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This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 01

Ymateb gan: | Response from: Fferylliaeth Gymunedol Cymru | Community Pharmacy Wales

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## Community Pharmacy Wales response to the Health and Social Care Committee's

### **Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

Date: May 2022

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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 Government in accordance with *Sections 83 and 85 National Health Service (Wales) Act 2006* as 'representative of persons providing pharmaceutical services'.

Community Pharmacy Wales is the only organisation that represents every community pharmacy in Wales. It works with Government and its agencies, such as local Health Boards, to protect and develop high quality community pharmacy-based NHS services and to shape the community pharmacy contract and its associated regulations, in order to achieve the highest standards of public health and the best possible patient outcomes. CPW represents all 712 community pharmacies in Wales. Pharmacies are located in high streets, town centres and villages across Wales as well as in the major metropolitan centres and edge of town retail parks.

In addition to the dispensing of prescriptions, Welsh community pharmacies provide a broad range of patient services on behalf of NHS Wales. These face-to-face NHS Wales services, available from qualified pharmacists 6 and occasionally 7 days a week, include, Pharmacist Independent Prescribing Services, Emergency Contraception, Discharge Medicines Reviews, Smoking Cessation, Influenza Vaccination, Palliative Care Medicines Supply, Emergency Supply, Substance Misuse and the Common Ailments services.

CPW is supportive of the narrative and intentions within the Welsh Government's *plan for transforming and modernising planned care and reducing waiting lists*. The plan is pragmatic and coordinated and takes account of the current backlog situation. CPW was heartened to see the recognition in the paper that *'The primary care workforce adapted very quickly in response to the pandemic and adopted a new clinical model at pace to support those in need of care*.

CPW is pleased to have the opportunity to respond to this important consultation which is part of the committee's inquiry into the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment. CPW believes that the community pharmacy network can help to relieve pressure in key parts of the health service, and in doing so, to help create a degree of headroom to reduce the backlog.

Community pharmacy can help to achieve the key objective of *'increasing health service capacity by providing better access to healthcare closer to home – to*

*doctors, nurses, dentists, optometrists and other healthcare professionals who work together so people receive the right care from the right professional.*

CPW is also fully supportive of the statement that *'community pharmacy services will continue to be promoted as an alternative to visits to urgent care services. They will play a vital role in supporting patients who may be already on a waiting list or require onward referral*

While CPW is pleased with the recognition of community pharmacy in the paper, CPW feel that the community pharmacy network across Wales is perfectly placed to make a more significant contribution to the delivery of the plan.

## **Part 2: Observations on the plan for transforming and modernising planned care and reducing waiting times.**

Within the paper there are many areas which CPW feel community pharmacies across Wales can make a significant contribution.

The key opportunities include :-

**Moving some diagnostic tests into community pharmacies:** CPW is fully supportive of the statement in the plan that: *diagnostic services need to be planned and delivered differently. Currently, these services are predominantly based in our main hospitals, serving urgent as well as routine planned care. The need to increase capacity provides an opportunity to deliver services in a different way, for example diagnostic hubs and community provision.* With improvements in technology many tests can be accurately undertaken using Point of Care Testing (finger prick testing). Provision of an extended range of diagnostic services through community pharmacies will be extremely convenient for patients and will release much needed capacity in diagnostic services. It would be helpful to also remove any existing barriers for example, community pharmacy cannot currently request blood tests, even when undertaking a prescribing role, and have instead have to refer to a GP.

The plan aims to *'develop regional treatment and diagnostic centres to further increase capacity. Provide local access to diagnostic procedures, with more tests undertaken at the same time'*. The community pharmacy network stands ready to take on this role.

**Move some routine monitoring of stable patients into community pharmacies:** The majority of patients with stable long-term conditions visit their pharmacy on a routine basis to obtain a supply of their medication. These same people, who are in regular contact with a capable healthcare professional, visit another part of the NHS and another healthcare professional for their annual monitoring and assessment. This is not good use of NHS resources and CPW would recommend that we look to move routine monitoring of people, who are

living with diabetes and respiratory conditions, into community pharmacy. This will provide headroom in GP practices to manage more complex cases and could reduce admissions due to exacerbations. The plan states that *'we will build on established self-management models as a core component of person-centred care providing information and education to support and empower people with long-term health conditions to understand and manage their own health and wellbeing effectively'*. CPW is confident that community pharmacies can take on more of this role.

**Using community pharmacy to reduce health inequalities:** The plan states that *'the Welsh Government is committed to reducing health inequalities. The pandemic has highlighted and worsened health inequalities and poor population health. Reducing health inequalities will enable more people to live longer, healthier and more productive lives'*. Evidence from public health Wales shows that community pharmacy is one of the areas of the NHS where the *Inverse Care Law* does not apply, in that there are a greater number of community pharmacies in areas of deprivation. CPW would suggest that this is leveraged to improve health outcomes in these areas.

**Give community pharmacies a greater role in health improvement:** The plan recognises that *'two of the biggest causes of avoidable ill health and death, and drivers of health inequality, are smoking and obesity. To tackle these and other health inequities, health bodies in Wales working with Public Health Wales will continue to promote healthier lifestyles including encouraging people to achieve and maintain a healthy weight'*. Community pharmacies are the most accessible part of NHS Wales and have, through their stop smoking outcomes, a proven record in change management. With over 700 pharmacies across Wales, located where people live, work and shop there is no other part of the NHS that can deliver health improvement support of the required nature at scale. Currently even the successful community pharmacy smoking cessation is subject to the vagaries of local commissioning and should be part of a suite of services available from every community pharmacy. There is also a significant opportunity to engage the network in the delivery of the *All-Wales Weight Management Pathway* and to allow community pharmacies to the National Exercise Referral Scheme and other services.

**Provide more routine vaccinations in community pharmacies:** Routine vaccination is a key weapon in preventing disease and demands for hospital care. Community pharmacies have clearly demonstrated their competence in vaccination through flu and Covid vaccination services and consideration should be given to expanding their vaccination role especially now that the public have shown their willingness and confidence to receive vaccinations in their local pharmacy.

**Grow the Independent Prescribing role:** Welsh Government has recognised the potential for community pharmacists to prescribe and have provided the

support needed to significantly grow the number of prescribers across the network. CPW would recommend that thought is now given to how we can best use this growing prescribing resource, for example to reduce demands on out of hours prescribing, to release capacity in other areas of the NHS.

**Supporting hospital discharge:** For the majority of patients returning home, or back into community care, following a period of time in hospital, ensuring that they receive, understand and can effectively use the medicines they were intended to receive is a key element of their continued care.

Welsh Government has previously fully recognised the importance of this part of the discharge process and the high level of errors that occur in practice. They responded pragmatically to this challenge by putting in place the Community Pharmacy Discharge Medicines Review (DMR) service following independent evidence on the value of the service. This is a home-grown service of which Welsh Government should feel justly proud however it is unfortunately a service that has not been leveraged and there remains a significant underutilisation of the service.

It is well recognised that errors occur in the hospital discharge process leading to inefficiencies and an unnecessary impact on patient care. The DMR remains a highly effective service which fully utilises the skills and expertise of community pharmacy teams and produces significant benefits to patients through the identification and resolution of medicines issues around discharge.

The current data on the performance of the service clearly shows that too many unnecessary medication errors still occur following discharge. These errors, if not spotted and addressed, could result in less-than-optimal treatment and affect the patient's condition, bringing harm to the patient and in a small number of cases resulted in the patient being readmitted into hospital. It also identifies that patients receiving the support of the DMR service were significantly less likely to have problems with their prescribed medicines following discharge than those patients that did not receive a DMR.

CPW recognise that the use of the service remains suboptimal and this needs to be addressed as a matter of urgency. This can be improved significantly by ensuring that when patients are discharged from hospital there is an automatic notification to their community pharmacy via the Choose Pharmacy platform.

**Driving work into community pharmacy:** The recent Pharmaceutical Needs Assessments conducted by health boards across Wales identified that the majority of patients are not aware of many of the services offered in community pharmacies. CPW feel that lessons can be learned from the excellent and coordinated effort made each year to make people aware of the benefits of flu vaccination with a campaign of a similar nature put in place to raise awareness of community pharmacy services. This would significantly help the people of

Wales to choose the best provider in support of the *Help Us Help You* principles and reduce pressure on many parts of the NHS.

**Speed up hospital discharge processes:** As part of the (E – Early Discharge) element of the SAFER guidance CPW is aware of the delay to discharge that can occur while patients wait to receive their discharge medicines from the hospital. We believe, following feedback from our contractors, that this is an unnecessary delay and can be removed by allowing the medicines to be provided by the patient’s local community pharmacy and delivered to the patient’s home if required with the minimum of delay. CPW would recommend that a community pharmacy Enhanced Service is put in place to address this unnecessary delay to hospital discharge.

**Addressing the long-standing issue of medicines compliance aids:** Some of the patients discharged from hospital will require the support of a compliance aid such as a monitored dosage system (MDS) or a MAR Chart. As the provision of MDS or MAR Chart support for carers is not an NHS service and is provided as a gesture of goodwill by the pharmacy contractors, patients are often held up in hospital while hospital pharmacy teams ring around to try to secure the support required by the patient. This is another unnecessary delay in discharge processes that can be easily addressed. CPW feels that we should have long ago resolved this issue as this is placing unnecessary pressure on social care, community and hospital pharmacy teams and delaying discharge. CPW would recommend that a national community pharmacy Enhanced Service covering the provision of MDS or MAR Chart support following discharge, where this is required, is put in place with the minimum of delay.

**Providing speedy access to key information:** To ensure that all elements of the community pharmacy services offer operate as effectively as possible it is essential that any remaining restrictions to community pharmacy routine access to the GP Medical Record in Wales are removed. A community pharmacist should be able to access a GP Medical Record at any time that they feel it is appropriate.

### Part 3: Conclusion

The plan is clear in its desire to ensure that *‘more care and support will be available from a wider range of local services and healthcare professionals to help you stay well and remain at home’*.

CPW is fully supportive of this aim and has laid out above several ways in which the community pharmacy network in Wales can help deliver the plan and release headroom in other parts of the service to tackle the challenge of the current waiting list.

CPW is happy to explore any of the elements touched on and will be a willing partner in instigating change.

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

CPW welcomes communication in either English or Welsh.

For acknowledgement and further Contact:

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This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 02

Ymateb gan: | Response from: Coleg Brenhinol yr Ymarferwyr Cyffredinol  
| Royal College of General Practitioners

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| <p><u>Royal College of GPs<br/>Cymru Wales</u></p> <p>May 2022</p> | <p><u>Response to Health and Social Care Committee’s request for<br/>written evidence</u></p> <p><u>Welsh Government’s programme for transforming and<br/>modernising planned care and reducing waiting lists- Royal<br/>College of GPs Cymru Wales</u></p> |
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## **Background**

In May 2022 the Welsh Government released its programme for 'transforming and modernising planned care and reducing waiting lists'. The programme notes that lengthy waiting lists are an historic issue. However, the challenge has been exacerbated by the suspension of planned care services due to COVID -19. This has caused approximately 500,000 referrals not to be received in a timely manner for secondary care treatment.

## **Request for written evidence**

The Health and Social Care Committee has requested overall views from relevant parties. It has also asked for specific input in response to several supplementary questions which will be addressed below.

## **Overall views:**

1. *Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits?*
2. *Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?*

## **RCGP response:**

The College is encouraged by the themes demonstrated in this Programme. It demonstrates an understanding of the challenges GPs are facing as they deal with the impact of long waiting lists, frequent follow-ups by patients on those waiting lists and the inevitable deterioration of patients’ symptoms while they await a referral. This was described in 'Waiting Well?'<sup>1</sup> where Professor Peter Saul of RCGP Wales is cited as saying that '*backlogs had resulted in the prescription of drugs such as antidepressants, when other treatment approaches might have been more appropriate.*' However, the Programme does not explain the steps to be taken

<sup>1</sup> Waiting Well paragraph 42 <https://senedd.wales/media/dfqbfj1/cr-ld15079-e.pdf>

which will lead to these changes, nor does it give clear targets to measure what a resilient and sustainable social care system looks like.

The College is concerned by the lack of targets in the sections of the plan entitled 'what do we want to achieve?'. This provides broad ideas as to the desired outcomes, but data and a clear framework for measuring these outcomes will be vital before we can comment on the efficacy of the Programme. For example, the College looks forward to the workforce plan, which we hope will provide further staffing to decrease GP workloads, which are currently neither sustainable nor safe.

While digital consultations and virtual tools are a great help in alleviating some of the pressure, it is important that the investment in digital infrastructure keeps pace with patient need. It is also important to note that remote consultation can improve convenience from the patient perspective, but it does not reduce the amount of time a GP needs to spend in the consultation and has been known to extend that timeframe as for questions that need to be asked in a virtual setting, the answers to which might be implicitly obvious in a face to face environment. The College notes that many GP surgeries are using the telephone as the primary tool for remote consultations and there is scope to expand use of online video consultation.

The College supports making full use of the multi-disciplinary team where clinically appropriate. Seeing the right person at the right time is the most important factor in a patient's treatment and rehabilitation.

The focus on health inequalities is welcome and we are working with Welsh Government on a project to help tackle this long-standing problem. To properly address the challenge of health inequalities, Government needs to look beyond just the health remit to consider how poverty and exclusion across the board impact on health outcomes.

The College draws the Committee's attention to its 8 Point Plan<sup>2</sup>, and is encouraged to see some similar themes in the Programme, particularly the focus on improving communication with the public to support improved health literacy, and the increased use of digital tools which we hope will include sensibly managed online appointment booking and video consultation in practice.

We would urge the Welsh Government to consider improving the clarity of triage by upscaling the role of Care Navigator as highlighted in the plan.

## **Supplementary Questions**

### **Meeting people's needs**

3. *Whether the plan includes sufficient focus on:*

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<sup>2</sup> RCGP 8 Point Plan, October 2021 <https://www.rcgp.org.uk/about-us/news/2021/october/rcgp-cymru-wales.asp>

- a. Ensuring that people who have health needs come forward.
- b. Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management.
- c. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time.
- d. Improving patient outcomes and experience of NHS services?

As in 'Overall Views' above, the College is encouraged to see consideration of all patients currently on the waiting list and the beginnings of a communication strategy to encourage those in need to come forward. However, as has been mentioned above and will be detailed below, the Programme lacks the specifics which would allow us to accurately predict its efficacy in terms of patient need.

We note that the idea of digital tools to facilitate communication between healthcare providers is being broached, however we feel that clear communication to both staff and patients is vital to ensure this is used effectively. We also highlight the potential of the introduction of Care Navigators as in our 8 Point Plan.<sup>3</sup>

As above, we support the use of multidisciplinary teams and look forward to seeing further detail on the application of these. As Professor Peter Saul is quoted in 'Waiting Well' *'the embedding of specialist staff, such as diabetic nurses or pain management specialists, into primary care practices was a key development'*<sup>4</sup> The Programme would also benefit from the further detail on the plan for estates as there is currently not space to house multiple disciplines and 'community hubs' within the infrastructure of GP practices. Furthermore, this lack of capacity results in a lack of training space for new members of the practice team entering the profession.

Detail is needed regarding the workforce plan, which we understand is forthcoming. We need to understand how digital consultations are going to be rolled out given that the current norm for GP practices is to hold a remote consultation via telephone. We do not yet know how or where the funding discussed in the report will be allocated.

The Programme implies that much of the practical application of these broad themes will be left to health boards. This is not unreasonable, but it will be important to ensure safeguards exist to measure a consistency of service and to identify areas of additional need due to existing inequality. As Professor Saul noted in Waiting Well *'I think it will deliver for some of them, but we've identified perhaps people in deprived areas who are less vociferous, who have less access, and I think there may be difficulties there. And I think the timescale is going to be longer than stated'*.

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<sup>3</sup> RCGP 8 Point Plan, October 2021 <https://www.rcgp.org.uk/about-us/news/2021/october/rcgp-cymru-wales.asp>

<sup>4</sup> Waiting Well? paragraph 248 <https://senedd.wales/media/dfqbfaj1/cr-ld15079-e.pdf>

## **Leadership and national direction**

4. *Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?*
5. *Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?*

The College supports the idea of collaboration between NHS and Social Services with the introduction of a Diagnostic Board as on page 19 of the Programme. However, the College feels far greater detail is required as to who will facilitate the introduction of the new systems discussed. There is an implication throughout the Programme that much of the detail of 'how' the processes will be put in place will be left to health boards, which leaves room for inconsistency and inequality through the system that we wish to improve, if not eradicate.

## **Targets and timescales**

6. *Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?*
7. *Is it sufficiently clear which specialties will be prioritised/included in the targets?*
8. *Do you anticipate any variation across health boards in the achievement of the targets by specialty?*

As mentioned above, the Programme lacks targets. The Programme highlights that 691,885 are currently on waiting lists with 251,647 waiting over 36 months (an increase of 223,353 on March 2020).

Under the sections entitled '*What do we want to achieve?*', themes and ideal outcomes are listed such as '*We will plan for planned care to be managed on a 52 weeks, seven days and 15 hours a day basis*' (page 30), and '*we want to support people to make informed decisions about their healthcare*' (page 32), it will be exceedingly difficult to measure the success of this project without a measurable target.

On page 23 of the Programme which discusses cancer diagnoses, there is an assertion that the first outpatient appointment should take place within 10 days of suspicion. However, there is no indication of when we are likely to get to that point and given the 251,647 patients waiting for over three years, this does not seem like a realistic goal for the near future.

Furthermore, page 18 describes how the Welsh Government intends to 'build capacity'. As stated above, we look forward to the workforce plan, and hope that it will be available as swiftly as practicable, and will provide the much needed detail of how that capacity will be built.

### **Financial resources**

9. *Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?*
  
10. *Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?*

The College notes that Welsh Government has given a recurrent £170m to support planned care recovery and that £20m a year has been invested to support recovery in the medium term. However, without clear indication of what new services, if any, will be created, where they will be housed and the staffing capacity, it is impossible to state whether there is sufficient revenue and funding to deliver the plan.

On page 28 the Programme notes '*Health board estates are no longer the sole resource for seeing and treating our patients. We will need to ensure that we use the physical estate as efficiently as possible,*' However, it is well documented that the estates are not sufficient for the multidisciplinary teams discussed elsewhere in the Programme and we need to be confident that while virtual consultations are available and are useful, there must be the facility for a patient to be seen in person should they require it.

### **Workforce**

11. *Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?*

The Programme discusses community hubs (page 20) bringing together health, social care and other services, which if properly staffed would make a considerable difference to the backlog and waiting lists. It also discusses the leasing of staffed scanners, outsourcing and insourcing of staff members from outside and from different parts of the health service. However, it does not discuss the staff numbers which will be needed to bring the plan into fruition. We look forward to seeing the workforce plan as well as the planning on general practice estates.

## **Digital tools and data**

*12. Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?*

The College notes that the Welsh Government plans to ensure that 35% of new appointments and 50% of follow up appointments are virtually delivered (page 16). These are reasonable indicative figures, but we should ensure flexibility in the system so that the patient is seen in the most appropriate way for their condition. There is also likely to be variation across Wales, including by age of patient and access to reliable technology.

We would like to emphasise again that many remote appointments within GP practices are carried out using the telephone, rather than any video conferencing software.

We believe that for video conferencing software to be widely used in the health sector there needs to be funding, communication and training with a clear plan to deliver the same being vital if we are to ensure that digital delivery becomes a reliable and trusted method of consultation.

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 03**

**Ymateb gan: | Response from: Coleg Brenhinol Pediatreg ac Iechyd Plant |  
Royal College of Paediatrics and Child Health**

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# RCPCH response to Health and Social Care Committee request for evidence on Welsh Government Plan to Transform Planned Care and Reduce Waiting Lists

## About the Royal College of Paediatrics and Child Health (RCPCH)

The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 500 members in Wales, 14,000 across the UK and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

We are grateful to the Health and Social Care Committee for the opportunity to help inform scrutiny of the Welsh Government's plan to Transform Planned Care Service and Reduce Waiting Times.

For further information please contact Gethin Matthews-Jones, Head of Devolved Nations via

## Overall views

As a College, we have welcomed the aims and ambitions set out in the Plan to Transform Planned Care and Reduce Waiting Lists (hereafter 'the plan'); and in particular the recognition that delays can have a particularly significant impact on children as many treatments are age or developmental stage critical. We're pleased that the Welsh Government recognises this and has now sent a clear statement that children and young people must be prioritised; with their needs and services considered and measured separately to adult services.

However, some of our members have questioned how all of this will be delivered. One member said that in their opinion, it would take an increase in the workforce including administrative support along with significant investment and improvement in IT and technology to achieve the stated aims. They noted that "this will require significant financial investment from the Welsh Government and will take time to allow for the additional clinicians to be trained... In terms of paediatrics and child health... there will need to be significant financial investment into children's services". The member questioned whether there would be dedicated or ringfenced additional funding for child health services, noting that when funding is delivered through existing budgets, it can be difficult for paediatrics to compete with adult services for additional funding.

## Meeting people's needs

We very much welcomed the recognition in this plan that:

“Waiting times for children must be considered differently to waiting times for an adult, as the illness will represent a higher proportion of a child's whole life and potentially have permanent long term impact on growth and development”<sup>1</sup>.

We agree with this assessment and welcome the commitment to act accordingly: “we will ensure that children's elective care is prioritised, as we respond to the needs of each child”<sup>2</sup>.

We also note the following in the plan:

“Waiting lists can now be measured by age allowing the recovery of children's health services to be managed effectively with their needs considered separately from those of adults”<sup>3</sup>.

Waiting lists should be measured by age for the reasons identified by the Welsh Government. To ensure transparency and to make the most of this opportunity to effectively manage children's services and understand where resources need to be focussed and action taken, these data should be regularly published and communicated externally. They should also be broken down by Health Board area to mitigate against geographical inequity within Wales. Finally, Welsh Government should consider how these data should be broken down to understand and take action on health inequalities. It would be helpful for the Welsh Government to set out how and when waiting times data will be published and communicated as part of this plan and its operationalisation.

We note the following in the plan:

“We will work towards accelerating the embedding of virtual approaches and offer telephone and video appointments so that 35% of new appointments and 50% of follow up appointments are delivered virtually”<sup>4</sup>.

We strongly recommend that in operationalising this commitment, that the Welsh Government and NHS services are mindful of our [Principles for Conducting Virtual Consultations with Children and Young People](#)<sup>5</sup>. Children and young people have different needs to adults with potential risks including safeguarding, confidentiality and digital exclusion. The principles described in our guidance aim to support clinicians who are consulting virtually with patients to provide care in a way that is in the best interests of children and young people, whilst protecting both from the risks associated with virtual consultations.

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<sup>1</sup> Welsh Government (2022). *Our programme for transforming and modernising planned care and reducing waiting lists in Wales*, p23. Available at: <https://gov.wales/sites/default/files/publications/2022-04/our-programme-for-transforming--and-modernising-planned-care-and-reducing-waiting-lists-in-wales.pdf>

<sup>2</sup> Welsh Government (2022), p.23.

<sup>3</sup> Welsh Government (2022), p.23.

<sup>4</sup> Welsh Government (2022), p.14.

<sup>5</sup> RCPCH (2020). *Principles for conducting virtual consultations with children and young people*. Available at: <https://www.rcpch.ac.uk/resources/principles-conducting-virtual-consultations-children-young-people>

## Targets and timescales

This is a top line plan setting out principles and a vision. We accept that detailed targets and timescales for each service may be beyond its scope. However, this does then raise the question of where such detailed planning will be located and whether we should expect further documents sitting under this one to operationalise these principles.

There are also areas within that plan that are particularly top line, where further detail is needed. For example, on dentistry and oral health, we note the following from the plan:

“We are making steady progress with recovery of dental services and as dentists respond to new ways of working, activity is still 50% compared to the same period pre-pandemic...Priority is being placed on those with highest risk and needs, this includes children who are in high risk groups, particularly those from disadvantaged socioeconomic backgrounds. More routine care will be provided as we move through recovery phases where throughput is able to increase safely and provide services in the community to support people’s needs closer to home”<sup>6</sup>.

Despite tooth decay being largely preventable, it is the leading reason why children aged five to nine require admission to hospital. Multiple tooth extractions can also result in the need for a child to go under general anaesthetic<sup>7</sup>. In pre-pandemic years, our State of Child Health data showed that children from lower socioeconomic groups are more likely to be at risk of tooth decay prevalence and severity. The good news is that between 2008 and 2016, prevalence of visually obvious tooth decay among 5 year old children in Wales fell from 47.6% to 35.4%. From 2014/15 to 2017/18, among 0 to 2 year olds in Wales, the rate of general anaesthetics performed for dental reasons fell from 2.8 to 1.7 per 1,000<sup>8</sup>. Given school closures and disruption to the Designed to Smile programme, which the Welsh Government says has driven much of this improvement<sup>9</sup>, it is important that we have up-to-date data on the prevalence of tooth decay on children in Wales and what this means for hospital admission and waiting lists for children requiring dental extractions and other treatment.

There is much in the statement on dentistry in the plan that we welcome, including the focus on children and young people; and on health inequalities. However, given the ongoing disruption to dentistry services, the Welsh Government should provide a more detailed explanation of these ‘recovery phases’ and set out a plan for ensuring that its own targets and ambitions for children being seen by dentists are being met.

In 2018, the Welsh Government’s [Dental care and treatment for very young children](#)<sup>10</sup> guidance stated that “we want all children to be taken to the dentist before the age of 1 - ideally as soon as deciduous teeth erupt. We want dental teams to see children routinely before there is a problem, provide preventive care and advice and support parents to keep their child’s teeth sound” while the Welsh Government’s ‘A Healthier Wales: The oral health and dental services response’ identified as a key priority for 2018-2021, a “year-on-year

<sup>6</sup> Welsh Government (2022), p.9.

<sup>7</sup> For pre-pandemic evidence on the need for anaesthetic in England (we are not aware of recent or comparable Wales data), see Royal College of Surgeons of England; 2019. *Hospital admissions for 5-9 year olds with tooth decay more than double those for tonsillitis*, available at: <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/dental-decay-hosp-admissions/>

<sup>8</sup> RCPCH (2020). *State of Child Health: Oral Health*. Available at: <https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/oral-health/>

<sup>9</sup> See Welsh Government (2019) *Welsh Government scheme puts a smile on Children’s faces*, available at: <https://gov.wales/welsh-government-scheme-puts-smile-childrens-faces>

<sup>10</sup> Welsh Government (2018) *Preventive dental advice, care and treatment for children from 0-3 Years*. Available at: <https://gov.wales/sites/default/files/publications/2019-03/preventive-dental-advice-care-and-treatment-for-children-from-0-3-years.pdf>

increase in the proportion of people who have seen an NHS dental practitioner in the last 2 years (1 year for children) in all Health Boards<sup>11</sup>. We are unclear as to whether these commitments are being met and if not, what actions are being taken to ensure they are met as quickly as possible.

Given the scale and impact of tooth decay; and the extent to which it is preventable, it is also surprising that there is little in the plan on preventing tooth decay in children in the sections of the plan dealing with prevention of ill health. In State of Child Health and elsewhere we recommended ensuring sufficient funding and resource for Designed to Smile; and that Welsh Government should resource and support fluoridation of public water supplies, particularly for areas where there is a high prevalence of tooth decay<sup>12</sup>.

## **Is it sufficiently clear which specialties will be prioritised/included in the targets?**

One member expressed concern to us that such a top line plan could be seen as setting priorities to the exclusion of others.

One service area that isn't given much prominence in the plan is around services for neurodivergent children and young people. One member expressed concern that funding for ND could fall between the cracks as their experience was that increased mental health funding isn't being made available to ND services.

We were pleased to note that the Minister for Social Services has confirmed that she will publish the findings of the demand and capacity review of neurodevelopmental (ND) services and announce a series of actions to support medium to long term service improvements<sup>13</sup>. It is our hope that these actions will be designed in partnership with clinicians enabling their views to be taken onboard. Member feedback suggests that there are very long waiting lists now in children's ND services and that addressing these will require new funding here and now to find immediate solutions; including enhanced administrative support, improving IT and infrastructure development.

We are not clear that ND services are prioritised and included in new targets, but hope that publication of the demand and capacity review, which we would urge the Welsh Government to do as quickly as possible, will provide an opportunity to develop the plan for children and young people's ND services.

## **Financial resources**

Members have fed back to us that to make short term progress in tackling waiting lists, immediate investment is required by child health services including IT and digital infrastructure and estates. We have elaborated elsewhere in this response. The need to specifically allocate or ringfence this funding for child health services has been fed back by members.

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<sup>11</sup> Welsh Government (2018). A Healthier Wales: *The oral health and dental services response*. Available at: <https://gov.wales/sites/default/files/publications/2019-03/the-oral-health-and-dental-services-response.pdf>

<sup>12</sup> RCPCH (2020), see: <https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/oral-health/#page-section-12>

<sup>13</sup> See Deputy Minister for Social Services in Senedd Cymru (2022), *Plenary, 11/05/22*. Available at: <https://record.assembly.wales/Plenary/12840#C424129>

## Workforce

Before the pandemic, we made the following recommendations in [State of Child Health](#), responding to the need for greater workforce planning:

“The strategy should:

- Consider the breadth of the child health workforce including medical, midwifery, nursing, allied health professionals, pharmacists, health visitors and school nurses.
- Address the recruitment and retention of the healthcare workforce.
- Ensure their healthcare workforce data is robust, reliable and comprehensive.
- Be based around robust and proactive modelling, to better match the changing needs of children and young people with the training and recruitment of our future child health workforce.<sup>14</sup>”

We were encouraged to hear that the Health Education and Improvement Wales (HEIW) workforce strategy, part of the response to A Healthier Wales, made commitments to deliver the capability to provide reliable and comprehensive data; and robust modelling based on that data. That strategy commits to creating “a centre of excellence for workforce intelligence for health and social care in Wales. This will use high quality standardised data sets, analytical methods and sophisticated modelling techniques to support workforce planning, development and productivity”. Its success criteria include “Intelligence led workforce planning enabling us to change our workforce to meet our population need”<sup>15</sup>.

This will be needed if we are to develop a workforce that will be able to deliver the Welsh Government’s plan to transform planned care and tackle waiting lists. Therefore, we are glad that the plan builds on that HEIW strategy. We note that the Workforce Strategy for Health and Care in Wales sets the vision and direction for the plan, but its implementation and delivery has to be prioritised.

The Welsh Government plan signals a further strategic document in development: “We will develop in social partnership a Workforce Delivery Plan for Wales which incorporates these commitments and will enable the delivery of this plan as it is implemented”. If this is the document that sets out how the HEIW strategy will become a reality, this would be welcomed. However, the important thing will be the end result and the material reality of whether we have sufficient numbers of paediatricians along with the wider child health workforce in midwifery, nursing, allied health professionals, pharmacists, health visitors and school nurses.

There is one other important document planned in this increasingly busy strategic landscape being developed by HEIW. In [March 2022 we responded](#) to the HEIW Mental Health Workforce Plan. The plan needs to be able to deliver the workforce required to support agreed and emerging models of care for children and young people, a number of which are outlined in the Welsh Government’s [Children and Young People’s Plan](#)<sup>16</sup>, also published in March 2022.

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<sup>14</sup> RCPCH (2020). See <https://stateofchildhealth.rcpch.ac.uk/evidence/workforce/child-health-workforce/#page-section-22>

<sup>15</sup> Health Education and Improvement Wales (2020). *A Healthier Wales: Our Workforce Strategy for Health and Social Care*. Available at: <https://heiw.nhs.wales/files/workforce-strategy/>

<sup>16</sup> Welsh Government (2022). *Children and young people’s plan: What we will do to support children and young people who are growing up, living and working in Wales*. Available at: <https://gov.wales/children-and-young-peoples-plan-html#section-90948>

Recommendations we put forward in our response included<sup>17</sup>:

- Modelling and scenario planning to account for the emerging political and strategic framework for children and young people's mental health. These may require upskilling groups of people other than those considered within the adult mental health frameworks identified in order to deliver the Whole School Approach, specialist in-reach programmes and the Nyth/Nest framework.
- Modelling and scenario planning engages with and builds upon the review of demand and capacity within ND services in Wales. It needs to consider whether there needs to be longer term intelligence gathering around demand and capacity within ND services.

In short, there is an increasingly busy strategic landscape around the health and social care workforce in Wales and we welcome this focus by the Welsh Government and HEIW. However, for the Welsh Government to reach the aspirations and meet the commitments made in the transformation plan, these will have to translate into appropriately staffed children's services. The Workforce Delivery Plan for Wales will need to be consulted upon and delivered quickly; and will need to set out in detail how and when workforce commitments will be realised. It will also need to integrate seamlessly with HEIW's mental health workforce plan, to set out how and when a mental health workforce to deliver the Welsh Government's commitments in this space will be achieved.

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<sup>17</sup> RCPCH (2022). *Mental Health Workforce Plan for Health and Social Care (Wales) consultation response*. Available at: <https://www.rcpch.ac.uk/resources/mental-health-workforce-plan-health-social-care-wales-consultation-response>

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 04

Ymateb gan: | Response from: Mind Cymru

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# Mind Cymru's response to the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

## About Mind Cymru

We're Mind Cymru, the mental health charity. We work nationally and locally.

Nationally, we campaign to raise awareness, promote understanding and drive change. We're also the first point of call for information and advice, providing mental health information to people in Wales over a million times every year. Locally, in communities across Wales, independent local Minds provide life-changing face-to-face support to more than 25,000 people each year.

Together, we won't give up until everyone experiencing a mental health problem gets support and respect.

We welcome the opportunity to respond to the Health and Social Care Committee's call for evidence on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

## Overall view

We are concerned that the Welsh Government's plan (the plan) for transforming and modernising planned care and reducing waiting lists does not sufficiently consider mental health services. The plan focuses on, and establishes long-term targets against, waiting times statistics which do not include mental health services. The executive summary makes clear that while mental health interventions are included within the definition of planned care, the plan does not cover all areas and "focuses on the planned care which is predominantly linked to waiting lists". This is despite the

plan recognising that waiting lists in mental health services – as in physical health services - have grown significantly and are likely to continue growing in the coming months.

Our view is that the plan contains lots of commitments which would significantly improve people's experiences of accessing mental health services, particularly in terms of improving the provision of appropriate information, building planned care capacity, and eliminating long-waiters at all stages. Similarly, we support the five goals for planned care transformation, outlined on page 5 of the plan, and would like to see further information on what actions are being undertaken to achieve these goals in mental health services. We believe the Welsh Government should urgently clarify whether the commitments outlined within the plan apply to mental health services and outline specific targets to measure progress toward reducing waiting times therein.

### **Waiting times within mental health services**

We share the Welsh Government's view, as outlined in the plan, of the impact of the (COVID-19) pandemic on people's mental health. We have previously highlighted to this Committee the negative and unequal impact the pandemic has had on people's mental health and how pre-existing inequalities and service-challenges have been compounded.<sup>1</sup>

We also share the Welsh Government's view that the pandemic is likely to have longer-term impacts on waiting lists for mental health services. However, as we highlighted in our written evidence to this Committee's inquiry into the impact of the waiting times backlog, it is important to recognise that mental health services were under considerable pressure before the pandemic, with many people facing unacceptably long waits for support, including hundreds of people waiting longer than a year for specialist psychological therapies and thousands of people waiting longer than the 26-week target.<sup>2</sup> This underpins the need to go beyond resetting mental health services to their pre-pandemic performance.

The plan notes that demand for mental health services surged post lockdown which added to waiting times and service pressures. Specifically, the plan highlights increased referrals to specialist mental health services, particularly those supporting young people with eating disorders (though it is worth noting that figures on referrals or waiting times for eating disorder specific services are not published by the Welsh Government). The plan goes on to highlight the Welsh Government's expenditure on mental health services and commitment to increased investment, which we

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<sup>1</sup> <https://business.senedd.wales/documents/s123799/MHI%2047%20-%20Mind%20Cymru.pdf>

<sup>2</sup> <https://business.senedd.wales/documents/s122255/WT%2025%20-%20Mind%20Cymru.pdf>

welcome, but does not adequately seek to set-out a plan for reducing waiting times within mental health services.

### Waiting times targets

In stark contrast with the sub-speciality referral-to-treatment waiting time statistics available for most physical health secondary care services, little information is available for mental health services. Statistics on waiting times for mental health services are only published for two parts of the system, Local Primary Mental Health Support Services and Specialist Child and Adolescent Mental Health Services. The equivalent waiting times figures for adults accessing secondary care, or adult mental health services, are not reported. This is despite clear waiting times standards being set, for example, for community mental health teams, “that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request.”<sup>3</sup> We would question the relevance of waiting times standards that are not reported.

Where data on mental health services is collected it is not always published, for example, waiting times for access to specialist psychological therapies are not currently published despite a commitment from the Welsh Government to do so from the first year of the Together for Mental Health 2019-22 delivery plan.<sup>4</sup> Additionally, improving the access, quality and range of psychological therapies and delivering a significant reduction in waiting times by the end of this Government, is one of six key priorities for the lifetime of the 2019-22 delivery plan. Clearly, it is not possible to measure progress toward this priority whilst waiting times information remains unpublished. This issue is further compounded by a lack of annual reporting of progress by the Welsh Government on the delivery of the Together for Mental Health Strategy. Despite a commitment to do so, no progress reports have been published against the Together for Mental Health 2019-22 delivery plan and so it is not clear why the commitment to publishing waiting times statistics, alongside other actions, have not been delivered.

The gap between the level of data and insights available into performance and waiting times within physical health and mental health services serves as a reminder of the significant efforts still required to deliver genuine parity and modernise mental health services. Understanding access, demand, outcomes and waiting times within mental health services has long been a significant

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<sup>3</sup> [https://senedd.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20\(Wales\)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf](https://senedd.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf)

<sup>4</sup> Action 04 (ii), [https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19\\_0.pdf](https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf)

challenge due to limited access to and availability of services-data, these issues have been raised in several inquiries by Senedd Committees in recent years yet remain an ongoing issue.

The Welsh Government is committed to developing a Mental Health Core Dataset (MHCDS) for Wales for implementation this year (2022).<sup>5</sup> However, whilst Mind Cymru has supported the Welsh Government in developing the MHCDS we remain significantly concerned at the ongoing delays in its delivery. The original Together for Mental Health Delivery Plan (2012-16) committed to ensuring the MHCDS was operational by 2015. The Welsh Government need to ensure there are no further delays in delivery of the Mental Health Core Dataset and that a full range of protected characteristics data is collected and published. Additionally, we believe the Welsh Government should urgently review what data is currently collected, alongside clarifying waiting times targets across the mental health services system, and ensure these figures are collected and published.

### **Mental health support for people waiting for physical health treatment**

The plan rightly recognises that ‘long waits for health interventions are resulting in increased emotional and mental health concerns amongst those waiting’ and that ‘people report that uncertainty about diagnosis is adding to the stress of waiting times.’ We wholeheartedly agree with this view and believe the plan could be strengthened by further commitments to improving mental health support for people facing long-waits. Specifically, we would want to see considerations of mental health support embedded across patient pathways and service-design to ensure timely access to appropriate support. For example, where a person is likely to face a long wait to access surgery or other treatment, information and or signposting should be provided to access support for their mental health.

In our written submission to this inquiry, we highlighted the contribution that third sector commissioned services can make in supporting the wider health and social care system. The sector plays an important role in the provision of support and information to people, including those waiting for specialist treatment for their physical and/or mental health. For example, Active Monitoring, which is delivered by Mind Cymru nationally in partnership with Local Mind’s across Wales and funded by the Welsh Government. The service offers a 6-week guided self-help course for a range of mental health concerns. It is open to all on a self-referral basis and delivers timely and short-term interventions for people experiencing a range of mental health problems. This can include people facing long waiting lists for more specialist mental health support but may also be

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<sup>5</sup> Action 04 (ii), [https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19\\_0.pdf](https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf)

beneficial for people experiencing physical health problems that are impacting on their mental health.

Such services could provide a means for mitigating the negative mental health impact of waiting-times backlogs by providing short-term support to those who need it. This will require improved links and referral processes between third-sector support and other health services. We believe the plan would be strengthened by further considering how the third sector, like allied health professionals, can contribute to a wider whole system approach that ensures timely care and support for people to manage their health and stay well, at every level.

### **Primary, secondary and tertiary prevention**

Tackling the current backlog whilst building sustainable capacity in the long-term needs to ensure that prevention is delivered at every level of the service. This approach needs to be underpinned by a commitment to primary, secondary and tertiary prevention. Whilst upstreaming prevention to tackle mental health problems before they occur is a widely supported long-term ambition, priority must also be given to ensuring that people currently waiting for support are able to access it in the short and medium-term. This will ensure that people who need support are able to access it in a timely way and will help prevent their mental health deteriorating further.

### **Financial resources**

We welcome the increased funding for mental health support announced in the Welsh Government's 2022-23 draft budget, including targeted funding for preventative and acute services for children and young people. However, linked to the above, the way that expenditure on mental health services is reported makes it difficult to assess whether funding is being utilised in the most effective way or is sufficient to tackle waiting times. The plan notes that the Welsh Government spends more on mental health services than any other aspect of the health service. However, whilst technically correct, this is largely down to the way in which expenditure on health services are categorised. Whilst physical health services are broken down into multiple expenditure categories, mental health expenditure forms only a single category. Additionally, it is not clear what formula is used to decide mental health ring-fence allocations or overall expenditure. In our evidence to this Committee's inquiry into mental health inequalities we highlighted our view that the Welsh Government the Welsh Government should re-join the Adult Psychiatric Morbidity Survey (APMS) which 'provides data on the prevalence of both treated and untreated psychiatric disorder in the adult population (aged 16 and over)'.<sup>6</sup> Wales last participated in the study in 2000. Alongside

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<sup>6</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-of-mental-health-and-wellbeing-england-2014#highlights>

measuring prevalence, the survey also provides insights on access to mental health services and unmet need which would ensure adequate and appropriate resources are allocated based on local need.

Issues around transparency of funding for mental health services have also previously been raised by the Senedd's Health Committee. In the Committee's scrutiny report of the Welsh Government's draft budget for 2020-21, it recommended that the Welsh Government provides a breakdown of the £745m ring-fenced allocation for mental health. We support this recommendation as a vital step to understanding funding for different aspects of the mental health services system. For example, how much funding is currently attached to the delivery of specialist psychological therapies?

### Conclusion

Our view is that, despite the plan recognising increasing waiting times and demand for mental health support, the plan does not adequately consider mental health services. We would like to see urgent clarity on whether the commitments outlined within the plan apply to mental health services. If not, we would question why secondary care mental health services have been excluded in a plan that ostensibly focuses on tackling backlogs and building capacity within secondary care.

The executive summary suggests the plan focuses on 'planned care that is predominantly linked to waiting times.' It is unfortunate that, a lack of clear waiting times statistics and data more generally for mental health services – which itself is a disservice – seemingly means that mental health services have been excluded from the plan, despite a recognition of growing waiting lists and demand for support. Our view is that mental health services should receive parity with physical health services and that reducing waiting times, building capacity and improving data collection across the system should be prioritised by the Welsh Government with clear a plan, timescales and targets for delivery.

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 05**

**Ymateb gan: Response from: Coleg Brenhinol y Therapyddion  
Galwedigaethol | Royal College of Occupational Therapists**

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# Consultation response - Transforming and modernising planned care and reducing waiting lists in Wales

8 June 2022

## About us

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 80 years; and today, we are thriving with over 35,000 members. Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole. Occupational therapists in Wales work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapy helps you live your best life at home, at work – and everywhere else. It's about being able to do the things you want and must do. That could mean helping you overcome challenges of learning at school, going to work, playing sport or simply doing the dishes. Everything is focused on increasing independence and wellbeing.

It's science-based, health and social care profession that's regulated by the Health and Care Professions Council.

An occupational therapist helps people of all ages overcome challenges completing everyday tasks or activities – what we call 'occupations'. Occupational therapists see beyond diagnoses and limitations to hopes and aspirations. They look at relationships between the activities you do every day – your occupations – alongside the challenges you face and your environment.

Then, they create a plan of goals and adjustments targeted at achieving a specific set of activities. The plan is practical, realistic and personal to you as an individual, to help you achieve the breakthroughs you need to elevate your everyday life.

This support can give people a renewed sense of purpose. It can also open new opportunities and change the way people feel about the future.

## Our response

**Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic and reduce long waits.**

Our members report that on the current levels of service that they will struggle to meet the requirements of this report. Our managers state they have not yet heard when the extra funding will be made available.

**Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?**

The plan is heavily influenced by the Welsh Government's previous policy direction especially "A Healthier Wales", which we as a Royal College supported. Our members see slow progress towards those goals, especially moving more services closer to home with an increased focus on primary care. We have several great services that focus on rehabilitation in community settings, but these are often short term funded and patchy throughout Wales. There needs to be an acceleration of the delivery of programmes that have proved to be successful.

**Whether the plan includes sufficient focus on:**

- **Ensuring that people who have health needs come forward;**
- **Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**
- **Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**
- **Improving patient outcomes and their experience of NHS services?**

Occupational therapy is still predominantly accessed through secondary and tertiary services and tends to focus on individuals, rather than on populations. Access to occupational therapy services needs to be early and easy, across the lifespan, preventing the development of long-term difficulties and addressing some of the wider social determinants of health. The plan talks about access to Allied Health Professions (AHP) and wanting people to have more opportunity for direct access to a wider range of AHPs in the community, without the need to be referred by another health professional. However, there is no plan to achieve this or outcomes to measure this. Occupational therapists and AHPs are highly skilled in providing self-management support but we need to be positioned in the right areas to deliver. Again, we have excellent examples throughout Wales of occupational therapists actively targeting waiting list reduction and providing excellent treatment. These need to be upscaled and delivered across the country.

**Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**

Our members are fully aware of the pressure of waiting lists and the current crisis in patient flow and discharge that is affecting hospital capacity. RCOT have had several meetings with senior managers and there appears to be little awareness of the plan at operational level in terms of concrete actions or funding

**Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?**

No, it does not.

**Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?**

No, there is a lack of targets within the plan and measurable outcomes.

**Is it sufficiently clear which specialties will be prioritised/included in the targets?**

AHP and rehabilitation is mentioned in the plan but there are no clear details of how this will be prioritised. Cancer rehabilitation/prehabilitation is particularly time sensitive and there appears to be no priority in the report targeting this area

**Do you anticipate any variation across health boards in the achievement of the targets by specialty?**

There is variation throughout Wales currently and there is nothing in this plan that addresses this issue.

**Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?**

Our members report significant problems accessing the infrastructure that is already in place and there is no clear direction on how facilities and estate will be expanded.

**Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?**

**Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**

No, the plan doesn't provide anything new in staff workforce planning or how to increase staff numbers to meet demand.

**Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

We believe that for video conferencing software to be widely used in the health sector there needs to be funding, communication, and training with a clear plan to deliver the same being vital if we are to ensure that digital delivery becomes a reliable and trusted method of consultation.

**Contact**

For further information on this submission, please contact:

Dai Davies  
Royal College of Occupational Therapists

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 06**

**Ymateb gan: | Response from: Coleg Brenhinol Podiatreg | Royal College of Podiatry**

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The Royal College of Podiatry's written evidence to the Health and Social Care Committee on Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

The Royal College of Podiatry is the professional organisation and trade union for podiatrists in the UK. The College represents qualified, regulated podiatrists across the UK and supports them to deliver high-quality foot and lower limb care and to continue to develop their skills.

Podiatrists are highly skilled healthcare professionals trained to diagnose, treat, rehabilitate, and prevent complications of the foot and lower limb. They enable people to manage foot and ankle pain, skin conditions of the legs and feet, treat foot and leg infections and assess and manage lower limb neurological and circulatory disorders. Podiatrists are unique in working across conditions rather than a disease specific area.

A podiatrist's training and expertise extends across population groups to those who have multiple chronic long term conditions, which place a high burden upon NHS resources (diabetes, arthritis, obesity, and peripheral arterial disease). In addition to delivering wider public health messages in order to minimise isolation, promote physical activity, support weight loss strategies and healthy lifestyle choices, podiatrists keep people mobile, in work and active throughout their life course.

## 1. Introduction

1.1 We welcome the Committee's inquiry into the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists. Given the urgency of

the situation it is vital that there is scrutiny of this plan to ensure it can deliver better experiences for patients, saving limbs and lives.

1.2 There is much to welcome in the Welsh Government's commitments in the plan – for example, to ensure that more care and support is available from a wider range of local health care professionals to help people stay well and stay at home. However, there is a lack of detail about how this will be delivered and where accountability will lie. While the plan anticipates a significant uncovering of late presentations as we emerge from the pandemic, there is insufficient explanation as to how the NHS will meet these needs, which are likely to be more complex and require higher levels of intervention and therapeutic time.

1.3 The coronavirus pandemic and the impact of COVID-19 means that a significant number of people require access to specialist rehabilitation services, including podiatry. Podiatrists work across a variety of specialisms including diabetic foot ulceration, vascular disease, musculoskeletal management, diabetes care, falls prevention and dermatology. Following the COVID-19 outbreak, podiatrists working across all these settings in Wales will be integral to the four groups of people requiring rehabilitation support as set out by the four nations paper on rehabilitation post COVID-19.<sup>1</sup>

1.4 Our comments highlight the unique position of podiatry to alleviate the care burden on NHS services in Wales through a combination of prevention, early intervention and salvage procedures. If the NHS is to reduce the care backlog and prevent avoidable loss of limbs and lives, then podiatry must be at the heart of its efforts to do so. Podiatry also has a huge amount to offer within public health, including easing pain, increasing mobility, and improving physical and mental health. The Royal College of Podiatry is working to ensure that the critical role which the podiatry profession has to play in this agenda is understood and implemented at all levels.

## 2. Overall views

2.1 The Royal College of Podiatry believe that there is a lack of detail in the plan as to how a more resilient and sustainable health and social care system will be built for the long term. In particular, there is a lack of detail about how services will be shifted, so that greater weight can be given to working to prevent complications within community health services. As highlighted in the Auditor General's recent report, "using existing resources to best effect should be a key priority. This will mean doing things differently by improving existing processes and systems. It will also mean doing things different and rethinking how, where and from whom patients get the advice and treatment they need".<sup>2</sup> We believe that podiatrists have a key role in achieving this.

2.2 As the experts in lower limb health and disease, podiatrists have the requisite knowledge, skills and training to work as First Contact Practitioners (FCPs) in primary care. Podiatrists in FCP roles have the potential to improve patient outcomes, reduce activity limitation, prevent further declines in sedentary related health conditions, reduce hospital admissions and positively contribute to the national health economy.

2.3 Podiatrists are trained to work autonomously and as part of multidisciplinary teams to safely diagnose, risk assess and triage, and provide advice and initiate treatment for

complications of the foot and lower limb. Podiatrists working as FCPs have the skills and competence to:

- Request and use diagnostic imaging or other tests such as blood screening or urine analysis
- Refer to or liaise with other health professionals across care settings, ensuring the patient is seen by the right person, at the right time, in the right place
- Supply or administer a range of medicinal products, and independently prescribe medicines.

2.4 Podiatrists also have a significant role in the public health and prevention agenda specifically around falls prevention, dermatology (malignant melanoma detection), diabetes prevention, arrhythmia detection, cardiovascular risk reduction, medicines management, antibiotic stewardship and keeping people mobile and active.

2.5 Podiatrists fulfilling FCP roles will not only enhance the foot and lower limb health of patients but will also improve their overall health and wellbeing. People should be able to access podiatric diagnostics and first line treatment in primary care, so they are able to remain active, socially connected and in work. It is only by having podiatrists placed within primary care settings as FCPs that these multiple needs will be met.

