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

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-18-17 Papur 7 / Paper 7

Royal College of Physicians (Wales)
Baltic House, Mount Stuart Square
Cardiff CF10 5FH

☎ +44 (0)75 5787 5119
💻 www.rcplondon.ac.uk/wales

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

**06 June 2017**

Dear Dai Lloyd AM,

I am writing today on behalf of the Royal College of Physicians (RCP) in Wales to ask the Senedd Health, Social Care and Sport Committee to consider holding a follow up session on the inquiry into winter preparedness 2016/7 which concluded earlier this year.

While we were not invited to give oral evidence to this inquiry, we did submit detailed written evidence (attached) and we were invited by the Welsh Government to give evidence to the National Programme for Unscheduled Care (NPUC) Board evaluation of the resilience of health and care services over winter 2016/17. I have attached our evidence to this evaluation, which was written after direct consultation with our fellows and members. We also published a short report in April 2017, *Feeling the pressure*, which highlighted the pressures faced by our doctors following a snapshot survey carried out in January 2017 (also attached).

Our fellows and members identified three top priorities for next winter:

1. Clinically-led, whole system forward planning
   Clinically-led, appropriately funded winter care planning should be started as early as possible every year. This should take a whole system approach to planning surge capacity, bringing in colleagues from across medicine, surgery, social care, and specialist services: winter planning must be the responsibility of *everyone* working in the NHS and social care. Innovative, patient-centred solutions should be encouraged; job planning should recognise that acute clinical input should concentrate on delivering planned care and research in the spring and summer, with a renewed focus on unscheduled care in the winter months.

2. Increased resources and staff capacity
   The NHS workforce is now at breaking point and the recruitment crisis in medicine is getting worse – last year, we were unable to fill 40% of consultant physician vacancies in Wales and there are major trainee rota gaps in every hospital in Wales. The NHS must focus on providing enough medical beds, supported by a safe and consistent level of staffing across medicine, nursing, the therapies, and allied and support services, including

phlebotomy. The Welsh Government and NHS Wales must develop an enforced all-Wales locum strategy which includes maximum fees for doctors.

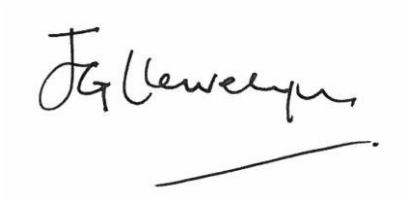
3. Social services and integrated care
   Social care must be an integral and forward thinking partner in winter care planning. Improved collaborative team working across health and social care should break down boundaries, with social services proactively encouraged to speed up the transfer of care out of hospital. This will require extra resource for social care teams across Wales, especially for those based in hospitals and working on the front line of winter care.

We remain unconvinced that health boards have learned from past experience. Winter planning should have begun already, with strategies being introduced now to plan ahead for the autumn. One of the biggest pieces of feedback we received from our members was that the most important interventions this past winter simply did not happen in time to make a real difference to patient flow, outcomes and experience.

The Committee may want to consider following up on this piece of work with the health secretary and the health boards, and the RCP would be happy to support this with any written or oral evidence that you may find useful.

If you would like any further information, please contact my colleague Lowri Jackson, RCP senior policy and public affairs adviser for Wales, by emailing Lowri.Jackson@rcplondon.ac.uk.

With best wishes,



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

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

# Inquiry into winter preparedness 2016/17

## RCP Wales response

**Key points**

- The challenges facing health boards as they prepare for winter are complex. They reflect wider pressures on the NHS and social care.
- Health boards are operating in an under-funded, under-doctored and overstretched context. This is resulting in an increasing demand on hospitals.
- Recent RCP research shows that 40% of advertised consultant physician vacancies in Wales were unfilled last year; in the majority of cases, this is because there are simply no applicants. This is having a significant impact on the ability of doctors to deliver high quality care for patients.
- A stretched social care system, staffing shortages, and lack of hospital beds all contribute to delayed transfers of care.
- The RCP, through its Future Hospital Programme and our work with hospitals in Wales, is exploring new and innovative ways of delivering care.
- This includes better coordination of care and treatment of patients to prevent unnecessary hospital admission and to help them leave hospital as soon as possible. We are also developing telehealth projects in north Wales and encouraging partnership working between hospital and community services.

