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Agenda - Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 2 - Senedd
Meeting date: Thursday, 11 May 2017
Members pre-meeting: 09.15
Meeting time: 09.30

For further information contact:
Sian Thomas
Committee Clerk
0300 200 6291
SeneddHealth@assembly.wales

Informal pre-meeting (09.15 - 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Inquiry into primary care - evidence session 3 - Royal College of Physicians

(09.30 - 10.10) (Pages 1 - 33)

Dr Gareth Llewelyn, Vice President for Wales, Royal College of Physicians
Lowri Jackson, Senior Policy and Public Affairs Adviser for Wales, Royal College of Physicians

Break (10.10 - 10.15)

3 Inquiry into primary care - evidence session 4 - Welsh Ambulance Services NHS Service Trust

(10.15 - 10.55) (Pages 34 - 38)

Dr Brendan Lloyd, Medical Director, Welsh Ambulance Services NHS Trust
Grayham McLean, Unscheduled Care Lead, Welsh Ambulance Services NHS Trust
Martin Woodford, Vice Chair, Welsh Ambulance Services NHS Trust

Break (10.55 - 11.00)

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

4 Inquiry into primary care - evidence session 5 - Royal Pharmaceutical Society and Community Pharmacy Wales

(11.00 - 11.40) (Pages 39 - 49)

Mair Davies, Director for Wales, Royal Pharmaceutical Society
Suzanne Scott-Thomas, Chair, Welsh Pharmacy Board, Royal Pharmaceutical Society
Judy Henley, Director of Contractor Services, Community Pharmacy Wales
Mark Griffiths, Chair, Community Pharmacy Wales

Break (11.40 - 11.55)

5 Inquiry into primary care - evidence session 6 - College of Occupational Therapists, Royal College of Speech and Language Therapists and Chartered Society of Physiotherapy

(11.55 - 12.55) (Pages 50 - 64)

Ruth Crowder, College of Occupational Therapists
Dr Alison Stroud, Royal College of Speech and Language Therapists
Philippa Ford, Chartered Society of Physiotherapy

Lunch break (12.55 - 13.30)

6 Inquiry into primary care - evidence session 7 - Royal College of Nursing

(13.30 - 14.10) (Pages 65 - 67)

Tina Donnelly, Director, Royal College of Nursing Wales
Alison Davies, Associate Director Professional Practice, Royal College of Nursing Wales

7 Paper(s) to note

Letter from the Royal College of Nursing regarding the Nurse Staffing Levels (Wales) Bill

(Pages 68 - 80)

8 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

9 Inquiry into primary care - consideration of evidence

(14.10 - 14.25)

10 Use of anti-psychotic medication in care homes - inquiry refresh

(14.25 - 14.35)

(Pages 81 - 84)

11 Forward Work Programme - consideration of correspondence

(14.35 - 14.45) (Pages 85 - 88)

By virtue of paragraph(s) vi of Standing Order 17.42

Agenda Item 2

Document is Restricted

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

Inquiry into primary care

RCP Wales response

About us

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn amcanu at wella gofal cleifion a lleihau salwch, yn y DU ac yn fyd-eang. Rydym yn sefydliad sy'n canolbwyntio ar y claf ac sy'n cael ei arwain yn glinigol. Mae ein 33,000 o aelodau o gwmpas y byd, gan gynnwys 1,200 yng Nghymru, yn gweithio mewn ysbytai a chymunedau mewn 30 o wahanol feysydd meddygol arbenigol, gan ddiagnosio a thrin miliynau o gleifion sydd ag amrywiaeth enfawr o gyflyrau meddygol.

For more information, please contact:

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RCP senior policy and public affairs adviser for Wales

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

SeneddHealth@assembly.wales

From the RCP vice president for Wales
O’r is-lywydd yr RCP dros Gymru
Dr Gareth Llewelyn FRCP

From the RCP registrar
O’r cofrestrydd yr RCP
Dr Andrew Goddard FRCP

3 February 2017

Inquiry into primary care

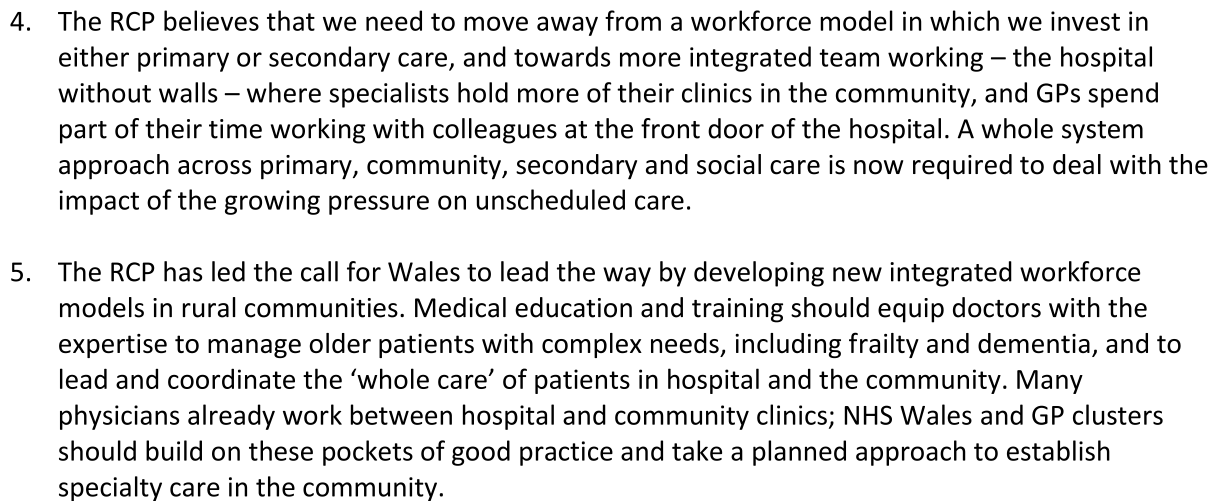
1. Thank you for the opportunity to respond to the Health, Social Care and Sport Committee inquiry into primary care. If you would find it helpful, we would be very happy to organise oral evidence on this inquiry to the Health, Social Care and Sport Committee from consultant physicians, trainee doctors or members of our patient carer network.

2. In the future, much more specialised care should be delivered in or close to the community. Physicians and specialist medical teams should expect to spend part of their time working in the community, providing care integrated with primary, community and social care services with a particular focus on optimising the care of patients with long-term conditions and preventing crises. Primary care should no longer be synonymous with general practice – community healthcare must include a wide variety of different professions, specialties and therapies.

   > ***For many specialties and for general physicians, there is an increasing need to devote sessions to working in the community, thereby forming part of a team … There are established examples of physicians working in this integrated fashion, crossing from the inpatient to the community arena, usually for patients with complex chronic conditions. Examples include community geriatricians, palliative care consultants, and integrated respiratory and diabetic physicians … [They] work closely with GPs and other health professionals working across acute and community settings. The sharing of information and joint working between and with GPs and social care is crucial.***[1]

3. Furthermore, people who live in nursing or residential care and often have multiple morbidities and complex medical needs should have access to enhanced primary care from GPs and to community services. There is also evidence to suggest that their care is improved by involvement of geriatric medicine physicians. This can be particularly effective when the community geriatric medicine team is linked to the acute services and care plans are shared between teams. These specialist teams can also have an important role in providing skills to the staff who work in care homes. This may reduce the need for admissions.

[1] Future Hospital Commission. *Future hospital: caring for medical patients.* A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013, p59



4. The RCP believes that we need to move away from a workforce model in which we invest in either primary or secondary care, and towards more integrated team working – the hospital without walls – where specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital. A whole system approach across primary, community, secondary and social care is now required to deal with the impact of the growing pressure on unscheduled care.

5. The RCP has led the call for Wales to lead the way by developing new integrated workforce models in rural communities. Medical education and training should equip doctors with the expertise to manage older patients with complex needs, including frailty and dementia, and to lead and coordinate the 'whole care' of patients in hospital and the community. Many physicians already work between hospital and community clinics; NHS Wales and GP clusters should build on these pockets of good practice and take a planned approach to establish specialty care in the community.

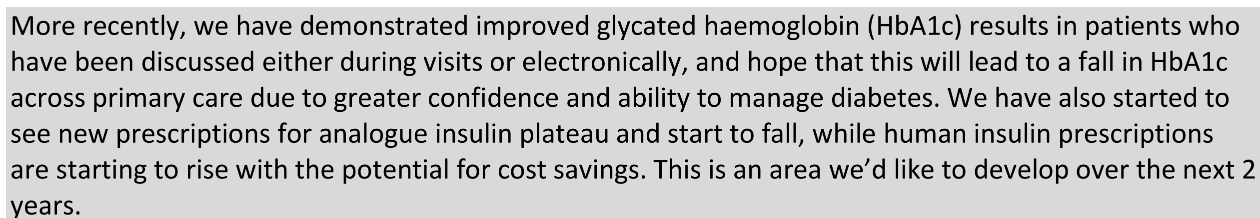
Case study: Delivering specialist diabetes care in the community

Managing a chronic disease such as type 2 diabetes requires the input of a multidisciplinary team across primary and secondary care. Historical models of care for diabetes have separated primary and secondary care elements and have led to the fragmentation of care, duplication of workload and long waits for senior specialist advice.

In Cardiff, which has a total of just over 23,000 people registered with diabetes, we have moved towards a more seamless diabetes service. We started with a small pilot study and began implementing the full model of care in 2010. Each of the 69 GP practices in the health board is allocated a diabetes consultant who visits the practice twice a year for case notes review, dissemination of best practice guidelines and face-to-face dialogue with GPs and their practice nurse.

There are eight full-time equivalent diabetes consultants and two academic diabetes consultants. Each consultant mentors 6–8 practices depending on the list size. In addition, GPs can request advice from their supporting consultant via an electronic system (similar to email but with robust audit) with a 5 day maximum response time for medication and management queries. Requests for advice are automatically routed to the appropriate consultant. This ensures that GPs have access to timely senior advice and develop a rapport with their consultant without the patient having to wait to be seen in an outpatient clinic. Secondary care outpatient referrals are triaged electronically to the appropriate consultant via the Welsh Clinical Communications Gateway (WCCG). The consultant can approve and book the referral into a clinic or request additional information. The latter opens a dialogue that may resolve the query. In addition, we have developed local type 2 diabetes prescribing guidelines which guide treatment choice and highlight cost differences between classes of treatment. The guidelines are intended to support primary care prescribing and draw attention to more cost effective prescribing where possible.

Over the first 2 years of implementation, new referrals to secondary care clinics fell by 35%. As a consequence, the waiting time for outpatient appointments fell from just under 6 months to between 4 and 6 weeks depending on the clinic. An audit of primary care found greater confidence overall in managing diabetes but especially in initiating non-insulin injectables, combining therapies and dose titration of oral and injected treatments. Practice staff find the electronic access to senior consultant advice within a working week particularly helpful. Advice offered for an individual patient will frequently be applied to other similar clinical scenarios leading to a ripple training effect.



More recently, we have demonstrated improved glycated haemoglobin (HbA1c) results in patients who have been discussed either during visits or electronically, and hope that this will lead to a fall in HbA1c across primary care due to greater confidence and ability to manage diabetes. We have also started to see new prescriptions for analogue insulin plateau and start to fall, while human insulin prescriptions are starting to rise with the potential for cost savings. This is an area we'd like to develop over the next 2 years.

So far, these changes have been made in a cost-neutral environment by asking primary and secondary care colleagues to work together in a different way. The model continues to evolve and we are recruiting community diabetes specialist nurses to support practices. We hope to fund these posts through more cost-effective use of human insulin where appropriate and reviewing the stop criteria for medications that are no longer effective. We also believe that this model could be helpful in supporting primary care to manage other chronic diseases. Its success depends on developing close, sustainable links with primary care. I am grateful to my colleagues in primary and secondary care for the hard work that has gone into establishing and sustaining this innovative model of care.