### 3. Meeting people's needs

3.1 The Royal College of Podiatry believes there is insufficient detail in the plan to demonstrate how people's needs will be met. As an example, podiatrists play a significant role in diabetes foot care. 80% of toe, foot and leg amputations are preventable with the right preventative care, at the right time. There is significant concern that the drop in routine appointments over the past two years will lead to a record level of foot ulceration and lower limb amputations out of the pandemic.<sup>3</sup> Given that routine diabetic foot screening halved in 2021 and that 4.9 million people in the UK have diabetes, tens of thousands of people inevitably will be suffering from delayed diagnoses for diabetic foot conditions with many suffering potentially deadly consequences.<sup>4</sup> Estimates show that by 2025, 1.2 million people with diabetes in the UK will - if they are to remain ulcer and amputation free<sup>5</sup> - require regular podiatry appointments. Despite the potential scale of this problem, there is no reference to diabetes or to foot screening within the plan.

### 4. Leadership

4.1 We note that the only reference to leadership in the plan is to the establishment of the Diagnostics Board. We strongly agree with the Auditor General that "the national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose".<sup>6</sup> Much of the implementation of the plan will rely on the actions of individual Health Boards, and leadership within these bodies. Yet there is little within the plan to identify or support leadership of delivery, or to identify accountability for delivery.

## 5. Workforce

5.1 The Auditor General has highlighted that the national plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions.<sup>7</sup> It is shocking that of the £200m funding from Welsh Government in 2021-22 to tackle waiting lists in planned care only £146m could be allocated to health boards – with the Welsh NHS Confederation identifying the workforce as “the number one limiting factor for NHS capacity”.<sup>8</sup>

5.2 The Royal College of Podiatry is extremely concerned that not enough podiatrists are being trained in Wales to meet the future podiatric needs of the Welsh population. Within podiatry there is an ageing workforce. Over 55% of the podiatry workforce in Wales are aged 50+. This workforce is a lot older than for other Allied Health Professions. It is imperative for the sustainability of the profession that we have adequate numbers of podiatrists being trained to replace those who are retiring. In addition, the number of people living in Wales with long term conditions which can affect the feet and lower limbs, such as rheumatoid arthritis, vascular disease and diabetes is rising. It is vital that the podiatry workforce is of sufficient size to meet the podiatric needs of the population both now and in the future as demand for podiatric intervention increases.

5.3 We are therefore surprised that the plan makes no reference to the NHS Wales Bursary Scheme or the opportunity to explore alternative routes to qualification, such as the podiatry apprenticeship route which is already available in England.

## 6. Digital tools and data

6.1 Welsh Government’s plan acknowledges that during the pandemic Allied Health Professionals have adopted new digital ways of working to deliver the highest quality of care and improve health outcomes. There is no further reference to how these AHPs might be supported to continue to use these digital tools or how further innovation could occur. Given the importance of digital tools and data we believe that this is an oversight which fails to reflect the needs of those working in the NHS and could result in local variations in service delivery that does not provide equitable access for patients.

For further information, please contact:

Tess Saunders, Policy and Public Affairs Officer (Wales)

Royal College of Podiatry

June 2022

References

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<sup>1</sup> <https://gov.wales/sites/default/files/publications/2020-05/allied-health-professionals-role-in-rehabilitation-during-and-after-covid-19.pdf>, Accessed on 31/05/2020

<sup>2</sup> Audit Wales, 2022, Tackling the Planned Care Backlog in Wales. Available at: <https://www.audit.wales/publication/tackling-planned-care-backlog-wales> [Accessed 31/05/2022].

<sup>3</sup> Kennedy, K. and Donnelly, L., 2022. Drop in health checks during Covid puts diabetics 'at greater risk of amputation'. [online] The Telegraph. Available at: <https://www.telegraph.co.uk/news/2022/02/09/drop-health-checks-covidputs-diabetics-greater-risk-amputation/> [Accessed 15 March 2022].

<sup>4</sup> Donnelly, L & Taylor, R (2021) 'Quarter of diabetes cases missed over lockdown as obesity soars' [online] The Telegraph. Available at Quarter of diabetes cases missed over lockdown as obesity soars (telegraph.co.uk) [Accessed 15 March 2022].

<sup>5</sup> Royal College of Podiatry, 2021. Saks Report. London: Royal College of Podiatry, p.11. Available at: [Accessed 15 March 2022].

<sup>6</sup> Audit Wales, 2022, Tackling the Planned Care Backlog in Wales. Available at: <https://www.audit.wales/publication/tackling-planned-care-backlog-wales> [Accessed 31/05/2022].

<sup>7</sup> Audit Wales, 2022, Tackling the Planned Care Backlog in Wales. Available at: <https://www.audit.wales/publication/tackling-planned-care-backlog-wales> [Accessed 31/05/2022].

<sup>8</sup> <https://www.bbc.co.uk/news/uk-wales-61634380>. Accessed on 31.05.22.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 07

Ymateb gan: | Response from: Coleg Brenhinol y Therapyddion Lleferydd ac Iaith | Royal College of Speech and Language Therapists

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Senedd Cymru Health and Social Care Committee consultation on The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

### Executive summary

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the Welsh Government's Plan for transforming and modernising planned care and reducing waiting lists and the opportunity to provide written evidence as part of the Committee's inquiry on the same. Our response is based on discussions with our members and follows broadly the terms of reference.

### **Key points**

- We welcome the notion of 'waiting well' which pervades through the Plan. However, there will need to be a continued investment in sufficient resources into patient information and communication and an enhanced approach to communicating with patients while they wait to help them manage their condition and know what to do if their condition gets worse.
- It is imperative that the necessary detail is provided that will support health boards to ensure they have sufficient workforce capacity to deliver the Programme's ambitions. There should be collaborative working with relevant NHS bodies and involving professional bodies' expertise like the RCSLT to develop the workforce plan at local, regional, and national level.
- We know that in some cases technological innovations have been positive. However, this is not the solution in every situation. For this reason, we would like to emphasise that there

should be flexibility in meeting the Programmes targets around digital approaches so that the patient is seen in the most appropriate way for their condition. There is also likely to be variation across Wales, including by age of patient and access to reliable technology.

- The RSCSLT believes that for there to be real sustained improvements in digital delivery, there will be a need to ensure that physical estates are used as efficiently as possible.
- We welcome the prioritisation of children within the Plan. COVID-19 has had a huge impact on children's development with SLT services experiencing a significant backlog of demand with growing waiting lists. We have been encouraged by recent positive investment via the Child Development Fund and Flying Start Capital Funding. However, the RSCSLT believes it is crucial that the prioritisation of children's services continues to be supported with substantial and sustained investment to both manage the consequences of the pandemic in the short term but also in the long-term to mitigate against further negative outcomes caused by a lack of services.
- There is a need to be more sophisticated in regards waiting times targets so that the whole pathway is timely.
- The national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose.<sup>1</sup>
- The Programme should come with a clear finance strategy. This should include determining the longer-term capital investment that will be required, as well as processes to assure that revenue sources will be sufficient to finance long-term service transformation.

### **About the Royal College of Speech and Language Therapists**

1. RSCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RSCSLT has 17,500 members in the UK (650 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.
2. Speech and language therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/ or swallowing difficulties.

### **Meeting people's needs**

3. The RSCSLT is in agreement with the themes highlighted in the Programme as it demonstrates an understanding of the challenges faced by speech and language therapists as they deal with the scale of backlog, unmet needs and increased demand post Covid. We particularly welcome the notion of 'waiting well' which pervades through the Plan. This has been evidenced well in relation to children as SLT Services have experienced a significant backlog of demand, with growing waiting lists, and late referrals for children with a high level of need, hence the developments in the Welsh Government Talk with Me: Speech, Language and Communication (SLC) Delivery Plan<sup>2</sup>, has come at an opportune time, with a greater focus on better universal provision for children and families by promoting and supporting children's SLC needs via introduction of the Talk with Me campaign,<sup>3</sup> by strengthening information available to people on websites, the introduction of a toolkit and a number of health boards developing helplines.

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<sup>1</sup> <https://senedd.wales/media/3pjhracie/agr-ld15132-e.pdf>

<sup>2</sup> <https://gov.wales/talk-me-speech-language-and-communication-slc-delivery-plan>

<sup>3</sup> <https://gov.wales/talk-with-me>

4. However, the RCSLT would like to emphasise that building on existing mechanisms, given the numbers of patients waiting, NHS bodies will need to ensure that they are investing sufficient resources into patient information and communication. The Programme refers to the need for health boards to develop a communication strategy which is very welcomed, however there is a lack of detail in the Programme which would make it difficult to comment on its efficacy in relation to patient needs.
5. Further, Surveillance of patients whilst they are on the waiting list also needs to be carefully managed to minimise and ideally avoid them coming to harm as a result of long waits for treatment. To help achieve the action within the Programme of *seeking to identify and prioritise the clinical needs of those waiting and focus on those in greatest need*, performance measures need to have a greater focus on patients' clinical needs rather than simply how long they have been waiting.<sup>4</sup>

### **Workforce**

The RCSLT welcomes that the Programme is due to be underpinned by a 'coordinated and focused' workforce plan as we believe that a sustainable workforce is a crucial element for the success of the Plan. Further we are pleased to see reference to the importance of rehabilitation.

### **Recruitment and retention**

6. The RCSLT believes that the plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions. The Welsh Government should work with relevant NHS bodies and involving professional bodies' expertise like the RCSLT to develop the workforce plan at local, regional, and national level. The plan should be based on a robust assessment of current capacity gaps and realistic plans to fill them. Understanding the vacancy rate and subsequent recruitment need is difficult. NHS Wales does not collect this information which is thought to impact the quality of workforce planning.<sup>5</sup> The RCSLT also await details of how or where the funding discussed in the programme will be allocated.
7. In relation to SLT services, SLT teams are dealing with increasing numbers of people needing the service without a fundamental change in capacity, which may impact on the intervention offered. Our members report that ensuring a sustainable workforce to respond to growing pressures is of concern. There will need to be a consideration of the number of speech and language therapists trained and the support that is put in place e.g. opportunities for blended working and crucially interlinked with this, the consideration of SLT training in Wales as we believe we need to see an urgent step change in training places to meet future demand given our workforce profile. This is especially pressing given recent policy initiatives such as the Flying Start expansion, changes to mental capacity legislation to include speech and language therapists as approved mental capacity practitioners, the potential and actual demand due to the implementation of the Additional Learning Needs and Educational Tribunal (Wales) Act 2018, an increase in demand for SLT services in certain clinical areas such as Gender Services and potential new roles within youth justice.

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<sup>4</sup> <https://senedd.wales/media/3pjhracie/agr-ld15132-e.pdf>

<sup>5</sup> <https://www.wcpp.org.uk/wp-content/uploads/2021/12/Challenges-and-Priorities-for-Health-and-Social-Care-Wales-Briefing-Note-.pdf>

8. It is also important to note that not all SLTs work in the NHS, many work in schools, in community settings, in justice and in the independent sector. We are seeing increased demand for SLTs across these areas too, for example, in prisons and Youth Offending Teams, and as registered intermediaries for the Ministry of Justice. Not all new SLTs will enter the NHS so it is important to factor this in to planning.
9. Retention of existing staff is a further problem, partially due to poor wellbeing but we have also seen a number of staff take early retirement over the last two years. Combined with such recruitment issues, this means the health and social care sector are struggling to maintain their current staffing levels, let alone increase them. Some health boards have reported more younger speech and language therapists are leaving to join the private sector due to workload pressures and stress and there is a sense that it will be easy to return to the NHS at a later date, mitigating the risk of leaving. The RCSLT believes that there needs to be a greater focus on retention and the development of existing professionals. We wish to see far greater clarity on routes for AHP progression from support worker roles through to advanced practitioner and consultant roles. The development of advanced practitioners in particular presents significant opportunities for role development and service innovation for AHPs.<sup>6</sup>

### **Wellbeing**

10. The SLT workforce itself has not been immune to the impact of COVID-19 and the continual burden of the pandemic for now over 2 years has meant they continue to experience profound personal effects.<sup>7</sup> The pandemic has left a legacy of a tired workforce which fundamentally threatens the ability of the NHS to function. Interventions aimed to support the mental and emotional wellbeing of health and social care workers were reported during the pandemic, however the impact of these is not yet known.<sup>8</sup> The availability of funding also calls into question the sustainability of these initiatives. The Programme cites as a priority - *to engage the workforce as Welsh government plan the recovery and reset to and understand the long-term workforce capacity, development and support needed both to recuperate and rebuild for the future*. The RCSLT looks forward to further details to this important action.
11. We would also like to highlight the tendency for and the impact of mixed messaging from Welsh government and health boards. On one hand, the message is one of commending staff for their resilience and hard work and acknowledgement of being overstretched and exhausted, however on the other, there is strong messaging around working to clear the backlog and reduce waiting lists, being creative and utilising new ways of working. There is a mismatch between the two which is causing anxiousness and leading to high stress levels.

### **Multidisciplinary working**

12. COVID-19 patients are presenting in the community with a range of complex needs, requiring a multidisciplinary approach to care management and longer-term rehabilitation.

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<sup>6</sup> For further details, please see RCSLT Wales submission - <https://www.rcslt.org/wp-content/uploads/2021/12/RCSLT-Wales-response-to-the-HSC-Committee-inquiry-on-workforce-003.docx>

<sup>7</sup> Royal College of Speech and Language Therapists, 2021. Speech and language therapy services after COVID-19. RCSLT. URL <https://www.rcslt.org/get-involved/building-back-better-speech-and-language-therapy-services-after-covid-19/>

<sup>8</sup> (Swansea University, 2021)

Any national policies or strategies need to reflect both the rehabilitation needs of COVID-19 patients and the ongoing support of existing patients. The programme mentions *access to rehabilitation and recovery services as being essential..... and that Welsh government will build capacity through new ways of working and expansion and utilisation of the AHP workforce* and further the commitment in the Programme of *developing multidisciplinary 'teams around the patient'*. The RCLT fully supports these actions as we believe collaboration will be essential to the effective delivery of the plan. However, we have concerns *over the* lack of detail of how this will be achieved.

### **Digital services and data**

13. The SLT workforce has responded rapidly to changing circumstances which has included the adoption of new ways of working, including greater utilisation of technology and digital in-service delivery. For example, the SLT workforce quickly moved to using Attend Anywhere<sup>9</sup> and many services are offering a blended approach with a combination of video and face to face appointments. The RCLT notes that the Welsh Government plans to ensure that *35% of new appointments and 50% of follow up appointments are virtually delivered*. In relation to this our members have voiced concerns as in some cases the utilisation of technologies has been positive, however, this not the solution in every situation, digital poverty and a lack of digital literacy are factors. The adoption of technologies may also not be suitable for a particular condition a person has or the age of the person with a communication or swallowing need, at both ends of the age range. Consideration also needs to be given to the challenges presented around school based services and adult services where the majority of service continues to be hospital based. For these reasons there will need to be flexibility around the targets for virtual approaches.
14. The RCLT believes that for there to be real sustained improvements in digital delivery, there will be a need to ensure that physical estate are used as efficiently as possible, for example by maximising community and primary care premises to enable care close to home, maximising space in care homes and in other settings such as schools. The programme cites an investment into infrastructure and estates but there is no detail as to how this will be achieved. It will be important to ensure that patient outcomes and patient experience are considered alongside any gains from a productivity perspective.
15. We would also like to highlight that we believe the success of the plan will depend on investment in digital technology for example, electronic patient records which would support the outcome of waiting well. Also more sophisticated systems to support validating of waiting lists. Presently Therapy Manager systems do not distinguish between different types of waits. We welcome the recent positive response by Welsh government to the report on the Waiting times backlog inquiry regarding shared patient records and the plans to introduce a new digital interface to ensure data can be shared across organisational and system boundaries. We look forward to seeing details and timeframes for this single national health and care record.<sup>10</sup>

### **Children's services**

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<sup>9</sup> <https://digitalhealth.wales/tec-cymru/vc-service/i-am-clinician/what-nhs-wales-video-consulting-service>

<sup>10</sup>

Page <https://business.senedd.wales/documents/s125743/Response%20from%20Welsh%20Government%20to%20the%20report%20Waiting%20Well%20-%20the%20impact%20of%20the%20waiting%20times%20backlog.pdf>

16. The RCSLT particularly welcome the focus on children’s services within the plan as we know that COVID-19 has had a huge impact on children’s development. Many children and young people have not received the same level of speech and language therapy during the pandemic. The [RCSLT’s Build Back Better report](#) published in March 2021, found that during the first UK-wide lockdown, across the UK, 81% of children and young people who had been receiving speech and language therapy before the pandemic received less during lockdown and 62% did not receive any. A number of other factors have also contributed to an increased level of need in children and young people, resulting in increased pressures on children’s SLT services. In some cases, specialist input from speech and language therapists is required in order to meet the higher needs of these children. For example, children who did not receive the 2.5 year health visitor check during the early stages of the pandemic are now rising 4 and could have significantly delayed language development<sup>11</sup> and an increase in the number of children starting school with delayed language, because they have not benefited from the language-rich environment and opportunities for social interaction that are provided by early years settings. We welcome the investment via the Child Development Fund in recent years as a result of the Welsh government ‘Talk with Me’ plan<sup>12</sup> and Flying Start Capital Funding. However, the RCSLT would like to emphasise that there needs to be substantial and sustained investment in children’s services and where SLTs are part of multi-agency teams to both manage the consequences of the pandemic in the short term but also in the long-term to mitigate against further negative outcomes caused by a lack of services. Short term funding is not adequate often regarding successful recruitment.
17. SLT services need to work with stakeholders to ensure that needs are met closest to the children and by the right person in the right place. This may mean that the SLT is not the best person to address needs. There will be many examples where ensuring that the wider workforce, e.g. in childcare settings and educational settings, is able to support children appropriately in their own environments for learning and development. Additionally, SLTs work in multi-disciplinary and multi-agency teams where children and young people need this, such as, where they have selective mutism and where they are known to Youth Justice Services. This will depend on how services are structured and funded. We look forward to seeing the detail to the actions on the prioritisation of this important area before we can comment on the Programmes efficacy.

### **Targets and Timescales**

18. The national Plan sets out high level ambitions to reduce waiting times. It includes target milestones to reduce the number of people waiting for treatment but lacks detail especially in the sections entitled ‘what do we want to achieve?’ The Programme provides broad ideas as to the desired outcomes, but it will be difficult to measure the success of the plan without data and a clear framework for measuring these outcomes. For example, as mentioned above the RCSLT looks forward to the forthcoming workforce plan, which we hope will address the demand in SLT services and SLT workforce capacity issues.
19. The RCSLT has some concerns around the Welsh Government ambition of *increasing the speed of diagnostic testing and reporting to 14 weeks for therapy interventions by spring 2024*. Our members felt that this target may be too crude and that there was a need for

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<sup>11</sup> <https://www.rcslt.org/wp-content/uploads/2021/12/Supporting-children-and-young-people-with-communication-and-swallowing-needs-December-2021.pdf>

<sup>12</sup> <https://gov.wales/talk-me-speech-language-and-communication-slc-delivery-plan>

more sophistication in regards waiting times targets. For example, there would need to be a consideration of follow up appointments and how technology may support meeting the target. Fundamentally there is a need for the whole pathway to be timely.

### **Leadership and national direction**

20. The challenge of the planned care backlog is huge, and it will require the NHS to transform at a scale and pace not seen before. The national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose.<sup>13</sup> The RCSLT is concerned that the Programme implies that much of the detail of how processes will be put in place will be left to health boards, which leaves room for inconsistency and inequality through the system which needs to be improved, if not eradicated.
21. The RCSLT was disappointed to hear the recent announcement that the NHS executive will be set up as a hybrid model rather than its own organisation. We believe that this is a huge opportunity missed by Welsh government as more now than ever we believe there needs to be a clearer distinction between the strategic management of NHS Wales and the delivery of Welsh government priorities. Looking forward, we hope that the new NHS executive membership will be diverse to include AHP representation.
22. We would also like to highlight that the Welsh government should make sure that its national plan comes with a clear finance strategy. This should include determining the longer-term capital investment that will be required, as well as processes to assure that revenue sources will be sufficient to finance long-term service transformation.

### **Further information**

We hope this paper will be helpful in supporting the committee discussions around the Programme for planned care and reducing waiting lists. We would be happy to provide further information if this would be of benefit. Please see below our contact details.

**Naila Noori, External Affairs Officer (Wales), Royal College of Speech and Language Therapists**

### **Confirmation**

This response is submitted on behalf of The Royal College of Speech and Language Therapists in Wales. We confirm that we are happy for this response to be made public.

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<sup>13</sup> <https://senedd.wales/media/3pjhracie/agr-ld15132-e.pdf>

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 08

Ymateb gan: | Response from: Tenovus Cancer Care

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## **Tenovus Cancer Care Response to the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

This response is formed by Tenovus Cancer Care, using the views and feedback of staff across the organisation, including those that work directly with people affected by cancer.

It is also formed by the opinions of those on our All-Wales Cancer Community – a community of people affected by cancer who are part of a community through Tenovus Cancer Care. Part of their involvement in this community is to contribute to policy consultations and support Tenovus Cancer Care to raise awareness of issues that affect them directly.

Overall, Tenovus Cancer Care welcome the focus of Welsh Government's proposal for planned care. This is a much-needed strategy to help the NHS and its partners tackle the backlog of planned care appointments, which has impacted greatly on people affected by cancer. This plan gives an overarching view of the approach that will be taken. In order for it to be successful, detail on how this will be implemented and achieved should be outlined in the new Cancer Services Action Plan, which is due to be published in the Autumn. The publication of this action plan cannot be delayed as it is vital if lives are to be saved and we at Tenovus Cancer Care are keen to work with the Welsh Government and the Wales Cancer Network Board to develop this.

We understand that the COVID-19 pandemic had a significant impact on the NHS and that there is catching up to do to get services running as they were before 2020. In May 2020, the *British Journal of Cancer* found that over a thousand fewer new cases of three common cancers were diagnosed in Wales in 2020 compared to 2019, equivalent to a reduction of 15 percent.<sup>1</sup> Extensive alterations to healthcare routes to diagnosis, increases in later-stage diagnoses and an increase in the number of undiagnosed patients with new cancers have and will continue to occur as a result of the pandemic. We therefore understand that managing expectations of what can be achieved needs to be considered and communicated effectively to people across Wales. However, we also believe that there should be a strong focus on finding solutions to both quickly and effectively address the backlog of people waiting to be seen, whilst ensuring that those newly coming into the system are not delayed by this. Clear messaging is essential in reassuring people where they are in the system and what they can expect next.

Tenovus Cancer Care welcomes using innovation to tackle the backlog and establish more efficient ways of working going forwards. Whilst we feel that using approaches such as digital and telephone appointments is a positive step forwards, this could cause concern and confusion for some people accessing the NHS. Many people struggled with mixed messaging during the pandemic about whether they should come forward to get checked. The Welsh Government and NHS must clearly communicate with people that any approach will be assessed against people's needs and is not one size fits all, but something that will be used for the benefit of both the NHS and patient. People should continue to receive person-centred care that meets their needs, no matter how long they wait.

The suggestion of patient initiated follow up needs careful consideration. The COVID-19 pandemic has proved that in Wales, people tend to not want to bother their doctor and now that people know how much pressure the NHS is under post-pandemic, they may be hesitant to initiate such follow ups. Not everyone is equally comfortable to chase up these appointments. The suggestion of patient initiated follow ups also does not fit in with the theme of regular communication for people on

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<sup>1</sup> <https://phw.nhs.wales/news/study-finds-significant-reductions-in-cancer-diagnoses-in-wales-during-the-covid-19-pandemic/>

where they are on the referral pathway and next steps. The messaging needs to be clear.

### **Tenovus Cancer Care Recommends:**

Welsh Government should devise a campaign to communicate with the public what they are doing to address planned care in Wales. This should cover:

- How they will address the backlog for planned care
- Plans for ways of being more efficient such as by using digital technology, but not at the expense of receiving quality, person-centred care
- How they will ensure that new people coming through the NHS system are not delayed by addressing the backlog
- Highlighting that communication between the pathway and the person is one of Welsh Government's points in the care plan so that people should be better informed of where they are on a pathway and what the next steps are
- What people can do if they feel they are not getting the communication or care that they need, including information on the Community Health Councils and planned changes going forwards
- Supporting people to wait well by signposting to services that could support them whilst they are waiting for the next steps in the NHS referral pathway. This could include referral/signposting to other NHS services, community-based services or the third sector.

We also recommend that the Welsh Government should utilise and build upon the support it has from the Third Sector to significantly broaden its messaging reach. For example, by developing joint campaigns on promoting the signs and symptoms of cancer and on preventative behaviours such as the use of sun cream, stopping smoking, maintaining a healthy weight as well as promoting screening and encouraging people to attend appointments; highlighting that cancer is not necessarily a death sentence and that if caught early it is treatable.

We are one amongst many charities working in Wales who could support with the efforts to reduce the backlog of planned care through alleviating pressure on existing NHS services.

For example, Tenovus Cancer Care will seek to work with the Wales Cancer Network as it starts to review provision of Systemic Anti-Cancer Therapy (SACT) support as our Tenovus Cancer Care call back service is a vital lifeline to patients who have just started treatment and a well-regarded service by Clinicians.

In addition, Tenovus Cancer Care have a newly launched counselling service for people across Wales who are affected by cancer. There will be many people going through this who are anxious and would like to speak with someone about their

experiences, to gain some reassurance and support or simply for a listening ear. Mental health and wellbeing support will be critical for the recovery of the NHS in Wales and is particularly important for people who have been affected by cancer during the COVID-19 pandemic and the difficulties that they faced during this period.

Tenovus Cancer Care welcomes Welsh Government's plans to develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into referral pathways. Sing With Us' choirs are an initiative established in Wales by Tenovus Cancer Care to provide social support and improve mental wellbeing amongst those affected by cancer, whether patients, the bereaved, family member, carers or health care staff. Research has already demonstrated that these choirs can reduce depression and anxiety amongst participants and improve social support networks and quality of life. Whilst they do not cure disease, there is some evidence that participating in these activities can reduce levels of stress hormones and enhance immune activity.<sup>2</sup>

### **Moving care closer to home**

Moving care closer to home is a theme throughout and is an approach that Tenovus Cancer Care supports, but there are some concerns about the feasibility of achieving this.

Over a period of many years many local hospitals and health facilities have been closed across Wales, with diagnosis, treatment and care being centralised in bigger hospitals in towns and cities. General hospitals have become increasingly under threat; for example, the repeated threat of closure of Withybush Hospital in Pembrokeshire. Powys no longer has a general hospital, forcing people to travel long distances to access the care that they need. For some, this care is often far over the border into England. For example, people affected by cancer often travel from Powys to Cheltenham or Birmingham and back every day for cancer treatment because they are unable to access this closer to home. This places additional financial, physical and emotional stress on these people compared with those that don't have to travel so far to access the same care. People affected by cancer who are eligible to claim money back on travel and parking for hospital appointments have told Tenovus Cancer Care that they have not seen their travel claim amount increase during the cost of living increase in 2022; leaving those travelling by car to pick up the price difference. The NHS is free at the point of use, but the distance people must travel (and decide to mitigate for missing work and other arrangements etc.) means that this is a hidden cost for people.

Moving care closer to home not only provides immediate benefits for the local population, but it also provides the opportunity to gather data and information to

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<sup>2</sup> Tenovus Cancer Choirs Study: the Benefits of Singing for Those Affected by Cancer - Full Text View - ClinicalTrials.gov

assess the needs of that population. Tenovus Cancer Care recently undertook work to assess lung cancer and inequalities across Wales and were unable to include Powys in this assessment due to the lack of information available. This is because people must travel out of area to receive the care and support that they need. We are therefore not getting a clear and accurate picture of the health needs of the population to effectively design services and support people in this area and in other areas of Wales where access to healthcare is also difficult.

By enabling people to access care closer to home we will have a more accurate picture of the different inequalities that exist across the country and how we can address people's needs in a more targeted way.

Tenovus Cancer Care welcome using innovation in order to help bring care closer to home and one of our many offers is mobile cancer support in the community. Cancer patients in Wales can travel up to 150 miles for treatment. Every round trip to hospital can cost nearly £70 and if someone relies on public transport, these journeys can take many hours. Our mobile support units cut journey times to hospital, making receiving treatment less stressful and less expensive for cancer patients. Despite this, our offer of mobile support units is often not taken up by health boards. Tenovus Cancer Care encourage Welsh Government to support health boards to actively seek out and utilise such available support to ensure cost savings and benefits for people that need to access those services. This joint working is something that is desired by both sectors, as stated in the article published on NFP Research: 75% of healthcare professionals see the potential of developing closer working relationships with charities since the COVID-19 pandemic.<sup>3</sup>

### **Prioritisation of diagnostic services/Diagnosing cancer early**

Tenovus Cancer Care welcome the formation of a Diagnostics Board. However, for this to be meaningful, it should be for more than "input" as is outlined in this plan. In order to achieve outcomes for people across Wales, the Diagnostics Board should have a programme of work and evidence that this is aligned with other agendas, such as the National Endoscopy Programme.

The disruption caused to people affected by cancer during the pandemic<sup>4</sup> may mean an increase in emergency presentations of cancer. From our own service provision, we saw a large increase in the proportion of patients with DS1500 accessing our benefits advice service.

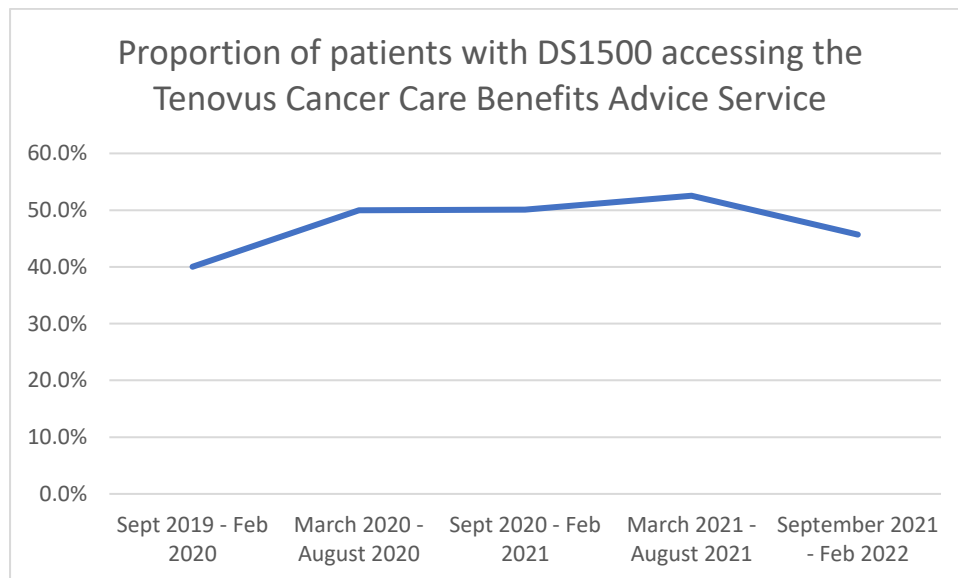
In the 6 months immediately prior to COVID-19, 40% of the patients accessing our benefits advice service were in possession of a DS1500 (indicating that they were unlikely to survive beyond the next 6 months). This increased to 50% in the first 6 months of the pandemic and peaked at 52.5% in the March – August 2021 period.

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<sup>3</sup> Charities during the pandemic: 5 observations from healthcare professionals | nfpResearch

<sup>4</sup> <https://www.macmillan.org.uk/get-involved/campaigns/we-make-change-happen/we-shape-policy/covid-19-impact-cancer-report.html>

This proportion has been decreasing since this peak but has yet to return to pre-pandemic levels.



Tenovus Cancer Care feel that it is important for the Welsh Government to take some responsibility for this, rather than laying the blame on “patients deciding not to come forward” as outlined in this action plan. People were told to ‘stay at home, protect the NHS’ and therefore it is inevitable that people would have stayed away and not sought advice.

Screening was paused for several months, which in the world of people affected by cancer is not a “very short time”. This will have had an impact on the number of people being diagnosed with cancer at a later stage.<sup>5</sup> It is unfair to suggest that these delays are down to patient behaviours. Later diagnosis in these circumstances is a result of the system not being able to carry out diagnostics such as endoscopies and having to instead put in place hurried solutions around the use of sensitive FIT tests (FIT in symptomatic) in primary care. Tenovus Cancer Care feel that Wales should use this hindsight as a learning opportunity to now quickly adopt new and emerging technologies, which are backed by evidence from pilots. These radical and innovative solutions are important to get the NHS in Wales to a stage where it can build back better than before, not just to how things were pre-pandemic. The health system was fragile before the pandemic and Wales must be better prepared for possible similar disruptions in the future.

At the end of the forward (page 1) the plan states that during COVID “more people than ever have been checked and treated for cancer” yet official figures show that the number of patients referred for cancer treatment in April 2020 dropped by more than 51% compared to the previous month and at this stage charities had already warned of a cancer “timebomb” due to Covid-19 disruption.<sup>6</sup> In a separate release,

<sup>5</sup> Millions in UK miss cancer screenings, tests and treatments due to Covid-19 | Cancer | The Guardian

<sup>6</sup> Coronavirus: Big drop in cancer referrals in Wales - BBC News

and as experienced by our own benefits team, Macmillan also stated that in 2021 the number of terminally ill people accessing end-of-life benefits has increased during the pandemic, with a warning of more evidence of a growing "cancer backlog"<sup>7</sup>.

In addition, about 3,500 cancer patients had been reported as "missing" from treatment services since the start of the coronavirus pandemic.<sup>8</sup> Tenovus Cancer Care was one of many cancer charities that called for a recovery plan for cancer services back then and Wales is still waiting for this to be drawn up.

The new cancer recovery services plan must be drawn up with the third sector as soon as possible if Wales is to make its approach to planned care a success.

### **Less Survivable Cancers**

Tenovus Cancer Care are pleased to see that cancer is being looked at as a whole disease area – that there is not a focus on high volume cancers at the expense of other cancers. Tenovus Cancer Care have been campaigning to raise awareness of the less survivable cancers, which are closely correlated with inequalities. The less-survivable cancers: Lung, liver, brain, oesophageal, pancreatic and stomach, have an average five-year survival rate of less than 20%. These six cancers account for over 69,000, and no less than 42% of the cancer deaths in the UK each year.<sup>9</sup>

Covid-19 has brought huge challenges to the health service, unlike anything we have previously experienced. This has had a serious and deeply concerning effect on people with cancer, with an alarming drop in cancer diagnoses and, in many places, backlogs building for vital diagnostic tests, treatments and surgery.<sup>10</sup>

For people who have one of these six less survivable cancers, early and fast diagnosis is critical to detecting the cancer at a stage when curative treatment is possible. However, these cancers often present with vague symptoms or are asymptomatic and are therefore hard to diagnose. As a result, three quarters of people with these cancers are diagnosed at a late stage and less than 16% of people diagnosed will survive five years or more. This was a serious problem before the pandemic. Covid-19 has now exacerbated this problem and we know that people will be diagnosed with cancer even later due to the disruption to health services.<sup>11</sup> Urgent referrals for possible cancer were 25% of the normal rate at the peak of the pandemic and, even now (date), are only at 75% the expected rate.<sup>12</sup>

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<sup>7</sup> Covid: Cancer worry as claims for end-of-life help rise in Wales - BBC News

<sup>8</sup> Covid: 3,500 'missing' from cancer services in Wales - BBC News

<sup>9</sup> <https://lesssurvivablecancers.org.uk/about-us-2/>

<sup>10</sup> <https://www.bbc.co.uk/news/uk-wales-54195580>

<sup>11</sup> <https://phw.nhs.wales/news/study-finds-significant-reductions-in-cancer-diagnoses-in-wales-during-the-covid-19-pandemic/>

<sup>12</sup> <https://www.pancreaticcancer.org.uk/wp-content/uploads/2021/04/APPG-report-The-Impact-of-Covid-19-on-Pancreatic-Cancer-Treatment-and-Care-in-England.pdf>

Lung cancer is the biggest cancer killer in Wales.<sup>13</sup> One-year survival rates lag slightly behind those for England and Northern Ireland. In addition, five-year relative survival for lung cancer in women in Wales is 10%, which is below the average for Europe (16%). In men the survival rate is 5%, which is also below the average for Europe (12%)<sup>14</sup>

In August 2021 there were around 8,600 urgent referrals for suspected cancer in Wales, 9% fewer than the same time the previous year whereas lung cancer referrals were down 26% in August compared to the same time in 2019. During the lockdown in April, there was a 72% drop in lung cancer referrals compared to the previous year.<sup>15</sup>

Smoking cigarettes is the single biggest risk factor for lung cancer. It is responsible for more than 70% of cases.<sup>16</sup>

Of the most common cancer types, lung cancer has the widest cancer death inequality, with a gradient of higher mortality in increasingly deprived areas.<sup>17</sup> The size of the differences in mortality between more and less deprived areas has increased over time.

Whilst we welcome action being taken to address lung cancer survival in Wales, we feel that there is already enough evidence to justify the need for lung health checks and targeted screening, which is currently being consulted upon by the UK Screening Committee. If they make recommendations for nations to develop and implement a Lung Screening Programme, we expect Wales to move at pace to put in place a comprehensive and optimal framework to deliver this new programme which will save many lives across Wales.

### **Tenovus Cancer Care Recommends:**

- The Welsh Government to support the implementation of the proposed Lung Health Check pilot in Cwm Taf Morgannwg and once the UK Screening Committee has made recommendations about a comprehensive lung cancer screening programme – for Welsh Government to work with its NHS partners to deliver this at pace. Rolling this intervention out will have a huge impact on cancer outcomes for people in Wales.

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<sup>13</sup> <https://www.uklcc.org.uk/sites/default/files/2021-12/An-overview-of-the-impact-and-priorities-for-lung-cancer-in-Wales.pdf>

<sup>14</sup> Lung cancer survival statistics | Cancer Research UK

<sup>15</sup> <https://news.cancerresearchuk.org/2020/11/20/covid-19-referral-drop-fears-for-lung-cancer-patients-in-wales/>

<sup>16</sup> [https://www.nhs.uk/conditions/lung-cancer/causes/#:~:text=develop%20the%20condition.-,Smoking,carcinogenic%20\(cancer%2Dproducing\).](https://www.nhs.uk/conditions/lung-cancer/causes/#:~:text=develop%20the%20condition.-,Smoking,carcinogenic%20(cancer%2Dproducing).)

<sup>17</sup> <https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/deprivation-gradient>

## **Leadership and Patient Experience**

The announcement regarding the establishment of the new NHS Executive has just been made<sup>18</sup>. This new function of NHS Wales will bring together senior teams within Welsh Government alongside key national NHS bodies which collectively should have the levers to drive improvement and put in place accountability structures for ongoing innovation and improvement in service delivery. Whilst the NHS in Wales has a difficult few years ahead to repair and rebuild, to be held to account on the care they deliver to their populations

Welsh Government itself has highlighted the role of the Executive as being essential in futureproofing the health system, stating that it's central purpose will be to support the NHS to deliver improved quality of care to people throughout Wales, resulting in better and more equitable outcomes, access and patient experience, reduced variation and improvements in population health<sup>19</sup>.

There is now an expectation that we will see a step change in performance, especially in relation to cancer waiting times and access to diagnostics and screening.

We know that there were thousands of people who went undiagnosed with cancer in 2020 and 2021. This strategy is vital in ensuring that no matter what the prognosis of these people is, they must receive the best possible treatment, care and support to enable them to navigate their pathways and achieve the best possible outcomes.

### **Please contact:**

Angie Contestabile

Policy and Public Affairs Manager, Tenovus Cancer Care

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<sup>18</sup> Written Statement: Update on setting up an NHS Executive for Wales (18 May 2022) | GOV.WALES

<sup>19</sup> *ibid*

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 09

Ymateb gan: | Response from: Y Groes Goch Brydeinig | British Red Cross

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## **British Red Cross written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

### **About the British Red Cross**

For the last 150 years the British Red Cross has been putting kindness into action. We have been helping people in Wales get the support they need, when they need it most. The British Red Cross has more than 19,600 volunteers in the UK and nearly 3,900 staff. We are part of the world's most wide-reaching humanitarian network, the International Red Cross and Red Crescent Movement, which has 17 million volunteers across 192 countries. The Red Cross has decades of experience supporting people with health and care needs when they return home from hospital, responding to UK emergencies from house fires to terror attacks, and supporting refugees and people seeking asylum.

The British Red Cross has a long history of working in partnership with the NHS, and we have seen a lot of good practice through our work. We have been supporting in various emergency departments across Wales since 2018, providing non-clinical, emotional support to patients. As a part of this service, we may also take people home and provide a short intervention which focuses on things like referrals to social services for care needs assessment, to support for home adaptations, to befriending type services. We recognise how hard NHS staff and volunteers are working, especially during the Covid-19 pandemic.

We welcome the opportunity to respond to the Senedd Health and Social Care Committee's request for written evidence on Welsh Government's plan for transforming and modernising planned care and reducing waiting lists (this will be referred to in the below submission as 'the plan'). This submission draws on our extensive experience as a service provider, working in partnership with the NHS and our growing research and evidence base into people's needs.

### **Summary**

The British Red Cross welcomes a plan to transform planned care services and reduce waiting times. The principles within the plan are common sense, however, it could benefit from a greater acknowledgement of the role of secondary preventative projects to ease pressures on planned care, and the role that the Voluntary and Community Sector (VCS) can provide in delivering such preventative services. There could also be greater emphasis on the role that the VCS can play in alleviating pressures on waiting times and the NHS workforce.

The plan also needs greater consideration of the wider context of life in Wales. In particular, the impact that the pandemic has had on existing health inequalities, but also the impact that other frameworks that Welsh Government are putting forward, such as the all-Wales framework for social prescribing will have on planned care. It is important that these areas are considered as avenues with which to alleviate pressures on the healthcare system.

The plan could also benefit from further detail on timescales and the planned use of digital tools.

### **Summary of recommendations**

The British Red Cross recommends that in ensuring the plan supports the delivery of sustainable health and social care services:

- The Welsh Government should recognise the VCS as a key health and social care partner within the plan, particularly in:

## Y Groes Goch Brydeinig

- Providing secondary preventative support in the community so that a person's health does not deteriorate.
- Its ability to play a wider role in alleviating workforce pressures.
- The Welsh Government and other funding bodies commit to sustainable, long term funding sources in order to continuously fund integrated care programmes and preventative projects within the community.
- The Welsh Government recognise that services to address general lower-level needs<sup>1</sup> contribute to wider prevention efforts and that Welsh Government reference this more strongly in the plan.
- The Welsh Government should give further consideration to the role that hospital discharge plays in supporting sustainable health and social care services and patient flow within the plan.
- The Welsh Government should strengthen the commitment to address health inequalities within the plan through further detail on the socio-economic drivers of health inequalities.
- The Welsh Government develop a Cross-Governmental plan to address health inequalities which should outline the action being taken across all government departments, setting out how success will be measured and evaluated through shared performance measures and outcomes for all public bodies in Wales.
- The Welsh Government prioritises reform of social care to deliver high quality, more accessible services, and develop a long-term settlement to enable sustainable social care funding.

In order to meet people's needs, we recommend that:

- The Welsh Government use the plan on transforming care as a mechanism to ensure people receive one-to-one, tailored support through social prescribing services which are available to them until they regain their independence and are confident in accessing health services.

In relation to the timescales of the plan, we recommend that:

- The Welsh Government provides further information on timescales to deliver the plan.

In order to adequately reduce workforce pressures, we recommend that:

- The Welsh Government utilise 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' and the robust workforce plan to address gaps in the workforce and should include how people who are not registered as health and social care staff can assist with alleviating workforce pressures.
- The Welsh Government ensures that there is a blended approach to deliver planned services, including text, phone, video, email and in-person, to best meet all patients' varying needs and allow services to work efficiently and address inequality of access to services.

In providing information on the digital tools Welsh Government will use, we recommend:

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<sup>1</sup> For the purposes of this consultation, lower-level needs refer to a situation where a person's condition is mild.

## Y Groes Goch Brydeinig

- The Welsh Government provides further detail on the ways in which digital tools and virtual wards, will be used to drive service delivery and efficiently manage waiting times while still ensuring those who are digitally excluded are supported.
- In developing the provision of digital tools, Welsh Government should make it clear in the plan that lead staff members that support information sharing in each health board should ensure that data sharing protocols and IT services support the flow of information between acute and community hospitals as well as key providers involved in discharge.

### Overall views

#### Balance between tackling backlog and building sustainable health and social care system:

##### *Prevention*

We welcome the plan's reference to prevention as a way of tackling the backlog and building a sustainable health and social care system. The British Red Cross supports the commitment to shift the health and care system towards prevention and welcomed 'A Healthier Wales' which put forward a whole system approach to health and social care and emphasises the importance of prevention and early intervention. However, in discussing prevention within the plan, it is important that the role of the VCS is referenced.

We recognise that prevention also encompasses preventing deterioration and reoccurrence (secondary prevention), as well as the primary prevention of ill-health. This is often achieved through practical and emotional support at home after the initial health crisis has hit, such as social prescribing and community connector support. Within our services, we have seen the range of positive impacts that social prescribing has in not only addressing loneliness and isolation, but in preventing escalation to other services. For example, our service evaluations<sup>2</sup> from our social prescribing in Pembrokeshire have highlighted the impact that social prescribing has on preventing reliance on health services. Our services help people to manage their own health as well as helping people to develop their own coping strategies. The VCS are also able to tap into its knowledge of community-based assets and support services to help to build people's personal resilience so that they can cope better with future crises and challenges they may face. Demand for health and social care provisions is likely to increase due to the impacts of Covid-19, so prevention, including secondary prevention, and early intervention will be vital.

However, in order to advance secondary preventative services, long-term funding is of fundamental importance. Our operational experience demonstrates that there is a lack of long-term funding provision. Short-term funding contracts lead to high staff turnover drawing focus to recruitment and away from quality of service for users. Therefore, we welcome the document's reference to investment in care closer to home and recommend that this includes funding a range of preventative services within the community. In addition, we also welcome the introduction of a five-year revenue investment fund in April 2022 and hope this best practice will be reflected in other funding streams.

From our operational insight, we are aware that tackling lower-level care needs<sup>3</sup> acts as a long-term preventative measure. However, in looking for opportunities to develop services, we

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<sup>2</sup> Evaluations from 2019/2020.

<sup>3</sup> Where a person's condition is mild.

have found that in practice there is a lack of investment in addressing low level care needs in Wales. In turn, this is likely to result in people accessing services once their need is higher, putting a strain on the health and social services system. In addition, it should be recognised that proper focus on preventative services is likely to be more cost effective as needs are addressed before they become more complex. While the plan references low complexity interventions, such as cataracts, these are very specific examples and may fail to acknowledge wider lower-level needs that can be treated in the community. Therefore, in order to achieve the ambitions of the Welsh Government's plan and help to create a sustainable health and social care system, the definition of prevention needs to account for a range of low-level needs to ensure adequate investment.

#### **The British Red Cross recommends that**

- **The Welsh Government should recognise the VCS as a key health and social care partner within the plan, particularly in providing secondary preventative support.**
- **The Welsh Government and other funding bodies commit to sustainable, long term funding sources in order to continuously fund integrated care programmes and preventative projects within the community.**
- **Welsh Government recognise that services to address general lower-level needs contribute to wider prevention efforts and that they reference this more strongly in the plan.**

#### *The role of hospital discharge*

Another element to ensuring that the plan supports the delivery of sustainable health and social care services is patient flow through hospital, including leaving hospital. Our operational experience in helping people home from hospital and research such as *Listening to what matters*<sup>4</sup> has emphasised the importance that leaving hospital at the right time with the right support in place has on maintaining independence. While the plan recognises the delays in discharge, its impact on bed availability and references the intention for discharge to become the default position post-treatment, the document does not acknowledge the role that effective and safe discharge has in helping patients to maintain independence and avoid readmittance. In addition, the plan does not acknowledge the community resources that will be needed to deliver on discharge as the default position. *Listening to what matters* highlights concerns raised by health and social care professionals that a seven-day service that exists in hospital does not exist in the community.<sup>5</sup> This links to the recommendations in the above section which reiterate the importance on investing in projects within the community.

#### **The British Red Cross recommends that**

- **The Welsh Government should give further consideration to the role that hospital discharge in supporting sustainable health and social care services within the plan.**

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<sup>4</sup> British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: [redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales](https://redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales)

<sup>5</sup> British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: [redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales](https://redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales)

*Addressing health inequalities*

In order to deliver equitable health and social care, it is important to acknowledge the health inequalities that existed before the pandemic and have been brought into sharp focus by Covid-19. The references to reducing health inequalities within the plan are welcome, however, the plan would benefit from further detail on how Welsh Government will address health inequalities. For example, there is no mention to the socio-economic drivers of poor health outcomes and little detail on the work of Public Health Wales, who have acknowledged influencing the wider determinants of health as one of their (PHW'S) strategic priorities. In addition, while there are intentions to explore access varying between specific characteristics or where a person lives, the proposed research to explore this further does not detail any time frames of analysis.

**Therefore, the commitment to address health inequalities within the plan should be strengthened through further detail on socio-economic drivers of health inequalities.**

It is important to note that health status alone does not contribute to inequalities in accessing quality healthcare, experiences of care and health outcomes. There are a wealth of other factors<sup>6</sup>, such as social connection, good work<sup>7</sup>, and transport. In fact, a growing body of research has found that wider determinants can have a greater influence on health than health care.<sup>8</sup> Without concerted efforts to address these inequalities, the long-term social and economic impact of Covid-19 risks further exacerbating them. This is likely to have an adverse impact on building a sustainable health and social care system. A Cross-Governmental plan is needed to address health inequalities which should be introduced to complement other plans for health and social care such as the plan we are consulting on.

**We support the joint call from over 30 organisations<sup>9</sup> in Wales for a Cross-Governmental plan to address health inequalities which should outline the action being taken across all government departments, setting out how success will be measured and evaluated through shared performance measures and outcomes for all public bodies in Wales.**

*Pressures on the social care system*

The plan highlights the significant pressures of the social care system, with increasing wages as one of the solutions. While this may be part of the solution, more needs to be done to ensure that we have a sustainable social care system. For example, our report *Listening to what matters*<sup>10</sup> highlighted wider concerns around the ability of the health and social care system to deliver new hospital discharge practices which focus on home first principles that aim to free up bed capacity. In particular, concerns were raised around the availability of social care in the community which was seen to be as the result of insufficient resource in the social care sector to meet demand.

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<sup>6</sup> Health Foundation (2018). 'What makes us healthy? An introduction to the social determinants of health. Retrieved from: [health.org.uk/publications/what-makes-us-healthy](https://www.health.org.uk/publications/what-makes-us-healthy)

<sup>7</sup> Work which provides stable employment, pays a living wage, and offers fair working conditions, work-life balance and career progression.

