Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Cefnogi pobl sydd â chyflyrau cronig

This response was submitted to the Health and Social Care Committee consultation on supporting people with chronic conditions.

CC58: Ymateb gan: | Response from: Royal College of Physicians

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Consultation response

Senedd inquiry into supporting people with chronic conditions

May 2023

Royal College of Physicians

Coleg Brenhinol y Meddygon (Cymru)

Senedd inquiry into supporting people with chronic conditions

RCP Cymru Wales consultation response

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25 May 2023

Supporting people with chronic conditions

The Royal College of Physicians (RCP) welcomes the opportunity to submit evidence to the Senedd health and social care committee inquiry into supporting people with chronic conditions. We would like to especially thank the frailty team at Bronglais hospital in Aberystwyth for their invaluable input into this response.

We would be very happy to organise a focus group with RCP fellows and members (including consultant physicians, trainees, specialty and specialist doctors and physician associates) during the next evidence gathering stage of this Senedd committee inquiry.

From page 7 of this response, we have included a variety of case studies that demonstrate good practice in treating and managing chronic conditions, especially in the community. On pages 24–27, we have set out some examples of cross-sector working in action where projects across Wales are supporting those living with chronic conditions and helping to reduce health inequalities. Other papers the committee may want to consider include:

- Under pressure: Collaboration, innovation and new models of integrated care in Wales. RCP, April 2023.
- Driving change together: Establishing the new NHS Wales Executive with a collaborative approach. RCP, April 2023.
- Cancer care at the front door: the future of acute oncology in Wales. RCP, January 2023.
- Our call for a poverty action plan to fight health inequalities. RCP, December 2022.

For a full selection of our reports, case studies and publications, please visit the RCP website.

Background

Healthcare systems, medical education and research worldwide are traditionally designed to deliver care for individual diseases. However, more and more people are living with multiple chronic conditions. Existing health systems are often fragmented, siloed and too often, responsible for exacerbating existing inequalities in access to prevention, diagnostics, treatment, and long-term support for chronic conditions. The term may be over-used, but there is genuinely a postcode lottery for many patients in Wales.

> *People with diabetes are twice as likely to have depression, nine in ten dementia patients have another long-term condition, and half of people with a heart or lung condition have musculoskeletal disorders such as back pain.* – UK government

Almost half (46%) of adults in Wales are living with a longstanding illness, and a third (33%) are living with a limiting longstanding illness. Adults in the most deprived areas of Wales are more likely to report longstanding illness / limiting longstanding illness.

This puts huge pressure on the Welsh NHS, social services and the third sector: for years we have been talking about shifting resource from treating disease to preventing disease, but so far, change has happened too slowly. During this inquiry, we would like the Senedd committee to consider cross-cutting themes including:

- The impact of chronic conditions on **mental health** and wellbeing.
- The health and care **workforce** (recruitment, retention, skills and new ways of working).
- The role of the **NHS Wales Executive** and the new strategic clinical networks.
- The impact of chronic conditions on widening **health inequalities**.
- The need for effective **third sector** involvement as design and delivery partners.
- The importance of building trust with **hard-to-reach groups** through co-production.
- The need for better **evidence and data**-driven decision making.
- The importance of **targeted intervention** to improve quality of access and outcomes.
- The role of collaboration, partnership working, **patient education** and signposting.

Ultimately, services should be designed around the patient, not their chronic condition.

We therefore welcome this inquiry into supporting people with chronic conditions and we ask the committee to consider the following key themes and issues.

Key themes and issues

NHS and social care services

The readiness of local NHS and social care services to treat people with chronic conditions within the community.

- **Integrated** (joined up) models of care, with hospital admission avoidance as default.
- **Workforce** planning to match patient demand.
- **Data** collection and analysis.
- **Communication** between professional groups and with the patient.
- **Prevention** of ill health through targeted interventions.
- **Training**, education and support for community-based professionals.

Example recommendations

- Ensure the new NHS Wales Executive and strategic clinical network avoid falling into condition-specific areas and silo working; develop cross-network approach from the off.
- Improve integrated working and communication between social services and acute care.
- Ensure effective joint working between primary, community and hospital care clinicians.
- Develop co-located services and teams which encourage closer working.
- Invest in early social worker/primary care intervention (hospital admission avoidance).
- Take a home first approach where possible; keep people at home for as long as possible.
- Develop delirium management protocols in the community.
- Invest in day centre care which supports informal/family carers at home for longer.
- Recruit more clinical nurse specialists to work in the community.
- Invest in anaemia services.
- Develop a consistent approach to effective advance care planning for people living in residential and nursing homes. This would prevent unnecessary admissions.
- Develop a clearer framework for proactive progression planning for people needing to move from residential to nursing placements.
- Ensure equity of provision of community services, avoiding a postcode lottery.
- Ensure that residential/nursing places especially for people living with dementia are mapped to projections of need.
- Develop structured career pathways and progression for carers in the community. This should include high quality training across both the public and private sectors.
- Invest in training, education and support for carers in the community (who should be treated with the same importance as those working in a hospital setting), district nurses, and informal carers.

Access to essential services and ongoing treatment, and any barriers faced by certain groups, including women, people from ethnic minority backgrounds and disabled people.

- **Rural** and remote access, including transport issues.
- **Digital** health, technology and IT, including connectivity issues.
- **Language** barriers, especially Welsh provision of healthcare.
- **Sensory** or cognitive impairment, especially in older people or those with ALN.

Example recommendations

- Consider the accessibility and relevance of patient self-management programmes for some groups, including people living with cognitive impairment.
- Recognise there may be barriers due to sensory impairment or language preference (including Welsh).
- Address digital health inequalities caused by a lack of technology expertise/equipment.
- Recognise that people living with cognitive impairments or those with challenging behaviour are often poorly served by community services and hospital can end up being the default option, despite being the wrong setting for care in many cases.

