Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 2 – Senedd
Meeting date: 19 September 2018
Meeting time: 09.15

For further information contact:
Claire Morris
Committee Clerk
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Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Autism (Wales) Bill

(9.30–11.00) (Pages 1 – 23)

Paul Davies AM, Member in charge of the Bill
Enrico Carpanini, Legal Services, Assembly Commission
Stephen Boyce, Research Service, Assembly Commission

Autism (Wales) Bill, as introduced

Explanatory Memorandum

3 Paper(s) to note

(11.00 – 11.05)

3.1 Letter from the Cabinet Secretary for Health and Social Services – Suicide Prevention

(Pages 24 – 25)

3.2 Letter from the Cabinet Secretary for Health and Social Services – Gender Identity Services

(Page 26)

3.3 Additional information following scrutiny of Public Health Wales on 5 July

Additional information following scrutiny of Public Health Wales on 5 July

3.4 Written evidence from The Royal College of Emergency Medicine Wales - Winter Planning 2018-19

(Pages 27 - 37)

3.5 Letter from the Royal College of General Practitioners - Out of Hours Services

(Pages 38 - 42)

3.6 Letter from the Cabinet Secretary for Health and Social Services - Patient Safety and Quality Information Programme

(Page 43)

3.7 Letter from Samaritans Cymru to the Chair - Suicide Prevention Inquiry

(Pages 44 - 45)

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

(11.05)

5 Autism (Wales) Bill: Consideration of evidence

(11.05-11.15)

6 Forward work programme

(11.15-11.35) (Pages 46 - 68)

7 Physical activity in children and young people: European evidence

(11.35-11.45) (Pages 69 - 83)

Agenda Item 2

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Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Ein cyf/Our ref: MA-P-VG-2032-18

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

23 July 2018

Dear Dai

Thank you for your letter dated 3 July 2018, requesting an update from the National Advisory Group (NAG) meeting held on 28 June to further inform the Health, Social Care and Sport Committee inquiry into suicide prevention. This letter focuses on those areas that I referred to during my attendance at the Committee on 27 June 2018.

Firstly, the Committee raised concerns regarding awareness and availability of the 'Help is at Hand' resource. This has been considered by the NAG and immediate agreed actions include working with Public Health Wales to raise the profile and awareness of the resource. Both Dr Liz Davies, Senior Medical Officer, Mental Health, and Public Health Wales have written to the Jacob Abraham Foundation and Tir Dewi providing copies of the Help is at Hand resource. Professor Ann John has also invited both organisations to meet with Public Health Wales to discuss their concerns.

The NAG also confirmed that the suicide and self harm training frameworks referenced in the midpoint review will be launched in England in July. There has been Welsh input into their development and the NAG is considering adoption in Wales. The NAG also discussed a post-vention pathway and possible steps to consider this for Wales.

With regards to a specific public awareness campaign, the NAG is currently reviewing the suicide and stigma campaign in Scotland with an emphasis on progress and impact, to inform recommendations for similar action in Wales. This will include considering the fit with existing programmes, for instance Time to Change Wales and the work of the National Partnership Board task and finish group exploring mental health stigma.

During the Committee meeting, concerns were also raised regarding inconsistencies in the make-up and operation of the Regional Forums. As I reflected at the Committee, the Regional Forums are responsible for their own local suicide prevention strategies in line with guidance issued by the NAG. Regional Forums report directly to the NAG, providing

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progress updates at meetings. Implementation oversight is maintained through the NAG. Whilst we would expect local variation based on local need and I have asked my officials to raise these concerns at a future NAG meeting.

I hope that this update assists the Committee in your inquiry.

Yours sincerely

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Agenda Item 3.2

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA-P/VG/2985/18

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
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23 August 2018

Dear Dai,

Following my letter to the Committee in June regarding gender identity services, I am writing to provide a further update on our progress towards improving services in Wales.

I published a written statement on 17 August to announce that, subject to the recruitment of specialist staff, the multi-disciplinary Wales Gender Team will start seeing patients at the end of October.

Cardiff and Vale University Health Board has also confirmed that arrangements will be in place by September for patients who have been seen and assessed by the London Gender Identity Clinic to continue their treatment here in Wales.

The full statement is available at:
https://gov.wales/about/cabinet/cabinetstatements/2018/ImprovementstoGenderIdentityServices/?lang=en

Work continues to develop NHS capacity to meet patient needs more broadly and to develop a fully integrated service from April 2019.

I will write again to update on progress towards this in due course.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

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Health, social care and sport committee - Winter Planning 2018-19

Written evidence submitted on the behalf of the RCEM Wales (September 2018)

The Royal College of Emergency Medicine Wales (RCEM Wales) is the single authoritative body for Emergency Medicine in Wales. RCEM Wales works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Views on the oral evidence session.

1. Despite the best efforts of clinical staff, winter 2017-18 saw poor patient experiences, record breaking 12-hour waits, crowding and Exit Block in Welsh emergency departments (EDs). For many emergency care staff, working in these busy and crowded environments was stressful, demoralising and sometimes overwhelming. And for patients, safety was often compromised as well as their dignity.[1]

2. At the oral evidence session held on 19 July 2018, many Health Boards expressed a degree of confidence that their plans will deliver better outcomes and experiences for patients this upcoming winter. Last years' poor performance, some explained, was in part due to a severe flu outbreak, low vaccination uptake figures, extreme weather conditions and the acuity of frail elderly patients.[2]

3. Yet, RCEM Wales takes the view that performance has been deteriorating for several years, despite influenza, challenging weather conditions and the ageing population – all of which are predicted annually. The main reasons for this continued deterioration are insufficient capacity to match demand, staffing shortages and deficient social care resources.

4. Some of these issues were raised by witnesses at the evidence session, including workforce shortages which were seen by a majority as detrimental to performance and safety. One Health Board commented: "there are some specialties where we can't get additional staff. That's one of the big impingements to delivery on a day-to-day basis, let alone the winter".[3]

5. It was also apparent that locum cover is increasingly being relied on to fill rota gaps, despite the expense:

"You can have all the money but if the posts are not there – even from an agency perspective – so, our contingency plans can often be based on the use of agency to include off-contract agency. If they then don't fill, we're left with the gap".[4]

6. There is also evidence that many Health Boards are relying on the goodwill of staff – which is arguably waning - to work overtime:

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[1] RCEM, Welsh EDs are severely stretched this winter (January 2018) and Patients in Welsh EDs increasingly put in harm's way (February 2018)
[2] Health, Social Care & Sport Committee, Evidence session on winter resilience plans, 2018-19 (19/07/18), please see, for example, paragraph two, 10, 93 in the transcript
[3] Ibid. Paragraph 83 and 255
[4] Ibid. Paragraph 105

"We put on extra capacity and extra staff to deal with [four-day weekends]. The problem we have is that lots of that is often based on overtime and on goodwill of staff, to get people to work additional hours – we have lots of vacancies".[5]

7. And where Health Boards acknowledged that extra capacity, in terms of hospital beds, is required to deal with demand and flow issues, other options are sort due to workforce deficits and budget constraints:

"All of our hospitals pretty much operate at capacity on a daily basis, and, even if there were additional moneys to open additional capacity, we wouldn't have the nurses and doctors and therapy staff available to put that on".[6]

8. Therefore, the majority of winter resilience plans – and the Welsh Government's transformation plans - focus on prevention, redirection and short-term solutions rather than long-term planning to solve the perpetual capacity and demand issues.