<sup>8</sup> Institute of Health Equity (2010). 'The Marmot Review: Fair Society, Healthy Lives.' Retrieved from: [instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review](https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review)

Future Generations Commissioner for Wales (2018). Advice to Welsh Government on taking account of the Well-being of Future Generations Act in the budget process. Retrieved from: [futuregenerations.wales/wp-content/uploads/2018/12/2018-11-29-FGC-Budget-Recommendations-ENG.pdf](https://www.futuregenerations.wales/wp-content/uploads/2018/12/2018-11-29-FGC-Budget-Recommendations-ENG.pdf)

<sup>9</sup> NHS Confederation (2021). 'Making the difference: tackling health inequalities in Wales.' Retrieved from: [nhsconfed.org/publications/making-difference-tackling-health-inequalities-wales](https://www.nhsconfed.org/publications/making-difference-tackling-health-inequalities-wales)

<sup>10</sup> British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: [redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales](https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales)

**Therefore, we recommend that Welsh Government prioritises reform of social care to deliver high quality, more accessible services, and develop a long-term settlement to enable sustainable social care funding.**

### **Meeting people's needs**

#### Ensuring that people who have needs come forward

As we adapt to Covid-19 longer-term, consideration should also be given to “hidden waiting lists”, which will be made up of people who have a health condition but have avoided seeking care or have not yet been referred for treatment because of the disruption caused by the pandemic. Therefore, it is positive that the plan acknowledges that individuals are yet to come forward and emphasises that communications will focus on encouraging individuals to seek help if they feel unwell.

In order to ensure that people who have health needs come forward, the role of social prescribing will be beneficial. In particular, insights from our research, *Fulfilling the promise*<sup>11</sup>, found that some of the loneliest people are completely isolated from not only other people but services too. Therefore, social prescribing is particularly important for people who are chronically lonely to help them to grow the confidence and independence they will need to reintegrate with services. Therefore, we welcome the references to social prescribing and the introduction of the all-Wales social prescribing framework in the plan.

**We recommend that in recognising the importance of social prescribing services, Welsh Government use the plan to ensure people receive one-to-one, tailored support which is available to them until they regain their independence and are confident in accessing health services.**

#### Supporting people who are waiting for treatment

A critical aspect of improving access to services is investment in patient-centred care and communication. Therefore, we welcome the plan's reference to targeted patient communication which also acknowledges the need to cater for those who are digitally excluded and those with language needs. These considerations are important to support people who typically fall through the gaps in the healthcare system. Given that these groups may fall through the gaps, communications should be monitored to ensure that these service users are receiving the communication that they need.

We believe patient-centred care involves taking a holistic approach to delivery of care, considering patients at all stages of their treatment journey and prioritising clear, two-way communication. This is important so that patients feel that they are listened to and seen, which in turn reduces the anxiety and stress associated with waiting.

As well as communications around waiting times, support to wait well is valuable.

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<sup>11</sup> British Red Cross, Coop and Kaleidoscope (2018). 'Fulfilling the promise: How social prescribing can most effectively tackle loneliness.' Retrieved from: [redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/fulfilling-the-promise-social-prescribing-and-loneliness.pdf](https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/fulfilling-the-promise-social-prescribing-and-loneliness.pdf)

**British Red Cross Waiting Well Service**

The British Red Cross has been working with the Welsh Government to pilot a waiting well support service in three health boards in Wales. The service will involve an offer of pastoral care in the individuals' own homes, initially on a face-to-face basis for up to six weeks, followed by a further period of telephone support for up to six weeks, dependent upon the assessed need of the individual referred.

The service will contribute to the continued well-being of the individual awaiting treatment from their local hospital(s) and will comprise of health and well-being checks and will alert the referrer should there be any change or deterioration. The service will continue to be available during the wait for admission and/or treatment and will link with and signpost to other services which may be able to provide any ongoing support either prior to or following treatment.

It is expected that having someone who is dedicated to the individuals' well-being as they continue to wait for treatment will lessen anxiety and assist in their day-to-day ability to function.

When referencing supporting people to wait well, Welsh Government should continue to acknowledge the role that the VCS can contribute to provide non-clinical support.

**Improving patient outcomes**

Ensuring those with the greatest need are treated in a timely way is important. Therefore, it is reassuring to see that this is one of the objectives of the plan.

In addition, from our operational experience, we know that listening to people's needs and what matters to them can make all the difference. Therefore, we welcome the plan's reference to what matters to the patient and its commitment to engage with people waiting for treatment to discuss whether the planned intervention is still suitable. It is also positive to see a £20 million a year investment committed to implement a values-based approach which focuses on improving outcomes that matter to patients.

It is important that commitments to improve patient experience are consistently implemented across Wales, with Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) referenced in the plan being key to measuring patient experience.

**Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system?**

The national direction within the plan to drive collaboration is missing a few elements. In particular, collaboration with a range of sectors, including the VCS will be key in increasing capacity within the health and social care system. Reference to multi-disciplinary teams and the increasing development of the voluntary reservist NHS health support team within the document is welcome. However, when discussing outsourcing, the document does not mention the VCS. We believe there is an opportunity to harness the power of the VCS to create better outcomes for people, while also relieving pressure on the NHS and improving patient flow within and between health and social care providers across Wales. We do this through our direct work in health settings, but also through our wider preventative work which we have touched on in the above sections.

## Y Groes Goch Brydeinig

**We recommend that when considering collaboration and collective effort to address waiting times, the Welsh Government acknowledges the work of the VCS within the plan.**

### **Are the targets and timescales realistic?**

While the plan states that it will take the whole of this Senedd term to deal with the backlog, with some key dates for ambitions, there is no clear timeline on when steps identified in the plan will take place.

**Therefore, we recommend that the Welsh Government provide further information on timescales within the plan.**

### **Anticipation of variation**

When planning to address needs, it is important to consider this at a local level, to ensure services are delivered in a way that serves the local population. However, while assessing need at a local level, it is fundamental that approaches are streamlined to a minimum standard to ensure that there is not a postcode lottery in tackling the backlog. Therefore, we welcome the document's reference to regional approaches but looking to eliminate variation and are eager to see how this is implemented in practice.

### **Financial resources**

It is difficult to assess whether there is sufficient funding to deliver the plan without further detail on the plan and its timescales. Without this, it is hard to ascertain if funds allocated for each year are suitable. However, as above, we would like to reiterate the importance of placing funding on long-term footing through long-term contracts, to ensure sustainability of services, as well as the importance of investment in community services.

### **Does the plan adequately address health and social care workforce pressures?**

While the plan references multi-disciplinary teams, there is no explicit reference to those who are not registered as health and social care staff, such as volunteers, which may aid capacity. This is also true of the 'Our Workforce Strategy for Health and Social Care' document which is mentioned in the plan.

**We recommend that Welsh Government utilise 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' and the robust workforce plan to address gaps in the workforce and should include how people who are not registered as health and social care staff can assist with alleviating workforce pressures.**

It is positive that the section on the current health infrastructure references that some services will be supported by the third sector.<sup>12</sup> However, when the plan discusses community services, this does not seem to include the VCS. As discussed above, we believe that the VCS can help to alleviate pressures in the health and social care space, including for the workforce itself, through the provision of additional capacity to complement the work by health and social care workers. For example, in our Emergency Department Well-being and Home Safe Services we provide emotional support to patients, alleviating pressures on medical staff who can focus on meeting patients' medical needs. We believe that this demonstrates the potential for the VCS to complement clinical treatment by providing pastoral support to people.

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<sup>12</sup> Note that we have referred to the third sector in this document as the VCS.

We recommend that the Welsh Government should invest in and recognise the voluntary and community sector to enable it to play a wider role in alleviating workforce pressures.

**Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

It is positive that the plan references a balance between digital tools and provision for those digitally excluded. In particular, we welcome reference to the use of a range of formats to communicate with patients. However, discussions around setting up virtual centres in rural communities as referenced on page 15 may fail to consider the digital exclusion that many people face in rural areas.<sup>13</sup> Other groups, such as older people, also experience digital exclusion. For instance, 52 per cent of people over 75 do not have broadband access and many older people do not use computers and smart phones.<sup>14</sup> It is important that people who are unable to use digital technology are not excluded from treatment options. In addition, it is important to note that many patients value face-to-face appointments and feel that remote consultations can lead to a lack of a personal or consistent relationship with their clinician.<sup>15</sup>

**Therefore, we recommend that the Welsh Government ensures that there is a blended approach to deliver planned services, including text, phone, video, email and in-person, to best meet all patients' needs and allow services to work efficiently and address inequality of access to services.**

The plan currently provides some detail on the ways in which digital tools will be used, such as for virtual appointments. However, further detail could be provided on how the planned care portal will operate. For example, work in Scotland has made clear that patients will be given a date range for their treatment while waiting.<sup>16</sup> It would be useful to understand if Wales will be following a similar model.

**Therefore, the Welsh Government should provide further detail on the ways in which digital tools and virtual wards, particularly the planned care portal, will be used to drive service delivery and efficiently manage waiting times while still ensuring those who are digitally excluded are supported.**

While the plan discusses digital tools for patients, there is little reference to how digital tools will be used to aid communication between various health and social care staff involved in a patient's care. In practice, we have found that communication between professionals could be improved. For example, in our report *Listening to what matters* some participants shared examples of situations where important medical information was not shared between

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<sup>13</sup> Honeyman M, Maguire D, Evans H and Davies A. Cardiff: Public Health Wales NHS Trust, (2020). 'Digital technology and health inequalities: a scoping review.' Retrieved from:

[phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/](http://phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/)

<sup>14</sup> Welsh Government, (2019) 'National Survey for Wales 2018-19: Internet use and digital skills.' Retrieved from: [gov.wales/sites/default/files/statistics-and-research/2019-09/internet-use-and-digital-skills-national-survey-wales-april-2018-march-2019-207.pdf](http://gov.wales/sites/default/files/statistics-and-research/2019-09/internet-use-and-digital-skills-national-survey-wales-april-2018-march-2019-207.pdf)

<sup>15</sup> The Patients Association, 2020, 'Pandemic Patient Experience: UK patient experience of health, care and other support during the COVID-19 pandemic.' Retrieved from: [patients-association.org.uk/Handlers/Download.ashx?IDMF=2fd4a424-8248-4743-a4d5-fe1d3f403d20](http://patients-association.org.uk/Handlers/Download.ashx?IDMF=2fd4a424-8248-4743-a4d5-fe1d3f403d20).

<sup>16</sup> The Times (11 May 2022). 'Website to show NHS delays.' Retrieved from: <https://www.thetimes.co.uk/article/website-to-show-nhs-delays-2d6m8fnl3>

## Y Groes Goch Brydeinig

hospitals.<sup>17</sup> This is an area where the use of technology could help to support effective communication of patient information.

**Therefore, in developing the provision of digital tools, we recommend that Welsh Government make it clear in the plan that lead staff members that support information sharing in each health board should ensure that data sharing protocols and IT services support the flow of information between acute and community hospitals as well as key providers involved in discharge.**

If you have any questions about any of the information contained in this document, or our further research, please contact Georgia Marks, Policy and Public Affairs Officer (Wales)

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<sup>17</sup> British Red Cross (2022). 'Listening to what matters: Placing people's needs at the centre of hospital discharge practice and policy in Wales. Retrieved from: [redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales](https://redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/placing-people-at-the-centre-of-hospital-discharge-in-wales)

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 10

Ymateb gan: | Response from: BMS Consultation

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## **BMS Consultation: Response to the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

### **Summary**

BMS is a leading global biopharmaceutical company focused on discovering, developing and delivering innovative medicines for patients with serious diseases in areas including oncology, haematology, immunology, cardiovascular and neuroscience. Our employees work every day to transform patients' lives through science.

In the UK, BMS employs approximately 1,000 people. Our ongoing partnerships with the NHS, academia and scientific institutes represent investment into the UK to the value of over £200 million. More than 750,000 NHS patients rely on our medicines to manage their disease, stay well and live their life to the full.

BMS recognises that the scope of the Welsh Government's plan goes beyond cancer, focusing on transforming and modernising planned care and reducing waiting lists. While this consultation response focuses on oncology, many of the recommendations are relevant for the wider health system. Furthermore, a national cancer strategy for Wales is expected later this year, and any recommendations in this consultation response - whilst important and relevant now for efforts to reduce waiting lists - should also be considered for any future cancer strategy.

### **Summary of recommendations:**

- The Welsh Government should issue further investment to meet the 10% increase in capacity required to effectively address the backlog.
- Any future national Welsh cancer strategy should set out how activity and funding is to be allocated according to tumour type, considering the needs of the population, and the expert views of clinicians and the patient community.
- BMS recommends that any future cancer strategy specifically sets out what it will do to achieve the changes set out within this plan across specific tumour types.
- A future cancer strategy should also include more robust actions to improve access to cancer treatment.
- The Welsh Government should ensure that health boards are able to confirm action within pre-defined timeframes to meet the commitments within this plan - ideally within less than three years for optimised cancer pathways.
- Over the next 10 years there should be renewed efforts and targeted investment to increase the levels of diagnosis, treatment, and positive outcomes for patients living with cancers with the greatest unmet need, including less-survivable cancers.
- Welsh health system partners should collaborate to improve data infrastructure and availability allowing for greater understanding of cancer types with the largest backlog in diagnostics and treatment along with the areas most affected.
- The Welsh Government should publish statistics for nursing vacancies to address staff shortages and improve workforce planning.
- Regional and local health leaders should tackle the barriers to adopting skill-mix approaches, whereby the roles and responsibilities of a team are designed around the needs of the patient.
- The Welsh health system should look to rapidly implement the community diagnostic hub model, coupled with increased focus on public awareness campaigns to encourage members of the public to come forward for tests.
- NHS Wales should drive greater public awareness on the potential role of genomic testing, alongside investment in clinical pathways to support wider rollout.
- A long-term strategy is needed that commits to funding molecular diagnostic services and ensures their place within an integrated health system.

- There should be immediate focus on increasing the number of patients diagnosed through screening programmes and urging patients to come forward through public awareness programmes. Public awareness campaigns must come with ring-fenced funding to ensure they are delivered continually.
- Any future national cancer strategy should clarify how funding for public awareness campaigns will be earmarked for specific tumour types. The cancer policy team should engage with the system to understand which cancers stand to benefit the most in terms of outcomes from public awareness campaigns.
- BMS wishes to see deeper and more sustained collaboration across different sectors, where organisations work together to implement and scale up best practice innovations, developed at a local level. The Wales Cancer Industry Forum represents an effective model for such collaboration.
- A bold systems leadership approach is required to tackle the scale of the diagnostic backlog, which has increased dramatically as a result of the pandemic. This approach draws on the collaborative and risk-friendly strategy taken by the US' 'Cancer Moonshot'.<sup>1</sup> The approach would encompass and help deliver on the attributes outlined in the Quality Statement for Cancer.<sup>2</sup>

### **Building a more resilient and sustainable health and social care system**

- BMS welcomes the plan's commitments to transform services to be sustainable for the longer term, including expanding services and capacity. It is important that the health system is prepared to meet the needs of patients now and in the future.
- New analysis from the Office of Health Economics (OHE), commissioned by BMS, demonstrates the scale of the COVID-induced backlog in cancer diagnosis and treatment in Wales. The analysis determines that the Welsh health service will need to exceed pre-pandemic diagnosis and treatment activity levels to clear the cancer backlog. It articulates how long it will take to tackle the backlog in each area based on the health service working at 2.5%, 5% and 10% above pre-pandemic activity.
- The serious limitations to cancer diagnosis and treatment data in Wales need to be addressed as a priority to ensure the cancer backlog is better understood.
- recognising that the scale of Wales's diagnostic capability challenges go beyond the bandwidth of any one organisation, a new approach requires deepened and sustained collaboration with patients, the NHS, the third sector, Government and industry to identify and implement solutions. BMS would welcome such partnerships across different sectors to implement and scale up best practice innovations developed at a local level.

### **The diagnostic backlog**

- Urgent cancer referrals fell significantly at the beginning of the COVID-19 pandemic. Referrals recovered to near pre-pandemic levels seven months later.<sup>3</sup>
- If Wales can increase the resources allocated to dealing with the cancer backlog by 10% compared to pre-pandemic levels, it will take 20 months to clear the cancer diagnostic backlog. An increase of only 2.5% to pre-pandemic activity will result in a 6.5 year wait to clear the backlog, and will hinder progress on the ambitions contained within this plan, particularly around reducing waiting times.
- Pathological data for cancer diagnosis is not readily available in Wales. This lack of data sharing prevents a complete understanding of the scale of the cancer backlog. Further, it results in an inability to determine which tumour types are the most prevalent across the health system in Wales.
- Laboratories are currently struggling to provide routine services, early detection and diagnosis of cancer and, in some cases tests, which should be provided under basic standards of care for cancer patients and specific tumour types. Laboratories focus

their budgets on immediate priorities and are therefore unable to plan for the adoption of newly approved tests.

- A long-term strategy is needed that commits to funding these relatively resource-poor services and ensure their place within an integrated health system. Given the substantial decreases in diagnosis levels between cancer types, resource should be split proportionally to cancer types that have been most affected by the pandemic. In the short to medium term, the Welsh health system should look to replicate the community diagnostic hub model implemented in England, coupled with increased focus on public awareness campaigns to encourage members of the public to come forward for tests.
- BMS therefore welcomes moves to join up diagnostic or treatment services regionally as set out in this plan. Particularly for cancers where delay to diagnosis and first treatment could drastically impact survival outcomes, approaches such as the one stop shop approach are necessary.
- BMS welcomes commitments in the plan to have rapid diagnostics to support early detection and diagnosis of cancer. BMS recommends that any future cancer strategy specifically sets out what it will do to achieve these changes within specific tumour types.

#### The treatment backlog

- Both initial cancer treatment and outpatient oncology referrals decreased during the onset of the pandemic.<sup>3</sup> In October 2020, both of these indicators recovered slightly but were still below pre-pandemic levels.
- Based on a 10% increase of pre-pandemic activity, it will take 10 months to clear the backlog in people waiting for their first cancer treatment. Even with a 10% increase, it will take 14.5 months to clear the backlog for outpatient referrals.
- Pathological data for treatment is unavailable and consequently it is difficult to fully understand the scale of the cancer treatment backlog.
- BMS is encouraged by the commitments within the plan to improve access to treatment. Efforts to improve uptake by separating lower acuity cancer pathways from emergency centres is also welcome. However, a future cancer strategy should include more robust actions to improve access to cancer treatment.
- Ensuring patients have access to treatment - particularly the most innovative therapies - is an important factor in improving outcomes. While England, and by virtue, Wales, ranks fourth for the availability of cancer medicines in Europe, nearly half of the cancer medicines approved by the European Medicines Agency (EMA) still have 'limited availability' in England and Wales.<sup>4</sup>

#### Ensuring that people who have health needs come forward and patient centred care

- Early detection and diagnosis of cancer is vital to improving a person's chances of survival as early-stage cancer is more responsive to treatment. In bowel cancer for example, five-year survival is over 90% if caught early, but less than 10% if diagnosed late.<sup>5</sup> However, in Wales, there were 20,000 fewer suspected cancer referrals between March and November 2020.<sup>6</sup>
- As Wales enters the interpandemic period it is expected that there will be an increased number of patients presenting with later stage cancer. As such, there should be immediate focus on increasing the number of patients diagnosed through screening programmes and urging patients to come forward through public awareness programmes. It will also be essential that patients are able to receive the latest and most innovative treatments. Public awareness campaigns must come with ring-fenced funding to ensure they are delivered continually.
- BMS is pleased that this plan recognises the need to communicate with the public to encourage those in need to come forward. In 2017, Cancer Research UK found that

22% of respondents were worried about wasting their doctor's time and 45% said they found it difficult to make an appointment.<sup>7</sup>

- Any future national cancer strategy should clarify how funding for public awareness campaigns will be earmarked for specific tumour types. The cancer policy team should engage with the system to understand which cancers stand to benefit the most in terms of outcomes from public awareness campaigns.
- BMS believes that cancer care should be holistic and person-centred. As such, BMS is encouraged by commitments in the plan to streamline pathways by minimising the number of hospital visits for patients, including personalised patient-initiated follow-up pathways for cancer.
- One way to bolster self-management and access to clinical support, if needed, is by ensuring that patients have consistent access to support from a named clinical nurse specialist (CNS), who often acts as a crucial first point of contact, enabling patients to receive a better experience across all aspects of care.<sup>8</sup> Providing CNSs with the capacity to undertake their role to the fullest potential, combined with a codified 'professional framework', could drive better outcomes for patients.<sup>8</sup>
- There should be greater focus on cancer types which have seen the greatest falls in diagnosis and treatment during the pandemic, as evidenced by the OHE data. Over the next 10 years, there should be renewed efforts and targeted investment to increase the levels of diagnosis, treatment, and positive outcomes for patients living with cancers with the greatest unmet need, including less-survivable cancers, typically defined as lung, pancreatic, liver, brain, oesophageal and stomach cancers. This should include a specific strategy which details funding allocation and targets for the expected increases in activity levels.

#### **Adequate funding to support improvements with clearly defined timelines**

- The Welsh Government should issue further investment to meet the 10% increase in capacity required to effectively address the backlog.
- The Welsh Government should also ensure that health boards are able to confirm that action on the commitments within this plan is able to commence within pre-defined timeframes, and ideally, in the case of optimised cancer pathways, within less than three years.
- Timelines for embedding optimal cancer pathways are not as explicit as they could be in the plan. BMS welcomes the ambition to streamline pathways, including personalised patient follow up. Similarly, commitments to streamline the diagnostic pathway and improve access to treatment are encouraging, but the Government should apply timelines and implementation metrics to ensure the success of these commitments. BMS would welcome the publication of an implementation plan to support the aspirations laid out within the plan.
- The plan is also not clear on who will be responsible for ensuring the continued use of amended treatment regimens developed during the pandemic, where it is clinically appropriate. This will likely require input from HCPs at different parts of the pathway and it is imperative that the health service is able to facilitate coordination in a consistent manner.
- BMS welcomes the funding announced for the implementation for the National Endoscopy programme, strengthening diagnostic and imaging services, implementation of the critical care plan and plans for improving cancer and stroke services. However, it is not clear how the £170m allocated to these aspirations, among others, will be allocated within each area. The Welsh Government should issue further investment to meet the 10% increase in capacity required to effectively address the backlog.



Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 11

Ymateb gan: | Response from: Cymorth Cancer Macmillan | Macmillan Cancer Support

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## **Health and Social Care Committee: Consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

### **Response from Macmillan Cancer Support**

Macmillan Cancer Support welcomes the Committee's decision to consider the Welsh Government's programme for transforming and modernising planned care in detail, and is grateful for the opportunity to provide written evidence on this matter.

We welcomed the publication of the plan in April as a positive step for recovering cancer and wider NHS services from the impact of the pandemic. The plan recognises the significant disruption from COVID-19 to the delivery of NHS services and the wider harms that many people in Wales have faced since March 2020.

It contains key ambitions relating to cancer services: notably enhancing the national target for Suspected Cancer Pathway performance from 75% to 80% by 2026 and increasing the speed of diagnostic testing and reporting to eight weeks by spring 2024.

We have set out some comments across several of the areas listed by the Committee, but for any further information please contact Tom Davies.

## **A new target for national Suspected Cancer Pathway performance**

One of the key ambitions of the programme to transform planned care is for the national target for Suspected Cancer Pathway performance to increase from 75% to 80% by 2026. This target relates to the percentage of people who start their first treatment for cancer within 62 days of cancer first being suspected.

We welcome the ambition to move from a 75% to 80% target. At the same time, we also have to recognise that performance will have to improve significantly for us to have any chance of meeting this goal. January 2022 saw a record low of just 53% of patients starting treatment on time, and the current 75% target has not been met once in the 34 months since the Suspected Cancer Pathway was introduced. We are also seeing historic levels of demand, with a record-high 15,300 suspected cancer pathways opened in March 2022 alone. For context, the average number of monthly referrals pre-pandemic was around 13,200.

We welcome the prioritisation of diagnostics in the planned care programme, particularly the commitment to establish a network of local community hubs and create a National Diagnostics Board. We also welcome the proposal to set up virtual centres in rural communities to allow people who are digitally excluded to make use of video consultations and other virtual approaches. All of these measures have the potential to help Wales reach the ambition of 80% Suspected Cancer Pathway by 2026, but we urgently need to see further detail and timescales for the delivery of these commitments.

## **Ensuring that people who have health needs come forward**

The biggest challenge for cancer services in the first year of the pandemic was the decline in people presenting at primary care services with potential symptoms, leading to the worrying backlog of missed cancer diagnoses. Therefore, the fact that cancer referrals are now consistently at or above pre-pandemic levels is very encouraging.

However, it is worrying to hear the Welsh Government report in the programme document that more cancer patients are now presenting with advanced cancers. This is something we have observed as well, through a 20% rise in DS1500 applications being reported by our welfare benefits advice teams in Wales (applications to the Department for Work and Pensions for people with fewer than six months to unlock or expedite access to welfare support).

We have said previously that the Welsh Government's 'Keep Wales Safe'/'Diogelu Cymru' campaign should have had a much stronger focus on urging those with potential cancer symptoms to seek help from their GP. Part of this campaign covered information about

accessing NHS services in Wales, but this focused primarily on the appropriate use of accident and emergency units, the Welsh Ambulance Service, primary care and other services. What was needed in addition to this was a strong push from the Welsh Government to reassure people that primary care services wanted to hear from them with any potential cancer symptoms.

The planned care programme states that the Welsh Government will continue to promote key messages about cancer symptoms and the importance of people presenting at primary care promptly, which is welcome. We were also pleased to see the Welsh Government respond positively to Recommendation 3 of the Committee's *Waiting Well* report that the Minister for Health and Social Services should work with NHS Wales and the third sector to deliver a national campaign within the next 12 months on cancer symptoms awareness. We look forward to seeing the proposals for this awareness campaign as soon as possible.

### **Improving patient outcomes and their experience of NHS services**

We welcome the focus within the planned care programme on better information and support for people waiting for diagnosis or treatment. It is positive to see the Welsh Government reference cancer pathways specifically and the fact they need to remain person-centred, with comprehensive information, support and holistic care for people throughout their cancer journey.

For those waiting for treatment to start, clear communication from health boards amidst potential disruption from COVID is crucial. If extreme pressures do result in disruption to cancer treatments, it is absolutely imperative that anyone whose treatment is affected is actively communicated with and monitored by health boards. In such circumstances, health boards should also be working across regional footprints where appropriate to ensure treatment can be rearranged as soon as possible.

The programme states that NHS organisations' websites and correspondence to patients should have clear structures signposting to appropriate support from third sector organisations. We would be keen to see further details on what this would look like as we know that, within cancer services, signposting to information and support can be inconsistent across Wales. For instance, we know from the 2016 Wales Cancer Patient Experience Survey that only 48% of people felt they had been given adequate signposting and information about financial help and benefits following their diagnosis.<sup>1</sup>

It is positive that the programme acknowledges the need for prehabilitation for those due to have surgery, but timely prehabilitation can also have benefits for patients who are due to receive chemotherapy, radiotherapy, and other non-surgical treatments.

## Health inequalities

Even before the pandemic there was a persistent gap between the least and most deprived areas of Wales in cancer survival. Looking at the most recent five-year survival rates published by the Welsh Cancer Intelligence and Surveillance Unit, for some cancers – such as colorectal – the survival gap between the least and most deprived parts of Wales is really significant.<sup>ii</sup> For other tumour sites such as breast and lung, the deprivation gap is smaller but has widened in recent years, which is of serious concern.

We welcome the Welsh Government's commitment to reduce health inequalities within the planned care backlog, and the recognition that these inequalities existed before the pandemic but in some cases have also been exacerbated by it. What is missing from the programme at this point is further detail on how the Welsh Government plans to identify and address these inequalities.

## Addressing workforce pressures

The health and care workforce remains the largest factor when considering how we can both tackle the waiting list backlog and support those people who have been waiting for diagnosis or treatment. Even before the pandemic this was a significant issue, with notable gaps in the diagnostic workforce in Wales as well as in the specialist cancer nurse workforce. The pandemic has only exacerbated these pressures.

Macmillan estimates that by 2030, we will need an additional 166 specialist cancer nurses in Wales (an increase of around 80%) in order to keep up with increasing cancer incidence.<sup>iii</sup> Ensuring that we have enough specialist cancer nurses will be crucial in achieving the Welsh Government's aims for high-quality person-centred care for everyone living with cancer in Wales.

It will also be important for the Welsh Government to identify those tumour sites where there are comparatively few specialist cancer nurses in Wales. For instance, our cancer workforce census published in 2018 highlighted that 74% of breast and 50% of gynaecology specialist cancer nurses were over the age of 50, which means they are often within 10 years of retirement.<sup>iv</sup> We also know the provision of secondary breast cancer clinical nurse specialists is a particular issue.

We welcome the recognition from the Welsh Government within the planned care programme that having a sustainable workforce in place will be key to tackling the planned care backlog, but also that this will not be enough to clear the planned care backlog. We would like to see further detail about plans for the Workforce Delivery Plan for Wales that

is mentioned within the programme, as the document does not go into any detail on what this might look like, who would develop this, or any timescales.

## References

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- <sup>i</sup> Wales Cancer Patient Experience Survey 2016, Welsh Government, Macmillan Cancer Support, July 2017. Available at: <https://gov.wales/sites/default/files/publications/2019-01/wales-cancer-patient-experience-survey-2016.pdf>
- <sup>ii</sup> Cancer Survival in Wales, 2002-2018. Welsh Cancer Intelligence and Surveillance Unit. Available at: <https://phw.nhs.wales/services-and-teams/welsh-cancer-intelligence-and-surveillance-unit-wcisu/cancer-survival-in-wales-2002-2018/>
- <sup>iii</sup> Cancer nursing on the line: why we need urgent investment across the UK, Macmillan Cancer Support, September 2021. Available at: <https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/4323-10061/cancer-nursing-on-the-line-why-we-need-urgent-investment-in-the-uk>
- <sup>iv</sup> Cancer workforce in Wales: A census of cancer, palliative and chemotherapy specialist nurses and support workers in Wales in 2017, Macmillan Cancer Support, 2018. Available at: [https://www.macmillan.org.uk/images/cancer-workforce-in-wales-census-of-cancer-palliative-and-chemotherapy-speciality-nurses-and-support-workers-2017\\_tcm9-326409.pdf](https://www.macmillan.org.uk/images/cancer-workforce-in-wales-census-of-cancer-palliative-and-chemotherapy-speciality-nurses-and-support-workers-2017_tcm9-326409.pdf)

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 12

Ymateb gan: | Response from: Age Cymru

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## **Consultation response**

### **Plan for transforming and modernising planned care and reducing waiting lists**

#### **For the Senedd's Health and social Care Committee**

**June 2022**

#### **Introduction**

Age Cymru welcomes the opportunity to provide further information on modernising planned care and reducing waiting times. As we have previously advised on these issues, older people are predominantly those most affected by delays in this area.

We are very pleased to see that the plan for transforming and modernising care includes many developments that will over time help older people's health and wellbeing improve.

In our most recent annual older people's survey<sup>1</sup> we saw a reduction in levels of satisfaction with health care services. Overall, 63% of people aged 50 or over had a negative experience of access to health care services. Within this, 73% had a negative experience of access to treatment and ongoing health checks, and 70% had a negative experience of both dental and GP access. Higher satisfaction rates were seen in access to eye care. For eye care this included usual sight checks as well as treatment services. In almost all areas satisfaction had gone down over previous surveys. The increase in delays will have undoubtedly contributed to reductions in satisfaction.

#### **Addressing backlogs**

The plan is ambitious in scope and includes some time scales for pandemic and waiting list recovery. It does set out well what needs to happen to address recovery, but little is included on exactly how change will be achieved. As a result, it is difficult to say whether this will address backlogs and reduce waiting lists to lower than pre-pandemic levels.

We welcome the split between planned care and emergency care as this will assist with maintaining treatment when otherwise this could reduce as a result of emergency pressures.

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<sup>1</sup> Due for publication later in June 2022

We appreciate the efforts that have been put into developing timelines within the plan, but further work is needed. We have some concerns that the target times for reducing waiting times simply refer to 'most specialties.' Few time frames are included in the plan on when milestones will be reached. The plan includes that these will be developed for sub specialities but it would be helpful to see how these are developed.

We know that some specialisms through the nature of the conditions have been harder hit with delays. There is a risk through this that if specific targets are not set, it could skew overall data and not reflect the differences in various specialisms. Different conditions have different impacts on people in different circumstances, so it would be helpful to see more granular data with which to estimate overall general wellbeing recovery which will help inform the positive impact of the plan.

In our recent survey more people responded to the questions on health care than in previous surveys. They told us of long delays with treatment, surgery and ongoing care than in any previous surveys. One respondent to our most recent survey told us of their reduced physical health whilst waiting for orthopaedic surgery,

“Limited opportunities for exercise or social engagement, combined with an increased workload. [...] I have been at Week 27 of a 55-week waiting list to see an orthopaedic consultant for 3 years, with no proactive contact from the local health board.”

A lack of clarity on this also means that planning for wider care and support around treatment itself such as prehabilitation, rehabilitation and social prescribing services is made more difficult. Without further breakdown it is difficult to see distance travelled and which areas require increased attention.

The plan focusses on prioritising those with a higher clinical need and states that regard will be given to the impact of delays for different conditions. We would hope that the impact on carers and wider families is considered. Improvements in information sharing between health and social care is needed to support appropriate decision making.

### **A further focus is needed on national campaigns**

The plan refers to improved communication before people access care services and has a specific focus on a national campaign to raise awareness of cancer symptoms as a means of getting people to come forward earlier. Such a focus is vital, given the difficulties over the pandemic of people waiting for diagnoses within target times. The plan also includes the need targeted communications to address health inequalities.

We would like to see other national campaigns developed further that focus on other conditions. In particular, we know that the effects of many musculoskeletal (MSK) conditions can be slowed down and helped through early diagnosis and advice on exercise, diet and lifestyle. Similarly, some effects of eye conditions can be helped with earlier advice and treatment. Given the huge backlogs in elective surgery for MSK conditions and eye conditions we believe such a targeted campaign is vital to

help older people earlier with these issues and reduce the need for high level interventions from health and social care.

For such campaign work it will be important to consider how information will be cascaded to be of greatest effect, and how people who are not digitally enabled are reached. The plan includes reference to building upon existing work of charities such as Age Cymru and we are keen to help in this area.

As changes in how services are delivered are planned, a communication plan around this needs to be carefully considered to prevent confusion for the public that explains why change is needed, what will be different and how changes will help people get the health care they need earlier. Ideally this should not be a 'one off' as changes may happen at different times in different regions according to each's priorities, and so an ongoing campaign is needed.

### **Improving patient experience**

The plan includes a focus on improved patient experience and this is most welcome. Older people have told us of the difficulties they have in accessing health care, of poor and non-existent communications from health and difficulties in transfer of appropriate information from one service to another within the NHS.

Increased focus is needed on how those living with dementia will be better supported through care pathways. We know that people living with dementia tend to have longer hospital stays than those who do not, and providing the right care following discharge can be difficult. We would like to see further detail included on how their needs can be better addressed either through hospital at home services where this is possible.

We welcome the additional focus in the plan on supporting people to wait well. The effects of delays will take time to reduce, but providing support whilst people wait will improve many people's situations. As with other areas further detail on how this is provided would be helpful. It is important in developing these support services that how people that are digitally excluded may have parity of service with those that are online and able to use apps, have zoom meetings with health professionals. People's communication needs vary so it is important that digital cost saving in providing more support to more people does not come at the cost of those that are digitally excluded.

The plan details how See-On-Symptom (SOS) and Patient Initiated Follow-Up (PIFU) as an alternative to face-to-face follow-ups will be rolled out as a priority for outpatients services. We understand that there is a need to ensure that less 'no-show' appointment time is lost and this can be an area where time savings are made. However, the plan would benefit on further detail on which conditions SOS and PIFU will be used for in order to consider whether this will be a worse experience for older people. We are concerned that there are groups of people who will struggle to initiate follow up themselves and so will lose access to the care they need. For example, in this year's annual survey one carer told us:

'I have had to help my father access essential care for various physical issues as they arose. I haven't got the energy to go through it all again to get appointments for menopause and mental health for myself'

This is from one of many people who told us of how burned out they are through providing unpaid care. It is vital that any such change is carefully managed takes into account the range of patient circumstances and an assessment of how such groups of people can be supported to access the ongoing care they need.

### **Care closer to home and patient transport needs**

We welcome the focus on care closer to home for conditions requiring repeated and ongoing health appointments. Older people have told us of issues with long distances to travel for treatment through the pandemic when services moved around in response to pandemic pressures. Providing care closer to home will benefit those in need of care, their carers and also wider support networks who are often called on to help with transport.

One respondent to our most recent annual survey said

“Had to cancel a hospital appointment because I couldn't get there in time using public transport. The appointment was at St Joseph's in Newport I live in Rhymney. Hopefully a new appointment will be made nearer home.”

We welcome recommendation 9 of the Waiting Well report that calls for the Health Minister to set out actions taken by health boards to find suitable venues for pain management, physiotherapy and occupational therapy both in hospitals and community settings. Such actions need to involve those needing care in their development to ensure that such venues are able to meet patient needs. Such venues can also assist with cascading health promotion and other campaign information. Linked to this, those needing these services are more likely to be experiencing reductions in emotional wellbeing. It would be highly beneficial to have information and advice available in these settings on opportunities for improving wellbeing.

Providing care closer to home can also help improve community cohesion and wellbeing. A recent Wales Centre for Public Policy report focusses on the importance of a good infrastructure in the population's wellbeing<sup>2</sup> so moving services closer to home will help in this regard.

More needs to be done to look transport options for health appointments. Whilst health board's responsibility lies mainly in service recovery, improving transport options will greatly improve patient experience and reduce missed appointments. Transport needs should be considered as part of regional board planning

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<sup>2</sup> Wales Centre for Public Policy Infrastructure and Long Term Wellbeing April 22 accessed 7/6/22 at <https://www.wcpp.org.uk/publication/infrastructure-and-longterm-wellbeing/>

considerations. Older people are less likely to have a car or be able to drive so transport issues disproportionately affect them. Providing care close to home will help, but there are long standing issues with public transport meaning independent travel is incredibly difficult for some older people. Further consideration is needed on how community transport can be provided. This is of particular importance for more rural areas but does affect all of Wales.

For services that are usually a 'one off,' such as hip replacement, we recognise the need for these to be centralised in centres of excellence in order to increase the volume of treatment and reduce waiting lists and also provide better clinical outcomes for people. We feel the plan needs an additional focus on how transport to services further from home are resourced, who provides them and how they can be accessed. Such developments should involve older people from the outset to both ensure they meet the needs of patients and also help prevent valuable resources being focussed on the wrong areas.

Regional partnership boards should consider this area of need as part of transformation fund projects.

### **Leadership and oversight**

The plan sets out well what needs to happen for planned care recovery, but there appears to be a gap in terms of national scrutiny, and what intervention will happen if targets for improvement are not met. It would be helpful to have a national hub to oversee change and support health boards through this.

The plan includes that health boards will develop more detail on targets for recovery and it would be helpful to see how they will develop these. For example, will there be national discussions across health boards to ensure that targets are reasonable and proportionate? Will target setting include international research evidence on improvements in planned care? National oversight is needed in order for this to be a useful and effective exercise. A procedure is needed to detail what would happen in the event that health boards fall behind in reducing delays and who will oversee improvements.

Discussions with health professionals indicate that more could be done to share good practice and the enactment of this plan can provide a good opportunity for health boards and services to share their learning on not only what works, but what they have tried that does not work in order to make the best use of the additional resources provided for planned care recovery.

### **Improved use of digital technology and shared communication between health and social care**

We welcome recommendation 19 of the waiting well report on improving connections between health and social care technologies as this is vital to ensuring all professionals involved in the care of a person have access to the right information

with which to provide the right response. Older people have told us of issues where their records have not been transferred from one health service to another and the difficulties this has caused.

Age Cymru have recently looked into delays in access to social care support.<sup>3</sup> Our work found issues of inappropriate discharge of vulnerable patients where discussions did not take place between health and social care. Older people have told us of circumstances where discharge happened without the right support in place which then led to emergency admissions.

Carers have told us of difficulties in finding out information on their loved ones, even in cases where a power of attorney was in place and how loved ones have been discharged to care homes a very long way from home without them knowing this was happening. Social care is becoming better at identifying carers and these records need to be available to health colleagues.

It is vital that social care and health records are able to speak to each other and that systems are in place for shared records to stop such cases from happening and reduce time wasted trying to get hold of information that should be easily available to professionals involved.

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<sup>3</sup> This report is currently being finalised and will be published shortly.

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**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 13**

**Ymateb gan: | Response from: Y Gymdeithas Feddygol Brydeinig Cymru |  
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# BMA

Cymru Wales

**Russell George MS**  
Chair, Health and Social Care Committee  
Senedd Cymru  
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10<sup>th</sup> June 2022

## Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

**Dear Russell**

Many thanks for your letter inviting BMA Cymru Wales to provide written evidence on Welsh Government's recently published plan for transforming and modernising planned care and reducing waiting lists, commonly known as the 'planned care recovery plan'.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

### Introduction

We welcome the opportunity to relay the views of our members regarding the planned care recovery plan. Firstly, it should be noted that we did have the opportunity to provide Welsh Government with comment on a draft iteration of the document. This stems from our comparatively constructive relationship with Welsh Government, and the ongoing commitment to social partnership working.

Our concerns raised at the time related to the absence of any reference to the role of primary care in the initial draft; however, the published document does pay reference to the role of general practice in this whole system challenge.

Our response below is arranged according to the Committee's outlined areas of focus in Annex 1 of your letter. Whilst we have not directly addressed each individual question, our comments and observations relate to the general theme under consideration. In responding, we have

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proposed a number of recommendations which they Committee may wish to consider. While these are detailed throughout, additionally we provide these for you in summary at the end of this document.

### Overall views

1. *Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.*
2. *Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?*

The strongest immediate piece of feedback expressed by our members on receipt of the published document was that the content was extremely 'high level' and lacking in specific and meaningful actions to address the routine care backlog.

While we agree with and endorse the ambitions outlined early on in the document, Welsh Government will need to translate the transformational and aspirational aims into tangible system change.

#### **Recommendation 1: Welsh Government should translate their aspirational Plan into real system change**

BMA Cymru Wales is already represented on many of the boards and groups that will be tasked with formulating actions from the plan (e.g., national clinical pathway development, the national planned care board, etc), however clinical input must be a key part of developing these plans. Given the ultimate reliance on existing personnel to deliver these changes it is vital that we consider wellbeing, morale as well as ensuring appropriate terms and conditions.

#### **Recommendation 2: Welsh Government should listen to frontline healthcare staff when developing their plans**

It is concerning that we hear from members about general lack of engagement locally with the clinical body about how the backlog will be tackled, and how the ever-increasing demand can be managed. These conversations must commence as soon as possible if any element of this plan is to be realised and should include clarity and specific details on workforce planning requirements.

#### **Recommendation 3: Welsh Government should start conversations with frontline staff as soon as possible**

Whilst the plan describes how *more* can be done and achieved by NHS Wales, we can not see how this can be done without either rationing treatment, which in turn creates further waiting list backlogs, or by significantly increasing the numbers of staff across NHS Wales.

### Meeting people's needs

3. *Whether the plan includes sufficient focus on:*
  - a. *Ensuring that people who have health needs come forward;*
  - b. *Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;*

- c. *Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;*
- d. *Improving patient outcomes and their experience of NHS services?*

Recurrent themes featuring throughout the plan include better communication, increased transparency of information and support for those waiting for treatment.

In particular, the promotion of self-care and maintaining wellbeing for those awaiting treatment is repeatedly referenced. This includes the launch of a new national patient information website and promotion of digital platforms supporting self-management and access to personalised information.

This is absolutely necessary given the scale of waiting times across most specialties, and should be seen as recognition of ongoing, long-standing staffing challenges across NHS Wales. However, digital campaigns and resources alone will not be sufficient and must be backed by mixed-media campaigns, community outreach and accessible material which reaches all sectors of the community including the digitally excluded. This must be done carefully; we are concerned this emphasis on self-management is likely to exacerbate existing health inequalities.

**Recommendation 4: When promoting the importance of self-care and maintaining wellbeing, Welsh Government must not rely solely on digital campaigns, instead they should carry out community based work to include digitally excluded communities and groups**

The plan references Health Boards working with Public Health Wales to encourage healthy behaviours with a cluster (of deprivation) based approach to reduce inequalities (p7). However, this is not enough. For parents who cannot afford to enrol children in sports clubs or cannot access or afford healthy food, this strategy will have little effect. The current economic climate will only further the expansion of this inequality gap.

The need for patient liaison services to address waiting list queries is paramount.

The plan mentions that systems for direct patient engagement will be delivered at a local level, which may include the set-up of communication hubs. We would welcome a more directive approach from Welsh Government which would see these facilities be mandated across all Health Boards. Such services have the potential to provide clear, transparent and personalised information about waiting lists in addition to signposting for other support services and could reduce pressure on GP services.

**Recommendation 5: Welsh Government's plan for direct patient engagement should be directive-based to ensure all health boards are mandated to provide appropriate facilities so that patients across Wales are supported**

At present, GPs' inability to access secondary care records leads to challenges when patients request updates on referrals, as the GP is required to write to secondary care for updates, only adding to delays. We have previously called for a shared dashboard providing accurate real-time data on waiting times accessible by clinicians from primary and secondary care.

**Recommendation 6: Welsh Government should roll out a shared dashboard to allow accurate real-time access to waiting times for patients and primary and secondary care**

## Leadership and national direction

4. *Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?*
5. *Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?*

While the plan is intentionally high level and does set out Welsh Government's clear ambition to tackle waiting times and reform the planned care process, there is however scant detail on delivery and accountability. Page 37 makes reference to periodic updates on progress as risks are continually assessed, however we would welcome further information on this reporting process, including risk assessment procedures and key milestones. More detail on overall accountability for the plan is needed and, while it may sit with the [hybrid NHS Wales Executive function](#), we recommend the Committee hold regular scrutiny sessions with senior leaders as the rollout of the plan proceeds.

**Recommendation 7: Welsh Government must provide further information on their plans for “periodic updates on progress” and the Senedd’s Health and Social Care Committee should hold regular evidence sessions with senior leader to scrutinise the roll out of the Plan**

## Targets and timescales

6. *Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?*
7. *Is it sufficiently clear which specialties will be prioritised/included in the targets?*
8. *Do you anticipate any variation across health boards in the achievement of the targets by specialty?*

We are concerned that the targets stated in the foreword may not be achievable given the scale of the backlog and ongoing pressures on the system. Taken in isolation, the targets around waiting times for appointments and treatments are at the higher end of what should be a bare minimum expectation. The targets instead appear ambitious and aspirational goals and we are concerned NHS Wales as a whole may struggle to meet them. Further detail is therefore needed from Welsh Government about how they will hold health boards to account on meeting targets.

**Recommendation 8: Welsh Government must provide further information about how it intends to hold health boards to account on meeting targets**

There are major workforce concerns that call into question the viability of these targets. The relative lack of data on vacancies in secondary care, coupled with what we know from our members about current pressures they are experiencing, mean it is difficult to make a judgement. A greater availability of statistics and a transparency of information may make this assessment easier.

**Recommendation 9: Welsh Government must ensure vacancy data and information is readily available from all health boards and trusts, and that this is consistently collected and presented to help understand the needs and pressures faced by staff**

There are other targets set out in the plan relating to different ways of working for outpatient appointments. 50% of follow-up appointments are to be virtual and 35% of new appointments likewise offered digitally. With certain types of appointment only being possible in person- eg spinal surgery or many other Musculo-skeletal issues- this could make such targets difficult to meet. Additionally, health inequalities could be widened for those who are digitally excluded.

The introduction of See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) are certainly positive developments but will be reliant on a properly functioning and responsive system that can appropriately manage patient queries.

There is a commitment to create dedicated surgical facilities separate to urgent and emergency care. We would welcome detail on how this will be achieved, given the current inflexible nature of the NHS Wales estate. Furthermore, general acute and more specialist services are located together on hospital sites; this can be important to ensure a sufficient throughput of patients to ensure medics can maintain competencies and satisfy training requirements.

**Recommendation 10: To fully understand how Welsh Government plans to create dedicated surgical facilities separate to urgent and emergency care, it must provide more detail on how it plans to adapt the current NHS Wales estate**

It is largely the same workforce that is relied upon to deliver planned care and unplanned care: when pressures are intense unplanned care will always take precedence. Fragmentation of these facilities and pathways will be extremely difficult to achieve.

Furthermore, many services which support surgical activity are not available outside regular hours of work, for instance there are no routine physiotherapy sessions on weekends. Patients who have procedures during these times may have less support.

### Financial resources

9. *Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?*
10. *Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?*

The plan makes reference to a significant investment at a national level of £170m from October 2021 to support planned care recovery. This is welcome, but we do not feel we are best placed to comment to a great degree about whether this is sufficient; the fact that this is by its very nature a high-level plan means we cannot comment about specific initiatives based on the amount of information available.

Greater information on Welsh Government plans for how and when these funds will be invested is critical.

**Recommendation 11: Welsh Government must provide more detail about how, when and where it plans to invest the £170m of funding announced in October 2021**

However, a fundamental re-shape of the outpatient/referral system through the introduction of local or regional diagnostic hubs will require a significant investment. As referenced in the report (p18), this is something BMA Cymru Wales strongly supports.

The report mentions that the creation of business cases for new diagnostic hubs is already underway. There is a lack of clarity about how the hubs will operate: how they will be staffed; if they will be located in new dedicated facilities or within existing; and how referrals from GPs will be handled. We would welcome clarity and engagement around this aspirational aim. It is likely that these new centres will have a significant lag time before they become operational, detail on plans for the immediate future are needed from Welsh Government.

**Recommendation 12: Welsh Government must detail its plans for the immediate future of services while it introduces its planned diagnostic hubs**

We suggest that the Senedd's Finance Committee may wish to scrutinise the overarching financial aspects of the Plan and associated projects/initiatives as they develop.

**Recommendation 13: The Senedd's Health and Social Care Committee should encourage the Senedd Finance Committee to scrutinise the overarching financial aspects of the Plan and associated projects/initiatives as they develop**

## Workforce

- 11.** *Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?*

This is the area which has attracted most attention from our members, who widely share concerns that staffing pressures across the system cause into question the viability of the plan. We are extremely concerned that there will be insufficient staffing capacity within the system to deliver upon the stated aims.

The same staff who have reported suffering from burnout and fatigue coming out of the height of the pandemic will be relied upon to reduce the backlog. We have stated this in previous evidence to the Health & Social Care Committee on HEIW's workforce plan<sup>1</sup>:

*"The impact these pressures have had on recruitment and retention of medical and other NHS staff may therefore be significant. Many staff have suffered burnout as a result of the pressures of working through the pandemic, prompting many to consider leaving the profession earlier than they might otherwise have planned or reduce the extent of their working week"*

The findings of the BMA's April 2021 survey of members in Wales demonstrated the precarious situation facing NHS Wales from a staffing perspective:

- almost a third of members have said that, as a result of COVID, they are more likely to take early retirement

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<sup>1</sup> P2, BMA Cymru Wales (8 Oct 21) *Health and social care workforce: consultation by the Welsh Senedd Health and Social Care Committee* [www.bma.org.uk/media/4810/bma-wales-response-to-an-healthier-wales-our-workforce-strategy-for-health-and-social-care-consultation-oct21.pdf](http://www.bma.org.uk/media/4810/bma-wales-response-to-an-healthier-wales-our-workforce-strategy-for-health-and-social-care-consultation-oct21.pdf)

- 21% stated they are more likely to leave the NHS for another career

From a staff wellbeing perspective, we must be realistic about what can be achieved from an already under pressure workforce. The creation of an adequately staffed, resourced and effective occupational health service for all NHS Wales staff is absolutely central to achieving this, and many other, Welsh Government and NHS Wales objectives.

Significant consideration must be put to whether existing NHS Wales workforce numbers are sufficient to deliver 'business as usual'. To ensure staff get the support they need, along with appropriate time to rest and to carry out additional training, action must be taken by Welsh Government to make sure appropriate and safe levels of staff are in place across NHS Wales.

