



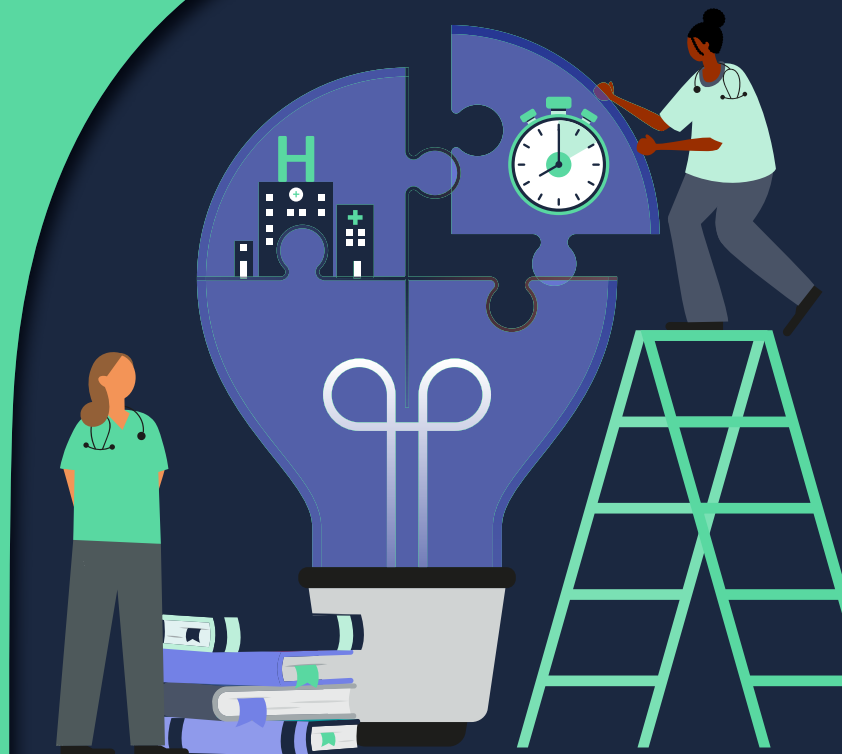
Royal College  
of Physicians

Coleg Brenhinol  
y Meddygon (Cymru)

# Thinking outside the box

Innovation in healthcare and  
education in west Wales

Cyswllt RCP Connect event report



# Foreword

I came away from our visits to Glangwili and Prince Philip hospitals feeling very uplifted. We heard some fantastic presentations, and I was inspired and energised by everything I heard. Widening access to medicine is crucial, especially in rural and remote areas where things are very different to central Cardiff. I want to thank everyone in the NHS in west Wales for all their hard work in delivering and supporting high-quality patient care across Hywel Dda University Health Board.

## **Dr Olwen Williams OBE**

Vice president for Wales

Royal College of Physicians (RCP)

Prince Philip Hospital (PPH) is a small, friendly, supportive site, very good for learning with strong links with medical schools. We deliver high-quality care: there's a high ratio of specialist trainees to patients. We get good feedback from trainees, which hasn't happened by accident, and most of the consultants were once more junior members of staff. This is a fantastic place to be. In general, we've got good relationships with management, which during the past couple of years, has been really important. We are, without doubt, the most culturally diverse employer in town, which is a real positive.

Yet perhaps we've now got more challenges than we've ever had. There are staffing shortages in some departments, including critical care, and we are expecting another reorganisation. There are high levels of chronic conditions in Llanelli, the impact of which we deal with every day. There has been a total collapse of social care with more than half of our inpatients medically fit for discharge but unable to leave the hospital. Furthermore, many of our consultants work for other hospitals as well as PPH, which means that people are not always on site when you want to speak to them.

This RCP Cyswllt event was an opportunity to discuss some of these key issues and hear from trainees and other colleagues about their vision for the future.

