Senedd Cymru / Welsh Parliament
Y Pwyllgor Cyllid / Finance Committee
Cynigion Cyllideb Ddrafft Llywodraeth Cymru 2021-22 / Welsh Government Draft Budget 2021-22
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Coleg Brenhinol y Meddygon Cymru / Royal College of Physicians Wales

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

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27 November 2020

Consultation: Welsh government draft budget 2021-22

Name of organisation:	Royal College of Physicians (RCP) Cymru Wales
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The RCP believes that a new focus on long-term funding for community medicine, social care and public health is now vital. The COVID-19 pandemic has exposed and exacerbated existing problems in the NHS – from workforce shortages to health inequalities. We therefore call on the Welsh government to prioritise social care, intermediate and community services in the next draft budget.

Aside from rota gaps, the single biggest concern reported by our doctors is the lack of capacity in the system to transfer people home or into community care. Many of those who are well enough to leave hospital remain trapped in the system, unable to go home or move into community care because of a lack of social services capacity and staff. The longer a person stays in a hospital bed, the greater the impact on their wellbeing and the bigger the risk of falls, depression and hospital-acquired infections.

While we acknowledge that the UK government's recent spending review included some extra money for the NHS (a consequential of which will come to the Welsh government), without a long-term sustainable funding settlement for social care, our doctors cannot provide the integrated, holistic care that our patients need and deserve.

The impact of COVID-19 has been huge, and it has affected every part of the NHS. In June, almost half of medical specialties expected to be working at lower than pre-COVID activity levels for at least a year and in November, 82% of our members across the UK reported delays in endoscopy tests for outpatients. We must use this opportunity to respond and rebuild by:

- improving integrated ways of working and investing in social and person-centred care
- increasing the workforce, supporting education and prioritising staff wellbeing
- encouraging protected time for quality improvement, service redesign and research
- harnessing the potential of new technologies and building upon progress in digital health.

While targeted funding will support clinicians to get by in the next 12 months, many of the pressures they face are caused by workforce shortages and there is no quick fix to this. The most effective way to reduce NHS backlogs and ease pressure is to increase the workforce that is available to treat patients. This will require long-term funding commitments which support the implementation of the new NHS and social care workforce strategy to prioritise the health, wellbeing and job satisfaction of staff and attract new talent.

RCP Cymru Wales launched its 2021 manifesto asks in September 2019, and we have attached these as an appendix to this submission.

However, we are updating this paper in light of the COVID-19 pandemic, and we will publish an updated version in the new year. This will include examples of services providing specialist medical care in the community and how they have adapted to working with COVID-19 while keeping people out of hospital and safe in their own homes.

Please do not hesitate to contact my colleague Lowri Jackson, RCP head of policy and campaigns for Wales by emailing Lowri.Jackson@rcplondon.ac.uk if you have any questions. All our Wales-focused reports are available to download from our website.

A copy of our 2021 manifesto asks is included with this response.

With best wishes,

Dr Olwen Williams
RCP vice president for Wales

Royal College of Physicians

Coleg Brenhinol y Meddygon (Cymru)

Breaking down barriers

Our action plan for the next Welsh government

September 2019

Foreword

As the Royal College of Physicians' team in Wales, our role is to listen to our members, fellows and physician associates working day in and day out in our NHS, and to highlight the key issues they raise to ensure excellence in the standards of training and working which delivers the best patient care.

The multidisciplinary medical team exists in an ever-changing and increasingly challenging environment, and our goals are to innovate and develop new healthcare delivery models that are sustainable for decades to come.

The concept of prudent and value-based healthcare is sound and we encourage its reinforcement by clinicians. We welcomed the Welsh government's 2018 publication *A healthier Wales: our plan for health and social care.* It is a plan that requires actions that are measurable, and to achieve this, the change needs to be led by patients and clinicians.

Our themes are familiar, challenging and deliverable: ensuring that people from all social sectors live in a healthy environment and are able look after their own health; that the health and social care systems are fully integrated to make the patient's journey within that system as easy as possible; that improved patient care is most likely to be achieved in units where clinicians are participating in research, the time for which needs to be protected; and that there needs to be a commitment to invest in increasing medical student numbers in Wales, and to expanding training opportunities for doctors and allowing for flexible career development, all with the ultimate aim of expanding and creating the modern workforce that will deliver uniformly high-quality care across Wales.

It is an honour to work in the Welsh NHS for our patients. We need to ensure that the principles of shared decision making extend not only to the doctor–patient relationship but also to the interaction between patient, doctor and policy makers.

Dr Gareth Llewelyn
RCP vice president for Wales

Recommendations

The RCP calls on all political parties in Wales to commit to our four-point action plan for the next Welsh government. The next Welsh government should:

1. **Develop, support and value the NHS workforce.**

   The next Welsh government must support doctors to deliver the best care possible by investing in training, education and career development. Consultants, trainee doctors and medical students must be encouraged to stay in Wales through an improved work–life balance and clinical leadership opportunities. Promoting new roles such as physician associates (PAs) will deliver high-quality multidisciplinary patient care and relieve NHS workforce pressures.

2. **Break down the barriers to patient-centred care.**

   The next Welsh government must support clinicians to develop innovative solutions to the NHS crisis, especially in rural and remote areas. The next Welsh government should invest in the long-term sustainability of the health and social care system. A renewed focus should be placed on developing integrated models of care and improving the experience of patients with complex needs.

3. **Make time for patient-facing research and innovation.**

   The next Welsh government must work with NHS Wales to support research activity in our hospitals and communities by protecting clinician time for research, showcasing project findings and involving patients. The NHS and patient care should be placed at the centre of Brexit negotiations.

