Engagement Proposals

An Alternative View

Sosppan

Pwyllgor ar gyfer Gwella Gwasanaethu Ysbyty

Ebrill 2012 **April 2012**

Introduction

This document, produced on behalf of the CIHS/SOSPPAN committee, sets out alternative proposals for the development of the health provision within the town of Llanelli and throughout the Hywel Dda Health Board region.

The proposals are innovative, achievable, manageable, affordable and sustainable. They make best use of existing resources. They meet the needs and aspirations of the population currently and into the future as the demographic makeup changes due to the increasing proportion of elderly people in the community.

A solution on this scale must meet the needs of the Clinicians, the safe and economical delivery of service to the Stakeholders and a service that suits the needs of society including ease and speed of access to unplanned needs as in the case of Accident and Emergency Services.

Catastrophic disablement or death caused by an essential service being located incorrectly is unacceptable and this is only one of a number of areas that we attempt to address in our proposals.

We are not only looking at the provision of a National Health Service from the viewpoint of just the hospitals but also the supporting infrastructures that embody the overall health care of our society from the foetus to the frail elderly.

This in turn demands inclusion of Social Services and the implementation of Care in the Private, Public and the Third Sectors.

Whilst the Third Sector or “not for profit” organisations should be incorporated into the planning of Care in Society it cannot and must not be relied upon to fulfil key roles without support facilities being made available for it by the State at whatever level. (An example of this would be reliance on an unpaid Carer, at whatever level, without some form of guarantee that they will be supported in organizing their wider living needs, including respite, when required.)

The Third Sector must not be over-tasked but rather should be the velvet glove covering the supporting hand of the NHS and County Council Care within and between the home and the Institutions.

History

Hywel Dda Local Health Board has had, as have many of the Health Boards in Wales, a difficult set of choices to make.

There are four District General Hospitals located in the area for good reason. It is because the demographics have required this in the past.

In a move some 10 years ago, a policy of “centralization” was mooted for Carmarthenshire and 5 years ago the foundations for this plan were laid and in the following 3 years, implemented robustly.

Unfortunately only part of this plan was implemented and that fragmented implementation has subsequently failed to fulfil the original concept of a centralized Accident and Emergency (West Wales Hospital) in one part of the County with Elective and some Acute Surgery being implemented at the other (Prince Philip Hospital).

This failure is, in large part, due to the fact that it was a fatally flawed and unworkable concept in the first place, with the wrong services unable to cope in the wrong place at the wrong time: placing the A&E centre in the town ranked fortieth in terms of its urban population within Wales as opposed to the town ranked, in isolation seventh in the same list and ranked fourth if the adjacent centres of Burry Port, Tumble, Crosshands and Glanamman are included. (Source: Office for National Statistics.)

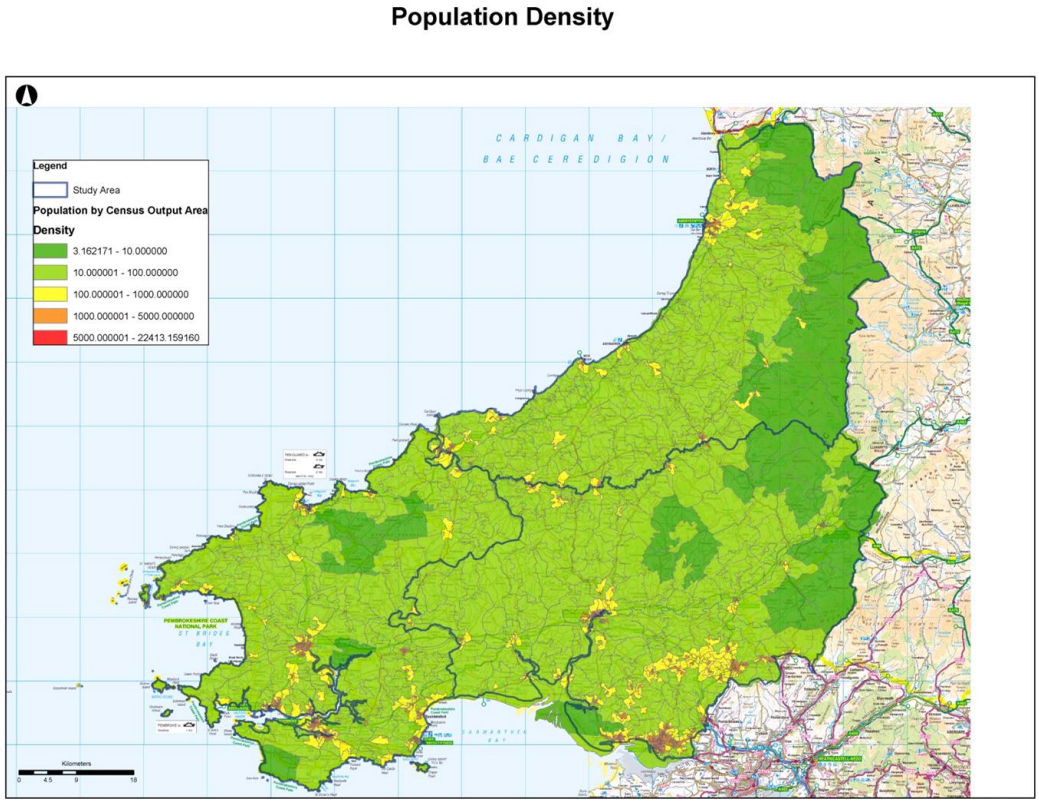

Fig 1. *Hywel Dda Health Board Area showing centres of population*

The next change occurred when a new LHB was formed (Hywel Dda LHB) which incorporated the three counties of Carmarthenshire, Cardiganshire and Pembroke. (See Appendix 1 & 2)

A further centralization policy was formulated at this stage. The obvious choice of centre based purely on an aerial view of the region was Carmarthen: in between (but not particularly central to) the other three District General Hospitals.

Many of the Services from Llanelli continued to be removed to WWH. Although Prince Philip Hospital had four operating theatres it was under-utilized, with staffing levels at the Consultant and Anesthetist level being run down at PPH and increased at WWH. This was a precursor to the further centralization of services from Withybush and Bronglais as indicated by the engagement proposals from Hywel Dda.

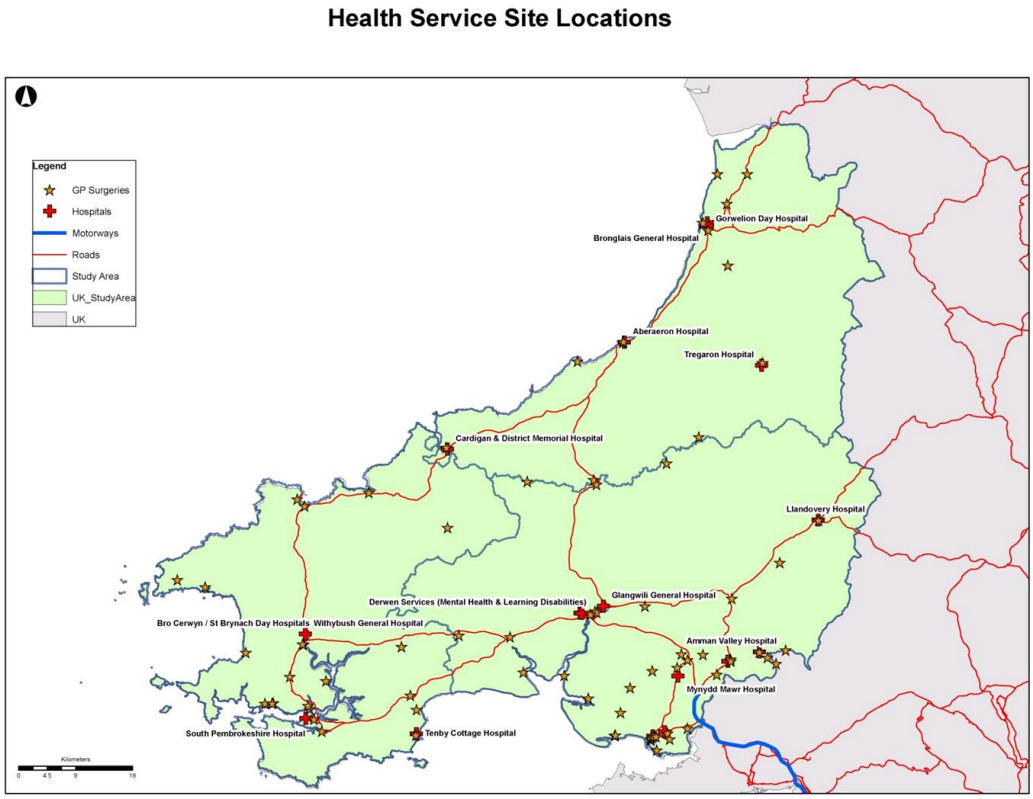

Fig 2. *Hywel Dda Health Board Area showing points of contact*

The Legacy

Demographically we are left with 4 distinct areas:

Llanelli Urban	60,000 people 16.62% of Hywel Dda catchment	
Llanelli Rural	39,000 people 10.80%	
	99,000 people 27.42%	
	Fair budget allocation*	£184,940,000
PPH Beds	205 provided (**290 required**)	

Carmarthen Urban	15,000 people	4.16% of Hywel Dda catchment
Carmarthen Rural	67,000 people	14.40%
	82,000 people	21.88%
	Fair budget allocation*	£153,160,000
WWH Beds	391provided (**240 required**)	
Cardigan Urban	16,000 people	4.43% of Hywel Dda catchment
Cardigan Rural	61,000 people	16.9%
	76,000 people	20.5%
	Fair budget allocation*	£143,500,000
Bronglais Beds	200 provided (**224 required**)	
Pembroke Urban	14,000 people	3.89% of Hywel Dda catchment
Pembroke Rural	104,000 people	28.8%
	117,000 people	31.2%
	Fair budget allocation*	£228,830,000
Withybush Beds	300 provided (**341 required**)	

A Total of	375,000 people
Budget of	£700,000,000
Total Beds	1096

- *As indicated above if the budget was allocated per head the greatest spend would be at Withybush Hospital, next Prince Philip Hospital, then West Wales Hospital and finally Bronglais Hospital.*

It is clear from the above figures that the policy of centralization is already well underway and the funding is hugely disproportionate to the population spread, with every hospital apart from the West Wales Hospital being severely disadvantaged.

If we look at the beds alone the following applies:

Prince Philip Hospital Llanelli is short of 85 beds
Withybush Hospital Pembroke is short of 41 beds
Bronglais Hospital Aberystwyth is short of 24 beds
West Wales Hospital Carmarthen is oversubscribed by 150 beds

In consequence this imbalance also applies to the budget.

This has left Llanelli stripped of its services but with the highest concentration of population in West Wales, in fact 27 per cent of the population supported by Hywel Dda is within the Llanelli (and PPH's) catchment area.

What is currently happening to the provision of Health Care in Llanelli will inevitably happen to the other areas with the loss of services locally.

This is a far cry from the heady days when Prince Philip Hospital was opened.

Prince Philip Hospital, Llanelli – The beginning…. May 1990

A modern, well-equipped District General Hospital built on the nucleus design and opened in May 1990. There were 239 acute and elective beds encompassing the following specialties:

- General Medicine
- Coronary Care Unit
- General Surgery
- Urology
- Orthopaedics
- I.T.U. & H.D.U
- A Central Treatment Suite with provision for a maximum of 40 patients incorporating a surgical day case theatre and endoscopic suite
- Out-patient department
- MRI scanner
- There were 6 Physicians whose interests include Cardiology, Respiratory Medicine, Endocrinology, Gastroenterology and Care of the Elderly; General Surgeons with Vascular, Upper GI, Breast and Colo-rectal interests; A & E Consultant, Community Paediatrician, 2 Histopathologists, Microbiologist, Haematologist, 3 Radiologists and 6 Consultant Anaesthetists.

Clinics are also held in Psychogeriatrics, Paediatrics, Obstetrics & Gynaecology, Ophthalmology, Dermatology, ENT, Oncology & Radiotherapy, GUM, Sexual Health, Mental Illness, Oral Surgery, Orthodontics, Rheumatology and Chemical Pathology.

Children's clinics are presently held at various sites. The Elizabeth Williams Clinic in Llanelli has been developed to provide a base for Children's health Services in Llanelli and includes clinical and office accommodation.

This provision remains the expectation of the people within Llanelli and beyond, as witnessed by the information downloaded off the Internet on March 26th 2012 attached as Appendix 3

The Degradation of Services

Llanelli (PPH) has been in the vanguard of changes that are proposed throughout the NHS, particularly Wales and are held up as a beacon for others to follow: proposals which have been initiated as a means of trying to make more efficient use of expenditure but which have been universally criticised for their inefficacy.

That they have been dressed up as means of improvement of the service where none can be observed has merely exacerbated the negative perception of the public at large.

A&E at Llanelli has been closed twice in the past decade, re-opened once and more recently restored to a limited service.

(See Appendix 1 and Appendix 2)

Since 1990 the following services have been removed from Prince Philip Hospital Llanelli.

- Surgical Emergencies
- Acute Medicine
- Cardiology
- Trauma
- Children
- Head Injuries
- Maternity
- Gynaecology
- Ears and Nose
- Throat and Eye
- Post Mortem

More recently Ward 5 has been earmarked for closure (for no apparent reason) – another 22 beds will be leaving Prince Philip Hospital and taken to West Wales hospital in August 2012.

At the end of March 2012 the Orthodontics Clinic was moved on the instructions of Hywel Dda from Murray Street, Llanelli to the Castle area in Carmarthen putting more stress on the population of Llanelli.

Over one thousand patients from Llanelli and Burry Port have had their provision moved at short notice in an exercise which was planned by the Health Board last summer but which has, yet again, been initiated without any consultation with or notification to the relevant parties.

The level of public consultation and information released by any of the Health Providers whether Carmarthen Trust or Hywel Dda has been minimalistic to say the least.

This is despite a number of government funded reports into the behaviour of the Local Health Boards and Trusts stating that public involvement is an absolutely key factor for acceptable change: time after time the very opposite has happened in relation to the Llanelli Stakeholders.

In fact there still exists some discrepancy between the Welsh Government's Health Minister and the Head of A&E for West Wales in their perception of what is available at Prince Philip Hospital. (See Appendix 3).

The Current Hywel Dda Operation and the impact of the Removal of Services for Llanelli

The medical fraternity has been concerned about providing safe services, the prerequisite for any Health service provision and, in this, they have succeeded.

However, whilst the level of health expertise and attention is excellent within the medical complexes, the distance that the population of Llanelli have to travel to benefit from that expertise is unacceptable and goes against the very tenets that Hywel Dda state – Right Care, Right Time, Right Place.

In fact, the flawed centralisation policy that has been imposed on the public in Llanelli means that they are in the position of actually getting a reduced service under the guise of improvements.

Around 100,000 people are in the position that, in the past five years, their provision of acute health services has been moved farther from their homes by some considerable time and distance.

The new policy (which Hywel Dda LHB inherited but has expanded considerably) has robbed the same 100,000 people of the “golden hour” and increased risks where any new policy should be aimed at reducing risk.

LLANELLI WARDS 2001	PEOPLE	PPH MILES	PPH MIN	WWH MILES	WWH MINUTES	EXTRA MILES	EXTRA MINS
Bigyn	6347	2	8	25.7	37	**23.70**	**29.00**
Burry Port	4209	5.9	19	16.8	31	**10.90**	**12.00**
Bynea	3091	2.4	9	25.2	35	**22.80**	**26.00**
Dafen	3433	0.3	1	24	32	**23.70**	**31.00**
Elli	3156	1.9	7	26.2	38	**24.30**	**31.00**
Felinfoel	1948	0.5	1	25	35	**24.50**	**34.00**
Glanymor	4888	2.9	11	20	40	**17.10**	**29.00**
Glyn	2032	7	17	11.2	21	**4.20**	**4.00**
Hendy	3039	4.6	11	21.1	27	**16.50**	**16.00**
Hengoed	3829	3.9	13	18.9	37	**15.00**	**24.00**
Kidwelly	3829	9.5	22	12	22	**2.50**	**0.00**
Llangannech	4510	3.1	9	21.7	28	**18.60**	**19.00**
Llannon	4999	4.9	10	17.6	27	**12.70**	**17.00**
Lliedi	5036	1.7	6	17.7	35	**16.00**	**29.00**
Llwynhendy	4276	1.9	7	25	34	**23.10**	**27.00**
Pembrey	3374	7.2	23	15.8	28	**8.60**	**5.00**
Pontyberem	2829	8.6	17	11.4	23	**2.80**	**6.00**
Swiss Valley	2434	1.2	5	24.6	33	**23.40**	**28.00**
Trimsaran	2553	5.9	15	14.7	26	**8.80**	**11.00**
Tycroes	2156	9.9	18	21.1	27	**11.20**	**9.00**
Tyisha	3995	2.9	11	20	40	**17.10**	**29.00**
SUB TOTAL PEOPLE	**75963**						

AMMAN WARDS 2001	PEOPLE	PPH MILES	PPH MIN	WWH MILES	WWH MINUTES	EXTRA MILES	EXTRA MINS
Betws	1834	12.2	25	21.7	34	**9.50**	**9.00**
Garnant	1965	16.1	36	25.6	45	**9.50**	**9.00**
Glanamman	2261	15.2	33	24.8	42	**9.60**	**9.00**
Gorslas	3742	11.1	18	14.6	19	**3.50**	**1.00**
Pontamman	2629	12.9	27	22.5	36	**9.60**	**9.00**
Quarter Bach	2933	18.5	43	32.4	49	**13.90**	**6.00**
Llandybie	2467	13.5	26	19.1	30	**5.60**	**4.00**
SUB TOTAL PEOPLE	**20495**						
GRAND TOTAL	**96458**						

(The above shows the distances[in miles and time] from people's houses to Prince Philip Hospital, West Wales Hospital by ambulance / car. The "EXTRA" figures show how much longer it is to get to WWH rather than PPH).

