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Welsh Parliament

Health and Social Care Committee

Waiting times backlog: stakeholder discussion

September 2022

Background

1. As part of the Health and Social Care Committee's inquiry into the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment, the Senedd held a debate in Plenary on 29 June 2022.

2. To inform the debate, the Committee held a private informal event on 29 June 2022 to discuss with stakeholders their views on:

- The Welsh Government's response to the Committee's report, *Waiting well? The impact of the waiting times backlog on people in Wales*.
- The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

3. A list of the organisations that participated in the event is attached at Annex 1. We are grateful to everyone who took part for sharing their views, experience and expertise with us.

4. This note summarises issues and themes discussed during the session. Reference to an issue does not necessarily represent endorsement either by all participants or by the Committee.

General views on the Welsh Government's plan

5. Stakeholders welcomed the plan; but questioned whether it will, as drafted, be deliverable for health services. The direction of travel was broadly thought to be correct, but there were concerns about whether there was sufficient focus on delivery or enough clarity about how or when the plan's ambitions would be achieved. There was a strong view that the pace of change needs to happen a lot more quickly but that the plan doesn't give that sense of urgency.

6. Some suggested the plan lacked vision and ambition in some areas, including cancer care and survival rates. There was a shared view that the ambition should not be to return to pre-pandemic levels but for a 'post-pandemic reset'. Some described the plan as a missed opportunity to set out a vision for the future, and said it fails to address the impact of future demographic shifts—for example socioeconomic factors or the evidence from the 2021 Census that Wales' population is ageing—on the service transformation needed.

7. Some felt the plan focuses too much on adults and physical health, to the detriment of children and mental health. The reference in the plan to the recovery ambitions relating to 'most specialties' also caused concern, as it isn't clear whether it includes, for example, mental health and orthopaedics.

Leadership and accountability

8. It is not sufficiently clear whose plan it is. It was published jointly by the Minister for Health and Social Services and the NHS Chief Executive, and uses 'we' throughout, but it isn't always clear who 'we' is. Stakeholders said it was not clear who was accountable for delivery or where power lies i.e. with the Welsh Government, the new NHS Executive or health boards. Similarly, the establishment of a diagnostic board was welcomed, but it wasn't clear where it fits in to accountability structures.

9. There was some support for annual reporting on progress against the plan, underpinned by regular data reporting.

10. We also heard that more clarity is needed more broadly about the role and function of the new NHS Executive. There were also suggestions that consideration should be given to a health and social care executive, not just an NHS executive.

Cooperation and joint working

11. There are good examples of local innovation, but insufficient national strategic leadership, including from the Welsh Government, means this is not coordinated, shared or rolled out. This can lead to duplication or missed opportunities.

12. It was suggested that delivering the plan will require improved cooperation and joint working between health boards, and that Welsh Government needs to hold health board chief executives and medical directors to account on this.

Social care

13. Supporting people effectively in the community could reduce waiting times by preventing the need for care or treatment, and improving hospital discharge. But, the plan says little about

the role of social care.

14. There were serious concerns about the lack of social care staff, and calls for urgent action to improve their pay and conditions in order to attract and retain staff.

Co-production

15. COVID has shown that partnership working can really work, but this is not really acknowledged in the plan. Greater recognition is also needed of the role of the third sector.

16. The plan treats patients as silent recipients of care, and there is not enough about co-production or the need to involve patients, families and carers in decisions.

'Missing' patients

17. Concerns were raised about whether the plan accurately reflects the scale of the challenge, including the 'missing' patients. There are many people who are still likely to come forward—potentially with more severe and complex needs as a result of the pandemic. It is not clear whether this is factored into the Welsh Government's plan.

18. Welsh Government need to get their messaging right about the pressures on the NHS and telling people to stay away from health services/use the NHS appropriately, and ensuring people with symptoms come forward.

19. There was also discussion of why patients may cancel their own appointments. Work is being undertaken by the Board of Community Health Councils to explore whether there are common factors (for example geographic or socioeconomic) or whether it relates to ongoing nervousness about COVID.

Data

Waiting times

20. While a lot of data is collected, there were concerns about its accuracy, and the level at which it is published. Datasets available elsewhere in the UK are not routinely published in Wales. It was suggested that improving the public availability of waiting times data could influence public behaviours and the choices people make in relation to their health.

21. Stakeholders supported our recommendation for improvements in the availability, accessibility, transparency and granularity of data. They suggested that waiting times data should be available monthly by health board, by geographic area, by diversity characteristics, and by type of treatment. A lot of the data which would enable these improvements is already collected, but not publicly available. There was also a view that Royal Colleges could have a role in helping with the collection of data.

