Health In Wales

Mike Hedges

Senedd Member

Swansea East

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This pamphlet will look at the structure of health in Wales, primary care, secondary care, and health improvement.

Current health structure in Wales.

The Welsh Ambulance Service was established in 1998 by the amalgamation of four existing ambulance Trusts, and the ambulance service provided by Pembrokeshire and Derwen NHS Trust.

Public Health Wales was created at the same time as the local health boards by the merger of National Public Health Service, Wales Centre for Health, Welsh Cancer Intelligence & Surveillance Unit, Congenital Anomaly Register & Information Service for Wales, and Screening Services Wales.

The 7 local Health boards that now plan, secure, and deliver healthcare services in their areas replaced the 22 LHBs and the 7 NHS Trusts which together performed these functions previously. The population sizes vary between Powys at just over 130,000 to Betsi Cadwaladr at just under 700,000.

Having the ambulance service run separately from hospitals does not work. Ambulances stacked outside hospitals and unable to attend 999 calls is the responsibility of the Welsh ambulance service not of the local health board.

The Swansea Bay university health board (SBUHB) area has three general hospitals based at Morriston, Singleton and Neath Port Talbot supported by Tonna and Gorseinon hospitals plus Cefn Coed hospital.

MORRISTON HOSPITAL is planned to become the centre of excellence for URGENT AND EMERGENCY CARE, SPECIALIST CARE AND REGIONAL SURGICAL SERVICES, including complex medical interventions.

SINGLETON HOSPTAL is planned to become a centre of excellence for PLANNED CARE, CANCER AND DIAGNOSTICS. The COVID-19 pandemic has had a significant impact on planned care services which have necessarily taken a temporary ‘back seat’ to the urgent demands on the NHS to manage the challenges created by the pandemic. Whilst planned

care is by its nature not urgent it is still essential, especially to patients awaiting care and who continue to suffer pain, discomfort, and a reduced quality of life due to a lack of treatment.

NEATH PORT TALBOT HOSPITAL is planned to become a centre of excellence for ORTHOPAEDIC AND SPINAL CARE, DIAGNOSTICS, REHABILITATION AND RHEUMATOLOGY. Along with all other planned care services, orthopaedic and spinal care services have been stretched by the COVID-19 pandemic.

The Betsi Cadwaladr University Health Board covering north Wales has three District based General hospitals in Gwynedd, Wrexham and Denbighshire supported by seventeen community hospitals.

Hywel Dda covering west Wales has four district general hospitals in Llanelli, Carmarthen, Haverfordwest and Aberystwyth supported by five community hospitals.

With hospitals, the local health board works in Swansea Bay where it is easy to move between hospitals and the recent proposed changes will, I believe, benefit patients.

The question that I think needs addressing is that if a health board cannot act as a single hospital on several sites as SBUHB does, what is the advantage of joining the hospitals together under one board.

If the same services are provided on one or more sites, why should they not be treated separately. Why add another layer of management without the benefit of centralising services as is planned in the SBUHB area.

Health needs

We all want two things from the health service one is the best possible medical intervention, and the other is a service as local as possible. The expectation that in every area of medicine that the best possible intervention would be local is recent. When I grew up in Swansea in the 1960s and 70s there was an acceptance that a referral would take place to Great Ormond Street for children with certain medical conditions or one of the London teaching hospitals for older patients with serious health needs.

I believe the over-riding importance in hospital provision is that the service is safe and staffed by suitably qualified and experienced doctors. I, as both a local politician and prospective patient believe that following a hospital stay the best possible outcome is most important.

Nothing is more important than the safety of the service being provided, and every patient has the right to the best possible treatment, and I do not believe anyone should be expected to accept anything else. Without being melodramatic, or shroud waving, failure to achieve this can lead to premature and unnecessary death and we have had patients losing their lives because of mistakes such as the wrong organ being removed.

However, the question must first be asked is what we should expect from the NHS at our local general hospitals and which specialist services we should expect to have to travel to obtain.

With some conditions and diseases, there are centres of excellence which patients request to visit to seek specialist advice and treatment which is not available at their local hospitals. Since becoming a MS, I've had a constituent contact me about supporting a referral to the Nuffield Hospital in Oxford because that is where the expertise existed for a certain knee problem. Another constituent requested my help in supporting a referral to Moorfields Hospital in London, which is one of the world's leading eye hospitals. Rare diseases and conditions may well require a British response with one 'centre of excellence' dealing with everyone who is afflicted by it. Pro rata, a disease or condition affecting a hundred people in Britain, would affect only five in Wales. In these circumstances it is inevitable that expertise and facilities will exist in only one hospital with a limited number of specialist clinical staff.

Within Wales we also have our own medical centres of excellence concentrating on various medical specialities. In 2010, Morriston Hospital's Welsh Centre for Burns and Plastic Surgery became a regional centre of excellence for Wales and the South West of England.