(See Appendix 4 and Appendix 5)

During the period of February 2010 through to February 2012 Glangwili dealt with 20,852 emergency patients delivered by ambulance in emergency situations.

We know that during this period Glangwili A&E was overcrowded, with patients spending the nights on trolleys and ambulances stacked outside waiting for A&E beds to become available. Some of these patients were then sent to Prince Philip Hospital due to Glangwili being unable to manage.

Quad erat demonstrandum: the centralisation of A&E services at WWH Glangwili is not working.

During the same period Prince Philip Hospital dealt with 9,114 patients in exactly the same emergency circumstances.

This is despite Hywel Dda LHB telling us that Prince Philip Hospital has not had an Accident and Emergency department for two years.

This surely begs the question: if Glangwili is unable to manage the A&E patients they are currently getting, how will they deal with an additional 9,114?

As noted previously, centralisation should, of course, take into account population levels and not just geography.

Moving away from these parameters has led to a flawed policy being implemented, which has now been proven by using the people of Llanelli as guinea pigs.

A system tried, tested and continuing to fail.

Failure of the Operational Delivery

Some of the symptoms of this failure include:

People waiting on trolleys in A&E at Prince Philip Hospital for hours overnight because there is no room for them in West Wales Hospital.

Patients in A&E at Llanelli waiting for hours for an ambulance after having been Triaged and stabilized.

Ambulances travelling from as far away as Aberystwyth to Llanelli in order to then transfer patients from Llanelli to West Wales Hospital.

People begging to be taken to their local hospital at Prince Philip, Llanelli and being refused by the ambulance crews who say they have to take them to West Wales under the orders of the Hywel Dda LHB 'for safety'.

People being discharged from West Wales after 22.30 in Carmarthen and having to find their own way home to Llanelli, a distance of some 25 miles. (By Taxi the cost is more than £25.00 one way)

The distance and poor Public Transport make it a full day expedition of over 6 hours to get to and from West Wales Hospital from Llanelli, plus the time at the hospital for the appointment itself. This is an intolerable burden on a healthy person, let alone one who, in needing the appointment in the first place, is clearly unwell.

The cost to business is huge, as people have to take much longer to attend appointments as patients or to visit relatives.

The cost to the individual is huge as the soaring price of fuel exacerbates the already high cost of running a vehicle and significantly increases the financial burden of any hospital stay or visit, whether using one's own transport or relying on private or public carriage.

The cost to the environment is massively detrimental due to increased travelling distances through a hilly terrain that significantly increases the level of air pollution, particularly from diesel vehicles.

Internal Ambulance transfers costs are excessive for what at certain times is little more than a "shuttle bus" service.

More than one visit a day to a patient in West Wales hospital by a resident from Llanelli by public transport is unfeasible. The elderly in particular will find this situation unbearable.

Public Transport to West Wales Hospital takes 3 hours and costs at least £10.00 each way. Taxis cost £25 each way

There is clear discrimination against, the Poor, the Disabled, the Elderly and the Vulnerable and more recently the families of children needing specialist dental treatment.

This in a town recognised at a European level as suffering severe social deprivation. The Demography Profile for the Hywel Dda Health Board Catchment clearly shows the area surrounding Llanelli and Burry Port as having by far the greatest level of Multiple Deprivation. (Source: NHS Wales: Public Health Wales…Appendix 6)

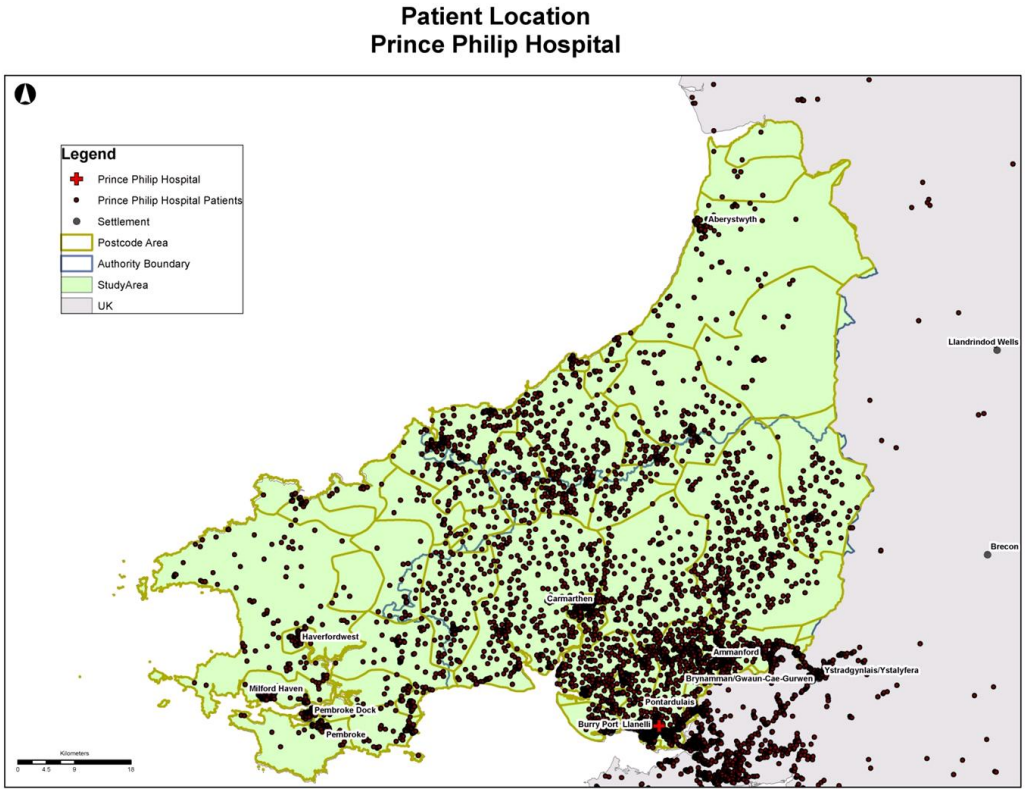

Fig 3: *Distribution of patients attending Prince Philip Hospital*

(See Appendix 7 – Letters)

To reiterate, Hywel Dda LHB are not delivering the health service provision at an acceptable level for the twenty first century that the public expect and deserve.

Change is essential but as has been shown, inconsiderate and inappropriate centralisation is not the answer.

The Hywel Dda Proposals (Engagement)

As at this stage Hywel Dda have made some suggestions as to where they see the future provision of Health Care under the slogan of “Right Care, Right Place, Right Time”. Indeed, the Hywel Dda Services Model “Our Vision” clearly espouses “Moving Care Closer to Home” as the prime objective: a laudable concept, where one would imagine that Care would be provided closer to home.

The question undoubtedly has to be: closer to whose home? Unfortunately, as can be seen from the continuing and unnecessary policy of centralization it is not the large majority of patients’ homes that are being considered.

In fact (although this policy has not hit Pembroke or Cardigan to date), Llanelli with its large and mainly Urban population has been hit hard, with many patients having to travel far farther for treatment, both Acute and General, including Accident and Emergency services.

The imposition of an unproven UCC unlinked to an adequate and local A&E at Prince Philip Hospital increases risks to patients in Llanelli and is of great concern.

(See Appendix 8)

Another facet of the policy is to treat more people at home rather than in hospital and the concept of Virtual Wards is being trialed presently. However, the staff are at breaking point and in our opinion this is a waste of a much-needed expert resource due to the unproductive travel time that these professionals are forced to undertake.

A further concern is the reliance of the NHS on Care being provided in the home by relatives or friends. This is firstly a retrograde step and secondly assumes that this care is naturally available where in fact this may not be the case.

Our further concern is that the use of GPs and Specialists in this environment has not been agreed or ratified and the extra home visits that they will have to make will dilute the service that they are currently able to offer.

We welcome the proposed use of Technology but have concerns at the capability of the LHB to deliver this when currently its’ booking and transport systems cannot interface with each other, leading to a major waste of time for both the Patients and the Clinicians through lost appointments and wasted journeys both internally and externally.

The links to Social Services which are such a key point to the success of providing a fully functioning Health Service are vague and do not allow for carer support, adequate convalescence, rehabilitation, respite or adequate domiciliary care for either our disabled or elderly.

There is much of this that could still be achieved with Centralisation, Specialisation and Distributed Treatment at the core. However there is no detail, no costing, no

methodology, and no mention of links across to the Surgeries, GPs, the Private or Public Sectors in the community in the provision of either preventative or remedial care.

This is to be expected at this stage as this is not a plan but a series of suggestions and proposals that have been distributed to many households in the Hywel Dda area. Feedback is hoped for from this exercise.

CIHS Proposals (Solution for Carmarthenshire, Cardigan and Pembroke).

CIHS have some proposals to make, as part of the “engagement process”, which we hope will be taken into account where appropriate in the Five Year Plan. Again we appreciate that these are “high level” but similarly to the current proposals from Hywel Dda this is of a necessity at this stage.

We see this as a golden opportunity for both Hywel Dda LHB and the public to really engage in a process of planning to take into account the health needs of the population for the next twenty years (to cover the “baby boomers”) across the whole of an integrated South West Wales allowing for the provision of Health excellence for the whole population.

We would agree with the LHB that using numbers to create “Centres of Excellence” is the way forward but this must be tempered with local provision for unplanned Accident and Emergency

The proposals that CIHS make are designed to be flexible enough so they allow a similar model to be used effectively in both a Rural and Urban Environment across the Hywel Dda Area.

To a large extent Hywel Dda has inherited a “Poisoned Chalice” with four District General Hospitals extended over a large area but with an extremely uneven population spread. 31% of the Population lives in an Urban Environment whilst the remaining 69 % live in Rural Areas.

The Building Blocks

It is essential that the solution can be applied across changing Rural and Urban environments.

The solution is based around the following building blocks:

4 District General Hospitals all providing Accident and Emergency Services

Excellent Public, Private and Third Sector Transport links 24 hours per day

Clinical Centres of Excellence within the Hospitals

Separate Convalescence / Rehabilitation Units attached to the Hospitals

Respite and Support in the Community for Carers, Vulnerable Elderly and the Disabled, run by the County Councils and including:

- Day Centres
- Luncheon Clubs
- Meals on Wheels
- Carer Support in the home
- Residential Respite
- Surgeries and Community Hubs
- High Quality Regulated and Inspected Domiciliary Care both Private and Public, and Third Sector Provision.
- State-run Residential Care Homes for the Elderly and Disabled

These “building blocks” to be similar across the whole provision of the Hywel Dda catchment to allow for inter changeability of staff and economy of training budgets.

Key Features

A. Four District General Hospitals all providing Accident and Emergency Services

High quality services and care must be delivered closer to home, meeting the future demographic, workforce and recruitment challenges: every significant centre of population must maintain an Acute Medicine and Accident Centre as well as a “Triage Area” for immediate assessment as to whether the patient needs to be directed to their GP at a Community Hub, to the Urgent Care Centre for immediate treatment and discharge, or to the attached A&E Department with supporting Acute Surgery for urgent intervention and probable admission to the hospital for further treatment.

It is essential that the UCC and A&E centre are based at the same premises, since failure to do this has been shown to increase the risk of misdiagnosis and subsequent risk to the patient. (See Appendix 8).

We feel that it is also worth investigating the idea of a limited A&E Service that can cope with immediate unplanned emergencies with at least an area that can stabilise a patient effectively rather than in the back of an ambulance. It is proposed that there should be an investigation into the use of Information Technology so that “Consultant / Specialist Backup” can be brought to bear from a linked major A&E unit.

This would be appropriate as part of a “Community Hub” in outlying districts like, but not limited to, Tregaron and Ammanford.

B. Excellent Public, Private and Third Sector Transport links 24 hours per day

Top class integrated Transport systems will be essential for a solution where Centres of Excellence will be distributed across the three counties.

Where specialist services are required patients should be either transported immediately by the ambulance to the relevant hospital, or if necessary, via the nearest A&E for stabilisation prior to transfer by local ambulance.

Ambulances will still be required for Emergencies but whether this is necessary for all internal trips should be open to debate.

Local transport services for non serious cases should be a pooled resource run by a combination of County Council vehicles and drivers and the Third Sector 24 hours a day, seven days a week 52 weeks a year.

If patients are discharged after 22.30 and before 08.00 where limited transport is available, it must be the hospital's responsibility to ensure these people have suitable transport to their place of normal residence before they are discharged from the hospital.

Round the clock bus service / shuttles should be available between all four major hospitals and their town centres for outpatients, discharged patients who are not vulnerable, staff and members of the public (visitors).

Where possible transport systems used by the LHB should also be coordinated with the Social Services Transport Provision.

C. Clinical Centres of Excellence

Specialist Services need to be placed where they will be most effective, easiest to access and attract the necessary funding through body mass.

Each hospital should have an Acute Beds section (ITU etc.) for patients recovering from any form of surgery and for observation of patients with serious conditions posing an immediate threat to life.

Elective planned surgery needs to be distributed across the whole of the Health Board with specialist areas in particular hospitals.

D. Convalescence / Rehabilitation Units

It is important that we should learn from the past and take on initiatives from the present as is being done by Carmarthenshire Social Services under the guidance of Sheila Porter.

Using interim solutions it has been proved that the use of even only 12 separate convalescence rooms is beneficial, however the current solution removes respite places from the pool, which is not an ideal compromise.

There should be separate buildings linked to each hospital for long term non-acute care, respite care, routine phlebotomy, podiatry, physiotherapy, dental care, ophthalmics and for convalescence, where people from all age groups can convalesce and be rehabilitated where necessary.

This would enable the release of all relevant patients from the Acute Hospitals and open up opportunities for the hospitals to operate to their maximum efficiency doing what they do best: attending to acute care and medical intervention so that the patient can return to their normal lifestyle as soon as possible.

In effect this would eliminate DTOC (bed blocking) and release much needed facilities. The convalescence areas should be staffed by specialist “Care Staff” as opposed to Acute Care nurses, who would be freed to do what they do best: care for patients with acute medical needs.

Rehabilitation areas should be staffed by specialist carers, physiotherapists and other appropriate practitioners as needed, ensuring that in all instances, the right care is in the right place at the right time.

The rehabilitation facility should be both in and out patient driven, include day centre facilities and be supported by local GPs, opticians, podiatrists, district nurses and social services.

Social Care Services should also be based at the Rehabilitation Units and should be used to monitor the overall health of the County’s population and their on-going requirements to lead as normal a life as possible with minimal unnecessary intrusion but an assurance of support as and when necessary.

Social Services, the implementation of “Care Packages” and Care in the Community will be demonstrably separated from the hospital environment and be more clearly focused on the home and community environments. Acute beds will be released quickly; eliminating DTOC but allowing time to put in place adequate Care Packages.

E. Respite and Support in the Community for Carers, Vulnerable Elderly and the Disabled, run by the County Councils:

The elderly, if physically and mentally able to cope, should be supported with Care Packages to enable them to live at home.

These Care Packages should be operated under the auspices of the County Council either using their “in house” resources and/or with the involvement of the Private Sector but with the oversight of the CSSIW inspectorate as with the Residential Sector.

The Care packages should also take into account physical changes to people’s properties and ongoing “at home physiotherapy”.

Support should also include Meals on Wheels, attendance at Luncheon Clubs, Day Centres and free transport between facilities for the vulnerable including the disabled and the elderly.

F. Community Hubs (and Surgeries)

The Community Hub concept, involving all relevant agencies should be supported with at-home preventative care and should be supported by GPs from their surgeries and using District Nurses where appropriate.

Further to this, general illness / disability can be supported at home using the 1950s model (renamed as Virtual Wards) by the GPs and District Nurses.

The Community Hubs should be largely based at existing sites, possibly those operated by the Local Authorities as Residential Homes, Day Centres or Sheltered Accommodation, or by expanding GP Surgeries. Such a strategy would minimize the need for additional construction costs. Refurbishment costs would inevitably be incurred.

G. State run Residential Care Homes for the Elderly and Disabled

Residential care in both the Private and Public sector should be expanded to take into account the 5% “year on year” increase in the elderly over the next 20 years and to allow for the increase in EMI.

Institutionalism should be avoided at all costs but residential care should not be shunned, especially concerning mobility and loneliness. The findings of the UK Government adviser, David Halpern, identifying that loneliness has a greater impact on older people's life expectancy than smoking, should be taken into account, as should the finding that loneliness is currently reaching epidemic proportions in the UK, with 3.1 million over-65s currently going for more than a week without seeing any family member or friend.

It has also been proved that loneliness can increase the onset of dementia, which puts large financial strain on the care agencies; making addressing these issues a critical feature of any viable health provision.

