

Health, Social Care and Sport
Committee
**Inquiry into winter preparedness
2016/17**

December 2016



National Assembly for Wales
Health, Social Care and Sport Committee

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The Committee was established on 28 June 2016 to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters, encompassing (but not restricted to): the physical, mental and public health and well-being of the people of Wales, including the social care system.

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South Wales West



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Chair's foreword



Winter is a hugely challenging period for our health and social care services. It is a time when the year-round pressures of an ageing population, increasing demand for services and workforce challenges are thrown into sharpest relief.

For this reason, we felt it was important to examine how prepared the Welsh NHS and social services are to deal with the pressures on unscheduled care services over the coming few months. As part of this, we wanted to look at the progress that has been made in this area over the past few years, particularly since the work done by our predecessor committee in 2013-14.

There is evidence of some clear improvements within the system during this time. The Welsh Ambulance Service NHS Trust is an obvious example, and they should be congratulated for this. However, a number of matters reported on by our predecessor committee in 2013, including inappropriate A&E admissions, patient flow through hospitals and delayed transfers of care, have been identified in the course of this inquiry as continuing to need attention as a matter of priority.

Many of our recommendations, although important in terms of managing additional winter pressures, need to be considered as part of a much wider, whole-system review of health and social care services in Wales. Indeed, our overriding conclusion is that a more resilient NHS and social care service would be better equipped to cope with the considerable spikes in demand over the winter period. Without that greater resilience, efforts to manage winter-specific pressures will be more about trying to limit their effects than achieving the whole-system change which is so greatly needed.

Considerable efforts and resources have gone into planning for the coming winter. Despite this, we are concerned about the ability of the system to cope with the additional pressures of the season, and its vulnerability to one significant event such as a flu outbreak or care home closure.

The evaluation of the arrangements for this winter period will take place next spring. We look forward with interest to the findings.

Dr Dai Lloyd AM, Chair

Conclusions and recommendations

General preparedness and service integration

1. It is clear from the evidence we heard that the many pressures facing the NHS in Wales are not restricted to a particular period or season but are, in fact, all year round. Nevertheless, it is also clear that there are seasonal spikes in demand, especially during the winter months, which put an already stretched system under further strain. As a consequence, planning for this period is essentially about trying to limit the effects of these spikes whilst continuing to deliver other core services, including elective activity.

2. As such, greater resilience within the health and social care services generally would enable them to manage better during times of exceptional seasonal pressure. Considerable efforts and resources are invested in planning for the winter period, with the planning process starting as early as March. Without that greater resilience, however, these efforts seem to be more about firefighting than effecting whole-system change - change which might enable different service approaches to be taken to managing unscheduled care pressures.

3. Specifically in relation to this winter period, there was a difference of opinion amongst providers about the levels of preparedness; this, in itself, is cause for some concern. After the widely reported and much examined pressures of the last few years, there should be more confidence across the entire sector that the problem is under control and manageable. That this is not the case may be due, in part, to a lack of communication between all the relevant parties, despite arrangements, such as integrated plans, being in place.

4. Further, the evidence we have heard suggests that the main focus seems to be on preparing the health service for the pressures of winter, with more limited attention paid to the social care aspect. This approach does not seem to adequately recognise the crucial role of the social care sector, both in terms of preventing hospital admissions over the winter period, particularly for older people, and in enabling those in hospital to move on at the appropriate point.

5. Overall, there is a need for greater integration between the health and social care sectors, both in the planning and delivery of services, and there is a need to include the independent sector (both care home and domiciliary services) in this work.

Recommendation 1. The Cabinet Secretary and Minister should, as a matter of priority, focus their attention on the greater integration of the health and social care sectors, both in the planning and delivery of services. The NHS, social care and independent sectors must be key players in this work. Page 21

6. There is also a need to enable better working arrangements between medical professionals, including GPs and pharmacists, to ensure that they are not in competition when it comes to delivering national prevention initiatives such as flu vaccinations.

Recommendation 2. The Cabinet Secretary should explore the options for enabling more effective working arrangements between GPs and pharmacists to minimise competition in delivering national prevention initiatives such as the influenza vaccination. Page 21

7. Linked to this, we have some concerns about the Welsh Government’s flu vaccination campaign, especially in relation to the relatively low uptake amongst NHS and social care staff. Vaccinating front-line staff is a key preventative measure, and we believe the Welsh Government and the sector should be more ambitious when setting targets in this area. We also have some concerns about the structure, visibility and targeting of the campaign this year. There is a need for clarity about the respective roles of GPs and pharmacists in the campaign and the strength and visibility of national messages to target groups. Further, we believe that more work should be done to understand the reasons why take-up of the flu vaccination is not higher across the board.

Recommendation 3. The Cabinet Secretary should ensure that arrangements are in place to evaluate the effectiveness of all Welsh Government campaigns relating to winter health, and to publish the lessons learned quickly. He should also ensure that arrangements are in place for effective whole-system learning from these evaluations. Page 22

8. In relation to funding, we welcome the additional investment of £50 million by the Welsh Government for winter pressures for this year. The Cabinet Secretary was quite specific about the outcomes he expected to see for this additional investment, including to contribute to dealing with the additional demands of unscheduled care and to maintain current performance in terms of planned activity, i.e. elective surgery over the winter period. We believe that these are ambitious targets for this level of investment, particularly given the financial challenges already facing a number of LHBs, and we ask that the Cabinet Secretary reports back to us at the end of the next quarter with details of progress against those targets. We are also interested to hear further from him at that time as to how the evaluation of these outcomes will feed into a general review of the whole system and the planning round for next winter.

Recommendation 4. The Cabinet Secretary should report back to us at the end of the next quarter with details of progress against targets for the additional £50 million investment by the Welsh Government in winter pressures for this year. Page 22

Demand on services

9. Despite the significant and growing year-round pressures on the NHS in Wales, the seasonal spike during the winter period is driven by a number of specific factors, not least age. At the one end, Wales has an ageing population who often present with a number of complex conditions and who can lose access to their more regular support networks during the winter months. There is also evidence of more admissions from vulnerable older people who have experienced falls during this period, and an increasing number of patients with mental health conditions, including dementia. Many, particularly older patients, are also in need of complex care packages in order to be discharged from hospital.

10. At the other end, there is a growing emergency workload during the winter relating to children, particularly with respiratory problems such as bronchiolitis. The evidence from specialists in this field was that more of these cases could be managed at home with the right support and information for parents. This has the potential to be a “quick win” for the Cabinet Secretary and LHBs, and should be examined further.

11. More generally, it is clear that more needs to be done around the design and delivery of services for both older people and children, and that a considerable part of this involves having the appropriate staff in the right place in the system to enable it to be more responsive to the needs of its patients. (Our specific comments on the workforce are set out in Chapter 5.)

12. In addition to age, another factor in the seasonal spike is the number of people accessing the wrong services. We heard that 20-30 per cent of people presenting at A&E would be more appropriately dealt with by a different type of service. We recognise the work already being undertaken to tackle this, including the Choose Well campaign, but we feel that other measures, particularly greater co-location of primary care services in A&E departments, should be the subject of specific research to evaluate their effectiveness and potential for wider roll out. (More specific comments on co-location of services and the Choose Well campaign are included in Chapter 7.)

Recommendation 5. The Cabinet Secretary should commission or review available research into the effectiveness of co-location of primary care services in A&E departments. Page 28

Service capacity and workforce

13. Adequate service capacity and sufficient workforce numbers are vital components in any effective healthcare system, particularly during times of exceptional strain such as the winter period. Based on the evidence we have heard, we are concerned about the ability of the health and social care system in Wales to cope with the predicted seasonal demands this year because of a lack of both of these components.

14. Specifically in relation to service capacity in hospitals, we are concerned about a lack of availability of beds to cope with demand, particularly given the high levels of occupancy reported currently. We recognise that bed occupancy rates are not the only measure of an efficient system, and that patient flow is also an important part of any such system. However, capacity is not just about bed numbers, but about having the workforce in place to staff those beds.

15. Given the well-documented, on-going difficulties in the NHS in Wales in terms of recruitment and retention of staff, the impact of this is likely to be felt particularly during times of added seasonal pressure, when difficulties facing LHBs in recruiting extra staff to run additional hospital capacity means the system has a limited ability to flex to meet increased demand. We note the planning process that has been undertaken by LHBs in order to gain an understanding of likely demand, and whilst this is important data, without the ability to secure the necessary staff, it is only part of the solution.

16. In relation to capacity within primary care, we were concerned to hear reports of insufficient shared understanding across the sector and more widely of the extent of the pressures facing these services this winter. We were also concerned to hear that additional investment from the Welsh Government, intended to mitigate these pressures, has been slow to make its way to the front line. We heard strong messages about the shortage in GPs and the difficulties in recruiting, which could make it difficult to access not just medical but other clinical services in primary care. We are also concerned about falling numbers of district nurses across Wales and the impact this will have on services over the winter, and note concerns about the increasingly changing role of district nurses as clinical support and advisors to other nursing and care staff. We believe these areas require further, immediate attention from the Welsh Government.

17. Capacity continues to be a significant problem in the domiciliary and care home sector, particularly given the increased reliance on it during the winter period and the very real concerns about its sustainability in light of a number of recent home closures. We note the steps being taken by the Minister and her officials in relation to gaining a greater understanding of the demands on the sector, and we were interested to hear that she will shortly be in a position to have the first market statement for the whole sector. We would be interested to see the results of this, and we ask that she makes this information publicly available at the earliest opportunity.

Recommendation 6. The Minister should publish details of the market analysis of the domiciliary and care home sector at the earliest opportunity in order to provide a clear picture of the capacity, sustainability and financial resilience of the sector.Page 38

18. The following points apply more widely than just in relation to winter pressures, but we feel it is important to include them in this report in order to reflect the evidence we have received.

19. The well-documented difficulties in recruiting for the domiciliary and care homes sector persist, with the independent care home sector continuing to be reliant on both EU and non-EU staff. Competition from other care and non-care organisations is impacting on the available workforce, and more generally, we feel there is a pressing need to make social care an attractive and valued place to work. Linked to this, is the potential for professional isolation of care homes nurses, with limited access to shared training with NHS and social care staff. We believe that the Minister needs to take a clearer role in setting the strategic direction and in monitoring progress in this area.

20. More broadly, we believe there is a need for improved training, skills development and supervision across all the health and social care sector, with an increased emphasis on working jointly across these sectors. We urge the Cabinet Secretary and Minister to give consideration to how best to achieve this.

Recommendation 7. The Cabinet Secretary and Minister should give consideration, as a matter of urgency, to the need for improved training, skills development and supervision across the health and social care sector. This should have an increased emphasis on joint working across these sectors.Page 38

Discharge from hospital

21. Despite some progress, delayed transfers of care remain an on-going issue, with evidence of rising numbers during the winter period. This problem is exacerbated by the often frail nature and increasingly complex needs of many patients waiting to be discharged.

22. We recognise the impetus that exists within hospitals to 'keep the system moving' in order to enable both admission and discharge, to ensure there is adequate capacity within hospitals to meet demand. However, there is a definite need for more effective discharge planning arrangements at a local level, including better engagement with the independent sector as part of this.