Another example can be seen with the neurosurgery department in Cardiff that provides specialised neurosurgical care for approximately 2.3 million people living in South, Mid and West Wales. The team is based on Heath Park at the University Hospital of Wales where they work with a wide range of related specialists.

Different practices currently exist within Wales to provide services across a region. For example, Oncology services in north Wales are managed by the Cancer Clinical Programme Group within the Betsi Cadwaladr University Health Board which acts as a regional centre. Chemotherapy is delivered on an 'out-patient' basis on all three acute hospital sites in north Wales using dedicated facilities. Meanwhile, inpatient facilities are at the North Wales Cancer Treatment Centre in Bangor. Referrals are made to Manchester for very rare cancers or very specialist cancer treatment.

Within the Hywel Dda and SBUHB health boards, a hub and spoke model for renal services is used. The nephrology service within Abertawe Bro Morgannwg University health board is based within Morriston Hospital and has responsibility for the care of patients with kidney disease living anywhere in south west Wales, stretching from Fishguard to Port Talbot. It receives referrals from GPs throughout this large geographical area as well as from clinicians based in the surrounding district general hospitals. There is a main unit in Morriston, which is also clinically responsible for satellite dialysis units in Aberystwyth, Carmarthen and Haverfordwest.

We need to decide what are the basic services that all district general hospitals should provide and how general hospitals within and between health boards can be organised to provide the medical services effectively and efficiently on which patients rely. Whilst we all want hospital treatment as near as possible to where we live, we also want the best possible treatment and the best chance of survival. Sometimes the two are mutually incompatible.

All patients who need to be in a hospital bed should have access to comprehensive medical treatment, along with diagnostic and rehabilitation facilities, enabling them to begin their rehabilitation promptly, without having to move between hospitals. This will assist quicker recovery, quicker discharge from hospital and improve patient health outcomes. We also need to strengthen community services, helping people to live as independently as possible in their communities. Given the choice, most people do not wish to go into hospital, and prefer to stay in their own homes.

Reconfiguration of the NHS is inevitable and has happened continuously since the birth of the NHS back in 1948. Here's something to consider: just how many TB sanatoriums are left in Wales?

Waiting lists have become too long, especially for those suffering pain and discomfort waiting for cataract, knee, hip, or back surgery.

According to Cymru versus Arthritis in Trauma and Orthopaedics (T&O) at the end of May 2021, the total number of people waiting for T&O treatment in Wales was 89,868 a further 2% increase since April 2021 (+1,950) and 31% higher (+27,750) than the average for 2019 (62,118).

We had 62,186 (69%) people on the waiting list for T&O waiting longer than 26 weeks compared to 15,323 people (25%) on average in 2019. The number of people waiting longer than 26 weeks continues to increase each month.

53,331 (59%) people on the waiting list for T&O were waiting longer than 36 weeks, compared to 6,570 people (11%) on average in 2019 and 52,822 the previous month

The number of people on the waiting list for T&O waiting over a year is 44,203 people, a little under half (49%) of all people waiting for T&O treatment compared to 2,472 people (4%) on average in 2019.

We need a programme to safely bring down waiting times for orthopaedic surgery such as hip and knee replacements and improved communications and support for people waiting in pain for orthopaedic services.

I agree with Cymru Versus Arthritis current priority policy calls which include:

A 'National Orthopaedic Recovery and Transformation Strategy' to be developed to safely bring down orthopaedic waiting times in Wales as soon as possible and to support the development of a more robust orthopaedic service, better protected from future winter and pandemic pressures.

People waiting for orthopaedic services to receive communications, signposting, and support to help them with the physical and mental health challenges of their wait for surgery and to support them to retain activity levels and independence. Many people are waiting in severe and worsening pain for life-changing orthopaedic services with no clear timeframe for surgery.

I add to those calls the creation of sites like NEATH PORT TALBOT HOSPITAL which will become a centre of excellence for ORTHOPAEDIC AND SPINAL CARE, DIAGNOSTICS, REHABILITATION AND RHEUMATOLOGY.

We also, must consider what is best for the patient. Is having a knee replacement carried out and the pain ending worth it, if you cannot go home at the end of your hospital stay and get discharged to a care home. Different people will have different answers to that, but an explanation of risk, threat and reward would produce informed choice.

For the hospital service to be able to provide the best possible service there is a need to recruit doctors at every level and especially consultants and there is a need for health authorities to produce robust recruitment plans and succession planning to ensure continuity of high-quality services. I also realise that the current Westminster government's policy on immigration is making it more difficult to recruit doctors and other health staff from abroad.

I also accept that every hospital cannot provide every service and more importantly that outreach facilities and treatment of patients in their own homes often leads to better outcomes than hospitalisation.