> *'Trust – whether building it, rebuilding it, or sustaining it – is vital, particularly as we strive to improve access to health services for people in our most underserved communities. [One workshop participant] told us that she had received a bowel cancer screening kit in the post and thrown it out, unsure what to do with it or why it was important. After our workshop, with information delivered from a trusted source, in a safe environment, she was ready to order a new kit for herself and share this with members of the community too. This is the difference between equality and equity. We are technically giving people the same access to services (equality), in this case by posting everyone a home bowel cancer screening kit. But differential levels of trust, knowledge and confidence in healthcare prevent people from taking those services up. Focusing on these gaps through authentic partnership in health education and literacy will enable eventual equity of access to NHS services.'* – Abeyratne and Amer-Sharif, 2023

Support available to enable effective self-management where appropriate, including mental health support.

- The role of the **third sector** in both the design *and* delivery of services.

Example recommendations

- Consider how 111 could contribute to the frailty/chronic conditions pathway.
- Consider how older people could be supported to live well in the community through student volunteer schemes, schools programmes, be-friending schemes.

Multiple conditions

The ability of NHS and social care providers to respond to individuals with multimorbidity rather than focusing on single conditions in isolation.

- **Information** (eg patient held records, patient information and empowerment)
- **Communication** systems (joined up software, functioning hardware, data)

Example recommendations

- Develop and roll out comprehensive geriatric assessment, frailty standards and guidelines nationally.
- Introduce a patient-held booklet akin to the 'red book' in paediatrics.
- Accept acute care professionals as trusted assessors for social services assessments.
- Streamline referral processes eg develop a once-for-all referral form.

- Improve advance care planning in nursing homes. Have the conversation earlier.
- Raise awareness around power of attorney arrangements and capacity assessments.

The interaction between mental health conditions and long-term physical health conditions.

- Improve the sharing of information and joint working arrangements.
- Recognise that mental health conditions are poorly recognised/managed which often leads to unnecessary hospital admissions.

Impact of additional factors

The extent to which services will have the capacity to meet future demand with an ageing population.

- **Workforce** planning, training, skills and professional development.

Example recommendations

- Plan the workforce against forecasted patient demand, especially in older people.
- Recognise the risk associated with having fewer people both in work and available to provide informal care.
- Improve working conditions for those working in care to increase the workforce.
- Consider how people who leave work to care for relatives can be supported financially.

Prevention and lifestyle

Action to improve prevention and early intervention (to stop people's health and wellbeing deteriorating).

- **Community** investment in staff and MDT approaches.
- Shift in resources **away from hospital** sites.
- **Targeted support** and early intervention.

Example recommendations

- Improve multidisciplinary team working in the community (see Borth integrated care).
- Invest in more frailty nurses, especially in the community
- Take proactive steps to educate younger adults on the importance of aging well.
- Raise awareness of power of attorney and best interests – (Links with advanced care planning) and understanding of capacity assessments.
- Take a proactive approach to social prescribing (see Cwm Taf Morgannwg service).

Effectiveness of current measures to tackle lifestyle/behavioural factors (obesity, smoking etc); and to address inequalities and barriers faced by certain groups.

- Invest in community exercise and healthy eating programmes.
- Build on the success of the national exercise referral scheme; develop and invest in local authority and third sector services, eg Red Cross support schemes.

Case study 1: Intermediate care in Carmarthenshire

'People want to come and work where they are empowered to innovate'

We call ourselves the cavalry in the community. We are an intermediate care team, with a GP, advanced nurse practitioners, physician associates, therapists, social workers, the third sector and Delta Wellbeing, which is a local authority trading company, wholly owned by Carmarthenshire County Council. Our sole purpose is to help patients get home, which might mean admission prevention or speedier discharge.

Across Carmarthenshire, our three community resource teams and intermediate care hub provide a range of health and care services particularly for older, frail and vulnerable people. The model takes a multi-agency approach including more seamless working between health and social care, along with other agencies and the 3rd sector working together in each locality. The priority is on prevention and early intervention. For patients with chronic conditions or who need end-of-life care, people can access community hubs for a range of assessments, advice, support and treatments, or the team can go out to visit people in their homes.

We are a Carmarthenshire service which means that Hywel Dda patients in Ceredigion or Pembrokeshire don't have access to these services. We try to work across local authority boundaries to standardise pathways and ways of working, but that's a work in progress.

We're the only place in Wales working like this. As an intermediate care team, we work across four pillars of care: reablement (helping the patient to become independent again), crisis response (when a patient in the community could be intercepted before arriving at the hospital front door), home based (when a patient needs a bit of extra support) and bed based (when a patient doesn't need an acute hospital bed, but isn't well enough to go home). The key thing is that there's a single access point, a one-stop shop where we are all co-located and able to flex our response based on patient need.

We were contacted when the hospital was in black alert and asked to do whatever we could to get people out of hospital. We can no longer work in silos: we need to work together, be in the same place so we can avoid scrambling around the same group of patients. If we're all working to different referral lists, we spread our energies and resources very thinly. So, we centralised all of the referrals for discharge, and we aim to turn people around in 72 hours. We're hitting that target in about 86% of cases. There's a lot of joint working and shared learning. We blur professional boundaries and ask how we could work differently within our competencies. Ultimately, it's about the discharge to assess model: if we can evaluate a person in their home environment, we can make the best decisions with them about their care. Because we are a multi-agency team, we can move the patient easily between the four pillars of care, depending on how they improve or deteriorate from day to day.

We work closely with the acute frailty team in the hospital to prevent admissions. And we've recently begun an ambulance pilot: one of our paramedics, based in our office, will pick patients off the 999 stack, ring them, make a clinical assessment and decide whether our crisis response team would be a more appropriate intervention. Perhaps they need some extra equipment – then we send in a therapist straight away. It's fantastic. We're making a big impact: of the 640 patients we've triaged in the past 3 months, we prevented 65% of them from coming to the hospital. Where we can keep a patient at home, we can send the ambulance to more serious medical emergencies. It's magic.

The co-location of services in an open plan office means that our paramedics can talk to our physiotherapists when an ambulance call comes in – they can avoid unnecessary interventions. If we weren't in the same space, those ad-hoc conversations wouldn't necessarily happen.

Unfortunately, we can't support the patients who are waiting for long-term care packages at present. That's the real challenge: if we can't solve the problem of social care capacity, patient flow through our service becomes blocked. Our vision is that all patients should be discharged home to assess, so that we can better support the patient in their own home.

