

## **Agenda – Health, Social Care and Sport Committee**

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Meeting Venue:

For further information contact:

Video Conference via Zoom

Helen Finlayson

Meeting date: 3 February 2021

Committee Clerk

Meeting time: 09.00

0300 200 6565

[SeneddHealth@senedd.wales](mailto:SeneddHealth@senedd.wales)

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In accordance with Standing Order 34.19, the Chair has determined that the public are excluded from the Committee's meeting in order to protect public health. This meeting will be broadcast live on [senedd.tv](http://senedd.tv)

### **Informal pre-meeting (09.00–09.30)**

#### **1 Introductions, apologies, substitutions and declarations of interest**

(09.30)

#### **2 COVID-19: Evidence session with Community Health Councils in Wales**

(09.30–10.15)

(Pages 1 – 104)

Alyson Thomas, Chief Executive – Board of CHCs in Wales

Donna Coleman, Chief Officer – Hywel Dda CHC

Geoff Ryall-Harvey, Chief Officer – North Wales CHC

Angela Mutlow, Chief Officer – Aneurin Bevan CHC

Research brief

Paper 1 – Community Health Councils

### **Break (10.15–10.25)**



**3 COVID-19: Evidence session with Royal College of General Practitioners Cymru Wales, Community Pharmacy Wales and Royal Pharmaceutical Society Wales**

(10.25-11.10)

(Pages 105 – 131)

Professor Peter Saul, Joint-Chair – RCGP Cymru Wales

Mark Griffiths, Chair – Community Pharmacy Wales

Suzanne Scott-Thomas, Chair of the Welsh Pharmacy Board– Royal Pharmaceutical Society

Paper 2 – Royal College of General Practitioners

Paper 3 – Community Pharmacy Wales

Paper 4 – Royal Pharmaceutical Society of Wales

**Break (11.10-11.20)**

**4 COVID-19: Evidence session with Royal College of Physicians, Royal College of Surgeons, and Royal College of Nursing Wales**

(11.20-12.05)

(Pages 132 – 147)

Richard Johnson, Royal College of Surgeons Director in Wales

Dr Olwen Williams, RCP Vice President for Wales

Lisa Turnbull, Policy, Parliamentary and Public Affairs Manager, Royal College of Nursing Wales

Paper 5 – Royal College of Physicians

Paper 6 – Royal College of Surgeons

**5 Paper(s) to note**

(12.05)

**5.1 Letter to the Minister for Health and Social Services regarding the Committee's inquiry into health and social care in the adult prison estate in Wales**

(Pages 148 – 161)

- 5.2 Letter from the Minister for Mental Health, Wellbeing and Welsh Language and the Deputy Minister for Health and Social Services regarding the Committee's inquiry into health and social care in the adult prison estate in Wales**  
(Pages 162 – 185)
- 5.3 Public experiences of Test, Trace, Protect (TTP) in Wales: Research commissioned by Senedd Cymru and produced in consultation with Senedd Research**  
(Pages 186 – 204)
- 5.4 Letter from the Chair to local health boards regarding waiting times**  
(Pages 205 – 206)
- 5.5 Letter from the Minister for Health and Social Services regarding waiting times funding**  
(Page 207)
- 6 Motion under Standing Order 17.42(ix) to resolve to exclude the public from the remainder of this meeting**  
(12.05)
- 7 COVID-19: Consideration of evidence**  
(12.05–12.15)
- 8 Forward work programme**  
(12.15–12.30) (Pages 208 – 210)

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# Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales

Evidence from the Board of Community Health Councils and the 7 CHCs in Wales



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# About the Board and Community Health Councils

The Board of Community Health Councils (the Board) is pleased to provide this submission to the Senedd Health, Social Care and Sport Committee's inquiry on behalf of the 7 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.

# Hearing from people during the coronavirus pandemic

When our nation entered the first lockdown in March 2020, the Board office and all CHCs needed to move quickly so that our volunteer members and staff were able to continue to amplify peoples' voices about in the NHS during these extraordinary times – working in new ways that kept everyone safe.

We are very grateful to our volunteer members and staff for their flexibility and creativity in identifying, introducing and adapting to different approaches to hearing from people and NHS bodies.

CHC volunteer members and staff continue to miss the vital role face-to-face contact has in hearing about and sharing the views and experiences of people across all communities about their local health services.

They have done whatever they can to enable people to share their views and experiences in a range of different ways. This has included on-line and text as well as more traditional ways including phone and post. CHCs have also developed new ways of hearing from people including on-line focus groups and Facetime chats with people being cared for in our hospitals.

People across Wales have been able to share their views and experiences of NHS care with us by completing our national and local surveys.

The direct feedback we receive through these surveys is only one way in which CHCs hear from people about their NHS services.

CHCs also find out about people's views and experiences in other ways:

- through enquiries coming into CHC offices
- patient/service user stories being shared with the complaints advocacy service



- contacts with local community networks
- information coming in to us from community representatives and groups
- social media discussions
- monitoring of health board activities and performance.

We know that what we hear doesn't reflect everyone's experience. People's individual views and experiences are all different.

Much of what we have heard throughout this pandemic reflect the very natural questions, anxieties, fears and frustrations we have all felt as the scale and pace of the virus and its effects on individuals, families and whole communities have become clearer.

It also reflects many of the issues and concerns that arise when people and organisations seek to learn and respond to something they have never dealt with before, and on a pace and scale that has never been seen before in our lifetime.

The most consistent and enduring message we have heard from people across Wales has been the grateful thanks, support and admiration for health and care staff and all key workers.

People appreciate that staff have worked tirelessly throughout the pandemic to keep people safe and provide the best possible care, treatment and support to people in difficult circumstances.

We are very grateful to the people who have shared their views and experiences with us. We also want to thank everyone working tirelessly every day so that health and care services can respond to this brutal and unforgiving virus in the best way possible.

This evidence focuses on what CHCs have heard about peoples' views and experiences in 3 key areas:

- the impact of delayed care and treatment on peoples' lives, and those who care for and about them
- test, trace and protect (TTP)
- the COVID-19 vaccination programme so far.

It mainly reflects what we have heard from people who simply wanted to share their views and experiences. This is so the NHS knows what is working well and where things are going wrong, so they could be put right as quickly as possible.

Throughout the pandemic, the numbers of people contacting the CHC complaints advocacy service for help and assistance to raise a formal concern with the NHS has been much lower than before the pandemic. Although the numbers are increasing, they continue to be lower than the same period last year. We know this is not because things aren't going wrong.

Many people tell CHCs they understand that things may not work as well as they should because of the pressures NHS staff are under. Others don't want to add pressure to an already overburdened NHS by taking time away from busy health and care staff to investigate their complaint.

CHCs anticipate that the number of formal concerns and complaints will increase as the wider situation begins to improve, and the longer term impact on people's health and wellbeing becomes clearer.

## **The impact on people waiting for care and treatment**

Throughout the pandemic, CHCs have heard continually from people across Wales about the impact of waiting for care and treatment on their day to day lives, the lives of those they care about, and their concerns about the future.

In November 2020, we published a report that set out the key things CHCs had been hearing throughout the different stages of the pandemic from people affected by delays in care and treatment. Our full report is included in this evidence at **Appendix 1**. We set out below the key themes we heard across Wales from people waiting for care and treatment through the different stages of the pandemic.

## In the early stages

In the early stages of the pandemic people knew and understood that their planned care and routine treatment would need to be postponed so that the NHS could respond effectively to the virus.

Some people heard from the NHS and were clear about what would happen. They found this helpful and reassuring.

Lots of people were unsure what would happen to their care and treatment across a wide range of services because no one told them what was happening. This lack of contact was very worrying for them.

Even though the Welsh Government had said that urgent cancer care and treatment would continue, and we heard some positive feedback on continuing cancer care, we also heard that many people were anxious about delayed results or their on-going cancer care, and the impact on people's condition in the longer term.

Where people were told treatment was being cancelled or postponed, they were not always clear why. This is because they didn't always have the information they needed to understand the things that led to the decision. This included understanding why the risks of catching COVID may be higher than postponing their treatment.

For many people who had already waited a long time for an operation before the pandemic, the impact of a further delay was often devastating, even if they understood why.

For some people better advice and information to help them manage while they were waiting would have made things easier for them.

We heard that some people with life-long conditions continued to receive ongoing care successfully, but in a different way. Many others described their on-going care as simply stopping, sometimes with no clear advice and information about the changes or when they might be seen again.

People who rely on routine Vitamin B12<sup>1</sup> injections consistently told us about their concerns about being switched to oral medication when they had previously been told this would not be suitable for them. This made people doubt the advice of their healthcare staff.

For people living with life-long conditions like diabetes, many worried that the lack of regular monitoring, check-ups and related treatment like eye care and podiatry was storing up bigger health problems later down the line.

Some people told us it would have been easier to make decisions about whether to attend for treatment if they had more information.

Many people had received treatment before the coronavirus pandemic affected NHS services in March. Some told us they still had great follow up care, even though the way they received their follow up care had changed.

Lots of people told us they didn't have any follow up contact or appointments after lockdown. We heard from some people that this was limiting their lives and they felt it had threatened their recovery.

The suspension of most screening services, although understandable, led to anxiety for many. We heard the worries people have about becoming ill in the future because vital early detection has not always been possible. People's anxieties increased if the communication between different parts of the NHS was inconsistent or if they had previously had treatment.

## Easing of the first lockdown

As the first lockdown restrictions eased, we heard from people who were frustrated that they were still waiting and couldn't get the care they needed, even though they had heard that their services had

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<sup>1</sup> **Pernicious anaemia** is an autoimmune condition that affects your stomach. An autoimmune condition **means** your immune system, the body's natural defence system that protects against illness and infection, attacks your body's healthy cells. Most people can be treated with B12 injections or tablets to replace the missing vitamins.

restarted. Lots of people felt some services seemed to be slow to restart and didn't understand why.

Most people understood why re-introduced services needed to be provided differently, even though this sometimes made things more difficult or made them worry things might be missed, for example if they were not seen face to face.

Many people facing continuing delays or cancellations were particularly frustrated if they didn't know when their care might restart. This was making more and more of a difference to people physically and mentally. Many worried more about further delays leading up to winter.

We saw that some health services were better than others in providing information for their population and for individuals about what is happening and their plans moving forward.

## **Re-introducing services**

We heard from some people that their care and treatment had continued successfully throughout the pandemic.

For others, as the pressures on the NHS started to ease, and the NHS began re-introducing services, CHCs heard about differences in the way and the speed in which some services were being re-introduced.

Sometimes the reasons for this were clear, but this wasn't always the case. If a certain kind of operation or treatment can be restarted in one area of Wales (or England), it doesn't make sense to people that it isn't available in another area, or if it takes much longer for people to be seen in one area than another.

## **Going back into lockdown and planning for the future**

Towards the end of the year, as the weather worsened, and the numbers of people catching Covid-19 in our communities and

hospitals increased, CHCs heard from local health services about services being reduced or suspended. This was so that hospitals didn't become overwhelmed as the NHS struggled to care for more and more people with Covid-19.

Increased sickness and lower resilience levels amongst healthcare staff further affected both those receiving care and treatment and those who have seen their treatment delayed further.

This time around CHCs heard in some areas about the suspension of all but the most urgent services, with the potential for permanent and life changing harm for people waiting to receive treatment.

Since the Welsh Government started letting people know again late in 2020 about the overall numbers of people waiting for care and treatment in Wales, the stark reality of the size of the backlog and the scale of the challenges facing the NHS as it tackles the harm caused by the coronavirus pandemic has become even clearer.

For those NHS services that were struggling before the pandemic, people are worried that the challenges are even bigger.

Looking beyond the numbers, the often heart-breaking and devastating impact on many people whose care and treatment has been delayed because of the pandemic is clear. The impact on each individual person has varied, with people describing a range of things affecting their day to day lives while they wait.

These include things like their overall mobility and independence, their ability to care for others, their involvement in family life, their resilience and ability to live with chronic pain, their ability to work and their overall mental health and wellbeing.

Looking forward, it is perhaps never been more important that the Welsh Government and the NHS in Wales engages with and involves people and communities in developing clear plans for recovery.

There is a continuing need for the NHS in Wales and the Welsh Government to make sure:

- [clear, consistent communication between people and NHS services at individual and community levels](#)

- easy access to advice, support and information about NHS services that is up to date and meets people's individual needs
- appropriate and active involvement by people in decisions about their care and treatment, and those of their loved ones
- the NHS gets things right in balancing the harm caused by or because of the pandemic
- services are reintroduced equitably for people living in all parts of Wales as soon as it is safe to do so
- new ways of delivering services that have made accessing care and treatment easier for many people continue to be developed and introduced. At the same time, it's vital that people aren't disadvantaged or excluded from being able to access services in ways that meet their individual needs.

## Test, trace and protect

Since it was first launched, CHCs have been hearing from people who shared their different experiences of using the test, trace and protect system.

### Getting a test

When it has worked well, people described getting a test as being an experience where they were able to book an appointment easily, and where they were tested in a timely way, by caring staff who explained clearly what would happen next. We heard from some people about how they liked the on-line booking arrangements.

Others told us about the abilities of the staff to put people at ease, and particularly those who may have specific needs.

When it hasn't worked so well, people have shared a range of reasons.

When test, trace and protect arrangements were first introduced, we heard from people about their difficulties in booking an appointment.

For some people, the long distances and arrangements to travel to and from test centres was difficult.

For some people who were living in the most vulnerable situations, and who may be digitally disadvantaged, we heard about the difficulties in making an appointment and travelling the sometimes long distances needed to get to a test centre.

Others told us about their frustrations that having booked an appointment in a test centre some distance away, closer slots became available but they were unable to cancel the original on-line bookings.

A few people told us there had been some difficulties matching the personal information they provided when they booked on-line with the information the test centre held when they arrived. This had caused some delay and confusion.

We heard from some people working in social care that they had difficulties in accessing a test at a time they could make given their caring responsibilities.

For people using home testing kits, we heard some concerns early on about their accessibility for people with a visual impairment or for people whose first language was not English.

Some people lacked confidence in using a home test because they were worried about doing it wrong, and maybe getting an unreliable result.

When testing capacity increased, and people could get tests through local and national arrangements, we heard less about the distance to travel or being able to get an appointment.

Some people wanted to make sure there wasn't any difference in the reliability of tests done in different ways, or being analysed in different laboratories.

Until the Welsh Government announced the introduction in December 2020 of twice weekly tests for frontline health and social care, we heard lots of concerns that some key health and care staff



such as domiciliary care workers were working in their local communities without regular testing.

People were worried that these workers could, through no fault of their own, be unwittingly spreading the virus from house to house.

## Getting a test result

We heard about the relief people felt when they received a negative result quickly. This meant they could get on with their lives, including going back to work. This was something that was especially important to people working in the health and care sector.

For those who received a positive result quickly, although this was worrying, people told us it meant they were clear about needing to self-isolate so that they were not transmitting the virus to others outside their home.

Where things hadn't gone so well, we heard a number of different reasons for this.

Some people told us the arrangements for getting test results in their local area was confusing. This was because there were 2 different numbers for people to call depending on whether the test centres were run by the local health board or as part of wider arrangements.

The information people needed to provide to get a result was different depending on which number they had booked on and this was causing problems.

CHCs heard from others about tests that had been lost and mix ups with results. In some cases people were first told they had tested positive only to be told later their test was negative. When this happened people were told to self-isolate as a precaution, often having a wider impact on households and extended families.

We heard from some people who were frustrated that results for people in the same household who had been tested at the same time were receiving their results at different times. This meant whole families were often waiting for the last person in their group to

receive their results before they knew whether they could return to school or work.

We heard most of all about people waiting too long for test results. Although we know that most people receive their test results quickly, for those that didn't, it made them feel more anxious and stressed. It led to longer periods of self-isolation that would not have been necessary for those with negative results.

## **Self-isolation and contact tracing**

We heard from some people that the advice they and family members had received from contact tracers was not always consistent. This confused them. This was sometimes about the need to self-isolate, and sometimes about the timescales people should self-isolate for.

Self-isolation requirements relating to school children and school communities was particularly confusing and unclear for some. This meant some people were less confident about the system overall.

For those people who had been advised to self-isolate, some were concerned that not everyone who they had been in close contact with had heard from contact tracers at all, or that the first contact from tracers took longer for some people in a group than others.

Some people who had been traced told us they had regular, daily calls from contact tracers, and that this was reassuring. Others told us that although they were told they would have daily calls, this didn't always happen. Sometimes people in the same family had different experiences.

In a few cases, we heard that the advice from contact tracers came too late, e.g., advising people in the same household to self-isolate from each other after they had all be isolating together for a number of days.

Some people doubted the reliability of the mobile app. This was because although they had been contacted through the app about being in close contact with others in the community, e.g., while out

shopping, people who had been with them were not contacted by tracers. When this happened, we heard that some people couldn't understand the reason why.

Until recently, CHCs were regularly hearing from people about their views and experiences of the test, trace and protect arrangements in Wales. People saw it as an important tool in identifying and protecting individuals and communities from the spread of coronavirus.

Over the past few months, and particularly since arrangements started to be made for the roll out of the COVID-19 vaccination programme in December 2020, CHCs have heard much less from people about their experiences of test, trace and protect.

This has generally been consistent with information from health boards that the issues and concerns that had been raised earlier were being or had been dealt with. It is also consistent with a shift in people's focus in general to the vaccination roll out arrangements.

It's important that there is a continued focus on the timely and effective operation of the test, trace and protect system as it will remain important in helping to protect us in the months ahead while the vaccination programme continues its roll out.

## **The vaccination programme so far**

Unsurprisingly, the positive news late last year about the approval of vaccines meant that people had lots and lots of questions and queries about how it was going to be rolled out in Wales and what this meant for themselves and those they care for and about.

### **Understanding how things will work**

Early on, the questions and queries CHCs heard were about things like:

- whether Wales would get its fair share of vaccines, and how this would be distributed fairly to all parts of Wales
- would people have a choice of vaccine, and was one more reliable than the other, what if the vaccine isn't kept in the conditions needed for it to work
- would it be suitable for me if I am a vegan, or have particular beliefs
- how long will it protect me/my loved one for
- what happens if I have an adverse reaction, and who do I tell
- will I have enough information to help me decide whether to have the vaccination
- if I was shielding before, will I be considered in the same category now and what if I am missed off the list
- where will I get the vaccine from
- will I, or the person I care about be a priority.

Lots of people were concerned that the arrangements for volunteering/applying to become a vaccinator were putting people off. They wanted things to be made simpler and quicker. We heard from others who were going through the process that they had found the training both helpful and reassuring.

As the NHS in Wales and the Welsh Government provided more information, and responded to the questions people were asking through frequently asked questions and other messaging, the number of questions and queries has reduced.

It hasn't always been easy for people to understand what the plans and arrangements mean for them in their area of Wales. Much of what they were hearing from television described arrangements in England, and it wasn't always made clear that there may be different arrangements in Wales. This was a particular concern in relation to the role and involvement of GPs in the roll out.

For many, the publication by the Welsh Government of its Vaccination Strategy provided a clearer picture of the way forward.

The need to provide clear, simple, consistent and accessible messaging to people around its contents will remain important throughout the roll out.

In one area of Wales, the CHC identified early concerns that the offer of vaccination by Mid-February for the first phase of the roll out was different to that in the other areas of Wales, and that this could lead to inequity. This matter was quickly addressed, although the public messaging locally took a little longer to be corrected.

We heard particular concerns about the priority levels set by the Joint Committee on Vaccination and Immunisation (JCVI) for unpaid carers, for adults with severe learning difficulties and for children identified as clinically extremely vulnerable.

Even though there is a lot of information available to people about the vaccination roll out arrangements, it can still be difficult for people to find the information they want at an all Wales and more local levels.

This is because there is a lot of information in lots of different places. Navigating a way through it all, and knowing what information is reliable and up to date can still be challenging for many people.

The individual communication to households in local areas has generally helped reassure people about both the overall arrangements in Wales, as well as the specific arrangements in their local area.

It has helped many people who were worried about being lost or left behind in the arrangements. Some health boards have introduced easy ways that people can get in touch if they are in the priority group being vaccinated but haven't yet had an invitation.

Some areas of Wales have responded quicker and have been clearer in their public messaging through these household communications than others. It has not always been clear early enough how people will be contacted, or that the information is also available to people in different formats to meet different communication needs.

CHCs are waiting to hear more about the arrangements being made to offer the vaccination to people who are homeless, or who may not be registered with a local GP.

## **Getting vaccinated in the early stages**

For those people who have already received their vaccination, the feedback CHCs have heard from people about their experiences across Wales has been very positive.

We've heard that people have been given the information they need about the vaccination to help them decide whether to have it, and what to do after they are vaccinated.

We have heard about a few things that have not worked so well for people attending for a vaccination. Where this has happened, e.g., long waits in the cold for some people to be vaccinated in one area, it's vital that health services learn quickly from this and share their learning with others.

It's also important that health services make sure that people who may have particular communication needs receive their vaccines from vaccinators who are skilled in providing care in a way that is sensitive to those needs.

In a few health board areas, we heard concerns from people that the roll out of vaccinations by local GPs would be starting later than other areas of Wales. This meant that, although the health boards were focusing on ensuring people could still get their vaccination at the same time or in some cases earlier, people needed to travel further to get their vaccination, especially people over the age of 80 years.

We also heard some early concerns about the way NHS bodies were arranging appointments for front line health care staff, notifying cancellations and making available vaccinations at short notice if people couldn't make their appointments.

CHCs have seen health boards respond quickly to deal with some of these early issues, including, for example, making it easier for

people to notify services if they have to cancel their appointment, and introducing clearer arrangements for offering last minute appointments if others make cancellations.

Lots of people had worries early on about transport to and from their vaccination appointments, and whether, for example, family members could take them safely. CHCs have also heard lots about the efforts being made locally to co-ordinate transport so that no one is unable to get to their appointment because they don't have their own transport.

More recently, we have heard some concerns from people that the arrangements are not always clear enough for people who are housebound.

Most of all, we have heard about the relief people feel when they, or their loved one, has received the vaccination.

This sense of relief has increased more recently as the number and speed at which the vaccinations are being rolled out is rising, particularly in some areas with significant geographic and demographic challenges.

## Further evidence

As well as the areas covered in this evidence, we have previously published 2 other national reports about people's views and experiences of health and care services during the coronavirus pandemic.

- **Maternity services in Wales: what CHCs have heard during the coronavirus pandemic** This is available through the following link [FINAL ENGLISH VERSION - Maternity care during the coronavirus pandemic.pdf \(wales.nhs.uk\)](#)
- **Living with coronavirus: Health and care services during Winter** This is available through the following link [Living with coronavirus - health and care services during winter \(Final\).pdf \(wales.nhs.uk\)](#)

## Future reports

Over the coming months, we will be publishing the following reports on what we have heard about key aspects of health service delivery during the coronavirus pandemic:

- Our COVID nation in 2020
- GP services
- Digital healthcare
- Dental care.



[www.communityhealthcouncils.org.uk](http://www.communityhealthcouncils.org.uk)

# Feeling forgotten?

Hearing from people waiting for NHS care and treatment during the coronavirus pandemic



# Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

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# About the Board and Community Health Councils

The Board of Community Health Councils (the Board) has produced this report on behalf of the 7 Community Health Councils (CHCs) in Wales.

CHCs are the independent watchdog of the National Health Service (NHS) within Wales. CHCs encourage and support people to have a voice in the design and delivery of NHS services.

CHCs work with the NHS, inspection and regulatory bodies. CHCs provide an important link between those who plan and deliver NHS services, those who inspect and regulate it and those who use it.

CHCs hear from the public in many different ways. Before the coronavirus pandemic, CHCs regularly visited NHS services to hear from people while they were receiving care and treatment. CHCs also heard from people at local community events, and through community representatives and groups.

Since the coronavirus pandemic, CHCs have focused on engaging with people in different ways.

This includes surveys, apps, videoconferencing and social media to hear from people directly about their views and experiences of NHS services as well as through community groups.

There are 7 CHCs in Wales. Each one represents the “patient and public” voice in a different part of Wales.

# Background & introduction

In 2018 we published our report 'Our lives on hold'<sup>1</sup>. The report described the impact on people living in Wales who were waiting a long time for NHS treatment. It identified that when we wrote our report, there had been some recent improvements in the time people had to wait for care and treatment.

The report also called for changes in the way the Welsh Government and the NHS judged how well the NHS was doing – so that the harm that can be caused by inactivity or “waiting too long” for care and treatment was included.

Since then, the coronavirus pandemic has changed everything. In March 2020 the Welsh Government took action to “continue to provide care and support to the most vulnerable people in our communities, whilst also making sure organisations and professionals were supported to prepare local responses to the public health emergency”.

For many people waiting for a diagnosis or treatment following their diagnosis, things were put on hold. As the NHS moved from the initial stages of the emergency, the Welsh Government issued guidance for NHS services on how it should balance the need to continue to respond to COVID-19 at the same time as providing other essential healthcare.

<sup>1</sup> 'Our lives on hold....Impact of NHS waiting time on patients' quality of life is available on our website at the following link  
<http://www.wales.nhs.uk/sitesplus/documents/899/Our%20lives%20on%20hold%20-%20ENGLISH%2010.05.20181.pdf>

It was identified that there were 4 types of harm that the NHS needed to focus on and guard against:

Harm from COVID-19 itself	Harm from an overwhelmed NHS and social care system
Harm from a reduction in non COVID-19 activity	Harm from wider societal actions / lockdown

Welsh Government said that essential services<sup>2</sup> should be maintained at all times throughout the pandemic, and that any backlogs must be urgently addressed.

It said that decisions to re-introduce routine services should be made “when it is safe and appropriate to do so”.

Making decisions about the risks of providing care and treatment during the pandemic involves clinical judgements. CHCs rely on other bodies to provide independent assurance on this.

This report focuses on what it has felt like for many people throughout the pandemic so far. It highlights the things we often heard from people living in Wales about the impact that delays in diagnosis or treatment are having – **in their own words**.

It will not reflect everyone’s experience. We know that people’s individual views and experiences are all different.

Our report doesn’t mean that people across Wales are not supportive of everyone working in the NHS throughout this

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<sup>2</sup> <https://gov.wales/sites/default/files/publications/2020-05/maintaining-essential-healthservices-during-the-covid-19-pandemic-summary-of-services-deemed-essential.pdf>

pandemic – their grateful thanks to healthcare workers continue for everything they have done and are doing.



### Our report also picks up on:

- how the NHS response has developed
- what it has done to respond to the things people were worried about early on
- what it is doing now and
- what it can do more of to make it easier for people to understand and manage through these difficult times.





# What we did

During the coronavirus pandemic, people across Wales have been able to share their views and experiences of NHS care with us by completing our national surveys.

The feedback we receive through these national surveys is only one way in which CHCs hear from people about their NHS services.

CHCs also find out about people's views and experiences in other ways:

- through enquiries coming into CHC offices
- stories being shared with the complaints advocacy service
- contacts with local community networks
- information coming in to us from community representatives and groups
- social media discussions
- monitoring of health board activities and performance.



So that services can respond quickly and appropriately, CHCs share with their health boards what they are hearing from people in their local communities on an on-going basis.

At a national level, the Board and CHCs across Wales meet with the Welsh Government every week to discuss what we are hearing across Wales and the actions needed.



We have heard regularly throughout the pandemic about the impact waiting for care and treatment is having on people and families. This report reflects the things we have heard through our national surveys and local CHC activities.

# Who we are hearing from

Here is a snapshot of the people who are sharing their views and experiences of NHS care during the coronavirus pandemic through our national surveys.



We do not always have the same kind of information about the people CHCs are hearing from directly because people do not always tell us everything about themselves when they come to share their experiences and views with us.

We heard from around **1,150** people through our national surveys.

Over **95%** shared their views and experiences in English

Over **three quarters** were women, and over **95%** were cisgender<sup>3</sup>

The youngest person we heard from was **21** and the oldest was **77**

Around **85%** identified as heterosexual

Around **90%** were White (Welsh, English, Scottish, Northern Irish, British)

Almost **40%** were carers

Almost a **quarter** had a disability or long term health condition

You can find out in our Equality Plan what we are doing to hear from different groups of people so that we can better represent the diversity of the communities we serve. You can find our Equality Plan on our website [www.communityhealthcouncils.org.uk](http://www.communityhealthcouncils.org.uk)

<sup>3</sup> Cisgender is a term for people whose gender identity matches their sex assigned at birth

# What we heard

## In the early stages – postponing routine and planned care

In March, as the coronavirus pandemic started to take hold in Wales as well as the UK and beyond, all of us entered lockdown.

The NHS in Wales took action to respond to the emergency. In order to provide care for the growing number of people with COVID-19 and help stop people catching the virus, the decision was made to postpone all non-urgent NHS care and treatment.

People who were most at risk were asked to shield themselves at home. Urgent NHS appointments with General Practitioners (GPs) started to change quickly and in different ways, firstly by telephone and then videoconferencing.

During these early stages of the pandemic people understood the reasons why planned care, as well as routine care and treatment needed to be postponed.

In the early stages, some people told us they had heard from the NHS and were clear about what would happen.

**“I received a letter from the Physiotherapy Outpatient Department ..... telling me about the impact of the situation on my referral.**

**The letter says they are contacting all physiotherapy patients, and it includes a telephone number for urgent advice about muscle and joint problems. I have found this to be very helpful as I am now clear what is happening.”**

Many others were unsure about what would happen to their care and treatment across a wide range of services because no one told them what was happening.

## People waiting for a diagnosis or treatment

We heard from some people how a delay in their treatment was something that they understood because the reasons had been explained to them.

**“I was due to have a maintenance course of immunotherapy treatment on 25th March. This was cancelled. I was given a full explanation of the reasoning behind this by my urology nurse ....., and was told that a cystoscopy would be undertaken when it was possible to do so.**

**I have been very worried, especially when the government was proposing that this lockdown could continue until the end of the year. This morning I received a phone call ..... booking an appointment for me to have the cystoscopy .....I can't tell you the relief I feel.”**



For many people who had been waiting for tests or a diagnosis before the pandemic, a lack of communication about their individual situation didn't help.

**“Was referred by GP for Ultrasound weeks prior to the Covid-19 situation - have received no communication whatever regarding the process and if it will go ahead when the situation settles. My understanding is that routine tests will no longer happen such as smear tests. Mine is due in the coming months but not aware of what will happen to those tests that will not occur during this pandemic.”**

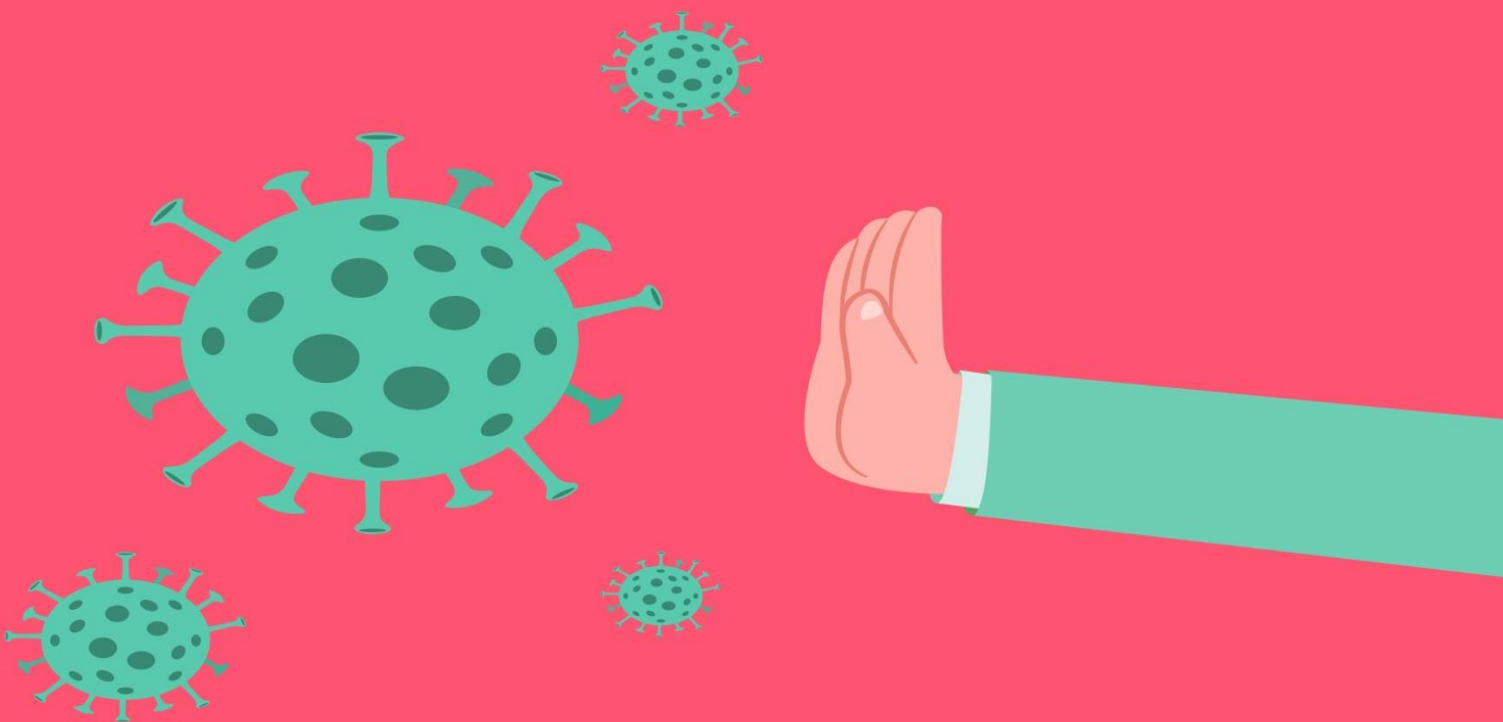


**“No result from a blood test over 2 months ago, appointment cancelled due to Covid-19”**

## People having cancer care

We heard from lots of people about what was happening with cancer care.