9. It is important to note that some areas of good practice were highlighted in the oral evidence. This includes shared learning from previous years, earlier resilience planning and integrated initiatives with social care providers. The fact that Health Boards are required to formally submit plans to the Welsh Government in September 2018 is positive and will hopefully help to improve accountability. It was particularly encouraging that one Health Board considered extra beds for the safety of patients:

"We regularly put additional beds on wards, so we are reviewing the risk on wards – it is a low-level boarding. So, I've made the decision personally that, if the risk is in the emergency department, and it is too high, then we need to consider how we 'board' a patient safely".[7]

10. Nevertheless, the College is of the opinion that NHS Wales will not see great improvements in performance and patient experiences for the foreseeable future unless workforce, capacity and social care resources are increased in the long-term. We would like to see more commitments by Health Boards to increase bed numbers and fill vital workforce vacancies.

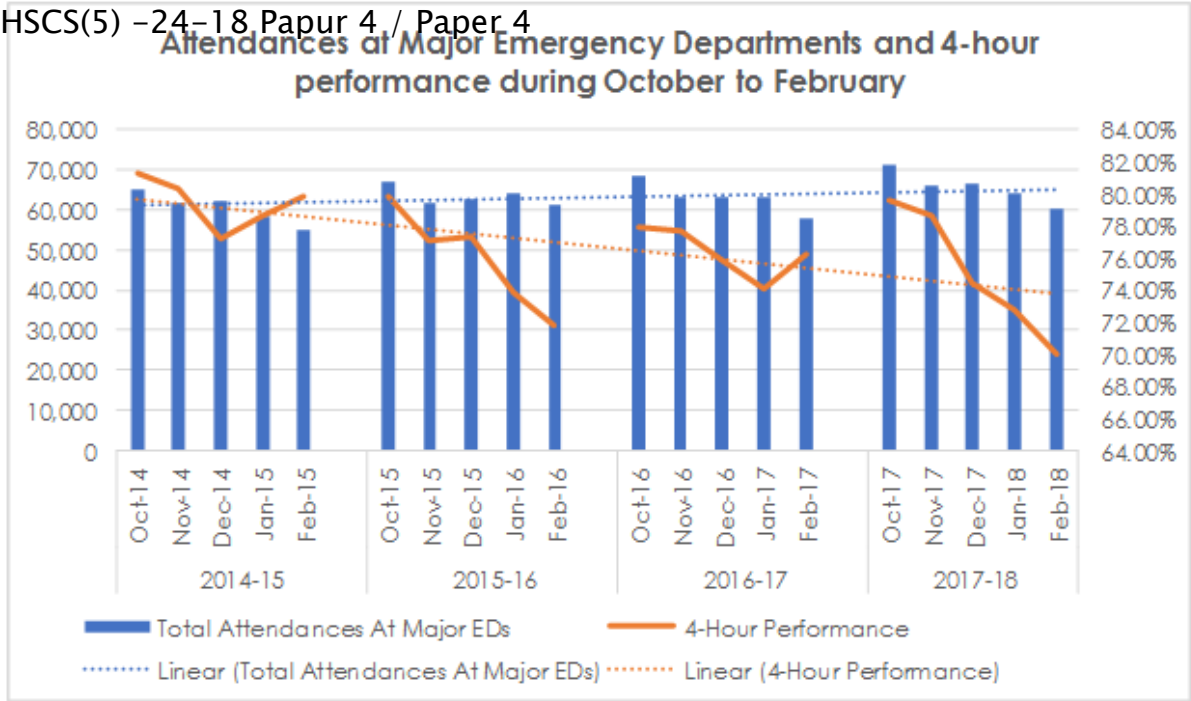
Question 1. In your view, how well prepared and equipped do you feel the Welsh NHS is to cope with the forthcoming winter, and where are any pressure points likely to be?

11. When asked about how it felt to work in an emergency department last winter and what their perceptions are on the forthcoming winter, many of our Members and Fellows commented that the situation feels worse than previous years, that they believe emergency care is in a state of crisis and that they do not have confidence that this winter will be any better.

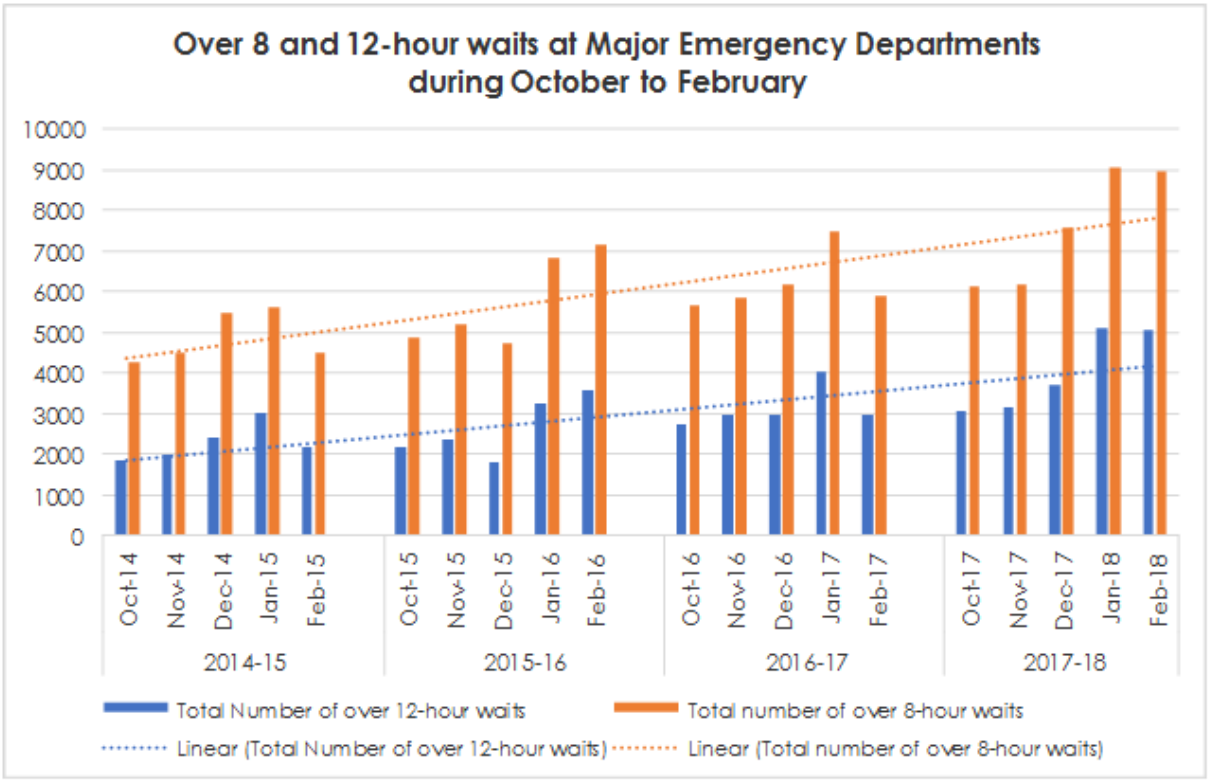
12. National data – in terms of the gradual increase of demand coupled with the decline in performance – shows that these responses are justified.

