HEALTH SERVICE RECONFIGURATION – LESSONS LEARNED REVIEW

Inquiry by Ann Lloyd on behalf of the Welsh Government

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the review being undertaken by Ann Lloyd on behalf of the Welsh Government of lessons learned from Health Service reconfiguration.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales has been active throughout the NHS reconfiguration process in Wales. Amongst our members, we would however note that there has been a widespread perception that the processes being undertaken have in many ways been flawed. Paradoxically, we believe that this has led to increased involvement and commitment to establishing processes that are fit for purpose, as well as an attempt to make changes that overcome parochial interests, secrecy and a lack of consistency in decision-making.

Our overwhelming conclusion is that health boards have been set up to fail, because they are inadequately financed for the expectations of both the public and politicians. Furthermore, we consider that a repeated inability to deliver a joined up approach, provide detailed financial analysis or adequate modelling of the consequence of proposed changes through a lack of credible data, severely weaken not only the argument for change (which we agree needs to take place) but also professional belief from many of our members that such changes will in fact be to the benefit of those we serve – i.e. our patients, and the wider population of Wales.

BMA Cymru Wales members have sought to engage positively with the reconfiguration process as it has been undertaken across Wales. Members of the BMA’s Welsh Council also contributed materially to the production of two position papers on the topics on service reviews [1] and reconfiguration [2]. These were


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published as the reconfiguration process was being undertaken in order to set out the principles that we believe should be followed. Sadly, we would note that this has not always been the case.

A full account of the involvement of BMA Cymru Wales in trying to move the NHS in Wales to a sustainable future would lead to many more pages of input than we are able to provide in the limited time that has been made available. We are disappointed that oral evidence for this inquiry has not been requested from us, but we will nonetheless attempt to précis our observations in this written submission.

A case study of the reconfiguration in North Wales

To provide more specific context to our views on the processes that have been undertaken as part of the recent Health Service reconfigurations that have been agreed upon in Wales, we present the following case study of the reconfiguration underway in North Wales in order to outline the perspective and experience of BMA Cymru Wales members at a local level:

In around 2009, we note that an initial exercise by Betsi Cadwaladr University Health Board concluded that there should be three emergency departments admitting unselected medical and surgical patients. The process involved several large meetings of ‘experts’ and ‘stakeholders’, with combined meetings undertaken as decisions were being made (involving several hundred attendees). Members of the public were welcomed and actively engaged in the process. In the view of our members, it was highly informative to have real patients talking about their lives, what works for them and what issues they would face in the light of change. The final report stated that, as obstetrics and paediatrics were undergoing imminent review, they would not be listed as ‘core specialties’ in this review of unscheduled care. (The expectation of those groups involved was that these would be added later.)

This exercise was evaluated by external consultants at significant cost to the health board. They commended the engagement process and made a number of recommendations for change for future engagement in other specialty areas.

Regrettably, we then observed that the process suddenly became less open and transparent. We would speculate that this was a result of the disagreements at board level about the sustainability of three acute hospital sites in North Wales, which have been documented elsewhere.

A number of semi-independent, specialty-specific workstreams then appeared which we observe narrowed the involvement of professional clinicians, had no or very limited public representation and whose minutes were either absent, delayed until BMA Cymru Wales requested them or disputed by our members. The data on which decisions were being formulated have been open to multiple interpretations and often not in the public domain. This has, in our view, been an on-going battle but we would acknowledge the help of the current health board team. We are not saying that an enormous amount of excellent and thoughtful work has not been undertaken, but we regretfully note that a degree of opaqueness developed that served to fuel the flames of paranoia amongst our members locally. These workstreams repeated the conclusion of the previous review of unscheduled care that neither paediatrics nor obstetrics were ‘core specialties’ (which, as we have seen, was not the case), and therefore agreed that further discussion about possible closures of service on one or more sites could be progressed. The BMA’s Clwyd North Division fundamentally objected both to this process and the premise that has followed, and brought this to the attention of the health board on many occasions.

