INTRODUCTION

This supplementary response from BMA Cymru Wales to the Parliamentary Review of Health and Social Care in Wales presents an overview of the findings we obtained from a survey that was conducted amongst our members in Wales. It should be read alongside our earlier response of 12 May 2017.

METHODOLOGY

To complement the written submission from BMA Cymru Wales to the Parliamentary Review of Health and Social Care in Wales, an online survey was produced based on the questions posed by the review panel in its call for evidence. Some of the questions posed by the review panel contained multiple parts, and these were broken down into individual questions for the purposes of our survey. Two further questions posed by BMA Cymru Wales were additionally included in the survey. The first of these asked respondents if they had to identify one thing the Welsh Government could do to improve health and social care services what would that be, and the other asked what could be done to engage them more effectively as clinicians in the way that services are delivered.

The survey responses that were obtained from our members were subject to a thematic analysis which was undertaken by Drs Ceri Jones, Robin Burrow and Aoife McDermott of Cardiff University. This thematic analysis was subsequently used to inform this supplementary response to the Parliamentary Review.

A number of themes emerged from our survey in response to the various questions that were asked. It should be noted, however, that many of those themes came up multiple times in response to different questions. This served to demonstrate that many of these common themes are seen as being key to improving a number of aspects of the provision and effectiveness of health and social care services in Wales.
To aid the presentation of the findings in those cases where a theme came up multiple times, the summaries of the views that were received within each occurrence of that theme have been amalgamated into one main overview. Each of these overviews have been presented at the point where these themes first appear within the response. Amalgamating the findings in this way means that considerable repetition has therefore been avoided in the way they are presented. Representative quotes taken directly from the survey responses we received have, however, still been included each time these themes occur throughout the overall response.

SURVEY FINDINGS

A description of the key themes which emerged in response to each of the questions asked in the BMA Cymru Wales survey of members are outlined below, listed by question.

- **Over next 5-10 years what should health and social care services prioritise to ensure a sustainable approach to improved outcomes and best value in health and social care in Wales?**

  **Recruitment and retention** – Improving recruitment and retention of appropriately qualified clinical staff in both primary and secondary care, as well as enhancing the numbers of medical students and doctors that are trained in Wales, were areas that respondents cited as key priorities. The ongoing challenges which currently exist were themselves viewed as major barriers to improvement, with respondents highlighting particular challenges within general practice and certain secondary care specialties.

  Improving both recruitment and retention were also seen as crucial to reducing individuals’ workloads and improving service quality. It was noted that understaffing contributes to poor morale and increased sickness absence, and these generally lead to worsening care for patients. Similarly, it was noted that retention is negatively impacted upon by stress and burnout, which is often caused by an ever-growing workload. This is something that was felt to have increasingly become an issue within primary care.

  It was felt that tackling these issues could also reduce Wales’ current reliance on locums, particularly in challenging areas such as North Wales and in more rural areas. It could therefore lead to a decrease in locum spend as well as aiding workforce planning.

  Respondents suggested that a way needs to be found to make posts in Wales more attractive, with recruitment campaigns being undertaken to promote Wales as a good place to work. Better long term, strategic planning was observed to be required in order to ensure that Wales can better recruit and retain staff. It was suggested this should be backed up by long term investment in training, as well as in recruitment and retention strategies, in order to provide sustainable staffing levels for the NHS in Wales. Some respondents suggested that, when considering who to recruit, there may also be scope in some instances for a review of roles and skill mixes. It was also noted that retention could be improved by ensuring staff feel better valued and engaged by health boards and trusts. Another suggestion made was that more supportive migration arrangements could encourage more staff to stay in Wales.

  Some of the individual views expressed in response to this question in our survey were as follows:

  “The biggest problem we face is not money. It is shortage of doctors. Welsh Government needs to significantly increase the number of medical students trained in Wales.”

  “Encourage appropriate entrants, reduce locum spend by making posts attractive, increase the numbers of medical students trained in Wales.”

  “Making training attractive and providing a sensible work-life balance is key to improving [recruitment and retention].”
“Posts should be made attractive, with long term planning of how to recruit and retain staff particularly in difficult to recruit areas such as North Wales and reduce the reliance on locums”

Improve primary care – Survey respondents highlighted a clear need for improved access to primary care, which would be dependent on the sector being adequately resourced. The related need to appropriately address the increasingly manifest challenges that exist in regard to recruitment and retention of GPs was also noted. Out of hours’ primary care is an area which was seen as requiring particular investment. It was suggested that doing so could also help lessen the strain that exists within secondary care services, and particularly within A&E. Some of our members suggested it could be beneficial to have open access GP surgery time on hospital sites, whilst some also felt it would be helpful if patients as a whole could receive better education about which services to access, and when.

In terms of the organisation and focus of primary care, effective cluster working was seen as an important contributory factor by a number of respondents, although some noted their frustration with the pace of cluster development and the barriers they see to effective cluster working in their areas. Other issues highlighted were the need for improvements regarding referrals and better support designed to enhance patients’ readiness for surgery.

Some of the individual views expressed in response to this question in our survey were as follows:

“Improved access to primary care combined with patient education might reduce the strain on secondary care.”

“Support of community based health services e.g. drive for GP recruitment, encourage GP retention, better support/funding for GPs, community nurses/district nurses.”

“Large investment in primary care.”

Reduce the pressure within secondary care – As well as the need to boost capacity within primary care in Wales, members saw a need to reduce the pressure on secondary care. They highlighted a clear need for more beds and theatre capacity, and also recognised the scope for enhancing outpatient capacity in order to reduce the pressure on acute services. In addition, they pointed to a need to restore the balance between unscheduled and elective care.

It should be noted that BMA Cymru Wales has previously provided more detailed views on our members’ perception of the need for more secondary care beds in our response to a recent inquiry by the National Assembly’s Health, Social Care and Sport Committee into winter preparedness.¹

Some of the individual views expressed in response to this question in our survey were as follows:

“Rapid access outpatient clinics to take pressure off acute services – replicating the huge success of Neurovascular (TIA) clinics in other areas.”

“Restoring the balance between unscheduled and elective care. Getting sufficient capacity into the pathways of care to deliver good care at the right time.”

“Separate elective and emergency/acute hospital tertiary services, elective surgery units/hospitals, initiatives to promote daycase/outpatient department based treatments.”

Improve social care – Respondents highlighted a need for improvements in social care, and for the integration of health and social care. Members also felt that social care needs more investment to enable

patients to be more rapidly discharged from hospital, and hence have a reduced length of stay. It was noted that the integration of health and social care, backed up by shared budgets, could allow people to leave hospital to appropriate care, without long waits for discharge. Respondents suggested that such an approach should be coordinated with rapid access to social care for those ready for discharge and subsequent support with rehabilitation.

It was noted that a lack of sufficient access to social care often leads to inappropriate admissions, delayed transfers of care and poor patient flow in secondary care. It was also felt that greater integration of health and social care could create more capacity in the system and better care for patients. Many of our members suggested there should more investment to improve discharge, and it was recognised that appropriate discharge would also help to release beds in acute care. Some GP clusters have also used funding to embed social workers within GP practices, and this was observed to have had a beneficial effect.

Some of the individual views expressed in response to this question in our survey were as follows:

“Improve social care provision through a combination of increased funding and better organisation. This in itself will keep people out of hospitals and enable more rapid discharge for those who are ready to leave hospital. This would save money overall by reducing expensive hospital stays.”

“A better connection between the medical/hospital and social services so patients being admitted with a social care package at home don’t have it stopped so quickly on entering hospital allowing for them to (potentially) be discharged quicker due to the package of care already being in place.”

“Rapid access to social care for when patients are ready to leave hospital, including good short term care for those who just need support over a short time period to assist in rehabilitation/adjusting to living in the community.”

More focus on prevention and early intervention – It was suggested that there needs to be a substantive focus on prevention and early intervention, as well as on public health programmes. In particular, respondents felt that patients need to be better educated about the choices they make, and be supported to take more responsibility for their own health. It was suggested that such education should begin in schools with children and young people, to help them look after their wellbeing and make healthy choices.

