Question marks.

A page-by-page commentary on and response to the discussion document

'Your Health / Your Future'

CHIS / SOSPPAN March 2012

1

The overall philosophy appears to be that the provision in centres of population should be downgraded in order that they suffer the same level of inconvenience as those in the outlying rural regions: if the same logic were applied in Scotland, Glasgow and Edinburgh Infirmaries would be downgraded and patients sent instead to the Isle of Skye for treatment.

Can the Board not see that this philosophy is fundamentally flawed: achieving equitable access to health services should not aim to reach the lowest common denominator?

2

Page two gives an excellent start to the discussion: high quality services and care delivered closer to home….provide more than 80% of services as locally as possible...ensuring that our hospitals meet the needs of patients who require a higher level of hospital care.....people believe their local hospital should provide every type of health service for the local community....they do not support keeping old hospital buildings open if they are not fit for modern healthcare.

But does the Hywel Dda Board believe their own words?

3

Page three brings first mention of the obsession with 'rural' provision at the expense of 'urban' provision; yet a critical fixed point is given as 'Services that can meet future demographic, workforce and recruitment challenges'. The greatest concentration of population is in Llanelli. The largest pool of working people is in Llanelli. The closest proximity to Schools of Medicine is Llanelli.

Can it be true that the plans seek to downgrade Prince Philip Hospital, Llanelli?

4

Page four states the laudable aim to achieve the very best services for our population for the future, yet goes on to express the need for the Hywel Dda Health Board ' to be recognised as Wales' leading integrated rural health and social care system'. The Board is clearly prepared to sacrifice the urban needs of the largest population centre in the county on the altar of rurality.

It goes on to state the aim of abandoning the frail and elderly to a lonely fate without hospital support, to allow 'our hospitals to concentrate on what they do best - provide acute care when it is needed'. There will clearly be many instances where care and support at home is the best option for the elderly patient: when significant mental and physical health problems do not present themselves and where the family support network is capable of caring for the individual, perhaps with some intervention from the health and social care services. Even under these conditions, the welfare of family carers is often compromised by the demands of the patient and may become an issue in itself.

In any event, it is invidious to think that a ‘one size fits all’ mentality will see less fortunate individuals, without close family or friends, condemned to see out their days ‘home alone’.

Does the Board not recognise that abandoning a frail elderly person to days alone at home, hungry, lonely, wearing nappies and sitting in their own excrement for hours at a time, lacking social stimulation and companionship, is simply inhuman and breaches their human right to live in dignity as enshrined in law?

5

Page five contains a chart which is breathtaking in its incredulity. The Hywel Dda VISION is shown as PLANNING for a system in which the more acute the need for medical support, the longer the time taken for it to become available. Thirty minutes for a minor injury, sixty minutes for access to an emergency department, ninety minutes to deal with major trauma. Can this be true?

The statement 'We know that people with frailty do not do well in hospital' is not encouraging. People with frailty do not do well ANYWHERE! They are FRAIL! At least in hospital they are under constant observation to keep them safe. At home, alone, these particular people are at greater risk!

Does the Hywel Dda Board recognise the difference between statistics and real people?

The statement 'we have already made a number of commitments to help us deliver this vision...' gives us further cause for concern and suspicion.

How can this be when we are told that 'absolutely no decisions have been made' (page2)?

How can over £150 million be already committed at this pre-consultation stage?

6

The 'investments' shown on page six clearly pre-empt the outcome of the consultation process. These must be scrapped pending proper completion of a meaningful consultation process, with all stakeholders being provided with the opportunity to explore all possible alternative proposals. All parties, particularly the Hywel Dda Board,

need an opportunity to develop properly costed plans worthy of meaningful consideration and which will truly benefit the majority of the catchment.

What reputable organisation would present such draconian plans for change without proper costing?

7

Page seven sees an acknowledgement that 'In rural Wales it is also the case that there are too few patients to run certain services safely or effectively'. This is self-evident: it is part of the price that a thinking individual pays for the many other pleasures inherent in the rural lifestyle. The aim to ' comply with best practice guidelines delivered across our rural community' is surely to be applauded, but certainly not at the expense of others! 'Treatment must be based on the best available evidence as quickly as possible for everyone regardless of where you live'. This is dangerously naïve and harks back to the philosophy expressed on page one. It ignores the demographic requirements.

