support information sharing in each health board should ensure that data sharing protocols and IT services support the flow of information between acute and community hospitals as well as key providers involved in discharge.

If you have any questions about any of the information contained in this document, or our further research, please contact Georgia Marks, Policy and Public Affairs Officer (Wales)

[17] British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 10
Ymateb gan: | Response from: BMS Consultation

BMS Consultation: Response to the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Summary

BMS is a leading global biopharmaceutical company focused on discovering, developing and delivering innovative medicines for patients with serious diseases in areas including oncology, haematology, immunology, cardiovascular and neuroscience. Our employees work every day to transform patients' lives through science.

In the UK, BMS employs approximately 1,000 people. Our ongoing partnerships with the NHS, academia and scientific institutes represent investment into the UK to the value of over £200 million. More than 750,000 NHS patients rely on our medicines to manage their disease, stay well and live their life to the full.

BMS recognises that the scope of the Welsh Government's plan goes beyond cancer, focusing on transforming and modernising planned care and reducing waiting lists. While this consultation response focuses on oncology, many of the recommendations are relevant for the wider health system. Furthermore, a national cancer strategy for Wales is expected later this year, and any recommendations in this consultation response – whilst important and relevant now for efforts to reduce waiting lists – should also be considered for any future cancer strategy.

Summary of recommendations:

- The Welsh Government should issue further investment to meet the 10% increase in capacity required to effectively address the backlog.
- Any future national Welsh cancer strategy should set out how activity and funding is to be allocated according to tumour type, considering the needs of the population, and the expert views of clinicians and the patient community.
- BMS recommends that any future cancer strategy specifically sets out what it will do to achieve the changes set out within this plan across specific tumour types.
- A future cancer strategy should also include more robust actions to improve access to cancer treatment.
- The Welsh Government should ensure that health boards are able to confirm action within pre-defined timeframes to meet the commitments within this plan – ideally within less than three years for optimised cancer pathways.
- Over the next 10 years there should be renewed efforts and targeted investment to increase the levels of diagnosis, treatment, and positive outcomes for patients living with cancers with the greatest unmet need, including less-survivable cancers.
- Welsh health system partners should collaborate to improve data infrastructure and availability allowing for greater understanding of cancer types with the largest backlog in diagnostics and treatment along with the areas most affected.
- The Welsh Government should publish statistics for nursing vacancies to address staff shortages and improve workforce planning.
- Regional and local health leaders should tackle the barriers to adopting skill-mix approaches, whereby the roles and responsibilities of a team are designed around the needs of the patient.
- The Welsh health system should look to rapidly implement the community diagnostic hub model, coupled with increased focus on public awareness campaigns to encourage members of the public to come forward for tests.
- NHS Wales should drive greater public awareness on the potential role of genomic testing, alongside investment in clinical pathways to support wider rollout.
- A long-term strategy is needed that commits to funding molecular diagnostic services and ensures their place within an integrated health system.

- There should be immediate focus on increasing the number of patients diagnosed through screening programmes and urging patients to come forward through public awareness programmes. Public awareness campaigns must come with ring-fenced funding to ensure they are delivered continually.
- Any future national cancer strategy should clarify how funding for public awareness campaigns will be earmarked for specific tumour types. The cancer policy team should engage with the system to understand which cancers stand to benefit the most in terms of outcomes from public awareness campaigns.
- BMS wishes to see deeper and more sustained collaboration across different sectors, where organisations work together to implement and scale up best practice innovations, developed at a local level. The Wales Cancer Industry Forum represents an effective model for such collaboration.
- A bold systems leadership approach is required to tackle the scale of the diagnostic backlog, which has increased dramatically as a result of the pandemic. This approach draws on the collaborative and risk-friendly strategy taken by the US' 'Cancer Moonshot'.[1] The approach would encompass and help deliver on the attributes outlined in the Quality Statement for Cancer.[2]

Building a more resilient and sustainable health and social care system

- BMS welcomes the plan's commitments to transform services to be sustainable for the longer term, including expanding services and capacity. It is important that the health system is prepared to meet the needs of patients now and in the future.
- New analysis from the Office of Health Economics (OHE), commissioned by BMS, demonstrates the scale of the COVID-induced backlog in cancer diagnosis and treatment in Wales. The analysis determines that the Welsh health service will need to exceed pre-pandemic diagnosis and treatment activity levels to clear the cancer backlog. It articulates how long it will take to tackle the backlog in each area based on the health service working at 2.5%, 5% and 10% above pre-pandemic activity.
- The serious limitations to cancer diagnosis and treatment data in Wales need to be addressed as a priority to ensure the cancer backlog is better understood.
- recognising that the scale of Wales's diagnostic capability challenges go beyond the bandwidth of any one organisation, a new approach requires deepened and sustained collaboration with patients, the NHS, the third sector, Government and industry to identify and implement solutions. BMS would welcome such partnerships across different sectors to implement and scale up best practice innovations developed at a local level.

The diagnostic backlog

- Urgent cancer referrals fell significantly at the beginning of the COVID-19 pandemic. Referrals recovered to near pre-pandemic levels seven months later.[3]
- If Wales can increase the resources allocated to dealing with the cancer backlog by 10% compared to pre-pandemic levels, it will take 20 months to clear the cancer diagnostic backlog. An increase of only 2.5% to pre-pandemic activity will result in a 6.5 year wait to clear the backlog, and will hinder progress on the ambitions contained within this plan, particularly around reducing waiting times.
- Pathological data for cancer diagnosis is not readily available in Wales. This lack of data sharing prevents a complete understanding of the scale of the cancer backlog. Further, it results in an inability to determine which tumour types are the most prevalent across the health system in Wales.
- Laboratories are currently struggling to provide routine services, early detection and diagnosis of cancer and, in some cases tests, which should be provided under basic standards of care for cancer patients and specific tumour types. Laboratories focus

their budgets on immediate priorities and are therefore unable to plan for the adoption of newly approved tests.
- A long-term strategy is needed that commits to funding these relatively resource-poor services and ensure their place within an integrated health system. Given the substantial decreases in diagnosis levels between cancer types, resource should be split proportionally to cancer types that have been most affected by the pandemic. In the short to medium term, the Welsh health system should look to replicate the community diagnostic hub model implemented in England, coupled with increased focus on public awareness campaigns to encourage members of the public to come forward for tests.
- BMS therefore welcomes moves to join up diagnostic or treatment services regionally as set out in this plan. Particularly for cancers where delay to diagnosis and first treatment could drastically impact survival outcomes, approaches such as the one stop shop approach are necessary.
- BMS welcomes commitments in the plan to have rapid diagnostics to support early detection and diagnosis of cancer. BMS recommends that any future cancer strategy specifically sets out what it will do to achieve these changes within specific tumour types.

The treatment backlog

- Both initial cancer treatment and outpatient oncology referrals decreased during the onset of the pandemic.[3] In October 2020, both of these indicators recovered slightly but were still below pre-pandemic levels.
- Based on a 10% increase of pre-pandemic activity, it will take 10 months to clear the backlog in people waiting for their first cancer treatment. Even with a 10% increase, it will take 14.5 months to clear the backlog for outpatient referrals.
- Pathological data for treatment is unavailable and consequently it is difficult to fully understand the scale of the cancer treatment backlog.
- BMS is encouraged by the commitments within the plan to improve access to treatment. Efforts to improve uptake by separating lower acuity cancer pathways from emergency centres is also welcome. However, a future cancer strategy should include more robust actions to improve access to cancer treatment.
- Ensuring patients have access to treatment – particularly the most innovative therapies – is an important factor in improving outcomes. While England, and by virtue, Wales, ranks fourth for the availability of cancer medicines in Europe, nearly half of the cancer medicines approved by the European Medicines Agency (EMA) still have 'limited availability' in England and Wales.[4]

Ensuring that people who have health needs come forward and patient centred care

- Early detection and diagnosis of cancer is vital to improving a person's chances of survival as early-stage cancer is more responsive to treatment. In bowel cancer for example, five-year survival is over 90% if caught early, but less than 10% if diagnosed late.[5] However, in Wales, there were 20,000 fewer suspected cancer referrals between March and November 2020.[6]
- As Wales enters the interpandemic period it is expected that there will be an increased number of patients presenting with later stage cancer. As such, there should be immediate focus on increasing the number of patients diagnosed through screening programmes and urging patients to come forward through public awareness programmes. It will also be essential that patients are able to receive the latest and most innovative treatments. Public awareness campaigns must come with ring-fenced funding to ensure they are delivered continually.
- BMS is pleased that this plan recognises the need to communicate with the public to encourage those in need to come forward. In 2017, Cancer Research UK found that

22% of respondents were worried about wasting their doctor's time and 45% said they found it difficult to make an appointment.[7]

- Any future national cancer strategy should clarify how funding for public awareness campaigns will be earmarked for specific tumour types. The cancer policy team should engage with the system to understand which cancers stand to benefit the most in terms of outcomes from public awareness campaigns.
- BMS believes that cancer care should be holistic and person-centred. As such, BMS is encouraged by commitments in the plan to streamline pathways by minimising the number of hospital visits for patients, including personalised patient-initiated follow-up pathways for cancer.
- One way to bolster self-management and access to clinical support, if needed, is by ensuring that patients have consistent access to support from a named clinical nurse specialist (CNS), who often acts as a crucial first point of contact, enabling patients to receive a better experience across all aspects of care.[Error! Bookmark not defined.] Providing CNSs with the capacity to undertake their role to the fullest potential, combined with a codified 'professional framework', could drive better outcomes for patients.[8]
- There should be greater focus on cancer types which have seen the greatest falls in diagnosis and treatment during the pandemic, as evidenced by the OHE data. Over the next 10 years, there should be renewed efforts and targeted investment to increase the levels of diagnosis, treatment, and positive outcomes for patients living with cancers with the greatest unmet need, including less-survivable cancers, typically defined as lung, pancreatic, liver, brain, oesophageal and stomach cancers. This should include a specific strategy which details funding allocation and targets for the expected increases in activity levels.

Adequate funding to support improvements with clearly defined timelines

- The Welsh Government should issue further investment to meet the 10% increase in capacity required to effectively address the backlog.
- The Welsh Government should also ensure that health boards are able to confirm that action on the commitments within this plan is able to commence within pre-defined timeframes, and ideally, in the case of optimised cancer pathways, within less than three years.
- Timelines for embedding optimal cancer pathways are not as explicit as they could be in the plan. BMS welcomes the ambition to streamline pathways, including personalised patient follow up. Similarly, commitments to streamline the diagnostic pathway and improve access to treatment are encouraging, but the Government should apply timelines and implementation metrics to ensure the success of these commitments. BMS would welcome the publication of an implementation plan to support the aspirations laid out within the plan.
- The plan is also not clear on who will be responsible for ensuring the continued use of amended treatment regimens developed during the pandemic, where it is clinically appropriate. This will likely require input from HCPs at different parts of the pathway and it is imperative that the health service is able to facilitate coordination in a consistent manner.
- BMS welcomes the funding announced for the implementation for the National Endoscopy programme, strengthening diagnostic and imaging services, implementation of the critical care plan and plans for improving cancer and stroke services. However, it is not clear how the £170m allocated to these aspirations, among others, will be allocated within each area. The Welsh Government should issue further investment to meet the 10% increase in capacity required to effectively address the backlog.

- In addition, BMS would like to know whether this funding will form part of a funding package for the future cancer strategy, or whether new funding will be made available.

Securing the workforce required for the Welsh health system

- Significant staffing shortages are impacting cancer care and outcomes. The UK has fewer doctors and nurses per capita than comparable countries, and the number of CNS is well below the level needed for personalised cancer care.[9,10]
- A significant rise in vacancies since the pandemic has further exacerbated these staffing challenges. As of July 2021, the clinical oncology vacancy rate in Wales in 20%, this is compared to 17% across the UK as a whole. This is set to rise to 45% by 2025.[11]
- The Welsh Government should publish statistics for nursing vacancies to address staff shortages and improve workforce planning.
- Planned care needs to consider the current and future health demands of the population. Regional and local health leaders should tackle the barriers to adopting skill-mix approaches, whereby the roles and responsibilities of a team are designed around the needs of the patient, to secure the right skills at the right level to meet those needs. If implemented, NHS Boards should also be mindful of not creating additional shortages if staff are upskilled and move onto new roles. In the short term, these can be filled by recruiting more support workers. However, in the medium to long term, the NHS must look to resolve talent pipeline issues to ensure that staff are able to upskill and progress without causing workforce shortages in other disciplines.

Using digital and data to drive system level transformation

- A key hurdle for the Welsh health system will be to overcome inadequacies in data collection. Data for cancer diagnosis is not readily available in Wales and this places constraints on service planning. This lack of data sharing hinders a comprehensive understanding of the scale of the cancer backlog. Further, it results in an inability to determine which tumour types are the most prevalent in Wales. The lack of data on treatment is particularly stark and resulted in an inability for the OHE to analyse treatment data and fully understand the scale of the cancer treatment backlog.
- Welsh health system partners should collaborate to increase data availability, allowing for greater understanding of the types of cancer with the largest backlog in diagnostics and treatment along with the areas most affected. The Wales Cancer Industry Forum represents an effective model for such collaboration.[12]

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[1] The National Cancer Institute (2021). 'The Cancer Moonshot: A Midpoint Progress Update'. [Accessed June 2022] Available at: https://www.cancer.gov/news-events/cancer-currents-blog/2021/cancer-moonshot-midpoint-progress-update#:~:text=%20The%20Cancer%20Moonshot%3A%20A%20Midpoint%20Progress%20Update,in%20research%20to%20reduce%20cancer%20risk...%20More%20
[2] Welsh Government (2021). 'Quality Statement for Cancer'. [Accessed June 2022] Available at: https://gov.wales/quality-statement-cancer-html
[3] OHE 'The COVID-induced cancer backlogs in the devolved nations'. Available on request. [Accessed June 2022]
[4] European Federation of Pharmaceutical Industries and Associations (2022). 'EFPIA Patients W.A.I.T. Indicator 2021 Survey.' Available at: https://www.efpia.eu/media/636821/efpia-patients-wait-indicator-final.pdf [Accessed: June 2022].
[5] Cancer Research UK (2021). 'Bowel Cancer – Survival'. Available at: https://www.cancerresearchuk.org/about-cancer/bowel-cancer/survival. [Accessed: June 2022].
[6] Cancer Research UK 'Wales: 4 in 10 with possible cancer symptoms didn't contact GP'. Available at: https://news.cancerresearchuk.org/2021/06/17/wales-4-in-10-with-possible-cancer-symptoms-didnt-contact-gp/#:~:text=Recent%20Welsh%20Government%20figures%20also%20show%2020%2C000%20fewer,he%20knows%20how%20important%20early%20diagnosis%20can%20be. [Accessed June 2022]
[7] The Health Foundation (2018). 'Radical rethink required to close gap on cancer survival between England and comparable countries'. Available at: https://www.health.org.uk/news-and-comment/news/radical-rethink-required-to-close-gap-on-cancer-survival. [Accessed: June 2022].
[8] Public Policy Projects & Bristol Myers Squibb (2021). 'Cancer Services in the UK: Restarting the Cancer Pathway'. Available at: https://publicpolicyprojects.com/publications/cancer-services-in-the-uk-restarting-the-cancer-pathway/. [Accessed: June 2022].
[9] The Nuffield Trust (2020). 'Resuming Health Services during the Covid-19 Pandemic: What Can the NHS Learn from Other Countries?'. Available at: https://www.nuffieldtrust.org.uk/research/resuming-health-services-during-the-covid-19-pandemic-what-can-the-nhs-learn-from-other-countries. [Accessed: June 2022].
[10] RCN (2021) 'Nursing in Numbers'. Available at: https://www.rcn.org.uk/news-and-events/news/w-rcn-wales-publishes-nursing-in-numbers-2021-report-revealing-current-workforce-statistics-231121 [Accessed: June 2022].
[11] The Royal College of Radiologists (2021). 'Oncology Workforce Census Wales'. Available at: https://www.rcr.ac.uk/sites/default/files/clinical-oncology-uk-workforce-census-2020-report-wales.pdf [Accessed: June 2022].
[12] Life Sciences Hub Wales (2019). 'Cancer Industry Forum'. Available at: https://lshubwales.com/success-stories/cancer-industry-forum-wales-open-business [Accessed: June 2022]

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 11
Ymateb gan: | Response from: Cymorth Canser Macmillan | Macmillan Cancer Support

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MACMILLAN CANCER SUPPORT
CYMORTH CANSER MACMILLAN

Health and Social Care Committee: Consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Response from Macmillan Cancer Support

Macmillan Cancer Support welcomes the Committee's decision to consider the Welsh Government's programme for transforming and modernising planned care in detail, and is grateful for the opportunity to provide written evidence on this matter.

We welcomed the publication of the plan in April as a positive step for recovering cancer and wider NHS services from the impact of the pandemic. The plan recognises the significant disruption from COVID-19 to the delivery of NHS services and the wider harms that many people in Wales have faced since March 2020.

It contains key ambitions relating to cancer services: notably enhancing the national target for Suspected Cancer Pathway performance from 75% to 80% by 2026 and increasing the speed of diagnostic testing and reporting to eight weeks by spring 2024.

We have set out some comments across several of the areas listed by the Committee, but for any further information please contact Tom Davies.

MACMILLAN CANCER SUPPORT
CYMORTH CANSER MACMILLAN

A new target for national Suspected Cancer Pathway performance

One of the key ambitions of the programme to transform planned care is for the national target for Suspected Cancer Pathway performance to increase from 75% to 80% by 2026. This target relates to the percentage of people who start their first treatment for cancer within 62 days of cancer first being suspected.

We welcome the ambition to move from a 75% to 80% target. At the same time, we also have to recognise that performance will have to improve significantly for us to have any chance of meeting this goal. January 2022 saw a record low of just 53% of patients starting treatment on time, and the current 75% target has not been met once in the 34 months since the Suspected Cancer Pathway was introduced. We are also seeing historic levels of demand, with a record-high 15,300 suspected cancer pathways opened in March 2022 alone. For context, the average number of monthly referrals pre-pandemic was around 13,200.

We welcome the prioritisation of diagnostics in the planned care programme, particularly the commitment to establish a network of local community hubs and create a National Diagnostics Board. We also welcome the proposal to set up virtual centres in rural communities to allow people who are digitally excluded to make use of video consultations and other virtual approaches. All of these measures have the potential to help Wales reach the ambition of 80% Suspected Cancer Pathway by 2026, but we urgently need to see further detail and timescales for the delivery of these commitments.

Ensuring that people who have health needs come forward

The biggest challenge for cancer services in the first year of the pandemic was the decline in people presenting at primary care services with potential symptoms, leading to the worrying backlog of missed cancer diagnoses. Therefore, the fact that cancer referrals are now consistently at or above pre-pandemic levels is very encouraging.

However, it is worrying to hear the Welsh Government report in the programme document that more cancer patients are now presenting with advanced cancers. This is something we have observed as well, through a 20% rise in DS1500 applications being reported by our welfare benefits advice teams in Wales (applications to the Department for Work and Pensions for people with fewer than six months to unlock or expedite access to welfare support).

We have said previously that the Welsh Government's 'Keep Wales Safe'/'Diogelu Cymru' campaign should have had a much stronger focus on urging those with potential cancer symptoms to seek help from their GP. Part of this campaign covered information about

accessing NHS services in Wales, but this focused primarily on the appropriate use of accident and emergency units, the Welsh Ambulance Service, primary care and other services. What was needed in addition to this was a strong push from the Welsh Government to reassure people that primary care services wanted to hear from them with any potential cancer symptoms.

The planned care programme states that the Welsh Government will continue to promote key messages about cancer symptoms and the importance of people presenting at primary care promptly, which is welcome. We were also pleased to see the Welsh Government respond positively to Recommendation 3 of the Committee's *Waiting Well* report that the Minister for Health and Social Services should work with NHS Wales and the third sector to deliver a national campaign within the next 12 months on cancer symptoms awareness. We look forward to seeing the proposals for this awareness campaign as soon as possible.

Improving patient outcomes and their experience of NHS services

We welcome the focus within the planned care programme on better information and support for people waiting for diagnosis or treatment. It is positive to see the Welsh Government reference cancer pathways specifically and the fact they need to remain person-centred, with comprehensive information, support and holistic care for people throughout their cancer journey.

For those waiting for treatment to start, clear communication from health boards amidst potential disruption from COVID is crucial. If extreme pressures do result in disruption to cancer treatments, it is absolutely imperative that anyone whose treatment is affected is actively communicated with and monitored by health boards. In such circumstances, health boards should also be working across regional footprints where appropriate to ensure treatment can be rearranged as soon as possible.

The programme states that NHS organisations' websites and correspondence to patients should have clear structures signposting to appropriate support from third sector organisations. We would be keen to see further details on what this would look like as we know that, within cancer services, signposting to information and support can be inconsistent across Wales. For instance, we know from the 2016 Wales Cancer Patient Experience Survey that only 48% of people felt they had been given adequate signposting and information about financial help and benefits following their diagnosis.[i]

It is positive that the programme acknowledges the need for prehabilitation for those due to have surgery, but timely prehabilitation can also have benefits for patients who are due to receive chemotherapy, radiotherapy, and other non-surgical treatments.

Health inequalities

Even before the pandemic there was a persistent gap between the least and most deprived areas of Wales in cancer survival. Looking at the most recent five-year survival rates published by the Welsh Cancer Intelligence and Surveillance Unit, for some cancers – such as colorectal – the survival gap between the least and most deprived parts of Wales is really significant.[ii] For other tumour sites such as breast and lung, the deprivation gap is smaller but has widened in recent years, which is of serious concern.

We welcome the Welsh Government's commitment to reduce health inequalities within the planned care backlog, and the recognition that these inequalities existed before the pandemic but in some cases have also been exacerbated by it. What is missing from the programme at this point is further detail on how the Welsh Government plans to identify and address these inequalities.

Addressing workforce pressures

The health and care workforce remains the largest factor when considering how we can both tackle the waiting list backlog and support those people who have been waiting for diagnosis or treatment. Even before the pandemic this was a significant issue, with notable gaps in the diagnostic workforce in Wales as well as in the specialist cancer nurse workforce. The pandemic has only exacerbated these pressures.

Macmillan estimates that by 2030, we will need an additional 166 specialist cancer nurses in Wales (an increase of around 80%) in order to keep up with increasing cancer incidence.[iii] Ensuring that we have enough specialist cancer nurses will be crucial in achieving the Welsh Government's aims for high-quality person-centred care for everyone living with cancer in Wales.

It will also be important for the Welsh Government to identify those tumour sites where there are comparatively few specialist cancer nurses in Wales. For instance, our cancer workforce census published in 2018 highlighted that 74% of breast and 50% of gynaecology specialist cancer nurses were over the age of 50, which means they are often within 10 years of retirement.[iv] We also know the provision of secondary breast cancer clinical nurse specialists is a particular issue.

We welcome the recognition from the Welsh Government within the planned care programme that having a sustainable workforce in place will be key to tackling the planned care backlog, but also that this will not be enough to clear the planned care backlog. We would like to see further detail about plans for the Workforce Delivery Plan for Wales that

is mentioned within the programme, as the document does not go into any detail on what this might look like, who would develop this, or any timescales.

MACMILLAN CANCER SUPPORT
CYMORTH CANSER MACMILLAN

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Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 12
Ymateb gan: | Response from: Age Cymru

Age Cymru – Creating an age friendly Wales

Consultation response

Plan for transforming and modernising planned care and reducing waiting lists

For the Senedd's Health and social Care Committee

June 2022

Introduction

Age Cymru welcomes the opportunity to provide further information on modernising planned care and reducing waiting times. As we have previously advised on these issues, older people are predominantly those most affected by delays in this area.

We are very pleased to see that the plan for transforming and modernising care includes many developments that will over time help older people's health and wellbeing improve.

In our most recent annual older people's survey[1] we saw a reduction in levels of satisfaction with health care services. Overall, 63% of people aged 50 or over had a negative experience of access to health care services. Within this, 73% had a negative experience of access to treatment and ongoing health checks, and 70% had a negative experience of both dental and GP access. Higher satisfaction rates were seen in access to eye care. For eye care this included usual sight checks as well as treatment services. In almost all areas satisfaction had gone down over previous surveys. The increase in delays will have undoubtedly contributed to reductions in satisfaction.

Addressing backlogs

The plan is ambitious in scope and includes some time scales for pandemic and waiting list recovery. It does set out well what needs to happen to address recovery, but little is included on exactly how change will be achieved. As a result, it is difficult to say whether this will address backlogs and reduce waiting lists to lower than pre-pandemic levels.

We welcome the split between planned care and emergency care as this will assist with maintaining treatment when otherwise this could reduce as a result of emergency pressures.

[1] Due for publication later in June 2022

We appreciate the efforts that have been put into developing timelines within the plan, but further work is needed. We have some concerns that the target times for reducing waiting times simply refer to 'most specialties.' Few time frames are included in the plan on when milestones will be reached. The plan includes that these will be developed for sub specialities but it would be helpful to see how these are developed.

We know that some specialisms through the nature of the conditions have been harder hit with delays. There is a risk through this that if specific targets are not set, it could skew overall data and not reflect the differences in various specialisms. Different conditions have different impacts on people in different circumstances, so it would be helpful to see more granular data with which to estimate overall general wellbeing recovery which will help inform the positive impact of the plan.

In our recent survey more people responded to the questions on health care than in previous surveys. They told us of long delays with treatment, surgery and ongoing care than in any previous surveys. One respondent to our most recent survey told us of their reduced physical health whilst waiting for orthopaedic surgery,

> "Limited opportunities for exercise or social engagement, combined with an increased workload. […] I have been at Week 27 of a 55-week waiting list to see an orthopaedic consultant for 3 years, with no proactive contact from the local health board."

A lack of clarity on this also means that planning for wider care and support around treatment itself such as prehabilitation, rehabilitation and social prescribing services is made more difficult. Without further breakdown it is difficult to see distance travelled and which areas require increased attention.

The plan focusses on prioritising those with a higher clinical need and states that regard will be given to the impact of delays for different conditions. We would hope that the impact on carers and wider families is considered. Improvements in information sharing between health and social care is needed to support appropriate decision making.

A further focus is needed on national campaigns

The plan refers to improved communication before people access care services and has a specific focus on a national campaign to raise awareness of cancer symptoms as a means of getting people to come forward earlier. Such a focus is vital, given the difficulties over the pandemic of people waiting for diagnoses within target times. The plan also includes the need targeted communications to address health inequalities.

We would like to see other national campaigns developed further that focus on other conditions. In particular, we know that the effects of many musculoskeletal (MSK) conditions can be slowed down and helped through early diagnosis and advice on exercise, diet and lifestyle. Similarly, some effects of eye conditions can be helped with earlier advice and treatment. Given the huge backlogs in elective surgery for MSK conditions and eye conditions we believe such a targeted campaign is vital to

help older people earlier with these issues and reduce the need for high level interventions from health and social care.

For such campaign work it will be important to consider how information will be cascaded to be of greatest effect, and how people who are not digitally enabled are reached. The plan includes reference to building upon existing work of charities such as Age Cymru and we are keen to help in this area.

As changes in how services are delivered are planned, a communication plan around this needs to be carefully considered to prevent confusion for the public that explains why change is needed, what will be different and how changes will help people get the health care they need earlier. Ideally this should not be a ‘one off’ as changes may happen at different times in different regions according to each’s priorities, and so an ongoing campaign is needed.

Improving patient experience

The plan includes a focus on improved patient experience and this is most welcome. Older people have told us of the difficulties they have in accessing health care, of poor and non-existent communications from health and difficulties in transfer of appropriate information from one service to another within the NHS.

Increased focus is needed on how those living with dementia will be better supported through care pathways. We know that people living with dementia tend to have longer hospital stays than those who do not, and providing the right care following discharge can be difficult. We would like to see further detail included on how their needs can be better addressed either through hospital at home services where this is possible.

We welcome the additional focus in the plan on supporting people to wait well. The effects of delays will take time to reduce, but providing support whilst people wait will improve many people’s situations. As with other areas further detail on how this is provided would be helpful. It is important in developing these support services that how people that are digitally excluded may have parity of service with those that are online and able to use apps, have zoom meetings with health professionals. People’s communication needs vary so it is important that digital cost saving in providing more support to more people does not come at the cost of those that are digitally excluded.

The plan details how See-On-Symptom (SOS) and Patient Initiated Follow-Up (PIFU) as an alternative to face-to-face follow-ups will be rolled out as a priority for outpatients services. We understand that there is a need to ensure that less ‘no-show’ appointment time is lost and this can be an area where time savings are made. However, the plan would benefit on further detail on which conditions SOS and PIFU will be used for in order to consider whether this will be a worse experience for older people. We are concerned that there are groups of people who will struggle to initiate follow up themselves and so will lose access to the care they need. For example, in this year’s annual survey one carer told us:

> ‘I have had to help my father access essential care for various physical issues as they arose. I haven't got the energy to go through it all again to get appointments for menopause and mental health for myself’

This is from one of many people who told us of how burned out they are through providing unpaid care. It is vital that any such change is carefully managed takes into account the range of patient circumstances and an assessment of how such groups of people can be supported to access the ongoing care they need.

Care closer to home and patient transport needs

We welcome the focus on care closer to home for conditions requiring repeated and ongoing health appointments. Older people have told us of issues with long distances to travel for treatment through the pandemic when services moved around in response to pandemic pressures. Providing care closer to home will benefit those in need of care, their carers and also wider support networks who are often called on to help with transport.

One respondent to our most recent annual survey said

> “Had to cancel a hospital appointment because I couldn't get there in time using public transport. The appointment was at St Joseph's in Newport I live in Rhymney. Hopefully a new appointment will be made nearer home.”

We welcome recommendation 9 of the Waiting Well report that calls for the Health Minister to set out actions taken by health boards to find suitable venues for pain management, physiotherapy and occupational therapy both in hospitals and community settings. Such actions need to involve those needing care in their development to ensure that such venues are able to meet patient needs. Such venues can also assist with cascading health promotion and other campaign information. Linked to this, those needing these services are more likely to be experiencing reductions in emotional wellbeing. It would be highly beneficial to have information and advice available in these settings on opportunities for improving wellbeing.

Providing care closer to home can also help improve community cohesion and wellbeing. A recent Wales Centre for Public Policy report focusses on the importance of a good infrastructure in the population’s wellbeing[2] so moving services closer to home will help in this regard.

More needs to be done to look transport options for health appointments. Whilst health board’s responsibility lies mainly in service recovery, improving transport options will greatly improve patient experience and reduce missed appointments. Transport needs should be considered as part of regional board planning

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[2] Wales Centre for Public Policy Infrastructure and Long Term Wellbeing April 22 accessed 7/6/22 at https://www.wcpp.org.uk/publication/infrastructure-and-longterm-wellbeing/

considerations. Older people are less likely to have a car or be able to drive so transport issues disproportionately affect them. Providing care close to home will help, but there are long standing issues with public transport meaning independent travel is incredibly difficult for some older people. Further consideration is needed on how community transport can be provided. This is of particular importance for more rural areas but does affect all of Wales.

For services that are usually a 'one off,' such as hip replacement, we recognise the need for these to be centralised in centres of excellence in order to increase the volume of treatment and reduce waiting lists and also provide better clinical outcomes for people. We feel the plan needs an additional focus on how transport to services further from home are resourced, who provides them and how they can be accessed. Such developments should involve older people from the outset to both ensure they meet the needs of patients and also help prevent valuable resources being focussed on the wrong areas.

Regional partnership boards should consider this area of need as part of transformation fund projects.

Leadership and oversight

The plan sets out well what needs to happen for planned care recovery, but there appears to be a gap in terms of national scrutiny, and what intervention will happen if targets for improvement are not met. It would be helpful to have a national hub to oversee change and support health boards through this.

The plan includes that health boards will develop more detail on targets for recovery and it would be helpful to see how they will develop these. For example, will there be national discussions across health boards to ensure that targets are reasonable and proportionate? Will target setting include international research evidence on improvements in planned care? National oversight is needed in order for this to be a useful and effective exercise. A procedure is needed to detail what would happen in the event that health boards fall behind in reducing delays and who will oversee improvements.

Discussions with health professionals indicate that more could be done to share good practice and the enactment of this plan can provide a good opportunity for health boards and services to share their learning on not only what works, but what they have tried that does not work in order to make the best use of the additional resources provided for planned care recovery.

Improved use of digital technology and shared communication between health and social care

We welcome recommendation 19 of the waiting well report on improving connections between health and social care technologies as this is vital to ensuring all professionals involved in the care of a person have access to the right information

with which to provide the right response. Older people have told us of issues where their records have not been transferred from one health service to another and the difficulties this has caused.

Age Cymru have recently looked into delays in access to social care support.[3] Our work found issues of inappropriate discharge of vulnerable patients where discussions did not take place between health and social care. Older people have told us of circumstances where discharge happened without the right support in place which then led to emergency admissions.

Carers have told us of difficulties in finding out information on their loved ones, even in cases where a power of attorney was in place and how loved ones have been discharged to care homes a very long way from home without them knowing this was happening. Social care is becoming better at identifying carers and these records need to be available to health colleagues.

It is vital that social care and health records are able to speak to each other and that systems are in place for shared records to stop such cases from happening and reduce time wasted trying to get hold of information that should be easily available to professionals involved.

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[3] This report is currently being finalised and will be published shortly.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 13
Ymateb gan: | Response from: Y Gymdeithas Feddygol Brydeinig Cymru | British Medical Association Cymru

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10th June 2022

Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Dear Russell

Many thanks for your letter inviting BMA Cymru Wales to provide written evidence on Welsh Government's recently published plan for transforming and modernising planned care and reducing waiting lists, commonly known as the 'planned care recovery plan'.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Introduction

We welcome the opportunity to relay the views of our members regarding the planned care recovery plan. Firstly, it should be noted that we did have the opportunity to provide Welsh Government with comment on a draft iteration of the document. This stems from our comparatively constructive relationship with Welsh Government, and the ongoing commitment to social partnership working.

Our concerns raised at the time related to the absence of any reference to the role of primary care in the initial draft; however, the published document does pay reference to the role of general practice in this whole system challenge.

Our response below is arranged according to the Committee's outlined areas of focus in Annex 1 of your letter. Whilst we have not directly addressed each individual question, our comments and observations relate to the general theme under consideration. In responding, we have

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proposed a number of recommendations which they Committee may wish to consider. While these are detailed throughout, additionally we provide these for you in summary at the end of this document.

Overall views

1. *Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.*
2. *Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?*

The strongest immediate piece of feedback expressed by our members on receipt of the published document was that the content was extremely 'high level' and lacking in specific and meaningful actions to address the routine care backlog.

While we agree with and endorse the ambitions outlined early on in the document, Welsh Government will need to translate the transformational and aspirational aims into tangible system change.

Recommendation 1: Welsh Government should translate their aspirational Plan into real system change

BMA Cymru Wales is already represented on many of the boards and groups that will be tasked with formulating actions from the plan (e.g., national clinical pathway development, the national planned care board, etc), however clinical input must be a key part of developing these plans. Given the ultimate reliance on existing personnel to deliver these changes it is vital that we consider wellbeing, morale as well as ensuring appropriate terms and conditions.

Recommendation 2: Welsh Government should listen to frontline healthcare staff when developing their plans

It is concerning that we hear from members about general lack of engagement locally with the clinical body about how the backlog will be tackled, and how the ever-increasing demand can be managed. These conversations must commence as soon as possible if any element of this plan is to be realised and should include clarity and specific details on workforce planning requirements.

Recommendation 3: Welsh Government should start conversations with frontline staff as soon as possible

Whilst the plan describes how *more* can be done and achieved by NHS Wales, we can not see how this can be done without either rationing treatment, which in turn creates further waiting list backlogs, or by significantly increasing the numbers of staff across NHS Wales.

Meeting people's needs

3. *Whether the plan includes sufficient focus on:*
    a. *a. Ensuring that people who have health needs come forward;*
    b. *Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;*

c. *Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;*
d. *Improving patient outcomes and their experience of NHS services?*

Recurrent themes featuring throughout the plan include better communication, increased transparency of information and support for those waiting for treatment.

In particular, the promotion of self-care and maintaining wellbeing for those awaiting treatment is repeatedly referenced. This includes the launch of a new national patient information website and promotion of digital platforms supporting self-management and access to personalised information.

This is absolutely necessary given the scale of waiting times across most specialties, and should be seen as recognition of ongoing, long-standing staffing challenges across NHS Wales. However, digital campaigns and resources alone will not be sufficient and must be backed by mixed-media campaigns, community outreach and accessible material which reaches all sectors of the community including the digitally excluded. This must be done carefully; we are concerned this emphasis on self-management is likely to exacerbate existing health inequalities.

Recommendation 4: When promoting the importance of self-care and maintaining wellbeing, Welsh Government must not rely solely on digital campaigns, instead they should carry out community based work to include digitally excluded communities and groups

The plan references Health Boards working with Public Health Wales to encourage healthy behaviours with a cluster (of deprivation) based approach to reduce inequalities (p7). However, this is not enough. For parents who cannot afford to enrol children in sports clubs or cannot access or afford healthy food, this strategy will have little effect. The current economic climate will only further the expansion of this inequality gap.

The need for patient liaison services to address waiting list queries is paramount.

The plan mentions that systems for direct patient engagement will be delivered at a local level, which may include the set-up of communication hubs. We would welcome a more directive approach from Welsh Government which would see these facilities be mandated across all Health Boards. Such services have the potential to provide clear, transparent and personalised information about waiting lists in addition to signposting for other support services and could reduce pressure on GP services.

Recommendation 5: Welsh Government's plan for direct patient engagement should be directive-based to ensure all health boards are mandated to provide appropriate facilities so that patients across Wales are supported

At present, GPs' inability to access secondary care records leads to challenges when patients request updates on referrals, as the GP is required to write to secondary care for updates, only adding to delays. We have previously called for a shared dashboard providing accurate real-time data on waiting times accessible by clinicians from primary and secondary care.

Recommendation 6: Welsh Government should roll out a shared dashboard to allow accurate real-time access to waiting times for patients and primary and secondary care

Leadership and national direction

4. *Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?*
5. *Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?*

While the plan is intentionally high level and does set out Welsh Government's clear ambition to tackle waiting times and reform the planned care process, there is however scant detail on delivery and accountability. Page 37 makes reference to periodic updates on progress as risks are continually assessed, however we would welcome further information on this reporting process, including risk assessment procedures and key milestones. More detail on overall accountability for the plan is needed and, while it may sit with the hybrid NHS Wales Executive function, we recommend the Committee hold regular scrutiny sessions with senior leaders as the rollout of the plan proceeds.

Recommendation 7: Welsh Government must provide further information on their plans for "periodic updates on progress" and the Senedd's Health and Social Care Committee should hold regular evidence sessions with senior leader to scrutinise the roll out of the Plan

Targets and timescales

6. *Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?*
7. *Is it sufficiently clear which specialties will be prioritised/included in the targets?*
8. *Do you anticipate any variation across health boards in the achievement of the targets by specialty?*

We are concerned that the targets stated in the foreword may not be achievable given the scale of the backlog and ongoing pressures on the system. Taken in isolation, the targets around waiting times for appointments and treatments are at the higher end of what should be a bare minimum expectation. The targets instead appear ambitious and aspirational goals and we are concerned NHS Wales as a whole may struggle to meet then. Further detail is therefore needed from Welsh Government about how they will hold health boards to account on meeting targets.

Recommendation 8: Welsh Government must provide further information about how it intends to hold health boards to account on meeting targets

There are major workforce concerns that call into question the viability of these targets. The relative lack of data on vacancies in secondary care, coupled with what we know from our members about current pressures they are experiencing, mean it is difficult to make a judgement. A greater availability of statistics and a transparency of information may make this assessment easier.

Recommendation 9: Welsh Government must ensure vacancy data and information is readily available from all health boards and trusts, and that this is consistently collected and presented to help understand the needs and pressures faced by staff

There are other targets set out in the plan relating to different ways of working for outpatient appointments. 50% of follow-up appointments are to be virtual and 35% of new appointments likewise offered digitally. With certain types of appointment only being possible in person- eg spinal surgery or many other Musculo-skeletal issues- this could make such targets difficult to meet. Additionally, health inequalities could be widened for those who are digitally excluded.

The introduction of See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) are certainly positive developments but will be reliant on a properly functioning and responsive system that can appropriately manage patient queries.

There is a commitment to create dedicated surgical facilities separate to urgent and emergency care. We would welcome detail on how this will be achieved, given the current inflexible nature of the NHS Wales estate. Furthermore, general acute and more specialist services are located together on hospital sites; this can be important to ensure a sufficient throughput of patients to ensure medics can maintain competencies and satisfy training requirements.

Recommendation 10: To fully understand how Welsh Government plans to create dedicated surgical facilities separate to urgent and emergency care, it must provide more detail on how it plans to adapt the current NHS Wales estate

It is largely the same workforce that is relied upon to deliver planned care and unplanned care: when pressures are intense unplanned care will always take precedence. Fragmentation of these facilities and pathways will be extremely difficult to achieve.

Furthermore, many services which support surgical activity are not available outside regular hours of work, for instance there are no routine physiotherapy sessions on weekends. Patients who have procedures during these times may have less support.

Financial resources

9. *Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?*
10. *Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?*

The plan makes reference to a significant investment at a national level of £170m from October 2021 to support planned care recovery. This is welcome, but we do not feel we are best placed to comment to a great degree about whether this is sufficient; the fact that this is by its very nature a high-level plan means we cannot comment about specific initiatives based on the amount of information available.

Greater information on Welsh Government plans for how and when these funds will be invested it critical.

Recommendation 11: Welsh Government must provide more detail about how, when and where it plans to invest the £170m of funding announced in October 2021

However, a fundamental re-shape of the outpatient/referral system through the introduction of local or regional diagnostic hubs will require a significant investment. As referenced in the report (p18), this is something BMA Cymru Wales strongly supports.

The report mentions that the creation of business cases for new diagnostic hubs is already underway. There is a lack of clarity about how the hubs will operate: how they will be staffed; if they will be located in new dedicated facilities or within existing; and how referrals from GPs will be handled. We would welcome clarity and engagement around this aspirational aim. It is likely that these new centres will have a significant lag time before they become operational, detail on plans for the immediate future are needed from Welsh Government.

Recommendation 12: Welsh Government must detail its plans for the immediate future of services while it introduces its planned diagnostic hubs

We suggest that the Senedd's Finance Committee may wish to scrutinise the overarching financial aspects of the Plan and associated projects/initiatives as they develop.