Some of the individual views expressed in response to this question in our survey were as follows:

“Making patients more responsible for their health decisions.”

“Provide better life chances for children and wellbeing education to improve their life choices.”

“Public health – alcohol, smoking, obesity, access to exercise.”

More investment – The need for more investment in services across the health and social care system as a whole was highlighted by many of the members who responded to the survey, with a lack of funding being seen as a key barrier to service improvement. It was felt that particular emphasis needs to be placed on providing more frontline staff to care for patients.

Some members also recognised the need for more honesty in the language used about resources, and in particular felt that the Welsh Government and Welsh health bodies should be more upfront in acknowledging that resources are finite.
Respondents also highlighted a need to look at the investment that may be required for particular care sectors and how that may impact on other sectors – for instance a lack of sufficient funding in social care was noted to lead to delayed transfers of care which then impacts on capacity within secondary care.

A lack of flexibility within central budgets was also seen as a barrier to improvement and innovation, with improved funding also recognised as an important enabler of service integration and a facilitator of greater participation by frontline clinicians in service development. It was also noted that providing funding to pump-prime new integrated solutions could, in certain circumstances, lead to efficiencies and cost savings further down the line.

Some of the individual views expressed in response to this question in our survey were as follows:

“I think that the NHS needs more money to support a wider range of services and longer life expectancy. I think this money should be raised openly through taxation.”

“Stop wittering about undefined ‘modernisation’ and bring funding up to European levels. The NHS is remarkably efficient now. Remember that other countries have been 10% ahead for years.”

**Improve community and palliative care** – Survey responses highlighted a need for more community-based services, including respite and rehabilitation services, nursing homes and community hospitals, in order to provide step down care and alternatives to hospital admission. Members observed that, in practice, more of such care is often provided in hospitals than in community settings and that there is therefore a need to improve community care to enable the change that they perceive is needed.

It was pointed out that such a transfer of care to community settings needs to be facilitated by an appropriate provision of funding, but it was also recognised that doing so could help with preventing delayed transfers of care as well as creating greater capacity for elective work to be undertaken. Using community hospitals to support recovery and rehabilitation via step down care could also reduce the pressure on acute services within secondary care whilst social care provisions are being put in place.

The need for more community-based care for the elderly was also highlighted. Some respondents suggested that there should be palliative specialists working in community settings, and a switch to more provision of care outside of hospitals that is delivered by teams of GPs and community nurses, facilitated by an appropriate transfer of resources and working closely with social care teams.

Another suggestion that was put forward was to have specialist palliative wards which are managed away from those dealing with unscheduled care.

It was also suggested that there should be more conversations with families and patients about palliative care in care homes, so that patients are cared for in the most appropriate place, with their care needs and views on resuscitation discussed. Some respondents also pointed to a need for more care home provision, recognising that there are many elderly people who live at home but struggle to look after themselves.

Some of the individual views expressed in response to this question in our survey were as follows:

“Realistic alternatives to admission, respite care, temporary residential care etc. GP out of hours and in hours fit for purpose.”

“As a surgeon on a high turnover ward with limited bed numbers I repeatedly see patients who are ready to move to a community hospital or nursing home or hospice but cannot due to lack of spaces. As a result multiple overnight stay patients cannot come and go from that bed. We can only know that there is not a bed for a patient on the day of surgery so the patient goes home and all the theatre staff, surgeon and anaesthetist do no work and the waiting list does not shrink and

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money and overtime is poured into very expensive extra lists just to bring the waiting down that could have been done for equivalently no money on the regular lists.”

“Patients with terminal illness should not be taken to hospitals. Every person over 80 should have resuscitation process discussed and written... Specialist palliative care doctors to work in community and same time in palliative wards with 24 hour cover and well paid, preferably more than senior consultants to make it lucrative.”

“Encourage the elderly to make choices about death – what they want hospital treatment for, where they want to die, whether they wish to donate.”

• What do you value about the service you deliver now?

Care for patients/make a difference – A common theme amongst the views our members expressed in responding to this question was around the difference they can make to patients’ quality of life and the wider community. The ability to help maintain and restore independence was seen as a particularly important aspect of the service they provide.

Some of the individual views expressed in response to this question in our survey were as follows:

“Safe surgery, restoring independence to patients, relieving disabling pain.”

“The multidisciplinary team and the way we work together to maintain the independence of elderly people.”

“The ability to make a difference to local communities.”

Continuity of care – Members also said that they value the ability to provide person-centred care that is focused on the holistic needs of their patients. Continuity of care is also something that they value highly. GP members, in particular, said they value the ability to develop ongoing relationships with their patients.

Some of the individual views expressed in response to this question in our survey were as follows:

“The ability to provide ongoing personalised care which encompasses all of the patient's health needs.”

“The daily contact with patients, and patients whom I have known over a number of years – continuity of care is worth a lot, it is priceless.”

“Personal continuing care. Including palliative and terminal care.”

Dedicated and committed staff – The commitment of staff and multi-disciplinary teams in their dedication to patient care, and their willingness to ‘go the extra mile’ despite increasing pressures, was also well recognised and noted as being highly valued.

Some of the individual views expressed in response to this question in our survey were as follows:

“Committed team players who will always go the extra mile. Supportive environment in which to work effectively.”

“As a multidisciplinary team... we get on well, get on with the job despite difficult circumstances and want to make it work despite the constraints.”
“Good colleagues trying to deliver safe care with budget restrictions.”

**Free at the point of delivery** – Respondents said they valued the fact that the NHS in Wales is free at the point of delivery, is equitable and serves the best interests of patients. However, some of our members also expressed their concern for its sustainability.

Some of the individual views expressed in response to this question in our survey were as follows:

“I value that everyone can be treated as required and that it is free at the point of care.”

“I believe in maintaining a national health service with healthcare available to all regardless of personal income or circumstance. I am proud that we have this service but struggle to see how it can continue under its current structure.”

“We provide holistic care that is equitable and free at the point of contact.”

**Provision of high quality care despite extreme pressure** – Respondents said they value the fact that high quality professional care is provided to patients in the face of increasing demand, combined with deficits in staff, time and resources. However, they also acknowledged that this may not be sustainable.

Some of the individual views expressed in response to this question in our survey were as follows:

“The incredible feat of the medical profession to manage patients at a high standard with limited time and staffing levels.”

“It still functions professionally even when stress on the system remains worryingly high.”

“Everyone is working together to benefit patients no matter how tough times are. Patients who are treated generally have good outcomes.”

It needs to also be acknowledged, however, that some survey respondents said they felt unable to cite anything that they currently value about the present service. This is clearly symptomatic of low morale. Those who felt this way, attributed this to poor working conditions, resources, culture and environment. They also felt these aspects of working in the NHS in Wales have deteriorated over recent years.

Some of the individual views expressed in response to this question in our survey were as follows:

“Difficult to answer as so over stretched and over worked that makes difficult to value anything.”

“Not sure as trying to provide a safe quality service is undermined by logistics, hierarchical management, lack of resources and no funding to move forward.”

- **What could be made better about the service you deliver now?**

**Reduce bureaucracy/streamline management** – Many survey respondents highlighted a need for less paperwork, administration and meetings which they feel detract from the time they are able to spend with patients. They also say that those working at the frontline need to be better supported and listened to. Related to this is the belief which came from a number of respondents that frontline clinicians should be given greater autonomy to make decisions about the treatment and care of their patients. It was apparent that respondents felt they should be trusted, and empowered, to come up with innovative and creative solutions to problems and challenges.

Too much bureaucracy is seen as a barrier to improvement and innovation. Within primary care, it was noted that cluster networks may be given allocated budgets but often struggle to make use of these
resources in a timely, effective and innovative manner due to the bureaucracy involved. It was also suggested that clusters should be subject to greater investment and that the potential for them to have greater autonomy to act needs to be recognised and addressed.