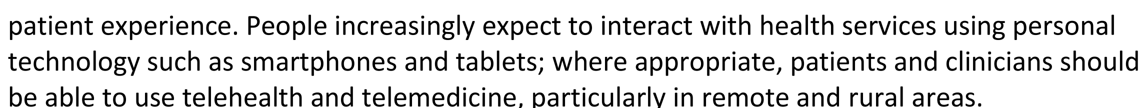
Dr Lindsay George
Clinical lead for diabetes, University Hospital Llandough
Cardiff and Vale University Health Board

6. The role of the community physician should be developed. Wales should actively promote itself as a place to develop highly specialist skills in rural and community-based medicine. We know from our own research that geography is important to trainees, and that most trainees would like to gain a consultant post where they have undertaken specialist training. Developing a rural training pathway for general medicine which splits time between the hospital and the community could boost medical recruitment in Wales in the future. Wales has a real opportunity to lead the way on innovative community health service design.

7. It is becoming increasingly clear that the community-based health and social care workforce will need to change and diversify in the future. Primary care should include more specialty clinics in the community which work with advanced nurse practitioners, specialist nurses and physician associates, for example. Optometry and podiatry services should be more widely commissioned in primary care, nursing shortages should be addressed, and innovative models of staffing involving allied health professionals such as occupational therapists and physiotherapists should be promoted. Pharmacists must play a bigger role in treating more complex patients with long-term conditions. Paramedics must be an integral part of these teams, helping to assess patients at an early stage of their treatment journey. This needs to be approached in an organised and structured manner, and the funding must be planned carefully, particularly for nursing posts and physician associate training courses.

8. Ideally, a formal evaluation of the current pilot bursary scheme for physician associates should be carried out as soon as possible. A successful evaluation should demonstrate improved access to care for patients and should measure patient, student and junior doctor experience. However, waiting until the first cohort of trainees from this pilot scheme have graduated means that we will not be able to evaluate this scheme until at least 2018, if not the year after. We recommend that the Welsh Government consider evaluating the impact of existing physician associates in other parts of Wales – especially those working in primary care – to find out more about their effect on patient care and any potential improvements to trainee experience.

9. Health boards and GP clusters should embrace innovation in order to improve communication with patients and between healthcare professionals and to improve quality of care and the



patient experience. People increasingly expect to interact with health services using personal technology such as smartphones and tablets; where appropriate, patients and clinicians should be able to use telehealth and telemedicine, particularly in remote and rural areas.

10. Telemedicine needs to be further embedded into everyday practice. Clinicians must continue to challenge resistance to change. The RCP Future Hospital development site in north Wales – CARe delivered with Telemedicine to support Rural Elderly and Frail patients (CARTREF) – is a telemedicine project that aims to improve access to care for frail older patients in rural Wales. The project allows patients to have follow-up hospital appointments by video clinics and means that patients and relatives can see specialists without travelling. The team can demonstrate patient satisfaction rates of 80%. This is just one of many examples of innovative clinical telemedicine and the future hospital workforce in Wales; best practice must be shared more consistently and rolled out in a structured way.

11. There are also some potential short-term wins. For example, moving the Quality Outcomes Framework census date to the end of the summer would help to ensure that at a peak time for unscheduled pressure, scheduled appointments would be freed up.

12. The Welsh Government and NHS Wales must ensure that lessons learned from the many GP cluster plans are written up, evaluated and if appropriate, rolled out more widely. GP clusters must also be encouraged to focus on unscheduled care rather than scheduled care from next year. We acknowledge that the problems in unscheduled care are far trickier to solve, and they have understandably not been the focus of GP clusters so far. However, the system must operate in a far more joined up fashion if we are to prevent unnecessary hospital admissions.

13. The RCP has long advocated standardised electronic patient records, which can save clinician time and improve patient safety. We have called for the electronic communication of referrals, outpatient letters and discharge summaries between primary and secondary care, using structured documents taken from structured records. The failure to develop these effective communication systems can lead to delays or impaired clinical decision-making. Access to health records and alternatives to admission *must* be available seven days a week.

14. We believe that patients should also be able to book appointments, receive reminders and check test results online. They should be able to record and upload their own findings, such as weight or glucose levels. Hospital records should be integrated into a summary patient record that conforms to national standards and contributes to a single comprehensive summary of the hospital records.

More information

15. More information about our policy and research work in Wales can be found on our website. **We would be delighted to provide oral evidence to the Committee or further written evidence if that would be helpful.** For more information, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at

With best wishes,

Dr Gareth Llewelyn
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

Annex 1

https://www.rcplondon.ac.uk/projects/outputs/patient-care-unified-approach

Annex 2

https://www.rcplondon.ac.uk/projects/outputs/teams-without-walls-value-medical-innovation-and-leadership

Health, Social Care and Sport Committee

Inquiry into Primary Care

RESPONSE FROM THE WELSH AMBULANCE SERVICES NHS TRUST

The Welsh Ambulance Services NHS Trust (WAST) welcomes the opportunity to provide a response to the Health, Social Care and Sport Committee, which will assist their consultation on primary care.

WAST has provided answers to the questions below that are applicable to the significant work it undertakes in conjunction with primary care: nationally, through the Directors of Primary Care and Mental Health (DPCMH); and, locally, via direct working with certain primary care clusters.

1. How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).

The Welsh Ambulance Services NHS Trust (WAST) continues to fully recognise the importance of developing a working relationship with primary care. In 2015 - 2016, an extensive analysis was undertaken to identify opportunities to develop future services in line with the needs of primary care. This involved engagement with key stakeholders such as the Directors of Primary Care & Mental Health Services, Primary Care Cluster Lead General Practitioners (GPs), and Public Health Wales (Cluster Regional Network events – Pacesetter Projects).

This engagement led to mutual recognition that integrated working between WAST and clusters will support the emerging model for a sustainable primary care service in Wales and improve patient flow within the unscheduled care system.

Through this collaboration, the following key points have been identified to illustrate how WAST can work with clusters, and health boards, to support primary care in driving transformational change and ensuring patient needs are met through a prudent approach to healthcare:

- Creating a scheduled service for the admission of patients to hospital, who require transport within an agreed timeframe, but not necessarily a 'blue light' ambulance. Our service improvement team has illustrated that this call volume is very predictable and has previously developed a model with Cwm Taf Health Board, which has proved to be successful in terms of increasing patient satisfaction and increasing the efficiency in patient handover at hospital. In terms of benefits, this approach can be summarised as improving patient flow for the high, and predictable call volume for GP (and other Health

Care Professional – HCP) requests for low acuity transport and hospital admission (within a stipulated time period of 1 to 4 hours).

- Education and training for 'Community Paramedics' to develop their skills in primary care, and attach them to clusters to respond to appropriate calls for both the 999 and primary care service. Such an approach potentially increases GP capacity to see patients at primary care centres.

- Providing Advanced Paramedic Practitioners (APPs), educated to master's degree level, to work as part of a multi-disciplinary team (MDT - pharmacist, district nurse etc.) to staff primary care hubs / support teams as part of enhanced services provided by clusters. Such an approach potentially increases GP capacity to assess the patients with more complex needs, and increases the capacity of clusters to provide more holistic care within communities.

- Introduce chronic disease plans that can be accessed / interpreted by paramedics for patients who are being treated and managed within the community. This will potentially avoid unnecessary conveyance of these patient groups to hospital, & enable paramedics to 'link in' with community teams.

- Future estate developments, where ambulances can be co-located with primary care centres. This would support enhanced services, create a working relationship for clinical leadership by GPs, and provide rapid responses to any critically ill / injured patients who require advanced life support (ALS) either within the community, or as a result of attending the centres.

2. The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

WAST has the capability to respond to the needs of a wide range of patients, and provides a similarly broad portfolio of services to achieve this including: critical care; clinical telephone triage and advice; scheduled patient transport; an, website-based health advice. As identified in point 1 above, there is also a significant opportunity to develop models of care that support the emerging multi-disciplinary team (MDT).

For this reason, the key priority agreed between WAST and the primary care community for 2017/2018 is the development of the MDT approach. Within WAST's Integrated Medium Term Plan (IMTP), the main objective is to focus on developing and evaluating the MDT models that have been agreed and will be initiated with clusters during the last quarter of 2016. Specific examples are outlined below:

- Primary Care Support Team Model (Hywel Dda – in operation): Role development for five Advanced Paramedic Practitioners (APPs), who are part of a GP- led MDT, which works with identified practices to provide additional support and increase the capacity / efficiency of that particular primary care service.

- GP Out of Hours Service (OOHs) model (Aneurin Bevan – planned for end of January 2017): Role development for two APPs undertaking home visits on behalf of the GP OOHs in AB Health Board area. The posts will be rotational, with APPs continuing to also undertake shifts for WAST.

- Primary Care Practice model (Cwm Taf – planned for end of January 2017): Role development for four APPs (trainees) undertaking home visits during the day, on behalf of the Aberdare practice as a result of calls being triaged by a GP, and allocated accordingly to the scope of the APPs' practice. In addition, the APPs will support Cwm Taf GP OOHs (as per the GP OOHs MDT model in Aneurin Bevan above) and WAST with any operational resilience plans, and will be required to undertake shifts for these services as and when required.

The above MDT models will ultimately inform the best option for the development of future joint team working between WAST and primary care. There will also be an indication of associated costs, and governance requirements to ensure sustainability of such changes.

In addition to the MDT models, there has also been agreement to test new ways of community working between Clusters and WAST's existing operational model:

- Community-based partnership model (Cardiff & Vale planned for end of January 2017)

Develop and test a new model and pathway linking the local rapid response vehicle (RRV) directly to the three local primary care practices within the Western Vale Primary Care Cluster Group. This will create collaborative working between the two unscheduled care services in that geographical area. The aim is to improve communications to avoid untimely responses and unnecessary patient admissions to hospital, create care packages for frequent service users, develop alternative care pathways and create chronic disease plans/anticipatory care plans for paramedics to utilise. This model is heavily dependent upon being clinically led by GPs, who will retain the duty of care for the patients, unless it is identified that the paramedics need to convey the patients to hospital.

- Community-based partnership model (Powys planned for April 2017)

A similar scheme to Western Vale Cluster, but enabling four paramedics to be part of an integrated team in the Llandrindod Wells Minor Injury Unit.

3. The current and future workforce challenges.

As identified in point two above, WAST and primary care colleagues have identified opportunities to develop / test new MDT models, based upon the findings of the Pacesetter Projects. This work has revealed both current and future challenges.

- The current challenge is to avoid the potential creation of an 'internal market'. There is a risk that paramedics or nurses are developed to a high level of clinical practice through educational programmes, but are then employed by individual practices, as opposed to undertaking rotational roles that would benefit the whole unscheduled care and primary care systems (e.g. WAST retain contracts of employment and colleagues work across both primary & emergency care).

- As well as developing APPs to directly support the emerging model for primary care (home visits, primary care hubs, support teams), a future challenge will involve identify training needs for paramedics to work in an integrated way with primary care, as part of a community - based service. This training needs analysis will inform WAST's Strategic Education and Development Group (SEDG) to develop paramedics beyond current critical care skills and meet the changing clinical demand.

In WAST's 2016-19 IMTP these challenges have been recognised, and the Year 2 options include:

- Development of business cases to inform service planning/ commissioning of joint services for agreed MDT models with Clusters to meet the healthcare needs of the population (Health Care Needs Assessment).

- Cost effective sourcing of estate opportunities, where WAST and primary care could undertake feasibility work to identify options to bring together joint centres / 'hubs' of community care leading to better access, advanced life support co-located with primary care for critically ill/injured patients, clinical support and supervision for paramedics and encouraging MDT working with GPs and community teams.

4. The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

WAST has observed occasions where funding is being dealt with at a local level as a response to a problem in recruiting General Practitioners (GPs), practice nurses, and community nurses, rather than as a strategic choice. For example, in Hywel Dda (see initiative described in paragraph two), APP costs have been re-charged to the HB, with funds being released as a result of GP vacancies.