Recommendation 13: The Senedd's Health and Social Care Committee should encourage the Senedd Finance Committee to scrutinise the overarching financial aspects of the Plan and associated projects/initiatives as they develop

Workforce

11. *Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?*

This is the area which has attracted most attention from our members, who widely share concerns that staffing pressures across the system cause into question the viability of the plan. We are extremely concerned that there will be insufficient staffing capacity within the system to deliver upon the stated aims.

The same staff who have reported suffering from burnout and fatigue coming out of the heigh of the pandemic will be relied upon to reduce the backlog. We have stated this in previous evidence to the Health & Social Care Committee on HEIW's workforce plan[1]:

> *"The impact these pressures have had on recruitment and retention of medical and other NHS staff may therefore be significant. Many staff have suffered burnout as a result of the pressures of working through the pandemic, prompting many to consider leaving the profession earlier than they might otherwise have planned or reduce the extent of their working week"*

The findings of the BMA's April 2021 survey of members in Wales demonstrated the precarious situation facing NHS Wales from a staffing perspective:

- almost a third of members have said that, as a result of COVID, they are more likely to take early retirement

[1] P2, BMA Cymru Wales (8 Oct 21) *Health and social care workforce: consultation by the Welsh Senedd Health and Social Care Committee* www.bma.org.uk/media/4810/bma-wales-response-to-an-healthier-wales-our-workforce-strategy-for-health-and-social-care-consultation-oct21.pdf

- 21% stated they are more likely to leave the NHS for another career

From a staff wellbeing perspective, we must be realistic about what can be achieved from an already under pressure workforce. The creation of an adequately staffed, resourced and effective occupational health service for all NHS Wales staff is absolutely central to achieving this, and many other, Welsh Government and NHS Wales objectives.

Significant consideration must be put to whether existing NHS Wales workforce numbers are sufficient to deliver 'business as usual'. To ensure staff get the support they need, along with appropriate time to rest and to carry out additional training, action must be taken by Welsh Government to make sure appropriate and safe levels of staff are in place across NHS Wales.

Recommendation 14: Welsh Government should legislate to ensure appropriate and safe levels of staff are in place across NHS Wales at all times

Recommendation 15: Welsh Government should ensure all staff can access appropriate and timely occupation health support

In primary care, the recent release of data from the Wales National Workforce Reporting System[2] demonstrates that despite the highest ever headcount of practitioners at 2,353 qualified GPs, this amounts to only 1,611 Full time equivalent (FTE) GPs working in Welsh practices. Whilst this dataset is new, future trends will demonstrate a gradual decrease in FTE numbers due to both the popularity of portfolio careers and the fact Wales has a significantly higher proportion of its GPs over 60 than other nations, meaning that a greater percentage will be nearing retirement[3].

Welsh Government therefore need to focus on retention in addition to recruitment, and an increase to GP training numbers beyond the current 160 new trainees per year.

Recommendation 16: Welsh Government must urgently increase the numbers of GP training numbers beyond the current 160 new trainees per year

The Plan acknowledges that general practice and other primary care services deliver "*around 90% of all NHS activity"* (p8). This highlights the significant burden shouldered by a pressurised workforce which is already insufficient in numbers to tackle business as usual, let alone perform additional activities.

In secondary care there is a lack of publicly accessible vacancy data from Health Boards. We have been required to resort to submitting Freedom of Information requests to health boards and trusts in order to understand secondary care vacancy data. Where data has been obtained, it demonstrates the scale of the challenge: in one health board as many as 48% of consultant posts were not filled by a permanent consultant; furthermore, the definition of a vacancy used by NHS organisations varies widely, with most underreporting. As an example, in many areas it is not until recruitment has been attempted, and failed, that a post is considered to be vacant).

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[2] Welsh Government (14 Apr 21) *General practice workforce: as at 31 December 2021* https://gov.wales/general-practice-workforce-31-december-2021

[3] P4, BMA Cymru Wales (8 Oct 21) Health and social care workforce: consultation by the Welsh Senedd Health and Social Care Committee

Recommendation 9 (as previously): Welsh Government must ensure vacancy data and information is readily available from all health boards and trusts, and that this is consistently collected and presented to help understand the needs and pressures faced by staff

We note the commitment to develop a Workforce Delivery Plan (p34), however without reliable workforce and vacancy data, proper planning cannot be carried out and could call into question the deliverability of much of this plan. HEIW, working with health boards and other key stakeholders, must take a leadership role in workforce planning in the immediate short-term future as well as tackling long-term staffing issues. HEIW's own integrated medium-term plan (IMTP) acknowledges this key role, with "*addressing gaps in workforce plans and programmes to support planned care recovery*" identified as a key milestone by March 2023[4]. This work needs to be accelerated in advance of that timescale as addressing the workforce gap will not be easy and is unlikely to be solved with money alone as Wales cannot, within the timescale of the plan, train new doctors to redress this shortfall so efforts must be made to draw them into Wales from elsewhere.

Recommendation 17: HEIW must take a leadership role in workforce planning in the immediate short-term future as well as tackling long-term staffing issues

The plan references that a factor in reducing waiting times will be '*additional sessional work at weekends and evenings*' to catch up, however the punitive taxation rules on NHS pensions could make this unviable for our most senior and experienced doctors. The pensions annual allowance and taper[5] have perverse consequences leading many of our most experienced doctors having to reduce their hours, turn down the opportunity of additional work, or outright retire from practice for fear of being hit with tax bills in the thousands for breaching the annual allowance by as little as £1. With this in mind, clinicians essentially have to pay out of their own pockets to undertake additional work.

Welsh Government should therefore continue to urge the UK Government to act in this area to ensure doctors can accept additional work without being disincentivised.

Recommendation 18: Welsh Government should urge the UK Government to take action to ensure doctors can accept additional work without being disincentivised by present tax and pension arrangements

Another means to reduce waiting times identified within the plan is to maximise the capacity within the private and independent sector. It should be recognised that this sector is extremely small in Wales, and often led by consultants in addition to their primary NHS role. Therefore, the workforce who will 'pick up the slack' are largely the same as those within the NHS.

Reliance upon an exhausted workforce to do more could lead to adverse consequences for both patients and said staff. While Welsh Government has taken action to legislate on safe nurse staffing levels, no action has been taken for doctors or other health staff.

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[4] HEIW (21 March 2022) *Integrated Medium-Term Plan 2022-25: Appendix F 'Detailed Deliverables and Milestones'* https://heiw.nhs.wales/files/heiw-impt-2022-25/

[5] For more detail please see *The impact of punitive pension taxation rules on doctors and the delivery of NHS services,* BMA (2020) www.bma.org.uk/media/2002/bma-briefing-on-the-impact-of-pension-taxation-jan-2020.pdf

During the 5th Senedd, the Health & Social Care Committee recommended[6]:

> *"In our view, it is impossible to separate out the issue of quality from the provision of appropriate staffing levels – they are inextricably linked. In order to deliver quality in service provision, the requisite staffing must be in place.*
>
> *"We recommend that the Minister amends the* [Health and Social Care (Quality and Engagement) (Wales)] *Bill to make specific provision for appropriate workforce planning/staffing levels as part of the duty of quality."*

Two and-a-half years later, this key recommendation has still not been acted upon by Welsh Government.

Given the pressures faced by staff across the Welsh NHS as a result of the pandemic, and the expectation that this will continue as work is undertaken to reduce the backlog for patients, it is critical that Welsh Government brings forward legislation to ensure safe and appropriate levels of staff are in place across NHS Wales.

Recommendation 14 (as previously): Welsh Government should legislate to ensure appropriate and safe levels of staff are in place across NHS Wales at all times

Digital tools and data

12. *Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?*

The plan is heavily reliant on the use of digital tools and data: from a patient information perspective to the increased prominence of e-advice across sectors. The commitment to improved transparency around waiting times through a shared digital platform is extremely positive, but we will only reap the benefits of this if it is informed by accurate and reliable data from all sectors. Infrastructure in secondary care is significantly behind primary care and more fragmented. This requires significant attention to unlock this proposed flow of information and data. Without this, patients and doctors will be unable to quickly and reliably access updates to waiting time information.

Furthermore, Welsh Government must provide regular updates on progress in this area and on the expected cost of this, so as to ensure that progress is supported by appropriate funding throughout.

Recommendation 19: Welsh Government needs to give urgent attention to secondary care IT and technology infrastructure to ensure waiting time and diagnosis information is available for staff and patients. Furthermore, Welsh Government should give regular updated on progress in this area and ensure funding levels remain as required

An over-reliance on a digital approach to communicate information to patients could exclude large sectors of the population and exacerbate health inequalities. However, it is clear that tools which can provide accurate, accessible and bespoke information to patients about their condition would be of significant benefit. Given these systems will provide access to sensitive patient data and need to interface with clinical records, it is absolutely vital that proper information governance procedures are followed, and safeguards put in place. GPs continue to

[6] P31, Senedd Health Social Care & Sport Committee (Nov 2019) *Health and Social Care (Quality and Engagement) (Wales) Bill* https://senedd.wales/laid documents/cr-ld12874/cr-ld12874 -e.pdf

be the designated 'data controller' for their patient records, and are thus personally liable for any data breach, with the Information Commissioner's Office able to undertake enforcement action[7]. We would welcome the opportunity to work with Digital Health & Care Wales to discuss information governance matters around these proposals.

Recommendation 20: In introducing greater access to information, it is vital that proper information governance procedures are followed, and safeguards put in place

Recommendation 21: Digital Health & Care Wales should consult with organisations, including BMA Cymru Wales, to ensure information governance matters are robust

Recommendations

Recommendation 1: Welsh Government should translate their aspirational Plan into real system change

Recommendation 2: Welsh Government should listen to frontline healthcare staff when developing their plans

Recommendation 3: Welsh Government should start conversations with frontline staff as soon as possible

Recommendation 4: When promoting the importance of self-care and maintaining wellbeing, Welsh Government must not rely solely on digital campaigns, instead they should carry out community based work to include digitally excluded communities and groups

Recommendation 5: Welsh Government's plan for direct patient engagement should be directive-based to ensure all health boards are mandated to provide appropriate facilities so that patients across Wales are supported

Recommendation 6: Welsh Government should roll out a shared dashboard to allow accurate real-time access to waiting times for patients and primary and secondary care

Recommendation 7: Welsh Government must provide further information on their plans for "periodic updates on progress" and the Senedd's Health and Social Care Committee should hold regular evidence sessions with senior leader to scrutinise the roll out of the Plan

Recommendation 8: Welsh Government must provide further information about how it intends to hold health boards to account on meeting targets

Recommendation 9: Welsh Government must ensure vacancy data and information is readily available from all health boards and trusts, and that this is consistently collected and presented to help understand the needs and pressures faced by staff

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[7] Information Commissioner's Office *Penalties* ico.org.uk/for-organisations/guide-to-data-protection/guide-to-le-processing/penalties/

Recommendation 10: To fully understand how Welsh Government plans to create dedicated surgical facilities separate to urgent and emergency care, it must provide more detail on how it plans to adapt the current NHS Wales estate

Recommendation 11: Welsh Government must provide more detail about how, when and where it plans to invest the £170m of funding announced in October 2021

Recommendation 12: Welsh Government must detail its plans for the immediate future of services while it introduces its planned diagnostic hubs

Recommendation 13: The Senedd's Health and Social Care Committee should encourage the Senedd Finance Committee to scrutinise the overarching financial aspects of the Plan and associated projects/initiatives as they develop

Recommendation 14: Welsh Government should legislate to ensure appropriate and safe levels of staff are in place across NHS Wales at all times

Recommendation 15: Welsh Government should ensure all staff can access appropriate and timely occupation health support

Recommendation 16: Welsh Government must urgently increase the numbers of GP training numbers beyond the current 160 new trainees per year

Recommendation 17: HEIW must take a leadership role in workforce planning in the immediate short-term future as well as tackling long-term staffing issues

Recommendation 18: Welsh Government should urge the UK Government to take action to ensure doctors can accept additional work without being disincentivised by present tax and pension arrangements

Recommendation 19: Welsh Government needs to give urgent attention to secondary care IT and technology infrastructure to ensure waiting time and diagnosis information is available for staff and patients. Furthermore, Welsh Government should give regular updated on progress in this area and ensure funding levels remain as required

Recommendation 20: In introducing greater access to information, it is vital that proper information governance procedures are followed, and safeguards put in place

Recommendation 21: Digital Health & Care Wales should consult with organisations, including BMA Cymru Wales, to ensure information governance matters are robust.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 14

Ymateb gan: | Response from: Ombwdsmon Gwasanaethau Cyhoeddus Cymru | Public Services Ombudsman for Wales

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Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Ymateb gan Ombwdsmon Gwasanaethau Cyhoeddus Cymru i ymgynghoriad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

'Cynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros'

Rydym yn falch o'r cyfle i ymateb i'r ymgynghoriad hwn.

Ein rôl

Fel Ombwdsmon Gwasanaethau Cyhoeddus Cymru (OGCC), rydym yn archwilio cwynion a wneir gan aelodau o'r cyhoedd sy'n credu eu bod wedi dioddef caledi neu anghyfiawnder oherwydd camweinyddu neu fethiant mewn gwasanaeth ar ran corff cyhoeddus yn fy awdurdodaeth, sydd yn ei hanfod yn cynnwys yr holl sefydliadau sy'n darparu gwasanaethau cyhoeddus a ddatganolwyd i Gymru. Ymysg y rhain mae:

- llywodraeth leol (cynghorau sir a chymuned)
- y Gwasanaeth Iechyd Gwladol (gan gynnwys Meddygon Teulu a deintyddion)
- landlordiaid cymdeithasol cofrestredig (cymdeithasau tai)
- Llywodraeth Cymru, ynghyd â'r cyrff a noddir ganddi.

Gallwn ystyried cwynion ynglŷn â gofal cymdeithasol a drefnir neu a ariennir yn breifat a gwasanaethau gofal lliniarol ac, mewn rhai achosion penodol, agweddau o ofal iechyd a ariennir yn breifat.

Rydym hefyd yn archwilio cwynion bod aelodau etholedig awdurdodau lleol wedi torri eu Codau Ymddygiad, sydd yn nodi'r egwyddorion ymddygiad cydnabyddedig y dylai aelodau eu dilyn mewn bywyd cyhoeddus.

Mae'r pwerau 'ar fy liwt fy hun' a ddyrannwyd ini dan Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019 (Deddf OGCC 2019) yn caniatáu ini ymchwilio pan fo tystiolaeth yn awgrymu y gall fod methiannau systematig, hyd yn oed os nad yw defnyddwyr gwasanaeth eu hunain yn gwneud cwynion. Mae'r ddeddf hefyd yn sefydlu'r Awdurdod Safonau Cwynion (CSA) er mwyn ysgogi gwelliant mewn gwasanaethau cyhoeddus drwy gefnogi delio â chwynion yn effeithiol drwy weithdrefnau model, hyfforddi a chasglu a chyhoeddi data ynghylch cwynion.

Ein hachosion sy’n ymwneud ag Amseroedd Aros rhwng Atgyfeirio a Thriniaeth (RTT)

Ym mis Ionawr eleni, gwnaethom gyflwyno ymateb i ymchwiliad y Pwyllgor ‘Effaith yr ôl-groniad o ran amseroedd aros ar bobl yng Nghymru sy’n aros am ddiagnosis neu driniaeth’. Byddai’n ddefnyddiol ailadrodd ein hymagwedd at achosion sy’n ymwneud ag RTT, yn ogystal â rhoi diweddariad i’r Pwyllgor am swmp ein gwaith achos perthnasol.

Ein hymagwedd

Rydym yn deall bod gan y GIG adnoddau cyfyngedig, ac yn anffodus, mae hyn yn golygu y bydd yna restrau aros am driniaeth. Mae’r pandemig wedi gosod pwysau digynsail ar y GIG yr ydym hefyd yn ymwybodol iawn ohono.

Rydym yn ystyried pob achos sy’n ymwneud ag RTT yn ôl ei rinweddau ei hun. Bydd pa un ai yw achos ble mae’r RTT wedi ei dorri yn gyfystyr â methiant mewn gwasanaeth neu gamweinyddu yn ddibynnol ar amgylchiadau pob achos. Ynddo’i hun, nid yw methu â chwrdd â’r RTT yn dystiolaeth o fethiant mewn gwasanaeth neu gamweinyddu.

Yr ystyriaeth bwysig gyntaf yw angen clinigol yr achwynydd unigol. Yn fras, hyd yn oed lle torrwyd RTT, ni fyddem ni fel rheol yn ymchwilio oni bai bod tystiolaeth o:

- brys clinigol
- angen dybryd
- camreoli rhestr aros.

Er mwyn inni ganfod methiant mewn gwasanaeth, byddai’n rhaid i’n cyngor clinigol awgrymu bod unrhyw fethiannau i fonitro, adolygu neu drin cleifion unigol sydd angen gofal ar frys wedi achosi niwed clinigol. Felly, mae ein trothwy ar gyfer canfod ‘methiant mewn gwasanaeth’ mewn perthynas â chwynion ynghylch RTT yn uchel.

Deallwn y gallai hyn beri rhwystredigaeth i bobl sydd yn cysylltu â ni, yn enwedig am ein bod yn disgwyl i’n hachwynwyr godi eu pryderon gyda’r corff perthnasol cyn cysylltu â ni. Fodd bynnag, mae hyn hefyd yn golygu, pan fyddwn yn ymchwilio i gwynion ynghylch RTT, mai’r rheswm am hynny yw eu bod yn ymwneud ag anghyfiawnder i’r achwynwyr a allai fod yn ddifrifol.

Ein llwyth gwaith

Ym mis Ionawr, dywedom fod gennym bryderon y byddwn yn gweld cynnydd sylweddol cyn bo hir yn nifer y bobl sy'n cysylltu â ni am faterion RTT. Roeddem yn ymwybodol o'r nifer cynyddol o bobl ar restrau aros yng Nghymru ac roeddem yn bryderus y byddai'r cynnydd hwnnw'n arwain yn fuan at lawer mwy o achosion ynghylch RTT yn cael eu cyflwyno i'n swyddfa.

Gwyddom yn awr fod nifer y bobl ar restrau aros yng Nghymru wedi cynyddu eto ers hynny. Rhoddodd y cyfryngau lawer o sylw hefyd i nifer y bobl ledled y DU a ddewisodd ddefnyddio darparwyr gofal iechyd preifat oherwydd nad oedd y GIG yn gallu darparu eu gofal o fewn amserlenni a oedd yn dderbyniol iddynt. [1]

Rydym yn categoreiddio ein cwynion ar sail eu prif pwnc, ac rydym yn dynodi nifer o achosion sy'n ymwneud â RTT yn bennaf. Fodd bynnag, gall cwynion sydd ynghylch materion eraill yn bennaf gynnwys pryderon ynghylch RTT. Yn ôl ein dadansoddiad:

- ers 2019, rydym wedi derbyn 9 cwyn lle RTT oedd y prif bwnc – a derbyniwyd 7 o'r rheini ers dechrau 22 yn unig.
- yn ystod 2019/20, dim ond 11 o gwynion a gaewyd gennym yn ymwneud ag oedi wrth drin neu atgyfeirio. Fodd bynnag, yn 2020/21 a 2021/22 fe wnaethom gau 108 cwyn o'r fath, gyda 5 cwyn berthnasol arall eisoes wedi'u cau yn y flwyddyn ariannol hon.

Ar y cyfan, mae nifer y cwynion sy'n canolbwyntio'n benodol ar RTT ac oedi mewn triniaeth yn parhau i fod yn eithaf prin. Fodd bynnag, rydym yn parhau i bryderu ein bod yn debygol o weld cynnydd yn y cwynion hyn.

Ein sylwadau ar gynllun Llywodraeth Cymru ar gyfer trawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

A fydd y cynllun yn ddigonol i fynd i'r afael â'r ôl-groniadau mewn gofal arferol sydd wedi cronni yn ystod y pandemig, a lleihau amseroedd aros hir..

Ar y cyfan, credwn fod y cynllun yn gynhwysfawr a phellgyrhaeddol. Mae'r cwestiwn ynghylch a fydd yn llwyddo yn ei amcanion yn dibynnu ar ei drefniadau adnoddau a gweithredu.

[1] Gweler er enghraifft The Guardian, 2 Mawrth 2022.

A yw’r cynllun yn sicrhau’r cydbwysedd cywir rhwng mynd i’r afael â’r ôl-groniad presennol, a chreu system iechyd a gofal cymdeithasol fwy gwydn a chynaliadwy ar gyfer y tymor hir?

Mae'r cynllun yn cyflwyno cyfres o fesurau i fynd i'r afael â'r amseroedd aros presennol ac i gynyddu gwydnwch a chapasiti'r gwasanaeth iechyd. Fodd bynnag, nid yw'n rhoi llawer o sylw i'r rhyngwyneb rhwng y system iechyd a gofal cymdeithasol. Mae rhywfaint o gyfeiriad at rôl cymorth yn y gymuned a phresgripsiynu cymdeithasol o ran mynd i’r afael ag anghydraddoldebau iechyd i leihau nifer y bobl y bydd angen ymyrraeth gofal wedi’i gynllunio iddynt yn y dyfodol. Mae cyfeiriad hefyd at gydgysylltu trefniadau rhwng gweithwyr iechyd a gofal proffesiynol yn well (t. 14). Fodd bynnag, byddai mwy o fanylion am sut y byddai’r system gofal cymdeithasol yn cael ei defnyddio a’i chefnogi i leddfu’r pwysau ar y GIG i’w groesawu.

A yw’r cynllun yn canolbwyntio’n ddigonol ar y canlynol:

- Sicrhau bod pobl ag anghenion iechyd yn cyflwyno eu hunain;

Nodwn fod y cynllun yn cyfeirio at y mater hwn, ond yn bennaf mewn perthynas â chleifion canser. Heb amheuaeth, mae’r sylw hwn i fynd i’r afael â rhwystrau i ddiagnosio cleifion canser yn brydlon i’w groesawu wrth gwrs. Fodd bynnag, byddem yn dadlau bod angen ymestyn y neges glir hon i gyflyrau eraill lle gall oedi mewn triniaeth mewn meysydd megis orthopaedeg ac offthalmoleg arwain at ddirywiad sylweddol. Wedi dweud hyn, cydnabyddwn fod y cynllun yn cynnwys rhai mesurau a all fynd i’r afael â’r rhwystrau a allai atal pobl â chyflyrau o’r fath rhag dod ymlaen (er enghraifft, y camau arfaethedig i hyfforddi mwy o ‘optometryddion rhagnodi annibynnol’ i ddarparu gofal yn y gymuned a lleihau’r angen i rai cleifion deithio i'r ysbyty).

- Cefnogi pobl sy'n aros am gyfnod hir am driniaeth, rheoli eu disgwyliadau, a'u paratoi ar gyfer cael y gofal y maent yn aros amdano, gan gynnwys hunanreoli â chymorth;

Ar sail ein gwaith achos, croesawn yn arbennig y sylw yn y cynllun i well cyfathrebu â chleifion a gwell rheolaeth ar ddisgwyliadau. Un o’r prif faterion a welwn yw pwysigrwydd cyfathrebu clir gan Fyrddau Iechyd ynghylch y galw ar y gwasanaeth, yr amserlenni disgwyliedig a’r cymorth sydd ar gael (e.e. **202002671**; **202104566)**. Hyd yn oed mewn cwynion am oedi na allwn eu cadarnhau (e.e. **202107132**), gwelwn yn aml fod y trallod ynghylch yr oedi mewn triniaeth yn cael ei waethygu gan ddiffyg eglurder ynghylch pryd y gellir disgwyl y driniaeth.

- Diwallu anghenion y rhai sydd â'r anghenion clinigol mwyaf, a'r rhai sydd wedi bod yn aros am amser hir;

Mae pwyslais i'w groesawu yn y cynllun ar flaenoriaethu'r rhai sydd â'r angen mwyaf. Mae cyfeiriadau hefyd at ddarparu gwybodaeth yn well i'r rhai sy'n aros hiraf. Mae'r cynllun yn cyfeirio'n gyson at gymorth i gleifion gynnal eu hiechyd wrth iddynt aros am driniaeth (t. 15, 22, 27, 31). Ar y sylwad olaf hwnnw, rydym yn sylwi ar yr ymrwymiad penodol i ddatblygu a gwreiddio dull rhagsefydlu safonol i wella canlyniadau a'r cynlluniau i ddefnyddio Mesurau Canlyniadau a Adroddir gan Gleifion gefnogi hyn.

Croesawn y cyfeiriadau a'r ymrwymiadau hyn oherwydd rydym wedi gweld enghreifftiau yn ein gwaith achos o rai arferion da perthnasol a amlygodd fanteision cymorth o'r fath. Er enghraifft, yn achos **202107132** trefnodd y Bwrdd Iechyd i ffisiotherapydd asesu claf a oedd yn aros am apwyntiad gosod clun newydd. Roedd hyn fel rhan o raglen ehangach a gynlluniwyd i helpu cleifion i wneud y gorau o'u hiechyd cyn llawdriniaeth, gyda chefnogaeth Ffisiotherapyddion Orthopedig.

- Gwella canlyniadau cleifion a'u profiad o wasanaethau'r GIG?

Er bod y cynllun ar y cyfan yn pwysleisio gwella canlyniadau cleifion yn glir, sylwn fod un agwedd fawr wedi'i hepgor, yn ymwneud â chwynion cleifion am amseroedd aros. Mae'n anochel y bydd rhai pobl yn dymuno cwyno i'r GIG am eu profiad. Credwn fod cymryd camau i egluro sut y gellir ystyried cwynion o'r fath o dan Gweithio i Wella yn rhan hanfodol o reoli disgwyliadau cleifion gan y GIG yng Nghymru. Gellid dadlau y gallai rhoi mwy o eglurder i gleifion yn hynny o beth hefyd gyfrannu at liniaru'r pwysau ar wasanaethau cwynion y GIG ar yr adeg heriol hon.

A yw'r cynllun yn darparu arweinyddiaeth ddigonol a chyfeiriad cenedlaethol i ysgogi cydymdrech, cydweithio a rhannu arloesedd ar lefelau lleol, rhanbarthol a chenedlaethol ar draws y system iechyd a gofal cymdeithasol gyfan (gan gynnwys meysydd iechyd meddwl, gofal sylfaenol a gofal cymunedol)?

A yw'r cynllun yn rhoi digon o eglurder ynghylch pwy sy'n gyfrifol am ysgogi trawsnewid, yn enwedig wrth ddatblygu gwasanaethau triniaeth a diagnostig newydd a/neu ranbarthol a moderneiddio gwasanaethau gofal a gynlluniwyd?

Nid yw'r cynllun yn ymddangos o fod yn cynnig llawer o fanylion am y trefniadau arweinyddiaeth a'r cyfrifoldeb am yrru'r trawsnewid a ragwelir. Felly, ni fyddem am fynegi barn ar y trefniadau priodol yn hynny o beth. Fodd bynnag, credwn y byddai'r

cynllun yn llwyfan da i gydnabod ac annog arferion da sy'n fwy rhagweithiol ac arloesol a ddaw i'r amlwg o fewn y GIG ei hun.

Rydym wedi sôn o'r blaen am rai enghreifftiau o sut mae'r pwysau sy'n gysylltiedig â phandemig wedi ysgogi ffyrdd newydd o feddwl a gweithio o fewn y GIG. Er enghraifft, tynnodd adroddiad gan nifer o gyrff y GIG ym mis Mawrth y llynedd sylw at enghreifftiau o arfer da ac arloesol o'r fath – o ddarpariaeth iechyd meddwl Digidol ar gyfer Plant a Phobl Ifanc ym Mwrdd Iechyd Prifysgol Aneurin Bevan, i ffyrdd newydd o ddarparu gwasanaethau diagnosteg cardioleg ar gyfer cymunedau gwledig yn ardal Bwrdd Iechyd Prifysgol Betsi Cadwaladr. Amlygodd astudiaeth arall arferion arloesol ym Mwrdd Iechyd Prifysgol Caerdydd a'r Fro, a oedd yn atal unigolion rhag canslo llawdriniaethau dewisol.

Mae'r enghreifftiau hyn yn dangos yr hyn y gellir ei gyflawni pan fydd staff y GIG yn cael eu grymuso a'u hymddiried i weithio gyda mwy o ddisgresiwn, hyblygrwydd a chydag egwyddorion gofal iechyd darbodus wrth wraidd cynllunio a darparu gwasanaethau. Mae ymgorffori'r ffyrdd hynny o weithio yn hanfodol os ydym am ddatrys yr argyfwng presennol sy'n gysylltiedig â rhestrau aros.

Sylwadau cloi

Hyderwn y bydd y sylwadau yn ddefnyddiol ichi. Os hoffech drafodaeth bellach ynghylch unrhyw rai o'm pwyntiau, mae croeso ichi gysylltu ag Ania Rolewska, ein Pennaeth Polisi.

M.M. Morris.

Michelle Morris

Ombwdsmon Gwasanaethau Cyhoeddus Cymru

Mehefin 2022

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 15
Ymateb gan: | Response from: Crohns & Colitis UK

CROHN'S & COLITIS UK

Cyflwyniad tystiolaeth Crohn's & Colitis UK: Cynllun Pwyllgor Iechyd a Gofal Cymdeithasol y Senedd ar gyfer trawsnewid a moderneiddio gofal wedi'i gynllunio a lleihau rhestrau aros

[Mehefin 2022]

1. Ynghylch y cyflwyniad hwn

1.1. **Crohn's & Colitis UK**[1] yw'r brif elusen ar gyfer pobl sydd wedi'u heffeithio gan Clefyd Crohn a Llid Briwiol y Colon yn y DU. Rydym yn gweithio i wella diagnosis, triniaeth, a gofal, i ariannu ymchwil i iachâd, i godi ymwybyddiaeth, ac i ddarparu gwybodaeth a chymorth.

1.2. Mae gan dros 26,000 o bobl yng Nghymru Glefyd Llid y Coluddyn (IBD), a'r ddau brif fath yw Clefyd Crohn a Llid Briwiol y Colon.[2] Mae'r rhain yn glefydau gydol oes y perfedd. Gallant effeithio ar bron bob rhan o'r corff a phob agwedd ar fywyd: o dreulio a chymalau i lefelau egni, iechyd meddwl, addysg a'r gallu i weithio. Nid oes iachâd hysbys.

1.3. Mae Clefyd Crohn a Llid Briwiol y Colon yn gofyn am waith monitro a rheoli llym, yn aml dros sawl degawd o'r oedran y ceir diagnosis. Os caiff ei adael heb ei drin, ei reoli'n wael neu mewn achosion o glefyd difrifol, gall Clefyd Crohn a Llid Briwiol y Colon achosi cymhlethdodau difrifol, sy'n gofyn am ymyrraeth feddygol a/neu lawfeddygol frys. Mae baich Clefyd Crohn a Llid Briwiol y Colon ar y GIG yn cynyddu flwyddyn ar ôl blwyddyn ac, fesul claf, mae'r costau'n debyg i ganser a chlefyd y galon.[3]

1.4. Mae nifer y bobl sy'n byw gyda Clefyd Crohn a Llid Briwiol y Colon yn y DU yn cynyddu o 1 ym mhob 123 o bobl i 1 ym mhob 67 o bobl dros 70 oed.[4] Mae'r boblogaeth hon sy'n heneiddio yn fwy tebygol o fod â sawl cyflwr hirdymor arall gan gynnwys clefyd rhwystrol cronig yr ysgyfaint, clefyd cronig yr afu, arthritis a chlefyd y galon.[5] Bydd diwallu eu hanghenion yn gosod baich cymdeithasol ac economaidd sylweddol ar lywodraethau a systemau iechyd yn y blynyddoedd i ddod.

1.5. Mae'r cyflwyniad hwn yn amlinellu ein hymateb i gynllun Pwyllgor Iechyd a Gofal Cymdeithasol y Senedd ar gyfer trawsnewid a moderneiddio gofal wedi'i gynllunio a lleihau rhestrau aros.

[1] www.crohnsandcolitis.org.uk

[2] Crohn's & Colitis UK (2022). New research shows over 1 in 123 people in UK living with Crohn's or Colitis (crohnsandcolitis.org.uk)

[3] Luces C, Bodger K (2006). Economic burden of inflammatory bowel disease: A UK perspective. *Expert Review of Pharmacoeconomics & Outcomes Research*. 6: 471-482.

[4] Ibid

[5] Irving, P., Barrett, K., Nijher, M. *et al.*, (2021). Prevalence of depression and anxiety in people with inflammatory bowel disease and associated healthcare use: population-based cohort study. *Evidence-based mental health*, 24(3), 102–109.

CROHN'S & COLITIS UK

2. Barn gyffredinol am y cynllun

2.1. Rydym yn croesawu'r cynllun i fynd i'r afael â'r ôl-groniadau mewn gofal arferol a lleihau amseroedd aros hir, gan gynnwys y gydnabyddiaeth i fynd i'r afael ag anghydraddoldebau iechyd mewn gofal sylfaenol ac eilaidd.

2.2. Fodd bynnag, rydym yn siomedig bod y cynllun presennol yn canolbwyntio ar flaenoriaethau proffil uchel fel canser a chlefyd y galon, ac yn anwybyddu cyflyrau difrifol a hirdymor fel Clefyd Crohn a Llid Briwiol y Colon, sy'n cario costau tebyg i'r gwasanaeth iechyd.[6]

2.3. Mae Llywodraeth Cymru wedi ymrwymo i roi Safonau IBD[7] ar waith ac wedi penodi Arweinydd Clinigol Cymru Gyfan, swydd sy'n profi i fod yn gatalydd mewn gwelliannau i wasanaethau ledled y wlad. Fodd bynnag, mae gofal IBD yng Nghymru yn parhau i fod heb ddigon o staff a diffyg adnoddau. Hyd yn oed cyn y pandemig, roedd gwasanaethau'n brwydro i ateb y galw. Rydym yn eich annog i ailymrwymo i Safonau IBD a darparu gofal teg i bobl sy'n byw gyda Chlefyd Crohn a Llid Briwiol y Colon.

2.4. Ar hyn o bryd, mae'r modd y gweithredir Safonau IBD yn amrywio'n fawr ar draws Byrddau Iechyd Cymru. Ni fydd dulliau rhanbarthol yn unig yn arwain at atal diagnosis, triniaeth ac ymchwydd mewn meddygfeydd brys. Rydym yn argymell bod y cynllun yn adfer Safonau IBD ac yn gwneud ymrwymiadau i fuddsoddi mewn offer digidol i fonitro eu gweithrediad ochr yn ochr â chanlyniadau cleifion mewn rhanbarthau i hybu tegwch mewn gofal.

2.5. Er mwyn annog pobl â Chlefyd Crohn neu Lid Briwiol y Colon i ddod ymlaen, rydym yn annog y llywodraeth i bartneru â sefydliadau cleifion mewn ymgyrchoedd ymwybyddiaeth y cyhoedd, buddsoddi yn natblygiad gweithwyr gofal iechyd proffesiynol cymunedol i nodi symptomau a defnyddio profion yn effeithiol, a datblygu a buddsoddi mewn llwybr diagnostig a arweinir gan gleifion sy'n safoni'r defnydd o brofion (FCP a FIT) mewn gofal sylfaenol.

2.6. Er mwyn gwneud diagnosis a thrin pobl â Chlefyd Crohn a Llid Briwiol y Colon yn effeithiol, rydym yn annog y llywodraeth i adolygu ac ehangu capasiti endosgopi drwy ailedrych ar fodelau gwaith (e.e. GIRFT) ac ychwanegu capasiti at adrannau presennol, yn hytrach na mynd i'r afael â'r diffyg drwy hybiau.

2.7. Er mwyn cefnogi hunanreolaeth cleifion, rydym yn argymell: cyfathrebiadau i hyrwyddo dewis a phersonoli, sicrhau bod y gwasanaeth yn monitro cleifion yn rheolaidd yn hytrach na darparu gofal adweithiol, a bod gan wasanaethau lwybrau clir i gleifion fynd allan ac yn ôl i PIFU pan fyddant yn profi fflerio.

[6] Luces, C. and Bodger, K. (2006). Economic burden of inflammatory bowel disease: A UK perspective. *Expert Review of Pharmacoeconomics & Outcomes Research*. 6: 471-482.
[7] IBD UK (2019). *IBD Standards Core Statements*. IBD-Standards-Core-Statements.pdf

2.8. Er mwyn rheoli amseroedd llawdriniaeth, rydym yn argymell bod Byrddau Iechyd yn cael eu mandadu i gyhoeddi eu hamserlenni llawdriniaethau i sicrhau bod canllawiau Ffederasiwn y Cymdeithasau Arbenigedd Llawfeddygol (FSSA) yn cael eu dilyn. [8]

[8] Clinical guide to surgical prioritisation during the coronavirus pandemic — Royal College of Surgeons (rcseng.ac.uk)

CROHN'S & COLITIS UK

3. Diwallu anghenion pobl

a) Sicrhau bod pobl ag anghenion iechyd yn dod ymlaen:

3.1. I bobl â Chlefyd Crohn neu Lid Briwiol y Colon, mae oedi cyn cael diagnosis, triniaeth neu lawdriniaeth wedi'i chynllunio'n gysylltiedig â chynnydd mewn llawdriniaethau brys, llawdriniaethau ehangach a chymhlethdodau sy'n peryglu bywyd, mwy o risg o ganser, marwolaethau a datblygiad clefydau. Yn 2020, datgelodd arolwg cleifion IBD UK fod 1 o bob 4 o bobl â Clefyd Crohn neu Lid Briwiol y Colon yng Nghymru wedi dweud eu bod wedi aros mwy na blwyddyn am ddiagnosis, gyda bron i hanner (47%) yn ymweld ag adrannau damweiniau ac achosion brys o leiaf unwaith cyn cael diagnosis.[9] Mae'r pandemig wedi gwaethygu'r problemau hyn - mae diffyg mynediad at arbenigwyr, meddyginiaethau, profion a gweithdrefnau wedi arwain at fflerau, cymhlethdodau ac iechyd meddwl gwaeth i lawer.[10]

3.2. Mae yna nifer o resymau pam na ddylai pobl sy'n byw gyda Chlefyd Crohn neu Lid Briwiol y Colon ddod ymlaen, gan gynnwys:

- **Diffyg dealltwriaeth ac ymwybyddiaeth y cyhoedd** o Clefyd Crohn a Llid Briwiol y Colon a'i symptomau. Teimlai 80% o'r rhai a ymatebodd i Arolwg Cleifion IBD y DU fod gan y cyhoedd ddealltwriaeth gyfyngedig neu ddim dealltwriaeth o gwbl o Clefyd Crohn a Llid Briwiol y Colon.
- **Symptomau a all fod yn gysylltiedig ag ystod o gyflyrau eraill.** Mae'r rhain yn cynnwys syndrom coluddyn llidus (IBS), canser y coluddyn, clefyd coeliag, endometriosis a chanser yr ofari.
- **Gall symptomau ymddangos yn annodweddiadol.** E.e. er mai dolur rhydd yw'r symptom mwyaf cyffredin, nid yw hyn yn bresennol ym mhob oedolyn â Chlefyd Crohn neu Lid Briwiol y Colon; ac nid yw hyd at 44% o blant ag IBD yn profi dolur rhydd.[11]

3.3. Mae rhwystrau systemig i gleifion ddod ymlaen, fel y datgelwyd gan arolwg annibynnol[12] diweddar a gomisiynwyd gan Crohn's & Colitis UK:

- Mae 1 o bob 3 yn dweud ei bod yn anodd cael apwyntiad meddyg teulu
- Mae 1 o bob 7 yn adrodd am anawsterau wrth drafod gwybodaeth sensitif am symptomau gyda derbynyddion
- Mae 1 o bob 7 yn poeni na fyddai'r symptomau allweddol (dolur rhydd, colli pwysau a phoen yn yr abdomen) yn cael eu cymryd o ddifrif.

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[9] IBD UK (2021). *Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*. CROJ8096-IBD-National-Report-WEB-210427-2.pdf

[10] Crohn's & Colitis UK (2020). Life in Lockdown: What patients told us about their healthcare | Crohn's & Colitis UK (crohnsandcolitis.org.uk)

[11] Sandhu BK, Fell JME, Beattie RM et al. on behalf of the IBD Working Group of the British Society of Paediatric Gastroenterology, Hepatology, and Nutrition (2010). Guidelines for the management of inflammatory bowel disease (IBD) in children in the United Kingdom. *Journal of Pediatric Gastroenterology and Nutrition*. 50 (Suppl 1): S1–S13. https://doi.org/10.1097/ MPG.0b013e3181c92c53

[12] UK wide with a sample size of 2,026 participants.

3.4. Mae'r arolwg cyhoeddus yn cadarnhau ymchwil a gynhaliwyd gennym gyda Choleg Brenhinol yr Ymarferwyr Cyffredinol[13] a oedd yn amlygu'r canlynol:

- Diffyg gwybodaeth am IBD mewn gweithwyr gofal iechyd cymunedol proffesiynol a'r angen am fwy o hyfforddiant mewn IBD.
- Diffyg hyder yn y defnydd o brofion calprotectin ysgarthol (FCP).

3.5. Er mwyn annog pobl â Chlefyd Crohn neu Lid Briwiol y Colon i ddod ymlaen, rydym yn annog y llywodraeth i bartneru â sefydliadau cleifion mewn ymgyrchoedd ymwybyddiaeth y cyhoedd, gwella argaeledd apwyntiadau meddygon teulu, buddsoddi yn natblygiad gweithwyr gofal iechyd proffesiynol cymunedol i adnabod symptomau a defnyddio profion yn effeithiol, a datblygu a buddsoddi mewn llwybr diagnostig a arweinir gan gleifion sy'n safoni'r defnydd o brofion[14] mewn gofal sylfaenol.

b. Cefnogi pobl sy'n aros am amser hir a chefnogi hunanreolaeth

3.6. Rydym yn croesawu ymrwymiadau'r cynllun i ddarparu cyfathrebu clir i gleifion. Rhaid i gyfathrebiadau ddiwallu eu hanghenion unigol, meithrin penderfyniadau ar y cyd, a chyfeirio at sefydliadau cleifion am ragor o wybodaeth a chymorth eang.

3.7. Rydym yn croesawu ymrwymiadau'r cynllun i gynnig cyfuniad o apwyntiadau rhithwir ac wyneb yn wyneb i gleifion allanol. Er ei bod yn bosibl y bydd gofal o bell yn cael ei groesawu i rai oherwydd ei gyfleustra a'i allu i leihau teithio, ni fydd yn briodol i bawb. Mae'n hanfodol bod gwasanaethau'n hybu dewis ac yn ystyried anghenion, dewisiadau ac amgylchiadau unigolion.

