



Royal College  
of Physicians

Coleg Brenhinol  
y Meddygon (Cymru)

# Positives from the pandemic

Health innovation and new ways  
of working in north Wales

Cyswllt RCP Connect event report



# Foreword

Ahead of our hybrid visit to north Wales, I was really looking forward to celebrating the achievements of my colleagues over the past couple of years. During the pandemic, clinicians have experienced some really difficult times, and sometimes we forget that during difficult times, amazing things can happen. Hearing Dr Osanlou discuss the clinical research facility, learning about how Dr Glen's team is encouraging and supporting sixth form students into medical school, listening to our trainees, Dr Ward and Dr Kempster talk about their original research – it's all so inspiring.

Sometimes we sit on things. We don't blow our own trumpets like we should. But we need to publicise the excellent work that's being done across the health board. To tell you the truth, I feel so much more positive, and I got my mojo back after listening to the speakers at this event.

**Dr Olwen Williams**

RCP vice president for Wales

Consultant in sexual health and HIV medicine

# Introduction

On 10 June 2022, the Royal College of Physicians (RCP) in Wales hosted a hybrid Cyswllt RCP Connect engagement event with physicians working across Betsi Cadwaladr University Health Board (BCUHB) in north Wales. Around 40 attendees joined us, either virtually or at the postgraduate centres in Ysbyty Glan Clwyd and Ysbyty Gwynedd.

The 2-hour meeting was free to attend and open to doctors-in-training, physician associates, staff, associate specialist and specialty (SAS) doctors and consultants. Chaired by Dr Mick Kumwenda, RCP regional adviser for north Wales, with conclusions from Dr Olwen Williams, RCP vice president for Wales, the group discussed medical education, workforce wellbeing, clinical research and innovation, and widening access to medicine.

# 'Some of the digital tools and innovative solutions will definitely stay with us'

Nobody really saw it coming. A pandemic on this scale caused huge challenges for those of us involved in medical education; we're still seeing the impact of redeployment on our junior colleagues, in terms of training progression, fatigue and so forth. Educational supervisors no longer had time to meet with trainees, and when they did meet, all they'd ever seen were people with COVID-19, which didn't make for a very well-rounded discussion at the time. Annual Reviews of Competence Progression (ARCP) were all done remotely, or in absentia, or simply didn't happen. That led to a lot of ill feeling among trainees. It was very disrupted, spaces would be repurposed at short notice, and we just didn't have enough time or environment to be able to teach them properly. There were no operations, no clinics. None of the usual rules applied.

In the end, it was the lack of patient contact that got to us all. We were physically separated, wearing masks – communication was very difficult. There's something lost in conversation over a virtual platform. We were doing far more consultations over the phone, with lots of office-based decision making, and patients themselves were reluctant to come into hospital because of the risk of catching COVID-19. However, now I'm hearing that medical students and junior doctors crave that face-to-face contact. They want to see patients and experience bedside teaching. Patients want to be back in clinic, interacting with their healthcare professional: now there's choice. We tend to see every new patient face to face the first time, then offer them telephone follow-up if appropriate. There's a cost- and time-saving element for patients to virtual follow-up when it works.

Of course, there are benefits to Teams and Zoom; it allows you to reach a wider audience, to help people access education in different ways. It gave us time to create new online content and allowed flexibility in the way people access their education. Technology also gave us new ways to disseminate knowledge; we spent a lot of time during the height of the pandemic working out the best way to get important information out to a wide audience quickly. There were times we surprised ourselves and achieved things that in normal times you'd say couldn't be done – like educating hundreds of nurses in the space of a couple of weeks on how to use continuous positive airway pressure (CPAP) machines. Some of the digital tools and innovative solutions will definitely stay with us, especially in a geographically dispersed healthcare environment like BCUHB. We're really focusing on how we get it right, especially as we develop plans for the new medical school in Bangor.