**"I obviously realise that in the current climate with the added pressures on the Health Board the situation is unprecedented and serious but feel that it must be managed so that possible cancer patients do not have their lives put at risk."**



Some people told us how well their treatment was continuing.

**“At present in middle of my course of treatment. Nurses have been incredible, kind caring, explaining changes in light of Covid19. They were professional and friendly at all times. They used PPE to keep us safe and measures to ensure we were well enough for treatment e.g. taking temperature in porch of unit.**

**Always kept updated of changes and asked if it was acceptable and satisfactory for me e.g., change of venue for blood tests. It was busier on one of days I was there but with two units combining it is expected. Everything ran smoothly and cannot praise staff enough. Also change in consultant appointment to telephone appointment which is sensible at this present time.”**



Even though the Welsh Government had said that urgent cancer care and treatment would continue, we heard that many people were anxious about delayed results or their on-going cancer care, and the impact on people's condition in the longer term.



**“I had a biopsy taken which was sent to the UHB for analyse. My GP advised that it could be skin cancer, since this I have had to attend surgery every other day to have my wound packed and dressed and as it is not healing, my GP upped their request for the results to urgent 4 weeks ago. It has now been 7 weeks since my biopsy was submitted and I am still waiting for the results, this is causing me to feel very stressed about my health condition.”**



In some cases, it was not always clear to people why cancer treatment had been cancelled or postponed.

**“Firstly I would like to start by saying a big thank you for all the hard work that frontline NHS staff are doing in the fight against the COVID19 Coronavirus pandemic. However I am writing this letter of complaint regarding the treatment of my sister who has recently been diagnosed with a grade 2 breast cancer tumour. She along with many other cancer patients appear to be the forgotten ones by this Health Board in this current crisis.**

**She was due to have a mastectomy operation this week, but has just been informed by her nurse that all cancer operations ... have been cancelled this week. I appreciate the need to ensure we have the correct capacity at our hospitals for COVID19 patients, but when I am hearing stories from members of staff ..... about how quiet wards are and how many empty beds there are. It beggars belief that someone has taken the decision to cancel lifesaving cancer operations. In my sister own words “ I feel like a ticking bomb” Is this really how any human being should be made to feel.**

**The average single mastectomy operation takes 90 minutes in theatre with the patient needing only one nights stay before being discharged the next day. By putting off these kinds of surgery you are increasing the patients risk of the cancer spreading and them then requiring re-assessment resulting in a more complex operation if the cancer has spread to the lymph nodes which results in them using more precious resources.**



## **People with postponed or cancelled operations**

Many people had already been waiting a long time for an operation even before the pandemic changed everything. Although they understood the reasons why their operations had been postponed or cancelled, the impact was often devastating.

**“Waiting for ovarian dermoid cyst removal. Attended Pre op date in October '19. An op date was given in January which was cancelled and then rearranged for April along with another pre op as previous had expired.**

**Symptoms have become increasingly difficult to manage leaving me with daily pain, tiredness, altered sensation to my left leg and overall has affected my mental health and wellbeing.**

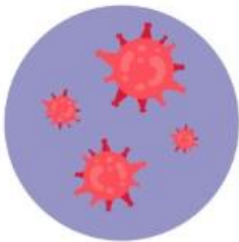
**Due to the coronavirus my operation and pre op were cancelled for April. This left me lost, angry and with nowhere to turn to. I went back to my GP in March who organised blood tests and ultrasound scan. A GP rang me to inform me that the cyst had tripled in size and to 'just put a hot water bottle on it and carry on with Codeine'. I ASKED for a copy to be sent to consultant.**

**I have rang every week for answers. No one will get back to me. Have been told today to 'hang fire' till July for another scan and will only operate if in pain!**

**“Had my operation cancelled twice after a 2 year wait now spending every day of lockdown in pain with 2 children at home as I'm a single parent”**



**“My daughter has a brachial cyst in her neck and was due an operation in March. It was cancelled due to the virus and has been steadily growing now to the point she cannot move her neck and she can feel it when swallowing. We are extremely worried that it could burst causing infection likely to be sepsis.”**



**“My ex wife was due to have a procedure relating to a heart problem but when she arrived she found out from a minor technician that all these procedures where now cancelled. Nobody of note was available to explain.**

**As a result she has now been sick from work so long that she will soon stop getting paid her full wage and is very stressed and crying a lot. There is no new date for the procedure yet”.**

Some people told us that things would have been easier if they had received better advice and information to help them manage while they were waiting.

**“As expected and appreciate and understand the cancellation of my Spinal Steroid Injection for pain management. No further information given. Has led to substantial increase in use of Morphine & Fentanyl.**

**It’s severely impacted my mobility only getting 2 hrs a day out of bed due to excruciating pain. This in turn is impacting my mental health to a very low mood & zero motivation.**

**But I accept what his happening and just have to ride it out till things change and understand the strains my health trust is under so I'm not complaining. But wish some one had contacted me to discuss how to best manage my severe pain than leaving me fend for myself.**

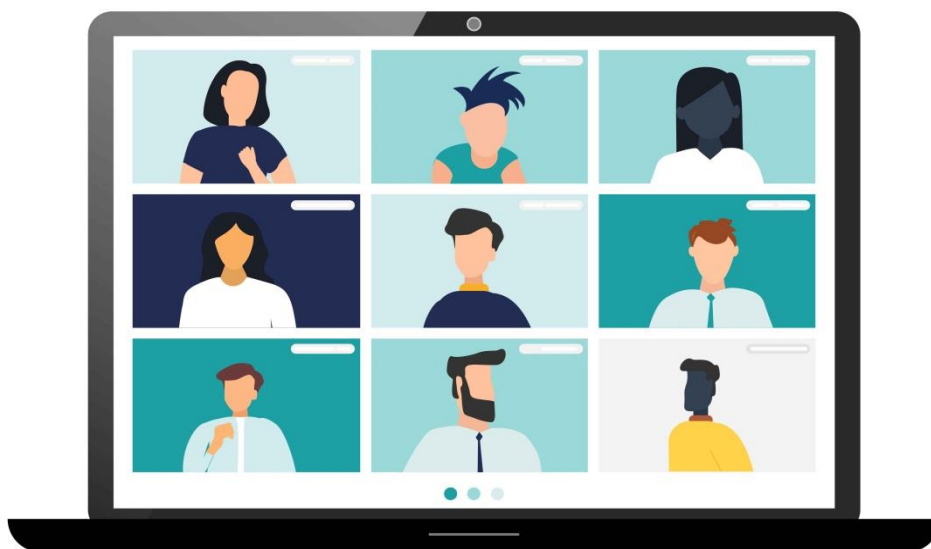
**Offered no support whatsoever but understand that pressures are being felt at my hospital so not blaming anyone. It is what it is and am sure I will get my procedure as soon as it's safe to do so.”**

## People having routine care for life-long conditions

We heard that for some people, their on-going care had continued, although in a different way.

**“My on going care for IBD ..... has been brilliant. Any question I have had has been answered by email v quickly by the IBD nurses sometimes within the hour I can't thank them enough...”**

**“I had my diabetic review from home using video call this is all very new to me and I felt very uncomfortable about it before hand. After I was talked through everything and had the call I was left surprised on how well it worked.”**



For many others, in the early stages of the pandemic their routine on-going care simply stopped. Sometimes, people were contacted a little later on with information about what might happen next.

**“COPD 23% lung function. All appointments stopped before my appointment at beginning of March for COPD check up. I've just been told they've been cancelled due to Covid 19, which is completely understandable.**

**I haven't been told if they will resume at any point and again as I am someone who has been shielding since I was ill in January I would not attend and appointment at the hospital anyway. I also was having fortnightly therapy sessions...., which owing to illness either myself or the therapist I haven't been to an appointment since December 2019.**

**She has rung me recently and stated there is a possibility of resuming our sessions via video link and will contact me when/if that becomes a reality. I haven't heard back from her in about a month so not available yet obviously.”**



For others, we heard there was no clear advice and information about the changes or when they might be seen again.

We heard from lots of people who rely on routine **B12 injections**<sup>4</sup> about their concerns that their treatment was being changed.

**“Near the start of the Covid-19 lockdown situation, I received a letter from my GP surgery saying that they were switching IM B12 injections to oral supplements.**

**This was obviously understandable under the circumstances, although the dose prescribed was 50mcg rather than 1mg which is the quantity recommended by NICE (see attached guidelines).**

**I queried this at the time and ended up having to buy B12 supplements at the correct level privately, which is an unreasonable expense for a known serious condition which should be covered by the NHS, particularly as I am a medical student myself and therefore not on a high income.”**

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<sup>4</sup> **Pernicious anaemia** is an autoimmune condition that affects your stomach. An autoimmune condition **means** your immune system, the body's natural defence system that protects against illness and infection, attacks your body's healthy cells. Most people can be treated with B12 injections or tablets to replace the missing vitamins.



Many people were really worried about changing from injections to oral supplements, as they had been told before this would not be suitable for them.

This made people doubt the advice and knowledge of their healthcare staff, and some people told us they felt their concerns went unheard.

**"..... has pernicious anaemia. She relies on B12 injections & was due to have one next week. She told me that her surgery are refusing to give her the injection and have told her she needs to take tablets instead. .... says WHO advice is that patients should still be having these injections.**

**.....has suffered with neurological problems in the past and she informs me that this injection is a life-saving injection for her. Her body cannot absorb the tablet orally which is why she must have an injection. She has explained this to the doctor at the surgery to no avail."**

**"Diagnosed as deficient in B12 in 2016. Have been having 10 week b12 injections and told no oral replacement would work and told how important it was to keep on top. During covid19 my injections have stopped and was advised to supplement with over the counter tablets and I will be ok.**

**This goes against all information the GP has told me for the past 4 years. This has increased my anxiety alone and generally leaving me doubting the advice given me now or in the past."**

For people living with **life-long conditions** like **diabetes**, we heard worries that the lack of regular monitoring and annual check ups is leading to bigger problems. We heard that some people felt abandoned.

**"they must not forget people with long term conditions. We are being abandoned."**

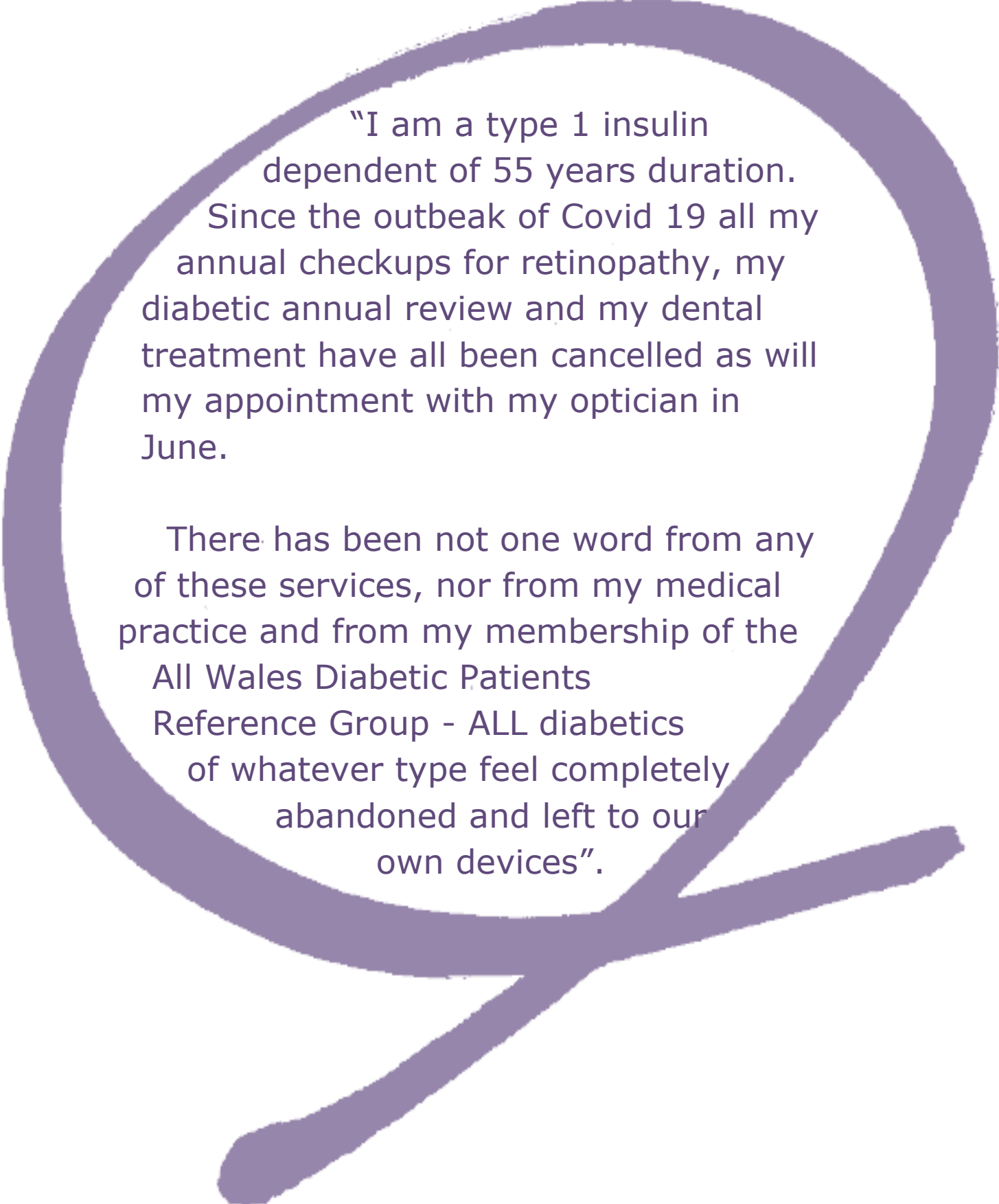
**"....letter to say all services postponed until further notice. Referred by podiatry about pressure area on foot and for potential review of footwear and caliper.**

**Also need to have shoes and caliper serviced regularly so as not to end up in position where I have nothing to wear and all appliance are in factory at the same time."**

**"My concern is that nothing routinely has been done, example 1 - my husband has not seen a diabetic nurse since last September, normally it used to be every 6 months, he has rang but the clinics were closed.**

**3 weeks ago I rang again, as he was due for annual checkup, they came and took a blood sample, shortly after a diabetic nurse rang and said she would put him in touch with a community diabetic nurse, she came last week and informed them he was having far too much insulin (cut intake by 10 units).**

**This is the first check in over 12 months and feels he could have died."**



“I am a type 1 insulin dependent of 55 years duration. Since the outbreak of Covid 19 all my annual checkups for retinopathy, my diabetic annual review and my dental treatment have all been cancelled as will my appointment with my optician in June.

There has been not one word from any of these services, nor from my medical practice and from my membership of the All Wales Diabetic Patients Reference Group - ALL diabetics of whatever type feel completely abandoned and left to our own devices”.

We heard that for some people, making decisions about whether to attend NHS places for check-ups would have been easier if they had better information.

**“I take my 90 year old mother for 6 - 8 weekly checks and injections at ..... clinic. My mother chose not to attend her next appointment as she is in a vulnerable category for Covid19.**

**She was contacted to see whether she still wanted the check but after discussion with me decided not to go ahead with the appointment. What would have been useful is more information regarding how this may impact her vision and to have a discussion in order to weigh the risks to make an informed decision.**

**Instead we were simply asked about the appointment. We hope we’ve made the right decision to protect her general health. But we simply don’t know whether we’ve jeopardised her visual (and therefore her independence) health. More information would have been useful.”**



## People needing follow up appointments after earlier care or treatment

We heard from some people that they were able to have great follow up care even though this was done in a different way.

**“Reason for the appointment was a blood test, which I need every 3 months following prostate cancer. Attending the surgery was different under present circumstances but the staff were careful and thorough. I also had an appointment for my Zoladex implant – again all went well, under present restrictions.”**



“The care during the pandemic has been amazing. The team have kept in regular contact via email / text messages / phone calls with any updates & have been offering Zoom meeting & virtual clinic appointments which have worked really well. They have even set up a virtual leisure centre which I've found so helpful during lockdown & shielding in order to maintain my lung health. Home spirometers were provided to be able to monitor my lung function at home. When I've had to visit the clinic for blood tests the staff have been really reassuring, wearing full PPE with robust procedures in place. I have been able to maintain access to all my medication that comes from the hospital & the Nurses were even bringing this to my car to prevent me having to enter the hospital.

The hospital has dedicated 2 parking spaces to CF patients which are by an entrance that's very near to the clinic, when I've needed to visit. Couldn't have asked for better care during a challenging time!”

For lots of people, we heard they had not had any follow up contact or appointments after the care or treatment they had received before the lockdown. This was a big worry for them.

**“my mum has chronic lymphocytic leukaemia and was due an appointment in April to check her bloods as they are climbing again. Obviously appointment was cancelled due to COVID like all other outpatient appointments but we don't know what happens next. No one has been in touch”.**

**“I had no follow up sessions for my hip replacement in February because they were cancelled.”**

For some people this was limiting what they do in their daily lives, as well as affecting their families and loved ones. For others, it was threatening their recovery.

**“Had to receive A&E care in May following which I was admitted to Cardiology. Care I received in Emergency department and on ward was excellent. However follow up care by GP was extremely difficult to access and resulted in several more visits to A&S for care reviews.”**



**"I have been seeing a Dermatologist..... since January. I was prescribed Isotretinoin for acne. This includes blood and pregnancy tests each month. My March blood test was cancelled and so was my appointment with the Dermatologist in March due to Covid-19.**

**I was told I would be contacted but wasn't. After a week of ringing his secretary, I had to send a photo of my negative pregnancy test. I was then sent a prescription by post. Today I tried to email for another prescription only to be told it is only prescribed for 4 months.**

**I am very disappointed about this as I was told by my consultant it would be for 6 months. My skin is not better yet and I have suffered side effects since taking the tablets.**

**I have now just been left in the middle of treatment with no contact or follow up appointment. I had been waiting for about 8 months to see the Dermatologist and feel it has been a waste of time. I've just been left. Very disappointed."**



**"I am worried about my eye care. I have had some laser treatment that stopped me from being able to drive for a bit. Then all of this started and I think I have not had an appointment when I should have.**

**I am the only driver in the house, my wife is disabled and we are not shielding. We are only in our fifties but we can't see our grandchildren now and we are worried about driving in the future if my sight gets damaged.**

**My wife is also a recently diagnosed diabetic. This whole situation has made us realise how vulnerable we are and more scared about how we will go shopping or get to our appointments or see our grandchildren again.**

**This is very depressing for us and makes our children worried too. I don't know when I will get another appointment or if I should risk going to it."**

**"I was given an appointment the same day after feeling suicidal in Jan 2020 at ..... I was offered advice and sent home with a referral to the community team. Who I am yet to hear from it is now May 2020. There has been no follow up what so ever".**

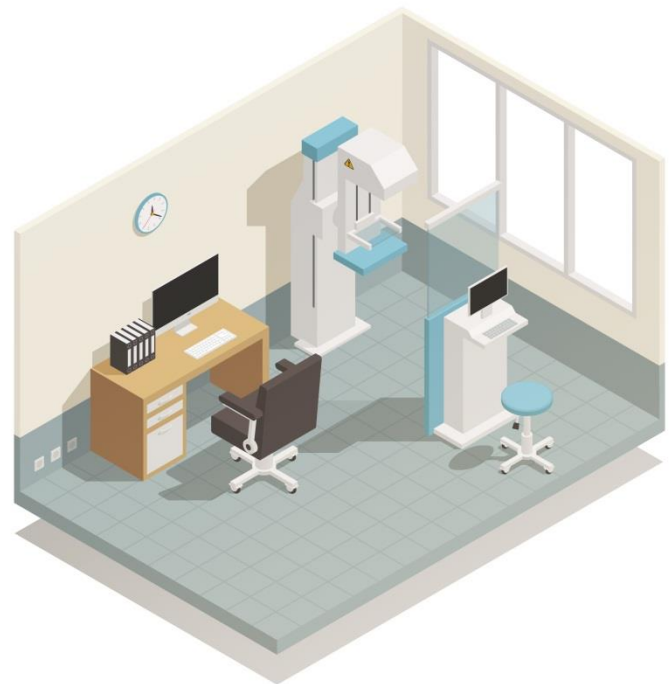
## People waiting for screening services

In the early stages of lockdown most screening services were suspended, although some urgent screening services continued. People were told that if they had any symptoms they should contact their GP without delay.

People were not always clear what they should do at this time. For some people, the messages from different parts of the NHS were not the same.

For others, not knowing when things might start again and how the NHS would deal with the backlog worried them.

For people who were due screening appointments following earlier treatment, the delays meant they felt even more anxious.



**“We are being told that we shouldn't miss serious issues, and screening etc. But it seems we cannot go to the surgery, so how does that work? People need to know what is available for them.**

**Also my smear test has been put back months, and I'm sure the situation is the same for thousands of others.....”**



**“Having a pain in my breast radiating to my underarm and down to my elbow I became concerned. After a month I phoned the breast screening and was given an appointment. However the virus struck and it was cancelled /postponed.**

**Concerned I phoned for a GP appointment but was told they were not seeing anybody in surgery but the Dr was making phone consultations. In order to get a phone consultation I had to detail my problem to the receptionist for her to consult with the doctor as to if he would make the call.**

**However she returned to the call to inform Dr said no need for an appointment just take paracetamol!!!!!!  
End of March, condition remains!”**

"I was told after my last cervical screening test (February 2019) that I should have another test in 1 year. I telephoned to arrange but was told that their allocation of appointments were all taken and to phone back in a few weeks.

It is difficult enough as it is to try and time these appointments around time of month and also childcare so I did not expect that (+ the fact that it takes a lot of courage to go arrange and go to these appointments in the first place anyway!).

By the time I was able to try again to make an appointment, we were in lockdown due to Covid-19. It is constantly at the back of mind that something may have changed since my last smear test. My mum had Cervical cancer at the age of 29."

"My daughter who is 28 was diagnosed with bowel cancer in Feb 19, she was due to have an MRI scan in April but it was cancelled, this is causing anxiety for us all as a family, we would like to know when routine screening will resume?"

## **Lockdown easing and the re-introduction of NHS services**

**In June, the lockdown restrictions started to ease. People were able to meet outside as long as they kept socially distanced, and families and others were able to create support bubbles. Shops selling non essential goods could trade again and places to eat also began to re-open.**

**Shielding ended for many people, although not for people who were at most risk from the virus.**

**More NHS services started to be re-introduced across Wales. This included screening services, as well as some eye care and dental services.**

**Many services were provided in different ways, using technology.**

As the lockdown restrictions eased, we heard from people who were frustrated that they were still waiting and couldn't get the care they needed, even though they had heard that their services had re-started.

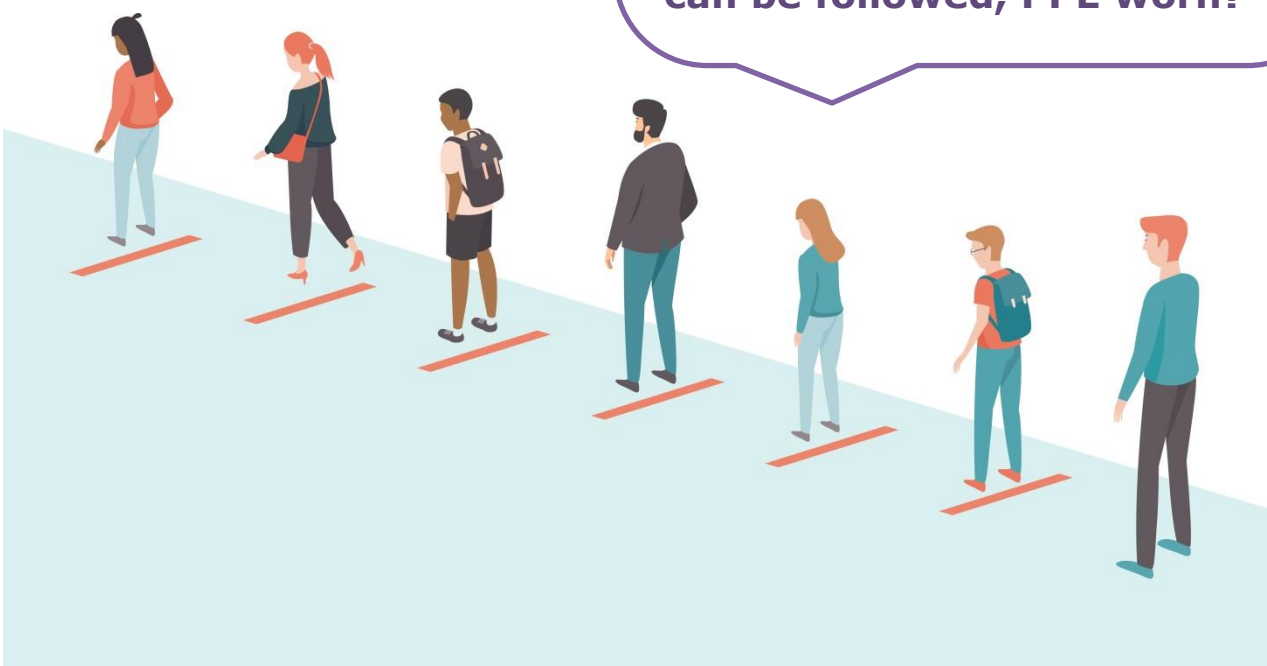
**"My husband's scan was cancelled and not rescheduled for 4 months. During this time, he had no face to face appointments with his consultant or any doctors at all - the cancer is back and has travelled to the lymph nodes in his neck. Had proper care been provided this could have been detected much earlier. I kept listening to the Health Minister say that the NHS was open for business.....I for one would say it wasn't".**

**“My GPs are still not doing cortisone injections. I am 63 years of age still working full time. I have worked every day through this virus but my knees are now so bad due to not being able to receive my cortisone injections I don't know how much longer I can go on for....”**

Lots of people felt that some NHS services were slow to re-open compared to other NHS services or wider services in the community, and didn't understand why this was happening.

**“Please resume normal health care for all, use social distancing and PPE, like everyone else has to. This is not fair.”**

**“I needed to see the Dr regarding eczema, but seems too difficult not things are done over the phone rather than face to face. Other medical places are open, I don't know why the GPs still aren't when social distancing can be followed, PPE worn?”**



**“IVF treatment has been cancelled. Despite the HFEA and Government announcing that it can resume the WFI have still not even applied to reopen.**

**The updates have been limited and I have heard from other people going through the same. No timeline is being given and when you are battling infertility it’s incredibly stressful. The impact that the delays are having on my mental health is substantial.**

**No support has been offered and it’s been very mixed messages on social media. I understand that the health boards are delaying it but it needs to resume now. Other NHS clinics are open and have restarted seeing patients but WFI seem to be incredibly slow and are dragging their feet.”**

When some services re-opened they were provided differently. Some people told us they wanted that to help them feel safe.

**“Screening appointment had to be cancelled March and still waiting for screening call (Breast)- Ophthalmology appointment had to be rearranged for August..... Make assurances that "business as usual" is safe - get the message out sooner and use the technology now available via video and phone”.**

**“Proper PPE and safety can and should be in place for dentists to carry out these treatments safely, so that patients can receive the level of care they deserve and that the NHS promises to provide.”**

We heard from others who felt that not being able to see healthcare staff face to face, or having to travel further to see their healthcare staff when services were reintroduced made things more difficult.

“People with long term conditions need regular face to face monitoring, especially as consultant appointments are now by phone. You need someone to actually see you. I had physio and 8 week post op all done by phone.

It is impossible to measure degrees of movement without physically seeing someone. I have had to choose my specially made shoes over the phone, not ideal.”







**“During the Coronavirus emergency my local surgery....has been closed. Every 10 weeks I receive a B12 injection, but at the beginning of the closure I was told my treatment was being suspended.**

**When it was eventually implemented I had to travel..... (having to catch 2 buses and a considerable walk - EACH WAY). I arrived at the stated time but was told I was half hour late (which I definitely was not) and had to go back home and come back in 2 days time again having to catch 2 buses each way and when you are not feeling well becomes exhaustive.**

**I contacted the Practice Manager regarding the reopening of the ... surgery but felt I was brushed off with the reply stating the reopening was under consideration for sometime in the future and to look at their website - which does not really tell you anything regarding the reopening”.**

Some people were relieved they didn't have to visit NHS premises but worried whether things would be missed if they were not seen face to face.

**"My diabetes care has mostly been phone based apart from blood tests. I have been a bit concerned that the usual hands on aspects have been missed I.e. Checking blood pressure, weight and foot care. I am still anxious about visiting the surgery but not sure what is worse."**

For lots of people facing continued delays, not knowing why or when their care might restart was particularly frustrating.

**"Whilst I understand that covid resulted in staff being relocated to work in covid wards I am left concerned that essential equipment and therapy stopped and has still not resumed. Patients have no idea when it will resume and in what form. Being offered a video call is no substitute for hands on help and therapy.**

**I would like to see a route map to get back to hands on therapy as it is not sufficient to say that it is no longer possible and Covid is likely to be with us all for years. The fear is that everything else will also stop until it is eradicated.**

**That cannot be acceptable..... communicate with users for the plan for their treatment/therapy/service to resume and in what period, what it will look like."**

**"..been waiting for an appointment since last October to see consultant about my knees had one letter to say they would contact me before lockdown Feb 2020, heard nothing contacted them to be told I was on a waiting list and it would be at least 6 months went into lockdown**

**- have heard nothing, contacted them last week and was told they are still not seeing anyone ..... I am now practically house bound being unable to walk any distance and in constant pain. Language used in letters need to be clear as to when I will be seen and any delay communicated with further dates."**

**"Communication, I understand why operations can't happen but keep me informed. The CMHT have no excuse really, all I need to do is speak to someone, the delay is bordering on cruel".**

**"Communication is key to help patients cope, i.e. reassurance that they remain on waiting lists and even if not known it would be great to know an approximation of when you may be seen or have treatment would make the wait a lot more bearable."**



**“Consultants and their teams should get in touch with people to explain why their illness isn’t important anymore. I’ve gone from having appointments every month to nearly 3 months without a single one.**

**My disease might be causing a lot more damage because it’s not being monitored when we know it is active. Also information on who to contact should you become unwell because I certainly don’t want to go to A&E as I’m in the shielding group... except I didn’t even get that letter until May!”**

During this time local health boards started to provide more general information about what was happening. This was found on their websites and in communities, explaining how local services were being provided during the pandemic, and when they were planning to re-introduce services.

Some local health boards are better than others letting people know what’s happening with their own care and with services more generally, including what the plans are moving forward.

As we moved into summer, when people started to be much more active in their communities and things were starting to feel as if they were getting back to some kind of normal, people started to get more frustrated that services seemed to be slow to restart.

Urgent care was being provided. NHS services were being re-introduced. Health boards were having to arrange services in different ways to separate patients receiving COVID care and those receiving non COVID care. However, many people didn’t know this was happening in their area.

People shared their worries that more and more people would become sick or get sicker with non COVID illnesses the longer it took to reintroduce services. Lots of people did not know what was happening with the field hospitals and whether these could be used to make a difference.

**“Use one hospital for non covid cases and one for covid cases so some planned operations could take place”**

**“The health service has not maintained its care of non covid patients and seems reluctant to restart.....Making services available again e.g.. checks in chronic conditions”**

**“I can understand operations were cancelled at the start but as soon as covid was under control all urgent ops should go ahead like other area, in particular children”**

**“It seems as though all other conditions, mine included (rheumatoid arthritis) have taken a back seat to the pandemic. More people are going to suffer because of lack of being able to get an appointment or treatment for non covid illnesses.**

**I suffer with rheumatoid arthritis and have not been able to see my rheumatologist or gp since March. I've been in pain and have been told to wait until the pandemic is over. I have a friend who was due to start therapy for trauma. I have another friend waiting for a cancer referral.”**

## **People facing cancellations and further delays**

Some people told us their appointments that had been arranged during lockdown were cancelled at short notice. This caused real difficulties for them and their families.

**"I received a date for an operation .... so promptly self isolated, took Covid test etc. On the morning of the operation the ward rung asking me if I was ready to go in earlier which I was. Just as I was about to leave the house the surgeon rang and said the operation was cancelled due to a lack of staff.**

**I was told to continue to self isolate which I have done so. We are now 2 weeks on and despite ringing twice, still have no rescheduled date for my operation.**

**This means myself and three teenagers have already self isolated for 1 month for no apparent reason. We have no symptoms, are not shielding and have no date. As you can imagine my teenagers are not too pleased with this. When I ring or email and ask they say it's up to the surgeon who does lists when it's rescheduled.**

**I read online that in England it must be rescheduled within 28 days. The lady ..... told me this wasn't the case in Wales, but it seems ludicrous to just leave people in isolation for no reason and just have people hanging on.**

**The fracture has had a huge impact on my life as I was super active before and it also means that I can't work.  
....."**

People were even more concerned about cancellations if they didn't know why the cancellation had happened, or when they didn't feel the information they got was helpful.