## **Dr Sam Rice**

RCP regional adviser for south-west Wales  
Hywel Dda University Health Board

# Thinking outside the box

On 7 September 2022, the Royal College of Physicians (RCP) in Wales visited hospitals in Hywel Dda University Health Board for a Cyswllt RCP Connect engagement event with physicians working across west Wales. Around 60 attendees joined us across two meetings which were held in person at the postgraduate centres in Prince Philip Hospital (PPH) and Glangwili General Hospital (GGH). The meetings were free to attend and open to doctors-in-training, physician associates (PAs), staff, associate specialist and specialty (SAS) doctors, and consultants.

Chaired by Dr Sam Rice in Llanelli (RCP regional adviser for south-west Wales) and Dr Nicholas Coles in Carmarthen (RCP college tutor for Glangwili Hospital) with conclusions from Dr Olwen Williams (RCP vice president for Wales), the group discussed medical education, innovation in planned care and community-based intermediate care.

## **A huge thank you to our speakers on the day:**

Dr Sam Rice, Helen Williams, Dr Robin Ghosal, Dr Lena Izzat, Dr Nicholas Coles, Dr Clive Weston, Dr Adrian Raybould, Dr Sioned Richards and Indeg Jameson. Their talks are written up as examples of innovation in action in this report.

## Key findings

Based on our discussions with colleagues in Prince Philip and Glangwili hospitals, RCP Cymru Wales believes that other health and care organisations in Wales should consider whether to take the following actions.

- Evaluate the competencies of international medical graduates (IMGs) and organise training immediately upon arrival in post.
- Establish a medical education trainers' forum for the health board as a peer network.

### **Workforce, education and wellbeing**

- Introduce whole health board grand rounds to spread learning across hospital sites.
- Innovate with new support roles, including junior doctor advocate and clinical teaching PAs.
- Develop an outpatient clinic spreadsheet to allow protected clinic time for trainees.
- Invest in and develop new roles like physician associates.

### **Service development**

- Explore whether advanced nurse practitioners (ANPs) and PAs could deliver specialist services in rural areas with senior medical support.
- Encourage clinician-led innovation and support new ideas where they improve patient care.
- Invest in acute frailty services and same day emergency care (SDEC) units.
- Invest in intermediate care, multidisciplinary team (MDT) working and community-based teams.

# Hot topics on the day

We heard from consultant physicians about the frustration they felt about the 'national emergency' in social care provision. The group identified a rapid growth in the number of older patients combined with staff shortages, partly due to concerns around pay and conditions, and the impact of Brexit.

' Days on call can be challenging at the moment. Starting your day with eight ambulances outside the front door, spending most of the day going in and out of ambulances where you can't examine people properly. Patients now accept this as normal, but it just doesn't lead to good practice. How are we going to cope for the coming winter? The stress on everyone working in the hospital of trying to deal with the backlog is considerable at times and our nursing staff in the acute medical units do take the brunt of this.'

– consultant physician

We also heard that consultants were anxious about the cost of locum agencies and asked us to take this concern to the General Medical Council (GMC) and British Medical Association (BMA), pointing out that the current system creates an escalating cycle where more locum posts are created, rota gaps are not filled, and there is a risk to continuity of care, career development, medical education, team morale and high-quality service standards.

Trainees told us that they felt encouraged to get to clinics and watch procedures but were often unable to leave the ward due to workload pressures.

' We don't really have enough support for the junior workforce. One of my colleagues hasn't been able to go to clinics since she started here. As a doctor, you don't want to leave jobs undone. Most doctors don't want to be selfish. Really, we need more junior doctors.'

– trainee physician



The group agreed that this wasn't selfish at all; attending clinics and teaching sessions is about investing in patient care and developing a doctor's clinical knowledge. It was suggested that trainees should look at developing a timetable of protected time for clinics.

**'It's in trainees' interests to build a strong foundation in general internal medicine. Don't restrict yourself to one specialty. Have a look at all the clinics available and divide them among yourselves. It's really critically important. It's not just about the service.'**

– consultant physician

The group discussed the role of PAs. There are no appointed PAs at PPH, but they are currently training students. The RCP encouraged PPH to look ahead and create specific roles for PAs for when they qualify.

**'PAs are invaluable. They are not taking training opportunities away from doctors. They are not trying to be doctors. They are complementary to doctors.'**

– RCP visit team

At Glangwili Hospital, we heard about the importance of recruitment, retention and enthusiasm.