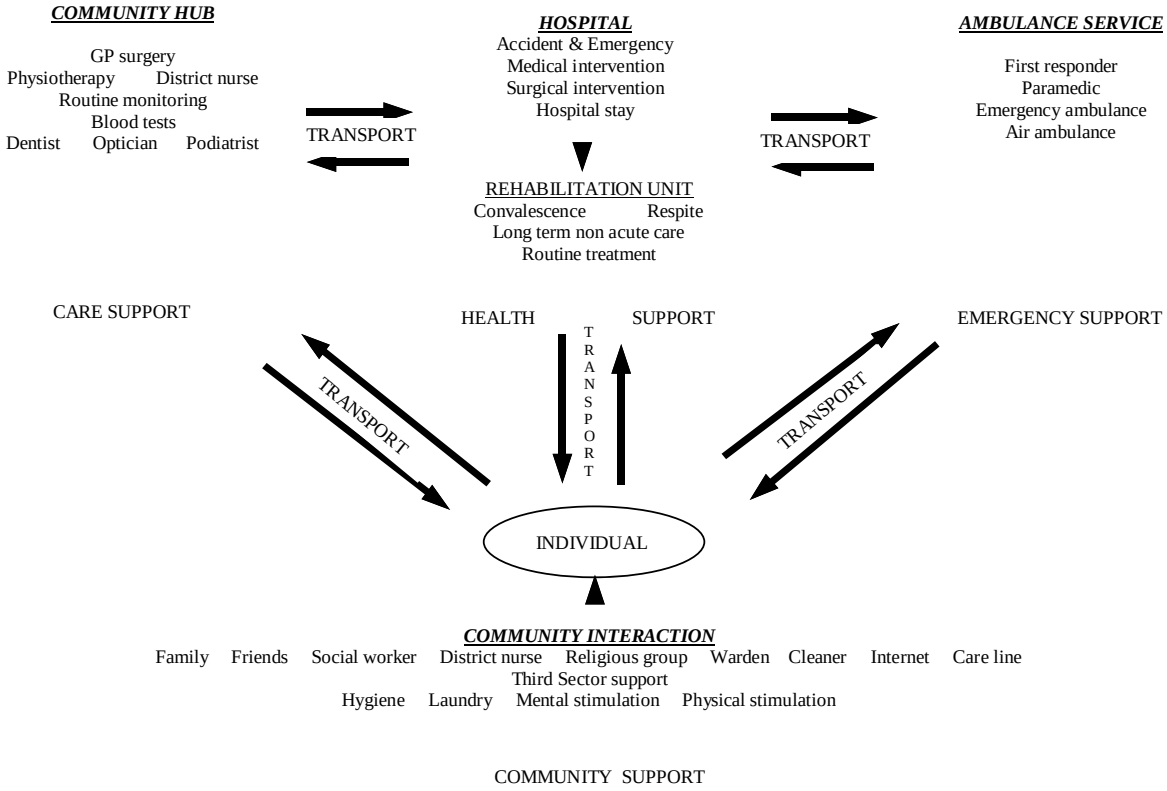

Fig 4. *Patient support model*

Savings / Economies

We believe that within these plans for an integrated Health Provision for the Hywel Dda area, sustainability and flexibility should be at the centre of the Plan.

There is a case to be made to involve local business and the community in these plans so that the investment by the Government has a beneficial effect throughout the local economies without extra costs and in fact expansion through savings.

We are confident that Hywel Dda LHB will provide a clinically safe solution within the confines of its buildings and this costs money.

Obvious money saving exercises are no doubt being carried out regarding reduction of supernumerate jobs left over during the combination phase of the original three Trusts and development of a “flat structure” management.

Typically “customer facing jobs” are still needed, as the number of patients far from decreasing will of course be on the increase especially at the “older end” of the

market. Basic old-fashioned job cuts at the “coal face” really are no longer an option and more innovative ways of making the money go farther are needed.

Also there will no doubt be a need to increase highly experienced staff for “Virtual Wards” and their management (District Nurses and GPs) so the balancing of the finances required for the increased movement of Care into the Community will be paramount.

This puts greater pressure on budgets and so looking at other areas that can provide savings and perhaps also help the local economy to thrive would be advantageous.

To this end CIHS would recommend that as part of the Plan for infrastructure change the following be also investigated:

Energy / Electricity Provision

There are a number of ways to make savings including using Combined Heat and Power and also Electricity Generation whether by wind or solar methodologies.

Although there could be significant investment the savings and sustainability are well worth implementing with paybacks possible within a decade for example:

> Birmingham Heartlands Hospital - £5,000,000 investment £700.000 annual savings.
>
> The Combined Heat and Power (CHP) scheme at Royal Shrewsbury Hospital has enabled the hospital to save more than £780,000 a year, annually.
>
> Sunderland Royal Hospital is a 970-bed acute hospital run by City Hospitals Sunderland NHS Foundation Trust is targeted to recover the £600,000 capital cost of its new CHP system in less than three years.

Local solutions

NHS organisations should investigate potential low carbon energy solutions which best suit their own circumstances. A small rural organisation may benefit most from installing biomass technology for heating, whereas a large urban hospital may benefit more from a Combined Heat and Power (CHP) installation. It is important to investigate the wider benefits for the community.

> For example, excess heat from CHP plant can sometimes be diverted into a district heating scheme which can provide affordable heating for the benefit of the wider community. Partnership solutions are also becoming more evident with community based District Energy Schemes and Community Heating Schemes.

Transport

In a Rural environment travel is a major factor due to the distributed nature of the Service Provision as opposed to the locations of the Residents.

Increasing the number and distance of journeys has a major impact on the Carbon Footprint that inadvertently centralisation of services has increased considerably. We are already talking of over a thousand tonnes per annum for current attendance figures and the engagement proposals to date appear to ensure that this will increase considerably.

Utilising electricity generated by wind or solar voltaic methodologies could be used to power internal transport within hospitals or indeed as transport between hospitals and major towns reducing fuel costs and CO2 emissions.

Food Production / Local Growth

Hospital food cooked with fresh local ingredients could put hundreds of millions of pounds back into the NHS, one hospital trust has said.

> "It doesn't actually cost any more and you are actually going to invest in local communities and the local suppliers you want to develop. On top of that it's actually going to save the NHS millions of pounds a year."

Catering managers at Nottingham City Hospital and the Queen's Medical Centre have switched to such a menu.

> The trust says the daily plate saving is £2.50 per patient.
>
> Trust catering manager said if replicated across the East Midlands the policy would save £6m a year - or £400m if adopted throughout the NHS.
>
> The food travels less distance than many of the 7,000 patients who choose from the menu each day.

The hospital contract is also supporting dozens of local farmers and has saved a number from going under.

> In its first year the farm-to-plate scheme has put a million pounds into the local economy and that is likely to double over the next 12 months.

Getting beef from down the road rather than South America sounded good but was thought it would be too expensive. There were also concerns there would not be enough fresh local produce to fill his cupboards.

Both fears were unfounded

This is an excellent example of both the Hospital and the local community benefitting by saving money.

These are just a couple of examples where money can be saved and innovative thinking in the broader terms should be investigated to create more savings

Conclusion

As stated this is designed as a discussion document to try and put the current situation in some form of context and trace the history that is forming the decisions of today and of tomorrow.

The alternative options that we have formulated are designed to take advantage of the Hywel Dda Board's offer of engagement prior to the formulation of their Development Plan, so that these options can be factored in or at least reasons be given why they cannot.

Where possible we have included referenced data to back up our case.

We fully support the concept of "No Change is not an Option" we would only qualify that with "Wrong Change is not an Option".

APPENDIX 1

2003 A & E CLOSURE

A & E INVESTIGATION – PRINCE PHILIP HOSPITAL, LLANELLI
EXECUTIVE SUMMARY

How did the Trust Prepare?

The Trust had been aware of difficulties in staffing A & E at Llanelli for some time. The position worsened in the summer of 2003, and the Clinical Team Leader advised of unacceptable clinical risks. Final protocols and contingency arrangements were made, but late in the day.

The legality of the steps taken by the Trust in response to this advice is not in doubt. The formulation of their response, and the communication of it to the public, is considered below.

How did the Board reach its Decision?

The conduct of the Trust Board meetings fell within the terms of its own Standing Orders and the decisions taken were based on clinical advice.

The July Trust Board meeting conducted much of its business around this matter after the public had been excluded. It is the right of the Chair to determine the conduct of business, but my conclusion is that discussion of this issue should have been taken in the part of the meeting open to the public. 199(d).03 2

What efforts had been made to recruit new staff?

There are clear difficulties, both regionally and nationally, in recruiting A & E staff. Although alternatives were actively considered by the Trust given the known difficulties at Prince Philip, more advertisements in 2003 might have been expecte once a decision was made.

In order to reassure the public for the future it is vital that no service change in the Trust's remit is brought forward other than by the LHB and that the LHB operate completely transparently on all service change matters. It is acknowledged however that this decision was taken in emergency circumstances.

How did the Trust Consult?

The main criticism of the events leading up to the 1 September 2003 is that until July 2003, it appears that no discussions or concerns had been raised with the LHB or CHC by the Trust (at least in formal meetings) around the sustainability or risks associated with the A&E service at Prince Philip

Hospital.. This meant that those channels to the wider public were not exploited and this was a missed opportunity. There needs to be a process formalised without delay so that such a situation can never happen again. 199(d).03 3

A revised circular should be issued by the Welsh Assembly Government, reforming the process for consultation which must be followed in such cases in the future, in order that the lessons to be learnt from experience in Llanelli can be shared across Wales.

Wider Concerns

It has been suggested that this reduction in service is part of a wider strategic intent by the Trust to 'run down' the Hospital, a point reinforced by press articles during compilation of the report about Surgery. This was vehemently denied by the Trust in their press statement in response, and I have found nothing to contradict the Trust's response.

Lessons to be Learnt

1) Services at "high risk" need to be shared with the CHC and LHB at the earliest possible stage. Risk analysis should be comprehensive and weighed appropriately.

2) Contingency plans need to be prepared for services viewed at "high risk" and again shared with the LHB and CHC at an early date.

3) All contingency plans should have a risk assessment undertaken for options.

4) Unless in an Emergency situation all service change should be introduced via the LHB, but in an Emergency the service provider must lead all discussion and action in the first instance.

5) Service change should be underpinned by a robust communication strategy.

6) The circular on service change needs re-issuing (under way).

7) The default position for Trust Board agendas should be that all items should be taken as part of public business (Part A), with only exceptional items, such as individual staff matters, taken in private (Part B). Regional Office should review Trust performance in this area as part of their routine Performance Management meetings.

8) Consideration should be given to what the Police call "Community Impact Assessments" for significant events. This requires an assessment to be made of the impact an event might have on (usually) a local community, and to consider how that might best be responded to by appropriate and supportive actions.

BACKGROUND

The Carmarthenshire NHS Trust restricted the opening hours of the A&E Department at the Prince Philip Hospital, Llanelli from 24hours/7 days to 8am to 8pm daily, with effect from 1 September 2003.

The Minister asked me to investigate the events leading up to that decision. The exact terms of reference were contained in a letter from Mrs Lloyd to the Chief Executives dated 19 September 2003 and appended (**APPENDIX 1**). I wrote to the Trust, and LHB on the 24 September requesting reports covering the events leading up to the A&E closure and including my timetable which I have largely adhered to.

I also wrote to the CHC on the 26 September asking for their comments. Copies of these letters are appended at (**APPENDIX 2**).

Having reviewed the replies which are factual chronologies of events, I have set out below my view of the events leading up to the 1 September 2003 under a number of headings. I received a letter from the Committee for the Improvement of Hospital Services dated the 9 October 2003 which was helpful in directing the areas I have looked at:-

1 Decision Making Process

(a) Legality

The extant guidance on the requirements to commence on major service change can be found in Welsh Health Circular. This circular predates LHBs and Trusts as Statutory Bodies and is currently being reviewed. However, the accepted position is that LHBs supersede references to Health Authorities, which means that the LHB inherit a responsibility to comment on any major change to services. “Emergency closures” are however allowed without consultation, in certain circumstances.

Paragraph 69 of WHC(91)47 states:-

“Regulation 192 of the CHC Regulations allows a District Health Authority (DHA) to decide any substantial development or substantial variation in the provision of its service without committing the CHC if it is satisfied that the interests of the health service do not allow time for consultation before decision.

In any such case DHAs are required to notify CHCs immediately of any decision taken and the reason why no consultation has taken place”. The CHC chronology of events indicate contact was made on the first day of the Chief Officers’ return from holiday.

In this case, the decision to restrict the opening hours was taken as a matter of urgency, following advice in a letter from Mr Jeremy Williams, Clinical Team Leader for A & E Services,dated 7 August 2003 that “the medical staffing situation in Prince Philip Hospital now presents the Trust with an unacceptable clinical risk”.

The subject was discussed in part A of the Trust Board meeting held on the 24 July 2003 (minute no. 03/170) refers. It was raised again in Part B of that meeting when discussing other staffing issues.

Standing Orders clearly give the Chair of the meeting discretion to allow discussion of any urgent or emergency matter of which it has not been possible to give notice through the published agenda.

The relevant Standing Order also states that the decision of the Chair of the meeting on questions of "order, relevancy and regularity…….. and his/her interpretation of Standing Orders is final".

I think this is clear and allows a Chair's discretion to take a matter in either part of the agenda and to discuss an item believed to be urgent and any such interpretation of a matter rests solely with the Chair.

The decision of the Trust Board following its discussion in Part B of the meeting held on the 24 July 2003 was that "in the event of locum cover not being available, the provision of a safe service was paramount and in accordance with the Trust's Standing Orders, the Chair, with the Executive Directors would take Chair's action to restrict the service should this become necessary" (reference minute 03/177.7).

The recommendation to restrict the opening hours was formulated at a meeting of the Executives of the Trust and the LHB on the 12 August 2003, following earlier discussions and it was accepted by the Trust Chair on the 15 August 2003.

Standing Orders state that where the Chair of the Trust (or in his/her absence, the Vice Chair), authorising action in respect of a matter on behalf of the Trust Board, which would normally have been considered by the Trust Board itself, such action shall be reported to the next meeting of the Trust Board.

This was done at the meeting of the Trust Board held on the 25 September 2003; the Chair's action was ratified and Minute 03/182.6 refers. That meeting was quorate in accordance with Standing Orders. The 'notes' of the meeting held on the 12 August 2003, indicate that the decision to restrict services at Prince Philip Hospital was affirmed by the LHB Executive in discussion with the LHB Chair and subsequently it was confirmed by the LHB on the 11 September 2003. The relevant LHB papers and minute were lodged with me.

In all the circumstances, I am satisfied that the decision making process in itself was legal. Whilst accepting that Standing Orders allow discretion for the Chair to take any issue in any part, given the increasing difficulty being experienced with recruitment, not taking a fuller discussion in part A of the meeting is a matter for criticism.

(b) Justification for the decision In the light of the absence of any suitable responses to the 28 June 2003 advert for medical staff and the medical advice for restriction of services on safety grounds, I believe there was little alternative open to the Trust but to take the decision it did.

This was procedurally correct. I would have expected the advice the Trust received to have been placed in a risk assessment process. It was and it confirms the effect of the decision to move risks downward.

The risk assessment was produced in late August and hence it is not clear what action would have been possible had it not confirmed the decision lowered the risks. This must have implications for any pre existing contingency plans.

A suggestion has been made that there should have been a special meeting of the Trust Board before the final decision to restrict this service was taken. That of course, is a decision for the Chair but Standing Orders were followed. It is clear that from the discussions in Part B of the meeting held on the 24 July 2003, the Trust Board was aware that problems could arise and they agreed that the Chair should make that decision should the situation warrant it.

2 Recruitment

Evidence of advertisements for staff required for the A&E Department and other recruitment efforts were lodged with me. For instance posts have been advertised on 10 separate occasions since April 2002. I noted that only two advertisements were placed during 2003, ie 8 February 2003 and 28 June 2003, which is a concern.

The Trust spent the intervening months reviewing its A&E structure (medical staffing) with the aim of developing a financially affordable integrated model whereby A&E staff grade doctors working at West Wales General Hospital would provide on-call cover resident at Prince Philip Hospital.

It was understood that it was on the basis of that work that the Trust readvertised on the 28 June 2003 (with a closing date of 11 July 2003) for the vacant posts, to allow implementation of the integrated model. This advertisement was unsuccessful and ultimately led to the emergency decision to restrict services.

Whilst it may be difficult to see that further advertisements would have made any difference to the situation since difficulty in recruiting in these areas is a feature known, both regionally and nationally, more advertisements in 2003 might have been expected.

To balance that comment the Trust made efforts to obtain suitably qualified staff from other Hospitals to provide cover for Prince Philip Hospital, but they were unable to help. The advertising efforts were also supplemented by discussions with the five separate Medical Agencies with a view to recruiting staff grade doctors through the payment of introductory fees:

The Welsh Recruitment Team have had details of all vacant posts in the Trust.

Alternative Staffing Models were also considered and rejected including the following with the reasons for rejection listed also. (The relevance of this section is not the detail where it might be possible to reach alternative conclusions, but that the Trust were able to demonstrate an analysis and reasons for rejection).

(i) Trust Doctor Appointments

In recognition of current recruitment difficulties at staff grade level and the fixed number of recognised A&E SHO posts available at Prince Philip Hospital, the alternative appointment of 'Trust' doctors in order to maintain the existing 24 hour A&E service provision at the hospital had been considered. However, as Trust grade doctors operate at the equivalent of 'SHO' level, this proposal would result in the removal of more experienced staff grade cover during key periods.

As such, existing SHO staff would, on occasions, be working without appropriate supervision. As the Trust is unable to recruit sufficient numbers of doctors with appropriate levels of experience/skills, this is considered to represent an unacceptable clinical risk as advised by the Trust's Medical Director.

(ii) Rotation of Staff Grade Doctors between WWGH and PPH

The structure of A&E medical staff across the Trust had been reviewed in an attempt to facilitate the rotation of staff grade doctors between WWGH and PPH. However, only 3 out of 5 staff grade posts at WWGH were filled by permanent staff grade doctors (ie 7 out of 10 A&E staff grade posts across the Trust were vacant) and therefore the Trust had insufficient numbers of permanent staff grades in post to enable 24 hour supervision of SHOs at PPH.

(iii) Recruit Locum Doctors into Substantive Posts

Attempts to persuade previous locum appointments to take up substantive posts had proved unsuccessful. This was believed to be due to the inability of NHS contractual rates to compete with those available via locum agencies.

(iv) General Practitioner Support for PPH A&E Out of Hours

This option has been rejected by General Practitioners due to concerns about clinical suitability and specialist expertise.

(v) Swansea NHS Trust Support for PPH A&E

Due to staffing pressures at Morriston and Singleton Hospitals, the Swansea NHS Trust had been unable to release A&E middle grade doctors to support the service at PPH.

(vi) Nurse Practitioners

Whilst the development of nurse practitioners is a key feature of the Trust's strategy for A&E services, the Trust does not currently have any qualified ENPs in post. As indicated above, the Trust is currently pursuing a nurse practitioner development programme but the training period is projected by the Trust as 18 – 24 months before ENPs will be appropriately qualified and experienced. As such, this model was not available to the Trust at this present time. This appraisal of alternative staffing options would be at the heart of a contingency plan.