The funding is all temporary too; we're asking the health board to recruit members of staff with regional integration fund monies, but that puts the organisation at financial risk in the long term. We work Monday to Friday, 8am–5pm, but everyone puts in extra unpaid hours, staying late, dropping equipment on their way home… We'd like to extend our hours. In an ideal world, we'd run a 24/7 service.

There's an appetite among health and care professionals to work in intermediate care. We have no problems recruiting. It's exciting; people want to come and work where they are empowered to innovate. We know that there are growing health inequalities, and access to healthcare services can differ depending on which day of the week you get ill. It's uncomfortable for us.

There's a lot of educating others and raising awareness that we can do in the acute setting. We go into the hospital to sit with our colleagues and go through their caseloads with them, trying to get people home that day. Often, if you don't work in the community, you don't know what's out there. You might think that there's only one solution – social worker referral. But it doesn't have to be statutory services all the time. We want to empower our acute colleagues to think differently and trust in community care again.

Basically, we decided to think differently, to combine forces and make change. There's nervousness in the team about the winter to come, but definitely a sense that we're stronger together. If we're pooling our resources, we're working smarter and better together. We want to be close to the hospital and to our community resource teams by upskilling our staff and sharing knowledge. We're hoping to bridge the gap between acute and community care and break down those walls. It's the right thing to do for the patient and for the health and care system.

Indeg Jameson
Carmarthenshire community lead for physiotherapy

Dr Sioned Richards
GP lead, Carmarthenshire intermediate care
Hywel Dda University Health Board

This case study is taken from ***Thinking outside the box*** *(RCP, 2022).*

Case study 2: A patient passport in app form

'When you're a patient who repeatedly arrives in the emergency department with the same kind of crisis, you usually know what needs to be done'

I'm a congenital heart patient who receives most of my planned specialist care in England, but any emergency care in north Wales. I had three open heart surgeries as a child, and several cardiac ablations since. After one very complicated ablation in 2018, I was transferred to ICU, intubated and monitored for five days. I can't quite piece together all the events, but I do remember waking up, very briefly, to a large group of medics around my bed. I don't know how but I managed to communicate that I had previously suffered endocarditis and septic shock and that they need to give me benzylpenicillin. Within minutes I was asleep again due to the anaesthetic medication I was prescribed. A few days later, I was certain the PICC line was brewing an infection. The first nurse I spoke to didn't take me too seriously, but I didn't give up, and persuaded an anaesthetist to replace the line for me. I really had to advocate hard that time.

I know my body; I know my condition. When you're a patient who repeatedly arrives in the emergency department with the same kind of crisis, you usually know what needs to be done. Of course, there are pathways, and people must be triaged, but only once in two years can I remember someone saying, 'let's cut out the unnecessary conversations and call in a cardiologist.' Sometimes it feels like there's a real lack of decision-making or initiative; as experienced as clinicians are in smaller hospitals, they don't often see very complex patients or people living with a rare disease.

Lowri Smith
Patient advocate

'Our app would enable the most complex patients to share accurate up-to-date information easily and quickly with clinicians at the front door'

The aim of our Bevan Exemplar project is to design a patient passport in app form, with relevant information about particularly complex patients and their conditions. Information could be uploaded by the patient themselves and by their clinical team or anyone involved in their care. It would be particularly useful for patients who travel between different organisations for their care.

We're still so dependent on paper notes. Even within the health board it can take time to get the notes around previous admissions and discharge letters when a patient is admitted to hospital. The idea is that patients would carry this information wherever they go; they could send the information to other teams via email so that anyone could access the files.

There's not much out there that's similar. We only found 12 studies into patient passports or patient owned health records or patient owned care since 2000. And they weren't particularly relevant – a lot of them were intended as patient information guides, and very few were patient-specific. There was one paediatric asthma study from New York, but it was very small. On the whole, the results were positive, but it was criticised for being on paper, which stresses the importance of this being an app. In an emergency people could easily forget a folder, but they're unlikely to forget their phone. We did find out recently that the personal child health record (or 'red book') is now available as an app in London, which makes a lot of sense.

Our app would enable the most complex patients to share accurate up-to-date information easily and quickly with clinicians at the front door, giving a detailed medical history, condition-specific advice and contact details for their specialist team, as well as reassuring the treating doctor that it's completely fine to ring the specialist team for advice.

Dr Katie Ward
Internal medicine trainee
Betsi Cadwaladr University Health Board

*This case study is taken from **Positives from the pandemic** (RCP, 2022).*

Case study 3: Community medicine in Torfaen

‘I cannot emphasise enough the importance of continuous support and investment’

Our team consists of a consultant geriatrician, specialty doctor, a geriatric trainee registrar and specialist nurses who administer IV treatments, independently review patients, and undertake comprehensive geriatric assessments. Torfaen CRT provides medical care to patients at home, and can administer blood or iron infusions, historically considered secondary care interventions. Additionally, we hold community hospital beds to facilitate direct admission and completely bypass unnecessary acute admissions for frail patients.

We saw a reduction in referral rates at the start of the pandemic in comparison with previous years. However, once the rate of hospital-acquired COVID cases began to rise, CRT referrals gradually increased. Complex and acutely unwell patients who were not suitable for community-based care would refuse hospital admission, as visits from their loved ones were prohibited. We cared for many of our frail patients with COVID-19 in the community and provided information to patients and their relatives to increase their understanding of COVID-19 and its treatment, including intravenous fluids, oral or intravenous antibiotics, and oral steroids. Some patients were assessed and started on home oxygen.

The outcomes of patients with COVID-19 infection, managed in the community under our team, have recently been published. Social and healthcare teams working together, a framework to structure a multidisciplinary approach and an attitude to change our ways of working will be key for better outcomes in future.

I cannot emphasise enough the importance of continuous support and investment. We face so many barriers when we seek extra funding, yet with even limited resources we are still expected to produce significant patient outcomes. Because we are a multidisciplinary team, the money needs to be fairly distributed across health and social care.