For more information, please contact:

**Lowri Jackson**
RCP senior policy and public affairs adviser for Wales
Lowri.Jackson@rcplondon.ac.uk
075 5787 5119

Royal College of Physicians (Wales)
Baltic House, Mount Stuart Square
Cardiff CF10 5FH
+44 (0)75 5787 5119
**www.rcplondon.ac.uk/wales**

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

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
**Dr Alan Rees MD FRCP**
Alan.Rees@rcplondon.ac.uk

SeneddHealth@assembly.wales

From the RCP registrar
O'r cofrestrydd yr RCP
**Dr Andrew Goddard FRCP**
Andrew.Goddard@rcplondon.ac.uk

**09 September 2016**

## Inquiry into winter preparedness 2016/17

1. Thank you for the opportunity to respond to your consultation on the National Assembly for Wales committee inquiry into winter preparedness 2016/17. Our response is based on the experiences of our fellows and members, and all quotations unless otherwise referenced, are taken from evidence submissions we received from RCP fellows and members.

2. The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,100 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

3. There are a number of barriers preventing hospitals from dealing effectively with unscheduled care winter pressures. The barriers include delayed transfers of care leading to ineffective management of patient flows. Studies from England suggest that as many as 40% of patients who die in hospital do not have the medical needs that require them to be there[1]. Furthermore, at least 25% of hospital beds are occupied by people with dementia, many of whom are likely to stay more than twice as long in hospital than other patients aged over 65[2]. This is often because of a lack of community based care. The situation is compounded by the challenging financial circumstances in which the NHS operates.

4. Managing the patient flow between the emergency department, the acute medical unit and specialty wards depends on effective transfers of care and timely discharge of patients. Underfunding of social care, a lack of beds and issues with recruitment and retention of doctors mean that hospitals often struggle to effectively transfer patients while maintaining a high level of care.

> *I do not think there is any serious planning. An increase in capacity is what is needed. This is the lesson that needs to be learned and it has not been.*
> [Consultant physician in Wales]

[1] Royal College of Physicians 2014. National care of the dying audit for hospitals, England: May 2014
[2] Alzheimer's Society. *Fix Dementia Care in Hospitals*. 2016

5. Our members and fellows are working in an, under-funded, under-doctored and overstretched health service. Patient demand matched with significant workforce gaps are making it difficult to care for patients. In 2014-2015, 21% of UK consultant physicians reported 'significant gaps in the trainees rotas such that patient care is compromised'[3]. These figures are concerning because the specialties most closely associated with alleviating winter pressure on unscheduled care are seeing the highest staffing gaps, with geriatric and acute medicine reporting the greatest number of cancelled and failed consultant appointments.

**A growing workforce crisis**

6. This staffing crisis is having a major impact on physicians' ability to swiftly assess patients after they present at emergency departments, to tailor their care plans and to achieve safe and timely transfers of care. This can negatively impact on patient experience and leaves wards unable to alleviate pressures on emergency departments. Targets are difficult to achieve unless there are enough staff to treat patients or transfer them into social care in a timely manner.

7. There is currently no real national strategic approach to medical workforce planning in Wales. Over the years, this has contributed to recruitment and retention challenges in the medical workforce, especially among trainee doctors. **We strongly support the development of a clinically led national medical workforce and training strategy for Wales.** Wales has a real opportunity to develop an innovative model, and we urge that clinical leadership be placed at the very centre of that process.

8. It is also crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea. These students may be more likely to stay in Wales for their postgraduate training, and if they do leave, they are more likely to return home afterwards. Only 30% of students in Welsh medical schools are Welsh domiciled. This compares to 55% in Scotland, 80% in England and 85% in Northern Ireland.[4] **Medical schools must offer more undergraduate places to Welsh domiciled students in order to grow and retain a home-grown workforce**, and they should invest in outreach programmes which encourage applications from rural, remote and Welsh speaking communities.