Whilst I have earlier commented on the late arrival of the confirming risk analysis, the above section did give confidence that alternative staffing options had been explored. In summary the Trust perhaps placed too much reliance on adverts being successful and less on the contingency of what might happen if they were not. They had however examined a range of alternative staffing models but none were helpful to the contingency plan.

3 No Public Consultation Period

Once there has been no suitable response to the 28 June 2003 advert and having received advice from its Senior Medical staff that the ongoing situation at Prince Philip Hospital was no longer 'safe' in clinical governance terms, the Trust was in an 'emergency' position.

It is clear that the verbal and written advice received from the Senior Clinician was that no other action, other than a restriction of hours of opening, was possible in order to provide a safe service. The LHB did not therefore have 'options' to consult the public about a fact acknowledged in their Board report.

In addition to the letter dated 7 August 2003 from Mr Jeremy Williams, (extract quoted above) the medical advice given to Trust officers can summarised as follows:

The continuing reliance on locums (due to all substantive staff grade posts being vacant) was considered untenable, due to difficulties associated with:

Locum staff availability

Concerns about service continuity and the risk of ad hoc closure at short/no notice in the absence of locums

Concerns about the clinical experience/quality of short term locums appointed

The extent of locum unfamiliarity with Trust systems and processes (particularly in view of all staff grade posts being covered by locums)

The need for the Trust's retired locum A&E Consultant to cover the department at night in the absence of locum staff grades

The limited prospect of recruitment in the light of attempts to recruit and the generally accepted view that A&E Doctors are in short supply (evidenced by difficulties experienced by other hospitals)

The increasing concern of the Medical Director, Clinical Director and Clinical Team Leader about the clinical decisions made by some locum appointees.

However, the fact that this service was vulnerable (from 2002 onwards), in terms of adequate staffing levels, was known and with the benefit of hindsight, it can be argued that it would have been prudent for the Trust to have had a continuing dialogue with the CHC, and formally with the LHB to alert them to the consequences should staffing resources fail.

The importance of ongoing communication should not be underestimated when there is a possibility of service change.

Good communications breeds trust and understanding

.
The chronology indicates a historic perspective to this problem dating back around 12 months.

Whilst there is evidence of a sharing of concern about the fragility of the service there was time for a detailed discussion with the CHC and the LHB about options in the ultimate event of a failure to recruit and potential collapse.

There may be of course a wider debate about the need not to worry potential patients unduly about a problem that might not occur, but on balance I am persuaded that the failures to engage partners in a dialogue prior to it becoming a crisis in late July/early August was a missed opportunity and hence a justifiable criticism.

4 Robustness of the Medical Protocols

Having made the decision on the 12 August ratified on 15 August to restrict services on the 1 September, everything then became extremely time constrained.

Final protocols and contingency arrangements were received by the Regional Office on the 20 August 2003, and whilst at that point they were looking to be acceptable, queries on them were still being received on the 28 August. This was extremely tight and simply reinforces the point under 3) above.

5 Risk Assessment

As previously stated there is a comprehensive Risk Assessment. I am advised this was finalised during the week 25 to 29 August 2003.

The Comparative Risk Assessment articulates the reasons which led to the Trust's Senior Medical Staff consideration that the clinical and service sustainability risks currently associated with the Prince Philip Hospital A&E service were not acceptable.

6 Regional Office Involvement

As it might be felt Regional Office had been inappropriately involved in the events leading up to the 1 September. I have separately submitted a chronology of involvement from the Civil Servant I asked to oversee the process.

As there might also be an indication that strategy discussions in the Region might have influenced the decision, I have separately submitted a paper on the chronology and current status of that work. I have also asked that the Director ask another senior officer to review that involvement and report the conclusions to the Director and not via this report.

7. Communications with Staff and Community

Communications were prejudiced by the urgent decision/ implementation. I have reviewed the chronology of meetings with the staff and the community.

From these I noted many were attended by senior Trust clinicians which, I believe, can be interpreted as being their personal commitment to the decision but many community meetings were held after the 1 September. I have been critical above of the communications/dialogue with partners prior to the decision.

Communications after the event indicate a number of relevant meetings but failed to carry community support.

8. Lessons to be Learnt

1) Services at “high risk” need to be shared with the CHC and LHB at the earliest possible stage. Risk analysis should be comprehensive and weighed appropriately.

2) Contingency plans need to be prepared for services viewed at “high risk” and again shared with the LHB and CHC at an early date.

3) All contingency plans should have a risk assessment undertaken for options.

4) Unless in an Emergency situation all service change should be introduced via the LHB, but in an Emergency the service provider must lead all discussion and action in the first instance.

APPENDIX 2

2007 A & E CLOSURE

INDEPENDENT INQUIRY INTO THE PROCESSES ON CONSULTATION AND IMPLEMENTATION OF THE RECONFIGURATION OF GENERAL SURGICAL SERVICES IN CARMARTHENSHIRE: OUTCOME OF THE FURTHER CONSULTATION ON THE REPORT'S RECOMMENDATIONS.

March 2008

Title of Document: *Independent Inquiry Report into the processes on consultation and implementation of the reconfiguration of general surgical services in Carmarthenshire*:
Outcome of the further consultation on the Report's recommendations.
Overview: This document outlines the response to a consultation carried out during October 2007 – January 2008. It was based on a report into the processes on consultation and implementation of the reconfiguration of general surgical services in Carmarthenshire, which was published in July 2007.
Action Required: No further action required
Further Information:
Contact Mid and West Wales Regional Office on 01267 225250 or
Lowri Lloyd-Hughes on 02920 823219; Lowri.Lloyd-Hughes@wales.gsi.gov.uk
Further Copies: Further copies are available electronically at
www.wales.gov.uk/consultations or at http://www.wales.nhs.uk/page.cfm?orgid=1&pid=7452
Related Documents:
Dr Neil Goodwin's Independent Inquiry Report into the processes on consultation and implementation of the reconfiguration of general surgical services in Carmarthenshire - available by request by contacting those listed under "**Further Information**" above.1

CONTENTS

Introduction to the Consultation Exercise

1. On the 1st February 2007, the former Minister for Health and Social Services, Dr Brian Gibbons AM, announced the setting up of an Independent Inquiry to look into the processes on consultation and implementation of the Reconfiguration of General Surgical Services in Carmarthenshire, in particular the decision to close emergency general surgery services at Prince Philip Hospital, Llanelli, Carmarthenshire. This decision had been implemented on the 2February 2007 following a period of public consultation which had been launched by Carmarthenshire Local Health Board in April 2006.nd

2. The National Assembly for Wales awarded a contract to undertake this work to GoodwinHannah Ltd;Dr Neil Goodwin, a director of GoodwinHannah Ltd led the Inquiry.

3. The Report of the Independent Inquiry was published on the 9th of October 2007. During her statement to Plenary Debate on that day in the Assembly, Mrs Edwina Hart AM MBE, the Minister for Health and Social Services, announced that she had asked the Regional Director for Mid and West Wales to conduct a formal consultation on the recommendations in conjunction with the Community Health Council. This has now been completed and its outcome is summarised in this document.

Consultation Arrangements

4. Dr Goodwin's Report (which is available electronically on the Welsh Assembly Government's internet site at: http://www.wales.gov.uk/consultations) included two sets of recommendations, which were in effect addressed to separate audiences:

   (i) the first set are aimed specifically at the NHS and other bodies in Carmarthenshire, and derive from the summary of findings on the processes relating to the reconfiguration of surgical services. There are eight of these addressed to those local bodies.
   (ii) the second set are placed under the heading "*Lessons for NHS Wales*". There are six of these and they have wider relevance to the NHS across Wales.

   The Minister decided that the consultation should focus on the recommendations aimed at Carmarthenshire.

5. The consultation arrangements were set out in a letter of 19th October, which the Regional Director sent to all those mentioned in Dr Goodwin's Report. This invited comments on the recommendations aimed at Carmarthenshire during a consultation period which ran from 19th October 2007 to 25th January 2008. A copy of this letter is attached at **Appendix 1.**

6. A similar letter was sent to professional bodies and organisations with an all Wales or an England and Wales remit which could be expected to have a

direct interest in the Carmarthenshire recommendations. In order to ensure that the consultation was publicised widely so that other Carmarthenshire interests might have an opportunity to comment, arrangements were made to:

(i) place information about it on the Welsh Assembly Government's website and inviting responses to the Public and Patient Involvement Branch of the Department of Health and Social Services;

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(ii) place information about it on the websites of the Carmarthenshire Association of Voluntary Services (CAVS) and the Carmarthenshire Community Health Council;

(iii) utilise the mailing systems of both these organisations. By virtue of this, CAVS conveyed the information to 151 voluntary and community groups in the County, whilst the Community Health Council passed it to the 72 Town and Community Councils and the 4 Town libraries in the County.

7. All of the correspondence and information issued also made clear my willingness to meet with anyone who might wish to do so.
8. The Community Health Council's advice was sought on arrangements for the consultation and the Chair and Chief Officer indicated that they were content with the overall approach being adopted.

9. Attached at **Appendix 2** is a list of all those who received letters and of the meetings which took place. It also identifies the 29 written responses received.

The Responses

10. In accordance with established practice, the consultation responses have been placed in the Assembly Libraries in Cardiff Bay and Cathays Park. The following paragraphs summarise the outcome of the consultation and this Report is available in electronic format on the Assembly's Internet and Intranet Sites on: http://www.wales.gov.uk/consultations and on the Howis website at: http://www.wales.nhs.uk/page.cfm?orgid=1&pid=7452 (internet) and http://howis.wales.nhs.uk/keypublications.cfm (intranet).

11. The comments made within the responses fall broadly into three categories:-

(i) expressions of concern about the changes in general surgical services that were introduced in February 2007, and concerns about the future of Prince Philip Hospital;
(ii) concerns about aspects of accuracy in Dr Goodwin's report; and
(iii) views on the recommendations directed at Carmarthenshire (the subject of the consultation).

Each of these is dealt with in turn in this Report:

Concerns about the changes to general surgical services and about the future of Prince Philip Hospital:

12. The purpose of this consultation was very clear from all the information made available about it. However, very strong views about the removal of emergency surgery from Prince Philip Hospital remain and a number of responses wished to criticise this and would like to see the decision overturned. There are strongly held views on the part of individuals, local authorities and voluntary groups and organisations reflecting the views of service users in Llanelli and the surrounding area about the impact of the service changes. Included among these are concerns about the need for local services to meet the needs of a large population base in the South East of Carmarthenshire – a population which is projected to continue growing - travel times to West Wales General Hospital, the cost of travel, difficulties over visiting arrangements and what is seen as the overall inadequacy of public transport.

    There is expressed disappointment at the fact that Dr Goodwin's report did not deal with these considerations and that he felt the changes were justified on clinical grounds. The former Minister sought assurances at the end of January 2007 that there were compelling clinical grounds for the implementation of these changes at the beginning of February. The Deputy Chief Medical Officer at the Welsh Assembly Government was asked to look at this and his assessment was that there was a need to withdraw emergency surgery from Prince Philip Hospital as the service was breaching patient safety and governance standards.

    Some respondents felt that Dr Goodwin left unanswered the question as to how the service had over time been allowed to get into this position. The fact that his terms of reference were specifically to look at the processes of consultation and implementation and did not include a re-examination of all the considerations for and against service change has to be re-emphasised, whilst at the same time recognising that these expressed views continue to be strongly held and very genuinely felt by many of the respondents. The care which must be taken over the handling of future service changes will need to be informed by this reality, and was clearly a consideration influencing the recommendations made by Dr Goodwin.

13. Some of the responses also indicate a concern that services at Prince Philip Hospital are being downgraded, no doubt with the changed arrangements for general surgical services being seen as indicating this. The statements that have consistently been made that Prince Philip Hospital is to be developed as a centre for excellence have not thus far provided reassurance to those who express this view, and Dr Goodwin's recommendations recognise the importance of developing a clear vision for the future which people can understand and believe in.

14. The view was also expressed that Dr Goodwin's report has given too much weight to local concerns about the removal of emergency surgical services from Prince Philip Hospital. The fact that people elsewhere in Carmarthenshire might have longer travel times and experience difficulty in getting to Prince Philip Hospital for elective surgery, but have not criticised the changes, has, some feel, not been recognised. While this is undoubtedly true, it does not take away from the need to achieve an effective balance between local concerns,

which **must** be heard, and delivering services to meet the needs of all the people of Carmarthenshire in any process of service development and change. That must be a key message to take forward on the basis of this experience.

Concerns about aspects of accuracy in Dr Goodwin's Report:

15. Some of the responses express unhappiness that there was not an opportunity to comment on matters of factual accuracy in the Report before it was finalised. There are a number of areas where it is felt there should have been acknowledgement of work done to produce the review of surgical services, to engage partners and to hold public meetings, which were felt by those organizing them to be accessible and generally useful in format. There is concern that it did not properly capture the intimidating nature of some of the actions that occurred, particularly in respect of key players and members of the Community Health Council. Also, the criticism of the timing of the consultation during the period leading up to Assembly elections was felt to be unfair on local leaders of the process. A view of considerable substance is the one which feels that Trust clinicians should have received greater recognition for the very important lead role they played in presenting the case for service change in the public meetings and in meetings with the Community Health Council. This point is well made and the importance of such a contribution to

16. These responses, while needing to be recorded, must be placed in context. At no point have they been offered in a way which seeks to undermine the recommendations in the Report. Indeed, the local health bodies leading this consultation process have without exception responded positively to these, seeing them as contributing to strengthening the approach to engaging service partners and the wider community in formulating future proposals for strengthening services for people in Carmarthenshire.

17. Before moving from the two areas of concern referred to in the preceding paragraphs (12-16), it is important to acknowledge the significance of a comment made during the discussion, which followed the Ministerial Statement at the October plenary. This emphasised the need for the Regional Director to ensure that the process was not "hijacked" by vested interests on either side of the debate to go back to historical issues. This has been a major consideration in handling the consultation, and the request to focus the responses to the Recommendations in Dr Goodwin's Report has needed constant reinforcement.

Responses to the recommendations aimed at Carmarthenshire

18. The overall reaction from respondents who have commented on these recommendations is that they represent a balanced package which, if implemented effectively, will improve joint working and wider engagement in understanding services and the need for service change in Carmarthenshire. In delivering them, there are the two underlying perspectives, which need to be noted. On the one hand, there is the view that their implementation requires major change in the underlying culture prevalent in health bodies in the County. On the other, there is the belief among bodies that they have already made headway in areas covered by the recommendations and they express an energy and commitment to progress them further.

19. Responses in respect of each recommendation are summarised below:

Recommendation 1:

Against the backdrop of the strategic proposals for acute services across Mid and West Wales, an exciting and compelling vision for developing Prince Philip Hospital as an elective surgical centre for West Wales and beyond should be agreed by the Local Health Board and Trust with stakeholders as soon as possible and signed off by all. The vision should be supported by an investment strategy with timescales and costs, and the vision and strategy should be widely publicised to local people. This process should be led by the Local Health Board:-

This was welcomed, as the development of such a vision would do a great deal to dispel concerns about the downgrading of Prince Philip Hospital. The Trust and the Local Health Board felt they had attempted to do so during the consultation exercise by indicating their wish to develop the hospital as a centre for elective excellence. The proposals to develop a short stay surgical unit and a second phase development to the existing Breast Care Centre had been shared. However, they both accept that the overall vision requires further development, engagement with stakeholders, a clearly defined investment strategy to evidence the intention to deliver the vision, and a more effective approach to communication so that local politicians, interested groups and the general public can be reassured as to the hospital's future.

The Local Health Board indicates that it is continuing to develop its patient and public involvement plans and using health panels as a positive mechanism to engage with the public about a broad range of service issues. In this way, it is seeking to establish an improved process of ongoing engagement.
The Local Health Board, Trust and County Council have appointed a joint press officer who has built a more positive relationship with the media and is seeking to provide more accessible information and positive messages about services whenever possible.

Responses also identify a need for Welsh Assembly Government and health organisations to consider ways of in future, setting out clear service strategies supported by clear investment plans so that the stakeholders and the public can be reassured about their delivery.
There is a general recognition that the leadership role in respect of the recommendation should rest with the Local Health Board.

Recommendation 2:

NHS organisations, their clinical staff and supporting financial and operational management systems should be aligned to support freedom of choice of Hospital (where clinically appropriate) by patients and local people requiring emergency and elective surgery:-
Freedom of choice is of course an important issue in the view of those who are concerned about having to go to West Wales General Hospital for emergency

general surgery. However, some responses consider that it is unrealistic to purse this within the policy context that applies in Wales. There is recognition of the importance of clinical governance issues and support for the objective of providing safe, equitable services as locally as possible.

Recommendation 3:

Implementation of the decision to withdraw emergency general surgery from Prince Philip Hospital and centralise the service at West Wales General Hospital should be rigorously performance managed by the Trust, Local Health Board and Ambulance Service in terms of:

- ***clinical governance and the clinical service impact on local people;***
- ***patient access to general surgical services in Carmarthenshire as evidenced by changes to waiting times, reductions in cancelled admissions and operations; and transport and ambulance journey times.***

The Local Health Board should coordinate agreement of the performance management process and format with the Trust, Ambulance Service, GP representatives and Community Health Council; and make the reports available to all stakeholders and the public on a regular basis. Quarterly would be reasonable:-

Responses made it clear that arrangements for performance managing the impact of the changes in surgical services were built in at the time when the Surgical Services Working Group was developing its proposals. This is undertaken by a Surgical Services Evaluation Group, led by the Local Health Board and involving key stakeholders. It has shown that there are positive outcomes in terms of reduced waiting times and no cancellations of any elective general surgery work at Prince Philip Hospital. Performance Reports are made available publicly through the Local Health Board and Trust Boards.