Dr Priya Fernando
Consultant in geriatric medicine
Torfaen Community Resource Team
Aneurin Bevan University Health Board

This case study is taken from ***No place like home*** *(RCP, 2022).*

The full version of this article first appeared in the RCP’s membership magazine, Commentary, in September 2021 and can be accessed online.

Case study 4: Acute care in Neath Port Talbot

'The solution to unscheduled care pressures lies in the community'

The Neath Port Talbot Acute Clinical Team (ACT) aims to improve patient care, prevent avoidable hospital admissions, and expedite discharge from acute hospitals. The team is part of the community resource team (CRT) and works closely with GPs and other health and social care professionals to manage a case load of complex and often acutely unwell patients using a comprehensive geriatric assessment (CGA) model. The service was set up in 2005 and serves a population of about 150,000. We interviewed Dr Adenwalla during the winter of 2020–21.

The team is nurse practitioner-led and operates 7 days a week until 10pm. A consultant geriatrician holds clinical responsibility for patients on the case load with support from a colleague 1 day a week. We accept referrals from all health professionals from primary and secondary care and aim to see patients the day they are referred, including weekends. We accept direct referrals from paramedics and have undertaken a successful pilot with the Welsh Ambulance Services NHS Trust (WAST), which enabled us to have direct access to the ambulance stack. This has led to the team undergoing training delivered by WAST in the use of the Physician Triage Assessment and Streaming Service (PTAS).

Our caseload is around 30 patients on any given day. We see about 1,200 new patients every year. The team always goes the extra mile, which is the only way to keep the service going and to meet the increasing demand in the community. During the second wave of the pandemic, the team worked with district nurses, long-term care teams, GPs and volunteers to look after patients in several care homes where the majority of the residents were infected with COVID-19. During this time, we provided specific medical treatments that included oxygen, IV antibiotics and fluids, anticoagulation, steroids, and end-of-life care. This prevented a significant number of inappropriate hospital admissions and provided better care for our patients.

Hospitals are firefighting. We have no long-term solution to look after our ageing population, and pressures that once caused a winter crisis have become a year-round problem. We need a national approach to care for our frail, older people – not a sticking plaster exercise that is carried out every winter. The impression seems to be that the answer to unscheduled care is about managing the front door of the hospital and the discharge process. I strongly feel that the solution to unscheduled care pressures lies in the community.

Most of the frail older population is in the community, especially in our care homes. GPs need support from secondary care specialists and the wider multidisciplinary team to provide the right care to the right person at the right time – but to do this, hospital at home teams need to be adequately resourced. Care home medicine is not simple; it's actually very complex. If our services were scaled up across our health board, we could look after 100–120 patients in the community. That would be equivalent to four or five medical inpatient wards and would have a significant impact on unscheduled care. The Welsh government need to make this a priority. It's very frustrating because there's so much rhetoric around improving care in the community, but the resource does not seem to follow.

A year later, we interviewed Dr Adenwalla again.

Our team had a very difficult time both emotionally and physically during the second wave of COVID-19. Care homes and our communities were badly affected. At one point, we were told that staff would be co-opted into working at the field hospital. We were rushed off our feet and, in the end, we were so busy in the community that moving us to the field hospital would have resulted in a large number of hospital admissions. In some ways, the experience has strengthened the team and reinforced the bonds between us.

Once we have completed our training in PTAS, we hope to gain access to the ambulance stack. This will enable us to take appropriate patients off the stack and prevent a paramedic visit and an admission. But it will take addition resource to undertake this in a consistent manner, while also completing the rest of our work. Virtual wards are being set up in all our GP clusters and, once established, will be able to provide comprehensive multidisciplinary care to the frail older population and to those with chronic disease.

Dr Firdaus Adenwalla, consultant geriatrician
Mrs Annette Davies, lead advanced nurse practitioner
Neath Port Talbot Acute Clinical Team
Swansea Bay University Health Board

This case study is taken from ***No place like home*** *(RCP, 2022).*

Case study 5: Avoiding admission in Bridgend

'People shouldn't be admitted to hospital simply because there is no alternative'

The Bridgend Acute Clinical Team (ACT) offers acute medical support and interventions for patients who are clinically stable enough to be treated at home. The ACT also supports older people with frailty who require urgent comprehensive geriatric assessment (CGA), multidisciplinary support or crisis intervention at home. The aim is to improve patient care and avoid hospital admission where possible. Referrals are accepted 365 days a year. We interviewed Thomas during the winter of 2020–21.

Our clinical practitioners and nurses can organise IV antibiotics, fluid replacement, undertake regular observations and diagnostic tests at home. This can speed up the hospital discharge process or avoid an admission altogether. If a patient deteriorates at home, the ACT can talk through the options and help them decide whether going into hospital is the right choice. An early referral from a GP means we can go out to people's homes and assess their needs before they reach crisis point.

Our consultant physicians are with us every morning under normal circumstances, and we'll do a 'virtual' ward round. If we need them to go out and see patients, they'll come with us. This was interrupted by the pandemic because the consultants were working on COVID-19 wards. We used technology to do our virtual ward rounds with them, but it was difficult. For some people in crisis, remote consultation doesn't work very well. They're often frail, perhaps with hearing impairments. It's important that we get out to see those patients in person.

Our service has proved extremely resilient. We had a major dip in activity during the first wave because we weren't receiving as many referrals. We kept ourselves busy by supporting district nurses and organising PPE for community services. We swabbed a lot of patients in the community for COVID-19 before a dedicated team was set up. But we are now as busy as we were before the pandemic.

We've worked very hard to build our relationships, particularly with GPs. We are also very well-integrated with health and social care; some staff in the team are employed by the health board, while others are employed by the local authority. Others are employed by the health board but funded by the local authority. The organisations locally have worked very closely together. It is more than co-location; it works well because everyone is engaged and signed up to it. I've been very lucky with the leadership that we've got here. We're also very good at supporting our staff and helping them to reflect on their practice.

Our data collection is excellent. We can prove that we're making a real difference: the ACT is estimated to avoid around 3,800 hospital bed days each year. People shouldn't be admitted to hospital simply because there is no alternative. We need more people on the ground – staff who can assess patients and make clinical decisions in the community. Ultimately, there is no other way of getting around it: if we're going to do more work, then we need more staff.