**'There's an appetite among health and care professionals to work in intermediate care. We have no problems recruiting. It's exciting; people want to come and work where they are empowered to innovate.'**

– community lead for physiotherapy

The group discussed the importance of communities of practice, protecting each other and achieving fulfilment at work when faced with increasing workload and service pressure.

**'We need to start them young. We have to find young people living and going to school in our communities and show them there's room for them in the NHS. We need to encourage them to remember their roots and come back to Wales to work.'**

– consultant physician

We heard about work carried out at GGH to answer the call issued by the [British Heart Valve Society](#) to follow up on all patients with a Trifecta heart valve. A [cluster of early valve failures](#) meant that the team in Glangwili set out to identify and assess all the patients with Trifecta valves. They found that in the vast majority of cases, any complications had been caught and dealt with; they noted a national (and local) shortage of specialists with a 20-week wait for echocardiology.

Overall, the team reviewed 32 patients: early valve degeneration was concerning in 20% of those people. There was an interesting discussion about governance and decision making around interventional procedures.



# Innovation in action

## 'We want to involve our juniors in every aspect of decision making across the health board'

Healthcare and education are continually evolving, we're constantly coming up against challenges, and we need to adapt and change. Our associate medical director (AMD) for education is well supported by the faculty team, which is continually being developed and we are looking at introducing a deputy AMD over the next few months. We're keen to share learning and work with other health boards and national bodies like the GMC.

The delivery of education and training was particularly impacted by COVID-19. Trainees weren't able to attend the medical education centres very much; this affected our relationship and engagement with them. They struggled to get exposure to some aspects of training, which was quite challenging. Balancing their workload with service provision and their education is something we're hoping to improve. Medical recruitment and retention continue to be issues across Hywel Dda, and high levels of sickness leave cause rota gaps and puts additional pressure on staff.

At the beginning of the year, we introduced whole health board grand rounds. We already work remotely and offer virtual teaching, so it was logical that we should hold a grand round for all staff working across primary and secondary care. They take place weekly with over 100 people joining us – we've been overwhelmed by the response. The teaching programme is fully booked up until mid-2023. People external to the health board want to get involved, which is fantastic. It's a blended approach: we do also encourage people to come to the lecture theatre for networking.

We have appointed our first clinical teaching physician associate this year and have had excellent feedback already. We wanted to support consistent simulation and clinical skills teaching for PA students, medical students, junior doctors and international medical graduates. We'll be rolling that out across the health board. We've also developed the role of medical education teaching fellows: these posts have protected time for classroom and ward-based teaching and have been really popular. Finally, we have created the role of junior doctor advocate: we recognised that we needed to strengthen the junior doctor voice. We want to involve our juniors in every aspect of decision making across the health board. We're going to appoint one for each acute site.

The health board also employs a high number of IMGs which poses some challenges. We want to provide the right support to IMGs, so they settle in local communities and into their NHS roles. Something that has worked well is our practical skills and procedures checklist. We send this self-assessment form to IMG doctors before they come to work with us so that we can benchmark their level of competency and support them with training as soon as they start work. We have posted online resources on a SharePoint page and invested in our simulation and clinical skills labs, run by experienced educators and technicians. Without these, we wouldn't always be able to meet the training needs of our doctors.

We're also keen to support trainers, who are very often overstretched with different roles, so we have established a medical education trainers' forum

to enable people to keep up to date with local and national developments, CPD, network and share good ideas and good practice. We held a virtual meeting with more than 50 people earlier this year, and we will meet face to face next month.

Everybody is approachable here. Staff working at the medical education centre are warm, professional and supportive. They advocate for trainees. We've written induction handbooks with information to help IMGs settle here: how to open a bank account,

where places of worship are, schools, shops – things that seem obvious to us, but make a world of difference to someone new to the country. We put on extra clinical training and we've tried to ensure their voices are heard and inform that work.