Some members referred to a need to reduce management layers and said that there should be a conscious drive to devolve more decision-making to the frontline. It was suggested there should be fewer non-clinical managers with less emphasis on a hierarchical management structure. Reducing bureaucracy was also highlighted as an enabler of change, and something which could lead to savings being made that could then be utilised to recruit more frontline staff that are able to provide direct clinical care to patients.

Some of the individual views expressed in response to this question in our survey were as follows:

"More consultant input with the patients. There are so many meetings that the patients can be marginalised and not get 1:1 access to their consultant."

"Less bureaucracy. Management listening to those at the front line and not making decisions without clinical input."

**More time with patients** – Many respondents told us they want to be able to spend more time with patients, to deliver more holistic, person-centred care. Many GPs in particular said they would like the opportunity to have longer consultations than 10 minutes per patient, in order to facilitate better exploration and understanding of patients’ issues. It was suggested that investment in longer appointment times, where appropriate, could be a way of preventing repeat visits and supporting the delivery of a safer service. Others highlight the need to have more time for reflective practice.

Some of the individual views expressed in response to this question in our survey were as follows:

"More time with patients so that they can be managed in an holistic way, thus negating the need for repeat recurrent visits because initially time wasn’t taken to really hear what their concerns are!"

"Longer average time per patient. Make it 15 not 10 mins in general practice."

"Having sufficient resources to spend longer with patients and be able to deliver a safe service. At present we are often so rushed it can feel dangerous."

**Better communication** – Respondents said they perceived a need to improve communication at all levels within the NHS in Wales, including between primary and secondary care. For instance, the need for discharge communication to be clear was mentioned a number of times in responses. Specific areas of communication which were identified as having potential for improvement included: timely discharge summaries; communication between hospital departments; communication between health and social care (particularly around referrals and discharge); and communication relating to mental health service provision.

It was also recognised that better communication between primary and secondary care could help facilitate greater mutual understanding of the demands faced within each sector, how blocks in the system could be better overcome and what interventions and joint-working initiatives could be utilised to deliver benefits for the system and for patients. One suggestion put forward was that there could be regular question and answer sessions between primary and secondary care.
Some of the individual views expressed in response to this question in our survey were as follows:

“A timely discharge summary and letter is worth several phone calls and precious minutes for us who have 10 minutes per patient. It frustrates me very much how often we chase appointments to be told ‘do an expedite letter’.”

“Better communication between primary and secondary care. Easier access to registrars for advice, hospital switchboard is dreadful. Quarterly meetings with secondary care representatives for Q&A session. This was a regular occurrence in NHS Scotland where I previously worked.”

Better social care – see page 3, ‘Improve social care’

Some of the individual views expressed in response to this question in our survey were as follows:

“Social support often takes weeks to organise, which primarily appears to be related to under-resourcing of social care. This translates into poor patient-flow in hospitals, leading to bed-crises and pressure ‘at the front door’. Lack of social care support also results in unnecessary hospital attendances and admissions.”

“There could be better joint working with social care, primary care and the third sector to ensure that people have their needs met in the most efficient manner possible rather than the current situation where too many people are being referred for specialist input that would not have been necessary had services at lower tiers of service responded effectively in the first instance.”

“The patient journey through health and social care should be a circle beginning and ending in the patient’s home, with good communication and team working at each step.”

More investment – see page 4, ‘More investment’

Some of the individual views expressed in response to this question in our survey were as follows:

“We do not have the infrastructure and systems in place to provide modern care, we need to make the capital investments to allow the system to rule quickly, get people in, provide an answer or therapy and get them out. Vast resources are wasted in efforts that only arise because of delayed access to definitive testing or treatment.”

“10% increase in funding instead of 20% cut.”

“Constant focus on overspend means no managerial time to invest in genuine improvements. Cut the service to match the funding better (98% rather than 102%) and we can improve things further”

Better public/patient education and involvement – It was suggested that health services could be enhanced by educating and encouraging patients to better look after their own health and wellbeing. Some respondents suggested a need to foster a cultural shift amongst the general population towards patients taking more responsibility for maintaining their own health.

Better educating patients about what to expect or not to expect from the health service was seen as important, as well as the need to provide patients with a greater understanding of what services they should be appropriately seeking to access in different circumstances and when. It was also felt it could be beneficial for patients to have greater knowledge of the costs involved in providing these services.

It was suggested there could also be benefit from having more education in schools around wellbeing and mental health, and that there should be more investment in educating the public more broadly
about health and wellbeing. To facilitate this, respondents suggested there is a need for more
government-led public health campaigns that are focused on self-care.

As touched upon in a previous answer, it was also recognised that there are occasions when there may
be a need for more open dialogue with patients about palliative and end of life care.

Another area in which a need for better public education and awareness was highlighted was in relation
to the concepts underlying the principles of prudent healthcare.

Some of the individual views expressed in response to this question in our survey were as follows:

“Make public aware about how to look after themselves and what not to expect from the health
service.”

“Encourage patients to do their bit for example engage in smoking cessation, exercise, maintain a
healthy weight & be thankful for what they do have rather than complaining & not taking
responsibility.”

“Better education and expectation of patients re: the use of A&E for minor ailments and non-
medical problems, particularly out-of-hours. More open discussion, particularly with elderly or
those with chronic ill health about what their priorities are for health care, especially towards end
of life.”

**Improve recruitment and retention** – see page 2, ‘Recruitment and retention’

Some of the individual views expressed in response to this question in our survey were as follows:

“There are not enough primary care professionals, particularly GPs to provide a high quality,
consistent service. There needs to be a planned increase in personnel to manage the known
demographic changes that will occur.”

“Service quality is impaired by longstanding vacancies of consultant and non-consultant medical
staff.”

“Investment in trainees. We are one consultant short, with no hope of recruiting a substantive
colleague unless/until trainees come out of training and wish to stay in this part of Wales.”

**Improve waiting times** – Survey respondents highlighted the need for an improvement in waiting times
for elective care. In support of this, it was felt that more hospital beds are needed. It was recognised that
reducing waiting times for patients would lead to improved quality of life and enhanced clinical
outcomes. There would also be benefits for primary care through reducing the need for repeat
appointments, thereby reducing demand.

Some of the individual views expressed in response to this question in our survey were as follows:

“I feel sorry for all the patients on my elective clinic and operating lists that wait many months for
treatment that would significantly improve their quality of life.”

“Waiting times have escalated over the past 3 years. Now patients are waiting 36 weeks for
routine appointments for orthopaedics, urology, dermatology, cardiology and general medicine.
Rheumatology is a longer wait. This has huge impact in general practice as patients regularly re-
attend with ongoing or worsening symptoms or requesting further fit notes or to request an
expediting letter.”
“Reduced waiting times including the same priority for follow up patients as new patients; trying to improve access for non-cancer patients with debilitating symptoms where early access to investigations/treatments can improve long term prognosis.”

Better IT systems – Members said that more integrated and centralised technology systems could support enhancements in safety, quality and efficiency, with new digital ways of working providing valuable innovations. Such improvements could cover areas such as electronic patient notes and shared information systems that can be accessed across care sectors, electronic discharge summaries, electronic referrals, increased use of mobile technologies and electronic prescribing.

It was pointed out that there is a need for IT systems need to be designed in a way that they can ‘talk to each other’ better, including between primary and secondary care. There is currently too much incompatibility between different systems used in different parts of the NHS and it was highlighted that this needs to be addressed.

In too many instances, it was also noted that IT systems are slow and out of date. The need for greater access to high speed fibre optic broadband was also cited. Many respondents identified the potential benefits of having greater access to computers, as well as specific forms of support such as electronic ordering (thereby reducing the need for paper forms). Respondents also advocated greater use of virtual care and telecare. Some respondents suggested that having improved IT systems for appointments could help lead to a reduction in the number of patients who don’t then attend them.

Having better IT infrastructure was also recognised as an enabler of change and increased service integration.

Some of the individual views expressed in response to this question in our survey were as follows:

“Better implementation of mobile IT in ward based environments to waste less time... A transition from paper patient notes to electronic formats.”