23. We recognise the important role of the Intermediate Care Fund (ICF) in helping to manage delayed transfers of care, and we welcome the continued investment in the Fund by the Welsh

Government in its draft budget for 2017-18. We acknowledge the Minister’s evidence of increased resilience and capacity as a result of the ICF, including the data about reduced bed days and hospital stays avoided as a result of particular ICF-funded schemes. Given this, we believe that the Cabinet Secretary and Minister need to have a clear position on the on-going nature of funding for these schemes, rather than the current year-by-year arrangements. Further, we believe there is a case for the Cabinet Secretary and Minister to be more specific about the outputs and outcomes expected for this additional investment over the course of the next budget period.

Recommendation 8. The Minister should make and publish arrangements for the structured sharing of good practice in relation to successful schemes being delivered via the Intermediate Care Fund. Page 42

Recommendation 9. The Cabinet Secretary and Minister should make clear the position about the long-term funding for successful schemes under the Intermediate Care Fund. They should also set out clearly how the additional investment in the Fund as part of the 2017-18 draft budget will be used, and what the expected impact will be. Page 43

24. Finally, as part of our recent consideration of the Welsh Government’s draft budget for 2017-18, we expressed interest in hearing more about the arrangements for increasing evaluation of the Fund, including arrangements for intelligence sharing across Wales.¹ We re-iterate that point here.

Service models

25. In terms of service modelling, we agree with the Cabinet Secretary that the real challenge is for genuine, whole-system learning. As part of this, there is a particular need to look at A&E services, including the potential for, and the available evidence relating to, co-locating primary care services and a possible role for “front-door physicians”. This could be an important tool to mitigate the problems associated with people presenting “inappropriately” to A&E.

26. We heard the claim from LHBs that they understand the dynamics of in-patient hospital services well, but that some patients were staying in hospital longer than is ideal; the level of bed occupancy remains very high in key specialties; and the increasing number of old and frail people needing care has impacted on capacity planning. There is a clear need to look at the way in which capacity planning is undertaken as a much more “whole systems” approach across health and social care services and encompassing the whole patient journey.

27. Further, there is a need to look at alternative models of care in the community as a preventative measure to avoid hospital admission, as well as the need for greater evaluation of existing services, such as those funded through the Intermediate Care Fund (discussed in the previous Chapter).

28. Finally, there is a need for greater integration across sectors and services, and more effective sharing of the good practice that exists in areas across Wales. On this point, we note that the Cabinet Secretary has commissioned an evaluation of the Choose Well campaign during the spring next year.

¹ Letter to the Cabinet Secretary for Health, Wellbeing and Sport and Minister for Social Services and Public Health regarding the Welsh Government’s draft budget 2017/18

We wait to see the results of this with interest and to hear from him in due course as to how this will feed into next year's planning process. We also look forward to the results of the 111 Pathfinder Pilot evaluation (see recommendation 3).

01. Background

Unscheduled care services

29. Emergency or unscheduled care is defined as any event that is unplanned or unscheduled where an individual is seeking attention from a health or social care professional. This includes emergency department provision and various assessment facilities such as medical assessment units or clinical decision units.

30. As at September 2016, emergency services in Wales are provided through 13 major acute hospitals with a major emergency department and 23 minor injury units provided within major acute or community hospitals.

31. Ambulance services in Wales are provided by a single ambulance trust, the Welsh Ambulance Services NHS Trust (WAST). This provides accident and emergency services, pre-hospital emergency treatment and care, urgent patient transfer, response to major incidents and non-emergency patient transport services.

32. Emergency care is also accessed via a wide range of other service provision, including:

- Primary care services, both in and out of hours;
- **NHS Direct Wales** – a nurse-led telephone advice service;
- Mental health care services – crisis resolution/home treatment services offering a rapid response for adults who are experiencing a mental health crisis;
- Urgent social care providers – social services have a major role in protecting the most vulnerable people in the community.

02. Performance Targets: key statistics

33. The NHS Wales Outcomes Framework 2016-17, released in WHC (2016) 23, is used to measure delivery throughout 2016-17. The Welsh Government sets national targets for its emergency care services as outlined below.

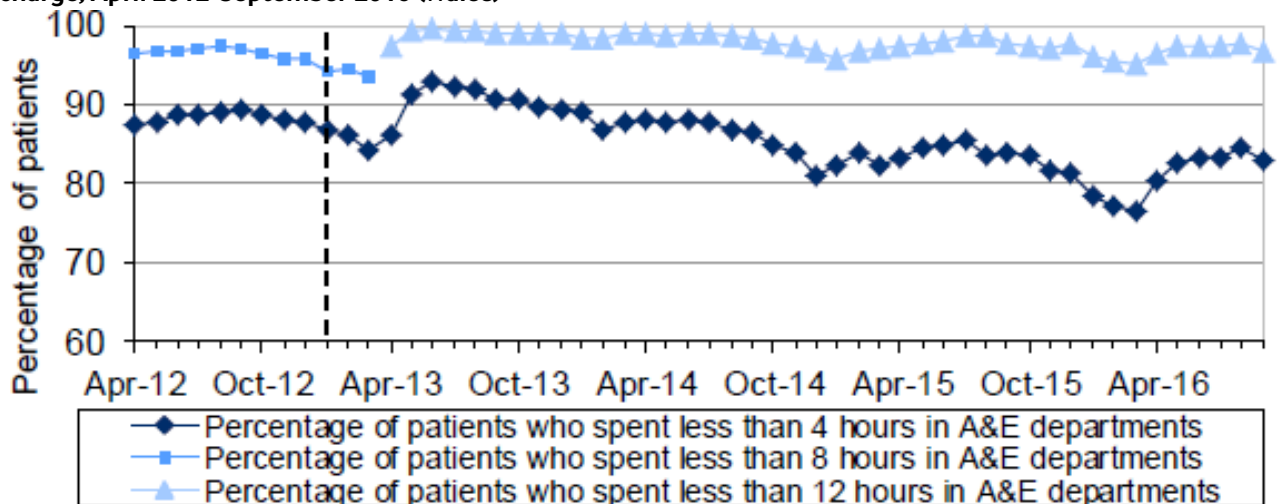
Emergency departments

34. The targets relating to time spent in A&E departments are:

- 95 per cent of new patients should spend less than 4 hours in A&E departments from arrival until admission, transfer or discharge;
- Eradication of 12 hour or more waits within A&E departments.

35. The Welsh Government has published statistics on time spent in NHS Wales A&E departments for the quarter ending September 2016, and Welsh Government figures show the trend over time:

Table 1: Percentage of patients spending less than 4, 8 or 12 hours in A&E from arrival until admission, transfer or discharge, April 2012-September 2016 (Wales)²



*Please note this chart does not start at zero

Source: Emergency Department Data Set, NWIS

- (a) Data from January 2013 onwards is not strictly comparable with data for previous months due to a change in methodology. Please see [key quality information](#) for more details.
- (b) Data for less than 12 hours is only shown from April 2013 when the target was introduced.
- (c) Data for less than 8 hours is shown until March 2013 when the target ceased.

36. The Cabinet Secretary for Health, Wellbeing and Sport stated in his paper to the Committee for its session on 15 September 2016:

“The latest published statistics show waiting times in hospital emergency departments in Wales are continuing to improve. Despite around 2,880 attendances every day, 83.2% of patients spent less than 4 hours in emergency departments being triaged, diagnosed and treated from arrival until admission, transfer or discharge. There was also a drop in the number of people waiting

² Statistics taken from Welsh Government website.

over 12 hours. There is more work to be done by health boards, and they are expected to work to improve patients' experiences and eliminate lengthy delays.”³

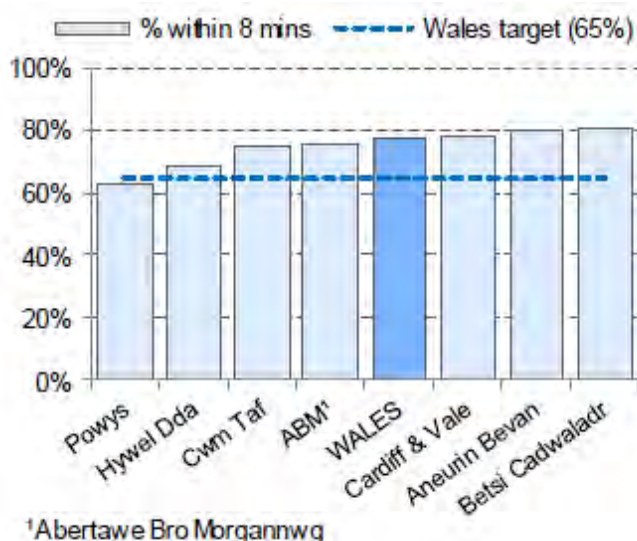
Ambulance response times

37. From 1 October 2015, WAST implemented a new clinical response model for a 12 month pilot period, which has recently been extended for an additional 6 months. During this trial, only the most serious calls, categorised as Red (immediately life-threatening), will have a response time target. All other calls will receive an appropriate response, either face-to-face or telephone assessment, based on clinical need. The new model has three categories of calls:

- Red: Immediately life-threatening (someone is in imminent danger of death, such as a cardiac arrest). The target is for 65 per cent of emergency responses to arrive within 8 minutes;
- Amber: Serious but not immediately life-threatening (patients who need treatment delivered on the scene and may then need to be taken to hospital);
- Green: Non urgent (can often be managed by other health services) and clinical telephone assessment.

38. The most recent statistics on ambulance response times in Wales published by the Welsh Government are for October 2016, and Table 2 below shows the trends:

Table 2: Emergency responses to red calls arriving at the scene within 8 minutes, October 2016⁴



Source: Welsh Government

39. Handover of patients from an ambulance to an emergency department: No patient should spend longer than 15 minutes being handed over from an emergency ambulance to a major emergency department. Individual LHB and all-Wales performance against this target is reported on a quarterly basis as part of the Ambulance Quality Indicators. As at September 2016, the all-Wales

³ Health, Social Care and Sport Committee, **Paper 3**, 15 September 2016

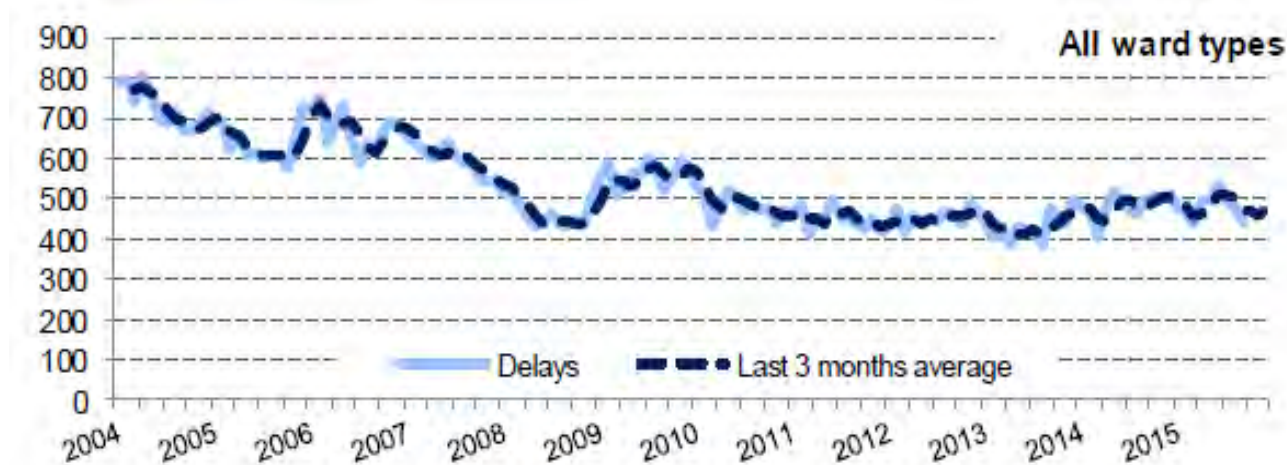
⁴ Statistics taken from Welsh Government website.

average performance against this indicator was 54.2 per cent, although performance varied significantly between LHBs.