**"Be honest with your communication. If you have to cancel an appt, don't send out generic letters which don't apply during a ... pandemic."**

**"I think keeping peopled informed as to what is happening would be good instead of giving appointments and the cancellation with no explanation."**

Many people still hadn't heard anything at all about when they might have an appointment. For people who were still waiting for appointments since lockdown started, we heard how this was making more and more of a difference to their lives, both physically and mentally.

**"I suffer with menorrhagia and suspected endometriosis. I have been put on numerous medications and nothing has stopped the pain. I get fobbed off each time I speak to a doctor, and I have been waiting for my referral to come back from the hospital since May 2020. My pain is getting worse. Nobody is taking me seriously"**



**“Since being referred 6 months ago by my GP to MCAS, I still have not been seen. I live in constant debilitating excruciating pain despite strong painkillers. My pain is increasing daily and limits capabilities greatly.”**

**“My father has been waiting for a cat scan since March to see the cause of bowel obstruction. He is struggling physically and emotionally the wait.**

**My mother in law has been waiting over a year to see a geriatrician with Parkinson symptoms and now is deteriorating because of dementia symptoms with the shaking. Her appointments have been cancelled twice due to Covid.”**



## People with worries about further delays leading up to winter

As we moved towards the autumn, we started to hear more concerns that people waiting for services may have to wait even longer if they have to be stopped again during winter.

**“Currently waiting for 2 urgent orthopaedic surgeries and am concerned that they may keep being postponed over the winter meaning not only months more in pain while waiting but also more long term damage being done in the meantime.....”**

**“As a full-time carer, who is asthmatic and awaiting a cardio referral, I do feel anxious about the winter. .... We're still awaiting appointments that have been delayed due to Covid-19. We're hoping we'll get seen before we hit the winter period.”**

**“I had a hip replacement beginning of this year and was due another 12/14 weeks later. Due to Covid I'm still waiting, I am very concerned about this I have been on sick from work for a year ready. I need to get this sorted before another break out and the usual winter illnesses.....A quick hip replacement so I can work and look after elderly parents”**



## **Dealing with the backlog and planning for the future**

As the pandemic continued to affect NHS care and treatment across Wales, people's concerns grew about the size of the backlog being created.

People worry that the NHS was struggling before, and want to know more about how it will catch up in the future. People want to be involved in planning for the future.

**"I can't see them catching up with the backlog unless plans are put in place. Inevitably, people will die of other illnesses, because the system was struggling before. It would be nice to see what plans are afoot to catch up with other health issues".**

**"I understand we are in a very difficult time, but in my professional opinion the surgery and other services offered by the Health Authority have been reduced by too much and you should be using your influence to encourage more face to face activity or we will find ourselves in another health pandemic caused by the backlog of undiagnosed illnesses during the current COVID-19 pandemic in the next 1 - 5 years."**

**"Liaise better with individual citizens, voluntary and council services to ensure solution are always co-produced and everyone is involved in planning, delivery and evaluation of our health service".**

## Reintroducing services at different times

CHCs know that there are differences across Wales in the way that services are being re-introduced.

We know that sometimes, this variation is because NHS staff may be unable to do their usual work because

they are needed more elsewhere or because of their own personal situation. It may be because NHS premises are not available to provide services in a safe way, or there may be other reasons.



If a certain kind of operation or treatment can be restarted in one area of Wales (or England), it doesn't make sense to people that it isn't available in another area, or if it takes much longer for people to be seen in one area than another.

People will feel this is unfair if no one explains the reason for this, and what is being done to make things better.

It is important that the different NHS bodies in Wales work together to make sure that decisions about restarting services get the balance right when thinking about the impact on people of waiting for treatment.

In November 2020, the Welsh Government started letting people know again about the numbers of people waiting for NHS care and treatment in Wales.

This will help make it easier for everyone to see where there are differences, to find out more and let people know why

there are differences, and to take action to make things fairer where this is needed.

## Learning from what we heard



**"I'm worried that the NHS is currently a Covid service."**

Throughout the pandemic, CHCs have heard the grateful thanks from people in Wales for everything health and care staff have done and continue to do to care for people when they are ill. We hope the feedback people have shared helps NHS staff and others to recognise and value what has worked well for people so far.

We also heard the heartbreaking and devastating impact on many people whose care and treatment has been delayed because of the pandemic. We heard the worries people have about becoming ill in the future because vital early detection has not always been possible.

We heard the difference it makes to people when they know and understand what is happening with their care and treatment, and where they can go to get further advice and support. This makes any delay easier to manage.

When this doesn't happen, people get more anxious and concerned – particularly if they don't know the reasons why or when they might be seen. They worry about being forgotten in the system, and often don't want to bother the NHS to find out at such a busy time.

**NHS bodies in Wales** need to respond to the worries people have shared with us by making sure:

- healthcare staff keep in regular touch with people waiting for care and treatment. This will help them know what is happening, how long they might need to wait, the reasons for the delay and what the delay might mean for them in the longer term
- people waiting for care and treatment know how to get advice and support while they are waiting
- healthcare staff involve people in discussions about the benefits and risks of treatment during the pandemic. This will help people feel involved in the decisions being made and that they have control over their own lives through shared decision making
- they explain clearly and simply when changes need to be made to the way services are provided during the pandemic, and what this means for people attending for care and treatment
- they provide up to date, clear and simple information about how local NHS services have changed during the pandemic, and what the plans are to reintroduce services
- they reach more people who may not be able to find things out by looking on-line. Not everyone has or is able to use a smartphone, tablet or computer. Accessible, up to date information should also be shared in other ways through community networks and groups.





The **Welsh Government** needs to make sure:

- healthcare services in Wales get things right in balancing the harm caused by or as a result of the coronavirus pandemic
- all NHS services for people living in Wales are reintroduced as soon as it is safe to do so, taking action to identify and address any unnecessary differences across Wales.

People living in Wales know and understand there are big challenges facing the NHS in the years ahead as it tackles the harm caused by the coronavirus pandemic. It will be as important as ever that it does so by involving people in developing its plans and designing its services for the future.

# Thanks

We thank everyone who took the time to share their views and experiences with us about their healthcare services and to share their ideas.

We thank the healthcare staff who are working so hard to care for people and their loved ones during the pandemic.

We hope the feedback people have taken time to share influences healthcare services to recognise and value what they do well – and take action where they need to as quickly as they can to make things better.

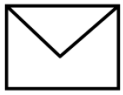
# Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.





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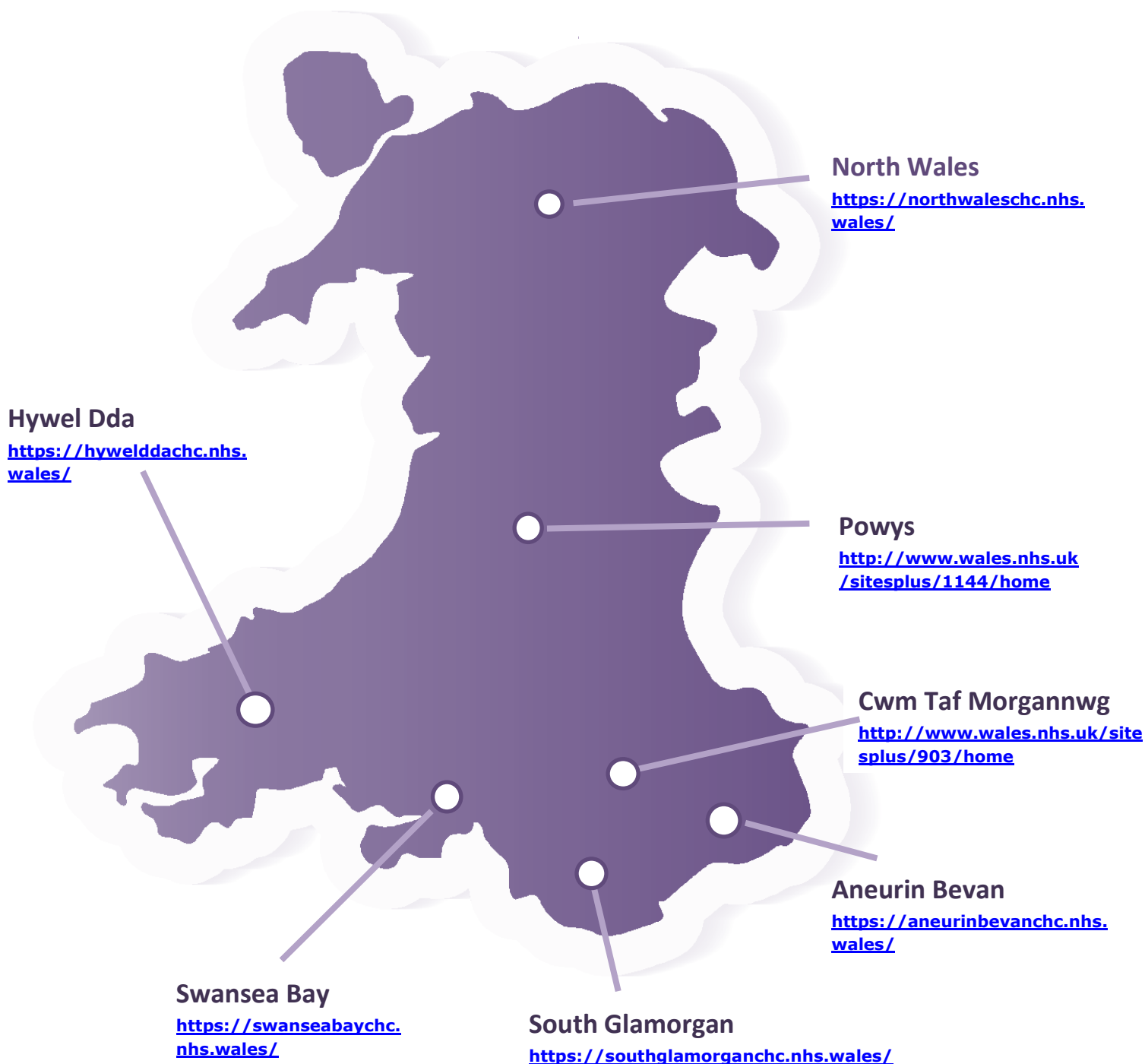


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# Agenda Item 3

## Evidence submitted by the Royal College of General Practitioners Wales to the Welsh Parliament Health, Social Care and Sport Committee inquiry into the Covid-19 outbreak on health and social care in Wales

Thank you for the opportunity to contribute to the inquiry into the Covid-19 outbreak on health and social care in Wales.

We would first and foremost like to recognise the tremendous dedication and work of all health and social care professionals along with other key workers during this most challenging of times.

Before addressing individual issues, the College would also like to put on record its appreciation for the way in which NHS Wales and Welsh Government have engaged with us, listened to our concerns, responded swiftly and considered our ideas. It is hoped that when we reach the 'new normal' post-Covid-19 that these constructive relationships will be maintained.

Our further comments are noted below by subject:

### Technology

- The rapid roll-out of remote consulting software and accompanying engagement from NWIS is to be applauded.
- The functionality of the Attend Anywhere software is limited in comparison to Accrux, with the latter tending to be the preferred choice of GPs. It is appreciated that in other areas of the health service Attend Anywhere may be preferable.
- An alternative to the charge of £85 for a remote working code-generator was appreciated, although it would have been helpful if this option had been introduced and publicised at the point when home working was required.
- The need for GPs to be able to utilise the latest technology for the benefit of their patients has been further highlighted by the pandemic. Urgent investment is required in general practice technology to bring it up to the highest possible standard and ensure the infrastructure is in place to make the most of new technology. Currently, ultrafast broadband coverage across Wales is the lowest of all the other nations in the UK – with only a third of the country being provided with 300MBs broadband.
- The College has previously called for the swift roll out of electronic prescribing software. Had this been enacted it would have been very beneficial during the pandemic. We would reiterate this urgent request and suggest that such a move would be very much in keeping with the new ways of working.
- Consideration must be given to how marginalised patients and those from economically disadvantaged areas can engage with technological advancements in primary care.
- The rapid roll out of the 111 telephone service across Wales was very welcome.

### Consultations

- For many consultations video and telephone have proved sufficient in replacing face to face. However, this is not universally the case either in terms of the ailment or of being the most appropriate for the individual patient. While there will be no turning back from the welcome technological advances we must not lose sight of the continued importance of the face to face consultation and the balance between them.

- We need to remain mindful that these technologies do not work for all patients and should emphasise the potential health inequalities impact of the GP model moving too far in this direction long term.
- The additional flexibility of remote consultation might appeal to GPs who are interested in taking on extra shifts but require a flexible work / life balance.
- It is also possible that this new flexibility of consultation format could facilitate access during extended hours. If this were to be the case it is important that the future workforce has sufficient capacity.

#### Personal protective equipment (PPE)

- It was apparent that there was insufficient resilience in the supply of usable PPE. At our first request to Welsh Government regarding provision of PPE we were informed that no provision was planned for GPs at that stage. This position rapidly evolved though the initial supply of PPE was patchy, poorly communicated and lacked clarity over the proper use of equipment. A further supply of stock was a marked improvement, although it took another upgrade until GPs had usable eye protection. By this time many GPs had purchased their own makeshift protective wear from online hardware retailers. It is entirely accepted that this is an extreme situation and that there is global demand on the supply chains. However, one of the lessons which should be learned from this pandemic is a need to shift focus proportionately towards resilience of supply and away from 'just in time' delivery which while sufficient in normal times was found wanting in a crisis.
- It is our view that primary care must be an integral consideration in future planning for PPE provision and resilience strategy.

#### Shielding

- Delays in shielding letters led to confusion for patients and GPs with information appearing in the media and on official websites before the letters were received.
- The decision to link shielding directly to provision of services such as prescription collection and supermarket deliveries created an unintended consequence that led to inclusion on the shielding list being desirable which in turn increased workload and put pressure on GPs to provide letters.
- There was miscommunication regarding Advance Care Planning (ACP) which led to some distress. When one controversy received news coverage it became even harder for GPs to have these vital conversations with patients. ACP is good medical practice and it should be part of routine primary care for health professionals and patients. In retrospect a better approach would have been for a clear message from Welsh Government that there was a need for ACP conversations and that these would be about best understanding the most comfortable environment for a patient while ensuring they were receiving all appropriate care. That would have then framed the conversation allowing GPs to have productive conversations with patients. As it was, GPs were having to broach the subject and then with undue haste, go into the more sensitive aspects of ACP.
- There was a need for earlier and clearer dialogue on messaging in consultation with front line clinicians.
- It is unclear to the College as to the extent of conversations between Welsh Government and organisations representing older people and extremely vulnerable patients. However, such discussions taking place prior to the issuing of shielding letters could have established greater

understanding of ACP. Working collaboratively with the relevant stakeholders involved, it should have been possible to ensure a consistently compassionate tone for such sensitive discussions

- A related matter was the conflation of ACP with the Do Not Resuscitate (DNR) instruction. ACP is good medical practice when carried out sensitively. ACP covers a far wider remit and should have been the focus with issues of DNR left primarily to the patient to raise unless specific circumstances made it relevant for the GP to do so. This conflation was not the responsibility of Welsh Government or the NHS, but rather a consequence of the overall short-comings regarding the communications around this most sensitive of topics.

### Care Homes

- GPs have continued to be available for care home work, but there have been instances in which lines of communication have not been what they should have and an improved procedure for care homes to notify GPs when residents are unwell would be beneficial.
- We have concerns about the limited supply of PPE for use by care home professionals and the level of guidance provided with regard to the correct use of PPE.
- Care Homes are particularly susceptible to virus outbreaks including more common diseases such as norovirus or flu. Greater training for care home staff in communicable diseases and appropriate procedures in the case of an outbreak would help with future incidents. This training opportunity would also seem to fit with the Welsh Government's aim of advancing social care work to a parity with that of health care. GPs regularly meet care home staff and are impressed by the skills they possess. Further formal training could bring with it accreditation.
- There is a need for greater consideration when discharging patients from hospital back into care homes. Regrettably, there were instances of infection spreading in a care home following a hospital discharge.

### Multi-disciplinary team

- It came to our attention that Health Visitors were re-deployed leading to some areas having a delay in referrals. This is unacceptable at a time when vulnerable children were being isolated at home and when there was a documented increase in domestic violence.
- District nursing teams have reported a lack of PPE which is essential if they are to appropriately provide palliative and other care in the community.

### Communications

- It is appreciated that the challenge of communicating different approaches taken by the Welsh Government to that of the UK has been a twenty-year issue. However, the topic is specifically relevant at a time of emergency in which the public are concerned. We feel that there has been a failure in the way announcements have been communicated to the public during this period. One example was the announcement to test all over 65s and care home residents in England but not in Wales, though Wales later adopted the policy in regard to care home residents. Under the devolution settlement, it is right and proper that both nations should make their own decision on policy based upon the scientific evidence. Furthermore, it is accepted that this will, on occasion, lead to divergence in approach. However, the communication of such divergence must be clear to patients. A further example of public

confusion related to the launch of the NHS Volunteer scheme which received great publicity from UK Government, but the Welsh equivalent lacked such profile of promotion when launched. We think it is essential that announcements made by UK Government are clear with regard to which nations they relate and where the media conflates England and the UK it is appropriately challenged. In normal times confusion over what is devolved can be an inconvenience, in times of a crisis it can cause unnecessary worry to an already concerned population.

- Related to the previous point, the College believes it is essential that Welsh Government and NHS Wales officials are fully informed of UK Government decision making prior to public statements and vice versa.
- It was noted at the time when those with symptoms were encouraged to make use of online services before contacting 111 by phone, that the NHS England 111.nhs.uk website simply rejected postcodes from Wales with no advice. A separate Welsh symptom checker existed, but with no link to it many patients will simply have concluded they had to phone 111 adding to already congested phone lines. The College raised this matter at both a UK and Welsh level. The response from Welsh Government indicated that there was awareness of the issue and a request for a link to be added had been submitted. It nonetheless took a few days for something as simple as adding a link to a website, typically a five-minute task at longest for most website editors.
- Where Welsh Government consciously chose to diverge from what was being announced at a UK level we think it important that this is clearly communicated with an explanation as to why it is the case. This should be tailored to inform the public.

#### Non-Covid work

- Initially, routine GP appointments were down compared to usual numbers. This is concerning as it suggests much routine care was not being accessed. This rebounded considerably following publicity from Government, NHS and the College to encourage those who needed an appointment to seek one. However, we do feel that this message must be sustained for the duration of the time while restrictions on public movement remain in place.
- There will be an additional wave of work as routine appointments pick up after some were paused to increase capacity to manage Covid-19 resources. We know from previous epidemics and pandemics that a divergence of resource can have a significant wider impact on health and wellbeing. For example, during the 2014 Ebola crisis, as many people died of untreated malaria, HIV and TB as died of Ebola. In 2009 during the flu epidemic in the UK there was a significant increase in deaths from strokes. There is a risk that the obvious emphasis on Covid patients will result in treatment for other health conditions being delayed if patients do not present in primary care.
- We should plan on the basis that there may be increased work from Covid survivors such as ongoing respiratory and renal impairment which will impinge on primary care workload.
- A particular concern relates to mental health support. The prevalence of Covid-19 and associated lockdown is likely to have led to some cases becoming more acute and the lack of normal routine a challenge for the wellbeing of many. After lockdown we are expecting a surge in those with negative mental health symptoms among patients with anxiety, agoraphobia, OCD, depression etc. This could include unique Covid based problems and severe grief reactions as a result of distancing and in terminal phases of life and restricted funerals. A further consideration would be mental health issues such as post-traumatic stress

following admission to intensive care units. Capacity in primary care for talking therapies must be available to cope with this increased demand.

#### Wellbeing of GPs and their colleagues

- There need to be concerted resources made available for health professionals' mental health and supporting them, including coping with stress. Burnout will be a huge risk after this crisis, with workload in general practice increasing and we need to be sure that there is support for professionals across the NHS where needed.

#### In conclusion

General practice has proved to be highly innovative and adaptable, moving the majority of work to remote consultations, making use of technology and rapidly embedding that technology to deliver care in a way that is safe for patients and doctors at this time. Our members have continued to provide continuity of care for those people who had Covid-19 and were referred back to the GP surgery, or who chose not to go to hospital, having follow up conversations with clinicians who know them.

RCGP Wales has worked constructively with NHS Wales, Welsh Government and health sector organisations including the BMA/GPC and Academy of Medical Royal Colleges, Wales. We will continue to do so as Wales seeks to minimise the impact of Covid-19.





## Community Pharmacy Wales response to the Health, Social Care and Sport Committee Inquiry into

### **The impact of the Covid-19 outbreak, and its management, on health and social care in Wales**

Date January 2021

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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 Assembly 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 713 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 sometimes 7 days a week, include Emergency Contraception, Discharge Medicines Reviews, Smoking Cessation, Influenza Vaccination, Palliative Care Medicines Supply, Emergency Supply, Substance Misuse and the Common Ailments services.

The normal functioning of the community pharmacy network in Wales has been significantly disrupted by the Covid-19 outbreak and as more and more GP practices moved to working behind closed doors the network found itself very much on the frontline of the primary care response to the outbreak. Now that we are eleven months into the outbreak, it is an opportune time to take stock and to reflect on our response to date ahead of a more formal review when the outbreak has passed.

CPW is therefore pleased to have the opportunity to respond further to this important inquiry.



## Part 2: The impact of the Covid-19 outbreak in Wales – recap on the early months of the outbreak

When we last gave evidence to the Committee on the impact of Covid-19 in May 2020, we grouped our evidence around the three themes below:

**1. The adaptation of the network:** As the public became alert to the potential of a lock down panic set in, with patients, whose health is dependent on a regular supply of prescribed medicines, understandably seeking to secure their future supply of medicines. There was a sudden and dramatic increase in requests to GP practices for repeat medication and in patients visiting their local pharmacy to obtain common medicines such as paracetamol and ibuprofen together with antibacterial products. There was a significant increase in prescription numbers, putting pharmacy teams and the medicines supply team under significant pressure.

The inadequacies in the current repeat prescribing arrangements were cruelly exposed and resulted in unnecessary pressure on both prescribers and dispensers. The lockdown period resulted in many more people self-isolating and despite messages to encourage patients to ask family members and friends to collect their medicines for them, the demand for medicines to be delivered was exponential with a trebling of workload.

Contractual requirements were overhauled so that the pharmacy network was able to focus on the priority activities of medicines supply, health and advice and the management of common ailments. This allowed the pharmacy network to focus on medicines supply and during this period community pharmacies were the only primary care contractors to keep their doors open.

**2. Protection of patients and the members of the pharmacy team:** As the aggressive nature of the virus became clear, community pharmacy teams quickly established infection control processes. Despite pulling out all the stops, members of the pharmacy teams often felt extremely unsafe and often had to own source their PPE. There were also issues around accessing tests.

**3. The financial impact on the network:** The outbreak took a financial toll on the network with the almost complete loss of non-healthcare sales income while at the same time we had to invest in safe distancing reducing efficiency; additional security; additional staff hours to meet increased workload; vastly increased medicines delivery; and advice and support on self-care. Since all of these elements bore additional cost we made good on a Welsh Government pledge to provide additional funding for the extra costs incurred by the network.

On 23<sup>rd</sup> December 2020, the Board of CPW accepted the offer of £5m from the Welsh Government towards covering our additional costs. In doing so we noted



that this will meet less than half of the costs actually and necessarily incurred by contractors to meet the challenges arising from Covid-19 in the first wave. The letter from CPW to Welsh Government accepting the offer is contained in an **Annex** to this submission.

### Part 3: The impact of the Covid-19 outbreak in Wales – Summer to end 2020

During the remainder of 2020 the demands on the community pharmacy network continued with little respite. We have grouped the main activities together under a series of headings below.

**1. Flu vaccination:** A central focus was on delivering flu vaccinations before and during the second wave of Covid 19, fully aware that the challenges during the autumn and winter might be even more acute than the first wave. 595 of 713 community pharmacies took part in the flu vaccination programme, which of course was more extensive than ever before since the cohort was expanded and from December flu vaccination was offered to individuals aged 50 to 65 years.

Here are the most up to date figures for the way in which community pharmacy performed:

	19/20	20/21
Sept	<b>1652</b>	<b>16464</b>
Oct	<b>38914</b>	<b>45687</b>
Nov	<b>16225</b>	<b>11475</b>
Dec	<b>4965</b>	<b>14615</b>
Jan	<b>1405</b>	
Feb	<b>442</b>	
Mar	<b>491</b>	
<b>TOTAL</b>	<b>64094</b>	<b>88241</b>

We believe this 37.7% increase on the flu vaccination delivery in 2019/20 through community pharmacy is a remarkable increase. We would also argue it could have been even more – maybe two or three times as high as November 2020 - if there hadn't been such a delay getting the Welsh Government vaccine into pharmacies as most pharmacies had run out of vaccine by the second week of November and some by the end of October. This delay may well have dissuaded many people in the 50-65 age brackets from having their vaccine if they were unable to access it.



**2. Advice Services:** Community Pharmacy Wales agreed in August 2020 to commission an audit designed to capture information regarding the range of unremunerated advice that pharmacies are giving to patients and local communities. The purpose of the audit was to help CPW assess the extent of these informal consultations as well as their impact on the patient and wider health care system. In total, over five hundred community pharmacies responded to the audit.

The key findings of the audit of pharmacy advice were:

- On average, each pharmacy recorded an average of 15.5 consultations per day. When extrapolated upward across all Welsh community pharmacies, this leads to over 11,000 advice consultations occur per day.
- These consultations included responding to symptoms (59%), advice relating to a known medical condition (19%) along with other types of intervention.
- Each consultation took on average 6.4 minutes with 16% combining both the pharmacist and a non-pharmacist. The average length of time a pharmacist spent with the patient was 6.1 minutes and for a non-pharmacist, 3.9 minutes. This means the average pharmacy spends 99 minutes per day in consultations with patient.
- Of these consultations, 14% were onward referred to the GP practice, however had the pharmacy not been there, 53.2% (5,308) of patients reported that they would have visited their GP practice in the first instance. This would have resulted in an additional 35,300 surgery consultations per week or, and additional 86 appointments in each of the 410 Welsh GP practices per week. A further 3.1% would have visited A&E or Minor Injuries resulting in an increase of 2,000 appointments per week.

Over eleven thousand advice sessions per day is a huge amount of engagement and equates to saving over thirty-five thousand GP appointments and two thousand A&E appointments. This demonstrates without question the huge value that community pharmacies possess in relieving stress on other parts of NHS Wales.

**3. December pressures:** With the announcement of a new lockdown for Wales at the end of December, in the middle of the busiest two weeks of the year for community pharmacies, the network once again experienced a significant rise in demand for our services. We took urgent steps to communicate with the public in a Christmas appeal for them to be patient and responsible and to remember that medicines will continue to be available and they can wait till their due date to collect them.

## Part 4: The impact of the Covid-19 outbreak in Wales – Vaccination

The focus of the community pharmacy network is currently on being actively involved in the roll out of the Covid-19 vaccine in Wales. On 14 January 2021 we issued an Action List as a public statement, the contents of which mirrored a letter sent to the Minister and were based on a 'four approach' call.

**1. A NATIONAL APPROACH:** We welcome the fact that a Patient Group Direction (PGD) applying in exactly the same way to every Local Health Board has been developed for the first time alongside a National Protocol. Taken together, these documents standardise service across every LHB. A service specification, the Primary Care Covid-19 Immunisation Service (PCCIS), has been developed for use by primary care contractors in Wales including community pharmacists. This allows significant freedom at Local Health Board level in the design and commissioning of services. Community Pharmacy Wales would prefer a single national plan for Wales for Covid-19 vaccination in primary care accompanied by a single national booking service. This would avoid the potential of different commissioning arrangements and lessen variability in vaccine rates.

**2. A MAXIMUM COMMISSIONING APPROACH:** Community pharmacies need to be involved at scale in providing the vaccine. To date (as of 14 January), only Hywel Dda LHB has even asked for expressions of interest from community pharmacists in participating in the PCCIS and even there those contractors who have expressed an interest have still not been commissioned. Everything needs to be sped up. At a minimum, all community pharmacies who currently deliver flu vaccine should be immediately invited to participate and absolutely no community pharmacy that expresses an interest should be turned down. There also needs to be confirmed extended opening hours and a clearer indication on supply volumes for all community pharmacies to meet as much demand as possible. There are around 600 pharmacies currently accredited to deliver flu vaccinations and if all these were doing, for example, just 10 Covid-19 vaccinations a day then it would equate to more than 6000 additional vaccines per day being delivered in a convenient and accessible setting.

**3. A WHOLE TEAM APPROACH:** There needs to be trust in the whole community pharmacy team to deliver to their fullest possible capability. To utilise the full team approach, CPW would like to see the National Protocol offered to all community pharmacies alongside the PGD service so as to include qualified pharmacy technicians and pre-registration pharmacists, provided they have completed the necessary online accreditation. They are skilled and professional members of the community pharmacy team and could double or treble the amount of vaccinations possible in a community pharmacy setting. Similarly, pharmacy support staff can also play their part to support the administrative process. Access to the Welsh Immunisation System (WIS) should not be confined just to community pharmacists but should be opened up



to other members of the pharmacy team, so that support staff can do the necessary administration in a single portal entry rather than tying up valuable community pharmacist time or duplicating efforts, as well as other vaccinators recording their own vaccinations.

**4. A FULL PRIORITISATION APPROACH:** While recognising this vaccination programme will be complex and challenging, Community pharmacists are ready to be utilised in maximising their role in vaccine delivery with urgency and determination to as many of the categories of people to be vaccinated as possible. We want to prioritise Covid-19 vaccine delivery in our daily work and play as full a role as possible in rolling out of the vaccination programme as quickly, broadly and safely as possible be it through on-site provision in community pharmacies, a trickle approach or a larger clinic approach. All options should be included to allow community pharmacy contractors to choose the right option to meet both the needs of their business and support the health of their local population.

Further to this Action List, every LHB in Wales has now finally issued a letter for expressions of interest in becoming part of the Covid-19 programme, with Swansea Bay issuing an EoI as late as 20<sup>th</sup> January. They also used their own form, as did BCU, instead of the standard EoI form used in the other five other LHBs. SBUHB are also asking contractors to have oxygen for resuscitation available (nobody else has asked for this) and this issue has been raised with the LHB.

Another important development was the pilot was carried out in Llanbedrog, Gwynedd from 14 to 16 January 2021. The outcomes of this pilot were:

- 115 vaccinations were carried out over the three days, the majority of these were provided in the pharmacy but some were delivered in care homes.
- During the pilot all access to WIS was pharmacist only which slowed the process down, support staff would require specific log-on codes to access.
- WIS was straightforward to use.
- Appointments – during the pilot the pharmacy had to book patients in themselves (using lists provided by GP practices), ideally appointment booking should be available centrally supported by LHB.
- Trialled both a 2 pharmacist model and single pharmacist model – both were achievable (and other services also provided).
- Potential to vaccinate 1 patient/ 5 minutes – if support staff able to do the admin functionality on WIS. In pilot was approximately 10-15 minutes per patient for the pharmacist to do it all (N.B. elderly cohort so extra time needed).



- Off site provision – access to WIS off-site using mobile phone as a hot-spot for laptop worked well, no issues.
- Need for a reserve list for additional doses in vials/ DNAs.
- Following the pilot a further supply of 10 vials have been provided and the three other pharmacies owned by the contractor have been commissioned (but only 10 vials between them).

Further to the pilot, 4 community pharmacies run by the contractor in the pilot have been commissioned to deliver a service in North West Wales, and the experience there has shown very positive feedback from elderly patients who were appreciative of a more localised service which enabled them to reduce travel distances.

The ongoing use of WIS also reinforced the need for community pharmacy teams to have fullest possible access to the system. Practical use of the system also repeatedly highlights the inadequacies of the system of booking in vaccine appointments. We fear that the continued use of a WIS system which is only partly accessible to community pharmacists and which does not utilise a national booking system will result in confusion, duplication, repeat appointments and wasted vaccine as the vaccine programme is expanded to include more providers. The way in which WIS is being utilised is a ticking time bomb for the whole vaccine programme.

At the time of this submission, we would contend that all four points in our Action List remain live, and their content is supported by the results of the subsequent pilot. It is important to remember that apart from the example above, no other community pharmacy anywhere in Wales has been begun delivering the service. Across all LHBs there have been updates which have been light on detail with little clear confirmation numbers or timescales said to be dependent on supply. We have noted that in some LHBs there seems to be unfair professional resistance to the use of community pharmacies in Covid-19 vaccine provision.

**Group 6 Onwards:** As the phased roll out of Covid-19 vaccination continues, we believe that community pharmacies can play a key role from Group 6 onwards. That is not to say we cannot help earlier, but we think this once we reach the working population (Group 6 and below) we are well placed to play a key role in vaccinating as many people as possible. Since there is still some weeks before we reach Group 6, there is plenty of time for LHBs to plan to utilise us to the maximum degree at that point. However, we would urge LHBs to start that process now, including commissioning and the planning of the distribution of vaccine. Again, unless this is done with urgency and pace, then this transition phase to a wider cohort at Group 6 is another ticking time bomb in the vaccine programme.





**Mass Vaccination Centres:** We would also like to place on record an additional concern. Many responses by Welsh Government ministers, including the First Minister, to questions on community pharmacy involvement have included reference to Mass Vaccination Centres. While MVCs are undoubtedly a key part of the roll-out they are not necessarily the best place for community pharmacists since if a community pharmacy is without a qualified pharmacist it cannot dispense. The last thing anyone would want is that a community pharmacy network that has continued to open and operate for the last ten months is brought to a standstill by diverting the pharmacists to MVCs. Their skills are generally better deployed in the community pharmacy setting, with perhaps some locum pharmacists despatched to the MVCs.