A year later, we interviewed Thomas again.

Last winter was very, very challenging. At one point, most of the team was off sick or isolating. I worked 3 weeks of long days over Christmas to keep our existing caseload ticking over. We made a lot of sacrifices. The service didn't collapse, and we didn't send anyone into hospital, but we certainly couldn't take on any new patients.

By February 2021, the unmet need was beginning to kick in again and we were hit with a secondary wave of all those people who had been getting quietly unwell at home. Some of our staff were suffering with fatigue, and were struggling to concentrate.

We've been asked to do extra work this winter: new facilities, new pathways. We've agreed to take it on, but the reality is that we don't have any more resources to do this. It's frustrating because we're doing very good-quality work. But when we're busy, our lead time increases, and it can take us up to a week to respond to an urgent case. Our colleagues are generally understanding, but we worry that people will start to lose the faith and stop referring to us.

When our staff numbers are low, hospital admissions rise. I feel like I'm fighting to maintain the service when we should be growing the team, which is frustrating. Hospital services continue to be the rich relation when it comes to prioritising resources.

Our winter plans are fragile. We're tired and under pressure. We need more staff, but when we recruit, we simply take from other existing teams, so it's robbing Peter to pay Paul. We need to train more doctors and nurses. It's only going to get worse.

Thomas Barton, lead advanced nurse practitioner
Acute Clinical Team, Bridgend Community Resource Team
Cwm Taf Morgannwg University Health Board

*This case study is taken from **No place like home** (RCP, 2022).*

Case study 6: The junior doctor perspective

‘Working in community medicine teaches pragmatic decision-making and improves patient-centred care’

At the time of writing, Dr Richard Gilpin was a specialist registrar in geriatric and general medicine in Cardiff and Vale University Health Board. When the pandemic began, he was working in a community resource team in south-east Wales.

Like most geriatric trainees, I completed a 6-month rotation with a community team. Mine was a unique experience, starting in February 2020 at the start of the pandemic. As a doctor who has always worked within the four walls of a hospital, two aspects of my new role struck me immediately. Firstly, the tests and advice you are used to aren’t immediately available – the idea of ‘quickly adding on a blood test’ is impossible. Secondly, we were very conspicuous. Passers-by would take photographs of us in full PPE entering a patient’s house at the start of the pandemic. The role teaches you to rely on clinical acumen, pragmatic decision-making and patient-centred care.

I certainly dealt with a greater number of critically unwell patients than the team would usually manage because of the pandemic. Many patients and families were scared that hospitalisation would result in harm from COVID-19 – which was a real possibility at the time. When a frail patient is admitted via the emergency department, we ask a list of questions about their function and social circumstances. The doctor will end up with a superficial idea of how the patient is at home, with the understandable errors and omissions. It is impossible to deliver the care we would wish to deliver when the patient is in a hospital gown and on a hospital trolley at 2am.

However, you can instantly understand a patient’s lifestyle when you are in their home. We saw one patient following two admissions with diarrhoea and a normal CT scan and colonoscopy. Her symptoms would improve in hospital and she would be discharged. Her fridge had out-of-date and rotting food in it, and we fixed her diarrhoea by sorting out her meals. For many patients, a comprehensive review in the community would have been the only way to truly understand the underlying issues.

Strangely, although I expected to feel isolated, this was far from the reality. Managing a caseload of up to 30 patients via a ‘virtual ward’ required regular and detailed conversation through morning board rounds, afternoon catch-ups and close liaison throughout the day. Although I am indebted to the senior doctors for their guidance and support, I learned most from the dedicated and enthusiastic nurse practitioners, who brought together their experience and clinical knowledge with clear, pragmatic decision-making.

A successful community resource team relies on several factors: the right staff, rapid access to the right diagnostics and interventions, and the right education and training.

Dr Richard Gilpin
Specialist registrar in geriatric and general medicine
(Now a consultant physician)

This case study is taken from ***No place like home*** *(RCP, 2022).*

Case study 7: Multidisciplinary working in north Wales

'The crucial thing is building those relationships, especially with social care'

The North Denbighshire Enhanced Care Service (ECS) works with GP practices to deliver enhanced care to a population of around 59,000 in north Wales. The multidisciplinary, multi-agency team provides 'step-up' (patients admitted to ECS by GPs) and 'step-down' (patients discharged early from acute and community hospitals) care to individuals with increased medical needs in their own homes.

Ours was the first service of its kind in north Wales. The team is made up of nurse practitioners, a physiotherapist, an occupational therapist, a social worker and healthcare support workers, supported by an administrator. We sit in the community resource team: patients remain under the care of their GP, and a consultant geriatrician from Ysbyty Glan Clwyd is directly available for advice and to assess patients at home when required.

It's a very broad, multidisciplinary, multi-agency team that treats around 285 patients a year, 95% of whom are stepped-up to prevent hospital admission. We estimate that this saves more than 3,000 acute hospital bed days annually. The team meets virtually now; remote working has allowed more people from across health, social care and the third sector to be involved, which is great. We consider ourselves a 'virtual ward'. Patients are at home, but we can request urgent diagnostics: CT scans, ultrasounds, blood tests and so on. We can also pull in expertise from other specialties, including respiratory medicine, psychiatry and palliative care. The whole team works well – we get things done. The crucial thing is building those relationships, especially with social care.

Unfortunately, due to the pandemic, our social care colleagues are all working from home. We miss the day-to-day interaction with social care – it can be very frustrating. Many of us have looked at our working practice and considered how to use our time and resources more efficiently. As clinicians, we've quickly learned how to make clinical judgements based on virtual technology. It was a steep learning curve.

Initially we struggled to access PPE and community testing for COVID-19. The emphasis was very much on the acute hospital setting. It took a long time for people to realise that patients on the virtual ward should have the same access to tests as inpatients. Now we have COVID-19 patients receiving step-down care following discharge from hospital. It has been challenging, but the healthcare staff who go into people's homes have done an incredibly brave job.