“I need the ability to put reports onto a clinical portal so that referring doctors can read them... I need to be able to read scans and recordings made in other hospitals.”

“IT – it is so archaic and slow and not acceptable in this age of IT advances.”

“Referrals are still faxed and there is no acknowledgement of receiving the referral, no information on when they will be seen and no official paper trail. Also, there is no central system you can access that informs you how you access different services in and out of hospital.”

Review the need for notes from doctors – According to survey respondents, many of the notes that are often required from doctors need to be recognised as an administrative burden that detract from valuable appointment time, particularly when resources have not been provided to cover the costs involved. There are many cases where members feel that such notes shouldn’t be seen as the responsibility of GPs and that there are other professionals more appropriate to assess and issue them.

Some of the individual views expressed in response to this question in our survey were as follows:

“No more ‘notes from the doctor’ that waste appointments for non-medical things or those that we cannot do (all for free). No more endless patients wanting expedite letters, antibiotics for dental problems, letters to support housing or PIP appeals etc etc etc. A mass information programme, run by the Welsh Assembly, would get rid of a lot of the demonisation of GPs, and free up a lot of surgery time.”

“Getting others to make decisions instead of asking GPs to provide ‘evidence’ of eligibility for services and benefits.”
Reduce workload – Many respondents reported that their workloads are unmanageable and unsafe, exacerbated by increased demand, pressure and a lack of sufficient staff. Reducing workload pressures, and protecting breaks and time off, are issues that they see as extremely important.

Excessive workload was also cited as an obstacle to further integration of services including between health and social care, with staff and providers often lacking the headroom to develop more integrated and innovative approaches that could lead to improved services for patients.

Some of the individual views expressed in response to this question in our survey were as follows:

“*The workload has become unsustainable. Everyone turns to the GP, and because we are essentially an open door, our workload – both in terms of patients and paperwork – has escalated*”

“*Too much pressure. Find a way to relieve pressure of the NHS staff.*”

“*Protecting the doctor’s break and off days, not forcing the doctors to work 12 days in a row with subsequent frequent on calls.*”

**What do you see as working well, and what examples of innovation and good practice could be replicated?**

Cluster working – Whilst the pace of cluster development within primary care has not been uniform across Wales, many of the GPs who responded to they survey said they feel they have seen some benefit from closer working of GPs and community staff as a result of their introduction. However, concerns were also expressed about the strategic and financial autonomy of GP clusters.

Some of the individual views expressed in response to this question in our survey were as follows:

“*Cluster working could be a useful tool in providing supra practice services and should be used as an employing service for all community staff, thus shedding layers of management.*”

“*Cluster works well. Good cooperation between GPs and other services.*”

Dedicated and committed staff – see page 6, ‘*Dedicated and committed staff*’

Some of the individual views expressed in response to this question in our survey were as follows:

“*NHS is running on goodwill of its frontline staff who go above and beyond their duty to meet the patients’ needs. That needs to be acknowledged and appreciated.*”

“*Every medic I know both in hospital and GP is working all out to provide the best service they can.*”

“*The staff in the surgery go above and beyond for the patients but this increases stress and burnout.*”

Team working – Team working, and particularly multi-disciplinary team working, was cited by respondents as an example of something that they felt is working well. Respondents also noted that community health teams, district nurses and palliative teams have led to more efficient discharges from hospital.

The need for further investment in community care was also noted – see page 5, ‘*Improve community and palliative care*’.
Some of the individual views expressed in response to this question in our survey were as follows:

“Cardiff and Vale UHB Cardiff resource team and elderly care providing good service... such as multidisciplinary approach involving consultant, physiotherapist and occupational therapist.”

“Working as a team member in a multi-disciplinary teams – more multi-disciplinary team working should be encouraged in other non-cancer areas of health care, this would avoid waste and replication of services and streamline patient journey and improve patient outcomes and length of stay.”

“Community health teams, with residential accommodation, have led to great discharges from hospital, with continuity of care for patients, and continuing support for their families.”

**New and enhanced roles** – Respondents said that they see enhanced nurse roles and responsibilities as a useful innovation (e.g. nurse prescribers and nurse practitioners). It was noted that these roles can serve to free up GP time in primary care, and thereby reduce workload.

Some of the individual views expressed in response to this question in our survey were as follows:

“Developing nursing expertise (specialist clinics, nurse-prescribing, etc.)”

“Increased role of nursing staff to deliver care, previously delivered by consultants.”

“Nurse practitioners in cataract pathway.”

**Use of technology** – see page 11, ‘Better IT systems’

Some of the individual views expressed in response to this question in our survey were as follows:

“There’s an excellent database used in Cardiff & Vale called PARIS where patient information is held. All community health services input into it which allows hugely improved communication.”

“Roll out WCCG [Wales Clinical Communications Gateway] Phase 2 – i.e. the electronic ‘response’ of specialists to the e-referrals they receive.”

“Teledermatology pre-screening of GP referrals is an excellent means of ensuring timely access to dermatology advice and triaging patient access to secondary care.”

**Virtual services** – It was noted that virtual wards and in-patients clinics have been seen to improve services, particularly in rural areas.

Some of the individual views expressed in response to this question in our survey were as follows:

“More capacity ambulatory care units with virtual inpatients as not everyone needs to be in a hospital bed whilst waiting for treatment.”

“There is a focus on service improvement (e.g. the virtual fracture clinic we are currently piloting).”

“Virtual clinics for new diabetics with early changes.”

**Rapid access clinics** – The potential for rapid access clinics to help with avoiding unnecessary hospital admissions was noted.
Some of the individual views expressed in response to this question in our survey were as follows:

“Rapid access clinics for frail and elderly patients, similar to how neurovascular clinics operate, but with access to multidisciplinary input and with the ability to set up home care rapidly.”

“Rapid access outpatient clinics could be implemented across a range of specialties, empowering clinicians to avoid hospital admissions that are often not completely necessary.”

“To have a rapid access clinic for older people to be seen within 24 to 48 hrs.”

- What do you see as barriers to improvement and how could these be overcome?

Bureaucracy – see page 7, ‘Reduce bureaucracy/streamline management’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Bureaucracy! It stifles innovation. We have some ideas about recruiting a colleague from abroad, but the Health Board has basically castigated our managers for being ‘cavalier’ or ‘off-piste’ for putting them forward. Difficult problems require imaginative, lateral-thinking solutions.”

“Bureaucracy and inability to recruit the right people. Politicians do need to trust professionals. Quality needs to be monitored but not people ground down.”

Poor culture – A view was expressed that, in order for improvements to be achieved, there needs to be a shift in attitudes and culture within the NHS in Wales towards one that is seen to be just, open and collaborative. The importance of having a culture that values staff and their wellbeing was something that was recognised by respondents. Many said they perceive the existence of a prevailing blame and bullying culture – something which they believe needs be addressed.

Some of the individual views expressed in response to this question in our survey were as follows:

“I think the major barriers are cultural and I think the Health Service in Wales is poor for many cultural reasons that relate to job performance and cultural expectations in Wales, allied with apathetic management. Please note I do not list funding; major change could be achieve even on the money available, but the attitudes do not support it.”

“The blame culture is not helpful as you end up with a demoralised workforce. The time has come for compensation payments to be severely limited so that the whole of society can benefit from generalised service improvements and not just the few individuals with massive pay outs.”

“Lack of investment has caused crisis after crisis and I believe many of my colleagues whistle blew and then were bullied out of their posts and so we are lacking in experienced staff across the board. This has a knock on effect and no one wants to stay for long and so the staff turnover is huge.”

Insufficient funding – see page 4, ‘More investment’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Not enough time, money or resources. With poor social care and patients waiting in hospital to go home, little can be done with no beds to spare.”
“8+ years of underfunding of the NHS has left it in tatters: crumbling fabric of the building; demoralised staff; too many managers focused on budget control rather than service improvement.”

“Lack of funding per head to resource what is needed... we have excellent consultant colleagues but there are not enough of them so waits are very long... and then it takes is months to receive clinic letters which is not safe.”