4. **Reduce health inequalities and help people to healthy lives.**

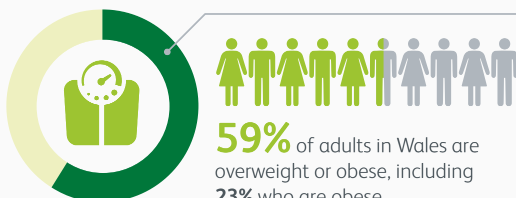
   The next Welsh government must show national leadership on public health by focusing on the importance of supporting people to live healthier lives, reducing avoidable illness and helping to keep people out of hospital. This includes effective action to tackle obesity, air pollution, smoking and alcohol abuse.

The Welsh NHS of the future

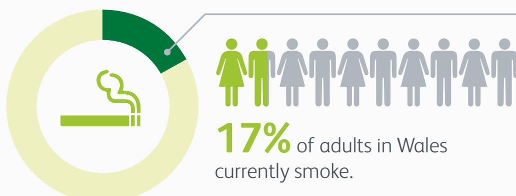
Our doctors work in hospitals and the community across 30 different medical specialties. More than 1,300 of our members work in Wales, diagnosing and treating thousands of patients every year with a huge range of conditions, including stroke, heart disease, diabetes and care of older people.

In fact, RCP consultants, trainees and specialty doctors are treating more patients than ever before. As people live longer, with more complex conditions, this increase in patient numbers is threatening to overwhelm our health and social care system – and Wales has an ageing population. In 2008, 18% of the population was over 65; by 2033 this is expected to rise to almost 26%.[1]

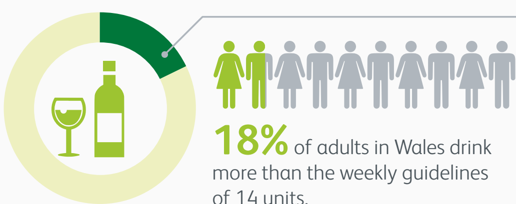
At a glance[2]



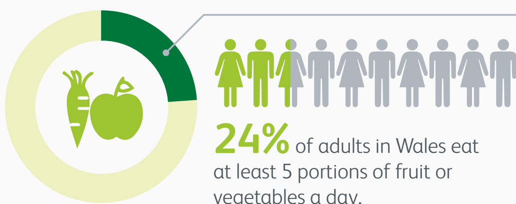
59% of adults in Wales are overweight or obese, including **23%** who are obese.



17% of adults in Wales currently smoke.



18% of adults in Wales drink more than the weekly guidelines of 14 units.



24% of adults in Wales eat at least 5 portions of fruit or vegetables a day.

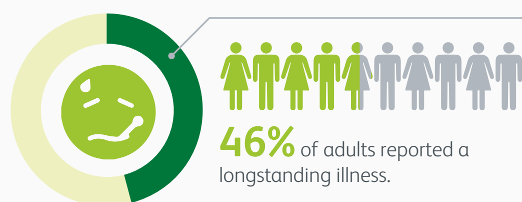
The proportion of adults in Wales with longstanding illnesses increases with age and in areas of social and economic deprivation. Musculoskeletal disorders (17%) and heart and circulatory illness (13%) are the most commonly reported complaints.[3]

'The number of patients attending the emergency and medical admissions units has steadily increased over the years, especially over the past 5 years. There has been an increase in the number of staff, but not enough to meet the requirements.'

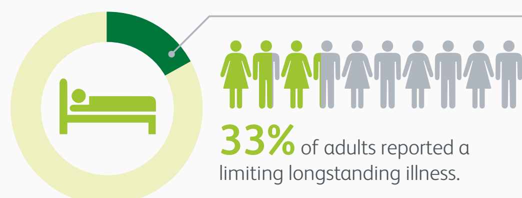
Consultant physician, NHS Wales

We need a workforce that meets the needs of our ageing population.

At a glance[3]



46% of adults reported a longstanding illness.



33% of adults reported a limiting longstanding illness.

Empowering clinicians to lead the way

Politicians in all parties have a responsibility to support clinically led, evidence-based change that will deliver better care for patients. Health boards and the Welsh government must ensure that change is genuinely led by patients and clinicians, and not presented as a 'done deal' at a late stage in the planning process. There is a real risk that without the genuine involvement of patients and clinicians, any proposed changes will lack ownership, credibility and are unlikely to result in lasting change.

Delivering a long-term vision for the NHS in Wales

In 2018, the Welsh government published *A healthier Wales: our plan for health and social care*.[4] The RCP has welcomed this long-term plan, which outlines a 'future vision of a whole system approach to health and social care, which is focused on health and wellbeing, and on preventing illness.' However, while the broad aims are to be welcomed, the plan lacks detail. The Welsh government has promised £100 million towards the transformation of NHS services, but there is currently very little useful information publicly available about where this is being spent. More than a year after the publication of *A healthier Wales*, this vision urgently needs to be translated into a clear and ambitious action plan which includes measurable outcomes and robust external evaluation.

The Brexit effect

The last few years have been dominated by discussions about when and how the UK should leave the EU. The 2016 decision to leave the EU will have significant implications on a range of policy issues, in particular for the NHS and the health of the people of Wales.

The NHS has an international workforce. To meet increasing demand and to cope with the shortage of doctors in training, the health service across the UK has become increasingly reliant on doctors who qualified outside the UK.[5] In 2017–18, half of new joiners were non-UK graduates, up from 44% in 2012.[6] Following the UK's withdrawal from the EU, it may become more difficult for international doctors to work in the UK, and some may have to acquire visas to work.

The NHS is already understaffed and struggling to meet patient need – uncertainty among doctors about whether they or their colleagues will be able to remain in the UK harms morale. Evidence shows that low morale has a negative effect on patient safety.[7]

The Medical Training Initiative

Existing immigration rules are also a major barrier to international doctors working in the NHS. The RCP's Medical Training Initiative (MTI) provides another avenue through which to recruit doctors from overseas,[8] but strict Migration Advisory Committee (MAC) rules for doctors have introduced significant restrictions.