3.8. Rydym yn argymell defnyddio PIFU ar gyfer yr amodau/sefyllfaoedd a ganlyn:

- Cleifion Crohn neu Lid Briwiol y Colon â chyflyrau sefydlog a chynllun gofal personol gyda monitro llym
- Gofal dilynol mewn gofal sylfaenol gyda Llid Briwiol y Colon risg isel a sefydlog yn seiliedig ar fodel gofal a rennir a monitro llym, gan aros ar y rhestr gwyliadwriaeth colonosgopi.

3.9. Fodd bynnag, byddai PIFU yn anaddas ar gyfer yr amodau canlynol:

- Cleifion sydd newydd gael diagnosis
- Oedolion ifanc yn trosglwyddo o wasanaethau plant i wasanaethau oedolion.
- Clefyd Crohn neu Lid Briwiol y Colon heb ei reoli/anhydrin neu'n ffaglu.
- Ffistwleiddio cymhleth Clefyd Crohn neu Lid Briwiol y Colon sy'n ansefydlog.
- Cleifion ddim yn cadw at feddyginiaeth
- Llid Briwiol y Colon acíwt difrifol.

[13] RCGP and Crohn's & Colitis UK Inflammatory Bowel Disease Spotlight Project 2017–2020, www.crohnsandcolitis.org.uk/ improving-care-services/health-services
[14] Including faecal calprotectin, faecal immunochemical test, C-reactive protein, coeliac screen, ferritin, liver function test, thyroid function +/- stool culture checked in primary care.

3.10. At hynny, dylid lleihau risgiau penodol gastroenteroleg i gleifion ar y llwybr PIFU trwy'r canlynol:

- **Monitro rheolaidd yn hytrach na gofal adweithiol:** Gall mynediad at FCP liniaru'r oedi rhwng dechrau fflachiad a symptomau.
- **Gwyliadwriaeth ar gyfer pobl** â Clefyd Crohn neu Lid Briwiol y Colon **sydd â risg uchel o ganser.**
- **Llwybrau clir allan ac yn ôl i PIFU**: i leihau oedi neu rwystrau i ffaglu cleifion rhag dychwelyd i wasanaethau a chael mynediad at gyngor arbenigol yn brydlon pan fyddant yn ffaglu.

3.11. Mae rhai gwasanaethau IBD wedi bod yn defnyddio pyrth ac apiau i gefnogi gofal mwy cydgysylltiedig sy'n canolbwyntio ar y claf, gan gynnwys Patient Knows Best, MyChart, My IBD Care a'r Porth IBD[15]. Ynghyd â chynlluniau gofal personol, gan gynnwys hunanreoli â chymorth, a FCP yn y cartref, mae'r rhain yn cynnig potensial mawr ar gyfer ymagwedd fwy effeithiol ac effeithlon at ofal parhaus ar gyfer cyfran o gleifion.

c) Diwallu anghenion y rhai sydd â'r anghenion clinigol mwyaf, a'r rhai sydd wedi bod yn aros am amser hir

3.12. Cyn y pandemig Covid-19, amseroedd aros ar gyfer llawdriniaethau dewisol Clefyd Crohn a Llid Briwiol y Colon yng Nghymru oedd yr hiraf o blith pedair gwlad y DU, gyda dim ond 46% o wasanaethau'n nodi bod hyn wedi digwydd o fewn 18 wythnos i atgyfeirio. Dywedodd traean (30%) o gleifion eu bod wedi aros mwy na 18 wythnos am lawdriniaeth IBD dewisol.[16]

3.13. Mae'r pandemig wedi gwaethygu'r problemau presennol gyda gofal Clefyd Crohn a Llid Briwiol y Colon ac wedi arwain at:

- Gostyngiad yn y diagnosisau o Clefyd Crohn a Llid Briwiol y Colon yr adroddir amdanynt[17]
- Canslo a lleihau mynediad i endosgopi a llawdriniaeth ar gyfer Clefyd Crohn a Llid Briwiol y Colon[18]
- Oedi gydag apwyntiadau ac anawsterau o ran cael gafael ar arbenigwyr IBD a meddygon teulu
- Amharu ar fynediad at feddyginiaeth hanfodol.

Mae hyn wedi arwain at bobl â Chlefyd Crohn a Llid Briwiol y Colon yn profi:

- Fflerau, a all achosi niwed pellach i'r coluddyn a chynyddu'r risg o ganser

[15] I want to offer remote care and/or monitoring for patients - Gastroenterology digital playbook - NHS Transformation Directorate (nhsx.nhs.uk)
[16] IBD UK (2021). *Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*. CROJ8096-IBD-National-Report-WEB-210427-2.pdf
[17] Bodger, K., Bloom, S., Dobson, L. *et al.*, (2021). PMO-37 COVID-19 impact on care and prescribing for inflammatory bowel disease: Data from the IBD Registry. *Gut*, **70:**A95-A96.
[18] Deputy, M., Sahnan, K., Worley, G. et al., (2022). The use of, and outcomes for, inflammatory bowel disease services during the Covid-19 pandemic: a nationwide observational study. *Aliment Pharmacol Ther*, **55**(7), 836-846.

CROHN'S & COLITIS UK

- Mae'n debygol y bydd angen mwy o driniaeth cyffuriau cost uchel a llawdriniaeth gymhleth.[19]

3.14. Mae angen canolbwyntio buddsoddiad nid yn unig ar flaenoriaethau proffil uchel fel canser a chlefyd y galon, ond hefyd ar gyflyrau fel Clefyd Crohn a Llid Briwiol y Colon, sy'n aml yn cael eu hanwybyddu, ond sy'n cario costau tebyg i'r gwasanaeth iechyd.[20]

3.15. Nid oes gan y cynllun ddiffiniad clir ar gyfer y term 'brys clinigol' (t. 23) yn ei ddull o flaenoriaethu cleifion. **Yn ogystal â'r farn glinigol, mae'n hanfodol bod cleifion yn cael eu cynnwys yn eu proses datblygu diffiniad 'brys yn glinigol'.**

3.16. **Rydym yn argymell datblygu a gweithredu llwybr diagnostig a arweinir gan gleifion sy'n safoni'r defnydd o brofion[21] ar gyfer cleifion â symptomau gastroberfeddol is (GI) nad ydynt yn gysylltiedig â chanser.** Mae ymchwil yn awgrymu bod gan FCP a phrawf imiwnogemegol ysgarthol (FIT) gywirdeb tebyg wrth wneud diagnosis o ganser y colon a'r rhefr ac IBD.[22] [23] [24] [25]

3.17. Mae'r cynllun presennol ar gyfer blaenoriaethu gwasanaethau diagnostig yn dibynnu ar fwy o offer, cyfleusterau newydd ac ehangu'r gweithlu diagnostig. Fodd bynnag, mae adroddiad arbenigol GIRFT ar gyfer gastroenteroleg yn awgrymu bod optimeiddio'r capasiti presennol trwy ddylunio gwasanaethau a threfnu'r gweithlu yr un mor bwysig a chost-effeithiol.[26] **Argymhellwn felly fod y cynllun yn ehangu capasiti endosgopi drwy gyfyngu ar amser arbenigol neu ychwanegu capasiti yn yr adrannau presennol.**

3.18. **Rydym yn argymell bod Byrddau Iechyd yn cael eu mandadu i gyhoeddi llinellau amser eu llawdriniaethau er mwyn sicrhau bod cymorthfeydd IBD yn cael eu blaenoriaethu yn unol â chanllawiau Ffederasiwn y Cymdeithasau Arbenigedd Llawfeddygol (FSSA) [27].** Rydym wedi clywed gan gleifion a chlinigwyr bod y ffordd y caiff y canllawiau hyn eu rhoi ar waith yng Nghymru yn anghyson. Bydd methu â chywiro hyn yn arwain at gyflwyno cymorthfeydd IBD brys, sy'n tueddu i fod yn fwy cymhleth a chostus.

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[19] Crohn's & Colitis UK (2020). Life in Lockdown: What patients told us about their healthcare | Crohn's & Colitis UK (crohnsandcolitis.org.uk)

[20] Luces, C. and Bodger, K. (2006). Economic burden of inflammatory bowel disease: A UK perspective. *Expert Review of Pharmacoeconomics & Outcomes Research*. 6: 471-482.

[21] Including faecal calprotectin, faecal immunochemical test, C-reactive protein, coeliac screen, ferritin, liver function test, thyroid function +/- stool culture checked in primary care.

[22] Mowat, C., Digby, J., Strachan, J.A., *et al*. (2016) Faecal haemoglobin and faecal calprotectin as indicators of bowel disease in patients presenting to primary care with bowel symptoms. *Gut*, **65**(9), 1463-1469.

[23] Elias, S.G., Kok, L., de Wit, N.J., *et al.*, (2016). Is there an added value of faecal calprotectin and haemoglobin in the diagnostic work-up for primary care patients suspected of significant colorectal disease? A cross-sectional diagnostic study. *BMC medicine*, **14**(1), 1-11.

[24] Widlak, M., Thomas, C., Thomas, M. *et al.*, (2017). Diagnostic accuracy of faecal biomarkers in detecting colorectal cancer and adenoma in symptomatic patients. *Alimentary pharmacology & therapeutics*, **45**(2), 354-363.

[25] Högberg, C., Karling, P., Rutegård, J. *et al.*, (2017. Diagnosing colorectal cancer and inflammatory bowel disease in primary care: The usefulness of tests for faecal haemoglobin, faecal calprotectin, anaemia and iron deficiency. *A prospective study. Scand J Gastroenterol*, **52**(1), 69-75

[26] Oates, B. (2021). Gastroenterology: GIRFT Programme National Specialty Report. Layout 1 (gettingitrightfirsttime.co.uk)

[27] Clinical guide to surgical prioritisation during the coronavirus pandemic — Royal College of Surgeons (rcseng.ac.uk)

CROHN'S & COLITIS UK

4. Arweinyddiaeth a chyfeiriad cenedlaethol

4.1 Rydym yn croesawu penodiad arweinydd clinigol IBD Cymru Gyfan sy'n profi i fod yn gatalydd mewn gwelliannau i wasanaethau ledled y wlad. Drwy'r arweinyddiaeth hon, mae IBD Cymru[28] wedi blaenoriaethu rhestr o gamau gweithredu sydd eu hangen i roi Safonau IBD ar waith ledled y wlad.[29]

4.2. Fodd bynnag, mae nifer o eitemau sydd heb eu gweithredu eto gan Fyrddau Iechyd:

- Defnydd arferol o FCP mewn gofal sylfaenol gyda cholonosgopi llwybr cyflym i gyfeirio'r rhai â lefelau uchel
- Pob ysbyty i gael clinigau ymgynghorol IBD penodedig
- Cefnogaeth i'w rhoi i ddatblygu achos busnes ar gyfer penodi staff ychwanegol lle mae angen clir gyda thystiolaeth bod diffyg staff yn effeithio ar ofal cleifion
- Dylai pob bwrdd iechyd gael cymorth clerigol neu weinyddol penodedig i weithio ochr yn ochr â nyrsys arbenigol
- Dylai cymorth deietegol penodol i IBD fod ar gael yn amserol ym mhob gwasanaeth IBD, a ddarperir trwy gyfuniad o apwyntiadau wyneb yn wyneb a thros y ffôn
- Dylid cefnogi achosion busnes i ddarparu sesiynau seicoleg, gan gynnwys opsiynau ar gyfer rhaglenni triniaeth unigol ar-lein a allai fod yn fwy cost-effeithiol.

4.3 **Er mwyn cyrraedd y targedau hyn, mae angen y cynllun i hyrwyddo arweinyddiaeth a rennir ar draws y rhanbarth, gyda thargedau mandadedig clir.**

4.4 Rydym hefyd yn argymell sefydlu Rhwydwaith Gastroenteroleg Arbenigol, sy'n cynnwys dau rwydwaith gweithredol: un ar gyfer cydgysylltu camau gweithredu yn benodol ar endosgopi, ac un arall ar driniaeth IBD.

[28] A joint initiative led and facilitated by Crohn's & Colitis UK that aims to develop a strategic approach to the improvement of standards of care for IBD patients of all ages across Wales and includes patients and representation from all NHS Wales Local Health Boards.
[29] IBD UK (2019). *IBD Standards Core Statements*. IBD-Standards-Core-Statements.pdf

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5. Targedau ac amserlenni

5.1. Mae Tabl 1 yn dangos y canlyniadau ar gyfer detholiad o ddangosyddion o'r Arolwg Cleifion IBD a Hunanasesiad Gwasanaeth[30] ar gyfer yr ysbytai yng Nghymru a ymatebodd.[31] Mae'r tabl yn rhoi cipolwg o'r amrywiad o ran cyflawni Safonau IBD ac ansawdd gofal ar draws byrddau iechyd Cymru. Rydym yn annog y Llywodraeth i arwain asesiad o effaith yr amrywiadau hyn mewn gwasanaethau IBD ar ganlyniadau cleifion, fel rhan o'i hymrwymiad i fynd i'r afael ag anghydraddoldebau iechyd ledled y wlad.

5.2. Hoffem hefyd i'r Llywodraeth sicrhau bod Byrddau Iechyd yn cyhoeddi eu **hamserlenni cymorthfeydd** i sicrhau bod canllawiau Ffederasiwn y Cymdeithasau Arbenigedd Llawfeddygol (FSSA) yn cael eu dilyn.[32]

5.3. Er ein bod yn cydnabod y gallai fod angen dulliau gweithredu rhanbarthol i leihau amseroedd aros ac i adeiladu capasiti gofal wedi'i gynllunio'n gynaliadwy, rydym yn pryderu am yr effaith y gallai hyn ei chael ar ganlyniadau cleifion IBD, o ystyried yr amrywiaeth sylweddol mewn ansawdd gofal ledled y wlad. Mae buddsoddi mewn offer digidol i fonitro sut a ble mae cleifion IBD yn cael mynediad at ofal eilaidd yn hanfodol.

5.4. Rydym felly'n annog y llywodraeth i osod targedau cenedlaethol clir i unioni'r materion hyn a gweithio gyda Byrddau Iechyd i fwrw ymlaen â gweithredu'r Safonau IBD.

[30] Carried out between July 2019 and January 2020.
[31] IBD UK (2021). *Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*. CROJ8096-IBD-National-Report-WEB-210427-2.pdf
[32] Clinical guide to surgical prioritisation during the coronavirus pandemic — Royal College of Surgeons (rcseng.ac.uk)

CROHN'S & COLITIS UK

Ysbyty	Cwmpas y Boblogaeth	Nifer y Cleifion IBD a Gefnogir	Nifer Ymatebwyr Arolwg Cleifion	Ansawdd gofal (da, da iawn a rhagorol)	Mae cleifion ag IBD yn cael eu gweld o fewn 4 wythnos i'w hatgyfeiriad cyntaf	Mae pob llawdriniaeth IBD dewisol yn digwydd o fewn 18 wythnos	Mae gan bob claf IBD gynllun gofal personol yn seiliedig ar asesiad anghenion cyfannol	Mae gan bob claf fynediad at endosgopi a delweddu nad ydynt yn aciwt o fewn 4 wythnos ac o fewn 24 awr ar gyfer cleifion sy'n ddifrifol wael neu sydd angen eu derbyn i'r ysbyty	Mae pob claf sydd ag IBD wedi'i gadarnhau yn cael ei gofnodi mewn system reoli glinigol electronig
Ysbyty Gwynedd	194,139	1,300	40	59%					
Glan Clwyd	225,000	700	33	43%					
Wrecsam Maelor	387,000	1,824	58	76%					
Llwynhelyg	125,055	450	34	91%					
Treforys (Pediatreg)	500,000	51	N/A	N/A					
Castell-nedd Port Talbot	142,906	750	15	92%					
Tywysoges Cymru	150,000	1,500	8	57%					
Brenhinol Morgannwg	150,000	600	31	55%					
Tywysog Siarl	200,000	700	17	50%					
Ysbyty Athrofaol Cymru Ac Ysbyty Athrofaol Llandochau	650,000	3,000	99	83%					
Brenhinol Gwent, Nevill Hall ac Ysbyty Ystrad Fawr	750,000	3,513	95	61%					
Cyfanswm (Cyflawnwyd)					**0**	**5**	**4**	**5**	**1**

Tabl 1. Canlyniadau ar gyfer detholiad o ddangosyddion o Arolwg Cleifion IBD 2020 a Hunanasesiad Gwasanaeth ar gyfer yr ysbytai yng Nghymru a ymatebodd. Mae coch yn nodi lle nad yw'r dangosydd wedi'i gyflawni eto, mae gwyrdd yn nodi lle mae wedi'i gyflawni.

CROHN'S & COLITIS UK

Mae'r cyflwyniad hwn wedi'i ysgrifennu gan Amy Deptford, Rheolwr Polisi yn Crohn's & Colitis UK. I gael rhagor o wybodaeth, ysgrifennwch at

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 16
Ymateb gan: | Response from: Coleg Brenhinol Llawfeddygon Lloegr | Royal College of Surgeons of England

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RCS ENGLAND
IN WALES

Cynllun Llywodraeth Cymru ar gyfer trawsnewid a moderneiddio gofal wedi'i gynllunio a lleihau rhestrau aros

Tystiolaeth ysgrifenedig gan Goleg Brenhinol Llawfeddygon Lloegr

Rhagymadrodd

1. Mae Coleg Brenhinol Llawfeddygon Lloegr (CBLL) yn sefydliad aelodaeth proffesiynol ac elusen gofrestredig sy'n bodoli i hyrwyddo gofal cleifion. Rydym yn cefnogi bron i 30,000 o aelodau yn y Deyrnas Unedig ac yn rhyngwladol drwy wella eu sgiliau a'u gwybodaeth, hwyluso ymchwil a datblygu polisi ac arweiniad.

2. Rydym yn croesawu'r cyfle i roi tystiolaeth i ymchwiliad Pwyllgor Iechyd a Gofal Cymdeithasol y Senedd i gynllun Llywodraeth Cymru ar gyfer trawsnewid a moderneiddio gofal wedi'i gynllunio a lleihau rhestrau aros.

Crynodeb

Mae CBLL yn annog y Pwyllgor i ystyried y pwyntiau a ganlyn ynghylch cynllun Llywodraeth Cymru ar gyfer trawsnewid a moderneiddio gofal wedi'i gynllunio a lleihau rhestrau aros:

- Rydym yn croesawu cyhoeddi Cynllun Adfer Gofal wedi'i Gynllunio Llywodraeth Cymru (y Cynllun) sy'n hen bryd.
- Gydag amseroedd aros yng Nghymru yn dal i godi, mae angen strategaeth glir arnom i fynd i'r afael â'r ôl-groniad. Mae bron i 700,000 o lwybrau cleifion yn aros i ddechrau triniaeth ledled Cymru a gall arosiadau hir am lawdriniaethau fod yn arbennig o ddinistriol i gleifion.
- Rydym yn croesawu'r cyllid ychwanegol sydd ar gael ar gyfer gofal wedi'i gynllunio a mwy o weithio rhanbarthol i leihau amrywiadau mewn mynediad at wasanaethau llawfeddygol ledled Cymru.
- Rydym wedi bod yn galw am ganolfannau llawfeddygol penodol neu ganolfannau dewisol sy'n gwahanu gofal brys a gofal wedi'i gynllunio ers peth amser. Yn hollbwysig, mae'r canolfannau hyn yn caniatáu i driniaeth wedi'i chynllunio barhau hyd yn oed os oes pigyn arall mewn achosion COVID-19 neu ffliw'r gaeaf.

- Rydym yn parhau i bryderu am gyflymder adferiad llawfeddygol yng Nghymru. O gymharu â Lloegr, mae adborth anecdotaidd gan ein haelodau yn nodi bod lefelau gweithgaredd llawfeddygol yn is. Fodd bynnag, nid yw'r data hwn yn cael ei gyhoeddi'n eang.

- Yng Nghymru, er bod Llywodraeth Cymru wedi cefnogi'r egwyddor, prin yw'r cynnydd a wnaed gan Fyrddau Iechyd o ran symud i fodel canolfan lawfeddygol gyda rhai meysydd yn gwneud yn well nag eraill.

- Mae angen ymagwedd gyson arnom i weld canolfannau dewisol ym mhob ardal Bwrdd Iechyd ac ar draws ffiniau Byrddau Iechyd er mwyn osgoi loteri cod post o ofal cleifion a sicrhau mynediad cyfartal i wasanaethau llawfeddygol.

- Mae'r targedau y mae Llywodraeth Cymru wedi'u gosod yn y Cynllun yn heriol. Bydd yn cymryd sawl blwyddyn cyn i amseroedd aros ostwng i lefelau cyn-bandemig. Rydym yn galw am adroddiad blynyddol i'r Senedd i olrhain cynnydd.

- Mae gennym bryderon bod rhai targedau yn y Cynllun yn ymwneud â rhai arbenigeddau yn unig, gan adael cleifion o bosibl heb syniad clir pryd y gallant ddisgwyl cael eu trin. Dylai'r targedau yn y Cynllun fod yn berthnasol i bob arbenigedd.

- Mae ein gweithlu dan bwysau ac mae angen cynllun gweithlu annibynnol, wedi'i gostio'n llawn, i ddatrys y broblem hirsefydlog o swyddi gwag. Ni ddylai cyflawni'r targedau yn y Cynllun ddod ar draul lles staff.

- Rhaid cefnogi hyfforddeion llawfeddygol i ddal i fyny â chyfleoedd hyfforddi a gollwyd cyn gynted â phosibl.

Amseroedd aros yng Nghymru

Rydym yn croesawu cyhoeddi Cynllun Adfer Gofal wedi'i Gynllunio Llywodraeth Cymru. Roedd yn hen bryd cael strategaeth glir ar fynd i'r afael â'r ôl-groniad.

Mae amseroedd aros yng Nghymru yn uwch nag erioed o'r blaen. Ar gyfer y data diweddaraf sydd ar gael, mae nifer y llwybrau cleifion sy'n aros am driniaeth yng Nghymru bellach yn 701,418. Mae mwy na 250,000 o lwybrau cleifion yn aros dros naw mis am driniaeth. Er mwyn cymharu ym mis Mawrth 2021 roedd 568,367 o lwybrau cleifion ar y rhestr aros ac roedd 216,418 wedi bod yn aros am fwy na naw mis. Ar gyfer mis Mawrth 2022 mae'r nifer fwyaf o lwybrau cleifion ar gyfer trawma a llawdriniaeth orthopedig [97,522], llawdriniaeth gyffredinol [86,544], ENT [59,346] ac wroleg [42,694].[i]

O bryder arbennig yw'r nifer fawr o gleifion sy'n aros mwy na dwy flynedd am driniaeth yng Nghymru. Ar gyfer y data diweddaraf sydd ar gael, mae 70,417 o lwybrau cleifion yn aros mwy na 105 wythnos. Dyma'r nifer uchaf ers dechrau cadw cofnodion. Yn Lloegr, mae gan lywodraeth y DU darged i ddileu arosiadau dwy flynedd erbyn Gorffennaf 2022. Er nad oes modd cymharu'r data'n uniongyrchol, roedd 9,146 o gleifion yn aros mwy na dwy flynedd yn Lloegr ym mis Mai 2022.[ii]

Roedd rhestr aros sylweddol yn bodoli yng Nghymru cyn COVID-19 ond mae’r sefyllfa wedi’i gwaethygu gan y pandemig. At hynny, nid yw GIG Cymru wedi cyrraedd ei dargedau amseroedd aros ers 2011.[iii]

Bellach mae perygl y bydd rhai cleifion yn gorfod aros blynyddoedd am driniaeth yng Nghymru, sy’n annerbyniol. Er mwyn mynd i’r afael â hyn, mae angen i Lywodraeth Cymru gyflawni’r ymrwymiadau a nodir yn y Cynllun ar fyrder.

Fel yr amlinellwyd yn ein ‘Cynllun Gweithredu ar gyfer Adfer Gwasanaethau Llawfeddygol yng Nghymru’ a gyhoeddwyd yn 2021, gall arosiadau hir am ofal wedi’i gynllunio gael ystod o effeithiau negyddol ar ofal cleifion. Y themâu cyffredin yw poen, trallod seicolegol, ofnau ynghylch dirywiad mewn iechyd, bygythiadau i gyflogaeth a cholli incwm, a diffyg ymddiriedaeth cynyddol mewn darparwyr gofal.[iv]

Mae cyfnodau hir o aros am lawdriniaeth hefyd yn peri risg o ddirywiad pellach yng nghyflwr cleifion, a all olygu bod angen llawdriniaeth fwy cymhleth. Yn anffodus, bydd rhai achosion pan fydd cleifion yn marw wrth aros am driniaeth.

Canolfannau llawfeddygol

Rydym wedi bod yn galw am ganolfannau llawfeddygol neu ganolfannau dewisol penodol yng Nghymru ers peth amser. Mae'r unedau hyn yn gwahanu gofal brys a gofal wedi'i gynllunio. Mae canolbwyntiau llawfeddygol yn creu theatrau llawdriniaethau a gwelyau wedi'u neilltuo gan alluogi mwy o lawdriniaethau i fynd rhagddynt. Mae canolfannau o’r fath yn creu mwy o gapasiti penodol ar gyfer llawdriniaethau wedi’u cynllunio i fynd rhagddynt ac yn helpu i leihau’r ôl-groniad o’r rhai sy’n aros am driniaeth hyd yn oed os oes cynnydd mawr arall mewn achosion COVID-19 neu ffliw’r gaeaf. Maent hefyd yn creu system iechyd fwy cynaliadwy a gwydn yn y tymor hwy.

Nid mater o newid trefniadaeth gwasanaethau ysbyty yn unig yw sefydlu canolfannau llawfeddygol neu ganolfannau dewisol. Mae angen inni hefyd gynyddu capasiti’r GIG yn sylweddol o ran theatrau llawdriniaethau a gwelyau llawfeddygol. Fel y cydnabu Archwilio Cymru, mae nifer y gwelyau yng Nghymru wedi gostwng yn gyson dros nifer o flynyddoedd.[v] Er ein bod yn cydnabod gallu’r sector annibynnol i wneud hynny darparu rhywfaint o gapasiti ychwanegol yn y tymor byr, mae angen inni sicrhau capasiti mwy cynaliadwy yn y GIG.

Yr adborth anecdotaidd gan ein haelodau yw bod adferiad gofal wedi’i gynllunio yng Nghymru wedi bod yn dameidiog ac yn anghyson. Mae gweithgaredd llawfeddygol yn parhau i fod yn is na'r lefelau cyn-bandemig mewn rhai ardaloedd daearyddol a rhai arbenigeddau llawfeddygol.

Rydym yn croesawu’r dull a amlinellir yn y Cynllun i wahanu gofal wedi’i gynllunio oddi wrth dderbyniadau brys. Fodd bynnag, ychydig o gynnydd a wnaed gan Fyrddau Iechyd o ran symud i fodel canolfan lawfeddygol. Gwyddom fod rhai ardaloedd (Caerdydd ac Aneurin Bevan er enghraifft,) yn gwneud yn well nag eraill. Croesewir hefyd y cynlluniau a gyhoeddwyd gan Fwrdd Iechyd Prifysgol Bae Abertawe i greu canolfannau rhagoriaeth lawfeddygol ar draws y tri phrif ysbyty ym Mae Abertawe. Mae'n werth nodi bod 91 o ganolfannau llawfeddygol dewisol ar waith yn Lloegr ar hyn o bryd.[vi]

Mae angen cyfeiriad cryf gan Lywodraeth Cymru i weld canolfannau dewisol ym mhob ardal Bwrdd Iechyd ac ar draws ffiniau Byrddau Iechyd. Mae hyn er mwyn osgoi loteri cod post o ofal cleifion a sicrhau mynediad cyfartal i wasanaethau llawfeddygol yng Nghymru.

Byddem hefyd yn annog Llywodraeth Cymru i gyhoeddi data ar weithgarwch llawfeddygol (yn erbyn lefelau cyn-bandemig) bob mis, wedi'i ddadansoddi fesul Bwrdd Iechyd ac arbenigedd. Mae hyn er mwyn nodi a chefnogi'r ardaloedd daearyddol a'r arbenigeddau llawfeddygol hynny sydd â lefelau is o weithgarwch llawfeddygol.

Mae'r gwasanaeth iechyd yng Nghymru yn wynebu pwysau dwys a pharhaus. Mae maint yr her yn ddigynsail. Rydym yn ymwybodol y bydd yn cymryd sawl blwyddyn cyn i amseroedd aros ddychwelyd i lefelau cyn-bandemig. Mae'r Gweinidog Iechyd wedi dweud y bydd yn cymryd tymor Senedd llawn ac mae Archwilio Cymru wedi dweud y gallai gymryd hyd at saith mlynedd neu fwy.[vii]

Rhaid inni sicrhau bod cyfathrebu â chleifion yn gyson ledled Cymru i roi gwybod iddynt am ba mor hir y bydd yn rhaid iddynt aros am driniaeth. Rhaid inni hefyd wneud yn siŵr eu bod yn cael eu cefnogi'n llawn yn ystod y cyfnod anodd hwn.

Blaenoriaethu

Drwy gydol y pandemig, mae'r GIG wedi ceisio blaenoriaethu cleifion â'r angen clinigol mwyaf. Mae blaenoriaethu clefydau sy'n sensitif i amser fel canser yn hollbwysig. Wrth i'r pandemig fynd rhagddo, dirywiodd iechyd mwy o gleifion a oedd yn aros am lawdriniaethau arferol. Gall amodau anfalaen fel torgest ddirywio os na chânt eu trin. Gall arosiadau hir am lawdriniaeth clun neu ben-glin arwain at gymalau cynyddol boenus a dirywiol. Oherwydd yr effaith ar ddatblygiad ac addysg plentyn, gall oedi cyn llawdriniaeth ar daflod hollt i blant ddod yn hollbwysig. Gall cleifion ddod yn analluog i barhau i weithio neu fyw'n annibynnol.

Dros amser, gall llawdriniaethau a ystyrir i ddechrau yn flaenoriaeth is ddod yn fwy brys. Mae'r nodau o flaenoriaethu yn ôl angen clinigol a mynd i'r afael â'r amseroedd aros hiraf ill dau yn bwysig. Mae angen cefnogi llawdriniaethau sy'n hanfodol o ran amser ac yn fwy 'arferol' ond llawer o oedi gyda buddsoddiad ledled Cymru.

Rydym yn croesawu elfennau o'r Cynllun i gefnogi cleifion tra'n aros am driniaeth. O ystyried bod rhestrau aros yn debygol o barhau i godi, mae cymorth i gleifion 'aros yn dda' yn bwysig.[viii] Rhaid gwneud ymdrechion i nodi cleifion a allai fod yn dirywio'n glinigol ar y rhestr aros fel y gellir eu hail-flaenoriaethu.

Targedau yn y Cynllun

Mae'r Cynllun yn nodi nifer o dargedau heriol ar gyfer adferiad gofal wedi'i gynllunio yng Nghymru. Mae gennym bryderon difrifol fod rhai o'r targedau yn y Cynllun yn ymwneud â rhai arbenigeddau yn unig. Gallai hyn olygu nad oes gan rai cleifion syniad clir pryd y gallant ddisgwyl cael eu trin. Dylai'r targedau yn y Cynllun fod yn berthnasol i bob arbenigedd ac mae angen mwy o fanylion ynghylch yr amserlenni ar gyfer y targedau a sut y cânt eu mesur.

Er mwyn sicrhau bod y targedau'n cael eu cyflawni'n dryloyw dylai fod adroddiad blynyddol gan Lywodraeth Cymru i'r Senedd.

RCS ENGLAND
IN WALES

Gweithlu

Mae'r pandemig wedi cael effaith andwyol ar iechyd a lles meddygon. Mae ein gweithlu eisoes wedi blino'n lân ac yn ormod o bwysau, ac mae arnom angen atebion i'r broblem hirsefydlog o swyddi gwag. Ni ddylai cyflawni'r targedau yn y Cynllun ddod ar draul lles staff.

Mae cadw ein gweithlu presennol a sicrhau bod staff newydd yn cael eu recriwtio yn her sylweddol. Mae arnom angen strategaeth gweithlu gadarn, wedi'i chostio'n llawn, sy'n darparu asesiad annibynnol o niferoedd y gweithlu presennol ac yn y dyfodol yng Nghymru. Mae deall y rhagamcanion hyn yn hollbwysig er mwyn sicrhau bod digon o staff i fodloni'r galw gan gleifion, lleihau'r ôl-groniad o ran amseroedd aros a sicrhau cynaliadwyedd hirdymor y system iechyd yng Nghymru.

Hyfforddeion

Bydd defnyddio hyfforddeion yn allweddol i gefnogi'r tîm llawfeddygol a'r gweithlu ehangach. Mae'r pandemig wedi cael effaith andwyol ar hyfforddiant meddygon ac amgylcheddau gwaith.

Mae cefnogi ein hyfforddeion llawfeddygol i ddatblygu eu hyfforddiant yn allweddol i fynd i'r afael â'r ôl-groniad o restrau aros. Rhaid helpu hyfforddeion llawfeddygol i ddal i fyny â chyfleoedd hyfforddi a gollwyd cyn gynted â phosibl, gyda rhaglenni hyfforddi pwrpasol sy'n cynnwys gwell amser theatr. Dylai pob llawdriniaeth gynlluniedig a wneir ar glaf y GIG, gan gynnwys cleifion y GIG sy'n cael eu llawdriniaeth mewn ysbyty annibynnol, gynnwys hyfforddai llawfeddygol i'w helpu i gael yr amser hyfforddi y mae wedi'i golli.

Bydd hybiau llawfeddygol yn helpu i gynyddu gweithgaredd llawfeddygol, a hefyd yn darparu cyfleoedd y mae mawr eu hangen ar hyfforddeion llawfeddygol i barhau â'u hyfforddiant. Rhaid inni sicrhau bod canolfannau llawfeddygol yn cynnwys hyfforddeion ac yn helpu i gynyddu nifer y cyfleoedd hyfforddi sydd ar gael ledled Cymru.

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[i] Stats Wales, Referral to treatment. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment [Accessed 8 Jun. 2022].
[ii] Information obtained from a press notice issued by the Department of Health and Social Care External Affairs team, dated 6 June 2022
[iii] Stats Wales, Referral to treatment. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment [Accessed 8 Jun. 2022].
[iv] RCS England, Action Plan for the Recovery of Surgical Services in Wales, March 2022.
[v] Audit Wales, *Tackling the Planned Care Backlog in Wales, May 2022.*
[vi] UK Parliament. 2022 [cited 8 June 2022]. Available from: https://questions-statements.parliament.uk/written-questions/detail/2022-05-16T00:00:00/2573
[vii] Audit Wales, *Tackling the Planned Care Backlog in Wales, May 2022.*
[viii] Audit Wales, *Tackling the Planned Care Backlog in Wales, May 2022.*

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 17
Ymateb gan: | Response from: Cymdeithas Genedlaethol Plant Byddar Cymru | National Deaf Children's Society Cymru

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National Deaf Children's Society CYMRU

Health and Social Care Committee request for written evidence on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

National Deaf Children's Society Cymru Response

June 2022

About Us

The National Deaf Children's Society is the national charity dedicated to creating a world without barriers for deaf children, young people and their families. We support children and young people aged 0-25 with all levels of deafness, from mild through to profound, including those with temporary hearing loss and a unilateral loss.

Introduction

We understand that the NHS has faced unprecedented pressure over the course of the pandemic and that staff have been working hard under very difficult circumstances. However, in many areas children are waiting long periods of time for a paediatric audiology appointment.

The National Deaf Children's Society Cymru welcomes the Welsh Government's commitment to prioritise children in early diagnosis and treatment and to assess children's waiting times differently to that of adults. It is important that target waiting times are not extended. We know how important early diagnosis can be for deaf children and young people. Delays in diagnosis can have significant impact on deaf children's language development, as well as their educational and social opportunities. The significant impact of delayed diagnosis has been recently highlighted within the BAA report into failings of audiology services in Lothian, Scotland.

Audiology

The National Deaf Children's Society Cymru is aware of significantly increased waiting times in many of our paediatric audiology services across Wales. Some are waiting well over a year to be seen. While there are certainly some underlying staffing shortages, the pandemic has further exacerbated these waiting times.

We note that the plan emphasises the need to focus on the clinically urgent and, while we understand and appreciate this, we would also emphasise that we also need to recognise the importance of not allowing long waiting times for review paediatric audiology appointments to continue. Indeed, access to review and routine appointments in paediatric audiology can be important in ensuring that a child has the appropriate support in place and that changing needs are met. Without this, children can be vulnerable to difficulties in their learning and social development as well as feelings of isolation and difficulties with emotional wellbeing.

In noting the emphasis within the plan on patient initiated follow-up, we would highlight the importance of ensuring that patients are aware of accessible means for contacting services across the board. We would also highlight that the context of an emphasis on patient initiated follow-up is different in different types of health services. For services such as paediatric audiology, patient initiated appointments are important, but routine appointments are also important and should not be discarded. They play a significant role in ensuring ongoing accessibility and picking up changing

needs. This is particularly important in paediatric audiology where parents may not always be able to accurately pick up how a child's hearing is changing.

We would like to see Welsh Government prioritise paediatric audiology as an area for investment during covid recovery. Given the difficulties with staff shortages and room availability, this may require some creative "out of the box" thinking and solutions.

In addition to addressing the immediate and pressing waiting times in many departments, we are mindful that there are longer term issues with staffing shortages that need to be resolved. As such, we were pleased to see the plan refer to looking at planning for a sustainable workforce. The National Deaf Children's Society has been delighted that the Welsh Government has recently established a Task and Finish Group to look into the findings of the recent report on failings in audiology services in Lothian in order to see whether there are learnings from this report in Scotland for Wales. As part of this work, consideration is being given to the audiology workforce in Wales. We urge that the Welsh Government takes on board the findings of this group and considers how to address these matters in the longer term.

Digital Working

We are mindful of increasing moves towards remote appointments and digital working. It is important that in making such moves, thorough consideration is given to access requirements. For example, for deaf patients, picture and audio quality as well as captioning or BSL interpretation could be important in order to access such an appointment. It is also important to consider patient preference and whether remote appointments are always an appropriate format. For example, it might be difficult to engage a young child in an assessment remotely.

The National Deaf Children's Society Cymru would welcome a clear caution within the plan regarding the above.

The NHS Estate

We welcome that the Welsh Government recognises the need to better utilise the healthcare estate. Availability of rooms for audiological testing can be an issue for services looking to provide extra clinics in order to reduce waiting times.

Mental Health

Research suggests that deaf young people are 60% more likely to experience mental health problems than other children.[1] It is not deafness itself that increases the incidence, but rather the barriers faced from living in a hearing-orientated world.

Previously, the Welsh Government called for all health boards in Wales to appoint a lead to assist with general awareness of the increased incidence of emotional wellbeing difficulties among the young deaf population and to aid referrals through to specialist deaf CAMHS in England. Unfortunately, the National Deaf Children's Society Cymru understands that these posts are no longer in place across many of our health boards. We would welcome moves by the Welsh Government to ensure that these roles are re-established and to again consider the support needs of deaf young people across Wales who require access to mental health support.

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[1] Department of Health and National Institute of Mental Health. Towards Equity and Access. 2005.

This is particularly timely as deaf young people and their families have told us that the pandemic has taken a further toll on emotional well-being for many deaf young people. During the pandemic, deaf young people have faced increased barriers such as communication difficulties as a result of facemasks and an inability to access usual levels of learning support.

Social Care

In 2020 we worked alongside RNID Cymru and the Welsh Government on developing guidance for social care workers. Knowing that the number of specialist social workers has been in decline and that the pandemic has impacted on social care needs, we are keen to see the publication of this guidance.

Speech and Language Therapy

With the introduction of the Additional Learning Needs Reforms in Wales and the availability of Individual Development Plans to children in the early years, specialist deaf speech and language therapists will be in even higher demand than previously. The early years play a significant role in a child's development and access to speech and language therapy early on can be crucial.

We understand that access to such specialist professionals can already be a postcode lottery and would be keen for the Welsh Government to give further consideration to this matter.

More information

The National Deaf Children's Society Cymru would welcome the opportunity to discuss these points further and receive some clarifications. Please do not hesitate to contact us
at for further information.

Thank you for taking the time to read our response.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 18
Ymateb gan: | Response from: RNIB Cymru

RNIB
Cymru

RNIB Cymru’s response to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

About RNIB

RNIB Cymru is the largest sight loss charity in Wales, providing support and services to blind and partially sighted people, their families, friends, and carers. We aim to improve lives and empower people to adapt to sight loss and keep their independence. We work in partnership with public, private and third sector bodies across Wales to deliver projects, training, services and give information, advice, and guidance.

We challenge inequalities by campaigning for social change and improvements to services. We believe that timely treatment should be available to all to prevent avoidable sight loss, and that the right support is there for people when prevention isn’t possible. We raise awareness of issues facing blind and partially sighted people on a daily basis.

Whether you have full, some, little or no sight, everybody should be able to lead independent and inclusive lives, without facing inequity and discrimination.

1. Will the plan be sufficient in addressing the backlogs in routine care that have built up during the pandemic, and reduce long waits.

1.1 RNIB Cymru welcomes this plan and the concerted effort by Welsh Government to reduce waiting lists. It's crucial, however, that improvements to services happen at pace as backlogs in planned care are leading to sight loss.

1.2 As of March 2022, there are currently just over 130,000 people in Wales assessed with the highest risk of sight loss. Half of them (65,000) are waiting beyond the target for their clinical appointment and are at immediate risk of going blind.[1]

1.3 Eye care services are some of the busiest in Wales, with hospital ophthalmology clinics seeing 11% of all outpatient appointments. The Royal College of Ophthalmology estimates that this will increase by 40% in the next 20 years.

1.4 Over the next 20 years ophthalmology demand is expected to increase by 16 per cent for conditions such as Glaucoma, 47 per cent for Age related Macular degeneration, 50 per cent for conditions such as cataract, and up to as high as 80 per cent for diabetic retinopathy.

1.5 By 2050, the number of people with sight loss is expected to double.[2]

1.6 A recent Wales Audit Office report[3] highlights that Ophthalmology is one of the specialities which could take far longer to recover than others because it was stretched even before the pandemic.

1.7 We know that the pandemic has exacerbated waiting lists and has had a substantial impact on theatre capacity, with around 20,000 operations per month currently taking place compared to almost 30,000 pre-covid.

1.8 Since 2018, eye care in Wales has taken a risk-based approach by introducing Eye Care Measures. This is the first service to do so. The Eye Care Measures assign patients a "Health Risk Factor", based on the severity of their condition and also a target date which they need to be

[1] Patients waiting for an ophthalmology outpatient appointment (gov.wales)

[2] RNIB sight loss data tool

[3] Tackling the Planned Care Backlog in Wales | Audit Wales

treated by, in order to reduce the risk of irreversible sight loss. The highest is HRF1, which means that there is “Risk of irreversible harm or significant patient adverse outcome” if patient target date is missed. Essentially, patients could go blind or suffer significant sight loss if treatment is delayed.