## Part 5: The impact of the Covid-19 outbreak in Wales – The Future

CPW is determined to learn from that experience and to ensure that it should influence the priorities of the sector, which we trust, will translate into the policy framework of the Welsh Government formed following the 2021 Welsh Parliament elections.

**THE COMMUNITY PHARMACY CONTRACTUAL FRAMEWORK:** The existing Community Pharmacy Contractual Framework was agreed almost two decades ago. CPW is currently working with Welsh Government to agree a substantially revised NHS contractual framework that will see the first major contractual change since that time placing much more emphasis on the clinical role that pharmacies provide.

The Covid-19 outbreak has really driven home the importance of the efficient supply of medicines in the community and has demonstrated the real advantage of the Welsh Government's strategy of ensuring that there is a local pharmacy in every community across Wales. To enable the new CPCF to function, we wish to see an expanded suite of universal national community pharmacy-based services, available from every community pharmacy in Wales with consistent service specifications. Embracing a standardisation of services result in consistent Wales-wide commissioning of community pharmacy services, improving quality and eliminating local differences.

**INDEPENDENT PRESCRIBING:** These reforms must also be matched by an expansion in the number of Independent Prescribers with the aim of having one in each community pharmacy by 2030, ensuring that all Community Pharmacist Independent Prescribers are properly utilised with fully commissioned services. In addition, with issues around the supply of medicines during the COVID-19 pandemic, the limitations on what a pharmacist can and cannot do have been highlighted, especially in relation to therapeutic substitution and generic substitution. We need to really empower pharmacists and enable them to be



able to make these small changes to prescriptions. That would require legislative change from UK Government.

**INFORMATION TECHNOLOGY:** There should be a single patient digital record for patients in Wales that community pharmacies have access to and is used by all providers of clinical services (whether that is GP/ secondary care, community pharmacy or whoever). The archaic system of still having green pieces of paper moving between GP practices and pharmacies, often via patients, must end. The crisis has highlighted the inefficiencies of paper based prescribing systems. A key priority for the next Welsh Government must be the development of a system that will enable the electronic transmission of prescriptions.

This will also facilitate improvements in the existing Repeat Dispensing service by transferring the management of repeat prescriptions from General Practice to community pharmacy. These developments in digital technology must ensure the ability of GP and community pharmacy systems to talk to one another. In the meanwhile, immediate steps must be taken to move a significant number of patients over to the Repeat Dispensing /Batch Prescription Service.

CPW would suggest that one of the key priorities following this outbreak is to introduce an efficient electronic prescription service and move the supply of repeat medication from GP practices to community pharmacies in its entirety, while at the same time ensuring that community pharmacies and GP practices are totally digitally integrated.

### Part 3: Conclusion

This second overview of the impact of the Covid-19 outbreak on the community pharmacy network is provided with a degree of hindsight and it must be recognised that the speed of change has been significant. But it also offers a frank assessment of where we are now in terms of the biggest issue facing health providers – Covid-19 vaccination – and looks ahead to some fundamental changes which need to occur.

We would particularly draw the attention of the Committee to the capacity of the community pharmacy network in respect of flu vaccination (paras 9-11) and our quantified ability and capacity to provide advice (paras 12-14), yet we have current serious concerns that we are not being utilised even in a superficial way, let alone fully, in the Covid-19 vaccination rollout (paras 17-25).



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

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CPW welcomes communication in either English or Welsh.

For acknowledgement and further Contact:

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23 December 2020

Andrew Evans  
Chief Pharmaceutical Officer  
Welsh Government



Lynne Schofield  
Head of Pharmacy & Prescribing  
Welsh Government

Dear Andrew and Lynne

### **REQUEST FOR ADDITIONAL FUNDING TO FINANCE THE NETWORK'S RESPONSE TO COVID-19**

I refer to your letter dated 18 December 2020 in the above connection.

The CPW Board is grateful for having the opportunity to meet with the Minister on 17 December 2020 to explain why its claim for additional funding is both reasonable and valid. The Board noted the Minister's response and understands that he has to make choices. The Board appreciates that he has had to make difficult choices over the recent past, such that the offer currently on the table is the best that he feels able to make.

However, the Board remains convinced that that the data collected from independent contractors as part of our Covid costs survey are accurate, real and valid. As such, the Board is concerned that your offer will meet less than half of the costs necessarily incurred by contractors to meet the challenges arising from Covid-19

In the circumstances, the Board accepts the final offer as set out in your letter dated 18 December 2020.

The Board appreciates the concession to delay the recovery of the advanced payment made to contractors in April. This will greatly assist contractors manage cash flow over the coming months. We look forward to discussing the arrangements for the collection of the outstanding amount in 2021/22.

The Board also appreciates the additional £0.6m of new money to help fund the seasonal flu vaccination service.

The Board welcomes the commitment to revisit the settlement before the end of the financial year in the event that further funding sources are identified and the agreement that acceptance of this settlement will not prejudice any further claim in the event of further disruption occurring as a result of the pandemic.

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Chief Executive: Russell Goodway OBE OSTJ

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I can confirm that the Board confirmed its previous position regarding the mechanism by which the £5m will be distributed to contractors. The Board understands and shares the Minister's view that the money must go to those that did the most work in response to the challenges posed by Covid-19. The Board feels that, as the Government's required focus during the first wave was on the supply of medicines, with the opportunity to deliver services severely limited, then any additional funding should be distributed by reference to the number of items dispensed by each contractor. The Board appreciates your willingness to distribute the additional funding on this basis.

We understand that you have agreed only to cover the additional costs incurred in March and April 2020. For that reason, we understand that this additional funding will be distributed by reference to the number of items dispensed by each contractor during that period.

On a personal note, I appreciate the difficulties we have all had to encounter over the past ten months and how challenging these negotiations have been for all of us. I just want to thank you for the spirit in which the negotiations have been conducted and to extend my personal good wishes to you both for Christmas and the New Year.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Russell Goodway'.

**RUSSELL GOODWAY**  
**CHIEF EXECUTIVE**

**ROYAL  
PHARMACEUTICAL  
SOCIETY**  
Wales Cymru

Dr Dai Lloyd MS  
Chair, Health, Social Care and Sport Committee  
Welsh Parliament  
Cardiff Bay  
Cardiff  
CF99 1SN

19 May 2020

Dear Dr Lloyd

**Response by the Royal Pharmaceutical Society in Wales to the Welsh Parliament Health, Social Care and Sport Committee's Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales**

Thank you for the recent opportunity of contributing verbal evidence to the Committee's inquiry into the COVID-19 outbreak. As the professional body representing pharmacists across all health care sectors, we are pleased to follow this up with supportive written evidence. In this submission we reflect on pharmacy's experience of dealing with the COVID-19 pandemic to date and importantly highlight key learning points and recommendations for future action by the Welsh Government and NHS Wales.

**Key points:**

The COVID-19 pandemic has reinforced the need for:

- Recognition that the pharmacy profession is essential and fundamental across all sectors of health and social care in national contingency planning from the outset and throughout all transitional phases during any public health crisis
- Urgent digitisation in pharmacy services including the need for read and write access to shared patient records and the development of a robust electronic prescribing solution across Wales.
- Enabling pharmacists to manage shortages in medicines through legislative change that allow pharmacists to use their professional judgement to make minor amendments to prescriptions in the event of a medicine being out of stock.
- Ongoing routine access to services and resources to support the mental health and wellbeing of all pharmacy teams in line with other health professional groups. There should be equity across all health care professionals.

**Pharmacy's commitment to patient care during the COVID-19 outbreak**

1. We are proud of the resolute commitment of the pharmacy profession across all sectors to maintaining the delivery of care and the supply of medicines during the pandemic. The profession has risen to the challenge of increasing workloads and innovative approaches to service design have been quickly found and implemented to ensure continuity of care.

Collaboration among pharmacy teams across different localities and with other professional groups has also been inspiring.

2. As a membership body representing all sectors of pharmacy, the RPS took a strategic decision at an early stage in the pandemic to mobilise all financial and human resources to support the profession across Great Britain to cope with the unprecedented challenges of dealing with this pandemic.

### **Government recognition of pharmacy teams**

3. We recognise the significant challenge faced by the Welsh Government in leading and coordinating the approach to COVID-19 across health and social care sectors. To date, we have welcomed the actions taken by the Welsh Government to support pharmacy teams. The ability to introduce flexible opening hours has, for example, been particularly welcomed in community pharmacy. This has ensured the time needed for a critical break from immediate patient facing pressures, to undertake clinical work without interruption and to prioritise the most vulnerable patients. The relaxation of contractual obligations has been very much welcomed by community pharmacy in coping with the increase in demand.
4. A great deal of work has been undertaken across the NHS by pharmacy professionals in response to the COVID-19 Pandemic which needs to be recognised. This includes:
  - **Maintaining access to vital medicines** in all sectors by re-designing supply processes, working with medical colleagues to change patients to alternative products which require less frequent administration, and implementing delivery initiatives to vulnerable people from community and hospitals.
  - **Planning and managing the supply of critical and end of life care medicines** as the demands have significantly increased and the supplies have decreased: Developing new service models, frameworks to support ethical professional decision making for individual patient care, and maintaining governance and advice to support alternative choices of medicines which can be unfamiliar to clinicians.
  - **Developing local protocols** to promote and enable access to medicines via clinical trials for COVID-19. Some medicines have only been available via trials and evidence is vital to inform on-going treatment choices.
  - **Advising on oxygen supplies** and providing quality control to enable the oxygen pipe infrastructures to be expanded in acute care.
  - **Maintaining clinical pharmacy services to acute care patients** with provision of training to grow ICU pharmacist numbers and continuing to support non- COVID services.
  - **Installing and running new pharmacies** and services to new field hospitals using novel service models.
  - **Advising on treatment options** using the limited evidence available and ensuring good governance is maintained.
  - **Aseptic preparation** of medicines in ready to use forms for acute care, saving nursing colleagues' time and the difficulty of undertaking this task while in full PPE.
5. It has been disappointing that, some headline policies have been announced by the Welsh Government without the necessary detail and limited information on implementation. The announcement of the Welsh Government's Death in Service Scheme is one such example. The announcement of this scheme initially left pharmacists and others across the health service looking for clarity on if and how the scheme applied to them. While the Minister for

Health and Social Care confirmed the scheme would apply to community pharmacy following its announcement, we have yet to see or fully understand the details of the scheme.

6. We have heard from our community pharmacy and primary care members about difficulties associated with lack of recognition as NHS key workers. While we recognise this is unintended, and Welsh Government do quite rightly include pharmacists and their teams as key workers, not having official NHS ID has meant that pharmacy team members have not been able to routinely benefit from positive initiatives, such as priority access for NHS frontline staff to supermarkets and free public transport.
7. We were pleased that the Welsh Government took action to introduce ID Cards for colleagues working in social care to address the very same issue. A similar scheme for community pharmacy and primary care staff would help them to access services. This would also solidify the place of community pharmacy teams in the NHS family.
8. While we appreciate the pace of change of coping with this public health crisis, we believe that more could be gained from further engagement between Welsh Government officials and professional bodies. We are pleased that we have benefited from regular discussion with the Chief Pharmaceutical Officer and Head of Pharmacy and Prescribing. This enables us to keep our members better informed and reassured with appropriate support and professional guidance. We welcome all further opportunities to work closely with the Welsh Government to provide a wide pool of expert opinion to input into and provide constructive challenge to policy-making.

**Recommendation 1: Plans for front line staff delivering NHS services must include consideration of all pharmacy teams, including community pharmacy from the very outset.**

**Recommendation 2: Key worker status for pharmacy professionals working in community pharmacy and primary care should be assured.**

## **Protecting pharmacy teams**

### *Personal Protective Equipment*

9. Ensuring pharmacy teams in all settings can deliver services without any compromise to their safety has been, and remains, our paramount concern in managing the coronavirus outbreak.
10. While there has been a variance in government responses to the distribution and provision of PPE across the UK, we have welcomed and congratulated the Welsh Government for its response in ensuring PPE equipment was supplied to pharmacy teams at an early stage. We were pleased that PPE was distributed rapidly to all 715 community pharmacies in Wales. Feedback from our members suggests that, generally, the standard of PPE and the speed of its distribution to pharmacy teams has met need.
11. We were pleased that the Welsh Government led the way among UK nations by introducing regulations on social distancing in the workplace. This was a welcome step. Unfortunately, the accompanying guidance caused some initial confusion among our membership regarding the use of PPE when 2 metre distances could not be maintained. This was concerning as one of our recent surveys revealed that 94% of respondents could not maintain social distancing



of two metres from other staff in their pharmacy. We were also aware of cases where pharmacists and their teams contracted COVID-19, disrupting the supply of local services.

12. We support all efforts by the Welsh Government to continue to proactively source PPE internationally, as well as supporting Welsh businesses to manufacture stocks. It is reassuring to hear the Health Minister confirming the sourcing PPE as his number one priority.
13. At the point when lockdown measures can be gradually relaxed in Wales, it can be expected that footfall within community pharmacies will grow, increasing the risks of viral transmission and ensuring the continuing need for PPE. The needs of hospital-based pharmacy teams should also be understood and supported during the transition to routine hospital services. Supply must continue to meet demand at this time.

**Recommendation 3: Assurances are needed from the Welsh Government about plans for the ongoing supply of PPE and clear guidance for its use by pharmacy teams during the transitional phase that will accompany the lifting of the lockdown restrictions.**

*Priority COVID-19 testing for pharmacists and their staff:*

14. Early testing of pharmacists and their staff has been a consistent feature in discussions with our members. We fully support early testing as a crucial step in facilitating an early return to work following self-isolation.
15. We have been pleased to hear reports from our members that access to testing for pharmacists and teams has generally been efficiently managed by Health Boards across Wales. However, we have been made aware of some variation in the time that pharmacists are waiting to get their results - sometimes up to 5 days after the test - resulting in a prolonged absence from work.

**Recommendation 4: Priority testing should continue to be available for pharmacists, their teams and household contacts. Pharmacists should be given access to antibody testing when it is rolled out in Wales.**

*A Strong Stance on Abuse*

16. Community pharmacies have been one of the few healthcare settings that has remained physically open to the public during the pandemic. It is therefore disappointing that community pharmacy teams have had to deal with incidents of aggression and, in some cases, violence from the public.
17. We escalated our concerns about the risks of abusive and violent behaviour towards community pharmacy staff to the police forces in Wales. We were very pleased with the quick and decisive response from the police and their commitment to increasing assurance visits to community pharmacies across Wales at this challenging time.
18. It was also reassuring to hear robust public messaging by the Welsh Government when reports of abuse and violence towards pharmacy teams emerged. This included public calls for patience and respect towards pharmacy teams by the First Minister, the Health and Social Care Minister and the Chief Pharmaceutical Officer. We know that pharmacy teams

have also appreciated the strong public stances taken from other MSs to encourage respectful behaviour at community pharmacies.

19. We are proud that during the pandemic, community pharmacy also committed to supporting victims of domestic abuse. Along with a number of pharmacies across the UK, we have supported the Safe Spaces scheme as part of the UK Says No More campaign<sup>1</sup>. We have also been pleased to advise on the potential roll out of the Welsh Government's Live Fear Free<sup>2</sup> initiative using community pharmacies to signpost victims of abuse to appropriate support.

### Medicines Delivery Services

20. On 5 May, we welcomed the launch by the Welsh Government of the new volunteer prescription delivery scheme to support those shielding. We appreciate the hard work and investment to deliver this service which appears to be comprehensive and includes additional safety mechanisms such as DBS checks and the use of *Pro Delivery Manager*. However, the time lag between letters being sent to the shielding groups advising them to arrange delivery of medication at the end of March and the launch of the scheme in early May has resulted in some community pharmacies proactively investing in their own strategies.
21. We also have concerns that lists of vulnerable patients requiring delivery was not shared with pharmacies who decided not to participate in the scheme. This places an expectation for patients to make themselves known to their community pharmacy.
22. The capacity of the volunteer scheme will need to be monitored as more people return to work and as lockdown measures are relaxed.

**Recommendations 5: A sustainable solution to medicine delivery to vulnerable people who remain isolating must be in place when the number of volunteers reduces. The solution should include supply from both community and hospital pharmacies, that continue to supply essential medicines.**

### Training, Mental Health and Wellbeing Support

23. We are incredibly proud of the resilience of the pharmacy profession in responding to the COVID-19 pandemic. However, we have concerns about the immediate and longer-term impact on the profession's mental health and wellbeing from coping with such unprecedented pressures. Initial results from an RPS survey of pharmacists published in December last year showed that 80% were already at risk of burnout<sup>3</sup>.
24. In correspondence to the Welsh Government we have emphasised the importance of establishing emotional and wellbeing support for pharmacy teams, including those teams who are not directly employed by the NHS. Good progress had already been made in this area including:

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<sup>1</sup> <https://uksaysnomore.org/safespaces/>

<sup>2</sup> <https://gov.wales/live-fear-free>

<sup>3</sup> [www.rpharms.com/about-us/news/details/Pharmacists-suffer-the-mental-health-consequences-of-workplace-pressure](http://www.rpharms.com/about-us/news/details/Pharmacists-suffer-the-mental-health-consequences-of-workplace-pressure)

- The development by Health Education Improvement Wales (HEIW) of a web-based portal to wellbeing resources.
  - The extension of the previously doctor only, 'Health for Health Professionals Support' service to all health professionals.
25. Access to wellbeing resources such as these and opportunities for one-to-one emotional and psychological support will continue to be important during and following the pandemic. This should extend to greater occupational health and wellbeing support for all pharmacy professionals in line with that provided for other health professionals contacted by the NHS including GPs and dentists.
26. Professional development has continued to be important to the pharmacy profession throughout the pandemic. The pandemic has further demonstrated the need for developing an adaptable and flexible pharmacy workforce in Wales which must be supported by access to consistent and quality-assured professional development. This should be underpinned by the development of a common post-registration career framework that ensures pharmacists in all settings can practice to the full extent of their education and training.

**Recommendation 7: NHS mental health and wellbeing services should continue to be available to all pharmacists and all health professional groups within and contracted by the NHS.**

**Recommendation 8: Protected education and training time should be mandatory within workforce planning for all pharmacists.**

## **Sustaining essential medicines supply**

### *Medicines Shortages*

27. We have heard from pharmacists concerned about the potential longer-term impact of the pandemic on medicines manufacturing. We are aware that the Government is monitoring how COVID-19 could affect the medicines supply chain and we would welcome further engagement on this issue.
28. Contingency planning is critical to mitigate the effects of any worsening of medicines shortages due to the COVID-19 pandemic. This should take into account flexible plans for returning, re-using and the storage of medicines and the possibility that supply of certain medicines will become increasingly difficult. We welcome the End of Life COVID-19 Medicines Service to supply 'Just in Time' Emergency Medicine Packs<sup>4</sup> and advice on re-use of end of life medicines in care homes<sup>5</sup>.
29. Hospital pharmacy teams have played a key role in maintaining supplies of critical care medicines and haemofiltration fluids at times of peak demand. We understand the supply chain of these medicines is fragile across the UK and believe it is imperative that health

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<sup>4</sup> <https://www.awttc.org/covid-19-eol-medicines-service>

<sup>5</sup> <https://gov.wales/sites/default/files/publications/2020-05/guidance-for-local-health-boards-and-nhs-trusts-on-the-reuse-of-end-of-life-medicines-in-hospices-and-care-homes.pdf>

boards recognise and address this in their planning for services for the pandemic as well as future routine services.

#### *Empowering Pharmacists to Manage Shortages*

30. The pressures of the pandemic, coupled with the potential shortages of essential medicines, has reinforced the importance of enabling pharmacists to manage shortages of medicines. Prior to the outbreak of COVID-19, the UK Government was already reviewing the effectiveness of Serious Shortage Protocols, which our members tell us have been overly-burdensome to date. We maintain that medicines legislation should be amended to allow pharmacists to use their professional judgement to make minor amendments to prescriptions in the event of a medicine being out of stock, such as: different quantities, strengths, formulations or generic versions of the same medicine (generic substitution).
31. A change in legislation on managing medicines would save patients having to go back to the prescriber and reduce the workload of GPs. For pharmacists in secondary care these substitutions are standard practice and in Scotland, processes are already in place to allow pharmacists to make interventions to deal with medicines shortages. We believe it is time to address this imbalance and improve access to medicines by enabling community pharmacists to make these simple changes. Our proposals to mitigate the risks of medicines shortages are laid out in our policy position on medicines shortages<sup>6</sup>.

**Recommendation 9: Welsh Government support is needed to progress legislative change to maximise the ability of pharmacists to use their clinical knowledge and professional judgment to more efficiently manage medicines shortages.**

#### *Pre-prepared Medicines*

32. Work to prepare medicines so that they are available and ready for use by intensive care nursing and medical staff can be time consuming. This is particularly the case when caring for patients at peaks of demand and when wearing PPE. Time taken to prepare and manipulate multiple medicines for critically ill patients would be better used for direct patient care.
33. With other NHS services paused due to Covid-19, numerous hospital pharmacy aseptic units have repurposed their time to prepare these medicines into syringes so that they are ready to administer. This has been very well received by front line staff colleagues. However, increased capacity will be required to sustain this service at peak demand and when more day-to-day services such as chemotherapy are restarted. We understand that a centralised 'once for Wales' unit hosted by NHS Wales Shared Services Partnership is being considered. This is a very welcomed development and should be supported by the Welsh Government.

**Recommendation 10: An ongoing centralised intravenous additive service (CIVAS) of ready prepared medicines should be developed in Wales.**

#### *Delivering vaccination services*

34. Given their accessibility and experience in administering vaccinations, pharmacists are well-placed to support potential vaccination against COVID-19 as well as continuing to support the seasonal flu vaccination programme. The delivery of such vaccination programmes will

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<sup>6</sup> <https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/shortage-policy>

require assurances that health professionals can work safely and be appropriately protected. We would welcome early discussions with the Welsh Government and NHS Wales on how this could be taken forward.

### **Increasing the pace of digitisation in pharmacy services**

#### *Electronic Prescribing*

35. The current pandemic has reinforced the urgent need for electronic prescribing systems in both secondary and primary care. Electronic prescribing systems allow prescriptions to be sent digitally to be dispensed in community pharmacies or allow remote access within hospital environments, eliminating the need for paper prescriptions, increasing efficiencies and improving the patient experience.
36. The electronic prescribing systems in England, and to some extent in Scotland, have proved particularly useful during this time. They have:
  - ensured timely access to medication for patients
  - avoided logistical problems
  - provided real time data on medicines use
  - reduced the risk of infection transmission by reducing footfall and eliminating paper use.
37. The need for a robust electronic prescribing system in Wales has been recognised for some time. Plans for a system for secondary care has been in place in Wales for over a decade, however a system is still not in place. This was also an issue highlighted in the Public Account Committee's 2018 report into Medicines Management which noted it's concerns around the need modernise prescribing systems<sup>7</sup>.

**Recommendation 11: National development and roll out of electronic prescribing in both secondary and primary care is urgently needed to ensure efficiencies and patient safety.**

#### *Video Consultations*

38. Responding to current needs, the Welsh Government in March rolled out a video consultation solution to all GP Practices throughout Wales. We understand that plans are in place to expand the *Attend Anywhere* service into secondary and community care. We would welcome this development so that patients can continue to benefit from existing community pharmacy services. We also believe this step will prove to be a positive long-term investment which will meet the aims the Welsh Government's plan for health and social care as outlined in 'A Healthier Wales'

**Recommendation 12: Video consultation solutions should be supported and rolled out to all community pharmacies in Wales.**

#### *Digitisation and integration of health and care records*

39. The pandemic has highlighted the importance of full integration and digitisation of health and care records to improve efficiencies and patient safety. While we have welcomed the

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<sup>7</sup> <https://senedd.wales/laid%20documents/cr-ld11478/cr-ld11478-e.pdf>

recent roll out of access to patient's medicines information in emergency situations via the Welsh GP Record to all community pharmacists, we maintain there is still a need to complete the digitisation and integration of health and care records, including read and write access to shared electronic patient records.

40. The Topol Review argued that this is urgently needed if the full benefits of digital medicine are going to be realised for the NHS, including earlier diagnosis, personalised care and treatment<sup>8</sup>. We fully support the Topol Review's conclusions and believe that steps are now urgently needed to propel long term investment in technology to support patient care going forward. The COVID-19 pandemic has underlined the need to realise these ambitions.

**Recommendation 13: Reduce the risk of medication errors and emergency hospital admissions by allowing all pharmacists to access and update a shared electronic patient record.**

We trust these issues are helpful in highlighting the experience of the pharmacy profession throughout the COVID-19 pandemic to date. We remain committed to working constructively with the Committee, the Welsh Government, NHS Wales and key stakeholders to minimise the impact of COVID-19 and to ensure pharmacy's contribution to patient care can be sustained and developed going forward. Please don't hesitate to get in touch should the Committee require any further information as this important inquiry progresses.

Yours sincerely



**Suzanne Scott-Thomas**  
Chair, RPS Wales Pharmacy Board



**Elen Jones**  
RPS, Director for Wales

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<sup>8</sup> [topol.hee.nhs.uk/wp-content/uploads/HEE-Topol-Review-2019.pdf](https://topol.hee.nhs.uk/wp-content/uploads/HEE-Topol-Review-2019.pdf)

# Agenda Item 4



**Royal College  
of Physicians**

Coleg Brenhinol  
y Meddygon (Cymru)

## Covid-19: Invitation for written evidence

### RCP Cymru Wales response

#### **About us**

Our 37,000 members worldwide, including 1,300 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, including stroke, care of older people, diabetes, cardiology and respiratory disease. We campaign for improvements to healthcare, medical education and public health.

In Wales, we work directly with health boards and other NHS Wales organisations, including Health Education and Improvement Wales; we carry out regular local conversation hospital visits to meet patients and staff; and we collaborate with other organisations to raise awareness of public health challenges.

We organise high-quality conferences, teaching and workshop events that attract hundreds of doctors every year. Our work with the Society of Physicians in Wales aims to showcase best practice through poster competitions and trainee awards. We also host the highly successful biennial RCP membership and fellowship ceremony for Wales.

To help shape the future of medical care in Wales, visit our website:

[www.rcplondon.ac.uk/wales](http://www.rcplondon.ac.uk/wales)

To tell us what you think – or to request more information – email us at:

[wales@rcplondon.ac.uk](mailto:wales@rcplondon.ac.uk)

Tweet your support:

[@RCPWales](https://twitter.com/RCPWales)

For more information, please contact:

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**12 May 2020**

## **Covid-19: Invitation for written evidence**

Thank you for the opportunity to respond to the Health Social Care and Sport Committees' invitation for written evidence on Covid-19. The Royal College of Physicians (RCP) Cymru Wales used the results of our two surveys looking into the availability of Personal Protective Equipment (PPE) and testing accessibility for our members and fellows to form our evidence base to this inquiry. We have also worked with consultant physicians, trainee and specialty doctors, and members of our patient carer network in Wales to produce this response.

We would be happy to organise further written or oral evidence if that would be helpful.

**Name of organisation:** Royal College of Physicians (RCP) Cymru Wales  
**Lead contact:** Senior Policy and Campaigns Advisor (Wales)

## **Our response**

### **Introduction**

We welcome the Health Social Care and Sport Committee's inquiry into COVID-19.

As a leading health organisation with an aim of being person centred and clinically led, our members are committed to supporting the global response to COVID-19 and are at the centre of the NHS response in Wales.

The RCP has been tracking the impact of COVID-19 on frontline clinicians during the pandemic through membership surveys. The first of which took place on the 1-2 April<sup>1</sup>, followed by a second on the 22-23 April.<sup>2</sup> We had 120 responses to both surveys.

We will conduct a third survey between the 13-14 May with a focus on the restart of non-COVID-19 services. These surveys alongside continued engagement with our members have informed the evidence in this submission.

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<sup>1</sup> RCP (2020) [first survey of members](#) about impact of Coronavirus

<sup>2</sup> RCP (2020) [second survey of members](#) about impact of Coronavirus





## **Summary**

- There have been improvements in the management of coronavirus in the last month, with a reduction in staff absence and increased access to tests for NHS frontline workers. Yet respondents to our surveys continue to highlight the clear problems that remain with access to Personal Protective Equipment (PPE) and access to tests for NHS workers' households.
- RCP Cymru Wales is concerned that access to PPE appears to have worsened despite an increased public focus on the issue. Access to PPE declined over April, with over a quarter (27%) of members saying they couldn't access the necessary PPE to manage coronavirus patients at the end of the month, compared to 22% at the start. These figures raise concerns about the level of protection provided to staff.
- The supply of PPE must be increased and stabilised so all healthcare workers can access the protective equipment they need when they need it. Welsh Government should be open and transparent with NHS workers about the challenges faced in sourcing PPE – while doing everything it can to direct supplies to where they are needed.


## **Recommendations:**

- The Welsh Government must do everything it can to procure PPE and stabilise logistics to ensure that no NHS and social care staff go without appropriate levels of PPE when they need it.
- The Welsh Government must continue to develop access to testing ensuring that household members of NHS staff are able to access testing. There must also be a focus on improving turnaround times for results.
- The Welsh Government should seek to continue to build trust with the professions by being open and transparent about ongoing challenges.
- The Welsh Government should seek to learn the lessons of the last few months and work with the professions to ensure that this learning is actioned going forward.

## **How well is Wales dealing with the outbreak**

### **Testing and the workforce**

- Access to testing has improved since our first survey with 93% of our members with symptoms saying that they were able to access tests for their patients and 91% for themselves (up from 26%). We found that where tests are available, the turnaround for results varied from 24 hours to a week for members. Therefore, it is crucial that we continue to work towards routine testing with timely results for all our NHS workers in Wales.
- Our surveys show that more needs to be done to increase the availability of tests for people who live with frontline NHS workers. 31% said they were still unable to access testing for a symptomatic member of their household. Knowing whether household members have



coronavirus could be the difference between an NHS frontline worker returning to work or potentially self-isolating for 14 days without confirmation of diagnosis. Those with symptoms or live with a symptomatic household member need to know as soon as possible whether they should rest or return to work.


- Increased testing may have reduced the number of people off sick due to suspected COVID-19 over April. Many members said that the potential negative effects of staff absence in their teams had been mitigated by re-deploying staff. Over a quarter (29%) of clinicians told us that they were working in an area of medicine that is different to their usual specialty.
- Annual leave has been cancelled or postponed in some Health Boards. These short-term fixes are not sustainable as the NHS begins to re-open and encourage the public to come forward for treatment for cancer, heart attacks, strokes or mental health conditions. Although every area prepared for a COVID-19 surge, the virus has affected different parts of Wales more than others. That means in some areas, where core services are reduced but the number COVID-19 patients has been relatively low, staff resource is stronger than usual.
- As we begin to restart and reset non-COVID-19 services, we must not only build in the time and space for staff to recuperate, restore and reflect, but also plan for how staffing levels will be affected by a surge in non-COVID-19 patients while the need to treat the virus continues.
- Although staffing levels have been a problem in areas of increased prevalence, one of the other big impacts of staff absence has been on team morale, as frontline NHS workers worry about whether their friends and colleagues who are off work unwell, with confirmed or suspected coronavirus, will recover. Many respondents said that the absence of staff members threw into sharp relief the importance of consistent access to PPE as the best protection against contracting the virus in the first place.

### **Personal Protective Equipment**

- It is concerning that access to PPE appears to have gotten worse over April, with over a quarter (27%) of RCP members saying they couldn't access the PPE they needed to manage coronavirus patients at the end of April, compared to 22% at the start of the month. Only half of doctors surveyed had consistent access to protective goggles. 49% said they could not always access a full-face visor and 30% could not always access a long-sleeved gown if working in high risk aerosol generating procedure (AGP) areas.
- Some members have begun sourcing their own items of PPE such as masks or scrubs because of their concerns that official stocks will run out, with 17% reusing PPE because of shortages. This follows with findings from the British Medical Association (BMA) that just over a third of hospital doctors reported sourcing their own PPE for personal or departmental use or had relied upon donations<sup>3</sup>. Doctors must be able to focus on treating patients with COVID-19 safe in the knowledge that the PPE they need will be there when they need it.
- PPE is only effective when it is properly fitted, so it is concerning to see that 21% either had not been fit tested or were unable to access fit testing for their PPE. Clinicians should not have to

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<sup>3</sup> BMA (2020) <https://www.bma.org.uk/media/2407/bma-covid-19-survey-results-for-hospital-doctors-4-may-2020.pdf> p12



choose between protecting their own health or that of their patients. Fit testing and fit checking must take place to properly protect staff.

- If masks are being reused it becomes even more important that fit checking takes place to protect staff. The RCP has been encouraging our members to have a PPE partner when donning and doffing PPE to ensure that this is done correctly to minimise risk. The BMA has raised concerns about the additional problems faced by women trying to get a secure fit for their PPE masks.<sup>4</sup>
- Despite the high proportion of female clinicians working in the NHS,<sup>5</sup> PPE masks are largely designed for male frames.<sup>6,7</sup> One RCP member told us that they only passed fit testing when the mask was tied very tightly – something that they worried might not be replicable in an emergency situation.
- Opaque PPE masks also present problems for healthcare workers, patients and carers who are deaf or suffer from hearing loss, whereas hoods with respirators which are transparent have been used with positive feedback from both wearers and patients in some hospitals. The RCP would encourage Government procurement teams to seek to expand the selection of PPE equipment that they are purchasing with the aim of ensuring that all members of the NHS workforce have the PPE that they need<sup>8</sup>.
- Members have suggested that good communications around PPE availability is key. Welsh Government needs to ‘work with the sector’ on messaging to ensure confidence.