**Recommendation 14: Welsh Government should legislate to ensure appropriate and safe levels of staff are in place across NHS Wales at all times**

**Recommendation 15: Welsh Government should ensure all staff can access appropriate and timely occupation health support**

In primary care, the recent release of data from the Wales National Workforce Reporting System<sup>2</sup> demonstrates that despite the highest ever headcount of practitioners at 2,353 qualified GPs, this amounts to only 1,611 Full time equivalent (FTE) GPs working in Welsh practices. Whilst this dataset is new, future trends will demonstrate a gradual decrease in FTE numbers due to both the popularity of portfolio careers and the fact Wales has a significantly higher proportion of its GPs over 60 than other nations, meaning that a greater percentage will be nearing retirement<sup>3</sup>.

Welsh Government therefore need to focus on retention in addition to recruitment, and an increase to GP training numbers beyond the current 160 new trainees per year.

**Recommendation 16: Welsh Government must urgently increase the numbers of GP training numbers beyond the current 160 new trainees per year**

The Plan acknowledges that general practice and other primary care services deliver "around 90% of all NHS activity" (p8). This highlights the significant burden shouldered by a pressurised workforce which is already insufficient in numbers to tackle business as usual, let alone perform additional activities.

In secondary care there is a lack of publicly accessible vacancy data from Health Boards. We have been required to resort to submitting Freedom of Information requests to health boards and trusts in order to understand secondary care vacancy data. Where data has been obtained, it demonstrates the scale of the challenge: in one health board as many as 48% of consultant posts were not filled by a permanent consultant; furthermore, the definition of a vacancy used by NHS organisations varies widely, with most underreporting. As an example, in many areas it is not until recruitment has been attempted, and failed, that a post is considered to be vacant).

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<sup>2</sup> Welsh Government (14 Apr 21) *General practice workforce: as at 31 December 2021*  
<https://gov.wales/general-practice-workforce-31-december-2021>

<sup>3</sup> P4, BMA Cymru Wales (8 Oct 21) Health and social care workforce: consultation by the Welsh Senedd Health and Social Care Committee

**Recommendation 9 (as previously): Welsh Government must ensure vacancy data and information is readily available from all health boards and trusts, and that this is consistently collected and presented to help understand the needs and pressures faced by staff**

We note the commitment to develop a Workforce Delivery Plan (p34), however without reliable workforce and vacancy data, proper planning cannot be carried out and could call into question the deliverability of much of this plan. HEIW, working with health boards and other key stakeholders, must take a leadership role in workforce planning in the immediate short-term future as well as tackling long-term staffing issues. HEIW's own integrated medium-term plan (IMTP) acknowledges this key role, with "addressing gaps in workforce plans and programmes to support planned care recovery" identified as a key milestone by March 2023<sup>4</sup>. This work needs to be accelerated in advance of that timescale as addressing the workforce gap will not be easy and is unlikely to be solved with money alone as Wales cannot, within the timescale of the plan, train new doctors to redress this shortfall so efforts must be made to draw them into Wales from elsewhere.

**Recommendation 17: HEIW must take a leadership role in workforce planning in the immediate short-term future as well as tackling long-term staffing issues**

The plan references that a factor in reducing waiting times will be 'additional sessional work at weekends and evenings' to catch up, however the punitive taxation rules on NHS pensions could make this unviable for our most senior and experienced doctors. The pensions annual allowance and taper<sup>5</sup> have perverse consequences leading many of our most experienced doctors having to reduce their hours, turn down the opportunity of additional work, or outright retire from practice for fear of being hit with tax bills in the thousands for breaching the annual allowance by as little as £1. With this in mind, clinicians essentially have to pay out of their own pockets to undertake additional work.

Welsh Government should therefore continue to urge the UK Government to act in this area to ensure doctors can accept additional work without being disincentivised.

**Recommendation 18: Welsh Government should urge the UK Government to take action to ensure doctors can accept additional work without being disincentivised by present tax and pension arrangements**

Another means to reduce waiting times identified within the plan is to maximise the capacity within the private and independent sector. It should be recognised that this sector is extremely small in Wales, and often led by consultants in addition to their primary NHS role. Therefore, the workforce who will 'pick up the slack' are largely the same as those within the NHS.

Reliance upon an exhausted workforce to do more could lead to adverse consequences for both patients and said staff. While Welsh Government has taken action to legislate on safe nurse staffing levels, no action has been taken for doctors or other health staff.

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<sup>4</sup> HEIW (21 March 2022) *Integrated Medium-Term Plan 2022-25: Appendix F 'Detailed Deliverables and Milestones'* <https://heiw.nhs.wales/files/heiw-impt-2022-25/>

<sup>5</sup> For more detail please see *The impact of punitive pension taxation rules on doctors and the delivery of NHS services*, BMA (2020) [www.bma.org.uk/media/2002/bma-briefing-on-the-impact-of-pension-taxation-jan-2020.pdf](http://www.bma.org.uk/media/2002/bma-briefing-on-the-impact-of-pension-taxation-jan-2020.pdf)

During the 5<sup>th</sup> Senedd, the Health & Social Care Committee recommended<sup>6</sup>:

*“In our view, it is impossible to separate out the issue of quality from the provision of appropriate staffing levels – they are inextricably linked. In order to deliver quality in service provision, the requisite staffing must be in place.*

*“We recommend that the Minister amends the [Health and Social Care (Quality and Engagement) (Wales)] Bill to make specific provision for appropriate workforce planning/staffing levels as part of the duty of quality.”*

Two and-a-half years later, this key [recommendation](#) has still not been acted upon by Welsh Government.

Given the pressures faced by staff across the Welsh NHS as a result of the pandemic, and the expectation that this will continue as work is undertaken to reduce the backlog for patients, it is critical that Welsh Government brings forward legislation to ensure safe and appropriate levels of staff are in place across NHS Wales.

**Recommendation 14 (as previously): Welsh Government should legislate to ensure appropriate and safe levels of staff are in place across NHS Wales at all times**

### Digital tools and data

**12.** *Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?*

The plan is heavily reliant on the use of digital tools and data: from a patient information perspective to the increased prominence of e-advice across sectors. The commitment to improved transparency around waiting times through a shared digital platform is extremely positive, but we will only reap the benefits of this if it is informed by accurate and reliable data from all sectors. Infrastructure in secondary care is significantly behind primary care and more fragmented. This requires significant attention to unlock this proposed flow of information and data. Without this, patients and doctors will be unable to quickly and reliably access updates to waiting time information.

Furthermore, Welsh Government must provide regular updates on progress in this area and on the expected cost of this, so as to ensure that progress is supported by appropriate funding throughout.

**Recommendation 19: Welsh Government needs to give urgent attention to secondary care IT and technology infrastructure to ensure waiting time and diagnosis information is available for staff and patients. Furthermore, Welsh Government should give regular updated on progress in this area and ensure funding levels remain as required**

An over-reliance on a digital approach to communicate information to patients could exclude large sectors of the population and exacerbate health inequalities. However, it is clear that tools which can provide accurate, accessible and bespoke information to patients about their condition would be of significant benefit. Given these systems will provide access to sensitive patient data and need to interface with clinical records, it is absolutely vital that proper information governance procedures are followed, and safeguards put in place. GPs continue to

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<sup>6</sup> P31, Senedd Health Social Care & Sport Committee (Nov 2019) *Health and Social Care (Quality and Engagement) (Wales) Bill* [https://senedd.wales/laid\\_documents/cr-ld12874/cr-ld12874-e.pdf](https://senedd.wales/laid_documents/cr-ld12874/cr-ld12874-e.pdf)

be the designated 'data controller' for their patient records, and are thus personally liable for any data breach, with the Information Commissioner's Office able to undertake enforcement action<sup>7</sup>. We would welcome the opportunity to work with Digital Health & Care Wales to discuss information governance matters around these proposals.

**Recommendation 20: In introducing greater access to information, it is vital that proper information governance procedures are followed, and safeguards put in place**

**Recommendation 21: Digital Health & Care Wales should consult with organisations, including BMA Cymru Wales, to ensure information governance matters are robust**

## Recommendations

**Recommendation 1: Welsh Government should translate their aspirational Plan into real system change**

**Recommendation 2: Welsh Government should listen to frontline healthcare staff when developing their plans**

**Recommendation 3: Welsh Government should start conversations with frontline staff as soon as possible**

**Recommendation 4: When promoting the importance of self-care and maintaining wellbeing, Welsh Government must not rely solely on digital campaigns, instead they should carry out community based work to include digitally excluded communities and groups**

**Recommendation 5: Welsh Government's plan for direct patient engagement should be directive-based to ensure all health boards are mandated to provide appropriate facilities so that patients across Wales are supported**

**Recommendation 6: Welsh Government should roll out a shared dashboard to allow accurate real-time access to waiting times for patients and primary and secondary care**

**Recommendation 7: Welsh Government must provide further information on their plans for "periodic updates on progress" and the Senedd's Health and Social Care Committee should hold regular evidence sessions with senior leader to scrutinise the roll out of the Plan**

**Recommendation 8: Welsh Government must provide further information about how it intends to hold health boards to account on meeting targets**

**Recommendation 9: Welsh Government must ensure vacancy data and information is readily available from all health boards and trusts, and that this is consistently collected and presented to help understand the needs and pressures faced by staff**

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<sup>7</sup> Information Commissioner's Office *Penalties* [ico.org.uk/for-organisations/guide-to-data-protection/guide-to-le-processing/penalties/](https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-le-processing/penalties/)

**Recommendation 10:** To fully understand how Welsh Government plans to create dedicated surgical facilities separate to urgent and emergency care, it must provide more detail on how it plans to adapt the current NHS Wales estate

**Recommendation 11:** Welsh Government must provide more detail about how, when and where it plans to invest the £170m of funding announced in October 2021

**Recommendation 12:** Welsh Government must detail its plans for the immediate future of services while it introduces its planned diagnostic hubs

**Recommendation 13:** The Senedd's Health and Social Care Committee should encourage the Senedd Finance Committee to scrutinise the overarching financial aspects of the Plan and associated projects/initiatives as they develop

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**Recommendation 20:** In introducing greater access to information, it is vital that proper information governance procedures are followed, and safeguards put in place

**Recommendation 21:** Digital Health & Care Wales should consult with organisations, including BMA Cymru Wales, to ensure information governance matters are robust.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 14

Ymateb gan: | Response from: Ombwdsmon Gwasanaethau Cyhoeddus  
Cymru | Public Services Ombudsman for Wales

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Mae'r ymateb yma hefyd ar gael yn Gymraeg.

This response is also available in Welsh.



**Response by the Public Services Ombudsman for Wales  
to the Health, Social Care and Sport Committee's consultation  
'The Welsh Government's plan for transforming and modernising planned  
care and reducing waiting lists'**

We are pleased to have the opportunity to respond to this consultation.

### **Our role**

As Public Services Ombudsman for Wales (PSOW), we investigate complaints made by members of the public who believe they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction, which essentially includes all organisations that deliver public services devolved to Wales. These include:

- local government (both county and community councils)
- the National Health Service (including GPs and dentists)
- registered social landlords (housing associations)
- the Welsh Government, together with its sponsored bodies.

We can consider complaints about privately arranged or funded social care and palliative care services and, in certain specific circumstances, aspects of privately funded healthcare.

We also investigate complaints that elected members of local authorities have breached their Codes of Conduct, which set out the recognised principles of behaviour that members should follow in public life.

The 'own initiative' powers we have been granted under the Public Services Ombudsman (Wales) Act 2019 (PSOW Act 2019) allow us to investigate where evidence suggests there may be systemic failings, even if service users themselves are not raising complaints. The Act also established the Complaints Standards Authority (CSA) to drive improvement in public services by supporting effective complaint handling through model procedures, training and collecting and publishing complaints data.

## **Our cases related to Referral to Treatment Times (RTT)**

In January this year, we submitted a response to the Committee's inquiry 'Impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment'. It would be useful to reiterate our approach to cases related to RTT, as well as update the Committee on the volume of our relevant casework.

### Our approach

We understand that the NHS has finite resources and, unfortunately, this means that there will be waiting lists for treatment. The pandemic has placed unprecedented pressures on the NHS which we are also acutely aware of.

We consider each case involving RTT on its own merits. Whether a case where the RTT has been breached amounts to service failure or maladministration will depend upon the circumstances of each case. A failure to meet the RTT time is not in itself evidence of service failure or maladministration.

The first important consideration is the clinical need of the individual complainant. Broadly, even where RTT has been breached, we would not normally investigate unless there is evidence of:

- clinical urgency
- imminent need
- waiting list mismanagement.

For us to find service failure, our clinical advice would have to suggest that any failings to monitor, review or treat individual patients in urgent need of care have caused clinical harm. The threshold for finding 'service failure' is therefore a high one in relation to complaints about RTT.

We understand that this may be a source of frustration to people contacting us, particularly as we normally expect our complainants to raise their concerns with the relevant body before contacting us. However, this also means that when we investigate complaints about RTT, it is because they involve potentially serious injustice to complainants.

### Our caseload

In January, we stated that we had concerns that we will soon be seeing a significant increase in people contacting us about RTT issues. We were aware of

the growing number of people on waiting lists in Wales and were concerned that that increase would soon translate into many more cases about RTT reaching our office.

We now know that the number of people on waiting lists in Wales has increased again since then. There has also been a lot of media attention on the number of people across the UK who chose to use private healthcare providers due to the NHS not being able to deliver their care within timeframes that they found acceptable.<sup>1</sup>

We categorise complaints according to their main subjects, and we identify a number of complaints as relating primarily to RTT. However, complaints principally about other matters may include RTT concerns. Based on our analysis:

- since 2019, we received 9 complaints with RTT as the central subject – and 7 of those were received since the start of 22 alone.
- during 2019/20, we closed only 11 complaints related to delay in treatment or referral. However, in 2020/21 and 2021/22 we closed 108 such complaints, with 5 further relevant complaints already closed in this financial year.

Overall, the numbers of complaints specifically focused on RTT and delay in treatment remain small. However, we remain concerned that we are likely to see an increase in these complaints.

### **Our comments on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists in Wales**

Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.

Overall, we think that the plan is comprehensive and far-reaching. Whether it will succeed in its objectives will depend on its resourcing and implementation arrangements.

Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?

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<sup>1</sup> See for example [The Guardian, 2 March 2022](#).

The plan presents a suite of measures to address both the current waiting times and increasing the resilience and capacity of the health service. It does not, however, dedicate much attention to the interface between the health and social care system. There is some reference to the role of support in the community and social prescribing on addressing health inequalities to reduce the number of people who will need planned care intervention in the future. There is also a reference to better coordination of arrangements between health and care professionals (p. 14). However, more detail on how the social care system would be used and supported to alleviate the pressure on the NHS would be welcome.

Whether the plan includes sufficient focus on:

- Ensuring that people who have health needs come forward;

We note that the plan does refer to this issue, but mainly in relation to cancer patients. This attention to tackling barriers to prompt diagnosis for cancer patients is of course welcome. However, we would argue that this clear message needs to be extended to other conditions where delay in treatment in areas such as orthopaedics and ophthalmology can lead to significant deterioration. This said, we acknowledge that the plan includes some measures that will tackle the barriers that may stop people with such conditions from coming forward (for example, the proposed steps to train more 'independent prescribing optometrists' to provide community-based care and reduce the need for some patients to travel to hospital).

- Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;

Based on our casework, we particularly welcome the attention in the plan to better communication with patients and better expectation management. One of the main issues that we are seeing is the importance of clear communication by the Health Boards on the demands on the service, expected timescales and support available (e.g. **202002671**; **202104566**). Even in complaints about delay that we cannot uphold (e.g. **202107132**), we often see that distress over the delay in treatment is compounded by the lack of clarity on when the treatment can be expected.

- Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;

There is a welcome emphasis in the plan on the prioritisation of those most in need. There are also references to better provision of information to those waiting the

longest. The plan does refer consistently to support for patients to maintain their health while waiting for treatment (p. 15, 22, 27, 31). On that latter note, we notice the specific commitment to develop and embed a standard prehabilitation approach to improve outcomes and the plans to utilise Patient Reported Outcome Measures to support this.

We welcome these references and commitments because we have seen in our casework examples of some relevant good practice that highlighted the benefits of such support. For example, in case **202107132** the Health Board arranged for a physiotherapist to assess a patient waiting for their hip replacement appointment. This was as part of a broader programme designed to help patients optimise their health before surgery, supported by Orthopaedic Physiotherapists.

- Improving patient outcomes and their experience of NHS services?

Although the plan on the whole clearly emphasises improving patient outcomes, we note that one major aspect that has been omitted relates to patients' complaints about waiting times. It is inevitable that some people will want to complain to the NHS about their experience. We think that taking steps to clarify how such complaints may be considered under Putting Things Right is an essential part of managing patient expectations by the NHS in Wales. More clarity for patients in that respect could arguably also contribute to alleviating the pressure on NHS complaints services at this challenging time.

Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?

Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?

The Plan does not appear to offer much detail on the leadership arrangements and responsibility for driving the envisaged transformation. We would not want to express an opinion on the appropriate arrangements in that respect. However, we consider that the plan would be a good platform to acknowledge and encourage more proactive and innovative good practice emerging from within the NHS itself.

We have talked before of some examples of how the pandemic-related pressures have prompted new ways of thinking and working within the NHS. For example, a [report](#) by several NHS bodies in March last year drew attention to examples of good

and innovative practice, from digital mental health provision for Children and Young People at Aneurin Bevan University Health Board, to new ways of delivering cardiology diagnostics services for rural communities in Betsi Cadwaladr University Health Board's area. Another [study](#) highlighted innovative practices at Cardiff and Vale University Health Board, which prevented the widespread cancellation of elective surgery.

These examples show what can be achieved when NHS staff are empowered and trusted to work with more discretion, flexibility and with principles of prudent healthcare at the heart of service planning and delivery. Embedding those ways of working is essential if the current waiting lists crisis is to be resolved.

### **Closing remarks**

We trust that you will find these comments useful. Should you wish to discuss any of my points further, please do not hesitate to contact Ania Rolewska, our Head of Policy

*MM Morris.*

**Michelle Morris**

**Public Services Ombudsman for Wales**

**June 2022**

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 15

Ymateb gan: | Response from: Crohns & Colitis UK

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## **Crohn's & Colitis UK evidence submission: Senedd Health and Social Care Committee plan for transforming and modernising planned care and reducing waiting lists**

[June 2022]

### **1. About this submission**

- 1.1. **Crohn's & Colitis UK**<sup>1</sup> is the leading charity for people affected by Crohn's and Colitis in the UK. We work to improve diagnosis, treatment, and care, to fund research into a cure, to raise awareness, and to provide information and support.
- 1.2. Over 26,000 people in Wales have Inflammatory Bowel Disease (IBD), the two main forms of which are Crohn's Disease and Ulcerative Colitis.<sup>2</sup> These are lifelong diseases of the gut. They can affect almost every part of the body and every aspect of life: from digestion and joints to energy levels, mental health, education and the ability to work. There is no known cure.
- 1.3. Crohn's and Colitis requires tight monitoring and management, often over several decades from the age of diagnosis. If left untreated, poorly managed or in cases of severe disease, Crohn's and Colitis can cause serious complications, which require emergency medical and/or surgical intervention. The burden of Crohn's and Colitis on the NHS is increasing year on year and, per patient, costs are comparable to cancer and heart disease.<sup>3</sup>
- 1.4. The number of people living with Crohn's or Colitis in the UK increases from 1 in every 123 people to 1 in every 67 people in those aged over 70.<sup>4</sup> This aging population is more likely to have several other long-term conditions including chronic obstructive pulmonary disease, chronic liver disease, arthritis and heart disease.<sup>5</sup> Meeting their needs will pose a substantial social and economic burden on governments and health systems in the coming years.
- 1.5. This submission outlines our response to the Senedd Health and Social Care Committee plan for transforming and modernising planned care and reducing waiting lists.

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<sup>1</sup> [www.crohnsandcolitis.org.uk](http://www.crohnsandcolitis.org.uk)

<sup>2</sup> Crohn's & Colitis UK (2022). [New research shows over 1 in 123 people in UK living with Crohn's or Colitis \(crohnsandcolitis.org.uk\)](https://www.crohnsandcolitis.org.uk)

<sup>3</sup> Luces C, Bodger K (2006). Economic burden of inflammatory bowel disease: A UK perspective. *Expert Review of Pharmacoeconomics & Outcomes Research*. 6: 471-482.

<sup>4</sup> Ibid

<sup>5</sup> Irving, P., Barrett, K., Nijher, M. *et al.*, (2021). Prevalence of depression and anxiety in people with inflammatory bowel disease and associated healthcare use: population-based cohort study. *Evidence-based mental health*, 24(3), 102-109.

## 2. Overall views of the plan

- 2.1. We welcome the plan to address the backlogs in routine care and reduce long waits, including the recognition to address health inequalities in both primary and secondary care.
- 2.2. However, we are disappointed that the current plan focuses on high-profile priorities such as cancer and heart disease, and overlooks serious and long-term conditions such as Crohn's and Colitis, which carry comparable costs to the health service.<sup>6</sup>
- 2.3. The Welsh Government has committed to implementing IBD Standards<sup>7</sup> and appointed the All-Wales Clinical Lead, a position that is proving to be a catalyst in service improvements across the country. However, IBD care in Wales remains understaffed and under-resourced. Even before the pandemic, services were struggling to meet the demand. We urge you to recommit to IBD Standards and deliver equity of care for people living with Crohn's and Colitis.
- 2.4. There is currently vast variation in the implementation of IBD Standards across Health Boards in Wales. Regional approaches alone will not result in preventing delayed diagnosis, treatment and surge of emergency surgeries. We recommend the plan reinstate IBD Standards and make commitments to invest in digital tools to monitor their implementation alongside patient outcomes in regions to drive up equity in care.
- 2.5. To encourage people with Crohn's or Colitis to come forward, we urge the government to partner with patient organisations in public awareness campaigns, invest in the development of community healthcare professionals to spot symptoms and use tests effectively, and develop and invest in a patient-led diagnostic pathway standardising the use of tests (FCP and FIT) in primary care.
- 2.6. To effectively diagnose and treat people with Crohn's and Colitis, we urge the government to review and expand endoscopy capacity by revisiting working models (e.g. GIRFT) and adding capacity to existing departments, rather than addressing the shortfall through hubs.
- 2.7. To support patient self-management, we recommend: communications to promote choice and personalisation, ensure service regularly monitor patients rather than deliver reactive care, and services have clear pathways for patients out and back into PIFU when they have flare ups.
- 2.8. To manage surgery times, we recommend that Health Boards are mandated to publish their surgery timetables to ensure the Federation of Surgical Specialty Associations (FSSA) guidance is followed.<sup>8</sup>

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<sup>6</sup> Luces, C. and Bodger, K. (2006). Economic burden of inflammatory bowel disease: A UK perspective. *Expert Review of Pharmacoeconomics & Outcomes Research*. 6: 471-482.

<sup>7</sup> IBD UK (2019). *IBD Standards Core Statements*. [IBD-Standards-Core-Statements.pdf](#)

<sup>8</sup> [Clinical guide to surgical prioritisation during the coronavirus pandemic – Royal College of Surgeons \(rcseng.ac.uk\)](#)

## 3. Meeting people's needs

### a) Ensuring that people who have health needs come forward:

- 3.1. For people with Crohn's or Colitis, delays to diagnosis, treatment or planned surgery are associated with a rise in emergency surgery, more extensive surgery and life-threatening complications, increased risks of cancer, mortality and disease progression. In 2020, IBD UK patient survey revealed that 1 in 4 people with Crohn's or Colitis in Wales reported waiting more than a year for a diagnosis, with almost half (47%) visiting A&E at least once before being diagnosed.<sup>9</sup> The pandemic has exacerbated these problems - lack of access to specialists, medicines, tests and procedures have led to flares, complications and poorer mental health for many.<sup>10</sup>
- 3.2. There are numerous reasons for people living with Crohn's or Colitis not to come forward, including:
  - **Lack of public understanding and awareness** of Crohn's and Colitis and its symptoms. 80% of those responding to the IBD UK Patient Survey felt that the public have limited or no understanding of Crohn's and Colitis.
  - **Symptoms that can be associated with a range of other conditions.** These include irritable bowel syndrome (IBS), bowel cancer, coeliac disease, endometriosis and ovarian cancer.
  - **Symptoms can present atypically.** E.g. while diarrhoea is the most common symptom, this is not present in all adults with Crohn's or Colitis; and up to 44% of children with IBD do not experience diarrhoea.<sup>11</sup>
- 3.3. There are systemic barriers for patients to come forward, as revealed by a recent independent survey<sup>12</sup> commissioned by Crohn's & Colitis UK:
  - 1 in 3 report difficulties in getting a GP appointment
  - 1 in 7 report difficulties in discussing sensitive symptom information with receptionists
  - 1 in 7 worry the key symptoms (diarrhoea, weight loss and abdominal pain) would not be taken seriously.

<sup>9</sup> IBD UK (2021). *Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*. [CROJ8096-IBD-National-Report-WEB-210427-2.pdf](#)

<sup>10</sup> Crohn's & Colitis UK (2020). [Life in Lockdown: What patients told us about their healthcare | Crohn's & Colitis UK \(crohnsandcolitis.org.uk\)](#)

<sup>11</sup> Sandhu BK, Fell JME, Beattie RM et al. on behalf of the IBD Working Group of the British Society of Paediatric Gastroenterology, Hepatology, and Nutrition (2010). Guidelines for the management of inflammatory bowel disease (IBD) in children in the United Kingdom. *Journal of Pediatric Gastroenterology and Nutrition*. 50 (Suppl 1): S1-S13. <https://doi.org/10.1097/MPG.0b013e3181c92c53>

<sup>12</sup> UK wide with a sample size of 2,026 participants.

- 3.4. The public poll confirms research we conducted with the Royal College of General Practitioners<sup>13</sup> which highlighted:
- Lack of knowledge about IBD in community healthcare professionals and the need for more training in IBD.
  - Lack of confidence in the use of faecal calprotectin (FCP) testing.
- 3.5. To encourage people with Crohn's or Colitis to come forward, we urge the government to partner with patient organisations in public awareness campaigns, improve availability of GP appointments, invest in the development of community healthcare professionals to spot symptoms and use tests effectively, and develop and invest in a patient-led diagnostic pathway standardising the use of tests<sup>14</sup> in primary care.

## *b. Supporting people who are waiting a long time for and supporting self-management*

- 3.6. We welcome the plan's commitments to provide clear communication to patients. Communications must meet their individual needs, foster shared decision-making, and signpost to patient organisations for further information and wide-ranging support.
- 3.7. We welcome the plan's commitments to offer a combination of virtual and face-to-face outpatient appointments. While remote care may be welcome to some for its convenience and ability to reduce travel, it will not be appropriate for everyone. It is essential that services promote choice and take into consideration individuals' needs, preferences, and circumstances.
- 3.8. We recommend the use of Patient initiated Follow-Up (PIFU) for the following conditions/situations:
- Crohn's or Colitis patients with stable conditions and a personalised care plan with tight monitoring
  - Primary care follow-up with low risk and stable Colitis based on a shared care model and tight monitoring, remaining on the colonoscopy surveillance list.
- 3.9. However, PIFU would be unsuitable for the following conditions:
- Newly diagnosed patients
  - Young adults transitioning from children to adult services.
  - Uncontrolled/refractory or flaring Crohn's or Colitis.
  - Complex fistulising Crohn's or Colitis that is unstable.
  - Patients not adhering to medication
  - Severe acute colitis.
- 3.10. Furthermore, the gastroenterology specific risks to patients on the PIFU pathway should be minimised by:

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<sup>13</sup> RCGP and Crohn's & Colitis UK Inflammatory Bowel Disease Spotlight Project 2017-2020, [www.crohnsandcolitis.org.uk/improving-care-services/health-services](http://www.crohnsandcolitis.org.uk/improving-care-services/health-services)

<sup>14</sup> Including faecal calprotectin, faecal immunochemical test, C-reactive protein, coeliac screen, ferritin, liver function test, thyroid function +/- stool culture checked in primary care.

- **Regular monitoring rather than reactive care:** Access to FCP can mitigate against the lag between the beginning of a flare and symptoms.
  - **Surveillance for people with Crohn's or Colitis with high risk of cancer.**
  - **Clear pathways out and back into PIFU:** to minimise delays or barriers to flaring patients getting back into services and accessing specialist advice promptly when flaring.
- 3.11. Some IBD services have been using portals and apps to support more joined-up patient-centred care, including Patient Knows Best, MyChart, My IBD Care and the IBD Portal.<sup>15</sup> Together with personalised care planning, including supported self-management, and FCP at home, these offer great potential for a more effective and efficient approach to ongoing care for a proportion of patients.

### *c) Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time*

- 3.12. Prior to the Covid-19 pandemic, waits for elective Crohn's and Colitis surgery in Wales were the longest of all four UK nations, with only 46% of services reporting that this took place within 18 weeks of referral. A third (30%) of patients reported waiting longer than 18 weeks for elective IBD surgery.<sup>16</sup>
- 3.13. The pandemic has exacerbated the existing issues with Crohn's and Colitis care and has led to:
- A reduction in reported diagnoses of Crohn's and Colitis<sup>17</sup>
  - Cancellation of and reduced access to endoscopy and surgery for Crohn's and Colitis<sup>18</sup>
  - Delayed appointments and difficulties accessing IBD specialists and GPs
  - Disrupted access to essential medication.

This has resulted in people with Crohn's and Colitis experiencing:

- Flares, which may cause further bowel damage and increase cancer risk
  - Likely increased need for more high-cost drug treatment and complex surgery.<sup>19</sup>
- 3.14. Investment needs to be focused not just on high-profile priorities such as cancer and heart disease, but also on conditions such as Crohn's and Colitis, which are often overlooked, but carry comparable costs to the health service.<sup>20</sup>
- 3.15. The plan lacks a clear definition for the term 'clinically urgent' (p. 23) within its approach to patient prioritisation. **In addition to the clinical view, it is essential that patients are involved in their 'clinically urgent' definition development process.**

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<sup>15</sup> [I want to offer remote care and/or monitoring for patients - Gastroenterology digital playbook - NHS Transformation Directorate \(nhsx.nhs.uk\)](#)

<sup>16</sup> IBD UK (2021). *Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*. [CROJ8096-IBD-National-Report-WEB-210427-2.pdf](#)

<sup>17</sup> Bodger, K., Bloom, S., Dobson, L. *et al.*, (2021). PMO-37 COVID-19 impact on care and prescribing for inflammatory bowel disease: Data from the IBD Registry. *Gut*, 70:A95-A96.

<sup>18</sup> Deputy, M., Sahnun, K., Worley, G. *et al.*, (2022). The use of, and outcomes for, inflammatory bowel disease services during the Covid-19 pandemic: a nationwide observational study. *Aliment Pharmacol Ther*, 55(7), 836-846.

<sup>19</sup> Crohn's & Colitis UK (2020). [Life in Lockdown: What patients told us about their healthcare | Crohn's & Colitis UK \(crohnsandcolitis.org.uk\)](#)

<sup>20</sup> Luces, C. and Bodger, K. (2006). Economic burden of inflammatory bowel disease: A UK perspective. *Expert Review of Pharmacoeconomics & Outcomes Research*. 6: 471-482.

- 3.16. **We recommend the development and implementation of a patient-led diagnostic pathway standardising the use of tests<sup>21</sup> for patients with non-cancer related lower gastrointestinal (GI) symptoms.** Research suggests that FCP and faecal immunochemical test (FIT) have similar accuracy in the diagnosis of both colorectal cancer and IBD.<sup>22 23 24 25</sup>
- 3.17. The current plan for prioritising diagnostic services is reliant on more equipment, new facilities and the expansion of the diagnostic workforce. However, the GIRFT speciality report for gastroenterology suggests that optimising current capacity through service design and workforce organisation is as important and cost-effective.<sup>26</sup> **We therefore recommend that the plan expands endoscopy capacity by capping specialist time or adding capacity in the existing departments.**
- 3.18. **We recommend Health Boards to be mandated to publish their surgery timelines to ensure IBD surgeries are prioritised in line with the Federation of Surgical Specialty Associations (FSSA) guidance.<sup>27</sup>** We have heard from both patients and clinicians that the implementation of this guidance in Wales is inconsistent. Failure to rectify this will result in the presentation of emergency IBD surgeries, which tend to be more complex and costly.

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<sup>21</sup> Including faecal calprotectin, faecal immunochemical test, C-reactive protein, coeliac screen, ferritin, liver function test, thyroid function +/- stool culture checked in primary care.

<sup>22</sup> Mowat, C., Digby, J., Strachan, J.A., *et al.* (2016) Faecal haemoglobin and faecal calprotectin as indicators of bowel disease in patients presenting to primary care with bowel symptoms. *Gut*, **65**(9), 1463-1469.

<sup>23</sup> Elias, S.G., Kok, L., de Wit, N.J., *et al.*, (2016). Is there an added value of faecal calprotectin and haemoglobin in the diagnostic work-up for primary care patients suspected of significant colorectal disease? A cross-sectional diagnostic study. *BMC medicine*, **14**(1), 1-11.

<sup>24</sup> Widlak, M., Thomas, C., Thomas, M. *et al.*, (2017). Diagnostic accuracy of faecal biomarkers in detecting colorectal cancer and adenoma in symptomatic patients. *Alimentary pharmacology & therapeutics*, **45**(2), 354-363.

<sup>25</sup> Högborg, C., Karling, P., Rutegård, J. *et al.*, (2017). Diagnosing colorectal cancer and inflammatory bowel disease in primary care: The usefulness of tests for faecal haemoglobin, faecal calprotectin, anaemia and iron deficiency. *A prospective study. Scand J Gastroenterol*, **52**(1), 69-75

<sup>26</sup> Oates, B. (2021). Gastroenterology: GIRFT Programme National Specialty Report. [Layout 1 \(gettingitrightfirsttime.co.uk\)](#)

<sup>27</sup> [Clinical guide to surgical prioritisation during the coronavirus pandemic – Royal College of Surgeons \(rcseng.ac.uk\)](#)

## 4. Leadership and national direction

- 4.1 We welcome the appointment of the All-Wales IBD clinical lead who is proving to be a catalyst in service improvements across the country. Through this leadership, IBD Wales<sup>28</sup> have prioritised a list of actions required to implement IBD Standards across the country.<sup>29</sup>
- 4.2. However, there are a number of items that have yet to be actioned by Health Boards:
- Routine use of FCP in primary care with fast-track to direct colonoscopy of those with high levels
  - All hospitals to have dedicated IBD consultant clinics
  - Support to be given to business case development for appointing additional staff where there is a clear need with evidence that lack of staff is affecting patient care
  - All health boards should have dedicated clerical or administrative support to work alongside specialist nurses
  - IBD specific dietary support should be available in a timely fashion in all IBD services, provided through a combination of face-to-face and telephone appointments
  - Business cases should be supported to provide psychology sessions, including options for individualised on-line treatment programmes which may be more cost-effective.
- 4.3 **To meet these targets, we need the plan to promote shared leadership across the region, with clear mandated targets.**
- 4.4 **We also recommend setting up a Specialist Gastroenterology Network, which include two operational networks: one for coordinating action specifically on endoscopy, and another on IBD treatment.**

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<sup>28</sup> A joint initiative led and facilitated by Crohn's & Colitis UK that aims to develop a strategic approach to the improvement of standards of care for IBD patients of all ages across Wales and includes patients and representation from all NHS Wales Local Health Boards.

<sup>29</sup> IBD UK (2019). *IBD Standards Core Statements*. [IBD-Standards-Core-Statements.pdf](#)

## 5. Targets and timescales

- 5.1. Table 1 shows the results for a selection of indicators from the IBD Patient Survey and Service Self-Assessment<sup>30</sup> for the hospitals in Wales who responded.<sup>31</sup> The table provides a snapshot of the variation in the achievement of the IBD Standards and quality of care across health boards in Wales. We urge the Government to lead an assessment of the impact of these variations in IBD services have on patient outcomes, as part of its commitment to address health inequalities across the country.
- 5.2. We would also like the Government to ensure Health Boards to publish their **surgery timetables** to ensure the Federation of Surgical Specialty Associations (FSSA) guidance is followed.<sup>32</sup>
- 5.3. Whilst we acknowledge that regional approaches maybe required to reduce waiting times and to build sustainable planned care capacity, we are concerned about the impact this may have on IBD patient outcomes, given the considerable variation in quality of care across the country. Investment in digital tools to monitor how and where IBD patients are accessing secondary care is essential.
- 5.4. We therefore urge the government to set clear national targets to rectify these issues and work with Health Boards to progress the implementation of the IBD Standards.

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<sup>30</sup> Carried out between July 2019 and January 2020.

<sup>31</sup> IBD UK (2021). *Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*. [CROJ8096-IBD-National-Report-WEB-210427-2.pdf](#)

<sup>32</sup> [Clinical guide to surgical prioritisation during the coronavirus pandemic – Royal College of Surgeons \(rcseng.ac.uk\)](#)

| Hospital   | Population Coverage | No. IBD Patients Supported | No. Patient Survey Respondents | Quality of care (good, very good and excellent) | Patients with IBD are seen within 4 weeks from their first referral | All elective IBD surgery takes place within 18 weeks | All IBD patients have a personalised care plan based on a holistic needs assessment | All patients have access to non-acute endoscopy and imaging within 4 weeks and within 24 hours for patients who are acutely unwell or require admission to hospital | All patients with confirmed IBD are recorded in an electronic clinical management system |
|--|---------------------|----------------------------|--------------------------------|---|---|--|---|---|--|
| Ysbyty Gwynedd   | 194,139             | 1,300                      | 40                             | 59%   |   |  |   |   |  |
| Glan Clwyd   | 225,000             | 700                        | 33                             | 43%   |   |  |   |   |  |
| Wrexham Maelor   | 387,000             | 1,824                      | 58                             | 76%   |   |  |   |   |  |
| Withybush  | 125,055             | 450                        | 34                             | 91%   |   |  |   |   |  |
| Morrison (Paediatric)  | 500,000             | 51                         | N/A                            | N/A   |   |  |   |   |  |
| Neath Port Talbot  | 142,906             | 750                        | 15                             | 92%   |   |  |   |   |  |
| Princess Of Wales  | 150,000             | 1,500                      | 8                              | 57%   |   |  |   |   |  |
| Royal Glamorgan  | 150,000             | 600                        | 31                             | 55%   |   |  |   |   |  |
| Prince Charles   | 200,000             | 700                        | 17                             | 50%   |   |  |   |   |  |
| University Hospital Of Wales And University Hospital Llandough | 650,000             | 3,000                      | 99                             | 83%   |   |  |   |   |  |
| Royal Gwent, Nevill Hall And Ysbyty Ystrad Fawr                | 750,000             | 3,513                      | 95                             | 61%   |   |  |   |   |  |
| <b>Total (Achieved)</b>  |                     |                            |                                |   | <b>0</b>  | <b>5</b>   | <b>4</b>  | <b>5</b>  | <b>1</b>   |

**Table 1.** Results for a selection indicators from the 2020 IBD Patient Survey and Service Self-Assessment for the hospitals in Wales who responded. Red indicates where the indicator has not yet been achieved, green indicates where it has been achieved.

This submission has been written by Amy Deptford, Policy Manager at Crohn's & Colitis UK. For further information, please write to

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 16

Ymateb gan: | Response from: Coleg Brenhinol Llawfeddygon Lloegr |  
Royal College of Surgeons of England

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# The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

## Written evidence from the Royal College of Surgeons of England

### **Introduction**

1. The Royal College of Surgeons of England (RCS England) is a professional membership organisation and registered charity that exists to advance patient care. We support nearly 30,000 members in the United Kingdom and internationally by improving their skills and knowledge, facilitating research and developing policy and guidance.
2. We welcome the opportunity to provide evidence to the Senedd's Health and Social Care Committee's inquiry into the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

### **Summary**

RCS England urges the Committee to consider the following points regarding the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists:

- We welcome the publication of the Welsh Government's Planned Care Recovery Plan (the Plan) which is long overdue.
- With waiting times in Wales still rising we need a clear strategy for tackling the backlog. Almost 700,000 patient pathways are waiting to start treatment across Wales and long waits for operations can be particularly devastating for patients.
- We welcome the additional funding made available for planned care and more regional working to reduce variation in access to surgical services across Wales.
- We have been calling for dedicated surgical hubs or elective centres which separate emergency and planned care for some time. Crucially, these centres allow planned treatment to continue even if there is another spike in COVID-19 cases or winter flu.

- We remain concerned about the pace of the surgical recovery in Wales. In comparison with England, anecdotal feedback from our members is that surgical activity levels are lower. However this data is not widely published.
- In Wales, although Welsh Government have supported the principle, Health Boards have made limited progress in moving to a surgical hub model with some areas faring better than others.
- We need a consistent approach to see elective centres in every Health Board area and across Health Board boundaries to avoid a postcode lottery of patient care and ensure equity of access to surgical services.
- The targets the Welsh Government has set in the Plan are challenging. It will take several years before waiting times reduce to pre-pandemic levels. We are calling for an annual report to the Senedd to track progress.
- We have concerns that some targets in the Plan only relate to some specialties, potentially leaving patients without a clear idea of when they can expect to be treated. The targets in the Plan should apply to all specialties.
- Our workforce is over-stretched and we need an independent, fully costed workforce plan to resolve the long-standing issue of staff vacancies. Delivering the targets in the Plan must not come at the expense of staff welfare.
- Surgical trainees must be supported to catch up on missed training opportunities as soon as possible.

## Waiting times in Wales

We welcome the publication of the Welsh Government's Planned Care Recovery Plan. A clear strategy on tackling the backlog was long overdue.

Waiting times in Wales are at unprecedented highs. For the latest available data the number of patient pathways waiting for treatment in Wales is now 701,418. In excess of 250,000 patient pathways are waiting over nine months for treatment. For comparison in March 2021 there were 568,367 patient pathways on the waiting list and 216,418 had been waiting more than nine months. For March 2022 the largest number of patient pathways are for trauma and orthopaedic surgery [97,522], general surgery [86,544], ENT [59,346] and urology [42,694].<sup>i</sup>

Of particular concern is the large number of patients waiting more than two years for treatment in Wales. For the latest available data 70,417 patient pathways are waiting more than 105 weeks. This is the highest number since records began. In England, the UK government has a target to eliminate two year waits by July 2022. Although the data is not directly comparable, there were 9,146 patients waiting more than two years in England in May 2022.<sup>ii</sup>

A significant waiting list existed in Wales before COVID-19 but the situation has been exacerbated by the pandemic. Moreover, NHS Wales has not met its waiting time targets since 2011.<sup>iii</sup>

There is now the risk that some patients will have to wait years for treatment in Wales, which is unacceptable. To tackle this, the Welsh Government urgently needs to deliver on the commitments set out in the Plan.

As outlined in our 'Action Plan for the Recovery of Surgical Services in Wales' published in 2021, long waits for planned care can have a range of negative impacts on patients' care. The common themes are pain, psychological distress, fears around deterioration in health, threats to employment and loss of income, and an increasing lack of trust in care providers.<sup>iv</sup>

Prolonged waits for surgery also risk further deterioration in patients' conditions, which can mean more complex surgery being required. There will sadly be some instances where patients die while waiting for a procedure.

## Surgical hubs

We have been calling for dedicated surgical hubs or elective centres in Wales for some time. These units separate emergency and planned care. Surgical hubs create ring-fenced operating theatres and beds enabling more operations to go ahead. Such centres create more dedicated capacity for planned operations to proceed and help reduce the backlog of those waiting for treatment even if there is another spike in COVID-19 cases or winter flu. They also create a more sustainable and resilient health system in the longer term.

Establishing surgical hubs or elective centres is not just about changing the organisation of hospital services. We also need to materially increase NHS capacity in terms of operating theatres and surgical beds. As recognised by Audit Wales, the number of beds in Wales has fallen steadily over many years.<sup>v</sup> While we recognise the ability of the independent sector to

provide some additional capacity in the short term, we need to ensure more sustainable capacity in the NHS.

The anecdotal feedback from our members is that the planned care recovery in Wales has been patchy and inconsistent. Surgical activity remains below pre-pandemic levels in some geographical areas and some surgical specialties.

We welcome the approach outlined in the Plan to separate planned care from emergency admissions. However there has been limited progress by Health Boards in moving to a surgical hub model. We know that some areas (Cardiff and Aneurin Bevan for example,) are faring better than others. The plans announced by Swansea Bay University Health Board to create centres of surgical excellence across Swansea Bay's three main hospitals are also welcome. Of note there are currently 91 elective surgical hubs operational in England.<sup>vi</sup>

We need strong direction from the Welsh Government to see elective centres in every Health Board area and across Health Board boundaries. This is to avoid a postcode lottery of patient care and ensure equity of access to surgical services in Wales.

We would also urge the Welsh Government to publish surgical activity data (against pre-pandemic levels) every month, broken down by Health Board and specialty. This is to identify and support those geographical areas and surgical specialties with lower levels of surgical activity.

The health service in Wales is facing intense and sustained pressure. The scale of the challenge is unprecedented. We are cognisant that it will take several years before waiting times are back to pre-pandemic levels. The Health Minister has indicated it will take a full Senedd term and Audit Wales has said it could take up to seven years or more.<sup>vii</sup>

We must ensure there is communication with patients consistently across Wales to keep them informed about how long they will have to wait for treatment. We must also make sure they are fully supported during this difficult time.

## **Prioritisation**

Throughout the pandemic, the NHS has sought to prioritise patients with the greatest clinical need. Prioritisation of time-sensitive disease such as cancer is paramount. As the pandemic progressed, the health of more patients waiting for routine operations deteriorated. Benign conditions such as hernias can deteriorate if left untreated. Long waits for hip or knee surgery can result in increasingly painful and deteriorating joints. Due to the impact on a child's development and education, delays to cleft palate surgery for children can become critical. Patients can become unable to continue working or living independently.

Over time, operations initially deemed a lower priority can become more urgent. The aims of prioritising by clinical need and addressing the longest waits are both important. Both time-critical and more 'routine' but much delayed operations need to be supported with investment across Wales.

We welcome elements of the Plan to support patients while waiting for treatment. Given waiting lists are likely to continue rising, support for patients to 'wait well' is important.<sup>viii</sup> Efforts must be made to identify patients who may be deteriorating clinically on the waiting list so they can be re-prioritised.

## Targets in the Plan

The Plan sets out a number of challenging targets for the recovery of planned care in Wales. We have serious concerns that some of the targets in the Plan only relate to some specialties. This potentially leaves some patients without a clear idea of when they can expect to be treated. The targets in the Plan should apply to all specialties and more detail is required around the timescales for the targets and how they will be measured.

To ensure transparent delivery against the targets there should be an annual report by Welsh Government to the Senedd.

## Workforce

The pandemic has had a detrimental effect on doctors' health and wellbeing. Our workforce is already exhausted and over-stretched, and we need solutions to the long-standing issue of staff vacancies. Delivering the targets in the Plan must not come at the expense of staff welfare.

Retaining our current workforce and ensuring the recruitment of new staff poses a significant challenge. We require a robust, fully costed workforce strategy providing an independent assessment of current and future workforce numbers in Wales. Understanding these projections is critical to making sure there are enough staff to meet patient demand, reduce the waiting times backlog and ensuring the long-term sustainability of the health system in Wales.

## Trainees

Utilising trainees will be key to supporting the surgical team and wider workforce. The pandemic has had a detrimental impact on doctors' training and working environments.

Supporting our surgical trainees to progress their training is key to tackling the waiting list backlog. Surgical trainees must be helped to catch up on missed training opportunities as soon as possible, with bespoke programmes of training that include enhanced theatre time. Every planned operation undertaken on an NHS patient, including NHS patients having their operation in an independent hospital, should include a surgical trainee to help them get the training time they have missed.

Surgical hubs will help increase surgical activity, and also provide surgical trainees with much-needed opportunities to continue their training. We must ensure that surgical hubs include trainees and help to increase the number of training opportunities available across Wales.

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<sup>i</sup> Stats Wales, Referral to treatment. <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment> [Accessed 8 Jun. 2022].

<sup>ii</sup> Information obtained from a press notice issued by the Department of Health and Social Care External Affairs team, dated 6 June

<sup>iii</sup> Stats Wales, Referral to treatment. <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment> [Accessed 8 Jun. 2022].

<sup>iv</sup> RCS England, Action Plan for the Recovery of Surgical Services in Wales, March 2021

<sup>v</sup> Audit Wales, *Tackling the Planned Care Backlog in Wales, May 2022*

<sup>vi</sup> UK Parliament. 2022 [cited 8 June 2022]. Available from: <https://questions-statements.parliament.uk/written-questions/detail/2022-05-16T00:00:00/2573>

<sup>vii</sup> Audit Wales, *Tackling the Planned Care Backlog in Wales, May 2022*



Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 17

Ymateb gan: | Response from: Cymdeithas Genedlaethol Plant Byddar  
Cymru | National Deaf Children's Society Cymru

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## Health and Social Care Committee request for written evidence on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

### National Deaf Children's Society Cymru Response

June 2022

#### About Us

The National Deaf Children's Society is the national charity dedicated to creating a world without barriers for deaf children, young people and their families. We support children and young people aged 0-25 with all levels of deafness, from mild through to profound, including those with temporary hearing loss and a unilateral loss.

#### Introduction

We understand that the NHS has faced unprecedented pressure over the course of the pandemic and that staff have been working hard under very difficult circumstances. However, in many areas children are waiting long periods of time for a paediatric audiology appointment.

The National Deaf Children's Society Cymru welcomes the Welsh Government's commitment to prioritise children in early diagnosis and treatment and to assess children's waiting times differently to that of adults. It is important that target waiting times are not extended. We know how important early diagnosis can be for deaf children and young people. Delays in diagnosis can have significant impact on deaf children's language development, as well as their educational and social opportunities. The significant impact of delayed diagnosis has been recently highlighted within the BAA report into failings of audiology services in Lothian, Scotland.

#### Audiology

The National Deaf Children's Society Cymru is aware of significantly increased waiting times in many of our paediatric audiology services across Wales. Some are waiting well over a year to be seen. While there are certainly some underlying staffing shortages, the pandemic has further exacerbated these waiting times.

We note that the plan emphasises the need to focus on the clinically urgent and, while we understand and appreciate this, we would also emphasise that we also need to recognise the importance of not allowing long waiting times for review paediatric audiology appointments to continue. Indeed, access to review and routine appointments in paediatric audiology can be important in ensuring that a child has the appropriate support in place and that changing needs are met. Without this, children can be vulnerable to difficulties in their learning and social development as well as feelings of isolation and difficulties with emotional wellbeing.

In noting the emphasis within the plan on patient initiated follow-up, we would highlight the importance of ensuring that patients are aware of accessible means for contacting services across the board. We would also highlight that the context of an emphasis on patient initiated follow-up is different in different types of health services. For services such as paediatric audiology, patient initiated appointments are important, but routine appointments are also important and should not be discarded. They play a significant role in ensuring ongoing accessibility and picking up changing

needs. This is particularly important in paediatric audiology where parents may not always be able to accurately pick up how a child's hearing is changing.

We would like to see Welsh Government prioritise paediatric audiology as an area for investment during covid recovery. Given the difficulties with staff shortages and room availability, this may require some creative "out of the box" thinking and solutions.

In addition to addressing the immediate and pressing waiting times in many departments, we are mindful that there are longer term issues with staffing shortages that need to be resolved. As such, we were pleased to see the plan refer to looking at planning for a sustainable workforce. The National Deaf Children's Society has been delighted that the Welsh Government has recently established a Task and Finish Group to look into the findings of the recent report on failings in audiology services in Lothian in order to see whether there are learnings from this report in Scotland for Wales. As part of this work, consideration is being given to the audiology workforce in Wales. We urge that the Welsh Government takes on board the findings of this group and considers how to address these matters in the longer term.