A more strategic approach might involve devolving further unscheduled care monies either to EASC or directly to WAST to ensure an integrated model of service delivery, which provides clinical support and expertise to GP clusters, while retaining the skills of APPs within WAST and provides an interesting professional development opportunity for staff. This could help reduce levels of attrition in terms of turnover and attract more APPs, either by encouraging existing paramedics to develop their skills and/or encourage colleagues from elsewhere to relocate to Wales. This could prevent the potential 'internal market' risk as described in paragraph 3.

5. **Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.**

   Not applicable (N/A) to WAST

6. **The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.**

   During the engagement and analysis exercise undertaken with all cluster lead groups, WAST had a very positive response. All cluster lead GPs were receptive to suggestions of joint working.

   From WAST's perspective, there is variation in the manner and speed with which we have been able to develop pieces of work with the clusters. Examples of good work are described above in answer to question 2 – specifically relating to the formation of multi – disciplinary team working, and the community based model that will directly link GPs with a response paramedic in the Western Vale geographical area.

7. **Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, *Setting The Direction.***

   N/A to WAST

8. **Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.**

   The evaluation criteria for measurement of the various models of community care being developed in conjunction with primary care (see question two above) include:

   - Reduction in the number of patients being conveyed / admitted to emergency departments by ambulance.
   - Increase in the number of alternative pathways accessed on behalf of patients by ambulance crews.
   - Compliance with WAST's operational plans (priority postings – vehicle availability for 999 calls) – i.e. an increase in capacity, and increased availability / presence in geographical areas, because of fewer journeys to hospital and a concomitant increase in the volume of patients remaining safely at home with community care packages in place.

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-14-17 Papur 3 / Paper 3

Agenda Item 4

Health, Social Care and Sport Committee
National Assembly for Wales
Pierhead Street
Cardiff
CF99 1NA

5th of December 2016

Dear Sir / Madam

RE: Inquiry into primary care

The Royal Pharmaceutical Society (RPS) Wales welcomes the opportunity to respond to the Inquiry into primary care.

Our comments on the specific points in the Committee's inquiry are stated below:

1. How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).
2. The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

We consider these first two points are dependent on one another.

We strongly believe that a multidisciplinary leadership team must be established within each cluster. We are aware that primary care clusters across Wales are at varying levels of maturity. In order for the potential of all the clusters to be maximised, a multidisciplinary leadership team will ensure better communication and sharing of information and resources between healthcare professionals in the network. It is important that mechanisms are established to encourage sharing of information and resources not only between healthcare professionals but also between health and social care professionals where appropriate.

Pharmacists should be an integral part of referral systems within the multidisciplinary team. Medicines are the most common interventions in the NHS today. It is essential for patients that their medicines and pharmaceutical needs are overseen and coordinated by a pharmacist at all points of the health and social care pathway to ensure they can benefit from their medicines and suffer no harm. We believe that where there is a medicine, there should be a pharmacist. Greater promotion and signposting to the role that pharmacists can play in supporting people during preventative and management phases of care in primary and community care settings is also needed to support patients.

Pharmacists could be referred to for common ailments, medicines advice and long term conditions support as well as signposting and referring directly to other health and social care professionals. Direct referral arrangements would allow GPs to focus on diagnosing and treating more complex conditions. This would also ensure

the patient journey is streamlined, reducing duplication and improving cost effectiveness and efficiency of services.

3. The current and future workforce challenges.

A holistic approach to recruitment and workforce planning is needed for healthcare, taking into account the contributions of all professional groups across primary, secondary and tertiary care in Wales. It is vital that patients are supported by the right healthcare professional with the right skills and knowledge at the right time. We believe community pharmacists, primary care pharmacists, specialist clinical pharmacists and consultant pharmacists provide opportunities across the care pathway and are a key part of turning prudent healthcare principles into reality. The Welsh Government's national plan for primary care already refers to using the skills and expertise of the wider primary care team, including pharmacists. We welcome this reference to the role of pharmacists and the need for a more fully integrated multidisciplinary workforce within primary and community care.

We are supportive of the need to ensure a strong and sustainable medical workforce. A coherent workforce strategy including all healthcare professions across all sectors should be developed. This would ensure all professionals are working at the top of their registration - a key aspiration in the Governments primary care plan and one we believe should apply equally to all sectors. We believe that the workforce and recruitment strategy should be based on data that takes account of the current and future need of the health care workforce as well as new models including the roles of specialist and consultant pharmacists to provide care traditionally provided by medical practitioners.

The pharmacy profession makes a significant and unique contribution to the healthcare of the people of Wales. As the third largest professional group in the NHS there is increasing recognition of the benefits of extended clinical roles for pharmacists and medicines management roles for pharmacy technicians. Their inclusion in primary and secondary care multi-disciplinary teams acts as an enabler and catalyst to ensuring better patient care. With this inclusion comes the requirement for increased multiprofessional team working and opportunities for multidisciplinary education and training.

Community pharmacies in Wales should be fully integrated into models of care delivered by GPs and hospitals, treating and caring for patients across the care pathway and in the context of their daily lives. The Welsh Government's Efficiency Through Technology Fund investment in choose pharmacy provides a significant opportunity to deliver greater integration of the pharmacy profession into models of care. The IT platform which allows community pharmacists access to appropriate parts of the Welsh GP patient record has the potential to allow pharmacists to play a greater role in patient facing care. We ask that this investment is fully utilised and built upon with the development of more services through community pharmacy to increase the services available to patients at a local level to support them with their medication and health needs. By focusing on the medication management of people with long term conditions for example, the pharmacy profession offers significant potential to help ease pressures on other primary care professionals, including GPs.

As experts in medicines, pharmacists want to ensure that the NHS in Wales fully utilises their skills, as a part of a patient's multidisciplinary care team. The role of the pharmacist as a clinician has been strengthened by the development of prescribing rights, providing opportunities for independent prescribing. Opportunities need to be created to enable pharmacist prescribers to practice in a way which supports the patient and the wider primary care team.

In order to make prudent healthcare happen in Wales it is essential that our highly-educated and skilled health professionals are used appropriately, spending time on work that cannot be undertaken by other, less expensive members of staff.

4. The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

With the current shortage of GP and nurse practitioners, pharmacists are ideally placed to work alongside their fellow professionals as part of a multidisciplinary team, ensuring the NHS is making the most effective use of all skills and resources and ensuring everyone works at the height of their clinical competence as stated in the principles of the prudent healthcare agenda.

Many of the clusters have funded new clinical roles for pharmacists to work alongside their doctor and nurse colleagues in general practice (we would welcome the opportunity to discuss examples of this practice). These new models not only provide new opportunities for patients to access support for their medicines but also provide new ways of working for healthcare professionals which could be very appealing in the recruitment of GPs, knowing that they will have the opportunity to work in a multidisciplinary team, where they will have the capacity to focus on what only they can do.

General comments

We welcome the Committee's inquiry into Primary Care and believe it is vital to take an important step to review the future direction for primary care in Wales. We are somewhat disappointed that the committee has referred to cluster groups as 'GP clusters' as opposed to 'primary care clusters' which is how they have been referred to by Welsh Government since the publication of 'Our plan for a primary care service for Wales up to March 2018'. We believe that the term 'primary care cluster' is far more inclusive, ensuring the expertise of the whole multidisciplinary care team are used in providing improved local health and wellbeing and reduced health inequalities. RPS Wales is encouraged by the focus on primary care by the Welsh Government and supports the remodeling of care to ensure greater integration of the fullest range of skills available to patients. We believe that patients in Wales should benefit from the full integration of a pharmacist's clinical expertise within primary care settings.

There is currently a lack of multi-disciplinary educational funds to facilitate learning programs across healthcare teams which we envisage would encourage multidisciplinary working. We appreciate current educational funding streams from WEDS are available but are concerned these are only accessible by the managed hospital sector for both pharmacists and pharmacy technicians and there is no investment in up-skilling the community pharmacy team to enable new professional services to be offered to patients. We are also concerned that primary care clusters are not releasing educational funds to pharmacy. We recommend that either a directive to ring fence monies or to re-allocate the funds to WEDS or a similar body would provide a helpful solution to enable the community pharmacy team to be incorporated into funding streams for multidisciplinary training. GPs and pharmacists must be given the opportunity to develop specialisms that support the complexity of conditions within their clusters. There is currently no central funding to provide protected time for community pharmacists to further develop their skills in offering new clinical services for patients.

As with other professions, pharmacy also faces recruitment challenges, particularly in rural and deprived areas of Wales. It is vital that patients are able to access high quality primary care services in rural areas and that steps continue to be taken to attract the right professionals to those areas. We are supportive of new and innovative approaches to attract high calibre healthcare professionals to Wales and feel that this should be done on a multidisciplinary basis.

On a final note, we believe it is vital that Primary Care Clusters invest in language provision across primary and community care. As the first point of contact in the healthcare system, primary and community care services must be able to deliver services through the medium of Welsh and support people with languages other than English wherever practicable. We are aware of pockets of excellent practice where Welsh language services are being offered routinely and we believe this element of service provision should be proactively planned for and invested in across Wales and via Cluster Groups. It is also important that Welsh speakers are able to make working in primary and community care a career choice.
I trust this information is helpful and would be very pleased to elaborate on any of the issues raised here at an oral evidence session Please do not hesitate to get in touch if you require any further information.

Yours sincerely

Suzanne Scott-Thomas, Chair, Welsh Pharmacy Board

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote

the profession's policies and views to a range of external stakeholders in a number of different forums.

The Community Pharmacy Wales response to The Health, Social Care and Sport Committee inquiry into

Primary Care

Date: January 2017

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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'.

CPW represents all 717 community pharmacy contractors in Wales. These include all the major pharmacy multiples as well as independent businesses. Contractors 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.

CPW is pleased to see that the Committee is reviewing the functioning of the GP cluster networks as CPW is particularly keen to see the networks operate effectively and to do so in an inclusive manner that makes full and effective use of all of the assets within the cluster to deliver improved care to local patients.

In its strategic delivery programme for primary & community services *Setting the Direction,* The Welsh Assembly Government recognised that *'success will be dependent upon strong engagement of communities and professionals from all agencies in the development and provision of these services'.* This desire for joined up, all encompassing working was reinforced in the 2015 Welsh Government document *Our plan for a primary care service for Wales up to March 2018.* The need for full engagement of all providers was clarified in this plan which states *'Primary care is about those services which provide the first point of care, day or night for more than 90% of people's contact with the NHS in Wales. General practice is a core element of primary care: it is not the only element – primary care encompasses many more health services, including, pharmacy, dentistry, and optometry'*.

CPW was excited at the time of the launch of these strategic documents as the network stood ready and willing to support GPs and other primary care providers improve the care provided to local communities. CPW is however concerned that, while the aim of local primary care and social care providers operating in partnership to improve patient care, is to be applauded, the operation of the clusters, to date, has made it difficult for community pharmacists to engage in a meaningful way with their local clusters. Community pharmacies are key local asset and a significant part of the local primary care estate. At a time when primary care in Wales is under unprecedented pressure, it is disappointing and somewhat perplexing, that local community pharmacists and other members of the pharmacy team find themselves unable to contribute to the local cluster agenda.

Part 2: Areas to be considered by the Health, Social Care & Sport Committee

2.1 How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).

CPW believes that the use of the term GP Cluster Networks may act as an unintended barrier to the engagement of other members of the primary care and social care teams. CPW would suggest that the term Primary Care Cluster should be universally used to encourage multidisciplinary engagement and ownership.

With a growing number of GP practices under pressure across Wales, CPW would suggest that the Welsh Government pause and reflect on whether the current structure remains fit for purpose or whether a properly representative multi-disciplinary structure is better-placed to weather the storm. In addition, CPW wonders whether the current number of 64 clusters is too many. One solution could be to have no more than 3 clusters per health board, depending upon health board size and geography and, if necessary have a small number of sub-clusters to support the delivery of agreed cluster priorities.