1.9 With one in two of the highest risk patients at immediate risk of going blind, tackling performance against the Eye Care Measures must be a priority for health boards and the Welsh Government.

1.10 As a result, we are concerned that the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists does not directly address the Eye Care Measures or how Health Boards will be held accountable around meeting the targets set out by the Measures. RNIB Cymru believes this is crucial for supporting the identification of pain points within the patient pathway.

Recommendations

- Welsh Government should publish its plans around how it will hold health boards to account around their performance against the Eye Care Measures

- Welsh Government should publish a timeline of when it will expect HBs to meet the targets

2. Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?

2.1 RNIB Cymru very much welcomes the Welsh Government’s efforts to encourage Health Boards to move more services in to the community and the significant changes to optometry that are underway. These changes will enable high street optometrists to provide services that go

well beyond eye tests, with the aim of reducing hospital eye care waiting lists by 'a third'.[4]

2.2 However, as well as planning for the future, as mentioned above, it's crucial that the immediate risks and challenges are addressed with urgency as patient pathways are transformed. For example, the absence of Eye Care Measures is very noticeable in the section around clinical prioritisation (page 22), as we're now in the situation where the vast bulk of the waiting list is categorised as the highest risk of irreversible sight loss/harm. Every person on that list is a priority and needs to receive treatment urgently.

Recommendations:

- Eye Care Measures must now be properly embedded in Health Board practise and action plans be developed to tackle performance and backlog. A national review at this point would be a timely and important exercise in supporting the Welsh Government and NHS to prioritise funding and action.

- Welsh Government and health boards must also develop a robust capacity and demand analysis of patients by sub-speciality, through extending ECM reporting to include data by condition.

- Welsh Government and health boards should also expedite implementation of the earlier recommendations of the Wales Audit Office's 2018 report into the management of outpatients[i], and the Public Accounts Committee's subsequent 2019 inquiry ([ii]), in particular to bring forward proposals for recording occasions when patients have come to harm as a result of waiting for a follow up outpatient appointment or treatment.

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[4] Statement: NHS Planned Care Recovery Plan – Tuesday, April 26

3. Whether the plan includes sufficient focus on:

3a. Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;

3.1 We know that patients often feel unsupported whilst waiting for treatment. They may not be given the advice or information to effectively self-manage their condition or may not be aware that they're in a category which puts them at significant risk of harm. This could then impact on their behaviour, for example, they may not think it important to attend outpatient appointments or take all of the precautionary measures recommended to manage their condition.

3.2 RNIB has been delivering an Eye Clinic Liaison Officer (ECLO) service across the UK for over twenty-five years giving a wealth of expertise and knowledge. Working with Health Board eye care teams, ECLO services enable patients to access critical early intervention support to help them to remain independent, manage their sight condition and to access both local and national support services. RNIB patient experience research found that as many as 77 per cent of patients said they would not have found or accessed support outside the hospital without the ECLO. ECLO's have told us that they are seeing more complex cases due to patients waiting up to a year for treatment, this leads to them spending more time with patients and offering increased levels of emotional support.

3.3 Patients accessing the RNIB Counselling service tell us that it is vitally important that when the time comes to deal with the emotional impact of sight loss, that the support they get comes from someone who has knowledge and understanding about sight loss conditions, as well as the range of support that can be offered as sight fails, and alternative coping mechanisms. RNIB currently offers counselling to 73 people per year affected by sight loss in Wales. There are often specific challenges faced by people who live in rural settings where transport links to services can be an issue. To lose your sight in an isolated environment can add a level of complexity and lead to increased levels of anxiety and isolation. Despite the dedicated resources we still have a number of

people on our waiting list in Wales, with a current waiting time of 9 months.

Recommendations:

- The Welsh Government should provide patients with adequate and appropriate information about their level of clinical need and the degree of urgency with which they need to receive treatment. In terms of eye care, this means that patients are aware of the health risk factor rating (HRF). Patients should know who they can contact and the support they should expect when waiting over target.
- Welsh Government and NHS Wales should launch an awareness campaign to increase patients' understanding of optometrists' new role as a result of eye care services being moved to the community. There should also be ongoing communication with patients around how this will change the way their eye care is delivered.
- In terms of preparing eye care patients to receive their care, HBs should provide information intended to reassure patients of the importance of attending their appointment; the importance of arriving on time to reduce the number of patients waiting in the clinic; and how to contact the Eye Clinic Liaison Officer (ECLO) if they have any concerns. This could help reassure patients of the need to attend their appointments and could reduce the high number of patients who do not attend.
- Welsh Government plans for the recovery and transformation of planned care should reflect the Health and Social Care Committee's recommendation around the need for a focus on supporting patients to wait well. This includes information being provided in accessible formats to meet the patients' communication needs while they wait, as well as promoting awareness of, and ensuring access to, the most appropriate interim practical and emotional support.
- The ECLO role needs to be embedded in any future patient pathways.
- It's crucial that counselling services are robustly resourced to meet current and future demand, and that they are accessible to people with sight loss.

- RNIBs counselling service specifically addresses the issues arising from sight loss and it's crucial that there are good referral and signposting links to this service, and that the service is resourced.
- Welsh Government should support the role of RNIB's accredited training module, which has been developed for the counselling professions in the UK.
- Further detail is required around how the Welsh Government and NHS Wales will deliver targeted support and signposting to people living in more deprived areas, people with learning disabilities, ethnic minority communities and any other groups that face additional barriers to accessing eye care.

3b. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;

3.4 As mentioned above, clarity is needed around how health boards and Welsh Government are going to prevent HRF1 patients (and particularly those waiting over target) from going blind.

3.5 Due to the waiting list backlog, we are now hearing of cataract patients meeting the threshold for a CVI (certificate of visual impairment) and being referred to Vision Rehabilitation support. This raises concerns that when a person's wait for a very low priority procedure exceeds a length of time, a person's condition can deteriorate significantly. Patients in the low priority categories may rarely get to the front of the queue unless there is dedicated capacity for them.

3.6 While we welcome the recognition that local authority rehabilitation services, including vision rehabilitation services, have a key role to play in improving personal independence, and in the recovery of services, we regret the lack of specific proposals to improve the quality and equity of provision. This is especially crucial as there are significant delays in eye care patients receiving timely treatment.

3.7 As detailed in the Wales Council for the Blind's report "Addressing a workforce crisis in Wales", there are areas with waiting lists of more than a year for vision rehabilitation support after referral with a CVI. Vision rehabilitation is a vital element in blind and partially sighted people regaining and maintaining independence following a sight loss diagnosis. The inevitable result of delayed or absent provision is a loss

of confidence and income for an individual, and an increased dependence on carers or care needs assessed services.

Recommendation

- The strategy needs to make clear how to signpost to and ensure integration of, local authority rehabilitation services, including more specialist rehabilitation services that work alongside those that provide hospital discharge reablement/rehabilitation.
- Health Boards should ensure that referrals into local authority vision rehabilitation services are made in a timely and systematic way, and that there is an equity of high-quality provision across Wales.

3c. Improving patient outcomes and their experience of NHS services

3.8 It's crucial that the information patients need to keep safe and well is accessible. We welcome the Welsh Government's emphasis on the importance of making sure that support and information is easily accessible to those who are waiting, however, changes need to happen at pace.

3.9 Many blind and partially sighted people in Wales report that they are not currently able to understand and make informed decisions about their own healthcare because:

i. Information about their health is not given to them in an appropriate format
ii. They are not routinely communicated with in a way that is appropriate to their needs.

3.10 Ineffective communication with patients with sensory loss is a patient safety issue. Patients are at risk by not receiving the right support to enable them to engage in and fully understand consultations with healthcare professionals.

3.11 We have also heard from ECLOs that patients have been removed from waiting lists or moved to the bottom of lists as the communications they've received have been inaccessible.

Recommendations

- Welsh Government should audit Health Boards' adherence to the All Wales Standards for Accessible Communication and Information with people with Sensory Loss, and implement an action plan to ensure this is standard practise within eye clinics.

- All health boards should also be mandated to include accessibility as a standing item on Eye Clinic Collaborative Group agendas.

- We would also like to request an update around a recommendation accepted by the Welsh Government on 23 September 2020, which called for the appointment of an accessibility lead within the Welsh Government to oversee the production of all key public health and other information in accessible formats, including implementation of and compliance with the standards.[5] Despite this recommendation being made and accepted, we know that there is no appointed Welsh Government lead for the All Wales Standards.

- NHS services should ensure that people with sight loss are asked about their communication needs and that any information is provided in their preferred accessible format.

- NHS IT systems and infrastructure must be available to support the collection and delivery of accessible information to people with sight loss.

- Key staff within health boards should receive training to better understand the communication needs of blind and partially sighted people and how to meet their communication preferences.

- Health boards should also undertake a comprehensive review of health board patient management systems to stop resource waste

5 Health and Social Care Committee, Waiting well? The impact of the waiting times backlog on people in Wales (April 2022)

and ensure the well-being, dignity and safety of the patient.

- It is essential that patient satisfaction with the service is collected. With the increased DNA (do not attend) and CNA (cannot attend) rates, understanding and learning from patient experience is vital to improving the clinical and patient service. Health Boards must collect, analyse, use and learn from patient feedback for quality improvement. It is unclear how this is being done at present.

4. Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?

4.1 A regional approach to eye care has been recommended to increase service capacity. This would help create fundamental change in the way eye care services are delivered as they recover. We are aware that three new regional clinical leads for eye care have been appointed which is to be welcomed, however, no regional groups for eye care have been established so it's unclear how this regional working will be delivered. As a result, we seek clarity on the progress around the development of regional eye care services, which will need to be allocated significant and sustainable resource and investment.

Recommendations:

- Welsh Government should also ensure that the Ophthalmic Planned Care Board examines the scope of more regional planning and identifies where pressures can be off-set or where risk-sharing can be enabled, and progress recommendations.

5. Is it sufficiently clear which specialties will be prioritised/included in the targets?

5.1 The absence of the Eye Care Measures from the document means that it's difficult to get a sense of measurable, realistic and achievable

timescales and targets. A delivery plan specific to Eye Care recovery should be developed and published.

5.2 Evidence suggests around 10% of new patients are at risk of irreversible sight loss compared to about 90% of follow-up patients. The current Referral to Treatment Time (RTT) in eye care is 24 weeks, which means the target of ‘No one waiting longer than a year for their first outpatient appointment by the end of 2022’ included in the plan is irrelevant in terms of eye care.

5.3 We do, however, welcome the plan’s commitment to developing targets and performance management alongside a real-time, visibility of the waiting list by sub speciality, robust demand and capacity plans that will enable teams to work effectively. RNIB Cymru has repeatedly called for this for several years.

6. Do you anticipate any variation across health boards in the achievement of the targets by specialty?

6.1 The plan outlines the importance of a fair and equitable approach to patient prioritisation to minimise health inequalities.

6.2 However, Eye Care Measures now also show that there is a significant postcode lottery to Health Board performance in terms of outpatient waiting times. For example, Betsi Cadwaladr UHB and Hywel Dda UHB have more than half of their HRF1 (the highest risk category of patients) over target and beyond what is clinically safe. Cardiff & Vale UHB is the better performing of the larger health boards with 30% of patients over target, however Cwm Taf Morgannwg is the worst performing – with 63% of patients, almost two-thirds of their highest risk patients, over target.

6.3. We are aware that gaps in the consultant workforce is leading to the exacerbation of some speciality waiting lists in some Health Boards, for example due to specialist shortages there is a huge backlog in Glaucoma patients. A workforce plan and a clear approach to regional working are essential to ensuring equity of service across Wales.

Recommendation

- Health Boards should share examples of good practice and learn, this is particularly important as such large variations exist across Wales in terms of patient access and outcomes.

7. Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?

7.1 Whilst we welcome the plan's focus on how it will address the immediate as well as long-term workforce challenges by moving eye care services into the community, it does not detail how it intends to upskill the optometry workforce or how the eye care workforce across primary and secondary care will see greater recruitment and retention. This is crucial to ensuring the challenges and backlogs are addressed at pace.

7.2 We know that the ophthalmic consultant workforce is ageing and there is an existing shortage. Recruiting and retaining a future proof workforce remains a challenge for Wales. Further work is needed to incentivise doctors to train and remain in Wales. Given too that the Royal College of Ophthalmology estimates that demand on services will increase by 40% in next 20 years (as mentioned above). The nursing workforce also faces many challenges including the appropriate training for eye care services.

7.3 We welcome the plan's commitment to developing multidisciplinary teams around the needs of patients, by ensuring that all members of the team have the support and professional development they need to use their skills and work at the top of their license to deliver their role effectively. As part of this, it's crucial that within the multidisciplinary team there are a sufficient number of health and social care professionals with skills and knowledge of sight loss and other disabilities.

7.4 Whilst some individual Health Boards are demonstrating good examples of workforce planning on a local scale, if we are to achieve service redesign and deliver additional capacity to meet current and future demand within the eye care system right across Wales, the pace of change must increase, and the work must be overseen by

government at a national level. There are also many key local recruitment issues that need urgent tackling in the short term.

Recommendation

To deliver the changes needed, we must see Welsh Government and HEIW develop a pan-Wales integrated and sustainable eye care workforce plan that is clearly linked to capacity and demand data.

This plan must:

- robustly hold health boards to account for developing local and regional plans which reflect local pathways,
- ensure that all health board IMTPs reflect and plan for workforce challenges,
- work with health boards to audit current workforce skills, map the resource implications of expanding future demand, and ensure the necessary sub-speciality workforce capacity.

8. Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?

8.1 Consultants have told us that the Electronic Patient Record (EPR) currently being rolled out is essential to delivering timely treatment and for improving eye care patient prioritisation.

Recommendation

- We recommend a review of the operational roll out and the ongoing impact of EPR.

For further information, please contact Liz Williams (Policy and Public Affairs Manager, RNIB Cymru)

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[i] Wales Audit Office, *Management of Follow-up Outpatients Across Wales*, 2018.

[ii] Public Accounts Committee Inquiry, *Management of follow up outpatients across Wales*, National Assembly for Wales, 2019.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 19
Ymateb gan: | Response from: Coleg Brenhinol y Seiciatryddion | Royal College of Psychiatrists

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RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

About

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

The College aims to improve the outcomes of people with mental illness and intellectual disabilities, and the mental health of individuals, their families and communities.

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

RCPsych in Wales represents more than 600 Consultant and Trainee Psychiatrists across Wales.

For further information please contact:

Daisy Noott
Policy Officer
Royal College of Psychiatrists Wales

We are pleased to respond to the Committee request for written evidence. We have answered against the areas highlighted. Ultimately, there is some variance across different areas of mental health speciality, however we hope this themed response proves helpful to the Committee. We would be happy to provide any further detail.

Overall views

The plan notes the 'increased complexity' in many people's presentations of mental ill-health and illness. This is evident.

Despite this, the plan also aims to 'de-medicalise' the approach to mental health services. This needs clarification and context, for fear of appearing as a contradictory stance that may be detrimental for some services and patients. Whilst understanding that for most people, mental ill-health as presented at primary care will not need specialist intervention, for some it will. We need to ensure that services are available for all. Any drive to de-medicalise care mustn't disadvantage people with chronic needs, or further perpetuate the stigma faced by people living with mental illness.

The plan also notes the increase in volume of referrals, which should alert us to ensure that we have the necessary medical resource to meet the need. Mental health services were already severely stretched before the pandemic. Pre-pandemic waiting times and barriers to access would have been unacceptable in any other area of medicine. The pandemic has intensified

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the impact of underlying issues such as workforce shortages, the mental health estate, and the need to develop technology and digital infrastructure.

We also can't forget the role of clinical prevention, and the role of clinical teams in preventing further deterioration and illness. The three kinds of interventions of promotion, prevention, and treatment are interrelated and complementary; however, they are somewhat different from one another. Psychiatrists are competent and specialist in prevention of mental illnesses and mental health promotion in various settings.

We can support people living with mental health problems to stay well and prevent people from relapsing or reaching crisis point. Drawing focus and appreciation away from this understanding, serves to further disadvantage those who are vulnerable.

- **Responding to ever increasing demand - Welsh Government must meaningfully invest in specialist psychiatric medical provision in Wales, both now and in the long term.**
- **We would wish to work with Welsh Government to ensure a better understanding of the needs of people with mental ill health and illness, ensuring that those needs are not only catered for, but that those needs aren't disadvantaged in national strategy.**

During the pandemic, we have seen many innovations to delivering secondary care mental health services. We have made proposals to Welsh Government to work directly with us to increasingly 'foster' this and future innovation. It's essential that we don't lose sight of what can be achieved.

We've highlighted 3 projects that have been initiated and clinically led by Psychiatrists in Wales, with the support of Welsh Government and key partners. There are many more that we could choose to highlight.

These projects also speak to a thorough understanding of prevention, and ultimately the type of innovation required to deliver services more sustainably and meet the challenges for the service in both the short and long term.

National rollout of video consultation

Prior to the pandemic, we endorsed and supported development of a pilot telehealth and video consultation project in a CAMHS service in Gwent, the CWTCH project.

When the pandemic struck, the project went on to inform the development of TEC Cymru. The roll-out of video consultation across the health and social care sector in Wales has received much deserving attention and recognition. This work (as well as the work of the CWTCH project) has been clinically led by a psychiatrist.

We have continued to work with TEC Cymru to develop opportunities for digital development within mental health and are currently working with colleagues internationally on shared learning and approaches.

We've highlighted recommendations on digital later in this document.

A national approach to increasing early and effective dementia diagnosis

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Whilst key aspirations for the Dementia Action Plan Wales[1] are to increase the number of people formally diagnosed with dementia by 3% annually and to improve early diagnosis and timely interventions – the pandemic has placed delays upon access to memory assessment and diagnostic services.

A pilot project was established to test the utility of FDG-PET brain imaging in patients with cognitive impairment; this was with the intention to aid an early, effective diagnosis of dementia. With the support of partners, an FDG-PET diagnostic pathway throughout Wales was then established to ensure equitable treatment. This was a collaboration between specialist commissioning services, psychiatrists, and radiologists. This is highlighted in the Deputy Minister for Mental Health & Wellbeing's Cabinet Statement update on dementia care.[2]

A national approach to treating Alzheimer's Disease before dementia, through disease modifying treatments is now needed in Wales. This is consistent with recommendations from joint research that we have undertaken with Alzheimer's Research UK.[3]

Through our joint research we found that psychiatrists are keen to embrace the arrival of new disease modifying treatments, but that their services needed support in order to increase access to biomarker tests for diagnosing Alzheimer's disease early and to meet the future requirements of a new treatment. Service developments can only be achieved with investment to increase and enhance capacity, infrastructure and clinical skills.

- **Welsh Government should work with the College to invest and develop the infrastructure for offering disease modifying treatments, brain health clinics, interventions for mild cognitive impairment, and the requisite clinical skills.**

Reversing the rise in drug related deaths

Substance misuse services had to adapt to how they treated patients during the pandemic, after face-to-face meetings, drop ins and admission to residential rehabilitation were paused. To adapt and sustain critical services throughout the pandemic, more than £3.3m was made available to support the rapid implementation of a clinically proven method of maintenance treatment, an injectable buprenorphine (Buvidal®) for at risk ex-heroin users.

Buvidal's long-acting, injectable formulation means that it can be administered to patients monthly rather than daily, which other forms of Opioid Substitution Treatment (such as methadone) require. The treatment reduces the need for daily contact thus reducing pressures on front line staff. By all accounts, Buvidal is a 'game-changer' that is helping people to turn their lives around and achieve unexpectedly positive outcomes, with many patients able to move into recovery in a manner many were unable to achieve to date.

Drug misuse deaths in Wales have fallen to their lowest levels since 2014 in the latest analysis from the Office of National Statistics. More research is now required on its further utility and application.

- **Welsh Government should work with the College and its proposals to resource a programme that will enable psychiatrists to undertake research locally and be supported in its development in national application.**

[1] https://gov.wales/sites/default/files/publications/2019-04/dementia-action-plan-for-wales.pdf
[2] Written Statement: Update on dementia care in Wales (5 April 2022) | GOV.WALES
[3] are-we-ready-to-deliver-disease-modifying-treatments_25may21.pdf (rcpsych.ac.uk)

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Meeting people's needs

We welcome the Welsh Government's commitment to addressing health inequalities, as we know that people living in more deprived areas in Wales are "more likely to require use of hospital services, especially in an emergency".[4] As the plan recognises, the wellbeing of young people, children, Black, Asian and Minority Ethnic communities, those in lower income households, women, and those with pre-existing mental health conditions has been disproportionately affected by the pandemic. Unless measures are targeted at these vulnerable groups, inequalities will continue to rise, and the backlog may be exacerbated.

We support calls for a cross-sector, cross-governmental approach to addressing health inequalities[5], as well as the work of the Senedd Health & Social Committee in establishing an inquiry into mental health inequalities.

Physical Health

People with severe mental illness (SMI) are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population.[6] It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented.[7] Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension. As a result, it's crucial that routine physical health monitoring is available and accessible to people with SMI.

In January, NHS England National Directors for Mental Health, for Learning Disability and for Health Inequality wrote to mental health trusts throughout England to ensure and prioritise the delivery of physical health checks for people with severe mental illness and people with a learning disability. Within this correspondence there was acknowledgement of the stark health inequalities faced by people with SMI and people with a learning disability, and how the pandemic has served to further exacerbate these inequalities.[8]

We have regularly requested a focus on physical health of people living with SMI from Welsh Government. This is particularly relevant in terms of care, waiting times and ultimately patient outcomes.

Unemployment

There is a well-recognised link between unemployment and poor mental health. The Adult Psychiatric Morbidity Survey 2014 showed that most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance, a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed.[9]

[4] Waiting well? The impact of the waiting times backlog on people in Wales (senedd.wales)
[5] Making the difference - April 2021.pdf (nhsconfed.org)
[6] (Mental Health Foundation 'Poverty and mental health' 2016).
[7] Association between schizophrenia and social inequality at birth: case–control study | The British Journal of Psychiatry | Cambridge Core
[8] https://www.england.nhs.uk/wp-content/uploads/2022/01/B1268-letter-delivery-of-annual-health-checks-for-people-with-severe-mental-illnesses-and-or-learning-disabili.pdf
[9] ncap-spotlight-audit-report-on-employment-2021-(2).pdf (rcpsych.ac.uk)

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Employment support can help someone with a mental illness to manage their condition and the impact it has on their life. One such example is the work undertaken in BCUHB into Individual Placement and Support (IPS) which supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.

As highlighted in our National Audit of Psychosis[10], Unemployment is the main psychosocial disability of people with psychosis. The societal costs of unemployment due to mental health problems are substantial. However, more importantly, at an individual level, unemployment is a key factor contributing to social and economic marginalisation, symptom exacerbation, risk of homelessness, and persists long after symptom resolution.

- **We would wish for a long-term commitment to expand the Individual Placement and Support (IPS) employment scheme across Wales, acknowledging the positive impact that the scheme has on decreasing readmission into services.**

Leadership and national direction

Earlier in the document, we highlighted the leading role of psychiatrists in innovation, and given recommendation for this to be supported. It is crucial that clinicians are given time, resource and ultimately that leading voice into how we can develop services to respond to challenges both in the short and long term.

Targets and timescales

The plan sets out some key ambitions including 'no one to wait longer than a year for their first outpatient appointment by the end of 2022' and 'eliminate the number of people waiting longer than two years in most specialties by March 2023'. It is difficult to envision how these ambitions will be met without further information detailing appropriate milestones and measurable targets for health boards to work to. Further clarification regarding which specialties are included in these targets and which are not is needed.

Financial resources

We note the Welsh Government's commitment to investing an additional £50m rising to £90m in 2024/5 to support mental health services. Whilst this additional funding is essential, money alone will not be able to tackle the waiting times and service pressure. Without further detail of exactly where these funds will be targeted it is difficult to confirm whether the funding is sufficient.

Additionally, a report by the Auditor General for Wales found that although £200m was made available during 2021-22 to help tackle the backlog, health boards were only able to spend £146m of this. An estimated £12.77m was returned to Welsh Government due to the ongoing impact of Covid-19 on services, staff shortages, recruitment and retention challenges, and limitations in the current NHS estate, all of which hinder the ability to increase activity and

[10] ncap-spotlight-audit-report-on-employment-2021-(2).pdf (rcpsych.ac.uk)

reshape services.[11] A detailed and clear funding strategy that ensures finances are fully utilised is needed.

Workforce

It is no secret that the NHS has faced extraordinary pressures during the pandemic. Staff have had to contend with a range of stressors including risk of infection, workload changes, sleep deprivation, loss of colleagues and sometimes providing care in less than adequate settings while reporting insufficient access to personal protective equipment. All of these may contribute to an increase in the prevalence of common mental disorders, as well as exposing staff to 'moral injury'. Sustainable recovery planning is essential, as it will not only impact on retention but also on recruitment. Our own member survey from September 2020 showed that across the UK, 52.6% of members confirmed their wellbeing had 'significantly suffered' (12.3%) or 'suffered' (40.3%) as a result of COVID-19 and the lockdown, while a mere 11.1% confirmed that it had 'significantly improved (2.9%) or 'improved' (8.2%). These headline percentages compare to 48.6% and 13.1% respectively in our second survey (in the field from 1-6 May) and 54.4% and 10.2% respectively in our third survey (in the field from 18-26 May)[12].

A cohort study of UK healthcare workers from April to June 2020 showed that staff were experiencing a high burden of adverse mental health outcomes with substantial levels of probable common mental disorders and of PTSD with lower levels of depression, anxiety, and substance use disorders[13]. This supports survey results from the BMA of over 1,900 doctors which showed that 78.4% of respondents stated that moral distress resonated with their experiences at work and 51.1% said the same about moral injury. Of the respondents who stated that moral distress resonated with their experiences at work 96.4% (of those who had worked before and during the pandemic) stated that the pandemic had exacerbated the risk of moral distress[14].

Moral injury and the development of mental illness are very real risks for staff working in unprecedented scenarios often well outside their organisational levels of experience and training. Without interventions to support staff and mitigate against the likelihood of adverse outcomes, there will be an impact on workforce supply. Moral injury is described when facing overwhelming demands for which one feels unprepared and where actions or inaction challenge an ethical code. It is associated with negative emotions such as shame or guilt and can lead to the development of mental illnesses such as depression and PTSD. Treating COVID-19 is a risk for moral injury. Professional codes teach staff to provide care only when they feel adequately trained, experienced and equipped to do so and many do not feel this way during the pandemic[15].

There is a need to prevent burnout and encourage people to talk about their mental health and seek support in the workplace when they need it – physical and emotional wellbeing of health and care staff must be of equal priority to that of patients, recognising staff who are psychosocially healthy are better able to meet the needs and preferences of patients. This will impact on demand for new ways of working, at least in the short-term and will have knock-on effects for the long-term as we prioritise mental health of staff and ensure that appropriate interventions are in place. The provision of regular reflective spaces such as supervision,

[11] https://www.audit.wales/publication/tackling-planned-care-backlog-wales
[12] Microsoft Word - RCPsych COVID 19 fifth survey summary - other issues
[13] Psychosocial impact of the COVID-19 pandemic on 4378 UK healthcare workers and ancillary staff: initial baseline data from a cohort study collected during the first wave of the pandemic - PubMed (nih.gov)
[14] bma-moral-distress-injury-survey-report-june-2021.pdf
[15] What should be done to support the mental health of healthcare staff treating COVID-19 patients? | The British Journal of Psychiatry | Cambridge Core

reflective practice groups[16], and Balint groups[17], where the emotional impact of working in such stressful conditions can be discussed in a safe environment, has been shown to increase resilience and prevent burnout. Psychological interventions for doctors based on cognitive science, for example mindfulness-based applications, which have been shown to be effective in mental health problems, among others have also been shown to alleviate stress[18], and improve the wellbeing of medical staff and other health professionals[19].

Mental Health Workforce Plan

We await the publication of the strategic Mental Health Workforce Plan which we hope will provide some further detail as to specific numbers of staff needed and how these targets will be met. Staff retention will need to be a focus, as staff increasingly are leaving or retiring early due to the pandemic.[20]

In June 2021, we established the Royal College Mental Health Expert Advisory Group[21] to ensure that Royal Colleges working across mental health could share information and learning. An area of priority for all College's was the Mental Health Workforce Plan.

The mental health system is going through significant change. We know that pressure will be placed upon staff through changing working practices, legislation, and reform (such as the mental health act), whilst managing the impact of the pandemic will take some time in recovery. There is much evidence already emerging around intentions and actions from staff wishing to leave the service post-pandemic.

These points in part, highlight the need to value psychiatrists working in the service in Wales. To ensure that posts are supported and made attractive, or we will simply fail to meet both the existing and future challenge.

There must be clear recognition of the increased demands that have been created by the pandemic, and significant resourcing to meet these demands.

- **Responding to ever increasing demand - Welsh Government must meaningfully invest in specialist psychiatric medical provision in Wales, both now and in the long term.**

In January 2022, we issued a significant report to inform the consultation on the Mental Health Workforce Plan[22] with accompanying recommendations.

Digital tools and data

[16] Impact of Reflection on Empathy and Emotional Intelligence in Third-Year Medical Students | SpringerLink
[17] Effect of Balint group training on burnout and quality of work life among intensive care nurses: A randomized controlled trial - ScienceDirect; Promoting empathy among medical students: A two-site randomized controlled study - ScienceDirect
[18] Do workplace-based mindfulness meditation programs improve physiological indices of stress? A systematic review and meta-analysis - PubMed (nih.gov)
[19] A systematic review of the impact of mindfulness on the well-being of healthcare professionals - PubMed (nih.gov)
[20] https://www.audit.wales/publication/tackling-planned-care-backlog-wales
[21] Royal College Mental Health Expert Advisory Group Wales – Grŵp Cynghori Arbenigol Iechyd Meddwl Colegau Brenhinol (royalcolleges.wales)
[22] https://heiw.nhs.wales/files/smhwfp-psychiatry-report/

In this document, we've previously highlighted some of our work in supporting and developing digital within mental health services in Wales.

The NHS has achieved remarkable transformation and adoption of remote technology on an unprecedented scale at unprecedented speed in response to Covid-19, which is actually fully in line with the Welsh Government's ambitions laid out in 'Informed Health and Care: A Digital Health and Social Care Strategy for Wales' and 'Improving people's lives through digital technologies: Digital Inclusion Progress Report and Forward Look 2018'.

The pandemic resulted in a paradigm shift in the provision of mental health services due to mandatory social distancing laws. From March 2020, the UK, along with the NHS observed a significant decrease in access to face-to-face appointments, and as a result, an increase in remote services. One common remote method for conducting appointments with patients was the use of video consulting (VC).

We co-authored a first of its kind mixed-methods and interview study on the use, value, benefits and challenges of a national video consulting service in NHS Wales.[23]

A total of 3561 participants provided mental health specific data. These data and its findings demonstrate that remote mental health service delivery, via the method of VC is highly satisfactory, well-accepted and clinically suitable for many patients, and provides a range of benefits to NHS patients and clinicians. Interestingly, clinicians working from 'home' rated VC more positively compared with those at their 'clinical base'.

We concluded that post 1-year adoption, remote mental health services in Wales have demonstrated that VC is possible from both a technical and behavioural standpoint. Moving forward, we suggest clinical leaders and government support to sustain this approach 'by default' as an option for NHS appointments.

Remote monitoring

We are supporting an ABUHB led project with TEC Cymru into how technology enabled care can be used to support students in schools. This is a Q lab funded project entitled TERMS (Technology enabled remote monitoring in school).

The pandemic has taken its toll on the nation's health, especially children and young people. School closures disrupted friendships and uncertainty about the future are all likely contributors to the mental health issues children are facing. Early intervention is key to treating mental illness and key to preventing children falling into a mental health crisis. We believe that the pandemic has created new, unique opportunities to further the Whole School Approach whilst maintaining safety and creating new ways of working which are 'pandemic-proof' to some extent.

Through co-produced research the TERMS project team have gained an understanding of the barriers, challenges and opportunities that exists while implementing technology enabled remote monitoring across agencies i.e. health and education. This learning is shaping the development of a technology enabled remote monitoring in school (TERMS) framework which

[23] Remote mental health services: a mixed-methods survey and interview study on the use, value, benefits and challenges of a national video consulting service in NHS Wales, UK | BMJ Open

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can be shared locally and nationally with other clinical teams and schools. The initial focus of the work has been on eating in school.

- **We would wish for support as this pilot project is evaluated and considered for development, and greater adoption.**

Throughout this response, we have highlighted the necessity to meaningfully resource services to manage the ever-increasing demand. We have also highlighted that opportunities do exist to deliver services in a sustainable way, both in the short and longer term, and that psychiatrists have a leading role in this work.

We would hope for greater detail from Welsh Government on the plan and are keen to inform this work.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 20
Ymateb gan: | Response from: Cymdeithas Cemegwyr y Cwmni | Company Chemists' Association

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COMPANY CHEMISTS' ASSOCIATION

Response

Welsh government

Our programme for transforming and modernising planned care and reducing waiting lists in Wales

June 2022

Respond via email: SeneddHealth@senedd.wales,

For enquiries regarding this response please contact

Company Chemists' Association
Coppergate House
10 Whites Row
London
E1 7NF

About the Company Chemists' Association (CCA)

Established in 1898, the CCA is the trade association for large pharmacy operators in England, Scotland and Wales.

The CCA membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 6,000 pharmacies, which represents nearly half the market.

CCA members deliver a broad range of healthcare and wellbeing services, from a variety of locations and settings, as well as dispensing almost 500 million NHS prescription items every year.

The CCA represents the interests of its members and brings together their unique skills, knowledge, and scale for the benefit of community pharmacy, the NHS, patients and the public.

CCA | COMPANY CHEMISTS' ASSOCIATION

Response

The CCA welcomes the opportunity to respond to the consultation on Modernising Planned Care and reducing waiting lists. Over the last two years, the pandemic has placed significant pressure upon the Health Service in Wales. Compounded by existing pre-pandemic demands, this has resulted in delayed care and treatment times. From March 2020 to Feb 2022 the total waiting list has increased by 51.4%, whilst those waiting over 36 weeks has increased further still. With such enormous rises in waiting times, it is essential that all Primary and Secondary Care are supported to get back to pre-pandemic levels.

The Welsh Government's plan to rectify waiting times shows clarity and focus, bringing all stakeholders together for a common goal. The plan adds new thinking to existing strategies, with a strong focus on how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times. Whilst the main focus centers on Secondary Care, we are pleased to see that the plan includes and recognises the vital frontline healthcare services delivered by primary care, including Community Pharmacy. Our response will concentrate on Community Pharmacy and the role it can play in a strategic partnership to tackle increased waiting times exacerbated by the pandemic.

During the COVID-19 pandemic, the community pharmacy network in Wales played a significant role in supporting millions of people, whilst also helping to keep pressure off GP practices, hospitals, and other public services during what has been a difficult time.

A key contribution from community pharmacy is its role in increasing access for patients particularly through: treatment for a range of common minor ailments; supplies of prescription medication in an emergency; or to access contraception (including emergency contraception). One in ten NHS seasonal influenza vaccinations are now provided by pharmacies and pharmacies have played an important role in delivering our hugely successful COVID-19 vaccination programme particularly in our most rural areas.

The 713 community pharmacies in Wales are well distributed being located on high streets, in shopping centres, supermarkets, and co-located with GP practices across every part of Wales. They are also distributed in the most deprived communities, and unlike most other healthcare settings – there are more community pharmacies in more deprived geographies (the "positive pharmacy law"). This puts community pharmacy in a prime location to support other healthcare professionals to drive down patient waiting lists.

In 2019–20, Welsh pharmacies provided a range of care, treatment and advice above and beyond the safe and timely supply of prescribed medications including:

- 75,000 Common Ailment Consultations – 80% of whom would have otherwise visited their GP
- 24,000 Emergency Contraception Consultations
- Administered more than 90,000 seasonal influenza vaccinations to people at the highest risk

- Supported over 12,000 discharges from hospital making sure people got the medicines they needed when they returned home after admission to hospital.

In addition, community pharmacy is continuing to develop it's role in clinical care.

- Access to the Welsh GP record is available to pharmacists providing the emergency medicine supply, seasonal influenza vaccination and independent prescribing services
- 146 pharmacists have accessed support from Health Education and Improvement Wales to train as independent prescribers
- The community pharmacy sector have agreed an innovative new contractual framework dramatically increasing the role of pharmacy in accessible care.

These services maximise the use of community pharmacies, improve access for patients, and take pressure off other parts of the NHS. This in turn helps other providers to focus on reducing patient waiting times.

We are pleased to see that within the consultation, community pharmacy services will continue to be promoted as an alternative to visiting to urgent care services. They will play a vital role in supporting patients who may be already on a waiting list or require onward referral.

The Consultation Case Study states that all community pharmacies in Wales are able to offer an extended range of services via a national clinical community pharmacy service, including treatment for common minor ailments, access to repeat medicines in an emergency, annual flu vaccination, and emergency contraception.

"Presgripsiwn Newydd A New Prescription" has helped to develop community pharmacy into a more focused member of the primary care team, working closer with partners through collaborative meetings. To improve patient safety, A New Prescription aims to move community pharmacy from primarily a medication supply function to a broader role meeting the clinical needs of patients and the public. Historically, community pharmacy has always been a location for advice and this role continues to be developed and built upon as thousands of people routinely access their local pharmacy for advice and urgent care.

The integration and collaboration of community pharmacies within primary care clusters is vital to realising the potential of community pharmacy and transforming care pathways in the way necessary to achieve the vision set out in Pharmacy: Delivering a Healthier Wales.

Community Pharmacy is well distributed across Wales with easy access, which supports the consultation aim of better access to healthcare closer to home. We would like to see even greater collaboration between healthcare professionals, normalising referrals between community pharmacy and other parts of the NHS. This will support people receiving the right care from the right professional, providing timelier access to treatments. One of the enablers to this is information standards, to support the digital infrastructure needed for a modern healthcare environment.

Operating at the heart of local communities often with teams drawn from those same communities, pharmacy teams are well placed to tackle health inequalities. Prevention is a key pillar to reducing health inequalities and community pharmacy has long been recognised for its vital contribution to public health initiatives. Pharmacy can work with health bodies in Wales as well as with Public Health Wales, to further promote healthier lifestyles. This includes encouraging people to achieve and maintain a healthy weight, be more physically active, stop smoking, screen for health conditions, and provide wholistic health checks. As stated in the consultation Primary and Community Care Primary care services, General Practitioners (GPs), dentists, opticians and pharmacists on average undertake around 90% of all NHS activity. Community pharmacy often has the greatest opportunity to provide interventions, with regular touchpoints through repeat prescription collection, as well as a recognised high street presence.

In summary the Community Pharmacy network is well distributed across Wales often located in areas of highest deprivation and greatest need. Pharmacies offer a highly accessible service, often with extended hours. A New Prescription has helped to develop community pharmacy's role beyond a primarily dispensing function, to the delivery of a vital suite of clinical services. By harnessing the clinical expertise of pharmacy teams, this will support the health service in Wales to help reduce the care and treatment backlog. We welcome the government's commitment to community pharmacy through the new contractual framework and encourage the NHS to explore even further avenues to utilise the growing expertise within the sector. To maximise this opportunity, there is a need to consider digital enablers to support a growing role and need for interconnected care. This includes standardisation of coding and APIs to facilitate further innovation in the future.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 21

Ymateb gan: | Response from: Parkinsons UK Cymru

PARKINSON'S UK
CYMRU
NEWID AGWEDDAU.
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YMUNWCH Â NI.

PARKINSON'S UK
CYMRU
CHANGE ATTITUDES.
FIND A CURE.
JOIN US.

Transforming and modernising planned care and reducing waiting lists

1. This submission serves to highlight the issues impacting the Parkinson's community that we feel need to be emphasised in light of this plan and acknowledging the recent publication of the 'My Neuro Survey' Wales report.
   Issues include:
   - people living with worsening symptoms post lockdown.
   - reduced access to all aspects of healthcare to manage the condition.
   - our position on Patient Initiated Follow-Up (PIFU) for people with Parkinson's.

2. We welcome the plan to transform and modernise planned care and reduce waiting lists and acknowledge that this is an opportunity to shape how we deliver healthcare effectively in the future.

3. However, we are also aware that services for people with Parkinson's were inconsistent throughout Wales prior to the pandemic and, with such an enormous multifaceted task ahead over the next four years, as set out in this plan, we must ensure that the needs of people living with Parkinson's in Wales are consistently considered.

4. We would seek assurances from Welsh Government that the findings presented here from the Parkinson's community, in the 'My Neuro Survey Wales' report and the report of the Cross Party Group on Neurological Conditions: Building the foundations for change: The impact of the Welsh Government's Neurological Delivery Plan are considered alongside the developments outlined in this plan.

5. The impact of the lockdown restrictions and reduced access to regular healthcare reviews, physiotherapy, speech and language therapy and occupational therapy since the start of the pandemic has had a significant impact upon people living with the condition being able to manage their Parkinson's symptoms.

6. Coupled with reduced access to regular physical activity and exercise as well as the negative mental health implications of reduced social interaction, isolation and loneliness the impact of the past two years on those living with Parkinson's means we must ensure those living with the condition are not left behind as we seek to rebalance and modernise.

7. About Parkinson's

Parkinson's is the fastest growing neurological condition in the world[1], and currently there is no cure. Parkinson's is what happens when the brain cells that make dopamine start to die. There are over 40 symptoms, from tremor and pain to anxiety. Some are treatable, but the drugs can have serious side effects.

8. In Wales, around 7,600 people are already living with Parkinson's. This is forecast to rise by around a fifth to approximately 9,000 by 2030.

9. What matters most to people affected by Parkinson's

[1] Dorsey, E. et al. (2018). Global, regional, and national burden of Parkinson's disease, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet Neurology, 17

The views and needs of people affected by Parkinson's are central to both the work that Parkinson's UK Cymru does, and our ultimate ambition, which is to find a cure and improve life for everyone affected by the condition.

10. In 2020 we asked people affected by Parkinson's - those living with the condition, their families and carers - what are the most important issues for us to campaign on through our 'What matters most?' survey and our coronavirus poll. As the pandemic hit halfway through our survey, causing a great deal of uncertainty, we used the poll to validate the views of our community. More than 2,300 people in the Parkinson's community responded to both surveys across the UK with 5% of responses from Wales.

