Consultation response

Social care delivery plan 2023 to 2026

June 2023

Royal College of Physicians

Coleg Brenhinol y Meddygon (Cymru)

Social care delivery plan 2023 to 2026

RCP Cymru Wales consultation response

Sent on behalf of:
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Social care delivery plan 2023 to 2026

The Royal College of Physicians (RCP) welcomes the opportunity to respond to the Social Care Wales social care delivery plan 2023 to 2026. **We believe that the actions in this delivery plan will support the ambition of the workforce strategy** and we would be very happy to organise a follow up conversation with the RCP vice president for Wales, or a focus group with leading fellows and members (including consultant physicians, trainees, specialty and specialist doctors and physician associates) if this would be helpful.

This response is submitted on behalf of the Royal College of Physicians, a registered charity and professional body for doctors and physician associates working across 30 medical specialties which range in size and scope from geriatric medicine (providing holistic care for older patients) through to nuclear medicine (using radioactive materials to aid diagnosis and treatment of disease). We are an independent patient centred and clinically led organisation that aims to educate, improve and influence for better health and care across the UK and the world.

In this response, we have included several case studies and signposted to other reports. Overall, our key message is that closer working between health and social care teams, and to that end, investment in the social care and community workforce will be absolutely crucial to the success of care closer to home and improving the experience of patients, families and carers. Ultimately, we urge the Welsh government to bring together workforce planning for health and social care in a meaningful way, working in partnership with primary, community and social care to design clinical pathways and patient journeys.

The new NHS Wales Executive and the proposed National Office for Social Care, working with Health Education and Improvement Wales (HEIW) and Social Care Wales will give us a real opportunity to redesign how we educate, develop and support the health and care workforce,

and it's vital that both organisations work very closely together with shared aims and priorities, supported by professional bodies and royal colleges to share information and intelligence.

We welcome the commitment to '**collaborative and partnership working at all levels'**, and we are especially pleased to see an action to '**maintain and develop peer support networks, communities and a national conference to share different ways of improving workforce well-being**'. We'd like to know more about how the social care workforce strategy will link with and influence the national workforce implementation plan in practice. We'd also like to learn more about how the social care workforce strategy will engage with the new strategic clinical networks being set up as part of the new NHS Wales executive body.

We support the actions listed in section 3: '**implement initiatives to support working across health and social care boundaries; develop ways of supporting multi-professional working; and identify and respond to workforce implications of new policy drivers and service models**' and would be keen to discuss how we could contribute to this work.

We are also interested in supporting the actions listed in section 7 to '**build capacity and capability in workforce planning and development across health and social care, supported by a standardised approach; develop workforce responses for professionals and key parts of the sector; and find out what a National Care Service would mean for the workforce**'.

Later in this response we have described some of the work we've been doing with regional partnership boards and how we are considering next steps for this collaborative work. We would be interested in hearing from Social Care Wales about how you think we could meaningfully contribute to policy development and the sharing of best practice in this space.

Welsh royal colleges and professional (RCAP) bodies advisory group

In July 2022, royal colleges, faculties, specialist societies and professional bodies in Wales established a multidisciplinary external advisory group on workforce planning, service transformation and other shared priorities.

Convened by the RCP, membership is made up of membership organisations representing tens of thousands of doctors, nurses, allied health professionals, therapists, pharmacists, dentists, paramedics and social workers in Wales. The group aims to work collaboratively with the Welsh government, NHS Wales, local authorities and other stakeholders to improve how we educate, attract, retain and redesign the health and care workforce while valuing, motivating and supporting staff to deliver high-quality patient care. We have organised workshops at a national level with a variety of stakeholders and organisations, including HEIW, the national clinical leads group and regional partnership boards.

To celebrate NHS 75, we will be publishing *The people who care*, a joint briefing endorsed by almost 30 organisations across health and social care that calls on the Welsh government to work with NHS Wales, local authorities, the third sector and other partner organisations to support staff to thrive, care, learn and feel valued. This paper will be launched at a Senedd event on 4 July 2023 and will be shared with Social Care Wales upon publication.

Our response

Our fellows and members work across 30 medical specialties, including diabetes, cardiology, respiratory medicine, stroke and care of older people. They work mostly in hospitals; some work in the community, providing care through hospital at home services, virtual wards or community resource teams. They provide specialist medical care to thousands of patients every year, many of whom are living with at least one long-term chronic health condition.

After all, 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.