There is inevitability about change, there has been over the years since the NHS was created. There was a big change in the 1980s and 90s with care in the community replacing long term hospitalisation and we no longer have TB sanatoriums. There has also been greater specialisation and sub specialisations with consultants.

If there is a need for medical reasons to move patients from their nearest hospital, then adequate public transport to allow family and friends to visit them is imperative. Both the

Welsh Government and Local Authorities have a duty to work with local bus companies to ensure that there is adequate public transport to the hospitals.

Primary care

Primary care is about those services which provide the first point of care, day, or night, for more than 90% of people's contact with the NHS in Wales.

One recent welcome advance is the creation of GP clusters. A cluster is a group of GP surgeries working together to pool resources and share best practice in a bid to help get patients fit and healthy, and to improve the way that patients are cared for on becoming unwell.

Wherever possible, the cluster will try to accomplish this in the heart of the community, sparing the need of having to travel to hospitals or central clinics.

The number of GP surgeries in a cluster are determined by factors such as geography and population. The clusters are working in partnership with the wider SBUHB dentists, opticians, community pharmacists, other health professionals and the voluntary sector as well as the local authority to create a new culture of health and well- being.

GPs now work alongside a wide range of health professionals in local surgeries and purpose-built health centres. These include practice and district nurses, children's services, pharmacists, and mental health professionals.

Patients don't always need to see a GP. The surgery may recommend seeing another health professional who is better suited to deal with their health issue.

The aim is to help patients stay at home and in their community for as long as possible because we know this is not only better for physical health, particularly of the elderly, but also mental well-being.

Hospital should be reserved as somewhere patients only go when necessary.

So, what goes wrong

We have

- Long queues in A+E
- Large numbers of patients contacting their GP

An example of how GP surgeries deal with patients is below

"If you wish to speak to a doctor, please contact the surgery to book a telephone consultation and a doctor will call you back. Please do not attend the surgery as all appointments are arranged following a telephone consultation."

So, what happens in practice.

Patients cannot get an appointment to see their GP

They are either too late or cannot get past the receptionist(s)

The only place they can go and guarantee seeing a doctor is A+E

A+E has now become the default walk in consultation. It should not be surprising that patients go to A+E when they have not had an accident and where their medical need is not an emergency.

Out -of-hours GPs should be installed in every A& E department to help deal with the patients who attend and a GP out of hours service should be given the job of assessing patients upon arrival to decide in what order they should be treated and dealing with non-medical emergency cases.

Patients should use pharmacy as their first point of call for advice for the management of minor conditions, such as cold and flu, and have a clear expectation around what pharmacy can offer. GP practices have reported that they are operating at capacity – with a significant proportion of consultation time spent on common ailments. One GP estimated that about four out of 40 appointments per day were for advice and treatment for common ailments. Another noted that the practice GPs considered that they spent a significant proportion of their time treating common ailments conditions, such as cold and flu.

The following is being done:
briefing GP practices on appropriate referrals and eligibility for the service – this has included a specific focus on improving understanding of restrictions associated with the provision of advice and treatment for the most common ailments;
preparing referral reference guides for GP practices focused on the top six common ailments and containing information about 'who to refer and who not to refer';
and preparing a template letter for pharmacists to document the patient's details and the reason for referral back to the GP practice – this has also helped to reduce the dependency on patients communicating to the practice the reasons for referral back to the GP practice.
Access alone is not a sufficient driver for some patients and changing behaviour is critical. There are significant cohorts of patients who prefer to see the GP for advice and treatment for common ailments. Changing the behaviour of these patients is challenging but essential.
Some suggestions
Train receptionists to the level of paramedics, they will have to be paid more but the saving in time and money will make up for it.
The receptionist can then refer the patient to the pharmacist, practice nurse, other health professional, GP, or A+E as appropriate.

Health inequality

It is well known that those who are least well off are more likely to suffer debilitating illnesses and to die young. We know that in the SBUHB area that there are considerable and increasing gaps between the most and least deprived areas.

We need to address the social contributors of poor health and well-being, such as loneliness and isolation, by studying what is effective in building and strengthening community connections such as social bonds and social bridges, collectively known as 'social capital'. Social capital is an important determinant of health, which supports better well-being and faster recovery from ill health, and there appears to be a strong link between living in a more deprived area and the lack of social support.

Removing barriers to social capital and community engagement is likely to help address the association between poor health and poor social capital, breaking the cycle of deprivation

and aiding the development of stronger communities. Social contributors of poor health and well-being, such as loneliness and isolation, can be and need to be addressed.

Resilient communities are those who are cohesive, well connected and can collectively use available resources. A Public Health Wales report on resilience acknowledges that social connections and engaging in community life is an essential part of individuals' mental well-being, because it creates a sense of belonging, solidarity, and enhances strong coping mechanisms.