**Poor IT systems** – see page 11, ‘Better IT systems’.

Some of the individual views expressed in response to this question in our survey were as follows:

“IT infrastructure, in particular access to high speed fibre-optic broadband.”

“Lack of technology in the Welsh NHS service and poor IT services. Creating an e referral system with all documentation online would greatly improve acute and ongoing care of patients. Also, providing a document with ALL the numbers and contact details of people that work for the health board. And also a central system that can provide information on different referral routes or ways to get hold of items/people you need in specific situations e.g. how to refer to rapid access chest pain clinic.”

“Information technology – shabby incomplete paper notes.”

**Lack of integration between healthcare and social care** – Respondents said they saw the lack of an integrated health and social care system, together with poor communication between health and social care – as well as between primary and secondary care – as significant barriers to improvement.

Some of the individual views expressed in response to this question in our survey were as follows:

“Better communication between secondary and primary care – I would not spend minutes at the end of a phone several times a day then.”

“I can’t understand why social care can’t get its act together. The major barrier appears to be money. But if social care was funded and operating properly, the savings in secondary care would significantly outweigh this investment.”

**Too many layers of management** – see page 7, ‘Reduce bureaucracy/streamline management’

Some of the individual views expressed in response to this question in our survey were as follows:

“Too much top down management.”

“...the health board had added more layers rather than take a step back to see where efficiency can be improved. This has slowed progress more and means any decisions take months or even years to push through.”

**Recruitment and retention challenges** – see page 2, ‘Recruitment and retention’

Some of the individual views expressed in response to this question in our survey were as follows:

“Recruiting staff to work in rural areas – need to promote these as areas of innovation and opportunity to develop careers.”

“Recruitment and retention. Making training attractive and providing a sensible work-life balance is key to improving these.”
“Understaffing leading to poor morale, staff sickness and worsening staff levels. Money across the board. Everyone is too stretched with their own workload to be able to help when patients fall through the gaps.”

**Insufficient patient education** – see page 9, ‘Better public/patient education and involvement’.

Some of the individual views expressed in response to this question in our survey were as follows:

“I do not advocate payment for appointments but patients should be aware of costs... Also should be made aware of costs of medicines.”

“Patient education and access to primary care. I hear repeatedly that patients can’t see their GPs and then inappropriately attend the Emergency Dept. because they feel that they need to see a Doctor.”

- **Thinking specifically about the systems in place or current ways of working in your area of work, what do you think could be improved?**

**Better communication** – see page 8, ‘Better communication’

Some of the individual views expressed in response to this question in our survey were as follows:

“Better and faster communication between hospitals and GPs and support services.”

“Hospitals don’t always communicate with GPs. CAMHS, CDAT are particularly bad. Mental health service provision is fragmented & difficult to navigate, v difficult to access for emergencies & far too slow at responding to routines.”

“Communication between primary and secondary care. Discharge letters are generally poor and lack information.”

**Reduce bureaucracy/streamline management** – see page 7, ‘Reduce bureaucracy/streamline management’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Devolve more decision-making to managers nearer the coal face. Local managers constantly have to refer upwards, taking the decision further away from the clinicians involved. The whole managerial tree is far and away too complex.”

“Ability to allow clinical staff to trial methods of improving care without being blocked or buried under a pile of red tape.”

**Better IT Systems** – see page 11, ‘Better IT systems’.

Some of the individual views expressed in response to this question in our survey were as follows:

“The IT – this is so archaic and slow and not acceptable in this age of IT advances.”

“IT and effective broadband, and using IT to make life easy not harder – amalgamating primary and community to reduce duplication, one virtual set of notes but using GP systems as we are already years ahead of anything offered in community and secondary care.”
“It is ridiculous (although UK-wide practice) that psychiatry and cancer services use separate computer systems to hospitals, meaning that when patients with cancer-related or psychiatric problems present to A&E, you are none the wiser until you find someone during the daytime that can give you that information. How can we treat patients holistically if we don’t share information between specialties?”

Management more visible at the frontline – It was noted that there could be benefit from managers within secondary care being more visible on wards as this could help them increase their understanding of service-related pressures faced by frontline staff. It could also help to ensure there is a broader focus on the quality of care that is provided, rather than a narrower focus that may be more concerned with simply meeting targets.

Some of the individual views expressed in response to this question in our survey were as follows:

“Managers seeing what is like to work on the ward and the pressures junior doctors face.”

“Strong visible senior leadership with clear message. Focus on quality of care, not on targets.”

Improve recruitment and retention – see page 2, ‘Recruitment and retention’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Neighbouring GP practices all struggling and unstable due to recruitment problems. Need more GPs desperately.”

“We need to employ more doctors (from overseas if needed) to plug the vast number of rota gaps. Health board are spending a lot of money on locum shifts covered by existing doctors, when employing an extra doctor is probably cheaper. On my rota 3.6 of 5 posts are filled, i.e. more than 1 vacancy every single week.”

“More consultant doctors need to be hired who are in specialist register of GMC before services become unsafe. Services need to be expanded after hiring more doctors as per needs of the patients and healthcare system.”

More time with patients – see page 8, ‘More time with patients’.

Some of the individual views expressed in response to this question in our survey were as follows:

“How is it possible to provide excellence in a 10 minute consultation?”

“More time to spend with patients. Healthcare has become more complex as technologies advance and the time talk and to explain is often lacking.”

“More flexibility for part time working and less pressure on filling rota gaps so that there is opportunity to learn as well as see and treat patients.”


Some of the individual views expressed in response to this question in our survey were as follows:

“There needs to be health professionals in schools working with families as keyworkers where health absences are identified (most absences will be found to relate to the issues which escalate into mental health problems later in life)... not just promoting the issues highlighted by Public
Health but also teaching self-care, appropriate illness behaviour, how to access the NHS appropriately.”

“I think the Welsh Government needs to address with the public a need to increase self care and self treat... I think public health campaigns/internet resources and a funded pharmacy minor illness scheme would take burdens off GP surgeries.”

**Improve social care** – see page 3, ‘Improve social care’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Funding to resource social care. There are never beds in the hospital because people who need recuperation, or convalescing, or permanent care package assessments, are waiting for funding or assessments.”

“There needs to be more provision of social care packages, which can be accessed quickly without delay for those patients that need them. There needs to be an increase in the capacity of residential and nursing homes available.”

- **What needs to happen to enable change?**

**Reduce bureaucracy/streamline management** – see page 7, ‘Reduce bureaucracy/streamline management’.

Some of the individual views expressed in response to this question in our survey were as follows:

“The biggest thing though in my book would be reduce NHS managers by 50 percent and spend that on frontline staff and direct clinical infrastructure.”

“More freedom to clusters, and also improved maturity of clusters over time.”

**Culture change** – see page 14, ‘Poor culture’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Recognition that ‘dialogue’ involves exchanging ideas in a climate of collegiality and mutual respect; there is no place for threats or recriminations.”

“Start focusing on the health and (mental) wellbeing of Drs and nurses and create a place where people enjoy being rather than the culture of fear and bulling.”

**Better communication** – see page 8, ‘Better communication’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Better communication. Q&A sessions between primary and secondary care on a quarterly basis would be a start.”

“Speaking directly to on the ground GPs to assess where services would be best placed and where log jams occur would lead to more productive working and reduce waiting times.”

“Greater understanding between primary and secondary care of demands.”
Improve community care – see page 5, ‘improve community and palliative care’.

Some of the individual views expressed in response to this question in our survey were as follows:

“A careful reorganisation of the assessment and rehabilitation units, centralising the medical staff in the acute hospital unit, who then refer to the community hospitals and the community rehabilitation teams for rehabilitation supervised by the therapy staff.”

“Funding for hospital step down units (outside of hospitals) which can focus rehabilitation and social care input and save the patient waiting in an acute hospital bed while these are being sorted.”

Honest debate – It was suggested that needs to be honest debate and dialogue with the public about the financial situation in the NHS. Part of this debate should relate to what the public can reasonably expect, as well as of the benefits of the prudent healthcare principles.