During the consultation, there were references, sometimes in writing, to the difficulties which some people had in accessing the emergency service at West Wales General Hospital.

There had been press coverage of some of these. The Community Health Council indicates that, as part of its statutory duties, it disseminates information on the Evaluation Group's findings through its normal communication channels.

Recommendation 4:

The Local Health Board needs to develop its external leadership role so that the public, politicians and other public service organisations understand that it, rather than the NHS Trust, is the statutory leadership body responsible for taking decisions about the commissioning and the future strategic direction of local NHS services. The Local Health Board could raise its public profile by, among other things, leading an ongoing programme of public engagement so that local communities are more

informed about how healthcare provision is changing because of developments in clinical practice.

A number of responses indicated that this was an important area for the Local Health Board to tackle. Its leadership role in respect of the consultation on surgical services had not been universally understood. The Local Health Board indicates that it is continuing to make progress on this. Its ongoing programme of public engagement events through health panels is focusing on making local communities better informed about healthcare provision and the need for development to reflect improved clinical practice.

It refers to the media strategies being developed in partnership with the Trust and the County Council and to the plans that are being jointly developed to improve services in the future. The health bodies reaffirm their commitment to more effective public engagement.

The work of the Patient and Public Involvement Committee of the Local Health Board will make an important contribution to its ongoing work programme in this area. The Community Health Council has also put forward suggestions for improving public engagement and is prepared to work with the Local Health Board to help it fulfil its leadership role.

Recommendation 5: The Trust and Local Health Board need to establish a more effective working relationship and accept joint ownership of local NHS issues and challenges such as strategic development and big operational issues such as financial management. This should be led by the chairs of the Local Health Board and Trust, supported by their chief executives and boards. Collectively they should lead a process of stronger inter-organisational engagement and discussion, and the development of mutually supportive and effective inter-personal relationships across the two organisations.

The Local Health Board response suggests that the Review of General Surgical Services was in itself an example of effective working relationships between the Trust and the Local Health Board. However, it agrees with the Trust and other health service views that this is an area for improvement and refers to the way in which joint working has been strengthened by the recent 3-month period of Focused Measures.

This involved the Chairs of both bodies requesting assistance from Welsh Assembly Government to develop jointly agreed financial plans, together with an outline service delivery model which would be the basis for further work to engage stakeholders and the wider community. Two Turnaround Directors were provided to work with the Boards, Chairs and Chief Executives and there have been joint Board Meetings and Steering Groups to take this forward. The Local Health Board and Trust have worked effectively together, and improved relationships are seen to have been established by respondents who work closely with them.

Recommendation 6: The Chair of the Local Health Board should lead a process for him and the Chair of the Trust to meet regularly with AMs and MPs to discuss healthcare matters of concern to themselves and local people.

The Chair of the Local Health Board has responded, recognising his lead role in this, and the Acting Chair of the Trust has confirmed her support. Both feel that they need to build upon previous experience to strengthen arrangements in this area. Their recognition of the importance of being able to share views on future service direction and change is mirrored in the comments of politicians who responded to the consultation.

Recommendation 7: In the context of Carmarthenshire being a pilot for implementing the Beecham report5 the chairs of the Local Health Board and Trust should agree with other public service leaders how best they can develop effective inter-personal and inter-organisational working relationships over and above the structural requirements set out by Beecham.

Both chairs have responded indicating that they are active members of the Carmarthenshire Local Service Board, that formal partnership agreements now exist between the Trust, Local Health Board and the local authority and that there have already been some joint appointments. This agreement has resulted in 7 Partnership Projects focusing on improving joint working between health and local government services - Continuing Care, Learning Disabilities, Adult Mental Health, Dementia Services, Delayed Transfers of Care, Community and Intermediate Care and Chronic Conditions Management. Carmarthenshire will be one of the demonstrator sites in Wales for developing a new Model of Chronic Disease Management.
The Chairs feel that they have already made considerable progress towards addressing the challenges set out in the recommendation.

***Recommendation 8: If the Committee for Improvement in Hospital Services continues in existence then it would be helpful to the NHS and external stakeholders if it could clarify its role and governance arrangements; and reflect on how best to influence and work with the statutory health bodies responsible for making decisions on behalf of local people, particularly the Community Health Council*.**

Among the responses were expressions of support for the Committee for the Improvement of Hospital Services and the part it plays in respect of services at Prince Philip Hospital. Others see it as being a self-promoting group, which does not reflect or represent the views of the community in Llanelli. The Committee sees itself as seeking to protect services over a period of years when it feels health bodies have not always been responsive to the concerns of that particular area.

The responses from the health bodies and the Committee itself offer the possibility that the historical tensions might be capable of being overcome through constructive action by the relevant partners. The Trust and the

Community Health Council in particular have welcomed the recommendation, look forward to a positive response from the Committee and confirmed their wish to establish a constructive working relationship with it in considering services for the future.

The Committee's response indicates that it convened a public meeting in Llanelli at which Dr Goodwin's recommendations were considered. The meeting was well attended and supported the continuation of the Committee's work and endorsed that it must engage with the health community and not fall into the trap of being a protest committee. It proposes to respond positively to the approach from the Community Health Council, which wished to explore the possibility of establishing a closer working relationship. It has also provided a copy of its Constitution and a statement of its role in recognition of the fact that this issue was raised by Dr Goodwin.

The Committee also offered views on one of the report's recommendations for the wider NHS. This dealt with the role of Community Health Councils. As these recommendations were not included in the consultation, those views have been passed to Welsh Assembly Government officials who have a lead responsibility for Community Health Councils and are actively considering the nature of guidance which would be helpful in the future.

Lessons for NHS Wales

20. Dr Goodwin's report identifies 6 lessons for NHS Wales, which have been drawn out from the work undertaken during his Inquiry. These were not the subject of the consultation and are as follows:
    - (i) the need for ongoing, meaningful and effective processes of public engagement;
    - (ii) the need for high quality public consultation processes, publications and decision-making;
    - (iii) the need for effective media management.;
    - (iv) the need for sustainable, trusting and effective inter-organisational relationships within and beyond the NHS;
    - (v) the need for clear organisational and individual accountabilities and responsibilities; and
    - (vi) the need to develop and support community councils.

21. Some of the responses have provided comments on these and they are supportive. The importance of introducing better ways of engaging partners, stakeholders and the public in developing proposals for strengthening services for the future is emphasized. These responses have been passed on to officials working on strengthening guidance to the NHS on approaches to engagement and consultation and to those who are providing further guidance on the role of Community Health Councils.

Conclusion

22. This consultation was embarked upon because of the continuing concerns raised about the process that led to the changes in general surgical services implemented in February 2007. It sought to establish whether the recommendations aimed at Carmarthenshire offered a constructive way forward.

23. On the basis of the meetings which were held and of the written responses received, a number of conclusions can be drawn:

i. respondents welcomed the opportunity to comment and a number thanked the Minister for enabling them to do so;

ii. they generally felt that the eight recommendations aimed at Carmarthenshire provided a basis for improving working arrangements and positive engagement for the future;

iii. responses showed evidence that progress is being made to put in place improved arrangements between health bodies, the health service and the local authority and that work is being done to implement better ways of engaging the wider community;

iv. it is clearly important to achieve a balance between local views (and they are important to listen to and to be informed by) and achieving the best pattern of services possible for the people of Carmarthenshire;

v. the past history surrounding service change in Llanelli in particular is a problem which individuals, local bodies, and health bodies in Carmarthenshire must put behind them. The need to ensure that the consultation process was not “hijacked” by vested interests on either side of the debate has been a major consideration in handling the consultation;

vi. the recommendation that an exiting and compelling vision for Prince Philip Hospital needs to be agreed by the Local Health Board and Trust with stakeholders should be seen in the context of future service changes here and in the wider NHS. There is a need for the Welsh Assembly Government and Health Organisations to consider ways of setting out clear service strategies supported by investment plans so that stakeholders and the public can be reassured about the delivery of proposed service changes;

vii. engagement has to be two ways – informing and listening - and there is a need to improve Welsh Assembly Government guidance to help the service and all stakeholders to become more confident and more skilful in how to do this;

viii. the Local Health Board is committed to fulfilling its lead responsibilities in the area of bringing about change to strengthen services for the future. The Community Health Council is also keen to play its part in making

engagement as effective as possible and it would be helpful to provide further guidance on the role of Community Health Councils which deal with this;

ix. the challenges that lie ahead are to achieve the most effective pattern of services possible. The developing partnership between the Trust, the Local Health Board and the local authority, the practical arrangements for working together to tackle a number of key service areas and the steps they are taking to use the media as an effective and far reaching communication tool are all encouraging signs;

x. the history of strained relationships between organisations in the past and the difficulty in connecting properly with wider community interests make the responses which suggest that a major cultural shift is needed entirely understandable.

This cultural change is needed on the part of the public bodies and other players such as the Committee for the Improvement of Hospital Services.

The responses to the consultation are encouraging and suggest that, with good will and determination, the situation can be improved. However, maintaining a process of cultural change can be difficult and will need to be pursued with vigour over the coming months by all the key players in Carmarthenshire.

24. The positive way in which the consultation was approached in the written responses and by those with whom meetings were held needs to be recorded. So also does the assistance of the Community Health Council and the Carmarthenshire Council for Voluntary Services in drawing the consultation to the notice of organizations with an interest across the whole of Carmarthenshire.

Graham Williams
Regional Director for Mid & West Wales
Department for Health & Social Services
March
2008Appendi
x 1 19
October 2007

APPENDIX 3

PERCEPTIONS OF THE A&E PROVSION AT LLANELLI

Yr Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant
Department for Health, Social Services and Children
Yr Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant
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Ffacs• Fax: 029 2082 3403
Eich cyf/Your ref
Ein cyf/Our ref AT/LG/06275/12
D. Haydn Jones
haydnjones633@btinternet.com

Dear Mr Jones

Thank you for your letter of 17 March to the Minister for Health and Social Services regarding proposed service change at Prince Philip Hospital. I have been asked to reply.

The Minister is in regular communication with the Chair of Hywel Dda Health Board and has been assured there are no plans for significant changes to services at Prince Philip Hospital.

The A&E Department will remain and options are currently being considered to enhance the role of the Breast Care Unit and Elective Orthopaedic services, and to provide a new Specialised Rehabilitation Centre of Excellence at Prince Philip.

Hywel Dda Health Board is in the process of engaging with staff and the local population to produce proposals for service change, which will be put forward in the next few months for formal public consultation.

The Welsh Government is committed to ensuring the NHS in Wales continues to provide safe, high quality and sustainable healthcare services. However, the Minister has made clear preserving the status quo is not a sustainable option.

The Minister understands how strongly people feel about the hospital services in their local area. I can reiterate her wish for our District Hospitals across Wales to develop as centres of excellence which are able to recruit and retain high calibre staff and provide first class care to their local populations.

It is essential for our hospitals to work closely with community services to enable the delivery of responsive, effective pathways of care and with other acute centres to ensure those

relatively few patients who require complex, specialist care receive it in the most appropriate setting.

Change is required to fulfil these objectives. Health Boards will be guided by relevant clinical evidence and will take full account of the distinctive characteristics of the populations they serve.

In the case of Mid and West Wales, particular attention needs to be paid to the challenges of rurality and travel times to other centres. Change must also be taken forward through plans which have been developed following extensive engagement and consultation with local communities and stakeholders, in line with National Guidance.

It is important for communities to think carefully about the case for change and to present any solutions they think could be adopted – but these must be safe and sustainable solutions and not simply demands for the status quo.

The current listening and engagement exercise being undertaken by the Hywel Dda Health Board has been extended until the end of April and should not be confused as formal consultation.

This is just the first step of ensuring all interested parties have every opportunity to comment on the outline service models being proposed.

The Minister has been assured the Hywel Dda Health Board will re-double its effort to ensure its engagement is efficient, comprehensive and effective. She believes it is vital all parties conduct discussions in a respectful and productive manner.

The Minister recognises change can be difficult, but it is also essential to enable high quality services to be delivered on a sustainable basis. This is a ‘once in a generation’ opportunity to get the health services right for the population of Mid and West Wales.

We must all play a part in designing and supporting the necessary changes. Where service changes are planned, the National Clinical Forum will provide Health Boards with clinical advice to provide assurance any new arrangements are clinically safe and lead to the best possible health outcomes for local populations.

I hope I have been able address your concerns

Yours sincerely

Sion Griffiths
Government Business Team

Prince Philip Hospital, Llanelli

This hospital is part of Hywel Dda Health Board

General hospital information

Address & description

Prince Philip Hospital,
Bryngwynmawr, Dafen, Llanelli, Wales, SA14 8QF
Tel: Work 01554 756 567

Prince Philip Hospital is a 205 bed major acute secondary care hospital in Llanelli. The hospital houses most clinical specialities including and A&E.

- Accident & Emergency - provides services for the town of Llanelli and surrounding area
- Antenatal Services
- Audiology
- Business Support
- Dermatology
- Dietetics
- ENT
- General Medicine
- General Surgical Services
- Gerontology
- Gynaecology
- Nursing
- Ophthalmology
- Oral Maxillofacial Surgery
- Orthodontics
- Orthopaedics
- Outpatients
- Paediatrics
- Pain Services
- Pathology

- Pharmacy
- Physiological Measurement Services
- Radiology
- Radiotherapy
- Rehabilitation
- Respiratory Services
- Rheumatology
- Speech & Language Therapy
- Adult In Patient Mental Health Services - on the PPH site
- Older Adult In Patient Mental Health Services - on the PPH site

Prince Philip Hospital is in physical condition B - sound and operationally safe.
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Prince Phillip Hospital, Llanelli

This is a busy, modern, well-equipped District General Hospital, built on the nucleus design and opened in May 1990. There are 220 acute and elective inpatient beds which support General Medicine (including cardiology, respiratory medicine, endocrinology, care of the elderly and gastroenterology), General Surgery (including vascular, breast and colorectal surgery), elective Orthopaedics and Urology.
The above specialities are supported by a combined medical /surgical 6 bedded ITU/HDU with facilities for ventilating 5 patients. The hospital also has a dedicated CCU.
A Central Treatment Suite with provision for a maximum of 40 patients provides surgical day case theatre, endoscopic suite and palliative care facilities. Additionally there is a new hospice facility.
The Helath Board offers state-of-the-art diagnostic imaging facilities at Prince Philip Hospital, including multi-detector CT and an MRI scanner. The Health Board has commissioned the expansion of a purpose built facility at PPH for the management of breast diseases.
Consultants in the following specialties are based at the hospital:

General Medicine	General Surgery
Haematology	Histopathology
Orthopaedics	Anaesthetics
Accident & Emergency	Urology
Microbiology	Radiology

In addition there are visiting consultants in Paediatrics, Obstetrics & Gynaecology, Ophthalmology, Dermatology, ENT, Oncology & Radiotherapy, GUM, Sexual Health, Mental Illness, Oral Surgery, Orthodontics, Rheumatology and Chemical Pathology.
Facilities at the hospital include:

A&E Department	6 bedded ITU / HDU
3 Inpatient Theatres	4 Bedded CCU
Day Surgery Theatre	X-Ray including MRI and CT Scanning

Departments included in the rotations:-

General Medicine

The Hospital provides all General Medical care facilities for the Community, including acute Medical Services and a large Outpatient commitment. There are 139 beds in the General Medical Wards, plus 4 in the Coronary Care Unit and 4 Intensive Therapy Unit, in addition to the Day Care facilities in the Central Treatment Suite. Special investigations available include full respiratory function tests, exercise ECGs, 24 hour Halter Monitoring, Echo-cardiograms, video sleeping monitoring and full upper and lower Gastro-Enterology Endoscopy Service and Bronchoscopy Service.

Additionally the Department is supported by Specialist Nurses in Diabetes, Elderly Medicine, Cardiac Rehabilitation and Respiratory Medicine.

A Full Shift Rota is in operation.

Working Hours:

Normal Working Day: 9.00am – 4.30pm. Post-take days 8.30am-4.30pm

Full Shift rota is currently in operation with prospective cover.

Resident support is provided by SpRs and Staff Grades working a second on-call rota.

General Surgery

This consists of General Surgery in its widest extent. There are 56 beds in Prince Philip Hospital, the Surgical Wards, 4 Intensive Therapy Unit, in addition to those in the Day Care facility. Special investigation facilities include Vascular Doppler Laboratory, Urodynamics Laboratory and Breast Screening.

There is a full shift rota in place which covers the Health Board across both sites; this is due to the recent Emergency/Elective Split on call. As all of the acute take is now in West Wales General Hospital F1's from both sites do the majority of their on call in that hospital.

Additionally, the Department is supported by Specialist Nurses in Continence, Stoma Care, Wound Care and Breast Care.

Working Hours:

Normal Working Day: 8.00am – 4.00pm

Full Shift rota currently in operation with prospective cover, the main on call rota is worked from West Wales General Hospital with F1's from each site participating in it.

Resident support is provided by SpRs and Health Board Dr's (Reg Level) working a second on-call rota based in West Wales General and non resident Staff Grade rota in Prince Philip Hospital

Accident & Emergency

Designed and built as a major unit, the Department has a 3 bay resuscitation room, 5 treatment areas, plaster room, theatre and recovery suite, children's' play area, relatives facility and is equipped with 'state of the art' monitoring and computerised patient record system. All Medical, Geriatric and Surgical emergencies are seen and assessed in the Department and total attendances are approximately 40,000 per annum.

Working Hours:

Full Shift rota is currently in operation with prospective cover.

Support is available in the department from the Consultant in Charge and Staff Grade doctor during normal working hours.

Anaesthetics/ITU

The department itself provides anaesthetic cover for general, urological, vascular, gastrointestinal and breast disease surgery as well as elective orthopaedics, gynaecology and ophthalmology as well as a six bedded ITU

The hospital does not provide Obstetric and Trauma services.