### Medicines and consumable shortages

- We also asked our fellows and members to tell us about access to medicines, oxygen and consumables. We asked them whether these shortages were new (since COVID-19) or pre-existing.
- 23% reported shortages in consumables since COVID-19, compared to 3% before its onset. New shortages in medicines were also reported in both inpatients (17% compared to 9%) and outpatients (12% compared to 11.5%).
- It is crucial that the flow of medicines and consumables is available to NHS staff and patients when it is needed.

### Response of health boards

- The innovation seen during this period should be evaluated as plans to return to a ‘business as usual’ NHS Wales are developed. Health Education and Improvement Wales (HEIW) will need to consider trainee doctors who were redeployed from their usual specialty training and will need to return to it.


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<sup>5</sup> RCNI (2019) [‘PPE one size fits all design is a fallacy that’s putting female health staff at risk’](#).

<sup>6</sup> NHS Employers (2019) [Gender in the NHS](#)

<sup>7</sup> TUC (2016) [‘Personal protective equipment and women’](#) p4; [Dr Helen Fidler in the Guardian](#), April 2019.

<sup>8</sup> [CPR, personal protective equipment and COVID-19](#)

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- While some things - like redeployment of staff - are not sustainable in the long term, other solutions for managing the outbreak of COVID-19 like virtual appointments and digital consultations could have equal benefit as we move forward.
  - In December 2019 a survey of RCP members found that fewer than 10% of respondents had conducted more than 4% of their outpatient consultations by video in the last week<sup>9</sup>. Yet social distancing has forced more clinicians to rapidly incorporate digital communication into their practice – with largely positive response from staff. New ways of working could be a positive to take from the pandemic.

### **Rehabilitation**

- In some of the more serious cases of COVID-19 recovery will mean the need for rehab services. Rehabilitation must be recognised as an unmissable part of COVID-19 recovery, and leaders and policymakers need to be taking urgent action to ensure that this is delivered.
- A comprehensive strategic approach to meeting rehabilitation needs is required as we work to help the recovery efforts from the pandemic.

### **Patient and staff safety**

#### **COVID-19 on BAME communities**

- Data has shown us that 94% of the doctors who have died from COVID-19 are from black and minority ethnic (BAME) backgrounds. The RCP has recently called for an individual risk assessment for healthcare workers in such areas in light of this alarming problem.<sup>10</sup>
- The RCP therefore welcomes the announcement that the Welsh Government will work with Public Health Wales to investigate why such a high number of people from BAME backgrounds are dying from the virus. The sooner we have more detail on the inquiry and when it will launch, the better.


#### **Training, Education and research**

- During the pandemic many trainees have been working in emergency rotas. Shifting trainees into 'normal' rostering needs to happen as soon as possible. We also need to make sure that people get adequate time to rest and recuperate from the past two months.
- We need to get our clinical academic trainees back into research and look for ways to extend their time in research to ensure they do not lose out. Improved patient care is most likely to be achieved in units where clinicians are participating in research. The time for which needs to be protected and there needs to be a commitment to invest in increasing medical student numbers in Wales.

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<sup>9</sup> RCP (2019) <https://www.rcplondon.ac.uk/news/survey-reveals-barriers-providing-good-care-and-confidence-new-solutions>

<sup>10</sup> [Individual risk assessment for healthcare workers](#)

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- It is important to expand training opportunities for doctors and allowing for flexible career development, all with the aim of expanding and creating the modern workforce that will deliver uniformly high-quality care across Wales.

### **Health and wellbeing of staff**


- The mobilisation of different parts of the workforce has been one of the successes of the response to the pandemic. This expanded workforce needs to be redistributed for the next phase and this gives rise to a few issues.
- Our survey showed that around a third (29%) of physicians are currently not working in their usual clinical areas. Reallocation of staff will need thought and care. We must be conscious that healthcare workers will need some time to recover and we need to be sure that the demands of the first wave have reduced enough to ensure appropriate capacity across specialties.
- Staff being redeployed to acute medicine and other areas, 41% of those working outside their specialty felt they were not getting enough support psychologically and emotionally. It is key that the impact of COVID-19 and working in new areas is not underestimated and staff wellbeing is cared for. We must also take care of forward planning to ensure staff can get time off and recuperate during future periods of activity.
- We welcome the steps taken so far to support the mental health and wellbeing of frontline health workers. It is important not to underestimate the toll of COVID-19 on doctors' mental health and wellbeing and the subsequent impact on the NHS' ability to deal with the outbreak.
- Although staff may not yet be absent from work as a result, many will be experiencing understandable mental health difficulties. 41% of those working in a different clinical area to normal felt they had not been given enough psychological or emotional support. Other polling for IPPR revealed 50% of healthcare workers surveyed said their mental health had deteriorated since the virus began<sup>11</sup>. Time off for NHS and social care staff to rest and recuperate must be part of any Government plan to 'restart' core NHS services in Wales.
- Whilst measures put in place regarding wellbeing across all health boards for the acute phase have been welcome. Evidence shows that doctors can be in their posts between three and five years which can sometimes lead to a strain on their health and wellbeing. Longer term investment is needed in this area and the RCP is producing a Wellbeing roadmap.

### **International workforce**

- The RCP recently commissioned YouGov to undertake polling. The results showed clear public support for acknowledging the contributions of NHS and social care staff who have worked during the coronavirus pandemic.
- Sixty-seven per cent of respondents thought it was unlikely that the NHS would have been able to tackle coronavirus without international staff, while 59% thought international staff who have worked in the NHS during the coronavirus pandemic should have the right to permanently stay in the UK.

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<sup>11</sup> IPPR (2020) [Care Fit for Carers](#), p12.

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- Currently, many people coming to work in the UK must pay an upfront annual fee (the NHS Health Surcharge) in order to be eligible to use the NHS as well as paying their visa fees. Today's polling showed that 59% of the public think international NHS and social care staff should not have to pay an annual charge to use the NHS.
  - The polling also revealed immense public appreciation for the international NHS and social care staff who have worked throughout the COVID-19 pandemic, with 69% of them calling for the government to publicly acknowledge their invaluable contributions.
  - The RCP has called on the government to create a new deal for international NHS and social care staff that recognises their vital role in the frontline response to COVID-19 and the important part they will continue to play in the future.
  - The proposed new deal includes three asks:
    - All NHS and social care staff, and their spouses and dependants, should be exempt from the International Health Surcharge.
    - All NHS and social care staff who have worked during the pandemic, and their spouses and dependants should be given indefinite leave to remain.
    - The proposed NHS Visa should be extended to social care staff.

### **What we are doing**

- The RCP continues to raise the issues that are important to our members such as the supply of PPE and access to testing at every opportunity. The RCP Vice President for Wales Dr Olwen Williams continue to work closely with national NHS Wales leaders across the UK including the Chief Medical Officers and national medical directors.
- We will continue to support our members with access to development materials, wellbeing resources and guidance.

### **Further evidence**

As part of our evidence, we are also submitting the following RCP Cymru Wales reports and recommendations for consideration. All of them can be accessed below or on our website.

- [Survey of fellows and members about the impact of COVID-19](#) (2020)
- [Time for research: Delivering innovative patient care in Wales](#) (2019)
- [Doing things differently: Supporting junior doctors in Wales](#) (2019)
- [Feeling the pressure: Patient care in an overstretched NHS in Wales](#) (2017)
- [Physicians on the front line: The medical workforce in Wales in 2016](#) (2016)



# Written submission to the Health and Social Care and Sport Committee's Inquiry into the Covid-19 outbreak on health and social care in Wales

## Introduction

- The Royal College of Surgeons of England is a professional membership organisation and registered charity, which exists to advance patient care. We support nearly 1000 members in Wales and nearly 30,000 members in the UK and internationally by improving their skills and knowledge, facilitating research and developing policy and guidance.
- Throughout the course of the COVID-19 pandemic, we have been determined in our efforts to ensure that surgeons and surgical teams are supported in delivering vital patient care and are not exposed to unnecessary risk.
- With this in mind, we welcome the opportunity to provide evidence to the Health and Social Care and Sport Committee's inquiry into the Covid-19 outbreak on health and social care in Wales.

### **Key recommendations:**

1. Long waits for planned surgery have a range of negative impacts on patients. Welsh Government and Health Boards should urgently consider what measures can be put in place to support patients while they wait for surgery.
2. COVID-19 has had a detrimental effect on the psychological wellbeing of NHS staff working under huge pressure. Support for the mental health and wellbeing for NHS staff must be considered a priority.
3. Over the coming months and years, every opportunity must be taken to support surgical trainees to gain experience and training time and complete their training.
4. To protect patients and enable urgent surgery to continue through the pandemic, COVID light sites should be established at pace across Wales. These should be planned strategically and collaboratively across Health Board boundaries to ensure a consistent, transparent approach and equity of access for patients.
5. Health Boards should start planning now for the recovery of surgical services in Wales. Resuming surgery must be a national priority. It is key both to the health of the nation, and our wider economic health.

6. Welsh Government should urgently develop a strategy to eliminate the waiting list backlog supported by sustained investment to increase the baseline capacity of the health service.
7. The Welsh Government should establish a national elective surgery recovery taskforce, to strategically plan for the recovery of elective surgical services in Wales.
8. Welsh Government should publish monthly elective surgery activity levels for Health Boards in Wales, to encourage the restoration of surgical activity.
9. Use of capacity in the independent sector should be maximised. These should be not as an alternative to, but in addition to NHS hospitals in Wales. This access should be equitable across Health Boards.

### **Waiting times in Wales**

- A huge waiting list for treatment has built up in Wales under the pandemic, many of which are for elective procedures. The latest available data shows 231,022 patients waiting more than 36 weeks to start treatment in November 2020. This compares to 22,879 in November 2019. There are now 529,269 in total waiting for treatment in Wales, the highest number since records began<sup>1</sup>.
- These are staggering figures. For many patients, a corrective operation is the best way to relieve debilitating pain and get people back up on their feet, back to work and enjoying life again.
- Restoring elective services in the context of COVID-19 represents one of the most complex challenges that the NHS in Wales has ever faced. The scale of the task should not be underestimated.
- A huge 'hidden waiting list' has built up over the past year in Wales. With referrals for treatment significantly down during the pandemic, as with England<sup>2</sup>, the 'real' waiting list for treatment could be far higher. Welsh Government should share their projections of what this might mean for waiting times in Wales.
- We understand of course that COVID makes it impossible for elective surgery to keep pace with demand right now. Throughout the pandemic, we have advocated prioritising surgery for those most in need. We worked with the NHS to establish prioritisation guidance, looking at the clinical position of each patient and determining the urgency of the treatment. We placed patients into five 'tiers', with the most urgent – life-saving – operations continuing, and other patients categorised by how long their treatment could safely be delayed<sup>3</sup>.
- However, a significant elective surgery backlog already existed in Wales prior to the pandemic, so an already parlous situation has deteriorated much further.
- The roll-out of a vaccine across the UK will offer some cause for optimism, but it will still be many months before we feel its full effect. In the meanwhile, the NHS is in the midst of an incredibly challenging winter.

<sup>1</sup> <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientpathwayswaitingtostarttreatment-by-month-groupedweeks-treatmentfunction>

<sup>2</sup> <https://www.health.org.uk/news-and-comment/charts-and-infographics/non-covid-19-nhs-care-during-the-pandemic>

<sup>3</sup> [https://fssa.org.uk/userfiles/pages/files/covid19/prioritisation\\_master\\_30\\_12\\_20.pdf](https://fssa.org.uk/userfiles/pages/files/covid19/prioritisation_master_30_12_20.pdf)



### The impact on patients

- It is important to remember that long waits for elective care can have a range of negative impacts on patients. The common themes are pain, psychological distress, fears around deterioration in health, threats to employment and loss of income, and increasing lack of trust in care providers. This contributes to an overwhelmingly negative picture of life described at its worst as being 'on hold' or in a 'no man's land'.
- Prolonged waits for surgery also risk further deterioration in patients' condition, which can mean more complex surgery than being required, and there will sadly be some instances where patients die while waiting for a procedure.
- **Welsh Government and Health Boards should urgently consider what measures can be put in place to support patients while they wait for surgery.**

### Workforce

- Surgeons, their teams and colleagues across the health service in Wales have shown dedication and extraordinary hard work during the COVID-19 pandemic.
- However, the feedback from our members is that the pandemic has left NHS staff from a wide range of roles exhausted, burnt-out and traumatised.
- **COVID-19 has had a detrimental effect on the psychological wellbeing of NHS staff working under huge pressure. Support for the mental health and wellbeing for NHS staff must be considered a priority.**
- Our guidance, "[Supporting wellbeing of surgeons and surgical teams during COVID -19 and beyond](#)" offers advice on how to spot when something is wrong and what healthcare managers can do to support staff.
- Over the coming months it will be important to continue to be prepared for an unstable workforce related to fatigue, illness or social issues.
- An expansion of the workforce will be necessary to recover surgical services. We cannot rely solely on recently retired staff to address the backlog. In addition, we need to bolster training and make better use of the range of professionals that form a surgical team.
- Furthermore, although consideration should be given to extending hours of elective surgery and operating at weekends, staff should not exceed recommended weekly working hours. Instead, modified hours should enable flexible working, and less than full time working for members of surgical teams.
- It is important to note that surgical training has been severely affected by the pandemic and there is a risk of a lost generation of surgical trainees. Getting elective operations up and running again is essential to the future of the surgical workforce, as limited elective activity has been identified as one of the key barriers to enabling trainees to access appropriate time in theatre.
- **Over the coming months and years, every opportunity must be taken to support surgical trainees to gain experience and training time and complete their training.**

### COVID light sites

- We have consistently been calling for COVID-light sites to be established at pace across Wales so that patients requiring cancer, urgent and planned surgery can be treated safely. No site can be considered completely COVID free, by this we mean a hospital site where only patients and staff who have self-isolated and been tested negative for COVID-19, are allowed to enter.

- Although all Health Boards do now have ‘green’ or COVID light pathways in place, as demonstrated by the experience of this winter when COVID admissions increase, these are not sufficient to protect surgical services, staff and patients.
- Establishing COVID-light areas was a real challenge across Wales. Our survey of surgeons in Wales conducted in September 2020 showed that 30% of respondents were unable to access such facilities<sup>4</sup>.
- **There is an urgent need for COVID- light sites, planned strategically and collaboratively across Health Board boundaries to ensure a consistent, transparent approach and equity of access for patients in Wales.**
- The sites need to work alongside regular testing for asymptomatic front-line staff and patients.

#### Planning for a more resilient system

- **Health Boards should start planning now for the recovery of surgical services in Wales. Resuming surgery must be a national priority. It is key both to the health of the nation, and our wider economic health. Welsh Government should urgently develop a strategy to eliminate the waiting list backlog supported by sustained investment to increase the baseline capacity of the health service.**
- **Urgent consideration should also be given by Welsh Government to the establishment of a national elective surgery recovery taskforce to strategically plan for the recovery of elective surgical services in Wales.**
- **The use of capacity in the independent sector should be maximised, along with scheduling modifications to increase hospital capacity. These should be not as an alternative to, but in addition to NHS hospitals in Wales.**
- When we emerge from the pandemic, we must look at how to build a more resilient health system. This entails reviewing the organisation of surgical services and committing to a strategic plan for the recovery of elective surgical services in Wales. This plan will need sustained investment in staff and bed capacity, along with support for new models of care such as surgical hubs.
- The pandemic has shown that working across local health systems is key to delivering better services and improved patient outcomes. Health Boards in Wales should work together to provide “mutual aid” at times of extreme pressure, so that surgery can continue. There are examples of this working well in England, where by collaborating, Trusts have been able to designate a hospital as a surgical hub so that high priority elective procedures can continue. In London, system-level working has been crucial to establishing an elective recovery programme which utilises certain hospitals across the capital as hubs for specified types of surgical procedure.
- While the surgical hubs model is not a “one-size-fits-all” solution, it is a useful approach for some geographies, and for some surgical specialties. Surgical hubs may be the product of the pandemic, but they are also a useful approach to tackling the elective backlog in Wales, if they are properly supported.
- We are keen that a spirit of co-operation in Wales is nurtured, to retain the benefits of these developments and establish an approach to delivering surgical services which has patients’ timely access to surgery at its core. The suspension of elective procedures at the start of the pandemic was not a one-off event in Wales. Surgery has been suspended during previous winters due to the impact of other infectious diseases such as flu and norovirus. In future, the use of models such as surgical hubs can help maintain planned

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<sup>4</sup> <https://www.rcseng.ac.uk/coronavirus/protecting-surgery-through-a-second-wave/>

surgery through “normal” winters. The coordination involved means that it is best managed at system-level.

- We saw how collaboration between clinicians and organisations during 2020 was key to keeping services going through the pandemic. Perversely, the crisis proved to be an effective force for breaking down institutional and cultural barriers. We must retain and nurture this culture of collaboration to create a more integrated system in Wales, which makes smarter use of resources. To do so entails planning services on a population footprint that runs well beyond a single hospital or Health Board. Although changes to structures have a short-term cost because of the disruption brought about by change, over the longer term, if done well, they bring benefits to taxpayers in more efficient use of resources, and benefits to patients in improved access to high quality services.
- However, there will be the opportunity to learn the lessons from this challenge for the future of surgical practice. We should consider how the system can adapt, including by taking advantage of new innovative surgical technologies, implementing speedy testing, supporting surgeons and perioperative clinical professionals and reconfiguring care pathways.

### Activity targets

- In England, stretching targets were set by NHS England for Trusts to restore elective activity levels by 80% by the end of September and 90% by the end of October 2020<sup>5</sup>. This provided a huge incentive and direction to the health service to restore surgical services over the summer, once the first wave of COVID had dissipated.
- In Wales, no equivalent activity target was set. After a significant reduction in provision of surgery during the ‘first wave’ of the pandemic, the feedback from our members in Wales was that the recovery of elective surgery services was patchy and inconsistent, with activity levels significantly diminished even up to December. This was reinforced by the results of our September survey of surgeons, which showed that, in some specialties, only just over a third of surgeons in Wales saw elective services back up and running<sup>6</sup>.
- As we plan for the recovery of surgical services once again, we need to ensure that planning is done strategically across Health Board boundaries to ensure equity of access to surgical services for patients.
- **Welsh Government should publish monthly elective surgery activity levels for Health Boards in Wales, to encourage the restoration of surgical activity.**

### Managing elective services during the pandemic

- Our guidance, ‘[Managing elective surgery during the surges and continuing pressures of COVID-19](#)’ provides a series of recommendations for managing elective surgical services during the COVID-19 pandemic, that can be adapted to support local decision making. We would urge Welsh Government and Health Boards in Wales to consider this guidance to manage elective surgical services over the coming months. It is structured under five main areas:
  1. Local cooperation for the coordination of resources and surgical care
    - Delivery of elective services on a networked basis, via an interconnected system of providers

<sup>5</sup> <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf>

<sup>6</sup> <https://www.rcseng.ac.uk/coronavirus/protecting-surgery-through-a-second-wave/>

- Avoiding meeting the demand of local surges by resorting to crisis measures, and engaging in early local and regional cooperation to protect essential resources for elective surgical pathways
  - Weekly forecasting of COVID-19 demand on capacity and resources as a baseline for determining the ability to add non-COVID-19 cases
2. COVID-light sites and extended services
- Use of COVID-light sites and physical pathways within and across hospitals, with segregation of both staff and patients from COVID-19 environments
  - Extension of core hours of service (including availability of staff, facilities and resources) during the week and at the weekend as a way of securing additional capacity and more balanced staffing levels throughout busy periods. Staff should not exceed recommended weekly working hours.
3. What hospitals and healthcare managers can do to support staff, including:
- Establishment of a multidisciplinary prioritisation committee and a prioritisation strategy that meets the needs of patients while making optimal use of existing facilities for elective cases. This includes:
    - a proposed approach for prioritising patients and for a phased increase of operating theatre availability
    - flexible planning on a weekly basis
    - use of day-case facilities
    - using local or regional anaesthesia where such options exist
    - using a lighter team for simpler procedures
    - ensuring length of stay is kept at optimum levels
    - use of facilities in the independent sector
4. Workforce
- Revision of job plans to allow more time spent in the operating theatre
  - Flexible working patterns across extended working days and weeks
5. Testing and PPE
- Twice-weekly testing for asymptomatic staff and patient testing 24–72 hours before surgery
  - Adequate staff training on proper use of personal protective equipment (PPE), including donning and doffing

Senedd Cymru  
Welsh Parliament  
**Agenda Item 5.1**  
**Cyflwyniad, Gofal Cymdeithasol a Chwaraeon**

Welsh Parliament  
**Health, Social Care and Sport Committee**

**Vaughan Gething MS**

Minister for Health and Social Services  
Welsh Government

7 December 2020

Dear Minister

**Inquiry into health and social care in the adult prison estate in Wales**

You will recall that, prior to the Covid-19 outbreak, the Committee was engaged in an evidence-gathering process as part of its inquiry into health and social care in the adult prison estate in Wales. You gave evidence as part of this inquiry at our meeting on 29 January 2020.

As a consequence of the outbreak, the Committee agreed to pause all non-Covid-19 related work, including this inquiry. However, given the advanced stage of the evidence-gathering at the time that the work was paused, and in the limited time left before dissolution, Members have agreed to write to you setting out the key issues we have identified to date and seeking an update from you on progress and/or developments in each of the areas set out in the Annexe to this letter. We are, of course, mindful of the likely impact of the pandemic on many, if not all of these areas.

I look forward to your response by 8 January 2021.

Yours sincerely



Dr Dai Lloyd AM  
**Chair, Health, Social Care and Sport Committee**



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## **Annexe: Inquiry into health and social care in the adult prison estate in Wales – key issues arising from our evidence-gathering.**

### **1. Impact of Covid-19**

Our evidence-gathering for this inquiry pre-dated the Covid-19 pandemic, but we wish to take this opportunity to explore the issue with you.

- 1. Can you outline the challenges for the delivery of health and social care in the Welsh prison estate during the pandemic, and the extent to which the Welsh Government has been working with HMPPS, Public Health Wales and others to protect the prison population and staff working in the Welsh prison estate, including any plans for vaccination of the prison population.**

### **2. Equivalence in the provision of health and social care**

The majority of responses we received focused on the principle that prisoners should have access to the same health and care provision equivalent to that in the community, without discrimination on the grounds of their legal situation. However, there was a sense that this is not reflected in the current prison healthcare system in Wales. The Prisons and Probation Ombudsman (PPO) raised specific concerns that two investigations into deaths at HMP Cardiff in 2019 found that the healthcare provision there was not equivalent to that in the community. The PPO stated “the Governor, the healthcare providers and the NHS Commissioners need to address this worrying situation as a matter of urgency”.

Time spent in custody was seen as an opportunity by many of those who submitted evidence to reach people who usually struggle to access health and social care services in the community. Several written responses, such as the Howard League for Penal Reform referred to the health of people in prison as a public health issue. As such, there was a view that there are substantial opportunities for improvement.

NHS Wales is responsible for planning and delivering prison health services in public prisons, and should plan services on the principle of equivalence. In the Partnership Agreement for Prison Health in Wales, the Welsh Government and HMPPS in Wales acknowledge their statutory obligation to ensure health services can be accessed to an equivalent standard of those within the community. The Partnership Agreement is based on taking forward a ‘whole prison approach’ to improving health and well-being and sets out an overarching aim to improve access to healthcare, and to enable prisoners to lead healthy lives and to reduce health inequality, stating: “prison should be a place where an individual can reform their lives”.

The Partnership Agreement sets out four key priorities, and you provided some detail of the work being done under each of these. These priorities are:

- Ensuring **prison environments** in Wales promote health and well-being for all;
- Developing consistent **mental health, mental well-being and learning disability services** across all prisons that are tailored to need;



- Producing a standardised clinical pathway for the **management of substance misuse** in prisons in Wales;
- Developing standards for **medicines management** in prisons in Wales.

Each of these priorities is covered separately in the relevant sections that follow.

### 3. Governance and oversight

A key message from the evidence we received is that strategic oversight for prison healthcare needs to be strengthened in Wales. **Public Health Wales (PHW) told us** that there is currently no structure for national oversight, which means there is often no clear process for obtaining national agreement on prison health related matters. It explained that “each prison health service has different policies and pathways for issues such as prescribing, screening, and substance misuse. This means patients will receive a different service depending on where they are located”.

PHW also told us that the lack of national oversight means there is little accountability for how health and social care recommendations from prison inspections and Ombudsman’s reports are considered beyond the individual prison. It said that many of these lessons could be shared across sites.

At a local level, Prison Health and Social Care Partnership Boards (PHSCPBs) have responsibility for the governance of prison health services. There was agreement from those we heard from (including from Health Boards and local authorities) that a review of the current arrangements for the planning of health and social care and governance services for prisoners in Wales was needed. On this point, **HMPPS in Wales called for** the role of PHSCPBs to be strengthened “to include strategic planning for health delivery, agreement of action plans, monitoring and reviewing progress as well as regular data collection”. It also stated that there should be “clear escalation routes for ongoing issues into the respective organisations”.

HMPPS in Wales also called for “a new Wales Prison Health Board” to be established by the Welsh Government to provide strategic planning for offender health in Wales. HMPPS in Wales argued that an All Wales Strategic Plan for prison health should be developed, including a National Implementation Plan to assist Local Health Boards to take forward the recommendations from the (proposed) Wales Prison Health Board.

Other witnesses (such as, the Royal College of General Practitioners (RCGPs), the BMA, the Royal Pharmaceutical Society and clinicians at HMP Cardiff) raised concerns about a lack of clinical leadership, and limited opportunities for prison healthcare departments across Wales to come together to discuss relevant issues. The RCGPs suggested the appointment of a clinical lead or champion to provide leadership and accountability. The BMA referred to a Prisoner Health Network, but suggested this was not fit for purpose.

Specifically in relation to HMP/YOI Parc, there was a shared view that governance arrangements for HMP/YOI Parc need to be looked at, both in terms of health and social care services, and the role



of Healthcare Inspectorate Wales and Care Inspectorate Wales in being able to regulate and inspect those services. The current private contractual arrangements with G4S for primary healthcare services mean that primary healthcare provision at HMP/YOI Parc does not fall under the remit of the HIW. The PPO raised concerns that there appeared to be no clear inspection oversight for the primary healthcare provision at HMP/YOI Parc. The PPO also called for the healthcare complaints process in relation to HMP Parc to be reviewed to bring it in line with the rest of the prisons in Wales and England.

In your evidence, you informed us that a 'Prison Health and Social Care Oversight Group' was being established, and you provided some detail of the role and responsibilities of this group, stating it will meet on a quarterly basis and will be jointly chaired by Welsh Government and HMPPS in Wales. Further, you stated that the Oversight Group will have responsibility for overseeing the implementation of the Partnership Agreement; will provide strategic leadership and oversight for Prison Health and Social Care Partnership Boards; and provide a point of escalation for Health Boards and prisons in relation to prison health issues.

Whilst your evidence also highlighted other assurance arrangements that are in place, including monthly meetings with HMPPS in Wales, and meetings with Health Board leads on a quarterly basis, you concluded that "the Prison Health and Social Care Oversight Group will be overseeing future delivery and implementation of prison health in Wales".

- 2. Can you provide an update on progress in establishing a prison Health and Social Care Oversight Group, and its work to date.**
- 3. What are your views on the HMPPS proposal that the Welsh Government should establish a Wales Prison Health Board to provide strategic planning for offender health in Wales. How would this would interact with the Oversight Group and the PHSCPBs.**
- 4. How confident are you that all PHSCPBs are meeting regularly and that existing arrangements are working effectively?**
- 5. How do you respond to calls for an All Wales Strategic Plan for prison health, including a National Implementation Plan to assist Local Health Boards to take forward the recommendations from any Wales Prison Health Board.**
- 6. What are your views on the proposals for a clinical lead/champion to address concerns about a lack of clinic leadership and accountability.**
- 7. What discussions has the Welsh Government had with HMPPS to address concerns in the health and social care inspection regimes at HMP Parc, specifically in primary healthcare provision. Whether there are any opportunities to legislate or otherwise address this gap when the contracts at HMP Parc expires?**





#### 4. Access to health records

Another key issue throughout the evidence we received related to the frequency of movement of prisoners both between prisons, and between prison and the community, and the impact of this on effective continuity of care.

Public Health Wales and the Royal Pharmaceutical Society stated that the provision of care could be “vastly improved” if prison health services could be supported to:

- have access to NHS numbers for those held in prison;
- have access to SystemOne outside of the prison setting, particularly for secondary care teams providing specialist care and GPs providing out of hours cover;
- improve communication between justice and health services on release dates and release plans for men held.

The BMA agreed that the process of sending information on reception and release could be improved. It stated “too often, prison GPs are completely left out of the loop when patients are released so there is no defined process (or administration time provided) for arranging informative and useful discharge summaries. Likewise, the transfer of individuals to other prison establishments is fraught with similar problems, particularly sudden transfers for security reasons”.

In relation to HMP/YOI Parc, Bridgend County Borough Council (CBC) highlighted the challenges in accessing prisoner’s health records, which are recorded on SystemOne. They explained that, within HMP Parc, access to this system is restricted by G4S health services. Of concern is their view that the lack of access to this system is ‘impeding’ the local authority social care team in discharging its functions under the Social Services and Well-being (Wales) Act.

We heard that, by the end of 2019, men going into custody in England will be registered with the prison and their notes will follow them, but that this would not be the case for Welsh men. Instead, we heard of a 2-tier system being created in Welsh prisons, where “Welsh men in English prisons will be safer than Welsh men at home in Welsh prisons because their medical team can see their historic record, and we can’t do that in Wales”. On this point, the BMA said one of the benefits of the English system would be the reduction in the risk of dual prescribing, arguing that it would be “safer to adopt consistent registration procedures across the English and Welsh prison estate because of the fluidity of transfer of prisoners across the two countries”.

On a practical point, the RCGP highlighted that, in Wales, the NHS Wales Informatics Service (NWIS) does not have a direct relationship with the supplier of System One, and that NWIS does not have expertise in using this system.

#### **8. Have there been any developments in the following areas and, if not, what support can the Welsh Government provide to enable:**

- **prison healthcare teams to have access to NHS numbers of prisoners when they are being held in prison;**



- **community healthcare teams to access SystemOne outside the prison setting; and**
- **better communication between justice and health services on release dates and release plans.**

**9. In relation to arrangements at HMP/YOI Parc, what support can the Welsh Government provide to the local authority in accessing prisoner health records on SystemOne?**

## **5. Access to healthcare**

### *Nursing provision*

We heard evidence from the RCN about concerns they had for the safety of nursing in Welsh prisons, both in terms of the quality of care able to be provided and violence against nursing staff.

The RCN told us that, in response to their 2017 Safe Staffing Survey undertaken with nurses working in prisons, 64 per cent said that “care was compromised on their last shift”. They also told us of significant concerns “regarding assaults on our members including physical attacks which can cause lasting health problems”. The RCN wanted to see the Assaults against Emergency Workers (Offences) Act 2018 fully enforced in all Welsh prisons, adopting a ‘zero tolerance’ approach.

### *GP provision*

We heard from the BMA that GP provision varies greatly across establishments, which impacts on the availability of services. It stated, “we know of one establishment where face to face GP provision has been reduced over the last few years from 6 sessions per day to 2-3 sessions currently, despite an increase in that establishment’s prison population and turnover”. They also noted that it is unclear what primary care provision is available at HMP Parc, because of the privately commissioned healthcare arrangements.

### *Dentistry*

The British Dental Association (BDA) told us that dental needs among the prison population are high. They cited the example of prisoners screened for dental treatment need at HMP Prescoed, 80 per cent of whom were in need of treatment, and 35 per cent required at least one tooth to be extracted. The BDA stated that the oral health needs of those in prison differ greatly to the needs of the general population, and that proper training was necessary to manage this. They also raised concerns about the high turnover and frequent transfers of prisoners, which meant that courses of treatment can go unfinished.

In addition to calling for a national IT system to enable dental information to be transferred between prisons, they also wanted clarity on waiting times, and oral healthcare plans developed for the prisons. Their biggest concern, however, related to the number of prisoners who miss their dental appointments, often as a result of communication issues and the logistics of getting prisoners to their appointments.



### *Allied health professionals*

The Royal College of Occupational Therapists recommended increasing the number of occupational therapists employed within and providing in-reach to prison services to advise on modifications and the design of buildings; to minimise potential risks in the prison environment through the provision of equipment and adaptations; and to advise on strategies and techniques to manage personal care and other activities of daily living within the prison environment.

Similarly, the Chartered Society of Physiotherapy (CSP) stated that physiotherapists should be a key member of the prison healthcare staff inside Welsh prisons, helping to tackle for example, the misuse of drugs related to chronic pain and issues relating to frailty for older prisoners. The CSP explained that this was not currently the case in most situations in Wales, meaning that prisoners needed to access physiotherapy services outside the prison setting, accompanied by prison officers.

The Royal College of Speech and Language Therapists referred to good practice at HMP Berwyn, which employs two speech and language therapists. Elsewhere, current speech and language therapy provision for men in prisons in Wales was said to be "extremely patchy".