11. People affected by Parkinson's in Wales told us they need:

- High quality health and social care
- Access to the right treatments at the right time
- To be able to access financial benefits
- To get their Parkinson's medication on time when in hospital or a care home

12. Cross Party Group on Neurological Conditions inquiry into the impact of the Neurological Conditions Delivery Plan

13. Prior to COVID-19, the Cross Party Group on Neurological Conditions inquiry on the impact of the Neurological Conditions Delivery Plan (NDCP) heard that people with neurological conditions had experienced poor access to treatments, services and support. In spite of the NDCP being in place since 2014.

14. In the first half of 2022, the Wales Neurological Alliance (WNA) has, for the first time, collaborated with the Neurological Alliances of Scotland, England and Northern Ireland to gather evidence from people living with neurological conditions across the UK.

15. The My Neuro Survey provides an important insight into whether people living with neurological conditions in each of our nations are getting the treatment and support they need. Over 8,500 people shared their experiences in the survey, 503 from Wales.

16. The findings from the neurological community in Wales are presented in this report alongside the Neurological Conditions Implementation Group's (NCIG) Position Statement for Neurological Services across NHS Wales report of March 2022.

17. The report concludes that: "People living with neurological conditions in Wales continue to report substantial barriers to accessing the treatment, services and support that they need from health and social care services."

18. The impact of coronavirus on people affected by Parkinson's: July 2020
Parkinson's UK and Lancaster University collaborated on a survey in April-May 2020 to find out the impact of the coronavirus restrictions on the Parkinson's community. Over 2,000 people across the UK affected by the condition completed it - 1,491 people with Parkinson's and 540 family members, friends and carers. 6.6% (116) of respondents were from Wales.

The full report is available **here.**

19. **Access to healthcare:** For those in regular contact with health services, many had appointments cancelled and alternatives were not routinely offered via telephone or online.

The statistics for Wales do not compare favourably to the other three nations or to the UK as a whole.

- 48% had appointments with their Parkinson's Nurse cancelled in Wales (33% across UK) and of these, 53% were not offered a phone or online appointment (53% across UK.)
- 57% in Wales had appointments with their Parkinson's Consultant cancelled (34% across UK) and of these, 80% in Wales were not offered a phone or online appointment (68% across UK.)
- Cancellation rates were also high for those accessing physiotherapy at 78% across Wales (70% across UK), speech and language therapy (76% in Wales, 57% across UK) and occupational therapy (78% in Wales, 55% across UK.)

20. Wales had the lowest number of respondents who decided to cancel appointments because they were worried about the coronavirus (8% for Wales, 15% for the UK.) Cancelled appointments were seen by many as a contributor to deterioration of the

condition and some were worried they were storing up future difficulties.

21. **Symptoms:** Many said their Parkinson's symptoms got worse since the restrictions began. Over a third experienced increased slowness of movement, stiffness and fatigue and over a quarter experienced increased tremor, anxiety and sleep problems. Stress and isolation and reduced access to health care and exercise (see below) were seen as causes of deterioration of their condition.

The impact of coronavirus on people affected by Parkinson's: August 2021

We again worked with Lancaster University in August 2021 to survey the Parkinson's community. This enabled researchers to measure the change in symptoms over the course of the restrictions and the pandemic. The full report is available here.

Worsening symptoms: The findings show that both motor and non-motor symptoms were heavily impacted. Overall, 8 in 10 people with fatigue (86%), stiffness (83%) and slowness of movement (88%) reported a decline in these symptoms.

Anxiety and depression also increased considerably with 7 in 10 people reporting that their anxiety had worsened in 2021, more than doubling the percentage from the previous year. And almost 4 times as many people with the condition said their depression got worse (rising from 13% to 48%).

Slowness of movement, fatigue and sleeping issues all doubled year-on-year, while muscle cramps increased threefold. We believe these significant declines could be in part because of government restrictions that limited people's access to physical activity.

Limited access to services: As well as a deterioration in symptoms, our community shared that they weren't able to access their healthcare services in quite the same way.

In the 3 months before our 2021 survey, over half (54.3%) of people with Parkinson's had an appointment with their care provider cancelled, with consultants cancelling slightly more frequently than nurses (31% compared to 28%).

Other appointments that had been cancelled include physiotherapist (18%), speech/language therapist (18%), occupational therapist (14%) and psychologist (6%).

Virtual appointments: Almost 3 in 5 people with Parkinson's (58%) had a phone or online appointment with their Parkinson's nurse and over a third (35%) had had one with their consultant. While aspects of these were seen positively, only 4 in 10 (40%) said they were pleased with the outcome of their consultant appointment.

Just under half (46%) of people with Parkinson's surveyed felt their doctor could understand them well, and fewer than a quarter (23%) felt the connection with their doctor was comparable to that of a face-to-face appointment.

Only 1 in 10 (12%) would recommend online or phone appointments to another person with Parkinson's.

Noting this low number who would recommend online or phone appointments to another person with Parkinson's, we are concerned by the inclusion of targets: "35% of new appointments and 50% of follow up appointments are delivered virtually." People living with Parkinson's, as individuals, must be a part of the decision making process as to whether this type of appointment is suitable for them, it cannot be a default position across services or patient groups.

Patient Initiated Follow Ups

Based on what people with Parkinson's have told us, we believe there are some key principles that should be met before a Patient Initiated Follow Up/ review (PIFU/R) pathway is considered for someone as follows:

- Patients and carers should be involved in a discussion/assessment about whether this approach is right for them and ultimately have the choice if they are moved onto this pathway.
- The move to this pathway needs to be in the best interests of the patient and carer.
- There needs to be flexibility in the pathway, rather than a general approach to all patients.

- There needs to be a recognition that Parkinson's is different for everyone, and that as the condition progresses the needs of individuals will increase and therefore the progression of the services required will need to change to meet this.
- There needs to be clear communication about what to expect if you are moved to this pathway - how to get in touch with your service if you need an appointment, timescales for response and what to do if you don't get one within that time frame and how you provide feedback or complain about the service.
- Patients, carers and professionals need to be open and honest about the pros and cons of the pathway.
- How the pathway is working for the individual with Parkinson's should be reviewed at every appointment, but at least on an annual basis.
- Each service should instigate a check-in system for all patients. If a service has not heard from their patient within 12 months they should contact them.
- Fixed appointment intervals should be preferably at 6 month intervals (12 months maximum) supplemented by a patient-initiated intermediate service.

Current NICE guidelines state that "people diagnosed with Parkinson's disease should be seen at regular intervals of 6–12 months to review their diagnosis". The evidence still supports regular reviews to make sure that cases of conditions like Progressive Supranuclear Palsy, Corticobasal degeneration and Multiple System Atrophy are not missed. NICE also states there should be a discussion with a Parkinson's specialist before any medication is started or changed, especially dopamine agonists as it needs to be carefully monitored for side effects.

The Neurological Alliance have also developed guidance on developing PIFUs in neurology for England[2].

Parkinson's is a complex, progressive condition that presents differently for everyone and people living with the condition need ongoing long term multidisciplinary care that flexes to meet their needs as it progresses.

While we know that some people with Parkinson's would prefer to contact their service as the need arises, others may find it particularly challenging to assess the progression of their own symptoms and therefore identifying that they need a review would be particularly difficult.

[2] The Neurological Alliance, June 2021 - https://www.neural.org.uk/wp-content/uploads/2021/06/Guidance-20210623-PIFU-principles-June-2021.pdf

Particular Parkinson's symptoms may make it more difficult for an individual to seek support when they get worse. This could include those living with anxiety and depression, those with cognitive issues, those with advanced Parkinson's, those who experience movement related issues, have problems with communicating or those who are more frail and those who live alone or have no carer or close relative who can assess the progression of an individuals' condition.

Parkinson's medications are vital at managing symptoms of the condition. Optimising Parkinson's medication is challenging as everyone responds differently to Parkinson's treatments, and medications become less effective over time as symptoms change.

All Parkinson's medications have potentially significant side effects, and can worsen other symptoms. The risk of impulse control disorders in those taking dopamine agonists must be monitored by professionals. It is also important that professionals review an individual regularly to assess whether the prescribed treatments and therapies are still effectively controlling their symptoms.

A move to PIFU/R could be problematic for those who do not already engage with a Parkinson's service regularly and also people from a tradition/culture where they don't wish to bother health professionals unless there's a crisis.

Professionals have also shared that Parkinson's should be reviewed regularly following diagnosis to ensure the diagnosis is correct. Subtle symptom changes could be missed when they could be more easily correctable, for instance posture.

We are also concerned that PIFU/R could be misused to discharge patients who need a regular review of their care to stay well.

For further information contact: Rachel Williams, Policy, Campaigns and Communications Manager, Parkinson's UK Cymru

Submitted on behalf of Parkinson's UK Cymru

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 22
Ymateb gan: | Response from: Cymdeithas Fferyllol Frenhinol Cymru | Royal Pharmaceutical Society in Wales

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Russel George MS,
Chair, Health and Social Care Committee
Senedd Cymru

Consultation: Views on The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Dear Russell,

Thank you for this further opportunity to support the committee's ongoing work on waiting times backlog.

Now that the Welsh Government's programme for transforming and modernising planned care and reducing waiting times is published, it's only right that the committee revisits this area and allows stakeholders across health and social care to comment on the plan.

Overall, we welcome the programme and steps outlined by the Welsh Government. As recognised in the foreword, the scale of the task after two years of the pandemic is significant. With this in mind, the recognition that a fresh approach to planned care is needed to meet the increased demand is completely right.

We also agree with the overall aim of the plan:

> *"The aim is to accelerate health and care recovery in the short to medium term focusing on stabilising and recovering the waiting lists, whilst developing and embedding longer-term transformative and innovative change".*

While the health service must do all that it can to accelerate access to treatment to those who have been waiting for care over the last two years, the scale of the challenge and pressures it will place on the health services necessitates exploring and developing new, more efficient approaches to planned care.

As we broadly agree with the principles in the plan, the points below are constrained to

- issues that have not been included in the plan and we believe merits consideration
- or where the perspective of pharmacists would be helpful for the committee.

Kind regards

Elen Jones
Director, the Royal Pharmaceutical Society's Welsh Pharmacy Board

Supporting the workforce

In our initial response to the committee's inquiry[1] we were clear that plans to meet the waiting times backlog must take into account the strain and pressures that the workforce has faced over the course of recent years. This means that we cannot keep asking the existing workforce to do more. We are clear that the key principles of pandemic recovery should be on working differently and smarter, while always ensuring that steps are taken to maintain a sustainable, resilient and supported workforce.

With these principles in mind, we're pleased to see the plan recognises the impact that the pandemic has had on workforce capacity and wellbeing and 'includes building a sustainable workforce' as an underpinning enabler.

The commitment to also "develop a focused workforce plan to underpin this panned care recovery plan" is crucial. Put simply, without such a plan to support the workforce in place, the aims for recovery will not come to fruition.

For pharmacy, priorities in such a plan are for:

1. All pharmacists must be given access to, and be enabled to take, appropriate rest breaks, both for the welfare of pharmacists and for patient safety
2. Pharmacists must have dedicated protected learning time within working hours
3. Investment is needed in the pharmacy workforce to train more pharmacy staff and upskill existing staff to work at the top of their competence
4. Pharmacists and their staff must have continued access to national wellbeing and occupational health support.

Further details on these points can be found in our initial written response to the inquiry and in our recently published statement on the needs of the pharmacy workforce[2].

Avoiding delays and complications through medicines optimisations

A key enabler for efficient and quick access to planned care that significantly reduces the risk of complications that can cause delays is to ensure a medicines optimisation process has taken place. This is not referenced in the plan but must be a central component of our approach to more efficient planned care.

Medicines optimisation is about ensuring that patients get the right choice of medicine, at the right dose, in a timely way, to get the best outcome in terms of disease/condition control and prevention of progression or secondary complications. By focusing on patients and their experiences, a further goal is to help patients to take their medicines correctly, avoid taking unnecessary medicines and improve medicines safety. Prescribing pharmacists based in hospitals, GP practices and community pharmacies, with their expert knowledge of medicines

[1] https://business.senedd.wales/documents/s122261/WT%2031%20-%20Royal%20Pharmaceutical%20Society%20Wales.pdf

[2] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/workforce

and their effects are well placed to lead on medicines optimisation across all conditions that require planned care e.g anticoagulation, heart failure, respiratory conditions.

In the context of planned care, effective medicines optimisation has two significant benefits:

1. Reducing the likelihood of a referral to specialist services: When a patient's medicines are not optimised for their treatment, they are much more likely to experience complications and to be referred to specialist services. Effective medicines optimisation at an early stage of treatment will negate this risk of referral, ease pressure on the system and create additional capacity for planned care.

2. Reduce the likelihood of complication before treatment/surgery: Medicines optimisation at an early stage after initial referral will significantly reduce the possibility of complications or side-effects emerging that will risk delaying a planned surgery and cause further delays and inefficiencies in the system.

Harnessing the skills of hospital based pharmacists

When discussing how the plan aims to transform the way planned care is provided, it's stated that "a wider range of health professionals will help you to stay well and remain at home". We support this priority but would also advocate for a wider range of health professionals from across the multidisciplinary team to be a more central part in leading planned care, particularly hospital-based pharmacists.

With a significant number of hospital pharmacists qualified as independent prescribers, there is huge potential for their expert clinical knowledge and skills to be better utilised and add additional capacity in planned care and to reduce waiting times. Already in Wales there are examples of hospital-based consultant pharmacists and their teams leading specialist mental health and renal care clinics. Meanwhile there are numerous examples of pharmacists taking a lead on medicines management and optimisation in various clinical specialities.

However, in order for all patients to benefit from the expert clinical skills of hospital pharmacists, all specialty multi-disciplinary teams providing planned care must include a hospital pharmacist and their medicines expertise. This should certainly be the case for those specialities identified in the plan as having the greatest number of people waiting for treatment (trauma and orthopaedics, ophthalmology, ear nose and throat (ENT), urology and gynaecology). The result of this will be safer and more effective use of medicines, while reducing the risk of complications and delay to treatment.

Prehabilitation

We were pleased to see that prehabilitation is a strong focus in the proposals to build sustainable planned care capacity. For patients, this is a vital part of making sure that they are in the best possible physical and mental state to get the best outcomes from their treatment. While for the NHS, effective prehabilitation has the benefit of reducing cancellations on the day of treatment and allow theatres to operate at full capacity

This is another area where the skills of pharmacists can play an important role within the multidisciplinary team[3]. They are well place to take a holistic view and to work with patients; providing them with an optimisation bundle which consists of medication reviews, screening checks and any lifestyle interventions to ensure maximum benefit from their treatment and for their recovery.

Community Pharmacy's Role

In our first written evidence to this inquiry[1] we stressed the important role of community pharmacists and their teams in helping to reduce waiting times and pressures on the system. We're pleased that the Welsh Government plan also recognised this role and pledges to continue to promote community pharmacy as an alternative to urgent care services via the newly introduced national clinical community pharmacy service.

Again, as mentioned in our first evidence, to make the most of the new clinical service, ongoing funding community pharmacists to complete independent prescribing training will be required.

Social Prescribing

We note the plan commits to "develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into our pathways. To make full use of these services and pathways, the role of community pharmacists must be a central part of this framework.

As the most accessible health professional on the high street, community pharmacists develop a strong relationship with their patients and are extremely well placed to identify people who could benefit from social prescribing. Furthermore, their training means they also possess the required communication and interpersonal skills for social prescribing.

Keeping people healthy & off waiting lists

Of course, the most effective ways to manage waiting times, is to keep people healthy and not be in need of treatment in the first place. We welcome the commitment of a more targeted approach to the causes of avoidable ill health and death in the plan.

Through smoking cessation services and in providing health coaching and behavioural advice, community pharmacy teams already play an important role in helping people to avoid preventable illness and stay well. However, pharmacy in Wales has signalled its intention to build on its public health role. In the profession's 10 year vision; Pharmacy: Delivering A Healthier Wales, there is a commitment to:

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[3] https://www.rpharms.com/wales/pharmacy-delivering-a-healthier-wales/putting-pdahw-into-action#5 (Prehabilitation pharmacy: Preparing patients for their cancer recovery by Marian Jones, Prehabilitation Pharmacist, Cardiff South West cluster)

"increase our focus on health, wellbeing and prevention with all community pharmacies becoming health and wellbeing hubs"[4].

Regional Treatment Centres

At RPS, we consistently support the principle that systems should be designed to allow patients to receive their care as close to home as possible. This is principle is also reflected in the Welsh Government plan with the exception of the proposal to:

> "*develop a network of regional clinical teams and centres flexibly to meet local demand. For some services, treatment centres or centres of excellence may be the best option. The development of green or cold sites will be considered for many routine procedures, which may mean that people will have to travel to access care in another health board".*

While recognising that this is not ideal, the situation post-pandemic does require new approaches and we accept that the evidence cited for high volume surgery centres is persuasive and will likely lead to a reduction of waiting times of treatment at a quicker rate.

As discussed in the document, communication to explain the rationale for this change in approach to the public will be important and that patients with travel challenges receive appropriate support.

Additionally, further information from the NHS/Welsh Government on the geographical coverage of these new regional centres would in the coming weeks/months and of the skills mix within teams working in this new model would be welcomed. From our perspective, we would stress that each regional centre should benefit from the expert skills and medicines knowledge of pharmacists within their multidisciplinary teams.

E-advice for primary care

When discussing steps to help reduce unnecessary referrals into secondary care, the plan references the newly introduced "e-advice" function. It's states that:

> *We have introduced e-advice; this new functionality allows primary care to e-mail the specialist team and access immediate advice about how to treat the individual.*

Despite stating that this new functionality is now in place for primary care, at this stage it has not been extended to community pharmacy, nor to our knowledge to the other primary care contracted professions (optometry and dentistry).

Considering the accessibility of community pharmacy and the high volume of patient engagement, access to this functionality would be a huge benefit to both pharmacists and their patients. For community pharmacists to be better integrated within the NHS and have access to specialist support and advice - the absence of which our members constantly tell is a source of huge frustration and a feeling of professional isolation. Meanwhile for patients they will be

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[4] https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/Pharmacy%20Vision%20English.pdf?ver=2019-05-21-152234-477

pointed in the right direction for their care at the point of their first interaction with the health service, regardless of whether the issue requires specialist input or not.

While not relevant for waiting times for planned care, we would encourage exploration by Welsh Government, Digital Health and Care Wales and the contractor bodies as to whether this functionality could be used for communication between community pharmacies and GP practices. This would be a much-needed solution to resolve prescription queries seamlessly, without pharmacists waiting on the phone to surgeries for extended periods of time or having referring patients back to surgeries with those problems.

Referrals

We share the concerns outlined in the plan around “potential missing referral of patients that are expected to present with their systems over the coming months”.

Community pharmacy is uniquely placed to help identify those people who would benefit from referral to specialist care but may not have been appropriately referred over the course of the pandemic. As the only health setting that remained open throughout Covid-19, pharmacists and their teams will have monitored their patients carefully through this period and will have spotted decline or changes in both their patients’ physical or mental health that indicates a referral is required.

However, despite being the most accessible health professional group with such regular interaction with patients, at present, community pharmacists are not able to directly refer patients to other parts of the health service. In circumstances where a referral could be safely and appropriately managed by the pharmacy team, they can only suggest and signpost patients to see their GP. This results in patients always having to take an extra step themselves before they get the care they need, rather than it being facilitated for them by the health service.

In addition, pharmacist prescribers working in primary care and hospital settings should also have referral rights with an agreed clinical pathway. This is for situations where they may not be able to progress a patient along the pathway and would be particularly important in extreme circumstances and in order to maintain patient safety (e.g. red flagging).

To streamline referral processes, we recommend that formal referral protocols/pathways should be developed for pharmacy teams to make direct referrals to other services. Their aim should be to remove burden from patients themselves and allow them to move through the health system more rapidly and efficiently. These protocols/pathways should be developed with input from across multidisciplinary team and patients’ representatives so that they are tailored to what patients need and expect.

Measuring & Monitoring progress

One aspect currently missing from the plan is reference to how progress will be measured and reported. In a situation where new ways of working are being developed, some new initiatives

will work better than others. It’s therefore important that we’re able to identify the most effective initiatives in meeting demand efficiently and providing the best possible outcomes for patients.

From a pharmacy perspective, as a growing number of pharmacists are now using their prescribing skills across all settings, having means to measure and identify where their skills in medicines optimisation are having the most effective impact is important. Such evidence can then inform workforce planning across all health boards and ensure that examples of new practice and ways of working that is proven to be effective can be replicated consistently across Wales.

This may be something that committee wishes to explore in any further reports or communication with the Welsh Government.

Adopting best practice

Health systems across the world will be facing similar challenges with treatment backlogs to those that we’re facing in Wales. We would hope that this plan remains flexible and able to adopt any initiatives from other UK countries or internationally that have proven to be especially effective in meeting reducing waiting times for planned care.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 23
Ymateb gan: | Response from: Cymdeithas Orthopedig Prydain | British Orthopaedic Assocation

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British Orthopaedic Association

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British Orthopaedic Association response to request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

At the British Orthopaedic Association (BOA) we welcome the publication of the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

We particularly welcome the proposals for:

- Delivering evidence-based treatments that add value.
- Additional sessional work at weekends and evenings.
- Partnering with the independent sectors to develop new approaches and models of care.
- Regional options which will allow protected planned care capacity at a higher volume than traditional hospital-based theatres.
- Consolidating urgent and emergency services to free capacity for planned care.
- Transformation and introduction of new models of care at practice, cluster, hospital and health board level.

We strongly believe that central direction is essential to manage resources effectively to optimise treatment for Welsh orthopaedic patients, and we believe there is a need for greater clarity than is currently set out in the plan on which specialties will be prioritised and included in any targets, and the targets themselves. Without operational incentive to drive elective recovery, we cannot understand how you expect elective recovery to be achieved for these patients who have already waited too long. It is easy for hospitals to redeploy orthopaedic beds, wards, nursing staff, theatre lists, anaesthetists and theatre teams to other areas, but this should not be tolerated.

Reducing waiting lists will also require adequate resource and investment to build capacity. It is clear that the elective orthopaedic surgical capacity could not meet the demand, prior to the pandemic. While we welcome the proposal for additional sessional work at weekends and evenings, this cannot be simply asking existing resource to work longer and harder. We would welcome greater clarity around how any additional funding will be used, and how its use and impact will be tracked and reported on. The BOA believes that the solution is likely to involve surgical hub centres, dedicated for elective treatment, which can operate 12 months of the year.

The British Orthopaedic Association strongly support the WOS concerns outlined in their response to the Welsh Government's plan and have full confidence in the Welsh orthopaedic leadership team. We are happy to help in any way to expedite elective recovery for the benefit of patients in Wales. It is imperative in our experience, that orthopaedic surgeons are involved in the development of strategies and solutions. The most successful high volume surgical treatment programmes that we have seen throughout the UK, occur when there is dynamic local clinical leadership, working with an engaged management towards a common goal.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 24
Ymateb gan: | Response from: Coleg Nyrsio Brenhinol Cymru | Royal College of Nursing Wales

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Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

Royal College of Nursing written evidence to the Health and Social Care Committee inquiry into 'the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists'

The Royal College of Nursing (RCN) Wales welcomes the opportunity to provide written evidence on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists. RCN Wales previously provided written and oral evidence on the inquiry into the impact of the waiting times backlog.

The Welsh Government's plan is centred around four commitments; increase health service capacity, prioritise diagnosis and treatment; transform the way Wales provides planned care and provide better support to patients. In order to deliver on these commitments there needs to be a significant investment in the workforce. The plan does not outline any meaningful investment in terms of increasing the nursing capacity with the health and social care sector.

The Royal College of Nursing Wales recommends:

1. The Welsh Government must continue to invest in all four fields of pre-registration nursing education.
2. The Welsh Government and Health Boards should harness the opportunity of newly qualified nurses being prescriber ready from 2023 and set out a clear plan to invest and develop the next step for these new graduates and the current workforce.
3. Health Education and Improvement Wales should develop a post-registration nursing strategy with a specific focus on district nursing.
4. Every health board should commit to investing in the role of the consultant nurse in order to meet the health needs of their population.
5. The Welsh Government and health boards should harness the knowledge and leadership of Infection Prevention and Control nurses in delivering education and leadership for the healthcare workforce.
6. The Welsh Government must establish a national retention strategy to encourage our nursing staff to keep working in the NHS.

7. The Welsh Government must ensure there is a whole system approach to digital technology. This must include an assessment of what is available across the NHS and how digital technology can be harnessed to improve planned care.

Increase health service capacity

In order to increase health service capacity, an investment in the workforce is necessary. Unfortunately, the plan does not set out any specific actions for how to address the challenges currently facing the workforce.

The NHS is the largest employer in Wales and currently employs almost 89,000 full-time equivalent (FTE) posts. Nursing is the single largest professional group within the NHS, representing 40% of the total workforce. 91% of this workforce is female.[1]

Currently the nursing workforce is facing intolerable pressure and this is having a devasting impact on wellbeing with many nurses burning out and deciding to leave the profession early. There is an urgent need to address this to ensure there is a workforce available to provide patients with safe and effective care.

A recent RCN survey found:

- Over half of respondents felt demoralised (53%), while only 13% felt fulfilled by their role.
- Only around one in five (17%) respondents agreed they had enough time to provide the level of care they would like. This has decreased from 22% in 2020.
- Two thirds of respondents worked additional time (63%). Of these, almost eight in ten (70%) were unpaid for these additional hours, 20% were given TOIL.
- Over half of respondents (53%) in Wales felt demoralised: only 13% felt fulfilled.
- Two thirds (60%) of respondents were unable to take their breaks that they were supposed to take
- Worryingly, nearly a quarter (24%) of Welsh respondents felt unable to raise concerns: this is 3% higher than the UK average and 4% higher than the Welsh 2020 finding.

Nursing staff are able to retire at 55. Table one outlines that 51% of the nursing and midwifery workforce are already eligible to retire or will be eligible to retire in the next 10 years. Without an investment in the nursing workforce the NHS will be unable to provide safe and effective care.

Table One: Staff Age Band by Staff Group March 2021

[1] Health Education and Improvement Wales 2021 *NHS workforce trends (as at 31 March 202).* Available at: https://heiw.nhs.wales/files/nhs-wales-workforce-trends-as-at-31-march-2021/, accessed 31 May 2022.

Age Band	Under 25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 60	Over 60
Nursing & Midwifery	4%	10%	12%	11%	12%	14%	15%	15%	7%
NHS Wales	**5%**	**10%**	**12%**	**11%**	**11%**	**13%**	**14%**	**16%**	**9%**

RCN Wales recommends the Welsh Government address this area of concern as a matter of urgency.

The Welsh Government must continue to increase nursing student commissioning for all four fields of nursing; adult, mental health, children and learning disability nursing. Between 2016 and 2021 student nursing places increased by 55.2%.[2] The Welsh Government consistently invested in nursing education with places rising from 1,418 in 2016 to 2,202 in 2021. However additional investment is needed due to the age profile of the workforce and demand to modernise and transform planned care.

In addition there is a need to encourage nurses to keep nursing in the NHS. This requires a retention strategy and investment in post-registration nursing. The Welsh Government must take leadership on this.

District Nurses (DNs)

RCN Wales was pleased to see the plan makes a reference to community and district nursing by detailing 'they have maintained high levels of activity over the last year seeing the most urgent cases face-to-face while undertaking more virtual activity where appropriate.' However, despite this recognition there is no recommendation to invest in district nursing.

There is a national shortage of DNs and the Welsh Government has not taken action to resolve this. Community nursing teams are led by DNs or nurses working towards a post-registration community nursing qualification. DN is a title given to those with a Specialist Practice Qualification (SPQ), a Nursing and Midwifery Council (NMC) recordable qualification. The qualification recognises a high level of skill, knowledge and practice. DNs are the experienced pinnacle of a community nursing team, providing leadership to the registered nurses and healthcare support workers.

Between September 2020 and September 2021 the workforce decreased by 48.3 FTE district nurses. The number of post-registration courses has not increased since 2017, despite the demand. This needs to change and investment in district nursing is needed urgently to ensure health service capacity can be maintained, and increase.

[2] Welsh Government 2021 *Written Statement: Expansion in training places for health professional workforce in Wales*. Available at: https://gov.wales/written-statement-expansion-training-places-health-professional-workforce-wales, accessed 31 May 2022.

Prioritise diagnosis and treatment

Prescriber ready nurses

To prioritise diagnosis and treatment there needs to be an understanding of the capacity and skills within the entire workforce. It is disappointing therefore to see that there was no recognition in the plan that all nurses graduating after 2023 will be prescriber ready.

In 2018, the NMC introduced a new curriculum and standards for pre-registration nursing, commencing September 2020. These standards were developed by extensive consultation with employers and other key stakeholders throughout the UK including NHS Wales.

On graduating newly qualified nurses will be prescriber ready and will have a new and wider variety of practical skills that can be utilised when they enter the workforce. The ability for nurses to be prescribers is essential for providing effective treatment in a timely manner.

RCN Wales recommends that the Welsh Government harness the opportunity of prescriber ready nurses and set out a clear plan to invest and develop the next step for these new graduates and the current workforce.

Consultant nurse

To provide excellent level diagnostic and treatment there needs to be a skilled workforce available to do this. Consultant nurses provide expert level care, leadership education and research, this in turn improves patient care and safety. Consultant nurses are essential for the delivery of high quality patient care, educating the next generation of health professionals, advancing research with health and social care and developing guidance and principles for quality patient care.

There are four main aspects to a consultant nurse's role:

1. **Expert clinical practice** (*direct and indirect practice*). Working directly with individuals, families and carers, whilst indirectly influencing clinical work through supervising and providing guidance to others, developing practice protocols and exploring practice issues.
2. **Professional leadership and consultancy.** Providing professional leadership and direct evidence based, client-centred recommendations to those involved in service development and delivery.
3. **Education, training and development.** Facilitate other clinicians to develop their roles, gain knowledge and skills either by strategic planning education

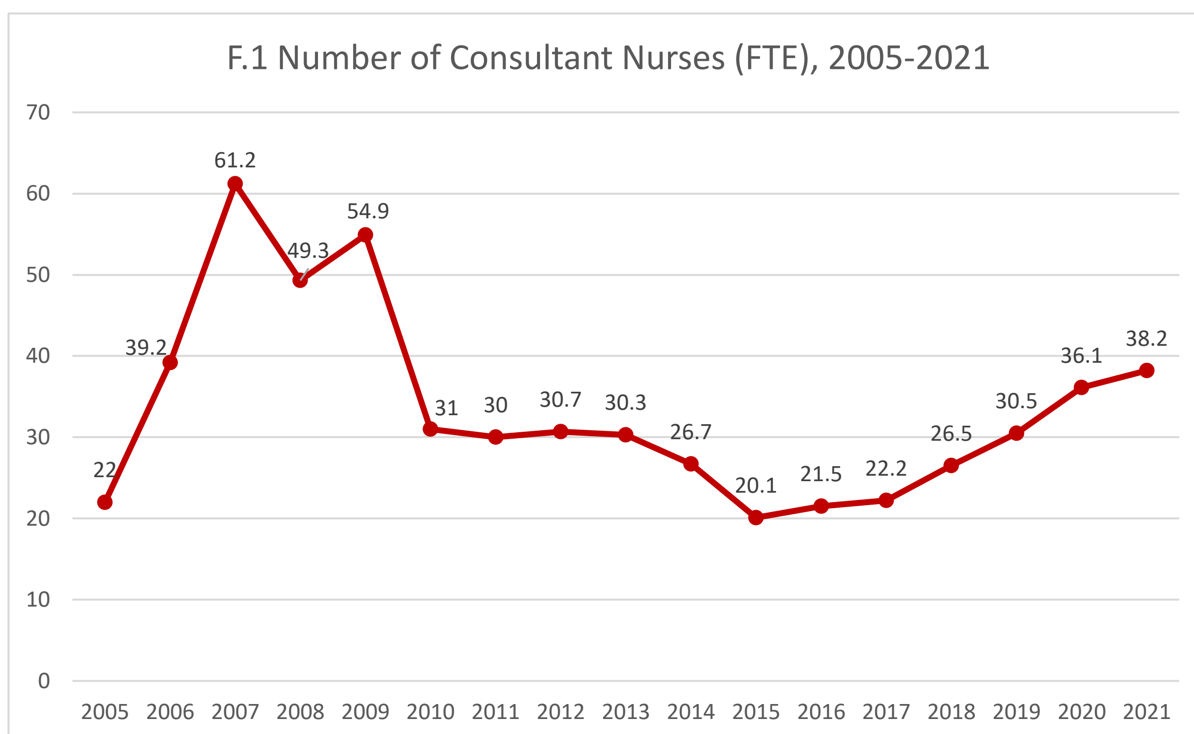
initiatives, advising on higher education routes or promoting positive learning and clinical settings.

4. **Practice service development, research and evaluation.** Develop evidence based protocols, research and explore implications of research upon service delivery.

In 2005, the previously known national body, Health Professions Wales, assessed the demand for consultant nurses in Wales and approved the need for 55 consultant nurses. The demand for consultant nurses has increased since 2005, due to a rise in the population, people living longer with more complex health requirements and an increase in comorbidity and complexity of care delivered to patients.

There was a rapid expansion of consultant nurses between 2007 and 2008. However as Figure 1 demonstrates the number of consultant nurses decreased sharply in 2010. Since 2017 there has been a consistent, albeit slow, increase in the number of consultant nurses, but Wales remains far below the required amount as set out by Health Professions Wales.

16 years since the demand was made clear by Health Professions Wales and Wales still falls short of the recommendations by 16.9 consultant nurses.[3][4]



[3] StatsWales, 2022, Nursing, Midwifery and Health Visiting Staff by grade and area of work, available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/nursingmidwiferyandhealthvisitingstaff-by-grade-areaofwork-year [Accessed 16 February 2022].

[4] StatsWales, 2022, Nursing, Midwifery and Health Visiting Staff by grade and area of work pre 2009 data, available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/Pre-2009/NursingStaff-by-Grade-Year [Accessed 7 March 2022].

Health boards must invest in the role of the consultant nurse to meet the health needs of their population. The amount of consultant nurses needed in a health board should be based on population need and assessed alongside other consultant level practitioners.

Transform the way Wales provides planned care and provide better support to patients

To transform the way Wales provides planned care and to better support patients there needs to be an investment in post-registration nursing and an acknowledgement of the importance of nursing leadership in transforming services.

General Practice Nursing

A significant proportion of the plan to transform services focuses on primary care, specifically GPs, but there is no mention of General Practice Nurses (GPNs). There are 1,397 nurses working in general practice.[5] This includes Advance Nurse Practitioners and Specialist Nurses who provide advance level care and support for patient including diabetes management, respiratory care and sexual health advise. They are also key to providing care for patients waiting for treatment or operations.

The value of GPNs, and specifically Advance Nurse Practitioners and Specialist Nurses should be recognised alongside medical colleagues.

The provision of primary and community care in Wales is based on 64 clusters. Clusters are often formed around the General Practice surgery and work together with key partners, i.e. community nursing teams, to provide care for their population. Every cluster has a lead, the majority of the time this is a GP. To transform and modernise services GPNs should have more of a leadership role in the strategic delivery of care, this includes having opportunities to, and being supported to become a cluster lead.

Infection Prevention and Control

Infection prevention and control (IPC) – the practical application of microbiology in clinical practice – puts patient safety firmly at the heart of health and social care delivery. Understanding how infections occur and are spread is crucial to the prevention of infections in all settings at all times.

IPC nurses promote the safety of patients, the public and the healthcare worker. The role is multifaceted, but the most familiar functions of an IPC nurse is to provide specialist advice, lead the healthcare workforce to carry out surveillance and develop policies and guidance.

[5] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/number-of-wider-practice-staff-employed-in-general-practices

As system leaders IPC nurses consider a holistic approach to the prevention of infection, acting as a bridge between public health, health protection and science.

The COVID-19 pandemic demonstrated the value of IPC advice and in particular the role of IPC nursing teams. It is time to reflect upon the lessons learned during the pandemic and ensure that going forward IPC nursing teams are recognised as an essential contributor to patient protection and safety.

To transform and modernise plan care IPC needs to take a central role. It is disappointed that within the plan IPC is only referred to when discuss limitation to capacity during the pandemic. Part of modernising services means being prepared for a possible outbreak of an infectious disease in the future. The Welsh Government and health boards should harness the knowledge and leadership of IPC nurses in delivering education and leadership for the healthcare workforce.

Investment in digital technology in the community

To ensure the plan is able to deliver on its priority to 'harness digital technology' there first needs to be an assessment and investment in digital technology for the community.

The importance and value of digital technology cannot be underestimated. The pandemic has aided significantly in advancing the use of digital technology in primary care but this is not necessarily the case for community services.

RCN Wales is aware that many members in the community still struggle to access IT services and support. RCN members have reported using a variety of equipment including laptops and mobile handheld devices, but they did not have regular access to their emails or office calendars from these devices and some members continue to use paper records. Unless there was an investment in digital technology for the community, the lack of IT reduces the plan's ability to harness digital technology.

There must be a whole-system approach to IT, starting with an assessment of what is available and how digital technology can be harnessed to improve planned care.

Regional Partnership Boards (RPBs)

Regional Partnership Board (RPBs) were established as part of the Social Services and Well-being (Wales) Act 2014.

There are currently seven RPBs. RPBs were designed to improve the wellbeing of the population and improve how health and care services are delivered, and yet there is no mention of them in the plan.

RPBs have an important role in the health and wellbeing of their population, it was therefore surprising that they were not included in the Welsh Government plan to transform and modernised planned care.

Despite their importance, RCN Wales believes that RPBs are currently limited in their abilities due to their limited membership. The guidance for RPBs outlines the requirement to have 'at least one person from the third sector who works with the local authority and local health board'. This is a very narrow description as such there is no membership relating to professional bodies or trade unions in RPBs. The lack of capacity for professional bodies and trade unions narrows the scope of the RPBs and would reduce their abilities.

Nurse directors are accountable for all nursing care provided within their local health board area including nursing care in the social care sector. The involvement of the nurse director should be made explicitly clear in the RPBs membership.

RCN Wales strongly recommends that to modernise service delivery RPBs should be included and the membership of RPBs expanded to include trade union representation, professional bodies and executive nurse directors.

About the Royal College of Nursing (RCN)

The Royal College of Nursing is the world's largest professional organisation and trade union for nursing, representing over 465,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 28,000 members in Wales. RCN members work in both the independent sector and the NHS. Around two-thirds of our members are based in the community. The RCN is a UK-wide organisation, with National Boards in Wales, Scotland and Northern Ireland.

The RCN represents nurses and nursing, promotes excellence in nursing practice and shapes health and social care policy.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 25
Ymateb gan: | Response from: Endometriosis UK

ENDOMETRIOSIS UK

YMATEB ENDOMETRIOSIS UK I YMGYNGHORIAD PWYLLGOR IECHYD A GOFAL CYMDEITHASOL SENEDD CYMRU AR GYNLLUN LLYWODRAETH CYMRU I DRAWSNEWID A MODERNEIDDIO GOFAL A GYNLLUNIWYD A LLEIHAU RHESTRAU AROS

TROSOLWG

Roedd problemau gydag amseroedd aros hir ar gyfer gofal endometriosis yng Nghymru cyn y pandemig, yn enwedig apwyntiadau canolfannau arbenigol gynecoleg/endometriosis a llawdriniaeth. Yn ôl y disgwyl, mae'r pandemig wedi peri i hyn waethygu.

Mae rhai sydd angen gofal trydyddol (arbenigol) yn enwedig, megis llawdriniaeth gymhleth mewn canolfan arbenigol endometriosis weithiau'n cael gwybod y bydd angen iddynt aros sawl blwyddyn am y llawdriniaeth honno. Gall gorfod aros yn hir am driniaeth gael effaith negyddol ar ansawdd bywyd gan gynnwys poen cronig parhaus a symptomau gwanychol sy'n golygu nad yw rhai'n gallu gweithio hyd yn oed. Mae hyn yn gwthio'r rhai sy'n gallu fforddio gofal preifat i fynd amdani, ac eraill yn mynd i mewn i ddyled i'w gael. Fodd bynnag, nid yw hyn yn opsiwn i'r mwyafrif helaeth.

Er mwyn lleihau rhestrau aros a moderneiddio gofal wedi'i gynllunio ar gyfer y rhai ag endometriosis, mae angen y newidiadau allweddol canlynol:

- Cynllunio strategol yn genedlaethol ar gyfer gofal endometriosis yng Nghymru gan gynnwys mesur ac ateb y galw am ofal endometriosis er mwyn sicrhau bod y rhai sydd angen yn gallu cael mynediad i ofal waeth beth fo'r ardal Bwrdd Iechyd. Byddai hyn yn cynnwys adeiladu capasiti'r GIG mewn adrannau gynaecoleg a chanolfannau endometriosis arbenigol i alluogi atgyfeiriadau cyflym o ofal sylfaenol i ofal eilradd, gan gynnwys ar gyfer laparosgopi diagnosteg lle bo angen i sicrhau nad yw diagnosteg yn achosi oedi mewn llwybrau gofal.

- Rhoi gofal arbenigol endometriosis dan gylch gorchwyl Pwyllgor Gwasanaethau Gofal Iechyd Arbenigol Cymru (WHSCC)[1] er mwyn sicrhau bod atgyfeiriadau ar draws Byrddau Iechyd yn cael eu hariannu'n gywir a bod bob claf sydd angen gofal arbenigol yn gallu cael mynediad iddo waeth ble maen nhw'n byw yng Nghymru.

- GIG Cymru a Byrddau Iechyd i adolygu meini prawf blaenoriaethu cleifion yn unol ag argymhellion RCOG[3] er mwyn ymgorffori ystyriaethau ansawdd bywyd, ac ar gyfer endometriosis byddai hyn yn cynnwys gallu cyflawni tasgau byw bob dydd a chael effaith ar ddeilliannau iechyd hirdymor, gan gynnwys osgoi anableddau i'r dyfodol.

- Sicrhau bod Cynllun Datblygu'r Gweithlu ar gyfer Cymru yn cynnwys mesurau penodol i sicrhau staffio priodol mewn gynaecoleg gan gynnwys gofal endometriosis i sicrhau nad yw staffio yn gohirio'r broses o daclo rhestrau aros neu ddatblygu gofal a gynlluniwyd cynaliadwy.

- Sicrhau bod gynaecoleg yn cael ei gynrychioli'n ddigonol ar y Bwrdd Diagnostig Cenedlaethol.

- Sicrhau bod argymhellion adolygiad Llywodraeth Cymru yn 2018 ar ofal endometriosis (3) yn cael eu gweithredu'n llawn yn unol â chanllaw NICE NG 73 ar endometriosis (4) a safon ansawdd NICE QS 172 ar endometriosis[2].