Our therapy teams have been under-staffed in the community for some time. We're covering a big geographical area and we can't give patients the intensive service they would receive if they were in a hospital. Despite all the challenges, the team still provides remarkable care. We won a health board achievement award in 2016 for quality in primary care, and we get so much positive feedback from patients and families. We're a close team – we really do support each other.

A year later, we interviewed Dr Chatterjee again.

The North Denbighshire ECS is as busy as ever. We are doing our best to accommodate ‘step-up’ patients from GPs to avoid hospital emergency department attendance. At the same time, we are ‘pulling’ patients from the acute inpatient wards to create space at Ysbyty Glan Clwyd, which is under relentless pressure.

The number of people at our virtual rounds has increased – some of us meet face-to-face in the ‘hub’ with the others joining virtually including a pharmacist from a large GP practice. We have had more social services colleagues contributing to the discussions, though there have been immense challenges in obtaining timely care packages due to workforce gaps in the care sector. Our South Denbighshire ECS colleagues now also join us to access consultant geriatrician advice on the complex cases.

Given the rising prevalence of frailty and complex co-morbidities in an ageing population in our patch, prompt access to diagnostic, therapeutic, rehabilitative and palliative interventions at the patient’s home is likely to be the way forward to reduce demand in hospital, while at the same time offering better patient experience in a clinically safe and effective manner.

Dr Indrajit Chatterjee (Chattopadhyay), consultant physician
Nicola Bone, physiotherapist
Sarah Wickerson, occupational therapist
Phil Rathbone, advanced nurse practitioner
North Denbighshire Enhanced Care Service
Betsi Cadwaladr University Health Board

This case study is taken from ***No place like home*** *(RCP, 2022).*

Case study 8: Bone health in Caerphilly

‘Without seeing patients face-to-face, it’s difficult to know the impact of their illness’

The Caerphilly Falls and Bone Health Service was established in 2012. The team runs face-to-face clinics at Ysbyty Ystrad Fawr and in the community, a multidisciplinary falls service through the local community resource team and a virtual bone health clinic for the wider area.

We’ve been running virtual bone health clinics since 2018. We’ve improved the way we treat patients with a higher risk of fractures, such as those with Parkinson’s disease and osteoporosis, and we’ve worked with GPs to identify at-risk patients at an earlier stage. We won an NHS Wales Award for demonstrating significant service improvement and promoting clinical research, and since 2016 we’ve worked with the Royal Osteoporosis Society (ROS) to develop new initiatives, improve patient communications, and deliver staff training.

Along with the district nursing team, GP surgeries and the community resource team, we aim to provide seamless care between the hospital and the community. We review shared care plans annually for those on specialist treatment to support our colleagues in primary care. When we receive a referral, we always write back to the GP to acknowledge their letter and outline our plan of action. Administrative support is crucial, as this is how we make sure the service is patient centred. It is vital that we communicate key messages about osteoporosis to people without overwhelming them with too much information.

I won’t say that COVID-19 hasn’t affected us, but we were running virtual bone health clinics and telephone appointments long before the pandemic. In response to COVID-19, we increased the number of our telephone clinics every week and completed over 500 consultations. We have also proactively reached out to GPs to offer remote support in managing bone health in the community to reduce unnecessary hospital admissions.

Having these services in place has really helped during the pandemic. We started out simply wanting to improve patient care, but when COVID-19 came along we felt lucky that we were well-prepared. It’s still a struggle, though. Without seeing patients face to face, it’s difficult to know the psychological impact of their illness. It’s hard to assess their loneliness, their fear and their cognitive function. We can’t do that on the phone, and we’re going to see the impact of COVID-19 on other services sooner rather than later.

There are things we could change. We still don’t have a good enough relationship with our local authorities, and I’d like to improve our communication with them. There is no network of intermediate care services in Wales; there’s not enough shared learning between health boards.

In the future, we’d like to provide more specialist support to our colleagues in primary care by running clinics in GP surgeries. We’d also like to develop our virtual bone health clinics so that families and carers can become more involved. Finally, we would like a falls and bone health specialist nurse. A senior nurse would provide a strategic lead for the service, as well as improving patient communication and data gathering.

A year later, we interviewed Dr Singh again.

In the past year, we have appointed two specialist nurses. We've also expanded our virtual bone health clinics, improved our data collection, and introduced a new set of six ROS standards to manage and improve osteoporosis and fragility fracture care in the community. We feel well-prepared for winter.

We've had a tough year, though. COVID-19 hit us very badly. But, at the same time, the pandemic has made me think differently. It has given us new opportunities. Virtual working has saved time and resources. It has improved communication with patients and families. It has allowed me to spend more time teaching doctors in training. Our relationship with primary care has improved, which means we are reaching more patients who are at risk.

In the longer term, I'd like to see bone health nurse specialists in every health board, with every service following the ROS standards, and much more networking across Wales.

Dr Inderpal Singh, consultant physician
Dr Anser Anwar, specialty doctor
Mrs Jane Power, medical secretary and administrative officer
Caerphilly Falls and Bone Health Service
Aneurin Bevan University Health Board

This case study is taken from ***No place like home*** *(RCP, 2022).*

Case study 9: Acute frailty services in Swansea Bay

An ageing population is a real challenge for unscheduled care. 20% of the population of Swansea are over the age of 65 with big increases in the population over 75. That puts a huge demand on our unscheduled care and community services, and an overwhelming pressure on our workforce.

25% of those coming into our emergency department (ED) are over the age of 60 and represent a frail cohort of patients, many of them affected by deprivation and chronic ill health. Around two-thirds of our beds are occupied by a frailty cohort, with around a third of our acute medical beds occupied by patients who have been in hospital for more than 3 weeks, which puts a huge pressure on the system and isn't good for the patient.

We want to support older people to live well at home, with access to good acute hospital care and rehabilitation facilities: we want to give patients choice and control over their health through using comprehensive geriatric assessment tools. Alongside our virtual ward model, we are stepping up patients to try and prevent admissions, and we will be rolling out a step-down facility to enable discharge into the community.

Having an integrated approach is key. We need to bring together primary and secondary care, community and social care, physical and mental health.