Delayed transfers of care (DToC)

40. Delays in the wider health and social care system can result in patients spending longer in hospital than is medically necessary. Statistics are collected on both the frequency of delays and the main reasons for them. Whilst there are no national DToC targets set, this is a key NHS Wales performance indicator. StatsWales publish monthly DToC figures and a quarterly Welsh Government report is published. The most recent figures are for October 2016 and Table 3 below shows the trends:

Table 3: Delayed Transfers of Care in Wales: October 2004 to October 2016⁵



Note: An increase in autumn 2009 was probably partly due to revised procedures.

41. Looking at trends since October 2004, while the actual number of delays fluctuates each month, the quarterly average has come down from 775 in the quarter ended 30 December 2004 to 500 in October 2016 – an increase of 9 (2%) on September 2016.

42. The Welsh Government figures for October 2016 report that:

- 153 patients were delayed on acute wards, 95 in mental health facilities and 252 on community, rehabilitation and other wards;
- Health care reasons accounted for 26 per cent of all delays, community care reasons for 22 per cent, selection of care home 17 per cent and waiting for availability of care home place 16 per cent;
- 187 patients (37%) were aged 85 and over, including 80 (16%) aged 90 plus;
- 235 patients (47%) had been delayed less than 3 weeks, while 24 (5%) had been delayed for more than 26 weeks.

⁵ Statistics taken from Welsh Government website.

03. General preparedness and service integration

General preparedness

43. The evidence we received from stakeholders offered a mixed view on the level of preparedness for winter 2016-17.

44. WAST stated that they were in a much stronger position than in previous years,⁶ and that:

“...the Welsh Ambulance Service has taken a more integrated approach to planning for the winter season this year, ensuring that plans developed at local level are more closely aligned with health board planning, while developing a multi-level, Wales-wide organisational plan that covers strategic, tactical and operational issues.”⁷

45. Similarly, the Association of Directors of Social Services (ADSS) reported that social services are “very prepared across Wales in relation to the pressures of winter, and indeed the pressures throughout the year ...”⁸ They went on:

“...we are a key part in a whole system of provision across services (...) So, we recognise that we need to play our full part in that provision throughout the winter period...”⁹

46. The Royal College of General Practitioners (RCGP), however, stated that “general practice (...) is currently under severe pressures already” and it could not be assumed that GPs would be able to absorb any further increases in workload. It said there was a “need to look at this in a more robust way”.¹⁰

47. BMA Cymru Wales and the Royal College of Emergency Medicine (RCEM) reported that services this winter were likely to be “very stretched” and that they were “relatively unprepared” for the winter period as well as for the year-round pressures.¹¹ Similarly, the Royal College of Paediatrics and Child Health (RCPCH) reported that, in spite of improvements, services were not quite ready.¹²

48. The Welsh NHS Confederation stated that LHBs had prepared winter plans, but these recognised there were still risks and challenges, including levels of demand, workforce, finance and capacity in social care.¹³

49. Care Forum Wales (CFW) stated “this winter, let’s hope for the best, but I think we need to plan for the worst.”¹⁴

50. The evidence submitted jointly by the Cabinet Secretary and Minister for Social Services and Public Health set out the ways in which health and social care services have prepared for winter, but

⁶ Written evidence, [WP 14](#)

⁷ Written evidence, [WP 14](#)

⁸ Health, Social Care and Sport Committee, Record of Proceedings (RoP), 29 September 2016, paragraph 313

⁹ RoP, 29 September 2016, paragraph 314

¹⁰ RoP, 29 September 2016, paragraphs 112 and 114

¹¹ RoP, 5 October 2016, paragraphs 6, 8, and 11

¹² RoP, 29 September 2016, paragraph 228

¹³ RoP, 5 October 2016, paragraphs 98 to 99

¹⁴ RoP, 19 October 2016, paragraph 100

acknowledged that the challenges facing health and social care reinforce the need for a 'whole systems approach' and robust joint planning. It noted:

“In recognition of the significant unscheduled care pressures experienced during winter, the Welsh Government instructed our services to commence planning earlier than ever this year.”¹⁵

51. On this point, we understand from the Cabinet Secretary that planning for this winter began in March and that the Welsh Government holds quarterly national seasonal planning events to inform the development of seasonal plans, including for the winter.

52. The joint evidence also outlined the monitoring and surveillance processes that will be in place, including weekly reporting from Public Health Wales on flu and infection control, fortnightly calls between the Welsh Government and a Local Health Board (LHB) winter resilience lead and weekly calls between the Welsh Government and Directors of Social Services. The Cabinet Secretary stated:

“I think we’re as well prepared as we can be, but that does not mean that I say that the system is in a perfect shape and there is not further improvement that we would expect to make.”¹⁶

53. Separately, we note the Cabinet Secretary’s **announcement on 3 November 2016** that an additional £50m would be made available to NHS Wales to deal with winter pressures on hospitals. This funding is intended to “sustain performance and meet the increased demand placed on services going into the winter period”. On this point, the Cabinet Secretary told us:

“The £50 million is about supporting and enhancing activity, and so part of this money will be against performance actually delivered. So, we’re not going to simply go through a formula and allocate money out to every health board regardless of the activity undertaken or planned to be undertaken.”¹⁷

54. In terms of ‘measuring the success’ of this additional investment, the Cabinet Secretary said that these measures would involve:

“All the different measures that we generate, whether it’s about our unscheduled care activity, but in particular, at the end of the year, whether you’ll see an increase in the number of people who’ve been seen in planned care as well. That will be one of the measures that we’ll look at. Whether it supported a shift in activity, keeping more people at home.”¹⁸

We’ll be able to have a range of measures for what we’ve been able to do to try and support people in different parts of the system, and how much additional elective activity we have or haven’t managed to deliver.”¹⁹

¹⁵ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

¹⁶ RoP, 17 November 2016, paragraph 5

¹⁷ RoP, 17 November 2016, paragraph 26

¹⁸ RoP, 17 November 2016, paragraph 15

¹⁹ RoP, 17 November 2016, paragraph 17

An integrated health and social care approach

55. In Taking Wales Forward,²⁰ the Welsh Government states:

“...the NHS needs to reflect the needs of our modern society, with closer links between health and social services, strengthened community provision and better organisation of general hospital and specialised services.”

56. The need for service planning and delivery that takes into account the patient journey across the whole health and social care system is a theme picked up by a number of stakeholders, including the Welsh NHS Confederation,²¹ Royal College of Nursing (RCN) Wales,²² BMA Cymru Wales²³ and the Welsh Local Government Association (**WLGA**) / Association of Directors of Social Services (ADSS)²⁴.

57. We heard from the ADSS about the effectiveness of joint working in the delivery of front-line services and also about the potentially positive role that Regional Partnership Boards (RPBs) could play in developing integrated working.²⁵ Similarly, we heard from Welsh Government officials as part of our scrutiny on the Welsh Government’s draft budget 2017-18 that RPBs are making a difference to improved joint working.²⁶

58. Whilst the evidence from CFW recognised the role RPBs could play in bringing together statutory and non-statutory partners, it believed they were still at too early a stage to have any real impact.²⁷ However, both ADSS and CFW were clear about the absolute necessity of enabling better and more integrated working across the health and social care sectors.²⁸

Integrating the independent sector

59. There were strong concerns expressed by CFW, which believed that the inclusion of non-statutory providers in winter planning was patchy and inconsistent. On this point, CFW stated that “partnership working (through the RPBs) is still at very early stages and our members still see problems which could be dealt with by better co-ordination and recognition of the work of the sector. (...) such partnership working requires better relationships to be built up together with mutual trust between the statutory and non-statutory sectors...”²⁹

60. It reported that individual local authority forums meet with varying degrees of regularity with their providers “to discuss any particular issues and how they iron those out”, but that “discussions with health are even more patchy, effectively, and so part of it comes down to this lack of integration within the system”.³⁰

61. It went on:

²⁰ [The Welsh Government’s 5 year programme for government, 2016](#)

²¹ Written evidence, [WP10](#)

²² Written evidence, [WPO2](#)

²³ Written evidence, [WP11](#)

²⁴ Written evidence, [WP17](#)

²⁵ RoP, 29 September 2016, paragraph 342

²⁶ RoP, 3 November 2016, paragraph 149

²⁷ RoP, 19 October 2016, paragraphs 15, and 73

²⁸ Written evidence, [WP13](#) and [WP17](#)

²⁹ Written evidence, [WP13](#)

³⁰ RoP, 19 October 2016, paragraph 73

“...there are elements of good practice (...)—but I go back to our central theme in today’s discussion, which is about how do you reduce pressure in the system. That only comes through collaborating, working in partnership, and that’s the sort of thing that really should be right across Wales, where people are looking at best practice...”³¹

62. Similarly, the **Public Policy Institute for Wales** report, “**Efficiency and the NHS Wales Funding Gap**” (October 2016), sets out the need for involvement from public bodies such as the Welsh Government, local authorities and LHBs to ensure market sufficiency and promote improvements in the care home sector.

63. The Minister acknowledged the important role of the independent care sector in terms of provision across Wales. She told us that “there is also a requirement for the regional partnership boards to have direct representatives on there from the care sector”:

“So, the care sector should feel that they are directly engaged right at the heart of service design and delivery right across Wales now.”³²

64. Further, the Deputy Chief Executive of NHS Wales confirmed:

“...we expect health boards to engage fully with all of their partners across the system, which includes the independent sector, local government and the third sector, as they develop an integrated plan, and we’ve seen very good examples of that through this year.”³³

Improved working between professionals

65. In its report, **Uptake of Influenza Immunisation 2015/2016**, Public Health Wales reported that during 2015-16 more individuals in clinical risk and priority groups in Wales received an influenza vaccine than in previous years. Although uptake in those aged 65 years and older (66.6%) and those in clinical risk groups (46.9%) decreased slightly compared to the previous season, the number of individuals eligible for and receiving the influenza vaccine has increased. Uptake amongst NHS staff, although up on previous years, was only 46 per cent.

