What’s the matter with the NHS in Wales? – Some frequently asked questions

1) Are there really doctor shortages?

Yes. For a few years now there has been a problem with a shortage of some types of doctors in the UK. The worst problems are in Paediatrics; Emergency Medicine (A&E); Surgery; Anaesthetics; Medicine; Obstetrics and Gynaecology, and Psychiatry. Not having enough doctors, particularly those in the middle-grade ranks (senior juniors, so to speak); is making it very difficult maintain safe medical rotas. This is making some services vulnerable because without enough doctors they become unsafe. No-one wants to run services which we know are unsafe, and where patients could come to harm as a result.

The doctor shortage issue sometimes reaches a crisis point and forces urgent changes. Neath Port Talbot Hospital is a case in point. We couldn’t recruit enough doctors to keep a safe acute medicine service, and had to then urgently move the service to other hospitals.

It’s not the first time doctor shortages have caused us problems. The Children’s Ward at Singleton Hospital had to merge with the one in Morriston Hospital in 2009 because of a shortage of paediatricians.

In 2008 the Minor Injury Unit at Singleton Hospital kept closing at very short notice because we just didn’t have enough A&E doctors. In the end GPs stepped in, and we also had to reduce the hours it was open.

So doctor shortages have been with us for a while … but the problem is getting worse. Even though we have a higher doctor head-count than in the past, we still don’t have enough to run modern-day NHS services.

Why?

There was a time when doctors worked or were on call for ridiculously long hours, sometimes several days at a time. The European Working Time Directive, which limits the hours people can be in work, has stopped that – and that’s good news. After all, would you really want to be treated by someone who was almost asleep on their feet?
Doctors working fewer hours though, mean we now need more of them to run services. So that’s the **first** pinch point.

NHS services are evolving, and increasingly doctors want to specialise. That’s great for patients, because their chances increase of being treated by an expert in their field.

But that also means that there are fewer generalists to share the more routine workload. It also means that doctors who specialise must have a minimum number of cases each year to ensure they can maintain - and expand – their specialist skills. This means services cannot be spread too thinly, or these expert teams will not remain sustainable.

Also, in large specialties like Trauma and Orthopaedics or General Surgery, modern standards insist that a minimum of eight Consultants are now needed for a viable rota.

Smaller hospitals are therefore less attractive to some doctors as a result, which makes it more difficult to fill vacancies; and a vicious circle begins - which can affect things like junior doctor training and threaten some services.

So the greater medical expertise developing in the NHS causes a **second** pinch point.

There are also other changes to doctors’ work patterns. For example, changes in the way doctors become Consultants. They now have different training pathways, which mean they are less likely to remain as long in the middle grades as they did in the past. So we have fewer of these doctors available with this level of experience.

In addition, changes to the Consultant Contract across Wales in 2010 reduced the number of sessions they worked each week, so we need more Consultants to maintain services.

Also, doctors in training (especially woman) are opting to work fewer hours to support a more acceptable work/life balance. (One in 13 doctors in training is now working less than full time).

So these changing work patterns all contribute to a **third** pinch point.

Traditionally, the NHS has recruited many of its medical staff from abroad. This still happens, but tightened UK immigration rules in recent
years has made it more difficult to both recruit from abroad, and for some foreign doctors working in the UK to be allowed to stay here.

(Meanwhile some of our UK-trained doctors are also leaving to work in countries like Canada, Australia and New Zealand.)

Therefore, fluctuating numbers of overseas doctors has created a **fourth** pinch point.

There is also a belief by some that Wales is not the first choice for some doctors. The reasons for this may include inaccurate perceptions of the country and its hospitals, or a mistaken belief that all medical staff must speak Welsh. The Welsh Assembly Government is tackling this problem with the Wales Medical Recruitment Campaign which includes recruitment fairs across the UK; overseas recruitment drives; an active Research and development programme; free accommodation for first-year trainees and a Medical Careers Wales website.

ABMU also does all it can to promote a ‘whole package’ approach to potential medical staff by providing practice and positive information about the merits of working for ABMU and the local area.

So, the perception of Wales by some doctors as not their first choice of where to work is the **fifth** pinch point.

All these factors have contributed to a longstanding and ongoing shortage of doctors.

### 2) All these NHS changes – aren’t they really just about saving money?

We don’t hide the fact that finance is a big problem. We are in the middle of a major world-wide economic crisis and the NHS is not immune from its effects. On top of that, our aging population is adding huge demands on services, as are the growing number of people with long term conditions like diabetes or chronic chest problems.

The Wales Audit Office estimates that by 2013/14 there will be a funding gap of £250m to £445m in NHS Wales just to **stand still** on services. We simply can’t afford to keep going as we are - we will just run out of money and some services will collapse.

However, experience has taught us that if we have services which are effective – (they help people get better faster) and efficient (they don’t
waste money, staff or supplies) – then they will also generally save money.