One of the difficulties facing community pharmacists, and we assume other organisations struggling to engage with the agenda, is the lack of transparency around cluster plans. For example, with only three months remaining of the 2016-17 financial year only one of the seven health boards has published their 2016-17 action plans and these were only published this month.

CPW has looked at the plans that have been put into the public domain and identified a significant number of opportunities for local community pharmacies to make a meaningful contribution to the achievement of the cluster's priorities. CPW feels that this is a most unsatisfactory, disappointing and somewhat frustrating situation that needs to be addressed. CPW is not being in any way critical of the cluster leads and their lack of awareness of how local pharmacy teams could have helped them meet their objectives as it is extremely difficult for any one profession to have a full understanding of another and to understand the support they could have, if approached, provided. It is therefore clear to CPW that this situation can only be addressed if the Terms of Reference for clusters includes a requirement to have a representative on the cluster committee from identified professions, one of which should be a community pharmacist. At present, what is on the ground perceived as exclusion from clusters, is demotivating for local community pharmacy teams and does not support a sense of cluster identity. CPW would ask the Committee to bring this forward as an issue that needs to be addressed.

2.2 The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

CPW believe that there needs to be a proper discussion about the role to be played by all agencies in the health and social care system and what services each should provide. CPW feel that it is not appropriate to leave this entirely in the hands of individual clusters and that it is incumbent upon Welsh Government to provide guidance to clusters on these matters.

Community pharmacies are unique amongst healthcare providers in that there is a legal requirement for a pharmacy to be under the direct control of a pharmacist during all of the hours they are open. CPW would therefore ask Welsh Government to set aside a budget to provide 'backfill' for local community pharmacy representatives to attend cluster meetings so that there are no financial barriers to engagement.

2.3 The current and future workforce challenges.

CPW feel that the current approach to community pharmacy workforce planning is not robust enough. It is essential, before there is any identification of gaps to be filled, that there is a clear understanding of the role that Welsh Government and its health boards want its community pharmacy network to fulfil in the medium to long-term. While CPW is fully supportive of increased pharmacy support to clusters, it is concerned that the health boards and clusters appear to be wedded to the idea of employing additional pharmacists to work in a cluster without first asking if the work could be carried out by the existing network, who are after all very well established and the first port of call for the majority of local patients. This approach appears to be unnecessarily costly and does not align with Prudent Healthcare principles.

In addition CPW would wish to see a more strategic approach taken to supporting community pharmacists to qualify as independent prescribers as the current route to independent prescribing status is unclear and strewn with obstacles.

2.4 The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

CPW is concerned about the wording of this question as it understood that the funding was for primary care to try out new ways of working. CPW has two key concerns with the current approach. Firstly, devolving funding to this level will make it incredibly difficult to track whether it has had a meaningful impact and, as a consequence, when it is money well spent and secondly, it is imperative that there is robust governance in place to ensure that any decision taken to invest cluster money is taken the basis of improved patient outcomes irrespective of which part of primary care is the recipient of that funding.

2.5 Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.

CPW has identified above why community pharmacy has a significant role to play in primary prevention. The evidence is unchallengeable that community pharmacy can deliver interventions in this area and if the services are available from community pharmacies they are welcomed by patients and they will readily take them up. For example, since the services were introduced, the majority of people choose community pharmacy as their outlet for stop smoking support, obtaining the morning after pill and their source of clean syringes and needles, with the supply from community pharmacy far outstripping the supply from other providers.

CPW would suggest that, with many GP practices under pressure to deliver core services, Welsh Government should be looking to pharmacists, nurses and other professionals to take on the mantle of primary prevention, leaving GPs free to provide the services only they can provide.

Welsh Government has invested significantly in the 'Add To Your Life' national health check and yet it is unclear following an assessment who patients at medium and high risk should turn to for unbiased information and support. Rather than signposting patients to

already stretched services, CPW would suggest that there should be formal links between the national health check and the community pharmacy network.

2.6 The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.

Given the lack of engagement with community pharmacy to date, CPW does not feel able to comment on this area.

2.7 Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, Setting the Direction.

CPW has expressed its concerns above at the lack of connectivity between the current operation of clusters and the Government's vision from a community pharmacy perspective. CPW would suggest that the bottom up approach is serving only to reinforce this disconnect. While the bottom up approach has much to commend it and is the basis of cluster engagement, CPW would suggest that clusters should still operate within clear parameters laid down by Welsh Government to ensure that there is effective engagement and the skills of all relevant parties are fully utilised to improve local patient outcomes.

2.8 Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.

CPW would suggest that there need to be national metrics established which are locally met, measured and reviewed. This will ensure that the success of any initiative is measured against nationally established patient outcome metrics and are not open to local interpretation or bias, thus ensuring that a similar service in one cluster is able to be more directly compared to that of another before good practice is shared.

Part 3: Conclusion

3.1 CPW understands the importance that clusters have in transforming primary care and therefore CPW would like to see all primary care pharmacy contractors become an integral part of primary care cluster working. Community pharmacy contractors can significantly support the primary care agenda helping to underpin the longer-term sustainability of primary care by using pharmacists' skills and abilities, in line with Prudent Healthcare principles to release capacity in GP practices and in A&E departments.

Community pharmacies are visited daily by those that are sick and those that are well and, as a result, have the largest daily footfall of all primary care outlets within a cluster boundary. Given an genuine opportunity to engage, local pharmacies could have a significant role to play in supporting the health and wellbeing needs of the local communities they serve. However, to date the integration of community pharmacy within the 64 primary care clusters across Wales has been variable and in the majority of cases is unfortunately non-existent. CPW would encourage the Health, Social Care & Sport

Committee, to ensure that there are appropriate arrangements in place to leverage the capacity and skills of the local community pharmacies within the clusters.

3.2 To facilitate this, CPW would recommend that the committee recommend that Welsh Government:-

a) Ensure cluster Terms of Reference contain a requirement to engage with local community pharmacies.
b) Seek to put in place arrangements for copies of cluster action plans to be shared with representatives of other primary care providers as soon as they are agreed.
c) Put in place arrangements to provide 'backfill' funding to facilitate a local community pharmacy representative to attend cluster meetings and other appropriate events.
d) Ensure that community pharmacy access to the Welsh GP Record is given a high priority.
e) Formally link the community pharmacy network to the 'Add To Your Life' national risk assessment

CPW agree that the content of this response can be made public and are happy to provide further information on request to members of the Committee and/or to appear before the Committee.

CPW welcomes communication in either English or Welsh.

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Response to the Health, Social Care and Sport Committee Inquiry into Primary Care From the College of Occupational Therapists

The contribution of occupational therapy to primary care and the wider multi professional team

1. *"A fantastic resource that has been greatly underused by primary care but that is where they should be based....The occupational therapist manages frailty issues much better than me! An experienced Occupational therapist working directly in our practice [has] prevented unnecessary admissions for patients through the prompt review… often on the same day. It has reduced the number of times some patients were calling for a GP visit thus better utilising the GPs time. It has been a signposting service ensuring that the most appropriate member of the multidisciplinary team sees patients; it has also enhanced use of the third sector services.* ***The occupational therapist has provided a wealth of experience, expertise and knowledge to the practice that was either unknown or under-utilised****" (*GP, Argyle Medical Group, College of Occupational Therapists 2016)

2. Occupational therapists can make an important contribution to the primary care work force (Donnelly et al 2014). A 'clear fit' has been identified between the holistic, health promoting nature of occupational therapy and primary care (Donnelly et al 2013, p1). Occupational therapists recognise the importance of meaningful activity/occupation in promoting mental and physical well-being. They are skilled in assessing the impact of developmental, physical and mental health conditions on a person's ability to participate in activities that are important to them, and in devising intervention plans that facilitate occupational engagement. The College is a member of the Ministerial Taskforce on Primary Care and has been pleased to be able to raise the issues in this paper at that forum.

3. The challenges facing health services include ageing populations and increasing numbers of patients with long-term conditions and complex multi-morbidities (Royal College of General Practitioners 2013). Occupational therapists can support the work of General Practitioners (GPs) by offering proactive input to help people manage their conditions, stay as active as possible and continue with their daily lives and help prevent an acute episode from happening. They work in partnership with other professionals and local agencies to help respond to crises and prevent unnecessary hospital admissions.

4. The need for integrated care that empowers people to take control of their own health and wellbeing (Royal College of General Practitioners 2015) is widely recognised. The College of Occupational Therapists (2015) 'Evidence Fact Sheet' demonstrates how occupational therapists make a valuable contribution to GP services including:
   I. ***Health promotion***. Address a range of health issues, for example, through promoting healthy lifestyle choices (Lambert et al 2010), facilitating engagement in fulfilling and meaningful occupation (Moll et al 2015) and pproactive health promotion.
   II. ***Empowering service users to manage their health conditions.*** Individual or group intervention to help people with mental or physical health issues cope with their condition within the context of their daily lives. For example, individuals with panic disorder (Lambert et al 2010), chronic obstructive pulmonary disease, diabetes (Donnelly et al 2013) or persistent pain (Carnes et al 2010).

III. ***Enabling people to function at home/within the community and to achieve personalised goals.*** improve service users' independence and functioning, for example as part of a reablement service (Littlechild et al 2010).
IV. ***Contributing to the provision of integrated primary care.*** provide person-centred support for people with long-term or complex health and social care needs.
V. ***Promoting social Inclusion/community engagement***. individual, group or community intervention for people at risk of isolation, for example people with mental health difficulties (Smyth et al 2011), older people (Mulry and Piersol 2014) and people living with dementia (Teitelman et al 2010.
VI. ***Maintaining/improving the health and mental wellbeing of older people in primary/residential care.*** The National Institute for Health and Care Excellence (2008) recommends that older people are offered group or individual sessions to facilitate engagement in daily routines and activities to maintain/improve health and wellbeing. Occupational therapists should be involved in 'the design and development of locally relevant training schemes for those working with older people' (National Institute for Health and Care Excellence 2008, p9).
VII. ***Vocational rehabilitation***. Help people to stay in or return to work, including provision of the 'Allied Health Professions Advisory Fitness for Work Report' (Allied Health Professions Federation 2013).
VIII. ***Fitness to drive***. assessing fitness to drive and, when appropriate, enabling individuals to continue to drive (Hawley 2015).
IX. ***Prevention of falls/other injuries.*** Home hazard assessments (National Institute for Health and Care Excellence 2015) and interventions to optimise functional activity and safety (College of Occupational Therapists 2015c). Falls prevention initiatives for at risk patients (Mackenzie et al 2013) and recovery intervention if a fall has occurred.
X. ***Preventing unnecessary hospital admissions.*** In partnership with other professionals such as paramedics, to help people remain safely at home and prevent unnecessary hospital admissions where appropriate by immediately intervening to avoid transfer to hospital.
Further detail, cost benefit examples and all above references are at:
https://www.cot.co.uk/sites/default/files/commissioning_ot/public/GP-services-2015.pdf

The shift to primary prevention in general practice to improve population health outcomes and target health inequalities.

5. It is evident that where occupational therapists have been working in primary care there is a reduction in emergency admission rates (College of Occupational Therapists 2016). Proactive support for people in their communities helps to improve population health and reduces the costs associated with ill-health. Occupational therapists are active health enablers, focused on what matters to the person so that they can help them to participate in the occupations they need, want or are expected to do. They understand the significant impact that occupations and daily living routines have on peoples' health and wellbeing and their intervention enables people who are frail or who are living with chronic conditions to continue with daily life.

6. As primary care teams start to access occupational therapy for the first time across Wales, they are beginning to realise the true potential of this workforce. The role of occupational therapists in reducing the pressure on primary care is being recognised, as demonstrated in "Reducing the Pressure of Hospitals: A Report of the Value of Occupational Therapy in Wales" (College of Occupational Therapists 2016).

