Cafodd yr ymateb hwn ei gyflwyno i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Flaenoriaethau'r Chweched Senedd

This response was submitted to the Health and Social Care Committee consultation on Sixth Senedd Priorities

HSC PSS 93

Ymateb gan: | Response from: Cymdeithas Rhewmatoleg Prydain | British Society for Rheumatology

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Blaenoriaethau cychwynnol a nodwyd gan y Pwyllgor
Initial priorities identified by the Committee

Mae'r Pwyllgor wedi nodi nifer o flaenoriaethau posibl ar gyfer ei waith yn ystod y Chweched Senedd, gan gynnwys: iechyd y cyhoedd a gwaith ataliol; y gweithlu iechyd a gofal cymdeithasol, gan gynnwys diwylliant sefydliadol a lles staff; mynediad at wasanaethau iechyd meddwl; arloesi ar sail tystiolaeth ym maes iechyd a gofal cymdeithasol; cymorth a gwasanaethau i ofalwyr di-dâl; mynediad at wasanaethau adsefydlu i'r rhai sydd wedi cael COVID ac i eraill; a mynediad at wasanaethau ar gyfer cyflyrau cronig tymor hir, gan gynnwys cyflyrau cyhyrysgerbydol.

The Committee has identified several potential priorities for work during the Sixth Senedd, including: public health and prevention; the health and social care workforce, including organisational culture and staff wellbeing; access to mental health services; evidence-based innovation in health and social care; support and services for unpaid carers; access to COVID and non-COVID rehabilitation services; and access to services for long-term chronic conditions, including musculoskeletal conditions.

C1. Pa rai o'r materion uchod ydych chi'n credu y dylai'r Pwyllgor roi blaenoriaeth iddynt, a pham?
Q1. Which of the issues listed above do you think should be a priority, and why?

BSR welcomes the Committee's focus on the health and social care workforce, access to services for long-term chronic conditions and access to mental health services.

Health and Social Care Workforce

Our recent report *Rheumatology workforce: a crisis in numbers* found that the adult, adolescent and paediatric rheumatology workforce is severely understaffed with long waiting times and patient care that falls below NICE standards. This is particularly pronounced in rural and regional centres where departments struggle to attract and retain consultants and other health care professionals in posts.

We recommend that there be one adult rheumatology consultant per 60,000-80,000 population dependent on local service demands (i.e. presence of local specialist MSK services, etc.). This figure is based on the findings from the National Early Inflammatory Arthritis Audit (NEIAA), which is based on performance against NICE Quality Standards. In Wales, there is approximately one consultant per 99,000 population far below our target. Also, with many trusts having low consultant numbers they are vulnerable to staff leave and retirements. At the time of writing our report, the Betsi Cadwaladr University Health Board had a consultant vacancy rate of 49%.

There is an urgent need to prioritise the development of more specialty training posts within Wales to address the shortage of adult rheumatology consultants. Specialty training posts are allocated by Wales Deanery School of Postgraduate Medical and Dental Education and the Specialty Training Committees to individual trusts based on training needs and where the best training is delivered, meaning larger units are generally allocated more trainees. However, trainee posts are distributed unevenly across the UK with fewer trainees per consultant found largely in rural and regional centres. We recommend the Committee engage with BSR and the Rheumatology Specialty Advisory Committee to discuss increasing the number of specialty training posts in rheumatology within Wales to ensure training posts are also allocated based on population need.

However, this is a long-term solution and in the interim the Committee should consider nationwide support for developing enhanced roles for AHPs, pharmacists and nurses within adult and paediatric rheumatology departments. Enhanced roles for AHPs, pharmacists and nurses, allowing them to extend their scope of practice within departments, would help address increasing service demands. AHP, pharmacist and nurse-led care is safe and effective, while also providing significant cost savings to Local Health Boards. For example, extended prescribing roles for pharmacists have been shown to reduce patient waiting times and provide cost savings by reducing consultant time. Freed-up consultant time can then be spent on the patients who would benefit most from their care. These roles must be recognised with appropriate Agenda for Change (AfC) banding in line with the specialist skills required and to ensure that they attract qualified candidates. We would welcome engagement with the committee on this.

Access to Services

People with long-term chronic conditions require multidisciplinary management to ensure all aspects of their care are delivered. This is particularly important in rheumatology. However, we know that many patients do not have access to the full range of services they need for their care. The committee needs to prioritise the accessibility of these services to ensure that patients live long and healthy lives.

It is essential that all rheumatology services have access to occupational therapy, physiotherapy, podiatry, psychology and pharmacy services, in line with NICE guidance (NICE. Guideline [NG100]: Rheumatoid arthritis in adults: management). However, staffing levels of nurses and other members of the MDT vary within rheumatology departments and often these services can only be accessed via a Local Health Board's core services, within dedicated MSK services or general

paediatrics. This is not always sufficient, and some patients will benefit from more specialist services.

In our 'Rheumatology workforce: a crisis in numbers', we found that some trusts had no access to some members of the MDT:

- 1/3 of Health Boards in Wales do not have a physiotherapist embedded in their adult rheumatology MDT.
- 1/3 of Health Boards in Wales do not have a pharmacist embedded in their adult rheumatology MDT.
- No adult or paediatric/adolescent rheumatology departments have a psychologist embedded in their team in Wales.
- 56% of Health Boards in Wales do not have a podiatrist embedded in their adult rheumatology team.