13. There were 1,030,045 attendances at Welsh emergency departments in 2017-18. This in an increase of 4.8% when compared to 2010-11 and is equivalent to the annual workload of one District General emergency department. In the same timeframe, average four-hour performance at Major departments has deteriorated from an average of 85.8% (2010-11) to 76.9% (2017-18). [8] The graph presented overleaf demonstrates this trend over the winter period.[9]

[5] Health, Social Care & Sport Committee, Evidence session on winter resilience plans, 2018-19 (19/07/18), paragraph 102
[6] Ibid. Paragraph 97
[7] Ibid. Paragraph 35
[8] Stats Wales, Performance against 4 hour waiting times target
[9] Ibid.



14. When we look at eight and 12-hour performance data, the picture is equally concerning.[10] January 2018 saw the highest number of 12-hour waits on record[11] and in December 2017 only 78.9% of patients spent less than four hours in all emergency care facilities from arrival until admission, transfer or discharge - the lowest performance since March 2016.[12]



15. As it is widely acknowledged, longer waits in emergency departments can lead to negative patient outcomes and even avoidable fatalities and are due to congestion in hospital wards[13] and insufficient social care provision in the community.

[10] Stats Wales, Performance against 8 and 12 hour waiting times target
[11] Welsh Government, NHS Activity & Performance Summary: December 2017/January 2018 (Feb 2018)
[12] Welsh Government, NHS Activity & Performance Summary: November/December 2017 (Jan 2018)
[13] Nuffield Trust, Understanding patient flow in hospitals (Oct 2016)

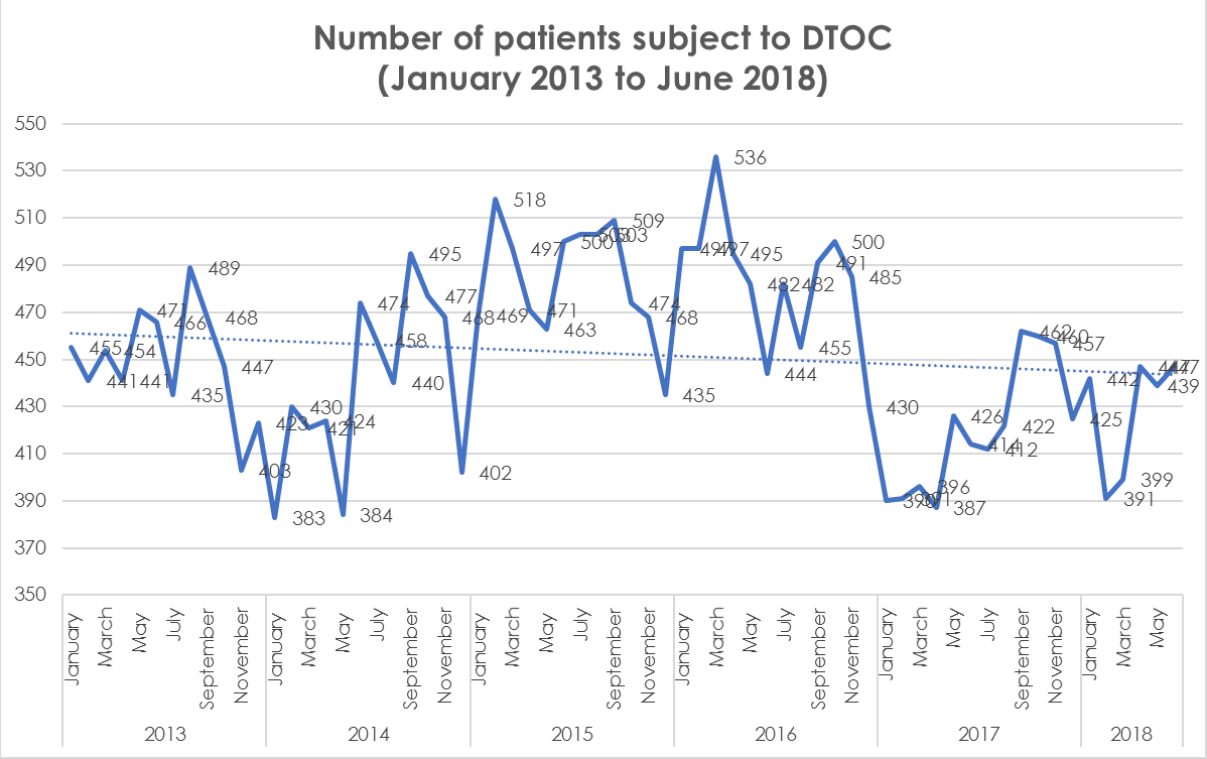
16. If these trends continue - and currently there is no substantial evidence to suggest otherwise - it is arguable that patient safety will continue to be compromised. NHS Wales is simply not well equipped to deal with the demand and acuity of patients requiring care this winter.

17. The main pressure points this winter pertaining to the emergency care system are likely to be 'Exit Block' - or the emergency department 'back door' - and ambulance waits.

18. Exit Block occurs when patients cannot be moved in a timely manner to a hospital ward because of a lack of available hospital beds. It is widely acknowledged that Exit Block causes harm to patients and avoidable mortality as well as being detrimental to patient dignity.[14]

19. In 2016/17, there were 1,292.6 fewer available beds in the NHS in Wales than there were in 2010/11. This represents a 10.6% decline in the total hospital bed base. In the same timeframe, average bed occupancy across NHS Wales has risen from 84.7% to unsafe levels of 87.4%.[15]

20. Delayed transfers of care (DTOC) are another serious cause of Exit Block. DTOC is most commonly a result of a lack of social care resources and continue to pose a serious problem. In 2017, the total number DTOC cases was 5042.[16]



21. This is important because the more patients subject to Delayed Transfers of Care – and the data does not specific how long each of these delays lasted – the fewer the available hospital beds to admit patients to when they arrive at A&E requiring further treatment.

22. An independent survey undertaken by the College in Wales found that 10 out of the 13 Major Emergency Departments in Wales regularly have patients waiting in ambulances for sustained periods of time. The remaining three Major Departments tend to have queues of patients waiting on trollies in hospital corridors until an appropriate bed becomes available.

[14] RCEM, Exit Block, British Journal of Hospital Medicine, Exit block in the ED: recognition and consequences (2014), CEEM, Improving emergency department patient flow (2016) and University of Sheffield, Exit block in emergency departments: a rapid evidence review (2015)
[15] Stats Wales, NHS beds summary data by year
[16] Stats Wales, Delayed transfers of care, delay stocks by age of residence

23. Ambulance waits are dependent on the flow of patients in the rest of the system. When Exit Block and ED crowding occurs, ambulance waits are inevitable.

24. Like Exit Block, ambulance waits are detrimental to patient dignity, can cause harm and detain emergency teams from reaching other unwell patients. Furthermore, long ambulance waits are a contributing factor in the poor morale and high stress levels of the workforce.[17]

25. Despite good intentions, many preventative, redirection and resilient plans have proven to be ineffective because the underlying problems remain - health and social care services are ill-equipped to meet patient requirements. This is in terms of staffing numbers, hospital beds and social care provision.[18] Until these issues are addressed, the College predicts that performance will not significantly improve.

