The Academy of Medical Royal Colleges Wales shares its concerns with the findings from the Out of Hours: Time to Care report

April 2016

We have read with concern your report on out of hours care in the Welsh NHS. We believe highlighting the issues raised by the illustrated case studies is important but we think further analysis is needed and we would query the generalisations made to support the conclusions drawn.

Undoubtedly the care received by the patients described in this report falls short of what should have been provided. However in the cases where the patients have died the Ombudsman accepts that the deaths were not necessarily attributable to poor care. Many of the patients were frail with pre-existing multiple morbidities.

We are not convinced that the main issue is the non availability of consultant staff. Of greater significance, we would suggest, is the fact that consultant staff on duty are failing in their contractual obligations. We believe Health Boards should emphasise in consultants’ job planning meetings that they are contractually required to be on call for an agreed number of weekends and nights. There is no excuse for junior doctors not being able to contact duty consultants outside of so called normal working hours to discuss patients.

We would also suggest that many of the inadequacies of care recounted could be ascribed to other low staffing levels across the NHS particularly with respect to nursing staffing levels. Many of the shortcomings described included failure by ward staff to alert doctors to patient deterioration.

Poor communication with patients and their relatives was fundamental in many of the illustrations leading to lack of clarity with respect to a person’s prognosis. If management plans had been decided on and documented early in each patients’ clinical course much uncertainty and distress could have been avoided.

Mr M’s case raises an important issue which we think is worthy of specific comment. We have observed that patients with abdominal pain are often referred to a MAU rather than for surgical assessment because of geographical proximity of the former. This can result in suboptimal management and particularly a delay in surgical input. Even when surgical input is requested the surgeon covering the unit is often very junior as appeared to be the issue in Mr M’s case. I think if there was a single learning point to be acted upon in this report it would be that patient’s with abdominal pain should not be referred to a MAU. Mr M’s
death could probably have been averted if he had been reviewed during Saturday. The fact that he was in the MAU and apparently not seen by any doctor is shocking. There is no excuse for this as the MAU will have a duty consultant physician rostered for out of hours weekend work.

We would be interested to know how the 12 example cases were selected. They cover a period of time from 2010 until 2014 and as such make up an absolutely tiny percentage of the patients treated by NHS Wales. We do not think they can be taken as representative of the service overall and therefore the validity of the report’s conclusions are also questionable.

Nevertheless the Ombudsman provides a vital service raising awareness of short comings in the NHS. The Academy of Medical Royal Colleges in Wales would welcome the opportunity to work with HIW and the Ombudsman in future Quality Improvement initiatives.

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