A change in the way a service is run may not cost less up front – in some cases it may even need additional investment. But, if change results in any of the following, then the longer term pressures (including costs) are likely to ease:

a) Patients don’t get ill in the first place, or as ill as they would have before the change: **Reduction in current and future demands on NHS services**

b) Patients receive the best care available, even if that means travelling further: **Better patient outcomes mean less need for follow-up care and better future health. Better use of staff and resources supports reliable, safe and affordable services**

c) Patients spend no more time in hospital than they need to: **Avoids wasting resources; frees up beds for other patients, so reduces costs of delays/rescheduling operations etc.**

d) Patients avoid unnecessary complications or infections: **Getting it right first time avoids prolonging treatment and reduces the need for follow up care**

e) Patient outcomes are as good as possible – which means they recover quickly or are as well as possible: **Reduces the need for follow up care, supports continuing good health**

f) The risk of unnecessary harm or death is kept to an absolute minimum. **Reduces follow up care and reduces risk of compensation pay outs (which can be millions of pounds, if, say, a birth goes wrong because the NHS is at fault).**

Could we consistently achieve all this by keeping services as they are? The short, but emphatic, answer is no. We don’t always get there even now.

We know, for example, that outcomes for patients using some hospital services at weekends are not as good as they are on weekdays. And a really stark figure is the RAMI (Risk Adjusted Mortality Indicator) rate for ABM University Health Board – it’s higher than that of a typical English peer NHS Trust. This means that some of our patients have a greater risk of dying than similar patients in England. That’s just not acceptable.
We do provide a lot of health services well, and in some we offer excellent results. But we can’t keep on providing all services in the same way that we have. We will have to make big changes.

Ironically, people often equate the number of beds a hospital has with the quality of the health service it provides. Yet there are more beds in Wales: 3.9 per 1,000 population; than in England: 2.6 beds per 1,000 population. But English outcomes are generally better than ours.

So there’s much more to it than just pumping money into hospital beds. Many of the potential changes we will be sharing over the autumn will highlight other ways of delivering care.

Albert Einstein once said: “Insanity: doing the same thing over and over again and expecting different results.”

Clearly, we have to keep that in mind as we all consider the need for change!

So to sum up, money is a major factor in the changes ahead; but it’s not the only one. Greater efficiency and effectiveness are just as important.

3) Why can’t all services be close to where I live?

Looking at the issues above you can see that staffing, finance, and growing demands on NHS services are some of the main issues driving change forward.

Even if we had limitless funds, we still wouldn’t have enough doctors across ABMU to duplicate every service on every hospital site. And even if we could find enough doctors, then the specialists among them would become deskilled because they just wouldn’t see enough patients!

It’s not just doctors, either. There are also staffing issues with other clinical staff, with many reaching retirement soon, for example. In short, spreading all our services too thinly doesn’t really work. Patients would not get the high level of expert care they expect and need in the 21st century NHS.

We absolutely understand that travel issues are a big worry for many people, and finding ways around this is very high on our agenda.

But the trade off for patients is this. Travelling a little further to a nearby ABMU hospital instead of your local one for some services may be less convenient. However, you are much more likely to be seen by an expert
team providing a sustainable service; and as a result, to get a better outcome.

So should the question really be: Do you want the closest service, or do you want the best service?

Of course hospital services are just one part of the NHS jigsaw. Just as important are community-based services. Did you know that over the last few years we’ve been investing in services like Community Integrated Intermediate Care Service, or CIIS?

Evidence shows that most people do better when they are in familiar environments, like their own homes. Many people, when given a choice, prefer not to go into hospital. Services like CIIS are a halfway house between GP and hospital care. Doctors, nurses and therapists deliver tailored packages of care to patients directly in their own homes.

CIIS helps to prevent people from going into hospital, and also supports people to leave hospital on time.

ABMU has also been investing heavily in several community-based resource centres where some services which are traditionally found in hospitals are now offered in community settings. These impressive new buildings are like super health centres for the 21st Century, and offer some diagnostic services and Warfarin services, for example, as well as traditional GP and/or dental and pharmacy care.

So increasingly, more and more services will be available directly in your local community which at one time would only have been in a hospital setting.

The future is likely to hold more hospital ‘centres of excellence’ which patients may need to travel to from time to time. But much of the routine care which was once based only in hospital settings is moving into the community – closer to people.

4) I’m hearing lots of rumours – when will decisions be made?

This is a time of major change in the NHS, and the pace of it can be hard to keep up with. But there are also processes in place to make sure patients and the public are kept closely involved.
Sometimes, when patient safety is at risk, a change will happen urgently – like the acute medicine service at Neath Port Talbot Hospital. But we want to avoid urgent change like this as much as possible. We want change to be planned, carefully thought through, and with the input of as many interested parties as possible.

When major changes to NHS services are under consideration, Health Boards in Wales must engage with Community Health Councils (CHC) and the public an over their initial ideas. Then, depending on how the engagement went, a formal consultation may follow.

If a CHC supports the change, the Health Board reports that to its own Board and the change moves forward. If the CHC opposes the change, the Health Board may amend the change until consensus is reached, or, if that doesn’t happen, the issue may go to the Assembly for Ministerial decision.

Currently there are two change programmes underway which affect ABMU, and there is overlap in some of the services being reviewed in each.

- Our own ABMU Changing for the Better, and
- The South Wales Programme, which involves ABMU, Cardiff and Vale, Cwm Taf, and Powys health boards. (Hywel Dda has its own change options but some of the services under review in the South Wales Programme affect Hywel Dda residents too.)

Both programmes have involved hundreds of front-line doctors, nurses, midwives and therapists who have been examining how services could look in the future.

Changing for the Better has been looking at seven key service areas: unscheduled care; long term conditions; care for frail, older people; care of children and young people; maternity and newborns, staying healthy and planned care.

In the South Wales Programme discussions have centred on major injury, major sickness or problems during childbirth.

Public engagement on both starts in September, when more details will be widely available.