66. At the same time, we heard evidence as part of our inquiry which highlighted concerns around the need for a more integrated approach in key national initiatives; specific to winter pressures was the flu vaccination programme.³⁴ On this point, the Royal Pharmaceutical Society (RPS) stated that professions were still working in silos³⁵ and that increased use could be made of services such as community pharmacists:

“We’ve currently got GPs giving flu vaccinations, we’ve got some community pharmacists, but actually there’s tension between those two professions on who’s going to deliver that. I would think that one of the urgent things that needs doing is some sort of facilitation so that those two contractors are pulling

³¹ RoP, 19 October 2016, paragraph 91

³² RoP, 17 November 2016, paragraph 31

³³ RoP, 17 November 2016, paragraph 33

³⁴ RoP, 29 September 2016, paragraphs 150 to 160

³⁵ RoP, 29 September 2016, paragraph 131

together to make sure that the targets are reached, and there is nothing happening there. That is definitely one of the solutions. If we could get those vaccination targets up by using everybody who's available to inject the population, and have access to all the population—you know, that is a solution that nobody's addressing at the moment.”³⁶

67. Similarly, the RCGP set out the need for effective co-operation on the flu vaccination programme:

“...the more people who can advertise that flu vaccinations are beneficial is helpful. We also need to make sure that we get private organisations like the care homes to be vaccinating their people (...) But there are lots of groups that need vaccination. Hospitals are a big issue—that the staff are not being vaccinated in the hospital.”³⁷

68. Witnesses strongly argued the need for a more effective collaborative approach, recognising that people should be able to access immunisation in a way or place that suits them, and possibly with a broader base of outlets, including the Third Sector, being able to promote the vaccination. There was concern expressed by some witnesses about the low vaccination take-up within the independent sector³⁸ and also that some people with chronic conditions were unaware they were eligible for the vaccination. The RCN Wales raised the need for research on why those in targeted groups – including staff – were not being vaccinated.³⁹

69. The joint evidence from the Cabinet Secretary and Minister emphasised the key role they felt could be played by national initiatives in tackling winter pressures and the opportunities to make enhanced use of community pharmacy services. Their evidence also stated:

“We have and continue to work with health boards and GPC Wales to change the national General Medical Services contract to reduce bureaucracy and to enable collaboration between individual GP practices and between GPs and other front line services in their communities, through the 64 primary care clusters.”⁴⁰

70. The Minister acknowledged that there had been difficulties in the past in terms of the relationship between GPs and community pharmacies in competing to deliver vaccines.⁴¹ However, we heard that the Cabinet Secretary had met in September with organisations involved in delivering the flu vaccination campaign, aiming to maximise uptake in at-risk groups through more integrated working and increasing uptake amongst both social and healthcare staff; the WLGA was also asked to consider including the vaccination of care staff in contractual agreements with care providers.⁴²

³⁶ RoP, 29 September 2016, paragraph 173

³⁷ RoP, 29 September 2016, paragraphs 200 and 201

³⁸ RoP, 29 September 2016, paragraph 348

³⁹ RoP, 5 October 2016, paragraph 263

⁴⁰ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

⁴¹ RoP, 17 November 2016, paragraph 38

⁴² Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

Our view

71. It is clear from the evidence we heard that the many pressures facing the NHS in Wales are not restricted to a particular period or season but are, in fact, all year round. Nevertheless, it is also clear that there are seasonal spikes in demand, especially during the winter months, which put an already stretched system under further strain. As a consequence, planning for this period is essentially about trying to limit the effects of these spikes whilst continuing to deliver other core services, including elective activity.

72. As such, greater resilience within the health and social care services generally would enable them to manage better during times of exceptional seasonal pressure. Considerable efforts and resources are invested in planning for the winter period, with the planning process starting as early as March. Without that greater resilience, however, these efforts seem to be more about firefighting than effecting whole-system change - change which might enable different service approaches to be taken to managing unscheduled care pressures.

73. Specifically in relation to this winter period, there was a difference of opinion amongst providers about the levels of preparedness; this, in itself, is cause for some concern. After the widely reported and much examined pressures of the last few years, there should be more confidence across the entire sector that the problem is under control and manageable. That this is not the case may be due, in part, to a lack of communication between all the relevant parties, despite arrangements, such as integrated plans, being in place.

74. Further, the evidence we have heard suggests that the main focus seems to be on preparing the health service for the pressures of winter, with more limited attention paid to the social care aspect. This approach does not seem to adequately recognise the crucial role of the social care sector, both in terms of preventing hospital admissions over the winter period, particularly for older people, and in enabling those in hospital to move on at the appropriate point.

75. Overall, there is a need for greater integration between the health and social care sectors, both in the planning and delivery of services, and there is a need to include the independent sector (both care home and domiciliary services) in this work.

Recommendation 1. The Cabinet Secretary and Minister should, as a matter of priority, focus their attention on the greater integration of the health and social care sectors, both in the planning and delivery of services. The NHS, social care and independent sectors must be key players in this work.

76. There is also a need to enable better working arrangements between medical professionals, including GPs and pharmacists, to ensure that they are not in competition when it comes to delivering national prevention initiatives such as flu vaccinations.

Recommendation 2. The Cabinet Secretary should explore the options for enabling more effective working arrangements between GPs and pharmacists to minimise competition in delivering national prevention initiatives such as the influenza vaccination.

77. Linked to this, we have some concerns about the Welsh Government's flu vaccination campaign, especially in relation to the relatively low uptake amongst NHS and social care staff.

Vaccinating front-line staff is a key preventative measure, and we believe the Welsh Government and the sector should be more ambitious when setting targets in this area. We also have some concerns about the structure, visibility and targeting of the campaign this year. There is a need for clarity about the respective roles of GPs and pharmacists in the campaign and the strength and visibility of national messages to target groups. Further, we believe that more work should be done to understand the reasons why take-up of the flu vaccination is not higher across the board.

Recommendation 3. The Cabinet Secretary should ensure that arrangements are in place to evaluate the effectiveness of all Welsh Government campaigns relating to winter health, and to publish the lessons learned quickly. He should also ensure that arrangements are in place for effective whole-system learning from these evaluations.

78. In relation to funding, we welcome the additional investment of £50 million by the Welsh Government for winter pressures for this year. The Cabinet Secretary was quite specific about the outcomes he expected to see for this additional investment, including to contribute to dealing with the additional demands of unscheduled care and to maintain current performance in terms of planned activity, i.e. elective surgery over the winter period. We believe that these are ambitious targets for this level of investment, particularly given the financial challenges already facing a number of LHBs, and we ask that the Cabinet Secretary reports back to us at the end of the next quarter with details of progress against those targets. We are also interested to hear further from him at that time as to how the evaluation of these outcomes will feed into a general review of the whole system and the planning round for next winter.

Recommendation 4. The Cabinet Secretary should report back to us at the end of the next quarter with details of progress against targets for the additional £50 million investment by the Welsh Government in winter pressures for this year.

04. Demand on services

Level of demand for unscheduled care

79. Last winter, Local Health Boards (LHBs) reported significantly increased levels of demand on their services. In January 2016, the then Deputy Minister for Health reported that the Welsh NHS had experienced a significant surge in demand for urgent and emergency care services above and beyond that experienced in the same period in 2015, with more severe surges in demand following the festive period.⁴³ His statement noted particular pressures on emergency ambulance calls, primary care out-of-hours consultations and attendances at emergency departments. Accident and Emergency (A&E) attendances were up to 23 per cent higher than the January 2015 average.

80. In September 2016, the Cabinet Secretary **reported** that, in terms of attendances at Welsh emergency departments, in the period March 2015-April 2016, 1,165,738 attendances were recorded. Attendances from January-March 2016 were the highest recorded for that same period and almost 9.3 per cent higher in 2016 than the same period in 2015.

Year-round pressures

81. The Welsh NHS has continued to see many pressures facing its unscheduled care services. The evidence we have heard as part of this inquiry has drawn attention to the continued and growing demand on unscheduled care services. On this point, WAST stated:

“The challenges faced by the Welsh NHS in managing the demands of the winter season have been well-documented in recent years. An older and increasingly unwell and frail population, the seasonal impact of potentially adverse weather and higher levels of sickness, both within the community and among NHS staff, coupled with long-standing system issues, can inhibit the ability of patients to be cared for in the community.

... What has become apparent more recently is that system pressures now persist across the year to a greater or lesser extent.”⁴⁴

82. The all-year round nature of pressures was also noted by the RCN Wales, Local Health Boards and BMA Cymru Wales, which stated:

“There is an ever increasing demand for health services across the NHS which is exacerbated during winter months. Demand within the health service is now so great that hospitals are full all year round, preventing the system from coping with a seasonal spike in demand.”⁴⁵

83. CFW stated “anecdotally there has never been as much pressure. It’s certainly year-round and, yes, you will find those areas where there will be a capacity at certain times, but you can see now the pressure on the system.”⁴⁶

⁴³ **Written statement** - Unscheduled care winter pressures, Deputy Minister for Health, 11 January 2016

⁴⁴ Written evidence, **WP14**

⁴⁵ Written evidence, **WP11**

⁴⁶ RoP, 19 October 2016, paragraph 24

84. The Welsh NHS Confederation also highlighted the further and increasing pressure on health services during the winter months, and noted the underlying factors in the rising demand:

“Changes in how people live their lives and the success of the NHS in keeping people alive for longer means demand for care is rapidly rising. An ageing population, combined with more people having increasingly complex needs, means that demand for health and social care services is predicted to grow rapidly in coming years.

Wales currently has the highest rates of long-term limiting illness in the UK. Between 2001-02 and 2010-11 the number of people with a chronic or long-term condition in Wales increased from 105,000 to 142,000. All these factors affect people’s health and increases demand on health and care services.”⁴⁷

Across the border

85. This picture is not confined to Wales, but is “recognised throughout the UK as a year round reality”.⁴⁸ The Health Select Committee of the UK Parliament has recently undertaken **an inquiry into planning for winter pressure** examining the steps needing to be taken to ensure that A&E departments are able to cope with the winter pressures. Evidence submitted to that inquiry by the **Department of Health, NHS England and NHS Improvement** reported on the growing and sustained demand on emergency and unscheduled care services, coupled with the impact the cold weather can have on the health of the very elderly, the very young and those with pre-existing and chronic conditions.

86. **Evidence submitted by the Nuffield Trust** to the same inquiry supported this, noting that cold weather is associated with higher admission rates, with a greater proportion of older people and those with respiratory conditions. Similarly, **research by The Kings Fund** demonstrated the significant growth in contacts with English GP practices by patients aged over 85.

An ageing population

87. We heard from stakeholders that, whilst there are significant and growing pressures all year round, the seasonal spike during the winter impacts particularly on the use of services by older people.

88. The impact of an ageing population in Wales, accompanied by increasing co-morbidity and frailty was recognised by a number of respondents, including BMA Cymru Wales, WAST, the RCGP, the RPS and the WLGA/ADSS. The RCEM stated:

“The NHS in Wales faces a significant challenge to meet the health needs of an ageing population with increasingly complex needs. (...) demand from this age group has grown and continues to grow considerably beyond mere demographic change...”⁴⁹

⁴⁷ Written evidence, **WP10**

⁴⁸ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

⁴⁹ Written evidence, **WP15**

89. In addition, both WAST and the RCGP commented on the rising admissions from vulnerable older people as a result of falls.⁵⁰ We also heard from ADSS that people in care homes are increasingly frail and with more complex needs, which impacted especially on discharge from hospital.⁵¹ The RCEM highlighted too the increased complexity of patient need:

“We have constant pressure throughout the year. What we do see in the winter is the case mix is slightly different, with more elderly, frail, vulnerable patients who have more complex health needs, attending emergency departments, and therefore often require lots more input—social care packages—to get them home.”⁵²

90. CFW stated:

“I think one of the things that is also worth saying is that what we’ve seen is increased dependency over the last at least 10 years within the sector...