**Bed shortages and a lack of capacity**

9. Hospital bed shortages also compound problems with patient flow. The UK has the second lowest number of hospital beds per 1,000 of the population among 23 European countries . Our members and fellows often cite that moving patients from acute medical units to general or specialty wards can be problematic because there are no beds available. These are older patient who are deemed well enough to receive care in the community but cannot be transferred due to a lack of services in community settings.

10. There is clear evidence that well run acute medical units (AMU) help reduce mortality, length of stay and readmissions[5]. AMUs staffed by multidisciplinary teams and led by acute medicine physicians have the potential to improve the quality and the safety of care of a significant proportion of acutely ill patients. We would urge health boards to invest in their general medical

[3] Federation of the Royal College of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2014-15.* London: Royal College of Physicians, 2016.
[4] NHS Education for Scotland. *Domicile of UK undergraduate medical students*. March 2013
[5] Scott, I; Vaughan, L; Bell, D. Effectiveness of acute medical units in hospitals: a systematic review. *International Journal for Quality in Health Care,* 2009; Volume 21, Number 6: pp. 397 –407.

workforce and AMUs to enable hospitals to respond more effectively and safely to the increasingly complex demands placed on the hospital with regard to acute medical care.

**Redesigning the ambulatory care system**

11. Some clinical teams, including those in Abertawe Bro Morgannwg University Health Board and Cwm Taf University Health Board have recognised that a new approach is needed to deal with the considerable pressures faced by emergency departments, and have successfully redesigned their systems to implement ambulatory emergency care (AEC) as part of the solution[6]. Ambulatory care is clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services[7].

12. Implementing AEC ensures that where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day with ongoing clinical care. Processes are streamlined, including review by a consultant, timely access to diagnostics and treatments all being delivered within one working day. This has improved both clinical outcomes and patient experience, while reducing costs. Clinical teams using this approach report managing significant numbers of emergency patients quickly, without the need for full admission, converting at least 20–30% of emergency admissions to AEC[8].

13. AEC can be particularly valuable in the assessment and management of frail, older patients being managed with pathways supported by a multidisciplinary team with good links to services in primary care, the community and local authorities. These links can offer rapid assessment and interventions for older people, which can avoid an inpatient stay. For older people, access to these services is important to live safely at home and avoid unnecessary readmission.

> *In my health board, the real positive aspects [of] winter planning have been quality improvement training for care home staff (and resultant anticipatory care planning), emphasis on proactive care planning for people with co-morbidities or those with frailty, and integrated working with the council and third sector.*
>
> [Trainee physician in Wales]

**Developing new models of care to prevent hospital admission**

14. The RCP is also working with local clinical teams through our flagship Future Hospital Programme (FHP) to develop innovative models of care to help meet patient need using current resources[9]. One Future Hospital site is based in north Wales, and has piloted the use of telehealth patient consultations over video link between hospital specialists and community healthcare teams.[10] However, two RCP Future Hospital sites in England are specifically working

[6] Royal College of Physicians. Acute Care Toolkit 10. Ambulatory Emergency Care. October 2014
[7] Royal College of Physicians. *Acute medical care: The right person, in the right setting – first time. Report of the Acute Medical Task Force.* London: RCP, 2007: p xxi. Endorsed by The College of Emergency Medicine, 2012.
[8] Blunt I. *Focus on preventable admissions: Trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013.* London: The Health Foundation and the Nuffield Trust, 2013.
[9] RCP Future Hospital Programme
[10] RCP Future Hospital development site: Betsi Cadwaladr University Health Board

to reduce the admission of patients to hospital and ensure that they receive care in the community: Mid Yorkshire NHS Hospital Trust and East Lancashire Hospitals Trust.