It has been identified that levels of deprivation varied considerably across each region in Wales, with pockets of high deprivation concentrated in the parts of urban centres and in the upper Valleys of South Wales. The association between deprivation and ill health is complex, but we know that lifestyle and environmental factors play a major part in the poorer health outcomes experiences by those most deprived

Another problem is obesity in children aged four to five as well as older children and young adults. Unless corrected early, this will lead to obese children growing into obese adults with an increasing chance of diabetes, heart disease and strokes.

To address these problems, Swansea was given Healthy City Status by the World Health Organisation. The World Health Organisation Healthy City network is a global movement consisting of cities that are committed to health and sustainable development. In the European network there are approximately one hundred cities across Europe that have achieved Healthy City status. Swansea is one of 28 cities in the UK that have achieved Healthy City status.

Improving health was one of the three key objectives of the Communities First clusters. We know that stopping smoking, improving diet, increasing exercise, and reducing obesity are four of the most important ways of reducing ill health. Improving the health of a community will not only reduce health service costs but will also improve the life chances of those who face a life of continual ill health and then early death.

I always recall the heavy smoker and drinker who was massively overweight, lived on a diet where the only fruit or vegetable eaten was a chip, describing himself as unlucky with his health and ignored those who said that his health problems were due to lifestyle choices.

Examples of what communities first did in Swansea East to improve the health of the communities it served:

The North West Cluster (Penlan, Blaenymaes, Portmead, Penplas, Ravenhill and Gendros) ran initiatives under the Healthier Communities Outcome:

Healthy Balance helped local residents gradually adopt a healthy lifestyle. Each week it ran a series of nutritional and physical activities for people to try out run in both the Penlan and Blaenymaes communities, giving local people the opportunity to improve diet and increase exercise.

The Cluster team also placed an emphasis on physical activities and co-ordinated diverse activities at a community level, (including Tai Chi, Swimming, and increasing local Gym/Leisure Centre usage). The team also supported local growing initiatives and put together and ran some environmental skills sessions in partnership with the Communities and Nature team in the City and County of Swansea.

Work also took place to raise awareness around the risks of smoking and to spread other key public health messages. The Cluster team worked with the City and County of Swansea Sports Development Section, the Positive Steps programme, and Local Health Board to promote and engage local people in the Expert Patients Programme, which was delivered to local people, with life limiting conditions. It really helped those people manage their conditions.

Within the East cluster (St Thomas, Port Tennant, Bonymaen, Trallwn and Birchgrove) several health initiatives took place including:

The successful slim to save provided dietary, fitness and lifestyle advice alongside practical cooking sessions. A growing project started in partnership with a local chapel where local residents were encouraged to grow food in their own gardens. Cookery classes and

demonstrations also took place as part of the healthy eating project with courses on nutrition also available.

Family lunch sessions were run weekly during term times to encourage families to both enjoy a healthy home cooked meal on a budget and to give advice on diet and exercise, recipe cards were also provided.

The North East cluster (Clase, Caemawr, Lower Morriston, Cwmrhydyceirw and Graigfelen) had two major health projects. The eat well project aimed at promoting a healthier lifestyle through eating healthier, developing cooking skills and food growing skills. The healthier lifestyle project gave a free health check, free nutritional advice, free fitness sessions and free weight management in a friendly and relaxed atmosphere

The South cluster (Hafod, Landore and Plasmarl) taught people how to cook healthy and nutritious meals on a budget. Several physical activity courses including Tai Chi and Zumba were provided. Health awareness, smoking cessation, blood pressure checks, and screening services were also provided.

Stopping smoking is probably the most important action that can be carried out to improve health and needs to be a priority. Overall a good job was done especially on diet and exercise, but with a lot left to be done especially on reducing smoking, increasing exercise, and reducing obesity.

This is why I was so unhappy that community first was ended. A lot of good initiatives involving local people improving their health ended. To improve the health of the people in Wales we need to end smoking, improve diet, increase exercise, and eradicate obesity.

We owe it to our most disadvantaged communities to act to improve the health of the people living there.

Recommendations

There is no magic wand, but changes are necessary to stop the health service becoming overwhelmed. My proposals are:

- The ambulance service should be spilt up and run by the individual health boards
- If a health board cannot organise different services on different sites, then it is reduced to one that can even if it means single hospital health boards in some areas
- A definition of what is a local hospital service and what is a regional service
- A National orthopaedic recovery and transformation strategy
- Sites as centres of excellence for orthopaedic and related treatment
- GP Receptionists trained to the level of paramedics
- Promote the use of pharmacies for minor ailments
- Out of hours GPs in every A+E department to assess patients
- Programme needed to end smoking, improve diet, increase exercise, and eradicate obesity.
- Target obesity in children