In addition the Department is supported by a Senior Operating Department Assistant, Operating Department Assistants and trained Anaesthetic Nurse(s).

Working arrangements including hours of duty, on-call etc

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APPENDIX 3C

The Consultant in emergency medicine and clinical programme director for unscheduled care Hywel Dda Health Board - writes:

“For too long the general public of Llanelli have had the mistaken perception that they may lose their local accident and emergency department when in fact Prince Philip Hospital has not possessed such a unit for a number of years ..... Patients would continue to be seen at Prince Philip if the unit was renamed urgent care centre

...We risk providing an out of date model that doesn’t provide patients with the best and safest emergency care.”

APPENDIX 4

Travel and Mortality

The relationship between distance to hospital and patient mortality in emergencies: an observational study

Jon Nicholl, James West, Steve Goodacre, Janette Turner

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. . . . . .
See end of article for
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. . . . . .
Emerg Med J 2007;24:665–668. doi: 10.1136/emj.2007.047654
Objectives: Reconfiguration of emergency services could lead to patients with life-threatening conditions travelling longer distances to hospital. Concerns have been raised that this could increase the risk of death.

We aimed to determine whether distance to hospital was associated with mortality in patients with lifethreatening emergencies.

Methods: We undertook an observational cohort study of 10 315 cases transported with a potentially lifethreatening condition (excluding cardiac arrests) by four English ambulance services to associated acute hospitals, to determine whether distance to hospital was associated with mortality, after adjustment for age, sex, clinical category and illness severity.

Results: Straight-line ambulance journey distances ranged from 0 to 58 km with a median of 5 km, and 644 patients died (6.2%). Increased distance was associated with increased risk of death (odds ratio 1.02 per kilometre; 95% CI 1.01 to 1.03; p,0.001).

This association was not changed by adjustment for confounding by age, sex, clinical category or illness severity. Patients with respiratory emergencies showed the greatest association between distance and mortality.

Conclusion: Increased journey distance to hospital appears to be associated with increased risk of mortality.

Our data suggest that a 10-km increase in straight-line distance is associated with around a 1% absolute increase in mortality.

It has recently been suggested that reconfiguration of emergency care to concentrate services in a limited number of specialist centres could save thousands of lives each year in the UK, and that opposing the closure of local services could counterintuitively cost lives.

1 In opposition to this view, concerns have been raised that reconfiguration could lead to acutely ill patients having to be transported greater distances to hospital with an associated risk of increased mortality.

Few published studies have addressed this issue, so there is a risk that policy-making may be driven by anecdote or supposition.

We have recently completed a study to assess the effect on mortality among patients with life-threatening emergencies of implementing response time standards in four ambulance services.

2 We have used these data to determine whether longer journey distances to hospital were associated with an increased risk of mortality.

METHODS

Call identification

Ambulance services use emergency medical dispatch (EMD) systems to prioritise 999 calls. Two systems were used during this study: the Advanced Medical Priority Dispatch System (AMPDS) and the Criteria Based Dispatch (CBD) system. Each provides structured protocols that allow trained emergency medical dispatchers to categorise 999 calls depending on urgency, and assigns each call a priority code based on condition and urgency.

The Department of Health (DH) has identified a set of EMD codes for each system that correspond to conditions that are potentially life-threatening and to which the highest priority (category A) ambulance response should be made.

We selected for inclusion in the study a subgroup of category A calls identified using the DH codes, in which the patient was reported as unconscious or not breathing or with acute chest pain.

We termed these A* calls. Exclusion criteria were A* calls where patients were found dead at the scene, or were discharged at the scene and not conveyed to hospital, or were treated in hospitals other than those in our study areas; calls where no vehicle attended the scene; and out-of-hospital cardiac arrests (the last category was excluded because survival from out-of-hospital cardiac arrest has clearly been shown to depend upon the time from call to treatment that can be provided by ambulance staff, rather than time or distance from scene to hospital).

3 Data collection

Consecutive, life-threatening category A ambulance calls were sampled annually from 1997 to 2001 from four ambulance services: the Royal Berkshire, Derbyshire, Essex and West Midlands.

These services were representative of the types of environment typically encountered in England and included urban, mixed urban and rural, and very rural areas. In 1999, the Derbyshire, Nottinghamshire and Leicestershire ambulance services merged to become East Midlands Ambulance Service NHS Trust.

Two services used CBD, one used AMPDS, and one used CBD at the beginning of the study and changed to AMPDS halfway through. From all category A calls, we sampled approximately 1000 consecutive A* calls from each service in each year, using the same sampling period for each service for all years.

The ambulance service dispatch system provided patient information (name, sex, age), grid reference for the incident, and dispatch category codes. This information was then used to identify the paper ambulance patient report forms (PRFs).

From the PRFs, further information was obtained about the patient (name, date of birth and address), incident description, the patient condition on arrival of the crew (including vital signs), details of treatment given, disposal of the patient (left at
Abbreviations: AMPDS, Advanced Medical Priority Dispatch System;
CBD, Criteria Based Dispatch; DH, Department of Health; ED, emergency department; EMD, emergency medical dispatch; GCS, Glasgow Coma Score; NHS, National Health Service; PRF, patient report form; REMS, Rapid Emergency Medicine Score 665

the scene or transported to hospital) and outcome at this point (alive or deceased).

From the grid references of the incident and hospital, we calculated the straight-line ambulance journey distance from scene to hospital. These straight-line distances were preferred to journey times to hospital because journey times depend on the accuracy and consistency with which times of leaving the scene and arrival at hospital are recorded, and they can also be affected by ''reverse causation''.

This occurs when the patient condition is a cause of the journey time rather than vice versa, such as when ambulances drive as fast as possible to hospital for critically ill patients but more slowly and with less risk for patients not critically ill.

If the patient was taken to hospital, the emergency department (ED) notes were identified and information recorded on time of arrival and discharge from the ED, patient condition including vital signs, cardiac rhythm (for cardiac patients), preliminary diagnosis, condition on leaving the ED and disposal.

If admitted, details of the length of stay, final diagnosis and disposition were recorded. For any patient who died, details were recorded of the date, time, place and cause of death.

If the patient died before reaching hospital and was taken directly to the mortuary, the cause of death was obtained by accessing death certificates from the coroner or the National Health Service (NHS) Central Registry.

Details of patients taken to hospital, for whom no records could be found, were also sent to the NHS Central Registry. For those identified as dead, the date, place and cause of death were obtained and used to identify those who had died as a result of the incident for which the call was made and those who had survived. Ethics approval was obtained, covering 27 hospitals that patients could be taken to within the geographical boundary of each of the ambulance services.

Analysis

We planned to test for an association between journey distance to hospital and mortality. Such an association could be confounded by illness severity. Patients living further from hospital may have a higher threshold for calling for help and may therefore be more ill and at higher risk of death.

There is currently no widely validated system for risk-adjusting emergency medical cases, but the Rapid Emergency Medicine Score (REMS) has been validated in a local setting4 and shown to predict mortality in our cohort.

5 This score uses six variables (age, Glasgow Coma Score (GCS), oxygen saturation, pulse, blood pressure and respiratory rate) to give each patient a score between 0 (lowest predicted mortality) and 20 (highest).

We therefore planned to examine whether patients with a longer journey distance had higher REMS scores and determine whether any association between distance and mortality was confounded by illness severity by testing the association in a multivariate analysis, with REMS score included as a covariate. Because full REMS scores were only available for a small number of patients, we also tried adjusting for partial scores based only on age and GCS, which were available for 80.8% of patients.

We also tried adjusting for sex, categorical age, and clinical category coded as chest pain (any cause), respiratory disease or symptoms, and injury, poisoning, asphyxiation or haemorrhage, or other and unknown.

By including ''other and unknown'' as a category all cases were included in this analysis.

All analyses were undertaken using SPSS V.11.0 (SPSS Inc, Chicago, Illinois, USA).

RESULTS

Numbers

During the 5-year period, A* calls resulted in ambulance attendance for 11 794 patients who met the study inclusion criteria and who were followed up to discharge or traced through the NHS Central Register. Of these, we excluded 1479 from this analysis because distance to hospital could not be calculated.

This resulted in a study sample of 10 315 (58.3% male, with a median age of 61 years).

Analyses

Ambulance journey distances ranged from 0 to 58 km, with a median of 5 km. Overall, 644 patients died (6.2%). Table 1 shows how mortality varied with straight-line distances,categorised as short (,10 km), medium (10–20 km) or long (.20 km).

Longer distances were associated with higher mortality (p,0.002, x2 test for trend). Logistic regression showed that mortality increased with each additional kilometre of distance travelled, with an odds ratio (OR) of 1.02 per kilometre (95% CI 1.01 to 1.03; p,0.001).

Some association was observed in all four clinical categories, but it was particularly striking for patients with respiratory problems (fig 1). A full REMS score could be calculated for 3882 patients (37.6%). The mean REMS score was 6.79 (95% CI 6.67 to 6.91) for those with a short journey distance, 7.22 (6.92 to 7.51) for those with a medium journey distance and 7.33 (6.78 to 7.88) for those with a long journey distance. The association between journey distance and mortality remained significant after inclusion of REMS score in the logistic regression to adjust for potential confounding by disease severity (OR=1.03; 95% CI 1.01 to 1.05; p=0.006).

Missing oxygen saturation information was the main reason why a full REMS score could not be calculated, so we repeated the analysis using only the age and GCS components of REMS.

We have previously shown that age, GCS and oxygen saturation are the only components of the REMS score that are independent predictors of mortality in our cohort.5 We were able to include 8335 (80.8%) cases and found that the

Table 1 Relationship between ambulance journey distance and survival to discharge
Distance category (km)

Outcome
Survived (%) Died (%) Total
0–10 7725 (94.2) 475 (5.8) 8200
11–20 1479 (92.3) 124 (7.7) 1603
21+ 467 (91.2) 45 (8.8) 512
Total 9671 (93.8) 644 (6.2) 10315

Figure 1 Variation in mortality with distance to hospital, by clinical category.

association between journey distance and mortality remained significant (OR=1.018; 95% CI 1.005 to 1.03; p=0.005). Adjusting for age, sex, and clinical category, and including all 10 315 patients in the analysis, strengthened the evidence for the observed association (OR=1.02; 95% CI 1.01 to 1.03; p,0.001).

DISCUSSION

Increased journey distance to hospital seems to be associated with increased risk of mortality, even after potential confounding by illness severity is taken into account.

Our data suggest that each additional kilometre is associated with a 2% relative increase in mortality. This equates to an approximate 1% absolute increase in mortality associated with each 10-km increase in straight-line distance.

Our results showa sharp increase in mortality in patients with respiratory problems, but less change in patients with chest pain. This is clinically plausible. This means that, other things being equal, closing local EDs could result in an increase in mortality for a small number of patients with life-threatening emergencies, who have to travel further as a result.

Other evidence

Our results concur with a number of studies from around the world that have shown increased mortality in rural compared with urban trauma. However, much of this can be explained by the increased severity of road traffic crashes and increased ambulance response times in rural areas.

Furthermore, results may not be generalisable from trauma to other emergency medical conditions nor from one emergency system to another.

Only a few studies have examined hospital accessibility and outcomes in the UK. Studies of road traffic crashes in Norfolk,6 all serious trauma in Scotland,7 and

ruptured abdominal aortic aneurysms in West Sussex8 all failed to find any relationship between time to hospital andmortality. However, in line with our findings, two studies of the relationship between accessibility and mortality in asthma patients have found a 10% increase in the relative risk of death for each 10-km increase in distance,9 and a 7% increase for each 10-minute increase in journey time.

10 Limitations

A number of potential limitations of our study should be considered when interpreting these results. First, this is an observational study, and inferring causality from our observed associations is fraught with difficulties, most notably by confounding.

Although we attempted to adjust for confounding by illness severity and case mix, it is possible that at least some of the observed association may be explained by residual confounding.

Second, we deliberately selected ambulance service calls that suggested patients might have life-threatening conditions and a high risk of mortality. Our findings should not be applied to the vast majority of patients transported to hospital by ambulance,who have a much lower risk of death. Third, our results reflect associations between distance and outcome within the emergency care system as it performed between 1997 and 2001.

Changes in performance in recent years or new policies that have changed to both increase distances and either improve care at the more distant facilities or improve the effectiveness of prehospital care could attenuate the potential effect of increased journey distance upon mortality.

The emergency medical system and future research

There is good evidence for some groups of emergency patients that care provided in specialist centres improves outcomes.

1 Examples include primary angioplasty for acute myocardial infarction,11 and care for major trauma patients with multiple injuries.12 In these cases we can be reasonably confident that with appropriate pre-hospital care and at distances typical in the UK, the benefits of specialist care, which is only available in certain centres, would outweigh any detriments resulting fromthe increased travel distances to the centres.

However, there are also some groups of critically ill patients who need urgent but
not specialist care. For example, patients in anaphylactic shock, choking, drowning, or having acute asthma attacks need urgent care that would be the same wherever it is provided.

For these patients, there may be a detriment in having to travel increased distances. Of course, if care for these types of patients, although the same wherever it is provided, were to be of higher quality in high-volume centres,

there might be other arguments for concentrating emergency care in some centres by closing local
EDs. However, although the evidence for improved outcomes at higher volumes is reasonably robust for a few conditions,it is almost non-existent for ED care

The debate between local emergency care and more distant, high-volume or specialist centre care has also confused the issue of hospital bypass with the issue of ED closure. The evidence that some critically ill patients have the capacity to
benefit from specialist care is an argument for bypass, not an argument for closure or restriction of hours of non-specialist centres.

Patients with specialist needs such as burns and serious head trauma are already taken directly or indirectly to specialist centres. The current debate should be about extending the list of patient conditions that should bypass local hospitals and be taken to specialist centres, rather than about the closure of locally accessible 24-hour EDs.

Closure enforces bypass for those patients who would benefit but at a cost for any patients who will not benefit.

Nevertheless, the optimum configuration of local and specialist emergency care centres for an effective and efficient emergency care system is unclear. Research is needed to investigate the benefits of different system configurations rather than the effectiveness of different services.

One potentially fruitful avenue for future research aimed at resolving these issues would be to model the emergency medical system, populating the model based on the epidemiology of emergencies in the UK, and using the available evidence on risks and benefits by distance or time and setting.

CONCLUSION

Decisions regarding reconfiguration of acute services are complex, and require consideration of many conflicting factors.

Our data suggest that any changes that increase journey distances to hospital for all emergency patients may lead to an increase in mortality for a small number of patients with life threatening medical emergencies, unless care is improved as a result of the reorganisation.

However, even then it is not certain that it would be acceptable to trade an increased risk for some groups of patients, such as those with severe respiratory compromise, for a reduced risk in other groups such as those with myocardial infarction.

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Competing interests: None.
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APPENDIX 5

AMBULANCE DATA

The problems centralising A&E at Glangwilli, Carmarthen and removing A&E form Prince Philip Hospital, Llanelli

The more I look at the proposed centralisation of A&E to Glangwilli in Carmarthen the more problems I see.

I'm from a transport background and I'm a National and Internationally qualified transport manager and I also have a Bsc Transport Management degree.

On top of that I spent 25 years as a lorry driver covering both the UK and Europe carrying all sorts of goods.

Carmarthen is basically a transport managers nightmare as due to the way roads narrow into the town it causes bottlenecks in the morning and evening rush hours.

When I went through Carmarthen from Llanelli in November 2010, by coach to give me an idea, the trip through to Glangwilli was a slow stop start journey during the morning rush hour.
Imagine an ambulance travelling under blues and twos carrying a seriously ill patient. If the vehicle tries to get through the town it is stuck, full stop, because even if vehicles pull up onto the pavements the ambulance is still unable to get through.

If this same ambulance tries to go around the town other traffic is trying to do the same and it's virtually grid locked.
The medical services in the UK operate a 'Golden Hour' criteria, this despite Hywel Dda senior management saying otherwise, which entails getting the patient stabalised and into hospital within this hour.

This is another area, 'The Golden Hour', which suggests the centralisation of A&E to Glangwill could cost lives

During the period of February 2010 through to February 2012 Glangwilli dealt with 20.852 emergency patients delivered by ambulance in emergency situations.

We know that during this period Glangwilli A&E was overcrowded with patients spending the nights on trolleys and ambulances stacked outside waiting for A&E beds to become available. Some of these patients were then sent to Prince Philip Hospital due to Glangwill being unable to manage which beggars belief.

During the same period Prince Philip Hospital dealt with 9.114 patients in exactly the same emergency circumstances. THIS IS DESPITE HYWEL DDA HEALTH BOARD TELLING US PRINCE PHILIP HOSPITAL HASN'T HAD AN A&E DEPARTMENT FOR TWO YEARS.

How then, with Glangwilli unable to manage the A&E patients they are getting, will they deal with another 9.114. Simple logic tells that they cannot.

We then come to the extra cost of delivering these emergency patients to Glangwilli because firstly we have the human cost. HOW MANY PATIENTS WILL DIE DUE TO THE GOLDEN HOUR BEING EXEEDED OR ALMOST SO WHEN IT CAN TAKE 45 MINUTES FOR AN AMBULANVE TO REACH GLANGWILLI?

This equates to at least a 75% chance of losing a patient on the journey. There is actually a 68 minute emergency ambulance trip to Glangwilli listed, maybe that patient had died eight minutes before arriving.

The financial cost is broken down like this:

Cost in fuel of sending 9.114 ambulance journeys from Prince Philip Hospital, PPH, to Glangwilli should all A&E services be removed from PPH.

These figures cover from:
February 2010 to February 2012

Ambulance journeys: 9.114
Average round trip: 40 miles
Mileage: 365.560
Average MPG: 15 = 24.304 gallons
Average fuel cost: = £6.00 per gallon
Total fuel Cost of extra ambulance journeys to Glangwilli from Llanelli: = £154.824

This is the extra cost to the West Wales Ambulance Service for the two years we are looking at. It seems to be a case of Hywel Dda handing on the cost to the ambulance service.