The MTI is a mutually beneficial scheme that provides junior doctors from all over the world with the opportunity to work and train in the UK, while giving trusts a high-quality, longer-term alternative to using locums to fill rota gaps.

The NHS workforce should be given the right to remain in the UK and be exempt from negotiations. We welcome Welsh government support for unambiguous permanent residence status to be granted to all European Economic Area health and social care workers and their families currently working in the UK, and their call for assurance that we will continue to recruit medical staff from Europe through quick and reliable systems.[9]

Following Brexit, the UK government must ensure that they:

- enable NHS doctors from EU member states to remain in the UK when it leaves the EU
- allow the NHS to continue to recruit doctors from overseas to meet rising patient numbers
- relax MAC rules for international doctors.

The next Welsh government should do everything in its power to:

- protect the rights of the NHS workforce to remain in Wales
- implement a clear long-term plan for staffing health and social care services in Wales.

Breaking down the barriers to… valuing the NHS workforce

Welsh hospitals are understaffed and overstretched. There are a number of reasons for this: an ageing population, an increase in patients with multiple complex health problems, difficulties in recruiting staff, and a more flexible approach to work among younger doctors. We simply haven't looked far enough ahead and planned accordingly.

Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) have now published their draft health and care workforce strategy.[10] It is reassuring that the document clearly acknowledges the huge challenge of recruiting and retaining NHS staff in Wales and the importance of a well-motivated workforce. To implement the ideas in this strategy, the NHS must now take an ambitious, patient-centred, clinically led approach, with staff health and wellbeing at its centre. The final strategy must be accompanied by a clear action plan, measurable milestones, sufficient financial resource and the means to hold NHS bodies to account. We need to accelerate change.

Workforce data are often patchy and unreliable – making it almost impossible to plan ahead. The Welsh government, NHS Wales and HEIW must commit to working together to gather reliable evidence on staffing, career pathways and working patterns, and they should commit to working with outside organisations including royal colleges to make these data readily accessible, transparent and easy to understand for patients, families and the general public.

Hospital teams are under increasing pressure from staffing shortages.

Rota gaps present one of the biggest concerns for doctors: in 2017, 60% of consultant physicians in Wales told us that they faced frequent rota gaps in their team. One-fifth reported that rota gaps were causing problems with patient safety – and the others all told us that rota gaps would probably cause problems were it not for stopgap solutions and workarounds.[11] This increases pressure on NHS staff, damages morale and puts patient care at risk.

'Over the years, the number of medical admissions has increased as the number of beds has declined and length of stay has reduced. We have now hit the buffers – there is not much more we can do to reduce length of stay further.'

Consultant physician, NHS Wales

The NHS could do much more to improve the working conditions and the morale of the medical workforce. The RCP Cymru Wales *Doing things differently* report suggests a wide variety of recommendations to support doctors.[12] Investing in staff health and wellbeing, improving flexibility in rotas, and balancing time between clinical practice and other activities such as training, research and leadership roles will all help to improve the morale of the workforce and the quality of patient care.

Promoting innovative staffing models, with new healthcare roles including PAs, can support medical teams to deliver high-quality care and relieve some of the workforce pressures facing the NHS. PAs work alongside physicians, GPs and surgeons, providing medical care as an integral part of the multidisciplinary team (MDT). Their duties include taking patient stories, carrying out physical examinations, and developing and delivering treatment plans. However, without statutory regulation, there are significant limitations on the level of support that PAs can provide – for example, PAs cannot currently order X-rays or prescribe. Now that the four UK governments have announced the General Medical Council (GMC) as the statutory regulator for PAs, the necessary legislation needs to be brought forward and enacted as soon as possible.

The next Welsh government should work with NHS Wales to:

- implement an ambitious patient-centred and clinically led national workforce and training strategy
- build strong medical teams and encourage a sense of belonging and identity at a hospital
- take a nationally coordinated and strategic approach to workforce planning and data collection
- guarantee protected time for research, education, quality improvement and leadership schemes
- invest in national programmes such as the chief registrar scheme[13] and flexible portfolio training[14]
- develop rural and remote medicine as a training pathway in which Wales is a world leader
- increase the supply of doctors across all parts of the medical workforce
- increase the number of medical student and postgraduate training posts in Wales
- increase the number of medical school places offered to Welsh-domiciled students
- make staff health and wellbeing a national priority
- appoint wellbeing staff to improve induction and support trainee doctors as they move around Wales
- plan fair and flexible rotas and take the pressure off trainee doctors to organise their own cover
- establish a junior doctor forum in every hospital with access to staff support
- support specialty doctors working in non-training jobs to develop their careers
- fill rota gaps by investing unspent trainee money in innovative clinical fellowships
- develop and invest in structured certificate of eligibility for specialist registration (CESR) courses with mentoring and support for specialty doctors
- invest in and regulate new healthcare roles such as PAs
- give overseas doctors the chance to train in the NHS using the MTI.[15]

Breaking down the barriers to… delivering patient-centred care

Aside from rota gaps, the single biggest concern reported by our doctors is the lack of capacity in the system to transfer patients home or into community care. As more hospitals find themselves under extreme pressure, patients are waiting longer for treatment at the front door. Many of those who are well enough to leave hospital remain trapped in the system, unable to go home or move into community care because of a lack of capacity and staff.

Investing in social and community care is vital to the long-term sustainability of the NHS. The focus shouldn't be on primary care vs secondary care – it's about changing the whole system. More GPs are working at the front door of hospitals in Wales, and hospital specialists are increasingly running clinics in the community. In addition to encouraging and supporting doctors and other healthcare professionals to lead change, we need to share this learning between health boards to increase the pace of service transformation. It is time for a whole-system approach across primary, community, secondary and social care to deal with the impact of the growing pressure on unscheduled care.