We have also developed an acute frailty model with same-day emergency care and an in-reach service into the acute medical unit and short stay ward. The plan is to bring together frailty expertise onto one site. We are also recruiting new ortho-geriatrics consultants which is exciting, and will be transformative, and we have done a lot of quality improvement work around older people and surgery, led by Dr David Burberry.

Staffing shortages are a real challenge in Swansea. We're making some progress, but workforce is the biggest obstacle to delivering our ambitions for older people.

Dr Rhodri Edwards
Consultant in geriatric medicine
Clinical director for intermediate care
Morriston Hospital

*This case study is taken from the **college report** that was published after the RCP president's November 2021 visit to Swansea Bay University Health Board (RCP, 2022).*

Case study 10: Lung cancer clinics in west Wales

The further west you travel into Wales, the more difficult it is to appoint specialist and consultant doctors. Hywel Dda is a big health board, much of it classed as rural and remote, and there is a real danger that the lack of access to specialist healthcare could exacerbate health inequalities.

Between 2013 and 2018, the lung cancer service in Hywel Dda was managed by three consultants with a subspecialty of lung cancer. A fourth physician was based at Bronglais Hospital, mostly focused on general medical and respiratory cases. There was no respiratory physician at all in Withybush Hospital, which meant that we had to travel a great deal to other sites using a rolling rota, and we were never in the same place for 2 days running. These are big distances to travel, and the days were long: often we were the first respiratory physician they'd seen in a week. It became unsustainable and burnout became a real issue; there were inconsistencies in the direction of travel for the service and it was confusing for the clinical nurse specialists (CNSs) when different consultants took different approaches to patient care.

Admittedly, with three of us working together, it was helpful to share good practice and discuss complex cases, and we were able to offer same day diagnostics for many patients. But the travelling for both staff and patients was inefficient, we had limited access to digital technology at some sites, then we lost a consultant to burnout. So as case numbers were going up, we had fewer doctors: only two consultants really, covering four hospitals.

We stopped visiting Withybush. We just couldn't do it. We couldn't offer same-day diagnostics at Glangwili or Bronglais, which meant that we were offering patients a different standard of care depending on where they lived in the health board, resulting in inequity. The optimal pathway at the time was daily specialist MDT clinics with same-day diagnostics, but that model had plenty of funding and staff. We wanted to do our best, but with such limited resource, it was becoming more and more difficult.

Then we lost another consultant. Now we were down to a single consultant covering the entire health board, supported by a general physician in Bronglais. The team was broken. The relationship with the CNSs was fraught. Without enough radiologists, I was being sent thoracic imaging. The service had gone from great to poor within a few years, not because of the people, but because of the circumstances.

The pandemic didn't help. Patients didn't see their GP during COVID-19, so they presented later, often with stage four lung cancer, which meant more hospital admissions. There was huge patient inequality, and no light at the end of the tunnel. There was no knight in shining armour waiting to rescue us: we spent months trying to recruit.

So, we turned to technology, and we upskilled our colleagues. We have trained our CNSs and our SAS doctors to work alongside me to deliver a lung cancer service. There is now a clear vision for the future of the service. We want patients to get high-quality care, no matter where they live: they will get the same care on the same pathway.

Now we run three clinics a week. We have hybrid clinics in PPH and GGH, with some virtual appointments and some face-to-face diagnostics, and we have a Withybush clinic that is completely virtual. We meet with the nurses three times a week to support them, answer questions and discuss complex cases. We track every single patient on the lung cancer pathway to avoid delays and reduce waiting times. In Withybush, if a patient needs a face-to-face appointment, they see the specialist lung cancer nurses in person, with the doctor joining the conversation virtually. They can see the scans on the computer, and they get a clear plan of action. The feedback from the nurses has been excellent and the patients love it. There's less travel, they are supported with the technology, it reduces clinical inequalities, and it gives smaller, local hospitals a really important role to play.

With a single consultant lead, there is a consistent thought process. The nurses feel supported; they are the bedrock of this model of care. There are some great training opportunities for juniors and SAS doctors. It allows for cross-site working and helps facilitate research. The downsides? It's very specialised, I'm very focused on lung cancer now. It's really hard as a single-handed consultant. Burnout is a real problem. The changes happened overnight which was tough, and the patients never stopped coming through the front door.

It's much more enjoyable now. It's no longer a difficult battle. Most importantly, there are very few negatives for the patients, and we've learned that it *is* possible, even with scarce resource, to deliver a quality service over a large geographical area. Ultimately, you need to build self-resilience and look after yourselves and your mental wellbeing. Embrace technology, build a strong multidisciplinary team and focus on what you want to achieve, and you can reduce those health inequalities – which is the single most important thing we need to do in Hywel Dda.

Dr Robin Ghosal
Hospital director, Prince Philip Hospital
Consultant in respiratory medicine
Clinical lead for lung cancer
Hywel Dda University Health Board

*This case study is taken from **Thinking outside the box** (RCP, 2022).*

Cross-sector working in action

These examples are taken from ***Everything affects health***, a joint paper from the RCP and the Welsh NHS Confederation Health and Wellbeing Alliance in 2022.

Housing and health

A Bevan exemplar project based in Hywel Dda University Health Board is developing an online health board resource with housing information, cross-sector referral pathways and bespoke performance management tools. The aim is to work with colleagues across Wales to share learning and good practice, leading to a national good practice guide on health and housing.

Employment rights and welfare benefits

The Pontio project offers befriending and one-to-one support to people living with and affected by multiple sclerosis (MS) in Wales. This includes advice on employment rights and welfare benefits, including Personal Independence Payment (PIP) and Employment and Support Allowance (ESA) claims, ways to manage MS and how to access treatments, health, social care services and housing.

Exercise and health

Access to outside space is crucial for good health. The parkrun practice initiative aims to raise awareness of parkrun among GPs and practice staff, encourage them to take part in parkrun and signpost patients/carers to parkrun events, support the growth of social prescribing and help build integrated and supportive local communities centred on wellness. The Cardiff Bay and Llansamlet Run Talk Run groups promote running and talking as a way of supporting mental health.

