RCP president’s visit
Swansea Bay University
Health Board

College report | 10 November 2021
Across the country, this past winter put medicine under a lot of pressure. The situation at Swansea Bay is better than many, but not without its challenges. This isn’t just about COVID-19: more people are presenting at the front door of the hospital with complex medical conditions and the acute take is getting busier and busier.

Overall, this was a good visit with very helpful presentations and plenty of engagement from all the groups we met, including consultant physicians, staff, associate specialist and specialty (SAS) doctors, physician associates (PAs), doctors in training and the health board leadership team. It was encouraging that so many people contributed to the visit and suggests to me that there is a good appetite for working together to improve patient care.

Workforce shortages and the lack of beds were the two main issues. It’s also key that the health board ensures that proposed changes to acute medicine are rolled out gradually, not switched over in one go. Consultants were supportive of the new chief executive and they generally agreed with the decision to reconfigure urgent and acute medicine onto one site.

Trainee feedback was very positive. Most felt very supported by their consultants and said that local teaching was good. However, there was unanimous agreement that an extremely heavy workload meant that it was almost impossible to get to outpatient clinics, which is a huge problem. Pre-COVID, trainee doctors were required to attend a certain number of clinics as part of their medical education. While this specific target is on hold because of the pandemic, clinics are still a vital part of the training and learning experience for junior doctors. Internal medicine trainees (IMTs) must be able to leave the wards to attend them, otherwise they will struggle to progress their careers. Protected blocks of clinic time would be one solution: this would free trainees from their ward commitments and allow the wider specialty team to cover planned staff absence.

The new plans for reconfiguration of services seem very sensible. However, I’m afraid the real success of these changes will depend entirely on having enough staff. If you haven’t got enough people to deliver the services, that’s when you run into problems: this is about patient safety, staff morale and medical training opportunities. With so many delayed transfers of care in the existing system, there will need to be a careful transition and not an overnight switch to the new structures.

Dr Andrew Goddard
RCP president
Consultant in gastroenterology
Foreword by the vice president for Wales

I am pleased to say this was a very positive and enjoyable visit. There was a real sense of togetherness among the physicians, a recognition that they had collaborated well over the past 2 years and become closer and more supportive as a result.

However, the issue that came through time and time again was the impact of staff shortages on workload, teaching and waiting lists, to name but a few. This means that every team in every hospital must ask themselves, how can we make our jobs more attractive?

We know there is a national shortage of consultant physicians; appointments are at their lowest ever level because of a lack of applicants. Worse still, we are not yet training enough medical students to allow for the projected increase in patient demand in a decade.

To begin with, I’d suggest two things: first, involve more clinicians in senior decision making. In Swansea we heard that while consultants felt engaged with the discussion, direction and development of reconfiguration plans, they felt a lot less engaged with the final decisions and they were very concerned about the reality of workforce and bed shortages and whether the implications of this were truly understood by the executive team.

Secondly, think about the wider team. Can you focus on developing and supporting your SAS workforce? The RCP is hoping to work with the General Medical Council (GMC) to make the certificate of eligibility for specialist registration (CESR) process much more straightforward. And how about your physician associates (PAs)? Are you asking them what they want?

People want to belong. They want to feel part of a bigger organisation where they are supported to develop their career and they feel valued for their skills. As experienced staff approach retirement or come close to burning out after the intensity of the past 2 years, we will have to work hard to keep those people in the NHS.

It has been a tough 2 years. As we emerge blinking from the Omicron wave, we may finally have some time to stop and reflect on the way we have been doing things in the NHS. There will be so many opportunities to change the way we work as we rebuild from the pandemic: successful transformation will depend on genuine involvement and engagement with the people it affects, and that means empowering clinicians to make key decisions.

Dr Olwen Williams
RCP vice president for Wales
Consultant in sexual health and HIV medicine
Introduction

On Wednesday 10 November 2021, consultants and trainees working at Swansea Bay University Health Board (SBUHB) hosted a virtual visit by Dr Andrew Goddard, RCP president, Dr Cathryn Edwards, RCP registrar, and Dr Olwen Williams, RCP vice president for Wales.