Question 2. To what extent has the RCEM been engaged in conversations with the Health Boards across Wales/Welsh Government in relation to the sustainability of emergency medicine in Wales and improving emergency department performance?

26. As a Member of the National Programme for Unscheduled Care Board (NPUC), the College continues to inform the Welsh Government on pressures on the emergency care system and advises on possible solutions.

27. As a part of this, the College has summitted evidence to the Welsh Government's winter evaluation for two consecutive years. Our evidence draws on the personal experiences of our Members and Fellows in Wales as well evidential research. The report evaluating the winter 2017/18 period was submitted to the NPUC Board on 21 June 2018.

28. Due to the ongoing work of the NPUC Board and Welsh Government, the RCEM Wales has seen greater system-wider ownership of the four-hour target, which we hope will aid patient flow. Vital winter planning has also started earlier than previous years and shared learning is encouraged.

29. The RCEM Wales also regularly meets with the Cabinet Secretary for Health and Social Services, the Chief Medical Officer, the Chief Executive of NHS Wales and key civil servants specialising in Unscheduled Care, amongst others. We meet with relevant stakeholders all year round to communicate our concerns relating to emergency care and performance and to offer our advice and services where necessary. Our main messages are based on our Vision 2020 campaign.[19]

30. In 2016, the Vice President and Vice President Elect of the RCEM Wales met with the Chief Executives of Wales' seven Local Health Boards to discuss system pressures. The College also encourages Health Boards to participate in our Winter Flow Project to widen the debate around emergency medicine. As a charitable body with no regulatory responsibilities, we can only inform and advise.

31. We support and encourage our Members and Fellows in Wales and Clinical Leads to engage with the management in their hospitals and to draw upon College guidance where appropriate.

[17] Nuffield Trust, Winter Insight: The ambulance service (2017)
[18] RCEM Wales, Vision 2020
[19] Ibid.

Question 3. To what extent does the deterioration of performance relating to the 4-hour and 12-hour A&E wait across the Health Boards in Wales demonstrate that the aim of shifting to primary and community-based care is not being realised in front line patient services? Has the pace of change been sufficient?

32. As evidenced above, the deteriorating performance in emergency departments is directly related to the availability of beds in the hospital and social care in the community. In essence, the four-hour emergency department target is an indicator of system-wide performance.[20]

33. It is also interesting to note that the growth in attendances at Welsh emergency departments is in step with the rising population. Since 2013/14 attendances in Wales have increased by 1.9%, whilst in the same period Wales' population has risen by 1.4%.[21]

34. Patient navigation and redirection from emergency departments is a common theme of transformation plans and winter plans across the UK. However, the College has estimated that only 15% of patients in emergency departments could have been treated elsewhere.[22] This is due to several reasons:

a. Often, the A&E Department is the only option available, especially at weekends, nights and public holidays.
b. The growing population and ageing demographic inevitably leads to an increase in ED attendances.
c. The A&E 'brand' is so strong it can be a victim of its own success, being seen by many as the first port of call before an out of hours GP service or a minor injury unit. This, along with the growing demand on services due to a growing an ageing population, suggests that redirection strategies have a limited success.[23]

35. Therefore, we would recommend that there is less emphasis on the need to redirect and educate patients away from the emergency department and there should be more impetus to increase resources where they are immediately required.

36. The College's co-location campaign proposes that additional services such as pharmacies, GPs, frailty teams and crisis mental health teams should be located alongside emergency departments to help tackle the increasing rate of Major attendances. This model aims to simplify access routes for patients – helping them to get the help they require more swiftly – and to help ease pressure on emergency departments.[24]

Question 4. Do you have a view on whether the Health Board's winter plans for 2018/19 need a stronger focus on the elderly and supporting people with frailty, particularly in terms of reducing unnecessary hospital admissions during the winter period?

37. NHS Wales' medical and social care workforce faces a significant challenge to meet the complex health and social care needs of the ageing population.

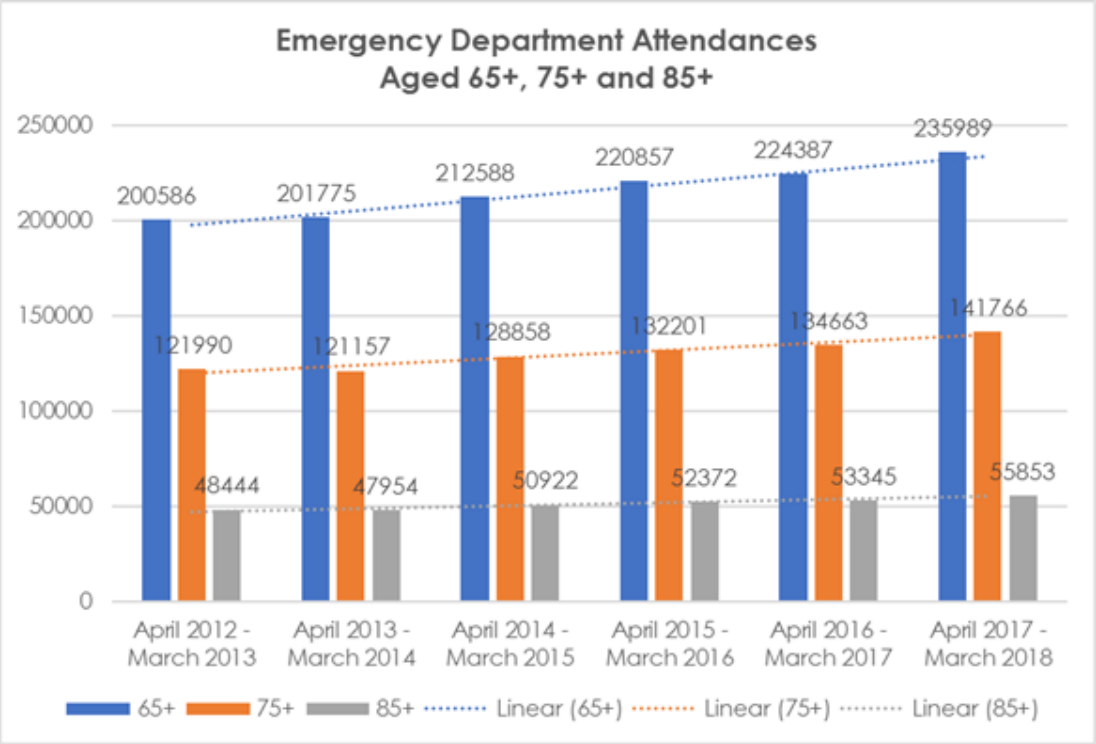
38. The figures on the next page show that the population of Wales – which already has considerable needs centred around an ageing population – has continued to become more elderly. From mid-2013 to mid-2017 the population of those over 65 years of age increased by 7.1%. In the same time period, the population as a whole increased by no more than 1.4%.[25]

[20] National Health Executive, The four-hour target: what's the point? (2016)
[21] Stats Wales, Accident and emergency and National level population estimates
[22] HSJ, Beyond the official data: a different picture of A&E attendances (2014)
[23] HSJ, Why the strength of the A&E brand is its Achilles' heel (2014)
[24] RCEM, Co-Location - the Hub concept
[25] Stats Wales National Level Population Estimates by Year (2018)