15. Mid Yorkshire NHS Hospitals Trust has established a Rapid Elderly Assessment Care Team (REACT) within the acute admissions unit at Pinderfields Hospital in Wakefield. REACT are a multidisciplinary team made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The team meet daily to coordinate the care and treatment of patients to help them leave hospital as soon as possible and prevent unnecessary hospital admission. The multidisciplinary nature of the team means that they are able to offer person centred care because they provide people both the health and therapeutic services they need.

16. Since the REACT team was established in 2014, Pinderfields Hospital has seen significant improvements in the number of patients receiving care in the community rather than being admitted to hospital. Comparing data from 2014 to 2015, there has been a 24% increase in the number of people with frailty being transferred to community care rather than moving onto a ward in hospital. The total number of hospital ward admissions for patients aged over 80 also decreased by 14% during the same period in 2014 to 2015. This quick assessment by a multidisciplinary team at the front door of the hospital ensures that patients are able to access the care most suitable to their individual needs and relieved some of the pressures faced by staff in the rest of the hospital.

17. The REACT team in Pinderfields Hospital has also been working closely with third sector providers to improve the transfer of care from the hospital to the community. Age UK regularly come into the acute assessment unit at the hospital to provide safe transfers of care into the community[11]; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has enabled frail older people to receive personalised care, which has helped them to maintain their independence and prevent readmission.

18. Another FHP development site at East Lancashire Hospitals Trust aims to identify frail older patients who are available for discharge the same day they present at hospital. The medical assessment unit (MAU) nurse monitors the acute intake of frail older people in order to identify patients suitable for rapid discharge, arranges their comprehensive geriatric assessment and liaises with secondary and social care professionals to plan for safe same-day discharge.

19. Preliminary data from the East Lancashire Hospitals Trust project suggests that 59% of admissions were avoided using this care model since the project started in 2014[12]. If admission can be avoided by streamlining the patient journey from the MAU through to social care, frail older people can be supported to leave hospital quickly and to live independently in the community.

20. In both these case studies, partnership working between hospital and community services has reduced delayed discharge. Integrated secondary and social care for older people can achieve

[11] Age UK. *Frailty in secondary care*.
[12] Temple, M; Dytham, L; Bristow, H. *Action learning at the Future Hospital development sites.* Future Hospital Journal 2016 Vol 3, No 1: 13–5

lower rates of bed use and the Kings Fund has found that hospitals operating in an integrated way also tend to have lower admission rates which provide a better patient experience.[13]

21. The problems facing emergency departments particularly during winter are complex and cannot be solved using a single solution. Reducing the volume of delayed transfers of care will go some way to alleviating pressures on emergency departments. The impact of an underfunded social care system is adding to the pressures being experienced in hospitals, with patients staying longer in hospital than necessary due to lack of services in the community. Furthermore, there is an ever-pressing need to find a national solution to problems with recruitment and retention of doctors. Without enough doctors on the ground, patient care will be compromised.

22. As the FHP project teams show, effective multidisciplinary working and the integration of healthcare services achieve better patient outcomes and experiences, thus alleviating winter pressures. This is why the RCP believes that we need to move away from a model of care in which we invest in either primary or secondary care, and towards integrated team working, where hospital specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital.

**A new integrated model of healthcare is needed**

23. We would welcome a mature conversation about the future of service design in Wales, and the vision needed at a national level to develop a new way of working. It is important that future investment into the health service does not go towards propping up the old, broken system. The Welsh Government must promote innovative models of integration and introduce shared budgets that establish shared outcomes across the local health and care sector. Spending money on the existing system will not change anything in the long term; health boards must invest in prevention and treatment of chronic conditions and allow clinicians to innovate.

24. Those living in rural and remote areas must not be forgotten either; it is these areas where the crisis in primary care is hitting hardest, and where a new ambitious model of care has the most potential. All of this will need a drastic change in mind-set, stronger clinical leadership and engagement, and more joined-up thinking between primary, secondary, community and social care teams.

For more information, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk.

