Bellis-Jones Hill
HEALTHCARE MANAGEMENT SOLUTIONS

Mr Mark Galbraith
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Dear Mr Galbraith,

As requested we have been reviewing the papers you sent us and the arguments they contain for further reducing the A&E provision at PPH. Your requirements are

- A precursor assessment of the extent to which the information is acceptable.
- An understanding if it stands up to scrutiny
- The identification of any gaps preventing your drawing up alternative options.

Our comments and recommendations are set out below.

RELEVANT BACKGROUND

Hywel Dda Health Board (HD) considers the difficulties it is experiencing in recruiting and maintaining adequate numbers of experienced A&E staff plus general financial pressures mean it cannot provide full Accident and Emergency services at its main hospitals. This has been exacerbated at PPH because services have been cut back in recent years to the extent that HD is now able to claim it cannot reasonably provide a full A&E service at PPH because the required back-up services, principally emergency-surgery and paediatrics, are not now available on-site. PPH undertakes only elective general surgery. In 2006 a Royal College of Surgeons review recommended emergency and elective surgery should be split and HD subsequently decided all emergency surgery should be undertaken at Glangwili Hospital due to its inability to sustain services on no sites.

A number of consultations have taken place and documents published, notably the Technical Document - Emergency and Urgent Care v8 Draft 3rd August 2012 which outlines their options, main conclusions and recommendations. The A&E facility at PPH is currently provided 8am to 10pm by consultant, middle grades and junior doctors and otherwise by GPs. All the options put forward as feasible by HD propose that A&E at PPH be downgraded to an Emergency Nurse Practitioner-led Urgent Care Centre (UCC) and the senior staff be transferred to provide viable A&E services at other hospitals.

HD's plans do not appear to involve a further general downgrading of PPH's capabilities. There is a proposal, soon to be decided, to develop an Orthopaedic Centre of Excellence in the south of HD's area providing leading edge orthopaedic services for those who live in Carmarthenshire and Pembrokeshire and increasingly from other parts of South Wales. In addition to a range of upper and lower limb surgical services, this centre will be co-located with a leading edge rehabilitation unit. Though there are two options for the location of this centre, HD states PPH is its preferred option as it already operates successfully as an elective centre for inpatient

orthopaedic services and has the capacity and facilities available to operate in a safe and effective manner, and has the space available to develop a new short stay unit on the same site

QUESTIONS TO BE ASKED

The Technical Document advances arguments for and against the options presented. Some of these are detailed below together with questions that we suggest you ask HD.

Service Profile

1. ***Analyses of PPH A&E Attendances***
    1. Statistics appear to substantiate the success of the current regime where the ambulance service, WAST, route surgical emergencies to Glangwili (Fig 8). A lower percentage is admitted - probably understandably in the circumstances.
    2. They analyse Carmarthenshire attendees (fig 12) but not in detail for Llanelli. You should request the data for Llanelli as this might show
        1. Different proportions and indicate Llanelli's service is not as "good" as the county average.
        2. The extent to which Llanelli residents routed to Glangwili fail to meet the 'Golden Hour' requirement for those conditions where this is important (e.g. heart attacks and stroke). The time taken to reach appropriate professional care (which we accept can start in the ambulance but is likely to involve A&E) can be critical. HD's risk assessment must have covered this already and they should have a good idea of the impact of expected longer journey times (and the current routing of surgical emergencies to Glangwili) on mortality and outcomes.
        3. As around 80% of PPH A&E attendances are minor the impact might not be as large as people expect.
    3. Our experience of English NHS data indicates that it should be relatively easy for the hospitals to analyse A&E attendances by patient postcode and by the conditions presented by patients on attendance.
2. ***Emergency attendances at Minor Injuries Units***
    1. Fig 13 shows 7% of total emergency attendances at minor injuries units within HD's area are followed up at a full Emergency Department on the same day. You should request the PPH data as this is a problem that is likely to escalate with a Nurse Practitioner-led service. You might ask what their experience is of this happening with such units.
3. ***GP provision of minor injury & wound care***
    1. If PPH A&E services are perceived as being less capable (it is the intention to better inform the public that they are) and it is a long way to a full ED then demand for GP services is likely to grow.
    2. You should try to obtain HD's assessment of the impact of their proposed changes on GP services capacity to determine if there is a likelihood of a poorer service from GPs and if the load on PPH UCC is sustainable.
4. ***Ambulance Information***
    1. We found this analysis confusing as we expected to see AS1and AS2 movements to Glangwili in the tables - there are none we can see but we understand surgical emergencies are taken to Glangwili.