7. In the Argyle Street Primary Care Practice in Pembroke Dock, the occupational therapist delivers an alternative, proactive model of care for identified frail, older patients. A wide range of occupational therapy interventions are required including rehabilitation programmes; assistive aids and home adaptations; advice; enabling techniques; supporting self-management of conditions; working with people to facilitate change; and engagement with other services. Placing an occupational therapist in the surgery:
   - Reduced demand on general practitioners and repeat visits by addressing and resolving underlying issues that are the root cause of multiple and regular contacts
   - Released GP, practice and community nursing staff time, enabling them to focus on doing what only they can do
   - Proactively resolved health and social issues at an early stage, minimising crisis situations that result in presentation or admission to the acute hospital: 14 patients avoided an acute hospital admission
   - Sustained people at home following discharge from hospital
   - Reduced falls, improved safety and confidence, enabling people to engage in daily life: 81% of patients who had fallen reported increased safety and confidence in their ability to undertake everyday activities: 12/13 patients reported no falls in the four weeks following occupational therapy intervention.

8. In Heathy Prestatyn Iach the occupational therapists work with people who have anxiety /depression or chronic disease as well as frail older people. Intervention and therapy include: social prescribing and signposting, helping to navigate through available support as well as delivering personal goal oriented brief interventions, Expert Patient Programmes such as COPD, anxiety, diabetes and other condition specific programmes. There is a partnership with Job Centre Plus and Public Health Wales to help people back to work. The occupational therapist often coordinates care across all sectors and within the practice. These interventions help reduce GP contact time and repeat attendances, as well as enabling people to increase their ability and quality of life. Locating occupational therapists in primary care allows both rapid response to acute crises and proactive action to prevent acute episodes. This proactive intervention is vital given the increasingly complex issues being managed in primary care .This new service is being evaluated and initial findings are showing positive effect, with patient's not returning to the practice with the same compliant

Working with Clusters and Health Boards

9. The College has had little direct engagement with clusters, which are more likely to interact with our members in their services. The publication of the primary care workforce plan with the clear statement from Welsh Government that therapists should be included as part of the wider team has increased the interaction with services across Wales. However, the different rates of development and maturity, coupled with the different ways in which clusters work, has made it difficult to identify the correct links and routes to inform clusters about the potential value of the occupational therapy contribution.

10. Occupational therapists employed in Health Boards are frequently and commonly working in community resource teams (CRT) across Wales as proposed in "Setting the Direction" (Welsh Government 2010). They are also members of other Health Board frailty, community mental health, learning disability, reablement and community rehabilitation teams as well as local authority locality teams and even integrated teams. Occupational therapists are also employed as primary care mental health practitioners to great effect. This plethora of community based services dissipates the resource of occupational therapy and diffuses its impact.

11. The ways in which CRTs interact with and provide multi-professional services for primary care is variable. As this quote from one occupational therapists identifies, the staff relocated to CRTs are in, but not part of, primary care: "*within frailty teams we are already working in primary care but I don't think we are always viewed as part of the primary care team & are often based away from other primary care services*"

12. The clear finding of the Pembroke Dock Project identified above was the difference that reliably timely response makes to the value of the occupational therapy intervention. The delay in accessing services which have different priorities and timescales makes them less than useful to GPs and primary care practices as they do not respond quickly enough. "*Having an occupational therapist attached to the practice has many benefits. Most of the referrals need quick turnaround as the problems are acute. The saving in social admissions [and] improved self-confidence for patients and families has already been noticed.* ***The occupational therapist is able to respond appropriately in that 24hr period instead of the several weeks previously****.*"
    It is only when the GP can be assured of a guaranteed rapid response that this is a viable alternative to hospital admission or calling an ambulance.

13. Our members identify that they are frequently part of planning conversations about embedding occupational therapy services in primary care, but the two routes of funding, via clusters or health boards can sometimes create complexities which delay improvements and innovation while decisions are taken over which budget should pay for it. These confusions and variabilities do not assist in making the best use of the occupational therapy workforce and neither are they conducive to person centred, well integrated care. There are now a number of different models across Wales where occupational therapists are working in primary care practices. This variability may meet local needs, but Health Boards need to agree the funding route and whether this is cluster funding or Health Board Primary Care Directorate funding.

Workforce challenges

14. Effective multidisciplinary, early intervention and preventative services require the right workforce and skill mix. Prudent Healthcare demands that staff do only what they can do and work to the top of their skillset. Ensuring occupational therapists are part of the wider primary care workforce will provide optimal access to their expertise in goal-setting and practical problem-solving in respect of barriers to independent living, in order to enable people to manage their own conditions and health and social care needs at home.

15. Occupational therapists are educated and qualified to work in any setting and under a generalist practice model: in mental and physical health services and with people of all ages They are the only Allied Health Professional to work in the NHS, Local Authority housing and social services departments, schools, prisons, voluntary and independent sectors, as well as vocational and employment rehabilitation services.

16. Current employment patterns have tended to drive practitioners to specialise as they increase their expertise. While new roles are enabling our workforce to develop expertise and a career in generalist roles, working in complex community settings requires an experienced level of practice and potentially some training/ development. There is potential as the service becomes more established and supported that second/ subsequent posts could allow wider skill mix. This will support learning and succession planning into the role

17. There are insufficient posts in primary care for occupational therapists to move into. New posts need to be created. Many of these, certainly in the short term, could come from re-designating/ re-locating existing workforce capacity. The main reason for this is that a significant proportion of existing posts already work with the same patient population. The experience around Wales at the moment is that when posts in primary care become available, occupational therapists are eager to fill them as working in primary care allows the effective employment of the profession's philosophy and interventions to maximise citizen's independence.

18. The College, in partnership with service managers across Wales, recommend that to make the most effective use of the existing workforce and deliver outcomes for citizens, Health Boards should remain the employers of occupational therapists and use service level agreements or commissioning arrangements to embed them into primary care. Employing the workforce in this way will enable occupational therapists to remain part of a wider workforce and career pathway. It allows access to professional governance, supervision and professional development, staff training and management for staff; to participate in other professional activities such as student learning, and meet the demands of Professional Registration. It also allows quality assurance of the quality of practice and enables cover for leave, sickness CPD time and skill demands and recruitment challenges for small or rural practices. This model also ensures access to existing community services such as integrated community equipment and adaptation services.

19. There are increasing demands for occupational therapists and Wales will need to consider how to train enough occupational therapists to meet that growing demand. This will need to include more Welsh speaking/ bilingual practitioners than at present.

<u>Conclusion</u>

20. As shown in the College's Report "*Reducing the pressure on hospitals A report on the value of occupational therapy in Wales"* (College of Occupational Therapists 2016) making more effective use of the existing workforce, in a more integrated manner would both improve lives and save money; enabling occupational therapists to become more embedded in primary care and responsive to the needs of citizens and GPs. The profession has a significant contribution to make in primary care, but the posts need to be established, either through relocation and use of the existing workforce, or in new posts. Greater coherence and clarity of services through primary, social care and community secondary care services in a single person centred approach will deliver both improved lives for citizens and make best use of public resources.

21. Please do not hesitate to contact the college via the Policy Officer for Wales at the address below for any further information.

Ruth Crowder, Policy Officer Wales, College of Occupational Therapists, P.O. Box 4156, Cardiff, CF14 0ZA,

References

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The College of Occupational Therapists is the professional body for occupational therapists and represents around 30,000 occupational therapists, support workers and students from across the United Kingdom and 1,600 in Wales. Occupational therapists are regulated by the Health and Care Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

National Assembly for Wales Health, Social Care and Sport Committee Consultation on Primary Care

Executive Summary

1. The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to contribute to the Health, Social Care and Sport Committee consultation on primary care**.** Our response below focusses on one key element within the terms of reference namely;

    - **the emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured)**

2. RCSLT Wales believes that in order to respond to the dual challenge of budget pressures and a rising population with complex needs, it is vital that the skills of allied health professionals, and in particular speech and language therapists (SLTs) are used more fully. Despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that too few GP Clusters include the role as part of a dedicated primary care integrated workforce. In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care and this can often mean the pressures in secondary care take precedence over opportunities to develop upstream approaches in the community to keep people well and avoid hospital admissions.

3. RCSLT are keen to emphasise a strategic approach to access for therapies for GP clusters. Without a strategic approach inequity of service is a risk across Wales.

About the Royal College of Speech and Language Therapists

4. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RCSLT has 15,000 members in the UK (450 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council). We promote excellence in practice and influence health, education, care and justice policies.

5. Speech and Language therapists treat, support and care for children and adults in community settings who have difficulties with speech, language and communication, and/or eating, drinking and swallowing. Managing swallowing problems (dysphagia) at home or in residential care reduces the risks of choking, chest infections, aspiration pneumonia, dehydration and malnutrition and decreases the need for crisis management that often results in unnecessary hospital admissions.

The Emerging Multi-Disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured)

6. RCSLT Wales believes that in order to respond to the dual challenge of budget pressures and a rising population with complex needs, it is vital that the skills of allied health professionals (AHPs), and in particular SLTs are used more fully. As highlighted by the Nuffield Trust, there is a need to reshape the health workforce to deliver the care that patients need and alleviate pressures on the health system[1]. SLT, as a profession, has developed considerably over recent years to adopt a more consultative, collaborative approach, in addition to its specialist role in managing the risk of harm and reducing functional impact for people with Speech, Language and communication support needs and swallowing difficulties. The profession has a vital role to play in the delivery of new models of care and shifting care from hospitals to community settings.

7. SLTs already undertake a number of roles as part of primary care teams with the aim of maximising independence and avoiding hospital admission. For example,

- SLTs provide telephone triage to care homes managing the communication and swallowing problems of those in their care,

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[1] Nuffield Trust (2016) Reshaping the workforce to deliver the care patients need: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/reshaping_the_workforce_web_0.pdf

removing the need for a GP visit. They provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease. SLT intervention is proven to reduce morbidity, mortality and prevent hospital admissions. SLTs have also been developing efficient and effective telehealth solutions in this regard. Evidence from a telehealth project in care homes has indicating savings of £60 on each tele swallowing assessment[2].

- Social return on investment research has highlighted the value of the provision of speech and language therapy for post-acute stroke patients. Every £1 invested in low intensity SLT is estimated to generate £2.30 in health care cost savings through avoided cases of chest infections.[3]
- There is emerging evidence of non-pharmacological treatment approaches and specifically speech and language interventions in the treatment of coughs[4]. Cough is the most common symptom for which patients seek medical advice and thus if speech and language therapy were to be considered as a routine treatment for the estimated 20% of chronic cough patients for whom medication is ineffective, there could be a significant positive impact on the reducing the economic burden of this condition[5].
- The Betsi Cadwaladr University Health board Speech and Language Therapy service provide a 'communicating with confidence' package that supports people living with communication disability to identify and work towards their functional and participative communication goals.

8. RCSLT believe that there would be significant benefits to innovations from these roles becoming more established within GP Clusters across Wales. In addition, significant additional opportunities exist to utilise SLTs to support the shift from hospital to community care. For example;

- providing rapid access to highly skilled dysphagia practitioners at the front door of hospitals or as a referral option for GPs/ DNs/Care Homes and ambulance services. This requires highly skilled professionals (Band 6 at a minimum).
- SLTs also provide support to care homes for communication difficulties and are well placed and skilled to support the dementia agenda. Opportunities exist for SLT/assistant skill mix for triage,

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[2] University College London (2016) London Speech and Language Therapy workforce scoping project, phase 2: modelling workforce transformation example, report available upon request.

[3] Matrix Evidence (2010). An Economic Evaluation of Speech and Language Therapy – Final report. London:Matrix Evidence

[4] Schappert, SM and Burt, CM (2006). *Ambulatory care visits to physician offices, hospital outpatient departments, and emergency departments: United States, 2001-02*. Vital Health Statistics 13. Feb;(159):1-66.

[5] Vertigan a and Gibson, P (2009). *Chronic cough and laryngeal dysfunction improve with specific treatment of cough and paradoxical vocal fold movement.* Cough 5: 4

education of nursing home staff, risk feeding management and Advanced Care Planning to support hospital admission avoidance.
- SLTs are well placed to deliver assessment for Mental Capacity.
- There is emerging evidence of the value of SLT posts in palliative care.
- Opportunities to input into primary care for children with multiple complex needs and the older child around transition where there are no services.
- The contribution SLT can make to the reduction of isolation and loneliness in elderly people which is more evident in those with communication difficulties[6].

9. Despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that too few teams across Wales stipulate inclusion of the role as part of a dedicated primary care integrated workforce. In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care – and this can often mean the pressures in secondary care take precedence over opportunities to develop upstream approaches in the community to keep people well and avoid hospital admissions. We would be keen to explore how we can exploit skill mix to ensure the contribution of the profession to primary care clusters and to community care in the long-term. Considerations need to focus on how we can ensure a team approach and look beyond individual roles to ensure the resilience of services.

10. Whilst understanding of the need for primary clusters to meet the needs of localities, RCSLT are keen to emphasise a strategic approach to access for therapies for GP clusters. Without a strategic approach inequity of service is a risk across Wales. Workforce planning and supply of workforce is likely to enter a new era of shortage of supply.

Further Information

11. We would be happy to provide any additional information required to support the Committee's decision making and scrutiny. For further information, please contact:

Dr Caroline Walters
Policy Officer, Wales
[redacted] / [redacted]

[6] Yorkston, K M, Bourgeois, M S and Baylor, C R (2010). ' Communication and Ageing'. *Physical Medicine and Rehabilitation Clinics of North America*, Volume 21, Issue 2, Pages 309-319

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Dr Dai Lloyd AM, Chair
Health Social Care and Sport Committee
Cardiff Bay
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3rd of February 2017

Dear Chair and Committee Members

Inquiry into primary care

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

Just over 20% of patients see their GP about a Musculoskeletal (MSK) problem each year. Evidence suggests that 85% of these cases can be dealt with effectively by a physiotherapist without any need to see the GP.[1]

The CSP has been included in the Cabinet Secretary's Ministerial Taskforce on the Primary Care Workforce and welcomes the fact that a multi-disciplinary approach is being taken.

The CSP notes the wide range of questions posed by the committee as part of the inquiry. The profession will concentrate on providing information around the multi-disciplinary team developments in primary care.

The emerging multi-disciplinary team – how health and care professionals fit into the new cluster model and how their contribution can be measured

1. The physiotherapy profession brings a wide range of skills to primary care, supporting GPs and the wider primary care team. Traditionally physiotherapy staff have been predominantly based in hospitals, with ward- based physiotherapists and community (MSK) outpatient services in hospitals and clinics. However, this picture is changing with physiotherapists and physiotherapy support workers increasingly as key members of services outside of the hospital environment, including: community resource teams; community based rehabilitation teams (eg pulmonary rehabilitation, post hip fracture, falls prevention) reablement services and in initiatives such as joint working with the Welsh Ambulance service to keep people out of hospital.

[1] Chartered Society of Physiotherapy 2016 'Physiotherapy Works for Primary Care Wales' http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/physiotherapy-works-prim

2. Most recently physiotherapists are taking on new roles within GP teams and practices due to the knowledge and skills they bring. Physiotherapy is an active and interactive practice that works in partnership with people to maximise their ability to move and function. In a primary care setting, physiotherapy has a valuable role to play in promoting health and wellbeing (e.g. of older people at risk of falling, of children and young people who are overweight/obese); in offering treatment and advice (e.g. for acute musculoskeletal injuries or exacerbations of respiratory disease); and rehabilitation (e.g. helping someone with a long-term condition optimise their ability to live independently). Physiotherapy is therefore a resource that can increase capacity of General Practices to address the health needs of local populations in ways that add value to primary care – as the examples in Appendix 1 show.

3. The CSP provided the following contribution to the Cabinet Secretary's Ministerial Taskforce on the Primary Care Workforce highlighting challenges faced by physiotherapy as part of the wider primary care workforce.

i) **Developing new roles in General Practice**. The case for physiotherapy operating in primary care is well understood in relation to the management of musculoskeletal (MSK) conditions. Already Health Boards across Wales have taken steps to develop General Practice Physiotherapist posts with a couple of Health Boards progressing faster than others. For example, Betsi Cadwaladr UHB provides physiotherapy in over 49 GP practices and has 19 physiotherapists qualified to prescribe medicines. Abertawe, Bro Morgannwg UHB offers an open access 'walk-in' clinic in Swansea, Neath Port Talbot and Bridgend. The North Wales experience has demonstrated reduced referrals to secondary care and a reduction in follow-up GP appointments. An audit carried out showed a 25% reduction in referrals to rheumatology, 62% to pain clinic and 40% to spinal specialists. Research from the CSP suggests that there is support for the roles with 8 out of 10 GPs having confidence in the model. [2]

   The CSP hopes the inquiry will generate an impetus for Health Boards to share learning from pilots and be supported to find ways of implementing evidence of 'what works' in practice across Wales. Most Health Boards physiotherapy services are either currently piloting a model or have piloted physiotherapists working in General Practice. To scale up service management and funding models are the areas that need to be worked through.

ii) **Self-referral/direct access for patients to physiotherapy**. Part of a physiotherapy service provision within the primary care and community setting includes providing a self-referral/direct access to physiotherapy services. This is not universally available across the whole of Wales. Four out of the seven Health Boards provide it with one Health Board offering a GP self-directed 'same day' service. In the main, self-referral is for MSK although ABMU has begun piloting self-referral for neurological conditions in Swansea. There remains a challenge to see all the Health Boards offering self-referral/direct access across the country. Concerns about capacity within the physiotherapy services may account for one of the reasons why it is not uniformly available.

[2] Wallace F, Harper J, Sturgess H. Primary healthcare monitor 2016: Chartered Society of Physiotherapy. London: nfpSynergy; 2016

However, recent research from Keele[3] has shown that after proactive promotion of self-referral services to the 10,000 patients in the pilots GP areas there was no increase in referrals and no increase in inappropriate referrals.

iii) **Community based physiotherapy.** Physiotherapists are integral to and often lead community-based services such as falls prevention, reablement and community pulmonary rehabilitation. Physiotherapy in community based settings provides support across a range of speciality groups (eg, respiratory, neurological, older people and frail elderly) to maintain strength, balance, mobility and independence, supporting more people to remain active and in their own homes. One of the challenges for services is developing a greater capacity in a primary care and community based setting while there continues to be a demand on hospital-based services. Investment in primary care, in rehabilitation and integrated community based services is a prerequisite to reducing demand on hospital-based care. Although this not an easy task and will require shifting of services and moving of resources. This becomes increasingly more difficult as services face an increase in the frail elderly accessing services, winter pressures, managing complex needs and co-morbidities. The role of rehabilitation will be critical.

iv) **New models – funding, management, governance.** Physiotherapy, along with other therapy and allied professions can provide a wide range of services in a primary care setting. There are challenges, however, that need to be addressed:

- GPs need to be aware of the full potential these professions can bring and then need to be supported, financially, to develop a new multidisciplinary approach.
- Funding will need to come from a number of sources – use of existing General Practice funding, service level agreements with teams in secondary care, Health Board primary care funding and new funding to support development and increase overall capacity where this is needed.
- Service management and human resource considerations are required to ensure that individuals have access to support, mentorship, training and development and resources (e.g. ICT, physical space) to ensure the service maintains its capacity to deliver safe, effective, high quality care to patients and their families. Employment models, including the importance of maintaining NHS terms and conditions will also need to addressed.

v) **Investment in staff to provide quality services.** To make the changes that are needed it will be essential to ensure quality employment through investment in staffing and professional development. For example, this includes ensuring there is support and capacity for staff to engage in service development, research and learning and their working environment. These are integral to delivery of high quality patient care, with high quality skills in high quality facilities. Continued investment in the existing physiotherapy workforce will be needed including through:

- Increasing the number of physiotherapists able to engage in independent prescribing, injection therapy and ordering diagnostics

[3] Bishop A, Tooth S, Protheroe J, et al. Direct access to physiotherapy for musculoskeletal problems in primary care: the stems pilot cluster randomised trial. Physiotherapy: *World Confederation for Physical Therapy Congress 2015 Abstracts, Singapore, 1-4 May 2015*. 2015;101(Supp.1):e152-e3. http://www.sciencedirect.com/science/article/pii/S0031940615003326

- Developing physiotherapists' broader advanced practice skills
- Facilitating physiotherapists' return to practice after a career break
- Facilitating flexible working (eg carer commitments)

Developments and investment in staff will need to be linked to an increase in student numbers.

vi) **Placement and learning opportunities in primary care.** We need to equip the physiotherapy workforce of the future (eg physiotherapy undergraduates and the physiotherapy/AHP support worker workforce) with behaviours, knowledge, skills and experience of primary care through their education and training. This will need to be considered by the education and service providers and will need a collaborative approach. The new Health Education Wales body set up to oversee strategic workforce planning, workforce design and education commissioning for NHS Wales will be able to promote such an approach to sustain development of the workforce in primary care for the future.

There must be a drive to increase student' access to patient experience and practice-based learning in primary care, and already we have seen colleagues from Cardiff University working with clinical teams and services to extend practice-based learning into community/primary care settings. The CSP is launching a campaign this year to encourage the profession to access a wider range of settings to support more practice based learning opportunities for students.

vii) **Widening Access and the Welsh Language.** Delivering services through the medium of Welsh is a challenge (not just for physiotherapy) and support will be needed to develop the capacity, to recognise and to value the current capacity to deliver services through the medium of Welsh if that is what the patient/service wishes to use. This links to Welsh Government's intentions to strengthen powers and extend the scope of the Welsh Language Act and their work around recruitment and retention and widening access.

4. The CSP has been working with the BMA Cymru Wales and supported by the RCGP Wales to develop guidance on setting up first contact physiotherapy practitioner posts in primary care. 'General Practice Physiotherapy posts – a guide for implementation and evaluation'[4] provides practical guidance for physiotherapists, GPs and those involved in funding and planning musculoskeletal (MSK) services. It provides detail on funding models, implementation considerations and physiotherapist's roles and measuring impact and benefits.

5. The CSP has also developed a cost calculator [5]– a web based tool which helps businesses understand the costs of a potential service to primary care. The cost calculator shows that if physiotherapy were available as a first contact in a practice GPs would be able to see their patients for 5 minutes longer each, increasing quality of care.

6. Measuring the benefits of physiotherapy as part of the multi-disciplinary team in primary care will have to be looked at across a range of areas. These include:

[4] CSP 2016 General Practice Physiotherapy posts – a guide for implementation and evaluation. http://www.csp.org.uk/publications/implementing-physiotherapy-services-general-practice-guide-implementation-evaluation

[5] CSP 2016 Cost Calculator http://www.csp.org.uk/publications/download-physiotherapy-cost-calculator

- Benefits for GPs - freeing up their time, with fewer repeat appointments and less money spent on locums

- Benefits for patients - swifter access to specialists in MSK and empowerment to self-manage

- Benefits in relation to NHS resources - less unnecessary testing and prescribing, less onward referrals to secondary care for physiotherapy treatment or consultant appointments and shorter waiting times in secondary care.

The CSP also suggests the potential benefits of reducing sickness absence and the further reduction in unnecessary GP appointments if UK government allows physiotherapists to issue 'Fit Notes' (currently under consideration in the Health and Work Green Paper) – something that has been called for by both the CSP and BMA UK.

Concluding comments

The CSP in Wales hopes this written submission is useful to the committee and looks forward to continuing to play an active role in the inquiry. The profession is keeping an overview of developments across Wales supporting primary care and general practice in particular. Developments to date are captured in Appendix 1.

If you require any further information from the professional body please do not hesitate to get in touch.

Yours sincerely

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

In association with:
Chartered Society of Physiotherapy Welsh Board
The Welsh Physiotherapy Leaders Advisory Group

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 56,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Agenda Item 6

1 February 2017

Response from the Royal College of Nursing Wales to the Health, Social Care & Sport Committee Committee's Inquiry into Primary Care

How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care)

I. The Royal College of Nursing would maintain that, in the spirit of widening professional engagement with the cluster networks, it would be helpful if they were referred to as simply 'clusters' or 'primary care clusters'. Primary care practice includes the nursing profession (General Practice Nurses for example) amongst others, and therefore the clusters are not just about GPs.