### Helen Williams

Head of medical education  
and professional standards  
Hywel Dda University Health Board

## 'It is possible, even with scarce resource, to deliver a quality service over a large geographical area'

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

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

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

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

Then we lost another consultant. Now we were down to a single consultant covering the entire health board, supported by a general physician in

Bronglais. The team was broken. The relationship with the CNSs was fraught. Without enough radiologists, I was being sent thoracic imaging. The service had gone from great to poor within a few years, not because of the people, but because of the circumstances.

The pandemic didn't help. Patients didn't see their GP during COVID-19, so they presented later, often with stage four lung cancer, which meant more hospital admissions. There was huge patient inequality, and no light at the end of the tunnel. There was no knight in shining armour waiting to rescue us: we spent months trying to recruit. So, we turned to technology, and we upskilled our colleagues. We have trained our CNSs and our SAS doctors to work alongside me to deliver a lung cancer service. There is now a clear vision for the future of the service. We want patients to get high-quality care, no matter where they live: they will get the same care on the same pathway.

Now we run three clinics a week. We have hybrid clinics in PPH and GGH, with some virtual appointments and some face-to-face diagnostics, and we have a Withybush clinic that is completely virtual. We meet with the nurses three times a week to support them, answer questions and discuss complex cases. We track every single patient on the lung cancer pathway to avoid delays and reduce waiting times. In Withybush, if a patient needs a face-to-face appointment, they see the specialist lung cancer nurses in person, with the doctor joining the conversation virtually. They can see the scans on the computer, and they get a clear plan of action. The feedback from the nurses has been excellent

and the patients love it. There's less travel, they are supported with the technology, it reduces clinical inequalities, and it gives smaller, local hospitals a really important role to play.

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

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

### Dr Robin Ghosal

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





# 'Almost half of these people shouldn't have been on a waiting list in the first place'

The cardiology outpatient waiting list has been horrendous for a long time, even before the pandemic. It was unmanageable – we were always facing an uphill struggle. Every single year we'd end up running extra or 'initiative clinics' to reduce waiting times. Staffing shortages, overwhelming numbers of patient referrals, a lack of joined up thinking, poor communication with primary care; these issues were combined with the fact that triage for outpatient referrals was never really a top priority. Something else always took precedence.

We've always had major staffing pressures, but during the pandemic it became even worse. The single-handed cardiologist at Witybush was redeployed into general medicine. There was sickness absence, retirements, we lost office space. Patients were presenting much later with chronic diseases. The old paper referral system could take months, with letters going back and forth between secondary and primary care, at the risk of being lost or delayed. We noticed a lot of referrals that could have been treated by general medicine or could have been managed in primary care. Others were duplicate referrals which took up a slot that could have been used by someone else. This was a chance to streamline the whole of the cardiac outpatient service across the health board.

In September 2021, I was seconded to work on a project to tackle the backlog after being told to shield for medical reasons. I wanted to look at what worked well across consultant-, CNS- and ANP-led services and avoid duplication as much as possible. It was pointless for patients to attend three similar clinics with the same resulting outcome. We wanted to formalise and expand the MDT, maybe giving the nurses more time to discuss cases with the consultants, and to educate juniors and GPs about what a good referral looked like. Could that patient be treated in primary care more quickly and

efficiently? Do they actually need a specialist referral that means sitting on a waiting list for up to 2 years?

I also looked at referral destination. Which was the best service or clinic to send patients? The default was general cardiology, but many patients could have been seen much more quickly by a specialist nurse clinic in a matter of weeks. I was conscious that referral letters could often be woefully inadequate, and the triage process was not always up to scratch, with key investigations sometimes missing from the patient history. Pre-pandemic, there are some patients who would have waited a year for cardiac surgery if they were lucky. With the new systems and more efficient collaboration, we're able to turn them around in 7 weeks.

We received almost 3,000 referrals to outpatient cardiology in 2021, just for Prince Philip Hospital. Every week, I would receive 90 patient records, all caught up in the pandemic backlog, to work through every week, often 12–14 hours a day and for each of those patients: I'd look at spreadsheets, clinical IT systems, check blood results, X-rays, ECGs, echocardiograms, coronary angiograms, Welsh Clinical Portal, their primary care record – the lot. We introduced a traffic light system and I'd contact the patient and their GP to apologise about the pandemic backlog and resulting delay in their care and let them know what was happening next.