2. We suggest you query this and also request an analysis of WAST journeys from the Llanelli area to PPH and each other hospitals by type of condition so you can better understand the impact on Llanelli residents of a further loss of A&E services and the potential for sending patients to other hospitals as a routine, even to hospitals out of HD's area.

5. ***Analysis of June & November attendances at PPH A&E***.
    1. This analysis covers 2 months and has some detail including postcode data.
    2. If HD's options are accepted then emergency medical patients will attend a nurse-led service. PPH has a significant number of medical admissions. It is not clear from the information provided how admissions will be authorised and by whom. We assume senior doctors (at least at Registrar level) in the Specialties will make this decision. There must be a risk that a nurse-led facility may miss more serious cases requiring admission than if assessed by a more senior doctor.
    3. Fig 20's commentary shows almost 25% of patients were transferred by 999 or 998 call. It is not clear if this indicates they came in wrongly on 999 (routed to an inappropriate hospital) or were transferred for a higher level of care (998) or were self-referred to an A&E that could not treat them. This should be followed up.
    4. DGH transfers (a confusing table as there is no explanation of the ways the transfers go in the chart) again show no transfers from PPH to Glangwili yet there must be some.

6. ***Out of area and out of hours***
    1. Fig 21 shows patients taken directly to out-of-area hospitals such as Morriston Swansea. An analysis by source would be useful. Patient postcodes should enable this and you can then see those coming from the PPH area.
    2. Fig 22 shows out of hours analyses. Significant numbers of Carmarthenshire patients are admitted. There appears to be no analysis of PPH versus Glangwili as calls are taken by phone and not hospital. We suggest you ask for a post code analysis of this data to determine the likely impact on a nurse led UCC. Analysing this post code analysis by conditions presented by patients would also be useful to better understand the demands on urgent care services.

7. ***Workforce***
    1. The dangers and impact of thinly spread emergency doctors is well understood.
    2. The commentary refers to Enhanced Nurse Practitioner (ENP) staff using their skills to better effect, using advanced skills and cost-effectively releasing medical staff time for more complex cases.
    3. However, PPH's current emergency services have access to senior staff in A&E. There will inevitably be a greater risk with an ENP-led service where there is no senior doctor in charge. There is a difference between having a senior doctor (ST4 or above) in charge of a service and having access to senior staff for difficult decisions. Also at night the service will be covered by Enhanced Role A&E GPs - again another significant risk area.
    4. New GMC standards are quoted as stating FY2 trainees cannot work out of hours without on site supervision. Yet the proposal appears to be that an ENP leads the service for many hours that normally might be considered out of hours (up to 10pm) before GPs take over.

8. Comparing against standards

1. There is a recognition of severe recruitment difficulties. "Thinly spread professional knowledge makes it difficult to share clinical experience when for example a second opinion is needed".
2. We suggest HD be asked how they plan to use electronic medicine, particularly Skype, to allow ENPs to access senior support and advice and for senior staff to 'examine' patients presenting with difficult to resolve conditions. This approach could be useful whatever decisions are taken on PPH A&E services.

9. Emergency and Urgent Care Options

1. The options identified by HD for the hospitals in its area are set out and evaluated.
2. Options 1, 2 and 3 are presented as viable.
3. They identify likely car travel times to Glangwili. This can be important as identified above.
    1. Option 1 (one ED at Glangwili) indicates 22% will take longer to get to Glangwili. This seems a significant risk
    2. Option 2 (one ED at Withybush) indicates 55% will take longer to get to Glangwili. This seems a very significant risk
    3. Option 3 (three EDs but a UCC at PPH) indicates as might be expected that 22% will take longer than 60 minutes. This is a significant risk although it is suggested the impact may be mitigated by the proximity of Carmarthen and new communication initiatives. They say they would have the ability to achieve the golden hour for 100% of the population though their data do agree with this.
4. These options though should result, they say, in better services being available at better staffed ED departments.