Anything below 100% access to AHP, pharmacy and psychology services is not acceptable. The data on access is self-reported by units in England and Wales for the NEIAA, which also shows that staffing and structural factors are linked to performance against NICE quality statements.

We would also like to note that paediatric rheumatology services also require access to all these members of the MDT, however the recently funded south Welsh rheumatology service does not currently have a full MDT. We also recognise that North Wales does not have a dedicated paediatric service. This requires special attention from the Committee to ensure that children and young people receive the highest quality of care, regardless of postcode.

Access to Mental Health Services

Mental health issues are common among people with long-term conditions, as the stress of diagnosis, living with symptoms and impacts on work and social life affect people's mental health. People with these conditions are 2-3 times more likely to experience mental health problems. For instance, over 430,000 adults in the UK have rheumatoid arthritis of which 1 in 6 are affected by depression (The State of Musculoskeletal Health 2019, Versus Arthritis). We welcome the committee's focus on access to mental health services and urge them to consider the impact of long-term conditions on mental health and the need for specialized services for these individuals.

In 'Rheumatology workforce: a crisis in numbers', we called for all adult and paediatric rheumatology departments to have access to specialized psychology support with expertise managing chronic MSK conditions and other long-term conditions. At present, very few adult and paediatric departments have psychologist embedded in their multi-disciplinary team. No adult or paediatric/adolescent rheumatology departments in Wales have a psychologist embedded in their team, and only 38% of trusts and health boards have access to psychology health professionals in England and Wales.

Access to mental health services is particularly important in paediatric and adolescent rheumatology because children and young people have unique psychosocial needs at this stage of their development. While 68% of paediatric rheumatology departments have integrated psychology services, this does include departments that have only a 0.1 WTE psychologist. We

know this is not sufficient to meet the needs of children and young people, and that waiting times are unacceptably long. In a survey of the paediatric rheumatology workforce, 38% reported their patients did not have access to a psychologist due in part to unacceptably long waiting lists ('Paediatric Rheumatology, State of Play 2020).

We do not know how often rheumatology patients are seeking mental health support through their GPs, paediatricians or by self-referring to services. Many departments may be opting to signpost their patients to these and equivalent services where available. However, access to these services is still limited, and while this may be sufficient for some patients, others will need services that are more specialised, with expertise in rheumatological and MSK diseases. This is why it is important that departments have access to dedicated psychology support beyond, ensuring patients receive support that is most suited to their needs.

Blaenoriaethau allweddol ar gyfer y Chweched Senedd
Key priorities for the Sixth Senedd

C2. Yn eich barn chi, pa flaenoriaethau allweddol eraill y dylai'r Pwyllgor eu hystyried yn ystod y Chweched Senedd mewn perthynas â:

a) gwasanaethau iechyd;

b) gofal cymdeithasol a gofalwyr;

c) adfer yn dilyn COVID?

Q2. In your view, what other key priorities should the Committee consider during the Sixth Senedd in relation to:

a) health services;

b) social care and carers;

c) COVID recovery?

Adfer yn dilyn COVID
COVID recovery

Some rheumatology departments continue to struggle with COVID-19 recovery, particularly addressing the backlog of patients. Some departments lost their clinic space and continue to struggle to regain spaces to see patients face-to-face as necessary for urgent care and joint examination. However, most importantly we suggest the Committee look in to the learning and innovative service models adopted by rheumatology departments throughout the pandemic.

The workforce crisis has required a number of processes to be simplified and streamlined, and in many cases lessons from this can be applied in the future. For some local health boards, this will present an opportunity to restructure services to ensure that it is responsive to the needs of its population. Since the start of the pandemic, Rheumatology departments have had to carefully consider where they can use their expertise most effectively, and redesign their services to ensure they can continue to deliver prompt treatment for patients with inflammatory arthritis and other inflammatory conditions. Departments could also look at assessing their new patient slots, asking whether there are enough slots to meet waiting time targets.

For example, Rheumatology departments adopted telephone appointments for follow-up patients and this has proved very successful with many departments now considering how virtual consultations (telephone and video) can be incorporated into our pathways of care. Most departments do plan to offer a hybrid model of care in the future, allowing for clinical need and patient preference to determine appointment type. This has the potential to reduce pressure on clinic rooms, provide more choice for patients (e.g. patients who find attending physical appointments due to work or caring responsibilities, etc.) and promote more flexible working for clinicians. It is worth remembering, however, video clinics will not be practical or effective for every patient. For some patients – those who are unfamiliar with the technology and/or those lacking

access to broadband – it may not be an appropriate option. It is also, for example, comparatively harder to provide accurate advice in some cases without an in-person examination.

Primary care is currently ahead of secondary care in terms of IT systems for recording diagnoses and outcomes and electronic prescribing among other things. There is an opportunity to align all electronic prescribing for patients in one place, (which, not coincidentally, would assist in identification for vaccination/booster). This could mean, for example, that repeat prescription of biologics may not need to be done in secondary care in the future