Some of the individual views expressed in response to this question in our survey were as follows:

“Turnaround in UK finances. Until this happens, greater honesty from the commissioners (WG) towards the public and LHBs about what they expect the money they put in will buy and what it won’t (and not just making up cost improvement targets out of thin air and expanding into new areas of service, e.g. adopting new NICE recommendations which have funding consequences at the same time).”

“Politicians must be more honest and must stop promising services then denying adequate resources to deliver these services.”

Better IT systems – see page 11, ‘Better IT systems’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Update and provide an adequate system with adequate training.”

“Digital transformation and innovation and investment into this.”

“Secondary care needs systems in place which work – delayed appointments/poor appointment systems are a cause of many ‘missed’ appointments.”

More investment – see page 4, ‘More investment’.

Some of the individual views expressed in response to this question in our survey were as follows:

“More investment (from general taxation as this is the most efficient way of supporting health care) in order to have more bodies on the ground so that more time can be spent dealing properly with patients’ needs the first time around.”

“More funding diverted into primary care to support and enable all the work that is done there. More social care funding.”

Improve recruitment and retention – see page 2, ‘Recruitment and retention’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Allow and encourage existing staff to stay and allow more who want to come from wherever they are qualified, i.e. free movement of populations.”
“More funding towards either recruiting more junior doctors or assistant nurse practitioners. The latter will be slightly more cost effective but will not be able to provide the care doctors can.”

“Promoting Wales as a place for career development and innovation.”

**Improve social care** – see page 3, ‘Improve social care’.

Some of the individual views expressed in response to this question in our survey were as follows:

“More investment in adult social care infrastructure – we have seen a care home closing in our area, and there are no carers available in the community.”

“Patients will continue to block beds until the system of social care is sorted out. First there needs to be a combined budget to prevent wrangling over who pays for what.”

**Better training** – Some respondents suggested that enhanced training could assist with attracting and retaining staff. It was also suggested there should be an exploration of ways in which medical training can be made more appealing as well as a focus on multi-professional training, and involving patients in training events.

Some of the individual views expressed in response to this question in our survey were as follows:

“Need to go back to the drawing board and help to bring the training of doctors back to being the best. Why can the South Africans and Canadians look after their junior staff while we just treat them as ward fodder?”

“Training days with delegates picked from across the disciplines of both primary and secondary care to maximise their understanding of each other’s challenges and pressures. Greater use of taster days to ensure more integrated understanding of how other departments work. Bring patients to the training days to achieve a more meaningful, 360 degrees approach and hence outcome.”

- **What would be the benefits in terms of improved outcomes?**

**Better morale** – Respondents pointed to the need for better morale, underpinned by the opportunity to feel more valued and face decreased workplace stress. It was recognised that this can lead to improved staff retention and decreased sickness absence. For patients, it was identified that increasing morale can also provide the potential for improved satisfaction and outcomes.

Some of the individual views expressed in response to this question in our survey were as follows:

“Happier doctors and nurses wanting to work together and prepared to go the extra mile because they are appreciated by their team and patients.”

“Better job satisfaction and reduced work stress among doctors would help retain juniors in the NHS. This would have a knock on effect in terms of improving patient care and experience among doctors.”

**More high quality care** – It was noted that improved outcomes could also lead to enhancements in the quality and safety of patient care, with improved continuity of care. This could lead to reduced morbidity and mortality, and increased patient satisfaction.
Some of the individual views expressed in response to this question in our survey were as follows:

“Quality would improve as would fairness, efficiency, accessibility and responsiveness.”

“More patients can be treated, more safety of patients can be expected, overloading of the healthcare system can be avoided and staff also can feel comfortable in treating patients. We can also gain confidence of patients again.”

A more effective and better planned system – Another potential benefit that was noted would be the establishment of a more efficient and effective system with less delays, shorter waiting times, more timely safe care, increased capacity and reduced hospital admissions. It was felt by many respondents that there is a need for improvements to the formal planning and organisation of healthcare delivery, with greater input from frontline clinicians.

It was further noted that there could be better patient flow, reduced lengths of stay, quicker discharges, fewer re-admissions and an improved interface between community and secondary care. In addition, there could also be less emphasis on institutional care and more care provided in the community, with Wales becoming a leader in new models of care.

Some of the individual views expressed in response to this question in our survey were as follows:

“Less time wasting and treatment delays... Patients would be provided with more timely care and fewer inappropriate hospital admissions.”

“Shorter hospital admissions, patients moved to appropriate wards sooner, patients seen sooner in assessment wards, ambulances able to offload quicker, shorter wait for ambulances”

“Freeing up hospital beds, Patients moving to a more appropriate and agreeable setting more quickly and simply.”

More empowerment of staff – Respondents suggested that staff could feel more empowered to drive changes, leading to better staff retention and improved overall care for patients.

Some of the individual views expressed in response to this question in our survey were as follows:

“Harnessing the enormous reserves of good will, work capacity, knowledge and skill which are already abundant within the existing NHS workforce.”

“More empowerment for staff to drive positive change. More appropriate solutions to problems from the people who deal with them day to day. Better and more effective overall care.”

What needs to change to ensure that co-production or co-design is routine in health and care services and that people are better able to stay healthy or manage their condition?

Improve public and clinical engagement in service design – The need for improved public engagement in service design was highlighted, as well as improved levels of engagement with frontline clinicians. Additionally, it was noted that there is a need to demonstrate to those providing feedback that their views are being taken seriously, and being appropriately acted on or taken into account.

Some of the individual views expressed in response to this question in our survey were as follows:

“Improved involvement of public in designing plans in first place.”

“Involvement from service users – listen to the patients.”
“Patient feedback needs to be taken seriously by medical staff, especially senior ones.”


Some of the individual views expressed in response to this question in our survey were as follows:

“A lot of public health campaigns, better education from young age.”

“Make these changes throughout Wales so all schools have the ‘run a mile each day’. all schools have better mental health support, teach about exam stress, teach mindfulness, teach about parenting etc.”

“Patient-doctor partnerships with patients taking some responsibility for maintaining their health.”

A more effective and better planned system – see page 21, ‘A more effective and better planned system’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Make it compulsory to have strategic plans and use co-production to create them.”

“Professionally led local integration supported by structural contractual change to enable us to fully realise the potential in the primary provider/user relationship. The most universal of these is that between doctor and patient.”

“Reduce the size of the units that are able to take autonomous decisions. In most [health boards/trusts] the size and scale that is being managed is too great to be efficient. I would reduce the size of each ‘business’ unit to a core unit focussed around a ‘lead’ consultant for each speciality and perhaps one manager.”

More investment – see page 4, ‘More investment’.

Some of the individual views expressed in response to this question in our survey were as follows:

“More hospital beds, more nursing homes, lesser number of managers, more auxiliary nurses in hospitals and in the community.”

“Properly funded social care availability in the community and nursing homes with particular emphasis on the elderly.”

“At present the current provision cannot adequately meet urgent and emergency demand so without proper long-term funding and the political will to ensure it is maintained very little will be achieved whatever success small local changes may bring about.”

Improve public health policy and legislation – Respondents said they recognised the need for particular macro-level public health interventions (e.g. through government policy) to address public health concerns and reduce the demand for services in the future.

Some of the individual views expressed in response to this question in our survey were as follows:

“Sugar tax.”
“National legislation – education in schools, control of advertising to children, legislation on fast/junk food. Minimum pricing alcohol.”

“Multi factorial as there needs to be legislation on certain things – sugar tax and education in schools, and even at health visitor level. This could alter peer influence on care and reduction of dental decay, diabetics and all that follow on.”

- Do you agree that the strategic direction of increasing primary, community and social care in local communities is the right approach to better meeting the needs of particular populations?

**General belief in the validity of the strategic direction** – A clear majority of those members who responded to the survey said they believed the proposed strategic direction of increasing care within local communities is the right approach, but a variety of reasons were given for why they perceive this to be the case.