I was also carrying out three, and later four remote general cardiology new patient clinics online every week. I would lead a full cardiology MDT with multiple subspecialties with access to five or six cardiac specialist nurses and ANPs from across the health board. In return the staff knew they could contact me by phone or email at any time, and I knew my patients were safe. I had access to CT coronary angiography and cardiac MRI outsource

priority lists at a private hospital in Newport so we could fast-track some patients and obtain a swift and definitive diagnosis.

Of course, I was relying heavily on electronic outpatient triage and on having a good relationship with the cardiology service delivery team in Carmarthenshire and the clinical teams across all hospital sites in the health board. Obviously, I was still not on site or in my own ward. But within a few months, the hard work paid off. Cardiology waiting lists reduced so much that the forecast for clearing the backlog was well ahead of schedule and the average waiting time to see a consultant was half what it used to be. Urgent cases were being assessed immediately.

It's only one study of course, but I found that over 9 months, assessing over 3,000 cardiac patients caught up in the pandemic backlog, many lessons were learned. In total, 47% of patients on the cardiology backlog new patient waiting list had been referred back to primary care with advice. Almost half of these people shouldn't have been on a waiting list in the first place. It's so inefficient. Only 9% were booked into an outpatient appointment, the majority of which were virtual. A total of 18% were booked for further cardiac tests, 12% were

referred into community cardiac services with MDT support, and 16% were kept under echo surveillance in our valve clinics.

It was a huge team effort, and hard work, but so well worth it. A lot has changed. We now have a new electronic referral triage system that has overhauled the outpatient referral system and resulted in seamless communication between primary and secondary care. I have been educating GPs and their trainees about a minimum basic dataset of clinical information required for each common cardiac condition that would ensure the right patient is seen at the right time and in the best clinic. Communication with GPs and the quality of referrals have improved. Virtual clinics seem to be the norm now. I've realised that redirection to the community is extremely valuable. Many referrals can be managed within primary care without even needing to come to cardiology. Some lessons from the pandemic have been totally invaluable.

#### Dr Lena Izzat

Consultant in cardiology and general internal medicine  
Hywel Dda University Health Board

## 'Our guiding principle was that the patients most at risk needed to be seen most quickly'

At the start of the pandemic there were 600 patients on the cardiology outpatients waiting list and a routine waiting time of 9 months. Referrals were triaged as urgent or routine and the hospital administration department was responsible for booking appointments. With a significant restriction on elective work as senior doctors were recruited to patient-facing acute services, it was clear that we would face problems with a growing patient backlog.

Our guiding principle was that the patients most at risk needed to be seen most quickly and so we placed a heavy emphasis on upfront triage, and we have been able to develop a flexible approach to patient management. With this in mind, we undertook a review and repeat triage of patients already on the waiting list. We utilised a traffic light system: green (no further action needed), amber (tests or routine follow up but not clearly high risk) and red (identified risk needing urgent face-to-

face follow up). After this, 45% of patients were discharged, 40% underwent routine follow up and only 15% were deemed urgent.

Prior to the epidemic we had a fledgling community cardiology service run by two advanced nurse practitioners. They now see low risk patients and are supported by a weekly consultant-led MDT. We have established a same-day echo clinic for high-risk patients and aim to get an outpatient appointment within 4 weeks. We have also moved from a weekly chest pain clinic to a telephone assessment pathway. Initially, I led this with support from junior doctors and we structured it as a training opportunity. This has now evolved into a nurse-led, consultant-supported service. We aim to speak to all patients referred with chest pain within a week (the current median is 6 days) and we aim to identify high risk patients as early as possible. The motto is 'do this week's work this week'. We use pacing services, heart failure services, cardiac rehabilitation and up-front cardiac tests to get the right patient to the right place in a timely manner. There are currently no waiting times for consultant outpatient clinic appointments and my outpatient

clinic is now rarely fully booked – waiting times have remained stable over the past 2 years and we're seeing high-risk patients and getting them through to treatment quickly.