The next Welsh government should commit to investing and promoting Wales as a world leader in rural and community-based medicine. Most trainees tell us that they would like to gain a consultant post where they have undertaken specialist training.[16] Developing a specialist rural health training pathway which splits time between the hospital and the community could boost medical recruitment in Wales in the future. We have a real opportunity to lead the way on innovative community health service design.

The NHS needs to start putting people at the very centre of the health service. This means including patients and their families in discussions about care planning, and acknowledging what can be changed about their choices, and what cannot. People who live in nursing or residential care and often have multiple health conditions and complex needs should have access to enhanced primary care teams, with specialist physicians who have an interest in the care of older people. Primary care should no longer be synonymous with general practice – community healthcare must include a wide variety of different professions, specialties and therapies.

MDTs should be working in the community to prevent admissions (the virtual ward concept).[17] All hospitals in Wales should adopt a discharge to assess approach.[18] Emergency departments should have social workers, occupational therapists and other allied health professionals on staff to assess and develop care plans for frail and complex patients; social services, clinicians and frailty teams should be working together from the point of admission to ensure that plans are put in place as soon as possible to allow for safe, earlier discharge.

Patients who regularly attend emergency departments should have a care plan agreed between clinicians, the patient and their advocate (if relevant). The Cardiff and Vale frequent attender service is an excellent example of what can be achieved when health professionals take ownership and integrate their work with that of other agencies.[19] Staff working in unscheduled care should have universal access to all medical records for each specialty, health board and primary care in Wales.

The next Welsh government should work with NHS Wales to:

- collaborate with doctors and other health professionals to redesign specialist services
- promote informed public debate on local health service redesign, nationally and locally
- adopt a whole system planning approach across primary, community, secondary and social care
- embed and strengthen all-Wales accessible communications and Welsh language standards
- invest in the early detection and management of chronic and high-risk conditions
- ensure the consistent application of all-Wales clinical pathways across every health board
- address health board variation in treatment and discharge procedures
- deliver more specialist medical care in the community
- focus on supporting and developing new models of care for rural and remote communities
- develop the role of community physicians
- address nurse, specialist healthcare professional and wider clinical team workforce shortages
- embed new technologies into everyday practice to reduce pressures on outpatient clinics
- improve communication links between primary, secondary, community and social care
- introduce electronic patient records to save time and improve patient safety
- support networks for sharing good practice and improving patient care across the system
- promote clinical leadership and clinically led quality improvement projects
- improve the patient experience by supporting shared decision-making and self-management
- develop a national plan for those patients with multiple chronic long-term conditions and complex needs
- commit to national action to support improvements in end-of-life care.

Breaking down the barriers to… patient-facing research and innovation

Research in the NHS covers a wide variety of areas, from quality improvement to epidemiology and clinical trials. Research-active hospitals have improved outcomes for patients[20,21] and many doctors regard research as an important part of their job and a very positive experience.

The Welsh NHS faces many challenges. Staffing shortages and financial pressures clearly cannot be ignored, nor can the need to deliver more integrated care to support patients, but we cannot afford to store up problems for the future by letting research fall by the wayside. In fact, in Wales, our integrated health system may open up more opportunities for population research by allowing more extensive data collection across settings. Investing in research will deliver long-term gains for patients and public health – which is after all what the NHS is there to do.

The science and research sector in Wales also has strong ties with the EU, through funding arrangements and EU-wide collaboration on research projects. The UK currently enjoys access to research funding from the EU, whose research and innovation budget for 2014–20 is around €120 billion,[22] with the UK being one of the leaders in Europe for conducting clinical trials.[23]

The European Medicines Agency (EMA) currently plays an important role in supporting early access for patients to the newest treatments and innovations. National regulatory systems can often take longer – for example, it takes typically 6–12 months longer for new drugs to reach Canada and Australia than the UK.[24] It is vitally important to the continued delivery of high-quality patient care that the UK maintains its global position as a centre for research and innovation.

High-quality research in the NHS is everyone's responsibility.

It is important that every clinician working in the NHS is research-active: this can mean identifying opportunities for new research, recruiting patients, supporting colleagues or leading trials themselves. Research and innovation should be part of health boards' core activity and understood to be a key indicator of improving patient care. Hospitals and community settings should increase their research activity and doctors should be supported to pursue research activity, allowing more patients than ever before to be involved with or benefit from clinical research.[25]

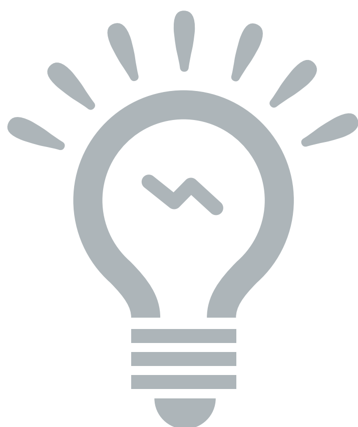
Too many clinicians fit in their research commitments around the rest of their job. With an increasing number of rota gaps in many hospitals, 43% of consultant physicians in Wales tell us that their research is one of the first things to be dropped when the service is under pressure.[11]

All NHS bodies in Wales should receive a regular report of research activity. An executive director on each health board or NHS trust should be made responsible for promoting research across the wider organisation, coordinating activity across primary, secondary and community care, and reporting on research activity and its impact on a regular basis. Patients should be made aware of ongoing research activity and given the opportunity to participate where appropriate. This includes observational studies, clinical trials and the use of data from patient records. The results of studies should be disseminated to patients who have participated.

All medical and allied health professionals, including doctors-in-training, should be encouraged and supported to learn more about research methodology and participation during their undergraduate training so that it becomes embedded in their education and training as they move forward in their careers. Staff working less-than-full-time should be given equal support and access to research training and development.