I have laid out so everyone can understand the reasons for keeping a fully operational A&E department at Prince Philip Hospital. It's pure common sense that a town the size of Llanelli, the largest patient base in the Hywel Dda area, which also has a growing population, has a hospital that is capable of looking after the medical emergencies we all know happen.

Prince Philip Hospital has been doing this since it opened in 1992.

As the old saying goes 'You don't mend what's not broken'

Tony Flatley 23/03/2012

Developing The Public Health Observatory For Wales
Datblygu Arsyllfa Iechyd y Cyhoedd i Gymru

Hywel Dda
Local Health Board

Demography Profile

Hywel Dda Local Health Board (LHB), covering a quarter of the landmass of Wales[1], is the second most sparsely populated LHB area. 31.4 per cent, 47.9 per cent, and 20.7 per cent of the population live in the local authority areas of Pembrokeshire, Carmarthenshire and Ceredigion respectively.

With 13% of Wales' population the area's age and sex profile is similar to that of Wales as a whole (Fig. 1), but there are notable differences with fewer people aged 25-44 and more people aged 55-79. In rural Pembrokeshire and Ceredigion, there are relatively high numbers of older people. Although the 2001 Census reported that one per cent of the population came from a black and ethnic minority background[4], the effect of migration since this time is more difficult to quantify.

Across Wales and the UK, the general fertility rate, the number of births per 1,000 women of child bearing age, had been falling until 2001/2002. However, it has been slowly rising since (Fig. 2). The Hywel Dda LHB area general fertility rate is lower than the Wales rate but closely reflects the Welsh pattern[5].

Key Statistics	Wales	Hywel Dda LHB
Area size [1]	20,779 km²	5,781 km²
Total population [2]	2,980,000	375,200
Life expectancy at birth - males [3]	76.8 years	77.1 years
Life expectancy at birth - females [3]	81.2 years	82.0 years
Persons per km² [1, 2]	143.4	64.9
% population from ethnic minority background (2001) [4]	2.1%	1.0%
Total number of births [5]	34,572	3,894
Number of deaths [6]	32,148	4,186
% lower super output areas (LSOAs) in most deprived 5th of Wales [7]	20%	10%

Fig 1: Population Pyramid Hywel Dda LHB and Wales
Data source: Office for National Statistics, mid year estimates 2007

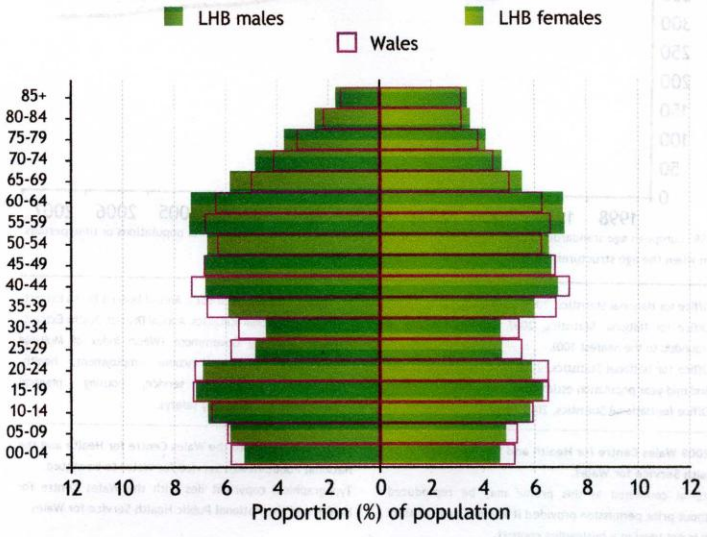
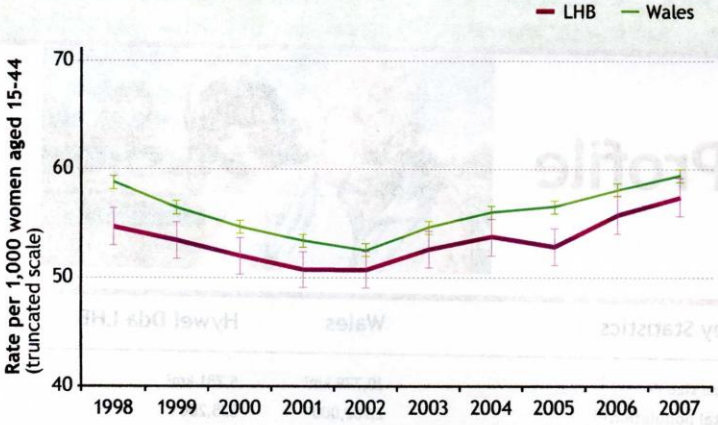


Fig 2: General Fertility Rate trend, Hywel Dda LHB and Wales, 1998 - 2007

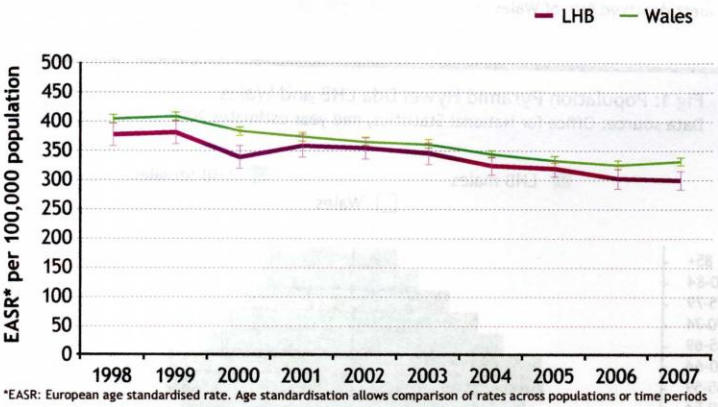
Data source: Office for National Statistics, Annual District Births Extract, mid year estimates



Error bars represent 95% confidence intervals. These reflect how random variation might influence the rate shown. This variation is greater in smaller populations, giving rise to wider intervals (for further details see website).

Fig 3: Under 75 mortality rate trend, Hywel Dda LHB and Wales 1998 -2007

Data source: Office for National Statistics, Annual District Deaths Extract, mid year estimates



*EASR: European age standardised rate. Age standardisation allows comparison of rates across populations or time periods even when the age structures in these populations/time periods are different.

1. Office for National Statistics, 2007 geography.
2. Office for National Statistics, 2007 mid year estimates (rounded to the nearest 100).
3. Office for National Statistics, 2005-07 deaths registration and mid-year population estimates data.
4. Office for National Statistics, 2001 Census.
5. Office for National Statistics, Annual District Births Extract.
6. Office for National Statistics, Annual District Deaths Extract.
7. Welsh Assembly Government (Welsh Index of Multiple Deprivation domains: income employment, health, education, access to service, housing, physical environment, community safety).

Acknowledgement to the Wales Centre for Health and the National Public Health Service for Wales to be stated.
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In Hywel Dda LHB area, the under 75 age-standardised mortality rate dropped by 22 per cent between 1998 and 2007 (Fig. 3). It has remained consistently below the Wales rate. This fall is likely to reflect not only the activities of health services, but also improvements in living standards in Hywel Dda during the latter part of the 20th century.

The greatest causes of death in people aged under 75 among Hywel Dda LHB residents are cancer, circulatory disease and respiratory disease, together accounting for 43%, 27% and 9% of approximately 1,400 deaths respectively during 2007[6].

Geographically based deprivation measures can be used to show inequalities in health and suggest areas likely to most need measures to improve health and manage ill-health. The Welsh Index of Multiple Deprivation 2008 is produced at a small area level called Lower Super Output Area (LSOA), and is derived from a broad range of factors[7].

In Hywel Dda LHB there are areas of deprivation including parts of Llanelli, Pembroke Dock and Cardigan (Fig. 4). 22 out of 230 of the LSOAs in the LHB (10 per cent) are among the most deprived fifth in Wales with 11 out of 230 (5 per cent) in the least deprived fifth. However, within less deprived areas there are often pockets of hidden deprivation.

Current projections see a rise in the older population (75 years and over) of Hywel Dda LHB residents from 35,000 (10% of the total population) in 2006 to 70,000

Fig 4: Overall Welsh Index of Multiple Deprivation 2008

Fifths of deprivation, Lower Super Output Areas.
Data source: Welsh Assembly Government

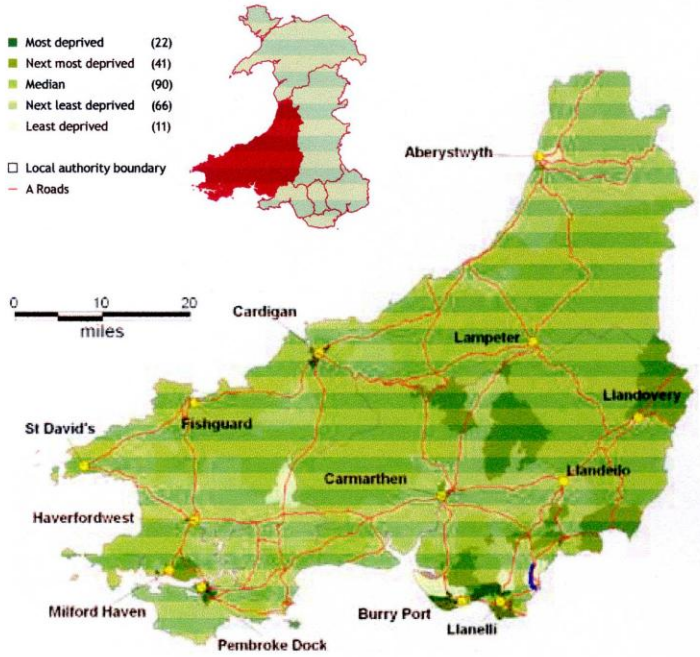
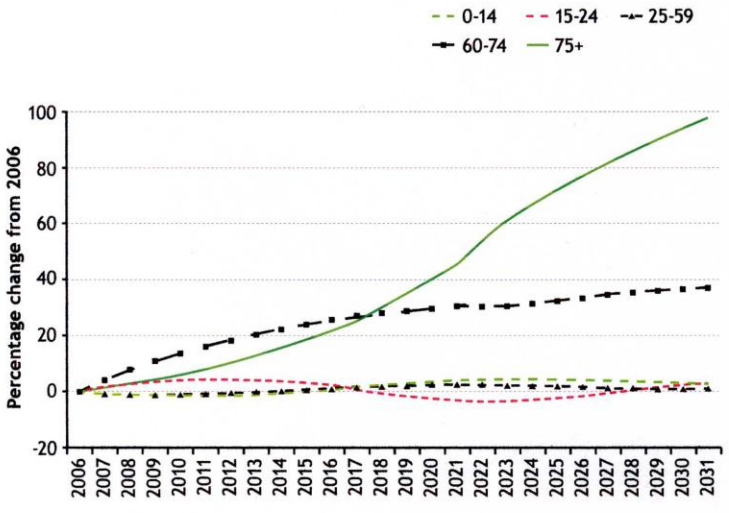


Fig 5: Population projections, Hywel Dda LHB

Data source: Derived from LA Population Projections (2006-based)
Welsh Assembly Government



(16% of the total population) in 2031 (Fig. 5). These estimates are based on assumptions about births, deaths and migration. The increase in the number of older people is likely to cause a rise in chronic conditions such as circulatory and respiratory diseases and cancers. Meeting the needs of these individuals will be a key challenge for the LHB. In the current economic climate, the relative (and absolute) increase in economically dependent and, in some cases, care-dependent populations will pose particular challenges to communities.

Further Information:

More detail on the demography of the residents of Hywel Dda LHB and Wales to accompany this profile is available at *www.wch.wales.nhs.uk*. This includes information at small area level, local variations in mortality and further resources to support LHB work.

This profile presents information for use by the newly formed Local Health Boards of Wales. It has been produced as the first of a series of information products made available by the newly created Public Health Observatory for Wales, a collaboration between the Wales Centre for Health and the National Public Health Service for Wales. LHB requirements will direct future profile development.

Contact us on:
profiles@wch.wales.nhs.uk

Design & Production: STORM | www.stormwc.co.uk

APPENDIX 7

Emails / Letters

I *have to travel from Llanelli to the Neath/Port Talbot hospital for Laser treatment on my skin cancer and now reading in the local paper it looks like i will have to travel to Withybush hospital for any treatment for my Crohns Disease ,Luckily i only have to my G Ps surgery for my diabetic treatment, Why do the Patients have to do all the traveling when the Doctor or consultant could do it*
Geoff Paine, 06.12.11

My dad was diagnosed with cancer. He travelled to Singleton for radiotherapy and West Wales General for clinic appointments, bypassing our local hospital where he had the diagnosis!!

J.Anthony, 24.11.2011

"My Father had an open wound on his leg and he was in agony. His ulcers were weeping and he had shingles. During the ride to hospital he screamed out in pain every time we went over a bump. The staff were extremely concerned at the state of his leg when they unbandaged it and called a Doctor to look at it.

The Doctor came and said that in time it would improve and suggested that as this was a chronic condition my father could have his wound re-bandaged and could be sent back home. I explained that he was in extreme pain and that the journey was an agony for him, siting the shingles that he had as well. I asked could he be admitted for a few days so that he could recover there (remember he was in the Hospital at the time).

The Doctor said that although he would like to admit him, he would have to be booked in at Glangwilli in Carmarthen and then transferred back down to Llanelli.

I was flabbergasted and obviously as my father was not in a fit state to travel in the first place I had to resign myself to the fact that he would be put through more agony on the transfer back to his Residential Care Home. He was 89 years old at the time.

This was not the fault of the people who were treating him to the best of their ability but down to the system that failed both my father and its own staff.

D.M.Cundy, 18.11.2011

I was taken to Glangwili Hospital by ambulance from my Health Centre suffering with chest pains. I was admitted to a "mixed ward" and told I would be kept in overnight.I was very worried as my husband was at home in bed with alzheimers, a heart problem and emphasemia and on oxygen 24 hours per day. I was assured by a staff member that the Carers would be notified and therefore be with him. Whilst I was in hospital I overheard a nurse speaking to a doctor saying "Have you noticed tonight that all the patients admitted are from Prince Philip Hospital. During that night in hospital I got up to go to the toilet and on my way back to the ward I was told that I could not return to my bed because they had an emergency with a man in the next bed. One of the nurses told me to sit by her at the desk in the corridor. They couldn't

get a hoist big enough as he was a big man. I had to sit there all night in the corridor. In the morning the doctor told me I could go home as they couldn't find anything wrong. When I arrived home the following day no one had been and my husband had been on his own for more than 24 hours. A short time later I was admitted to Prince Philip with the same pain.
Anon, 19.02.2012

I am a GP in Cornwall, but I was brought up in Burry Port and educated at Llanelly Boys' Grammar School. I find it incredible that the largest conurbation in Carmarthenshire is being deprived of its A&E Department along with other acute services in Secondary Care. From Burry Port it takes a good 30 minutes to get to Glangwili, whereas Prince Philip is only 15 minutes away. My mother still lives in Burry Port and finds appointments at Prince Philip much easier to get to than Glangwili. This summer she had major orthopaedic surgery at Prince Philip Hospital and neither of us can speak highly enough of the care she received there, both during her admission and post-operatively in the community. I am told that Burry Port people feel that the only thing that matters in Carmarthenshire is Carmarthen, and that the Llanelli area has been completely ignored for years, both in terms of health provision and social infrastructure. This should not be allowed to happen. I have seen similar problems in Cornwall over the last 20 years. Hospital care has been concentrated in Truro, but the West Cornwall Hospital in Penzance still survives despite many attempts to severely downgrade it. This has been achieved through public protest, both in the media and on the streets with mass demonstrations. I suggest the people of Llanelli continue to protest vigorously against these proposals. If there is one thing politicians hate it is losing votes at the next local elections. Good luck with your campaign to preserve services at Prince Philip Hospital
Dr Ian Gethin, 22.12.2011

november 2011 after going to see my G.P. about a hernia i have he sent me from the surgery to be admitted to hospital i asked to be sent to PPH but was told i could only go to Carmarthen as that was the place the specialist was because he thought i would have to be operated on immediately. I arrived at the hospital at 6pm and i had a bed by 11.30 my husband never got home until 12.30am over 7 hours after we left Llanelli .I was in for 4 days can you imagine how much it cost for the family to visit me twice a day and where does the carbon footprint stand now.We think it is disgracefull that we are treated the way we are when we are the town with the biggest population i am a pensioner and when i was younger we payed 2 pence a week from our pay to the hospital fund and i know my parents did before me.I hope you will get the support that our hospital deserves and the people of Llanelli stand up and get counted before it is too late.We have lost our childrens ward our maternity ward and the other ones they are proposing to close now the way it is going there will be nothing left by the end of the year and once they have gone we will not get them back as we know what has happened in the past
Maureen Simonite, 19.02.2012

as a member of staff for pph i have to say that it is now a very unsettled place to work. no one is sure if their jobs are safe or for that matter if their family are...without a viable hospital nearby! which i fear and so do all staff working for this trust is going to be the ultimate outcome NO local hospital!
‘very concerned staff’, 11.01.2012

I currently work at pph and find it very alarming that the proposed future changes are going to put lives at risk. The media coverage state that the a and e department only deal with minor cases as we do not have the facilities to cope with any serious medical or surgical problems. We do on a daily basis deal with acute critical ill patients and have a team of experienced dedicated staff who feel degraded by these comments ,the reason we have not got the facilities to deal with patients is the fact that this service such as surgical and paediatric etc have been taken away, This does not stop the people coming to pph. Many patients have to wait in the department many hours for an ambulance for transfer as the ambulance service are busy dealing with 999emergencies in the community , so how will they cope with the obvious increase in demand ??? I think the powers behind these changes are more concerned with number crunching and are happy to put the lives of the people of Llanelli at risk. They should be thinking of reinstating services not taking more away.
Margaret, 13.01.2012

4 yrs ago I was admitted to glangwilli hospital as an emergency, because there was no option to go to PPH I had to travel 20 miles in pain when I could have been in PPH in 5 minutes where my condition could have been stabilised, this is what was done in carmarthen after which I was sent home to wait 2 weeks for my surgery. On top of this I then had to travel to singleton hospital for radiotherapy every day for 4 weeks and a further 9 wks for chemotherapy. I had wonderful care in both these hospitals but why should I and many others like me have to bypass our own hospital just because the service we require is not provided locally.
Rosalind Pitt, 19.02.2012

The powers that be, have TOTAL disregard as to how patients are supposed to get to Glangwili for their appointments - as many do not have a car, or the money for the transport costs up and back, given that it's a 35 mile round trip - for services that used to be provided locally. People who work are also experiencing problems, as what used to mean a couple of hours off work to come to PPH, now means they have to take a day's annual leave to attend their appointments. This in iteself, causes problems for some patients who work for small businesses, as they do not have cover when their staff take time off - which isn't a problem for the one-off hospital appointment but is a major problem for patients with chronic medical problems, requiring regular hospital visits. No-one in Llanelli should be complacent here, as, at some time or another, IT IS GOING O AFFECT YOU, OR SOMEONE IN YOUR FAMILY and we need to voice our opinions if we want to keep the services we have and bring back the ones we have scandalously lost!
Charmaine John, 23.11.2011

How much more can we take? Save Prince Philip Hospital as soon we will have no NHS, let alone a decent hospital in the area. NHS cuts are wrong and against the principals and spirit of a free health service for all. Only the rich will be able to afford to pay the poor will suffer as usual..
Elio De Filippo, 22.11.2011

A LLANELLI man left stranded at Glangwili when his wife was rushed to hospital had no choice but to walk more than 20 miles to get home.