### **Digital Working**

We are mindful of increasing moves towards remote appointments and digital working. It is important that in making such moves, thorough consideration is given to access requirements. For example, for deaf patients, picture and audio quality as well as captioning or BSL interpretation could be important in order to access such an appointment. It is also important to consider patient preference and whether remote appointments are always an appropriate format. For example, it might be difficult to engage a young child in an assessment remotely.

The National Deaf Children's Society Cymru would welcome a clear caution within the plan regarding the above.

### **The NHS Estate**

We welcome that the Welsh Government recognises the need to better utilise the healthcare estate. Availability of rooms for audiological testing can be an issue for services looking to provide extra clinics in order to reduce waiting times.

### **Mental Health**

Research suggests that deaf young people are 60% more likely to experience mental health problems than other children.<sup>1</sup> It is not deafness itself that increases the incidence, but rather the barriers faced from living in a hearing-orientated world.

Previously, the Welsh Government called for all health boards in Wales to appoint a lead to assist with general awareness of the increased incidence of emotional wellbeing difficulties among the young deaf population and to aid referrals through to specialist deaf CAMHS in England. Unfortunately, the National Deaf Children's Society Cymru understands that these posts are no longer in place across many of our health boards. We would welcome moves by the Welsh Government to ensure that these roles are re-established and to again consider the support needs of deaf young people across Wales who require access to mental health support.

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<sup>1</sup> Department of Health and National Institute of Mental Health. Towards Equity and Access. 2005.

This is particularly timely as deaf young people and their families have told us that the pandemic has taken a further toll on emotional well-being for many deaf young people. During the pandemic, deaf young people have faced increased barriers such as communication difficulties as a result of facemasks and an inability to access usual levels of learning support.

### **Social Care**

In 2020 we worked alongside RNID Cymru and the Welsh Government on developing guidance for social care workers. Knowing that the number of specialist social workers has been in decline and that the pandemic has impacted on social care needs, we are keen to see the publication of this guidance.

### **Speech and Language Therapy**

With the introduction of the Additional Learning Needs Reforms in Wales and the availability of Individual Development Plans to children in the early years, specialist deaf speech and language therapists will be in even higher demand than previously. The early years play a significant role in a child's development and access to speech and language therapy early on can be crucial.

We understand that access to such specialist professionals can already be a postcode lottery and would be keen for the Welsh Government to give further consideration to this matter.

### **More information**

The National Deaf Children's Society Cymru would welcome the opportunity to discuss these points further and receive some clarifications. Please do not hesitate to contact us at for further information.

Thank you for taking the time to read our response.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 18

Ymateb gan: | Response from: RNIB Cymru

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# RNIB Cymru's response to the Health and Social Care Committee consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

## **About RNIB**

RNIB Cymru is the largest sight loss charity in Wales, providing support and services to blind and partially sighted people, their families, friends, and carers. We aim to improve lives and empower people to adapt to sight loss and keep their independence. We work in partnership with public, private and third sector bodies across Wales to deliver projects, training, services and give information, advice, and guidance.

We challenge inequalities by campaigning for social change and improvements to services. We believe that timely treatment should be available to all to prevent avoidable sight loss, and that the right support is there for people when prevention isn't possible. We raise awareness of issues facing blind and partially sighted people on a daily basis.

Whether you have full, some, little or no sight, everybody should be able to lead independent and inclusive lives, without facing inequity and discrimination.

# **1. Will the plan be sufficient in addressing the backlogs in routine care that have built up during the pandemic, and reduce long waits.**

1.1 RNIB Cymru welcomes this plan and the concerted effort by Welsh Government to reduce waiting lists. It's crucial, however, that improvements to services happen at pace as backlogs in planned care are leading to sight loss.

1.2 As of March 2022, there are currently just over 130,000 people in Wales assessed with the highest risk of sight loss. Half of them (65,000) are waiting beyond the target for their clinical appointment and are at immediate risk of going blind.<sup>1</sup>

1.3 Eye care services are some of the busiest in Wales, with hospital ophthalmology clinics seeing 11% of all outpatient appointments. The Royal College of Ophthalmology estimates that this will increase by 40% in the next 20 years.

1.4 Over the next 20 years ophthalmology demand is expected to increase by 16 per cent for conditions such as Glaucoma, 47 per cent for Age related Macular degeneration, 50 per cent for conditions such as cataract, and up to as high as 80 per cent for diabetic retinopathy.

1.5 By 2050, the number of people with sight loss is expected to double.<sup>2</sup>

1.6 A recent Wales Audit Office report<sup>3</sup> highlights that Ophthalmology is one of the specialities which could take far longer to recover than others because it was stretched even before the pandemic.

1.7 We know that the pandemic has exacerbated waiting lists and has had a substantial impact on theatre capacity, with around 20,000 operations per month currently taking place compared to almost 30,000 pre-covid.

1.8 Since 2018, eye care in Wales has taken a risk-based approach by introducing Eye Care Measures. This is the first service to do so. The Eye Care Measures assign patients a "Health Risk Factor", based on the severity of their condition and also a target date which they need to be

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<sup>1</sup> [Patients waiting for an ophthalmology outpatient appointment \(gov.wales\)](#)

<sup>2</sup> RNIB sight loss data tool

<sup>3</sup> [Tackling the Planned Care Backlog in Wales | Audit Wales](#)

treated by, in order to reduce the risk of irreversible sight loss. The highest is HRF1, which means that there is “Risk of irreversible harm or significant patient adverse outcome” if patient target date is missed. Essentially, patients could go blind or suffer significant sight loss if treatment is delayed.

1.9 With one in two of the highest risk patients at immediate risk of going blind, tackling performance against the Eye Care Measures must be a priority for health boards and the Welsh Government.

1.10 As a result, we are concerned that the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists does not directly address the Eye Care Measures or how Health Boards will be held accountable around meeting the targets set out by the Measures. RNIB Cymru believes this is crucial for supporting the identification of pain points within the patient pathway.

## **Recommendations**

- Welsh Government should publish its plans around how it will hold health boards to account around their performance against the Eye Care Measures
- Welsh Government should publish a timeline of when it will expect HBs to meet the targets

## **2. Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?**

2.1 RNIB Cymru very much welcomes the Welsh Government's efforts to encourage Health Boards to move more services in to the community and the significant changes to optometry that are underway. These changes will enable high street optometrists to provide services that go

well beyond eye tests, with the aim of reducing hospital eye care waiting lists by 'a third'.<sup>4</sup>

2.2 However, as well as planning for the future, as mentioned above, it's crucial that the immediate risks and challenges are addressed with urgency as patient pathways are transformed. For example, the absence of Eye Care Measures is very noticeable in the section around clinical prioritisation (page 22), as we're now in the situation where the vast bulk of the waiting list is categorised as the highest risk of irreversible sight loss/harm. Every person on that list is a priority and needs to receive treatment urgently.

### **Recommendations:**

- Eye Care Measures must now be properly embedded in Health Board practise and action plans be developed to tackle performance and backlog. A national review at this point would be a timely and important exercise in supporting the Welsh Government and NHS to prioritise funding and action.
- Welsh Government and health boards must also develop a robust capacity and demand analysis of patients by sub-speciality, through extending ECM reporting to include data by condition.
- Welsh Government and health boards should also expediate implementation of the earlier recommendations of the Wales Audit Office's 2018 report into the management of outpatients<sup>i</sup>, and the Public Accounts Committee's subsequent 2019 inquiry (ii), in particular to bring forward proposals for recording occasions when patients have come to harm as a result of waiting for a follow up outpatient appointment or treatment.

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<sup>4</sup> [Statement: NHS Planned Care Recovery Plan](#) – Tuesday, April 26

### **3. Whether the plan includes sufficient focus on:**

#### **3a. Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**

3.1 We know that patients often feel unsupported whilst waiting for treatment. They may not be given the advice or information to effectively self-manage their condition or may not be aware that they're in a category which puts them at significant risk of harm. This could then impact on their behaviour, for example, they may not think it important to attend outpatient appointments or take all of the precautionary measures recommended to manage their condition.

3.2 RNIB has been delivering an Eye Clinic Liaison Officer (ECLO) service across the UK for over twenty-five years giving a wealth of expertise and knowledge. Working with Health Board eye care teams, ECLO services enable patients to access critical early intervention support to help them to remain independent, manage their sight condition and to access both local and national support services. RNIB patient experience research found that as many as 77 per cent of patients said they would not have found or accessed support outside the hospital without the ECLO. ECLO's have told us that they are seeing more complex cases due to patients waiting up to a year for treatment, this leads to them spending more time with patients and offering increased levels of emotional support.

3.3 Patients accessing the RNIB Counselling service tell us that it is vitally important that when the time comes to deal with the emotional impact of sight loss, that the support they get comes from someone who has knowledge and understanding about sight loss conditions, as well as the range of support that can be offered as sight fails, and alternative coping mechanisms. RNIB currently offers counselling to 73 people per year affected by sight loss in Wales. There are often specific challenges faced by people who live in rural settings where transport links to services can be an issue. To lose your sight in an isolated environment can add a level of complexity and lead to increased levels of anxiety and isolation. Despite the dedicated resources we still have a number of

people on our waiting list in Wales, with a current waiting time of 9 months.

### **Recommendations:**

- The Welsh Government should provide patients with adequate and appropriate information about their level of clinical need and the degree of urgency with which they need to receive treatment. In terms of eye care, this means that patients are aware of the health risk factor rating (HRF). Patients should know who they can contact and the support they should expect when waiting over target.
- Welsh Government and NHS Wales should launch an awareness campaign to increase patients' understanding of optometrists' new role as a result of eye care services being moved to the community. There should also be ongoing communication with patients around how this will change the way their eye care is delivered.
- In terms of preparing eye care patients to receive their care, HBs should provide information intended to reassure patients of the importance of attending their appointment; the importance of arriving on time to reduce the number of patients waiting in the clinic; and how to contact the Eye Clinic Liaison Officer (ECLO) if they have any concerns. This could help reassure patients of the need to attend their appointments and could reduce the high number of patients who do not attend.
- Welsh Government plans for the recovery and transformation of planned care should reflect the Health and Social Care Committee's recommendation around the need for a focus on supporting patients to wait well. This includes information being provided in accessible formats to meet the patients' communication needs while they wait, as well as promoting awareness of, and ensuring access to, the most appropriate interim practical and emotional support.
- The ECLO role needs to be embedded in any future patient pathways.
- It's crucial that counselling services are robustly resourced to meet current and future demand, and that they are accessible to people with sight loss.

- RNIBs counselling service specifically addresses the issues arising from sight loss and it's crucial that there are good referral and signposting links to this service, and that the service is resourced.
- Welsh Government should support the role of RNIB's accredited training module, which has been developed for the counselling professions in the UK.
- Further detail is required around how the Welsh Government and NHS Wales will deliver targeted support and signposting to people living in more deprived areas, people with learning disabilities, ethnic minority communities and any other groups that face additional barriers to accessing eye care.

### **3b. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**

3.4 As mentioned above, clarity is needed around how health boards and Welsh Government are going to prevent HRF1 patients (and particularly those waiting over target) from going blind.

3.5 Due to the waiting list backlog, we are now hearing of cataract patients meeting the threshold for a CVI (certificate of visual impairment) and being referred to Vision Rehabilitation support. This raises concerns that when a person's wait for a very low priority procedure exceeds a length of time, a person's condition can deteriorate significantly. Patients in the low priority categories may rarely get to the front of the queue unless there is dedicated capacity for them.

3.6 While we welcome the recognition that local authority rehabilitation services, including vision rehabilitation services, have a key role to play in improving personal independence, and in the recovery of services, we regret the lack of specific proposals to improve the quality and equity of provision. This is especially crucial as there are significant delays in eye care patients receiving timely treatment.

3.7 As detailed in the Wales Council for the Blind's report "Addressing a workforce crisis in Wales", there are areas with waiting lists of more than a year for vision rehabilitation support after referral with a CVI. Vision rehabilitation is a vital element in blind and partially sighted people regaining and maintaining independence following a sight loss diagnosis. The inevitable result of delayed or absent provision is a loss

of confidence and income for an individual, and an increased dependence on carers or care needs assessed services.

### **Recommendation**

- The strategy needs to make clear how to signpost to and ensure integration of, local authority rehabilitation services, including more specialist rehabilitation services that work alongside those that provide hospital discharge reablement/rehabilitation.
- Health Boards should ensure that referrals into local authority vision rehabilitation services are made in a timely and systematic way, and that there is an equity of high-quality provision across Wales.

## **3c. Improving patient outcomes and their experience of NHS services**

3.8 It's crucial that the information patients need to keep safe and well is accessible. We welcome the Welsh Government's emphasis on the importance of making sure that support and information is easily accessible to those who are waiting, however, changes need to happen at pace.

3.9 Many blind and partially sighted people in Wales report that they are not currently able to understand and make informed decisions about their own healthcare because:

- i. Information about their health is not given to them in an appropriate format
- ii. They are not routinely communicated with in a way that is appropriate to their needs.

3.10 Ineffective communication with patients with sensory loss is a patient safety issue. Patients are at risk by not receiving the right support to enable them to engage in and fully understand consultations with healthcare professionals.

3.11 We have also heard from ECLOs that patients have been removed from waiting lists or moved to the bottom of lists as the communications they've received have been inaccessible.

## Recommendations

- Welsh Government should audit Health Boards' adherence to the All Wales Standards for Accessible Communication and Information with people with Sensory Loss, and implement an action plan to ensure this is standard practise within eye clinics.
- All health boards should also be mandated to include accessibility as a standing item on Eye Clinic Collaborative Group agendas.
- We would also like to request an update around a recommendation accepted by the Welsh Government on 23 September 2020, which called for the appointment of an accessibility lead within the Welsh Government to oversee the production of all key public health and other information in accessible formats, including implementation of and compliance with the standards.<sup>5</sup> Despite this recommendation being made and accepted, we know that there is no appointed Welsh Government lead for the All Wales Standards.
- NHS services should ensure that people with sight loss are asked about their communication needs and that any information is provided in their preferred accessible format.
- NHS IT systems and infrastructure must be available to support the collection and delivery of accessible information to people with sight loss.
- Key staff within health boards should receive training to better understand the communication needs of blind and partially sighted people and how to meet their communication preferences.
- Health boards should also undertake a comprehensive review of health board patient management systems to stop resource waste

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<sup>5</sup> Health and Social Care Committee, Waiting well? The impact of the waiting times backlog on people in Wales (April 2022)

and ensure the well-being, dignity and safety of the patient.

- It is essential that patient satisfaction with the service is collected. With the increased DNA (do not attend) and CNA (cannot attend) rates, understanding and learning from patient experience is vital to improving the clinical and patient service. Health Boards must collect, analyse, use and learn from patient feedback for quality improvement. It is unclear how this is being done at present.

#### **4. Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**

4.1 A regional approach to eye care has been recommended to increase service capacity. This would help create fundamental change in the way eye care services are delivered as they recover. We are aware that three new regional clinical leads for eye care have been appointed which is to be welcomed, however, no regional groups for eye care have been established so it's unclear how this regional working will be delivered. As a result, we seek clarity on the progress around the development of regional eye care services, which will need to be allocated significant and sustainable resource and investment.

##### **Recommendations:**

- Welsh Government should also ensure that the Ophthalmic Planned Care Board examines the scope of more regional planning and identifies where pressures can be off-set or where risk-sharing can be enabled, and progress recommendations.

#### **5. Is it sufficiently clear which specialties will be prioritised/included in the targets?**

5.1 The absence of the Eye Care Measures from the document means that it's difficult to get a sense of measurable, realistic and achievable

timescales and targets. A delivery plan specific to Eye Care recovery should be developed and published.

5.2 Evidence suggests around 10% of new patients are at risk of irreversible sight loss compared to about 90% of follow-up patients. The current Referral to Treatment Time (RTT) in eye care is 24 weeks, which means the target of 'No one waiting longer than a year for their first outpatient appointment by the end of 2022' included in the plan is irrelevant in terms of eye care.

5.3 We do, however, welcome the plan's commitment to developing targets and performance management alongside a real-time, visibility of the waiting list by sub speciality, robust demand and capacity plans that will enable teams to work effectively. RNIB Cymru has repeatedly called for this for several years.

## **6. Do you anticipate any variation across health boards in the achievement of the targets by specialty?**

6.1 The plan outlines the importance of a fair and equitable approach to patient prioritisation to minimise health inequalities.

6.2 However, Eye Care Measures now also show that there is a significant postcode lottery to Health Board performance in terms of outpatient waiting times. For example, Betsi Cadwaladr UHB and Hywel Dda UHB have more than half of their HRF1 (the highest risk category of patients) over target and beyond what is clinically safe. Cardiff & Vale UHB is the better performing of the larger health boards with 30% of patients over target, however Cwm Taf Morgannwg is the worst performing – with 63% of patients, almost two-thirds of their highest risk patients, over target.

6.3. We are aware that gaps in the consultant workforce is leading to the exacerbation of some speciality waiting lists in some Health Boards, for example due to specialist shortages there is a huge backlog in Glaucoma patients. A workforce plan and a clear approach to regional working are essential to ensuring equity of service across Wales.

## **Recommendation**

- Health Boards should share examples of good practice and learn, this is particularly important as such large variations exist across Wales in terms of patient access and outcomes.

## **7. Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**

7.1 Whilst we welcome the plan's focus on how it will address the immediate as well as long-term workforce challenges by moving eye care services into the community, it does not detail how it intends to upskill the optometry workforce or how the eye care workforce across primary and secondary care will see greater recruitment and retention. This is crucial to ensuring the challenges and backlogs are addressed at pace.

7.2 We know that the ophthalmic consultant workforce is ageing and there is an existing shortage. Recruiting and retaining a future proof workforce remains a challenge for Wales. Further work is needed to incentivise doctors to train and remain in Wales. Given too that the Royal College of Ophthalmology estimates that demand on services will increase by 40% in next 20 years (as mentioned above). The nursing workforce also faces many challenges including the appropriate training for eye care services.

7.3 We welcome the plan's commitment to developing multidisciplinary teams around the needs of patients, by ensuring that all members of the team have the support and professional development they need to use their skills and work at the top of their license to deliver their role effectively. As part of this, it's crucial that within the multidisciplinary team there are a sufficient number of health and social care professionals with skills and knowledge of sight loss and other disabilities.

7.4 Whilst some individual Health Boards are demonstrating good examples of workforce planning on a local scale, if we are to achieve service redesign and deliver additional capacity to meet current and future demand within the eye care system right across Wales, the pace of change must increase, and the work must be overseen by

government at a national level. There are also many key local recruitment issues that need urgent tackling in the short term.

## **Recommendation**

To deliver the changes needed, we must see Welsh Government and HEIW develop a pan-Wales integrated and sustainable eye care workforce plan that is clearly linked to capacity and demand data.

This plan must:

- robustly hold health boards to account for developing local and regional plans which reflect local pathways,
- ensure that all health board IMTPs reflect and plan for workforce challenges,
- work with health boards to audit current workforce skills, map the resource implications of expanding future demand, and ensure the necessary sub-speciality workforce capacity.

## **8. Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

8.1 Consultants have told us that the Electronic Patient Record (EPR) currently being rolled out is essential to delivering timely treatment and for improving eye care patient prioritisation.

## **Recommendation**

- We recommend a review of the operational roll out and the ongoing impact of EPR.

For further information, please contact Liz Williams (Policy and Public Affairs Manager, RNIB Cymru)

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<sup>i</sup> [Wales Audit Office, \*Management of Follow-up Outpatients Across Wales, 2018.\*](#)

<sup>ii</sup> [Public Accounts Committee Inquiry, \*Management of follow up outpatients across Wales, National Assembly for Wales, 2019.\*](#)

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 19

Ymateb gan: | Response from: Coleg Brenhinol y Seiciatryddion | Royal College of Psychiatrists

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## **Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

About

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness and intellectual disabilities, and the mental health of individuals, their families and communities.

In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales represents more than 600 Consultant and Trainee Psychiatrists across Wales.

For further information please contact:

Daisy Noott  
Policy Officer  
Royal College of Psychiatrists Wales

We are pleased to respond to the Committee request for written evidence. We have answered against the areas highlighted. Ultimately, there is some variance across different areas of mental health speciality, however we hope this themed response proves helpful to the Committee. We would be happy to provide any further detail.

### **Overall views**

The plan notes the 'increased complexity' in many people's presentations of mental ill-health and illness. This is evident.

Despite this, the plan also aims to 'de-medicalise' the approach to mental health services. This needs clarification and context, for fear of appearing as a contradictory stance that may be detrimental for some services and patients. Whilst understanding that for most people, mental ill-health as presented at primary care will not need specialist intervention, for some it will. We need to ensure that services are available for all. Any drive to de-medicalise care mustn't disadvantage people with chronic needs, or further perpetuate the stigma faced by people living with mental illness.

The plan also notes the increase in volume of referrals, which should alert us to ensure that we have the necessary medical resource to meet the need. Mental health services were already severely stretched before the pandemic. Pre-pandemic waiting times and barriers to access would have been unacceptable in any other area of medicine. The pandemic has intensified

the impact of underlying issues such as workforce shortages, the mental health estate, and the need to develop technology and digital infrastructure.

We also can't forget the role of clinical prevention, and the role of clinical teams in preventing further deterioration and illness. The three kinds of interventions of promotion, prevention, and treatment are interrelated and complementary; however, they are somewhat different from one another. Psychiatrists are competent and specialist in prevention of mental illnesses and mental health promotion in various settings.

We can support people living with mental health problems to stay well and prevent people from relapsing or reaching crisis point. Drawing focus and appreciation away from this understanding, serves to further disadvantage those who are vulnerable.

- **Responding to ever increasing demand - Welsh Government must meaningfully invest in specialist psychiatric medical provision in Wales, both now and in the long term.**
- **We would wish to work with Welsh Government to ensure a better understanding of the needs of people with mental ill health and illness, ensuring that those needs are not only catered for, but that those needs aren't disadvantaged in national strategy.**

During the pandemic, we have seen many innovations to delivering secondary care mental health services. We have made proposals to Welsh Government to work directly with us to increasingly 'foster' this and future innovation. It's essential that we don't lose sight of what can be achieved.

We've highlighted 3 projects that have been initiated and clinically led by Psychiatrists in Wales, with the support of Welsh Government and key partners. There are many more that we could choose to highlight.

These projects also speak to a thorough understanding of prevention, and ultimately the type of innovation required to deliver services more sustainably and meet the challenges for the service in both the short and long term.

#### National rollout of video consultation

Prior to the pandemic, we endorsed and supported development of a pilot telehealth and video consultation project in a CAMHS service in Gwent, the CWTCH project.

When the pandemic struck, the project went on to inform the development of TEC Cymru. The roll-out of video consultation across the health and social care sector in Wales has received much deserving attention and recognition. This work (as well as the work of the CWTCH project) has been clinically led by a psychiatrist.

We have continued to work with TEC Cymru to develop opportunities for digital development within mental health and are currently working with colleagues internationally on shared learning and approaches.

We've highlighted recommendations on digital later in this document.

#### A national approach to increasing early and effective dementia diagnosis

Whilst key aspirations for the Dementia Action Plan Wales<sup>1</sup> are to increase the number of people formally diagnosed with dementia by 3% annually and to improve early diagnosis and timely interventions – the pandemic has placed delays upon access to memory assessment and diagnostic services.

A pilot project was established to test the utility of FDG-PET brain imaging in patients with cognitive impairment; this was with the intention to aid an early, effective diagnosis of dementia. With the support of partners, an FDG-PET diagnostic pathway throughout Wales was then established to ensure equitable treatment. This was a collaboration between specialist commissioning services, psychiatrists, and radiologists. This is highlighted in the Deputy Minister for Mental Health & Wellbeing's Cabinet Statement update on dementia care.<sup>2</sup>

A national approach to treating Alzheimer's Disease before dementia, through disease modifying treatments is now needed in Wales. This is consistent with recommendations from joint research that we have undertaken with Alzheimer's Research UK.<sup>3</sup>

Through our joint research we found that psychiatrists are keen to embrace the arrival of new disease modifying treatments, but that their services needed support in order to increase access to biomarker tests for diagnosing Alzheimer's disease early and to meet the future requirements of a new treatment. Service developments can only be achieved with investment to increase and enhance capacity, infrastructure and clinical skills.

- **Welsh Government should work with the College to invest and develop the infrastructure for offering disease modifying treatments, brain health clinics, interventions for mild cognitive impairment, and the requisite clinical skills.**

#### Reversing the rise in drug related deaths

Substance misuse services had to adapt to how they treated patients during the pandemic, after face-to-face meetings, drop ins and admission to residential rehabilitation were paused. To adapt and sustain critical services throughout the pandemic, more than £3.3m was made available to support the rapid implementation of a clinically proven method of maintenance treatment, an injectable buprenorphine (Buvidal®) for at risk ex-heroin users.

Buvidal's long-acting, injectable formulation means that it can be administered to patients monthly rather than daily, which other forms of Opioid Substitution Treatment (such as methadone) require. The treatment reduces the need for daily contact thus reducing pressures on front line staff. By all accounts, Buvidal is a 'game-changer' that is helping people to turn their lives around and achieve unexpectedly positive outcomes, with many patients able to move into recovery in a manner many were unable to achieve to date.

Drug misuse deaths in Wales have fallen to their lowest levels since 2014 in the latest analysis from the Office of National Statistics. More research is now required on its further utility and application.

- **Welsh Government should work with the College and its proposals to resource a programme that will enable psychiatrists to undertake research locally and be supported in its development in national application.**

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<sup>1</sup> <https://gov.wales/sites/default/files/publications/2019-04/dementia-action-plan-for-wales.pdf>

<sup>2</sup> [Written Statement: Update on dementia care in Wales \(5 April 2022\) | GOV.WALES](#)

<sup>3</sup> [are-we-ready-to-deliver-disease-modifying-treatments\\_25may21.pdf \(rcpsych.ac.uk\)](#)

## Meeting people's needs

We welcome the Welsh Government's commitment to addressing health inequalities, as we know that people living in more deprived areas in Wales are "more likely to require use of hospital services, especially in an emergency".<sup>4</sup> As the plan recognises, the wellbeing of young people, children, Black, Asian and Minority Ethnic communities, those in lower income households, women, and those with pre-existing mental health conditions has been disproportionately affected by the pandemic. Unless measures are targeted at these vulnerable groups, inequalities will continue to rise, and the backlog may be exacerbated.

We support calls for a cross-sector, cross-governmental approach to addressing health inequalities<sup>5</sup>, as well as the work of the Senedd Health & Social Committee in establishing an inquiry into mental health inequalities.

### Physical Health

People with severe mental illness (SMI) are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population.<sup>6</sup> It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented.<sup>7</sup> Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension. As a result, it's crucial that routine physical health monitoring is available and accessible to people with SMI.

In January, NHS England National Directors for Mental Health, for Learning Disability and for Health Inequality wrote to mental health trusts throughout England to ensure and prioritise the delivery of physical health checks for people with severe mental illness and people with a learning disability. Within this correspondence there was acknowledgement of the stark health inequalities faced by people with SMI and people with a learning disability, and how the pandemic has served to further exacerbate these inequalities.<sup>8</sup>

We have regularly requested a focus on physical health of people living with SMI from Welsh Government. This is particularly relevant in terms of care, waiting times and ultimately patient outcomes.

### Unemployment

There is a well-recognised link between unemployment and poor mental health. The Adult Psychiatric Morbidity Survey 2014 showed that most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance, a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed.<sup>9</sup>

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<sup>4</sup> [Waiting well? The impact of the waiting times backlog on people in Wales \(senedd.wales\)](https://www.senedd.wales)

<sup>5</sup> [Making the difference - April 2021.pdf \(nhsconfed.org\)](https://www.nhsconfed.org)

<sup>6</sup> (Mental Health Foundation 'Poverty and mental health' 2016).

<sup>7</sup> [Association between schizophrenia and social inequality at birth: case-control study | The British Journal of Psychiatry | Cambridge Core](https://www.cambridge.org/core)

<sup>8</sup> <https://www.england.nhs.uk/wp-content/uploads/2022/01/B1268-letter-delivery-of-annual-health-checks-for-people-with-severe-mental-illnesses-and-or-learning-disabili.pdf>

<sup>9</sup> [ncap-spotlight-audit-report-on-employment-2021-\(2\).pdf \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk)

Employment support can help someone with a mental illness to manage their condition and the impact it has on their life. One such example is the work undertaken in BCUHB into Individual Placement and Support (IPS) which supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.

As highlighted in our National Audit of Psychosis<sup>10</sup>, Unemployment is the main psychosocial disability of people with psychosis. The societal costs of unemployment due to mental health problems are substantial. However, more importantly, at an individual level, unemployment is a key factor contributing to social and economic marginalisation, symptom exacerbation, risk of homelessness, and persists long after symptom resolution.

- **We would wish for a long-term commitment to expand the Individual Placement and Support (IPS) employment scheme across Wales, acknowledging the positive impact that the scheme has on decreasing readmission into services.**

### **Leadership and national direction**

Earlier in the document, we highlighted the leading role of psychiatrists in innovation, and given recommendation for this to be supported. It is crucial that clinicians are given time, resource and ultimately that leading voice into how we can develop services to respond to challenges both in the short and long term.

### **Targets and timescales**

The plan sets out some key ambitions including 'no one to wait longer than a year for their first outpatient appointment by the end of 2022' and 'eliminate the number of people waiting longer than two years in most specialties by March 2023'. It is difficult to envision how these ambitions will be met without further information detailing appropriate milestones and measurable targets for health boards to work to. Further clarification regarding which specialties are included in these targets and which are not is needed.

### **Financial resources**

We note the Welsh Government's commitment to investing an additional £50m rising to £90m in 2024/5 to support mental health services. Whilst this additional funding is essential, money alone will not be able to tackle the waiting times and service pressure. Without further detail of exactly where these funds will be targeted it is difficult to confirm whether the funding is sufficient.

Additionally, a report by the Auditor General for Wales found that although £200m was made available during 2021-22 to help tackle the backlog, health boards were only able to spend £146m of this. An estimated £12.77m was returned to Welsh Government due to the ongoing impact of Covid-19 on services, staff shortages, recruitment and retention challenges, and limitations in the current NHS estate, all of which hinder the ability to increase activity and

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<sup>10</sup> [ncap-spotlight-audit-report-on-employment-2021-\(2\).pdf \(rcpsych.ac.uk\)](#)

reshape services.<sup>11</sup> A detailed and clear funding strategy that ensures finances are fully utilised is needed.

## Workforce

It is no secret that the NHS has faced extraordinary pressures during the pandemic. Staff have had to contend with a range of stressors including risk of infection, workload changes, sleep deprivation, loss of colleagues and sometimes providing care in less than adequate settings while reporting insufficient access to personal protective equipment. All of these may contribute to an increase in the prevalence of common mental disorders, as well as exposing staff to 'moral injury'. Sustainable recovery planning is essential, as it will not only impact on retention but also on recruitment. Our own member survey from September 2020 showed that across the UK, 52.6% of members confirmed their wellbeing had 'significantly suffered' (12.3%) or 'suffered' (40.3%) as a result of COVID-19 and the lockdown, while a mere 11.1% confirmed that it had 'significantly improved' (2.9%) or 'improved' (8.2%). These headline percentages compare to 48.6% and 13.1% respectively in our second survey (in the field from 1-6 May) and 54.4% and 10.2% respectively in our third survey (in the field from 18-26 May)<sup>12</sup>.

A cohort study of UK healthcare workers from April to June 2020 showed that staff were experiencing a high burden of adverse mental health outcomes with substantial levels of probable common mental disorders and of PTSD with lower levels of depression, anxiety, and substance use disorders<sup>13</sup>. This supports survey results from the BMA of over 1,900 doctors which showed that 78.4% of respondents stated that moral distress resonated with their experiences at work and 51.1% said the same about moral injury. Of the respondents who stated that moral distress resonated with their experiences at work 96.4% (of those who had worked before and during the pandemic) stated that the pandemic had exacerbated the risk of moral distress<sup>14</sup>.

Moral injury and the development of mental illness are very real risks for staff working in unprecedented scenarios often well outside their organisational levels of experience and training. Without interventions to support staff and mitigate against the likelihood of adverse outcomes, there will be an impact on workforce supply. Moral injury is described when facing overwhelming demands for which one feels unprepared and where actions or inaction challenge an ethical code. It is associated with negative emotions such as shame or guilt and can lead to the development of mental illnesses such as depression and PTSD. Treating COVID-19 is a risk for moral injury. Professional codes teach staff to provide care only when they feel adequately trained, experienced and equipped to do so and many do not feel this way during the pandemic<sup>15</sup>.

There is a need to prevent burnout and encourage people to talk about their mental health and seek support in the workplace when they need it – physical and emotional wellbeing of health and care staff must be of equal priority to that of patients, recognising staff who are psychosocially healthy are better able to meet the needs and preferences of patients. This will impact on demand for new ways of working, at least in the short-term and will have knock-on effects for the long-term as we prioritise mental health of staff and ensure that appropriate interventions are in place. The provision of regular reflective spaces such as supervision,

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<sup>11</sup> <https://www.audit.wales/publication/tackling-planned-care-backlog-wales>

<sup>12</sup> [Microsoft Word - RCPsych COVID 19 fifth survey summary - other issues](#)

<sup>13</sup> [Psychosocial impact of the COVID-19 pandemic on 4378 UK healthcare workers and ancillary staff: initial baseline data from a cohort study collected during the first wave of the pandemic - PubMed \(nih.gov\)](#)

<sup>14</sup> [bma-moral-distress-injury-survey-report-june-2021.pdf](#)

<sup>15</sup> [What should be done to support the mental health of healthcare staff treating COVID-19 patients? | The British Journal of Psychiatry | Cambridge Core](#)

reflective practice groups<sup>16</sup>, and Balint groups<sup>17</sup>, where the emotional impact of working in such stressful conditions can be discussed in a safe environment, has been shown to increase resilience and prevent burnout. Psychological interventions for doctors based on cognitive science, for example mindfulness-based applications, which have been shown to be effective in mental health problems, among others have also been shown to alleviate stress<sup>18</sup>, and improve the wellbeing of medical staff and other health professionals<sup>19</sup>.

### Mental Health Workforce Plan

We await the publication of the strategic Mental Health Workforce Plan which we hope will provide some further detail as to specific numbers of staff needed and how these targets will be met. Staff retention will need to be a focus, as staff increasingly are leaving or retiring early due to the pandemic.<sup>20</sup>

In June 2021, we established the Royal College Mental Health Expert Advisory Group<sup>21</sup> to ensure that Royal Colleges working across mental health could share information and learning. An area of priority for all College's was the Mental Health Workforce Plan.

The mental health system is going through significant change. We know that pressure will be placed upon staff through changing working practices, legislation, and reform (such as the mental health act), whilst managing the impact of the pandemic will take some time in recovery. There is much evidence already emerging around intentions and actions from staff wishing to leave the service post-pandemic.

These points in part, highlight the need to value psychiatrists working in the service in Wales. To ensure that posts are supported and made attractive, or we will simply fail to meet both the existing and future challenge.

There must be clear recognition of the increased demands that have been created by the pandemic, and significant resourcing to meet these demands.

- **Responding to ever increasing demand - Welsh Government must meaningfully invest in specialist psychiatric medical provision in Wales, both now and in the long term.**

In January 2022, we issued a significant report to inform the consultation on the Mental Health Workforce Plan<sup>22</sup> with accompanying recommendations.

### **Digital tools and data**

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<sup>16</sup> [Impact of Reflection on Empathy and Emotional Intelligence in Third-Year Medical Students | SpringerLink](#)

<sup>17</sup> [Effect of Balint group training on burnout and quality of work life among intensive care nurses: A randomized controlled trial - ScienceDirect; Promoting empathy among medical students: A two-site randomized controlled study - ScienceDirect](#)

<sup>18</sup> [Do workplace-based mindfulness meditation programs improve physiological indices of stress? A systematic review and meta-analysis - PubMed \(nih.gov\)](#)

<sup>19</sup> [A systematic review of the impact of mindfulness on the well-being of healthcare professionals - PubMed \(nih.gov\)](#)

<sup>20</sup> <https://www.audit.wales/publication/tackling-planned-care-backlog-wales>

<sup>21</sup> [Royal College Mental Health Expert Advisory Group Wales – Grŵp Cynghori Arbenigol Iechyd Meddwl Colegau Brenhinol \(royalcolleges.wales\)](#)

<sup>22</sup> <https://heiw.nhs.wales/files/smhwp-psychiatry-report/>

In this document, we've previously highlighted some of our work in supporting and developing digital within mental health services in Wales.

The NHS has achieved remarkable transformation and adoption of remote technology on an unprecedented scale at unprecedented speed in response to Covid-19, which is actually fully in line with the Welsh Government's ambitions laid out in 'Informed Health and Care: A Digital Health and Social Care Strategy for Wales' and 'Improving people's lives through digital technologies: Digital Inclusion Progress Report and Forward Look 2018'.

The pandemic resulted in a paradigm shift in the provision of mental health services due to mandatory social distancing laws. From March 2020, the UK, along with the NHS observed a significant decrease in access to face-to-face appointments, and as a result, an increase in remote services. One common remote method for conducting appointments with patients was the use of video consulting (VC).

We co-authored a first of its kind mixed-methods and interview study on the use, value, benefits and challenges of a national video consulting service in NHS Wales.<sup>23</sup>

A total of 3561 participants provided mental health specific data. These data and its findings demonstrate that remote mental health service delivery, via the method of VC is highly satisfactory, well-accepted and clinically suitable for many patients, and provides a range of benefits to NHS patients and clinicians. Interestingly, clinicians working from 'home' rated VC more positively compared with those at their 'clinical base'.

We concluded that post 1-year adoption, remote mental health services in Wales have demonstrated that VC is possible from both a technical and behavioural standpoint. Moving forward, we suggest clinical leaders and government support to sustain this approach 'by default' as an option for NHS appointments.

### Remote monitoring

We are supporting an ABUHB led project with TEC Cymru into how technology enabled care can be used to support students in schools. This is a Q lab funded project entitled TERMS (Technology enabled remote monitoring in school).

The pandemic has taken its toll on the nation's health, especially children and young people. School closures disrupted friendships and uncertainty about the future are all likely contributors to the mental health issues children are facing. Early intervention is key to treating mental illness and key to preventing children falling into a mental health crisis. We believe that the pandemic has created new, unique opportunities to further the Whole School Approach whilst maintaining safety and creating new ways of working which are 'pandemic-proof' to some extent.

Through co-produced research the TERMS project team have gained an understanding of the barriers, challenges and opportunities that exists while implementing technology enabled remote monitoring across agencies i.e. health and education. This learning is shaping the development of a technology enabled remote monitoring in school (TERMS) framework which

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<sup>23</sup> [Remote mental health services: a mixed-methods survey and interview study on the use, value, benefits and challenges of a national video consulting service in NHS Wales, UK | BMJ Open](#)

can be shared locally and nationally with other clinical teams and schools. The initial focus of the work has been on eating in school.

- **We would wish for support as this pilot project is evaluated and considered for development, and greater adoption.**

Throughout this response, we have highlighted the necessity to meaningfully resource services to manage the ever-increasing demand. We have also highlighted that opportunities do exist to deliver services in a sustainable way, both in the short and longer term, and that psychiatrists have a leading role in this work.

We would hope for greater detail from Welsh Government on the plan and are keen to inform this work.

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 20**

**Ymateb gan: | Response from: Cymdeithas Cemegwyr y Cwmni | Company Chemists' Association**

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## Response

Welsh government

# **Our programme for transforming and modernising planned care and reducing waiting lists in Wales**

June 2022

Respond via email: [SeneddHealth@senedd.wales](mailto:SeneddHealth@senedd.wales),

For enquiries regarding this response please contact

**Company Chemists' Association**  
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### **About the Company Chemists' Association (CCA)**

Established in 1898, the CCA is the trade association for large pharmacy operators in England, Scotland and Wales.

The CCA membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 6,000 pharmacies, which represents nearly half the market.

CCA members deliver a broad range of healthcare and wellbeing services, from a variety of locations and settings, as well as dispensing almost 500 million NHS prescription items every year.

The CCA represents the interests of its members and brings together their unique skills, knowledge, and scale for the benefit of community pharmacy, the NHS, patients and the public.

## Response

The CCA welcomes the opportunity to respond to the consultation on Modernising Planned Care and reducing waiting lists. Over the last two years, the pandemic has placed significant pressure upon the Health Service in Wales. Compounded by existing pre-pandemic demands, this has resulted in delayed care and treatment times. From March 2020 to Feb 2022 the total waiting list has increased by 51.4%, whilst those waiting over 36 weeks has increased further still. With such enormous rises in waiting times, it is essential that all Primary and Secondary Care are supported to get back to pre-pandemic levels.

The Welsh Government's plan to rectify waiting times shows clarity and focus, bringing all stakeholders together for a common goal. The plan adds new thinking to existing strategies, with a strong focus on how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times. Whilst the main focus centers on Secondary Care, we are pleased to see that the plan includes and recognises the vital frontline healthcare services delivered by primary care, including Community Pharmacy. Our response will concentrate on Community Pharmacy and the role it can play in a strategic partnership to tackle increased waiting times exacerbated by the pandemic.

During the COVID-19 pandemic, the community pharmacy network in Wales played a significant role in supporting millions of people, whilst also helping to keep pressure off GP practices, hospitals, and other public services during what has been a difficult time.

A key contribution from community pharmacy is its role in increasing access for patients particularly through: treatment for a range of common minor ailments; supplies of prescription medication in an emergency; or to access contraception (including emergency contraception). One in ten NHS seasonal influenza vaccinations are now provided by pharmacies and pharmacies have played an important role in delivering our hugely successful COVID-19 vaccination programme particularly in our most rural areas.

The 713 community pharmacies in Wales are well distributed being located on high streets, in shopping centres, supermarkets, and co-located with GP practices across every part of Wales. They are also distributed in the most deprived communities, and unlike most other healthcare settings – there are more community pharmacies in more deprived geographies (the “positive pharmacy law”). This puts community pharmacy in a prime location to support other healthcare professionals to drive down patient waiting lists.

In 2019–20, Welsh pharmacies provided a range of care, treatment and advice above and beyond the safe and timely supply of prescribed medications including:

- 75,000 Common Ailment Consultations – 80% of whom would have otherwise visited their GP
- 24,000 Emergency Contraception Consultations
- Administered more than 90,000 seasonal influenza vaccinations to people at the highest risk

- Supported over 12,000 discharges from hospital making sure people got the medicines they needed when they returned home after admission to hospital.

In addition, community pharmacy is continuing to develop its role in clinical care.

- Access to the Welsh GP record is available to pharmacists providing the emergency medicine supply, seasonal influenza vaccination and independent prescribing services
- 146 pharmacists have accessed support from Health Education and Improvement Wales to train as independent prescribers
- The community pharmacy sector have agreed an innovative new contractual framework dramatically increasing the role of pharmacy in accessible care.

These services maximise the use of community pharmacies, improve access for patients, and take pressure off other parts of the NHS. This in turn helps other providers to focus on reducing patient waiting times.

We are pleased to see that within the consultation, community pharmacy services will continue to be promoted as an alternative to visiting to urgent care services. They will play a vital role in supporting patients who may be already on a waiting list or require onward referral.

The Consultation Case Study states that all community pharmacies in Wales are able to offer an extended range of services via a national clinical community pharmacy service, including treatment for common minor ailments, access to repeat medicines in an emergency, annual flu vaccination, and emergency contraception.

“Presgripsiwn Newydd A New Prescription” has helped to develop community pharmacy into a more focused member of the primary care team, working closer with partners through collaborative meetings. To improve patient safety, A New Prescription aims to move community pharmacy from primarily a medication supply function to a broader role meeting the clinical needs of patients and the public. Historically, community pharmacy has always been a location for advice and this role continues to be developed and built upon as thousands of people routinely access their local pharmacy for advice and urgent care.

The integration and collaboration of community pharmacies within primary care clusters is vital to realising the potential of community pharmacy and transforming care pathways in the way necessary to achieve the vision set out in Pharmacy: Delivering a Healthier Wales.

Community Pharmacy is well distributed across Wales with easy access, which supports the consultation aim of better access to healthcare closer to home. We would like to see even greater collaboration between healthcare professionals, normalising referrals between community pharmacy and other parts of the NHS. This will support people receiving the right care from the right professional, providing timelier access to treatments. One of the enablers to this is information standards, to support the digital infrastructure needed for a modern healthcare environment.

Operating at the heart of local communities often with teams drawn from those same communities, pharmacy teams are well placed to tackle health inequalities. Prevention is a key pillar to reducing health inequalities and community pharmacy has long been recognised for its vital contribution to public health initiatives. Pharmacy can work with health bodies in Wales as well as with Public Health Wales, to further promote healthier lifestyles. This includes encouraging people to achieve and maintain a healthy weight, be more physically active, stop smoking, screen for health conditions, and provide wholistic health checks. As stated in the consultation Primary and Community Care Primary care services, General Practitioners (GPs), dentists, opticians and pharmacists on average undertake around 90% of all NHS activity. Community pharmacy often has the greatest opportunity to provide interventions, with regular touchpoints through repeat prescription collection, as well as a recognised high street presence.

In summary the Community Pharmacy network is well distributed across Wales often located in areas of highest deprivation and greatest need. Pharmacies offer a highly accessible service, often with extended hours. A New Prescription has helped to develop community pharmacy's role beyond a primarily dispensing function, to the delivery of a vital suite of clinical services. By harnessing the clinical expertise of pharmacy teams, this will support the health service in Wales to help reduce the care and treatment backlog. We welcome the government's commitment to community pharmacy through the new contractual framework and encourage the NHS to explore even further avenues to utilise the growing expertise within the sector. To maximise this opportunity, there is a need to consider digital enablers to support a growing role and need for interconnected care. This includes standardisation of coding and APIs to facilitate further innovation in the future.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 21

Ymateb gan: | Response from: Parkinsons UK Cymru

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## Transforming and modernising planned care and reducing waiting lists

1. This submission serves to highlight the issues impacting the Parkinson's community that we feel need to be emphasised in light of this plan and acknowledging the recent publication of the ['My Neuro Survey' Wales report](#).

Issues include:

- people living with worsening symptoms post lockdown.
  - reduced access to all aspects of healthcare to manage the condition.
  - our position on Patient Initiated Follow-Up (PIFU) for people with Parkinson's.
2. We welcome the plan to transform and modernise planned care and reduce waiting lists and acknowledge that this is an opportunity to shape how we deliver healthcare effectively in the future.
  3. However, we are also aware that services for people with Parkinson's were inconsistent throughout Wales prior to the pandemic and, with such an enormous multifaceted task ahead over the next four years, as set out in this plan, we must ensure that the needs of people living with Parkinson's in Wales are consistently considered.

4. We would seek assurances from Welsh Government that the findings presented here from the Parkinson's community, in the 'My Neuro Survey Wales' report and the report of the Cross Party Group on Neurological Conditions: Building the foundations for change: The impact of the Welsh Government's Neurological Delivery Plan are considered alongside the developments outlined in this plan.
5. The impact of the lockdown restrictions and reduced access to regular healthcare reviews, physiotherapy, speech and language therapy and occupational therapy since the start of the pandemic has had a significant impact upon people living with the condition being able to manage their Parkinson's symptoms.
6. Coupled with reduced access to regular physical activity and exercise as well as the negative mental health implications of reduced social interaction, isolation and loneliness the impact of the past two years on those living with Parkinson's means we must ensure those living with the condition are not left behind as we seek to rebalance and modernise.

## 7. About Parkinson's

Parkinson's is the fastest growing neurological condition in the world<sup>1</sup>, and currently there is no cure. Parkinson's is what happens when the brain cells that make dopamine start to die. There are over 40 symptoms, from tremor and pain to anxiety. Some are treatable, but the drugs can have serious side effects.

8. In Wales, around 7,600 people are already living with Parkinson's. This is forecast to rise by around a fifth to approximately 9,000 by 2030.

## 9. What matters most to people affected by Parkinson's

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<sup>1</sup> Dorsey, E. et al. (2018). Global, regional, and national burden of Parkinson's disease, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet Neurology*, 17

The views and needs of people affected by Parkinson's are central to both the work that Parkinson's UK Cymru does, and our ultimate ambition, which is to find a cure and improve life for everyone affected by the condition.

10. In 2020 we asked people affected by Parkinson's - those living with the condition, their families and carers - what are the most important issues for us to campaign on through our ['What matters most?' survey and our coronavirus poll](#). As the pandemic hit halfway through our survey, causing a great deal of uncertainty, we used the poll to validate the views of our community. More than 2,300 people in the Parkinson's community responded to both surveys across the UK with 5% of responses from Wales.

### **11. People affected by Parkinson's in Wales told us they need:**

- High quality health and social care
- Access to the right treatments at the right time
- To be able to access financial benefits
- To get their Parkinson's medication on time when in hospital or a care home

### **12. Cross Party Group on Neurological Conditions inquiry into the impact of the Neurological Conditions Delivery Plan**

13. Prior to COVID-19, the [Cross Party Group on Neurological Conditions inquiry on the impact of the Neurological Conditions Delivery Plan \(NDCP\)](#) heard that people with neurological conditions had experienced poor access to treatments, services and support. In spite of the NDCP being in place since 2014.

14. In the first half of 2022, the Wales Neurological Alliance (WNA) has, for the first time, collaborated with the Neurological Alliances of Scotland, England and Northern Ireland to gather evidence from people living with neurological conditions across the UK.

15. The [My Neuro Survey](#) provides an important insight into whether people living with neurological conditions in each of our nations are getting the treatment and support they need. Over 8,500 people shared their experiences in the survey, 503 from Wales.

16. The [findings from the neurological community in Wales are presented in this report](#) alongside the Neurological Conditions Implementation Group's (NCIG) Position Statement for Neurological Services across NHS Wales report of March 2022.

**17. The report concludes that: "People living with neurological conditions in Wales continue to report substantial barriers to accessing the treatment, services and support that they need from health and social care services."**

### **18. The impact of coronavirus on people affected by Parkinson's: July 2020**

Parkinson's UK and Lancaster University collaborated on a survey in April-May 2020 to find out the impact of the coronavirus restrictions on the Parkinson's community. Over 2,000 people across the UK affected by the condition completed it - 1,491 people with Parkinson's and 540 family members, friends and carers. 6.6% (116) of respondents were from Wales.

The full report is available [here](#).

**19. Access to healthcare:** For those in regular contact with health services, many had appointments cancelled and alternatives were not routinely offered via telephone or online.

The statistics for Wales do not compare favourably to the other three nations or to the UK as a whole.

- 48% had appointments with their Parkinson's Nurse cancelled in Wales (33% across UK) and of these, 53% were not offered a phone or online appointment (53% across UK.)
- 57% in Wales had appointments with their Parkinson's Consultant cancelled (34% across UK) and of these, 80% in Wales were not offered a phone or online appointment (68% across UK.)
- Cancellation rates were also high for those accessing physiotherapy at 78% across Wales (70% across UK), speech and language therapy (76% in Wales, 57% across UK) and occupational therapy (78% in Wales, 55% across UK.)

20. Wales had the lowest number of respondents who decided to cancel appointments because they were worried about the coronavirus (8% for Wales, 15% for the UK.) Cancelled appointments were seen by many as a contributor to deterioration of the

condition and some were worried they were storing up future difficulties.