Year	Population all ages	Population aged 65 and over
Mid 2013	3,082,412	600,630
Mid 2014	3,092,036	614,747
Mid 2015	3,099,086	624,773
Mid 2016	3,113,150	634,637
Mid 2017	3,125,165	643,269

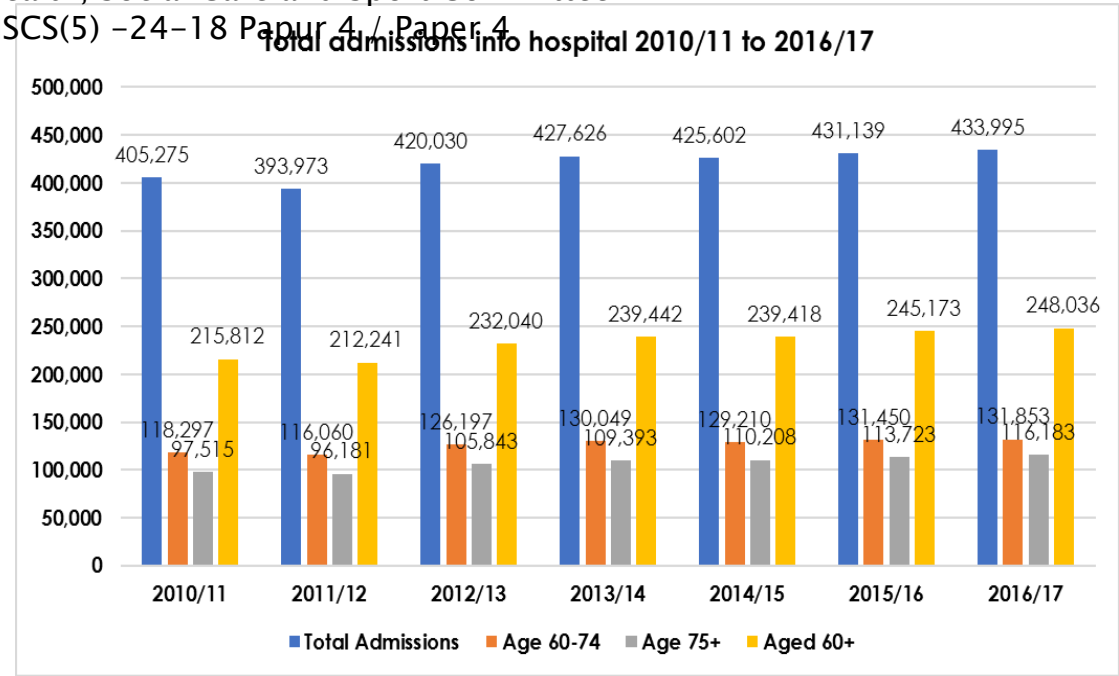
39. This in turn is reflected in an increasing propensity to access health and social care services. Demand from people over 65 years of age continues to grow considerably and has resulted in rising numbers of GP appointments,[26] demand for social care services and pressures in secondary care services, including A&E Departments.

40. The figures presented below are taken from Stats Wales. It shows that the number of ED attendances of those over the age of 65 has steadily grown since 2012-13 by 17.6% whilst the overall number of attendances has only increased by 2%.[27] The median time that patients over the age of 75 spend in an A&E Department can be three times longer than patients under the age of 75.[28] This is due to the complexity of conditions that often accompanies older age.



41. Data from NHS Wales Informatics Service shows a gradual increase in the number of admissions into hospital over the last couple of years – and a significant proportion of those consist of patients over 65 years of age.[29] The King's Fund bears this out and has found that patients over the age of 65 can account for 70% of bed days.[30]

[26] The King's Fund, Understanding pressures in general practice (2016)
[27] Stats Wales, Number of attendances in NHS Wales accident and emergency departments by age band, sex and site
[28] Stats Wales, Mean and Median time spent in A&E and A&E Attendances by age band
[29] Informatics Service, Annual PEDW Data Tables (2017)
[30] The King's Fund, Continuity of care for older hospital patients (2013)



42. A frail person's ability to recover their former independence is greatly affected by a prolonged hospital stay.[31] The Health Foundation estimates that 8-12% of admissions into hospital will result in harm to a patient.[32] The longer a person stays in a hospital bed, the greater the impact on their mental health and the more likely they are to develop a life-threatening hospital infection.[33]

43. Furthermore, in over half of DTOC cases in Wales, delays are a direct result of hospital staffs' inability to discharge patients into an appropriate social care setting. Whilst more people require care in the community, data from Stats Wales shows that the number of care homes in Wales for older adults has reduced by 9% and the number of places has fallen by 4%.[34]

Year	Total Settings (Older Adult Care Homes)	Number of Places
March 2011	704	23,340
March 2012	694	23,199
March 2013	684	23,050
March 2014	675	22,816
March 2015	670	22,713
March 2016	653	22,092
March 2017	642	22,217
March 2018	643	22,466

44. Yet, the LE Wales has predicted that the number of over 65s requiring local authority funded domiciliary care or residential or nursing homes will rise by 47% and 57% between 2013 and 2030.[35] Local authorities are already increasingly unable to meet demands for care and the responsibility of arranging care is often left to the patient and their families. [36]

45. In light of the above evidence, the College was pleased to see localised attempts to improve links between health and social care, as described by some of the Health Boards. However, more needs to be done to ensure the recruitment and retention of social care staff is improved,[37] social care resources are increased and DTOC diminished.

[31] The King's Fund, Continuity of care for older hospital patients (2012)
[32] The Health Foundation, Is the NHS getting safer? (2015)
[33] Forbes, 4 Ways Hospitals Can Harm You (2014)
[34] Stats Wales, CSSIW Services and Places by Setting Type and Year
[35] LE Wales, Future of Paying for Social Care in Wales (2014)
[36] Welsh Government, Parliamentary Review of Health and Social Care in Wales, Interim Report (2017)
[37] The Guardian, Social care in Wales: 'Brexit poses risks to staffing and services' (2016)

Question 5. The RCGP has warned that pressures on the Welsh NHS, particularly during the winter period are highly likely to lead to patient safety being severely compromised. Do you share their concerns in relation to the fragility of GP out of hours services and what is the impact of gaps in out of hours provision on the smooth workings of accident and emergency services?

46. The Royal College of Emergency Medicine Wales, along with many other medical colleges, has publicly warned for a number of years that resourcing and staffing issues are detrimental to the safety of patients.[38]

47. Rota gaps place strain on the service. It means that sometimes the emergency department is the only option available to patients. It affects the flow of patients throughout the system and it is also detrimental to the wellbeing of staff.[39]

48. The College estimates that only 15% of ED patients could have been treated elsewhere.[40] If out of hours GP services were strengthened, this figure might be slightly reduced.