Currently we are focused on reducing unacceptable delays in accessing cardiac physiology tests and imaging investigations for coronary artery disease, as most patients on the outpatient waiting list are awaiting cardiac investigation. All of this has been hard work, but it is fulfilling and rewarding, and the pandemic provided the impetus to take this initiative. Sustainability is an issue. Other doctors aren't so comfortable using the telephone as an assessment tool. It's also difficult to job plan – the system needs flexibility to deal with fluctuations, variations and referrals. There's no perfect model of care; I have to accept that there's risk and some limitations to what I'm doing. My role – and what I want – is to do the most good, for the most patients.

#### Dr Adrian Raybould

Consultant cardiologist, Glangwili Hospital  
Hywel Dda University Health Board



# 'Reducing length of stay makes a massive difference to patients'

I've been a consultant geriatrician at GGH for around 4 years. We're a small hospital and we struggle to recruit, although we're all doing our best. When I first arrived, there was no acute frailty service here. I had recently come from Morrision Hospital where I'd set one up from scratch, knocked the length of stay down by at least a week, and in some cases a month, which made a massive difference to patients. Our data told us that patients were less likely to come back into hospital, and more likely to live longer with an acute frailty service at the front door.

We're trying to replicate the model here. It's slow going, but we now have an advanced nurse practitioner and we're linking with intermediate care in Carmarthenshire. On a daily basis I see patients in A&E or in the back of an ambulance, then we'll work our way towards the admissions unit. We use surrogate frailty markers to identify patients who have come in with immobility, confusion, delirium, dementia, incontinence, Parkinson's disease, and those who have a package of care or are living in a care home. The multidisciplinary team will then carry out a comprehensive geriatric assessment.

As well as a consultant and an ANP, we have access to occupational therapists, physiotherapists, a social worker, and the [Delta Wellbeing](#) team who screen patients for social services. (They can provide short-term care while waiting for a longer-term package.) We have a pharmacist who joins us from time to time. The key member of the team is the frailty nurse. They pull everything together; they manage all the communications between different members of the team, and they make sure that everybody is working together to speed up discharge.

We're also developing a frailty pathway in our SDEC units with consultant support, nurses and healthcare assistants. The idea is to move our frail patients out of A&E, treat them as quickly as possible and refer them into intermediate care – we want to get the patient home with support.

## Dr Nicholas Coles

RCP college tutor for Glangwili Hospital  
Consultant in care of the elderly medicine  
Hywel Dda University Health Board



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

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

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

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

We're the only place in Wales working like this. As an [intermediate care team](#), we work across four pillars of care: reablement (helping the patient to become independent again), crisis response (when a patient in the community could be intercepted before arriving at the hospital front door), home based (when a patient needs a bit of extra support) and bed based (when a patient doesn't need an acute hospital bed, but isn't well enough to go home).

The key thing is that there's a single access point, a one-stop shop where we are all co-located and able to flex our response based on patient need.

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

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

The co-location of services in an open plan office means that our paramedics can talk to our physiotherapists when an ambulance call comes in – they can avoid unnecessary interventions.

If we weren't in the same space, those ad-hoc conversations wouldn't necessarily happen.

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

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

There's an appetite among health and care professionals to work in intermediate care. We have no problems recruiting. It's exciting; people want to come and work where they are empowered to innovate. We know that there are growing health

### Indeg Jameson

Carmarthenshire community lead  
for physiotherapy  
Hywel Dda University Health Board

inequalities, and access to healthcare services can differ depending on which day of the week you get ill. It's uncomfortable for us.

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

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

### Dr Sioned Richards

GP lead, Carmarthenshire intermediate care  
Hywel Dda University Health Board



# Educating, improving, influencing

Through our work with patients and doctors, the Royal College of Physicians (RCP) is working to achieve real change across the health and social care sector in Wales. We represent 42,000 physicians and clinicians worldwide – educating, improving and influencing for better health and care. More than 1,600 members in Wales work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions. We campaign for improvements to healthcare, medical education and public health.

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