The next Welsh government should:

- implement the recommendations of the Reid[26] and Diamond reviews[27]
- provide clear national leadership on the importance of medical research
- increase quality-related research funding to Welsh universities in 2019/20
- review clinical research funding streams in Wales, especially if the UK leaves the EU as planned
- tackle the growing skills gap in science, technology, engineering and mathematics (STEM) subjects
- evaluate schemes such as Sêr Cymru[28] which aim to increase research workforce capacity
- work with the medical community to ensure NHS staff have protected research time.



The next Welsh government should work with NHS bodies to:

- ensure that research activity is integral to the work of their organisation
- ensure that NHS boards receive a regular update on research activity and findings
- ensure there is a direct link between research teams and the board
- use job planning to protect time for clinical research
- provide opportunities to showcase research, including to patients and the public
- ensure research and development departments are equipped to provide leadership, support and advice
- ensure transparency for funding and resource allocation
- facilitate the translation of research into practice across the NHS.

The next Welsh government should work with the UK government to:

- maintain the UK's and Wales' position as a world leader for research and innovation
- negotiate continued access to EU research funding, or provide equivalent replacement funding
- clarify how the adoption of EU regulations will impact on Wales to reduce uncertainty in the sector.

Breaking down the barriers to… helping people live healthier lives

It has never been more important to support people to live healthier lives, reduce avoidable illness and help keep people out of hospitals for longer. Previous successful policies, such as the smoking ban in public places and the sugary drinks levy, show the impact that interventions can have.

The Welsh Public Health Act 2017 was a welcome step forward, but there is still plenty to be done. The next Welsh government must show real national leadership on public health and inequalities by giving health professionals the independence, authority and resources to make a difference. The health of the nation should be a driving force in every single Welsh government decision.

'Better health is central to human happiness and wellbeing. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more.'[29]

Physicians and medical teams have a key role to play, not only in managing ill health, but also in supporting people to lead healthier lives. Harnessing the skills and expertise of doctors across the system can help to build a healthier future for individuals, communities and Wales.

As a priority, the NHS must invest in multidisciplinary, clinically led specialist weight management services across Wales, with national standards for service and delivery.[30] Obesity is a chronic disease which doesn't sit comfortably within current funding and organisational structures. It needs an overarching and clinically led MDT treatment approach which has not been achieved by the All Wales Obesity Pathway over the past decade. Thousands of patients are being let down every year, while the cost of obesity to the Welsh NHS is projected to reach £465 million per year by 2050, with a wider cost to society and the economy of £2.4 billion.[31]

Air pollution affects everyone. It is a risk factor in strokes, heart disease and asthma attacks, and can cause cancer. Every year more than 2,000 lives are cut short in Wales as a result of poor air quality. [32] A Welsh Clean Air Act would enshrine WHO air quality guidelines in law; mandate the Welsh government to produce a statutory air quality strategy every 5 years; place a statutory duty on local authorities to appropriately monitor and assess air pollution, and take action against it; and introduce a 'right to breathe' where local authorities have to inform vulnerable groups when levels are breached. The next Welsh government should also introduce targets to reduce air pollution in the NHS by providing free park-and-ride schemes, investing in the electrification of NHS vehicles and encouraging staff to cycle, walk and take public transport to work.

Alcohol misuse places a huge burden on the NHS, the police and the wider community. Almost one in five adults in Wales drink more than the weekly recommended limit.[2] Of all alcohol sold, it is the very cheap products, such as large bottles of strong cider, that play the biggest part in alcohol-related harm. The simplest way to reduce demand for alcohol is to raise its price and we know that the introduction of a minimum unit price (MUP) for alcohol is an effective and evidence-based way to tackle health inequalities and reduce consumption.[33] We have strongly supported the introduction of a MUP in Wales and we urge the next Welsh government to implement the 2018 legislation as soon as possible, and to evaluate its impact. Integrated alcohol and substance misuse treatment and prevention services should be established where there are gaps. These should take a whole-person treatment approach which recognises complex needs and provides integrated support across a range of services including healthcare, social care, housing and others.

The total cost of smoking to society, including healthcare, social care, lost productivity, litter and fires, was conservatively estimated in 2015 to be around £14 billion per year in the UK.[34] More than 5,000 deaths every year in Wales are attributable to smoking, and more than 26,000 hospital admissions every year are linked to smoking.[35] The next Welsh government should develop and push ahead with a renewed and ambitious tobacco control plan once the 2017–20 plan comes to an end.

The next Welsh government should:

- ensure all health boards invest in specialist, clinically led obesity treatment services
- appoint a national clinical lead for severe and complex obesity, accountable to the first minister
- set clear and accountable targets for preventing and reducing obesity
- collect data which allows continuous evaluation of the success of public health programmes
- commit to using income from the Soft Drinks Industry Levy to fund public health programmes
- introduce calorie labelling on menus
- introduce a Clean Air Act for Wales that will improve the quality of the air we breathe
- introduce targets to reduce air pollution in the NHS
- tackle the harmful impact of alcohol by implementing MUP legislation
- support and invest in integrated alcohol and substance misuse treatment and prevention services
- invest in a whole-person treatment approach that supports people with a range of complex needs
- place a renewed focus on delivering and extending an ambitious Tobacco Control Plan for Wales[36]
- reduce health inequalities by targeting smoking cessation services at specific high risk groups
- support the 'Smokefree Spaces' campaign
- take action to help young people by funding youth-specific smoking cessation services
- create a clear consensus statement on the use of e-cigarettes for smoking cessation
- implement effective regulation of e-cigarettes
- tackle illegal tobacco in Wales by investing in a Wales-wide public awareness campaign
- ensure that all pharmacies across Wales offer advanced smoking cessation level 3 services.

The next Welsh government should work with the UK government to:

- restrict unhealthy promotions and introduce a 9pm watershed on junk food adverts
- review alcohol duty rates so that they accurately reflect the amount of alcohol in any drink
- ensure that consumers have accurate on-product information and consumption guidelines.

What is the RCP doing to help?