49. The latest GP patient survey, for example, showed that 7.3% of respondents went to A&E when their GP practice was closed.[41]

50. There is also evidence to suggest that co-locating full time and out of hours GP services next to the emergency department reduces waiting times and improves patient experience. A study published in the BMJ evaluating the impact of integrating a GP into a paediatric emergency department concluded: "introducing a GP to a paediatric ED service can significantly reduce waiting times and admissions but may lead to more antibiotic prescribing".[42]

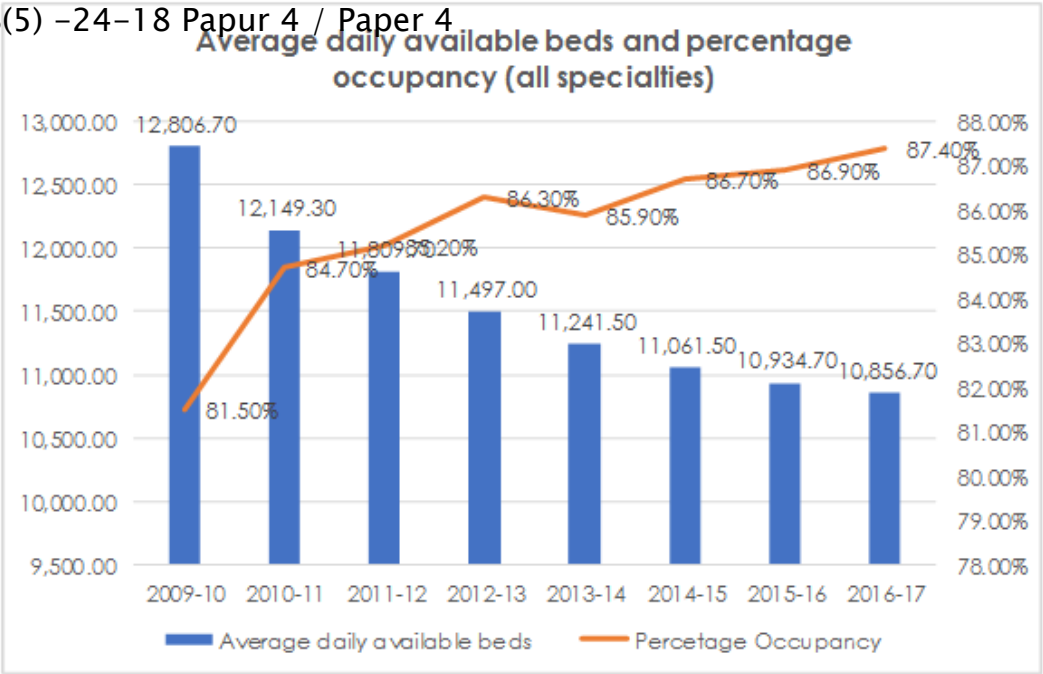
51. Nevertheless, as the Nuffield Trusts rightly points out, patients attending minor injury units instead of GP practices are not a significant cause of the A&E demand and performance issues. For Major attendances – which drive performance and Exit Block issues - GP surgeries are not a realistic alternative.[43]

52. To improve performance, there needs to be a balance between providing viable out of hours care and resourcing the wider health and social care system to adequately match demand.

Question 6. How confident are you in the demand projections and capacity modelling that has been done by the Local Health Boards in Wales to inform their winter planning for 2018/19, specifically in relation to additional winter bed capacity?

53. As the next graph illustrates, the number of beds available in NHS Wales has fallen by over 15% in the space of seven years whilst bed occupancy levels have exceeded safe levels of 85%.[44] This is despite a growing and ageing population and a rising number of patients over the age of 65 requiring more complex health care requirements, both within and without the hospital setting.[45]

[38] For example: Wales Online, 'Catastrophic' surge in A&E waits are 'compromising patient care' (2018), BBC, A&Es in Wales 'like a battlefield' (2018), ITV, 'Emergency care in Wales is in a state of crisis,' says senior A&E doctor (2017)
[39] RCEM, Sustainable Working
[40] HSJ, Beyond the official data: a different picture of A&E attendances (2014)
[41] GP Patient Survey (2018)
[42] BMJ, To GP or not to GP (2017)
[43] Nuffield Trust, Why extending GP hours won't solve the A&E crisis (2017)
[44] Stats Wales, NHS beds by organisation and site
[45] RCEM Wales submission to the Finance Committee's inquiry into the cost of caring for an ageing population (2018)



54. The NHS Confederation wrote in its written evidence: "a wide range of positive actions have been planned to further improve local and national resilience, including an increase in available bed capacity both in hospital and in the community". Despite highlighting that there were almost 400 additional beds or bed equivalents identified for last winter, it was not made clear how many more beds will be committed for winter 2018-19.[46]

55. It is also important to note that available beds can become superfluous if there aren't enough staff to manage them. In many cases, it is also not clear how many more beds there are, where those beds are situated and for how long.

56. Many Health Boards in their written and oral evidence also noted that there were an insufficient number of beds last winter, there were no firm commitments to increase bed capacity in the short or long term. This is mostly due to budget constraints.[47]

57. Having the correct number hospital beds, and the nursing staff on the wards to manage them, is important to tackle Exit Block and ED crowding. The College estimates that we need at least 250 more hospital beds in Wales to get occupancy rates back to safe levels.[48]

Question 7. What are the key emergency medicine workforce challenges this forthcoming winter? For example, is there sufficient capacity across the Health Boards to ensure additional senior decision-makers are at the 'front-door' to promote early assessment and treatment?

58. Emergency departments require a workforce of sufficient size and with the necessary number of senior decision makers to treat patients effectively and in a timely fashion.

59. Although the total A&E workforce has increase by 7% between 2014 and 2017[49] many of our Members and Fellows have reported feeling stressed or burnt-out at work. There are several reasons for this: a lack of resources in the rest of the system that creates difficult working environments; an insufficient number of middle grade emergency medicine staff; and too few emergency medicine consultants to keep up with demand compounded by existing vacancies.

[46] Meeting of the Health, Social Care and Sport Committee, 19 July 2018, Public Document Pack
[47] Health, Social Care & Sport Committee, Evidence session on winter resilience plans, 2018-19 (19/07/18) and Public Document Pack
[48] RCEM Wales, Vision 2020
[49] Stats Wales Medical and dental staff by grade and year

60. Whilst emergency medicine training posts at year one (ST1) have a 100% fill rate in Wales, only 67% of higher specialist training posts (ST4-6) in Emergency Medicine are being filled.[50]

61. Furthermore, the number of specialty doctors have decreased by 3.5% between 2014 and 2017, the number of senior house officers has diminished from 16.0 to 5.0 and the number of foundation house officers (2) has fallen by 21%.[51] This means that consultants are sometimes required to cover rota gaps of junior doctors.

62. To achieve safe, sustainable staffing levels, the College is calling for 100 extra emergency medicine consultants in Wales, and at least 20 extra emergency medicine training places per annum for four years.[52]

63. As well as aiding patient care, increasing the workforce should help to reduce the £13.6 million being spent annually by the Welsh NHS on agency, bank and locum doctors to cover staffing shortages in EDs.[53] It should also aid the recruitment and retention of staff and will help to ensure that there are enough senior decision makers at the front door.

Question 8. How effective have fast track referral systems been in Welsh hospitals - where some patients bypass the emergency department, such as in paediatric services and mental health in terms of improving patient flow, reducing ambulance hand over delays and alleviating some pressure on emergency departments?

64. The RCEM Wales has seen little evidence that fast track referral systems have noticeably reduced pressures on emergency departments. In fact, attendances have increased by 4.8% in the space of six years.[54]

65. This is partly because many fast track referral systems are not full time, seven days per week measures. Like our co-location concept, referral systems must be made available out of hours for the benefit to be realised.

Conclusion.