**10. How do you respond to the concerns of the above health professions about prisoner access to healthcare.**

**11. What actions can the Welsh Government take to improve this position?**

## **6. Mental health**

Much of the evidence we received highlighted the percentage of men in Welsh prisons with mental health issues, referencing research and statistics that demonstrate that people in prison are more likely to suffer from mental health problems than people in the community.

HMPPS in Wales stated that "mental health interventions are not consistent across Local Health Boards, and the average referral time varies across the estate". The BMA described mental health services as 'under-resourced compared to the huge demand placed on them', and written evidence from a clinician at HMP Cardiff described mental health services in Welsh prisons as "woefully underfunded". Bridgend CBC provided an example of this, stating that "the mental health in-reach services at HMP Parc were commissioned to meet the needs of 720 prisoners; the prison population of HMP Parc is closer to 1,800 men.

In addition, the issue of waiting times for transfers of prisoners to secure mental health facilities was raised in several written responses. HMPPS in Wales put the delay in transfers down to shortages in the number of beds within secure psychiatric hospitals in the community.

Many of the written responses focused on lower level mental health needs, stating that there is little evidence of any support for men who might benefit from early intervention support or well-being interventions. The BMA, for example, called for 'better availability of psychological interventions for anxiety, depression and PTSD', all of which they say are overrepresented in the prison population compared with the community. The RCGPs agreed that the lack of provision of primary mental health care needed urgently addressing.



HMPSS in Wales called for mental health needs assessments to be standardised across prisons in Wales to provide consistency throughout the secure estate. They also wanted to see revised national guidance providing advice on mental health interventions in prisons.

In your evidence, you clarified that the mental health workstream of the Partnership Agreement is being led by the Welsh Government in partnership with the Royal College of Psychiatrists. You stated that work was underway to develop draft standards, which would include universal mental health standards as well as specific interventions for dementia, crisis care, learning disability, brain injury and autism spectrum disorder. You also emphasised that the standards for mental health in prison will include a specific focus on dementia and you referred Members to the Welsh Government's Dementia Action Plan for Wales 2018-22.

**12. It is unclear from the Partnership Agreement whether it includes plans to expand the number of secure hospital beds and the contribution this extra capacity will make to reducing waiting times. Can you provide any further information on this point?**

**13. Can you update the Committee on progress with the draft mental health standards?**

#### *Self-harm and suicide*

There are well known risks relating to suicide and self-harm for people in prison – something this Committee identified in its 2018 [Suicide prevention report](#). The RCN told us that a working group was set up in autumn 2018 to establish the development of consistent mental health services in Welsh prisons but go on to say that no update has been provided. In their response to this Committee's Suicide prevention follow-up consultation, the Royal College of Physicians (RCP) stated that they have been approached by Welsh Government about undertaking a review of the provision of mental health services in prisons. They said this work was almost ready to begin.

**14. Can you provide an update on the review of mental health service provision in prisons that you have commissioned from the RCP.**

#### *Substance mis-use*

There was agreement amongst those submitting evidence that more work was needed to reduce the impact of substance misuse, including from the use of psychoactive substances. This needed to include a commitment to reduce substance misuse in prison, as well as the supply of, and demand for, illicit drugs in prisons.

HMPPS in Wales referred to the Expert Advisory Group for Medicines in Scotland which provides advice to NHS Boards Drug Treatment Centres on the appropriate use of medicines and other therapeutic interventions in prisons. They suggested a similar panel should be introduced in Wales by the Welsh Government.

**15. What is your view on the HMPPS suggestion that the Welsh Government should establish an Expert Advisory Panel for Medicines in Wales similar to that in place in Scotland.**



Issues relating to substance misuse were prominent during the Committee's visits to prisons in Wales. In particular, concerns were raised by prisoners at HMP Cardiff around prescribing medication, particularly early days prescribing (i.e. support for men who require opiate substitute medication on reception to prison to avoid withdrawal symptoms). In English prisons, prisoners who are dependent on drugs are offered opiate substitution treatment, whereas in Welsh prisons psychosocial and clinical support is given.

Currently, Local Health Boards in Wales are responsible for delivering substance misuse clinical treatment and interventions in prisons in Wales, delivered in the South Wales area by the jointly commissioned Dyfodol service and in the North by Betsi Cadwaldr University Health Board. We understand that the Welsh Government is currently developing a service specification for substance misuse in prisons in Wales but there is no further detail of this.

**16. Can you provide further information on work to produce a service specification for substance misuse in prisons in Wales.**

The RCN raised specific concerns about the widespread use of psychoactive substances such as spice in Welsh prisons, and the impact the use of these substances has on the health and safety of healthcare staff working in prisons. The RCN said they would like to see the HMPPS guidance updated and revised urgently to ensure the safety of prison staff is properly accounted for, and they wanted to see greater levels of training for healthcare staff in how to deal with psychoactive substance related incidences.

This workstream of the Partnership Agreement is being led by Welsh Government, in partnership with Public Health Wales. Your written evidence stated that a draft Substance Misuse Treatment Framework for prisons is being developed, and you clarified that this will include the clinical treatment pathway – from initial assessment in the prison to follow-on care and support following release – for alcohol and drugs and for co-occurring mental health and substance misuse issues. You said that you were expecting to be able to publish a final version of the framework in autumn 2020.

**17. Can you provide an update on progress with the Substance Misuse Treatment Framework.**

You also referred to the Welsh Government's Substance Misuse Delivery Plan 2019-22 and the Mental Health Delivery Plan 2019-22, which set out actions to address issues faced by prisoners in accessing support both in prison and post-release, including those with co-occurring substance misuse and mental health problems. You stated that you had established a "Deep Dive Group" made up of a range of clinicians, providers and commissioners, including representatives from the housing sector, to address barriers to progress in this area.

**18. Can you provide further information on the work of the Deep Dive Group, including any outputs or recommendations they have produced.**



### *Medicine management*

Currently, medicine management issues are addressed at a local level. The BMA said it would welcome a formal mechanism for the streamlining of prescribing policies across the Welsh prison estate, explaining that “what happens in one establishment can have a massive impact at another”.

The Royal Pharmaceutical referred to professional standards for optimising medicines in secure environment. These are aimed at services provided in England as good practice, but did not apply to Wales. You confirmed that the Welsh Government was leading the medicines management workstream of the Partnership Agreement, in partnership with the Royal Pharmaceutical Society. The work of the RPS in this area would be to appraise health boards on their progress against current standards for medicines management in a secure environment, and then develop plans for each prison or health board to improve their performance against those standards.

#### **19. Can you provide an update on progress with this workstream.**

### *Prison Environments*

Your written evidence states that the workstream in relation to the prison environment is being led by HMPPS. At the time of our session with you, we asked you about the key outcomes indicators and performance measures for this workstream, and you told us you were not aware of them because that work had not yet been completed. You said that, whilst so many factors relating to the environment and to the regime in the prison are the responsibility of the prison service because they own the physical structure of the prison, you had a direct interest in the outcome of the workstream and how it would feed into the Welsh Government’s ability to deliver national indicators and standards.

#### **20. Can you now provide an update on the prison environment workstream and, in particular, the development of key outcome indicators and performance measures.**

#### **21. How will these help you, in partnership with HMPPS, to monitor progress in this area.**

## **6. Social care and an ageing prison population**

We have consistently heard that the number and proportion of the prison population that are older prisoners (defined as 50 and over) has increased and is projected to keep growing, and that this cohort of prisoners is likely to have greater social and healthcare needs. Resettlement and Care for Older ex-Offenders and Prisoners (RECOOP) said that people aged over 50 are the fastest growing group in the prison population and meeting their needs will continue to be one of the biggest challenges facing the criminal justice system for years ahead.

Despite this, Public Health Wales stated that there is a lack of evidence of the needs of older people in prison in Wales, and the impact of the prison environment on the ageing process. There were calls for more effective planning of health and care services for older prisoners, including those living with dementia and frailty. The Older People’s Commissioner stated that this included



looking at the physical environment as well as investment in staff training to support older prisoners with complex needs. She stated that there should be a specific focus on the recruitment and retention of social care staff working with or in prisons. HMPPS in Wales believed that there was a greater role for Social Care Wales in ensuring the social care needs of prisoners in Wales are met. There were also calls for a national strategy for older prisoners.

Specifically in relation to funding, we heard that focused planning and funding specifically for the needs of older people in prison was now needed, with a joined up approach across health, care and prison agencies. On this point, the Older People's Commissioner emphasised the need for sufficient funding for those local authorities that have prison populations within their boundaries". HMPPS in Wales raised concerns about 'significant funding reductions in allocations for social care in prisons', and called for the funding allocations for social care provision in prisons in Wales to be reviewed by the Welsh Government to ensure that needs are adequately met. Bridgend CBC were similarly supportive of a funding review, saying that having analysed the cost of providing assessment and care within HMP Parc, it is considerably higher than the cost of providing equivalent care in the community.

In your evidence, you stated that work in relation to social care will continue to be informed by developments led by the Ministry of Justice arising from the delivery of the recommendations within the HMIP **Thematic Report, Social Care in Prisons in England and Wales.**

You also stated that you will want to "continue to support MoJ and HMPPS to review and revise key operational requirements and to work through the Prison, Health and Social Care Partnerships to identify and address any barriers to effective partnership working and the implementation of HMPPS in Wales Strategy for the management of Older Persons in custody in the Welsh Region".

On the question of funding for social care, in 2016-17, specific grant funding of £0.448m was provided to local authorities to meet the social care needs of prisoners. In 2017-18, £0.412m was again distributed as a specific grant. From 2018-19, and in line with the Partnership Agreement, £0.391m was transferred to the revenue support grant and £0.371m for 2019/20 and future years. In your evidence, you confirmed that the reduction in this grant "reflected the reductions in different parts of our budget settlements". You also stated that the transfer of funding to the revenue support grant was agreed following requests from local authorities.

**22. Can you update us on work in this area?**

**23. Can you provide us with a copy of the HMPSS Strategy for the management of older persons in custody in the Welsh Region.**

**24. How do you respond to calls for a national strategy for older prisoners?**

**25. How do you respond to calls for the Welsh Government to review the funding allocations for social care provision in prisons in Wales to ensure that needs are adequately met.**



## 7. Funding

The Welsh Government receives funding for prisoner healthcare in public sector prisons in Wales through the Welsh Block. Since 2004-05, the UK Government provides approximately £2.544m to the Welsh Government for this purpose. You confirmed that the block transfer has not been updated since 2004-05.

We heard evidence that prisons in Wales are underfunded by the UK Government. The RCN and the RCGP both stated that the current funding system for prison healthcare is outdated, with the RCGP describing the funding as it currently stands as "insufficient", having not received uplifts since the NHS took over responsibility for prison health. The RCN stated that "calling for reform should be a priority for Welsh Government". Both the Royal Pharmaceutical Society and Public Health Wales agreed.

Clinks state that the baseline budget for prisoner healthcare across Local Health Boards needs to be reviewed. They suggest this review should consider the level of funding and the inconsistency in funding models stating "a consistent funding arrangement for healthcare in all Welsh prisons should be established with transparency for how services will be commissioned from those funds"

In your written evidence, you stated that "prison health has been identified as a priority for 2019/20 for the Health Boards in Wales", and you set out that an additional £1 million of recurrent, annual funding has been provided. You confirmed that Swansea Bay University Health Board, Cardiff and Vale University Health Board and Aneurin Bevan University Health Board have all received funding which will support improved access to mental health and co-occurring mental health and substance misuse services in HMP Swansea, HMP Cardiff and HMP Usk and Prescoed. In respect of HMP Berwyn, there is a direct funding relationship between HMPPS and Betsi Cadwaladr University Health Board. It has been agreed that the funding for the prison health services at HMP Berwyn will be part of a future transfer to the Welsh Government once the prison is up to capacity and is fully operational.

**26. What recent discussions have you had with the UK Government about resourcing and funding arrangements for Welsh prisons.**

**27. What work have you undertaken to review the level of funding and arrangements for funding models across Welsh prisons.**

## 8. Data

In relation to data collection, we heard evidence of concerns about the limited data set in the Welsh adult prison estate. In terms of trying to improve data collection, you stated that, "as part of the partnership agreement, we'll end up having a standard set of national indicators and we can then use those to report on for prisoner outcomes. So, that is work that is actively being pursued."

**28. Can you provide an update on work in this area.**





## Agenda Item 5.2



Llywodraeth Cymru  
Welsh Government

Dr Dai Lloyd AM  
Chair, Health, Social Care and Sport Committee

SeneddHealth@senedd.wales

28 January 2021

Dear Dai,

Thank you for your letter of 07 December 2020 to Vaughan Gething MS, Minister for Health and Social Services, regarding your inquiry into health and social care in the adult prison estate in Wales.

We are responding because as Minister for Mental Health, Wellbeing and Welsh Language I have overall responsibility for offender health within my ministerial portfolio and social care falls within the portfolio of the Deputy Minister for Health and Social Services.

A joint ministerial update has been provided on the areas you have raised which is attached in the Annex to this letter. I hope you find these responses helpful. As you will appreciate the focus of our work since March 2020 has been on responding to the Coronavirus 2019 pandemic and we have worked closely with Her Majesty's Prison and Probation Service, Public Health Wales and other partners in this regard. This is reflected in the responses provided.

Yours sincerely



**Julie Morgan AS/MS**  
Y Dirprwy Weinidog Iechyd  
a Gwasanaethau Cymdeithasol  
Deputy Minister for Health  
and Social Services



**Eluned Morgan AS/MS**  
Y Gweinidog Iechyd Meddwl,  
Llesiant a'r Gymraeg  
Minister for Mental Health,  
Wellbeing and Welsh Language





Llywodraeth Cymru  
Welsh Government

## ANNEX

### Health Social Care and Sport Committee progress on Key Issues

<b>1. Impact of Covid-19</b>	
Our evidence-gathering for this inquiry pre-dated the Covid-19 pandemic, but we wish to take this opportunity to explore the issue with you.	
<b>Question</b>	<b>Progress</b>
1.1 Can you outline the challenges for the delivery of health and social care in the Welsh prison estate during the pandemic, and the extent to which the Welsh Government has been working with HMPPS, Public Health Wales and others to protect the prison population and staff working in the Welsh prison estate, including any plans for vaccination of the prison population	<p>Since the start of Coronavirus – 2019 (COVID-19) outbreak, the Welsh Government has worked in close partnership with HMPPS Wales, Public Health Wales (PHW) including local prison healthcare teams to enable the delivery of health and social care in the custodial estate.</p> <p>Management of COVID-19 has followed the All-Wales Prison Outbreak Plan and the Public Health England 'Interim advice on preventing and controlling outbreaks of COVID-19 in prisons and other prescribed places of detention (PPD).</p> <p>The Outbreak Control Team's membership included Public Health Wales, prison health teams, prison senior management, local health boards, the Welsh Government and HMPPS senior staff. As part of this, each prison has been assigned a Consultant in Communicable Disease Control (CCDC) by Public Health Wales, who is familiar with their establishment and works closely with the prison to advise on local issues.</p> <p>Following the closure of the prisons as a result of the first wave outbreaks, this meeting evolved to become the All Wales COVID-19 Management Group, with the same membership.</p>

In addition, in response to COVID-19 locally in Welsh prisons, Incident Management Teams (IMTs) have been established for each prison by Public Health Wales. These are chaired by a Consultant in Communicable Disease (CCDC) local to the prison and attended by prison healthcare teams and senior management as well as representatives from the Local Health Board. These have continued throughout the second wave and are currently in place for every Welsh prison.

HMPPS also took proactive steps to support prisons to monitor, manage and mitigate the threat of large numbers of staff and prisoners becoming infected with COVID-19 and to reduce the likelihood of the infection spreading throughout the prison system. Measures have included the requirement for every establishment to develop an Exceptional Regime Management Plan (ERMP) to ensure consistent delivery of essential regime services with critical staffing pressures and national steps to reduce the prison population.

HMPPS in Wales has worked collaboratively with Public Health Wales to implement general infection controls before cases of COVID-19 were seen in Welsh prisons. On 14 February 2020 formal advice was sent from PHW to HMPPS in Wales on the need for accessible handwashing facilities across the estate, on entrance for visitors to prisons. Literature on handwashing was shared by HMPPS to be distributed to staff and residents. This included providing prisoners with easy read posters on handwashing, which were also posted in multiple areas within the prisons. Handwashing videos were also circulated to HMPPS staff, and photographic guides on correct handwashing techniques were placed in staff and prisoner toilets. In addition, hand sanitiser dispensers were placed throughout the prisons.

Guidance from Public Health England (PHE) was distributed to Welsh prisons on 11 February 2020 which included use of Personal Protective Equipment (PPE) and environmental cleaning and decontamination. As prisons are non-devolved, the national public health guidance documents they follow are often issued by Public Health England. These are then used in Wales in consultation with Public Health Wales. Wherever Public Health Wales have

issued a prison specific guidance document, for instance with contract tracing, Welsh prisons have implemented the PHW advice.

Following this, HMPPS produced the Interim guidance for 'Provision of Personal Protective Equipment and Hygiene provision to manage Coronavirus - 2019 across HMPPS' business areas – Roles and Responsibilities on the 28/02/2020. This identified Single Points of Contact (SPOCs) in each prison who were responsible for the effective management of PPE and associated hygiene products. These products were procured centrally by HMPPS and distributed to local hubs. PHE has since published full guidance: <https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance/covid-19-prisons-and-other-prescribed-places-of-detention-guidance>

On 31st March 2020 a new population management strategy was launched, under which all Inter Prison Transfers (IPT) were immediately suspended (save for those approved by Gold under exceptional circumstances) to minimise the risk of transmission between establishments. The management of COVID-19 has followed The Communicable Disease Outbreak Plan for Wales (Part 6 of this document is the Outbreak Plan for Prisons in Wales). <https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/the-communicable-disease-outbreak-plan-for-wales/>

Alongside these national measures to minimise movement between sites, equivalent steps were undertaken to reduce contact between different risk groups within each establishment's population. The way that HMPPS has managed this is outlined in the HMPPS prison compartmentalisation and cohorting strategy which was published at the end of March and is referenced in more detail below in the "protecting vulnerable prisoners" section.

Subsequently an updated population strategy ("Protect and Mitigate") was issued by HMPPS Gold Command, permitting limited allocations between local and training prisons. In Wales, this change was discussed and approved

at the All Wales OCT. Movements within prisons, between cells and wings were also reduced where possible by all prisons.

To protect vulnerable prisoners, HMPPS instructed the prisons to implement cohorting in all prisons. Cohorting is the Public Health England (PHE) strategy for the care of large numbers of people who are ill or who present heightened infection risk by gathering all those who are symptomatic into one area (or multiple designated areas) and establishing effective barrier control between this group and the wider population.

Following the Government guidance on social shielding, isolation and social distancing that was introduced on 23 March, HMPPS launched a prison cohorting strategy on 31 March. This extended the concept of 'cohorting' to include shielding in a way which leads to effective compartmentalisation of prisons.

There are three component parts of the HMPPS Cohorting Strategy; arrangements to protect those most susceptible to the virus, measures to isolate those who are symptomatic (and any cell-sharers) and provision to hold newly received prisoners separated from the main population until enough time has passed for COVID-19 infection to be expressed in symptoms if they are infected. The HMPPS cohorting strategy is to create at least three areas within the establishment to achieve distance between the symptomatic, those newly arriving, and those who are most vulnerable in every prison.

The shielding units are used for the temporary isolation of those prisoners within the NHS England and Wales vulnerable persons cohort until the Welsh Government advises shielding is no longer required; reducing the likelihood of this susceptible group contracting the virus.

In addition, in Welsh prisons HMPPS have created additional space in the prison estate, with the installation of temporary, single occupancy cells alongside the scheme to release low-risk offenders. This has included units in HMP Prescoed that can house 40 men, with single bed units and bathroom

facilities. HMPPS also moved men from HMP Parc and HMP Cardiff to HMP Prescoed to provide additional capacity. In addition to this, a 38 extra accommodation spaces were created at HMP Parc.

Alongside these measures, HMPPS in Wales and Public Health Wales have created a Wales specific National contact tracing guidance for Welsh prisons. Underneath this, prisons have local contact tracing plans that reflect the individual nature of the establishment. These plans have adapted the Test Trace Protect strategy which is in place at a national level. We also have protocols in place with colleagues in England to share information on cases which have crossed between England and Wales.

For vaccinations, the Heads of Healthcare in each prison has joined the Vaccine Planning Boards in their respective Local Health Board. Each prison health team has been engaged in preparatory work to enable vaccine roll-out when available, this has included ensuring PPE supplies, fridge space and staffing levels are readily available.

## 2. Equivalence in the provision of health and social care

The majority of responses we received focused on the principle that prisoners should have access to the same health and care provision equivalent to that in the community, without discrimination on the grounds of their legal situation. However, there was a sense that this is not reflected in the current prison healthcare system in Wales.

Question	Progress
2.1 Can you provide an update on progress in establishing a prison Health and Social Care Oversight Group, and its work to date.	<p>A new joint WG/HMPPS Prison Health and Social Care Oversight Group was established in the summer of 2020, with its first meeting taking place on the 26<sup>th</sup> June 2020. A second meeting took place on the 14<sup>th</sup> October 2020 and the most recent on 13<sup>th</sup> January 2021.</p> <p>The main remit of the Group is to oversee the progress of the agreed priorities for prison health and social care. Work to date has focused mainly on providing oversight and accountability to the COVID-19 response in Welsh prisons. It has also acted as a point of escalation for Prison Health and Social Care Partnership Boards (PHSCPBs), and has facilitated cross-government discussions on Brexit, Substance Misuse and Personality Disorder pathways.</p>

<p>2.2 What are your views on the HMPPS proposal that the Welsh Government should establish a Wales Prison Health Board to provide strategic planning for offender health in Wales. How would this would interact with the Oversight Group and the PHSCPBs.</p>	<p>The HMPPS proposal for a Wales Prison Health Board led to the establishment of the Prison Health and Social Care Oversight Group, which serves the same function.</p> <p>The Oversight Group provides strategic leadership and acts as a point of escalation for any issues that cannot be resolved locally at the PHSCPBs. The PHSCPBs have escalation to the Oversight Group as a standing agenda item, and there is also a representative for the PHSCPBs as a member of the Oversight Group. A standard template for escalation to the Oversight Group has been shared with all the PHSCPBs.</p>
<p>2.3 How confident are you that all PHSCPBs are meeting regularly and that existing arrangements are working effectively?</p>	<p>There has been increased engagement with the PHSCPBs over the last year. There is now a clear route for the PHSCPBs to raise issues to the highest levels in HMPPS in Wales and also the Welsh Government. In addition, the Heads of Healthcare for each prison meet every fortnight with Public Health Wales, the Welsh Government Offender Health Leads and HMPPS in Wales, where they can discuss any issues that arise in delivery or any problems in the functioning of the PHSCPBs.</p>
<p>2.4 How do you respond to calls for an All Wales Strategic Plan for prison health, including a National Implementation Plan to assist Local Health Boards to take forward the recommendations from any Wales Prison Health Board.</p>	<p>In terms of a Strategic Plan, the Partnership Agreement is now in place. This is a collaborative agreement between the Welsh Government, HMPPS, Health Boards and Public Health Wales. It sets out the agreed national priorities for improving prison health with 4 clear workstreams. The priorities are built around the agreement that this is a whole prison approach to improving the health and wellbeing outcomes of prisoners in Wales.</p> <p>They priorities are:</p> <ul style="list-style-type: none"> <li>• The wider prison environment and its contribution to improving health and wellbeing outcomes.</li> <li>• Mental health and the development of agreed standards for mental health services in prisons. .</li> </ul>



	<ul style="list-style-type: none"> <li>• Substance misuse and the development of a new Substance Misuse Treatment Framework for prisons.</li> <li>• Medicines Management - Led by Welsh Government in collaboration with the Royal Pharmaceutical Society.</li> </ul>
<p>2.5 What are your views on the proposals for a clinical lead/champion to address concerns about a lack of clinic leadership and accountability.</p>	<p>A Clinical Lead for Offender Health has now joined the Prison Health and Social Care Oversight Group to provide clinical leadership and accountability.</p>
<p>2.6 What discussions has the Welsh Government had with HMPPS to address concerns in the health and social care inspection regimes at HMP Parc, specifically in primary healthcare provision. Whether there are any opportunities to legislate or otherwise address this gap when the contracts at HMP Parc expires?</p>	<p>The contract expiry at HMP Parc has provided an opportunity for all partners to evaluate the existing health and social care delivery and consider what changes could be made to better meet current and future demands. As part of this work, the Welsh Government has provided funding for a new health needs assessment which will be completed in the first quarter of 2021. The needs assessment will evaluate which services and interventions would provide appropriate levels of care for the complex population at HMP Parc. The needs assessment will influence the future service specification at the end of the current contract.</p> <p>To further inform the service specification, there is currently a Parc Expiry Project Board led by HMPPS, which includes a Health Workstream. The Health Workstream has several smaller Task and Finish groups, whose main focus is to investigate the delivery requirements and help inform the wider health and social care population needs assessment and planning arrangements. Membership includes Adult Mental Health, Substance Misuse, Scheduled and Unscheduled Care (Primary and Secondary), Medicines Management and Youth.</p> <p>There is also a group dedicated to finding future digital healthcare interventions for the prison. Each of these groups has representatives from the Welsh Government, local health and social care representatives and also HMPPS in Wales.</p>

Cwm Taf Morgannwg University Health Board provides oversight of health and social care delivery at HMP Parc, following the transfer of secondary care from Swansea Bay UHB to. This is attended by HMP Parc's health team, senior management and HMPPS. There are also representatives from Cwm Taf Morgannwg UHB as the secondary care provider. In line with similar arrangements in other Welsh prisons, the Local Health Board member is responsible for reporting into their internal governance structures on any issues they deem appropriate, including risk management. This group can also bring issues to the Prison Health and Social Care Oversight Group.

**3. Access to health records**

Another key issue throughout the evidence we received related to the frequency of movement of prisoners both between prisons, and between prison and the community, and the impact of this on effective continuity of care.

Question	Progress
<p>3.1 Have there been any developments in the following areas and, if not, what support can the Welsh Government provide to enable:</p> <ul style="list-style-type: none"> <li>▪ prison healthcare teams to have access to NHS numbers of prisoners when they are being held in prison;</li> <li>▪ community healthcare teams to access System One outside the prison setting; and</li> <li>▪ better communication between justice and health services on release dates and release plans.</li> </ul>	<p>Welsh Government Officials will discuss this issue further with the NHS Wales Informatics Service.</p>
<p>3.2 In relation to arrangements at HMP/YOI Parc, what support can the Welsh Government provide to the local authority in accessing prisoner health records on SystemOne?</p>	<p>A Healthier Wales sets out our expectation everyone in Wales experiences a whole system approach to seamless support, care or treatment through services designed around individuals, based on their unique needs and what matters to them, as well as quality and safety outcomes. This includes ensuring effective arrangements to deliver access to systems and records for all authorised practitioners.</p>

**4. Access to healthcare**

**For further details see Annex, areas include:**  
**Nursing provision**  
**GP Provision**  
**Dentistry**  
**Allied Health professionals**

Question	Progress
<p>4.1 How do you respond to the concerns of the above health professions about prisoner access to healthcare.</p>	<p>Offenders should have equitable access to health services both in the secure estate and community settings. Prison healthcare in public sector prisons is delivered by the NHS and overseen by the Local Health Boards. Partnership Boards, co-chaired by the prison Governor and includes representatives from the Local Health Board oversee health and social care in public sector prisons.</p> <p>We are committed to improving health and well-being in public sector prisons but this can only be achieved by a ‘whole prison approach’ which includes ensuring the environment and regime promote and support well-being. We have identified prison health and wellbeing as a priority for health boards, who have responsibilities in this area.</p> <p>We recognise that offenders are a vulnerable population who frequently present with complex needs and high levels of ill health, often as a result of inequalities. In a direct response, actions to support this group are included in the Welsh Government’s mental health, substance misuse, suicide and self-harm prevention and dementia strategies.</p> <p>We also have the Partnership Agreement for Prison Health in Wales. This outlines agreed priorities between Her Majesty’s Prison and Probation Service (HMPPS), the Welsh Government, Health Boards and Public Health Wales. The Partnership Agreement for Prison Health recognises the importance of a whole prison approach and includes a specific focus on mental health, substance misuse, medicines management and the role of the wider prison environment in improving the health and wellbeing of those in prison.</p>

<p>4.2 What actions can the Welsh Government take to improve this position?</p>	<p>The Prison Health and Social Care Oversight Group is now in place and it will act as a point of escalation for any issues that cannot be resolved locally at the PHSCPBs. The PHSCPBs have escalation to the Oversight Group as a standing agenda item, and there is also a representative for the PHSCPBs as a member of the Oversight Group. A standard template for escalation to the Oversight Group has been shared with all the PHSCPBs.</p>
<p><b>5. Mental health</b>  Much of the evidence we received highlighted the percentage of men in Welsh prisons with mental health issues, referencing research and statistics that demonstrate that people in prison are more likely to suffer from mental health problems than people in the community.</p>	
<p><b>Question</b></p>	<p><b>Progress</b></p>
<p>5.1 It is unclear from the Partnership Agreement whether it includes plans to expand the number of secure hospital beds and the contribution this extra capacity will make to reducing waiting times. Can you provide any further information on this point?</p>	<p>In October 2020 the Welsh Government has revised and republished the Together for Mental Health Delivery Plan in response to the impact of COVID-19. The revised Delivery Plan includes the commitment that the National Collaborative Commissioning Unit (NCCU) will support health boards to undertake an audit of current secure in-patient provision and develop a secure in-patient strategy for Wales. The audit of current secure in-patient provision took place in 2020, with the secure inpatient strategy being developed in 2021.</p>
<p>5.2 Can you update the Committee on progress with the draft mental health standards?</p>	<p>Welsh Government has commissioned the Royal College of Psychiatrists to draft the standards for mental health services in the prisons. The original intention was to finalise the standards and to implement these in 2020. However, some elements of this work have been delayed due to the impacts of COVID-19. Universal standards for mental health services (which include a focus on admission and assessment / case management and treatment / referral, discharge and transfer / patient experience / patient safety / environment / Welsh Language / workforce capacity and capability / workforce training, CPD and support / Governance / 24 hour mental health care) have been drafted. These are currently being finalised, along with condition specific standards for people with dementia and autism. The Welsh</p>

Government will work with the Health Boards and the prisons over the coming months to support their implementation.

## 6. Self-harm and suicide

There are well known risks relating to suicide and self-harm for people in prison – something this Committee identified in its 2018 Suicide prevention report. The RCN told us that a working group was set up in autumn 2018 to establish the development of consistent mental health services in Welsh prisons but go on to say that no update has been provided. In their response to this Committee’s Suicide prevention follow-up consultation, the Royal College of Physicians (RCP) stated that they have been approached by Welsh Government about undertaking a review of the provision of mental health services in prisons. They said this work was almost ready to begin.

Question	Progress
6.1 Can you provide an update on the review of mental health service provision in prisons that you have commissioned from the RCP.	The Welsh Government commissioned the Royal College of Psychiatrists to develop new standards for mental health services in the prisons. Further work will be needed to support the relevant Health Boards and the prisons – with the view to implementing these new standards in 2021.

## 7. Substance Misuse

There was agreement amongst those submitting evidence that more work was needed to reduce the impact of substance misuse, including from the use of psychoactive substances. This needed to include a commitment to reduce substance misuse in prison, as well as the supply of, and demand for, illicit drugs in prisons. HMPPS in Wales referred to the Expert Advisory Group for Medicines in Scotland which provides advice to NHS Boards Drug Treatment Centres on the appropriate use of medicines and other therapeutic interventions in prisons. They suggested a similar panel should be introduced in Wales by the Welsh Government.

Question	Progress
7.1 What is your view on the HMPPS suggestion that the Welsh Government should establish an Expert Advisory Panel for Medicines in Wales similar to that in place in Scotland.	Officials will discuss with HMPPS their suggestion to establish in Wales a similar body to the Expert Advisory Group for Medicines in Scotland before giving any further feedback to Committee.
7.2 Can you provide further information on work to produce a service specification for substance misuse in prisons in Wales.	We have responded to 7.2 and 7.3 together as they relate to the same subject as the service specification being referred to it the Substance Misuse Treatment Framework (SMTF).