With best wishes,

**Dr Alan Rees**
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

**Dr Andrew Goddard**
RCP registrar
Cofrestrydd yr RCP

[13] Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use. Exploring variation*. London: The King's Fund, 2012.

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

# Evaluation of health and care winter resilience 2016/17

## RCP Wales feedback

### About us

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

### Amdanom ni

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

For more information, please contact:

**Lowri Jackson**
RCP senior policy and public affairs adviser for Wales
Lowri.Jackson@rcplondon.ac.uk
075 5787 5119

Royal College of Physicians (Wales)
Baltic House, Mount Stuart Square
Cardiff CF10 5FH
+44 (0)75 5787 5119
**www.rcplondon.ac.uk/wales**

National Programme for Unscheduled Care Board
Welsh Government
Cathays Park
Cardiff CF10 3NQ

Jasmine.Hagger@wales.gsi.gov.uk

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
**Dr Gareth Llewelyn FRCP**
Gareth.Llewelyn@rcplondon.ac.uk

From the RCP registrar
O'r cofrestrydd yr RCP
**Dr Andrew Goddard FRCP**
Andrew.Goddard@rcplondon.ac.uk

**20 April 2017**

# Evaluation of health and care winter resilience 2016/17

Thank you for the opportunity to respond to your consultation on the evaluation of health and care winter resilience 2016/17. The Royal College of Physicians (RCP) has worked with consultants, trainee doctors and members of our patient carer network in Wales to produce this feedback, and we would be happy to organise further written or oral evidence if that would be helpful.

## Key recommendations

**What should be considered the top three priorities for next winter?**

1. Clinically-led, whole system forward planning
   Clinically-led, appropriately funded winter care planning should be started as early as possible every year. This should take a whole system approach to planning surge capacity, bringing in colleagues from across medicine, surgery, social care and specialist services: winter planning must be the responsibility of *everyone* working in the NHS and social care. Innovative, patient-centred solutions should be encouraged; job planning should recognise that acute clinical input should concentrate on delivering scheduled services and research in the spring and summer, with a renewed focus on acute unscheduled care in the winter months. There are also several targeted system interventions that would help: for example, addressing RTT deadlines earlier in the year and enforcing an all-Wales patient repatriation policy.

2. Increased resources and staff capacity
   The NHS workforce is now at breaking point and the recruitment crisis in medicine is getting worse – last year, we were unable to fill 40% of consultant physician vacancies in Wales and there are major trainee rota gaps in every hospital in Wales. The NHS must focus on providing enough medical beds, supported by a safe and consistent level of staffing across medicine, nursing, the therapies, and allied and support services, including phlebotomy. The Welsh Government and NHS Wales must develop an enforced all-Wales locum strategy which includes maximum fees for doctors.

3. Social services and integrated care
   Social care must be an integral and forward thinking partner in winter care planning. Improved collaborative team working across health and social care should break down boundaries, with

social services proactively encouraged to speed up the transfer of care out of hospital. This will require extra resource for social care teams across Wales, especially for those based in hospitals and working on the front line of the winter care crisis.

## Our response

**What is your experience of how resilient the whole system has been when providing care during the winter months?**

The changing patient demographic

Our members told us that while there is indeed a peak in the number of medical emergencies over the winter period, they do not see a *huge* spike in numbers. However, the patient illnesses at this time of year are often more serious, particularly in respiratory medicine. Our members told us that they also saw an increase in emergency surgery due to the aging population this year. Figures from one major teaching hospital in south Wales show that there has been a steady increase in the number of patients over 65 admitted to hospital over recent years. An average of 10 more older patients are admitted every week in winter compared with summer – and these patients tend to stay in hospital longer.

Missed deadlines and poor project management

While several of our fellows and members in Wales reported an improvement in whole system working this winter, we also found that some key projects, funded by the Intermediate Care Fund, were not in place in time for the winter months, due to long lead times for appointing hospital-based social workers. This could have made a huge difference to patient care and delayed transfers.