Through our work with patients, consultants and trainees, we are working to achieve real change across hospitals and the wider health and social care sector in Wales. You can also help to inform the RCP's work in Wales by sending us your comments, ideas and examples of good practice.

Our 36,000 members worldwide (including 1,300 in Wales) work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions, including stroke, care of older people, cardiology and respiratory disease. We campaign for improvements to healthcare, medical education and public health. In Wales, we work directly with health boards, NHS trusts and HEIW; we carry out regular hospital visits to meet clinicians, patients and managers; and we collaborate with other organisations to raise awareness of public health challenges.

We organise high-quality conferences, teaching and workshop events that attract hundreds of doctors every year. Our work with the Society of Physicians in Wales aims to showcase best practice in Wales, through poster competitions and trainee awards, and we host a highly successful biennial RCP membership and fellowship ceremony for Wales.

Our work to influence national change in Wales has ensured that the RCP has a powerful voice across a wide variety of policy areas, including the medical workforce, NHS reform and public health challenges. We have consistently called for a more joined-up approach to the recruitment and retention of NHS staff, for action to ensure a better work–life balance for doctors, and for a clinically led national health and care workforce and training plan. Our messages on alcohol, obesity and tobacco have been instrumental in shaping public health policy over the past few decades.

We will continue our work to keep medicine brilliant, but a whole-system problem needs a whole-system solution. Now is the time for the health and care sector to come together and do things differently.

To help shape the future of medical care in Wales, visit our website:
www.rcplondon.ac.uk/wales

To tell us what you think – or to request more information – email us at:
wales@rcplondon.ac.uk

Tweet your support:
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#MeddygaethynWych

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Breaking down barriers

On the front line of patient care in Wales

September 2019

‘It is important to understand the complicated relationship patients have with their medication’

We wanted to evaluate how the Patient and Carer Network (PCN) can work with clinicians in acute hospitals to help patients understand the decisions made about their care. We are especially interested in the area of deprescribing – the process of reviewing and stopping potentially inappropriate medications in order to improve quality of life.[1] Prescription medication is an integral aspect of care for many frail older patients, with some patients prescribed up to 25 different medications at one time. However, we know that there has been little research into how patients feel about deprescribing in hospital, and so we have been gathering information through informed consent and data collection, and a detailed patient questionnaire.

It is important to understand the complicated relationship patients have with their medication. How do they cope with taking medication at home after leaving hospital? What are the psychological effects of being prescribed multiple medications? Are they keen to make decisions themselves about their medication? Particularly interesting from the clinical point of view, we wanted to explore whether the patient feels that the doctor is giving up on them if a medication were to be stopped.

The most positive aspect of the project has been the opportunity for the PCN to engage with patients, doctors and nurses, as these relationships are core to the role of the PCN. Deprescribing – especially in our target group of those with capacity and over 65 years old who are taking more than one medication – has been welcomed by patients who are eager to learn more, despite it being a potentially controversial subject. The level of support from the research and development team at Aneurin Bevan University Health Board has been outstanding; they have provided guidance for the project and arranged access to clinical settings where necessary. Furthermore, the ward staff have been exceptionally inviting and accommodating, despite working in a busy environment.

The logistics involved in obtaining permission for a PCN member to enter the ward environment was an obstacle, but we have learned from the process and hope it will be more streamlined for future projects. We are keen to share the learning through our networks and committees in Wales, and by presenting at conferences, and we hope to use this as a pilot for a larger project to be run on a national scale, ideally though our PCN members.

Dr Richard Gilpin
Specialist registrar in geriatric and general medicine
Aneurin Bevan University Health Board
RCP Trainees Committee representative for Wales

Ceri McDade
RCP Patient and Carer Network representative for Wales

Case study

2

'We were encouraged to challenge outpatient referral habits'

Reform of the outpatient system is needed – demand for outpatient review continues to rise, while the system is increasingly affected by a shortage of clinical staff, and there is patchy uptake of technology which is designed to improve efficiency. This has resulted in increased waiting times for those at greatest clinical need, despite recognition of the large burden of unnecessary appointments for those who could be better managed elsewhere. The Wales Audit Office review of outpatient management in 2015[2] encouraged clinicians to challenge outpatient referral habits, and recommended that clinical leaders take managed risks to ensure services offer timely review for those at greatest clinical need.

In 2014, the rheumatology team at ABMU (now Swansea Bay University Health Board) designed a project to look at outpatient capacity and demand. Thirteen per cent of new patients were waiting for over 26 weeks (the Welsh government target) and 1,624 patients exceeded their target waiting time for follow-up appointments. We initially undertook a detailed evaluation of referral pathways during a facilitated event attended by clinicians, managers and waiting list booking staff. We focused on referral prioritisation, guided by prudent healthcare principles,[3] with the aim of reducing new patient waiting times and addressing the excessive waiting times for our existing follow-up caseload.

We designed criteria for accepting new patient referrals using national guidelines defining appropriate rheumatology caseload. Inappropriate referrals were redirected to other services such as physiotherapy / chronic pain or returned to the referrer with tailored investigation/management plans. Letters were sent directly to patients, explaining the rationale behind these decisions.

By March 2015, new patient waiting times had fallen to 4–6 weeks across all sites in the health board. We were able to convert new patient clinics to follow-up activity with a significant reduction in the number of patients waiting longer than their target date from 1,624 in March 2014 to 253 in January 2016. Subsequent work in 2018 showed that, of 474 patients whose referrals were returned between June 2015 and May 2016, only four were later diagnosed with inflammatory disorders, having been re-referred with new features.

Initial reservations regarding the potential personal liabilities of misdirected referrals were overcome by agreeing to collective responsibility for the project with regular feedback. The introduction of electronic referral prioritisation facilitates timely and effective electronic dialogue with referrers and we would strongly recommend this approach. We have also been able to demonstrate that the principles underpinning the project are robust and support the reduction of inappropriate variation through evidence-based approaches.