- Cynnal neu gomisiynu archwiliad i nodi bylchau a heriau i weithrediad adolygiad llywodraeth Cymru 2018/canllawiau NICE

- Lleihau amser diagnosis o'r cyfartaledd presennol o 9 blwyddyn i gyfartaledd o ddim mwy na blwyddyn, a fydd yn golygu:
    - Llwybrau clir ar gyfer diagnosis a buddsoddi i gapasiti diagnostig mewn adrannau gynecoleg
    - Gwella hyfforddiant ac addysg ymarferwyr gofal iechyd - dylai bob gweithiwr gofal iechyd proffesiynol gan gynnwys meddygon teulu ac ymarferwyr adrannau damweiniau a gofal brys allu nodi arwyddion a symptomau endometriosis
    - gwella ymwybyddiaeth a dealltwriaeth y cyhoedd o endometriosis gan gynnwys addysg lles mislifol yn ysgolion Cymru a chyllid ar gyfer ymgyrchoedd ymwybyddiaeth cyhoeddus

1. A fydd y cynllun yn ddigonol i fynd i'r afael â'r ôl-groniadau mewn gofal arferol sydd wedi cronni yn ystod y pandemig, a lleihau amseroedd aros hir?

Rydym yn croesawu'r bwriad i fynd i'r afael â'r ôl-groniadau sydd wedi cronni yn ystod y pandemig a lleihau amseroedd aros hir. O ran gwasanaethau gynaecoleg i'r rheiny sydd ag endometriosis posibl neu sydd wedi cael diagnosis o endometriosis, rydym yn nodi'r hyn a ganlyn:

- Bu i bobl ag endometriosis yng Nghymru brofi amseroedd aros hirach na chyfartaledd y DU ar gyfer apwyntiadau gynaecoleg a llawdriniaeth cyn y pandemig. Daeth adolygiad Llywodraeth Cymru ar ofal endometriosis yn 2018[3] i'r casgliad nad oedd "*darpariaeth gwasanaeth ledled gofal sylfaenol, gofal eilradd a gofal trydyddol yn bodloni anghenion, gan arwain at ddiffyg mynediad i ofal priodol i fenywod ym mhob rhan o Gymru".* Daeth ymchwiliad ar Endometriosis yn 2020 gan y Grŵp Seneddol Trawsbleidiol (APPG)[4] i'r casgliad fod pobl yng Nghymru yn profi oedi o ran cael eu hatgyfeirio i apwyntiadau ysbyty. Bu i'r un arolwg ddod i'r casgliad pan roedd pobl ag endometriosis yn clywed fod angen llawdriniaeth arnynt:
    - Bu i 48% aros mwy na 6 mis (cyfartaledd y DU yn 30%)
    - Bu i 6% aros mwy na blwyddyn (cyfartaledd y DU yn 7%)

- Rhyddhaodd Coleg Brenhinol yr Obstetregwyr a'r Gynaecolegwyr (RCOG) adroddiad ym mis Ebrill 2022 wnaeth ddod i'r casgliad fod gynaecoleg ledled y DU, gan gynnwys yng Nghymru, wedi gweld y cynnydd mwyaf o ran canran yn rhestrau aros yn ystod y pandemig[5] ac roedd y cynllun yn cydnabod mai gynaecoleg oedd un o'r arbenigeddau gyda'r nifer fwyaf o bobl yn aros.

- Mae canllawiau NICE ar ddiagnosis a rheoli endometriosis (NG 73) sydd wedi cael eu mabwysiadu yng Nghymru, yn nodi bod angen i unrhyw un sydd ag endometriosis posibl neu ddiagnosis o endometriosis dwfn gael ei atgyfeirio i ganolfan arbenigol endometriosis y Gymdeithas Endosgopi Gynaecolegol Prydain (BSGE). Mae tair canolfan o'r fath yng Nghymru; dwy ganolfan wedi'u hachredu'n llawn yn Ysbyty Athrofaol Cymru ac Ysbyty Singleton yn Abertawe, a chanolfan dros dro yn Ysbyty Brenhinol Gwent yng Nghasnewydd. Golyga hyn na all llawer o bobl ag endometriosis sydd angen gofal arbenigol gael mynediad i'r gofal hwnnw yn y Bwrdd Iechyd maen nhw'n byw ynddo, ac felly mae angen atgyfeiriad i ganolfan BGSE mewn ardal Bwrdd Iechyd arall. Gall y rhai sydd angen gofal arbenigol yng Ngogledd Cymru gael eu hatgyfeirio at ganolfannau BSGE yng Nglannau Myrswy. Mae trefniadau atgyfeirio trawsffiniol yn bodoli, er nad ydynt yn cael eu defnyddio bob amser.

- Ni fu erioed unrhyw gynllunio cenedlaethol ar gyfer gofal endometriosis yng Nghymru er mwyn mesur ac ateb y galw yng ngofal eilradd (gynaecoleg) a gofal trydyddol (canolfannau arbenigol endometriosis).

- Nid yw trefniadau cyllid presennol yn cefnogi atgyfeiriadau i ganolfannau BSGE ar draws Byrddau Iechyd, sy'n golygu bod y canolfannau hynny sydd yn derbyn cleifion o'r tu allan i'w ardal Bwrdd Iechyd heb gyllid digonol, neu ddim cyllid o gwbl. Nodwyd hyn yn adolygiad Llywodraeth Cymru yn 2018[1] a wnaeth nodi fod y ganolfan BSGE yng Nghaerdydd "wedi'i ariannu'n annigonol" a bod hyn wedi arwain at "amseroedd aros hir ar gyfer y llawdriniaeth fwyaf cymhleth". Heb gau'r bwlch cyllid hwn, rydym yn poeni na fyddwn yn gallu mynd i'r afael â'r ôl-groniadau mewn gofal arbenigol endometriosis (trydyddol) a lleihau rhestrau aros.

- Rydym yn croesawu'r cynlluniau i ddileu amseroedd aros hir ac yn nodi y gallai gwaith sesiynol ychwanegol ar y penwythnosau a gyda'r nos fod o fudd o ran gofal arbenigol endometriosis, cyn belled ag y bod mesurau er enghraifft o ran staffio ac amser theatr yn cael eu rhoi ar waith i sicrhau bod modd cyflawni hyn.

Ein hargymhellion:

- Cynllunio strategol yn genedlaethol ar gyfer gofal endometriosis yng Nghymru gan gynnwys mesur ac ateb y galw am ofal endometriosis er mwyn sicrhau bod y rhai sydd angen yn gallu cael mynediad i ofal waeth beth fo'r ardal Bwrdd Iechyd. Byddai hyn yn cynnwys adeiladu capasiti'r GIG mewn adrannau gynaecoleg a chanolfannau endometriosis arbenigol i alluogi atgyfeiriadau cyflym o ofal sylfaenol i ofal eilradd, gan gynnwys ar gyfer laparosgopi diagnosteg lle bo angen i sicrhau nad yw diagnosteg yn achosi oedi mewn llwybrau gofal.

- Rhoi gofal arbenigol endometriosis dan gylch gorchwyl Pwyllgor Gwasanaethau Gofal Iechyd Arbenigol Cymru (WHSCC)[6] er mwyn sicrhau bod atgyfeiriadau ar draws Byrddau Iechyd yn cael eu hariannu'n gywir a bod bob claf sydd angen gofal arbenigol yn gallu cael mynediad iddo waeth ble maen nhw'n byw yng Nghymru.

- Cryfhau trefniadau presennol ar gyfer atgyfeiriadau traws-ffiniol i ganolfannau BSGE yn Lloegr, er enghraifft ar gyfer y rhai yng Ngogledd Cymru sydd angen gofal o'r fath.

- Mynd i'r afael â staffio ac amseroedd theatr mewn canolfannau arbenigol endometriosis i alluogi gwaith sesiynol ychwanegol ar benwythnosau a chyda'r nos er mwyn lleihau nifer y bobl sy'n aros am gyfnodau hir.

2. A yw'r cynllun yn sicrhau'r cydbwysedd cywir rhwng mynd i'r afael â'r ôl-groniad presennol, a chreu system iechyd a gofal cymdeithasol fwy gwydn a chynaliadwy ar gyfer y tymor hir?

Mewn gofal endometriosis, mae taclo'r ôl-groniad ac adeiladu rhagor o ofal mwy gwydn a chynaliadwy gan gynnwys capasiti gofal a gynlluniwyd cynaliadwy yn hynod gysylltiedig. Mae profiad pobl ag endometriosis yng Nghymru o amseroedd aros hir cyn y pandemig yn nodi nad oedd capasiti gofal a gynlluniwyd, yn enwedig mewn gofal trydyddol sy'n digwydd mewn canolfannau arbenigol endometriosis BSGE, yn ddigonol er mwyn ateb y galw.

Hefyd, bu i'r adroddiad APPG 2020[2] ddod i'r casgliad fod capasiti annigonol i weld mewn gofal eilradd (gynaecoleg) ledled y DU i ateb y galw am wasanaethau endometriosis. Mae'r problemau uchod o ran

atgyfeiriadau ledled Byrddau Iechyd a threfniadau cyllid ar gyfer canolfannau BSGE yn ffactorau allweddol sydd angen eu datrys yn hyn o beth hefyd, yn ogystal â chynllunio capasiti strategol cenedlaethol.

Ein hargymhellion

- Cynnal cynllunio cenedlaethol strategol ar gyfer gofal endometriosis yng Nghymru, gan gynnwys mesur ac ateb y gal war gyfer gofal i sicrhau mynediad i bawb sydd ei angen. Byddai hyn yn cynnwys adeiladu capasiti'r GIG mewn adrannau gynaecoleg a chanolfannau arbenigol endometriosis i alluogi atgyfeiriadau cyflym o ofal sylfaenol i eilradd, gan gynnwys ar gyfer laparosgopi diagnosteg lle bo angen.

- Rhoi gofal endometriosis arbenigol dan gylch gorchwyl Pwyllgor Gwasanaethau Gofal Iechyd Arbenigol Cymru (WHSCC)[6] i sicrhau bod canolfannau BSGE yn cael eu hariannu'n briodol i dderbyn atgyfeiriadau ar draws Byrddau Iechyd gan alluogi pob claf sydd angen gofal arbenigol i gael mynediad iddo waeth ble maen nhw'n byw yng Nghymru.

3. A yw'r cynllun yn canolbwyntio'n ddigonol ar y canlynol:

a. Sicrhau bod pobl ag anghenion iechyd yn cyflwyno eu hunain;
b. Cefnogi pobl sy'n aros am gyfnod hir am driniaeth, rheoli eu disgwyliadau, a'u paratoi ar gyfer cael y gofal y maent yn aros amdano, gan gynnwys hunanreoli â chymorth;
c. Diwallu anghenion y rhai sydd â'r anghenion clinigol mwyaf, a'r rhai sydd wedi bod yn aros am amser hir;
d. Gwella canlyniadau cleifion a'u profiad o wasanaethau'r GIG?

Mae sicrhau bod pobl ag endometriosis yn cyflwyno eu hunain yn ymwneud yn fawr ag ymwybyddiaeth ac addysgu'r cyhoedd ac ymarferwyr gofal iechyd. Mae angen i addysg gyhoeddus ac ymwybyddiaeth ddechrau yn yr ysgol gydag addysg llesiant mislifol a chafodd hyn ei gynnwys yn y cod RSE newydd yng Nghymru ar ddiwedd 2021. Mae addysg llesiant mislifol yn addysgu plant beth sy'n arferol, a beth sy'n anarferol am y mislif, felly pe byddai rhywun yn profi symptomau a all fod yn endometriosis, gallant adnabod hynny a cheisio cymorth.

Rhaid i ymarferwyr gofal iechyd gan gynnwys meddygon teulu ddeall arwyddion a symptomau endometriosis fel bod modd i unrhyw un ag endometriosis posibl gael eu cymryd o ddifrif a chael eu hatgyfeirio'n gyflym at brofion, i ganolfan gynaecoleg neu ganolfan arbenigol endometriosis fel bo angen. Mae hyn yn golygu bod angen i feddygon teulu ddeall canllaw NICE NG 73 ar ddiagnosis a rheoli endometriosis. Gall penodiad diweddar nyrsys endometriosis ym mhob Bwrdd Iechyd yng Nghymru chwarae rhan o ran helpu i wella ymwybyddiaeth a dealltwriaeth o endometriosis mewn gofal sylfaenol, ond ni allan nhw fod yn bennaf cyfrifol. Gall meddygon teulu hefyd gael mynediad i adnoddau gan gynnwys pecyn cymorth llesiant mislifol a modiwl e-ddysgu gan Goleg Brenhinol y Meddygon Teulu (RCGP).

Mae'r ffocws ar gefnogi pobl sy'n aros am amser hir i gael triniaeth yn benodol berthnasol i'r rhai sy'n aros am lawdriniaeth endometriosis yng Nghymru. Cafodd yr angen am gymorth, gan gynnwys cyngor ar sut i reoli symptomau, rheoli poen a chymorth iechyd meddwl i'r rhai ar restrau aros am lawdriniaeth ei nodi gan ymatebwyr Cymraeg i'n harolwg effaith Covid 2021[7].

O ran cefnogi'r rhai gyda'r anghenion clinigol mwyaf sydd wedi bod yn aros am amser hir, rydym yn nodi:

- Fel clefyd sy'n gallu bod yn gronig ac yn wanychol, gall amseroedd aros hir am lawdriniaeth ar gyfer endometriosis arwain at ddirywiad yn ansawdd bywyd yr unigolyn gan gynnwys yr anallu i fynd i'r gwaith neu addysg, a chael anawsterau'n cyflawni tasgau byw bob dydd.

"Mae rhestrau aros yn arwain atom yn cronni dyledion wrth fynd yn breifat, neu'n waeth byth, mewn poen am flynyddedd. Mae'n creu effaith ddomino lle mae ein bywydau bob dydd yn newid, rydym yn cyfaddawdu ein cyflogaeth neu'n methu â bod yn rhiant ffit ac ati"

"Dwi wedi bod yn aros am lawdriniaeth frys i gael bag colostomi ers 2018. Roedd e i fod i ddigwydd yn 2019, ac yna digwyddodd Covid. Mae endo wedi niweidio fy ngholuddyn fel nad oes modd ei drwsio, ac mae pethau mor wael fel na allaf adael y tŷ"

- Os nad yw'n cael ei drin, gall endometriosis waethygu, gan arwain at lai o allu i gyflawni tasgau byw bob dydd tra'n aros ac yn arwain at angen rhagor o ymyriadau llawdriniaeth cymhleth, sy'n costio mwy i'r GIG yn ogystal â chael effaith negyddol fwy ar ansawdd bywyd y claf gan gynnwys amser gwella hirach.

- Er nad yw'n derm swyddogol, yn aml cyfeirir at endometriosis fel "gynaecoleg anfalaen", sy'n golygu nad yw'n ganser, sy'n rhoi argraff anghywir am effaith y clefyd. Rydym yn cefnogi'r alwad ddiweddar gan Goleg Brenhinol yr Obstetregwyr a'r Gynaecolegwyr i stopio defnyddio "anfalaen" a chytuno y gallai defnyddio'r term hwnnw fod wedi cyfrannu at beidio â blaenoriaethu anghenion iechyd menywod gan gynnwys rhai ag endometriosis, a all egluro'r cynnydd yn rhestrau aros gynaecoleg[8].

- Er bod y rhaglen yn cydnabod yr angen am "ddull teg a chyfartal o ran blaenoriaethu cleifion i leihau anghydraddoldebau iechyd", sy'n cydnabod effaith amseroedd aros hir gan gynnwys y boen a'r symptomau parhaus, iechyd yn gwaethygu, ac effaith ar ffordd o fyw, credwn nad yw hyn wedi'i ddatblygu'n ddigonol. Yn ei adroddiad ar restrau aros gynaecoleg[3], mae RCOG wedi galw am drawsnewid y ffordd y mae cleifion yn cael eu blaenoriaethu gan gynnwys ystyried nodweddion ehangach megis ansawdd bywyd ac anghenion critigol.

Ein hargymhellion

- Sicrhau bod addysg llesiant mislifol priodol i oedran effeithiol yn cael ei gweithredu ym mhob ysgol yng Nghymru fel y cytunir yn y cod RSE.
- Gweithio gyda Byrddau Iechyd i wella dealltwriaeth ac ymwybyddiaeth o endometriosis mewn gofal sylfaenol, yn enwedig ymysg meddygon teulu i sicrhau bod atgyfeiriadau oherwydd endometriosis posibl yn digwydd mewn modd amserol.
- GIG Cymru a Byrddau Iechyd i ddylunio pecynnau cymorth priodol i rai ag endometriosis ar restrau aros ar y cyd â rhanddeiliaid perthnasol gan gynnwys BSGE, RCOG ac elusennau megis Endometriosis UK sy'n cynrychioli'r gymuned endometriosis. Dylai pecynnau cymorth o'r fath gynnwys:
    - gwell cyfathrebu â chleifion
    - gwybodaeth ar beth i'w ddisgwyl o lawdriniaeth
    - cyngor ar sut i baratoi ar gyfer llawdriniaeth
    - ble i ddod o hyd i gyngor a chymorth hunan-reoli, er enghraifft drwy nyrsys endometriosis y Byrddau Iechyd, er byddwn yn argymell bod yn ofalus yn hyn o beth oherwydd ni all y nyrsys fod yn gyfrifol ar eu pennau eu hunain
    - atgyfeirio a sicrhau mynediad i wasanaethau megis rheoli poen, ffisiotherapi'r pelfis a chymorth iechyd meddwl
    - atgyfeirio i wybodaeth bellach megis gwefannau Endometriosis Cymru ac Endometriosis UK

- GIG Cymru a Byrddau Iechyd i stopio defnyddio'r term "gynaecoleg anfalaen".

- GIG Cymru a Byrddau Iechyd i adolygu meini prawf blaenoriaethu cleifion yn unol ag argymhellion RCOG[3] er mwyn ymgorffori ystyriaethau ansawdd bywyd, ac ar gyfer endometriosis byddai hyn yn cynnwys gallu

cyflawni tasgau byw bob dydd a chael effaith ar ddeilliannau iechyd hirdymor, gan gynnwys osgoi anableddau i'r dyfodol.

4. **A yw'r cynllun yn darparu arweinyddiaeth ddigonol a chyfeiriad cenedlaethol i ysgogi cydymdrech, cydweithio a rhannu arloesedd ar lefelau lleol, rhanbarthol a chenedlaethol ar draws y system iechyd a gofal cymdeithasol gyfan (gan gynnwys meysydd iechyd meddwl, gofal sylfaenol a gofal cymunedol)?**
5. **A yw'r cynllun yn rhoi digon o eglurder ynghylch pwy sy'n gyfrifol am ysgogi trawsnewid, yn enwedig wrth ddatblygu gwasanaethau triniaeth a diagnostig newydd a/neu ranbarthol a moderneiddio gwasanaethau gofal a gynlluniwyd?**

Mae hi'n bwysig fod gofal sylfaenol, gynaecoleg a chanolfannau arbenigol endometriosis yn cydweithio er mwyn ysgogi trawsnewid mewn gofal endometriosis, a fydd yn cynnwys gweithredu'n llawn canllawiau presennol NICE ac argymhellion gan adolygiad Llywodraeth Cymru ar ofal endometriosis[1]. Mae hi hefyd yn bwysig fod gynaecoleg yn cael ei gynrychioli'n ddigonol yn y bwrdd diagnostig cenedlaethol o ystyried yr angen a nodwyd eisoes i ymestyn capasiti diagnostig adrannau gynaecoleg a chanolfannau arbenigol endometriosis.

Ar hyn o bryd yng Nghymru, mae hi'n cymryd 9 mlynedd ar gyfartaledd i gael diagnosis o endometriosis yng Nghymru, sy'n golygu y gall y rhai ag endometriosis ddioddef yn gorfforol ac yn feddyliol, wrth beidio â chael y gofal iawn nac enw am eu symptomau. Gall yr oedi arwain at y clefyd yn gwaethygu, yn ogystal â straen o ran ymweliadau cyson â'r meddyg teulu a'r ysbyty sy'n methu ag adnabod achos am symptomau. Mae hefyd yn ddefnydd gwael o adnoddau'r GIG. Gall gwella gwasanaethau diagnostig ddarparu cyfle i leihau amser diagnosis ar gyfer endometriosis yn ogystal â rhyddhau adnoddau'r GIG sydd ar hyn o bryd yn cael ei wario ar apwyntiadau "gwastraff".

Ein hargymhellion:

- Llywodraeth Cymru, Grŵp Gweithredu Iechyd Menywod (WHIG), GIG Cymru a'r Byrddau Iechyd i gydweithio i sicrhau bod argymhellion adolygiad Llywodraeth Cymru yn 2018 ar ofal endometriosis (3) yn cael eu gweithredu'n llawn yn unol â chanllaw NICE NG 73 ar endometriosis (4) a safon ansawdd NICE QS 172 ar endometriosis[9]. Byddai hyn yn cynnwys, ond heb fod yn gyfyngedig i:
  - Rhwydweithiau clinigol wedi'u rheoli ledled Cymru yn cysylltu gofal sylfaenol, gofal eilradd a gofal trydyddol
  - Mae gan bawb ag endometriosis posibl neu ddiagnosis o endometriosis fynediad i gynaecolegydd gydag arbenigedd o ran rhoi diagnosis a rheoli endometriosis, gan gynnwys llawdriniaeth laparosgopig; bydd cyflawni hyn yn golygu datblygu a phenodi gynaecolegwyr sydd ag arbenigedd mewn endometriosis, gweithio'n agos gyda BSGE a RCOG i ddiffinio rolau a chymwyseddau.
  - Mynediad i gyfleusterau rheoli poen gan gynnwys gwasanaethau nad ydynt yn ffarmacolegol megis ffisiotherapi pelfig a chymorth seicolegol, gan alinio â chanllaw poen cronig NICE[10]

- Cynnal neu gomisiynu archwiliad i nodi bylchau a heriau i weithrediad adolygiad llywodraeth Cymru 2018/canllawiau NICE

- Gofal arbenigol endometriosis (trydyddol) i ddod o dan gylch gorchwyl Pwyllgor Gwasanaethau Gofal Iechyd Arbenigol Cymru (WHSCC) i sicrhau cynllunio cenedlaethol, cyllid digonol a mynediad teg waeth ble mae rhywun yn byw yng Nghymru.

- Gwella ymwybyddiaeth y cyhoedd ac ymarferwyr gofal iechyd o arwyddion a symptomau endometriosis yn ogystal â symleiddio llwybrau atgyfeirio ar gyfer diagnosis i helpu i leihau amser diagnosis i lai na pedair blynedd ar gyfartaledd erbyn 2025, ac o dan flwyddyn erbyn 2030.

- Sicrhau bod gynaecoleg yn cael ei gynrychioli'n ddigonol ar y Bwrdd Diagnostig Cenedlaethol.

6. **A yw'r targedau a'r amserlenni yn y cynllun yn ddigon manwl, mesuradwy, realistig a chyraeddadwy?**
7. **A yw'n ddigon clir pa arbenigeddau a fydd yn cael eu blaenoriaethu/cynnwys yn y targedau?**
8. **A ydych yn rhagweld unrhyw amrywiad ar draws byrddau iechyd o ran cyflawni'r targedau fesul arbenigedd?**

Rydym yn croesawu'r targedau ar apwyntiadau cyntaf cleifion allanol a lleihau nifer y rhai sy'n aros dros flwyddyn neu ddwy. Rydym yn nodi fod gynaecoleg yn cael ei gydnabod yn y rhaglen fel un o'r arbenigeddau gyda'r nifer fwyaf o bobl yn aros. Fodd bynnag, byddem yn falch o gael eglurder o ran a yw gynaecoleg wedi'i gynnwys yn "rhan fwyaf o'r arbenigeddau" yn y targedau a nodwyd eisoes.

Ein hargymhellion:

- Dylai gynaecoleg gan gynnwys gofal endometriosis fod yn un o'r arbenigeddau sydd wedi'i flaenoriaethu yn y targedau. Y rhesymau dros hyn yw bod gynaecoleg yn un o'r arbenigeddau gyda'r nifer fwyaf o gleifion yn aros. Roedd y broblem o amseroedd aros hir mewn gynaecoleg nad yw'n ganser yn bodoli cyn y pandemig, ac felly mae'n broblem sydd angen ei datrys ers cyfnod hir.

9. **A oes digon o gyllid refeniw a chyfalaf ar gael i gyflawni'r cynllun, gan gynnwys, lle bo angen, fuddsoddi mewn seilwaith ac ystadau a'u hehangu er mwyn sicrhau bod capasiti'r gwasanaethau yn bodloni'r galw?**
10. **A yw'r cynllun yn ddigon clir ynglŷn â sut y dylai cyllid ychwanegol ar gyfer trawsnewid gofal a gynlluniwyd gael ei ddefnyddio yn y modd mwyaf effeithiol, a sut y caiff defnydd ac effaith y cyllid eu holrhain a sut yr adroddir ar hynny?**

O ran ariannu gofal endometriosis, mae'n hanfodol mesur y galw am wasanaethau er mwyn gwybod a yw'r cyllid ar gael yn ddigonol er mwyn sicrhau y gall y capasiti ateb y galw. Mae hyn yn benodol bwysig ynghylch gofal canolfannau arbenigol endometriosis (trydyddol).

Ein hargymhellion

- Mesur y galw am ofal endometriosis yng Nghymru mewn gofal eilradd a thrydyddol i sicrhau y gall capasiti fodloni'r galw.
- Rhoi gofal arbenigol endometriosis dan gylch gorchwyl y Pwyllgor Gwasanaethau Gofal Iechyd Arbenigol Cymru (WHSCC)[6] i sicrhau bod canolfannau BSGE yn cael eu hariannu'n briodol i dderbyn atgyfeiriadau ar draws Byrddau Iechyd er mwyn galluogi mynediad i ganolfannau arbenigol waeth ble mae rhywun yn byw yng Nghymru.
- Sicrhau bod cyllid ac adnoddau ar gyfer nyrsys endometriosis Byrddau Iechyd gyfystyr â chyfrifoldebau a llwyth gwaith ac adolygu os bydd newidiadau sylweddol yn cael eu cyflwyno.

11. A yw'r cynllun yn mynd i'r afael yn ddigonol â phwysau ar y gweithlu iechyd a gofal cymdeithasol, gan gynnwys cadw, recriwtio a chefnogi staff i weithio'n hyblyg, datblygu eu sgiliau a gwella o drawma'r pandemig?

Rydym yn croesawu cydnabyddiaeth o'r angen i fwrw ymlaen â phwysau ar y gweithlu iechyd a gofal cymdeithasol a datblygiad Cynllun Cyflawni'r Gweithlu ar gyfer Cymru.

Mae angen datrys problemau'r gweithlu gan gynnwys recriwtio a chadw clinigwyr ag arbenigedd mewn endometriosis er mwyn gallu datrys yr ôl-groniad wedi'r pandemig a chyflawni gofal a gynlluniwyd cynaliadwy yn y dyfodol. Er enghraifft, yn y ganolfan BSGE yn Ysbyty Athrofaol Cymru yng Nghaerdydd, mae nifer y meddygon ymgynghorol wedi lleihau o tri i ddau, wedi i un ymddeol y llynedd.

Mae barn ymysg rhai yn y gymuned endometriosis yma yng Nghymru fod amseroedd aros hir i gael gofal (gan gynnwys cyn y pandemig) yn gysylltiedig â niferoedd annigonol o glinigwyr gydag arbenigedd mewn endometriosis i ddarparu'r gofal sydd ei angen.

> "*Yn syml, does dim digon o feddygon ymgynghorol i ateb y gal war gyfer menywod fel fi sy'n dioddef o boen cronig oherwydd y cyflwr hwn sy'n gallu gweinyddu triniaeth a gofal o safon i ateb y galw a'r safon sydd ei angen."*

Yn fwy eang ym maes gynaecoleg, mae Coleg Brenhinol yr Obstetregwyr a'r Gynaecolegwyr (RCOG) wedi nodi fod y gweithlu yn broblem sydd angen ei datrys i sicrhau nad yw'n creu oedi o ran taclo ôl-groniad y pandemig ac yn galw ar bob cenedl yn y DU i ddatblygu a gweithredu cynlluniau gweithlu gynaecoleg.

Ein hargymhellion:

- Cynnal cynlluniau strategol cenedlaethol ar gyfer gofal endometriosis yng Nghymru gan gynnwys mesur a bodloni'r galw am ofal endometriosis i sicrhau mynediad i bawb sydd ei angen. Byddai hyn yn cynnwys adeiladu capasiti'r GIG mewn adrannau gynaecoleg a chanolfannau arbenigol endometriosis i alluogi atgyfeiriadau cyflym o ofal sylfaenol i ofal eilradd, gan gynnwys laparosgopi diagnostig lle bo angen.
- Sicrhau bod Cynllun Datblygu'r Gweithlu ar gyfer Cymru yn cynnwys mesurau penodol i sicrhau staffio priodol mewn gynaecoleg gan gynnwys gofal endometriosis i sicrhau nad yw staffio yn gohirio'r broses o daclo rhestrau aros neu ddatblygu gofal a gynlluniwyd cynaliadwy.

12. A oes digon o eglurder ynglŷn â sut y bydd offer a data digidol yn cael eu datblygu a'u defnyddio i ysgogi darpariaeth gwasanaethau a rheoli amseroedd aros yn fwy effeithlon?

Rydym yn croesawu'r defnydd o adnoddau digidol a data i gefnogi a galluogi darpariaeth gwasanaeth lle bo'n briodol. Byddem yn gwerthfawrogi rhagor o eglurder ar sut bydd canllawiau cenedlaethol ar gyflyrau addas a chleifion ar gyfer adolygiadau rhithwir yn cael eu datblygu. Rydym yn croesawu'r porth gofal a gynlluniwyd arfaethedig gyda manylion ar amseroedd aros a gwasanaethau cymorth sydd ar gael; mae diffyg gwybodaeth ar y ddau beth yma'n rhywbeth y gwnaeth y gymuned endometriosis yng Nghymru drafod gyda ni. Fodd bynnag, ni all pawb ddefnyddio ap iechyd, neu nid yw pawb eisiau gwneud hynny na chael adolygiad rhithwir am sawl rheswm gan gynnwys llythrennedd ddigidol, mynediad i ddyfeisiau, anableddau a ffactorau economaidd-cymdeithasol a diwylliannol.
Rydym yn croesawu'r defnydd o ddata i fesur perfformiad a datblygu data rhestrau aros amser go iawn fesul is-arbenigedd a all helpu i gynllunio capasiti.

Ein hargymhellion

- Dylai canllawiau cenedlaethol ar amodau a chleifion sy'n addas ar gyfer adolygiadau digidol sicrhau bod unrhyw glaf sy'n dymuno optio allan o hyn yn gallu gwneud hynny, ac y bydd trefniadau amgen nad ydynt yn ddigidol yn cael eu rhoi ar waith.
- Rhaid sicrhau darpariaeth y wybodaeth yn yr ap gofal a gynlluniwyd all-lein ar gyfer y rhai na all ddefnyddio ap o'r fath, neu sy'n teimlo'n anghyfforddus yn gwneud hynny.
- Datblygu casglu data safonol ar wasanaethau endometriosis ledled pob Bwrdd Iechyd ac ystyried sefydlu cofrestrfa endometriosis.

AMDANOM NI

Endometriosis UK yw elusen arweiniol y DU yn cefnogi'r rhai sy'n cael eu heffeithio gan endometriosis. Rydym yn darparu gwybodaeth ar ein gwefan a thaflenni gwybodaeth, a chymorth uniongyrchol drwy linell gymorth, grwpiau cymorth a fforwm ar-lein. Rydym yn codi ymwybyddiaeth ac yn ymgyrchu i wella bywydau pawb sy'n cael eu heffeithio gan endometriosis, ac yn cyfrannu at ymchwil. Rydym yn gweithio'n agos gyda sefydliadau iechyd menywod megis RCOG a RCGP.

Bydden ni'n falch trafod y cyflwyniad hwn yn fanylach gyda'r pwyllgor. Cysylltwch ar bob cyfrif ar
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[1] Welsh Health Specialised Services Committee

[2] NICE guideline NG73 on Endometriosis: diagnosis and management, 6 Medi 2017 a NICE Quality Standards QS172 on Endometriosis, 6 Awst 2018

[3] Endometriosis care in Wales: Provision, care pathway, workforce planning and quality and outcome measures, Adroddiad Grŵp Tasg a Gorffen Endometriosis Llywodraeth Cymru, 16 Ebrill 2018

[4] Endometriosis in the UK – Time for Change, Adroddiad Ymchwiliad y Grŵp Seneddol Trawsbleidiol (APPG) ar Endometriosis, Hydref 2020

[5] Left too long – understanding the scale and impact of gynaecology waiting lists, Coleg Brenhinol COG, 4 Ebrill 2022

[6] Welsh Health Specialised Services Committee

[7] Effaith Covid-19 ar endometriosis, arolwg Endometriosis UK, 2021 (adroddiad data Cymru a gyflwynwyd yn gyfrinachol i Bwyllgor Iechyd a Gofal Cymdeithasol y Senedd mewn ymateb i'r ymgynghoriad ar amseroedd aros)

[8] Dismissal of women's health problems as 'benign' leading to soaring NHS lists, The Guardian, 2 Mehefin 2022

[9] NICE guideline NG73 on Endometriosis: diagnosis and management, 6 Medi 2017 a NICE Quality Standards QS172 on Endometriosis, 6 Awst 2018

[10] NICE Guideline NG 193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain, cyhoeddwyd 7 Ebrill 2021,

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 26

Ymateb gan: | Response from: Fair Treatment for the Women of Wales

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Senedd Health and Social Care Committee Inquiry:

The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Name of organisation: FTWW: Fair Treatment for the Women of Wales

1. FTWW is the only patient-led women's health equality charity in Wales, supporting and advocating for women and people assigned female at birth who are disabled and / or living with long-term health conditions in Wales. We campaign for better women's health services and equitable access to them, particularly as many of the health issues which predominantly affect females have suffered historical lack of investment and prioritisation in Wales and beyond.

2. **The Committee asks whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic and reduce long waits.**

3. We note that the first of the Welsh Government's Five Goals for Planned Care is 'Effective referral to the most appropriate setting'. However, at the same time, there continues to be a strategic commitment to 'care closer to home'. This creates a potential contradiction which the Welsh Government will need to address head-on and communicate to both patients and health boards. Whilst FTWW's members have long

expressed a willingness to travel for more specialised services, other people may have differing views and / or issues which make travelling more difficult – the Welsh Government and health boards will need to ensure there are mechanisms to engage effectively with individuals affected and, where necessary, provide them with the necessary support to access services situated farther afield.

4. It should be said that FTWW is fully supportive of any move towards routinely enabling patients to cross health board boundaries to access 'most appropriate' care, which must include specialist services unavailable in their locality, the historical prevention of which has created a significant postcode lottery in Wales. With this in mind, we also note that there is no reference to tertiary care in the section exploring 'integration', an omission which needs rectifying.

5. When describing 'care closer to home', we would argue that there is a need for more detail regarding what those services might be and for genuine engagement with public / patients to establish their views about the services they would expect to be delivered within the community. For our members, this would constitute services like pelvic physiotherapy and low-level mental health support targeted at those living with chronic health conditions and pain.

6. As already mentioned, we are pleased to see a reference to 'regional (diagnostic) centres' but would like to emphasise that even the provision of (presumably low complexity) high volume services will, in some instances, require upskilling of personnel if we are to avoid missed diagnoses and repeated referrals into services.

7. In FTWW's recent submission to Health Education and Improvement Wales's Education and Training Plan 2023-24 consultation, we mentioned the need to improve diagnostic capabilities in gynaecological ultrasound, as well as more investment in minimal access training for gynaecologists across Wales. Given that gynaecology is listed as one of the specialties with the greatest number of people waiting, this will be essential if we are to ensure patient need can be adequately addressed both locally and in regional centres.

8. **The Committee asks whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?**

9. Regional working and centres of excellence are concepts for which FTWW has called repeatedly as a way of better treating a number of health conditions with which our members are living. However, we wonder how this move fits with the Welsh Government's previous decision not to offer multi-disciplinary centres / one-stop shops for long COVID and similar conditions like ME and, also, (rare) auto-immune conditions

like lupus. We hope that this Plan means that there will be scope for further discussion with patients affected to ensure that these populations can similarly anticipate a move towards multi-disciplinary centres of excellence.

10. We would also ask that the Welsh Government explicitly acknowledge that, in some instances, travel outside of Wales will be required and that it will investigate ways to support those people with limited means / capacity with their additional travel needs.

11. When it comes to ensuring resilient and sustainable services, co-production is rightly mentioned as being key. However, this firstly requires agreement on what it is / what it entails (it isn't just 'engagement' or 'consultation'). We welcome use of terminology like 'involvement' and 'collaboration' but this needs to come from a place of equity of esteem and value, particularly as the Plan describes co-production as a means to deliver 'value-based care'.

12. For patients to be involved and collaborators in health service design and evaluation, they need to be properly supported throughout their participation and beyond, and this often requires time, commitment, and careful facilitation – all of which FTWW has been pleased to offer the Welsh Government and health boards over the last few years. However, we still encounter barriers to participation on occasions, with service providers not fully cognisant of what co-production involves or its benefits. Additionally, there remains a lack of resourcing for this kind of activity which poses considerable challenges to its sustainability and further expansion. We would urge the Welsh Government to address this funding gap as a priority if it is serious in its commitment to embedding co-production in strategic planning, decision-making, and service design.

13. The Plan mentions a few instances where a co-productive approach will be taken, including the development of patient pathways. We would urge the Welsh Government to expand this to include the development of PROMS and PREMS, cited throughout the Plan as being vital instruments in assessing service effectiveness. This is important to ensure that the right questions are being asked and in the most user-friendly way. Similarly, with regards to 'one-stop shops', we would urge that robust engagement with patients takes place so that we can be sure they fully accommodate patient needs.

14. **The Committee asks whether the plan includes sufficient focus on:**

- **Ensuring that people who have health needs come forward;**
- **Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**

- **Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**
- **Improving patient outcomes and their experience of NHS services**

15. We are pleased to see that the vital role of the third sector in supporting and improving the wellbeing of citizens and patients is referenced and endorsed throughout the Plan. In particular, we note the Welsh Government's commitment to a 'national framework for social prescribing to embed access to prevention services and wellbeing activities into our pathways', based on the acknowledgement that the third sector is well-placed to improve cost-efficiencies by 'reducing follow-ups and presentations'.

16. As an organisation supporting a growing number of people in Wales living with long-term and recurrent health issues, helping them to better 'self-manage' their condition(s) and navigate often complex pathways, we welcome the Welsh Government's endorsement of this kind of activity. We have spent several years creating a safe, peer-led space for our members and building both trust and resources so that they are better equipped to manage their own health and advocate for themselves and others. However, a move towards formally integrating a third sector offer into the country's health services also creates the very real danger of over-burdening organisations / groups already groaning under the weight of increasing pandemic-related demand, to the point where they can no longer support those in need of their services. This is an organisational risk to third-sector providers and the NHS but, even more importantly, it runs the risk of leaving clients / patients without a service on which they may have come to rely.

17. Alongside formalising referral pathways into community activities / support, therefore, the Welsh Government must concurrently address the huge funding and capacity gap being experienced by the third sector. We would urge that funding application processes are co-produced to make them accessible to smaller / grassroots providers.

18. The Plan also mentions 'helping people to manage their conditions without surgery' which we would suggest is a laudable aim if not always possible, not least due to lack of investment in research for some conditions, i.e., endometriosis. In fact, for many 'benign' gynaecological conditions, the 'best' offer we currently have is major surgery, such as hysterectomy and oophorectomy - but this is often because no non-surgical treatment or cure has been identified due to a lack of research prioritisation and investment. Certainly, as an adjunct to surgery and / or current medical 'management' of symptoms, we would urge much more emphasis on pelvic physiotherapy, something which we see as being an essential component of 'care closer to home'.

19. We would also like to draw the Committee's attention to the Plan's aim to address 'widening health inequalities' through Public Health Wales campaigns and activities to 'promote' and 'encourage' healthier lifestyles. Unless activity is directed towards engagement, including via grassroots advocacy organisations, endeavours like this will only have partial success because they don't identify or address causation. 'Specific signposting to local support services to help people to achieve and maintain a healthy weight, be more physically active and cease smoking' is referenced as a core part of 'Communications and engagement' but naively fails to include any sense of engaging with people to establish their reasons for not maintaining a healthy lifestyle or attempting to resolve the factors underpinning health inequalities / 'unhealthy' lives.

20. **The Committee asks whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**

21. We are concerned that there is no detailed reference to a NHS Executive in this Plan, not least what we see as the ideal option: an independent entity with sufficient powers to address the most intractable issues currently preventing regional collaboration, making consistent co-production of services a reality, overseeing implementation and performance, and ensuring accountability. We believe that many of the very laudable aims of this Plan will be difficult to achieve without something of this nature in place.

22. We note that one of the key purposes of this Plan is to eliminate the prospect of long waiters at all stages of the pathway – this needs to explicitly reference tertiary / specialist care which may not be available 'close to home' or even in Wales. It is this part of the pathway that has previously proved to be the most problematic in terms of equitable access. The Plan posits, 'regional waiting lists (and) the transfer of patient care across health board boundaries' as the solution, which FTWW would absolutely endorse. However, this approach will require considerable oversight and a much more hands-on approach to health board collaboration.

23. The Welsh Government will need to listen to clinicians, patients, and managers when barriers to collaboration are articulated – not least the block-funding arrangements in Wales which do not always work in the best interests of patients with complex conditions. We believe that the Welsh Health Specialised Services Committee (WHSSC) may be well-placed to address some of these issues but would suggest that its remit be expanded and its deliberations made more transparent, with wider engagement (including with patient groups) a core part of its activity and decision-making.

24. With regards to the Committee's focus on the 'entire health and social care system, including mental health', we do have some concerns regarding the Welsh Government's intention to, '(where appropriate) de-medicalise our approach to mental health services' and wonder if this terminology and approach would be deemed acceptable for 'physical health services'?

25. We believe that there is a vital distinction to be made between mental 'wellbeing' and mental health / mental illness, where mental wellbeing can likely be supported via a non-medical approach, as opposed to mental (ill) health. It is worth emphasising that, in many instances, Wales still doesn't adequately support or treat those with serious mental illness or routinely allow access to tertiary / specialist services where they are not available in the locality, including serious peri-natal mental health issues, eating disorders, or obsessive-compulsive disorder. Nor does the system in Wales routinely ensure that workable shared-care agreements are in place for those forced to pay privately for a diagnosis of autism / ADHD (most likely to be women / people assigned female at birth).