22. Orthopaedics was raised as an area where significant improvements are needed to avoid variations across treatment types and lengths of waits being 'hidden' among high level data. There were calls for data to be published by indicative treatment types, such as hip, knee or hand surgeries, and by the 1-4 categorisations introduced at the start of the pandemic (although there was also a view that these categorisations are no longer appropriate). Some data is already available via the National Joint Registry, but it is difficult to interpret.

Workforce

23. Data about the workforce also needs to be improved, including the availability of demographic workforce data by specialism. It was suggested that the age profile in some specialisms, with significant proportions of staff in their 50s or older, means that services face a capacity cliff edge.

Patient information

24. Patients need honest and transparent information about how long they will be waiting for diagnostics and treatment, relevant signposting to sources of support, and clearer guidance about what to do if they are in pain or their condition worsens. It's as simple—and as important as that.

25. Poor communication can result in frustration or potentially even harm for patients, or promises being made in national messaging that cannot be fulfilled at a local level. We heard examples of poor practice from health boards, including long delays in the preparation of communications to patients. There is a need for consistent messaging and clear, accessible and effective communication approaches to be developed by communication and engagement experts, that can then be tailored to local need and patients' specific circumstances. This will require greater prioritisation and funding for communications and engagement work, and the involvement of clinicians.

26. Good examples raised with us include Hywel Dda UHB's single point of contact model, and Betsi Cadwaladr UHB's Expert Patient programme (which supports people in managing their chronic conditions and their psychological and physical wellbeing) and national exercise

referral schemes. We heard that the 'Waiting Well' pilots should be extended across all health boards and services. But, we were told that it isn't always clear, including to primary and secondary care physicians, what schemes and services are available.

Changes to elective care delivery

Surgical hubs

27. Many stressed the need for an entire system reset, not just focusing on one part of the health system. Changes in England to the way in which surgery is delivered were said to be proving effective, and stakeholders were pleased with the Welsh Government's commitment to develop surgical hubs in Wales. There was a view that the uncoupling of emergency/urgent care and elective care is the only way to make inroads into the backlog but serious concerns were expressed about the pace of change and the capacity of the workforce to achieve this. A view that national direction is needed to make this happen, especially where there's a need for collaboration and/or regional working. That isn't currently there.

28. To ensure surgical hubs are a success, other parts of the system also need improving. There needs to be greater investment in primary care—in general practice specifically, to stop people going to A&E because they can't get appointments. There also needs to be a real focus on social care so that people who are medically fit can be discharged from hospital more quickly. There needs to be greater involvement of families and carers in discharge planning. Consideration also needs to be given to transport and travel planning for patients treated at regional surgical hubs, particularly for people living in more deprived areas who may otherwise face barriers in accessing treatment.

Innovative approaches

29. We heard about historic overoccupancy in Welsh hospitals meaning that patients are frequently found beds on the 'wrong' wards i.e. a patient waiting for surgery may be placed on a medical ward or vice versa. This increases the burden on staff, and decreases the efficient throughflow for elective surgical procedures. Virtual wards can work well, but may not be suitable for all patients, particularly older people who may then end up in hospital requiring urgent treatment.

30. It was suggested that services and clinicians need to think laterally, innovate and adopt different working practices where clinically appropriate. This might include, for example, greater use of digital technology, or conducting simpler surgical procedures under local anaesthetics or in clinics rather than operating rooms to free up facilities and staff for more complex operations.

31. Changes to the approach to outpatient services could also help, for example remote consultations and telephone triage. Dermatology services were highlighted as a service that adopted these innovations successfully before the pandemic, and could provide an example for other services.

32. Embedding social prescribing early in patient pathways could help avoid people's conditions deteriorating—it shouldn't just be focused on people who have been waiting for a long time already. To avoid unnecessary referrals within the health service, secondary care clinicians should have access to social prescribers, not just primary care practitioners.

Separation between primary and secondary care

33. We heard that GPs may feel forced to make referrals that are inappropriate because they have no other options available to them. There's a lack of community and district nursing—for example, that would help ensure an elderly patient could be kept out hospital over the weekend. The integration agenda needs a reboot. GPs need to have better access to diagnostic tests so that patients are 'ready' to see specialists when the time comes, having had all the tests needed beforehand. GPs can do more—an example given was FIT testing, but that requires other work GPs currently do shifting elsewhere in primary care i.e. pharmacy.