Some of the individual views expressed in response to this question in our survey were as follows:

“*This is where the bottleneck that stifles productivity in acute care exists.*”

“*Need to stop patients needing to come into hospital, and when they have been treated need to get them out of hospital into a safe comfortable environment in the community. As the elderly population expands this will become increasingly important.*”

“A lot of referrals to hospital are inappropriate and unnecessary. Many social situations of ‘not coping at home’ could be dealt with in the community.”

**Better for patients** – Respondents also recognised that this approach can have a positive impact on patients themselves, as they may benefit from being able to remain within their home environment rather than being treated in hospital. It was recognised that being treated in the community, can have a positive impact on a patient’s quality of life.

Some of the individual views expressed in response to this question in our survey were as follows:

“*Home is where people live and want to be. Hospitals spread infection and people lose their independence and mobility. Most services can be delivered in the community.*”

“*Observation that for the majority of people, treatment and care in their own community is important to them and benefits their quality of life. More likely to result in continuity of care, which is also important to people*”

“*Because hospitals are fundamentally risky and expensive places and disabling to patients particularly the elderly.*”

**Cost efficiency** – Another benefit cited from following this approach, if handled correctly, is that it can be substantially more cost effective by reducing the need for costly hospital admissions.

Some of the individual views expressed in response to this question in our survey were as follows:

“*Found to be most cost effective model.*”

“*Because primary care is better value for money and saves hospital admissions.*”

“It is more cost effective. It is easier to access. Community resources can be better targeted to the needs of specific communities which vary hugely across my city of Cardiff.”
**Need for more investment to underpin the strategic direction** – In line with earlier comments about the general need for more investment in health and social care services, the particular need for greater levels of investment in primary, community and social care services was highlighted as being key to ensuring the proposed strategic direction can deliver.

Some of the individual views expressed in response to this question in our survey were as follows:

“Currently outpatient services, and care at home, is inadequate. In current state, the inpatient bed number is inadequate and cannot be further reduced until care in the community is at least on a par with what that person would receive in hospital.”

“More and more is being shifted from secondary to primary care without any increased work force, time or money to do it.”

“This is another con – everybody knows this is a wheeze to divert patients away from hospital with the temptation of more funds for community services. Beds will then close, and the funds will then be cut, leaving primary care services holding the baby with no back up plan at all. Result? Local primary care services get all the complaints and law suits, and local hospitals get off the hook! – sorted!!”

**To what extent should services and processes be standardised across Wales, to achieve the right balance between national level and local decision making and allow room for innovation?**

This is a question which did not solicit a uniform view from those who responded to the survey. More respondents expressed the view that services and processes should be standardised across Wales than those who gave a contrary view. However, it was also apparent that many do not see the issue as being clear-cut and believe there is a need for a balance to be struck. Whilst the overall benefit of driving up standards across Wales was acknowledged, concern was also raised that too much of a drive towards standardisation could stifle innovation, add to bureaucracy, and limit the ability of services to be able to respond effectively to differing needs in different localities.

The following themes therefore emerged from responses:

**Need for improved service quality and fairness** – The need to ensure that high quality standards are achieved right across Wales was cited, as well as the need for patients in different parts of Wales to feel they are being fairly treated.

Some of the individual views expressed in response to this question in our survey were as follows:

“Best practice must be spread out and delivered regardless of health board. Mediocrity is not acceptable.”

“Standardising processes would be a good idea so people throughout Wales get treated fairly.”

“I believe services and processes should be standardised as much as possible. Standardisation based on sound evidence-based principles should not exclude scope for innovation.”

**Needs vary across different localities** – Some respondents placed more emphasis on the need for services provided to be able to respond to differing needs in different areas. It was also noted that solutions which are right for some parts of Wales may not be right for other parts of the country.
Some of the individual views expressed in response to this question in our survey were as follows:

“Standardisation will not work in Wales as major differences across Wales. North Wales continually forgotten and as a result is poorer and patients are disadvantaged. Local decision MUST be taken into consideration and step away from the Cardiff model fits all.”

“Standardisation can only take place across a level playing field. Populations and needs vary dramatically. You need to assess need across areas.”

“Regions of Wales are extremely diverse and healthcare has evolved differently to accommodate this. Services and processes should be equitable but not necessarily the same.”

**Standardisation can inhibit effectiveness/innovation** – Some respondents expressed the view that services and processes should not be standardised because of concerns that doing so would, in the long-run, inhibit operational effectiveness and the capacity to innovate.

Some of the individual views expressed in response to this question in our survey were as follows:

“Less so – desire for national standardisation stifles innovative approaches and local initiatives”

“Standardisation is the opposite to co-production, so it has no place if NHS Wales wishes to survive. It results in inferior care, increased mortality and increased costs, i.e. the ideal way to kill off the NHS.”

“This would stifle innovation. Some degree of autonomy is essential.”

- **What do you understand by integration?**

The responses obtained highlighted the fact that integration, in terms of its application to health and social care services, is clearly something which can apply in different ways in different circumstances. Respondents did however recognise the benefits that can be derived from integration where it is used effectively. They noted that such benefits can include improved collaboration between different service providers; improved communications; the potential to break down barriers between different services, including between health and social care; increased efficiency; and improving funding arrangements.

It was also noted that current funding arrangements can, at times, be a barrier to being able to provide what may be best for a patient. This can include circumstances when patients may need to transition from health to social care, or vice versa, and budgetary concerns can take precedent over need. It was suggested that this is something that could be avoided if these services were provided from one integrated budget.

Some of the individual views expressed in response to this question in our survey were as follows:

“My understanding of integration is that policies and services from different areas of Wales would be brought together. It could also mean having different services working under the same roof or within a close distance, thus facilitating integration of services and improvement of the service for the end-user. This might also result in saving money on the physical set-ups of services and possibly also on administration.”

“That the total net budget is held by one authority, so paying more to get a patient out of hospital is ‘worth it’ as the same authority has to cover the cost of that hospital bed. More money spend in e.g. palliative care in nursing homes, free up beds within the hospital, saving money for the same organisation. Once community, social, and hospital are different pots, everyone will fight to protect their own pot at the expense of others spending more from their pot.”
“Funding healthcare and social care from the same pot, thereby forcing these two systems to cooperate with each other.”

- **What steps are needed to further integrate services?**

**Changes to organisation and planning of services/revised funding arrangements** – Key factors which could lead to services being further integrated were noted as including changes to the way services are organised, planned and funded. It was also noted, however, that the extent to which this might need to be done would depend on what services might be integrated. Whilst in some cases, it was recognised that this could involve decisions taken at local health board level, in other cases it could require decisions to be taken by the Welsh Government or changes to legislation. Some respondents pointed out that, in some cases, increased funding may also be required to drive forward integration.

Some of the individual views expressed in response to this question in our survey were as follows:

- “Health and social care budgets should be amalgamated.”

- “If primary care had more access to investigations then patients may be referred with many diagnoses already made. Secondary care could then treat relatively quickly rather than organising further tests and repeating others. Might improve morale and job satisfaction in primary care where they can actually practice medicine rather than just refer for further investigation.”

- “Combine social care, clinical care, mental health and physical therapies so that they are co-ordinated from one source.”

**Improve teamwork/collaborative working** – It was noted that integration may be achieved in some circumstances through improved team working or joint working through collaboration. This could also apply to initiatives being undertaken between different services or service providers, including those involving collaboration with service providers from outside of health and social care. Respondents also suggested that culture change may be required in some circumstances to reduce what they would perceive as resistance to change.

Some of the individual views expressed in response to this question in our survey were as follows:

- “GP surgeries should work more collaboratively.”

- “A dismantling of much of the silo based working that has arisen as the primary care team was dismantled over the past 5 years.”

- “Culture change, e.g. truly facilitate co-working between health, police, social services.”

**Reduce workload** – see page 12, ‘Reduce workload’.

Some of the individual views expressed in response to this question in our survey were as follows:

- “Everyone needs more time. As I have said already: each person has a full caseload and communication takes extra time.”

- “Time to discuss, meet, work out how to use skills available.”
More investment – see page 4, ‘More investment’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Money!!! Explain what advantages are and how going to work.”