Dr Usha Srinivasan
Consultant physician in rheumatology
Swansea Bay University Health Board

Andrea Mills
Service manager for rheumatology
Swansea Bay University Health Board

Case study

3

'I am proud to say that intermediate care in Wales is emerging as a specialty within a specialty'

In 2007, we began our journey to design a pioneering collaboration between health and social care services in Gwent. Our aim was to deliver the best possible community care for older people and for any adult struggling with clinical frailty – 12 years on, the Gwent Frailty Programme has evolved and transformed into one of the UK's most respected and recognised services, and the model of care has been emulated by several centres across England and Scotland. Wales has led the way in making this programme a reality – many other parts of the UK have struggled to do the same.

The journey has, at times, been arduous. As the programme developed, patient needs kept altering, due to rapidly changing demographics in Gwent and across the country. It often still feels like hitting a moving target. The key to staying relevant has been our ability to adapt and respond to change. Being subjected to scrutiny and regular evaluations has helped the programme to stay viable and find its place among the core services of Gwent.

Community resource teams are the nerve centres of the Gwent Frailty Programme. They are made up of multidisciplinary team members, from therapy staff, social care and voluntary sector workers, to a rapid response arm supported by senior medical and nursing staff. The team's resource and skills are designed in accordance with the needs of frail and older people with complex needs and multiple comorbidities. Employees are paid from a pooled health and social care budget.

Referrals into the service are from primary and secondary care via a single point of access. The focus of the teams is to prevent unnecessary admissions into hospital, allow early supported discharges, and support re-enablement and falls prevention. Comprehensive geriatric assessment[4] is the cornerstone on which care plans are built and developed. Access to therapists, social care and consultant-led rapid medical services are fundamental in providing our community-based response, which, in turn, delivers care closer to home in line with the Aneurin Bevan University Health Board Clinical Futures programme.[5]

Patients are extremely satisfied with the service. Unexpected mortality is very low, thanks to clear lines of governance and rigid surveillance in the community by the clinical teams. The cost of the programme is being evaluated via a multicentre randomised controlled trial and the results are imminent. Integration, wellbeing and the use of new technologies are all on the agenda for the future. We are also developing community frailty units which are capable of delivering enhanced nursing and medical care. I am proud to say that intermediate care in Wales is emerging as a specialty within a specialty.

Dr Jaideep S Kitson
Consultant physician in geriatric medicine
Clinical director for intermediate care
Aneurin Bevan University Health Board

Dr Gagan Belludi
Consultant physician in geriatric medicine
Aneurin Bevan University Health Board

'This has been an amazing project to be involved with'

Wales has the highest prevalence of diabetes in the UK. Almost 200,000 people now live with diabetes, or 7.4% of the adult population – and the numbers are rising every year. If current trends continue, it is estimated that 311,000 people in Wales will have diabetes by 2030. The disease costs the NHS in Wales approximately £500 million a year, of which 80% is spent on managing complications, most of which could be prevented.[6]

Delivering appropriate advice and support to such large numbers of people with type 2 diabetes is both essential and a considerable challenge. Audit data from 2015 showed that less than 1% of this group had ever attended a validated education course in Wales.[7] We needed a new way to reach out to the many thousands of people who have diabetes and aren't receiving the support they deserve to manage their disease properly – especially those living in rural, isolated areas, perhaps feeling socially isolated, perhaps economically deprived.

We started thinking about ways to support and empower patients with chronic conditions. We put together a working group which includes: Diabetes UK Cymru; the Diabetes Research Unit Cymru; patient groups; and eHealth Digital Media Ltd. Our goal was not only to develop content, but also to think about how we could distribute that content. We decided to create a series of digital education films which focused on behavioural change in patients with diabetes.

Our media company partners put together around 10 films about type 2 diabetes for us and we approached two GP surgeries, especially one with a huge list of people who had been referred in for an education package for diabetes, but there no was no education package available. We received immediate feedback through the system, which helped us to develop films on other topics, and the national diabetes lead for Wales secured us some all-Wales funding. The links can be sent out through text message directly to a mobile phone and accessed on the move.

The project has been extremely effective, and it is relatively low-cost. If current rates of use continue, we are on track for a 30,000 click-through rate in 2019, with diabetes alone achieving 2,000 clicks per month. Usage is steadily growing and has doubled since last year. We're also expanding into some parts of England using a system developed to cost pennies per patient. Our primary evaluation has demonstrated a statistically significant reduction in average blood glucose levels (HbA_{1c}) in those interacting with the content.[8] The project was previously shortlisted for the NHS England Innovation Awards and the NHS Wales Awards. It received a Quality in Care (QiC) Diabetes Award commendation in 2018 and in 2019, was announced as a QiC Diabetes Award finalist for an animation on insulin safety in collaboration with the Cambridge Diabetes Education Programme.

The films are between 5 and 10 minutes long, depending on content. It works well for people who are in work – if you've just received a diabetes diagnosis, there's no way you're going to be able to get to an education course which is half a day every week for 6 weeks, even if there is one available in your area. We know the uptake is very poor for these courses. We provide links at the end of the films, signposting patients towards more information, or other learning materials.

This has been an amazing project to be involved with, but like any new way of working, a considerable amount of effort has been needed to promote the new system. At times, it has been difficult to get the healthcare profession to engage with it. Embedding the delivery into standard primary care practice has taken some time, but recent work with primary care IT providers has really helped, and now the diabetes films are officially built into the GP system as part of a diabetes review. The important thing for us now is to raise awareness and get the message out to patients and clinicians.

Following the success of the diabetes films, we have pulled together content for chronic obstructive pulmonary disease (COPD), chronic pain, lymphoedema, heart failure, social prescribing,[9] end-of-life care, cancer survival, and more recently, dementia,[10] some of which are funded by the Welsh government on an all-Wales basis.