Between 2018 and 2028, the number of people aged over 65 in Wales is projected to increase by 16% while the number of those aged over 75 is projected to increase by 29%. We know that prolonged stay in acute hospitals increases the risk of hospital-acquired infections in older frail patients, which means that keeping older people out of hospital and in their own home has never been more important.

Virtual wards, hospital at home and health inequalities

Over the next few months, the vision of care closer to home as set out in *A healthier Wales* must be supported by a significant investment in community resource and staffing, especially in social and intermediate care. In January 2022, supported by the British Geriatrics Society, we launched *No place like home: Using virtual wards and 'hospital at home' services to tackle the pressures on urgent and emergency care*. We have consistently argued that getting people home from hospital more quickly needs a substantial increase in the number of social care staff, so we welcome this workforce plan. After all, there are simply not enough doctors, nurses, therapists and social care staff in the system.

We do not actually know the scale of the current situation with delayed transfers of care (DTOC) from hospital. This data has not been published since February 2020 when the Welsh government suspended DTOC reporting requirements and introduced COVID-19 discharge requirements. This makes it very difficult to judge the overall impact on individuals and organisations and means that we are relying in the main on the anecdotal evidence of patients and clinicians. However, the Welsh NHS Confederation has estimated that up to 15% of hospital beds are occupied by people who are medically fit to leave hospital but don't have the right care in place to be able to return home. As an immediate priority, the NHS and Welsh government should begin publishing this data again: transparency is key to accountability.

The new social care delivery plan 2023-26 should prioritise investment in staff for:

1. **Virtual wards and 'hospital at home' services:** We need to expand the number of virtual wards and 'hospital at home' services that provide specialist medical care in the community across Wales. These teams can help to reduce hospital admissions, get people home more quickly, and improve the quality of patient care.

2. **Prevention of ill-health and tackling inequalities:** The Welsh government should develop a cross-government strategy to tackle avoidable illness and reduce health inequalities. Many of the barriers to truly integrated health and social care exist outside the structures of the NHS and will only be achieved through cross-government action, shared performance measures and outcomes, led by the first minister.

Community resource teams (CRTs) are made up of health and social care professionals who coordinate care for people living at home. Models vary across Wales: some teams provide intermediate acute healthcare, others are integrated with social care and provide holistic assessment, treatment and support for both short and long-term care. However, CRTs are often under-resourced and under-recognised. During the pandemic, some CRT staff have been redeployed to other parts of the NHS, which has reduced the capacity of community teams to treat patients at home and keep them out of hospital in the first place.

A **virtual ward** is a multidisciplinary team meeting involving primary care, secondary care, the local authority and voluntary services. The aim is to reduce pressure on unscheduled care by preventing inappropriate hospital admissions and improving flow through hospital by expediting discharge. This is done by providing comprehensive multidisciplinary care in the community. During a virtual ward round, health and care professionals discuss how to support frail older patients, those with chronic disease and those with increasing social care needs. The aim is to do this within their own community. In addition, virtual wards can improve patient experience, reduce NHS costs and lead to more collaborative working.

Hospital at home services provide short-term, intensive, hospital-level care for acute medical problems in a patient's home. This is provided by multidisciplinary healthcare teams led by a senior clinician. It can provide urgent access to relevant blood tests, ultrasounds and hospital-level diagnostics and interventions and gives access to the same specialty advice as would be provided for any hospital inpatient. Providing specialist healthcare at home could reduce pressure on NHS resources and be less disruptive to frail older patients, while leading to higher levels of patient satisfaction.

Our work with regional partnership boards

In the past couple of years, the RCP has worked collaboratively with other royal colleges, professional bodies, NHS organisations and regional partnership boards to share best practice, develop policy ideas, and collate recommendations for change.

Our report *Under pressure: Collaboration, innovation and new models of integrated care in Wales* sets out the findings from a workshop with the Welsh RCAP advisory group and the regional partnership boards (RPBs).

RPBs told us their top three asks of RCAP bodies are:

- **Information**: Communicating with our membership and raising awareness of RPBs.
- **Influence**: Helping to drive change at a national level and among our membership.
- **Intelligence**: Sharing best practice and spreading innovation.

We also heard that RPBs would like to:

- Work towards wider, **inclusive engagement** with their local populations and develop **collaborative working** with the health and care professions.
- Develop stronger **partnership working** and build relationships outside of their usual stakeholder groups.
- Ensure **strong leadership** to drive change backed up by effective communication and consistent messaging for local populations.
- Support clear, consistent and honest **national communications** about RPBs and the wider challenges facing the health and care sector.