Diagnostics

34. It's unclear how the ambitions in the plan (when it comes to diagnostics) will be achieved and by when. The plan confirms that community diagnostic centres will be rolled out but it's been very slow compared to other countries.

Investment, financial scrutiny and transformation

35. The investment attached to the plan was welcomed by all. There was a shared view that money must be spent wisely to deliver sustainable transformation and achieve value for money, not just 'patch things up', and that health boards must be scrutinised on this. It was noted that health boards handed back some of the £170m made available in 2021-22 because they couldn't spend it all.

36. Stakeholders talked about the transformation funding that had been provided to Regional Partnership Boards (RPBs) to help scale up good practice and questioned what had happened to that money, including how it was being spent and whether it was going where was needed. It was suggested that the NHS Executive could have a role to play here. It was also suggested that there should be more investment in clusters.

37. It was felt there were too many pilots and there needed to be a commitment to longer

term funding that goes beyond pilots. Innovative change needs longer than a year, and the shift to multi-year funding was welcomed as a positive development that would help third sector organisations support people on waiting lists, and help speed up the process of hospital discharge, where appropriate. But, funding arrangements can also be very complex, with some allied health professional posts, for example, being funded from a number of different streams.

Workforce

38. There was agreement that money itself isn't enough. The capacity of the workforce is the key limiting factor on the deliverability of the Welsh Government's plan. Engaging clinicians is key to delivering the plan, and there is appetite for this among the workforce, but we were told that the plan does not reflect the real fragility of the workforce including fatigue following the pandemic. In addition, long waiting times, the resultant inability of clinicians to provide their patients with the care or treatment they need, and the relentless flow of patient complaints, are damaging staff morale.

39. We heard concerns that the joint Health Education and Improvement Wales and Social Care Wales workforce strategy is not delivering fast enough when it comes to building a sustainable workforce. Overreliance on newly-qualified staff who may lack experience or resilience was also raised. This is exacerbated by insufficient time being made available for CPD or developing skills, as there is no time for anything beyond mandatory training.

40. There was a shared view that there's a problem with retention as much as recruitment, and suggestions that more needs to be done in terms of succession planning, making effective use of staff who are approaching retirement to support and train their colleagues, and addressing issues relating to pension rules which are affecting staff nearing, at, or after retirement age. It was suggested that access to flexible working and improvements in work life balance are key, not least because if people are unable to get this flexibility as NHS employees, they may leave to work as agency staff. Several stakeholders highlighted the level of agency staff spend as a concern. Others noted that the capacity of the private sector, including available of agency staff, varied across Wales and should not be relied upon.

41. The focus needs to be the entire NHS workforce—not just doctors and nurses. The stakeholders weren't convinced by some of the workforce changes that have been taking place. For example, they say that while they are welcome, having lots of Advanced Nurse Practitioners can put pressure on GPs who need to supervise them; too many associate physicians, although brilliant, can put pressure on senior clinicians who are accountable for them, and other changes such as paramedics working in primary care settings isn't always the right approach either. They

said paramedics need to be in ambulances, given the challenges there. There was a view that such an approach was simply moving the workforce problem (i.e. staff shortages) from one part of the system to another.

42. A view was expressed that increasing the number of medical school training places is a step in the right direction but it's not a short or medium term solution to tackling the backlog. There were also concerns that training places are based on what health boards estimate they can afford in respect of future workforce needs, rather than future service capacity needs. It was also suggested that the number of training places does not take sufficient account of dropout rates, or of the potential for people to want to work flexibly or part time.

NHS estate as a barrier to change

43. Issues with lack of physical space were identified as barriers to new models of care in both primary and secondary care. GP practices can't expand to include other healthcare professionals such as physiotherapists because there isn't enough space to house them, and GPs are having to work on a rota because there aren't always enough consulting rooms. The development of surgical hubs is also going to require investment in the NHS estate.

Other comments

44. Wales has a lot to be proud of and we should be celebrating what NHS Wales is good at.

45. Stakeholders were not confident that enough is being done to learn from COVID to ensure that services and the workforce are better prepared in the event of a future pandemic. Some suggested that services had been better during COVID because they were led from the ground.

Annex 1: Organisations participating in the discussion event

46. The following organisations took part in the event:

- Age Cymru
- Audit Wales
- Board of Community Health Councils
- British Orthopaedic Association
- British Red Cross
- Cymru Versus Arthritis
- Royal College of GPs
- Royal College of Nursing
- Royal College of Occupational Therapists
- Royal College of Physicians
- Royal College of Surgeons
- Wales Cancer Alliance
- Wales Carers Alliance
- Welsh NHS Confederation