As an example, we would raise the issue of neonatal care in North Wales. We could not (and still do not) understand how a neonatal unit serving 7,500 deliveries in North Wales was regarded as unsustainable, in favour of a neonatal unit serving 4,500 deliveries at a District General Hospital on the Wirral (Arrowe Park), which somehow was seen as sustainable. The outcomes of care in North Wales were known for small babies, but we failed, even through FOI requests, to secure comparable data for Arrowe Park. The public

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2 http://bma.org.uk/-/media/files/pdfs/about%20the%20bma/how%20we%20work/uk%20and%20national%20councils/welshcouncilreconfiguration.pdf
consultation on neonatal care very much supported it staying in North Wales, but somehow this was able to be ignored by the only ‘public’ entity that could have stopped it – the Community Health Council (CHC). The lack of independence perceived by our members between the CHC and health board was a contributing factor in our severe disappointment and conclusion that the process was not fit for purpose. The subsequent consequences for the health board are again well documented in the public domain.

We would note that the health board’s new executive team has attempted to rectify the position and address some of our concerns. At a joint meeting of all three North Wales BMA Divisions, senior clinical staff expressed uncertainty about the process and the future of their services across the region.

The principal complaint of our members is that senior medical staff outside of the management hierarchy have not been listened to, and that there are persistent elements of the ‘old’ health board pressing on regardless – despite the possibility that this would be detrimental to patients – because that is the course they appear to have been instructed to set upon. This is despite a new health board structure being consulted on at present.

A further example detailed by our members involves the provision of major vascular surgery in North Wales. Backed by a report from the Royal College of Surgeons, the expert work-stream considering this service, concluded that it should be centralised at Ysbyty Glan Clwyd due to the relatively small numbers involved. This was consulted on with the public and subsequently agreed. However, without prior public warning, an interim plan was then presented to the health board from outside the agreed process for a two-site model, with centralisation to take place in January 2015. Despite several expert opinions being expressed from inside and outside the health board that this was not only unnecessarily disruptive but also risked the long-term centralisation because junior surgical trainees were being pulled from the Glan Clwyd site (so major vascular surgery would be unable to return once removed), the health board seems intent on pressing on with this interim plan, citing this as ‘an operational interpretation of the strategic decision’.

This dichotomous and contradictory position, where the health board was making a commitment it knew it may not be able to fulfil, is a perfect example of two fundamental problems with the processes of service reviews and reconfiguration as they exist currently – i.e. there is really no such thing as an independent or unbiased view on what should happen, and a failure to consider interdependencies both clinically and outside the organisation(s) has contributed massively in our view to the current state of chaos and confusion.

A solution to the first problem was seen in the independent review of neonatal care in North Wales commissioned by the First Minister. We are hugely impressed that this difficult decision was based largely on access, inequalities and the rural nature of much of North Wales, but would highlight our belief that substantial local services are needed on all three acute sites in order to move only the most specialised and specified cases. Any service that routinely sends large numbers of vulnerable patients – of whatever age – far from home and their families constitutes a disservice to the public in our view.

Whilst we note that there is an obvious interdependency between neonatal care and obstetrics, for example, it would seem to us that the interdependencies which exist between general medicine, surgery and orthopaedics (trauma) have led to confusing scenarios being proposed by a planning team that is both detached from and seemingly at odds with frontline clinicians. This team appears to be pushing ahead with a timetable based on health board managerial priorities rather than the need to derive the best result for patients.

Such a pace of change has given rise to criticism that some of the decision-making processes being followed have not allowed sufficient time for proper involvement, engagement and consultation with clinicians, let alone with members of the public. We do not consider that the partial engagement that has taken place – which we see as having been undertaken simply to claim ‘clinician involvement’ – has provided enough time for considered judgements to be made that are based on an analysis of actual or potential consequences. We also remain to be convinced that the information systems being relied upon to provide follow up data on the outcomes of the service change are adequate for the task.
In all of this, we note that the reviews undertaken have failed to engage significant partners in joint responsibility for the future of the NHS in Wales. We observe for instance that the ‘U’ in BCUHB – i.e. university – remains an un-tapped potential source of revenue, medical and other staff. In this regard, we have seen no formal university-provided contributions of note considered as part of the current service reviews being undertaken in North Wales, and we further note that the NHS has also been generally absent from the Welsh Deanery’s reconfiguration meetings. We are concerned that the unnecessary consequences of such a disconnect are starting to manifest in staffing crises in many departments and specialties. In our view, such disjointed working is at the heart of what is wrong with the NHS in Wales – with Wales after all only being equivalent in size to an average English health region. We believe that Wales should be able to do better given the devolved situation it enjoys in regard to both health and education.