Adrian Davies, of Old Lodge, trekked along winding country roads from Carmarthen to Llanelli in the dark to get home to his stepson, who suffers from learning disabilities.

His wife Sian was rushed to hospital by ambulance in the afternoon, but by the time Mr Davies was told she would be kept in overnight, the buses had stopped running.

"I went with my wife in the ambulance and I didn't have transport to get back home," he said.

"I walked along the back roads because you can't walk on the dual carriageway, and there were no lights. It was getting dark, but I was more concerned about my wife being in hospital and how she was doing."

Mr Davies, who suffers from diabetes and has a pin in his foot, said he was determined to get home as quickly as possible.

"I had to do it because my stepson was at home," he said. "I had no other choice.

"But it's not just me affected by this — there are a lot of other people who don't have transport."

The 40-year-old fears more and more people could become stranded at Glangwili if services are taken away from Prince Philip Hospital.

"This is one of the major difficulties," he said. "People will be going to hospitals long distances away, and not having the transport to get back.

"I could have walked back from Prince Philip Hospital in less than half an hour, but it took me a few hours from Carmarthen.

"We only have one or two ambulances in Llanelli, but we have a huge population.

"I don't know how they will manage if everyone has to go to Glangwili for emergencies.

"There's not enough time in life — if there's something wrong with you, you need to be in hospital as quickly as possible."

A Hywel Dda spokeswoman said the health board "regretted" to hear about this situation, and said it showed why the board was working with partners to improve transport services.

"We would like to make it clear that there are a range of innovative non-emergency transport schemes currently in place, or being piloted, for patients within Hywel Dda Health Board," she added.

Llanelli Star 12.03.2012

A LLANELLI man was left stranded on crutches at Glangwili Hospital in the small hours after being taken there for emergency treatment.

Aled Rees, of Morfa, was left without money or a phone after he was taken to Carmarthen by ambulance when he started vomiting blood.

The 21-year-old was taken some 24 miles away, despite asking to be taken to Prince Philip Hospital, which lies three miles from his doorstep in Granby Close.

And he said he feared that his situation could be commonplace if plans to take accident and emergency services away from Prince Philip Hospital go ahead.

"I was literally stranded without anywhere to go," he said. "I called for an ambulance at 8.30pm and was taken to Carmarthen.

"I asked if I could go to Prince Philip Hospital but they said I had to go to Glangwili — I was too faint to argue so I had to go along with it. I was in the hospital for a few hours before they diagnosed me with stress and told me to leave at 5.30am.

"It was the middle of the night, freezing cold and I only had a T-shirt and a pair of joggers on.

"I didn't have a clue how I was going to get home — I didn't have my phone or any money, there was no public transport running and I was on crutches due to a knee injury.

"It was a scary situation and I didn't know what to do. I actually thought I would have to sleep rough."

As luck would have it, Mr Rees was able to borrow a mobile phone from someone outside the hospital to call his sister-in-law, who lives in Johnstown.

“She happened to be up anyway with her newborn baby and she came to pick me up,” he said.

The former Coleg Sir Gâr student said he was worried he may find himself in the situation again.

“I am due to have an operation on my knee ligaments, and I haven’t been told whether it is in Llanelli or Carmarthen,” he said.

“If I have to go to Carmarthen for treatment I may not be able to get home again — it’s really worrying.”

Last week, the Star reported on the case of Adrian Davies, who was left stranded at Glangwili when his wife was rushed to hospital.

Mr Davies, of Old Lodge, said he had no choice but to walk all the way back to Llanelli to get home. He trekked along winding country roads from Carmarthen in the dark to get home to his stepson, who suffers from learning disabilities.

Like Mr Rees, he too fears more people could end up stranded at Glangwili if PPH loses further services.

“There are a lot of other people who don’t have transport,” said Mr Davies.

A Hywel Dda Health Board spokeswoman offered no explanation why the patient was taken to Carmarthen, rather than Llanelli. She said: “We regret to hear about the situation this patient found themselves in.

“This demonstrates why the board is working with partners to improve transport services in our area and it is a key part of discussions currently ongoing as part of the listening and engagement exercise.

“We would like to make it clear that there are a range of innovative non-emergency transport schemes currently in place, or being piloted, for patients within Hywel Dda Health Board. We would encourage this patient to contact us directly in order that we can fully investigate the situation.”

A Wales Ambulance Service spokesman said: “We work closely with our health board partners to ensure we take patients to the most clinically appropriate healthcare setting as suited to the patient’s need.

“We are more than willing to discuss this particular case with the individual or family concerned in this matter should they wish to contact us directly.”

Llanelli Star 19.03.2012

A LLANELLI pensioner was forced to lie on the street with a fractured arm and broken nose for 90 minutes before an ambulance arrived, his wife claims.
Evan Jones, 87, tripped and fell while out with his wife Eurwen, suffering a nasty cut across his head, a cracked bone in his nose and a compound fracture in his arm.
Passers-by stopped to help the former school master and his wife, who said several calls for an ambulance were made.
But an hour-and-a-half later, Mrs Jones said her husband was still lying in agony on the wet pavement waiting to be taken to hospital. When the ambulance did turn up, Mr Jones was taken to Glangwili Hospital, rather than Llanelli's Prince Philip.
"The whole time he was there he was bleeding from his head wound and his nose. He was in a bit of a state, an awful lot of pain and couldn't move his arm," said Mrs Jones.
"It was horrifying to have to stay there and watch him.
"The pavement was wet, it was windy, and to make matters worse it was raining. There were people coming by saying, 'You're not still here?'. They were horrified.
"He kept on saying, 'How did I get here?' and he can remember people saying the ambulance will be here in a minute - he said he has never had such a long minute."
Mrs Jones, of Gilbert Crescent, has thanked kind-hearted members of the public who came to offer their help during the Inkerman Street ordeal.

"There were some wonderful neighbours there and people passing in cars, and they brought duvets and umbrellas for him to keep him warm and dry," she said.
"There was an absolutely marvellous woman there called Lizzie, from Denham Avenue, who stayed with him the whole time.
"If anyone deserves a medal, she does. He could have lost consciousness - he did for a while - but she put him in the recovery position and talked to him the whole time to make sure he was OK. That poor soul shouldn't have had to stay there on her knees in a thin blouse for an hour-and-a-half, but she did."
When an ambulance arrived, Mrs Jones said the driver and paramedics were "wonderful", but added that everyone who witnessed the incident was "incensed" at the delay.
"It shouldn't have happened," she said. "It wasn't any human fault, it was the fault of the system.
"There aren't enough ambulances for the size of the town and if one is caught up at hospital or delayed then it is out of action. Because they have to go to Morriston or Glangwili it takes time. In the time it took us to get to Glangwili they could have done at least three trips to Prince Philip Hospital if it was in full operation - and it should be."
A Hywel Dda spokeswoman said: "A patient's clinical needs will always be assessed in accordance with established procedures in place with the Wales Ambulance Service to ensure appropriate immediate care is provided. The patient will be taken to the nearest hospital with the service in place to provide the right treatment as soon as possible."
An ambulance service spokesman declined to comment on individual cases, but added: "We are continuing to improve our ambulance response times across Wales year on year, achieving national performance targets. However, we recognise there is more work to do."

Llanelli Star 14.09.2011

A RUGBY player who broke his ankle during a match in Burry Port had to endure an hour-long wait for an ambulance in the pouring rain.
Paul Mason, a player for Laugharne RFC, was playing against Burry Port RFC on Saturday, March 3, when the incident happened.
To add insult to injury, the sportsman was then taken 16 miles to Glangwili Hospital instead of Prince Philip Hospital in Llanelli, which lies only six miles away.
Laugharne RFC secretary George Phillips labelled the incident "horrific".
"They took around 50 minutes to get to the game," he said. "It was bucketing it down with rain and he was in agony.
"We were unable to move him, which meant the game had to be delayed.
"When the ambulance finally turned up I asked them where they had come from and they said Tumble.
"I thought they were going to say Haverfordwest, which would have explained the long wait.
"They also told me that the call had been downgraded because it wasn't life-threatening.
"He had dislocated his ankle and broken his fibula. It was awful."
A spokesman for the Wales Ambulance Service said it regretted the long wait.
He said: "We very much regret that at the time of this incident we were experiencing a very high number of calls and extended hospital handovers, which resulted in the delay of the ambulance attending the scene.
"However, as soon as the first ambulance did become available it was dispatched immediately.
"While we cannot go into the details of individual cases, we would be more than willing to discuss this further with the person concerned."
Asked why the casualty was taken to Glangwili Hospital instead of Prince Philip, the spokesman said: "We work closely with our health board

partners to ensure that we take patients in our ambulances to the most clinically appropriate healthcare setting as suited to the patient's need."
A Hywel Dda Health Board spokeswoman said: "It would not be appropriate to discuss an individual's medical history through the media. If the patient has any concerns we encourage him to contact us directly."

Llanelli Star 14.03.2012

AN elderly woman from Llanelli who died after a car crash last week has been described as "full of fun".
Kathleen Bowden, 87, died last Wednesday after the car she was travelling in was involved in a collision with another vehicle in Pwll Road in Moreb. She was taken to Glangwili Hospital suffering from neck injuries but died shortly after the incident.
A Dyfed-Powys Police spokeswoman confirmed an inquest into Mrs Bowden's death had been opened and adjourned.
Judith McIlroy, manager of the Haven Residential Home in Llanelli, where Mrs Bowden had lived for the last three years, said she would be sorely missed by all the residents.
"Obviously we are very shocked and saddened by what happened," she said.
"Kathleen was a lovely lady.
"She was very outgoing, always full of fun.
"Everyone is deeply shocked and saddened about what's happened - it was a massive shock.
"This was the last thing we expected."
Mrs McIlroy added that Mrs Bowden was very close to her sister.
"They used to go shopping," she said.
"I believe they were going out for a picnic when the crash happened."
Mrs McIlroy said she was well-known by all the residents at the home and regularly took part in activities there.
"Whether we were going out ourselves or having a concert in the home, she was always the first," said Mrs McIlroy.
"The home is still coming to terms with it at the moment.
"Obviously our thoughts are with her sister who we understand is still in hospital."
Mrs McIlroy said Mrs Bowden's funeral was currently being organised and a date was yet to be set.
A Wales Ambulance Service Trust spokeswoman said a second patient - believed to be Mrs Bowden's sister - was taken to hospital shortly after the accident, suffering a possible fractured ankle and an arm injury.
The fire service said a third person was treated at the scene as a precaution.
An eyewitness to the crash last week said one of the casualties had to be cut from the vehicle.
College student Joanne Rees, 18, was on her way home shortly after the incident when a road block was put in place.
"The road was in chaos. There were three ambulances, three police cars and two fire engines there, and we could see someone being cut out of a car," she said.
A fire service spokeswoman said two crews from Llanelli spent just over an hour at the scene.
She said: "One female adult was removed from the vehicle by the fire service using a spinal board."

Llanelli Star 03.04.2012

A LLANELLI grandmother says she is only alive today because of prompt lifesaving action by medics at Prince Philip Hospital.
Linda Jenkins, of Bryn Road, suffered a heart attack on February 28, 2012, which meant she needed urgent attention at PPH.
"If it wasn't for Prince Philip Hospital being there I wouldn't be here today to tell the story," she said.
"They saved my life. There's no doubt about it - I was told if I had had to go to Morriston or Glangwili, I wouldn't be here.
"It's vital for my children and grandchildren that this hospital remains open.
"I just collapsed. God knows what would have happened if it wasn't for Prince Philip Hospital."
She branded current health board proposals to downgrade its accident and emergency department to a potentially part-time, nurse-led unit "scandalous, terrible".
Health bosses insist they would not consider unsafe solutions as they strive to make the most of scarce resources, but Mrs Jenkins, who has four grandchildren, said: "They are playing with the lives of people."
The 63-year-old was rushed to PPH after complaining of chest pains at Vauxhall Surgery.
Her daughter, Anna, 40, said: "It took two-and-a-half hours to stabilise her - that's how bad the heart attack was. She was a week and a half in intensive care."
The family shared their experience with Llanelli councillor Winston Lemon, who said the case highlighted the need to retain full hospital services in such a densely populated area.
"Without it, Mrs Jenkins could have lost her life," he said.
"She would have been forced to travel to Morriston or Glangwili.
"It only strengthens the argument to keep the A&E open in Llanelli, where the biggest population in Carmarthenshire live.
"Let this be a message to Hywel Dda and the Welsh Government to keep these facilities open and available to the people of Llanelli."
A Hywel Dda spokeswoman said: "The health board is clear that our services must meet safety and quality standards.
"Adult medical emergencies, such as cardiac and respiratory arrests and stroke, are dealt with at Prince Philip Hospital 24-a-hours a day in collaboration with the clinical decisions unit.
"Future provision of these services is currently part of our listening and engagement process. Absolutely no decisions have yet been made but we are clear that no change is not an option.
"The people of Llanelli can be reassured they will continue to benefit from being served by three hospitals in the locality, Prince Philip, Glangwili and Morriston Hospital which has a specialist cardiac unit containing the latest technology which provides patients with the best possible outcomes.
"The funding challenge in the public sector, and particularly in the NHS in Wales, has been well publicised and cannot be ignored.
"The challenge we all face is to make sure we are making the best use of scarce resources," she added.

Llanelli Star 11.04.2012

APPENDIX 8

Urgent Care Centre

Urgent care centres 'putting patients' lives at risk', doctors warn

The introduction of medical centres designed to ease the pressure on overstretched A&E departments is putting patients' lives at risk, doctors have warned.

The College of Emergency Medicine, which represents A&E doctors, said that it is concerned that "urgent care" centres are acting as a barrier, preventing seriously ill patients from getting the treatment they need.

It found that two patients have already been put at risk after staff at such centres failed to correctly diagnose their symptoms.

In one case, a man who had a stroke was sent home from an urgent care centre because staff could not work out what was wrong. He was eventually admitted to hospital and recovered.

In another incident, urgent care centre staff failed to spot that a baby had meningitis. Emergency treatment was delayed but the child made a full recovery.

John Heyworth, president of the CEM, said: "These are worrying examples of things going wrong in urgent care centres.

"In emergency departments we are used to seeing patients who may develop serious complications.

"We want to make sure GPs appreciate the risks and handle things very carefully.

"Speaking to colleagues around the country, our concern is that having a barrier to people actually getting in to A&E is not helpful."

He added: "Patients tend to know when they are very sick and although around 10 to 20 per cent of patients may use the service inappropriately, the majority will go to their GP if they have a minor problem."

Dozens more of the centres are due to open to prevent patients with minor ailments clogging up emergency departments.

Discussions to set up urgent care centres, which are particularly used for out-of-hours care, are under way at almost all of the UK's 270 A&E departments.

Schemes are already running in Maidstone in Kent, Portsmouth and South-East Hampshire, Huntingdon in Cambridgeshire and Nottingham.

Dr Heyworth said: "In some cases, where they sit alongside A&E they can work very well, but it is no good imposing them on hospitals and preventing patients from actually getting in.

"Another big worry is that money that should be going into hospital emergency departments is being diverted into these urgent care centres."

Those in favour of the introduction of the centre claim that by preventing 15 "inappropriate" attendances at A&E per day a local primary care trust could save £328,000 a year.

If three patients a day were stopped from being admitted to a ward when they would be better off at home, a trust could save £6,000 a day, or £2 million a year.

The Department of Health has published a number of strategy documents, including the Direction of Travel for Urgent Care, which make clear that the creation of more urgent care centres is seen as the best way to improve service to patients.

Dr Richard Vautrey, of the British Medical Association's GPs' committee, said: "We should not assume that GPs are less able to assess risk but we need to recognise that patients themselves are usually able to select the area of the health service they need to access, depending on the severity of their condition."

A Department of Health spokesman said: "Urgent care centres play an important role in providing emergency care for non-patients without taking up valuable A&E resources.

"It is for local NHS organisations working with local people to decide whether urgent care centres are a good idea when organising their services.

"We have been clear that any changes to existing services should be based on what is best for patients."

A three-day conference of the CEM in Brighton this week will give doctors from around the country a chance to discuss their concerns over the scheme.