## Dr Daniel Menzies

Consultant respiratory physician  
Clinical director for medical education  
Betsi Cadwaladr University Health Board



# ‘Ultimately, it’s my job to represent junior doctors’ interests at a senior level’

Before the pandemic, there was a big focus on personal resilience training. The emphasis was on looking after yourself to prevent burnout, manage stress at work and stop yourself developing low mood, anxiety or depression. But the elephant in the room is that if you’re working a very intensive rota with a massive workload, starting early and leaving late, no amount of mindfulness is going to make a difference. Then COVID-19 struck.

Staff were asked to work outside of their normal environment and working pattern, and there was a sense of suppressed fear around the place. But for the first time we started talking about wellbeing and hearing about NHS staff burnout in the news. Clinical psychologists in the health board came together to produce staff wellbeing services and set up a hub for drop-in emotional support. The executive board approved funding to continue offering wellbeing services in the long term and I was appointed as an advocate of safe working and wellbeing in April 2022. My role is to monitor adherence to the working time directive and keep an eye on junior doctors’ hours and their wellbeing. NHS organisations in Wales and the British Medical Association have agreed that doctors’ workload should be monitored twice a year, to protect them from working too much.

Moving forward we want to know whether people want drop-in clinics, or perhaps they would prefer to email me, or contact me through the postgraduate centre or through the junior doctor forum. Should this apply to consultants as well as juniors? We’re also considering how best to measure the success of the role. Essentially, we’re trying to flesh out where we’re going with this. We want to ensure that facilities are improved – out-of-hours food, rest facilities, mediation with senior colleagues. Ultimately, it’s my job to represent junior doctors’ interests at a senior level.

## Dr Maddie Phipps

Consultant in pain management  
Advocate of safe working and wellbeing  
Betsi Cadwaladr University Health Board



# 'When you're a patient who repeatedly arrives in the emergency department with the same kind of crisis, you usually know what needs to be done'

I'm a congenital heart patient who receives most of my planned specialist care in England, but any emergency care in north Wales. I had three open heart surgeries as a child, and several cardiac ablations since. After one very complicated ablation in 2018, I was transferred to ICU, intubated and monitored for 5 days. I can't quite piece together all the events, but I do remember waking up, very briefly, to a large group of medics around my bed. I don't know how but I managed to communicate that I had previously suffered endocarditis and septic shock and that they need to give me benzylpenicillin. Within minutes I was asleep again due to the anaesthetic medication I was prescribed.

A few days later, I was certain the peripherally inserted central catheter line was brewing an infection. The first nurse I spoke to didn't take me too seriously, but I didn't give up, and persuaded an anaesthetist to replace the line for me. I really had to advocate hard that time.

I know my body; I know my condition. When you're a patient who repeatedly arrives in the emergency department with the same kind of crisis, you usually know what needs to be done. Of course, there are pathways, and people must be triaged, but only once in 2 years can I remember someone saying, 'let's cut out the unnecessary conversations and call in a cardiologist.' Sometimes it feels like there's a real lack of decision making or initiative; as experienced as clinicians are in smaller hospitals, they don't often see very complex patients or people living with a rare disease.

**Lowri Smith**  
Patient advocate



# 'Our app would enable the most complex patients to share accurate up-to-date information easily and quickly with clinicians at the front door'

The aim of our Bevan Exemplar project is to design a patient passport in app form, with relevant information about particularly complex patients and their conditions. Information could be uploaded by the patient themselves and by their clinical team or anyone involved in their care. It would be particularly useful for patients who travel between different organisations for their care.

We're still so dependent on paper notes. Even within the health board it can take time to get the notes around previous admissions and discharge letters when a patient is admitted to hospital. The idea is that patients would carry this information wherever they go; they could send the information to other teams via email so that anyone could access the files.