26. Whilst we believe that a move towards regional centres of excellence for various physical health conditions is a positive development, we are concerned that there is no suggestion that this same approach will be applied to those mental health conditions which require a similarly specialised and multi-disciplinary approach. As such, we would urge caution regarding any possible further dilution of mental health services as this may well end up adding to the existing backlog of patients needing to access care.

27. The Committee asks whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?

28. As mentioned in our response to the previous question, we perceive there to be a lack of clarity in the Plan regarding who has ultimate responsibility for ensuring the development of regional centres / hubs. As patients, we are all too aware that, historically, advice from the Welsh Government to the health boards that 'geographical boundaries should not be barriers to care' has not, for the most part, led to any discernible change. However, we also appreciate how and why the current operational and funding system in Wales creates these barriers. Systemic issues will need to be addressed by an (ideally independent) Executive Team if we are to make Goal 4, 'Giving individuals more choice and control over their care' a reality.

29. The Welsh Government needs to appreciate that genuine commitment to shared decision-making of this nature will require enabling of equitable access to tertiary and specialist services, even if situated out of area (and a reporting system in place for

patients for whom this isn't facilitated) and that this will inevitably lead to increased demand. For this to be manageable on the part of providers, dedicated funding will be necessary so, as mentioned already, it may be that the WHSSC is involved in discussions of this nature. We would strongly urge that a co-productive approach to the WHSSC's decision-making be facilitated, with patient advocacy organisations like our own enabled to have dialogue with the Committee.

30. **The Committee asks if the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?**

31. Whilst the Plan does mention some general (and aspirational) timescales, part of its implementation needs to be making a more detailed workplan publicly available so that patients and healthcare professionals have clear expectations and can hold providers to account should these targets and timescales not be met – this should be seen as a key part of any constructive dialogue.

32. Goal 5 is to, 'Measure what's important, transforming care to better meet the clinical need of the patient'. FTWW commends the Welsh Government's refreshed commitment to patient-centred care and references to co-production throughout the Plan. However, as already mentioned, this requires PROMS and PREMS themselves to be co-produced, consistently collected, and scrutinised alongside more traditional (largely quantitative) performance measures. Unless there are personnel in a NHS Executive team charged with ensuring these measures are universally applied, studied, and used meaningfully / to drive improvement, there will continue to be variation and inequality in service provision.

33. **The Committee asks if it is sufficiently clear which specialties will be prioritised / included in the targets?**

34. The Plan mentions 7 specialties which have the greatest number of people waiting and which will, presumably be prioritised for attention, although that is not made explicit. As an organisation focused on female health, we are all too aware of the impact the pandemic has had on gynaecology services, although it is important to appreciate that it has merely exacerbated pre-existing issues and gender-based inequalities in health. We are aware that work to improve planned gynaecology is already underway.

35. Crucially, gender bias hasn't just affected those conditions typically associated with female health – as FTWW's work as part of the #WomensHealthWales Coalition has demonstrated, there are a significant number of specialties where women and people assigned female at birth make up the majority of those affected but whose needs are not reflected in service provision and investment: this needs to be urgently addressed if

we are not to perpetuate existing health inequalities. As the Welsh Government looks to direct action towards the 'ten highest demand conditions', it is important to be mindful of the role historical and unconscious biases may have played, and still be playing, in data collection.

36. The Plan states early on that its intention is to, 'Eliminate the number of people waiting longer than two years in most specialties by March 2023'. The Welsh Government needs to be more explicit in its references to 'most specialties' – which ones does it anticipate not being part of this group? We note that openness and transparency are mentioned at various points within the document so this is a significant omission – reasoning should also be given.

37. **The Committee asks if we anticipate any variation across health boards in the achievement of the targets by specialty?**

38. The Plan describes 'work(ing) with health boards to prioritise diagnostics and identify gaps in demand and capacity at a local and national level'. To get a complete picture, we would advise also reaching out to patient advocacy organisations like our own who have pan-Wales membership and who can help to identify need and capacity issues from the patient perspective.

39. It can be problematic accurately assessing demand if neither clinician or patient are aware of the benefits or existence of a service (as we have found with both pelvic physiotherapy and specialist menopause provision). Without that awareness, a request to access the service won't be made by either party, resulting in an inadequate assessment of need. It is issues like this that can result in variation across health boards in the achievement of targets, so there needs to be a body charged with issuing clear expectations, guidance, and oversight of activity (including communication between health care professionals and the patient community).

40. The Plan goes on to state that, 'Further analysis of the waiting list needs to be undertaken to ensure we really understand variations in access not only from where a person lives but also by their relevant characteristics…' We were surprised not to see sex and gender referenced here, particularly in the context of UK-wide women's health strategies / plans under development precisely to address these historical and enduring disparities in care.

41. Equally, we would urge considerable attention be paid to disability and neurodivergence which see those people affected at particular risk of encountering barriers to appropriate, timely, and effective healthcare. All health boards and personnel should receive training, ideally designed and delivered by those with protected characteristics,

on how best to engage, support, and tailor their offer to individuals / communities affected, thereby reducing the possibility of unnecessary variation and inequality in service provision and access.

42. **The Committee asks if there is sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?**

43. The Plan states that, ‘We expect health boards to plan services regionally…for specialised services’. Whilst we absolutely agree with this aim, it is not enough to issue an ‘expectation’ unless there is high-level focus on addressing the barriers and facilitators to making it happen in reality and a designated body charged with ensuring that ‘expectations’ are met.

44. Clearly, there will need to be funding directed towards both facilities, equipment, and training for personnel in regional ‘centres of excellence’ if they are to be truly of the highest quality. By ensuring this level of investment, it is possible that Wales could provide services both to domestic patients and those farther afield.

45. In terms of infrastructure, as mentioned, we would see the WHSSC as being a mechanism by which pan-Wales access to specialist services might be facilitated but its remit and functionality would likely need revisiting.

46. **The Committee asks if the plan is sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?**

47. The Plan describes the monies allocated to NHS organisations to support planned care recovery plans, but we regret that there is no reference to any funding for the third sector organisations supporting this work, despite the sector being mentioned throughout as an essential partner in both the design and delivery of care.

48. The successful attainment of the five goals mentioned at the start of the Plan very much relies on organisations who can provide direct channels of communication to patients, and facilitate and support their involvement, ensuring a co-productive (and therefore efficient and effective) approach to the design and delivery of healthcare in Wales. This is something the Welsh Government acknowledges will improve patient experiences and outcomes and provide considerable long-term efficiency savings if done properly. We cannot emphasise enough how this kind of activity needs adequate, sustainable, and accessible funding.

49. **The Committee asks if the plan adequately addresses health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**

50. We don't feel that these issues are addressed in any great detail in the Plan as it stands, although we note the reference to Allied Health Professionals (AHPs) and the need for improved access to them in the community, 'without the need to be referred by another health professional'. This streamlined approach would reduce the number of appointments required whilst also empowering patients to take charge of this aspect of their personal healthcare journeys.

51. We would like to reiterate the need for more pelvic physiotherapists across Wales and also alert the Committee to the fact that, as far as we are aware, unlike any other type of physiotherapy service, a referral from either the GP or consultant is required to access these AHPs. Given the prevalence of both pelvic pain conditions, and continence issues, this is both a gap and an anomaly which needs addressing.

52. In terms of recruitment or re-training, we would urge the Welsh Government to explore funded training places and bursaries in exchange for a period of commitment to service-provision in the locality. In addition, the referral requirement for these patients (most commonly women / people assigned female at birth) needs to be reconsidered as it seems a stark example of gender health inequality.

53. **The Committee asks if there is sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

54. With the Plan's stated aim of moving towards a more effective combination of care closer to home and centralised specialist care, we would like to see further exploration of both wearables and digital / remote communications as ways to improve collaboration between specialist and local teams, and the individual patient themselves. This would enable those who have accessed a specialist intervention outside of their locality to be better supported closer to home whilst waiting and afterwards.

55. We note the Welsh Government's comment that 'Strengthening telephone and e-advice services' has proved beneficial for a significant number of patients – but we would also advise that this move has, at the same time, excluded others with particular needs and / or impairments. The Welsh Government and health boards must ensure reasonable adjustments are readily made for those who require them and that inequalities are not exacerbated in the rush to progress remote and digital healthcare.

56. The prospect of unwittingly causing and / or perpetuating inequality is of great concern to FTWW. The Plan states its aim of 'accelerating the embedding of virtual approaches so that 35% of new appointments are delivered virtually', a seemingly arbitrary (and high) target which poses a very real risk of delaying diagnosis and referrals, not least because physical / in-person examinations can play a hugely significant part in expediting access to appropriate care. We are very concerned that a move towards over one third of new appointments being carried out virtually may end up having the opposite effect to that intended by the Welsh Government.

57. The Plan goes on to suggest that provisions for the digitally excluded will be resolved by, 'setting up virtual centres in rural communities'. It is important to remember that it is not just those in rural locations who are digitally excluded – there are many different reasons for not wishing / being able to access or benefit from virtual health appointments which need to be properly explored and ameliorated through a variety of means. We would suggest that there needs to be much more engagement with citizen / patient advocates from a range of sectors to explore causation and solutions.

58. Finally, the Welsh Government acknowledges that the success of this Plan will be underpinned by accurate data, something with which we would wholeheartedly concur. In light of this, we envisage the need for coding to be revisited in secondary care so that diagnoses and modes of intervention / treatment are more accurately recorded. This would allow more accurate assessment of what interventions are taking place and their effectiveness, as well as better tracking of individual patient trajectories. In addition, we would like to see menstrual / gynaecological conditions added to the Quality Assurance and Improvement Framework (QAIF) in Primary Care as this is a key mechanism for collecting data on prevalence and impact, as well as driving improvements in care.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 27
Ymateb gan: | Response from: Cancer Research UK

The Senedd Cymru Health and Social Care Committee consultation: The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Cancer Research UK Response – June 2022

Cancer Research UK welcomes the opportunity to respond to the Committee's ongoing inquiry into the Welsh Government's plan for reducing waiting times and tackling NHS backlogs ('Recovery Plan'). Our response offers an assessment of relevant announcements in the Recovery Plan and how the Plan could make an impact for people affected by cancer in Wales.

We welcome the prioritisation of cancer in the Plan, and the acknowledgement of the enormity of the challenge faced by cancer services to recover post-pandemic. However, we believe there should be greater ambition – in terms of improving waiting times and access to innovations – for cancer patients in Wales than the current plans would deliver.

Our submission focuses on the questions most relevant to Cancer Research UK's evidence and expertise.

Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.

The problems facing cancer services in Wales are significant and have been exacerbated by the COVID-19 pandemic.

NHS cancer waiting times for March 2022 show that the percentage of patients receiving their first treatment within 62 days of being suspected of having cancer was below pre-pandemic levels at 59**%**. This is well below the Suspected Cancer Pathway performance target, which aims for 75% of patients to start treatment within 62 days of first suspecting cancer. No Health Board has met the 75% target since it was set in February 2021.

One of the contributing factors to the long waiting times are delays in diagnostics. The NHS diagnostic and therapy service waiting times for March 2022 show a major increase in the number of people waiting over 8 weeks for one of 7 key tests[1] most commonly used to diagnose cancer, compared to pre-pandemic levels. By the end of March 2022, around **16 times** more people were waiting more than 8 weeks for one of these diagnostic tests compared to before the pandemic.[21]

We now know that in the year between April 2020 and March 2021, 1,700 fewer people began cancer treatment in Wales.[2] Many factors contributed to this, with some people reluctant to present to primary care with symptoms due to not wanting to burden an overwhelmed system or because of safety fears during the height of the pandemic. We know that fewer patients began treatment following screening programmes being paused for some time. Disruption to services affected patients, risking increased later stage diagnosis when cancer is much harder to treat and worsening survival chances.

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[1] 7 key tests most commonly used in the diagnosis of cancer are Non-Cardiac MRI, Non-Cardiac CT, Non-Obstetric Ultrasound, Colonoscopy, Flexible Sigmoidoscopy, Cystoscopy and Gastroscopy Welsh Government Interactive Stats Dashboard

[2] Compared to March 2019. 2019 numbers adjusted for working days, based on Wales Cancer Waiting Times data.

The pandemic put a huge strain on NHS staff[3], who worked their hardest to maintain cancer services with limited capacity, in part due to increased infection control measures and high staff absences due to COVID-19.

There is a real risk that the improvements we've seen in cancer survival in recent decades could now stall.

Cancer Research UK has long called for a cancer strategy for Wales to deal with the immediate issues facing services, and to embed systems and capacity to boost efficiency and outcomes for the future. The Cancer Services Delivery Plan came to an end in 2020, with no replacement until the publication of the Quality Statement for Cancer in March 2021. The Quality Statement is a series of high-level policy statements, and did not deliver what was needed to support services to recover from the pandemic and improve for the future.

The NHS Recovery Plan for Planned Care goes some way to address the short to medium-term issues that cancer services face in Wales, but we do not believe it is ambitious enough to tackle the deeper barriers to improving cancer outcomes in Wales.

The key areas covered in the Recovery Plan, that are relevant to cancer services include the below (taken directly from the Plan):

- *We will establish a network of local community hubs to co-locate frontline health and social care and other services. These will provide a consistent approach to support health checks for people in deprived areas and potentially detect health issues that can be treated to prevent the conditions worsening.*
- *Cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026.*
- *Welsh Government to form a Diagnostics Board. The board will bring together key partners from across the NHS and Social Services, and will have delegated authority from the NHS Wales Leadership Board to provide direction on all diagnostics related matters including service models and allocation of available resources. The board will use input from national programmes such as Imaging, Pathology and Endoscopy and agree a holistic diagnostics approach for Wales.*

These commitments are welcome and will go some way to tackle the backlog in cancer services. But the plans will still leave cancer patients in Wales behind in terms of access to timely diagnosis and services. Moreover, without further injection of funding for key initiatives like the roll out of community diagnostic hubs across Wales, it is difficult to see how their implementation will have tangible impact and meaningfully expand capacity.

For example, whilst it is a positive step to increase the cancer waiting time target to 80%, from 75%, of people to receive first treatment within 62 days of GP referral, we need to reflect on the fact that no health board has met the current Single Cancer Pathway target since it came into force. Therefore, significant investment in diagnostics – staff and infrastructure – will be needed to boost capacity in the system to meet new more ambitious targets.

In summary, we need more detail on how cancer services will be supported to transform and improve further and faster than is set out in the Recovery Plan.

The Minster for Health and Social Services has recently announced a new NHS Cancer Services Action Plan will be developed by the Cancer Network Board[4]. We understand that this will bring together the local and national planning response to the Cancer Quality Statement (published March 2021) and the

NHS Recovery Plan for Planned Care into one document, and that this will cover the three-year planning cycle.

The announcement of the new Action Plan is positive. It is an opportunity to set out an ambitious plan that tackles the immediate issues of capacity to manage demand in the system, and that sets cancer services up to transform into the future.

But it must do more than simply bring together existing plans. With renewed ambition and political will for services to improve, we could see the transformation in diagnosis, treatment, and outcomes that people affected by cancer in Wales need and deserve.

Recommendation:

The NHS Cancer Services Action Plan must tackle the immediate challenges such as long waiting times as well as set out how Wales is preparing services for new cancer innovations and transforming cancer services for the future. There are key elements needed in a strategy to see transformation in cancer services:

1. Identifying ambitions and making them a reality
   - The NHS Cancer Services Action Plan should aim for transformation in cancer services, with bold ambitions that bring together cancer services and the health system around a shared vision for change that will deliver a real step change in cancer outcomes.
   - This must be underpinned by ambitious, measurable objectives with achievable timelines.
2. Tracking progress
   - There must be robust reporting mechanisms that regularly and transparently update on progress.
3. Empowering leadership to drive transformation
   - To drive change and lend credibility to any transformation agenda, there must be dedicated leadership, bringing the right people together including clinical expertise, system management and transformation, IT and infrastructure experts, service planners, third sector partners and patients
   - Underpinning strong and diverse leadership through the Wales Cancer Network should be a robust framework for governance and implementation, through the new NHS Executive.
4. Embedding joined up cancer services
   - A key principle to guide the new Action Plan should be ensuring that everyone has equitable access to timely diagnosis and the most effective evidence-based treatment and support.
   - Where inequalities persist, consideration should be given to how adequate capacity and expertise can be brought together to enable timely access and transformation, including where consolidation of services would support this, as well as where cancer services could be brought closer to communities and patients.
5. Investing in people and infrastructure
   - Lasting transformation that will deliver improvements in outcomes will be impossible without adequate investment, most notably in growing the cancer workforce across the strategy as well as infrastructure for kit, facilities, informatics and data collection
   - Long-term investment will also support testing innovative approaches to service delivery in opportunity areas such as early detection and diagnosis, digital pathology and developing an integrated IT system

Do you anticipate any variation across health boards in the achievement of the targets by specialty?

The current variation across health boards in access to cancer services is stark. Under the national waiting times statistics there is a worrying picture of variation and inequality, both by geography and cancer type.

There is substantial variation between Health Boards in relation to cancer waiting times, with Cwm Taf Morgannwg UHB seeing just 45% of patients starting treatment within 62 days of first being suspected of cancer in March 2022 compared with 70% of patients in Betsi Cadwaladr UHB.[5] While no part of Wales is currently hitting this target, it is unacceptable that where someone lives in Wales is impacting their access to timely diagnosis and treatment.

We welcome the increased ambition for cancer waiting times, as timely diagnosis and treatment has an important role to play in improving patient experience and can also help improve cancer outcomes. However, no health board has met the existing target since its introduction and it is not currently clear in the Recovery Plan how Welsh Government will expect or support services to recover current waiting times, or to achieve the new target. We also do not believe the new target will help services to reduce variation in waiting times across health boards without targeted support. It is essential that the Recovery Plan is backed with funding for policies which will expand capacity to support services to meet the current target and ensure they are prepared for the future one.

One of the key announcements for cancer diagnostics in the Recovery Plan is the introduction of two new community diagnostic hubs. This is a welcome step from Welsh Government, as Cancer Research UK have advocated for this approach for some time, and we included this recommendation in our previous evidence to this inquiry. The Recovery Plan commits to two new community diagnostic hubs, with more to follow by the end of the Senedd term.

The concept of community diagnostic hubs was established in the Sir Mike Richards Review into Diagnostics in England in 2020, which demonstrated the opportunity for taking 'elective' diagnostics out of hospitals and running such services in 'community diagnostic centres'. These could be sited on high streets or car parks. They would increase capacity in diagnostics, as well as making it easier for patients to access the tests they require. Since this report, NHS England has already begun a programme of setting up 150 community diagnostic centres across England.

Wales has been falling behind on this innovation. Rapid diagnostic centres, which are for people with vague symptoms that could be cancer, have taken several years to roll out from Wales since the initial pilots were set up in 2018. Therefore, whilst the move to introduce community diagnostic hubs in Wales is very welcome, the extent of the investment will not meet demand or make demonstrable improvement to many waiting for cancer diagnosis or treatment in Wales. We need to see Welsh Government committing to going further, through more investment in this initiative, and faster, to truly make the transformation needed to improve cancer diagnosis. Where possible, the new community diagnostic hubs should be located in areas of greatest need – those with the longest waiting times, in the first instance.

There is also a commitment in the Recovery Plan to form a Diagnostics Board, which will bring together key partners from across the NHS and Social Services, and 'agree a holistic diagnostics approach' for Wales. This is an important development for cancer diagnostic services, however the Recovery Plan lacks detail on how the Board will operate, governance and accountability. The Diagnostics Board could be a way to ensure that variation across health boards is reduced in waiting time targets, but without the detail on how the Board will operate and what resource it will be given to work to bring up all health boards, it is impossible to say with certainty what impact it will have.

As developments for the new Diagnostic Board continue, it will be essential to understand the responsibilities of the Board and governance, to understand how to drive innovations in diagnostics across Wales.

Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?

Gaps in the NHS workforce are a fundamental barrier to transforming cancer services and improving cancer survival. Even before the pandemic, Wales was experiencing significant gaps in the diagnostic and cancer workforce, such as in imaging, endoscopy, pathology, and non-surgical oncology. These gaps have severely affected its ability to diagnose cancers early and provide the most effective cancer treatment.

The Royal College of Radiologists (RCR) found that shortfall of clinical radiology consultants in Wales is 37% – higher than the UK average of 33%. In 2020, Wales had just 7.8 radiologists (who read and interpret medical images in order to diagnose, treat and monitor diseases) per 100,000 people, compared to the European average of 12.8. Without action, shortages show no sign of abating, with Wales seeing the slowest growth in the clinical radiology workforce in the UK – averaging just two additional Whole Time Equivalent (WTE) radiologists per year.[6]

Shortages are evident across the cancer pathway. For example, the RCR found that in Wales there is a 20% shortfall of clinical oncologists (CO), who are specialists key to treating cancer patients given their role in using radiotherapy and chemotherapy to treat and manage patients with cancer. The current trend of retirements outnumbering training completions means that without action there will be 10 fewer CO consultants in post in 2025 than now.[7]

These shortages have serious consequences for patients. The RCR found that 60% of clinical directors believed there were insufficient radiologists to deliver safe and effective patient care in Wales.[8] The NHS has relied on the goodwill of its workforce to keep services running, with over one in four doctors in Wales, England and Northern Ireland reporting they worked more than their contracted hours without pay – this is unsustainable.[9] NHS Wales' spending on agency staff almost trebled from £50 million to £143 million between 2010/11 and 2018/19, showing the financial burden that workforce shortages have in Wales.[10]

The NHS workforce has borne a massive burden through the pandemic. We know that NHS staff are exhausted after responding to COVID-19[11], as well as trying to maintain cancer services.

Against this context, we need to see a significant boost in the diagnostic workforce if we are to speed up cancer diagnosis in Wales. Getting recruitment and retention right in cancer services is essential if we are going to recover and transform services. Commitments to reduce waiting times through increasing targets or introducing community diagnostic hubs will not be achieved without a concerted effort to boost workforce numbers across the cancer pathway.

The Recovery Plan does not adequately address the pressures that the workforce face in cancer services. These shortages will hinder the effective roll out of the Recovery Plan, including ambitions to establish community diagnostic hubs to increase capacity and productivity. Without growth in the diagnostic workforce, staffing these hubs will require drawing healthcare professionals out of acute care, meaning overall diagnostic capacity does not improve.

In 2020, Health Education and Improvement Wales (HEIW) and Social Care Wales published the Workforce Strategy for Health and Social Care in Wales.[12] It is unclear what progress has been made

in implementing the strategy. As a result, it is unlikely the diagnostic and cancer workforce will have the capacity it needs to meet the challenge in cancer services now and in the future.

However, with the announcement of the NHS Cancer Services Action Plan, there is an opportunity to develop and deliver a long-term strategy to build a cancer workforce fit for the future.

We will now look to the NHS Cancer Services Action Plan to deliver the detail and ambition needed to plan for a workforce with the resource they need to transform cancer services and improve the lives of those affected by cancer now, and in the future.

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[1] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Cancer-Waiting-Times/Monthly/suspectedcancerpathwayclosedpathways-by-localhealthboard-tumoursite-agegroup-gender-measure-month

[2] Analysis by Cancer Research UK Cancer Intelligence Team based on Welsh Government Cancer Waiting Times data

[3] BMA, 2021. BMA survey COVID-19 tracker survey February 2021. Accessed April 2021 via https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf.

[4] https://record.senedd.wales/WrittenQuestion/85056

[5] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Cancer-Waiting-Times/Monthly/suspectedcancerpathwayclosedpathways-by-localhealthboard-tumoursite-agegroup-gender-measure-month

[6] Royal College of Radiologists. 2021. Clinical radiology UK workforce census 2020 report. Accessed August 2021 via https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-ukworkforce-census-2020-report.pdf

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[9] BMA, 2021. BMA survey COVID-19 tracker survey February 2021. Accessed April 2021 via https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf.

[10] https://heiw.nhs.wales/files/key-documents/workforce/workforce-strategy-for-health-and-social-care-final-pdf/

[11] BMA, 2021. BMA survey COVID-19 tracker survey February 2021. Accessed April 2021 via https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf.

[12] HEIW, 2020. A Healthier Wales: Out Workforce Strategy for Health and Social Care. Accessed October 2021 via https://socialcare.wales/cms_assets/file-uploads/Workforce-strategy-ENG-March-2021.pdf

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 28

Ymateb gan: | Response from: Conffederasiwn GIG Cymru | Welsh NHS Confederation

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Welsh NHS Confederation
Conffederasiwn GIG Cymru

	The Welsh NHS Confederation response to the Health and Social Care Committee's consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists
Contact:	Nesta Lloyd-Jones: Madelaine Phillips:
Date:	13 June 2022

Introduction

1. The Welsh NHS Confederation (WNHSC) welcomes the opportunity to respond to the Health and Social Care Committee's consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

2. The WNHSC represents the seven Local Health Boards, three NHS Trusts, Digital Health and Care Wales and Health Education and Improvement Wales (our Members). We also host NHS Wales Employers.

3. The scale of the challenge in planned care cannot be over emphasised as the NHS continues to go through the most challenging period in its history. Despite the best endeavours of NHS leaders and staff, the backlog will take years to reach a healthier position and there must be an effort to manage public expectations around what the NHS can deliver. The WNHSC has called for a clear and sustainable long-term funding strategy for health and social care to allow for the necessary long-term investments in staff and capital required to meet the needs of the people of Wales.

Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.

4. Members said the plan could be a helpful framework to support recovery and reduce long waits. However, there were some very clear concerns relating to whether the plan provides the clarity and detail required to address the backlog, which represents a significant challenge to the NHS and patients. It is always important to remember that behind the numbers, lie people and their families and members have expressed concern over the physical and mental health impacts which long waits can create.

5. NHS organisations have to overcome significant barriers to deliver on the plan and will require support to do so. Some of these issues include: the on-going impact of COVID on services; the impact of emergency demand on key resources and facilities; the state of the NHS estate; limited short-term funding; and critically, significant workforce recruitment and development challenges.

6. Members highlighted that the health and care workforce is the key factor in whether the plan would be able to reach its aspirational targets. The successful delivery of the plan

will be compromised without clear detail and support to ensure the correct workforce is in place. This will require an increased investment to continue to drive up the number of students and trainees across professional groups. Specifically, members did highlight a need for emphasis on 'double recruiting' to plan earlier for retirements. The current pressures on the workforce due to the backlog will also have an effect on driving forward the transformation agenda at pace.

7. Concerns were also raised in terms of the growing demand and the inability of patients to access General Practitioners' adequately given the increase in demand across the system. Members called for clarity in terms of a GP strategy and any further work to be undertaken with primary care to support the plan.

Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?

8. Members observed the plan does attempt to strike this balance, but it was expressed that there needed to be more emphasis on long-term sustainability, e.g. workforce solutions, training timescales and how health boards and NHS trusts can manage patients presenting with more complex needs. It should not be assumed that transformation will drive sustainability at this time due to the scale of the backlog and the pressure on staff.

9. Members also observed that the plan did not directly address the issue of patient flow and the significant number of clinically-optimised patients in hospital, and potential social care sector solutions. It will be essential going forward that the social care sector receive adequate support if the recovery ambitions are to be realised due to the interdependent nature of the system. The WNHSC have previously called for a sustainable financial model for the care sector, to ensure it has the required long-term investment to attract, recruit, train and retain a sustainable domestic workforce.

Whether the plan includes sufficient focus on:

- *Ensuring that people who have health needs come forward;*

- *Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;*

- *Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;*

- *Improving patient outcomes and their experience of NHS services?*

10. Adequately addressing the above points will require a strong dialogue with the public and our members did note that the plan contained no assessment of public opinion regarding these increased levels of engagement. Therefore, there needs to be an effort to reach

out to the population to take on more responsibility for self-help to allow the treatment of those most in need.

11. Whilst the commitment in the plan to coordinate national messaging in relation to public health campaigns and availability of waiting list information was welcomed, members highlighted that it did not go into detail about how hard-to-reach and vulnerable communities will be targeted.

12. In our briefing, Reshaping the relationship between the public and the NHS, we called for Welsh Government and political leaders to engage in an honest conversation with the public on the scale of the challenge to ensure the public's expectations are managed. The briefing also argued for a 'Deal for Health' which sets out what the public and staff are entitled to from the NHS and the contributions that patients and the public can make to their own health and wellbeing. This engagement will be crucial in creating healthier communities and contributes to the creation of a sustainable service by reducing pressure on the NHS.

13. Members were clear that addressing greatest clinical need will not necessarily prioritise those who have waited longest and there will inevitably be a conflict for clinicians to balance clinical need with consideration of length of wait. Whilst the plan does reiterate clinical need as the primary driver for patient prioritisation, the advent of phased maximum wait targets will pose challenges for health boards in placing an appropriate balance between both priorities.

14. In terms of outcomes, members noted that the plan does not provide a lot of detail and suggested more clarity is needed in terms of timelines on delivery.

15. Members have suggested that greater emphasis and clarity is also needed in areas such as rehabilitation and how patients can be supported and motivated with self-management.

Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?

16. Members have highlighted examples where NHS organisations are working collaboratively and opportunities for regional and national working will continue to be sought to effectively address the backlog.

17. Members felt that the plan did offer a direction for increased partnership between organisations to enable equality of access for populations across Wales and generally presents a position of national leadership from NHS Wales. However, concerns were expressed that solutions presented in the plan lack pragmatism. Members cited a focus on areas such as see-on-symptom and patient initiated follow up within the plan, but stressed that delivery will be down to individual clinicians as to what is appropriate for a patient.

18. It was felt that the plan needs to articulate both transformation and recovery in terms of overall national resource, which is UK-wide. Members also sought more detail in terms of the role of private providers and third sector, and within the wider community.

Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?

19. Members felt that there was an expectation that health boards would work closely together on regional priorities, with the establishment of a National Diagnostics Board an important step in this direction. However, it was noted that organisations will often not have the additional resources to deliver, and the role of regional solutions will be limited by challenges of demand and capacity.

Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?

20. Members raised concerns over the targets contained in the plan, with key delivery risks being the volume and rate at which demand, that reduced during the pandemic period, might return, and the success of efforts to generate sufficient workforce resources to sustain increased activity over the longer term.

21. There were specific concerns around the 52-week outpatient target, with members saying this will be very difficult to achieve by the end of 2022 for a high volume of specialities. Members cited the depletion of outpatient accommodation as one of the reasons why this would be a particular challenge.

Is it sufficiently clear which specialties will be prioritised/included in the targets?

22. Members noted that the plan overall focuses on the NHS system and how patients access it rather than how different specialties should be prioritised.

23. Also, it was highlighted that the plan offers some scope for local variation with regard to those specialties that will achieve the 104-week target by March 2023. This reflects the size of the challenge faced by health boards and the reality that waiting times prior to the pandemic varied across Wales.

Do you anticipate any variation across health boards in the achievement of the targets by specialty?

24. Members anticipate variation across health boards due to factors such as existing variation in clinical risk and workforce availability.

Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?

25. Investments outlined in the plan cannot be viewed in isolation and must be understood within the wider financial settlement for health boards. For those who remain in a financial deficit, prioritisation of resources will be a continuing challenge. Capital funding has also reduced this financial year therefore moving forward transformation will be more difficult.

26. Members did observe that the full revenue implications of meeting the ministerial priorities are unclear, and a costed programme could usefully be developed. It was also suggested that early notice of when funding becomes available would be helpful to accommodate timelines for recruitment, practice change, etc.

27. Members highlighted a number of factors which could compromise the plan within the funding allocated, including reliance on premium cost private sector capacity in the short to medium term while longer term solutions are developed and workforce shortfalls are addressed. Financial planning is also subject to uncertainty around the hidden backlog in community and primary care, which will have a consequent impact on conversion rates and demand for diagnostic services.

28. In a previous response to the Finance Committee, the WNHSC has called for the development of a 5-year investment plan for service change to reshape the NHS estates and infrastructure. This remains vital to support the NHS to deliver on the plan's ambitions.

Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?

29. The plan does not specify how the additional funding should be used to greatest effect, however there is an expectation that it will be targeted to ensure its ambitions are met. Members anticipate reporting mechanisms to mirror those currently in place for 2021/22.

30. Digital funded investment, both capital and revenue, are an essential part of transforming and modernising planned care and waiting lists. The COVID response demonstrated the value of standard digital solutions, deployed nationally at pace and developed and enhanced through a lean but effective governance and service process. This does not appear to be a consideration and digital investment should be part of the allocation alongside estates and infrastructure.

Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?

31. Workforce supply and current workforce pressures is a key limiting factor in delivering on the plan, with many examples of difficulties to recruit required personnel across a range of professional groups and an increasing level of retirements. Members suggested that a

collective approach to recruitment of specialist skills is required to both bolster the current theatre staffing and support the proposed developments.

32. There will inevitably be a conflict between recovery priorities and the continuing need to allow staff to rest and recover after their experiences of the pandemic. Members expect this to be a continuing challenge, and the rate of improvement will be directly influenced by the availability of staffing resources to deliver the increased volumes of care required.

Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?

33. Digital can be a key enabler for transforming and modernising planned care and reducing waiting lists but members felt there was insufficient clarity on this point, with calls for the plan to make a stronger commitment to digital services. Investment in new tools could allow existing staff to work effectively as recovery efforts face the challenge of finding and maintaining increased capacity.

34. Members said the plan lacked a strategic commitment to ‘mainstreaming digital’ as a primary driver of transformation across the whole system. There is a need to ‘lock in’ the lessons of the pandemic, particularly the accelerated delivery of services which were funded centrally and delivered nationally.

Conclusion

35. Among NHS organisations, there continues to be a number of concerns over the ambitions set out in the plan and the system’s capacity to achieve them. Whilst staff are working tirelessly to help patients, there are limiting factors which prevent the effective address of the backlog.

36. Capital funding and investment will continue to impact on the service, with the current state of the estate having major implications on the physical capacity of the NHS to make inroads in planned care backlogs.

37. Challenges in social care are also having serious ramifications across the whole system and on the ability of the NHS to tackle the backlog. This will require a sustainable social care funding model to address problems in care in the community and hospital discharge.

38. Workforce is the number one limiting factor for NHS capacity. Recruiting and retaining staff is a priority, with wellbeing support, flexible working and upskilling all being considered by NHS leaders to effectively support existing staff whilst attracting new employees.

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This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 29

Ymateb gan: | Response from: Coleg Brenhinol y Meddygon Cymru | Royal College of Physicians Wales

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10 June 2022

Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

RCP Cymru Wales response

Name of organisation: Royal College of Physicians (RCP) Cymru Wales
Lead contact: Lowri Jackson, head of policy and campaigns for Wales
Contact details:

Key points

The Royal College of Physicians (RCP) has welcomed the publication of the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists ('the planned care recovery plan'). Below is our response to the Senedd Health and Social Care Committee consultation. We have tried to be concise (as requested) but where the committee would find more detailed information helpful, we are happy to provide further written or oral evidence.

In summary:

- There is a concerning lack of detail on how the plan will be delivered.
- There are too few measurable targets, especially on social care and patient outcomes.
- There is no detail on how ambitious cancer targets will be met.
- There is no clear measurement framework for delivering this plan.
- A clearly co-produced workforce plan should be an immediate priority.
- We welcome a commitment to better communication with patients.
- It is impossible to comment on funding without more detail about delivery of the plan.
- We welcome the focus on health inequalities. This needs to be cross-governmental.
- Data collection must improve and become more transparent.
- The move to digital healthcare needs investment in education, estates and equipment.
- The impact on health professional education and training is not discussed in any detail.
- There is a risk that without a strong central guiding hand, local plans will be inconsistent.

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The plan lacks detail on accountability, delivery and engagement

It is difficult to disagree with the aims and intentions of this planned care recovery plan, including the assertion that 'reducing waiting times will require new solutions and a range of actions' (p2). Unfortunately, this document lacks any detail around the 'alternative options', especially around data collection, outcome measurement, workforce planning and digital technology. Page 2 sets out 'four clear commitments to people in Wales' which are neither specific nor measurable.

Page 3 does set out five new targets on capacity, diagnosis, delivery and information, but there is no detail on how these will be met without a huge increase in workforce and major investment, and some RCP fellows and members have described them as 'unrealistic'.

We understand that the Welsh government itself is developing the proposed planned care workforce plan (p8). However, it would be helpful to understand what role Health Education and Improvement Wales (HEIW) will have in the drafting of this plan, given that they are intended to be the national strategic workforce body for Wales.

It is unclear how much external stakeholder engagement there has been during the drafting of this plan. The RCP was not involved in its drafting or design, and neither were other royal colleges and professional bodies that we have spoken to. Without third sector and patient advocacy organisations as well as professional bodies involved, it is difficult to predict how successful or effective this plan will be.

We were pleased to see a focus on reducing health inequalities, promoting healthier lifestyles and engaging the workforce at the front of the plan. Again, however, there is little to no detail on *how* this will be achieved, *who* will take ownership and *when* it will happen. It is impossible to hold the Welsh government and NHS organisations to account without more detail.

A stronger central guiding hand is needed

We are concerned that Welsh government is placing too much responsibility on local health boards to decide *how* to implement these changes. This risks inconsistency across different NHS organisations, resulting in unequal access to high quality healthcare for patients across Wales.

A stronger central guiding hand would be welcome, as recommended by the 2016 OECD review of health care quality. The Welsh government published their national clinical framework more than a year ago, and we are still to see any tangible progress on most quality statements, clinical networks or implementation plans – or even a system for prioritising, agreeing and publishing quality statements (as promised by the Minister on 21 January 2022). The Welsh government has referred stakeholders to the individual integrated medium-term plans (IMTPs) of health boards as the delivery vehicles for these quality statements, but without sufficient national oversight, this is likely to result in a fragmented and piecemeal approach.

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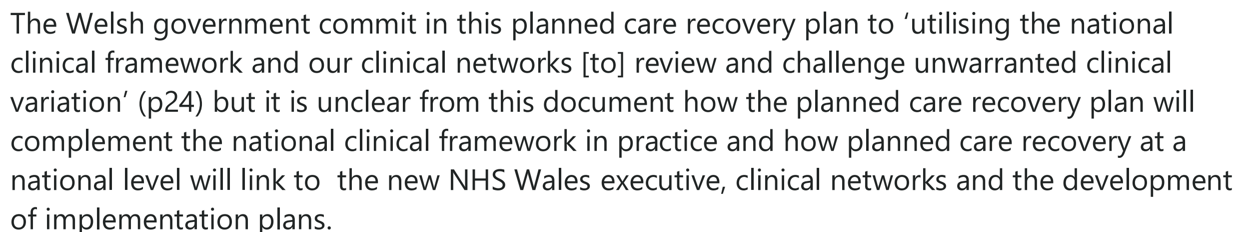

The Welsh government commit in this planned care recovery plan to 'utilising the national clinical framework and our clinical networks [to] review and challenge unwarranted clinical variation' (p24) but it is unclear from this document how the planned care recovery plan will complement the national clinical framework in practice and how planned care recovery at a national level will link to the new NHS Wales executive, clinical networks and the development of implementation plans.

Conclusions

Ultimately, while we welcome this planned care recovery plan and its focus on reducing health inequalities, improving communication, early diagnosis and treatment, building capacity and reducing waiting times, there are too many unanswered questions. There is not enough detail on *how* the plan will be delivered. We lack the workforce to deliver this plan – there are simply not enough health and care professionals in the system – and there are no clear milestones. There was little public or third sector engagement while it was being written. Commitments on improving data collection and digital technology are vague and unclear, and will require major investment in education, estates and equipment, including measures to increase digital inclusion for patients and avoid exacerbating existing inequalities in access to healthcare.

The Welsh government should now publish a detailed action plan or delivery framework with specific milestones to measure progress on meeting targets within this planned care recovery plan. This should provide more information on how NHS organisations will be held accountable for the delivery of the plan so that external organisations are able to scrutinise outcomes more effectively. The promised workforce plan should be published as soon as possible, following genuine engagement with the third sector and professional bodies, 'based on a robust assessment of current capacity gaps and realistic proposals for addressing them' (Audit Wales, 2022). After all, increased investment in the NHS cannot improve patient care if we simply don't have the staff to treat patients.

Educating, improving, influencing

Through our work with patients and doctors, the Royal College of Physicians (RCP) is working to achieve real change across the health and social care sector in Wales. We represent over 40,000 physicians and clinicians worldwide – educating, improving and influencing for better health and care. Over 1,500 members in Wales work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions. We campaign for improvements to healthcare, medical education and public health.

Lowri Jackson
RCP head of policy and campaigns for Wales

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This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 30
Ymateb gan: | Response from: Bwrdd Cyngor Iechyd Cymuned | Board of Community Health Councils

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Welsh Government's plan for transforming and modernising planned care and reducing waiting lists: consultation response

The Board of Community Health Councils (the Board) is pleased to submit this consultation response on behalf of Community Health Councils (CHCs) in Wales.

CHCs are independent bodies that reflect the views and represent the interests of people living in Wales in their National Health Service (NHS). CHCs encourage and support people to have a voice in the design, planning and delivery of NHS services.

There are 7 CHCs in Wales. Each one is made up of local volunteer members who live in the communities they serve, supported by a small team of paid staff. Each CHC:

- Carries out regular visits to health services to hear from people using the service (and the people providing care) to influence the changes that can make a big difference

- Reaches out more widely to people within local communities to provide information, and to gather views and experiences of NHS services.

  CHCs use what they hear to check how services are performing overall and to make sure the NHS takes action to make things better where this is needed

- Gets involved with health service managers when they are thinking about making changes to the way services are delivered so that people and communities have their say from the start

- Provides a complaints advocacy service that is free, independent and confidential to help people to raise their concerns about NHS care and treatment.

The Board of CHCs (the Board) exists to support, assist, advise and manage the performance of CHCs. It represents the collective views of CHCs across Wales.

CHCs in Wales do not have a statutory role in reflecting the views and representing the interests of people who may or do need to access social care services in Wales.

In the same way that people's individual health and care needs do not stop at organisational boundaries, neither do people's views and experiences of the health and care services they receive. So CHCs often hear what people think about their health and care services overall, and not just those provided by or funded by the NHS.

CHCs have used what they have heard from people across Wales and from NHS providers about health and care services to inform the following collective response to the consultation questions.

Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.

CHCs welcome the clear focus in the plan on addressing the things that people have told us matters most to them when they are waiting for a diagnosis or treatment. It acknowledges and responds to the main issues we hear from people living in all parts of Wales who are waiting longer than anyone would like for a diagnosis or treatment.

It sets out - in high level terms - what will be done (and in many but not all areas how), to address these issues. It sets some key targets so that the public have some idea how quickly they can expect things to get better.