**21.Symptoms:** Many said their Parkinson's symptoms got worse since the restrictions began. Over a third experienced increased slowness of movement, stiffness and fatigue and over a quarter experienced increased tremor, anxiety and sleep problems. Stress and isolation and reduced access to health care and exercise (see below) were seen as causes of deterioration of their condition.

### The impact of coronavirus on people affected by Parkinson's: August 2021

We again worked with Lancaster University in August 2021 to survey the Parkinson's community. This enabled researchers to measure the change in symptoms over the course of the restrictions and the pandemic. The full report is available [here](#).

**Worsening symptoms:** The findings show that both motor and non-motor symptoms were heavily impacted. Overall, 8 in 10 people with fatigue (86%), stiffness (83%) and slowness of movement (88%) reported a decline in these symptoms.

Anxiety and depression also increased considerably with 7 in 10 people reporting that their anxiety had worsened in 2021, more than doubling the percentage from the previous year. And almost 4 times as many people with the condition said their depression got worse (rising from 13% to 48%).

Slowness of movement, fatigue and sleeping issues all doubled year-on-year, while muscle cramps increased threefold. We believe these significant declines could be in part because of government restrictions that limited people's access to physical activity.

**Limited access to services:** As well as a deterioration in symptoms, our community shared that they weren't able to access their healthcare services in quite the same way.

In the 3 months before our 2021 survey, over half (54.3%) of people with Parkinson's had an appointment with their care provider cancelled, with consultants cancelling slightly more frequently than nurses (31% compared to 28%).

Other appointments that had been cancelled include physiotherapist (18%), speech/language therapist (18%), occupational therapist (14%) and psychologist (6%).

**Virtual appointments:** Almost 3 in 5 people with Parkinson's (58%) had a phone or online appointment with their Parkinson's nurse and over a third (35%) had had one with their consultant. While aspects of these were seen positively, only 4 in 10 (40%) said they were pleased with the outcome of their consultant appointment.

Just under half (46%) of people with Parkinson's surveyed felt their doctor could understand them well, and fewer than a quarter (23%) felt the connection with their doctor was comparable to that of a face-to-face appointment.

**Only 1 in 10 (12%) would recommend online or phone appointments to another person with Parkinson's.**

Noting this low number who would recommend online or phone appointments to another person with Parkinson's, we are concerned by the inclusion of targets: "35% of new appointments and 50% of follow up appointments are delivered virtually." People living with Parkinson's, as individuals, must be a part of the decision making process as to whether this type of appointment is suitable for them, it cannot be a default position across services or patient groups.

### **Patient Initiated Follow Ups**

Based on what people with Parkinson's have told us, we believe there are some key principles that should be met before a Patient Initiated Follow Up/ review (PIFU/R) pathway is considered for someone as follows:

- Patients and carers should be involved in a discussion/assessment about whether this approach is right for them and ultimately have the choice if they are moved onto this pathway.
- The move to this pathway needs to be in the best interests of the patient and carer.
- There needs to be flexibility in the pathway, rather than a general approach to all patients.

- There needs to be a recognition that Parkinson's is different for everyone, and that as the condition progresses the needs of individuals will increase and therefore the progression of the services required will need to change to meet this.
- There needs to be clear communication about what to expect if you are moved to this pathway - how to get in touch with your service if you need an appointment, timescales for response and what to do if you don't get one within that time frame and how you provide feedback or complain about the service.
- Patients, carers and professionals need to be open and honest about the pros and cons of the pathway.
- How the pathway is working for the individual with Parkinson's should be reviewed at every appointment, but at least on an annual basis.
- Each service should instigate a check-in system for all patients. If a service has not heard from their patient within 12 months they should contact them.
- Fixed appointment intervals should be preferably at 6 month intervals (12 months maximum) supplemented by a patient-initiated intermediate service.

Current NICE guidelines state that "people diagnosed with Parkinson's disease should be seen at regular intervals of 6–12 months to review their diagnosis". The evidence still supports regular reviews to make sure that cases of conditions like Progressive Supranuclear Palsy, Corticobasal degeneration and Multiple System Atrophy are not missed. NICE also states there should be a discussion with a Parkinson's specialist before any medication is started or changed, especially dopamine agonists as it needs to be carefully monitored for side effects.

The Neurological Alliance have also developed guidance on developing PIFUs in neurology for England<sup>2</sup>.

Parkinson's is a complex, progressive condition that presents differently for everyone and people living with the condition need ongoing long term multidisciplinary care that flexes to meet their needs as it progresses.

While we know that some people with Parkinson's would prefer to contact their service as the need arises, others may find it particularly challenging to assess the progression of their own symptoms and therefore identifying that they need a review would be particularly difficult.

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<sup>2</sup> The Neurological Alliance, June 2021 - <https://www.neural.org.uk/wp-content/uploads/2021/06/Guidance-20210623-PIFU-principles-June-2021.pdf>

Particular Parkinson's symptoms may make it more difficult for an individual to seek support when they get worse. This could include those living with anxiety and depression, those with cognitive issues, those with advanced Parkinson's, those who experience movement related issues, have problems with communicating or those who are more frail and those who live alone or have no carer or close relative who can assess the progression of an individuals' condition.

Parkinson's medications are vital at managing symptoms of the condition. Optimising Parkinson's medication is challenging as everyone responds differently to Parkinson's treatments, and medications become less effective over time as symptoms change.

All Parkinson's medications have potentially significant side effects, and can worsen other symptoms. The risk of impulse control disorders in those taking dopamine agonists must be monitored by professionals. It is also important that professionals review an individual regularly to assess whether the prescribed treatments and therapies are still effectively controlling their symptoms.

A move to PIFU/R could be problematic for those who do not already engage with a Parkinson's service regularly and also people from a tradition/culture where they don't wish to bother health professionals unless there's a crisis.

Professionals have also shared that Parkinson's should be reviewed regularly following diagnosis to ensure the diagnosis is correct. Subtle symptom changes could be missed when they could be more easily correctable, for instance posture.

We are also concerned that PIFU/R could be misused to discharge patients who need a regular review of their care to stay well.

**For further information contact:** Rachel Williams, Policy, Campaigns and Communications Manager, Parkinson's UK Cymru

Submitted on behalf of Parkinson's UK Cymru

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 22**

**Ymateb gan: | Response from: Cymdeithas Fferyllol Frenhinol Cymru |  
Royal Pharmaceutical Society in Wales**

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Russel George MS,  
Chair, Health and Social Care Committee  
Senedd Cymru

**Consultation: Views on The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

Dear Russell,

Thank you for this further opportunity to support the committee's ongoing work on waiting times backlog.

Now that the Welsh Government's programme for transforming and modernising planned care and reducing waiting times is published, it's only right that the committee revisits this area and allows stakeholders across health and social care to comment on the plan.

Overall, we welcome the programme and steps outlined by the Welsh Government. As recognised in the foreword, the scale of the task after two years of the pandemic is significant. With this in mind, the recognition that a fresh approach to planned care is needed to meet the increased demand is completely right.

We also agree with the overall aim of the plan:

*"The aim is to accelerate health and care recovery in the short to medium term focusing on stabilising and recovering the waiting lists, whilst developing and embedding longer-term transformative and innovative change".*

While the health service must do all that it can to accelerate access to treatment to those who have been waiting for care over the last two years, the scale of the challenge and pressures it will place on the health services necessitates exploring and developing new, more efficient approaches to planned care.

As we broadly agree with the principles in the plan, the points below are constrained to

- issues that have not been included in the plan and we believe merits consideration
- or where the perspective of pharmacists would be helpful for the committee.

Kind regards



Elen Jones  
Director, the Royal Pharmaceutical Society's Welsh Pharmacy Board

## **Supporting the workforce**

In our initial response to the committee's inquiry<sup>1</sup> we were clear that plans to meet the waiting times backlog must take into account the strain and pressures that the workforce has faced over the course of recent years. This means that we cannot keep asking the existing workforce to do more. We are clear that the key principles of pandemic recovery should be on working differently and smarter, while always ensuring that steps are taken to maintain a sustainable, resilient and supported workforce.

With these principles in mind, we're pleased to see the plan recognises the impact that the pandemic has had on workforce capacity and wellbeing and 'includes building a sustainable workforce' as an underpinning enabler.

The commitment to also "develop a focused workforce plan to underpin this planned care recovery plan" is crucial. Put simply, without such a plan to support the workforce in place, the aims for recovery will not come to fruition.

For pharmacy, priorities in such a plan are for:

1. All pharmacists must be given access to, and be enabled to take, appropriate rest breaks, both for the welfare of pharmacists and for patient safety
2. Pharmacists must have dedicated protected learning time within working hours
3. Investment is needed in the pharmacy workforce to train more pharmacy staff and upskill existing staff to work at the top of their competence
4. Pharmacists and their staff must have continued access to national wellbeing and occupational health support.

Further details on these points can be found in our initial written response to the inquiry and in our recently published statement on the needs of the pharmacy workforce<sup>2</sup>.

## **Avoiding delays and complications through medicines optimisations**

A key enabler for efficient and quick access to planned care that significantly reduces the risk of complications that can cause delays is to ensure a medicines optimisation process has taken place. This is not referenced in the plan but must be a central component of our approach to more efficient planned care.

Medicines optimisation is about ensuring that patients get the right choice of medicine, at the right dose, in a timely way, to get the best outcome in terms of disease/condition control and prevention of progression or secondary complications. By focusing on patients and their experiences, a further goal is to help patients to take their medicines correctly, avoid taking unnecessary medicines and improve medicines safety. Prescribing pharmacists based in hospitals, GP practices and community pharmacies, with their expert knowledge of medicines

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<sup>1</sup> <https://business.senedd.wales/documents/s122261/WT%2031%20-%20Royal%20Pharmaceutical%20Society%20Wales.pdf>

<sup>2</sup> <https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/workforce>

and their effects are well placed to lead on medicines optimisation across all conditions that require planned care e.g anticoagulation, heart failure, respiratory conditions.

In the context of planned care, effective medicines optimisation has two significant benefits:

1. Reducing the likelihood of a referral to specialist services: When a patient's medicines are not optimised for their treatment, they are much more likely to experience complications and to be referred to specialist services. Effective medicines optimisation at an early stage of treatment will negate this risk of referral, ease pressure on the system and create additional capacity for planned care.
2. Reduce the likelihood of complication before treatment/surgery: Medicines optimisation at an early stage after initial referral will significantly reduce the possibility of complications or side-effects emerging that will risk delaying a planned surgery and cause further delays and inefficiencies in the system.

### **Harnessing the skills of hospital based pharmacists**

When discussing how the plan aims to transform the way planned care is provided, it's stated that "a wider range of health professionals will help you to stay well and remain at home". We support this priority but would also advocate for a wider range of health professionals from across the multidisciplinary team to be a more central part in leading planned care, particularly hospital-based pharmacists.

With a significant number of hospital pharmacists qualified as independent prescribers, there is huge potential for their expert clinical knowledge and skills to be better utilised and add additional capacity in planned care and to reduce waiting times. Already in Wales there are examples of hospital-based consultant pharmacists and their teams leading specialist mental health and renal care clinics. Meanwhile there are numerous examples of pharmacists taking a lead on medicines management and optimisation in various clinical specialities.

However, in order for all patients to benefit from the expert clinical skills of hospital pharmacists, all specialty multi-disciplinary teams providing planned care must include a hospital pharmacist and their medicines expertise. This should certainly be the case for those specialities identified in the plan as having the greatest number of people waiting for treatment (trauma and orthopaedics, ophthalmology, ear nose and throat (ENT), urology and gynaecology). The result of this will be safer and more effective use of medicines, while reducing the risk of complications and delay to treatment.

### **Prehabilitation**

We were pleased to see that prehabilitation is a strong focus in the proposals to build sustainable planned care capacity. For patients, this is a vital part of making sure that they are in the best possible physical and mental state to get the best outcomes from their treatment. While for the NHS, effective prehabilitation has the benefit of reducing cancellations on the day of treatment and allow theatres to operate at full capacity

This is another area where the skills of pharmacists can play an important role within the multidisciplinary team<sup>3</sup>. They are well placed to take a holistic view and to work with patients; providing them with an optimisation bundle which consists of medication reviews, screening checks and any lifestyle interventions to ensure maximum benefit from their treatment and for their recovery.

### **Community Pharmacy's Role**

In our first written evidence to this inquiry<sup>1</sup> we stressed the important role of community pharmacists and their teams in helping to reduce waiting times and pressures on the system. We're pleased that the Welsh Government plan also recognised this role and pledges to continue to promote community pharmacy as an alternative to urgent care services via the newly introduced national clinical community pharmacy service.

Again, as mentioned in our first evidence, to make the most of the new clinical service, ongoing funding community pharmacists to complete independent prescribing training will be required.

### **Social Prescribing**

We note the plan commits to “develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into our pathways. To make full use of these services and pathways, the role of community pharmacists must be a central part of this framework.

As the most accessible health professional on the high street, community pharmacists develop a strong relationship with their patients and are extremely well placed to identify people who could benefit from social prescribing. Furthermore, their training means they also possess the required communication and interpersonal skills for social prescribing.

### **Keeping people healthy & off waiting lists**

Of course, the most effective ways to manage waiting times, is to keep people healthy and not be in need of treatment in the first place. We welcome the commitment of a more targeted approach to the causes of avoidable ill health and death in the plan.

Through smoking cessation services and in providing health coaching and behavioural advice, community pharmacy teams already play an important role in helping people to avoid preventable illness and stay well. However, pharmacy in Wales has signalled its intention to build on its public health role. In the profession's 10 year vision; Pharmacy: Delivering A Healthier Wales, there is a commitment to:

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<sup>3</sup> <https://www.rpharms.com/wales/pharmacy-delivering-a-healthier-wales/putting-pdahw-into-action#5>  
(Prehabilitation pharmacy: Preparing patients for their cancer recovery by Marian Jones, Prehabilitation Pharmacist, Cardiff South West cluster)

*“increase our focus on health, wellbeing and prevention with all community pharmacies becoming health and wellbeing hubs”<sup>4</sup>.*

## **Regional Treatment Centres**

At RPS, we consistently support the principle that systems should be designed to allow patients to receive their care as close to home as possible. This principle is also reflected in the Welsh Government plan with the exception of the proposal to:

*“develop a network of regional clinical teams and centres flexibly to meet local demand. For some services, treatment centres or centres of excellence may be the best option. The development of green or cold sites will be considered for many routine procedures, which may mean that people will have to travel to access care in another health board”.*

While recognising that this is not ideal, the situation post-pandemic does require new approaches and we accept that the evidence cited for high volume surgery centres is persuasive and will likely lead to a reduction of waiting times of treatment at a quicker rate.

As discussed in the document, communication to explain the rationale for this change in approach to the public will be important and that patients with travel challenges receive appropriate support.

Additionally, further information from the NHS/Welsh Government on the geographical coverage of these new regional centres would in the coming weeks/months and of the skills mix within teams working in this new model would be welcomed. From our perspective, we would stress that each regional centre should benefit from the expert skills and medicines knowledge of pharmacists within their multidisciplinary teams.

## **E-advice for primary care**

When discussing steps to help reduce unnecessary referrals into secondary care, the plan references the newly introduced “e-advice” function. It states that:

*We have introduced e-advice; this new functionality allows primary care to e-mail the specialist team and access immediate advice about how to treat the individual.*

Despite stating that this new functionality is now in place for primary care, at this stage it has not been extended to community pharmacy, nor to our knowledge to the other primary care contracted professions (optometry and dentistry).

Considering the accessibility of community pharmacy and the high volume of patient engagement, access to this functionality would be a huge benefit to both pharmacists and their patients. For community pharmacists to be better integrated within the NHS and have access to specialist support and advice - the absence of which our members constantly tell is a source of huge frustration and a feeling of professional isolation. Meanwhile for patients they will be

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<https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/Pharmacy%20Vision%20English.pdf?ver=2019-05-21-152234-477>

pointed in the right direction for their care at the point of their first interaction with the health service, regardless of whether the issue requires specialist input or not.

While not relevant for waiting times for planned care, we would encourage exploration by Welsh Government, Digital Health and Care Wales and the contractor bodies as to whether this functionality could be used for communication between community pharmacies and GP practices. This would be a much-needed solution to resolve prescription queries seamlessly, without pharmacists waiting on the phone to surgeries for extended periods of time or having referring patients back to surgeries with those problems.

## **Referrals**

We share the concerns outlined in the plan around “potential missing referral of patients that are expected to present with their systems over the coming months”.

Community pharmacy is uniquely placed to help identify those people who would benefit from referral to specialist care but may not have been appropriately referred over the course of the pandemic. As the only health setting that remained open throughout Covid-19, pharmacists and their teams will have monitored their patients carefully through this period and will have spotted decline or changes in both their patients’ physical or mental health that indicates a referral is required.

However, despite being the most accessible health professional group with such regular interaction with patients, at present, community pharmacists are not able to directly refer patients to other parts of the health service. In circumstances where a referral could be safely and appropriately managed by the pharmacy team, they can only suggest and signpost patients to see their GP. This results in patients always having to take an extra step themselves before they get the care they need, rather than it being facilitated for them by the health service.

In addition, pharmacist prescribers working in primary care and hospital settings should also have referral rights with an agreed clinical pathway. This is for situations where they may not be able to progress a patient along the pathway and would be particularly important in extreme circumstances and in order to maintain patient safety (e.g. red flagging).

To streamline referral processes, we recommend that formal referral protocols/pathways should be developed for pharmacy teams to make direct referrals to other services. Their aim should be to remove burden from patients themselves and allow them to move through the health system more rapidly and efficiently. These protocols/pathways should be developed with input from across multidisciplinary team and patients’ representatives so that they are tailored to what patients need and expect.

## **Measuring & Monitoring progress**

One aspect currently missing from the plan is reference to how progress will be measured and reported. In a situation where new ways of working are being developed, some new initiatives

will work better than others. It's therefore important that we're able to identify the most effective initiatives in meeting demand efficiently and providing the best possible outcomes for patients.

From a pharmacy perspective, as a growing number of pharmacists are now using their prescribing skills across all settings, having means to measure and identify where their skills in medicines optimisation are having the most effective impact is important. Such evidence can then inform workforce planning across all health boards and ensure that examples of new practice and ways of working that is proven to be effective can be replicated consistently across Wales.

This may be something that committee wishes to explore in any further reports or communication with the Welsh Government.

### **Adopting best practice**

Health systems across the world will be facing similar challenges with treatment backlogs to those that we're facing in Wales. We would hope that this plan remains flexible and able to adopt any initiatives from other UK countries or internationally that have proven to be especially effective in meeting reducing waiting times for planned care.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 23

Ymateb gan: | Response from: Cymdeithas Orthopedig Prydain  
| British Orthopaedic Association

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## **British Orthopaedic Association response to request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

At the British Orthopaedic Association (BOA) we welcome the publication of the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.

We particularly welcome the proposals for:

- Delivering evidence-based treatments that add value.
- Additional sessional work at weekends and evenings.
- Partnering with the independent sectors to develop new approaches and models of care.
- Regional options which will allow protected planned care capacity at a higher volume than traditional hospital-based theatres.
- Consolidating urgent and emergency services to free capacity for planned care.
- Transformation and introduction of new models of care at practice, cluster, hospital and health board level.

We strongly believe that central direction is essential to manage resources effectively to optimise treatment for Welsh orthopaedic patients, and we believe there is a need for greater clarity than is currently set out in the plan on which specialties will be prioritised and included in any targets, and the targets themselves. Without operational incentive to drive elective recovery, we cannot understand how you expect elective recovery to be achieved for these patients who have already waited too long. It is easy for hospitals to redeploy orthopaedic beds, wards, nursing staff, theatre lists, anaesthetists and theatre teams to other areas, but this should not be tolerated.

Reducing waiting lists will also require adequate resource and investment to build capacity. It is clear that the elective orthopaedic surgical capacity could not meet the demand, prior to the pandemic. While we welcome the proposal for additional sessional work at weekends and evenings, this cannot be simply asking existing resource to work longer and harder. We would welcome greater clarity around how any additional funding will be used, and how its use and impact will be tracked and reported on. The BOA believes that the solution is likely to involve surgical hub centres, dedicated for elective treatment, which can operate 12 months of the year.

The British Orthopaedic Association strongly support the WOS concerns outlined in their response to the Welsh Government's plan and have full confidence in the Welsh orthopaedic leadership team. We are happy to help in any way to expedite elective recovery for the benefit of patients in Wales. It is imperative in our experience, that orthopaedic surgeons are involved in the development of strategies and solutions. The most successful high volume surgical treatment programmes that we have seen throughout the UK, occur when there is dynamic local clinical leadership, working with an engaged management towards a common goal.

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 24**

**Ymateb gan: | Response from: Coleg Nyrso Brenhinol Cymru | Royal College of Nursing Wales**

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## Royal College of Nursing written evidence to the Health and Social Care Committee inquiry into ‘the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists’

The Royal College of Nursing (RCN) Wales welcomes the opportunity to provide written evidence on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists. RCN Wales previously provided written and oral evidence on the inquiry into the impact of the waiting times backlog.

The Welsh Government’s plan is centred around four commitments; increase health service capacity, prioritise diagnosis and treatment; transform the way Wales provides planned care and provide better support to patients. In order to deliver on these commitments there needs to be a significant investment in the workforce. The plan does not outline any meaningful investment in terms of increasing the nursing capacity with the health and social care sector.

### **The Royal College of Nursing Wales recommends:**

1. The Welsh Government must continue to invest in all four fields of pre-registration nursing education.
2. The Welsh Government and Health Boards should harness the opportunity of newly qualified nurses being prescriber ready from 2023 and set out a clear plan to invest and develop the next step for these new graduates and the current workforce.
3. Health Education and Improvement Wales should develop a post-registration nursing strategy with a specific focus on district nursing.
4. Every health board should commit to investing in the role of the consultant nurse in order to meet the health needs of their population.
5. The Welsh Government and health boards should harness the knowledge and leadership of Infection Prevention and Control nurses in delivering education and leadership for the healthcare workforce.
6. The Welsh Government must establish a national retention strategy to encourage our nursing staff to keep working in the NHS.

7. The Welsh Government must ensure there is a whole system approach to digital technology. This must include an assessment of what is available across the NHS and how digital technology can be harnessed to improve planned care.

### Increase health service capacity

In order to increase health service capacity, an investment in the workforce is necessary. Unfortunately, the plan does not set out any specific actions for how to address the challenges currently facing the workforce.

The NHS is the largest employer in Wales and currently employs almost 89,000 full-time equivalent (FTE) posts. Nursing is the single largest professional group within the NHS, representing 40% of the total workforce. 91% of this workforce is female.<sup>1</sup>

Currently the nursing workforce is facing intolerable pressure and this is having a devastating impact on wellbeing with many nurses burning out and deciding to leave the profession early. There is an urgent need to address this to ensure there is a workforce available to provide patients with safe and effective care.

A recent RCN survey found:

- Over half of respondents felt demoralised (53%), while only 13% felt fulfilled by their role.
- Only around one in five (17%) respondents agreed they had enough time to provide the level of care they would like. This has decreased from 22% in 2020.
- Two thirds of respondents worked additional time (63%). Of these, almost eight in ten (70%) were unpaid for these additional hours, 20% were given TOIL.
- Over half of respondents (53%) in Wales felt demoralised: only 13% felt fulfilled.
- Two thirds (60%) of respondents were unable to take their breaks that they were supposed to take
- Worryingly, nearly a quarter (24%) of Welsh respondents felt unable to raise concerns: this is 3% higher than the UK average and 4% higher than the Welsh 2020 finding.

Nursing staff are able to retire at 55. Table one outlines that 51% of the nursing and midwifery workforce are already eligible to retire or will be eligible to retire in the next 10 years. Without an investment in the nursing workforce the NHS will be unable to provide safe and effective care.

*Table One: Staff Age Band by Staff Group March 2021*

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<sup>1</sup> Health Education and Improvement Wales 2021 *NHS workforce trends (as at 31 March 2021)*. Available at: <https://heiw.nhs.wales/files/nhs-wales-workforce-trends-as-at-31-march-2021/>, accessed 31 May 2022.

| Age Band            | Under 25  | 25 - 29    | 30 - 34    | 35 - 39    | 40 - 44    | 45 - 49    | 50 - 54    | 55 - 60    | Over 60   |
|---------------------|-----------|------------|------------|------------|------------|------------|------------|------------|-----------|
| Nursing & Midwifery | 4%        | 10%        | 12%        | 11%        | 12%        | 14%        | 15%        | 15%        | 7%        |
| <b>NHS Wales</b>    | <b>5%</b> | <b>10%</b> | <b>12%</b> | <b>11%</b> | <b>11%</b> | <b>13%</b> | <b>14%</b> | <b>16%</b> | <b>9%</b> |

RCN Wales recommends the Welsh Government address this area of concern as a matter of urgency.

The Welsh Government must continue to increase nursing student commissioning for all four fields of nursing; adult, mental health, children and learning disability nursing. Between 2016 and 2021 student nursing places increased by 55.2%.<sup>2</sup> The Welsh Government consistently invested in nursing education with places rising from 1,418 in 2016 to 2,202 in 2021. However additional investment is needed due to the age profile of the workforce and demand to modernise and transform planned care.

In addition there is a need to encourage nurses to keep nursing in the NHS. This requires a retention strategy and investment in post-registration nursing. The Welsh Government must take leadership on this.

#### *District Nurses (DNs)*

RCN Wales was pleased to see the plan makes a reference to community and district nursing by detailing ‘they have maintained high levels of activity over the last year seeing the most urgent cases face-to-face while undertaking more virtual activity where appropriate.’ However, despite this recognition there is no recommendation to invest in district nursing.

There is a national shortage of DNAs and the Welsh Government has not taken action to resolve this. Community nursing teams are led by DNAs or nurses working towards a post-registration community nursing qualification. DNA is a title given to those with a Specialist Practice Qualification (SPQ), a Nursing and Midwifery Council (NMC) recordable qualification. The qualification recognises a high level of skill, knowledge and practice. DNAs are the experienced pinnacle of a community nursing team, providing leadership to the registered nurses and healthcare support workers.

Between September 2020 and September 2021 the workforce decreased by 48.3 FTE district nurses. The number of post-registration courses has not increased since 2017, despite the demand. This needs to change and investment in district nursing is needed urgently to ensure health service capacity can be maintained, and increase.

<sup>2</sup> Welsh Government 2021 *Written Statement: Expansion in training places for health professional workforce in Wales*. Available at: <https://gov.wales/written-statement-expansion-training-places-health-professional-workforce-wales>, accessed 31 May 2022.

## Prioritise diagnosis and treatment

### *Prescriber ready nurses*

To prioritise diagnosis and treatment there needs to be an understanding of the capacity and skills within the entire workforce. It is disappointing therefore to see that there was no recognition in the plan that all nurses graduating after 2023 will be prescriber ready.

In 2018, the NMC introduced a new curriculum and standards for pre-registration nursing, commencing September 2020. These standards were developed by extensive consultation with employers and other key stakeholders throughout the UK including NHS Wales.

On graduating newly qualified nurses will be prescriber ready and will have a new and wider variety of practical skills that can be utilised when they enter the workforce. The ability for nurses to be prescribers is essential for providing effective treatment in a timely manner.

RCN Wales recommends that the Welsh Government harness the opportunity of prescriber ready nurses and set out a clear plan to invest and develop the next step for these new graduates and the current workforce.

### *Consultant nurse*

To provide excellent level diagnostic and treatment there needs to be a skilled workforce available to do this. Consultant nurses provide expert level care, leadership education and research, this in turn improves patient care and safety. Consultant nurses are essential for the delivery of high quality patient care, educating the next generation of health professionals, advancing research with health and social care and developing guidance and principles for quality patient care.

#### **There are four main aspects to a consultant nurse's role:**

1. **Expert clinical practice** (*direct and indirect practice*). Working directly with individuals, families and carers, whilst indirectly influencing clinical work through supervising and providing guidance to others, developing practice protocols and exploring practice issues.
2. **Professional leadership and consultancy**. Providing professional leadership and direct evidence based, client-centred recommendations to those involved in service development and delivery.
3. **Education, training and development**. Facilitate other clinicians to develop their roles, gain knowledge and skills either by strategic planning education

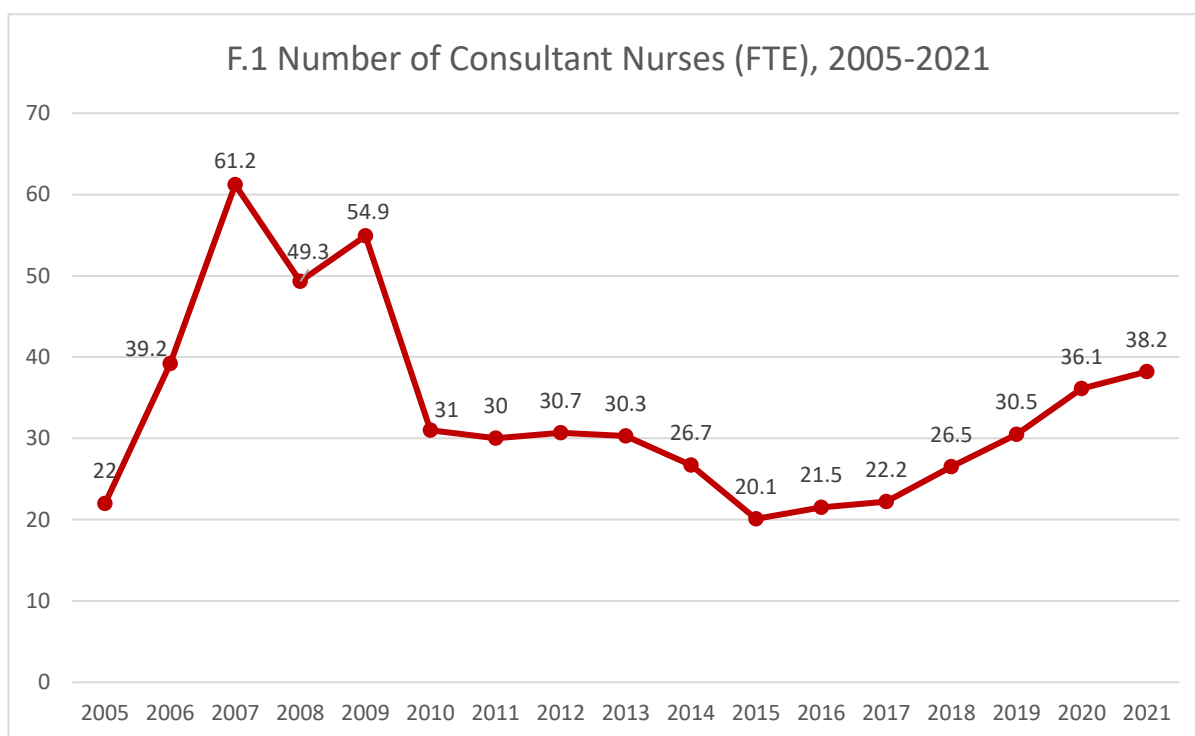
initiatives, advising on higher education routes or promoting positive learning and clinical settings.

4. **Practice service development, research and evaluation.** Develop evidence based protocols, research and explore implications of research upon service delivery.

In 2005, the previously known national body, Health Professions Wales, assessed the demand for consultant nurses in Wales and approved the need for 55 consultant nurses. The demand for consultant nurses has increased since 2005, due to a rise in the population, people living longer with more complex health requirements and an increase in comorbidity and complexity of care delivered to patients.

There was a rapid expansion of consultant nurses between 2007 and 2008. However as Figure 1 demonstrates the number of consultant nurses decreased sharply in 2010. Since 2017 there has been a consistent, albeit slow, increase in the number of consultant nurses, but Wales remains far below the required amount as set out by Health Professions Wales.

16 years since the demand was made clear by Health Professions Wales and Wales still falls short of the recommendations by 16.9 consultant nurses.<sup>34</sup>



<sup>3</sup>StatsWales, 2022, Nursing, Midwifery and Health Visiting Staff by grade and area of work, available at: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/nursingmidwiferyandhealthvisitingstaff-by-grade-areaofwork-year> [Accessed 16 February 2022].

<sup>4</sup> StatsWales, 2022, Nursing, Midwifery and Health Visiting Staff by grade and area of work pre 2009 data, available at: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/Pre-2009/NursingStaff-by-Grade-Year> [Accessed 7 March 2022].

Health boards must invest in the role of the consultant nurse to meet the health needs of their population. The amount of consultant nurses needed in a health board should be based on population need and assessed alongside other consultant level practitioners.

## Transform the way Wales provides planned care and provide better support to patients

To transform the way Wales provides planned care and to better support patients there needs to be an investment in post-registration nursing and an acknowledgement of the importance of nursing leadership in transforming services.

### *General Practice Nursing*

A significant proportion of the plan to transform services focuses on primary care, specifically GPs, but there is no mention of General Practice Nurses (GPNs). There are 1,397 nurses working in general practice.<sup>5</sup> This includes Advance Nurse Practitioners and Specialist Nurses who provide advance level care and support for patient including diabetes management, respiratory care and sexual health advise. They are also key to providing care for patients waiting for treatment or operations.

The value of GPNs, and specifically Advance Nurse Practitioners and Specialist Nurses should be recognised alongside medical colleagues.

The provision of primary and community care in Wales is based on 64 clusters. Clusters are often formed around the General Practice surgery and work together with key partners, i.e. community nursing teams, to provide care for their population. Every cluster has a lead, the majority of the time this is a GP. To transform and modernise services GPNs should have more of a leadership role in the strategic delivery of care, this includes having opportunities to, and being supported to become a cluster lead.

### *Infection Prevention and Control*

Infection prevention and control (IPC) – the practical application of microbiology in clinical practice – puts patient safety firmly at the heart of health and social care delivery. Understanding how infections occur and are spread is crucial to the prevention of infections in all settings at all times.

IPC nurses promote the safety of patients, the public and the healthcare worker. The role is multifaceted, but the most familiar functions of an IPC nurse is to provide specialist advice, lead the healthcare workforce to carry out surveillance and develop policies and guidance.

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<sup>5</sup> <https://stats.wales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/number-of-wider-practice-staff-employed-in-general-practices>

As system leaders IPC nurses consider a holistic approach to the prevention of infection, acting as a bridge between public health, health protection and science.

The COVID-19 pandemic demonstrated the value of IPC advice and in particular the role of IPC nursing teams. It is time to reflect upon the lessons learned during the pandemic and ensure that going forward IPC nursing teams are recognised as an essential contributor to patient protection and safety.

To transform and modernise plan care IPC needs to take a central role. It is disappointed that within the plan IPC is only referred to when discuss limitation to capacity during the pandemic. Part of modernising services means being prepared for a possible outbreak of an infectious disease in the future. The Welsh Government and health boards should harness the knowledge and leadership of IPC nurses in delivering education and leadership for the healthcare workforce.

#### *Investment in digital technology in the community*

To ensure the plan is able to deliver on its priority to ‘harness digital technology’ there first needs to be an assessment and investment in digital technology for the community.

The importance and value of digital technology cannot be underestimated. The pandemic has aided significantly in advancing the use of digital technology in primary care but this is not necessarily the case for community services.

RCN Wales is aware that many members in the community still struggle to access IT services and support. RCN members have reported using a variety of equipment including laptops and mobile handheld devices, but they did not have regular access to their emails or office calendars from these devices and some members continue to use paper records. Unless there was an investment in digital technology for the community, the lack of IT reduces the plan’s ability to harness digital technology.

There must be a whole-system approach to IT, starting with an assessment of what is available and how digital technology can be harnessed to improve planned care.

#### *Regional Partnership Boards (RPBs)*

Regional Partnership Board (RPBs) were established as part of the Social Services and Well-being (Wales) Act 2014.

There are currently seven RPBs. RPBs were designed to improve the wellbeing of the population and improve how health and care services are delivered, and yet there is no mention of them in the plan.

RPBs have an important role in the health and wellbeing of their population, it was therefore surprising that they were not included in the Welsh Government plan to transform and modernised planned care.

Despite their importance, RCN Wales believes that RPBs are currently limited in their abilities due to their limited membership. The guidance for RPBs outlines the requirement to have 'at least one person from the third sector who works with the local authority and local health board'. This is a very narrow description as such there is no membership relating to professional bodies or trade unions in RPBs. The lack of capacity for professional bodies and trade unions narrows the scope of the RPBs and would reduce their abilities.

Nurse directors are accountable for all nursing care provided within their local health board area including nursing care in the social care sector. The involvement of the nurse director should be made explicitly clear in the RPBs membership.

RCN Wales strongly recommends that to modernise service delivery RPBs should be included and the membership of RPBs expanded to include trade union representation, professional bodies and executive nurse directors.

#### **About the Royal College of Nursing (RCN)**

The Royal College of Nursing is the world's largest professional organisation and trade union for nursing, representing over 465,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 28,000 members in Wales. RCN members work in both the independent sector and the NHS. Around two-thirds of our members are based in the community. The RCN is a UK-wide organisation, with National Boards in Wales, Scotland and Northern Ireland.

The RCN represents nurses and nursing, promotes excellence in nursing practice and shapes health and social care policy.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 25

Ymateb gan: | Response from: Endometriosis UK

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## **RESPONSE TO SENEDD HEALTH & SOCIAL CARE COMMITTEE REQUEST FOR WRITTEN EVIDENCE ON WELSH GOVERNMENT'S PLAN FOR TRANSFORMING AND MODERNISING PLANNED CARE AND REDUCING WAITING LISTS**

### **OVERVIEW**

The Welsh Government's programme for transforming and modernising planned care and reducing waiting lists provides an opportunity to tackle the problem of long waits for endometriosis care in Wales that go back to before the pandemic.

Prior to the pandemic, many with endometriosis in Wales experienced long waits for planned care such as surgery and the pandemic has predictably made this worse. This is particularly acute for those needing tertiary (specialist) care, such as complex surgery at a British Society of Gynaecological Endoscopy (BSGE) accredited endometriosis specialist centre<sup>1</sup>, who are in some cases being told informally they may wait for several years for that surgery. This is pushing those who can afford it or are prepared to get in debt, to seek private care, but this is not an option for the vast majority.

To reduce waiting lists and modernise planned care for those with endometriosis, the following key changes are needed:

- Strategic national planning for endometriosis care in Wales including measuring and meeting the demand for endometriosis care including endometriosis specialist centres to ensure that those who need care can access it regardless of Health Board area. This would involve building NHS capacity in gynaecology departments and endometriosis specialist centres to allow prompt referrals from primary to secondary care, including for diagnostic laparoscopy.
- Place endometriosis specialist care under the remit of the Welsh Specialist Healthcare Services Committee (WHSCC)<sup>2</sup> to ensure that cross Health Board referrals are properly funded and that all patients who need specialist care can access it regardless of where they live in Wales.
- NHS Wales and Health Boards to review patient prioritisation criteria as per the recent call<sup>3</sup> from the Royal College of Obstetricians and Gynaecologists (RCOG) in order to incorporate quality of life considerations, which for endometriosis would include ability to perform daily living tasks and impact on long-term health outcomes including avoiding future disability.
- Make sure that the Workforce Delivery Plan for Wales includes specific measures to ensure appropriate staffing in gynaecology including endometriosis care.
- Ensure that gynaecology is adequately represented in the National Diagnostics Board.
- Fully implement the recommendations of 2018 Welsh government review on endometriosis care<sup>4</sup> in line with NICE guideline NG 73 and NICE quality standard QS 172<sup>5</sup>
- Undertake or commission an audit to identify the gaps and challenges to implementation of the 2018 review/NICE guidance
- Reduce diagnosis time from the current average of 9 years to an average of 1 year or less, which will require:
  - Clear pathways for diagnosis and investment in diagnostic capacity in gynaecology departments and endometriosis specialist centres
  - Healthcare practitioner training and education to ensure all HCPs including GPs and A&E practitioners recognise the signs and symptoms of endometriosis

- Improving public awareness and understanding of endometriosis through effective implementation of menstrual wellbeing education in all Welsh schools and public awareness campaigns

## RESPONSE TO QUESTIONS

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| <b>1. Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits</b> |
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We welcome the intention to address the pandemic backlog and reduce long waits. In relation to gynaecology services for those with suspected or confirmed endometriosis, we note the following:

- Those with endometriosis in Wales experienced longer waits than the UK average for gynaecology appointments and surgery before the pandemic. The 2018 Welsh government review on endometriosis care<sup>4</sup> concluded that “*service provision across primary, secondary, and tertiary care is not meeting need, resulting in lack of access to appropriate care for women across Wales*”. A 2020 inquiry by the All Party Parliamentary Group (APPG) on Endometriosis<sup>6</sup> found that those in Wales experienced delays in getting referred for hospital appointments. The same survey found that when those with endometriosis were told they needed surgery:
  - 48% waited more than 6 months (UK average 30%)
  - 6% waited more than a year (UK average 7%)
- The Royal College of Obstetricians and Gynaecologists (RCOG) released a report in April 2022<sup>3</sup> which found that across the UK including in Wales, gynaecology has seen the biggest percentage increase in waiting lists during the pandemic, and the Welsh Government plan recognised gynaecology as one of the specialities with the greatest number of people waiting.
- The NICE guideline on endometriosis diagnosis and management (NG 73)<sup>5</sup> which is adopted in Wales, requires that anyone with suspected or confirmed deep endometriosis is referred to a BSGE<sup>1</sup> endometriosis specialist centre. There are three such centres in Wales; two fully accredited centres at University Hospital of Wales in Cardiff and the Singleton Hospital in Swansea, and a provisional centre at the Royal Gwent Hospital in Newport. This means that many with endometriosis who need specialist care, cannot access that care in the Health Board are they live in thus requiring referral to a BSGE centre in another Health Board area. Those requiring specialist care in North Wales can be referred to BSGE centres in Merseyside and cross-border referral arrangements exist, although are not always used.
- There has never been any national planning for endometriosis care in Wales in order to measure and meet demand in both secondary care (gynaecology) and tertiary care (endometriosis specialist centres).
- Current funding arrangements do not support cross Health Board referrals to BSGE centres, leaving those centres accepting patients from outside their Health Board area with insufficient or no funding. This was identified in the 2018 Welsh government review<sup>4</sup> which noted that the BSGE centre in Cardiff was “inadequately funded” and that this has led to “long waiting times for the most complex surgery”. Without addressing this funding gap, we fear that it will not be possible to address the backlog in endometriosis specialist (tertiary) care and reduce long waits.
- We welcome the plans to eliminate long waiters and note that additional sessional work at weekends and evenings could be useful in relation to endometriosis specialist care as long as measures for example in relation to staffing and theatre time are put in place to ensure deliverability.

### **Our recommendations:**

- Undertake strategic national planning for endometriosis care in Wales including measuring and meeting the demand for endometriosis care to ensure that those who need care can access it regardless of Health Board area. This would involve building NHS capacity in gynaecology departments and endometriosis specialist centres to allow prompt referrals from primary to secondary care, including for diagnostic laparoscopy where required to ensure diagnostics are not a bottleneck in care pathways.
- Place endometriosis specialist care under the remit of the Welsh Specialist Healthcare Services Committee (WHSCC)<sup>2</sup> to ensure that cross Health Board referrals are properly funded and that all patients who need specialist care can access it regardless of where they live in Wales.
- Strengthen existing arrangements for cross-border referrals to BSGE centres in England for those in North Wales who need such care.
- Address staffing and theatre time at endometriosis specialist centres to enable additional sessional work at weekends and evenings to help eliminate long waiters.

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| <b>2. Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?</b> |
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In endometriosis care, tackling the backlog and building more resilient and sustainable care including sustainable planned care capacity are closely connected. The experience of those with endometriosis in Wales of long waiting times before the pandemic indicates that planned care capacity, particularly in tertiary care which takes place in endometriosis specialist centres, was not sufficient to meet demand.

The 2020 APPG report<sup>6</sup> also found that across the UK there appeared to be insufficient capacity in secondary care (gynaecology) to meet demand for endometriosis services. The aforementioned problems with cross Health Board referrals and funding arrangements for BSGE centres are key factors that need addressing in this respect as well as national strategic capacity planning.

### **Our recommendations:**

- Undertake strategic national planning for endometriosis care in Wales including measuring and meeting the demand for care to ensure access for all who need it. This would involve building NHS capacity in gynaecology departments and endometriosis specialist centres to allow prompt referrals from primary to secondary care, including for diagnostic laparoscopy where required.
- Place endometriosis specialist care under the remit of the Welsh Specialist Healthcare Services Committee (WHSCC)<sup>6</sup> to ensure that BSGE centres are properly funded to accept cross Health Board referrals enabling all patients who need specialist care to access it regardless of where they live in Wales.

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| <b>3. Whether the plan includes sufficient focus on:</b> <ul style="list-style-type: none"><li>a. Ensuring that people who have health needs come forward;</li><li>b. Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;</li><li>c. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;</li><li>d. Improving patient outcomes and their experience of NHS services?</li></ul> |
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Ensuring that those with endometriosis come forward is very much a question of awareness and education of the public and healthcare practitioners. Public education and awareness needs to start in school with menstrual wellbeing education and this was included in the new RSE code in Wales in late 2021. Menstrual wellbeing education teaches children what is normal and what is not about periods, so should someone have symptoms that may be endometriosis, they can recognise the need to seek help.

Healthcare practitioners including GPs must understand the signs and symptoms of endometriosis so that anyone with suspected endometriosis is taken seriously and swiftly referred on for tests, to gynaecology or an endometriosis specialist centre as needed. This requires that GPs understand the NICE guideline NG 73 on endometriosis diagnosis and management. The recent appointment of endometriosis nurses in each Welsh Health Board can play a role in helping to improve awareness and understanding of endometriosis in primary care, but the responsibility cannot fall solely on them. GPs can also access resources including a menstrual wellbeing toolkit<sup>7</sup> and e-learning module<sup>8</sup> from the Royal College of GPs (RCGP).

The focus on supporting people waiting a long time for treatment is particularly relevant to those waiting for endometriosis surgery in Wales. The need for support, including advice on how to manage symptoms, pain management and mental health support, for those on surgery waiting lists was identified by Welsh respondents to our 2021 Covid impact survey<sup>9</sup>.

When it comes to supporting those in greatest clinical need who have been waiting a long time, we note:

- As a disease that can be chronic and debilitating, long waits for surgery for endometriosis can involve deterioration in the individual's quality of life including inability to go to work or attend education and difficulties undertaking daily living tasks.

*"Waiting lists lead us to accumulate debt to go private or even worse leave us debilitated by pain for years at a time. Creating a domino effect where our day to day lives change, we jeopardise our employment or are unable to be a fit parent and so on"*

*"I have been waiting for urgent surgery to have a colostomy bag since 2018. It was due to happen 2019 then covid happened. Endo has damaged my bowel beyond repair and things are so bad I can't leave the house"*

- If untreated, endometriosis may progress, leading to reduced ability to undertake daily living tasks while waiting and the need for more complex surgical interventions, which are more costly to the NHS as well as having a greater negative impact on quality of life of the patient including longer recovery time.
- While not an official term, endometriosis is often referred to as "benign gynaecology", meaning non-cancer, which gives a false impression of the impact of the disease. We support the recent call from RCOG to stop using "benign" and agree that use of the term may have contributed to de-prioritisation of women's health needs including those with endometriosis, which may partly explain the growth in gynaecology waiting lists<sup>10</sup>.
- While the programme acknowledges the need for a "fair and equitable approach to patient prioritisation to minimise health inequalities", which recognises the impact of long waits including continued pain and symptoms, worsening health, and an impact on lifestyle, we feel this is not sufficiently developed. In its report on gynaecology waiting lists<sup>3</sup> RCOG have called for an overhaul in the way patients are prioritised including taking wider considerations including quality of life into account alongside clinical need.

### **Our recommendations:**

- Ensure effective implementation of age-appropriate menstrual wellbeing education in all Welsh schools as agreed in the RSE code.
- Work with Health Boards to improve understanding and awareness of endometriosis in primary care, in particular with GPs to ensure that referrals for suspected endometriosis happen in a timely manner.
- NHS Wales and Health Boards to design appropriate support packages for those with endometriosis on waiting lists in consultation with relevant stakeholders including BSGE, RCOG and charities such as Endometriosis UK who represent the endometriosis community. Such support packages should include:
  - improved patient communications
  - information on what to expect from surgery
  - advice on how to prepare for surgery
  - where to find self-management advice and support, for example via the Health Board endometriosis nurses, although we would caution that this cannot be left solely to Health Board nurses
  - signposting and ensuring access to services such as pain management, pelvic physiotherapy and mental health support
  - signposting to further information for example the Endometriosis Cymru and Endometriosis UK websites
- NHS Wales and Health Boards to stop using the term “benign gynaecology”.
- NHS Wales and Health Boards to review patient prioritisation criteria as per RCOG recommendations<sup>3</sup> in order to incorporate quality of life considerations, which for endometriosis would include ability to perform daily living tasks and impact on long-term health outcomes including avoiding future disability.

- 4. Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**
- 5. Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?**

It is important that primary care, gynaecology and endometriosis specialist centres work together to drive transformation in endometriosis care, which will involve fully implementing existing NICE guidance<sup>5</sup> and recommendations from the Welsh government review on endometriosis care<sup>4</sup>. It is also important that gynaecology is adequately represented in the National diagnostics board given the aforementioned need to expand diagnostic capacity in gynaecology departments and endometriosis specialist centres.

It currently takes on average 9 years to get a diagnosis of endometriosis in Wales, which means those with endometriosis can suffer both physically and mentally while not getting the right care, nor a name for their symptoms. The delay may result in the disease progressing, along with the distress of repeated GP and hospital visits that fail to identify a cause for symptoms. It is also a poor use of NHS resources. Improving diagnostic services can provide an opportunity to reduce diagnosis time for endometriosis as well as freeing up NHS resources currently spent on “wasted” appointments.

### **Our recommendations:**

- Welsh government, Women’s Health Implementation Group (WHIG), NHS Wales and Health Boards to work together to ensure that full implementation of the recommendations of 2018 Welsh government review on endometriosis care<sup>4</sup> in line with NICE guideline NG 73 on endometriosis and NICE quality standard QS 172 on endometriosis<sup>5</sup> This would include, but not be limited to:
  - Managed clinical networks across Wales linking primary, secondary and tertiary care

- All with confirmed or suspected endometriosis have access to a gynaecologist with expertise in diagnosing and managing endometriosis, including laparoscopic surgery; achieving this requires developing and appointing to the role of gynaecologist with expertise in endometriosis, working closely with BSGE and RCOG to define role and competencies.
- Access to pain management including non pharmacological service such as pelvic physiotherapy and psychological support, aligning with NICE chronic pain guideline<sup>11</sup>
- Undertake or commission an audit to identify the gaps and challenges to implementation of the 2018 Welsh government review/NICE guidance
- Endometriosis specialist (tertiary) care to come under the remit of the Welsh Specialist Healthcare Services Committee (WHSCC) to enable national planning, sufficient funding and equitable access to care regardless of where someone lives in Wales.
- Improve public and healthcare practitioner awareness of the signs and symptoms of endometriosis as well as streamlining referral pathways for diagnosis to help reduce diagnosis time to on average of under four years by 2025 and under one year by 2030.
- Ensure that gynaecology is adequately represented and addressed in the National Diagnostics Board.

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| <p><b>6. Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?</b></p> <p><b>7. Is it sufficiently clear which specialties will be prioritised/included in the targets?</b></p> <p><b>8. Do you anticipate any variation across health boards in the achievement of the targets by specialty?</b></p> |
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We welcome the targets on first outpatient appointments and eliminating those waiting more than 1 or 2 years. We note that gynaecology is recognised in the programme as being one of the specialties with the greatest number of people waiting. However, we would welcome clarity as to whether gynaecology is included under the “most specialties” in afore mentioned targets.