<p>7.3 Can you provide an update on progress with the Substance Misuse Treatment Framework.</p>	<p>Within the letter it states that the RCN would like to see training available for psychoactive substances. The Welsh Government have a national website which covers harm reduction in Wales. This website has e-learning which includes a module for new psychoactive substances – please see link below <a href="https://www.harmreductionwales.org/training-and-elearning-harm-reduction-wales/">https://www.harmreductionwales.org/training-and-elearning-harm-reduction-wales/</a></p> <p>In addition, psychoactive substances and how to effectively manage individuals who have been using these form part of the SMTF with advice on psychosocial interventions.</p> <p>The latest draft of the Substance Misuse Treatment Framework for the Clinical Pathway for the Management of Substance Misuse in Prisons in Wales has incorporated the second set of feedback and comments from HMPPS, Dyfodyl, Public Health and Welsh Government Colleagues on:</p> <ul style="list-style-type: none"> <li>• The clinical pathway for assessment and management of substance misuse including complex care, multiple dependencies and co-occurring substance use and mental health</li> <li>• Screening, diagnosis and treatment of blood borne viruses, Tuberculosis and sexually transmitted infections</li> <li>• Support for resettlement in line with the development work on ‘Accommodating offenders in Wales strategic framework’</li> <li>• Workforce realignment and development</li> </ul> <p>Due to the current pandemic, the series of stakeholder events across Wales has been delayed and it is expected that this work will be undertaken in 2021.</p>
<p>7.4 Can you provide further information on the work of the Deep Dive Group, including any outputs or recommendations they have produced.</p>	<p>Due to the pandemic the group was suspended, but reconvened on 14<sup>th</sup> December 2020, with good attendance and representation from a variety of sectors.</p> <p>The meeting:</p> <ul style="list-style-type: none"> <li>• Reviewed working practices during pandemic</li> <li>• Captured lessons learned/identified new areas of work</li> </ul>

	<ul style="list-style-type: none"> <li>• Discussed the current work plan.</li> </ul> <p>Future actions-</p> <ul style="list-style-type: none"> <li>• To review current work plan by 29<sup>th</sup> January 2021</li> <li>• Identify new actions and reprioritise all actions</li> <li>• Identify if “quick wins exist”</li> <li>• Next meeting due April 21.</li> </ul>
<p><b>8. Medicine management</b></p> <p>Currently, medicine management issues are addressed at a local level. The BMA said it would welcome a formal mechanism for the streamlining of prescribing policies across the Welsh prison estate, explaining that “what happens in one establishment can have a massive impact at another”. The Royal Pharmaceutical referred to professional standards for optimising medicines in a secure environment. These are aimed at services provided in England as good practice, but did not apply to Wales. You confirmed that the Welsh Government was leading the medicines management workstream of the Partnership Agreement, in partnership with the Royal Pharmaceutical Society. The work of the RPS in this area would be to appraise health boards on their progress against current standards for medicines management in a secure environment, and then develop plans for each prison or health board to improve their performance against those standards.</p>	
<p><b>Question</b></p>	<p><b>Progress</b></p>
<p>8.1 Can you provide an update on progress with this workstream.</p>	<p>Due to the high levels of pressure that have been placed on the prison healthcare teams during the COVID-19 pandemic, elements of this workstream are currently paused. Additionally, as dispensation of medication has been significantly affected by regime changes in response to COVID-19, we have been advised to pause some elements of the workstream until these systems return to normal, this was to avoid artificial skewing of the findings.</p> <p>Prior to March 2020, the Royal Pharmaceutical Society secured the tender to lead this workstream on behalf of the Welsh Government. The contract includes initial data collection and assessment; prisons visits; and an individual Status and Improvement Report for each establishment. Through this work, consideration will also be given to national policies that need to be developed to support medicines management in the prisons.</p>

A key element of this workstream was in prison engagement with Pharmacy teams. This work has been postponed, but desk-based research and surveys re-started in October. The RPS also held a virtual engagement session with prison health teams in Autumn 2020 to set out the priorities of the workstream and gather support for the audit, as well as to introduce the Audit Tool to the teams. WG officials have also established monthly meetings with the Contractors to provide oversight to this work.

In addition to this, work is currently underway to assess the data capture capability of current NHS Wales IT systems to help facilitate this work.

**9. Prison Environments**

Your written evidence states that the workstream in relation to the prison environment is being led by HMPPS. At the time of our session with you, we asked you about the key outcomes indicators and performance measures for this workstream, and you told us you were not aware of them because that work had not yet been completed. You said that, whilst so many factors relating to the environment and to the regime in the prison are the responsibility of the prison service because they own the physical structure of the prison, you had a direct interest in the outcome of the workstream and how it would feed into the Welsh Government's ability to deliver national indicators and standards.

<b>Recommendation</b>	<b>Progress</b>
<p>9.1 Can you now provide an update on the prison environment workstream and, in particular, the development of key outcome indicators and performance measures.</p>	<p>The prison environment workstream commenced in January 2020, beginning with visits to each prison in Wales to conduct focus groups and survey the establishments for any issues that could impact well-being. This work was also to find areas of best practice which can be shared throughout Wales. The workstream conducted initial visits to the prisons from January to March 2020, and created findings reports that highlighted areas working well, areas of improvement and key issues raised in the prisoner forums. This included promotion of the work being done at HMP Parc for men with Autism, following their recent accreditation from the Autistic Society.</p> <p>However, due to the Coronavirus outbreak HMPPS have had to make changes to the workstream to adjust for resourcing impact and regime alterations. This has resulted in pausing some elements of the workstreams but also expanding its remit to include environmental changes in response to COVID-19, and well-being interventions for staff and prisoners. The workstream will resume work on the Environmental Health Indicators when</p>



the regime and community restrictions have lifted, so the next round of visits can take place.

The expanded remit since March 2020 includes:

- The initiation of a staff and prisoner COVID-19 testing pilot, which began in HMP Swansea on the 7th Oct and HMP Berwyn the week after
- Working with Public Health Wales to implement Exceptional Delivery Models (EDMs), to bring back key areas of the prison regime, such as outdoor gym, education and OMU
- Development of mental health kits for men in isolation, including meditation guides
- Creation of new content for the prison radio station to help with loneliness
- Access to the C.A.L.L mental health line rolled out to Welsh prisons
- Working with partners to review and develop innovative ways for in cell exercise
- Working with Local Health Boards (LHBs) to implement use of iPads
- Implementing additional signage to inform social distancing
- Developing contact tracing guidance for each of the prisons with Public Health Wales
- On-going complex case consultations with case managers including WISDOM and High-Risk Pathway consultations
- Creating of distraction packs for residents and service users across prisons and probation. This included easy read adaptations of national and local communications to aid communication for men with learning difficulties
- Supporting the Brain Injury linkworker service across the Cardiff & Swansea Clusters
- Key Worker support extended for managing complex cases and development of Key Worker resource packs to structure sessions/contact with service users in light of COVID-19
- Digital messages (audio and visual from the men to their families) at HMP Cardiff
- Establishment of virtual online visits for prisons
- Emotional Health accredited learning in cell at HMP Swansea
- Weekly newsletters keeping men informed of COVID-19 restrictions
- Mobile libraries created in all prisons to keep men occupied

	<p>Key progress made by HMPPS since the outbreak began to support staff has included:</p> <ul style="list-style-type: none"> <li>• Working with local resilience forums to facilitate staff testing</li> <li>• Reflective practice sessions to staff across NPS &amp; PSPs where requested &amp; weekly dial ins</li> <li>• Staff Well-Being support packs (i.e. anxiety busting packs) as well as collating evidence-based guidance for managers across Directorate</li> <li>• Adapting existing training packages so they can be delivered via video or webinars (Building Resilience, Professional Boundaries etc) to staff</li> </ul>
<p>9.2 How will these help you, in partnership with HMPPS, to monitor progress in this area</p>	<p>When completed, the Environmental Health indicators will outline specific areas of focus for each prison, which will provide a baseline to monitor improvements and inform interventions. These will feed into the National Prison Health Indicators being developed as part of the partnership agreement for offender health.</p>
<p><b>10. Social care and an ageing prison population</b></p> <p>We have consistently heard that the number and proportion of the prison population that are older prisoners (defined as 50 and over) has increased and is projected to keep growing, and that this cohort of prisoners is likely to have greater social and healthcare needs. Resettlement and Care for Older ex-Offenders and Prisoners (RECOOP) said that people aged over 50 are the fastest growing group in the prison population and meeting their needs will continue to be one of the biggest challenges facing the criminal justice system for years ahead.</p>	
<p><b>Question</b></p>	<p><b>Progress</b></p>
<p>10.1 Can you update us on work in this area?</p>	<p>Ensuring that older prisoners receive the right care and support is a key priority of HMPPS in Wales and the Welsh Government. As prisoners get older, their health social care needs can also increase. Others will also have a co-existing mental health condition or chronic health problem and/or disability. Institutionalisation can be an issue, as well as loss of contact with family and friends.</p> <p>The Prison Health and Social Care Oversight group has set out the agreed national priorities for older prisoners across the prison estate. Those</p>

priorities reflect the strategic national priorities of the Welsh Government such as those set out in A Healthier Wales.

The Social Services and Well-Being (Wales) Act 2014 and associated frameworks establish clear rights to social care. As part of this partnership, the National Care and Support Pathway for Adults in the Secure Estate sets out key steps and those responsible at each step, for identifying, referring, assessing and meeting the care and support needs of adults in the secure estate, as well as planning for, and upon their release back to the community.

Locally, all prisons in Wales have Memorandums of Understanding with relevant local authorities which outline how social care is provided, and the prisons and local authorities work closely to support the delivery of these services. Prison Health and Social Care Partnerships are integral to securing and delivering consistent health, social care and well-being outcomes for everyone in prison in Wales.

Our approach has proved effective in delivering our national priorities within the non-devolved environment. Currently, the health and social care needs of older prisoners with Dementia are being met by in reach services or hospital-based care. The recent HMIP thematic into Social Care cited good practice at HMPs Cardiff and Usk and Prescoed, reporting that the referral pathway had driven a target for initial screening and assessment by respective local authority social care teams within 24 hours of referral.

Dementia is also a named condition in the Mental Health Workstream under the Partnership Agreement for Prison Health. The Royal Collage of Psychiatrists will be undertaking a review of current Dementia provision in Welsh prisons and establishing new standards for care in this area.

HMP Usk holds the highest proportion of older prisoners of all the prisons in Wales, with 10% of the population over 70. The prison caters specifically for Men Convicted of Sexual Offences population, and vulnerable individuals.

	<p>HMP Usk has taken an innovative approach to caring for older prisoners and has become a hub for best practice that is shared across the Welsh estate.</p> <p>To support offenders with Dementia, HMP Usk and Prescoed work closely with social care and third sector colleagues, enabling them to deliver real differences to the men in their care. The professional relationship the prison has developed with Monmouthshire County Council has been essential in meeting the needs of an aging population, as well as their partnership with the Salvation Army.</p>
<p>10.2 Can you provide us with a copy of the HMPSS Strategy for the management of older persons in custody in the Welsh Region</p>	<p>Officials have contacted HMPPS in Wales for the strategy for the management of Older Persons in custody in the Welsh Region and will forward accordingly when received.</p>
<p>10.3 How do you respond to calls for a national strategy for older prisoners?</p>	<p>It is imperative that the needs of the older prisoner population continue to be assessed and planned for coherently across the devolved and non-devolved responsibilities. This is integral to our partnership working with HMPPS through the Prison Health and Social Care Oversight Group, and the local partnership arrangements. The Group is leading a whole prison approach to improving the health and well-being outcomes across the estate in Wales including the evolving age-profile of the prison population and their needs for care and support.</p> <p>The Group has already identified the wider prison environment as a key priority to support and secure well-being and ensure equitable health and social care arrangements. These are consistent with the UK Government's priorities for older prisoners published in November 2020 which also include purposeful activities for offenders and preparing them for release and resettlement.</p> <p>Alongside this, we are consulting on our vision for an age friendly Wales (<a href="https://gov.wales/sites/default/files/consultations/2020-12/consultation-document_0.pdf">https://gov.wales/sites/default/files/consultations/2020-12/consultation-document_0.pdf</a>). Our draft Strategy sets out the national aims to enhance well-being; to improve local services and environments; to build and retain people's own capability and to tackle age-related poverty. We have ensured the draft Strategy highlights the needs of older prisoners as part of a whole</p>

	<p>system approach to seamless support, care or treatment through services designed around individuals, based on their unique needs and what matters to them, as well as quality and safety outcomes.</p> <p>We will continue to work across national Governments, together with all relevant partners and agencies, to secure improved outcomes for all people across Wales that includes but is not limited to health and social care.</p>
<p>10.4 How do you respond to calls for the Welsh Government to review the funding allocations for social care provision in prisons in Wales to ensure that needs are adequately met.</p> <p>Task Page 182</p>	<p>The way social care funding in prisons has been distributed was considered, reviewed and agreed with local government as part of the formal arrangements established under our Local Government Partnership Scheme. The purpose of the Scheme is to ensure consistent, fair and equitable arrangements to transfer specific grants to the settlement. The Scheme reflects local government's request for greater flexibility to manage their resources.</p> <p>Those decisions were re-considered at the Welsh Government's request, following representations received from one local authority. Local government representatives re-confirmed the original decision to distribute the available funding across all 22 local authorities from 2018/19.</p>
<p><b>11. Funding</b></p> <p>The Welsh Government receives funding for prisoner healthcare in public sector prisons in Wales through the Welsh Block. Since 2004-05, the UK Government provides approximately £2.544m to the Welsh Government for this purpose. You confirmed that the block transfer has not been updated since 2004-05.</p> <p>We heard evidence that prisons in Wales are underfunded by the UK Government. The RCN and the RCGP both stated that the current funding system for prison healthcare is outdated, with the RCGP describing the funding as it currently stands as "insufficient", having not received uplifts since the NHS took over responsibility for prison health. The RCN stated that "calling for reform should be a priority for Welsh Government". Both the Royal Pharmaceutical Society and Public Health Wales agreed</p>	
<p><b>Question</b></p>	<p><b>Progress</b></p>

<p>11.1 What recent discussions have you had with the UK Government about resourcing and funding arrangements for Welsh prisons.</p>	<p>The Welsh Government does not receive funding from the UK Government for prisoner healthcare on an annual basis. In 2014-15 the Welsh Government received a recurrent transfer into the Welsh Block of £2.544m to support prisoner healthcare in public prisons in Wales. No additional specific funding has been provided to Welsh Government (by the UK Government) for prison healthcare since that time.</p> <p>The Welsh Government wrote to the relevant Health Boards in March 2020 to request information on current costs associated with providing primary and secondary health services in the prisons (including annual capital, revenue and staffing costs for providing healthcare). The intention was to use this review of funding to inform discussions with the UK Government – regarding future funding for prisons in Wales.</p>
<p>11.2 What work have you undertaken to review the level of funding and arrangements for funding models across Welsh prisons.</p>	<p>As noted for question 11.1 - The Welsh Government wrote to the relevant Health Boards in March 2020 to request information on current costs associated with providing primary and secondary health services in the prisons (including annual capital, revenue and staffing costs for providing healthcare). The intention was to use this review of funding to inform discussions with the UK Government – regarding future funding for prisons in Wales. The impact of the pandemic has meant this review was paused in 2020. The intention is to return to these conversations in 2021, in the context of recovery planning for the prisons.</p> <p>To support the prison health priority, Welsh Government has allocated an additional £1million of recurrent funding to support local health boards to improve access to health services in the public prison estate. Swansea Bay UHB, Cardiff and Vale UHB and Aneurin Bevan UHB have all received funding which will support improved access to mental health and co-occurring mental health and substance misuse services in HMP Swansea, HMP Cardiff and HMP Usk and HMP Prescoed.</p> <p>In respect of HMP Berwyn, there is a direct funding relationship between HMPPS and Betsi Cadwaladr University Health Board. It has been agreed that the funding for the prison health services at HMP Berwyn will be part of a</p>

future transfer to the Welsh Government once the prison is up to capacity and is fully operational.

**12. Data**

In relation to data collection, we heard evidence of concerns about the limited data set in the Welsh adult prison estate. In terms of trying to improve data collection, you stated that, “as part of the partnership agreement, we’ll end up having a standard set of national indicators and we can then use those to report on for prisoner outcomes. So, that is work that is actively being pursued.”

**Question**

**Progress**

12.1 Can you provide an update on work in this area.

This work is currently paused due to resourcing constraints caused by Covid-19.





**Public experiences of Test, Trace, Protect (TTP) in Wales**

**Research commissioned by Senedd Cymru and produced in consultation with Senedd  
Research**

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## TOP-LINE SUMMARY

### Key findings

- Experience of Test, Trace, Protect Service (TTPs): Participants' experience of TTPs was variable. There was considerable variation in the time taken for TTPs to contact individuals from the time of presumed exposure (33% within one day and 64% within 3 days, 36% 4 days or more). There was also considerable variation in terms of the frequency of follow-up contact (e.g. 25% daily contact versus 50% no further contact).
- Views on TTPs: Participants' satisfaction with TTPs was mixed. Overall, roughly half (48%) were satisfied with their experience of TTPs, compared to little over one-third (36%) who were dissatisfied. Roughly half of the survey respondents were satisfied with the ability of TTPs to answer their questions (54%). Most participants felt the advice from TTP was clear (70%) and easy to carry out (76%)
- Adherence: Reported adherence to self-isolation guidance was high, with 80% of survey respondents reporting having fully isolated and only 1% suggesting they didn't isolate at all. Most commonly reported challenges to self-isolation were: physical health challenges (e.g. lack of exercise, unusual aches and pains etc.) (46%), mental health challenges (e.g. anxiety, feeling down, loneliness etc.) (46%), adjusting to usual daily routine (34%). Although not as common, important challenges which may require some self-isolators to be provided with additional support included lack of access to essentials (20%), care commitment challenges (14%) and financial challenges (12%).
- Self-isolation support scheme: Very few survey respondents (8%) were informed about the self-isolation support scheme by TTP contact tracers. Just over half (53%) didn't know about it at all. Just under one-in-four (27%) felt that their income was negatively affected by having to self-isolate (of which, one-in-ten (10%) strongly agreed that it had).
- Mental health: One of the main challenges' participants experienced was the mental health impacts of self-isolation. Three-quarters of survey respondents (75%) did not have their emotional or mental wellbeing checked on by TTP contact tracers. Over half (53%) felt that they would have liked more information about support for their mental health while self-isolating

### Key recommendations

- **Recommendation 1:** TTPs should ensure greater consistency in communications between contact tracers and those being asked to self-isolate, for example in terms of time-to-contact (consistently low, ideally within 1-2 days) and in terms of the frequency of subsequent contacts (consistently high, ideally daily).
- **Recommendation 2:** TTPs should consistently ensure that *all* those required to self-isolate are asked about their financial situation and, where relevant, provided specific information support for applying for self-isolation payments or other forms of financial assistance.
- **Recommendation 3:** TTPs should consistently enquire into the mental and emotional wellbeing of *all* those asked to self-isolate and should provide resources and links for available and relevant mental health support.
- **Recommendation 4:** People who do *not* feel they have the capability, opportunity or motivation to adhere to self-isolation need to be systematically identified and provided with support resources to help them adhere.

## BACKGROUND

The Test, Trace, Protect Strategy forms part of the Welsh Government’s Leading Wales out of the Coronavirus Pandemic Framework.<sup>1</sup> The strategy involves community health surveillance and contact tracing, with a view to identifying and supporting those requiring self-isolation in order to mitigate the transmission of coronavirus in Wales.<sup>2</sup> Current guidance suggests that people should self-isolate for ten days if: they develop symptoms; they have tested positive for Covid-19 (even without symptoms); they live with someone, or someone from their extended household has developed symptoms or tested positive; or they have been contacted by the TTP service and told to self-isolate (as a result of being in contact with someone who has tested positive).<sup>3</sup>

A rapid review of the wider (pre-Covid-19) literature on adherence to quarantine found that adherence decisions were associated with people’s knowledge of the disease and quarantine measures (e.g. clear instructions), social norms (e.g. around ‘civic duty’); high perceived benefits of quarantine and high perceived risk of the disease, as well as practical issues such as running out of supplies or the financial consequences of being out of work.<sup>4</sup> Research findings in relation to the current coronavirus pandemic in the UK match this earlier literature on adherence.

Earlier in the COVID-19 pandemic (between March-September), complete adherence to self-isolation guidelines was low for both those with Covid-19 symptoms (18.2%) and for

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<sup>1</sup> <https://gov.wales/leading-wales-out-coronavirus-pandemic>

<sup>2</sup> <https://gov.wales/test-trace-protect-coronavirus>

<sup>3</sup> <https://gov.wales/self-isolation>

<sup>4</sup> [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

those contacted by contact tracers (10.9%).<sup>5</sup> Non-adherence with symptoms was associated with: being male, being in a younger age groups, having a dependent child in the household, being in a lower socio-economic group, experiencing greater hardship during the pandemic and being a key worker.<sup>5</sup>

However, more recent data (released January, 2021) suggests that younger adults (aged 18-59) are more likely to isolate for longer compared to older adults (aged 60+), and that there was no significant difference between men and women.<sup>6</sup> Overall, the COVID Social Study survey found that 4 out of 5 people are isolating for at least the recommended number of days (10 or more) when they are told they have come into contact with someone who has symptoms of Covid-19 (Fancourt et al 2021). They also found that less than 2 in 3 isolated for 10 days or more when they themselves had symptoms of Covid-19.<sup>6</sup>

However, this research does not explore differences between those who had confirmed positive tests for Covid-19, and those who had symptoms but no confirmed positive test. It is possible for example that a higher proportion of non-adherence is amongst those who had not tested positive and who believed their symptoms may have been due to a non-Covid illness. It may also be due to the fact that whereas self-isolating following a confirmed positive test or following instruction from NHS contact tracers is a legal requirement, self-isolating following the onset of Covid-19 like symptoms, prior to or in the absence of a test, is not.

Those in a lower income group are less likely to self-isolate for the recommended length of time and are much more likely not to isolate at all.<sup>6</sup> Research on other countries suggests that those from lower or less stable incomes backgrounds may lack the practical capacities to adhere.<sup>7,8</sup> It may be that some, particularly those in low-paid occupations, are reluctant to take Covid-19 tests when experiencing possible symptoms for fear of a positive test and the loss of income that self-isolation might entail.<sup>9</sup>

Large, longitudinal surveys provide an important overview of the broad patterns of adherence to self-isolation. However, further research is necessary to explore the nuances behind adherence and non-adherence to self-isolation. For example, binary measures looking at whether participants did or did not leave home do not distinguish between those who may have left the home frequently and visited potentially higher-contact indoor environments (e.g. shops, certain workplaces) compared to those who left the home once or infrequently and visited likely lower-contact outdoor environments (e.g. parks for exercise). Similarly, it is important to know whether those who state they isolated for 10 days or more were fully isolated during that time and whether those who state they self-isolated for 1-5 days were still partially isolated or whether they returned to general guidelines. In this mixed-methods study, we explore in depth adherence to self-isolation in Wales. Qualitative research is used to explore some of these nuances around how participants understand self-isolation and adherence, with quantitative research exploring specific behaviours associated with self-isolation. We also explore participants' views and experiences of the Test, Trace, Protect

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<sup>5</sup> <https://www.medrxiv.org/content/10.1101/2020.09.15.20191957v1.article-info>

<sup>6</sup> [https://b6bdc03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5\\_bf013154aed5484b970c0cf84ff109e9.pdf](https://b6bdc03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_bf013154aed5484b970c0cf84ff109e9.pdf)

<sup>7</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00382>

<sup>8</sup> [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3598215](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3598215)

<sup>9</sup> <https://www.theguardian.com/society/2021/jan/16/low-paid-shun-covid-tests-cost-of-self-isolating-too-high>

service in Wales. Specifically, we aim to explore the extent to which they found the service to be effective (for example, whether they found the advice to be clear), the extent to which they were able to follow the advice given, and what challenges and supports to self-isolation they experienced and received or might have liked or needed.

## METHODS

### Design

We conducted a cross-sectional mixed methods study, combining quantitative questionnaires with qualitative interviews conducted in December 2020 and January 2021. Ethical approval for the study was granted by Swansea University’s School of Management Research Ethics Committee and Swansea University’s College of Human and Health Sciences Research Ethics Committee.

### Participants

Eligibility criteria for this study were (1) Living in Wales; (2) Aged 18 or older; (3) To have been contacted by Test, Trace, Protect (TTP) during the pandemic and have been told to self-isolate (either because they tested positive for Covid-19, or because they were told they had been in contact with someone who had tested positive for Covid-19). Sampling for the study was non-probability, combining convenience and snowball sampling approaches. Recruitment took place primarily via social media. This included: targeted paid-for Facebook ads (adults in Wales); targeted posts in Facebook community groups (including both general community groups focused on local issues, and specifically local coronavirus support and information groups); and via Twitter networks (e.g. re-tweets). A formal press release was also publicised by Swansea University in order to boost recruitment. Interview participants were compensated for their time with a £10 gift card (Amazon). Survey respondents completed the survey voluntarily. Informed consent for interviews and surveys was provided. As of 26<sup>th</sup> January 2021, 14 interviews had been conducted and the survey had received 78 responses. Participants’ demographic characteristics for the total survey sample and interviews are reported below (Tables 1-3) (all survey questions were optional and response totals for each question are provided within the results). Data collection is ongoing.

Characteristics	N = 120
<b>Gender</b>	
Male	28 (23%)
Female	90 (75%)
Prefer not to say	2 (2%)
<b>Ethnic group</b>	
White	111 (93%)
BAME	9 (7%)
<b>Age</b>	
18-29	25 (21%)
30-39	28 (23%)

40-49	25 (21%)
50-59	30 (25%)
60-69	10 (8%)
<b>Living status</b>	
Alone	14 (12%)
With friends or parents	15 (14%)
With partner	32 (24%)
With partner and children	43 (42%)
With children	9 (8%)
<b>County</b>	
Blaenau Gwent	5 (4%)
Caerphilly	6 (5%)
Monmouthshire	1 (1%)
Newport	7 (6%)
Torfaen	4 (1%)
Wrexham	1 (1%)
Conwy	1 (1%)
Cardiff	11 (9%)
Vale of Glamorgan	3 (3%)
Bridgend	4 (3%)
Merthyr Tydfil	1 (1%)
Rhondda Cynon Taf	11 (9%)
Carmarthenshire	4 (3%)
Ceredigion	2 (1%)
Pembrokeshire	3 (3%)
Powys	3 (3%)
Neath Port Talbot	9 (8%)
Swansea	44 (37%)

Table 1: Demographic characteristics reported by survey respondents

<b>Question</b>	<b>N = 121</b>
<b><i>Have you been contacted by TTP?</i></b>	
Yes, by phone	75 (62%)
Yes, I was told to isolate by the app	25 (21%)
No	15 (12%)
Maybe, I'm not sure	6 (5%)
<b><i>Why were you contacted by TTP?</i></b>	<b>N = 103</b>
I had a positive Covid test	28 (27%)
I was in contact with someone who tested positive for Covid	62 (60%)
Other/not sure	11 (11%)

Table 2: Details of survey respondents' TTP contact

<b>Characteristics</b>	<b>N = 14</b>
<b>Gender</b>	
Male	5 (36%)
Female	9 (64%)
<b>Ethnic group</b>	
White	13 (93%)
BAME	1 (7%)
<b>Age</b>	

18-29	4 (29%)
30-39	3 (22%)
40-49	2 (14%)
50-59	2 (14%)
60+	2 (14%)
Did not say	1 (7%)

Table 3: Demographic characteristics of interviewees

## Data collection and analysis

Interviews were semi-structured and conducted by SW, and the interview schedule was designed by SW and PW. Interviews lasted between 30 minutes and 1 hour in length, were conducted either via phone or online (Zoom) and were audio recorded and transcribed. Interviews sought to initially explore: participants' encounters and experience with TTP (e.g. 'tell me about your experience with TT'); participants' self-reported adherence and their understandings (e.g. 'did you stick to the guidance; what did this involve?'); participants' views on perceived barriers and facilitators to adherence to self-isolation (e.g. 'were there any things that made self-isolating challenging?', 'were there any things that helped you self-isolate?'). Interview data were analysed in accordance with a framework approach.<sup>10</sup> SW and KD analysed the transcripts and developed and applied the thematic coding framework.

The survey was administered via Qualtrics.<sup>11</sup> The survey included: Basic background demographics (5 items); questions focused on the TTP service and on adherence to self-isolation (e.g. how frequently they were contacted, whether they self-isolated) (6 items); questions concerning respondents' perceptions of their capabilities, opportunities, and motivations to adhere to self-isolation guidance (adapted from the COM-B Questionnaire)<sup>12</sup> (9 items), and perceptions of TTP derived from focus group findings (10 items). COM-B questions are on an 11-point scale from 0-10, with 0 being "not at all" and 10 being "very much so". An example question is: "I had the PHYSICAL opportunity to self-isolate. What is physical opportunity? The environment provides the opportunity to engage in the activity concerned (e.g. sufficient time, the necessary materials/resources, reminders)". Relevant survey questions are reported with data in the results section along with response category frequencies and descriptive statistics. All data was kept securely and confidentially in line with ethics committee requirements in order to protect participants' identities.

## RESULTS

### Participants experiences of the Test, Trace, Protect Service

Participants' experiences of TTPs was variable. There was considerable variation in the time taken for TTPs to contact participants from the time of presumed exposure (e.g. 33% within

<sup>10</sup> <https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-13-117>

<sup>11</sup> [https://swanseachhs.eu.qualtrics.com/jfe/form/SV\\_07HhIFNqXTxlnOR](https://swanseachhs.eu.qualtrics.com/jfe/form/SV_07HhIFNqXTxlnOR)

<sup>12</sup> <https://www.nature.com/articles/s41562-020-0887-9>

one day and 64% within 3 days, versus 36% 4 days or more; N = 94) (Figure 2). There was also considerable variation in terms of the frequency of follow-up contact (e.g. 25% daily contact versus 50% no further contact; N =102) (Figure 3).

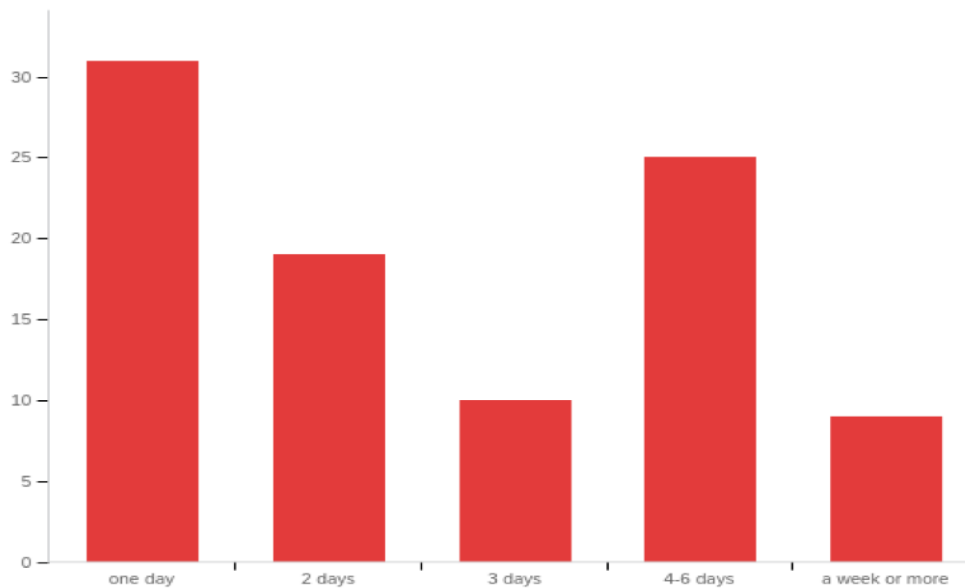


Figure 2.: How long did it take for TTP to contact you (Y axis: number of people)

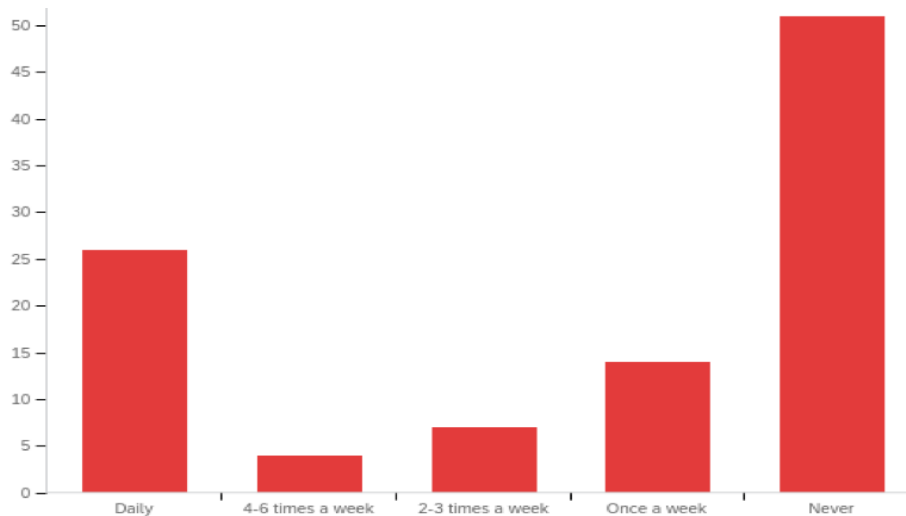


Figure 3.: How often were you contacted after the initial call (Y axis: number of people)

### Participants views of the Test, Trace, Protect Service

Participants’ satisfaction with TTPs was mixed. Overall, roughly half (48%) were satisfied with their experience of TTPs, compared to a little over one-third (36%) who were dissatisfied (Figure 4). Roughly half of the participants were satisfied with the ability of TTPs to answer their questions (54%). Most participants felt the advice from TTP was clear (70%, N=98) and easy to carry out (76%, (N = 97); Figures 5 and 6).