It recognises the key elements that will be needed to deliver what is an ambitious programme that, to be successful, must tackle once and for all some long standing and systemic issues that have been made worse, but have not been caused by, the COVID-19 pandemic.

The 'transformation' it identifies as necessary to bring down waiting lists and create a sustainable health and care system for the future must be achieved with people and communities through co-production. How it does this will be key to the plan's success.

But:

- CHCs question whether the plan sufficiently recognises the stark reality of just how fragile the current NHS workforce is – including in the primary care sector where the NHS relies so heavily on doctors, dentists, etc., operating as independent contractors.

  The plan leans heavily on this fragile foundation. CHCs are increasingly seeing practices that have previously been thought of as "stable" GP and dental providers resign their NHS contracts because of recruitment and retention issues. No service is immune to folding as 'burnout' and recruitment issues continue.

- CHCs question whether the plan itself gives sufficient attention to the role of the social care system in enabling its successful delivery.

CHCs also think that it will be easier to judge whether the plan will be sufficient to address the backlogs in care when more detailed information is available from healthcare planners and providers.

Setting out 'what, when and how' the high-level ambitions described in the plan will be turned into clear, co-ordinated, and collaborative

actions locally, regionally, and nationally - through things like the workforce delivery plan - is key.

Without this it is not clear that the plan's ambition will be anything more than aspirational in nature.

Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term

CHCs welcome the clear focus in the plan on taking immediate and short-term actions like commissioning more treatment from non-NHS providers to bring down waiting lists more quickly while developing the capacity to design and implement more sustainable arrangements for the future.

But the main focus of the plan is around building a more resilient and sustainable healthcare system – with social care providers and local authorities referenced as partners but not extensively referred to/included as active contributors to a strengthened, more integrated health and social care system.

Whether the plan includes sufficient focus on:

- **Ensuring that people who have health needs come forward;**
- **Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**
- **Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**
- **Improving patient outcomes and their experience of NHS services?**

CHCs welcome the recognition in the plan of the importance of maintaining a strong, sustained communications strategy bringing

together local and national communications to help make sure people have enough of the right kind of information when and how they need it to empower them to come forward when they identify a health need.

The plan also recognises the importance of making sure that once people seek help having identified a health need that they can get that help through their doctor, dentist or other healthcare professional.

However, its vital that the messaging and the reality of people's experience match up. CHCs continue to hear most of all each day from people who cannot get to see a doctor or dentist when they need one – for too many people it still feels a long way off the kind of access aimed for through the new GP access commitment.

Effective monitoring, action and clear reporting to the public on performance in these kinds of areas must be a key part of the wider communications strategy.

CHCs welcome the strong focus in the plan on supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management – including by working together with the 3rd sector to provide help, advice and support.

CHCs also recognise the key part that continued development of digital technology can play in achieving this – and the recognition that digital technology cannot be the only answer if no one is to be left behind.

CHCs are keen to see that this recognition in the plan is translated into practical and comprehensive action in areas like sustainable 3rd sector funding models and developing arrangements that are flexible enough to support people's individual help, advice and support needs.

CHCs are still hearing too often from people that they are offered a 'one size fits all' approach.

The plan provides a clear focus on prioritising those in greatest clinical need through a range of actions including better clinical list validation, refined primary care referral following early diagnostics and improved quality of referrals to aid initial triage.

The plan is clear about the range of things that will improve patient outcomes including earlier diagnosis, co-productive approaches to individual care, better care pathways and quicker treatment.

It also acknowledges the importance of capturing and using patient feedback to drive further developments and action where needed.

CHCs want this to be part of a clearer, stronger and more meaningful performance measurement, monitoring and reporting system that helps manage performance at all levels and drives improvements in health and care services on the things that matter most to people about their care and treatment.

Whether the plan provides sufficient:

- **leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**

- **clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?**

The plan itself sets out a clear and simple national direction to respond to the immediate and longer-term challenges in reducing waiting times.

It is much less clear within the plan itself how this direction and intention to work collaboratively and collectively at all levels will be driven in practical terms.

CHCs know from its day-to-day activities locally, regionally, and nationally that there are already many different planning, programme and project groups and networks in place to drive design, development, and improvement in the NHS in Wales. Some of these are permanent arrangements and some are 'task and finish' groups.

It is not always clear to CHCs (or others) how they all fit together, who's responsible for doing what and when, and who is accountable to who and for what overall. As well as this, the part the new NHS Executive will play in all of this is still being developed.

So, unless those working within the NHS itself are clear who is responsible for doing what and when, there is little hope of people and communities effectively informing and influencing its thinking.

CHCs welcome the commitment to more regular performance information, eg., through a weekly performance dashboard. It is important that the more detailed delivery arrangements that underpin the plan set out very clearly overall:

- the levers in place to encourage collective effort, collaboration and innovation across the NHS, and the consequences of not doing so
- how working together will deliver equitable service provision that responds to the particular challenges facing people living in all parts of Wales, eg., rurality, deprivation,etc.

- who is responsible for doing what, how (where appropriate) and when
- how and when progress should be reported, and to who
- who will take action if things aren't going to plan.

If those involved in healthcare are to be properly valued and recognised for the way in which they work collaboratively and innovatively then this must be recognised in performance measurement and management arrangements at all levels.

Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?

CHCs welcome the very clear commitments in the plan about what people can expect and by when in terms of reducing the waiting lists overall (even though these are longer than anyone would want). This simple approach along with regular, more frequent progress and performance reporting should mean that people can easily measure whether these high-level commitments are met.

CHCs also note that the plan clearly states that it has been developed with NHS services and that there is confidence within the NHS that the plan is deliverable.

However, given CHCs concerns about the resilience of the workforce and its capacity to drive and respond to continuing 'transformation' at every level, we are unable to clearly assess how realistic and achievable the plan is without seeing the more detailed delivery plans that will support it.

Is it sufficiently clear which specialties will be prioritised/included in the targets?

The plan refers to some aspects of specific services where CHCs regularly and consistently hear concerns from people about waiting times. This includes, for example, children's services, mental health

services, cancer care, etc. It also focuses on the key aspects within service areas that people worry about such as diagnostics.
It doesn't focus in more detail on the whole range of specialties, including those we hear most often about such as orthopaedics.

CHCs expect the high-level targets set out in the plan to apply to waiting times in respect of all NHS services – for everyone on a waiting list for any NHS specialty. People living in Wales need to be reassured that everything that can reasonably be done will be done to make their wait as short as it is possible to be – the plan must achieve this.

The range of more detailed delivery plans must clearly set out how the different challenges will be addressed across specialties and geographical areas - whether that be for example a workforce plan, cancer plan or NHS body Integrated Medium Term Plan (IMTP).

Do you anticipate any variation across health boards in the achievement of the targets by specialty?

CHCs want the more detailed plans that support delivery to clearly set out how and when the existing variation across health boards will be addressed through a collaborative approach and new/different ways of working that meet the needs of people and communities.

Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?

The plan doesn't provide any detail about the breakdown of the available funding (including additional sums), between revenue and capital.

It's important that the way in which funding is made available supports short term actions to address waiting time backlogs

equitably as well as developing services for the longer term in a sustainable way for people living in all parts of Wales.

Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?

The plan focuses at a very high level on the key things that the NHS will need to focus on to transform the way planned care is delivered in the ways that matter most to people.

CHCs expect that the funding model in place to support delivery will provide sufficient focus so that the more detailed NHS delivery plans can respond flexibly in a way that best meets the needs of their population considering things like geography and demography.

Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?

The plan recognises the need to address the key issues affecting the existing health and care workforce. The introduction of the real living wage in social care is welcome but CHCs do not currently have sufficient detailed knowledge of this sector to identify what more may be needed to put it on a more sustainable footing.

CHCs are seeing daily the impact on NHS care resulting from shortages in staff (some long standing and some related to the direct impact of COVID-19), and the impact on the quality of care when those delivering it are physically and emotionally exhausted.

CHCs welcome the commitment to work together with the health and care workforce to develop more detailed plans to address the workforce pressures. This should help provide assurance that those

more detailed plans respond to the key aspects from the perspective of the workforce in all parts of Wales.

Similarly, CHCs want to see that the views and experiences of patients and service users inform and influence the priorities within the workforce delivery plan.

Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?

CHCs welcome the commitments in the plan to use digital tools and data to drive service delivery and more efficient management of waiting times – enabling people to feel more in control of their healthcare by being able to access advice, support and information about their care and treatment.

CHCs also welcome the clear commitment in the plan to reduce digital exclusion. It is vital that any developments recognise that there will always been some people whose individual needs cannot be met through their direct use of digital technology to access healthcare.

The focus on developing services must always include consideration of how things need to work for those who do not use technology.

Detailed planning for digital transformation needs to recognise and respond to the impact of digitisation on capacity – whilst easier digital access can often save capacity and better manage demand, it can also increase demand.

This has been the case with systems such as e-Consult and AskMyGP, where increased demand has resulted in a reduction in the availability in the operating hours of the systems in many cases.

Communication and engagement

CHCs welcome the commitment in the plan to strong and co-ordinated engagement and communication at local and national levels – and recognise the urgency of the need to move forward with clear, collaborative, and co-ordinated plans to recover and transform services for the future.

But this can only be achieved effectively if those responsible for designing and planning services for the future live up to the commitment to engage and involve people and communities in the design and development of their healthcare services.

This must be more than simply communicating why and how things are going to change. It's about working together with people and communities to identify the way services should be delivered in the future – recognising and responding to the things that matter most to people about how their services are provided.

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This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 31
Ymateb gan: | Response from: Diabetes UK Cymru

Diabetes UK Response

Written by: Mathew Norman, Policy and Public Affairs Manager (Wales)

Submitted as: Submission as an organisation.

Authorisation to publish the submission: Happy for submission to be published as Diabetes UK Cymru.

About us

Diabetes UK's vision is a world where diabetes can do no harm. We lead the fight against Wales' largest growing health crisis, which involves us all sharing knowledge and taking on diabetes together.

Over 209,015 people live with diabetes in Wales, equivalent to 1 in 13 people, the highest level of prevalence of any of the UK Nations. The last twenty years have seen a rapid increase in the diagnosis of diabetes; this is due in part to a growing rate of type 2 diabetes diagnoses, with an estimated 65,000 people in Wales living with undiagnosed type 2 diabetes.

The continued prevalence of obesity suggests that an estimated 580,000 people in Wales could be at risk of developing type 2 diabetes, the most common form of diabetes, accounting for 90% of all cases. By 2030 the number of adults with diabetes in Wales is likely to grow from 8% to 11%.

Further information on diabetes can be found on our website.

Response

We thank the Committee for the opportunity to respond to the enquiry into the Welsh Government's plan for transforming and modernising planned care and waiting lists.

Overall, Diabetes UK Cymru welcomes a review of how to transform and modernise planned care to reduce long waiting lists. Diabetes, regardless of its type and no matter how well managed, can lead to complications later in life. Delays in treatment for people living with diabetes can have devastating consequences, from the deterioration and loss of eyesight, kidney failure, amputations, and complications from lack of access to mental health support.

With obesity as one of the causes of Type 2 diabetes, elected planned care like bariatric surgery can enable people with Type 2 diabetes to go into remission and improve their health outcomes. Unfortunately, such life changing interventions can be delayed or cancelled due to waiting times, causing both emotional and physical distress.

Therefore, we welcome the Welsh Government's transformative plan to reduce waiting times; however, we have some concerns with the application of the plan, especially with the proposed change to how patients interact with planned care with a move to more digital platforms and patient self-managed digital resources.

We have responded under specific areas of focus in the plan.

Funding

One of the concerns is the funding gap to support the recommendations of the plan and no clear indication of how much long-term funding will be available. Throughout the report, indications of

funds have been hinted at, especially for 'significant' amounts to reduce the backlog of waiting times in the short term. We welcome specific sums such as £262million annually to equip and train the next generation of healthcare workers; however, no details are given on how long this level of funding will be maintained, how this funding will be distributed, which health boards will be receiving the budget needed or how innovations and proposals in this plan will be implemented.

Staff Recruitment and Retainment

One of the wide-ranging concerns of the NHS is staff recruitment, and retention and Diabetes UK Cymru feels that this issue is not addressed or discussed within the plan.

As highlighted in the Committee's report, 'Waiting Well?', evidence collected by stakeholders indicated that by asking more from the already overworked and stretched NHS workforce, healthcare professionals would either leave the profession or reduce their hours.[1]

The plan presented by the Welsh Government proposes an aspiration to offer planned care to be managed on 52 weeks, seven days and 15 hours a day basis. However, what is not evident in the plan is how these additional services needs will be met. With one hand the plan commits to ensure a sustainable workforce and with the other states that '… simply continuing to grow the existing workforce will not be enough to deliver…' services.

We look forward to developing the Workforce Delivery Plan for Wales to clarify how these needs will be met and how recruitment and training in Wales will be delivered.

With a clear understanding of how the workforce will be supported and recruited, Diabetes UK Cymru welcomes increased access to services on weekends. Especially for those managing lifelong conditions like diabetes. 7 out of 10 of our beneficiaries recently indicated to us that they find the management of their diabetes overwhelming: especially when trying to maintain a full-time job and personal and family commitments. Improving access to education and screening will help improve the management of diabetes and reduce the complications that may occur.

Digital Care

The plan throughout makes reference to the use of new technologies to free up health care professionals' time to focus on patient care and reduce the backlog. Concerning the new General Medical Service (GMS) contract, the significant change to access GP services on a blended model grants exciting new positive developments which will allow patients to access the care in a way that benefits them.

Access to new technologies such as Continuous Glucose Monitors (CGM) and Flash Glucose Monitors (usually referenced as Flash) can be fundamentally life-changing in the management of Type 1 (and other types that require insulin) diabetes. Recent changes in NICE guidelines support referrals for this monitoring technology. Increased access to such technologies does not only improve the lives of thousands but also can help reduce complications and increase better management of diabetes.

However, underpinning any new development of digital services requires a review of how digital data is collected and stored in NHS Wales. Different health boards utilise different data management systems with no clear universal access or data collection. Investment is needed to support a

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[1] 'Waiting Well' The impact of the waiting times backlog on people in Wales, April 2022, Health and Social Care Committee.
https://business.senedd.wales/documents/s124284/Waiting%20well%20The%20impact%20of%20the%20waiting%20times%20backlog%20on%20people%20in%20Wales%20-%207%20April%202022.pdf

universal means of collection and storage. There is no clear indication of how this will be undertaken, and it is concerning that there will not be a review when the plan indicates that accurate data will underpin it.

Access to technology is also a concern for Diabetes UK Cymru, primarily as the plan seeks to develop a planned care portal alongside the NHS app to inform patients and provide up-to-date information on waiting times and supported services. The report references widening health inequalities and poor population health; however, with a cost-of-living crisis, access to certain technologies and services may not be seen as a necessity when compared to putting food on the table and turning on the heating.

Patients who are not as technologically savvy or literate may also struggle to access such services. More must be done to ensure that these groups are supported so that we don't further reduce health equalities in our most deprived and vulnerable communities.

With 2,353 GPs to over 3.2 million registered patients in Wales, we can see the benefits of digital services to support people in Wales; however, we have concerns that it may impact the quality of care delivered and call for continued monitoring of the delivery of services as a digital approach is undertaken.[2] This ensures that no patient receives lower quality of care and that diagnoses for potentially fatal conditions such as Type 1 diabetes are not missed.

Prevention

Support for policies that focus on prevention is lightly referenced throughout this document, with a clear link between health inequalities, deprivation, smoking and obesity. We welcome the commitment to develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into pathways. Some conditions such as cancer are referenced throughout, and others, such as diabetes, which can be preventable for some with Type 2 diabetes, are not mentioned at all. We believe that explicit reference to diabetes is needed given its prevalence.

As the plan indicates, policies which focus on prevention can reduce the need to access services in the future and improve waiting times and, in turn, can reduce the cost associated with diabetes which accounts for 10% of NHS Wales budget.

This month, during diabetes week, the Wales Diabetes Prevention Plan is being launched in Wales, welcomed; we look forward to a full rollout, with a commitment to increase provision and support for people in Wales to be educated on the adverse effects of their lifestyle, which contributes to their obesity and possible future diagnosis of conditions like Type 2 diabetes.

Mental health support is also welcomed as part of Welsh Government's plan. Diabetes UK Cymru understands too well the long-term implications of the lack of access to dedicated services for people with long-term conditions like diabetes. We call for dedicated services such as those highlighted by Dr Rose Stewart's recent report 'From Missing to Mainstream 'calling for integrated dedicated psychological services for people living with diabetes.[3] Every pound invested in services that help to support people living with diabetes and prevent long-term conditions supports a healthy

[2] Stats Wales, 2022.

[3] From Missing to Mainstream; A Values based action plan for Diabetes Psychology in Wales, Dr Rose Stewart, All Wales Diabetes Implementation Group, 2022.

lifestyle and reduces pressures on the NHS. We welcome current investment and hope to see long-term dedicated levels of funding to support mental health services.

Private Sector

There are two references to private providers and the private sector in the plan as means to help reduce the pressures on the NHS. We have some concerns that no clarity is given on which services will need private sector support nor whether those with private healthcare may benefit from using such services, creating a disparity in the quality of care for those more deprived.

We understand that resources from external bodies may need to be utilised from time to time to reduce pressures faced by the NHS, such as expanding certain services into pharmacies and using new technologies. However, we would welcome further detail to accompany the plan regarding how the private sector will support services and whether access to these services may be impacted.

Regional Diagnostic Hubs

The plan assures that services will be as local to the patient as possible with the investment and development of Diagnostic Hubs that are established away from acute hospital sites. We welcome such proposals, especially if a network is established to co-locate frontline health and social care services to grant a consistent approach to support health checks for patients, especially from deprived areas.

There is no further detail on which services would be granted at these hubs; neither are we given details around the number, how they will be funded nor how they will be staffed. References to the use of artificial intelligence to assist the workflow is mentioned in the report, which again raises concerns we noted earlier around data retention and access to technologies.

If such hubs were to include education, management support and screening service for people with diabetes, such as eye care services, this would be welcomed. Services such as eye screening are vital to prevent conditions leading to deterioration and loss of sight for people with diabetes. During the pandemic, eye statistics for all measures for the activity of sensory services were remarkedly lower than in previous years. In contrast, the number of eye care and hearing specialist practitioners increased in 2020-21. During 2019 – 20, 36% of patients eligible for Diabetic Eye Screening Wales service did not attend the service, and out of those who did, 30.3% were found to have some degree of diabetic retinopathy.[4] Unfortunately, access to services is still causing anxiety for many people with diabetes, who may fear irreparable damage to their eyesight when they cannot access routine care.

Conclusion

We welcome the ambitious transformative plan by the Welsh Government to address and tackle the current backlog of patients waiting for care. We hope that this plan ensures that the health needs of patients come first with dedicated support throughout their treatment pathway.

People living with diabetes, no matter how well they manage their condition, can face complications with their condition, which often need surgical intervention. Through dedicated patient-led support for the prevention of diabetes and planning diabetes care, waiting times and pressures on the NHS can be reduced.

[4] Welsh Government Statistics, September 2021, Sensory Health (eye care and hearing statistics): April 2019 to March 2021, https://gov.wales/sensory-health-eye-care-and-hearing-statistics-april-2019-march-2021-html.

We welcome this transformative approach and look forward to continued collaboration with the Welsh Government, Stakeholders and the Senedd.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 32
Ymateb gan: | Response from: Cymru Versus Arthritis

The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Written evidence submitted to the Senedd Health and Social Care Committee's *Inquiry into the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment* from Cymru Versus Arthritis, June 2022

Introduction

About the charity

- Versus Arthritis is the UK's largest voluntary organisation supporting people with arthritis and musculoskeletal (MSK) conditions. The charity provides a range of services: local peer support groups/services; award winning publications; activity and exercise videos & resources, an online community and helpline – 0800 5200 520. We also fund world leading research. For more information about our charity, please visit our website.

About Arthritis and MSK conditions

- An estimated 970,000 people live with arthritis/MSK in Wales.[i]
- There are over 100 such conditions, including osteoarthritis, gout, rheumatoid arthritis, lupus, psoriatic arthritis, axial spondyloarthritis, fibromyalgia and juvenile idiopathic arthritis (JIA).
- MSK conditions can strike at any age, including childhood.
- Common symptoms include joint pain, stiffness, and fatigue. Symptoms can significantly impact on mobility, dexterity and many other aspects of daily life. They are among the leading causes of persistent pain and disability.
- For more info on MSK conditions, please see our 'The State of MSK Health 2021' report here.

Record waiting times impacting on people living with arthritis in Wales – in figures

Trauma & Orthopaedics (T&O), as of the end of March 2022:

- the total number of people waiting for T&O in Wales was 97,522. The pre-pandemic average for 2019 was 62,118;
- 53,332 (55%) people on the T&O waiting list were waiting longer than 36 weeks, compared to 6,570 people (11%) on average in 2019;
- 39,171 (40%) people on the waiting list for T&O were waiting longer than 53 weeks (1 year), compared to 2,473 people (4%) on average in 2019;
- 20,445 (21%) people on the waiting list for T&O were waiting longer than 105 weeks (2 years) compared to 76 people (0.001%) on average in 2019.

Submission summary

- We welcome:
    - The publication of the plan and the additional funding ringfenced for planned care recovery.
    - The recognition that orthopaedic services have been among the worst hit services during the pandemic and the impact on those waiting.
    - The support for a transformation agenda through '*Regional options which will allow protected planned care capacity at a higher volume than traditional hospital based theatres*' the commitment to '*…introduce regional and wider models of care to ensure equitable access. This may involve regional waiting lists, the transfer of patient care across health board boundaries, central hubs that offer those waiting a long time a more suitable appointment or the national commissioning of services.*' And '*Regional plans for aspects of orthopaedic services based on the orthopaedic clinical strategy work*.' We support the development of surgical hubs / elective centres and the ring-fencing of planned care facilities from other services. Developing travel provision and co-production of plans are vitally important to support this approach.
    - The recognition of the need to provide communications and support for people as they wait for treatment/surgery and the development of innovative online resources to support this aim.
    - The commitment to publish additional data to support the recovery process.
    - The plan's support for '*Partnering with the independent sectors to develop new approaches and models of care.*'
- However, there are aspects of the plan that require clarification or additional detail to support planned care recovery:
    - Waiting times targets are framed in relation to 'most' specialities rather than 'all'. The Plan does not clarify which services are to be included/prioritised in the targets and which are not. We are concerned that some of the hardest hit services, including inpatient elective orthopaedics interventions such as knee and hip replacements, will not be included for the 'most' specialities prioritised to achieve the targets. We are concerned that the targets could theoretically work against the prioritisation of some of the more life-changing and effective surgical intervention. People are waiting in severe and worsening pain for life-changing operations such as a hip or knee replacement and are losing mobility and independence, with significant impact on wider physical and mental health. Such procedures are extremely effective at reducing or eliminating pain and restoring mobility and independence. Yet, these services may not be prioritised within the 'most' specialities targets.
    - The plan lacks detail, modelling and projections re how targets can be met in orthopaedics. Note, we are aware that policy work is ongoing in relation to national planning for elective orthopaedics within Welsh Government, however, we do not the timeline to publication. We would like to see a National Recovery and Transformation Plan for Elective Orthopaedic Services published for consultation as soon as possible.

- There is a lack of commitment in the plan for national leadership on supporting people waiting for treatment. However, we understand the Welsh Government has subsequently recruited to a leadership role in this field. We are awaiting details re remit of the new role.
- We would like to see greater detail on the plan's commitment to publish additional data re waiting times. We would like to see monthly activity data published for indicative treatments / surgery services by HB.
- Addressing workforce issue will be key to recovery. We would like to see further detail on actions to be taken to address staff shortages.

Full submission

The impact of longer waiting times on people with arthritis / MSK

- Waiting times for services such as orthopaedics that are of vital importance to tens of thousands of people living with arthritis and MSK conditions in Wales have hit record levels and have continued to increase beyond the peak of pandemic related pressures. Many of those on the waiting list are waiting in severe and worsening persistent pain for an orthopaedic intervention such as a hip or knee replacement. The impact of the long waits can be devastating for individuals and their families, limiting people's mobility and independence, impacting on all aspects of a person's life, including employment, family life and physical and mental health.
- We appreciate the scale of the challenges facing the NHS, we are realistic about the timeframe necessary to clear the backlog. However, we believe that due to the extent and the continued escalation of health impacts of those waits, in terms of the numbers of people impacted, the impact on individuals and families and the consequences for the wider health and social care infrastructure and wider economy, reducing the orthopaedic waiting times and clearing the backlog needs to be a top tier priority for all relevant NHS bodies and the Welsh Government.
- We are particularly concerned at the significant growth of people waiting over two years for orthopaedic operations. As of the end of March 2022, the number of people waiting over 105 weeks (2 years) had grown to 20,445, or 21% of the T&O waiting list. This compares to 76 people (0.001%) on average in 2019.
- Evidence shows that delaying surgery can lead to worse outcomes for people who have been referred for hip and knee joint replacement, particularly waiting times beyond 6 months.[ii]
- Versus Arthritis surveyed people waiting for joint replacement surgery across the UK in late 2020 and found: 81% reported their physical health had worsened, 90% said their pain levels had deteriorated, 90% reported reduced mobility, 78% said they were now less independent, 72% reported a deterioration in their mental health.[iii]

Clarity re waiting times targets

- We believe that it would strengthen the recovery planning process if the Plan's waiting times / recovery targets were made clearer re which services they relate to. Setting recovery targets in relation to 'most' specialities, rather than 'all' will not reassure people with musculoskeletal (MSK) conditions waiting in severe and worsening pain for life-changing surgery such as a hip or knee replacement that the Plan necessarily includes the services

they are waiting for. The use of 'most' in the wording for the targets provides too much space for more challenging service backlogs – including some of the most effective and life-changing treatments such as hip replacements – to be outside prioritised services. The targets could in theory work to deprioritise such services in favour of services more likely to achieve the targets and fulfil the 'most' specialisms criteria.
- We are concerned that there is no target for achieving the pre-pandemic 26 weeks wait target. Without this, does the Plan's one year wait target by 2025 effectively become the new planned care waiting times target in Wales?

Recovery and transformation of planned care services

- We are very concerned at the rate of progress restarting services between pandemic waves during the pandemic and the pace of progress rebuilding capacity during recovery since the pandemic. We are also concerned at the disparity in the pace of rebuilding capacity between health boards. We would like to see a clearer roadmap to achieve pre-pandemic activity levels across Wales and a clearer mechanism to monitor progress.
- The recovery plan does not offer time-framed projections, modelling or targets regarding activity levels expected / required of Health Boards to meet the waiting times / recovery targets included in the plan or a timeframe to produce such modelling. The plan states work will commence with HBs re setting 'clear targets for improvement' but no timeframe is provided.
- Such detailed planning for orthopaedics is contained in the 'Orthopaedic Clinical Strategy Work' referenced on page 37 of the recovery plan, however no timeframe is provided for the publication of this work or for Welsh Government national planning for orthopaedics informed by this commissioned work. We believe the publication of a comprehensive, detailed plan for the full recovery and transformation of orthopaedic services is key to recovery and to building a robust and efficient elective orthopaedic service for the people of Wales. Such a national plan is needed to drive the creation of the regionalised, national orthopaedic service outlined but not detailed in the recovery plan.
- A national orthopaedic plan is needed to look beyond the recovery of elective orthopaedic services to provide planning for the transformation of the service to fully clear the backlog and to provide high quality services in a timely manner for the long term. It will need to offer a roadmap for achieving 100% of pre-pandemic activity levels and to achieve the 100%+ levels required to clear the backlog in the coming years and how and what workforce and facilities issues will need to addressed to achieve these aims. We understand that a material increase in orthopaedic resource, across workforce and facilities is required to address the service needs of the nation and its aging population.
- It should be noted that orthopaedic waiting times were too long and were growing before the pandemic began. Further, elective orthopaedic service were regularly paused due to external pressures such as winter pressures. Transformation is needed to build a more robust service capable not only of clearing the backlog, but of withstanding external pressures and of achieving low waiting times and keeping them low for the long term. We believe that waiting times no higher than 6 months should not be an unrealistic target when the surgical intervention can be only an hour's operation that can fully restore mobility and independence to someone waiting in severe persistent pain.
- We welcome the commitment for 'Regional plans for aspects of orthopaedic services based on the orthopaedic clinical strategy work.' and the acknowledgment of the need to transform services. However, we await the planning detail necessary to show what that will look like or how and when it will be delivered for elective orthopaedic services.
- We support the Royal College of Surgery of England's call for surgical hubs / elective centres. Progress is being made at the local level in some HB areas to develop surgical hubs, for

example in Swansea Bay UHB. That progress is welcome, however we would like to see an acceleration and greater prioritisation of this process across Wales and we would like to see more national planning to ensure regional, cross-HB area solutions are evaluated and taken forward where most appropriate. We would like to see the aims for surgical hubs cover not only greater capacity and efficiency and supporting vital recruitment and retention initiatives, but also to focus on delivering the highest quality health outcomes for service users.

- We welcome the commitment to greater regional working where necessary/beneficial for certain services/treatments and we accept this will involve more travel for some people. Such changes should take into account travel support needs of services users. WG and HBs should also ensure more regularly accessed services, such as prehab and rehab (that work with less frequently accessed services that may be regionalised such as surgery) remain available locally.
- We believe that all options should be evaluated to reduce orthopaedic waiting times during recovery. Choices available to service-users, such as accessing services outside their HB area, should be communicated to them.
- We welcome the plan's support for 'Partnering with the independent sectors to develop new approaches and models of care.' We would like to see greater detail with guidance for the use of private services to speed up the process of recovery for elective orthopaedic services. We understand that this is a shorter term approach to lowering the waiting lists, however we believe that with the waiting lists as long as they are and with the health need as great as it is, short term solutions should be utilised to help reduce waiting times as more longer term, sustainable solutions are developed and implemented. We would like to see more data published to monitor HBs' use of orthopaedic private sector capacity in Wales to provide greater clarity and inform recovery planning and implementation. Further, greater clarity is needed re whether HB funding will be available for people to access private sector services, including in other regions and nations, both within the UK and beyond.
- We welcome the Plan's commitment to equitable access to services and recognition that this may require regional lists and transfers to other HBs. Patient choice should be central to this process where possible and travel provision will be key to eliminate barriers to access services that may be delivered at a regional hub as future transformation plans are implemented.

Communication, information and support for people waiting for treatment / surgery

- We welcome the acknowledgement of the impact of longer waits on those waiting and the need for communication and information to help people manage the challenges of the longer waits. It is important to note that the impact extends far beyond the physical health deterioration and increased symptoms and pain levels that people experience as they wait for orthopaedic surgery. For example, many people experiencing severe and worsening pain as they wait for surgery struggle with the mental health impacts this brings and may struggle with isolation and loneliness as leaving the house becomes more difficult or not possible independently. The impacts extend to family relationships and increasing pressures on carers, on financial security and employment – on every aspect of a person's life. Communication, signposting and support needs to help patients manage all of these challenges.
- For communications and support to be most effective in helping someone to 'wait well', or at least wait as well as possible, we would like to see recognition of the need for communications and support *early* in the service user's wait for treatment. For example, for someone waiting for a knee or hip replacement, early access to info and support re self-management skills/secondary prevention/safe exercise could impact positively on

independence, QoL and fitness for surgery as they wait. Leaving such intervention too long reduces the chance of compliance, pain levels / deconditioning may have already increased, leading to a downward spiral of ill-health. To support this, we like to see a greater focus during recovery on the expansion of provision of MTD in primary care, e.g. expansion of access to First Contact Practitioners (FCPs).

- We welcome the Plan's commitment to HBs developing a 'Communication strategy' for people waiting. We believe this should be extended to a commitment to each HB developing its own 'Waiting list support strategy', which would include communication, but also cover information and signposting provision beyond the health care providers and support provision to help people waiting for surgery to overcome barriers to safe exercise (pain levels, fear of damaging joints, etc) .
- Cymru Versus Arthritis has advocated for an all Wales plan or guidance to support the development of communications, information and support services for people on waiting lists. We welcome the recent appointment of a seconded lead to head up the Welsh Government's work in this field. We are awaiting details of the remit of the new role. We would like to see the Welsh Government also utilise the expertise it now has with its recently recruited Persistent Pain National Clinical Leads and its MSK National Clinical Leads to support the development of guidance for waiting well. Such work could provide the foundations for a longer term, more holistic and secondary prevention focussed change in the approach to support for people living with MSK conditions that have their condition primarily managed within primary care, such as osteoarthritis.
- We welcome the commitment to develop a 'Planned Care Portal' app for patients. We would welcome greater detail re timeframe for delivery and how the third sector can engage in the process. Third sector engagement will be key to the success of this app and will avoid unnecessary duplication of effort. The portal should make use of the high quality resources already developed in the third sector. For example. The Versus Arthritis website hosts an array of resources and videos to help people with arthritis to remain active.[iv] We are currently supplementing that resource with a series of videos for people waiting for / recovering from orthopaedic surgery to help them retain or increase their activity levels.
- Digital exclusion must be taken into account in the delivery of communications, information and support for people on waiting lists. We would like to see approaches such as single points of contact systems for people on waiting lists currently offered by at least one HB in Wales evaluated and improved and/or expanded as appropriate. It needs to be simple and straightforward for people to reach out for support and advice as and when their circumstances change whilst they wait for treatment.
- As a follow on to the Plan, we would like to see a stronger national steer re the development of local services to support people on waiting lists to increase their activity levels / access safe exercise – such as the 'ESCAPE pain' programme and resources.[v] A number of HBs have expanded their provision of ESCAPE pain over the past 24 months to support people on waiting lists.

Data

- We welcome the commitment to produce more data to monitor progress: '*This plan will be underpinned by accurate data. Targets and performance management will be developed alongside a real-time, visibility of the waiting list by sub speciality, robust demand and capacity plans that will enable teams to work effectively*.' We would like to see further detail re what data will be published and a timeframe for when this new stream of data will be accessible to the public.
- Versus Arthritis has advocated for the publication of granular monthly activity data – e.g. number of elective hip and knee replacements undertaken by each HB – to provide greater

transparency to monitor progress restoring services and achieving the capacity / throughput required to meet the plan's targets. We would like to see a national hub for HBs recovery planning and reporting of progress with such data.

Workforce issues

- Workforce issues are key to tackling the backlog and the transformation of orthopaedic services. The Workforce Delivery Plan needs to be published as soon as possible.

Contact details

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Cymru Versus Arthritis

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[i] https://www.versusarthritis.org/media/24238/state-of-msk-health-2021.pdf
[ii] The Lancet Rheumatology (2021). Too long to wait: the impact of COVID-19 on elective surgery. Accessed here: https://www.thelancet.com/journals/lanrhe/article/PIIS2665-9913(21)00001-1/fulltext
[iii] Versus Arthritis (22 October-December 2020). Impossible to Ignore Joint Replacement Survey of 906 people (65 in Wales)
[iv] https://www.versusarthritis.org/exercise
[v] https://escape-pain.org/

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros

This response was submitted to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

PCWL 33
Ymateb gan: | Response from: Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

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Suzanne Rankin
Chief Executive

15 June 2022

Russell George MS
Chair, Health and Social Care Committee
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Dear Russell

Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Thank you for the opportunity to comment on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists. Our comments are summarised against each of the matters set out in your Annex 1 below.

Overall views

1. *Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.*

   In overall terms we feel the planned care plan has the right ambitions but acknowledge that the timescales stated in the plan will be a challenge for Health Boards in light of the volume of the backlog, suppressed demand, workforce constraints and continuing operational pressures.

   For context, in order to deliver the plan, we will not only have to revert to pre-pandemic levels of activity but also go above and beyond. This will require us to maximise our own resources in addition to commissioning additional activity and transforming and modernising the way we work. We, therefore, welcome the additional financial resource that Welsh Government have provide to support the planned care recovery and transformation.

2. *Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?*

   We feel that as well as plans to tackle the current backlog, the right things are being focused on in the plan to build a more resilient and sustainable health and social care e.g. care closer to home, separating planned care and urgent & emergency care, development of regional treatment centres and diagnostic facilities. The 5 goals approach to transformation is supported. The focus on promotion of healthier lifestyles e.g. healthy weight, physically active and stopping smoking is welcomed. The whole system approach i.e. we cannot deliver planned care unless the unscheduled care system is in balance and supported by the right social care system too, is clearly referenced in the plan. In this context, we also welcome publication of the Welsh Government Six Goals for Urgent and Emergency Care.

Meeting people's needs

3. *Whether the plan includes sufficient focus on:*

a. *Ensuring that people who have health needs come forward*

   The plan states that changes to the GMS contract will see significant changes to the way people access their GP services which should make things easier for people to come forward. As part of the plan, Health Boards are asked to develop a communications strategy that will support patients to manage their conditions and focus on encouraging individuals to seek help if they are unwell. There is a specific focus on access to dentistry, optometry and community pharmacy services and as part of the cancer section a commitment to promoting key messages about cancer symptoms to encourage patients to come forward.

   From a public health perspective, there is work to do on improving referrals in from people who traditionally do not access primary care services and wait until they are so ill that they need emergency care i.e. addressing what we refer to this as the 'inverse care law'. We would also need to be careful that referral thresholds do not further disadvantage some populations, as we know there is variation in when people present for care.

b. *Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management*

   The plan commits to providing better information for patients including access to personalised information and more help so patients can decide the most appropriate option for them, helping patients to prepare for surgery. The plan will build on established self-management models as a core component of person-centred care. Support for people with long term conditions to manage their own health and wellbeing effectively is also highlighted.

c. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time

The plan mentions clinical prioritisation of patients (those categorised as urgent) and those who have been waiting the longest but there is a risk that in prioritising urgent patients, some routine patients may wait longer as a consequence. The ambitions set out, however, are focused on time rather than clinical risk and this is something that could be strengthened.

The plan also asks Health Boards to consider the specific needs of children, and makes reference to considering waiting times for children differently to waiting times for an adult as the illness will represent a higher proportion of a child's whole life and potentially have a long-term impact on growth and development. Our view is that paediatrics is an area that needs more development and ought to be strengthened with a specific profile and plans in the document. Access to mental health services is also highlighted with eating disorders, young people, and general increased demand as areas identified for prioritisation.

d. Improving patient outcomes and their experience of NHS services

In terms of cancer, the plan referenced the need to embed National Optimal Pathways to streamline the patients journey and reduce avoidable delays and combining first clinician review with as many diagnostic results as possible to minimise time to diagnosis and first treatment.

The section on patient prioritisation and minimising health inequalities does draw attention to what matters to patients in terms of isolation, inability to work, mobility limitations etc and the impact this may have on patient outcomes. However, fully engaging, in a meaningful way, with underserved populations in the planning of services so that accessibility (whether that is through outreach elements, translation of information etc.) can be considered up front not as an add on is essential.

From a public health perspective, the inequality of care once in the system is not mentioned, we know that people who have protected characteristics generally have worse outcomes and a worse experience of care. We will need this monitored as standard, and data collection is poor which adds to the complexity of this issue, this should be standard with PROMS and PREMS but might need additional thinking through to reach all groups.

Leadership and national direction

4. Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?

Yes, we agree that the plan provides sufficient leadership and national direction, however we recognise that there is more work to do in terms of collaboration across Health Board boundaries and across the health and social care system to deliver sustainable system change.

5. *Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?*

   Not in all areas. For some areas it is very clear that, for example Welsh Government or Health Boards are taking the lead, but in other areas it is not as clear who the 'we' is that is being referred to in the plan.

Targets and timescales

6. *Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?*

   Yes, the targets and timescales are sufficiently detailed and measurable. As stated above under Q1, some of these targets are challenging to deliver within the timescales set out.

7. *Is it sufficiently clear which specialities will be prioritised/included in the targets?*

   Other than where specific reference has been made to certain services (e.g. mental health, children's services), we have made an assumption that the targets apply to all specialities.

8. *Do you anticipate any variation across health boards in the achievement of the targets by speciality?*

   Yes, we can anticipate that there will be variation across the health board as not all specialities are at the same starting position having been affected in different ways as a consequence of the pandemic. Therefore, delivering the targets in some specialities will be quicker/more realistic than in others which are still some way off a return to pre-pandemic levels of activity.

Financial resources

9. *Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?*

   It is unlikely that there is sufficient revenue and capital funding in place as things stand, however it may be that further funds are made available over the four year term of the plan. For example, the plan points to the need to establish community diagnostic hubs away from acute hospital sites which will require investment in equipment, facilities and workforce. There is no mention of how this will be funded and we know that capital availability is currently extremely limited.

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10. *Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?*

There are some specific areas identified in the plan for funding e.g. mental health (50m rising to 90m in 24/25) and £262m annually to equip and train the next generation of health workers. £170m recurrent funding has been made available to support planned care recovery across Wales. Endoscopy, cataracts, orthopaedics, imaging, critical care, cancer and stroke services have been identified as the priority areas but we already know that the allocation for our own Health Board will not cover all these areas. Whilst we are aware from a Health Board perspective on the mechanisms for reporting spend against the investment and activity, and the forums in which we are held to account, we could not see this set out in the plan.

Workforce

11. *Does the plan adequately address health and social care workforce pressures, including retention, recruitment and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?*

The plan acknowledges the impact the pandemic has had on staff and that workforce capacity and capability will be key to the success of delivering the plan. However, it also acknowledges that we will not be able to recruit our way out of the challenges we face. There is a commitment to spending £262m annually to equip and train the next generation of health workers and developing a coordinated and focused workforce plan. However, it is not clear what the detail of the plan looks like. It is also worth noting that the expectations from the plan is that Health Boards start delivering from now but there will be a lead in time to the corresponding workforce strategy coming to fruition. We will, therefore, need to have to put interim solutions into place such as asking our staff to do additional shifts to fill current gaps or use private sector/locums/agency staff. We would also strike a note of caution about the ambition to deliver planned care over 52 weeks, 7 days and 15hrs a day which will be a considerable ask in terms of workforce.

Digital tools and data

12. *Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?*

The Welsh Government plan references access for patients to a national patient information website and support services, but there are no timescales associated with this or how these developments will facilitate efficiencies. However, it is helpful to see references in the plan to digital tools in place within primary care to enable remote consultations and from an outpatient perspective plans to integrate e-referral and e-advice systems in order to manage the majority of non-urgent cases in the most appropriate setting. We note the positive plans for referral pathways to be supported by a digital interface, the roll out of

SOS and PIFU pathways, use of digital technologies to reduce the need for face to face contact, video consultations and group clinics to prepare patients for treatment and digital platforms for patients to self-manage conditions. From a public health perspective, digital exclusion is mentioned, and while technology will help many we need to remember that this may increase inequalities without additional options being made available for patients.

I hope you find the above comments helpful.

Yours sincerely

Suzanne Rankin
Chief Executive