#### **Our recommendations:**

- Gynaecology including endometriosis care should be one of the specialties prioritised in the targets. The reasons for this are that gynaecology is one of the specialties with the greatest number of patients waiting and the problem of long waits in non-cancer gynaecology existed before the pandemic and are thus a long-term problem overdue for addressing.

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| <p><b>9. Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?</b></p> <p><b>10. Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?</b></p> |
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In relation to funding endometriosis care it is necessary to measure the demand for services in order to know if funding available is sufficient to ensure capacity can meet demand. This is particularly important in relation to endometriosis specialist centre (tertiary) care.

#### **Our recommendations**

- Measure demand for endometriosis care in Wales in both secondary and tertiary care to ensure that capacity can meet demand.

- Place endometriosis specialist care under the remit of the Welsh Specialist Healthcare Services Committee (WHSCC)<sup>6</sup> to ensure that BSGE centres are properly funded to accept cross Health Board referrals enabling access to specialist care regardless of where someone lives in Wales.
- Make sure that funding and resources for Health Board endometriosis nurses is commensurate with responsibilities and workload and review if significant changes are introduced.

**11. Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**

We welcome recognition of the need to address health and social care workforce pressures and the development of a Workforce Delivery Plan for Wales.

Workforce issues including the recruitment and retention of clinicians with expertise in endometriosis need addressing in order to be able to tackle the pandemic backlog and deliver sustainable planned care in future. For example, at the BSGE centre at University Hospital of Wales in Cardiff, the number of consultants has reduced from three to two, following the retirement of a consultant last year.

There is a view among some in the endometriosis community in Wales that long waits to access care (including before the pandemic) are linked to insufficient numbers of clinicians with expertise in endometriosis to provide the care needed.

*“There is simply just not enough consultants for the demand of women like myself who suffer in chronic pain because of this condition that are able to administer quality treatment and care to the demand and standard we need.”*

In gynaecology more broadly, RCOG has identified workforce as an issue that needs tackling to ensure it does not hinder tackling the pandemic backlog and calls on all UK nations to develop and implement gynaecology workforce plans<sup>3</sup>.

**Our recommendations:**

- Undertake strategic national planning for endometriosis care in Wales including measuring and meeting the demand for endometriosis care to ensure access for all who need it. This would involve building NHS capacity in gynaecology departments and endometriosis specialist centres to allow prompt referrals from primary to secondary care, including for diagnostic laparoscopy where required.
- Make sure that the Workforce Delivery Plan for Wales includes specific measures to ensure appropriate staffing in gynaecology including endometriosis care to ensure that staffing does not hinder tackling waiting lists or developing sustainable planned care.

**12. Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

We welcome the use of digital tools and data to support and enable service delivery where appropriate. We would appreciate greater clarity on how national guidance on suitable conditions and patients for virtual reviews will be developed. We welcome the proposed planned care portal with details on waiting times and available support services; lack of information on both is something that was flagged to us by the endometriosis community in Wales. However, not everyone can or wishes to use a health app or have a virtual review for a variety of reasons including digital literacy, access to devices, disability, socioeconomic and cultural factors.

We welcome the use of data to measure performance and develop real time waiting list data by sub-speciality that can help capacity planning.

### Our recommendations:

- National guidance on conditions and patients suitable for digital reviews should ensure that any patient wishing to opt out is able to do so, and alternative non digital arrangements will be made available.
- Provision must be made for the information available in the planned care app to be made available offline for those who cannot use such an app or feel uncomfortable to do so.
- Develop standardised data collection on endometriosis services across all Health Boards and consider the establishment of an endometriosis registry.

### ABOUT US

Endometriosis UK is the UK's leading charity supporting those affected by endometriosis. We provide information through [our website](#) and information leaflets, and direct support through a helpline, support groups, and an online forum. We raise awareness and campaign to improve the lives of all those affected by endometriosis, and are involved in research. We work closely with other women's health organisations including RCOG and RCGP.

We would be happy to discuss this submission in further detail with the Committee. Please contact us on

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<sup>1</sup> [British Society of Gynaecological Endoscopy – Endometriosis Specialist Centres](#)

<sup>2</sup> [Welsh Health Specialised Services Committee](#)

<sup>3</sup> [Left too long – understanding the scale and impact of gynaecology waiting lists](#), Royal College of COG, 4 April 2022

<sup>4</sup> [Endometriosis care in Wales: Provision, care pathway, workforce planning and quality and outcome measures](#), Report of the Welsh Government Endometriosis Task and Finish Group, 16 April 2018

<sup>5</sup> [NICE guideline NG73 on Endometriosis: diagnosis and management](#), 6 September 2017 & [NICE Quality Standards QS172 on Endometriosis](#), 6 August 2018

<sup>6</sup> [Endometriosis in the UK – Time for Change](#), Inquiry Report of All Party Parliamentary Group (APPG) on Endometriosis, October 2020

<sup>7</sup> [RCGP Menstrual Wellbeing Toolkit](#)

<sup>8</sup> [RCGP e-learning module on endometriosis](#)

<sup>9</sup> The impact of Covid-19 on endometriosis, Endometriosis UK survey, 2021 (Welsh data report submitted in confidence to Senedd Health and Social Care Committee in response to the consultation on waiting times)

<sup>10</sup> [Dismissal of women's health problems as 'benign' leading to soaring NHS lists](#), The Guardian, 2 June 2022

<sup>11</sup> [NICE Guideline NG 193: Chronic pain \(primary and secondary\) in over 16s: assessment of all chronic pain and management of chronic primary pain](#), published 7 April 2021,

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 26

Ymateb gan: | Response from: Fair Treatment for the Women of Wales

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## **Senedd Health and Social Care Committee Inquiry:**

### **The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

**Name of organisation: FTWW: Fair Treatment for the Women of  
Wales**

1. FTWW is the only patient-led women's health equality charity in Wales, supporting and advocating for women and people assigned female at birth who are disabled and / or living with long-term health conditions in Wales. We campaign for better women's health services and equitable access to them, particularly as many of the health issues which predominantly affect females have suffered historical lack of investment and prioritisation in Wales and beyond.
2. **The Committee asks whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic and reduce long waits.**
3. We note that the first of the Welsh Government's Five Goals for Planned Care is 'Effective referral to the most appropriate setting'. However, at the same time, there continues to be a strategic commitment to 'care closer to home'. This creates a potential contradiction which the Welsh Government will need to address head-on and communicate to both patients and health boards. Whilst FTWW's members have long

expressed a willingness to travel for more specialised services, other people may have differing views and / or issues which make travelling more difficult – the Welsh Government and health boards will need to ensure there are mechanisms to engage effectively with individuals affected and, where necessary, provide them with the necessary support to access services situated farther afield.

4. It should be said that FTWW is fully supportive of any move towards routinely enabling patients to cross health board boundaries to access ‘most appropriate’ care, which must include specialist services unavailable in their locality, the historical prevention of which has created a significant postcode lottery in Wales. With this in mind, we also note that there is no reference to tertiary care in the section exploring ‘integration’, an omission which needs rectifying.
5. When describing ‘care closer to home’, we would argue that there is a need for more detail regarding what those services might be and for genuine engagement with public / patients to establish their views about the services they would expect to be delivered within the community. For our members, this would constitute services like pelvic physiotherapy and low-level mental health support targeted at those living with chronic health conditions and pain.
6. As already mentioned, we are pleased to see a reference to ‘regional (diagnostic) centres’ but would like to emphasise that even the provision of (presumably low complexity) high volume services will, in some instances, require upskilling of personnel if we are to avoid missed diagnoses and repeated referrals into services.
7. In FTWW’s recent submission to Health Education and Improvement Wales’s Education and Training Plan 2023-24 consultation, we mentioned the need to improve diagnostic capabilities in gynaecological ultrasound, as well as more investment in minimal access training for gynaecologists across Wales. Given that gynaecology is listed as one of the specialties with the greatest number of people waiting, this will be essential if we are to ensure patient need can be adequately addressed both locally and in regional centres.
8. **The Committee asks whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?**
9. Regional working and centres of excellence are concepts for which FTWW has called repeatedly as a way of better treating a number of health conditions with which our members are living. However, we wonder how this move fits with the Welsh Government’s previous decision not to offer multi-disciplinary centres / one-stop shops for long COVID and similar conditions like ME and, also, (rare) auto-immune conditions

like lupus. We hope that this Plan means that there will be scope for further discussion with patients affected to ensure that these populations can similarly anticipate a move towards multi-disciplinary centres of excellence.

10. We would also ask that the Welsh Government explicitly acknowledge that, in some instances, travel outside of Wales will be required and that it will investigate ways to support those people with limited means / capacity with their additional travel needs.
11. When it comes to ensuring resilient and sustainable services, co-production is rightly mentioned as being key. However, this firstly requires agreement on what it is / what it entails (it isn't just 'engagement' or 'consultation'). We welcome use of terminology like 'involvement' and 'collaboration' but this needs to come from a place of equity of esteem and value, particularly as the Plan describes co-production as a means to deliver 'value-based care'.
12. For patients to be involved and collaborators in health service design and evaluation, they need to be properly supported throughout their participation and beyond, and this often requires time, commitment, and careful facilitation – all of which FTWW has been pleased to offer the Welsh Government and health boards over the last few years. However, we still encounter barriers to participation on occasions, with service providers not fully cognisant of what co-production involves or its benefits. Additionally, there remains a lack of resourcing for this kind of activity which poses considerable challenges to its sustainability and further expansion. We would urge the Welsh Government to address this funding gap as a priority if it is serious in its commitment to embedding co-production in strategic planning, decision-making, and service design.
13. The Plan mentions a few instances where a co-productive approach will be taken, including the development of patient pathways. We would urge the Welsh Government to expand this to include the development of PROMS and PREMS, cited throughout the Plan as being vital instruments in assessing service effectiveness. This is important to ensure that the right questions are being asked and in the most user-friendly way. Similarly, with regards to 'one-stop shops', we would urge that robust engagement with patients takes place so that we can be sure they fully accommodate patient needs.
14. **The Committee asks whether the plan includes sufficient focus on:**
  - **Ensuring that people who have health needs come forward;**
  - **Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**

- **Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**
- **Improving patient outcomes and their experience of NHS services**

15. We are pleased to see that the vital role of the third sector in supporting and improving the wellbeing of citizens and patients is referenced and endorsed throughout the Plan. In particular, we note the Welsh Government's commitment to a 'national framework for social prescribing to embed access to prevention services and wellbeing activities into our pathways', based on the acknowledgement that the third sector is well-placed to improve cost-efficiencies by 'reducing follow-ups and presentations'.

16. As an organisation supporting a growing number of people in Wales living with long-term and recurrent health issues, helping them to better 'self-manage' their condition(s) and navigate often complex pathways, we welcome the Welsh Government's endorsement of this kind of activity. We have spent several years creating a safe, peer-led space for our members and building both trust and resources so that they are better equipped to manage their own health and advocate for themselves and others. However, a move towards formally integrating a third sector offer into the country's health services also creates the very real danger of over-burdening organisations / groups already groaning under the weight of increasing pandemic-related demand, to the point where they can no longer support those in need of their services. This is an organisational risk to third-sector providers and the NHS but, even more importantly, it runs the risk of leaving clients / patients without a service on which they may have come to rely.

17. Alongside formalising referral pathways into community activities / support, therefore, the Welsh Government must concurrently address the huge funding and capacity gap being experienced by the third sector. We would urge that funding application processes are co-produced to make them accessible to smaller / grassroots providers.

18. The Plan also mentions 'helping people to manage their conditions without surgery' which we would suggest is a laudable aim if not always possible, not least due to lack of investment in research for some conditions, i.e., endometriosis. In fact, for many 'benign' gynaecological conditions, the 'best' offer we currently have is major surgery, such as hysterectomy and oophorectomy - but this is often because no non-surgical treatment or cure has been identified due to a lack of research prioritisation and investment. Certainly, as an adjunct to surgery and / or current medical 'management' of symptoms, we would urge much more emphasis on pelvic physiotherapy, something which we see as being an essential component of 'care closer to home'.

19. We would also like to draw the Committee's attention to the Plan's aim to address 'widening health inequalities' through Public Health Wales campaigns and activities to 'promote' and 'encourage' healthier lifestyles. Unless activity is directed towards engagement, including via grassroots advocacy organisations, endeavours like this will only have partial success because they don't identify or address causation. 'Specific signposting to local support services to help people to achieve and maintain a healthy weight, be more physically active and cease smoking' is referenced as a core part of 'Communications and engagement' but naively fails to include any sense of engaging with people to establish their reasons for not maintaining a healthy lifestyle or attempting to resolve the factors underpinning health inequalities / 'unhealthy' lives.
- 20. The Committee asks whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**
21. We are concerned that there is no detailed reference to a NHS Executive in this Plan, not least what we see as the ideal option: an independent entity with sufficient powers to address the most intractable issues currently preventing regional collaboration, making consistent co-production of services a reality, overseeing implementation and performance, and ensuring accountability. We believe that many of the very laudable aims of this Plan will be difficult to achieve without something of this nature in place.
22. We note that one of the key purposes of this Plan is to eliminate the prospect of long waiters at all stages of the pathway – this needs to explicitly reference tertiary / specialist care which may not be available 'close to home' or even in Wales. It is this part of the pathway that has previously proved to be the most problematic in terms of equitable access. The Plan posits, 'regional waiting lists (and) the transfer of patient care across health board boundaries' as the solution, which FTWW would absolutely endorse. However, this approach will require considerable oversight and a much more hands-on approach to health board collaboration.
23. The Welsh Government will need to listen to clinicians, patients, and managers when barriers to collaboration are articulated – not least the block-funding arrangements in Wales which do not always work in the best interests of patients with complex conditions. We believe that the Welsh Health Specialised Services Committee (WHSSC) may be well-placed to address some of these issues but would suggest that its remit be expanded and its deliberations made more transparent, with wider engagement (including with patient groups) a core part of its activity and decision-making.

24. With regards to the Committee's focus on the 'entire health and social care system, including mental health', we do have some concerns regarding the Welsh Government's intention to, '(where appropriate) de-medicalise our approach to mental health services' and wonder if this terminology and approach would be deemed acceptable for 'physical health services'?
25. We believe that there is a vital distinction to be made between mental 'wellbeing' and mental health / mental illness, where mental wellbeing can likely be supported via a non-medical approach, as opposed to mental (ill) health. It is worth emphasising that, in many instances, Wales still doesn't adequately support or treat those with serious mental illness or routinely allow access to tertiary / specialist services where they are not available in the locality, including serious peri-natal mental health issues, eating disorders, or obsessive-compulsive disorder. Nor does the system in Wales routinely ensure that workable shared-care agreements are in place for those forced to pay privately for a diagnosis of autism / ADHD (most likely to be women / people assigned female at birth).
26. Whilst we believe that a move towards regional centres of excellence for various physical health conditions is a positive development, we are concerned that there is no suggestion that this same approach will be applied to those mental health conditions which require a similarly specialised and multi-disciplinary approach. As such, we would urge caution regarding any possible further dilution of mental health services as this may well end up adding to the existing backlog of patients needing to access care.
- 27. The Committee asks whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?**
28. As mentioned in our response to the previous question, we perceive there to be a lack of clarity in the Plan regarding who has ultimate responsibility for ensuring the development of regional centres / hubs. As patients, we are all too aware that, historically, advice from the Welsh Government to the health boards that 'geographical boundaries should not be barriers to care' has not, for the most part, led to any discernible change. However, we also appreciate how and why the current operational and funding system in Wales creates these barriers. Systemic issues will need to be addressed by an (ideally independent) Executive Team if we are to make Goal 4, 'Giving individuals more choice and control over their care' a reality.
29. The Welsh Government needs to appreciate that genuine commitment to shared decision-making of this nature will require enabling of equitable access to tertiary and specialist services, even if situated out of area (and a reporting system in place for

patients for whom this isn't facilitated) and that this will inevitably lead to increased demand. For this to be manageable on the part of providers, dedicated funding will be necessary so, as mentioned already, it may be that the WHSSC is involved in discussions of this nature. We would strongly urge that a co-productive approach to the WHSSC's decision-making be facilitated, with patient advocacy organisations like our own enabled to have dialogue with the Committee.

**30. The Committee asks if the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?**

31. Whilst the Plan does mention some general (and aspirational) timescales, part of its implementation needs to be making a more detailed workplan publicly available so that patients and healthcare professionals have clear expectations and can hold providers to account should these targets and timescales not be met – this should be seen as a key part of any constructive dialogue.

32. Goal 5 is to, 'Measure what's important, transforming care to better meet the clinical need of the patient'. FTWW commends the Welsh Government's refreshed commitment to patient-centred care and references to co-production throughout the Plan. However, as already mentioned, this requires PROMS and PREMS themselves to be co-produced, consistently collected, and scrutinised alongside more traditional (largely quantitative) performance measures. Unless there are personnel in a NHS Executive team charged with ensuring these measures are universally applied, studied, and used meaningfully / to drive improvement, there will continue to be variation and inequality in service provision.

**33. The Committee asks if it is sufficiently clear which specialties will be prioritised / included in the targets?**

34. The Plan mentions 7 specialties which have the greatest number of people waiting and which will, presumably be prioritised for attention, although that is not made explicit. As an organisation focused on female health, we are all too aware of the impact the pandemic has had on gynaecology services, although it is important to appreciate that it has merely exacerbated pre-existing issues and gender-based inequalities in health. We are aware that work to improve planned gynaecology is already underway.

35. Crucially, gender bias hasn't just affected those conditions typically associated with female health – as FTWW's work as part of the #WomensHealthWales Coalition has demonstrated, there are a significant number of specialties where women and people assigned female at birth make up the majority of those affected but whose needs are not reflected in service provision and investment: this needs to be urgently addressed if

we are not to perpetuate existing health inequalities. As the Welsh Government looks to direct action towards the 'ten highest demand conditions', it is important to be mindful of the role historical and unconscious biases may have played, and still be playing, in data collection.

36. The Plan states early on that its intention is to, 'Eliminate the number of people waiting longer than two years in most specialties by March 2023'. The Welsh Government needs to be more explicit in its references to 'most specialties' – which ones does it anticipate not being part of this group? We note that openness and transparency are mentioned at various points within the document so this is a significant omission – reasoning should also be given.

**37. The Committee asks if we anticipate any variation across health boards in the achievement of the targets by specialty?**

38. The Plan describes 'work(ing) with health boards to prioritise diagnostics and identify gaps in demand and capacity at a local and national level'. To get a complete picture, we would advise also reaching out to patient advocacy organisations like our own who have pan-Wales membership and who can help to identify need and capacity issues from the patient perspective.

39. It can be problematic accurately assessing demand if neither clinician or patient are aware of the benefits or existence of a service (as we have found with both pelvic physiotherapy and specialist menopause provision). Without that awareness, a request to access the service won't be made by either party, resulting in an inadequate assessment of need. It is issues like this that can result in variation across health boards in the achievement of targets, so there needs to be a body charged with issuing clear expectations, guidance, and oversight of activity (including communication between health care professionals and the patient community).

40. The Plan goes on to state that, 'Further analysis of the waiting list needs to be undertaken to ensure we really understand variations in access not only from where a person lives but also by their relevant characteristics...' We were surprised not to see sex and gender referenced here, particularly in the context of UK-wide women's health strategies / plans under development precisely to address these historical and enduring disparities in care.

41. Equally, we would urge considerable attention be paid to disability and neurodivergence which see those people affected at particular risk of encountering barriers to appropriate, timely, and effective healthcare. All health boards and personnel should receive training, ideally designed and delivered by those with protected characteristics,

on how best to engage, support, and tailor their offer to individuals / communities affected, thereby reducing the possibility of unnecessary variation and inequality in service provision and access.

**42. The Committee asks if there is sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?**

43. The Plan states that, 'We expect health boards to plan services regionally...for specialised services'. Whilst we absolutely agree with this aim, it is not enough to issue an 'expectation' unless there is high-level focus on addressing the barriers and facilitators to making it happen in reality and a designated body charged with ensuring that 'expectations' are met.

44. Clearly, there will need to be funding directed towards both facilities, equipment, and training for personnel in regional 'centres of excellence' if they are to be truly of the highest quality. By ensuring this level of investment, it is possible that Wales could provide services both to domestic patients and those farther afield.

45. In terms of infrastructure, as mentioned, we would see the WHSSC as being a mechanism by which pan-Wales access to specialist services might be facilitated but its remit and functionality would likely need revisiting.

**46. The Committee asks if the plan is sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?**

47. The Plan describes the monies allocated to NHS organisations to support planned care recovery plans, but we regret that there is no reference to any funding for the third sector organisations supporting this work, despite the sector being mentioned throughout as an essential partner in both the design and delivery of care.

48. The successful attainment of the five goals mentioned at the start of the Plan very much relies on organisations who can provide direct channels of communication to patients, and facilitate and support their involvement, ensuring a co-productive (and therefore efficient and effective) approach to the design and delivery of healthcare in Wales. This is something the Welsh Government acknowledges will improve patient experiences and outcomes and provide considerable long-term efficiency savings if done properly. We cannot emphasise enough how this kind of activity needs adequate, sustainable, and accessible funding.

49. **The Committee asks if the plan adequately addresses health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**
50. We don't feel that these issues are addressed in any great detail in the Plan as it stands, although we note the reference to Allied Health Professionals (AHPs) and the need for improved access to them in the community, 'without the need to be referred by another health professional'. This streamlined approach would reduce the number of appointments required whilst also empowering patients to take charge of this aspect of their personal healthcare journeys.
51. We would like to reiterate the need for more pelvic physiotherapists across Wales and also alert the Committee to the fact that, as far as we are aware, unlike any other type of physiotherapy service, a referral from either the GP or consultant is required to access these AHPs. Given the prevalence of both pelvic pain conditions, and continence issues, this is both a gap and an anomaly which needs addressing.
52. In terms of recruitment or re-training, we would urge the Welsh Government to explore funded training places and bursaries in exchange for a period of commitment to service-provision in the locality. In addition, the referral requirement for these patients (most commonly women / people assigned female at birth) needs to be reconsidered as it seems a stark example of gender health inequality.
53. **The Committee asks if there is sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**
54. With the Plan's stated aim of moving towards a more effective combination of care closer to home and centralised specialist care, we would like to see further exploration of both wearables and digital / remote communications as ways to improve collaboration between specialist and local teams, and the individual patient themselves. This would enable those who have accessed a specialist intervention outside of their locality to be better supported closer to home whilst waiting and afterwards.
55. We note the Welsh Government's comment that 'Strengthening telephone and e-advice services' has proved beneficial for a significant number of patients – but we would also advise that this move has, at the same time, excluded others with particular needs and / or impairments. The Welsh Government and health boards must ensure reasonable adjustments are readily made for those who require them and that inequalities are not exacerbated in the rush to progress remote and digital healthcare.

56. The prospect of unwittingly causing and / or perpetuating inequality is of great concern to FTWW. The Plan states its aim of 'accelerating the embedding of virtual approaches so that 35% of new appointments are delivered virtually', a seemingly arbitrary (and high) target which poses a very real risk of delaying diagnosis and referrals, not least because physical / in-person examinations can play a hugely significant part in expediting access to appropriate care. We are very concerned that a move towards over one third of new appointments being carried out virtually may end up having the opposite effect to that intended by the Welsh Government.
57. The Plan goes on to suggest that provisions for the digitally excluded will be resolved by, 'setting up virtual centres in rural communities'. It is important to remember that it is not just those in rural locations who are digitally excluded – there are many different reasons for not wishing / being able to access or benefit from virtual health appointments which need to be properly explored and ameliorated through a variety of means. We would suggest that there needs to be much more engagement with citizen / patient advocates from a range of sectors to explore causation and solutions.
58. Finally, the Welsh Government acknowledges that the success of this Plan will be underpinned by accurate data, something with which we would wholeheartedly concur. In light of this, we envisage the need for coding to be revisited in secondary care so that diagnoses and modes of intervention / treatment are more accurately recorded. This would allow more accurate assessment of what interventions are taking place and their effectiveness, as well as better tracking of individual patient trajectories. In addition, we would like to see menstrual / gynaecological conditions added to the Quality Assurance and Improvement Framework (QAIF) in Primary Care as this is a key mechanism for collecting data on prevalence and impact, as well as driving improvements in care.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 27

Ymateb gan: | Response from: Cancer Research UK

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## The Senedd Cymru Health and Social Care Committee consultation: The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

Cancer Research UK Response – June 2022

Cancer Research UK welcomes the opportunity to respond to the Committee's ongoing inquiry into the Welsh Government's plan for reducing waiting times and tackling NHS backlogs ('Recovery Plan'). Our response offers an assessment of relevant announcements in the Recovery Plan and how the Plan could make an impact for people affected by cancer in Wales.

We welcome the prioritisation of cancer in the Plan, and the acknowledgement of the enormity of the challenge faced by cancer services to recover post-pandemic. However, we believe there should be greater ambition – in terms of improving waiting times and access to innovations – for cancer patients in Wales than the current plans would deliver.

Our submission focuses on the questions most relevant to Cancer Research UK's evidence and expertise.

Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.

The problems facing cancer services in Wales are significant and have been exacerbated by the COVID-19 pandemic.

NHS cancer waiting times for March 2022 show that the percentage of patients receiving their first treatment within 62 days of being suspected of having cancer was below pre-pandemic levels at 59%. This is well below the Suspected Cancer Pathway performance target, which aims for 75% of patients to start treatment within 62 days of first suspecting cancer. No Health Board has met the 75% target since it was set in February 2021.

One of the contributing factors to the long waiting times are delays in diagnostics. The NHS diagnostic and therapy service waiting times for March 2022 show a major increase in the number of people waiting over 8 weeks for one of 7 key tests<sup>1</sup> most commonly used to diagnose cancer, compared to pre-pandemic levels. By the end of March 2022, around **16 times** more people were waiting more than 8 weeks for one of these diagnostic tests compared to before the pandemic.<sup>21</sup>

We now know that in the year between April 2020 and March 2021, 1,700 fewer people began cancer treatment in Wales.<sup>2</sup> Many factors contributed to this, with some people reluctant to present to primary care with symptoms due to not wanting to burden an overwhelmed system or because of safety fears during the height of the pandemic. We know that fewer patients began treatment following screening programmes being paused for some time. Disruption to services affected patients, risking increased later stage diagnosis when cancer is much harder to treat and worsening survival chances.

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<sup>1</sup> 7 key tests most commonly used in the diagnosis of cancer are Non-Cardiac MRI, Non-Cardiac CT, Non-Obstetric Ultrasound, Colonoscopy, Flexible Sigmoidoscopy, Cystoscopy and Gastroscopy Welsh Government Interactive Stats Dashboard

<sup>2</sup> Compared to March 2019. 2019 numbers adjusted for working days, based on Wales Cancer Waiting Times data.

The pandemic put a huge strain on NHS staff<sup>3</sup>, who worked their hardest to maintain cancer services with limited capacity, in part due to increased infection control measures and high staff absences due to COVID-19.

**There is a real risk that the improvements we've seen in cancer survival in recent decades could now stall.**

Cancer Research UK has long called for a cancer strategy for Wales to deal with the immediate issues facing services, and to embed systems and capacity to boost efficiency and outcomes for the future. The Cancer Services Delivery Plan came to an end in 2020, with no replacement until the publication of the Quality Statement for Cancer in March 2021. The Quality Statement is a series of high-level policy statements, and did not deliver what was needed to support services to recover from the pandemic and improve for the future.

The NHS Recovery Plan for Planned Care goes some way to address the short to medium-term issues that cancer services face in Wales, but we do not believe it is ambitious enough to tackle the deeper barriers to improving cancer outcomes in Wales.

The key areas covered in the Recovery Plan, that are relevant to cancer services include the below (taken directly from the Plan):

- *We will establish a network of local community hubs to co-locate frontline health and social care and other services. These will provide a consistent approach to support health checks for people in deprived areas and potentially detect health issues that can be treated to prevent the conditions worsening.*
- *Cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026.*
- *Welsh Government to form a Diagnostics Board. The board will bring together key partners from across the NHS and Social Services, and will have delegated authority from the NHS Wales Leadership Board to provide direction on all diagnostics related matters including service models and allocation of available resources. The board will use input from national programmes such as Imaging, Pathology and Endoscopy and agree a holistic diagnostics approach for Wales.*

These commitments are welcome and will go some way to tackle the backlog in cancer services. But the plans will still leave cancer patients in Wales behind in terms of access to timely diagnosis and services. Moreover, without further injection of funding for key initiatives like the roll out of community diagnostic hubs across Wales, it is difficult to see how their implementation will have tangible impact and meaningfully expand capacity.

For example, whilst it is a positive step to increase the cancer waiting time target to 80%, from 75%, of people to receive first treatment within 62 days of GP referral, we need to reflect on the fact that no health board has met the current Single Cancer Pathway target since it came into force. Therefore, significant investment in diagnostics – staff and infrastructure – will be needed to boost capacity in the system to meet new more ambitious targets.

In summary, we need more detail on how cancer services will be supported to transform and improve further and faster than is set out in the Recovery Plan.

The Minister for Health and Social Services has recently announced a new NHS Cancer Services Action Plan will be developed by the Cancer Network Board<sup>4</sup>. We understand that this will bring together the local and national planning response to the Cancer Quality Statement (published March 2021) and the

NHS Recovery Plan for Planned Care into one document, and that this will cover the three-year planning cycle.

The announcement of the new Action Plan is positive. It is an opportunity to set out an ambitious plan that tackles the immediate issues of capacity to manage demand in the system, and that sets cancer services up to transform into the future.

**But it must do more than simply bring together existing plans. With renewed ambition and political will for services to improve, we could see the transformation in diagnosis, treatment, and outcomes that people affected by cancer in Wales need and deserve.**

**Recommendation:**

The NHS Cancer Services Action Plan must tackle the immediate challenges such as long waiting times as well as set out how Wales is preparing services for new cancer innovations and transforming cancer services for the future. There are key elements needed in a strategy to see transformation in cancer services:

1. Identifying ambitions and making them a reality
  - The NHS Cancer Services Action Plan should aim for transformation in cancer services, with bold ambitions that bring together cancer services and the health system around a shared vision for change that will deliver a real step change in cancer outcomes.
  - This must be underpinned by ambitious, measurable objectives with achievable timelines.
2. Tracking progress
  - There must be robust reporting mechanisms that regularly and transparently update on progress.
3. Empowering leadership to drive transformation
  - To drive change and lend credibility to any transformation agenda, there must be dedicated leadership, bringing the right people together including clinical expertise, system management and transformation, IT and infrastructure experts, service planners, third sector partners and patients
  - Underpinning strong and diverse leadership through the Wales Cancer Network should be a robust framework for governance and implementation, through the new NHS Executive.
4. Embedding joined up cancer services
  - A key principle to guide the new Action Plan should be ensuring that everyone has equitable access to timely diagnosis and the most effective evidence-based treatment and support.
  - Where inequalities persist, consideration should be given to how adequate capacity and expertise can be brought together to enable timely access and transformation, including where consolidation of services would support this, as well as where cancer services could be brought closer to communities and patients.
5. Investing in people and infrastructure
  - Lasting transformation that will deliver improvements in outcomes will be impossible without adequate investment, most notably in growing the cancer workforce across the strategy as well as infrastructure for kit, facilities, informatics and data collection
  - Long-term investment will also support testing innovative approaches to service delivery in opportunity areas such as early detection and diagnosis, digital pathology and developing an integrated IT system

Do you anticipate any variation across health boards in the achievement of the targets by specialty?

The current variation across health boards in access to cancer services is stark. Under the national waiting times statistics there is a worrying picture of variation and inequality, both by geography and cancer type.

There is substantial variation between Health Boards in relation to cancer waiting times, with Cwm Taf Morgannwg UHB seeing just 45% of patients starting treatment within 62 days of first being suspected of cancer in March 2022 compared with 70% of patients in Betsi Cadwaladr UHB.<sup>5</sup> While no part of Wales is currently hitting this target, it is unacceptable that where someone lives in Wales is impacting their access to timely diagnosis and treatment.

We welcome the increased ambition for cancer waiting times, as timely diagnosis and treatment has an important role to play in improving patient experience and can also help improve cancer outcomes. However, no health board has met the existing target since its introduction and it is not currently clear in the Recovery Plan how Welsh Government will expect or support services to recover current waiting times, or to achieve the new target. We also do not believe the new target will help services to reduce variation in waiting times across health boards without targeted support. It is essential that the Recovery Plan is backed with funding for policies which will expand capacity to support services to meet the current target and ensure they are prepared for the future one.

One of the key announcements for cancer diagnostics in the Recovery Plan is the introduction of two new community diagnostic hubs. This is a welcome step from Welsh Government, as Cancer Research UK have advocated for this approach for some time, and we included this recommendation in our previous evidence to this inquiry. The Recovery Plan commits to two new community diagnostic hubs, with more to follow by the end of the Senedd term.

The concept of community diagnostic hubs was established in the Sir Mike Richards Review into Diagnostics in England in 2020, which demonstrated the opportunity for taking 'elective' diagnostics out of hospitals and running such services in 'community diagnostic centres'. These could be sited on high streets or car parks. They would increase capacity in diagnostics, as well as making it easier for patients to access the tests they require. Since this report, NHS England has already begun a programme of setting up 150 community diagnostic centres across England.

Wales has been falling behind on this innovation. Rapid diagnostic centres, which are for people with vague symptoms that could be cancer, have taken several years to roll out from Wales since the initial pilots were set up in 2018. Therefore, whilst the move to introduce community diagnostic hubs in Wales is very welcome, the extent of the investment will not meet demand or make demonstrable improvement to many waiting for cancer diagnosis or treatment in Wales. We need to see Welsh Government committing to going further, through more investment in this initiative, and faster, to truly make the transformation needed to improve cancer diagnosis. Where possible, the new community diagnostic hubs should be located in areas of greatest need – those with the longest waiting times, in the first instance.

There is also a commitment in the Recovery Plan to form a Diagnostics Board, which will bring together key partners from across the NHS and Social Services, and 'agree a holistic diagnostics approach' for Wales. This is an important development for cancer diagnostic services, however the Recovery Plan lacks detail on how the Board will operate, governance and accountability. The Diagnostics Board could be a way to ensure that variation across health boards is reduced in waiting time targets, but without the detail on how the Board will operate and what resource it will be given to work to bring up all health boards, it is impossible to say with certainty what impact it will have.

As developments for the new Diagnostic Board continue, it will be essential to understand the responsibilities of the Board and governance, to understand how to drive innovations in diagnostics across Wales.

Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?

Gaps in the NHS workforce are a fundamental barrier to transforming cancer services and improving cancer survival. Even before the pandemic, Wales was experiencing significant gaps in the diagnostic and cancer workforce, such as in imaging, endoscopy, pathology, and non-surgical oncology. These gaps have severely affected its ability to diagnose cancers early and provide the most effective cancer treatment.

The Royal College of Radiologists (RCR) found that shortfall of clinical radiology consultants in Wales is 37% – higher than the UK average of 33%. In 2020, Wales had just 7.8 radiologists (who read and interpret medical images in order to diagnose, treat and monitor diseases) per 100,000 people, compared to the European average of 12.8. Without action, shortages show no sign of abating, with Wales seeing the slowest growth in the clinical radiology workforce in the UK – averaging just two additional Whole Time Equivalent (WTE) radiologists per year.<sup>6</sup>

Shortages are evident across the cancer pathway. For example, the RCR found that in Wales there is a 20% shortfall of clinical oncologists (CO), who are specialists key to treating cancer patients given their role in using radiotherapy and chemotherapy to treat and manage patients with cancer. The current trend of retirements outnumbering training completions means that without action there will be 10 fewer CO consultants in post in 2025 than now.<sup>7</sup>

These shortages have serious consequences for patients. The RCR found that 60% of clinical directors believed there were insufficient radiologists to deliver safe and effective patient care in Wales.<sup>8</sup> The NHS has relied on the goodwill of its workforce to keep services running, with over one in four doctors in Wales, England and Northern Ireland reporting they worked more than their contracted hours without pay – this is unsustainable.<sup>9</sup> NHS Wales' spending on agency staff almost trebled from £50 million to £143 million between 2010/11 and 2018/19, showing the financial burden that workforce shortages have in Wales.<sup>10</sup>

The NHS workforce has borne a massive burden through the pandemic. We know that NHS staff are exhausted after responding to COVID-19<sup>11</sup>, as well as trying to maintain cancer services.

Against this context, we need to see a significant boost in the diagnostic workforce if we are to speed up cancer diagnosis in Wales. Getting recruitment and retention right in cancer services is essential if we are going to recover and transform services. Commitments to reduce waiting times through increasing targets or introducing community diagnostic hubs will not be achieved without a concerted effort to boost workforce numbers across the cancer pathway.

The Recovery Plan does not adequately address the pressures that the workforce face in cancer services. These shortages will hinder the effective roll out of the Recovery Plan, including ambitions to establish community diagnostic hubs to increase capacity and productivity. Without growth in the diagnostic workforce, staffing these hubs will require drawing healthcare professionals out of acute care, meaning overall diagnostic capacity does not improve.

In 2020, Health Education and Improvement Wales (HEIW) and Social Care Wales published the Workforce Strategy for Health and Social Care in Wales.<sup>12</sup> It is unclear what progress has been made

in implementing the strategy. As a result, it is unlikely the diagnostic and cancer workforce will have the capacity it needs to meet the challenge in cancer services now and in the future.

However, with the announcement of the NHS Cancer Services Action Plan, there is an opportunity to develop and deliver a long-term strategy to build a cancer workforce fit for the future.

We will now look to the NHS Cancer Services Action Plan to deliver the detail and ambition needed to plan for a workforce with the resource they need to transform cancer services and improve the lives of those affected by cancer now, and in the future.

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<sup>1</sup> <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Cancer-Waiting-Times/Monthly/suspectedcancerpathwayclosedpathways-by-localhealthboard-tumoursite-agegroup-gender-measure-month>

<sup>2</sup> Analysis by Cancer Research UK Cancer Intelligence Team based on Welsh Government Cancer Waiting Times data

<sup>3</sup> BMA, 2021. BMA survey COVID-19 tracker survey February 2021. Accessed April 2021 via <https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf>.

<sup>4</sup> <https://record.senedd.wales/WrittenQuestion/85056>

<sup>5</sup> <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Cancer-Waiting-Times/Monthly/suspectedcancerpathwayclosedpathways-by-localhealthboard-tumoursite-agegroup-gender-measure-month>

<sup>6</sup> Royal College of Radiologists. 2021. Clinical radiology UK workforce census 2020 report. Accessed August 2021 via [https://www.rcr.ac.uk/system/files/publication/field\\_publication\\_files/clinical-radiology-ukworkforce-census-2020-report.pdf](https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-ukworkforce-census-2020-report.pdf)

<sup>7</sup> Royal College of Radiologists. 2021. Clinical oncology UK workforce census 2020 report. Accessed August 2021 via [https://www.rcr.ac.uk/system/files/publication/field\\_publication\\_files/clinical-oncology-ukworkforce-census-2020-report.pdf](https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-oncology-ukworkforce-census-2020-report.pdf)

<sup>8</sup> Royal College of Radiologists. 2021. Clinical radiology UK workforce census 2020 report. Accessed August 2021 via [https://www.rcr.ac.uk/system/files/publication/field\\_publication\\_files/clinical-radiology-ukworkforce-census-2020-report.pdf](https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-ukworkforce-census-2020-report.pdf)

<sup>9</sup> BMA, 2021. BMA survey COVID-19 tracker survey February 2021. Accessed April 2021 via <https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf>.

<sup>10</sup> <https://heiw.nhs.wales/files/key-documents/workforce/workforce-strategy-for-health-and-social-care-final-pdf/>

<sup>11</sup> BMA, 2021. BMA survey COVID-19 tracker survey February 2021. Accessed April 2021 via <https://www.bma.org.uk/media/3810/bma-covid-tracker-survey-february-2021.pdf>.

<sup>12</sup> HEIW, 2020. A Healthier Wales: Out Workforce Strategy for Health and Social Care. Accessed October 2021 via [https://socialcare.wales/cms\\_assets/file-uploads/Workforce-strategy-ENG-March-2021.pdf](https://socialcare.wales/cms_assets/file-uploads/Workforce-strategy-ENG-March-2021.pdf)

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 28

Ymateb gan: | Response from: [Confederasiwn GIG Cymru | Welsh NHS Confederation](#)

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|                 |   |
|-----------------|---|
|                 | The Welsh NHS Confederation response to the Health and Social Care Committee's consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists |
| <b>Contact:</b> | Nesta Lloyd-Jones:<br>Madelaine Phillips:   |
| <b>Date:</b>    | 13 June 2022  |

## Introduction

1. The Welsh NHS Confederation (WNHSC) welcomes the opportunity to respond to the Health and Social Care Committee's consultation on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists.
2. The WNHSC represents the seven Local Health Boards, three NHS Trusts, Digital Health and Care Wales and Health Education and Improvement Wales (our Members). We also host NHS Wales Employers.
3. The scale of the challenge in planned care cannot be over emphasised as the NHS continues to go through the most challenging period in its history. Despite the best endeavours of NHS leaders and staff, the backlog will take years to reach a healthier position and there must be an effort to manage public expectations around what the NHS can deliver. The WNHSC has called for a clear and sustainable long-term funding strategy for health and social care to allow for the necessary long-term investments in staff and capital required to meet the needs of the people of Wales.

## **Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.**

4. Members said the plan could be a helpful framework to support recovery and reduce long waits. However, there were some very clear concerns relating to whether the plan provides the clarity and detail required to address the backlog, which represents a significant challenge to the NHS and patients. It is always important to remember that behind the numbers, lie people and their families and members have expressed concern over the physical and mental health impacts which long waits can create.
5. NHS organisations have to overcome significant barriers to deliver on the plan and will require support to do so. Some of these issues include: the on-going impact of COVID on services; the impact of emergency demand on key resources and facilities; the state of the NHS estate; limited short-term funding; and critically, significant workforce recruitment and development challenges.
6. Members highlighted that the health and care workforce is the key factor in whether the plan would be able to reach its aspirational targets. The successful delivery of the plan

will be compromised without clear detail and support to ensure the correct workforce is in place. This will require an increased investment to continue to drive up the number of students and trainees across professional groups. Specifically, members did highlight a need for emphasis on 'double recruiting' to plan earlier for retirements. The current pressures on the workforce due to the backlog will also have an effect on driving forward the transformation agenda at pace.

7. Concerns were also raised in terms of the growing demand and the inability of patients to access General Practitioners' adequately given the increase in demand across the system. Members called for clarity in terms of a GP strategy and any further work to be undertaken with primary care to support the plan.

### **Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?**

8. Members observed the plan does attempt to strike this balance, but it was expressed that there needed to be more emphasis on long-term sustainability, e.g. workforce solutions, training timescales and how health boards and NHS trusts can manage patients presenting with more complex needs. It should not be assumed that transformation will drive sustainability at this time due to the scale of the backlog and the pressure on staff.
9. Members also observed that the plan did not directly address the issue of patient flow and the significant number of clinically-optimised patients in hospital, and potential social care sector solutions. It will be essential going forward that the social care sector receive adequate support if the recovery ambitions are to be realised due to the interdependent nature of the system. The WNHSC have previously [called](#) for a sustainable financial model for the care sector, to ensure it has the required long-term investment to attract, recruit, train and retain a sustainable domestic workforce.

### **Whether the plan includes sufficient focus on:**

- *Ensuring that people who have health needs come forward;*
  - *Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;*
  - *Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;*
  - *Improving patient outcomes and their experience of NHS services?*
10. Adequately addressing the above points will require a strong dialogue with the public and our members did note that the plan contained no assessment of public opinion regarding these increased levels of engagement. Therefore, there needs to be an effort to reach

out to the population to take on more responsibility for self-help to allow the treatment of those most in need.

11. Whilst the commitment in the plan to coordinate national messaging in relation to public health campaigns and availability of waiting list information was welcomed, members highlighted that it did not go into detail about how hard-to-reach and vulnerable communities will be targeted.
12. In our briefing, [Reshaping the relationship between the public and the NHS](#), we called for Welsh Government and political leaders to engage in an honest conversation with the public on the scale of the challenge to ensure the public's expectations are managed. The briefing also argued for a 'Deal for Health' which sets out what the public and staff are entitled to from the NHS and the contributions that patients and the public can make to their own health and wellbeing. This engagement will be crucial in creating healthier communities and contributes to the creation of a sustainable service by reducing pressure on the NHS.
13. Members were clear that addressing greatest clinical need will not necessarily prioritise those who have waited longest and there will inevitably be a conflict for clinicians to balance clinical need with consideration of length of wait. Whilst the plan does reiterate clinical need as the primary driver for patient prioritisation, the advent of phased maximum wait targets will pose challenges for health boards in placing an appropriate balance between both priorities.
14. In terms of outcomes, members noted that the plan does not provide a lot of detail and suggested more clarity is needed in terms of timelines on delivery.
15. Members have suggested that greater emphasis and clarity is also needed in areas such as rehabilitation and how patients can be supported and motivated with self-management.

**Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**

16. Members have highlighted examples where NHS organisations are working collaboratively and opportunities for regional and national working will continue to be sought to effectively address the backlog.
17. Members felt that the plan did offer a direction for increased partnership between organisations to enable equality of access for populations across Wales and generally presents a position of national leadership from NHS Wales. However, concerns were expressed that solutions presented in the plan lack pragmatism. Members cited a focus on areas such as see-on-symptom and patient initiated follow up within the plan, but stressed that delivery will be down to individual clinicians as to what is appropriate for a patient.

18. It was felt that the plan needs to articulate both transformation and recovery in terms of overall national resource, which is UK-wide. Members also sought more detail in terms of the role of private providers and third sector, and within the wider community.

**Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?**

19. Members felt that there was an expectation that health boards would work closely together on regional priorities, with the establishment of a National Diagnostics Board an important step in this direction. However, it was noted that organisations will often not have the additional resources to deliver, and the role of regional solutions will be limited by challenges of demand and capacity.

**Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?**

20. Members raised concerns over the targets contained in the plan, with key delivery risks being the volume and rate at which demand, that reduced during the pandemic period, might return, and the success of efforts to generate sufficient workforce resources to sustain increased activity over the longer term.

21. There were specific concerns around the 52-week outpatient target, with members saying this will be very difficult to achieve by the end of 2022 for a high volume of specialities. Members cited the depletion of outpatient accommodation as one of the reasons why this would be a particular challenge.

**Is it sufficiently clear which specialties will be prioritised/included in the targets?**

22. Members noted that the plan overall focuses on the NHS system and how patients access it rather than how different specialties should be prioritised.

23. Also, it was highlighted that the plan offers some scope for local variation with regard to those specialties that will achieve the 104-week target by March 2023. This reflects the size of the challenge faced by health boards and the reality that waiting times prior to the pandemic varied across Wales.

**Do you anticipate any variation across health boards in the achievement of the targets by specialty?**

24. Members anticipate variation across health boards due to factors such as existing variation in clinical risk and workforce availability.

**Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?**

25. Investments outlined in the plan cannot be viewed in isolation and must be understood within the wider financial settlement for health boards. For those who remain in a financial deficit, prioritisation of resources will be a continuing challenge. Capital funding has also reduced this financial year therefore moving forward transformation will be more difficult.
26. Members did observe that the full revenue implications of meeting the ministerial priorities are unclear, and a costed programme could usefully be developed. It was also suggested that early notice of when funding becomes available would be helpful to accommodate timelines for recruitment, practice change, etc.
27. Members highlighted a number of factors which could compromise the plan within the funding allocated, including reliance on premium cost private sector capacity in the short to medium term while longer term solutions are developed and workforce shortfalls are addressed. Financial planning is also subject to uncertainty around the hidden backlog in community and primary care, which will have a consequent impact on conversion rates and demand for diagnostic services.
28. In a previous response to the Finance Committee, the WNHSC has [called](#) for the development of a 5-year investment plan for service change to reshape the NHS estates and infrastructure. This remains vital to support the NHS to deliver on the plan's ambitions.

**Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?**

29. The plan does not specify how the additional funding should be used to greatest effect, however there is an expectation that it will be targeted to ensure its ambitions are met. Members anticipate reporting mechanisms to mirror those currently in place for 2021/22.
30. Digital funded investment, both capital and revenue, are an essential part of transforming and modernising planned care and waiting lists. The COVID response demonstrated the value of standard digital solutions, deployed nationally at pace and developed and enhanced through a lean but effective governance and service process. This does not appear to be a consideration and digital investment should be part of the allocation alongside estates and infrastructure.

**Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**

31. Workforce supply and current workforce pressures is a key limiting factor in delivering on the plan, with many examples of difficulties to recruit required personnel across a range of professional groups and an increasing level of retirements. Members suggested that a

collective approach to recruitment of specialist skills is required to both bolster the current theatre staffing and support the proposed developments.

32. There will inevitably be a conflict between recovery priorities and the continuing need to allow staff to rest and recover after their experiences of the pandemic. Members expect this to be a continuing challenge, and the rate of improvement will be directly influenced by the availability of staffing resources to deliver the increased volumes of care required.

### **Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

33. Digital can be a key enabler for transforming and modernising planned care and reducing waiting lists but members felt there was insufficient clarity on this point, with calls for the plan to make a stronger commitment to digital services. Investment in new tools could allow existing staff to work effectively as recovery efforts face the challenge of finding and maintaining increased capacity.
34. Members said the plan lacked a strategic commitment to 'mainstreaming digital' as a primary driver of transformation across the whole system. There is a need to 'lock in' the lessons of the pandemic, particularly the accelerated delivery of services which were funded centrally and delivered nationally.

### **Conclusion**

35. Among NHS organisations, there continues to be a number of concerns over the ambitions set out in the plan and the system's capacity to achieve them. Whilst staff are working tirelessly to help patients, there are limiting factors which prevent the effective address of the backlog.
36. Capital funding and investment will continue to impact on the service, with the current state of the estate having major implications on the physical capacity of the NHS to make inroads in planned care backlogs.
37. Challenges in social care are also having serious ramifications across the whole system and on the ability of the NHS to tackle the backlog. This will require a sustainable social care funding model to address problems in care in the community and hospital discharge.
38. Workforce is the number one limiting factor for NHS capacity. Recruiting and retaining staff is a priority, with wellbeing support, flexible working and upskilling all being considered by NHS leaders to effectively support existing staff whilst attracting new employees.

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 29**

**Ymateb gan: | Response from: Coleg Brenhinol y Meddygon Cymru | Royal College of Physicians Wales**

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10 June 2022

## Welsh Government's plan for transforming and modernising planned care and reducing waiting lists

### RCP Cymru Wales response

**Name of organisation:** Royal College of Physicians (RCP) Cymru Wales  
**Lead contact:** Lowri Jackson, head of policy and campaigns for  
**Contact details:** Wales

#### Key points

The Royal College of Physicians (RCP) has welcomed the publication of the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists ('the planned care recovery plan'). Below is our response to the Senedd Health and Social Care Committee consultation. We have tried to be concise (as requested) but where the committee would find more detailed information helpful, we are happy to provide further written or oral evidence.

#### In summary:

- There is a concerning lack of detail on how the plan will be delivered.
- There are too few measurable targets, especially on social care and patient outcomes.
- There is no detail on how ambitious cancer targets will be met.
- There is no clear measurement framework for delivering this plan.
- A clearly co-produced workforce plan should be an immediate priority.
- We welcome a commitment to better communication with patients.
- It is impossible to comment on funding without more detail about delivery of the plan.
- We welcome the focus on health inequalities. This needs to be cross-governmental.
- Data collection must improve and become more transparent.
- The move to digital healthcare needs investment in education, estates and equipment.
- The impact on health professional education and training is not discussed in any detail.
- There is a risk that without a strong central guiding hand, local plans will be inconsistent.