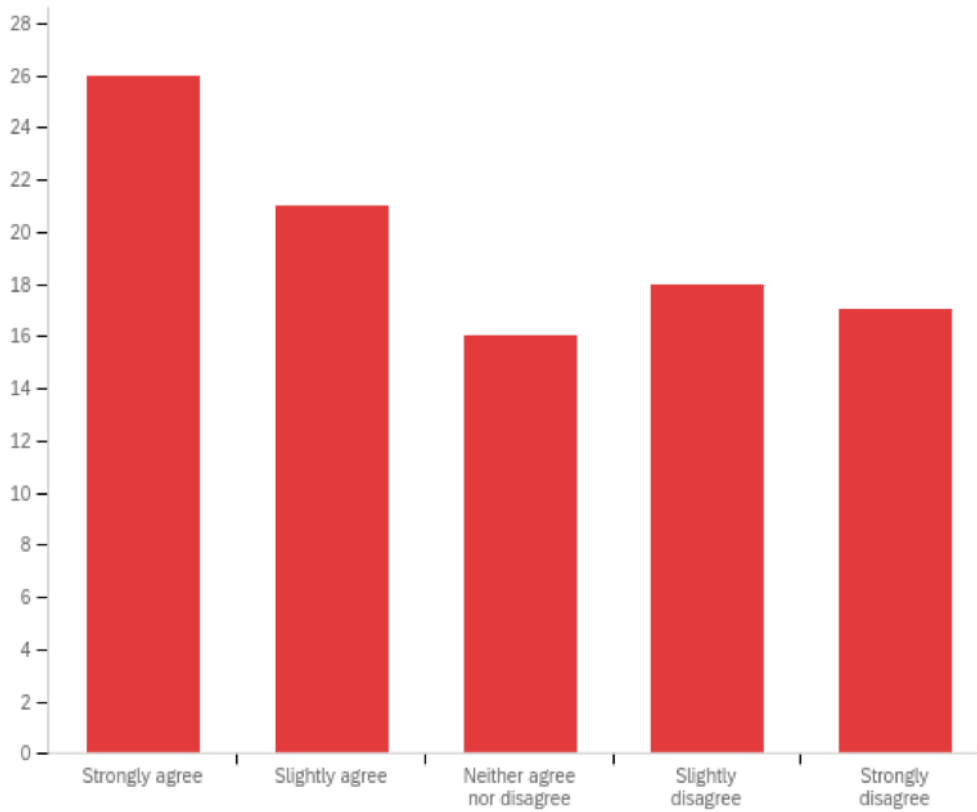


Figure 4.: Overall, I was satisfied with my experience with Test, Trace and Protect (Y axis: number of people).

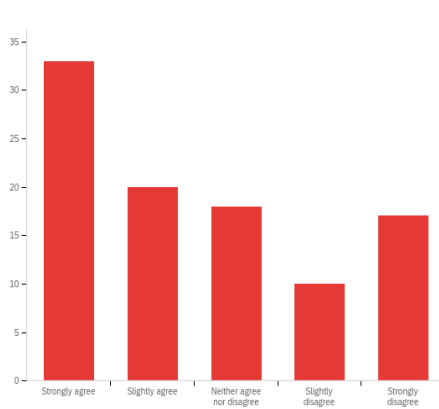


Figure 5: I was satisfied with the ability of my Test, Trace and Protect contact to answer my questions (Y axis: number of people)

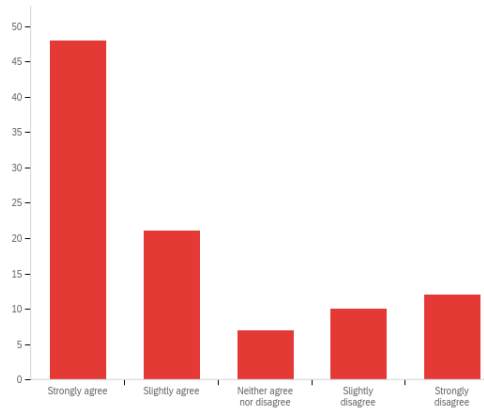


Figure 6: The advice from Test Trace Protect was clear (Y axis: number of people)

## Adherence

Overall, adherence to self-isolation among survey respondents was high, with 80% of participants reporting having fully isolated and only 1% suggesting they didn't isolate at all (N = 96; Figure 7).

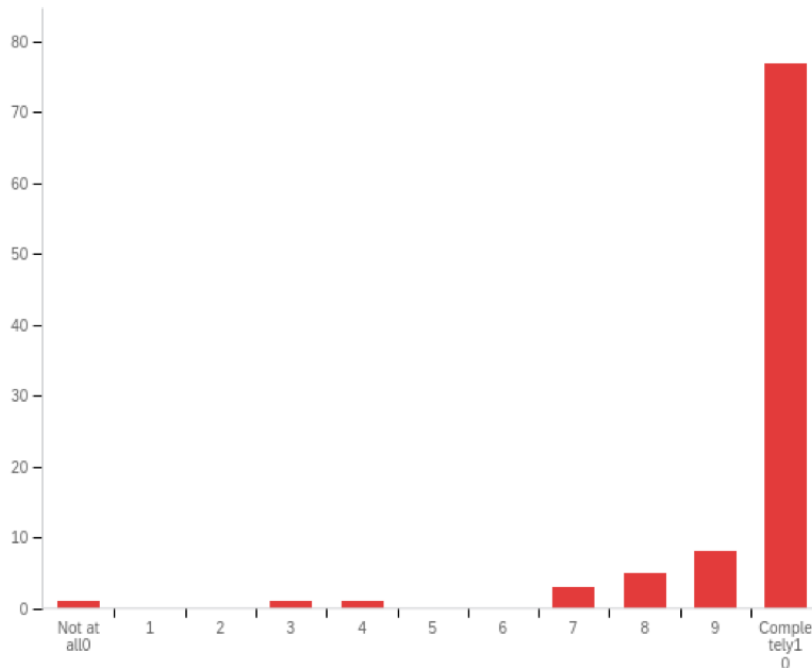


Figure 7: How closely did you follow Test, Trace, Protect's Instructions to self-isolate (Y-axis: number of people)

Qualitative data from the survey (Box 1) and interviews found a number of different understandings and experiences of what self-isolation meant to participants, and there was variety in the extent to which they actually followed official rules. For some, the self-isolation period entailed staying at home entirely and even avoiding contact with those inside their household, while others had a much looser interpretation. One of the most common reasons for non-adherence was to exercise, and this varied from brief once per day exercise during the later stages of self-isolation to long periods of exercise during the self-isolation period. However, amongst those who did leave the house for exercise, participants generally reported taking risk-management ('harm-reduction') steps to minimize the likelihood of infecting others (e.g. going to remote locations, going very early in the morning). People also found it difficult to adhere to guidance (rather than rules) on self-isolating within the household. This may link, as discussed below, to the fact that some participants reported receiving guidance on how to self-isolate within the household whereas others didn't. However, it was also reported by some that self-isolating within the household was unrealistic or impossible for them (e.g. if they had children to care for).

*Strict self-isolation*

“Followed completely even kept a distance from children”

“My entire household isolated completely, didn’t leave the house. We had shopping delivered and other family members didn’t go to work”

“Remained in my house from receiving the letter until the date that was specified. I also slept apart from my partner in a spare room and we kept 2+ meters apart during the isolation

“Stayed inside but found it difficult to distance from family family still at home including 18 month old son”

“Stayed in, didn’t even go out to exercise. Did go out in the car for a drive for a change of scenery! Didn’t leave the car though”

“Had 14 days isolation - After a negative test on the 7th day, I started to run outdoors at 5am for 20min each day”

“Myself and my husband both isolated but we did take our 4 dogs for a walk as we were completely alone and made sure we kept our distance, this was easier as we did this after dark”

“Stayed in other than to exercise but was out on my own exercising for up to 5 hours a day”

“Took no notice of the infringement of my civil liberties for a disease with a 99.75% survival rate and little evidence of asymptomatic spread”

*No self-isolation*

*Box 1: Descriptions of self-isolation understandings and behaviour (from survey)*

Interviewees also reported a high degree of adherence to self-isolation. Only two interviewees (14%) stated that they did not adhere fully to self-isolation guidelines. Non-adherence in this instance was related to trips outside the home for exercise. For one participant, this included one trip outside the home to exercise, and for the other participant this involved multiple trips outside the home for exercise. In the first instance, the reason cited for instance non-adherence was to help the mental health of the self-isolator. They also described they knew it went against self-isolation regulations, and how in doing so, they took steps to avoid being in contact with others (going at 5am in the morning) and to avoid being “tracked”:

“I didn't do the two weeks. I think I got to the seventh or eighth day, and I decided to go for a run. I think I was in like a headspace of needing to get out ... from not having

contact with anyone up to that stage and being alone and not being able to get out it was sort of a release... But I was really paranoid about doing it and I didn't take my phone, I didn't take my GPS watch. I thought I'd be like tracked. ... Yeah, it was just really tough. I did struggle with that period of time” (Participant 1, Male, 20s)

In the second instance, the participant felt that they were not breaking self-isolation guidelines by leaving the house for exercise or essential shopping. In this instance, the participant had been informed indirectly via the organisation (school) they worked for, and were not contacted directly by TTP, despite being told by their school they would be. As such they seemed to conflate general government ‘stay at home’ guidance with the stricter and more specific self-isolation guidance:

“I was expecting - and school told me to expect - a track and trace notification, but I didn't get one ... I think it was ten days I isolated for, as did the family, we stayed in ... [I was] just following the news, and from what school had told me, it was a case of don't leave the house unless it was for exercise, don't go anywhere unless it's essential, it tricky with shopping, we did some online shopping but there was other stuff we needed to get out for, but I followed the government guidelines as best I could” (Participant 14, Male, 50s)

All other participants reported completely adhering to self-isolation guidelines for the full duration of their required self-isolation period. When asked why they self-isolated completely for the full period, reasons commonly cited included doing to reduce transmission of the virus, something that was often framed as the “sensible” thing to do:

“Yes absolutely [we isolated completely] ... we were sensible enough to think, we don't want to mix, we don't want to mix, we don't want this to spread any further, so it wasn't a problem to stay home and isolate at all.” (Participant 2, Female, 50s).

As well as it being the “sensible” or necessary thing to do to prevent further transmission, adherence to self-isolation was also framed in terms of how easy or difficult self-isolating was (“it wasn't a problem at all”). We explore further participants' perceptions of their capacity to self-isolate, and the ways in which contextual factors aided or hindered self-isolation.

### **COM-B: Capabilities, Opportunities and Motivations to adhere.**

Participants reported on their capabilities, opportunities, motivations and behaviours (COM-B) to self-isolate using a modified COM-B scale (11-point scale from 0-10 with 0 being “not at all” and 10 being “very much so”).<sup>13</sup> Overall, they reported a very high opportunity and motivation to self-isolate. The majority reported that they had the physical opportunity to self-isolate (e.g. sufficient time, the necessary materials / resources, reminders) (64% ‘very

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<sup>13</sup> <https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1111/bjhp.12417>

much so') (N=99), the social opportunity to self-isolate (e.g. support from friends, family, local community, social networks) (54% 'very much so') (N=101), the motivation to self-isolate (e.g. I have the desire to, I feel the need to) (68% 'very much so') (N=101), the automatic motivation (e.g. 'the thought of not self-isolating didn't even occur to me (78% 'very much so)'), the physical ability to self-isolate (e.g. I have sufficient physical stamina, I can overcome disability, I have sufficient physical skills) (78% 'very much so') (N=99), and the psychological ability to self-isolate (e.g. having the knowledge, resilience, cognitive and interpersonal skills, having the ability to engage in appropriate memory, attention and decision making processes ) (77% 'very much so') (N = 98). However, it is important to note that there were 2-6 individuals who reported 'not at all' in every category and 9-17% of participants scored 5 or below on the COM-B questions.

### Key facilitators and barriers impacting adherence to self-isolation

Although adherence was high, participants did report a number of challenges to self-isolation. The most commonly reported challenges to self-isolation were: physical health challenges (e.g. lack of exercise, unusual aches and pains etc.) (46%), mental health challenges (e.g. anxiety, feeling down, loneliness etc.) (46%) and adjusting to usual daily routine (34%) (Figure 8). Although not as common, important challenges which may require some self-isolators to be provided with additional support included lack of access to essentials (20%), care commitment challenges (14%) and financial challenges (12%).

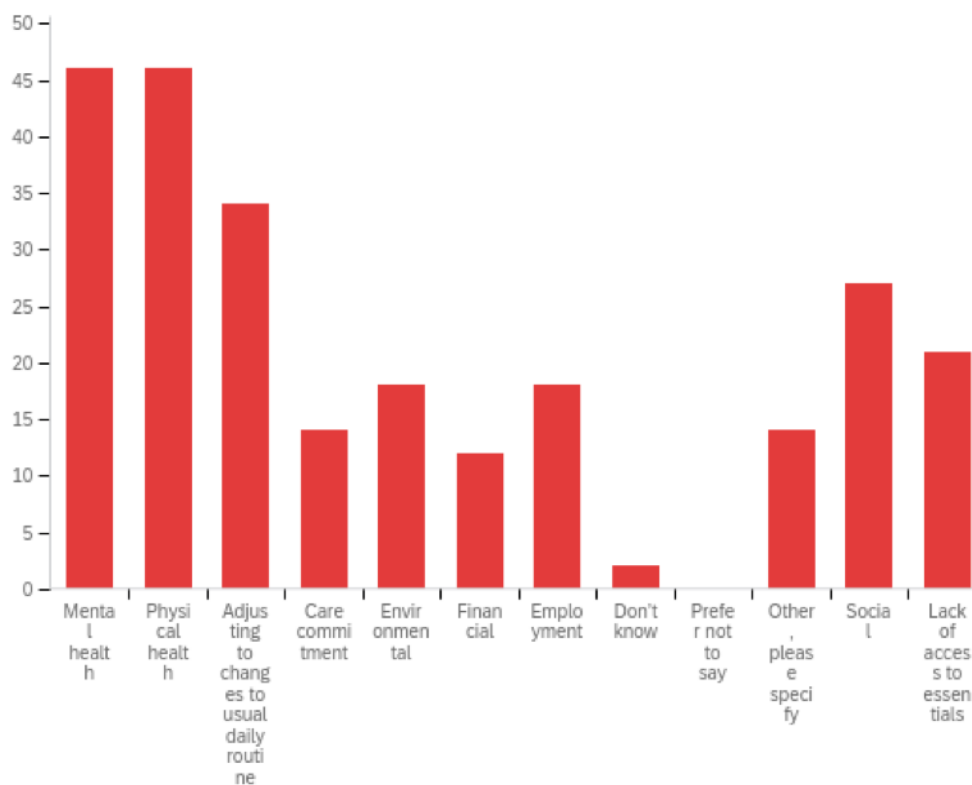


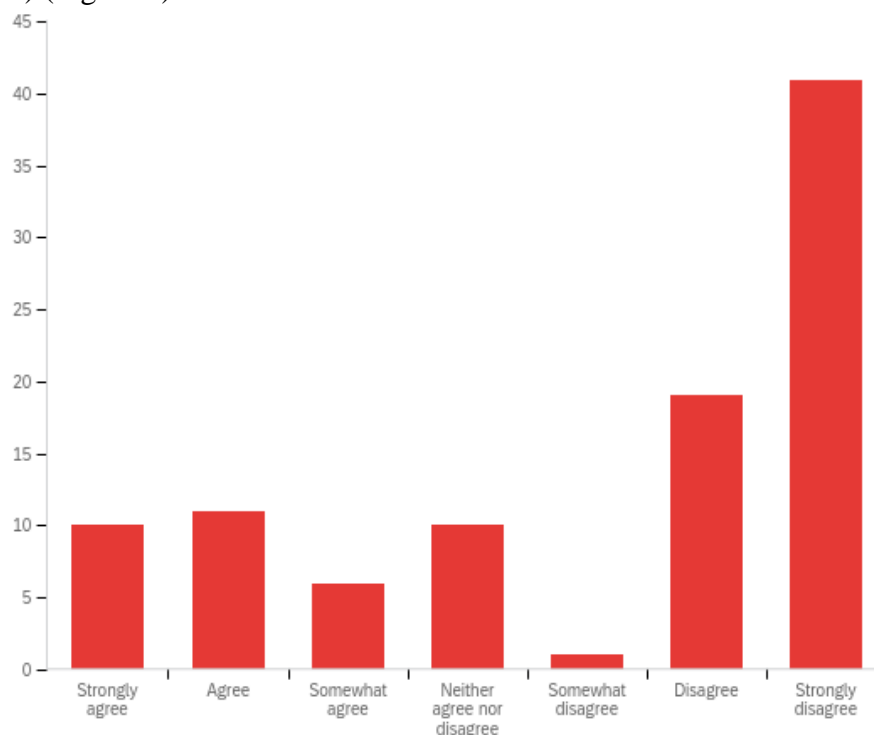
Figure 8: Please tell us about the challenges you faced while self-isolating (Y-axis: number of people)

Some participants experienced multiple challenges and described how they would have benefitted from more support from TTPs, particularly financial support and emotional and mental health support:

“Main challenges were [we were] unable to work and lost income as unwell and run own business but only short period; other main challenge was absolutely no health support you are left to get on with it without any proper advice and support about what to expect or how to manage symptoms; the worry is overwhelming as you move through the days waiting to see if you are going to tip into more serious symptoms; I am very well educated as is my husband & keep up to date but found the lack of health and care support appalling; I think there should be a call from someone to check on you & give advice; I feel traumatised by the whole event” (Anonymous survey respondent)

### *Financial support*

Just under two-thirds (62%) of survey participants did not feel that having to self-isolate negatively impact their affected their income, although one-in-ten (10%) strongly agreed that it had (N = 98) (Figure 9).



*Figure 9: Having to self-isolate negatively affected my income (Y-axis: number of people)*

The vast majority of survey participants (92%, N=96) were not informed by TTP about the government’s £500 self-isolation scheme. 3 applied, 1 of whom was refused. 51 people (53%, N=96) didn’t know about it at all (Figures 10-11)

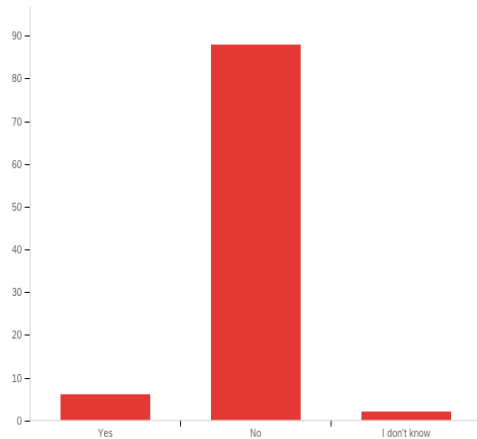


Figure 10. Were you informed about the £500 self-isolation support scheme?

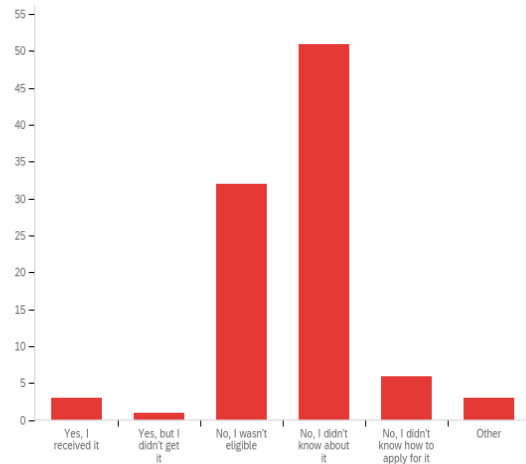


Figure 11: Did you apply for the £500 self-isolation support scheme?

As with survey participants, few interview participants discussed their financial situation with contact tracers, including their ability to cope financially during self-isolation and the existence of the self-isolation support scheme. Most participants stated that having to self-isolate did not negatively impact their financial situation. These participants were mostly receiving stable income, for example because they were retired and receiving a pension because they were able to work from home or had a salaried job with a supportive employer. However, those participants who were either self-employed or in precarious (‘zero-hour’) occupations were financially adversely impacted by the self-isolation period. For example, one participant received no financial support from their employer or government and from their own research felt they were not entitled to it (despite, *prima facie*, meeting eligibility criteria):

“She [the contact tracer] mentioned, nothing like that [the self-isolation support scheme]. I did learn about it by going on the government website, but from what I read I wouldn't be entitled to it. Anyway, and for the [company], I was on a zero hours contract. And the [company] actually refused to pay me.” (Participant 1, Male, 20s).

In terms of getting essential items, most participants were able to draw on their existing social networks in order to ensure they had essential items such as food and medications supplied during the self-isolation period.

#### *Emotional and mental health support*

One of the main challenges' participants experienced was the mental health impacts of self-isolation. The majority of participants (75%, N=97) did not have their emotional or mental wellbeing checked on by TTP (Figure 12). Over half (54%, N=96) felt that they would have liked more information about support for their mental health while self-isolating (and over

half (53%, N=96) felt their mental health was negatively affected by having to self-isolate (Figure 13)

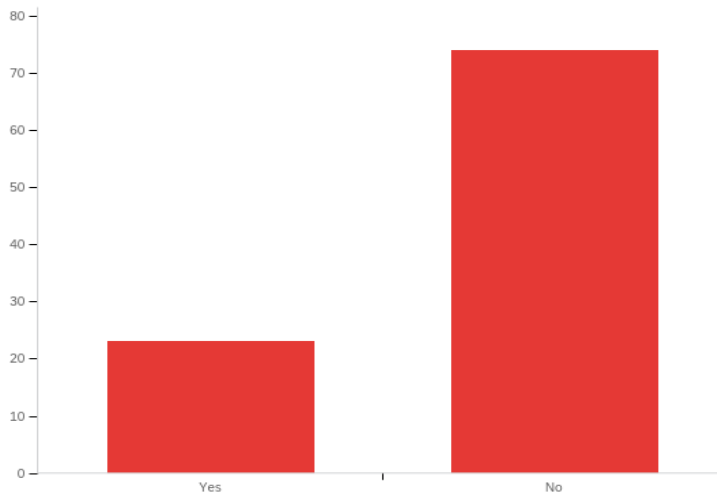


Figure 12: Did anyone from Test, Trace, Protect check in on your wellbeing while isolating?

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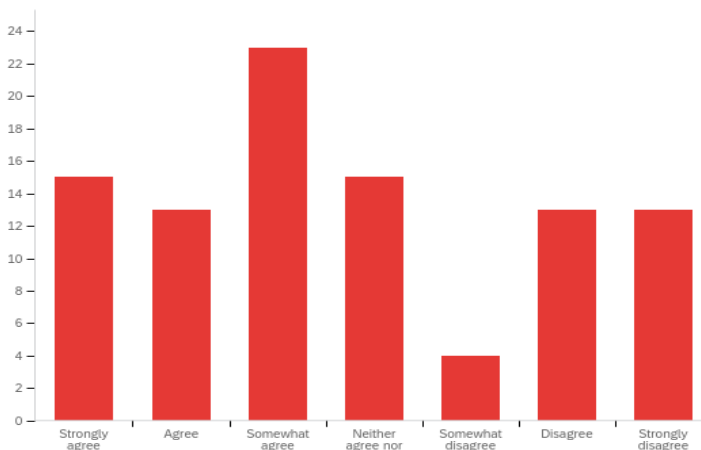


Figure 13: Having to self-isolate negatively affected my mental health (Y-axis: number of people)

Interviews revealed that those living alone found self-isolation particularly challenging in terms of their mental health. For them, self-isolation felt “claustrophobic” and like a “prison”:

“I’m in a two-bedroom apartment. And yeah, I got my got my laptop or my iPad. I got my phone, but there’s only so much you could like watch or listen to ... And yeah, I think by the end of the first week I was starting to feel enclosed in my head and thinking I’m never going to like see my friends or my family again. ... It just felt claustrophobic. And I thought, oh god, this is how a prisoner feels.” (Participant 9, Female, 40s)

One interviewee, who had reported not completely self-isolating, attributed their non-adherence to the need to leave the house in order to protect their mental health. For them, leaving to exercise was a necessary “release”. One participant described how this negative



experience had made them less adherent to public health guidance since completing self-isolation:

“I didn't do the two weeks. I think I got to the seventh or eighth day, and I decided to go for a run. I think I was in like a headspace of needing to get out ... from not having contact with anyone up to that stage and being alone and not being able to get out it was sort of a release... But I was really paranoid about doing it and I didn't take my phone, I didn't take my GPS watch. I thought I'd be like tracked. ... Yeah, it was just really tough. I did struggle with that period of time ...[Now] I don't want to give my details to anywhere like say if we went like a restaurant ... just in case you get pinged again, because I know that period of time was really difficult. ... I don't think I could do that period of time again. It made me think I would not ever like to go to prison, put it that way.” (Participant 1, Male, 20s)

Many interviewees felt that it would be beneficial for contact tracers to check on self-isolators' emotional wellbeing:

“The track and trace didn't really come back to me to check if everything was ok, regarding, you know, your mental state. Its ok for me because I know a lot of people around, but say someone lives on their own and don't get out, it must be bad for them” (Participant 5, Male, 70s)

## **RECOMMENDATIONS**

Our research suggests that public experiences of Test, Trace, Protect in Wales are highly variable. Participants' satisfaction with TTPs was mixed. Overall, roughly half of survey respondents (48%) were satisfied with their experience of TTPs, compared to little over one-third (36%) who were dissatisfied. Roughly half of the survey respondents were satisfied with the ability of TTPs to answer their questions (54%) and most felt the advice from TTP was clear (70%) and easy to carry out (76%). Overall, we suggest four key recommendations:

**Recommendation 1: TTPs should ensure consistency in its communications with those being asked to self-isolate, for example in terms of time-to-contact (consistently low, ideally within 1-2 days) and in terms of the frequency of subsequent contacts (consistently high, ideally daily).**

Participants were asked how long it took for TTP to contact them after their date of exposure (if they felt they knew it). Roughly one-third (36%) of participants suggested that they believed it was four or more days from the time of contact with a positive case that they were contacted. Quickly contacting those who have been in contact with positive cases is an essential component of an effective contact tracing system. The World Health Organisation benchmark for successful contact tracing system is to trace and quarantine 80% of close

contacts within 3 days of a case being confirmed.<sup>14</sup> It is important to note that our data is based on a limited sample size and the perceptions of the respondents themselves. As such, these findings may not be an accurate reflection of the actual time taken between exposure and contact. However, our data does suggest, from the point of view of those contacted by TTP, that there is much variability in the time taken between the perceived moment of contact with an infected individual and the point at which they themselves are asked to self-isolate. Latest available data suggests that 76% of close contacts that were eligible for follow-up were reached within 2 days of the positive case being referred to contact tracers.<sup>15</sup> TTP should continue to strive to consistently quickly reach contacts as soon as possible after a positive test result has been received.

One key recommendation is for TTPs to consistently provide frequent follow-up contact. Although one-in-four (25%) received daily contact, half (50%) received no follow-up contact beyond the contact. Regular follow-up contact is not only a way to monitor and potentially protect against non-adherence to self-isolation but is also a means to monitor, and where necessary mitigate against, some of the potential emotional and mental health difficulties experienced by those self-isolating. We recommend daily follow-up contact for all self-isolators, ideally by phone. We make further recommendations as to the suggested content of the follow-up communications below.

**Recommendation 2: TTPs should ensure that *all* those required to self-isolate are asked about their financial situation and, where relevant, provided specific information support for applying for self-isolation payments or other forms of financial assistance.**

Very few survey respondents (8%) were informed about the self-isolation support scheme by TTP contact tracers. Just over half (53%) didn't know about it at all. Just under one-in-four (27%) felt that their income was negatively affected by having to self-isolate (of which, one-in-ten (10%) strongly agreed that it had). Losing income during self-isolation is likely a major risk factor for non-adherence. Existing research suggests that financial constraints are a risk factor for non-adherence.<sup>16</sup> As such we recommend that in their initial call, contact tracers consistently establish whether those asked to self-isolate are likely to lose income as a result of self-isolating. The initial call should also consistently assess individuals' eligibility for the self-isolation support scheme. Although official decisions over eligibility are made following an application, contact tracers can help determine *prima facie* whether individuals may be eligible, and where relevant ensure that participants are confident they know how to apply. Where applicable, follow-up information from TTPs can be sent soon after the initial phone call (e.g. via email) to provide links to the self-isolation support scheme and other relevant financial aid). During one of the follow-up 'check in' calls, contact tracers should enquire with relevant individuals whether they were able to apply, whether the application was successful and whether they are meeting basic financial needs during self-isolation.

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<sup>14</sup> <https://apps.who.int/iris/handle/10665/332073>

<sup>15</sup> <https://gov.wales/test-trace-protect-contact-tracing-coronavirus-covid-19-16-january-2021-html>

<sup>16</sup> <https://www.medrxiv.org/content/10.1101/2020.09.15.20191957v1.full.pdf>

**Recommendation 3: TTPs should *consistently* enquire into the mental and emotional wellbeing of those asked to self-isolate and should provide resources and links for available and relevant mental health support.**

A standardised script for TTPs contact tracers should include a basic screening question to assess individuals' wellbeing (e.g. "have you been feeling sad or anxious so much that it affected your functioning?"). All self-isolators should be systematically provided with resources on promoting emotional wellbeing during self-isolation and should receive a daily contact (ideally via phone call if possible, or by text if not) to check-in on individuals wellbeing. Those identified as experiencing or being at risk of experiencing particular emotional difficulty should be provided with more detailed and specific mental health resources (e.g. Samaritans, Mind) or where necessary be referred to the relevant mental health. Ideally, contact tracers would be provided basic training in identifying those at high of mental and emotional difficulty during self-isolation.

**Recommendation 4: People who do *not* feel they have the capability, opportunity or motivation to adhere to self-isolation need to be systematically identified and provided with support resources to help them adhere.**

A minority of individuals reported severe physical, psychological and motivational difficulties with self-isolation. Additional supports for enabling and incentivizing these individuals should be provided where possible, including, as suggested above financial and emotional support. Screening with a modified COM-B to check on adherence motivation may be useful immediately following initial contact (for example a link sent to a screening webform via text and/or email). In addition to systematically identifying those individuals who are at risk of losing income and/or experiencing financial hardship as a result of self-isolation and those who may be at high risk of experiencing emotional difficulty, TTPs contact tracers should seek to systematically identify those who have care commitments and those who lack access to essentials. Contact tracers should consistently ask standardized questions, for example "will you be able to get all your essential items (e.g. medicines and food) during the self-isolation period?" and "do you have anyone that you have caring responsibilities for that you will need support with during your self-isolation period?". Where relevant, TTPs can help link self-isolators with relevant Covid-19 self-isolation support voluntary groups and with relevant local care support services.

20 January 2021

Dear Colleague

As you know, the Health, Social Care and Sport Committee is currently undertaking an **inquiry** into the impact of Covid-19 on health and social care in Wales.

We last met with a number of health boards before the summer recess, and we discussed the effect of the pandemic on waiting times, and the time it may take to return to the pre-pandemic position. This is a matter that the Committee is very interested in, and it was the subject of discussion at the Committee's **meeting** with the Minister for Health and Social Services and the Chief Executive of NHS Wales on 25 November 2020.

We are conscious of the enormous pressure that the pandemic has placed on the health service, and the corresponding impact on waiting times for non-COVID-19 services. At this stage, we are looking to get a realistic and practical picture of the current position. I am therefore writing to all health boards to seek answers, as far as possible at present, to the following questions:

1. What are the main areas of pressure, and what plans do you have in place to deal with these?
2. How will you prioritise the delivery of non-COVID services to target reductions in waiting times?
3. How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?
4. What estimates or projections have you made of the time needed to return to the pre-pandemic position?
5. Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?



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6. What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?
7. What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?

I appreciate that this is a particularly challenging time for the health service and am conscious of the pressures you must be under so would welcome brief responses to these questions. I would be grateful if you could respond **by Thursday 11 February**. This is to enable your response to inform an oral evidence session on these matters in late February.

Yours sincerely



Dr Dai Lloyd MS  
**Chair, Health, Social Care and Sport Committee**



**Vaughan Gething AS/MS**  
**Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol**  
**Minister for Health and Social Services**

**Agenda Item 5.5**



Ein cyf/Our ref VG/0468/21

**Llywodraeth Cymru**  
**Welsh Government**

Dr Dai Lloyd MS  
Chair, Health, Social Care and Sport Committee  
Welsh Parliament  
Cardiff Bay  
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CF99 1SN

1 February 2021

Dear Dai

I refer to the letter you sent to health boards on 20 January regarding the Committee's inquiry into the impact of Covid-19 on health and social care.

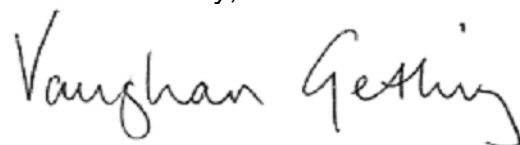
You refer in point 7 of your letter to an additional allocation of £30m for waiting times. I wanted to clarify that Welsh Government has not made a separate allocation of funding in this financial year for waiting times. As you will be aware, most organisations have had to suspend the majority of routine care to ensure workforce and bed capacity to manage the ongoing impact of Covid-19. As such, the routine care that has been able to continue this year has been funded from core health board allocations, and has not required additional funding.

It is possible that you were referring to the £30m for transformation of unscheduled and emergency care that was included within the Winter Protection Plan, and formed part of the NHS stabilisation funding package that I announced jointly with the Minister for Finance and Trefnydd in August last year. This funding has been used to support services and provide resilience in emergency care services over the winter period.

This Government is committed to addressing the backlog of patients waiting for routine care, but, as I have said on several occasions, this is likely to take a number of years, and will require sustained investment during the course of the next Senedd term.

I trust this clarifies the funding position.

Yours sincerely,



**Vaughan Gething AS/MS**  
**Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol**  
**Minister for Health and Social Services**

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

# Agenda Item 8

By virtue of paragraph(s) vi of Standing Order 17.42

Document is Restricted