The visit was hosted by Morriston and Singleton hospitals and attended by doctors working across SBUHB. During the visit, we met with trainee doctors and consultant physicians, before presenting our initial feedback to members of the health board leadership team. Around 70 consultants, trainees and PAs joined the meeting, both online and in person, with several providing written evidence beforehand. This report is intended to provide constructive recommendations to the health board and clinicians in the Swansea Bay area.

A special thank you to Dr Maneesh Udiawar, RCP college tutor at Morriston, and Dr Chin Lye Ch’ng, former RCP college tutor at Singleton, for organising the visit, as well as Dr Tai Anjum for his presentation on ‘The new medical care model for SBUHB’ and Dr Rhodri Edwards for his presentation on ‘Transforming acute frailty services in SBUHB’.

Another big thank you must go to the trainees who presented on ‘Internal medicine training at Morriston Hospital’: Dr Su Thiri Aye and Dr Aung Min Saw, who are RCP associate college tutors at Morriston Hospital.

We also invited written evidence from clinicians working across SBUHB and we have included these submissions as an appendix to this report.

In the spirit of collaboration and improvement, we hope to organise a follow-up visit within the next 6–12 months to hear from trainees and consultant physicians about where progress has been made.

Headline findings

› Consultants felt supported by their colleagues and there was a sense of team spirit.
› Trainee doctors said they would choose to return to SBUHB to work as consultants.
› There was very good engagement during the visit.
› Most doctors were enthusiastic about proposed changes to urgent and planned care.
› However, many doctors had serious reservations about workforce and bed shortages.
› Written evidence reflected concerns about workload, capacity and engagement.

Recommendations

As an immediate priority:

› In collaboration with clinicians, royal colleges, Health Education and Improvement Wales (HEIW) and other bodies, the health board should develop and consult on a publicly available workforce plan which sets out health and care workforce numbers and the projected numbers needed for the next 5–10 years, alongside a local recruitment and retention strategy. This should consider the impact of the proposed reconfiguration of acute services and the development of the SBUHB centres of excellence, as well as changes in patient demand and working patterns among staff, such as people working part time.

› Proposed changes to urgent and planned care services in the Swansea Bay area should be phased in gradually, with a clear transition period. There should be no overnight switchover. Clinicians should be genuinely engaged in decision making.
The health board should also:

**The impact of the pandemic**

- Consider how to build and repair relationships with those clinicians who feel that the pandemic workload fell unfairly on some medical specialties.

**Workforce shortages**

- Consider how other staff groups, eg PAs and SAS doctors, can be supported to develop their career and feel a stronger sense of belonging.
- Consider how best to connect doctors with wellbeing and mental health services.

**Medical education and training**

- Consider introducing a protected block of outpatient clinic time for trainees.
- Ensure that regional teaching is planned with enough notice to allow trainee doctors to book study leave and attend.
- Improve data and information access and data governance processes to enable trainee doctors to undertake quality improvement (QI) and audit projects.
- Encourage trainee doctors to carry out QI projects around improving rotas, widening clinic access or developing new teaching opportunities.
- Continue to support and develop junior doctor forums.

**Pressures at the front door**

- Ensure there has been substantial recruitment before implementing any proposed changes to urgent and planned care. An increase in workforce should be a pre-requisite to bringing together acute medicine onto one site.

**Clinical engagement**

- Involve clinicians not only in discussion and development, but also in decision making about changes to the way medicine is planned and delivered in Swansea Bay.

‘We are very happy with this report and think it reflects the actual situation on the ground. The recommendations are solid and realistic.’ – trainee doctor
# Background and context

**Swansea Bay University Health Board (SBUHB)** runs NHS services in the Neath, Port Talbot and Swansea areas, as well as specialist services for south-west Wales and some very specialist services for people from further away. They plan and provide services at three main hospitals (Morriston, Singleton and Neath Port Talbot) as well as a community hospital in Gorseinon, primary care resource centres, GP surgeries, dentists, chemists and opticians and providing community services such as district nursing, therapy, school nursing and health visiting. They provide a range of specialist mental health and learning disabilities services in hospitals and community facilities. They employ approximately 12,500 staff and spend around £1 billion every year on providing health services for the 390,000 people who live in the Swansea Bay area.

### GMC national training survey 2021

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Morriston Hospital is one of the largest hospitals in Wales with around 720 beds. It is the regional acute tertiary hospital for south-west Wales, offering a range of specialist services, including trauma and orthopaedics, renal medicine, neurology, oral and maxillofacial surgery and it hosts the regional cleft lip and palate service for children and adults. It offers one of two cardiac centres in Wales and is home to the Welsh Centre for Burns and Plastic Surgery, and bariatric surgery for Wales. It has a modern intensive care unit. Morriston has one of the busiest emergency departments in Wales and hosts the Emergency Medical Retrieval and Transfer Service Cymru (EMRTS). It also provides acute medical beds and a wide range of surgical and urological services, children’s wards and a children’s high dependency unit. It has a full range of diagnostic and therapeutic services, and outpatient services. Over the past few years Morriston has been undergoing a £100 million-plus redevelopment with new buildings replacing pre-war estate.

Singleton Hospital hosts a range of services including acute assessment, acute medicine and care of older people. It has about 330 beds and provides a regional, consultant-led maternity unit and neonatal intensive care. Other services include ophthalmology, ear, nose and throat, and genitourinary services. The South West Wales Cancer Institute and a separate chemotherapy day unit are also at Singleton. Bone marrow transplants are carried out by the haematology service.

Neath Port Talbot Hospital was opened in 2003 and has about 200 beds. It provides a range of inpatient, outpatient and day-case services, as well as some specialist services, including regional fertility services and neurorehabilitation. They have a minor injury unit (open 7 days a week from 7.30am until 11pm), a midwifery-led birth centre, planned orthopaedic and general surgery, care of older people, rheumatology and radiology. It also has a urology suite, endoscopy and day surgery. The hospital also has a children’s assessment unit, a children’s centre and in-patient mental health services. The Afan Nedd Day Unit at the hospital provides a range of multidisciplinary services for patients who have multiple health problems. There is also a palliative care unit which provides support and therapy for patients diagnosed with cancer. There are no medical trainees except dermatology trainees. All inpatients/on-call are covered by non-training grades.

With thanks to:
Members of the RCP visit team:  
Dr Andrew Goddard, president, Royal College of Physicians  
Dr Cathryn Edwards, registrar  
Dr Olwen Williams, vice president for Wales  
Dr Mick Kumwenda, RCP regional adviser (north Wales)  
Dr Hilary Williams, RCP regional adviser (south east Wales)  
Dr Vivek Goel, RCP regional adviser (south east Wales)  
Dr Sam Rice, RCP regional adviser (south west Wales)  

Representative of HEIW:  
Dr Shaun Smale, head of the school of medicine

Representatives of SBUHB:  
Emma Woollett, board chair  
Mark Hackett, chief executive  
Dr Richard Evans, executive medical director  
Gareth Howells, executive director of nursing  
Debbie Eyitayo, executive director of workforce and OD  
Dr Alastair Roeves, interim deputy medical director  
Dr Martin Bevan, joint group medical director, NPT and Singleton service group  
Dr Chris Hudson, clinical director of medicine, NPT and Singleton service group  
Dr Mark Ramsey, unit medical director, Morriston Hospital  
Dr Manju Krishnan, clinical director for medicine, Morriston service group  
Fiona Hughes, group service manager  
Kay Myatt, head of learning and development  
Donna Hole, medical education lead  
Llinos Hodder, postgraduate medical and dental manager
The impact of the pandemic

It was no surprise to hear that the COVID-19 pandemic has had a profound impact on the doctors that we met during our visit to SBUHB. However, as with other visits we have carried out during the past 2 years, it was good to hear that both consultants and trainees felt supported by their colleagues and there was a strong sense of camaraderie and team spirit.

‘It has been a very challenging year. We have supported each other, but it has been a stressful time.’
– consultant physician

‘People worked really hard and well together during COVID-19 and we are good at finding solutions. I’m very proud to work here with some excellent colleagues. I really do enjoy working here.’
– consultant physician

The general internal medicine (GIM) rota at Morriston Hospital during the first wave of COVID-19 was staffed by respiratory medicine, care of older people, stroke medicine, gastroenterology and acute medicine with some support from neurology on the wards. Gastroenterology doctors later left the GIM rota to focus on specialty work.

There was a perception among some physicians at Morriston that the workload had fallen unfairly on certain medical specialties at times during the pandemic; others told us that the situation had varied from hospital to hospital within the health board. The visit team felt that perhaps communication had broken down.

‘Everybody feels they’re under pressure and everybody [sees] it from their own perspective. [A lack of accurate information and clear communication] can allow misperceptions to grow.’
– RCP visit team

‘The brunt of COVID-19 work fell onto medicine. We owe a huge gratitude to the physicians who managed that. It has been both physically and emotionally draining. The trainees were absolutely brilliant too: their leadership and feedback has changed the way we delivered COVID care.’
– health board senior leadership team

While the executive team clearly recognised the contribution of physicians during our feedback session, it was not always clear that the doctors involved felt appreciated. Many of the written responses to our call for evidence focused on a feeling that a small number of specialties had shouldered more of the COVID-19 workload than others. This may be an unfair perception, but it is no less harmful even if it is inaccurate.

In the short term, the health board should consider how they can improve these relationships, and in the longer term, an increase in workforce is needed, alongside the successful implementation of new models of care to get people home sooner.
Workforce shortages

Repeatedly we heard from both consultants and trainees that the biggest issue remains an acute shortage of staff across the health board, leading to an unmanageable workload, especially at Morriston Hospital. Trainees told us that this was having a negative effect on their medical education and their training experience.

‘There are not enough staff and that is having a detrimental impact on training. We need to recruit more because there doesn’t seem to be a contingency plan for staff sickness.’ – consultant physician

Some doctors told us they felt unsafe treating patients at times, especially if there were rota gaps due to annual leave or staff sickness. It was felt that the health board needed to focus on recruitment and long-term retention as there was too much reliance on locums, many of whom stayed for only a few months before moving on, which is not very helpful.

‘The biggest problem is a lack of staff. We have a business case for workforce expansion which is floating around, not really going anywhere. We can predict the number of gaps, but we can’t recruit into those gaps until they happen – which means that we end up recruiting in August for a start date of November when we’re at our busiest. The new recruits get a poor induction (we don’t have the time to concentrate on settling them in) and they don’t get the opportunity to attend clinics.’

– consultant physician

In 2021, 59% of consultant physician posts advertised in Wales went unfilled. That’s three in every advertised five posts remaining empty, and in 63% of those cases, it was because there were no applicants at all. – RCP advisory appointments committees (AAC) data

‘Rota gaps are an issue. Consultants are supportive, but they say there’s not much they can do. Decisions about staffing come from senior management, and trainees are needed on the wards. There should be a strategic approach from the leadership because otherwise we’re inevitably going to struggle to deliver on these good intentions.’ – trainee doctor

‘It’s an ongoing and repetitive problem. All the specialties are constantly moving doctors and locums around, just to get us through the day. We spend a significant amount on locums which is why it doesn’t make sense that the business case is constantly being held up.’

– consultant physician
However, we recognise that this is a national problem. There are not enough consultants across Wales and the UK, and we are not training enough medical students. This needs to be urgently addressed by the Welsh and UK governments by increasing the number of medical students over the coming years to ensure that we are training enough doctors to meet predicted patient demand in the coming decade.

‘There aren’t enough [doctors] to deliver all the clinic and all the procedures and all the ward commitments that are required. There’s a dearth of consultant physicians across the UK.’ – consultant physician

The health board argued that they have changed their ways of working and improved recruitment to some of the hard-to-fill specialties. This approach should be expanded and developed for other parts of the medical workforce.

‘In medical recruitment, we’ve changed the way that we pitch some of our jobs and we’ve been able to recruit to some difficult specialties (eg mental health). Perhaps the cost of living in west Wales, combined with the desire for more green space during lockdown has focused people’s minds.’ – health board senior leadership team

‘There are some issues with the Welsh consultant contract. We are not able to easily match contracts with applicants from England which is quite a challenge. There’s no mechanism where we can give people parity with their NHS England salary. Fixing that would benefit Wales.’ – health board senior leadership team

The staff, associate specialist and specialty doctor (SAS) perspective

SAS doctors are an essential part of the medical workforce and make up around 30% of the UK physician workforce. The RCP has recently developed a new strategy for SAS doctors which aims to drive engagement with this vital group of doctors. During our visit to SBUHB, we heard from specialty doctors who felt that given the locum spend, more support for SAS doctors, including mentorship and support for the certificate of eligibility for specialist registration (CESR) process would be very welcome. Investing in substantive SAS posts could free up both trainees and SAS doctors to go to clinics and progress in their careers.
‘We need far more nurses, doctors and allied health professionals in post before any changes are implemented. Without addressing these issues, the proposed changes will lead to consultants leaving the health board.’ – consultant physician

We also heard that funding for PA posts is often only available for a year and teams struggle to make PAs permanent – which often means they train up, then leave after a year. One PA told us that it took 3 years to find a permanent post at the health board.

The health board acknowledged these staffing issues, and said they were working jointly with the local authority to make roles more attractive through improved terms and conditions.

‘Recruitment is a real challenge. In the wider health economy, and the care home sector in particular, zero-hour contract jobs are less attractive than secure hours in the retail sector. We’re trying to work with the local authority to recruit, because there are more benefits to being employed by the NHS and that might appeal more to the local community.’ – health board senior leadership team

The health board told us that they were about to appoint an SAS advocate lead and wanted to use the reconfiguration of acute services to improve how they recruit and encourage SAS doctors who ‘sometimes feel like a lost tribe’. This role should be linked into work being done by HEIW, the BMA and the royal colleges to support and develop SAS doctors.

Staffing the wider team

Many of the doctors were very concerned about the impact of staff shortages combined with the forthcoming reconfiguration of acute services across Swansea Bay. There was real concern that there were not enough nurses, allied health professionals and PAs in post to handle the extra workload caused by combining the acute take at one hospital while maintaining planned care, elective surgery and cancer services at another. We were told that nurse staffing was ‘diabolical … which has a massive impact on medical education and patient experience’.

‘We should be encouraging SAS doctors to take up different roles to make the job more attractive. There is variation between departments in how they use the wide skillset of SAS doctors; in some teams, they are just used as a service provider which is why they lack motivation. Perhaps more consultant mentors would help, or support for CESR processes. When there is no such support, departments are unable to attract SAS doctors.’ – specialty doctor
**Wellbeing and mental health**

We heard feedback that wellbeing support could have been improved during the pandemic. The trainees had felt supported by their consultants, and the consultants had felt supported by their consultant colleagues, but not necessarily by the health board. Doctors are historically reluctant to engage with wellbeing and mental health support, and the NHS should find innovative ways of connecting with this hard-to-reach group.

**The backlog**

Consultants were split on the issue of the backlog. In some specialties it was felt that waiting lists were becoming a constant juggle, targets were not being met, and this was having an impact on patient safety. On the other hand, some specialties felt their waiting lists had improved at the expense of the medical take (fewer doctors were now on the acute rota).

‘We have put all our resources into making sure that our cancer 2-week wait targets are met, but our urgent and routine waiting lists are becoming biblical, as are our clinic waits. It is morally exhausting.’ – consultant physician
Medical education and training

During our meeting with trainees, we heard that the quality of teaching was very good, and adapted well at the beginning of the pandemic, but staff shortages and the ensuing heavy workload are stopping trainees from attending clinics, practising core procedures and taking time away from the wards for learning opportunities. Regional teaching dates are often announced at short notice which limits the ability of trainees to take study leave.

‘Clinics are almost treated as “if you have time, then go”, rather than an important aspect of training.’ – trainee doctor

Consultants agreed that trainees were struggling to attend outpatient clinics, which is a crucial part of their medical education and contributes towards their career progression.

‘Clinics are a problem for our trainees. Because of the pandemic, we’ve lost clinic space, and because of social distancing, our capacity for trainees in the room is halved. We’ve got devoted and hardworking juniors and I feel quite bad I’m not able to offer them the training that they once had.’ – consultant physician

There is an active monthly junior doctor forum at Singleton, which has improved engagement and implemented several changes. However, due to workload, trainees often struggle to get to it and it isn’t always well attended. Trainees felt that the best way to encourage junior doctors into a particular specialty was for specialty registrars and consultants to actively encourage and develop internal medicine trainees (IMTs). Others pointed out that clinical leadership within a team is crucial and often it makes a huge difference to the trainee’s experience during a rotation.

There is weekly teaching at Morriston, but as many trainee doctors struggle to leave the ward, there is generally quite a low turnout among trainees for grand round. Cardiology was flagged as particularly problematic in accessing clinic time and securing clinical supervision. (It is up to trainees to find a clinical supervisor themselves.) Stroke and geriatric medicine were flagged as being particularly good for supervision and clinic attendance opportunities.

Quality improvement and audit

Being unable to access audit and QI opportunities can have a negative impact on a trainee’s higher specialty job and future career prospects. We heard that staff shortages among QI leads had led to significant delay in approving QI projects and was stopping clinicians from carrying out audits that are necessary to career progression.
Case study: internal medicine training at Morriston Hospital

In Morriston, there are IMT doctors working across cardiology, respiratory medicine, intensive care, gastroenterology, renal medicine, neurology, geriatric medicine, diabetes and endocrinology, acute medicine, rheumatology and stroke medicine.

We have weekly IMT, simulation and skills teaching as well as grand round. Some of the departments have their own teaching sessions. There is onsite PACES teaching and there are various all-Wales mandatory IMT study days.

Trainees were recently surveyed by their associate college tutors, who found that local teaching and clinical supervision were generally rated good, and supervisors could be contacted easily for help.

‘Whenever trainees want to take study leave, they worry about leaving colleagues short-staffed.’

However, the survey also found that an excessive workload is having a major impact on trainees’ ability to go to clinics, access core procedures, regional teaching and study leave days, and take up leadership, management, audit, research and teaching opportunities. Other trainees flagged poor induction processes.

Dr Su Thiri Aye and Dr Aung Min Saw
RCP associate college tutors
Morriston Hospital
Pressures at the front door

Currently, Morriston hosts the emergency department for the Swansea Bay area while Singleton has a medical assessment unit with a semi-selective take. (The minor injuries unit (MIU) has temporarily closed due to staff shortages so there are no walk-in patients.) Neath Port Talbot has a 7-day minor injuries unit staffed by emergency nurse practitioners, triage nurses and healthcare support workers.

Over the past few years, the health board has been consulting on proposed changes to urgent and planned care services in the Swansea Bay area. In essence, the plan is to consolidate the acute (general medical) take on one hospital site – Morriston.

However, the acute take has grown exponentially during the pandemic, with some specialties leaving the general medical rota (while still attempting to provide outreach and support to the general medical take). Overall, the general medical workload has increased substantially which is having an impact on morale, clinic time and teaching opportunities: one consultant physician called the situation ‘disheartening’.

‘As doctors, we are juggling lots of balls in the air, just to keep everything going. We’re seeing a lot more complex general medicine: people have been simmering away at home with various illnesses. The big challenge is how we can treat more and more patients with a very limited number of physicians.’ – consultant physician

The Changing for the future programme

Under the Changing for the future programme, the three acute hospitals (Morriston, Singleton and Neath Port Talbot) will be developed as ‘centres of excellence’.

- Morriston will be the centre of excellence for urgent and emergency care, complex care, specialist care and regional surgery.
- Singleton will be the centre of excellence for planned healthcare, women’s health, cancer care and diagnostic tests and routine day surgery.
- Neath Port Talbot will be the centre of excellence for orthopaedic and spinal care. It will also host rehabilitation, rheumatology, outpatients, day surgery and a 7-day MIU.

There are now fewer physicians on the general medical rota. These doctors are trying to manage their own wards and specialty clinics at the same time as keeping an eye on patients who are moved around the hospital on a day-to-day basis.
What is the medical take?

Medical patients make up the majority of acute unscheduled admissions to most NHS secondary care hospitals. These patients are usually admitted via the acute medical take and their number and complexity are increasing. One-third of all hospital admissions are via the acute medical take. The medical take in most hospitals is generally managed by a senior trainee doctor (under consultant supervision) in a medical specialty who dual accredits in general internal medicine (GIM). Medical registrars are often the most senior medical decision-maker in the hospital out of hours and are responsible for coordinating management of the most unwell patients. Currently, there is a shortage of dually accrediting trainees, particularly in acute medicine and geriatric medicine.

While most doctors were supportive of the general idea of consolidating acute medicine at Morriston, there was some apprehension about staff and bed shortages, a perceived lack of communication between planned and urgent care teams, and the potentially negative impact on medical education and training opportunities. Some medical registrars told us they were currently covering oncology, maternity services and surgery at times during their shifts at Singleton. This should not be happening.

The health board is planning to combine management for acute medicine at both sites when the changes take effect. We also heard that where there are two separate services at present (eg gastroenterology, respiratory medicine), these will be brought together. The health board recognises that a critical mass of physicians is needed to practise specialty medicine and deliver GIM effectively. They assured us that these changes will deliver that critical mass.

During our feedback session with the health board, the leadership team told us that they recognised the importance of general medicine and were cognisant of the need to plan carefully and mitigate the impact on medical training and patient safety (eg ensuring safe and rapid transfers of care between hospitals). We were reassured to hear that the health board would not risk a ‘big bang’, but would take a phased approach.

‘General medicine is the golden thread that runs through all hospitals. In the middle of the night when somebody gets sick, the medical registrar gets called. We need a team spirit in medicine, with GIM at the core.’ – health board senior leadership team

The health board assured us that they are keen to make sure that people get a good training experience from the new case mix across two sites and they were planning a much more consultant-based and delivered service going forward, particularly around acute medicine.

‘GIM is the backbone of the hospital. It’s an important shared identity and contribution. We know that sites without acute medicine aren’t always attractive for medical training so we are talking to HEIW about this and we will need to develop a blended approach for people working across two sites.’ – health board senior leadership team
Case study: the new medical care model for SBUHB

The plan is to move all unscheduled care to Morriston and create one front door for acute medicine for the health board. We know that what we do in the first 2 days of a patient’s journey determines what happens to them in the longer term, and we are trying to get it right the first time by improving our pathways. We want to have a consultant-led take, 12 hours a day, 7 days a week: this will improve patient safety, avoid treatment delays and help the rapid discharge policy.

The acute hub at Morriston brings together the acute GP-led unit, the urgent primary care centre and ambulatory emergency care. Patients will be referred from primary care, the emergency department, as walk-in patients or via the ambulance service, then triaged through the acute hub (bypassing the emergency department where appropriate), leading to a timely senior clinician review in line with our rapid discharge policy. An alternative to admission, the acute hub will provide same-day investigations, treatment and rehabilitation therapies. If a patient needs to be admitted, they’ll come into the acute medical unit (AMU).

The AMU will be a 24/7 rapid access facility with a 12-hour turnaround. On a busy day we can see around 120 patients. We are co-located with the ambulatory emergency care teams so that staff can talk to one another and work flexibly to meet patient demand.

Getting people home is very important. We have a consultant review twice a day where the specialities can signpost to outpatient clinics or discharge patients. There are eight GP clusters in SBUHB: each has (or soon will have) access to a virtual ward staffed by therapists, geriatricians and a multidisciplinary team.

We are also in the process of centralising rehabilitation to a dedicated facility in Neath Port Talbot Hospital and we are working with social services by training nurses to do basic assessments, which will speed up the process of getting people home.

Capacity and workforce remain the real issues. Where are we going to find all the staff we need? However, we have begun to recruit, and we are working with local authorities to commission care home beds so we can transfer patients who are waiting for long-term care.

Dr Tal Anjum
Consultant in stroke medicine
Clinical lead for stroke
Morriston Hospital
New ways of working

‘We have huge waiting lists in all areas. The medical takes are huge. There is broad support for the plan to reorganise services across Swansea and bring all acute medicine onto one site, but there is great concern that there will not be enough beds or staff in Morriston when the change occurs.’ – consultant physician

The success of these plans will depend a great deal on other parts of the system: the assumption is that delivering more care in the community will free up inpatient hospital beds, and establishing more virtual clinics will free up clinical and patient time. The health board appears to understand the need to avoid a ‘big bang’ approach to reorganising hospital services, and the RCP strongly supports a careful and phased approach to reconfiguration of acute services, in close collaboration with the clinicians themselves.

A ‘delayed transfer of care’ (DTOC) occurs when a patient is ready to leave a hospital or similar care provider, but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. DTOCs can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

Several clinicians told us that while they welcomed the move from Singleton to Morriston, they were concerned about the loss of bed space for acute medicine. There were mixed feelings on whether commissioning extra beds in the community would work as a long-term solution and consultants were adamant that the health board should introduce a gradual approach to reducing the number of beds available.

‘In the long term we’re hoping that the virtual wards model will reduce the need for inpatient beds, but we need to be very careful and use a phased approach to shutting wards. It is a highly challenging situation.’ – consultant physician

The health board told us that they are working with primary care to develop pre-hospital and admission avoidance pathways, palliative care consultants are looking at how terminally ill patients can be enabled to die more comfortably at home, and they have brought primary and secondary care leads together to look at how to bring down waiting lists.

‘We have made some progress in building a relationship with community services and the local authority. As clinicians and geriatricians, I’m not sure that we’re engaged as much as we could be, although it is getting better.’ – consultant physician
Case study: transforming acute frailty services in SBUHB

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 orthogeriatrics 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.

Workforce is 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
Clinical engagement

While there was widespread support for the new chief executive – ‘he seems to understand the problems’ – we heard that frequent staff changes at executive level were unsettling.

‘There has been enormous churn in the health board executive team. There’s no consistency, no organisational memory, there’s a different plan every year, and every time a new team comes in, they change the structures again.’ – consultant physician

Some consultants felt there had been lack of genuine clinical engagement: there is a big difference between discussion and decision making, and several doctors told us that they felt consulted but not necessarily listened to. The health board may wish to consider how they can engage in a way that genuinely puts clinicians themselves into the driving seat.

‘It feels as though medicine has been marginalised in the discussion and delivery of health board planning. Frequently it is only the medical director who is in the room when significant changes are being planned.’

– consultant physician

We were told that there is clinical engagement at discussion stage, but decisions about acute medical service redesign are taken at an executive level, frequently with no medic in the room: in fact, we heard that consultants perceived there to be an absence of medical input into core health board management decisions.

‘The engagement informs the plan and is a genuine exercise, but in the end the decisions are taken in the absence of medical staff.’ – consultant physician

‘Decisions are made in a closed room, with people who do hardly any work on the ground, those who don’t know the reality on the ground. Decisions are made and we are informed – but not involved with – those decisions.’

– consultant physician

However, the health board executive team was keen to stress that changes are clinically led, staff have been given the opportunity to engage, and things are improving. They told us they have established a clinical senate (including representatives from medicine, nursing and the therapies) which meets monthly to share good practice and innovation. We also heard that SBUHB is the most rapidly improving health board in terms of medical engagement scores. The health board may wish to consider whether there is anything else they could be doing to improve engagement and communication with physicians, especially in decision making.
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.

Over 40,000 members worldwide (including more than 1,500 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.

We organise high-quality conferences and teaching. Our work with the Society of Physicians in Wales showcases best practice through poster competitions and trainee awards. We work directly with NHS bodies, we carry out hospital visits, and we collaborate with other organisations to raise awareness of public health challenges.

Speaking out on behalf of physicians in Wales