66. The situation laid out above is not a new phenomenon. Difficulties treating patients in a timely fashion because of a lack of available beds and social care in the community has been a feature of the Welsh and other UK health systems for some time. Planning must address the need to cope with rising numbers of the frail elderly – with complex interactions between health and social care and long-term co-morbidities. This solution requires significant planning and funding, but it is necessary for the sustainability of the Welsh NHS.

67. To address pressures in EDs this winter, the College recommends that Health Boards focus on Exit Block and DTOC. Promoting system-wide ownership of the four-hour target, ring-fencing emergency department space and perhaps boarding patients onto hospital wards during times of peak escalation might help to safeguard patients and increase flow. We also need to plan discharges earlier, within 48 hours of admission to a ward, to decrease cases of delayed discharges.

[50] Data provided by the Head of School for Emergency Medicine (May 2018)
[51] Stats Wales Medical and dental staff by grade and year
[52] RCEM Wales, Vision 2020
[53] Data released in 2017 revealed that Health Boards across Wales spent nearly £14m on agency, bank and locum doctors to cover shifts in emergency units during 2016.
[54] Stats Wales, Performance against 4 hour waiting times target

Agenda Item 3.5

Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu
CYMRU WALES

6 September 2018

Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Dear Dai

Welsh out of hours services

Thank you for your letter of 7 August 2018 relating to out of hours services.

The evidence session looks like it was a useful undertaking and encouraged local health boards to think proactively about the winter. There appeared to be widespread recognition that out of hours services had serious weaknesses; there is mounting evidence that this is the case and we hope it leads to action to address this.

We note the emphasis being placed on multidisciplinary working and this is something we welcome. The College believes GPs at the heart of wider teams of primary care professionals will be vital in organising and planning services.

You asked a number of specific questions relating to out of hours services, and our answers are below.

Out of hours services

To what extent has the RCGP been engaged in conversations with the Health Boards across Wales/Welsh Government about tackling the gaps in GP out of hours services?

The College attends monthly meetings with Assistant Medical Directors in each local health board. Out of hours has regularly been discussed, but too often it is a case of “preaching to the converted”, with inadequate internal health board mechanisms to take forward the concerns and solutions expressed to the group. As the Wales Audit Office report highlighted, decisions about resourcing made by health boards lie at the heart of many of the problems, and there has been no contact between RCGP Wales and the Directors of Finance who hold the purse strings.

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We have also been in contact with Welsh Government and have urged them to send a clear message to local health boards that out of hours services should be prioritised and adequately resourced. In May the College attended a 'clinical summit' on unscheduled care pressures, to have an open conversation on pressures and solutions. The meeting was attended by Welsh Government representatives, including the NHS Chief Executive, as well as organisations in the health sector. A follow up meeting is scheduled for October. The College also has relatively regular meetings with Welsh Government officials, including those who lead on out of hours services. However we have not been asked for advice on specific plans.

As well as the College, we would also stress the importance of LHBs consulting with GP practices. We understand the Welsh Government has stressed the meaningful involvement of clinicians as a priority. We are aware of some incidents of this happening, although we don't have the information to say how widespread this has been.

To what extent will the All Wales action plan to address the challenges facing GP out of hours services in Wales (referred to in the Cabinet Secretary's letter) address your concerns about the mismatch between capacity and demand in out of hours services this forthcoming winter?

This document has not been shared with RCGP Wales at the time of writing. Following your letter, we have been in contact with Welsh Government on 9 August to request a copy. Given the level of expertise on urgent primary care within RCGP Wales, it is disappointing that we have not been offered the opportunity to feed into this document

Do you agree with the Health Boards that the current, GP-led model of out of hours services is not sustainable? Would you agree that focusing on trying to get more GPs back onto the out of hours rota is not a long term solution?

The current model is unsustainable because of long-term underinvestment and lack of support. As the recent Wales Audit Office report made clear, Welsh Government and local health boards have not prioritised services. It also found that between 2004-05 and 2016-17, notional funding from the Welsh Government for out of hours services decreased by 21% in real terms (pg 25).

A GP-led model is essential. The College would express serious concerns about any attempt to move away from a GP-led model, but believe GPs should be leading a multidisciplinary team. Services are unsustainable because of a lack of support and a failure of leadership from Welsh Government and local health boards.

Out of hours services need to be more than GPs and we strongly encourage the increased use of a wider, multidisciplinary workforce in out of hours services. Ensuring patients see the right person at the right time was something we called for our document 'Meeting urgent needs: improving out of hours services in Wales. The use of staff such as advanced nurse and paramedic practitioners, pharmacists, community psychiatric nurses and palliative care nurses should be encouraged. Urgent repeat medications are still often dealt with by GPs, when provision already exists for it to be obtained from pharmacy.

In this context, the role of GP leadership is perhaps more important than ever before. Language such as 'flight controller' or 'conductor of the orchestra' is often used. 'Meeting urgent needs' highlights the importance of 'GP supervision for multidisciplinary staff'. While

the 'model' may change to incorporate more primary care professionals, the importance of GP leadership must not be neglected. However, at present there are not primary care trained multidisciplinary team members available in sufficient numbers to fill the gaps, and all too often a flight controller or clinical lead job is a highly stressful role trying to juggle inadequate resources and holding the personal risk for an overstretched service. It is not surprising that most GPs are less than enthusiastic about doing this!

There are around 3,000 GPs in Wales, with important roles in training, education and clinical leadership as well as in the provision of patient care. RCGP Wales figures indicate this is around 400 full time equivalent GPs below what is needed. As a result, simply asking to more GPs to fill out of hours shifts is likely to lead to gaps in service elsewhere. Many GPs who have traditionally supported out of hours services will no longer work in out of hours services due to concerns over clinical risk and patient safety within the services. Committing to training sufficient MDT staff, making sure there are adequate call handling and other support staff and addressing the under resourcing of services might encourage them to return. Working conditions also need to be improved, with adequate access to cups of tea during a shift.

We agree that the current model is unsustainable. We agree that there is a need to further develop multidisciplinary working in out of hours services with GP leadership.

Does the RCGP have more confidence in the strategic direction and pace of change around the GP out of hours agenda?

While there appears to be an increasing commitment to fix it, the College still lacks confidence that adequate steps are being taken to address the challenges. The solutions still appear to be targeted at the out of hours services themselves, rather than an entire health board approach being taken to meet the needs of patients. A suggested approach is highlighted in the RCGP Wales document 'Meeting urgent needs: improving out of hours services in Wales'. The document outlined 'essential and achievable' steps that would result in quick improvement. These ideas were intended as steps that could begin to turn services around as a matter of urgency. For example, employing and training more call handlers would address call abandonment rates, allowing patients to access services instead of spreading demand across the NHS. It is non-clinical recruitment and something that should be achievable relatively quickly. We believe it should be in place before the 2018/19 winter.

In addition, it highlighted the need for pathways that work for patients. Rather than patients with mental health issues experiencing long delays within the out of hours system, the use of health board resource could speed up the patient jouney and relieve pressure on services. For example, patients with mental health issues often face long delays within the out of hours system, a better option would be CPNs performing the initial triage who can rapidly escalate to psychiatry admissions.

Should the 111 programme be rolled out at a greater pace?