As RCAP bodies, we promised that we would:

- **Communicate** with health and social care professionals across Wales.
- Develop **shared messages** at a national level.
- Identify **good practice** and new ways of community working.

In discussing issues around workforce during this workshop, we heard that the biggest pressure facing health and social care is staffing shortages. While we recognise that we need to think about how existing health and care staff can work differently, we must acknowledge that recruitment into social care is extremely challenging in some parts of Wales. NHS pay, terms and conditions are often seen as preferable to those in the local authority sector.

> *'The shortage of staff is a major issue in rural Wales – it is really very difficult to recruit. Since the pandemic, so many people have left the NHS and social care workforce; we have an ageing population and fewer younger people living locally who understand the implications of health and care transformation.'* – RPB lead

Moving staff from the acute sector into preventative community-based roles will be key, but this is happening too slowly, and without a more strategic national approach to how we train, recruit and deploy staff, it will have limited success. National, regional and local workforce strategies have been developed, but the Welsh government should continue to ensure that regional partnership boards, royal colleges, professional bodies and the third sector are all involved in developing a national approach to workforce planning.

We also heard that RPBs are central to service transformation but must often compete with short-term pressures. The regional integration fund is increasingly being used to support winter planning. Staff are stretched, both on the ground and at a senior level. We heard that senior managers are often very supportive of a project but have limited capacity for oversight, which affects the rate of progress.

> *'Everybody is happy to discuss the process of transformation, but the day-to-day pressures are also important. Some staff and managers go to lots of different meetings, and they are spread across a variety of projects with limited resource. Health and social care staff capacity is very stretched across both local authorities and health boards. People are under a lot of pressure since the start of the pandemic.'* – RPB lead

Ultimately, there aren't enough people working in health and care, so any extra money is spent on supporting and sustaining existing staff. Some posts are funded through RIF for transformation, but still some staff are worried about the risk of losing their job if the funding is stopped. The RIF process sets out the need for health boards and local authorities to taper and match-fund staff costs, which would help RPBs to reinvest funding into further service innovation and transformation.

The deputy minister for social services has encouraged us to 'continue to build on this [work] in [our] ongoing engagement and forge a positive working relationship to ensure everyone's voices can be heard in the shaping and development of our integrated community care system for Wales.' We are now considering our next steps for this work stream.

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'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: 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 3: 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 4: 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 5: 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 6: 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 7: 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).*

Educating, improving, influencing

Through our work with patients and doctors, the Royal College of Physicians (RCP) is working to achieve real change across the health and social care sector in Wales. We represent 40,000 physicians and clinicians worldwide – educating, improving and influencing for better health and care. Over 1,600 members 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. We campaign for improvements to healthcare, medical education and public health.

Key reports and briefing papers

How are Welsh government ministers working to reduce the impact of inequalities? RCP, 2023

Under pressure: Collaboration, innovation and integrated care in Wales. RCP, 2023

Driving change together: A clinically led, patient centred NHS executive for Wales. RCP, 2023

Workforce data: Welsh RCAP-HEIW joint workshop. RCP, 2023.

Cancer care at the front door: the future of acute oncology in Wales. RCP, 2023.

A poverty action plan to fight health inequalities. RCP, 2022.

Thinking outside the box: Innovation in west Wales. RCP, 2022.

Everything affects health: How collaborative working can reduce inequalities. RCP, 2022.

When will Welsh government publish the national health and care workforce plan? RCP, 2022.

Positives from the pandemic: Innovation in north Wales. RCP, 2022.

RCP Cymru Wales response to NHS Executive for Wales stakeholder questionnaire. RCP, 2022.

Setting up an NHS executive for Wales. RCP, 2022.

Bringing the clinical voice to the conversation: A new advisory group. RCP, 2022.

Mind the gap: The cost-of-living crisis and the rise in inequalities in Wales. RCP, 2022.

No place like home: Tackling the pressures on urgent and emergency care. RCP, 2022.

Response to Welsh government's health and social care winter plan 2021 to 2022. RCP, 2022.

Response to Senedd inquiry on hospital discharge and patient flow. RCP, 2022.

Ending the postcode lottery: the case for an independent NHS Wales executive. RCP, 2021.

Snowed under: Winter pressures in Wales. RCP, 2021.

Response to 'A Healthier Wales: A workforce strategy for health and social care'. RCP, 2019.

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