Post-pandemic support for vulnerable people

Back to Community Life from Improvement Cymru supports people who are struggling to leave their home and get back to community life since the pandemic. These include people with dementia, people previously shielding or people who are vulnerable. The initiative began in Mountain Ash and has been created in partnership with local people, the police, local volunteer agency, local transport, local authority, third sector, health and social care, shops and businesses, with information provided to local shops and amenities to help them support people.

The role of leisure and culture in wellbeing

The Welsh NHS Confederation and Community Leisure UK (Wales) have highlighted the contribution of charitable trusts to the health and wellbeing of people in Wales through a collection of case studies, including the Escape Pain programme in Cardiff, reminiscence therapy in care homes in Bridgend, yoga for women struggling with menopause in Swansea, and a reading project in Flintshire.

Financial advice for people with sight loss

RNIB Cymru's advice line supports blind and partially sighted people to claim the benefits to which they're entitled. Welfare benefit advisers carry out a full benefit check and support people with sight loss to claim the benefits they may be missing out on. Advisers also help blind and partially sighted people to challenge a benefit decision if it's felt they should be awarded more. RNIB Cymru has also published information around benefits rights, the blind person's tax allowance and pension credit. They have created new factsheets about help with energy bills and about cost of living support grants.

Fighting fuel and food poverty

Through tenant support teams, housing associations distribute food bank vouchers to those in need. Additionally, many Community Housing Cymru members support food banks with monetary donations. Newydd Housing Association is piloting a project that aims to make food affordable and accessible for all homes across the Vale area. Cartrefi Conwy is working to encourage healthy eating, food growing and cooking by delivering cooking education sessions. Adra supports the Bwyd café, which coordinates foodbank distribution in Bangor and distributes waste food from supermarkets. Grŵp Cynefin, Adra and Cyngor Sir Ynys Môn have jointly funded 'energy wardens' to provide tenants with advice on switching energy suppliers and tariffs. This joint initiative has led to around £140,000 of savings and support, demonstrating the merit of pooling resources for maximum impact.

The holistic needs of cancer patients

Tenovus Cancer Care provides benefits advice to people affected by cancer and has seen an increase in patient referrals for both financial advice and their counselling service. Around 40% of those people have received a terminal cancer diagnosis. In response to inequalities of lung cancer incidence, survival and mortality, the charity has published Tackling inequalities: lung cancer, calling for leadership and investment in lung cancer screening, improved signposting to stop smoking, and targeting efforts at those areas and communities with greatest need.

Peer support in women's health

Fair Treatment for the Women of Wales (FTWW) provides peer support and advocacy for women and people assigned female at birth who are disabled and/or living with long-term health issues. Many members of the charity's online community are experiencing escalating financial hardship and deteriorating wellbeing. FTWW helps them get involved in projects like Women's Health Wales – FTWW, which increases confidence, reduces isolation and addresses historical health inequalities.

Arts and health

The Cultural Cwtsh, funded by the Arts Council of Wales, is a suite of fun and stimulating online resources made by artists to support the healthcare workforce in Wales as they look to recover from the intense pressures of working throughout a pandemic. The Welsh NHS Confederation is working with the Arts Council for Wales to improve wellbeing among health and care staff. The Wales Arts Health and Well-being Network (WAHWN) has made a wide variety of case studies available, including cARTrefu which supports the wellbeing of care home residents through creative activity.

Underrepresented voices

Public Health Wales, the future generations commissioner for Wales and Futures Literacy researchers (FLiNT) have worked with Wales' most underrepresented communities to create a climate and nature emergency policy. Using creative character-led storytelling activities, workshops and storytelling competitions, participants were asked to share what the future of Wales with climate change looks and feels like for them. It revealed the interconnected way participants viewed the climate and nature emergencies alongside their local environment and access to green space. Many also shared their concern of being left behind by transport inequalities.

Cost of living information hub

Powys County Council has launched an information hub with advice and support about dealing with the cost of living. The council has worked with local partner organisations to pull together a wide range of information in one place to ensure people know what help is already available and how to access it. The council is also creating a network of warm spaces across Powys.

Supporting people living with a learning disability

A team made up of staff from Betsi Cadwaladr University Health Board (BCUHB) and Flintshire County Council has launched a new initiative in Flintshire to support people with a learning disability, living in their own homes, who need medication administering via a gastrostomy feeding tube. The initiative supports education and training for care staff to administer medication safely and effectively via gastrostomy tubes. This helps people live more independently at home and imposes less restrictions, providing an improved quality of life and giving nurses time to see more patients. The team is sharing the results of the initiative to promote the model of care with the aim of implementing it across north Wales.

Here to help campaign

The Welsh Government is working with public sector partners to share key messages around the cost-of-living support available to people in Wales through the 'Here to help' campaign. The campaign includes information on how to access support and from whom, and how people can help others in their community to access support available in areas such as childcare expenses, finances, electricity bills and school meals.

Poverty, housing and health in older people

'Hospital to a healthier home' services support the NHS and social services by addressing home safety risks, barriers to independent living, and fuel poverty. Funded by Care and Repair Cymru, these services support older people living with sensory loss and/or dementia, and stroke survivors; support older and vulnerable people on issues such as fuel poverty, energy efficiency and the warm homes agenda; and collaborate on campaigns around falls prevention and winter preparedness.

Supporting older people to live well

Age Connects organisations across Wales operate and fund a wide variety of projects designed to reduce the inequalities that affect older people, including 'vaxi taxi' services to get older people to COVID-19 vaccination appointments, advice and advocacy on welfare benefits, social care funding and fuel poverty, day centres, support workers and community outreach for those affected by dementia, befriending and volunteering schemes, nail-cutting and podiatry services.

Cynon Linc community hub

Cynon Linc is a vibrant community hub in the heart of the Cynon Valley. Formerly a council-run older people’s day care centre, Age Connects Morgannwg took over the building as an asset transfer in 2018 and secured £2.8 million of funding to transform the centre into a multi-generational, integrated hub operating as a social enterprise and raising money through rent, room hire, restaurant sales, events and fundraising. There’s a GP practice, mental health support, homelessness support, information hub, social enterprise café, pre-school childcare, youth club, fitness and wellbeing classes and social groups for carers, along with a large function hall for events, parties and conferences.

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