111 is just a Number. Without strong and adequately resourced services sitting behind it, it is unlikely to make a significant difference. However it should be used as a catalyst to deliver the type of system we want. It should be used to recognise the importance of the community based services 111 feeds into. It should also be used to develop the triage and multidisciplinary workforce we need. LHBs are likely to be in a better position to determine whether they should increase the pace of the roll out, although if certain aspects are

identified as working well, there is a role for Welsh Government in promoting good practice and ensuring it is rolled out more widely.

Workforce

Is the answer to capacity issues in out of hours services to provide services at fewer sites?

No. The underlying issue is under-resourcing and lack of capacity. Services would need to be planned to ensure they are accessible for patients. They would also need to consider the importance of creating a positive working environment for anyone working in them.

Have the Health Boards across Wales made sufficient progress towards multi-disciplinary team working, (for example, through advanced nurse practitioners, advanced paramedics, physician associates and palliative care nurses etc.) to alleviate winter pressures?

No. Too often MDT professionals have been introduced in a crisis situation without adequate understanding of their competencies. This has placed patients at risk and put MDT staff in a difficult position. MDT staff have a huge amount to offer services, but their individual knowledge skills and competencies need to be understood and pathways adapted accordingly. As an example, not all nurses will be able to diagnose and treat young children, and not all paramedics are competent to provide palliative care. Additional training, support and mentoring needs to be provided.

Pockets of good practice exist such as the way nurses are used and trained in BCU, or the way pharmacists have been integrated into 111, but these have not been systematised across Wales.

Workforce shortages across different professions can limit progress, and it is important to recognise that staff are adapting to a new way of working while under significant pressure. It can be difficult to find the necessary headspace when workload pressures are so intense many are just getting through day by day. There is also a lot of work to be done with public perceptions, as there can be some pushback about being seen by someone other than a GP.

Is there sufficient focus on mental health in the Health Board's winter plans given the additional pressures this can put on services during busy winter periods?

Health board winter plans have not been shared with RCGP wales. We have local advocates in each health boards who would be able to provide expertise if requested. We believe the solutions to dealing with mental health problems in the out of hours period are as described above.

Is there sufficient focus in the Health Board's winter plans on hospital admission prevention and the role of primary care in managing patients, particularly the elderly and those with chronic conditions safely in the community?

The distribution of resources makes it very difficult to deliver preventative healthcare. This lack of support, coupled with increasing demand, means access to general practice remains

too difficult. The 2017/18 National Survey for Wales results revealed that 42% of people found it difficult to make a convenient appointment.

Effectively managing elderly patients and those with chronic conditions requires strong general practice and primary care. We do not believe this is adequately prioritised by Welsh Government or LHBs. It is an issue all year round, and the increased illness in the winter months only exacerbates the issue.

Every patient whom GPs successfully manage to keep at home rather than admit to hospital needs ongoing medical, nursing and care support, and a mechanism needs to be in place to resource this.

Promotion of flu vaccination

Flu, gastroenteritis and norovirus can put short-term strains on health and social care services during the winter period. Are GPs doing enough to promote and increase uptake levels, particularly among high risk patients?

GPs work hard to ensure good vaccination rates, and no GP wants unused vaccine sitting in their fridges at the end of the season! Increased public awareness of the benefits is needed, especially among younger patients with chronic disease

Yours sincerely

[redacted]

[redacted]
Chair
Royal College of General Practitioners Wales

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P-VG 2796-18

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
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11 September 2018

Dear Dai,

I am writing to inform you of the new 'Patient Safety and Quality Improvement Programme for Care Homes' which will commence on 1 October 2018.

This national quality improvement programme is being developed by the Public Health Wales 1000 lives improvement service. It aims to build on and improve supportive care home environments and learn from good practice to improve the overall quality of care for older people in care homes in Wales over a three year period.

Understanding the context and nature of the care homes system is imperative in order to spread quality improvement and behaviour change. The programme will build a mechanism for distributed learning among participants and organisations, through organic learning and peer networks. The quality and reach of engagement will be sufficient for organisations to feel valued and listened to, and for different sectors of the organisation, including frontline staff, residents and families, to understand each other's contribution to achieving outcomes.

The programme will both complement and enhance existing care home initiatives, support delivery of the Welsh Government's dementia action plan and assist with implementation of a number of the recommendations of the Health, Social Care and Sport Committee's Inquiry into the use of anti-psychotic medication in care homes.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

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Agenda Item 3.7

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Dai Lloyd AM
National Assembly for Wales
Cardiff Bay
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Thursday 13th September 2018

Dear Dai,

Suicide Prevention Inquiry Draft Report

Firstly, may I commend you on your contribution to the debate on the Children, Young People and Education Committee report on its inquiry into the Emotional and Mental Health of Children and Young People. We welcome your comments and are particularly encouraged by your continued focus on prevention, early intervention and 'empowering our teachers'.

As I'm sure you will know, Samaritans Cymru were heavily involved with the Inquiry into the Emotional and Mental Health of Children and Young People and were pleased to speak at the launch of the report. We welcomed *Mind over Matter* and believe its recommendations set out the step change needed to improve the outlook of children and young people's mental health in Wales.

We were pleased to provide a briefing for Assembly Members ahead of the debate and were delighted to hear so many members share their contributions and personal comments. We have shared our further comments with Lynne Neagle AM and believe the Welsh Government response needs to be stronger and fully recognise the step change needed.

Following our contribution to the Loneliness and Isolation Inquiry, we were delighted to welcome your committee's Inquiry into Suicide Prevention. We were pleased to provide written and oral evidence and highlight the role that schools and educational settings have to play in suicide prevention.

Since the launch of our teaching resources in 2014, known as DEAL (Developing Emotional Awareness and Listening), we have lobbied extensively to achieve the following -

- Fulfilling the potential of the the focus on health and wellbeing in the new curriculum; the inclusion of emotional health and wellbeing lessons on the curriculum should be statutory.
- Emotional, mental health and suicide awareness training for all existing and new teaching staff across all schools in Wales
- Increased confidence in teaching staff and basic mental health literacy by the inclusion of emotional and mental health awareness in Initial Teacher Training (ITT)

As your Committee is now in the stage of drafting your report on suicide prevention, we wanted to take the opportunity to share our view on the potential of the recommendations of *Mind over Matter* in reducing suicide in Wales. As we stated in both Inquiries, we believe that investment in prevention and early intervention can reduce human, social and economic costs. Emotional and mental health education in schools should be viewed as a form prevention and early intervention which could reduce pressure on CAMHS, reduce specific mental health problems and suicidal ideation.

We know there are recommendations in *Mind over Matter* which target suicide specifically and we have welcomed them (Recommendation 16). We have urged the Welsh Government to approach the emotional and mental health of children and young people in new and innovative ways and have said that *Mind over Matter* could be a significant driver for change.

With regards to the role of education and suicide prevention in Wales, we would like to once again, strongly commend *Mind over Matter* for its vision and focus. We believe a strong focus on the role of education is needed to reduce suicide in Wales; school years are the crucial opportunity to equip children and young people with the skills they need to build their resilience and improve their emotional health. Provision and understanding of this approach is not sufficient in Wales at the current time.

As always, we would be delighted to meet or further discuss our shared areas of work. May I take this opportunity to thank you for your continued support of our work in Wales and your commitment to driving change in these crucial areas.

Yours Sincerely,

[redacted]

[redacted]
Executive Director for Wales
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Agenda Item 7

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