The clear experience of many of our North Wales members has been a sense that things are being done ‘to them’ rather than ‘with them’, and that engaging their professional expertise has been regarded as secondary to some higher health board plan. We have, however, not found evidence that such a plan actually exists (or existed), but we do note there is a positive intention from the new executive team to endeavour to do things differently. The process is incomplete and therefore, in one sense, this current review might be thought to be a little premature. The public seem to have little idea, if any, of what is being proposed and we are unconvinced from past experience that the CHC will represent the public impartially.

An inability to consider patients as individuals, or to recruit the expertise and knowledge of frontline clinical staff more widely, has in our view already led to unnecessary excess costs. As a result of a lack of vision and planning for changes in medical trainees several years ago, for example, service change will now be reactive rather than proactive, and therefore not necessarily based on what may be best for patients.

A failure to meaningfully engage primary care teams on account of stakeholder meetings being held during office hours is another example where many of our members feel they have been left with little idea of what the health board is planning until it may be too late for them to intervene. Primary care colleagues on the North Wales Local Medical Committee (LMC) state that they have very little idea of the health board’s intentions, and that they are fire-fighting the current crisis and future collapse of general practice in North Wales. They clearly remain unconvinced that any reconfiguration that shifts work to the community away from secondary care can be sensibly contemplated given the current problems which exist within primary care in relation to funding, pay cuts and escalating recruitment difficulties.

**Further observations**

We observe that many of the comments made above regarding the reconfiguration in North Wales can also be extrapolated across to both the South Wales Programme and the reconfiguration of services in West Wales – although our members do acknowledge the efforts that have gone into trying to engage them, particularly in relation to the South Wales Programme.

Our overriding criticism, however, is that clinical engagement and decision-making has been requested in the face of woefully incomplete data on current activity and outcomes with poor capacity for evaluating or monitoring the effects of any changes proposed. In many cases we have been asked to express a preference between options that have simply not been worked through in terms of how they will fully impact on the delivery of the services affected. Asking our members to give a balanced clinical assessment with a lack of full detail and costings being presented has, as a result, led to decisions being based on un-evidenced opinion and often parochial interests, rather than on proper assessments of patient health needs. Given the world class expertise in health economics that exists in several Welsh universities, the lack of economic analysis that has been provided for health boards, localities, government and the Welsh public itself is, in our view, both hugely disappointing and a fundamental flaw in the process followed.

In relation to the South Wales Programme, we outlined some specific concerns in the response we submitted to the consultation at the time. For instance, we expressed concern that the consultation document had failed to make a sufficiently-detailed and evidence-based case for the changes proposed. This

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included: a lack of detail regarding how any current gaps in service provision would be bridged ahead of the development of the proposed new Specialist and Critical Care Centre at Cwmbran (or what contingencies were in place should this new hospital not in fact be delivered); a lack of detail regarding how both the ambulance service and primary care services (including out of hours GP services) would be appropriately enhanced; and a lack of full and detailed workforce modelling to underpin each option proposed (including detail of how this would impact in each case on training for doctors).

Another concern raised repeatedly by our members across Wales, is that what is presented as clinical advice is often not sourced from practising clinicians. For instance, such advice may have come from managers who may have previously worked as doctors but who are no longer undertaking direct clinical practice. Alternatively, such advice may have been formulated by managers who may have discussed matters with clinical staff but then present their own interpretation rather than the source clinical view. Another related concern is that clinicians may on occasions be hand-picked by management to provide advice, but that such advice may not constitute a representative view of the wider clinical staff group providing a particular service.

Whatever happens next across Wales will have a financial and personal cost – not just for the NHS, but for patients and their families. The failure we perceive for the ‘bigger picture’ to be considered is not necessarily the fault of individual health boards, which may be struggling with cumbersome and over-complex organisational issues that are woefully present throughout both the NHS and government in Wales. In our view, there are too many clinical decisions being taken by employees within the NHS who do not themselves treat patients, and the service reviews, as they stand, have not to date addressed this fundamental issue. What is critical to the future of the NHS in Wales is clearly what happens next, and it is our view that meaningful clinical engagement will be crucial to future success.


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