'This is a brilliant film. It shows what living with dementia is really like, which is so much better than reading about it. This film is a real-life example of how people with dementia struggle to focus on a target when surrounded by distracting information. All the observations and ideas in the film fit with the scientific evidence, but such evidence is bit dry to read and it doesn't really reach the very people who could make the most of this knowledge.'

Professor Andrea Tales, chair in neuropsychology and dementia research, Centre for Innovative Ageing, Swansea University

We are now developing films to support the diabetes remission agenda, as well as producing content in different languages, and we are also working with colleagues abroad to explore ways of exporting the system outside of the UK, especially to India.

We really want to do something similar for obesity. The issue with obesity is that it's not part of any of existing funding streams, but has an impact on almost all chronic conditions. It would be helpful to top-slice some of the existing funding for chronic conditions because there is no specific money for obesity. Helping people to feel more empowered can only be a positive thing.

Dr Sam Rice, Professor Jeff Stephens and Dr Julia Platts
Consultant physicians in diabetes and endocrinology
Hywel Dda University Health Board

Kimberley Littlemore
Director, eHealth Digital Media Ltd

‘Pharmacists can offer a high-quality specialist service as part of the wider admissions team’

In 2015, the National Institute for Health and Care Excellence (NICE) updated their medicines reconciliation guidance saying that patients should have their medicines reconciled within 24 hours of admission to hospital, and ideally a member of the pharmacy team would be involved. This recommendation really changed the workload for clinical pharmacists.

It is well-documented that harm can be caused when there are problems in the way that information about medicines is transferred between care settings, or when people move between care settings, perhaps from their own home or from a nursing home into a hospital. As a profession, we accepted the new NICE recommendations because they are all about patient safety – but the reality is that most hospital-based pharmacy medicines reconciliation systems are reactive. The pharmacy team are often unable to carry out medicines reconciliation for hours, sometimes days after an admission, when prescribing mistakes have already happened. There is a staggering amount of inefficiency in the current process and it causes an awful lot of rework.

So we thought, what if the pharmacy team was there at the start? What if we did the clerking drug history and we fitted into the process from the beginning? All of us would prefer to be making a positive contribution to patient care, rather than correcting mistakes that we could have prevented. A great deal of our workload is focused on spotting what has gone wrong: if the process were slicker, or certainly if fewer errors were made, it would be better for the patients. It helps out our medical colleagues by taking some of the burden off them, and it meets prudent healthcare principles, being what we are best qualified to do.

Singleton Hospital in Swansea was already pioneering this with pharmacists. So we decided to try it out with pharmacy technicians, as we were confident that they were capable. We think it’s the first example of technicians transcribing a medication chart at the point of admission in the UK, so it’s a relatively novel approach and not at all widespread.

Ordinarily, with adult patients referred to hospital by their GP, when the patient arrives, they are triaged by a nurse and will wait to see a junior doctor, who will clerk them, perform the drug history and write the medication chart, and they’ll be seen later by a consultant physician. They may or may not be admitted at that stage, and if they are admitted, a member of the pharmacy team would see them (hopefully within 24 hours, but almost certainly within 48 to 72 hours) and double-check the drug history and chart transcription carried out by the junior doctor.

During our pilot, once the referral phone call came from the GP, the pharmacy team (usually the technician) would access the patient’s information from their electronic individual health record to start collating the drug history. When the patient arrived, our technicians completed the drug history together with the patient, as well as checking other sources like outpatient clinic records – we always cross-check our data here, which is best practice. We are really proud of our technicians, they are fantastic; everyone who took part in the pilot volunteered.

‘There was good verbal feedback from the juniors. I thought it was excellent because I could read everything, it was very comprehensive – it was far more accurate and up-to-date.’

Consultant physician

Our job was to document the drug history in the medical clerking document, and transcribe the medicines from the drug history to the patient’s medication chart: two tasks that junior doctors would previously have done. Then the clerking document and medication chart would go into a green envelope, which was sealed and a sticker was put on the back to say that only the prescriber was to open the envelope. The prescriber would still check and sign the charts and decide if the medications are appropriate, but now they know they are looking at an accurate drug history list.

New medicines come onto the market all the time, so trying to keep track of them all would be almost impossible for most junior doctors. When we collected our baseline data, in our control group of 16 patients, there were 44 discrepancies on the medication charts written by junior doctors, whereas our pharmacy technicians – some of whom do drug histories all day every day – didn't make any discrepancies when transcribing 25 charts during the pilot. We've since trialled a version of the project in the hospital's emergency department, which is even more high-stress and high-pressure, and it went well.

'It's about providing care in the right place, by the right person, at the right time. When we start writing our next integrated medium-term plans, this project will be included because it would save a huge amount of hassle in the long term.'

Consultant physician

If we wanted to roll this out more widely, we would need investment in the workforce – new pharmacy team members. What we actually found is that almost half of the patients we saw were not admitted, so these were patients that wouldn't normally come into contact with the pharmacy service. But at the same time, we were freeing up junior doctor time by taking on that role, which is a big reallocation of resource. There's also the question of education and extra training for our technicians – this is a way of working which requires them to operate under more pressure than they experience in the current system. It's also crucial to keep lines of communication open and make sure everyone involved is well-briefed – early engagement between different teams is vital. Finally, we don't want to risk de-skilling junior doctors, as the final decision about patient care still rests with the medics.

'It boils down to time. The ideal situation is that you have a multidisciplinary, multiprofessional ward round for every single patient, but that's not feasible. However, by having pharmacy colleagues on the ward, we're co-located, and we can ask their advice about a patient's clinical assessment and management.'

Consultant physician

However, ultimately it's about changing the way that we all think. Pharmacists can offer a high-quality specialist service as part of the wider admissions team. We're not there to get in the way of our medical colleagues – we are there to help and to save time, and improve patient safety.

David McRae
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