II. Clusters have a responsibility to ensure that professional development opportunities are available to those working within them, including General Practice Nurses (GPNs) and Healthcare Support Workers, not only to enable essential revalidation, but also as a way of upskilling the primary care workforce and thus reducing the demand on GPs.

The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

III. The nursing workforce is a central part of the multi-disciplinary team, providing a significant proportion of patient care in primary and community care. Despite this, nursing is often overlooked as a profession when primary and community care services are planned and the workforce considered. Directors of Primary Care Local Health Board levels should always include senior nurses in service and workforce community planning alongside other professions.

IV. Access to training such as non-medical independent prescribing, minor illness and clinical patient assessment modules will give the knowledge and confidence that the nursing workforce need, to support the GPs within clusters and recognise them as practitioners in their own right.

The current and future workforce challenges.

V. The Royal College of Nursing is supportive of the principle of the move towards treating increasing numbers of patients outside of the hospital setting and in the community and their homes. People generally prefer to receive care at home, enabling them to maintain greater independence and, when the care is of a high quality, often preventing future illness or accidents. However, there must be sufficient investment in the primary and community care workforce to ensure a high quality of care.

VI. In order to enable appropriate investment, improve workforce planning and ensure the right skill mix of the workforce, the statistical data and performance information on care provided in community settings must be made available. We know that there is a current paucity in this data, and this must be rectified.

VII. Within the GP surgery it is often the General Practice Nurse, supported by the healthcare support worker that will see, advise and treat people appropriately. GPNs undertake a huge range of assessments and interventions, immunisation and vaccination, the management of long-term conditions and cervical cytology. The Welsh Government should, together with the Local Health Boards and NHS Trusts, ensure that Advanced Nurse Practitioner posts are created across Wales in order to strengthen the primary care team and help reduce the pressure on GPs. This will require sufficient provision for extending nursing skills and appropriate training and education is available.

VIII. Primary care services must be delivered based on the needs of the population, and this includes Welsh language provision.

The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

IX. Recent research evidence has shown that attendance at cluster meetings by GPNs is, generally speaking, very low. Funds directed towards enabling GPNs and nursing teams to be released in order to attend cluster meetings will help foster a whole system approach, and help tackle the current perception of ‘GP’ cluster networks. This would also promote access to training and education opportunities for the workforce. The Welsh Government either needs to provide the funding to enable GPNs and Healthcare Support Workers to be released (and to pay for the necessary backfilling) or the GP practices themselves need to make these funds available.

Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.

X. As mentioned earlier, the Royal College of Nursing is in favour of the shift towards primary prevention, but this requires appropriate workforce investment. The registered workforce needs to be allowed the time to educate and train non-registered colleagues who are increasingly expected to share the workload. Any approach needs to involve the whole multi-disciplinary team, and not solely the GP workforce.

Coleg Nyrsio Brenhinol
Cymru
Royal College of Nursing
Wales

The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.

XI. Three examples of best practice which the Royal College of Nursing would like to highlight are:
- Cardiff and Vale University Health Board – Nursing Frailty Team. This is involving the development of the Primary Care Nurse for Older People Role, for the North Cardiff Area.
- Hywel Dda University Health Board and Betsi Cadwaladr University Health Board – requests have been made from cluster leads to the Primary Care Lead Nurse at Public Health Wales, requesting help to develop Cluster Consultant Nurses.

Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.

XII. It is important that cluster network meetings and stakeholder engagement activities do not involve the same people time after time, and that efforts are made to ensure that engagement is as wide as possible. Anecdotal evidence suggests for instance that GPNs cannot attend due to time and workload constraints. Similarly, if meetings are consistently held between 9 – 5pm on weekdays, GPs and other key stakeholders will consistently be unable to attend. In order for the effectiveness of the cluster networks to be properly assessed, it is essential that GPs, GPNs, healthcare support workers and other members of the primary care workforce on the ground are engaged with and involved.

About the Royal College of Nursing

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

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25 April 2017

Dr Dai Lloyd AM
National Assembly for Wales
Ty Hywel
Cardiff CF99 1NA

Dear Dr Dai Lloyd

Re: Nurse Staffing levels (Wales) Act 2016 statutory guidance consultation

I am writing to share some concerns the Royal College of Nursing has with the draft statutory guidance on the Nurse Staffing Levels Act. We have of course responded to the consultation, and a copy of our response is enclosed. This letter summarises our concerns.

As you know, the Royal College of Nursing campaigned passionately for the introduction of this landmark legislation, and we did so in the name of saving lives and improving patient care. Research shows that poor nurse staffing levels increase mortality rates compared to better staffed wards. It is our belief that the statutory guidance as drafted will not ensure that sufficient staffing levels are maintained nor that patient care is improved.

As a Royal College we worked extremely hard to see the Nurse Staffing Levels Act become reality and we are immensely grateful for support the legislation received from the Welsh Government and from all the political parties involved in shaping it.

The statutory guidance that sits alongside the Act will be key to its successful and effective implementation, and I am sure you will understand therefore our concern. The Royal College of Nursing have been closely involved throughout the development of this guidance, and have played an active part in the stakeholder engagement events. We are disappointed the consensus of those events have not

been reflected in the draft guidance. Outlined below are the key areas which we need significant strengthening in the guidance.

Staffing ratio

RCN Wales have maintained consistently that the Nurse Staffing Principles, published by the Chief Nursing Officer in 2012, should be explicitly reflected in the statutory guidance. This includes the principle that "the number of patients per Registered Nurse should not exceed 7 by day". There is no reference to a 7:1 patient to nurse ratio in the draft guidance.

We understand that the recommended ratio is subject to changes in academic research, and it is for that reason that we agreed not to put the ratio on the face of the Bill. This principle is central to the ethos of the Act however, which is to ensure that there are appropriate nurse staffing levels to provide appropriate care for patients, and it is therefore essential that the ratio is included in the guidance. The guidance can then be updated and reissued as necessary if the recommended ratio changes.

Supernumerary role of Ward Sister

Equally important is that the Ward Sister or Charge Nurse should not be included in the numbers when calculating the number of patients per Registered Nurse. Ward Sisters are central to the running of a ward; as well as being key to ensuring high standards of patient care, they also play a key part in providing staff learning and development opportunities, HR management, recruitment, sickness and absence management, appraisals and disciplinary procedures.

The Wards Sister's ability to manage these multiple demands can determine the morale of the team and therefore the quality of care provided in hospitals. It is vital therefore that they are not included in the calculations of nurse to patient ratio so that they have sufficient time to fulfil these vital duties. It is also important that this requirement is mentioned explicitly in the guidance. We do not feel it is appropriate for statutory guidance to rely on any implicit or shared understanding.

Student nurse mentorship

Some nurses on a ward will be acting as mentors for nursing students. The role as a mentor is critical in helping to facilitate the development of future generations of nurses. Some of the duties involved in mentoring student nurses include: assessing, evaluating and giving constructive feedback; observing students practising skills under the appropriate level of supervision; providing time for reflection, feedback and monitoring; and documenting a student's progress. As is the case with the Ward Sister/Charge Nurse, this is an important role which is ultimately about protecting the public. We do not feel this has been adequately reflected in the guidance.

Nurse mentors must be afforded sufficient time to perform the role properly (for the benefit of students and patients), and this must be taken into account when calculating the nurse staffing levels. It is also important that this requirement is

mentioned explicitly in the guidance. We do not feel it is appropriate for statutory guidance to rely on any implicit or shared understanding.

Reporting and accountability for the Health Boards
Another fundamental issue is that of reporting and monitoring. Whilst we understand that there is no requirement for the Welsh Government to issue statutory guidance under section 25E of the Act, the Royal College would maintain that it is essential that guidance in some form, statutory or non-statutory, is issued to Health Boards in order to assist them in collecting and reporting this data. Consistency between Health Boards in their approach to collecting and reporting the data will be crucial to workforce planning and public scrutiny. This will also assist with improving public confidence and trust in the healthcare system.

Vaughan Gething, as Cabinet Secretary, has rightly insisted that any extension of the Nurse Staffing Levels Act to other areas of nursing care is dependent on having the evidence to demonstrate the effectiveness of the existing Act. Without clear guidance for Health Boards on how to show compliance with the legislation and on monitoring their progress towards meeting the required staffing levels, demonstrating the Act's success will be impossible.

Welsh language
The status of the Welsh language as equal to English means that patients should have access to care in their preferred language, and this should be expressly conveyed in the guidance. We welcome that the guidance states that consideration must be given to supporting patients and families whose first language is not English or Welsh, and yet this highlights even more starkly the fact that the specific needs of Welsh language speakers have been completely omitted from the guidance as drafted. Given the current Welsh Government strategy More Than Just Words and the context of the forthcoming NHS Wales Standards, it is surprising that the Welsh language is given no specific reference, apart from in relation to Informing Patients.

I would be very happy to discuss this with you further if you require, and please do contact my office if you or your officials require any further information in the meantime.

Kind regards

Yours sincerely

TINA DONNELLY, CBE, TD, DL
DIRECTOR, RCN WALES

Consultation on statutory guidance required by Section 25D of the Nurse Staffing Levels (Wales) Act 2016

Consultation Response Form

Your name: Lisa Turnbull (this name to be used for queries only, please ascribe authorship to the organisation)

Organisation (if applicable): Royal College of Nursing Wales

email / telephone number: 02920 680 738

Your address: Royal College of Nursing Wales, Ty Maeth, King George V Drive East, Cardiff, CF14 4XZ

I am a/an *(please select one from the following)*		
	Patient / Family member or carer of a patient	
	Member of the public	
	Member of NHS staff	
	Local Health Board / NHS Trust	
	Organisation with an interest in the health service	✓
	Voluntary sector representative (community group, volunteer group, self-help group, cooperative, enterprise, religious group, not-for-profit organisation)	
	Other group not listed above	

1) On a scale of 1 to 5, where 1 is not helpful at all and 5 is very helpful; how helpful did you find the following parts of the guidance? (Please tick one option for each part)						
Part	**1**	**2**	**3**	**4**	**5**	**Don't Know**
Overall approach		✓				
Section 25B						
Designated person		✓				
Reasonable Requirements		✓				
Nurse staffing level	✓					
Reasonable steps			✓			
Informing patients		✓				
Situations where section 25B applies			✓			

2) If you feel part of the guidance could be improved, please tell us about it below. You may wish to consider whether anything could be added or removed from the guidance, or whether wording could be changed to improve clarity.	
Part	**Improvement**
Overall approach	The Royal College of Nursing Wales has serious concerns regarding the draft guidance and cannot support the document in its current form. The intention of the Act was to improve patient safety and care provided to patients during care administered by Registered Nurses and Support staff. We know from research that patient mortality rates are significantly higher with low registered nurse staffing levels and all other outcomes for patients are also significantly lower with low nurse staffing levels. Introducing statutory guidance that is weaker and extremely vague and also less than the current non-statutory guidance will result in poorer care for patients and a likely increase in patient mortality and morbidity. We have consistently maintained that the CNO's Principles should be reflected explicitly in the guidance, and that this must include the principle that "the number of patients per Registered Nurse should not exceed 7 by day". There is no reference to a 7:1 patient to nurse ratio in the draft guidance. We do not accept that this will be too prescriptive and restrictive, and indeed because it is in guidance can over a period of time be subjected to review provided this is accepted as guidance and not excluded completely. We also believe that when the CNO principles were issued there was a requirement for health boards to implement the principles, the change in behaviour to this implementation we believe has been in a direct response to the legislation and without it is simply relates to the act having no power in terms of protecting the principles. There is also no recognition of the supernumerary role of the Ward Sister/ Charge Nurse. The level of responsibility and multi-faceted demands of this role mean that they should not be included in calculations of nurse to patient ratio. It is essential they are afforded sufficient time to fulfil their duties to the highest possible standard. The role of this professional in multi – faceted and does require an overall ability to seek to work with patients when demand requires as an additional resource to complement existing provision by the primary Registered Nurse who will requires expertise from the ward sister, if they are included in the numbers this would be in addition to all other elements of the role and if included in the overall numbers would result in lack of time to provide care requirements to those in need. Additionally, the guidance does not adequately reflect the fact that many nurses on acute wards will be as part of

	their role and part of the Nursing and Midwifery Council requirements (NMC Professional regulator - non devolved to Wales role ie required to meet UK standard of regulation) will be mentoring student nurses, and therefore have additional demands on their time. This must be explicitly mentioned as a factor when calculating nurse staffing levels. The reporting and accountability processes of Health Boards is another area which the Royal College of Nursing is very concerned about. Whilst we understand that there is no requirement for the Welsh Government to issue Statutory Guidance under section 25E of the Act, the Royal College would maintain that it is essential that guidance is issued, and that whilst it might not be included as statutory guidance it may be issued as non-statutory guidance and that this must be issued to Health Boards in order to assist them in collecting and reporting this data. Consistency between Health Boards in their approach to collecting and reporting the data will be crucial to workforce planning and public scrutiny. This is not a process currently that is robust and we believe does not therefore relate to accurate staffing criteria being implemented.
Designated person	The wording “sufficient seniority” in point 7 is open to interpretation. It may be helpful to consider whether grading or banding should be specified. This will enable staff of relevant experience and seniority to use high levels of professional experience and therefore enable a more accurate assessment of need.