Can it possibly make sense to REMOVE prompt access to treatment for the huge urban majority merely to EQUALISE the difficulties of access experienced by the tiny rural minority?

8

Page eight yet again states the aim to ensure 'access to healthcare is as equitable as possible for our whole population'. This seems to fly in the face of the demographic distribution, unless the words ‘AS POSSIBLE’ are taken at their face value.

The document notes the number of 'unnecessary Emergency Department attendances and hospital admissions'.

Attendance at A&E is because a situation is perceived by the patient as 'an emergency' and is therefore, ipso facto, a 'real' emergency and a ‘necessary attendance’, even if the situation subsequently proves to be dealt with by straightforward (to the hospital world) medical intervention. Furthermore, it is often the local GP surgery that has directed the patient to A&E as a double check for their diagnosis. The patient may also have to attend A&E as a last resort when faced with an unacceptable delay in seeing a doctor at their local surgery, contrasting sharply with

the equivalent situation for pet owners and their neighbourhood veterinary practice! The later paragraph, relating to future staff retirements, is an unbelievable admission of administrative incompetence. Any organisation of any description has to deal with succession management as a routine process to cater for staff migration and ageing. The next paragraph is even more bizarre. 'The work of our consultants and specialist staff is not coordinated as well across the Health Board as it could be'. Confessing to presiding over a shambles is hardly the best qualification for moving an organisation forward!

Can it be that the Health Board does not recognise their own catastrophic failures to fulfill their basic functions?

9

Page nine starts with a statement so blasé as to be incredible. Paramedics are wonderful individuals and are valued by the community well beyond their paltry remuneration. But they are not doctors! Their role is indeed to stabilise the patient, but then to transfer the patient to a hospital for more expert attention. FAST.

A single co-ordination centre for transportation could be more threat than benefit. Will it be manned efficiently? Will it be operated effectively? How much will the system cost? Who will pay?

The need to 'make the best use of the money we have' is accepted. The best way to achieve this, in a rural analogy, is to 'prune the top of the tree and allow the roots to flourish'.

Can the Board not see that the grossly top-heavy administrative layers must be cut away to release funds for front line services?

Investing in 'health and wellness in order to limit future demand on costly treatment' is a laudable proposition for younger generations.

Would anyone dare to leave today's elderly, the generation which saw this country through the worst of times, to fend for themselves in their hours of need?

10

Page ten includes the admission that 'too many people are travelling too far for services'. The obvious corollary is that more front line staff are needed at more centres closer to the places of need.

The recognition that 'we need to eliminate waste' is welcome. Can the Board not see that it is they who bear the responsibility for this waste, since it under their control?

11

Page eleven clearly exposes the CURRENT weaknesses of 'care in the community', in which 'primary, community and social care services currently can't always provide an

alternative' to hospitalisation. The current system is characterised by long delays in gaining access to GPs in their surgeries, let alone having GPs making home visits. Health and social workers are stressed out on tortuous circuits at great personal risk as they rush by car from one home patient to the next, frequently failing to keep to their schedules and constantly under pressure to minimise patient contact time. It is no surprise that staff sicknesses are a major problem under current conditions.

How can the Board propose a vast increase in this already struggling structure with its added pressures and especially the administrative nightmare that would rapidly develop?

12

Page twelve contains a classic example of PR speak: 'We need to make sure that older people maintain their independence and those with chronic conditions know how to care for themselves but have good access to specialist care when they need it.' In other words:' Keep out of our way until you're on death's door and then we'll see you off'. There is nothing at all wrong with the principle of proactive prevention rather than reactive intervention. For a large group of the population, however, independence from the health services is at the cost of unbearable dependence on family and friends, or abandonment to a miserable empty existence.

It is especially heartening to see the statement ' Too many of our patients are travelling too far for services we could deliver locally'. This is absolutely correct and underlines the insanity of reducing services that have for decades been available locally at Prince Philip Hospital and transferring them instead to centres twenty miles away or further. The statement that '30% of hospital admissions could be avoided if there was better access to community based services....' begs the question 'Why are these patients admitted?' They cannot just turn up and demand admission! They are admitted only when clinicians determine that admission is necessary for their welfare and treatment. Why does the Hywel Dda Board suspect that their own clinicians are admitting so many patients without good cause? Does the Board intend pursuing incompetency procedures against these clinicians? Who really is the incompetent party in this situation?