## **The plan lacks detail on accountability, delivery and engagement**

It is difficult to disagree with the aims and intentions of this planned care recovery plan, including the assertion that 'reducing waiting times will require new solutions and a range of actions' (p2). Unfortunately, this document lacks any detail around the 'alternative options', especially around data collection, outcome measurement, workforce planning and digital technology. Page 2 sets out 'four clear commitments to people in Wales' which are neither specific nor measurable.

Page 3 does set out five new targets on capacity, diagnosis, delivery and information, but there is no detail on how these will be met without a huge increase in workforce and major investment, and some RCP fellows and members have described them as 'unrealistic'.

We understand that the Welsh government itself is developing the proposed planned care workforce plan (p8). However, it would be helpful to understand what role Health Education and Improvement Wales (HEIW) will have in the drafting of this plan, given that they are intended to be the national strategic workforce body for Wales.


It is unclear how much external stakeholder engagement there has been during the drafting of this plan. The RCP was not involved in its drafting or design, and neither were other royal colleges and professional bodies that we have spoken to. Without third sector and patient advocacy organisations as well as professional bodies involved, it is difficult to predict how successful or effective this plan will be.

We were pleased to see a focus on reducing health inequalities, promoting healthier lifestyles and engaging the workforce at the front of the plan. Again, however, there is little to no detail on *how* this will be achieved, *who* will take ownership and *when* it will happen. It is impossible to hold the Welsh government and NHS organisations to account without more detail.

## **A stronger central guiding hand is needed**

We are concerned that Welsh government is placing too much responsibility on local health boards to decide *how* to implement these changes. This risks inconsistency across different NHS organisations, resulting in unequal access to high quality healthcare for patients across Wales.

A stronger central guiding hand would be welcome, as recommended by the [2016 OECD review of health care quality](#). The Welsh government published their national clinical framework more than a year ago, and we are still to see any tangible progress on most quality statements, clinical networks or implementation plans – or even a [system for prioritising, agreeing and publishing quality statements](#) (as promised by the Minister on 21 January 2022). The Welsh government has referred stakeholders to the individual integrated medium-term plans (IMTPs) of health boards as the delivery vehicles for these quality statements, but without sufficient national oversight, this is likely to result in a fragmented and piecemeal approach.



The Welsh government commit in this planned care recovery plan to ‘utilising the national clinical framework and our clinical networks [to] review and challenge unwarranted clinical variation’ (p24) but it is unclear from this document how the planned care recovery plan will complement the national clinical framework in practice and how planned care recovery at a national level will link to the new NHS Wales executive, clinical networks and the development of implementation plans.

## Conclusions

Ultimately, while we welcome this planned care recovery plan and its focus on reducing health inequalities, improving communication, early diagnosis and treatment, building capacity and reducing waiting times, there are too many unanswered questions. There is not enough detail on *how* the plan will be delivered. We lack the workforce to deliver this plan – there are simply not enough health and care professionals in the system – and there are no clear milestones. There was little public or third sector engagement while it was being written. Commitments on improving data collection and digital technology are vague and unclear, and will require major investment in education, estates and equipment, including measures to increase digital inclusion for patients and avoid exacerbating existing inequalities in access to healthcare.

The Welsh government should now publish a detailed action plan or delivery framework with specific milestones to measure progress on meeting targets within this planned care recovery plan. This should provide more information on how NHS organisations will be held accountable for the delivery of the plan so that external organisations are able to scrutinise outcomes more effectively. The promised workforce plan should be published as soon as possible, following genuine engagement with the third sector and professional bodies, ‘based on a robust assessment of current capacity gaps and realistic proposals for addressing them’ (Audit Wales, 2022). After all, increased investment in the NHS cannot improve patient care if we simply don’t have the staff to treat patients.

### **Educating, improving, influencing**

Through our work with patients and doctors, the Royal College of Physicians (RCP) is working to achieve real change across the health and social care sector in Wales. We represent over 40,000 physicians and clinicians worldwide – educating, improving and influencing for better health and care. Over 1,500 members in Wales work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions. We campaign for improvements to healthcare, medical education and public health.

#### **Lowri Jackson**

RCP head of policy and campaigns for Wales

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**This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)**

**PCWL 30**

**Ymateb gan: | Response from: Bwrdd Cyngor Iechyd Cymuned | Board of Community Health Councils**

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## Welsh Government's plan for transforming and modernising planned care and reducing waiting lists: consultation response

The Board of Community Health Councils (the Board) is pleased to submit this consultation response on behalf of Community Health Councils (CHCs) in Wales.

CHCs are independent bodies that reflect the views and represent the interests of people living in Wales in their National Health Service (NHS). CHCs encourage and support people to have a voice in the design, planning and delivery of NHS services.

There are 7 CHCs in Wales. Each one is made up of local volunteer members who live in the communities they serve, supported by a small team of paid staff. Each CHC:

- Carries out regular visits to health services to hear from people using the service (and the people providing care) to influence the changes that can make a big difference
- Reaches out more widely to people within local communities to provide information, and to gather views and experiences of NHS services.

CHCs use what they hear to check how services are performing overall and to make sure the NHS takes action to make things better where this is needed

- Gets involved with health service managers when they are thinking about making changes to the way services are delivered so that people and communities have their say from the start
- Provides a complaints advocacy service that is free, independent and confidential to help people to raise their concerns about NHS care and treatment.

The Board of CHCs (the Board) exists to support, assist, advise and manage the performance of CHCs. It represents the collective views of CHCs across Wales.

CHCs in Wales do not have a statutory role in reflecting the views and representing the interests of people who may or do need to access social care services in Wales.

In the same way that people's individual health and care needs do not stop at organisational boundaries, neither do people's views and experiences of the health and care services they receive. So CHCs often hear what people think about their health and care services overall, and not just those provided by or funded by the NHS.

CHCs have used what they have heard from people across Wales and from NHS providers about health and care services to inform the following collective response to the consultation questions.

**Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.**

CHCs welcome the clear focus in the plan on addressing the things that people have told us matters most to them when they are waiting for a diagnosis or treatment. It acknowledges and responds to the main issues we hear from people living in all parts of Wales who are waiting longer than anyone would like for a diagnosis or treatment.

It sets out - in high level terms - what will be done (and in many but not all areas how), to address these issues. It sets some key targets so that the public have some idea how quickly they can expect things to get better.

It recognises the key elements that will be needed to deliver what is an ambitious programme that, to be successful, must tackle once and for all some long standing and systemic issues that have been made worse, but have not been caused by, the COVID-19 pandemic.

The 'transformation' it identifies as necessary to bring down waiting lists and create a sustainable health and care system for the future must be achieved with people and communities through co-production. How it does this will be key to the plan's success.

But:

- CHCs question whether the plan sufficiently recognises the stark reality of just how fragile the current NHS workforce is – including in the primary care sector where the NHS relies so heavily on doctors, dentists, etc., operating as independent contractors.

The plan leans heavily on this fragile foundation. CHCs are increasingly seeing practices that have previously been thought of as "stable" GP and dental providers resign their NHS contracts because of recruitment and retention issues. No service is immune to folding as 'burnout' and recruitment issues continue.

- CHCs question whether the plan itself gives sufficient attention to the role of the social care system in enabling its successful delivery.

CHCs also think that it will be easier to judge whether the plan will be sufficient to address the backlogs in care when more detailed information is available from healthcare planners and providers.

Setting out 'what, when and how' the high-level ambitions described in the plan will be turned into clear, co-ordinated, and collaborative

actions locally, regionally, and nationally - through things like the workforce delivery plan - is key.

Without this it is not clear that the plan's ambition will be anything more than aspirational in nature.

### **Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term**

CHCs welcome the clear focus in the plan on taking immediate and short-term actions like commissioning more treatment from non-NHS providers to bring down waiting lists more quickly while developing the capacity to design and implement more sustainable arrangements for the future.

But the main focus of the plan is around building a more resilient and sustainable healthcare system – with social care providers and local authorities referenced as partners but not extensively referred to/included as active contributors to a strengthened, more integrated health and social care system.

### **Whether the plan includes sufficient focus on:**

- **Ensuring that people who have health needs come forward;**
- **Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management;**
- **Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time;**
- **Improving patient outcomes and their experience of NHS services?**

CHCs welcome the recognition in the plan of the importance of maintaining a strong, sustained communications strategy bringing

together local and national communications to help make sure people have enough of the right kind of information when and how they need it to empower them to come forward when they identify a health need.

The plan also recognises the importance of making sure that once people seek help having identified a health need that they can get that help through their doctor, dentist or other healthcare professional.

However, it's vital that the messaging and the reality of people's experience match up. CHCs continue to hear most of all each day from people who cannot get to see a doctor or dentist when they need one – for too many people it still feels a long way off the kind of access aimed for through the new GP access commitment.

Effective monitoring, action and clear reporting to the public on performance in these kinds of areas must be a key part of the wider communications strategy.

CHCs welcome the strong focus in the plan on supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management – including by working together with the 3<sup>rd</sup> sector to provide help, advice and support.

CHCs also recognise the key part that continued development of digital technology can play in achieving this – and the recognition that digital technology cannot be the only answer if no one is to be left behind.

CHCs are keen to see that this recognition in the plan is translated into practical and comprehensive action in areas like sustainable 3<sup>rd</sup> sector funding models and developing arrangements that are flexible enough to support people's individual help, advice and support needs.

CHCs are still hearing too often from people that they are offered a 'one size fits all' approach.

The plan provides a clear focus on prioritising those in greatest clinical need through a range of actions including better clinical list validation, refined primary care referral following early diagnostics and improved quality of referrals to aid initial triage.

The plan is clear about the range of things that will improve patient outcomes including earlier diagnosis, co-productive approaches to individual care, better care pathways and quicker treatment.

It also acknowledges the importance of capturing and using patient feedback to drive further developments and action where needed.

CHCs want this to be part of a clearer, stronger and more meaningful performance measurement, monitoring and reporting system that helps manage performance at all levels and drives improvements in health and care services on the things that matter most to people about their care and treatment.

### **Whether the plan provides sufficient:**

- **leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?**
- **clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?**

The plan itself sets out a clear and simple national direction to respond to the immediate and longer-term challenges in reducing waiting times.

It is much less clear within the plan itself how this direction and intention to work collaboratively and collectively at all levels will be driven in practical terms.

CHCs know from its day-to-day activities locally, regionally, and nationally that there are already many different planning, programme and project groups and networks in place to drive design, development, and improvement in the NHS in Wales. Some of these are permanent arrangements and some are 'task and finish' groups.

It is not always clear to CHCs (or others) how they all fit together, who's responsible for doing what and when, and who is accountable to who and for what overall. As well as this, the part the new NHS Executive will play in all of this is still being developed.

So, unless those working within the NHS itself are clear who is responsible for doing what and when, there is little hope of people and communities effectively informing and influencing its thinking.

CHCs welcome the commitment to more regular performance information, eg., through a weekly performance dashboard. It is important that the more detailed delivery arrangements that underpin the plan set out very clearly overall:

- the levers in place to encourage collective effort, collaboration and innovation across the NHS, and the consequences of not doing so
- how working together will deliver equitable service provision that responds to the particular challenges facing people living in all parts of Wales, eg., rurality, deprivation, etc.

- who is responsible for doing what, how (where appropriate) and when
- how and when progress should be reported, and to who
- who will take action if things aren't going to plan.

If those involved in healthcare are to be properly valued and recognised for the way in which they work collaboratively and innovatively then this must be recognised in performance measurement and management arrangements at all levels.

### **Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?**

CHCs welcome the very clear commitments in the plan about what people can expect and by when in terms of reducing the waiting lists overall (even though these are longer than anyone would want). This simple approach along with regular, more frequent progress and performance reporting should mean that people can easily measure whether these high-level commitments are met.

CHCs also note that the plan clearly states that it has been developed with NHS services and that there is confidence within the NHS that the plan is deliverable.

However, given CHCs concerns about the resilience of the workforce and its capacity to drive and respond to continuing 'transformation' at every level, we are unable to clearly assess how realistic and achievable the plan is without seeing the more detailed delivery plans that will support it.

### **Is it sufficiently clear which specialties will be prioritised/included in the targets?**

The plan refers to some aspects of specific services where CHCs regularly and consistently hear concerns from people about waiting times. This includes, for example, children's services, mental health

services, cancer care, etc. It also focuses on the key aspects within service areas that people worry about such as diagnostics. It doesn't focus in more detail on the whole range of specialties, including those we hear most often about such as orthopaedics.

CHCs expect the high-level targets set out in the plan to apply to waiting times in respect of all NHS services – for everyone on a waiting list for any NHS specialty. People living in Wales need to be reassured that everything that can reasonably be done will be done to make their wait as short as it is possible to be – the plan must achieve this.

The range of more detailed delivery plans must clearly set out how the different challenges will be addressed across specialties and geographical areas - whether that be for example a workforce plan, cancer plan or NHS body Integrated Medium Term Plan (IMTP).

### **Do you anticipate any variation across health boards in the achievement of the targets by specialty?**

CHCs want the more detailed plans that support delivery to clearly set out how and when the existing variation across health boards will be addressed through a collaborative approach and new/different ways of working that meet the needs of people and communities.

### **Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?**

The plan doesn't provide any detail about the breakdown of the available funding (including additional sums), between revenue and capital.

It's important that the way in which funding is made available supports short term actions to address waiting time backlogs

equitably as well as developing services for the longer term in a sustainable way for people living in all parts of Wales.

**Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?**

The plan focuses at a very high level on the key things that the NHS will need to focus on to transform the way planned care is delivered in the ways that matter most to people.

CHCs expect that the funding model in place to support delivery will provide sufficient focus so that the more detailed NHS delivery plans can respond flexibly in a way that best meets the needs of their population considering things like geography and demography.

**Does the plan adequately address health and social care workforce pressures, including retention, recruitment, and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?**

The plan recognises the need to address the key issues affecting the existing health and care workforce. The introduction of the real living wage in social care is welcome but CHCs do not currently have sufficient detailed knowledge of this sector to identify what more may be needed to put it on a more sustainable footing.

CHCs are seeing daily the impact on NHS care resulting from shortages in staff (some long standing and some related to the direct impact of COVID-19), and the impact on the quality of care when those delivering it are physically and emotionally exhausted.

CHCs welcome the commitment to work together with the health and care workforce to develop more detailed plans to address the workforce pressures. This should help provide assurance that those

more detailed plans respond to the key aspects from the perspective of the workforce in all parts of Wales.

Similarly, CHCs want to see that the views and experiences of patients and service users inform and influence the priorities within the workforce delivery plan.

### **Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?**

CHCs welcome the commitments in the plan to use digital tools and data to drive service delivery and more efficient management of waiting times – enabling people to feel more in control of their healthcare by being able to access advice, support and information about their care and treatment.

CHCs also welcome the clear commitment in the plan to reduce digital exclusion. It is vital that any developments recognise that there will always be some people whose individual needs cannot be met through their direct use of digital technology to access healthcare.

The focus on developing services must always include consideration of how things need to work for those who do not use technology.

Detailed planning for digital transformation needs to recognise and respond to the impact of digitisation on capacity – whilst easier digital access can often save capacity and better manage demand, it can also increase demand.

This has been the case with systems such as e-Consult and AskMyGP, where increased demand has resulted in a reduction in the availability in the operating hours of the systems in many cases.

## Communication and engagement

CHCs welcome the commitment in the plan to strong and co-ordinated engagement and communication at local and national levels – and recognise the urgency of the need to move forward with clear, collaborative, and co-ordinated plans to recover and transform services for the future.

But this can only be achieved effectively if those responsible for designing and planning services for the future live up to the commitment to engage and involve people and communities in the design and development of their healthcare services.

This must be more than simply communicating why and how things are going to change. It's about working together with people and communities to identify the way services should be delivered in the future – recognising and responding to the things that matter most to people about how their services are provided.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 31

Ymateb gan: | Response from: Diabetes UK Cymru

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# Diabetes UK Response

**Written by:** Mathew Norman, Policy and Public Affairs Manager (Wales)

**Submitted as:** Submission as an organisation.

**Authorisation to publish the submission:** Happy for submission to be published as Diabetes UK Cymru.

## About us

Diabetes UK's vision is a world where diabetes can do no harm. We lead the fight against Wales' largest growing health crisis, which involves us all sharing knowledge and taking on diabetes together.

Over 209,015 people live with diabetes in Wales, equivalent to 1 in 13 people, the highest level of prevalence of any of the UK Nations. The last twenty years have seen a rapid increase in the diagnosis of diabetes; this is due in part to a growing rate of type 2 diabetes diagnoses, with an estimated 65,000 people in Wales living with undiagnosed type 2 diabetes.

The continued prevalence of obesity suggests that an estimated 580,000 people in Wales could be at risk of developing type 2 diabetes, the most common form of diabetes, accounting for 90% of all cases. By 2030 the number of adults with diabetes in Wales is likely to grow from 8% to 11%.

Further information on diabetes can be found on our website.

## Response

We thank the Committee for the opportunity to respond to the enquiry into the Welsh Government's plan for transforming and modernising planned care and waiting lists.

Overall, Diabetes UK Cymru welcomes a review of how to transform and modernise planned care to reduce long waiting lists. Diabetes, regardless of its type and no matter how well managed, can lead to complications later in life. Delays in treatment for people living with diabetes can have devastating consequences, from the deterioration and loss of eyesight, kidney failure, amputations, and complications from lack of access to mental health support.

With obesity as one of the causes of Type 2 diabetes, elected planned care like bariatric surgery can enable people with Type 2 diabetes to go into remission and improve their health outcomes. Unfortunately, such life changing interventions can be delayed or cancelled due to waiting times, causing both emotional and physical distress.

Therefore, we welcome the Welsh Government's transformative plan to reduce waiting times; however, we have some concerns with the application of the plan, especially with the proposed change to how patients interact with planned care with a move to more digital platforms and patient self-managed digital resources.

We have responded under specific areas of focus in the plan.

## Funding

One of the concerns is the funding gap to support the recommendations of the plan and no clear indication of how much long-term funding will be available. Throughout the report, indications of

funds have been hinted at, especially for 'significant' amounts to reduce the backlog of waiting times in the short term. We welcome specific sums such as £262million annually to equip and train the next generation of healthcare workers; however, no details are given on how long this level of funding will be maintained, how this funding will be distributed, which health boards will be receiving the budget needed or how innovations and proposals in this plan will be implemented.

### **Staff Recruitment and Retainment**

One of the wide-ranging concerns of the NHS is staff recruitment, and retention and Diabetes UK Cymru feels that this issue is not addressed or discussed within the plan.

As highlighted in the Committee's report, 'Waiting Well?', evidence collected by stakeholders indicated that by asking more from the already overworked and stretched NHS workforce, healthcare professionals would either leave the profession or reduce their hours.<sup>1</sup>

The plan presented by the Welsh Government proposes an aspiration to offer planned care to be managed on 52 weeks, seven days and 15 hours a day basis. However, what is not evident in the plan is how these additional services needs will be met. With one hand the plan commits to ensure a sustainable workforce and with the other states that '... simply continuing to grow the existing workforce will not be enough to deliver...' services.

We look forward to developing the Workforce Delivery Plan for Wales to clarify how these needs will be met and how recruitment and training in Wales will be delivered.

With a clear understanding of how the workforce will be supported and recruited, Diabetes UK Cymru welcomes increased access to services on weekends. Especially for those managing lifelong conditions like diabetes. 7 out of 10 of our beneficiaries recently indicated to us that they find the management of their diabetes overwhelming: especially when trying to maintain a full-time job and personal and family commitments. Improving access to education and screening will help improve the management of diabetes and reduce the complications that may occur.

### **Digital Care**

The plan throughout makes reference to the use of new technologies to free up health care professionals' time to focus on patient care and reduce the backlog. Concerning the new General Medical Service (GMS) contract, the significant change to access GP services on a blended model grants exciting new positive developments which will allow patients to access the care in a way that benefits them.

Access to new technologies such as Continuous Glucose Monitors (CGM) and Flash Glucose Monitors (usually referenced as Flash) can be fundamentally life-changing in the management of Type 1 (and other types that require insulin) diabetes. Recent changes in NICE guidelines support referrals for this monitoring technology. Increased access to such technologies does not only improve the lives of thousands but also can help reduce complications and increase better management of diabetes.

However, underpinning any new development of digital services requires a review of how digital data is collected and stored in NHS Wales. Different health boards utilise different data management systems with no clear universal access or data collection. Investment is needed to support a

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<sup>1</sup> 'Waiting Well' The impact of the waiting times backlog on people in Wales, April 2022, Health and Social Care Committee.

<https://business.senedd.wales/documents/s124284/Waiting%20well%20The%20impact%20of%20the%20waiting%20times%20backlog%20on%20people%20in%20Wales%20-%207%20April%202022.pdf>

universal means of collection and storage. There is no clear indication of how this will be undertaken, and it is concerning that there will not be a review when the plan indicates that accurate data will underpin it.

Access to technology is also a concern for Diabetes UK Cymru, primarily as the plan seeks to develop a planned care portal alongside the NHS app to inform patients and provide up-to-date information on waiting times and supported services. The report references widening health inequalities and poor population health; however, with a cost-of-living crisis, access to certain technologies and services may not be seen as a necessity when compared to putting food on the table and turning on the heating.

Patients who are not as technologically savvy or literate may also struggle to access such services. More must be done to ensure that these groups are supported so that we don't further reduce health equalities in our most deprived and vulnerable communities.

With 2,353 GPs to over 3.2 million registered patients in Wales, we can see the benefits of digital services to support people in Wales; however, we have concerns that it may impact the quality of care delivered and call for continued monitoring of the delivery of services as a digital approach is undertaken.<sup>2</sup> This ensures that no patient receives lower quality of care and that diagnoses for potentially fatal conditions such as Type 1 diabetes are not missed.

## **Prevention**

Support for policies that focus on prevention is lightly referenced throughout this document, with a clear link between health inequalities, deprivation, smoking and obesity. We welcome the commitment to develop a national framework for social prescribing to embed access to prevention services and wellbeing activities into pathways. Some conditions such as cancer are referenced throughout, and others, such as diabetes, which can be preventable for some with Type 2 diabetes, are not mentioned at all. We believe that explicit reference to diabetes is needed given its prevalence.

As the plan indicates, policies which focus on prevention can reduce the need to access services in the future and improve waiting times and, in turn, can reduce the cost associated with diabetes which accounts for 10% of NHS Wales budget.

This month, during diabetes week, the Wales Diabetes Prevention Plan is being launched in Wales, welcomed; we look forward to a full rollout, with a commitment to increase provision and support for people in Wales to be educated on the adverse effects of their lifestyle, which contributes to their obesity and possible future diagnosis of conditions like Type 2 diabetes.

Mental health support is also welcomed as part of Welsh Government's plan. Diabetes UK Cymru understands too well the long-term implications of the lack of access to dedicated services for people with long-term conditions like diabetes. We call for dedicated services such as those highlighted by Dr Rose Stewart's recent report 'From Missing to Mainstream' calling for integrated dedicated psychological services for people living with diabetes.<sup>3</sup> Every pound invested in services that help to support people living with diabetes and prevent long-term conditions supports a healthy

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<sup>2</sup> Stats Wales, 2022.

<sup>3</sup> From Missing to Mainstream; A Values based action plan for Diabetes Psychology in Wales, Dr Rose Stewart, All Wales Diabetes Implementation Group, 2022.

lifestyle and reduces pressures on the NHS. We welcome current investment and hope to see long-term dedicated levels of funding to support mental health services.

### **Private Sector**

There are two references to private providers and the private sector in the plan as means to help reduce the pressures on the NHS. We have some concerns that no clarity is given on which services will need private sector support nor whether those with private healthcare may benefit from using such services, creating a disparity in the quality of care for those more deprived.

We understand that resources from external bodies may need to be utilised from time to time to reduce pressures faced by the NHS, such as expanding certain services into pharmacies and using new technologies. However, we would welcome further detail to accompany the plan regarding how the private sector will support services and whether access to these services may be impacted.

### **Regional Diagnostic Hubs**

The plan assures that services will be as local to the patient as possible with the investment and development of Diagnostic Hubs that are established away from acute hospital sites. We welcome such proposals, especially if a network is established to co-locate frontline health and social care services to grant a consistent approach to support health checks for patients, especially from deprived areas.

There is no further detail on which services would be granted at these hubs; neither are we given details around the number, how they will be funded nor how they will be staffed. References to the use of artificial intelligence to assist the workflow is mentioned in the report, which again raises concerns we noted earlier around data retention and access to technologies.

If such hubs were to include education, management support and screening service for people with diabetes, such as eye care services, this would be welcomed. Services such as eye screening are vital to prevent conditions leading to deterioration and loss of sight for people with diabetes. During the pandemic, eye statistics for all measures for the activity of sensory services were remarkably lower than in previous years. In contrast, the number of eye care and hearing specialist practitioners increased in 2020-21. During 2019 – 20, 36% of patients eligible for Diabetic Eye Screening Wales service did not attend the service, and out of those who did, 30.3% were found to have some degree of diabetic retinopathy.<sup>4</sup> Unfortunately, access to services is still causing anxiety for many people with diabetes, who may fear irreparable damage to their eyesight when they cannot access routine care.

### **Conclusion**

We welcome the ambitious transformative plan by the Welsh Government to address and tackle the current backlog of patients waiting for care. We hope that this plan ensures that the health needs of patients come first with dedicated support throughout their treatment pathway.

People living with diabetes, no matter how well they manage their condition, can face complications with their condition, which often need surgical intervention. Through dedicated patient-led support for the prevention of diabetes and planning diabetes care, waiting times and pressures on the NHS can be reduced.

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<sup>4</sup> Welsh Government Statistics, September 2021, Sensory Health (eye care and hearing statistics): April 2019 to March 2021, <https://gov.wales/sensory-health-eye-care-and-hearing-statistics-april-2019-march-2021-html>.

We welcome this transformative approach and look forward to continued collaboration with the Welsh Government, Stakeholders and the Senedd.

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 32

Ymateb gan: | Response from: Cymru Versus Arthritis

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# The Welsh Government's plan for transforming and modernising planned care and reducing waiting lists



Written evidence submitted to the Senedd 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* from Cymru Versus Arthritis, June 2022

## Introduction

### About the charity

- Versus Arthritis is the UK's largest voluntary organisation supporting people with arthritis and musculoskeletal (MSK) conditions. The charity provides a range of services: [local peer support groups/services](#); award winning [publications](#); activity and exercise [videos & resources](#), an [online community](#) and [helpline](#) – 0800 5200 520. We also fund world leading [research](#). For more information about our charity, please visit our [website](#).

### About Arthritis and MSK conditions

- An estimated 970,000 people live with arthritis/MSK in Wales.<sup>i</sup>
- There are over 100 such conditions, including osteoarthritis, gout, rheumatoid arthritis, lupus, psoriatic arthritis, axial spondyloarthritis, fibromyalgia and juvenile idiopathic arthritis (JIA).
- MSK conditions can strike at any age, including childhood.
- Common symptoms include joint pain, stiffness, and fatigue. Symptoms can significantly impact on mobility, dexterity and many other aspects of daily life. They are among the leading causes of persistent pain and disability.
- For more info on MSK conditions, please see our 'The State of MSK Health 2021' report [here](#).

### Record waiting times impacting on people living with arthritis in Wales – in figures

Trauma & Orthopaedics (T&O), as of the end of March 2022:

- the total number of people waiting for T&O in Wales was 97,522. The pre-pandemic average for 2019 was 62,118;
- 53,332 (55%) people on the T&O waiting list were waiting longer than 36 weeks, compared to 6,570 people (11%) on average in 2019;
- 39,171 (40%) people on the waiting list for T&O were waiting longer than 53 weeks (1 year), compared to 2,473 people (4%) on average in 2019;
- 20,445 (21%) people on the waiting list for T&O were waiting longer than 105 weeks (2 years) compared to 76 people (0.001%) on average in 2019.

## Submission summary

- We welcome:
  - The publication of the plan and the additional funding ringfenced for planned care recovery.
  - The recognition that orthopaedic services have been among the worst hit services during the pandemic and the impact on those waiting.
  - The support for a transformation agenda through *'Regional options which will allow protected planned care capacity at a higher volume than traditional hospital based theatres'* the commitment to *'...introduce regional and wider models of care to ensure equitable access. This may involve regional waiting lists, the transfer of patient care across health board boundaries, central hubs that offer those waiting a long time a more suitable appointment or the national commissioning of services.'* And *'Regional plans for aspects of orthopaedic services based on the orthopaedic clinical strategy work.'* We support the development of surgical hubs / elective centres and the ring-fencing of planned care facilities from other services. Developing travel provision and co-production of plans are vitally important to support this approach.
  - The recognition of the need to provide communications and support for people as they wait for treatment/surgery and the development of innovative online resources to support this aim.
  - The commitment to publish additional data to support the recovery process.
  - The plan's support for *'Partnering with the independent sectors to develop new approaches and models of care.'*
- However, there are aspects of the plan that require clarification or additional detail to support planned care recovery:
  - Waiting times targets are framed in relation to 'most' specialities rather than 'all'. The Plan does not clarify which services are to be included/prioritised in the targets and which are not. We are concerned that some of the hardest hit services, including inpatient elective orthopaedics interventions such as knee and hip replacements, will not be included for the 'most' specialities prioritised to achieve the targets. We are concerned that the targets could theoretically work against the prioritisation of some of the more life-changing and effective surgical intervention. People are waiting in severe and worsening pain for life-changing operations such as a hip or knee replacement and are losing mobility and independence, with significant impact on wider physical and mental health. Such procedures are extremely effective at reducing or eliminating pain and restoring mobility and independence. Yet, these services may not be prioritised within the 'most' specialities targets.
  - The plan lacks detail, modelling and projections re how targets can be met in orthopaedics. Note, we are aware that policy work is ongoing in relation to national planning for elective orthopaedics within Welsh Government, however, we do not the timeline to publication. We would like to see a National Recovery and Transformation Plan for Elective Orthopaedic Services published for consultation as soon as possible.

- There is a lack of commitment in the plan for national leadership on supporting people waiting for treatment. However, we understand the Welsh Government has subsequently recruited to a leadership role in this field. We are awaiting details re remit of the new role.
- We would like to see greater detail on the plan's commitment to publish additional data re waiting times. We would like to see monthly activity data published for indicative treatments / surgery services by HB.
- Addressing workforce issue will be key to recovery. We would like to see further detail on actions to be taken to address staff shortages.

## Full submission

### **The impact of longer waiting times on people with arthritis / MSK**

- Waiting times for services such as orthopaedics that are of vital importance to tens of thousands of people living with arthritis and MSK conditions in Wales have hit record levels and have continued to increase beyond the peak of pandemic related pressures. Many of those on the waiting list are waiting in severe and worsening persistent pain for an orthopaedic intervention such as a hip or knee replacement. The impact of the long waits can be devastating for individuals and their families, limiting people's mobility and independence, impacting on all aspects of a person's life, including employment, family life and physical and mental health.
- We appreciate the scale of the challenges facing the NHS, we are realistic about the timeframe necessary to clear the backlog. However, we believe that due to the extent and the continued escalation of health impacts of those waits, in terms of the numbers of people impacted, the impact on individuals and families and the consequences for the wider health and social care infrastructure and wider economy, reducing the orthopaedic waiting times and clearing the backlog needs to be a top tier priority for all relevant NHS bodies and the Welsh Government.
- We are particularly concerned at the significant growth of people waiting over two years for orthopaedic operations. As of the end of March 2022, the number of people waiting over 105 weeks (2 years) had grown to 20,445, or 21% of the T&O waiting list. This compares to 76 people (0.001%) on average in 2019.
- Evidence shows that delaying surgery can lead to worse outcomes for people who have been referred for hip and knee joint replacement, particularly waiting times beyond 6 months.<sup>ii</sup>
- Versus Arthritis surveyed people waiting for joint replacement surgery across the UK in late 2020 and found: 81% reported their physical health had worsened, 90% said their pain levels had deteriorated, 90% reported reduced mobility, 78% said they were now less independent, 72% reported a deterioration in their mental health.<sup>iii</sup>

### **Clarity re waiting times targets**

- We believe that it would strengthen the recovery planning process if the Plan's waiting times / recovery targets were made clearer re which services they relate to. Setting recovery targets in relation to 'most' specialities, rather than 'all' will not reassure people with musculoskeletal (MSK) conditions waiting in severe and worsening pain for life-changing surgery such as a hip or knee replacement that the Plan necessarily includes the services

they are waiting for. The use of 'most' in the wording for the targets provides too much space for more challenging service backlogs – including some of the most effective and life-changing treatments such as hip replacements – to be outside prioritised services. The targets could in theory work to deprioritise such services in favour of services more likely to achieve the targets and fulfil the 'most' specialisms criteria.

- We are concerned that there is no target for achieving the pre-pandemic 26 weeks wait target. Without this, does the Plan's one year wait target by 2025 effectively become the new planned care waiting times target in Wales?

### **Recovery and transformation of planned care services**

- We are very concerned at the rate of progress restarting services between pandemic waves during the pandemic and the pace of progress rebuilding capacity during recovery since the pandemic. We are also concerned at the disparity in the pace of rebuilding capacity between health boards. We would like to see a clearer roadmap to achieve pre-pandemic activity levels across Wales and a clearer mechanism to monitor progress.
- The recovery plan does not offer time-framed projections, modelling or targets regarding activity levels expected / required of Health Boards to meet the waiting times / recovery targets included in the plan or a timeframe to produce such modelling. The plan states work will commence with HBs re setting 'clear targets for improvement' but no timeframe is provided.
- Such detailed planning for orthopaedics is contained in the 'Orthopaedic Clinical Strategy Work' referenced on page 37 of the recovery plan, however no timeframe is provided for the publication of this work or for Welsh Government national planning for orthopaedics informed by this commissioned work. We believe the publication of a comprehensive, detailed plan for the full recovery and transformation of orthopaedic services is key to recovery and to building a robust and efficient elective orthopaedic service for the people of Wales. Such a national plan is needed to drive the creation of the regionalised, national orthopaedic service outlined but not detailed in the recovery plan.
- A national orthopaedic plan is needed to look beyond the recovery of elective orthopaedic services to provide planning for the transformation of the service to fully clear the backlog and to provide high quality services in a timely manner for the long term. It will need to offer a roadmap for achieving 100% of pre-pandemic activity levels and to achieve the 100%+ levels required to clear the backlog in the coming years and how and what workforce and facilities issues will need to be addressed to achieve these aims. We understand that a material increase in orthopaedic resource, across workforce and facilities is required to address the service needs of the nation and its aging population.
- It should be noted that orthopaedic waiting times were too long and were growing before the pandemic began. Further, elective orthopaedic services were regularly paused due to external pressures such as winter pressures. Transformation is needed to build a more robust service capable not only of clearing the backlog, but of withstanding external pressures and of achieving low waiting times and keeping them low for the long term. We believe that waiting times no higher than 6 months should not be an unrealistic target when the surgical intervention can be only an hour's operation that can fully restore mobility and independence to someone waiting in severe persistent pain.
- We welcome the commitment for 'Regional plans for aspects of orthopaedic services based on the orthopaedic clinical strategy work.' and the acknowledgment of the need to transform services. However, we await the planning detail necessary to show what that will look like or how and when it will be delivered for elective orthopaedic services.
- We support the Royal College of Surgery of England's call for surgical hubs / elective centres. Progress is being made at the local level in some HB areas to develop surgical hubs, for

example in Swansea Bay UHB. That progress is welcome, however we would like to see an acceleration and greater prioritisation of this process across Wales and we would like to see more national planning to ensure regional, cross-HB area solutions are evaluated and taken forward where most appropriate. We would like to see the aims for surgical hubs cover not only greater capacity and efficiency and supporting vital recruitment and retention initiatives, but also to focus on delivering the highest quality health outcomes for service users.

- We welcome the commitment to greater regional working where necessary/beneficial for certain services/treatments and we accept this will involve more travel for some people. Such changes should take into account travel support needs of services users. WG and HBs should also ensure more regularly accessed services, such as prehab and rehab (that work with less frequently accessed services that may be regionalised such as surgery) remain available locally.
- We believe that all options should be evaluated to reduce orthopaedic waiting times during recovery. Choices available to service-users, such as accessing services outside their HB area, should be communicated to them.
- We welcome the plan's support for 'Partnering with the independent sectors to develop new approaches and models of care.' We would like to see greater detail with guidance for the use of private services to speed up the process of recovery for elective orthopaedic services. We understand that this is a shorter term approach to lowering the waiting lists, however we believe that with the waiting lists as long as they are and with the health need as great as it is, short term solutions should be utilised to help reduce waiting times as more longer term, sustainable solutions are developed and implemented. We would like to see more data published to monitor HBs' use of orthopaedic private sector capacity in Wales to provide greater clarity and inform recovery planning and implementation. Further, greater clarity is needed re whether HB funding will be available for people to access private sector services, including in other regions and nations, both within the UK and beyond.
- We welcome the Plan's commitment to equitable access to services and recognition that this may require regional lists and transfers to other HBs. Patient choice should be central to this process where possible and travel provision will be key to eliminate barriers to access services that may be delivered at a regional hub as future transformation plans are implemented.

#### **Communication, information and support for people waiting for treatment / surgery**

- We welcome the acknowledgement of the impact of longer waits on those waiting and the need for communication and information to help people manage the challenges of the longer waits. It is important to note that the impact extends far beyond the physical health deterioration and increased symptoms and pain levels that people experience as they wait for orthopaedic surgery. For example, many people experiencing severe and worsening pain as they wait for surgery struggle with the mental health impacts this brings and may struggle with isolation and loneliness as leaving the house becomes more difficult or not possible independently. The impacts extend to family relationships and increasing pressures on carers, on financial security and employment – on every aspect of a person's life. Communication, signposting and support needs to help patients manage all of these challenges.
- For communications and support to be most effective in helping someone to 'wait well', or at least wait as well as possible, we would like to see recognition of the need for communications and support *early* in the service user's wait for treatment. For example, for someone waiting for a knee or hip replacement, early access to info and support re self-management skills/secondary prevention/safe exercise could impact positively on

independence, QoL and fitness for surgery as they wait. Leaving such intervention too long reduces the chance of compliance, pain levels / deconditioning may have already increased, leading to a downward spiral of ill-health. To support this, we like to see a greater focus during recovery on the expansion of provision of MTD in primary care, e.g. expansion of access to First Contact Practitioners (FCPs).

- We welcome the Plan's commitment to HBs developing a 'Communication strategy' for people waiting. We believe this should be extended to a commitment to each HB developing its own 'Waiting list support strategy', which would include communication, but also cover information and signposting provision beyond the health care providers and support provision to help people waiting for surgery to overcome barriers to safe exercise (pain levels, fear of damaging joints, etc) .
- Cymru Versus Arthritis has advocated for an all Wales plan or guidance to support the development of communications, information and support services for people on waiting lists. We welcome the recent appointment of a seconded lead to head up the Welsh Government's work in this field. We are awaiting details of the remit of the new role. We would like to see the Welsh Government also utilise the expertise it now has with its recently recruited Persistent Pain National Clinical Leads and its MSK National Clinical Leads to support the development of guidance for waiting well. Such work could provide the foundations for a longer term, more holistic and secondary prevention focussed change in the approach to support for people living with MSK conditions that have their condition primarily managed within primary care, such as osteoarthritis.
- We welcome the commitment to develop a 'Planned Care Portal' app for patients. We would welcome greater detail re timeframe for delivery and how the third sector can engage in the process. Third sector engagement will be key to the success of this app and will avoid unnecessary duplication of effort. The portal should make use of the high quality resources already developed in the third sector. For example. The Versus Arthritis website hosts an array of resources and videos to help people with arthritis to remain active.<sup>iv</sup> We are currently supplementing that resource with a series of videos for people waiting for / recovering from orthopaedic surgery to help them retain or increase their activity levels.
- Digital exclusion must be taken into account in the delivery of communications, information and support for people on waiting lists. We would like to see approaches such as single points of contact systems for people on waiting lists currently offered by at least one HB in Wales evaluated and improved and/or expanded as appropriate. It needs to be simple and straightforward for people to reach out for support and advice as and when their circumstances change whilst they wait for treatment.
- As a follow on to the Plan, we would like to see a stronger national steer re the development of local services to support people on waiting lists to increase their activity levels / access safe exercise – such as the 'ESCAPE pain' programme and resources.<sup>v</sup> A number of HBs have expanded their provision of ESCAPE pain over the past 24 months to support people on waiting lists.

#### Data

- We welcome the commitment to produce more data to monitor progress: *'This plan will be underpinned by accurate data. Targets and performance management will be developed alongside a real-time, visibility of the waiting list by sub speciality, robust demand and capacity plans that will enable teams to work effectively.'* We would like to see further detail re what data will be published and a timeframe for when this new stream of data will be accessible to the public.
- Versus Arthritis has advocated for the publication of granular monthly activity data – e.g. number of elective hip and knee replacements undertaken by each HB – to provide greater

transparency to monitor progress restoring services and achieving the capacity / throughput required to meet the plan's targets. We would like to see a national hub for HBs recovery planning and reporting of progress with such data.

### **Workforce issues**

- Workforce issues are key to tackling the backlog and the transformation of orthopaedic services. The Workforce Delivery Plan needs to be published as soon as possible.

## Contact details

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<sup>i</sup> <https://www.versusarthritis.org/media/24238/state-of-msk-health-2021.pdf>

<sup>ii</sup> The Lancet Rheumatology (2021). Too long to wait: the impact of COVID-19 on elective surgery. Accessed here:

[https://www.thelancet.com/journals/lanrhe/article/PIIS2665-9913\(21\)00001-1/fulltext](https://www.thelancet.com/journals/lanrhe/article/PIIS2665-9913(21)00001-1/fulltext)

<sup>iii</sup> Versus Arthritis (22 October-December 2020). Impossible to Ignore Joint Replacement Survey of 906 people (65 in Wales)

<sup>iv</sup> <https://www.versusarthritis.org/exercise>

<sup>v</sup> <https://escape-pain.org/>

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Gynllun Llywodraeth Cymru i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [Welsh Government's plan for transforming and modernising planned care and reducing waiting lists](#)

PCWL 33

Ymateb gan: | Response from: Bwrdd Iechyd Prifysgol Caerdydd a'r Fro |  
Cardiff and Vale University Health Board

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**Suzanne Rankin**  
**Chief Executive**

15 June 2022

Russell George MS  
Chair, Health and Social Care Committee  
Welsh Parliament  
Cardiff Bay  
Cardiff  
CF99 1SN

Dear Russell

**Request for written evidence: Welsh Government's plan for transforming and modernising planned care and reducing waiting lists**

Thank you for the opportunity to comment on the Welsh Government's plan for transforming and modernising planned care and reducing waiting lists. Our comments are summarised against each of the matters set out in your Annex 1 below.

**Overall views**

- 1. Whether the plan will be sufficient to address the backlogs in routine care that have built up during the pandemic, and reduce long waits.*

In overall terms we feel the planned care plan has the right ambitions but acknowledge that the timescales stated in the plan will be a challenge for Health Boards in light of the volume of the backlog, suppressed demand, workforce constraints and continuing operational pressures.

For context, in order to deliver the plan, we will not only have to revert to pre-pandemic levels of activity but also go above and beyond. This will require us to maximise our own resources in addition to commissioning additional activity and transforming and modernising the way we work. We, therefore, welcome the additional financial resource that Welsh Government have provide to support the planned care recovery and transformation.

2. *Whether the plan strikes the right balance between tackling the current backlog, and building a more resilient and sustainable health and social care system for the long term?*

We feel that as well as plans to tackle the current backlog, the right things are being focused on in the plan to build a more resilient and sustainable health and social care e.g. care closer to home, separating planned care and urgent & emergency care, development of regional treatment centres and diagnostic facilities. The 5 goals approach to transformation is supported. The focus on promotion of healthier lifestyles e.g. healthy weight, physically active and stopping smoking is welcomed. The whole system approach i.e. we cannot deliver planned care unless the unscheduled care system is in balance and supported by the right social care system too, is clearly referenced in the plan. In this context, we also welcome publication of the Welsh Government Six Goals for Urgent and Emergency Care.

### **Meeting people's needs**

3. *Whether the plan includes sufficient focus on:*

- a. *Ensuring that people who have health needs come forward*

The plan states that changes to the GMS contract will see significant changes to the way people access their GP services which should make things easier for people to come forward. As part of the plan, Health Boards are asked to develop a communications strategy that will support patients to manage their conditions and focus on encouraging individuals to seek help if they are unwell. There is a specific focus on access to dentistry, optometry and community pharmacy services and as part of the cancer section a commitment to promoting key messages about cancer symptoms to encourage patients to come forward.

From a public health perspective, there is work to do on improving referrals in from people who traditionally do not access primary care services and wait until they are so ill that they need emergency care i.e. addressing what we refer to this as the 'inverse care law'. We would also need to be careful that referral thresholds do not further disadvantage some populations, as we know there is variation in when people present for care.

- b. *Supporting people who are waiting a long time for treatment, managing their expectations, and preparing them for receiving the care for which they are waiting, including supported self-management*

The plan commits to providing better information for patients including access to personalised information and more help so patients can decide the most appropriate option for them, helping patients to prepare for surgery. The plan will build on established self-management models as a core component of person-centred care. Support for people with long term conditions to manage their own health and wellbeing effectively is also highlighted.

*c. Meeting the needs of those with the greatest clinical needs, and those who have been waiting a long time*

The plan mentions clinical prioritisation of patients (those categorised as urgent) and those who have been waiting the longest but there is a risk that in prioritising urgent patients, some routine patients may wait longer as a consequence. The ambitions set out, however, are focused on time rather than clinical risk and this is something that could be strengthened.

The plan also asks Health Boards to consider the specific needs of children, and makes reference to considering waiting times for children differently to waiting times for an adult as the illness will represent a higher proportion of a child's whole life and potentially have a long-term impact on growth and development. Our view is that paediatrics is an area that needs more development and ought to be strengthened with a specific profile and plans in the document. Access to mental health services is also highlighted with eating disorders, young people, and general increased demand as areas identified for prioritisation.

*d. Improving patient outcomes and their experience of NHS services*

In terms of cancer, the plan referenced the need to embed National Optimal Pathways to streamline the patients journey and reduce avoidable delays and combining first clinician review with as many diagnostic results as possible to minimise time to diagnosis and first treatment.

The section on patient prioritisation and minimising health inequalities does draw attention to what matters to patients in terms of isolation, inability to work, mobility limitations etc and the impact this may have on patient outcomes. However, fully engaging, in a meaningful way, with underserved populations in the planning of services so that accessibility (whether that is through outreach elements, translation of information etc.) can be considered up front not as an add on is essential.

From a public health perspective, the inequality of care once in the system is not mentioned, we know that people who have protected characteristics generally have worse outcomes and a worse experience of care. We will need this monitored as standard, and data collection is poor which adds to the complexity of this issue, this should be standard with PROMS and PREMS but might need additional thinking through to reach all groups.

## **Leadership and national direction**

*4. Whether the plan provides sufficient leadership and national direction to drive collective effort, collaboration and innovation-sharing at local, regional and national levels across the entire health and social care system (including mental health, primary care and community care)?*

Yes, we agree that the plan provides sufficient leadership and national direction, however we recognise that there is more work to do in terms of collaboration across Health Board boundaries and across the health and social care system to deliver sustainable system change.

5. *Whether the plan provides sufficient clarity about who is responsible for driving transformation, especially in the development of new and/or regional treatment and diagnostic services and modernising planned care services?*

Not in all areas. For some areas it is very clear that, for example Welsh Government or Health Boards are taking the lead, but in other areas it is not as clear who the 'we' is that is being referred to in the plan.

## Targets and timescales

6. *Are the targets and timescales in the plan sufficiently detailed, measurable, realistic and achievable?*

Yes, the targets and timescales are sufficiently detailed and measurable. As stated above under Q1, some of these targets are challenging to deliver within the timescales set out.

7. *Is it sufficiently clear which specialities will be prioritised/included in the targets?*

Other than where specific reference has been made to certain services (e.g. mental health, children's services), we have made an assumption that the targets apply to all specialities.

8. *Do you anticipate any variation across health boards in the achievement of the targets by speciality?*

Yes, we can anticipate that there will be variation across the health board as not all specialities are at the same starting position having been affected in different ways as a consequence of the pandemic. Therefore, delivering the targets in some specialities will be quicker/more realistic than in others which are still some way off a return to pre-pandemic levels of activity.

## Financial resources

9. *Is there sufficient revenue and capital funding in place to deliver the plan, including investing in and expanding infrastructure and estates where needed to ensure that service capacity meets demand?*

It is unlikely that there is sufficient revenue and capital funding in place as things stand, however it may be that further funds are made available over the four year term of the plan. For example, the plan points to the need to establish community diagnostic hubs away from acute hospital sites which will require investment in equipment, facilities and workforce. There is no mention of how this will be funded and we know that capital availability is currently extremely limited.

*10. Is the plan sufficiently clear on how additional funding for the transformation of planned care should be used to greatest effect, and how its use and impact will be tracked and reported on?*

There are some specific areas identified in the plan for funding e.g. mental health (50m rising to 90m in 24/25) and £262m annually to equip and train the next generation of health workers. £170m recurrent funding has been made available to support planned care recovery across Wales. Endoscopy, cataracts, orthopaedics, imaging, critical care, cancer and stroke services have been identified as the priority areas but we already know that the allocation for our own Health Board will not cover all these areas. Whilst we are aware from a Health Board perspective on the mechanisms for reporting spend against the investment and activity, and the forums in which we are held to account, we could not see this set out in the plan.

## **Workforce**

*11. Does the plan adequately address health and social care workforce pressures, including retention, recruitment and supporting staff to work flexibly, develop their skills and recover from the trauma of the pandemic?*

The plan acknowledges the impact the pandemic has had on staff and that workforce capacity and capability will be key to the success of delivering the plan. However, it also acknowledges that we will not be able to recruit our way out of the challenges we face. There is a commitment to spending £262m annually to equip and train the next generation of health workers and developing a coordinated and focused workforce plan. However, it is not clear what the detail of the plan looks like. It is also worth noting that the expectations from the plan is that Health Boards start delivering from now but there will be a lead in time to the corresponding workforce strategy coming to fruition. We will, therefore, need to have to put interim solutions into place such as asking our staff to do additional shifts to fill current gaps or use private sector/locums/agency staff. We would also strike a note of caution about the ambition to deliver planned care over 52 weeks, 7 days and 15hrs a day which will be a considerable ask in terms of workforce.

## **Digital tools and data**

*12. Is there sufficient clarity about how digital tools and data will be developed and used to drive service delivery and more efficient management of waiting times?*

The Welsh Government plan references access for patients to a national patient information website and support services, but there are no timescales associated with this or how these developments will facilitate efficiencies. However, it is helpful to see references in the plan to digital tools in place within primary care to enable remote consultations and from an outpatient perspective plans to integrate e-referral and e-advice systems in order to manage the majority of non-urgent cases in the most appropriate setting. We note the positive plans for referral pathways to be supported by a digital interface, the roll out of

SOS and PIFU pathways, use of digital technologies to reduce the need for face to face contact, video consultations and group clinics to prepare patients for treatment and digital platforms for patients to self-manage conditions. From a public health perspective, digital exclusion is mentioned, and while technology will help many we need to remember that this may increase inequalities without additional options being made available for patients.

I hope you find the above comments helpful.

Yours sincerely



**Suzanne Rankin**  
**Chief Executive**