> *'The whole system was severely challenged. Due almost entirely to the lack of outflow, unscheduled care was under huge pressure and scheduled surgery was severely curtailed.'*
>
> Consultant physician in diabetes and general medicine, NHS Wales

Finance and staffing

Our members told us that they did not receive enough financial resource to cope with the demands of winter this year, and those areas which were not funded coped worst – for example, bringing in extra senior decision-makers for medical outliers in surgical wards. Capacity was a significant issue and the numbers of outliers in surgical wards was high – often doubling the numbers of patients a medical team needed to care for. Length of stay for medical patients on surgical wards is far longer than for those on medical wards particularly for rehabilitation or complex care planning needs.

> *'Throughout the winter and most of the time we are under-resourced. The system is not resilient. However, there were considerable efforts to draw up contingency plans for the Christmas period and indeed other bank holiday periods. There are some very hardworking people (managerial and clinical) trying to make the system work for patients and staff, but the impact they can make is limited if the overall strategy is flawed.'*
>
> Consultant physician in geriatric and general medicine, NHS Wales

Staffing was also highlighted as a major problem, especially in nursing, which had an impact on the effectiveness of many initiatives. One member observed that even where extra funds were available, the health board was frequently unable to recruit both extra nursing and medical staff. This has a knock on effect on staff wellbeing and sickness rates at a time of year when flu, stomach bugs and other illnesses are far more common. We were told that in one hospital, the decision was taken to open extra beds without adequate staffing, a move which was reported as a patient safety risk via the safe haven system, and later closed down after a review.

It is also worth remembering that reduced staffing capacity has a major negative effect on the ability of senior doctors to teach and train the next generation of doctors. This in turn affects recruitment into trainee posts and junior doctor positions, and exacerbates the wider workforce crisis.

> *'The quality of those we could recruit to winter pressure posts was extremely variable. The acuity and volume of patient seen in winter months is always much more intense, and requires huge efforts by the nursing and medical teams.'*
>
> Consultant physician in endocrinology and general medicine, NHS Wales

One member suggested that an all-Wales policy on locum fees should be developed, arguing that the cost of employing locum nurses and doctors is exorbitant, and has a detrimental effect on the money available to the wider NHS.

Lack of wider corporate ownership of the winter pressures challenge

One member felt that there was a lack of wider corporate buy-in to winter resilience. He noted that surgical and specialist services are not currently included in winter planning processes, despite scheduled workload decreasing (because beds are taken up by medical inpatients and elective care is then cancelled due to a lack of beds). He argued that health boards should plan more strategically to redistribute nurses and doctors to support unscheduled care and increased winter admissions.

Competing service priorities

Fellows and members also told us that they would welcome a refreshed look at some of the service delivery deadlines. For example, hospitals are expected to achieve referral to treatment times (RTT) and GPs are asked to hit their Quality Outcomes Framework (QOF) targets at exactly the time when the NHS is struggling with winter pressures. This severely affects system resilience, and pulls health professionals in several directions at once. We recognise that the cabinet secretary has temporarily suspended most QOF requirements for practices in order to free up capacity to deal with winter pressures, but this deadline should be changed in the longer term.

> *'It is difficult for the system to focus on the front door as well as discharging patients when other priorities are around at the same time.'*
>
> Consultant physician in gastroenterology and general medicine, NHS Wales

**To what extent were you engaged in the planning process for winter 2016/17?**

There was an extremely mixed response to this question, suggesting that there is no overall strategic approach across health boards to involving clinicians in the planning process. Some members, especially those in management positions, told us that they had been heavily involved in the planning process.

> *'We have benefited greatly from clinical management-led winter planning. Preparation began in mid-summer, and was informed by experience in the previous year … many clinicians fed in to the process.'*
>
> Consultant physician in endocrinology and general medicine, NHS Wales

Others were much less positive:

> *'There was no meaningful clinical input requested regarding plans and little has happened regarding concerns about bed and staffing.'*
>
> Consultant physician in geriatric and general medicine, NHS Wales

**Have local initiatives introduced as part of the winter plans been visible to you? What is your view/ experience of how successful they have been in improving service delivery to patients?**

There was a general feeling among members that while local initiatives had been put in place in most areas, they were often either too late to make a difference, or could not cope with the pressures placed on them. These initiatives included an increased social work presence in hospital, a community response team, a dedicated pathway for minor injuries, and more nursing home places in the community.