So, the sorts of residents that are now in nursing homes are much more dependent. We’re seeing a lot more palliative care cases, for example, and in terms of the input that’s needed, the pressure is greater. (...) We see people either with significant needs in terms of dementia or significant needs in terms of physical support.”⁵³

91. A similar picture in terms of demand for services was set out by the Public Accounts Committee in the Fourth Assembly, in its [report on Unscheduled Care](#). That report highlighted an increase in the number of older people attending emergency departments and that those patients tended to experience the longest waiting times.

92. The evidence from the Cabinet Secretary outlines the ongoing increase in demand on health and social care as a result of the changing demographic, and notes also the growing number of A&E attendances in 2015-16 – up 2 per cent from the previous year.⁵⁴

Children

93. In relation to children and young people, both the RCPCH and BMA Cymru Wales noted the significant use of services by those aged 0-18.

94. The RCPCH told us about the growing emergency seasonal workload relating to children, who make up around 25 per cent of the emergency workload during the winter. It commented that a particular challenge amongst children was that of increased respiratory problems such as bronchiolitis, a condition which could require extended in-patient care, possibly including high-dependency or intensive care support:

“Children are not small adults... The illnesses affect them in a different way. The treatments are different, and we can’t make preparations for adults and expect to use the same structures for children. It simply won’t work.

⁵⁰ RoP, 29 September 2016, paragraphs 40, and 114

⁵¹ RoP, 29 September 2016, paragraph 321

⁵² RoP, 5 October 2016, paragraph 11

⁵³ RoP, 19 October 2016, paragraph 30

⁵⁴ Health, Social Care and Sport Committee, [Paper 1](#), 17 November 2016

Our wards are packed during the winter months with different illnesses among children. Also, not just that there are more children, but their needs are different, more intense, during the winter, and we're not currently prepared for that."⁵⁵

95. In its evidence, the RCGP reported:

"...at least a doubling if not a tripling of children with fever, and respiratory illness, for which I think it's perfectly understandable for parents to maybe access their GP service rather than deal with it at home."⁵⁶

96. However, we heard that approximately 80 per cent of children tended to be in-patients for around 24 hours or sometimes less and more of these cases could be supported at home if parents had appropriate support and information.⁵⁷ This rise in demand during the winter months does, however, present a challenge, with a need to flex and escalate bed and nursing capacity to a level sufficient to meet this seasonal increase.

97. The Cabinet Secretary recognised the points made about the need for support for parents, saying:

"...this is about the Choose Well messages to help and support parents when their child is ill. Anyone who is a parent knows that children can be ill at any time of the year, but more likely so in winter, and about how we help and support people.

... It does also return to the need for a whole system approach about where is the right place to care for a child, and where a parent is worried about how you meet and deliver against their health need and support parents to help look after their own children."⁵⁸

98. He assured us that specific account had been taken of children's needs in the planning process for winter, including "how different health boards need to help each other".⁵⁹

"Inappropriate" attendances at A&E

99. We heard from respondents about the number of people presenting at A&E but potentially accessing the wrong service for their needs. By way of example, the RCEM stated:

"Any redirection services usually have 20 to 30 per cent of people. That's our best estimate. So, 15 to 30 per cent of people could probably be served with a different type of service, not necessarily an emergency service."⁶⁰

⁵⁵ RoP, 29 September 2016, paragraphs 228, and 251

⁵⁶ RoP, 29 September 2016, paragraph 176

⁵⁷ RoP, 29 September 2016, paragraph 238

⁵⁸ RoP, 17 November 2016, paragraph 59

⁵⁹ RoP, 17 November 2016, paragraph 60

⁶⁰ RoP, 5 October 2016, paragraph 50

100. Research by The King's Fund (2016) on the level of “inappropriate” attendances indicated that around 13 per cent of people who attend A&E are discharged without requiring treatment, and a further 35 per cent receive guidance or advice only.

101. In their joint evidence, the Cabinet Secretary and Minister refer to research undertaken by the Primary Care Foundation in 2010, which suggests that approximately 16 per cent of A&E attendances would be more appropriately dealt with in primary care.⁶¹

102. Their submission highlights the Choose Well campaign as a key part of the national approach in Wales to ensuring information is targeted and available about what services are available locally as alternatives to A&E.⁶² We heard from the Cabinet Secretary that he has asked for an evaluation of the Choose Well campaign to be undertaken in the spring of next year.⁶³

Our view

103. Despite the significant and growing year-round pressures on the NHS in Wales, the seasonal spike during the winter period is driven by a number of specific factors, not least age. At the one end, Wales has an ageing population who often present with a number of complex conditions and who can lose access to their more regular support networks during the winter months. There is also evidence of more admissions from vulnerable older people who have experienced falls during this period, and an increasing number of patients with mental health conditions, including dementia. Many, particularly older patients are also in need of complex care packages in order to be discharged from hospital.

104. At the other end, there is a growing emergency workload during the winter relating to children, particularly with respiratory problems such as bronchiolitis. The evidence from specialists in this field was that more of these cases could be managed at home with the right support and information for parents. This has the potential to be a “quick win” for the Cabinet Secretary and LHBs, and should be examined further.

105. More generally, it is clear that more needs to be done around the design and delivery of services for both older people and children, and that a considerable part of this involves having the appropriate staff in the right place in the system to enable it to be more responsive to the needs of its patients. (Our specific comments on the workforce are set out in Chapter 5.)

106. In addition to age, another factor in the seasonal spike is the number of people accessing the wrong services. We heard that 20-30 per cent of people presenting at A&E would be more appropriately dealt with by a different type of service. We recognise the work already being undertaken to tackle this, including the Choose Well campaign, but we feel that other measures, particularly greater co-location of primary care services in A&E departments, should be the subject of specific research to evaluate their effectiveness and potential for wider roll out. (More specific comments on co-location of services and the Choose Well campaign are included in Chapter 7.)

⁶¹ Health, Social Care and Sport Committee, Paper 1, 17 November 2016

⁶² Health, Social Care and Sport Committee, Paper 1, 17 November 2016

⁶³ Health, Social Care and Sport Committee, Paper 1, 17 November 2016

Recommendation 5. The Cabinet Secretary should commission or review available research into the effectiveness of co-location of primary care services in A&E departments.

05. Service capacity and workforce

Service capacity

Hospital bed capacity

Table 4: Available bed numbers and percentage (%) of available beds occupied, NHS Wales

Year	Surgical acute	Medical acute	Geriatric medicine	Intensive care	High dependency
2010-11	2685 (79.9%)	4608 (89.5%)	1490 (90.4%)	126 (73.7%)	106 (68.7%)
2011-12	2547 (81.2%)	4696 (88.8%)	1307 (91.4%)	121 (75.1%)	89 (73.3%)
2012-13	2439 (81.9%)	4714 (89.9%)	1289 (94.2%)	109 (79.9%)	83 (74.1%)
2013-14	2427 (82.1%)	4640 (89.1%)	1271 (94.2%)	100 (78%)	81 (74%)
2014-15	2448 (83.3%)	4569 (90.1%)	1219 (95.6%)	128 (81.4%)	80 (74.8%)

Source: StatsWales NHS beds summary year by year

Note: There is some rounding of the available beds figures

107. We heard evidence about a lack of sufficient bed capacity to cope with demand. The Royal College of Surgeons (RCS)⁶⁴, the Royal College of Physicians (RCP)⁶⁵, the RCEM⁶⁶ and BMA Cymru Wales⁶⁷ all raised concerns about this issue, the latter two bodies reporting a reduction in available in-patient beds in Wales from 12,149 in 2010-11 to 11,061 in 2014-15, with an increase in the bed occupancy from 84.7 per cent to 86.7 per cent over the same period.

108. There is some debate about safe and appropriate levels of percentage bed occupancy, with work from the [Royal College of Physicians of Edinburgh](#) setting out 85 per cent, and [other research](#) in the BMJ suggesting 80-85 per cent. In its evidence to us, BMA Cymru Wales stated:

“Once you go above 85 per cent bed occupancy, you can predict that you can’t cope with fluctuations. You need about a 20 per cent surplus of beds to cope with the kind of fluctuations that we’re talking about. When you’ve got bed occupancies running at 86 or 87 per cent, you start getting C. diff; that delays the discharge of patients as well.”⁶⁸

109. The RCEM stated that this high percentage of bed occupancy also meant that patients were being placed on wards which were not specific or appropriate to their needs, resulting in a slower recovery time and delayed discharge from hospital. As a result, the RCEM believed there was an argument for ring-fencing unscheduled care beds.⁶⁹

110. We heard from BMA Cymru Wales⁷⁰ that, as well as too many hospital beds being lost, the majority of beds were now being used for emergencies, compared with a historical base of only around a third of beds providing emergency care. The BMA also argued that increased demand had pushed the more efficient use of fewer beds beyond the limit of safety.⁷¹

⁶⁴ Written evidence, [WP19](#)

⁶⁵ Written evidence, [WPO6](#)

⁶⁶ Written evidence, [WP15](#)

⁶⁷ Written evidence, [WP11](#)

⁶⁸ RoP, 5 October 2016, paragraph 47

⁶⁹ RoP, 5 October 2016, paragraphs 58 and 59

⁷⁰ RoP, 5 October 2016, paragraph 48

⁷¹ Written evidence, [WP11](#)

111. Some respondents also commented that a lack of staffing was a contributing factor to dealing with high occupancy rates. The Welsh NHS Confederation reported that capacity planning was an issue all year round across all specialties, and Professor Adam Cairns from Cardiff and the Vale UHB outlined that:

“...what we can see is that a lot of very frail and older people are staying in hospital longer than they want to and longer than we’d like them to (...) the reason why capacity isn’t open, usually, is because we can’t get the staff to run the capacity.”⁷²

Our (elective) plan for the winter is essentially to make sure that we can maintain the treatment of very sick and urgent patients who are elective stream, and we’ll do everything that we can to maintain the profile that we’ve planned to deliver for less urgent patients.”⁷³

112. Responding to this evidence, the Cabinet Secretary acknowledged that occupancy levels are higher than previously but that, in his view, “we’re in a better position than last year”.⁷⁴ He told us that in order to manage the expected demand across the winter, integrated plans had identified “over 370 additional beds or bed equivalents across the system to manage the pressures”. In addition, he stated that “organisations are also considering the way in which they use their surgical and medical beds to best manage unscheduled care pressures”. He went on:

“It is also important to note that in view of the staffing challenges and the impact this can have on opening surge capacity, health and social care organisations have also focussed on prevention, admission avoidance, reducing lengths of stay and improving discharge.”⁷⁵

113. He confirmed that:

“...in terms of our ability to plan for winter (...) we do think the additional capacity that we’re planning to be able to deliver in the system will allow us to maintain flow across the system.”⁷⁶

114. Further to this, we heard from the Deputy Chief Executive of NHS Wales about research⁷⁷ on effective bed and throughput management at 90 per cent occupancy in some English NHS Trusts. He argued that “some of the best-performing systems were running with quite high occupancy rates” and that “we need to be careful about placing too much emphasis on a particular figure. It’s about how the system is working in a way that optimises the contribution of each part of the system.”⁷⁸

⁷² RoP, 5 October 2016, paragraphs 123 and 124

⁷³ RoP, 5 October 2016, paragraph 129

⁷⁴ RoP, 17 November 2016, paragraph 77

⁷⁵ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

⁷⁶ RoP, 17 November 2016, paragraph 85

⁷⁷ Nuffield Trust, **Understanding patient flow in hospitals**, October 2016

⁷⁸ RoP, 17 November 2016, paragraph 86

115. However, research published by **Monitor** and the report on winter pressures from the UK Health Select Committee⁷⁹ is more equivocal and continues to sound concerns about high levels of bed occupancy.

Capacity in the domiciliary care and care home sector

116. There is an increased reliance on the care home sector in supporting those people who are frail and ill; as at April 2015 there were 22,706 care home beds across Wales provided in 673 care homes and distributed between local authorities, larger and smaller group providers and single home providers. Single home providers account for around 50 per cent of this provision.

117. Despite this reliance on the sector, we heard concerns about its sustainability. The ADSS noted that, although capacity in traditional residential care has been relatively resilient,⁸⁰ many areas had reported a scarcity of specialist EMI (elderly, mentally infirm) and nursing home capacity. The Older People's Commissioner **has stated previously** there was a lack of strategic overview and market development to ensure there are sufficient and appropriate care home places for older people in Wales.

118. CFW emphasised what they saw as the significant challenges facing the independent care sector, with their Chair **stating in August 2016** that the ageing population, a chronic lack of funding and a huge recruitment problem meant the profession was facing an unprecedented crisis and social care is at tipping point. CFW also argued that the impact is likely to be “catastrophic by the winter” when the NHS is under most pressure and relies on the 12,000 nursing beds in the independent sector.⁸¹

119. CFW also stressed the challenging financial cost of setting up new care homes, and expressed concerns that the independent sector, as a key provider of services, was not better involved in winter planning:⁸²

“We’re very much with the Joseph Rowntree report on this in their inquiry. (...) They came to the view, and I think that Care Forum Wales would share it, that it’s actually not a crisis, but simply dysfunction. Because the independent sector is now so important and so large, but not connected, then anything that happens in that chain of events causes a major issue.”⁸³

120. In the view of CFW:

“We’re only one significant nursing home failure from complete calamity in any part of Wales. There isn’t anywhere, in any of the health boards in Wales, where they could sustain, as I believe, 60 people quickly. There isn’t any significant business continuity, so where do people go?”⁸⁴

⁷⁹ House of Commons Health Committee, **Report - Winter pressure in accident and emergency departments**, October 2016, paragraphs 42 to 46

⁸⁰ Written evidence, **WP17**

⁸¹ **Care Forum Wales, Social Care News, 31 August 2016**

⁸² RoP, 19 October 2016, paragraphs 45 and 46

⁸³ RoP, 19 October 2016, paragraph 14

⁸⁴ RoP, 19 October 2016, paragraphs 14 and 15

121. Responding to this, the Minister told us that the majority of care homes in Wales are small, so that, if they close, “we do have the capacity and are able to absorb that impact.”⁸⁵

122. Similarly, the Welsh Government’s Director of Social Services and Integration did not agree with CFW’s assessment, although he acknowledged that “each and every care home that closes, if they close in emergency circumstances, has both an impact on the citizen and an impact on the professionals working around those individuals”.⁸⁶ He confirmed that the Welsh Government was “looking to plan more effectively around strategic commissioning for care homes”.⁸⁷

123. We heard from CFW about the challenges for the care home sector in supporting increasingly frail residents against what they believe is a backdrop of sustained cost pressures driven by reduced levels of local authority payments for care, as well as the need for an “adult conversation” between providers, commissioners and regulators about the level of service that can be provided within available costs and the management of appropriate levels of risk.⁸⁸

124. The ADSS also voiced concerns about the fragility of care services, especially in domiciliary care, noting the difficulties facing the sector:

“I’m talking about capacity—shortages of domiciliary care provision in some parts of Wales, and in some areas, some specialist areas of care home provision are quite strained, particularly around dementia. You will find that those areas are not as available as we’d like them to be.”⁸⁹

125. Responding to these concerns, the Minister told us “we’ve been working hard to understand the capacity that we have in the sector”. She went on:

“We’ve got the care home steering group (...) that provides the strategic direction for the sector and one thing that they wanted to do was ask the national commissioning board to undertake some work to get a complete picture of the state of the market across Wales. So, (...) they’ve undertaken detailed market analysis of the care-home sector in every region across Wales (...) [and] we’ll be shortly in a position where we will have a market-position statement for the whole of the care sector.”⁹⁰

126. The ADSS stressed the financial challenges facing the sector, including the increase in the Living Wage and the £60 cap on payment for services, and set out that the protection and safeguarding of funding for social care is of paramount importance.⁹¹

Primary care capacity

127. We heard evidence from a number of witnesses on this issue. There was a feeling that there is no real shared understanding of how stretched primary care services are, with winter seeing increased demand in terms of an increase in respiratory infections, flu and other diseases, which can

⁸⁵ RoP, 17 November 2016, paragraph 95

⁸⁶ RoP, 17 November 2016, paragraph 97

⁸⁷ RoP, 17 November 2016, paragraph 97

⁸⁸ RoP, 19 October 2016, paragraphs 36, and 39

⁸⁹ RoP, 29 September 2016, paragraph 320

⁹⁰ RoP, 17 November 2016, paragraph 93

⁹¹ RoP, 29 September 2016, paragraph 322

be more severe in those with chronic conditions. The RCGP argued that the urgent care caseload impacted on the ability of primary care to focus effectively on management of those chronic conditions in people who themselves can need increased support from unscheduled care services.⁹²

128. Linked to this was a concern that the additional £42.6m Welsh Government investment into primary care in 2016-17 is not getting to the front line. Evidence from the RCGP stated that GPs were already under significant pressure, it was very difficult for them to absorb the additional work and that:

“...any money that’s coming through the cluster system seems to be really very slow in actually making any difference to most of the practices. The way that the clusters work is very varied across Wales, so that is putting increased inequalities into the system.”⁹³

129. In their joint submission, the Cabinet Secretary and Minister acknowledged the key importance of primary care and set out some details of how the additional funding has been used, including additional pharmacists, physiotherapists, nurse triage and other primary care support.⁹⁴ The Cabinet Secretary argued that “with the investment we’ve made in clusters and the primary care fund, we’ve got about another 250 people in primary care across Wales”.⁹⁵

Workforce

130. Workforce issues were highlighted as a major concern by all those we heard from. Although most responses highlighted these as year-round concerns, there was a clear message that the increased winter pressure on services highlighted and accentuated gaps and limitations in the workforce. On this point, Professor Adam Cairns from Cardiff and the Vale UHB stated:

“...I do think that this winter is going to be quite challenging from the staffing perspective, not because we’re not trying, not because there’s a delay, not because we’re holding money back, not because we don’t want to. It’s simply because we simply haven’t got the workforce presenting itself to us in the numbers that we need to cover all of the gaps that we’ve got.”⁹⁶

131. There was a consistent message also about the key role of training and skills development and the constraints on this caused by limited time and resources.

Medical workforce

132. The problems in recruiting sufficient medical staff, both for hospital and GP services, was a recurring theme in the evidence we heard. In relation to A&E consultants, the RCEM stated:

“If we look at the projection of where we should be at level pegging, Wales has about 62 or 63 consultants at the moment. If we compared to Scotland, there’s 200 plus consultants, and we have comparable ratios of population, so 5 million to 3 million—we’re way behind in figures.”⁹⁷

⁹² Written evidence, [WP07](#)

⁹³ RoP, 29 September 2016, paragraphs 112 to 114, and 141

⁹⁴ Health, Social Care and Sport Committee, [Paper 1](#), 17 November 2016

⁹⁵ RoP, 17 November 2016, paragraph 104

⁹⁶ RoP, 5 October 2016, paragraph 138

⁹⁷ RoP, 5 October 2016, paragraph 90

133. The RCEM also emphasised the need to look at the terms and conditions for medical staff in Wales with a view to making it more attractive to work here.

134. The RCGP response raised concerns about problems in recruiting and retaining GPs, as did BMA Cymru Wales. The Welsh NHS Confederation also set out the difficulties that NHS Wales was having in recruiting core medical staff in key specialties such as A&E, Paediatrics and Medicine, echoing evidence from the RCPCH, the RCEM and the RCP Wales. Again, the difficulties in terms of medical recruitment are a theme echoed across the UK.

135. Responding to this evidence, the Cabinet Secretary told us that, whilst there are more staff in the system this year, “the honest truth is that, this winter and next, we will be reliant on recruitment from other parts of the world too as well”. He pointed to “bank, locum and agency arrangements”, but acknowledged that use of these arrangements created challenges in controlling spend.⁹⁸ In his view:

“...staffing the capacity is a bigger challenge than actually identifying what you need.”⁹⁹

Domiciliary and care home workforce

136. Research undertaken by the Public Policy Institute for Wales on the Care Home Sector in Wales indicates that there is a shortage of staff prepared to work in the domiciliary and care home sector and suggests that councils and the Welsh Government need to systematically monitor services in order to plan future provision.¹⁰⁰

137. CFW reported that competition from other care and non-care organisations was impacting on the available workforce and that:

“I think it’s fairly clear, from what I’ve already said, that staffing’s an issue. The recruitment of nurses within the sector is a significant issue.

...if we had a level playing field on payments for commissioned services that enabled similar terms and conditions, then I think that would help the sector work as a whole.”¹⁰¹

138. On this point, the Minister told us:

“I do think that there is a job here for Government in terms of creating the framework and the climate for good social care and good employment in social care, and a job for local government as commissioners of services locally, but there is also a job for the providers in the independent sector, and for local government as well, and that’s to create and provide jobs that people want to take.

... There is a clear message there to employers as well that they need to step up and give employees the kind of quality working conditions that they need.”¹⁰²

⁹⁸ RoP, 17 November 2016, paragraph 109

⁹⁹ RoP, 17 November 2016, paragraph 109

¹⁰⁰ Public Policy Institute for Wales, [Report - The Care Home Market in Wales: Mapping the Sector](#), (October 2015).

¹⁰¹ RoP, 19 October 2016, paragraphs 7, and 82

¹⁰² RoP, 17 November 2016, paragraph 113

139. The independent sector and social care workforce remains very reliant on both EU and non-EU staff, with research¹⁰³ indicating that nearly 1 in 5 care workers was born outside of the UK – around 266,000 people. Non-EU migrants accounted for the greatest proportion of migrants working in care – some 191,000 people – approximately 1 in 7. About 14 per cent of non-EU migrants and some 40 per cent of the EU migrants working in adult social care arrived in the UK between 2011 and 2015. In addition, they emphasised that competition from other care and non-care organisations is impacting on the available workforce.

140. CFW also raised concerns about access to training for staff from the independent sector, and the potential professional isolation of independent care home nurses (a point also made by the RCN):

“Some care providers—and it depends on the size, nature and geographical location of the provider—also provide their own, and there are companies that work specifically in the sector. I think the experience is that NHS training is less likely to be opened up to independent providers than local authority training, but also there can be issues about access to local authority training just in terms of the amount of training and the number of places that are available, effectively.”¹⁰⁴

141. Acknowledging this point, the Minister told us that “the terms and conditions of the people providing domiciliary care directly impacts upon the quality of the care that people receive, which is why we’re taking such a strong interest in this, in the professionalisation and the resilience of the social care staff themselves”.¹⁰⁵

Nursing workforce

142. The RCN Wales argued that, in relation to nursing, there is a year-round lack of capacity in terms of the workforce and ensuring the right skills are available in the right place.¹⁰⁶

143. In terms of capacity, the fall in the number of district nurses was highlighted as a particular area of concern. **StatsWales** reports an increase in the numbers of nurses described as working in the community from 3,477 in 2011 to 3,915 in 2015,¹⁰⁷ although **coverage of figures relating specifically to district nurses** in Wales has noted a fall from 712 in 2009 to 412 in 2015, accompanied by an increased caseload.

144. The Cabinet Secretary’s evidence acknowledged these figures but also set out that LHBs have been seeking to shift skills mix at local level, using experienced district nurses to direct, lead and advise community nursing teams.¹⁰⁸ He also set out the intention of strengthening District Nursing Teams over the winter period.¹⁰⁹

145. In terms of skills, RCN Wales argued that there remains a need for greater clarity around the roles and skills of individual elements of the nursing workforce, and that skill mix could be key in ensuring effective management of patients in the community over the winter. Some research has

¹⁰³ Independent Age, **Report - Brexit and the future of migrants in the social care workforce**, September 2016

¹⁰⁴ RoP, 19 October 2016, paragraph 84

¹⁰⁵ RoP, 17 November 2016, paragraph 114

¹⁰⁶ RoP, 5 October 2016, paragraph 202

¹⁰⁷ Headcount as opposed to whole time equivalent

¹⁰⁸ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

¹⁰⁹ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

indicated the role senior nurses can play in advising care home staff, an approach supported by RCN Wales¹¹⁰.

146. We also heard from RCN Wales about the potential for expanded nurse roles in prevention and community management of chronic conditions, as well as the need for ensuring skills are matched to the need of patients in the community, so that staff are able to give appropriate support and escalate care where necessary.¹¹¹

147. Finally, RCN Wales raised issues around training and clinical supervision. In particular, they expressed concerns about the professional and support needs of independent sector nurses, many of whom will be the single qualified nurse in a care home, and called for more integrated training with LHBs.¹¹²

Flexibility of workforce

148. A number of witnesses identified the need to be able to “flex” the workforce numbers, responding to periods of higher demand during the winter. CFW identified the limitations caused by the high cost of agency staff and stated:

“...in terms of the nursing shortage, it is part of the general pressures on the sector, but what it also means is that there isn’t capacity there to expand and create more beds to meet winter pressures at the moment.”¹¹³

149. Similarly, Dr Mair Parry from the RCPCH outlined that:

“I do think that we need to think about nurse numbers. We need the health service to be more flexible, because in the summer, we don’t need to staff six intensive care beds on a ward in the hospital where I work, but in the winter, we do, and we need that flexibility in order to respond to the season. We also need to be quite robust, because it’s not just this winter where bronchiolitis will be a problem.”¹¹⁴

150. The LHBs outlined that they were not able to recruit easily the extra staff required to run additional hospital capacity during times of pressure, and this did put constraints on the ability of hospitals to provide flexible or additional surge capacity during the winter.

Our view

151. Adequate service capacity and sufficient workforce numbers are vital components in any effective healthcare system, particularly during times of exceptional strain such as the winter period. Based on the evidence we have heard, we are concerned about the ability of the health and social care system in Wales to cope with the predicted seasonal demands this year because of a lack of both of these components.

152. Specifically in relation to service capacity in hospitals, we are concerned about a lack of availability of beds to cope with demand, particularly given the high levels of occupancy reported

¹¹⁰ RoP, 5 October 2016, paragraphs 255 to 258

¹¹¹ RoP, 5 October 2016, paragraphs 218, and 228

¹¹² RoP, 5 October 2016, paragraph 247

¹¹³ RoP, 19 October 2016, paragraph 9

¹¹⁴ RoP, 29 September 2016, paragraph 254

currently. We recognise that bed occupancy rates are not the only measure of an efficient system, and that patient flow is also an important part of any such system. However, capacity is not just about bed numbers, but about having the workforce in place to staff those beds.

153. Given the well-documented, on-going difficulties in the NHS in Wales in terms of recruitment and retention of staff, the impact of this is likely to be felt particularly during times of added seasonal pressure, when difficulties facing LHBs in recruiting extra staff to run additional hospital capacity means the system has a limited ability to flex to meet increased demand. We note the planning process that has been undertaken by LHBs in order to gain an understanding of likely demand, and whilst this is important data, without the ability to secure the necessary staff, it is only part of the solution.

154. In relation to capacity within primary care, we were concerned to hear reports of insufficient shared understanding across the sector and more widely of the extent of the pressures facing these services this winter. We were also concerned to hear that additional investment from the Welsh Government, intended to mitigate these pressures, has been slow to make its way to the front line. We heard strong messages about the shortage in GPs and the difficulties in recruiting, which could make it difficult to access not just medical but other clinical services in primary care. We are also concerned about falling numbers of district nurses across Wales and the impact this will have on services over the winter, and note concerns about the increasingly changing role of district nurses as clinical support and advisors to other nursing and care staff. We believe these areas require further, immediate attention from the Welsh Government.

155. Capacity continues to be a significant problem in the domiciliary and care home sector, particularly given the increased reliance on it during the winter period and the very real concerns about its sustainability in light of a number of recent home closures. We note the steps being taken by the Minister and her officials in relation to gaining a greater understanding of the demands on the sector, and we were interested to hear that she will shortly be in a position to have the first market statement for the whole sector. We would be interested to see the results of this, and we ask that she makes this information publicly available at the earliest opportunity.

Recommendation 6. The Minister should publish details of the market analysis of the domiciliary and care home sector at the earliest opportunity in order to provide a clear picture of the capacity, sustainability and financial resilience of the sector.

156. The following points apply more widely than just in relation to winter pressures, but we feel it is important to include them in this report in order to reflect the evidence we have received.

157. The well-documented difficulties in recruiting for the domiciliary and care homes sector persist, with the independent care home sector continuing to be reliant on both EU and non-EU staff. Competition from other care and non-care organisations is impacting on the available workforce, and more generally, we feel there is a pressing need to make social care an attractive and valued place to work. Linked to this, is the potential for professional isolation of care homes nurses, with limited access to shared training with NHS and social care staff. We believe that the Minister needs to take a clearer role in setting the strategic direction and in monitoring progress in this area.

158. More broadly, we believe there is a need for improved training, skills development and supervision across all the health and social care sector, with an increased emphasis on working jointly

across these sectors. We urge the Cabinet Secretary and Minister to give consideration to how best to achieve this.

Recommendation 7. The Cabinet Secretary and Minister should give consideration, as a matter of urgency, to the need for improved training, skills development and supervision across the health and social care sector. This should have an increased emphasis on joint working across these sectors.

06. Discharge from hospital

Delayed transfers of care

159. Delayed transfers of Care (DToC) from hospital remain an issue and the evidence we received highlighted this as a major concern for the winter period.

160. Looking at trends since October 2004, while the actual number of delays fluctuate each month, the quarterly average has come down from 775 in the quarter ended 30 December 2004 to 455 in August 2016 - a decrease of 27 (5.6%) on July 2016.

161. However, the most recent figures¹¹⁵ show a slight rise in numbers:

- the total DToC number was 500, an increase of 9 (2%) on September;
- 153 were delayed on acute wards, 95 in mental health facilities and 252 on community, rehabilitation and other wards;
- health care reasons accounted for 26 per cent of delays, community care reasons for 22 per cent, selection of care home 17 per cent and 16 per cent were waiting for a care home place to become available;
- 187 patients (37%) were aged 85 and over, including 80 (16%) aged 90 plus.

162. On this point, the Welsh NHS Confederation stated:

“The most significant issue is not the numbers of people presenting at ED but the ability to provide alternatives to admission alongside the ability to transfer patients safely and quickly from hospital to their place of residence and to prevent readmission.”¹¹⁶

163. Likewise, our predecessor Committee in the last Assembly heard from the Chief Executive of Cwm Taf UHB on the importance of mapping and planning the whole patient journey:

“...it’s about increasing what we can do to avoid people coming into hospitals. That’s working very closely with our community staff, and nursing homes and residential homes particularly, to be able to keep people there and wrap support around them, rather than bringing them into hospital. The other critical factor for us is keeping our back door moving, which is working with social services to make sure that people are not staying in hospital any longer than is clinically indicated.”¹¹⁷

164. CFW also identified DToC as an area for concern, and one where they believed practical co-operation between sectors was vital. It cited the example that improved joint working could ensure that providers are willing to take on the care of new people for example, on Fridays, rather than be

¹¹⁵ Figures for October 2016

¹¹⁶ Written evidence, **WP10**

¹¹⁷ Health and Social Care Committee, Record of Proceedings (RoP), 3 December 2015, paragraph 288

concerned that appropriate support, medical supplies or case notes will not be available to enable them to take on care safely over the weekend.¹¹⁸

165. The RCEM discussed their recent report into hospital demand pressures and ED performance,¹¹⁹ which indicated the impact that delays in A&E and DToC were having on reducing patient flow through the system. They also highlighted the extent of DToC pressures that are related to the availability of care homes.

166. Alongside the need to avoid hospital admissions, we heard from the Director of the Unscheduled Care Programme Board that:

“The second big issue in the emergency department is releasing space within the hospital so that patients can get into the bed that they need to get into. That gets us to discharge. If we’re not discharging the right number of patients on a daily basis, the system will block up.

We can predict, broadly, the level of demand that’s coming through the system. So, we’ll know (...) on average, in a hospital in Wales (...) you’d have to discharge about 40 patients a day to stop the system blocking up.”¹²⁰

167. LHB representatives outlined the services that had been put in place to tackle DToC, including discharge lounges, daily multi-disciplinary ward rounds, rapid response teams and re-ablement services.¹²¹ These measures were also highlighted by the Cabinet Secretary and Minister.¹²²

168. At the same time, the LHBs acknowledged the importance of getting the discharge planning process right in tackling DToCs; they emphasised the necessity of working through, in detail, how discharges were to be delivered with the other agencies involved, including local authorities and the independent sector. Professor Cairns, Chief Executive of Cardiff and the Vale UHB outlined:

“...we are reducing the number of over-65s who get admitted to hospital and we’re reducing the number of people being admitted with long-term conditions. Part of our challenge relates to capacity in domiciliary care and nursing homes. In Cardiff, there are some big commissioning challenges for us in that arena. We’re fully engaged with our local authority partners. They are very supportive and are working very hard to help us to secure a better position.”¹²³

169. CFW also highlighted the importance of detailed discharge planning, indicating that although there were discussions around individual cases, there was a need for a more systematic approach, agreed locally between agencies, which incorporated independent sector providers.

170. The ADSS outlined the impact of the very frail nature, and complex needs, of many patients being discharged, and the blockages caused by the limited availability of direct care in community settings.

¹¹⁸ Written evidence, **WP13**

¹¹⁹ Royal College of Emergency Medicine report: **Exit Block: Hospital Demand Pressures and ED Performance, 2016**

¹²⁰ RoP, 5 October 2016, paragraph 143

¹²¹ RoP, 5 October 2016, paragraphs 168 to 170

¹²² Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

¹²³ RoP, 5 October 2016, paragraph 181

171. The Cabinet Secretary acknowledged that delayed transfers of care were a challenge, both in terms of moving people from one part of the NHS to another or discharging them, either to their own homes with a package of support or into a residential facility. He went on to say that, although there had been a downward trend over the last five years, he was not happy with the rate of progress:

“It would be wrong of me to say that we won’t see delayed transfer being a feature of the system in winter. The challenge is how we do more to minimise the problem they present for the whole system, but importantly for the individual who’s in the wrong place.”¹²⁴

172. We heard from the Welsh Government’s Director of Social Services and Integration about specific actions being taken in relation to DToC:

“The Cabinet Secretary and the Minister have asked officials to go around each of the regional partnership boards to hold a direct conversation in relation to delayed transfers of care. Those conversations have been taking place; they’re just due to be finalised. And those conversations have focused in each of the areas on what the partnerships can do together to work more effectively, and there are some simple things that can be done as well that will help.”¹²⁵

The Intermediate Care Fund

173. The funding provided through the Intermediate Care Fund (ICF) was regarded by witnesses as especially important in helping to tackle DToC. The key objective of the ICF is prevention - avoiding unnecessary admissions to hospital or residential care and delays when someone is due to be discharged from care. The Welsh Government has committed to continued ICF investment of £60m in 2017-18, comprising £50m revenue and £10m capital.

174. ADSS told us that, without the ICF-funded schemes, DToC levels would potentially have been much higher. It called for these schemes to be put on a recurring footing:

“...we know what works now—it’s all well-evaluated in terms of the development of intermediate care services, for example. What we need to make sure is that we’ve got the right capacity in those services going forward, and that means sustainable long-term investment.”¹²⁶

175. The Cabinet Secretary and Minister reported that a range of different integrated models of care and support have been established with ICF funding, including preventative and re-ablement solutions, single points of access, housing and telecare improvements, rapid response teams, dementia care and seven-day social work support.¹²⁷

176. The Minister also cited examples of savings as a result of specific schemes operating under the Fund:

¹²⁴ RoP, 17 November 2016, paragraph 41

¹²⁵ RoP, 17 November 2016, paragraph 54

¹²⁶ RoP, 29 September 2016, paragraph 342

¹²⁷ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

“I can give the example of the Pembrokeshire Intermediate Voluntary Organisations Team (...) That provides a comprehensive, seven-day admission-prevention and discharge-support service. To date we’ve been able to demonstrate that 1,090 bed days have been saved, and 109 hospital admissions avoided, because of that particular investment.

Similarly in north Wales, we have the step up, step down service, which is avoiding admissions and facilitating earlier discharge. There we’re able to show that the services avoided a total of over 5,000 hospital bed days, equating to avoided costs to the NHS of the best part of £1.5 million.”¹²⁸

177. We note that the previous Finance Committee’s **report on the 2016-17 Budget** welcomed the ICF’s impact on the provision of preventative services, but also indicated there was insufficient evidence that the balance of funding was shifting significantly towards preventative healthcare that will reduce demands on the health service.¹²⁹ Similarly, the Cabinet Secretary for Finance and Local Government has identified the need for wider learning from, and adoption of good practice from, successful ICF schemes.¹³⁰

Our view

178. Despite some progress, delayed transfers of care remain an on-going issue, with evidence of rising numbers during the winter period. This problem is exacerbated by the often frail nature and increasingly complex needs of many patients waiting to be discharged.

179. We recognise the impetus that exists within hospitals to “keep the system moving” in order to enable both admission and discharge, to ensure there is adequate capacity within hospitals to meet demand. However, there is a definite need for more effective discharge planning arrangements at a local level, including better engagement with the independent sector as part of this.

180. We recognise the important role of the ICF in helping to manage delayed transfers of care, and we welcome the continued investment in the Fund by the Welsh Government in its draft budget for 2017-18. We acknowledge the Minister’s evidence of increased resilience and capacity as a result of the ICF, including the data about reduced bed days and hospital stays avoided as a result of particular ICF-funded schemes. Given this, we believe that the Cabinet Secretary and Minister need to have a clear position on the on-going nature of funding for these schemes, rather than the current year-by-year arrangements. Further, we believe there is a case for the Cabinet Secretary and Minister to be more specific about the outputs and outcomes expected for this additional investment over the course of the next budget period.

Recommendation 8. The Minister should make and publish arrangements for the structured sharing of good practice in relation to successful schemes being delivered via the Intermediate Care Fund.

¹²⁸ RoP, 17 November 2016, paragraphs 20 and 21

¹²⁹ Finance Committee, **Report - Scrutiny of Welsh Government Draft Budget 2016-2017**, February 2016

¹³⁰ Finance Committee, Record of Proceedings (RoP), 19 October 2016, paragraph 192

Recommendation 9. The Cabinet Secretary and Minister should make clear the position about the long-term funding for successful schemes under the Intermediate Care Fund. They should also set out clearly how the additional investment in the Fund as part of the 2017-18 draft budget will be used, and what the expected impact will be.

181. Finally, as part of our recent consideration of the Welsh Government's draft budget for 2017-18, we expressed interest in hearing more about the arrangements for increasing evaluation of the Fund, including arrangements for intelligence sharing across Wales.¹³¹ We re-iterate that point here.

¹³¹ Letter to the Cabinet Secretary for Health, Wellbeing and Sport and Minister for Social Services and Public Health regarding the Welsh Government's draft budget 2017/18

07. Service models

182. The need to look critically at different service models in managing unscheduled care and tackling winter pressures was a key issue identified in a number of responses.

A&E services

183. BMA Cymru Wales and the RCEM set out proposals for this, including possible co-location with some primary care services, use of “front door” physicians and early senior clinical involvement in assessment, diagnosis and treatment.¹³²

184. Similarly, evidence from the Director of the Unscheduled Care Programme Board identified that A&E attendances were broadly made up of around 70 per cent minor injury or illness and 30 per cent of major injury or illness and there was a need to provide services that separated out but protected services for both elements.

185. The Cabinet Secretary and Minister also identified actions set out in LHB Winter Plans to manage patient flow in A&E, including front door triage, ambulatory care pathways, strengthened clinical presence in hospital and the community to support improved and earlier decision-making, stronger joint working between A&E and GP Out of Hours and increasing 7-day hospital working including pharmacy and diagnostics.¹³³

186. However, the numbers of patients waiting over 4, 8 and 12 hours in A&E in Wales have remained high:

Table 5: Percentage of patients spending less than 4, 8 or 12 hours in A&E from arrival until admission, transfer or discharge, July-September 2016 (Wales).

Time waiting	July	August	September
<4 hours	83.2	84.9	82.8
<8 hours	94.1	94.5	93.4
<12 hours	97.4	97.6	96.8

Source: [Information and Statistics NHS Wales](#)

Service models in primary and community care

187. There was continued emphasis in the evidence we received on the need for robust primary and community care services to manage discharges effectively but also to avoid unnecessary hospital admission and re-admission during winter. The RPS highlighted the role that community pharmacists could play in providing advice and support to patients, especially on common ailments, noting that evidence suggested that between 1.4 per cent and 15.4 per cent of hospital admissions were drug related and preventable.¹³⁴

188. Both LHB representatives and the Welsh NHS Confederation¹³⁵ identified a number of initiatives designed to support patients in the community, including joint working initiatives with local authorities and the Third Sector. These included:

¹³² RoP, 5 October 2016, paragraphs 14 to 20

¹³³ Health, Social Care and Sport Committee, [Paper 1](#), 17 November 2016

¹³⁴ Written evidence, [WP18](#)

¹³⁵ Written evidence, [WP10](#)

- the use of re-ablement services, rapid response domiciliary care and community-based step-up and step-down facilities;
- increased use of the Frailty Pathway across a number of hospital sites, as well as patient pathways to prevent and manage falls, as well as community-based support for mental health (Cardiff and the Vale);
- multi-disciplinary team working to identify patients at particular risk during winter and target the provision of appropriate support;
- the Choose Well campaign, designed to give people greater information and help them make effective choices about which services to use.

189. In addition, evidence from the Cabinet Secretary and Minister outlined primary and community-based services designed to strengthen service resilience for the coming winter, including:

- winter communications campaigns, including Choose Well, Beat Flu, Stay Healthy this Winter and Choose Pharmacy;
- the introduction of the 111 Pathfinder Pilot in Abertawe Bro Morgannwg UHB, aimed at co-ordinating the management of unscheduled care and providing links into GP Out of Hours services;
- increased capacity in the community, including Community Resource Teams, strengthened District Nursing Teams and Community Paramedic Pilots in Powys, Rhondda and the Vale of Glamorgan.¹³⁶

190. Again, the Cabinet Secretary acknowledged that the challenge involved spreading the learning from these developing models across the whole system.¹³⁷

191. He also told us that he had asked for a “proper evaluation” of the Choose Well campaign to be undertaken in spring 2017 “so that we will then have some learning from it in the summer that could then apply to next winter’s campaign as well”.¹³⁸

Ambulance services

192. We heard evidence about the progress that WAST had made in a number of areas, including more use of transfer from ambulance directly to hospital wards rather than via A&E, reducing the number of “frequent callers” through pro-active case management, improved clinical prioritisation of amber calls, alterations in staff rotas to direct more resources at peak activity times, the provision of better lifting equipment and work on piloting the roll-out of the “Return to Area” service trialled initially in Cwm Taf.

Our view

193. In terms of service modelling, we agree with the Cabinet Secretary that the real challenge is for genuine, whole-system learning. As part of this, there is a particular need to look at A&E services, including the potential for, and the available evidence relating to, co-locating primary care services

¹³⁶ Health, Social Care and Sport Committee, **Paper 1**, 17 November 2016

¹³⁷ RoP, 17 November 2016, paragraph 121

¹³⁸ RoP, 17 November 2016, paragraphs 174 and 175

and a possible role for “front-door physicians”. This could be an important tool to mitigate the problems associated with people presenting “inappropriately” to A&E.

194. We heard the claim from LHBs that they understand the dynamics of in-patient hospital services very well, but that some patients were staying in hospital longer than is ideal; the level of bed occupancy remains very high in key specialties; and the increasing number of old and frail people needing care has impacted on capacity planning. There is a clear need to look at the way in which capacity planning is undertaken as a much more “whole systems” approach across health and social care services and encompassing the whole patient journey.

195. Further, there is a need to look at alternative models of care in the community as a preventative measure to avoid hospital admission, as well as the need for greater evaluation of existing services, such as those funded through the ICF (discussed in the previous Chapter).

196. Finally, there is a need for greater integration across sectors and services, and more effective sharing of the good practice that exists in areas across Wales. On this point, we note that the Cabinet Secretary has commissioned an evaluation of the Choose Well campaign during the spring next year. We wait to see the results of this with interest and to hear from him in due course as to how this will feed into next year’s planning process. We also look forward to the results of the 111 Pathfinder Pilot evaluation (see recommendation 3).