“Respect for general practice, and the funds to practice good quality basic medicine.”

“More finances and more people on the ground.”

Better IT systems – see page 11, ‘Better IT systems’.

Some of the individual views expressed in response to this question in our survey were as follows:

“In my specialty, a robust information technology infrastructure and willingness by staff to accept and manage change.”

“Upgrade services especially IT services. All Wales portal for accessing documents, scans, bloods etc. would be invaluable.”

“Get a decent IT system for NHS Wales.”

• What do you understand by prudent health and social care?

Efficient use of resources – Many respondents identified a key element of the principle as being about the efficient use of available resources.

Some of the individual views expressed in response to this question in our survey were as follows:

“To provide the highest quality service permissible within a defined and often reducing resources.”

“Appropriate use of resources by patients and doctors.”

“Welsh Govt. catchphrase. Optimum and efficient use of resources.”

• What steps are needed to ensure the principles of prudent health and social care are embedded in routine practice?

Honesty about costs and service provision – Some respondents highlighted the need for an honest dialogue with patients about treatment and service provision.

Some of the individual views expressed in response to this question in our survey were as follows:

“Patients need to be told that treatments that don’t have an evidence base will not be provided.”

“There needs to be honesty that some things cannot be funded. This needs to be made clear by central government. Usually unpopular decisions are made to appear the responsibility of clinician.”

“More realism in discussions with patients/fewer ‘miracle cures’ and more concentration on likely outcomes.”

Some of the individual views expressed in response to this question in our survey were as follows:

“Education. Prompts. Different pathways. Longer consultations and fewer interventions. Self-management and the information to allow patients to do so.”

“You need to educate… and people need to get used to the word no.”

“Education, education, education and then massive change in attitude in the population and the medical profession – start early, e.g. schools, medical school etc.”

Review and improve clinical practice – In many cases, it was suggested that there may be a need to review and improve aspects of current clinical practice in order to ensure that they are underpinned by the principles of prudent healthcare.

Some of the individual views expressed in response to this question in our survey were as follows:

“Always striving for improvement; not accepting continuing with something just because it is tradition. Looking and striving for ways to improve.”

“The right care at the right time by the right professional.”

“Constantly remind health care practitioners of the need to avoid waste of resources by promoting healthy living, timely diagnosis of conditions and provision of cost-effective treatments when indicated.”

“Evidence-based practice: already embraced by the overwhelming majority of doctors and nurses. Similar high standards should be mandatory in service planning.”

Review and revise funding arrangement and priorities – Some respondents felt that the key issue was to review funding arrangements and funding priorities.

Some of the individual views expressed in response to this question in our survey were as follows:

“Stop wasting money on inappropriate information gathering.”

“Likely a need to spend to save – firefighting rather than working effectively tends to create difficulties”

• What actions are needed to ensure services have a sustainable workforce for the future that matches the strategic direction?

Investment in education and training – Respondents highlight the need for enhanced opportunities for medical education and training in Wales, backed up by appropriate investment.

Some of the individual views expressed in response to this question in our survey were as follows:

“Improvement in school system and university entrance so Wales produces more of its own workforce. Better future scanning in numbers. Think of needs of Generation Y so need to sell cities, lifestyle and access to rest of the world.”
“Further Investment is needed to increase medical school numbers in Wales together with increasing the numbers of doctors in general practice specialty training in Wales. Further financial support is required to attract young doctors to train and remain in Wales.”

Motivation and morale – Many respondents pointed to the need to better look after, and thus retain, the existing workforce.

Some of the individual views expressed in response to this question in our survey were as follows:

“There has been a change in the outlook of the younger members of staff since I qualified in medicine in 1988. For my era it is a vocation where you completed the work no matter what time you finished. Now it is just a job where you finish on time and collect your pay.”

“Making sure staff feel appreciated – this does not mean more money necessarily but actually listening to what we say and not dismissing us as irrelevant.”

“Be respectful to doctors and understand our needs. Understand our need to have breaks. Understand the need for us to be rewarded when we do tremendous hard work. Be appreciative”

More investment – see page 4, ‘More investment’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Increased funding, no further unjustified pension changes.”

“Good competitive levels of pay and good working conditions, succession planning, investment in recruitment and training.”

“Fair pay – especially for support workers. Value the workforce. Train the workforce. Foster personal development.”

Better strategic planning – As touched upon previously in relation to tackling recruitment and retention challenges, respondents identified a need for better strategic planning to underpin this. See page 2, ‘Recruitment and retention’.

Some of the individual views expressed in response to this question in our survey were as follows:

“Health needs are going to increase partly because we are living longer, and partly because medicine is getting sub specialised.”

“Proper succession planning.”

“Adequate training within a defined geographical area.”

• If the Welsh Government had to choose just ONE thing that it could do to improve health and social care services in Wales, should would that be?

This was one of two questions we posed in our survey to members in addition to those posed by the panel. A variety of responses were received, the most common of which were represented by the following themes:

• More investment
• Integrate health and social care
• New public health interventions/public education
• Improve recruitment and retention
• Improve pay and conditions
• Streamline management and reduce management intervention
• Revise funding arrangements
• Improve communication and engagement
• Improve social care
• Improve IT systems

• Thinking about your current role, what needs to be done to engage you more effectively as a clinician in the way services are delivered?

Acknowledgement, support and recognition – Many members reported a need to feel more supported. They also said they would like to see their contributions better recognised and acknowledged.

Some of the individual views expressed in response to this question in our survey were as follows:

“*I need to be acknowledged more for my acumen, there is no positive reinforcement process. Good work gets side lined. Nobody bothers for nobody.*”

“Less tired, more supported.”

Listening and acting on suggestions – Respondents highlighted need for frontline clinicians to be listened to, and for their suggestions to be acted upon.

Some of the individual views expressed in response to this question in our survey were as follows:

“*Being listened to would help.*”

“*Ask my opinion. Board members should come to the front line. I have never seen a member in theatres asking staff opinions.*”

“*Actually enact one change that I suggest or demonstrate that you have changed one of your own plans based on the concerns I raise.*”

More investment – see page 4, ‘More investment’.

Some of the individual views expressed in response to this question in our survey were as follows:

“*Provide my practice with better funding, so that we can help keep patients out of hospitals.*”

“*Pay me for the 2 sessions per week I currently do for free!*”

“*Paid time out of practice. Developing resources will take a large amount of time and clinicians have the grassroots knowledge to do this quickly and effectively. We need backfill payments to practices to employ locums (if we can find one!)*”

Reduce workload – see page 12, ‘Reduce workload’.

Some of the individual views expressed in response to this question in our survey were as follows:

“*Staff morale is generally low as they feel they are losing the battle with a never ending workload that is only increasing, with little support from the public or government.*”

“*N/A as now retired. I might have stayed on longer if the workload had been more manageable.*”
“I need time to do my work. My in-surgery workload is unsustainable.”

IN CONCLUSION

We hope that the findings from this survey prove useful to members of the review panel in terms of understanding some of the views and concerns of our members in relation to the specific questions they have asked in their call for evidence. This hopefully provides further useful input from BMA Cymru Wales that is additive to that which we have already provided through our earlier contributions. These include the feedback we provided during Ruth Hussey’s attendance at recent meetings of BMA Welsh Council and BMA Welsh Consultants Committee, the oral evidence we provided on 4 May 2017, and the written submission we provided on 12 May 2017.

When considering the findings from our survey, it is notable that some themes in particular came up multiple times in the responses that were received to the questions asked. These themes clearly represent areas which our members perceive as being important in relation to delivering improved health and social care services in Wales. (They do, however, need to be considered alongside those issues that we have already highlighted within our earlier written submission as the key issues which we identify for health and social care services in Wales.) These repeat themes include the need to pursue initiatives aimed at tackling recruitment and retention challenges (including through better valuing staff and reducing workload pressures to avoid burnout); the need for more investment in health and social care services; the need to reduce bureaucracy; the need to improve communications at different levels within the NHS in Wales; and the need to improve IT systems.