There's not much out there that's similar. We only found 12 studies into patient passports or patient-owned health records or patient-owned care since 2000. And they weren't particularly relevant – a lot of them were intended as patient information guides, and very few were patient-specific. There was one paediatric asthma study from New York,

but it was very small. On the whole, the results were positive, but it was criticised for being on paper, which stresses the importance of this being an app. In an emergency people could easily forget a folder, but they're unlikely to forget their phone. We did find out recently that the personal child health record (or 'red book') is now available as an app in London, which makes a lot of sense.

Our app would enable the most complex patients to share accurate up-to-date information easily and quickly with clinicians at the front door, giving a detailed medical history, condition-specific advice and contact details for their specialist team, as well as reassuring the treating doctor that it's completely fine to ring the specialist team for advice.

## Dr Katie Ward

Internal medicine trainee  
Betsi Cadwaladr University Health Board



# 'It's a really good news story for north Wales: we've built our reputation locally, regionally, nationally and beyond, which is fantastic'

When the pandemic began, the whole of society had to adapt, including the NHS. We took a one Wales approach to the COVID-19 vaccine study. Being in north Wales, I was very keen that we should play a part; everything was set up phenomenally quickly. We had real engagement from BCUHB executive team in setting up the [Novovax research trial](#), which we managed in 8 days, and is the biggest study in terms of both financial income and participants that we've ever had in north Wales. It was a huge effort from the whole team, and we've even managed to over-recruit to some very competitive trials.

We've really upskilled our team. There were a lot of staff members who wanted to get involved in research but didn't really know how to get started. It's brilliant that we have had GPs get involved, some of whom are now ready to run large scale trials.

We're also part of the COV-Boost vaccine trial, the first study in the world to look at boosters, designated by the UK government as the most important study in the world in 2021. There are various sub-studies, some of which we led from north Wales, informing into Welsh, UK and worldwide booster policy.

The experience has raised our profile, with television appearances and recognition from national organisations in Wales. It's a really good news story for north Wales: we've built our reputation locally, regionally, nationally and internationally, which is fantastic – it's good to have some success stories outside of south Wales.

My plan was always to set up a new clinical research facility. We did a lot of stakeholder engagement with academic institutions, NHS bodies, participants, patients and staff, and opened our doors in October 2021. We're undertaking early phase clinical studies.

You know, across north Wales and its bordering areas, there are around 1,000,000 who don't routinely have access to experimental medicines: patients often have to travel to Manchester or Cardiff which can be very difficult. We're hoping to tackle this healthcare inequality, and we are considering a hub and spoke model to recruit patients from the English border areas, and as far over as Bangor which would be really exciting.

We started out in rented accommodation, but we quickly realised we need increased capacity. Following a £1.6 million business case, I'm hoping that in 2023, we can open a bespoke unit with state-of-the-art facilities, including laboratories, clinical sinks, ensuite side rooms, a participant relaxation room, resuscitation facilities, 24/7 temperature monitoring equipment, and 24/7 junior doctor on-call cover. We're now taking part in a commercial phase one study which is a first for north Wales. There's a [new website](#) and we've recruited two academic trial fellows who link us with Bangor University and the medical school. There's a research pharmacist joining us soon, and we're hoping to branch out into genomics studies.

We want to raise awareness and encourage people to get involved. North Wales has such huge potential. We've empowered staff to run studies independently, which will undoubtedly help with recruitment and retention of staff in BCUHB. It's already helped us to develop a local, national and international reputation and I think it's just great that we're flying the flag for Wales and the north.

## Dr Orod Osanlou

Director, North Wales Clinical Research Facility  
Consultant in clinical pharmacology and therapeutics and general internal medicine  
Senior clinical lecturer pharmacology/pharmacy,  
Bangor University

# 'In some cases, the decision to admit an older, frail person could put them at risk of contracting and dying from COVID-19 in hospital'

During my postgraduate research degree, I studied hospital acquired pneumonias (HAPs) which are a form of bacterial nosocomial infection. They are very common and a leading cause of death, but there is very little previous research out there. A scoping review of the literature found two themes: firstly, people catch HAPs when they have poor health or if they are taking certain medications, or if they are intubated, and secondly, patients with HAPs end up less able to care for themselves.

I am particularly interested in frailty, which affects older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. I wanted to know how frailty affects how a patient may or may not develop a HAP, and specifically, how they will appear when examined by doctors who are trying to diagnose HAP. Again, this is not something that had been studied before.

With the help of my colleague, we carried out research in Ysbyty Gwynedd over 5 months on two medical wards, and found that interestingly, a patient's frailty score didn't have much of an impact on how they presented with HAP, or how quickly they acquire one. We did find that it may be the case that the higher a frailty score, the more likely a patient is to die during their time in hospital should they acquire a HAP.

When the COVID-19 pandemic began, we halted the study to avoid affecting our results. However, we continued collecting some data regarding number of admissions, length of stay, age, PPE usage and number of HAP diagnoses. At this time, older, more frail patients were not being admitted for fear of them being put at risk of contracting and dying from COVID-19 in hospital, and we found there was a huge drop in rates of HAP. Length of stay also dropped significantly, and there was a big change in how we cared for inpatients.

Logically, therefore, the less time a patient stays in hospital, the less likely they are to catch HAP. However, this was happening while there was also widespread and mandated PPE use with social distancing measures in place. So should hospitals continue the routine wearing of PPE and isolate patients with HAP in order to reduce infection rates in the future?

## Dr Peter Kempster

Former RCP associate college tutor  
Internal medicine trainee  
Betsi Cadwaladr University Health Board





# 'In the last cohort before COVID-19, every sixth-form student who completed the full 2-year programme got an offer for at least one medical school'

Between 2009 and 2011, there wasn't one single applicant to medical school from half of the schools in the UK. A fifth of medical school undergraduates and a third of Oxbridge undergraduates are privately educated, while only 6% of children in the UK as a whole are privately educated. This represents a waste of talent; it means that the medical workforce demographic doesn't represent the population it serves. It leads to underserved geographical areas.

I don't believe that widening access to medicine has to be about turning troubled drug-addicted teens into doctors. I think it's about the hundreds of state school children in north Wales with A grades who simply don't see medicine as a viable option. They don't understand the system, they don't know how to play the game during the medical school interviews because they don't have the parents or the support network to teach them. They don't have the sense of confidence and self-belief that some children get from private school.

Here in north Wales, [the local SEREN network](#) identifies state school children with excellent GCSE grades and invites them to a welcome event with universities showcasing engineering, law and medicine – which is where I come in. To get into medical school, applicants need to ace the University Clinical Aptitude Test (UCAT) and the interview. Around 40 sixth formers will sign up at the beginning of Year 12, and the numbers do drop off: we make them go through hurdles.

It's a tough system. It has to take precedence over everything else. We set them assignments they have to complete to be accepted for work experience. It's interesting that the stricter we are, the more they take it seriously. They are split into groups, with weekly sessions where they might have to give a talk about a difficult subject or take part in a group activity around ethics. They do practice UCAT questions and online quizzes. The survivors get to spend a week in the hospital at the end of Year 12. The following year, there's a lot of interview practice for those who decide to go ahead with an application to medicine.

In recent times, we've moved a lot of our content onto Teams and SharePoint, which has been great and has allowed us to expand the programme. There's a very successful dentistry stream now using the same format. The Welsh government has funded an administrator and it's part of the job plan for our academic foundation 2 trainees. It takes up a lot of volunteer time. We need people to get involved, offer clinic time and act as interviewers. But it's worth it. In the last cohort before COVID-19, every sixth-form student who completed the full 2-year programme got an offer for at least one medical school.

**Dr John Glen**  
Honorary senior lecturer  
University of Bangor

# Educating, improving, influencing

Through our work with patients and doctors, the Royal College of Physicians (RCP) is working to achieve real change across the health and social care sector in Wales. We represent 40,000 physicians and clinicians worldwide – educating, improving and influencing for better health and care. Over 1,600 members in Wales work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions. We campaign for improvements to healthcare, medical education and public health.

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