Reasonable Requirements	It is important that patient's nursing needs are accurately and expertly assessed. At point 9, the "ward nursing team" should therefore include a specified level of seniority to ensure that the assessment of patient need is made by a nurse with an appropriate level of experience and training. We are very concerned to ensure that we require the recording of a Registered Nurse as being on the Highest level of registration and not Nursing Associate level should the NMC confirm registration of the Associate level.
Nurse staffing level	In the table at point 10 specifying the required establishment, the final sentence states "This includes a resource to cover all staff absences and other functions that reduce their time to care for patients." It is here that there must be explicit reference to the mentoring of student nurses, any Continuous Professional Development (CPD) any further training requirements, in addition to the supernumerary role of the Ward Sister/Charge Nurse. All of these demands will reduce the amount of time that registered nurses are able to spend caring for patients and subsequently meeting the required standards for providing safe care and preventing patients being put at risk. These should be explicitly listed so as to ensure that they are always factored in when making the staffing calculations. We would also question the requirement to undertake the calculation every six months and whether or not this is sufficient, given how frequently the make-up of a ward can change (often on a daily or even hourly basis). As outlined in points 23 to 26 in the Introduction to Section 25C, there are a number of factors which the designated person must be mindful of when making the calculation, all of which are very changeable. The important thing is that the designated person is alerted to any changes which may result in the need to recalculate the required nurse staffing level, and that the guidance allows for enough flexibility for an informed judgement to be made. We are concerned that it is too prescriptive to state "every six months" and that this will result in external factors which may affect the required staffing level not being taken into account. A more regular review would be monthly with quarterly reporting but stating exception reports when clear issues of concern are raised this is reported directly, and these times are also recorded for review.

Reasonable steps	Important that there is parity between the different professional portfolios in terms of how their professional opinions are taken into account.
Informing patients	More detail is required in this section to advise Health Boards of how they might present this information i.e. where and in what format. This would not be designed to be too prescriptive, but rather provide suggestions as to how patients could be informed of the staff level. One suggestion for instance might be a sticker or poster similar to a food hygiene rating which could be displayed on the doors to the ward, or notice board in the ward. We do also feel that this should be available to patients as part of their admission pack clearly engaging with patients and advising them that the Board take their care and safety seriously.
Situations where section 25B applies	Content with this section.

3) On a scale of 1 to 5, where 1 is not helpful at all and 5 is very helpful; how helpful did you find the following parts of the guidance? (Please tick one option for each part)

Part	**1**	**2**	**3**	**4**	**5**	**Don't Know**
Section 25C						
Introduction to section 25C		✓				
Professional Judgement	✓					
Evidence Based workforce planning tool			✓			
Patient wellbeing is particularly sensitive to care provided by a nurse		✓				

4) If you feel part of the guidance could be improved, please tell us about it below. You may wish to consider whether anything could be added or removed from the guidance, or whether wording could be changed to improve clarity.

Part	**Improvement**
Introduction to section 25C	

Professional Judgement	Point 27 should state "each calculation **must** include all of the following", rather than "can include all or any of the following". Each one of the considerations listed is imperative to making an informed professional judgement and should not therefore be treated as an either/or list. The 5th bullet point relating to qualifications, competencies, skills and experience needs further elaboration and clarification. Student nurses should be included in the listing "health professionals or other staff" as Registered Nurses who are mentoring these student nurses will be required to delegate tasks and supervise where appropriate and also assess competency and record this for the student record as part of the regulatory requirements. Further detail could also be included on the final bullet point relating to administrative functions. This is a very broad term and it would be helpful to specify that this could include the following: - Patient discharge (often a complex and lengthy administrative process) - Documenting progress of student nurses and providing written feedback - HR management such as sickness and absence management, appraisals and disciplinary procedures (particularly relevant for Ward sisters) - Ward rotas and rostering - Responding to Inspectorate documentation and visits - Ward stocks and refurbishment and equipment documentation - Compliance to Health and Safety requirements etc

Evidence Based workforce planning tool	Content with this section
Patient wellbeing is particularly sensitive to care provided by a nurse	It would be useful at point 36 to include a list of example such as dementia, mental health issues, complex diabetic needs, learning disabilities etc. The NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals recommends that factors to determine nurse staffing requirements include a need for a: *"holistic assessment of each patient's nursing needs and take account of specific nursing requirements and disabilities, as well as other patient factors that may increase nursing staff requirements, such as:* - *difficulties with cognition or confusion (such as those associated with learning difficulties, mental health problems or dementia)* - *end-of-life care* - *increased risk of clinical deterioration* - *need for the continuous presence of a member of the nursing team (often referred to as 'specialing' care)."* We would recommend that the statutory guidance includes a specification of requirements such as this.

5) We would like to know your views on the effects that the guidance would have on the Welsh language, specifically on: **i) opportunities for people to use Welsh; and** **ii) treating the Welsh language no less favourably than English.**
Given the current Welsh language strategy More Than Just Words and the context of the forthcoming NHS Wales Standards, it is surprising that the Welsh Language is given no specific reference, apart from in relation to Informing Patients. We welcome that the guidance states that consideration must be given to supporting patients and families whose first language is not English or Welsh, and yet this makes even shows even more starkly the fact that the needs of Welsh language speakers have been completely omitted.

6) **Please also explain how you believe the guidance could be formulated or changed so as to have:**

i) **positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language; and**

ii) **no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.**

In addition to the bullet point under point 27 relating to the Welsh language, the Welsh Government strategy More than Words states there must be an "active offer" of services available in the Welsh language. This must be made to all patients. Moreover the guidance should be compatible with the forthcoming NHS Welsh Language Standards. Therefore, the guidance should state that designated person must consider the recruitment and deployment of Welsh speaking staff.

7) **Would further statutory guidance on workforce planning on this specific issue be beneficial? If yes, please give details.**

This question is unclear in its meaning.

Further guidance on workforce planning would certainly be beneficial, and we would strongly advocate for additional guidance relating to the accounting and reporting mechanisms for Health Boards. The intent at the Bill stage was clear – a key enforcement of this legislation was intended to be through increased public transparency.

8) **What sort of information would be beneficial in any additional workforce planning guidance, that is not already in existence elsewhere?**

The CNO's principles must be incorporated explicitly in the guidance. Without this incorporation the 2012 document will undoubtedly be deemed superseded and patient care and safety will not be central to workforce planning.

9) **We have asked a number of specific questions. If you have any related issues that we have not specifically addressed, please raise them here.**

The Royal College of Nursing campaigned passionately for the introduction of this landmark legislation, and we did so in the name of saving lives and improving patient care.

Section 25 D this section places a duty on Welsh Ministers to consult upon the issue of guidance we are disappointed that whilst participating in two consultative periods none of the results of those meetings were incorporated in this current consultation which challenges why the two meetings took place and why our opinions and those of other were not taken into account

Research shows that poor nurse staffing levels increase mortality rates compared to better staffed wards. It is our belief that the statutory guidance as drafted will not ensure that sufficient staffing levels are maintained and that patient care is improved.

The introduction of the California law on staffing levels (with an explicit ratio) reduced 30 day mortality rates by between 10 and 13%. We cannot see that such similar benefits will be achieved in Wales without similar safeguards.

The Royal College of Nursing have been closely involved throughout the development of this guidance, and have played an active part in the stakeholder engagement events. We are disappointed therefore that a number of our key recommendations have not been included in the draft guidance. As a result, the Royal College of Nursing cannot support the guidance as currently drafted. The key areas which we need significant strengthening in the guidance, much of which has been covered in our response above, are outlined below:

<u>Staffing ratio</u>
The Royal College of Nursing Wales have maintained consistently that the Nurse Staffing Principles, published by the Chief Nursing Officer in 2012, should be explicitly reflected in the statutory guidance. This includes the principle that “the number of patients per Registered Nurse should not exceed 7 by day”. There is no reference to a 7:1 patient to nurse ratio in the draft guidance.

<u>Supernumerary role of Ward Sister</u>
Equally important is that the Ward Sister or Charge Nurse should not be included in the numbers when calculating patients per Registered Nurse. Ward Sisters are central to the running of a ward; as well as being key to ensuring high standards of patient care, they also play a key part in providing staff learning and development opportunities, HR management, recruitment, sickness and absence management, appraisals and disciplinary procedures. Their ability to manage these multiple demands can determine the morale of the team and therefore the quality of care provided in hospitals. It is vital therefore that they are not included in the calculations of nurse to patient ratio so that they have sufficient time to fulfil these vital duties.

<u>Student nurse mentorship</u>
Some nurses on a ward will be acting as mentors for nursing students. The role as a mentor is critical in helping to facilitate the development of future generations of nurses. Some of the duties involved in mentoring student nurses includes: assessing, evaluating and giving constructive feedback; observing students practising skills under the appropriate level of supervision; providing time for reflection, feedback and monitoring; and documenting the student’s progress. As is the case with the Ward Sister/Charge Nurse, this is an important role which is ultimately about protecting the public. We do not feel this has been adequately reflected in the guidance. Nurse mentors must be afforded sufficient time to perform the role properly (for the benefit of students and patients), and this must be taken into account when calculating the nurse staffing levels.

Reporting and accountability for the Health Boards

Another fundamental issue is that of reporting and monitoring. Whilst we understand that there is no requirement for the Welsh Government to issue statutory guidance under section 25E of the Act, the Royal College would maintain that it is essential that guidance in some form, statutory or non-statutory, is issued to Health Boards in order to assist them in collecting and reporting this data. Consistency between Health Boards in their approach to collecting and reporting the data will be crucial to workforce planning and public scrutiny. Without clear guidance for Health Boards on how to show compliance with the legislation and on monitoring their progress towards meeting the required staffing levels, demonstrating the Act's success will be impossible.

As a Royal College we worked extremely hard to see this the Nurse Staffing Levels Act become reality and we are immensely grateful for support the legislation received from the Welsh Government and from all the political parties involved in shaping it.

The statutory guidance that sits alongside the Act will be key to its successful and effective implementation. Unfortunately it is our belief that the statutory guidance as drafted will not ensure that sufficient staffing levels are maintained and that patient care is improved. This consultation is an opportunity for the Welsh Government to strengthen thus guidance and in doing so ensure that the benefits of the Nurse Staffing Levels (Wales) Act are full realised and that the good intentions and hopes of the legislators who passed the Act are achieved.

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐

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Agenda Item 11

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