Other points

1. The whole document generally considers just the hospitals within HD. There is mention of the Regional Trauma Centre 8 miles away from PPH at Morriston General Hospital. This begs the question as to whether emergency care should be delivered to the population of Llanelli by the A&E at Morriston rather than, principally, Glangwili. Though HD might consider this a heresy, we would suggest that as representatives of the people of Llanelli, the Council should not consider it bound by HD's limitations and it might wish to explore this as a viable option. Figures in the Technical Document show 1153 attending Morriston from Llanelli - this should not be relied on as WAST would route surgical emergencies to Glangwili, not Morriston. If Morriston were a preferred destination the numbers might be considerably higher and the service better - especially as regards the 'Golden Hour'. Revenue would have to follow the patient to fund the extra demand for Morriston's facilities but that should be seen as a problem for HD and not for the people of Llanelli.

2. The possible introduction at PPH of an Orthopaedic Centre of Excellence and a leading edge rehabilitation unit may significantly change the context and tone of your arguments. Demographic changes are such that there are proportionately more older people many of whom suffer orthopaedic trauma and would at present require transfer to Glangwili for major surgery to repair say a fractured neck of femur. If PPH has this new facility presumably fewer patients would be routed to Glangwili and more to PPH. We recommend you pursue this with vigour.

RECOMMENDED APPROACHES

Having looked at the data and the analyses provided it seems to us that Llanelli Rural Council is faced with three options:

a) ***Pursue the argument (and analyses) with HD in an attempt to maintain the current status quo (at minimum).*** This is not an entirely satisfactory option but we feel that it would be quite hard (politically and possibly practically) to reverse the past decisions to reduce the range of services and related staff at PPH. Pursuit of such an option may also be reasonably expensive in terms of professional services and take some time and with no guarantee of success.

b) ***Examine the practicalities of adopting an Emergency Nurse Practitioner-led Urgent Care Centre (UCC) but negotiating the option of sending the more serious A&E cases to the A&E/Regional Trauma Centre at Morriston Swansea.*** This is only eight miles away and will be a lot less remote for some patients than Glangwili, and it will much improve achievement of the "Golden Hour" target as well as simply being more accessible and convenient. As already observed, this option may not be popular with HD as some funding for the increased use of Morriston A&E would almost certainly be diverted to it from HD. However, if patient care is seen as the guiding need, then how the funding is channelled should be seen as being of secondary importance.

A further development of this could be to negotiate to allow individual patients to opt for Glangwili or Morriston in the event they are advised, possibly by WAST staff, that equally good care would be provided by either hospital and travelling distance/time is a key factor for the patient and relatives.

c) ***Accept the proposals that are the subject of the HD consultation.*** This is clearly the HD-preferred option. However, we believe that while it may be convenient for HD it also carries the potential for considerable long-term risk for the population of Llanelli that has yet to be fully rigorously and objectively assessed and communicated. For this option to be even remotely acceptable, such a rigorous analysis needs to be undertaken and accepted.

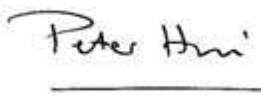
We suggest you propose the analysis be carried out, or at least reviewed, by an independent panel of experts. It could be appointed by HD, who would fund it, but the membership must be agreed with Llanelli Rural Council. Only if they are then persuaded of the merits of the arguments should the Council consider accepting this HD option. The merit of this option is that it puts the

onus on HD to make their case in the “court of public opinion”; something that they have yet to do convincingly.

We hope that this document assists the Council in its deliberations and we would be happy to assist further if invited. Please do contact me directly if there are any matters of calcification that we can assist with.

We look forward to hearing from you.

Yours sincerely,



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