The aims to 'provide care closer to your home, to reduce the need for you to go to hospital unnecessarily and if you do need to be admitted, to get you home quicker;' seems to show a lack of understanding, by the Hywel Dda Health Board, of the distinction between ATTENDANCE for treatment at a hospital clinic as a visiting patient and ADMISSION to hospital for a longer period, requiring a bed and nursing. Surely it is only the former which could be carried out through community based services, and then only if the appropriate levels of medical expertise were available at each centre. The implication is that resources would have to be duplicated to provide support at many more centres throughout the community.

How many centres? Where would they be built? Would they include the current GP surgeries? What new levels of medical expertise would be brought into these centres and at what cost?

Does the Board not recognise that it would be more efficient to properly utilize those centres which currently exist? These centres are the fully equipped hospitals that the Hywel Dda Health Board inherited, placed closest to the main concentrations of population because of an efficacy which has developed through the generations.

13

Page thirteen shows quite clearly the slavery to statistics of the administrator, as opposed to the concern for the individual patient of the clinician. Births are not entirely unplanned! There is an obvious case for a mobile team of obstetricians to diagnose and deal with mothers and babies within the catchment.

It is a disgrace that no Level 2 unit exists in Hywel Dda four years after clear guidance was received from the RCO. This is yet another example of administrative incompetence.

14

What an admission! Page fourteen contains the breathtaking statement ' Currently we do not have a high dependency unit for children in Hywel Dda Health Board ..... This puts a great strain on the children and their families and would require fewer transfers IF WE ORGANISED OUR SERVICES BETTER'. The obvious need for training and recruitment of 'dedicated neonatal nurses' is there for all to see, but has the Hywel Dda Health Board seen it? If not, why not? If so, why has it not addressed this issue long ago? The admission 'We do not meet these quality standards' four years after they were issued is not at all encouraging!

15

The 'What we should have...' section on page fourteen is vague; confusing and begging the question 'What do you plan to do about it?'

Is it beyond the wit of man to merge three teams into one?

Is it not a purely administrative function to ensure a certain number of hours are available for a certain member of staff?

16

Rurality is mentioned twice on page sixteen with no acknowledgement of the urban need within the Hywel Dda catchment ..... but the need 'to minimise travelling whilst maintaining standards' is a welcome reiteration. To minimise travelling the service has to be provided as close as possible to the user. In this case the user is the mother and child unit, the provider is the Hywel Dda Board. It is self-evident that, to meet the declared target, every district hospital must have a fully functioning maternity unit.

17

Page seventeen has a truly memorable statement, one that will go down in the annals of incompetent management for all time: ' On too many occasions, patients have gone to Prince Philip Hospital in an emergency and required urgent transfer. This is not a safe situation so we need to ensure that everyone is aware of the services available at the hospital'.

NO! This is not a safe situation because those charged with tending to the urgent emergency needs of the largest concentration of population within their area of responsibility are failing dismally to meet their obligations!

The people in need of emergency care go to their nearest major hospital, which has met their needs for decades, unaware that distant administrators have surreptitiously removed those vital services to support their own private agenda.

The Health Board's own figures prove that thousands of Llanelli people every year are being denied their right to emergency health care at their own hospital and are being forced to accept the inadequate alternative of transportation to Glangwili.

It is the **duty** of the Hywel Dda Health Board to provide emergency health care for the urban district of Llanelli in the hospital which is in the town, is modern, well equipped and staffed with people of the highest calibre.

Can the Board not see that such a dismal failure to meet the needs of the population is cause for the provider to rethink their provision, not for the people to acquiesce to an entirely unacceptable alternative?

Confession that they cannot ensure that an experienced doctor is always available, anywhere within their region, to deliver emergency services *'because of the way our emergency services are organised' is* yet another confession of abject failure.

The acceptance that 'it is important to have fast access to a consultant and fast access to diagnostic tests' only underlines the need to reinstate these facilities which were previously available in Llanelli.

These same facilities could surely be made available, in this age of electronic communication, to the outlying rural areas via appropriate use of information technology.

Are the administrators aware of the potential of IT to improve rural services without degrading their urban counterparts?

18

'The best outcomes are achieved when patients with emergency surgical problems or trauma injuries are treated by a consultant ..... and where there are no delays in accessing theatres'. These words on page eighteen receive a loud 'amen' from every clear thinking person. The solution is **NOT** to force the victim to endure a long uncomfortable ambulance journey when the necessary facilities are already available close at hand. It is universally accepted that the initial 'golden hour' is critical in dealing with medical emergencies. If that hour is wasted in a lengthy road journey the likelihood that the patient will survive is greatly reduced.

Is the Board prepared for the avalanche of 'criminal negligence' claims which will surely follow this cavalier refusal to meet the public's needs and demands?

19

'Only at Prince Philip Hospital do we manage to separate planned care from unplanned care'. This, on page nineteen, is surely a good thing. So why even consider downgrading the only hospital which is doing things properly!

Yet another admission of failure to comply fully with accepted standards is linked with the lack of senior doctors on site at all times. If the money wasted on overpaid administrators was redirected towards medical front line staff then the resources would be in the right place at the right time.

Can the board not recognise that the top heavy and burgeoning bureaucratic structure is syphoning off the life-blood of the Health Service at the expense of patient support and the safe delivery of essential services?

20

The challenge on page twenty, 'To deliver emergency care that is safe, responsive and accessible.....' is all that the people within the Board's catchment have been pleading for. It is what they now demand.

The claim 'We have tried to fill our vacant posts.....' is disputed in many quarters. It has been suggested that this is merely a smokescreen to mask the sub-plot to centralise services geographically, regardless of the demographic profile which demands a very different distribution.

Does not the Board realise that any organisation with such notoriety for incompetent financial and organisational management will find it difficult to recruit staff? It is THEIR failure which is regularly in the national headlines. It is THEIR failure which is all too frequently debated in government. It is THEIR failure which has produced one of the most disillusioned workforces in the country. It is THEIR failure which sees one of the highest staff absence rates through illness.

21

'Too many patients have no option but to access more specialised medical treatments outside of Hywel Dda Health Board. In planned care we need clinical team working to develop more specialised services which are currently not available'. The concept of team working is a welcome outbreak of common sense and it can only be hoped that this idea of teamwork will permeate through to other key areas such as obstetrics, which has been commented on in point 15.

22

It is worrying that, on page twenty two, the declared aim is to achieve 'critical mass'! Critical mass leads to a nuclear explosion. And that is, indeed critical!

In the world of computers it is widely recognised that nonsense input produces nonsense output. This nonsense deserves nothing less! The entire page is a neat illustration of the state of disarray which exists in the Hywel Dda Health Board. A more appropriate epithet would be 'Critical Mess'!

23

Page twenty three offers hope once more: if only the Board follows the directions as they themselves set out: clinical teams working together? YES! More accessible outpatient clinics and diagnostics? YES! YES! Swift diagnosis? YES! As many surgical and orthopaedic surgery procedures as possible delivered locally? YES! Operations not cancelled? YES! Involve other professionals? Reduce the need for surgery? Better pain management? Short waiting times? Rotas to support doctors in training? Making services attractive to doctors? YES! YES! and four more times YES!

24

On page twenty four there are depressing statements once more that remind us of the failure of the Hywel Dda Health Board to deliver on so many fronts. Some statements do show a recognition of the way forward: 'we need enough doctors....' , ' maintaining working rotas for doctors...' , 'team working.....', 'no single handed doctors....', 'you have the best outcome if you are assessed by a senior, experienced doctor', but the unhappy ending says it all for the Board: '**we cannot guarantee that you will always be seen by a senior doctor'.**

What a way to end! What a damning failure to close a depressing positional statement. The people of the Hywel Dda Health Board area deserve better than this.

The 100,000 people within the catchment of Prince Philip Hospital demand:

- **A major emergency department commensurate with the size and nature of the catchment, with significant centres of industrial, commercial and educational activity.**
- **Acute medical inpatient services appropriate for the size and nature of the catchment.**
- **Out-of-hours acute surgical and trauma service.**
- **Restoration of the full range of elective surgical services including gastric, colorectal, vascular, urology and pancreaticobilary.**
- **Continuation of the Breast Care facility.**
- **Dedicated surgical facilities to support day and short stay surgery including orthopaedics.**
- **Inpatient elective service and centre for complex orthopaedic surgery.**
- **Obstetric care with improved maternity and paediatric provision.**
- **Biomedical laboratory facilities to support all hospital functions.**