**What is your view on whether lessons have been learned from previous winters when considering delivery over winter 2016/17?**

Members felt that while in many cases lessons have been learned, not all of these have been responded to in a timely manner. One member highlighted particular issues with significant nursing shortages which have been exacerbated by GP cluster recruitment from secondary care into primary care. Without sufficient numbers of nurses, hospitals are unable to open extra surge beds during particularly busy time periods.

**Do you feel that local organisations are taking a whole system view when developing service enhancements for winter?**

There was firm support for increased cooperation between social care and the NHS. While one member noted that their local authority had greatly improved their response this winter, supported by money from the Intermediate Care Fund, the most important interventions simply did not happen in time to make a concerted difference to outcomes.

**To what extent did the additional planned actions support delivery of a standard of care you would expect to provide to patients?**

> *'The problem was not the standard of care, it was inadequate capacity.'*
>
> Consultant physician in diabetes and general medicine, NHS Wales

Again, members reiterated the importance of joining up demand with service delivery deadlines. Meeting referral to treatment (RTT) targets before the winter begins would free up clinicians to treat patients at the front door over the busiest months. However, this means releasing RTT money before the winter begins.

**What are your views on whether there was sufficient capacity available to support delivery of timely and quality care to patients over the Christmas period?**

There was general agreement that there was not sufficient capacity available to support the delivery of timely and quality care to patients over the Christmas period.

> *'[It] fell short of ensuring a high standard of care. While efforts were made by the clinical staff to ensure good care, it fell short because of difficult circumstances. Patient experience (and that of their significant others) was significantly affected negatively (long waits in A&E and staying there for long periods before moving to a ward). I do not feel that there are enough beds for medical patients and yet [my health board] is still pursuing a policy of bed reduction (on the back of significant reductions … in the community and acute sectors). However, the adequate staffing of beds is a difficult problem as well.'*
>
> Consultant in geriatric and general medicine, NHS Wales

**To what extent do you think there was sufficient preparation for the post-Christmas period?**

It is the post-Christmas period which needs the most coordinated and effective social services response. There was some recognition that this was better this year than in previous years, and that health boards prepared in some detail, but in the end, it was felt they didn't have the resources to offer an effective service. One member also observed that some patients are disadvantaged if they are admitted into a hospital outside of their local authority area as it can often more difficult to organise social care or rehabilitation support for these patients when they are medically fit to be transferred out of acute care.

**Have you observed evidence of integrated working between health and social care staff either in hospital or in the community?**

There was a mixed response to this question. Some members told us that while integrated working had improved on previous years, it was still not as effective as it should be, and often broke down over local authority and health board boundaries. Others told that they were actually unable to see any evidence of systematic integrated working between social care staff and hospital staff. All agreed that there was a major resource and capacity problem in social care.

> *'We have excellent engagement with our social care colleagues, which varies depending on the care organisation, but what can be achieved with the limited resources available is often frustrating. The process of moving people out of hospital once they are admitted is difficult – it can take two weeks to achieve social work allocation, another week to move cases forward, and another week to obtain funding or obtain a place in a residential or nursing home. A month can pass quite easily for a patient with complex discharge needs.'*
>
> Consultant physician in endocrinology and general medicine, NHS Wales

One member suggested that NHS Wales develop a more robust repatriation policy, especially for those hospitals providing super-specialised services. Patients are currently transferred to specialist centres from all parts of Wales, and the current repatriation policy does not work for patients or organisations – patient flow is currently severely affected by delays in getting patients home.

**For more information**

Please note that more information about our policy and research work in Wales can be found on our website. If you have any questions, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk.