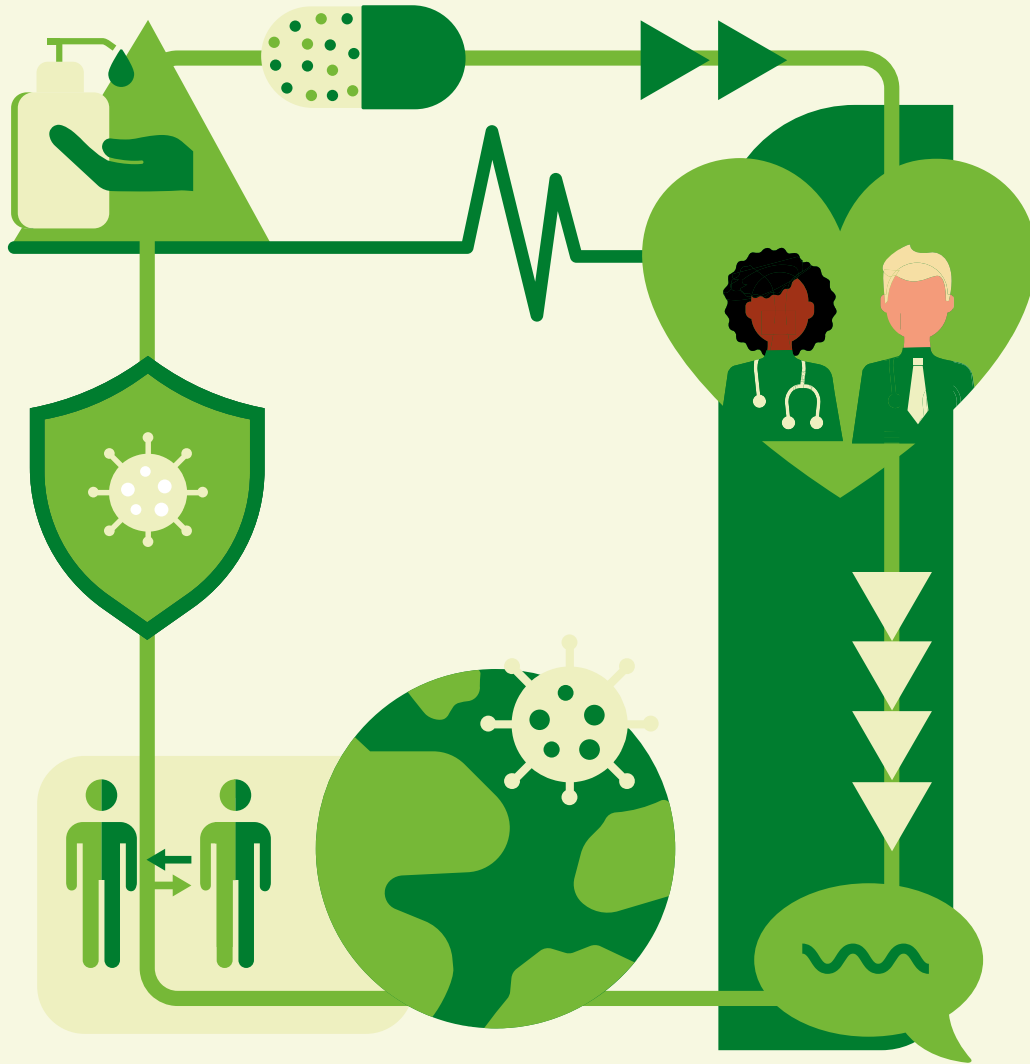




Royal College  
of Physicians

Coleg Brenhinol  
y Meddygon (Cymru)



# Recover, rebuild, renew

An update to our action plan  
for the next Welsh government

March 2021

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## A year like no other

So many things have changed during the past year. Every aspect of life is different. The ways in which we shop, socialise, work and learn are almost unrecognisable. Our NHS and social care systems were transformed overnight: staff were redeployed, hospitals were redesigned, non-COVID-19 face-to-face activity was drastically reduced, and patient pathways were completely restructured.

As we emerge from the impact of a second wave, combined with winter pressures and clinician exhaustion, it is time to think beyond the pandemic. From virtual outpatient clinics to a new focus on workforce wellbeing, we must use this opportunity to embed new ways of working into the way the NHS cares for its patients and staff.

The past 12 months have put immense strain on the health and care workforce. Thousands of clinicians and care workers are exhausted; some will be close to burnout. Around 90% of all hospital inpatients with COVID-19 are cared for by physicians, and this disease is taking a physical and emotional toll on every single one of them. In January 2021, a survey of members of the Royal College of Physicians (RCP) found that almost one-third had sought mental health support during the pandemic.<sup>1</sup>

Even before the pandemic, high workload pressures were common. In an RCP survey in February 2020, almost half of respondents in Wales told us that their workload is excessive always or most of the time, and they never, or only sometimes, feel in control of their workload. A quarter felt emotionally drained at work always, or most of the time.<sup>2</sup>

More than one-third of consultant physicians in Wales will reach retirement age in the next

10 years. In our 2019–2020 annual census of consultant physicians in Wales, carried out just before the pandemic began, 40% of respondents reported daily or weekly rota gaps, and 23% said this causes significant patient safety problems in their hospital. Almost three-quarters of respondents in Wales said their work-life balance had been negatively affected by rota gaps and consultant vacancies.<sup>3</sup>

Since March 2020, our lives have been dominated by the profound effects of the COVID-19 pandemic. As we recover and rebuild, we must address longer-term issues of health inequalities, reduce workforce pressures, improve access to clinical research opportunities, and bring together an oft-fragmented health and social care system.

In September 2019, RCP Cymru Wales published an action plan for the next Welsh government with over 80 recommendations. This report reaffirms our commitment to those ideas. We also highlight the work of consultant colleagues working in community resource teams during the pandemic, many of whom have continued with home visits, providing specialist care to frail, older patients as well as those with multiple complex needs.

Finally, if there is one positive thing to come out of the past year, it is the resourcefulness and innovation shown by our trainee doctors – our future NHS Wales consultants. I am proud to say they have more than risen to the challenge; here we showcase some of the best examples of their work to improve patient care and medical education from across Wales.

Daw eto haul ar fryn.

Above the dark clouds, there is blue sky.

**Dr Olwen Williams OBE**  
RCP vice president for Wales

# Recommendations

## Specialist care closer to home

The next Welsh government should work with NHS Wales to:

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

- > commit to national action to support improvements in end-of-life care.

## Wellbeing and the workforce

The next Welsh government should work with NHS Wales to:

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

- > invest in and regulate new healthcare roles such as physician associates
- > give overseas doctors the chance to train in the NHS using the medical training initiative (MTI)
- > ensure that research activity is integral to the work of their organisation
- > ensure that NHS boards receive a regular update on research activity and findings
- > ensure there is a direct link between research teams and the board
- > use job planning to protect time for clinical research in a more equitable fashion across Wales
- > provide opportunities to showcase research, including to patients and the public
- > ensure research and development departments are equipped to provide leadership and advice
- > ensure transparency for funding and resource allocation
- > facilitate the translation of research into practice across the NHS.

## The impact of health inequalities

The next Welsh government should work with NHS Wales to:

- > develop a cross-government strategy to reduce health inequalities
- > integrate the impact of the socio-economic duty and the Wellbeing of Future Generations Act
- > ensure all health boards invest in specialist, clinically led obesity treatment services
- > appoint a national clinical lead for severe and complex obesity, accountable to the first minister
- > set clear and accountable targets for preventing and reducing obesity
- > introduce a Clean Air Act for Wales that will improve the quality of the air we breathe
- > support and invest in integrated alcohol and substance misuse treatment and prevention services
- > place a renewed focus on delivering and extending an ambitious Tobacco Control Plan for Wales.

# Specialist care closer to home

The next Welsh government must support clinicians to develop innovative solutions as we rebuild the post-pandemic NHS. A renewed focus should be placed on enabling health and social care systems to work more closely together, thus allowing key workers to provide seamless care and improve the experience of patients with complex needs.

COVID-19 forced the NHS to redesign services overnight. Where these changes have made a positive impact on the lives of patients and staff, innovation should be embedded into everyday practice. This includes video clinics and remote consultations, where they can be used appropriately.

Primary, intermediate, community, secondary and social care colleagues should work together more closely to share learning and strengthen relationships. The care closer to home narrative must be supported by a significant investment in resources and staffing, especially in social care.

**‘One patient begged me to get him home. He went on a long waiting list for step-down care, caught COVID-19 in our hospital and died. This will stay with me for some time and makes me sad and angry.’**

– Consultant physician, NHS Wales

Collaboration between GPs and geriatricians should be at the forefront of the design and delivery of the care of frail older people. Strong professional relationships across primary and secondary care are built on good communication.<sup>4</sup> Specialist intermediate care in the community reduces unnecessary hospital admissions and enables people to stay at home for longer.

**‘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.’**

– Tom Barton, Bridgend acute clinical team

However, these teams are often under-resourced and under-recognised. In some cases, staff have been redeployed to the COVID-19 effort, which has reduced the capacity of community teams to treat patients at home and keep them out of hospital in the first place. Expanding specialist medical care in the community, alongside primary care, will be key to rebuilding the post-pandemic NHS.

New challenges are emerging. Persistent symptoms lasting longer than 3 weeks are thought to affect 10–20% of patients following SARS-CoV-2 infection.<sup>5</sup> Long COVID is not yet fully understood and, because it is a new illness, services are patchy and inconsistent across Wales. The next Welsh government must ensure that all health boards are supported to care for these patients as our knowledge of the illness improves.

## Community resource teams

Community resource teams (CRTs) are integrated intermediate care teams of health and social care professionals who work to coordinate care for people living at home. These teams aim to reduce avoidable admissions to hospital, expedite discharge, and improve the quality of life for patients with complex health and care needs. CRTs can include community physicians; care assessment and reablement services; mobile response teams; and telehealth facilities. They often work closely with GPs and primary care to coordinate short and longer-term care in the community.



## Case study

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### ‘We are going into people’s homes where the risk is high on both sides’

*Gwent Frailty is a multidisciplinary service which aims to reduce unnecessary hospital admissions and facilitate early hospital discharge. Referrals to the service are made by healthcare professionals and processed by a central single-point-of-access (SPA) team which links medical and social care professionals with community resource teams.*

‘COVID-19 took us by surprise. Massive changes had to be made because we didn’t understand the illness. There was a little bit of stepping back while we thought about how we could keep our staff safe. We had immediate concerns that while we were focusing on COVID-19, there would be patients deteriorating in the community with other illnesses.

We decided to manage the risk. We knew we needed to be out there in the community delivering the same quality of patient care while taking precautions. That was the most important thing. All the consultants were doing a lot more home visits; it is easier for senior clinicians to take rapid and decisive decisions to keep patients at home. We made the choice to give up our supporting professional activities (SPA) time and prioritise our clinical work. We also used technology to offer direct advice and virtual consultations with GPs.

We learned a lot. Staff adapted very quickly: they worked differently across the service when needed. We developed an integrated assessment unit which helped frail, older and complex patients to get home sooner. This was run by a multidisciplinary team alongside discharge liaison services with occupational therapists and physiotherapists. The service ran into difficulties during the second wave when beds were needed by much younger, acutely unwell patients, but we are keen to restart the service when we can.

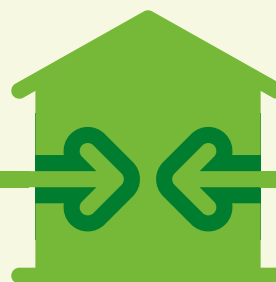
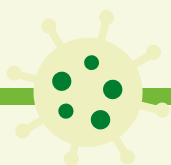
The Welsh government needs to prioritise intermediate care, frailty and community medicine. There has been amazing work done by intensive care doctors and emergency medicine. The pressure they face is unbelievable. But we have carried on doing home visits in very challenged areas throughout the whole pandemic.

During the second wave, we are successfully managing to keep some very complex, intense, multi-morbid patients out of hospital. We’re doing our bit to prevent the surge into secondary care. But the team is exhausted. People don’t understand what primary care, intermediate care and community teams have achieved over the past year. We have kept so many patients out of hospital, and it would be nice to have that acknowledged. There’s less recognition or understanding of what we’ve done. We are going into people’s homes where the risk is high on both sides.

Everyone talks about a whole-system approach, but the resources are all in secondary care. There’s so much value in early intervention, so many opportunities to have a longer-term impact on hospital flow. We’ve done a lot of pilot projects and we’re often approached to share our learning with other health boards, but it’s almost like we must continuously prove our worth to access funding. It is quite frustrating. Intermediate care is caught in the middle between primary and secondary care. Slowly, we need to become a stronger voice.’

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**Dr Jaideep Kitson, consultant physician**  
**Kate Fitzgerald, Gwent Frailty programme manager**  
Aneurin Bevan University Health Board



**Key recommendations from *Breaking down barriers: our action plan for the next Welsh government*.<sup>6</sup> The next Welsh government should work with NHS Wales to:**

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- > commit to national action to support improvements in end-of-life care.





## Wellbeing and the workforce

The next Welsh government must support doctors to deliver the best care possible by investing in training, education, and career development. Physician associate regulation must be fast-tracked, medical school places should be increased and there should be more flexible working. Perhaps most importantly, all clinicians must be allowed time and space to rest and recuperate.

**‘I am very concerned about the lasting impact [of the pandemic] on the mental health and wellbeing of all my colleagues, including doctors and nurses. Some of my team are broken already, and we haven’t reached the peak in my area’**

– Consultant physician, NHS Wales

The NHS workforce has gone above and beyond during the pandemic. In July and August 2020, the General Medical Council (GMC) national training survey provided a stark warning: 59% of trainees in Wales felt somewhat or highly burnt out because of their work.<sup>7</sup> Consultants and specialty doctors also reported feeling the strain, with 84% saying that their work was emotionally exhausting.<sup>7</sup>

**‘My last proper leave was several months ago. I have worked continuously. I’ve supported almost everybody I could. Mentally and physically, I am exhausted. I know now that I must stop.’**

– Consultant physician, NHS Wales

Even more concerning is that one-third of consultant physicians have an increased risk of a COVID-19-related death. The risk is mainly driven by age, gender, and ethnicity, and is highest in male consultant physicians over 60, especially from BAME backgrounds.<sup>8</sup> More than 90% of all doctors and consultant colleagues who died during the first wave were BAME.<sup>9</sup>

**‘I really was apprehensive. Every visit I did, I was scared, and I didn’t know what I was taking home to my kids and my wife. I’m still anxious. This job is my passion, but I’d be lying if I said I was not worried about it.’**

– Consultant physician with a BAME background, NHS Wales

Now is the time to repay these clinicians. Healthcare professionals deserve fair, flexible and filled clinical rotas; guaranteed protected time for research; innovation, leadership and medical education; investment in junior and specialty doctor forums for every hospital; and a named executive lead responsible for supporting and improving staff wellbeing in every health board.



### ‘Working under the physical and emotional strain is just breaking people’

‘My team is patient-facing; we support people with chronic conditions to manage the psychological impact of their diagnosis and treatment. But at the beginning of the pandemic, we didn’t have the technology set up to support patients remotely. Because we had some capacity, we offered to help colleagues who were working in the existing staff psychological wellbeing service.

The health board took it really seriously. They funded all sorts of staff wellbeing support, including extra psychology staff, and this was made available to everyone who worked for the health board. We already had a clinical health psychologist working in critical care, so we extended our service to support this role in supporting ICU staff and COVID-19 ward staff. With them we developed and sourced online coping resources which were shared on the health board intranet, by email and on social media. We also set up a generic contact email and a 7-day staff helpline which also meant my team were able to work flexibly around their caring responsibilities if they had children at home.

We were expecting trauma work, but it didn’t happen. Staff coped pretty well during the first wave. In the end, my team returned to patient-facing work; we developed our capacity to carry out remote consultations. Some of our patients had deteriorated in that time; they were very vulnerable, and COVID-19 was quite frightening for them.

But we did continue to work on an ad-hoc basis with some colleagues. Staff were tired by now, and worried that the second wave was coming. They hadn’t had a break. Many of the senior consultants were not switching off at all – their phones were always turned on, and they were monitoring cases from home during evenings and weekends. Medics are not great at asking for help, but in the end, several doctors did access one-to-one support services.

We offered some advice sessions. We talked to management about the ‘always on’ culture that had developed; they hadn’t been aware, and they stepped in. Better communication between the consultants and managers seemed to ease the pressure they were putting on themselves.

The workload is worse than ever now. People are tired. The intensity, the PPE, the emotional strain: it’s immense. And they’re expected to do the same number of hours in a shift as before the pandemic. It’s awful. Working under that physical and emotional strain is just breaking people; it’s a workforce capacity issue. We need more doctors, more nurses, more allied health professionals.

As clinical health psychologists, it’s part of our role to support staff to do the best job they can. If we’re not looking after our colleagues, their patients aren’t going to be getting the best care possible. Investment in preventative wellbeing services is so important; if we can persuade staff to seek help before they burn out, we can keep them in the workforce.’

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#### **Dr Bethan Lloyd, consultant clinical psychologist**

Head of clinical health psychology: general health  
Hywel Dda University Health Board





For healthcare workers, the anxiety of caring for patients with COVID-19 alongside personal danger, fear of placing loved ones at risk, extended shifts, disrupted processes, rota gaps and wider social restrictions have only compounded pressures.<sup>10</sup> The emotional and physical toll of working through a global pandemic for a year has left doctors exhausted and in desperate need of rest.

There have been many positive messages about the hard work and resilience of NHS and other key workers. But when the pressure of the pandemic passes, doctors tell us they are concerned it will only be replaced with the pressure of tackling the backlog.

In February 2021, an RCP membership survey found that half of respondents were not getting enough sleep.<sup>11</sup> A large proportion (63%) felt tired or exhausted and 27% said they felt demoralised. Despite this, 63% said there had been no discussion in their organisation about timetabled time off to recuperate. Staff must be given time off to rest and recover from the pressure of the pandemic, so they are ready to face the next challenge of tackling pent-up demand of non-COVID-19 care.

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**‘I am exhausted. In respiratory medicine, we have been dealing with growing pressures for almost a year, and we have been at the front door throughout the pandemic. We have had severe staff shortages because of sickness, and the emotional toll of working on a COVID-19 ward is huge. I was an enthusiastic new consultant at the start of this, and now feel broken.’**

– Consultant physician, NHS Wales

Belonging to a team is important; feeling supported and valued by your colleagues is essential, especially during a crisis. But this won't be enough in the long term. The NHS must deliver now on the priorities in its health and social care workforce strategy and deliver systemic change. This should include flexible working arrangements, investment in diagnostics and new technologies, and an increase in workforce numbers. A recruitment strategy is no use without a sustainable retention strategy.

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**‘Offering wellbeing services doesn't make up for an unprecedented workload, inadequate staffing, the risk of acquiring COVID-19, or a lack of training.’**

– Trainee physician, NHS Wales

The impact of this pandemic on NHS staff will last a very long time. Their patients, friends and colleagues have been critically ill, some have died. Many will have had COVID-19 themselves; others will be diagnosed with long COVID in the months to come. A growing backlog of non-COVID healthcare threatens to overwhelm the system. Thousands of doctors – many not used to seeing death in their usual roles – have been deployed away from their specialty and their colleagues. Junior doctors have lost months of education and medical training.<sup>12</sup>

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**‘We're seeing a lot of trainees who are experiencing symptoms of long COVID. Pre-pandemic, around a quarter of our referrals would be related to exam stress and career progression. Another third might be health-related referrals. The rest would be professionalism concerns. But since September 2020, the proportion of people with health issues has doubled. The effects of long COVID are crippling when you take a high-achieving individual who's used to a fast-paced life. Some are unable to get out of bed, unable to even sit up in bed.’**

– Professional support unit manager, Health Education and Improvement Wales

Eighty per cent of respondents to one north Wales survey of trainee doctors said that the pandemic had negatively impacted their learning. Forty-three per cent felt their progression to specialty training would be harmed, and 70% did not think they were adequately involved in the decision-making process around redeployment.<sup>13</sup>

### ‘NHS staff will need mental health support to move forward from a devastating year’

‘Information about COVID-19 moved so quickly at the beginning. This newly unpredictable working environment meant that we needed a clear, accessible and rapid way to get up-to-date information out to as many healthcare professionals as possible. We established a WhatsApp group in which only group admins could publish information, which allowed us to post a daily *COVID-19 update and quick reference guide*. A similar group was also set up in the neighbouring hospital, and both sites communicated regularly to ensure continuity across the health board. This project was a personal success for us, knowing that a broad cohort of staff had instant access to relevant COVID-19 information.

Another key challenge we faced was the sudden halt in medical training and junior doctor rotations. The change in focus from specialty training to emergency care was clearly needed but risked leaving some trainees underprepared for the challenging transition from internal medicine trainee to medical registrar later in their career. The real danger was that this might deter some trainees from taking up higher specialty roles.

*The Call the medical reg* course was initially developed in Wales; it has become very successful over the years. This year, we collaborated with Health Education and Improvement Wales to run the course on a virtual platform. This opened the course to more delegates from a wider geographical spread and allowed some speakers to pre-record talks. Smaller break-out sessions added variety and encouraged networking. We showed that high quality learning can be achieved using a virtual platform, and we hope to develop and expand the course online in the future.

In setting up the daily *COVID-19 update* WhatsApp group, we realised this was also an opportunity to share wellbeing strategies. Healthcare professionals are at increased risk of moral injury and mental health struggles, especially during a pandemic. In addition to general wellbeing resources, our in-house clinical psychology team offered both individual and group sessions either face-to-face or via telephone for all staff members.

There was also a focus on the welfare of junior doctors: this included help with arranging flights when relatives were unwell overseas; sensitively altering on-call shift patterns when needed; providing scrubs and toiletries; and delivering shopping and checking-in on colleagues who were self-isolating. We recognised that the foundation doctor cohort were particularly vulnerable during the national lockdown period, given the majority were resident on the hospital grounds. Better communication made staff feel more informed and valued, and improved team morale. Our research found that the proportion of healthcare professionals needing extra support for mental health and wellbeing increased from 40% in May 2020 to 62% in September 2020. Seventy-three per cent told us they would consider clinical psychology sessions or other similar resources in the future.

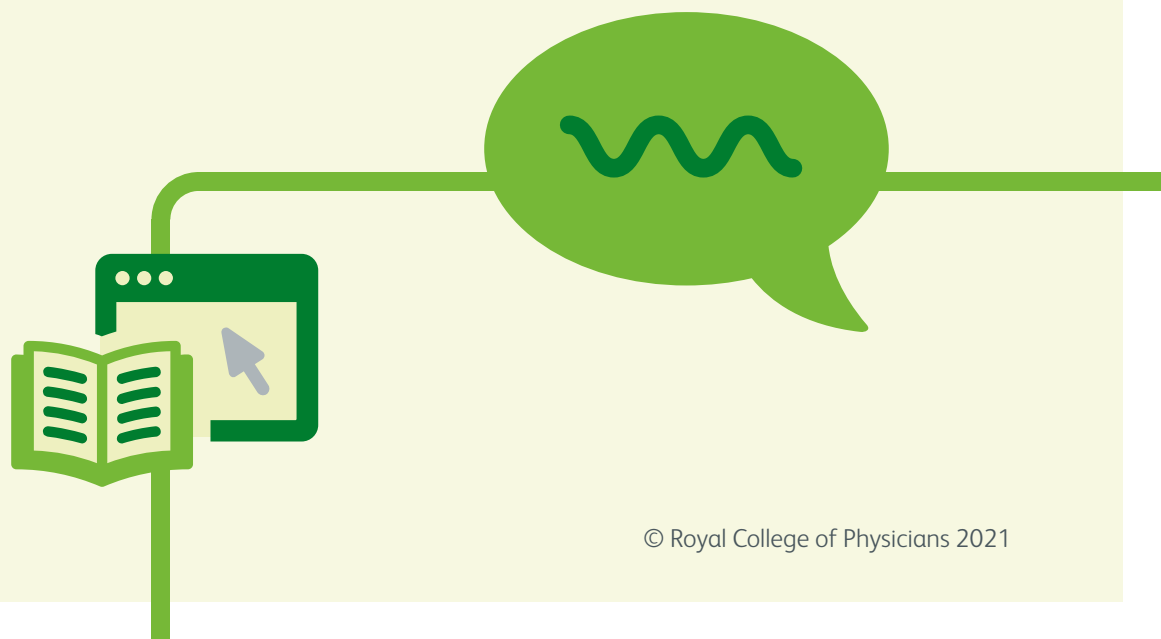
In retrospect, it left us asking whether it should just be during a pandemic that we are *this* mindful of our wellbeing, or should this be the baseline standard? After the pandemic, NHS staff will need mental health support to move forward from a devastating year.’

**Dr Kate Edwards, trainee doctor**

**Dr Melanie Nana, trainee doctor**

**Dr Madhu Kannan, consultant physician**

Awarded second prize in the 2020 Wales poster competition awards, a collaboration between the RCP, the Society of Physicians in Wales and Health Education and Improvement Wales



The Welsh government must plan in the knowledge that forms of post-traumatic stress disorder (PTSD) may become more prevalent among the workforce over the next few years. NHS leaders should encourage open conversations about mental health while being a flexible and supportive employer.

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**‘A systematic review of psychological consequences of infectious disease outbreak ... indicates that ... 40% of [health professionals] reported persistently high PTSD symptoms 3 years after post exposure. PTSD symptoms were also significantly higher among exposed healthcare workers (HCWs) ... particularly among allied HCWs, followed by nurses and physicians.’<sup>14</sup>**

Many healthcare professionals have worked antisocial hours in a state of sleep deprivation and a heightened state of anxiety for months now. There is also the risk of moral injury, where barriers – including a lack of resources, time, staff or beds, all of which have been prevalent at times during this pandemic – prevent clinicians providing the quality of care they want to provide.

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**‘Moral injury is often talked about as the gap between what did happen and what should have happened, and if that gap can’t be reconciled, it can cause deep-rooted feelings of guilt, shame, anxiety, depersonalisation and the loss of empathy [and] the pandemic has become the perfect breeding ground for moral distress.’<sup>15</sup>**

The harm caused by moral injury is very real. The NHS must learn to recognise it, encourage staff to talk about it and needs to start addressing its root causes. Wellbeing resources can only go so far. We need to think beyond the pandemic: addressing rota gaps must be an absolute priority. Having enough staff on a shift allows time to eat and drink, get some fresh air, have a sit down or a hot drink. Above all, clinicians who feel appreciated and part of a team provide better patient care.

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**‘It’s much easier to be kind to others when others are being kind to you.’<sup>15</sup>**

**‘It comes down to how valued people feel. In organisations where staff feel they are supported, listened to, and concerns over vaccination, PPE, workload, and staffing levels are being addressed, people are in a much better place psychologically.’<sup>16</sup>**

Staff are physically and mentally exhausted. Doctors must be enabled and encouraged to take their annual leave in long enough blocks to allow for rest and recuperation. This might mean less activity in the short term, but it is an investment in the future which allows staff to recover and recharge.<sup>12</sup> In the longer term, the NHS must recruit and retain more doctors by offering a better work-life balance and more opportunities for education, quality improvement and research.

Recent research from the King’s Fund shows that successful disaster recovery requires a focus on mental health and wellbeing; the involvement of all voices and communities; collaboration across agencies, organisations and services; and the prioritisation of workforce wellbeing.<sup>17</sup> It is vital that clinicians and patient groups are central to plans to rebuild and redesign the NHS.

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**‘I think one of our challenges is how we communicate with staff – emails do get lost and it doesn’t feel fair to use WhatsApp for official things, but we haven’t found the solution yet.’**  
– NHS Wales clinical director

Research has also been crucial in tackling the pandemic, in providing both vaccines and new treatments. The importance of medical research has never been more obvious and Welsh hospitals and vaccine trial programmes have contributed a huge amount to this work. Every health board, especially those in areas of high disease prevalence, should guarantee protected clinical time for research, encourage patients to become involved, and ensure that findings are embedded into NHS working practice. Patients and doctors should have the ability to participate in and conduct research wherever they work in Wales, which means ensuring more equal access to research opportunities.

## Key recommendations from Breaking down barriers: our action plan for the next Welsh government.<sup>6</sup> The next Welsh government should work with NHS Wales to:

- > deliver on their commitment to make staff health and wellbeing a national priority
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- > ensure research and development departments are equipped to provide leadership and advice
- > ensure transparency for funding and resource allocation
- > facilitate the translation of research into practice across the NHS.



# How junior doctors rose to the challenge of COVID-19

## ‘We felt empowered to proactively involve relatives in day-to-day care’

‘Nothing could have prepared us for the reality of communicating with patients and their families during the pandemic. As the first wave hit, we found ourselves having some very difficult conversations with families; instead of doing this face-to-face, we were using video and telephone calls to break bad news or ask about resuscitation.

When surveyed by a group of junior doctors, colleagues highlighted issues including a lack of non-verbal cues, difficulty in conveying empathy, difficulty in pacing conversations, and being unable to give non-verbal comfort. Very few had received any formal training in remote communication. We worked with a palliative care consultant to develop a teaching session on virtual communication.

The session emphasised the importance of preparation, updating relatives regularly, and building a rapport with families. We felt empowered to proactively involve relatives in day-to-day care and became more confident in conducting difficult conversations virtually. Investing in teaching programmes specifically focused on virtual communication would improve patients’, relatives’, and junior doctors’ experiences during the COVID-19 pandemic.’

**Dr Gwen Cartwright, trainee doctor** with Dr Alex Tuck, Dr Ben Pyrke, Dr Hattie White, Dr Emily Murphy, Dr Katy Figg, Dr Badr Abdalla and Dr Mark Reynolds  
Cardiff and Vale University Health Board  
Highly commended in the 2020 Wales poster competition awards

## ‘I would like to see more of a focus on the wellbeing of healthcare professionals’

‘The pandemic changed everything overnight. Doctors from paediatrics, surgery and radiology were redeployed to unfamiliar surroundings, responsible for caring for patients with unfamiliar diseases as well as COVID-19. This led to a large group of professionals working outside their usual scope of practice without the knowledge or clinical experience which contributes to safe patient care.

As a redeployed specialty trainee, I felt that these doctors would welcome a succinct, accessible and user-friendly digital reference to use in the acute medical unit and on the medical wards. I wanted to help redeployed doctors feel more confident in their ability to provide excellent patient care.

I asked colleagues what topics they felt would be most useful, and specialist nurse colleagues supported me in developing a learning tool entitled *Cheat sheets for medicine*, which was peer reviewed by two consultants in acute medicine. The postgraduate education team kindly sent the cheat sheets to all redeployed staff with their induction materials.

The *Cheat sheets* gave redeployed doctors confidence to manage unwell medical patients. Perhaps more importantly, it helped them to understand that when in doubt, escalating patient care to more senior team members would be encouraged and supported. Given the feedback we received, I would love to see *Cheat sheets for medicine* included with induction materials for doctors starting in foundation posts in post-COVID times.

When the first wave began, all our clinical teaching was put on hold for the good of the system and our patients. Working alongside a consultant colleague in the acute medical unit, I set up some short, socially distanced teaching sessions which later developed into an interactive, multi-specialty programme. Medical trainees worked alongside redeployed colleagues to teach 10-minute topics to small groups of junior doctors.

Everyone was very enthusiastic; there were lively WhatsApp group chats before and after each session. I think we enjoyed taking control of our learning in an innovative way; it improved our team working, wellbeing and morale. Providing doctors in training with a regular ‘safe space’ was very valuable, particularly during a pandemic. The multidisciplinary nature of the teaching improved working relationships in what can be a very busy and stressful environment.

As we emerge from the pandemic, I would like to see more of a focus on the wellbeing of healthcare professionals. The vast and ever-increasing workload at the front door, in addition to staffing pressures, sometimes results in a poorer quality of care than we would ideally like to provide.’

**Dr Alice Hoole, trainee doctor**  
Cardiff and Vale University Health Board  
Highly commended in the 2020 Wales poster competition awards

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## ‘It was incredibly positive to work across specialties and disciplines’

‘As the number of COVID-19 cases increased globally, we decided to organise a patient simulation scenario across the emergency, medical and intensive care departments. We wanted to test COVID-19 policies, assess staff understanding, and identify areas for improvement.’

We took a multidisciplinary approach; healthcare professionals from each department were involved in designing the simulation to ensure as many issues as possible were considered. The simulation was run in real time; it began in the emergency department and involved clerical, nursing, radiology and medical staff among others. We filmed the simulation so that we could review it afterwards; we collected written feedback and sent out learning points; and we presented the findings at grand rounds.

It was very useful. We identified lots of areas for change across different departments. Staff became more aware of COVID-19 protocols, and it generated a lot of discussion afterwards. It was incredibly positive to work across specialties and disciplines; it improved inter-departmental relationships and led to further collaborations. Encouraging a less hierarchical and territorial, more collaborative approach would improve patient care and lead to so many benefits for both clinicians, hospitals and the wider NHS.’

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### **Dr Victoria Lewis, trainee doctor**

Hywel Dda University Health Board  
Highly commended in the 2020 Wales poster competition awards

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## ‘Morale was perhaps higher than we expected’

‘When the pandemic started to gather pace, nobody knew how the mass redeployment of doctors into unfamiliar working environments would affect their wellbeing. We conducted research across three NHS organisations: one in Cardiff and two in London, working with a multidisciplinary team of clinicians, including acute medical directors, medical education teams, wellbeing advisors, junior doctors and consultants to design a survey and distribute it at different hospitals. We focused on morale, work-life balance, support, safety and concerns, and received responses from over 30 specialties and across all grades.’

During the first peak, morale was perhaps higher than we expected; doctors felt valued, confident and well rested in their new role. The three most common concerns were training opportunities, PPE and family health. We shared our findings at a very senior level, and saw the recommendations acted upon very quickly. While redeployment during the second wave has been less prevalent, we are currently exploring some of the long-term effects of redeployment and the pandemic on the mental health and medical training of doctors.’

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**Dr Ryan Faderani, trainee doctor** with Dr Massimo Monks, Dr David Peprah and Dr Martin Edwards  
Cardiff and Vale University Health Board

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## ‘Communication is so important in every area of medicine’

‘At the start, everything about this virus was so new and overwhelming. Relatives and friends of patients were banned from visiting hospitals; it became more and more difficult to communicate with families. Panic and miscommunication led to complaints.’

We designed a structured communication tool which helped COVID-19 ward teams to keep on top of regular family updates. By using this chart, we all knew which healthcare professional had last spoken to a patient’s family, when and what they had said. Before the project, only 55% of families were updated daily, and repetitive conversations were the norm. After a month, there was a 40% improvement in overall satisfaction among both family members and medical staff, and almost a 40% improvement in the total number of families updated per day.

Communication is so important in every area of medicine, and the team effort behind this project worked wonders. After all, the wellbeing of a patient and their family should be our priority during any hospital stay.’

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### **Dr Lokapriya Ananthan, trainee doctor** **Dr Andrew Lansdown, consultant physician**

Cardiff and Vale University Health Board  
Highly commended in the 2020 Wales poster competition awards



# The impact of health inequalities

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

It's vital that we face up to the impact of long-term chronic illness on our society. This pandemic has highlighted the widening gap in health inequalities and sharply demonstrates the link between poverty and poorer COVID-19 outcomes.

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**‘Men, older people, people from Black, Asian and minority ethnic groups, people with existing health conditions, disabled people and people living in deprived areas have higher coronavirus mortality rates. The [pandemic] recovery must be targeted at those who have lost the most, and this opportunity must be used to rectify existing inequalities.’<sup>18</sup>**

We now urgently need a cross-government strategy for tackling wider health inequalities in Wales.

A recent RCP survey found that 61% of respondents in Wales thought governments across the UK should be doing more to address health inequalities, and 82% wanted to see a government strategy to reduce inequalities in health. Sixty-three per cent were concerned that the health gap between wealthy and deprived areas is growing. Eighty-two per cent thought that all parts of government should have to consider the impact of their policies on people who are less well off, with more than half strongly agreeing.<sup>19</sup> Twenty-five per cent of respondents selected long-term health conditions as the health inequality they were most concerned about, with 17% opting for poor mental health.

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**‘We’re already seeing the long-term impact of COVID-19. The disease takes it out of you: a stay in intensive care is tough. Even before this pandemic began, we often saw patients [living in more deprived areas] presenting**

**with chronic conditions – and even cancers – at a far younger age than those living in more affluent areas. There isn’t a simple answer. The legacy of this disease in deprived areas will be on a par with the loss of industry in the eighties and nineties.’**

**– Consultant physician, NHS Wales**

The introduction of the socio-economic duty in March 2021 provides us with an exciting opportunity to refocus efforts on improving outcomes for the most disadvantaged people in our society. It's vital that the Welsh government ensure that this, together with the Wellbeing of Future Generations Act, makes a real and tangible difference to people's lives. The government should also raise awareness and support other organisations not named in the legislation to consider socio-economic disadvantage and health inequalities when making strategic decisions.

**Key recommendations from Breaking down barriers: our action plan for the next Welsh government.<sup>6</sup> The next Welsh government should work with NHS Wales to:**

- > **develop a cross-government strategy to reduce health inequalities**
- > **integrate the impact of the socio-economic duty and the Wellbeing of Future Generations Act**
- > **ensure all health boards invest in specialist, clinically led obesity treatment services**
- > **appoint a national clinical lead for severe and complex obesity, accountable to the first minister**
- > **set clear and accountable targets for preventing and reducing obesity**
- > **introduce a Clean Air Act for Wales that will improve the quality of the air we breathe**
- > **support and invest in integrated alcohol and substance misuse treatment and prevention services**
- > **place a renewed focus on delivering and extending an ambitious Tobacco Control Plan for Wales.**



# Recover, rebuild, renew

## An update to our action plan for the next Welsh government

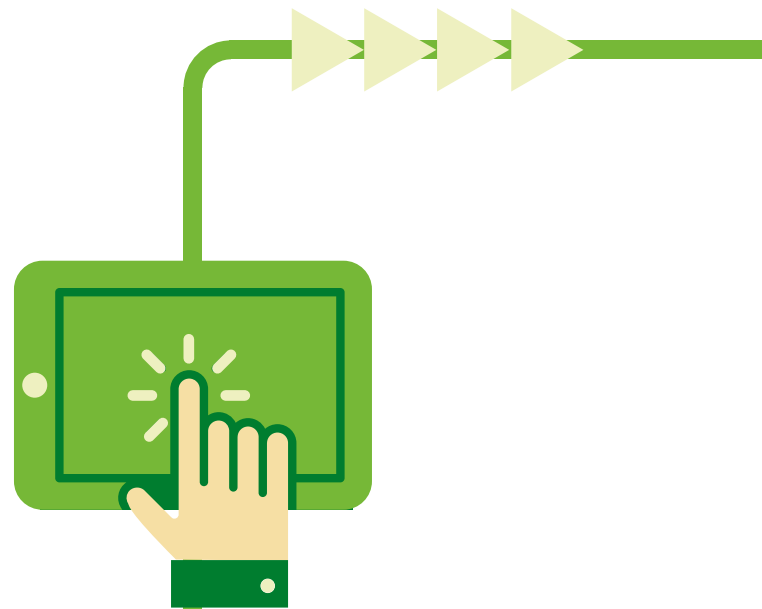
Through our work with patients, consultants, and trainees, we are working to achieve real change across hospitals and the wider health and social care sector in Wales. You can also help to inform the RCP's work in Wales by sending us your ideas and examples of good practice.

Our 39,000 members worldwide, including 1,450 in Wales, work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions, including stroke, care of older people, cardiology, and respiratory disease. We campaign for improvements to healthcare, medical education and public health. We work directly with health boards, trusts and Health Education and Improvement Wales (HEIW); we carry out hospital visits and we collaborate with other organisations to raise awareness of public health challenges.

We organise high-quality conferences, teaching and workshop events that attract hundreds of doctors every year. Our work with the Society of Physicians in Wales showcases best practice in Wales through poster competitions and trainee awards.

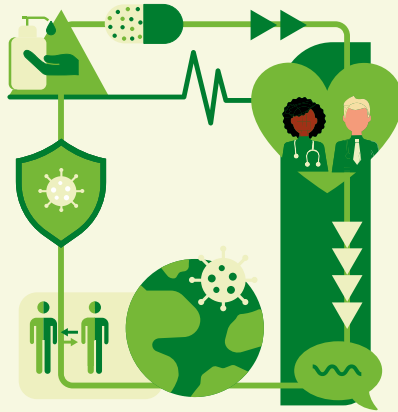
**Find out more about the RCP's work in Wales or email us at [wales@rcplondon.ac.uk](mailto:wales@rcplondon.ac.uk).**

**Tweet your support: [@RCPWales](https://twitter.com/RCPWales)**



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