Consultation Response

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Sosppan

Pwyllgor ar gyfer Gwella Gwasanaethu Ysbyty

Hydref 2012 **October 2012**

Community Services and Primary Care

At a simplistic level, the Hywel Dda Health Board's proposals make good sense in maximising the contribution of GP surgeries towards the health provision of the local community and bringing such care closer to the patient. In reality, such a move depends entirely of the ability and willingness of GPs to fulfil the additional obligations which will inevitably be placed upon them. There is significant evidence that GPs are struggling to meet their current commitments: the waiting time to see a GP in Llanelli means that patients are forced to self-present at the A&E department of Prince Philip Hospital for attention and in so doing, exacerbate the workload on the already overstretched staff of that department. The alternative for the patient, however, is to wait for weeks to see a GP – by which time they have either recovered naturally, or died! If additional GPs are to be recruited to meet the need, it begs the questions as to where these individuals are to be found and where the funding is to come from to support such an initiative. It also has major implications for the time frame for the implementation of any proposals.

Hospital Services - Women and Children Services

SOSPPAN welcomes the intention to develop a Paediatric High Dependency Unit and a Level 2 Neonatal Unit, co-located with a Complex Obstetric Unit. Such facilities are long overdue within the Hywel Dda LHB region. We clearly would urge that these facilities should be as close as possible to the centre of greatest population with the greatest concentration of young women and the highest level of social deprivation: of the alternatives offered we would therefore reluctantly have to support the Glangwili option, whilst preferring to have such facilities available Llanelli.

Hospital Services – Emergency Care

Neither Option A nor Option B provides what is necessary to meet the emergency medical care that the Llanelli region requires.

With the largest, most urban, most industrial and most socially deprived area within the Hywel Dda catchment, Llanelli must have, at the very least, an accident unit led at all times by a doctor of grade ST4 or above, supported on-site with 24-hour access to Acute Medicine, Level Two Critical Care, Non-Interventional Coronary Care, Diagnostic Radiology including X-ray, ultrasound and CT Scan, Essential Laboratory Services including biochemistry, haematology, blood transfusion, microbiology and infection control, together with mortuary services. The current proposal has no credibility as a solution for a town of the size and nature of Llanelli.

The recently published PPH Factsheet on Prince Philip Hospital defines the Emergency Medical Admissions Unit in terms which are welcomed and which, if combined with an Accident Centre operated as described above, would meet the needs and aspirations of the community.

Hospital Services – Planned Care

We support the development of an Orthopaedic Centre of Excellence at Prince Philip Hospital, with its proximity to training centres further east providing a ready source of expertise.

Further Comments

NO CHANGE TO ANY ISSUE INCLUDED IN THIS CONSULTATION SHOULD BE INITIATED UNTIL A THOROUGH, INDEPENDENT AND AUTHORITATIVE RISK ASSESSMENT HAS BEEN CARRIED OUT AND BEEN SUBJECT TO PUBLIC SCRUTINY.

The Longley Report and SOSPPAN

We welcome and applaud the thoughtful contribution to the national debate on the most efficacious configuration of hospital services in Wales, which has been produced by Professor Marcus Longley, a greatly respected contributor in this field. The political controversy shrouding his report should not be allowed to detract from the content and the closing paragraphs of his conclusions are paramount:

"Through this review of the evidence, two themes recur. First, the evidence is seldom so unequivocal that the answer is immediately clear. It therefore requires interpretation and application to particular circumstances, and needs to be set in the context of the complex inter-dependencies which are typical of modern healthcare, both in hospital and outside. Second, health policy is usually about working out acceptable compromises between competing objectives – quality and safety, accessibility, cost.

Hence this paper – an attempt to present the non-specialist reader with a summary of what the evidence does support, so that he or she may make up their own mind"

Professor Longley repeatedly emphasises in his report that evidence is "frustratingly vague, inconclusive, contradictory, or simply non-existent" and does not always point to a single answer. "Readers therefore have to weigh the evidence for themselves, taking into account the interpretations placed upon it, and applying their own common sense."

We in SOSPPAN would reiterate our contention that whilst 'no change' is not an option, 'wrong change' would be the worst possible outcome for future generations within Wales.

Professor Longley notes that only six of the thirteen Accident and Emergency Departments in Wales have provided data. **The Hywel Dda Health Board is one of those which has failed to supply such data**, and Prince Philip Hospital, Llanelli is not recognised as even possessing an A&E department, despite assurances to the contrary from the Minister for

Health and Social Services. In any event, Professor Longley notes that "all of these data are beset by a variety of definitional and quality issues, and all should be treated with caution".

He states ".....experts are not always right, and their opinions should be treated with caution".

Professor Longley notes that in General Trauma and Emergency Care it is not the size of the unit that matters but rather the compliance with clinical standards within the unit, whatever its size. Indeed, he observes that **"smaller hospitals often show better compliance" but that outcomes are better "where senior doctor cover is available 24/7".**

We would suggest that our strategy, as set out in the pages that follow, of establishing Centres of Excellence in all of the Hywel Dda hospitals to support parallel A&E and Urgent Care Centres sits well with Professor Longley's observations.

Another approach would see the merit in situating major fully functional A&E and Urgent Care Centres in the three major centres of Bronglais, Withybush and Prince Philip Hospital. A Community Hub based at Glangwili Hospital would cater for minor injuries within the small rural community it serves. This scenario should be a part of the general discussion.

Professor Longley's observations regarding Stroke Care are critical as the incidence of Stroke within our increasingly aged population becomes greater.
In areas such as Maternity and Paediatrics he finds no evidence of a consistent relationship between outcomes and size of unit from the published research.

There is good evidence to link positive patient outcomes after surgery with individual surgeon volume rather than hospital volume and the concept of clinical networking is supported, again in line with our 'Alternative View' proposals.

In considering the relationships between other determinants than volume in considering patient outcomes, Professor Longley concludes that "Many of these factors are unrelated to hospital size; others can be correlated with hospital size, sometimes inversely.....hospital configuration.....is never sufficient in itself".

In all, we would argue that this report supports our argument that the blind stampede towards centralising Hywel Dda services in Glangwili is unwise, unwarranted, unwanted and unnecessary.

We have argued our case for reducing rather than extending the distances that patients and visitors have to travel. Professor Longley is unequivocal:" The location of services - and therefore travel time - .....can literally be a matter of life and death".

He goes on ".....the issue with the greatest impact for most patients is the adequacy of non-emergency transport.....for patients and.....their visitors". We have ourselves highlighted this issue and suggested strategies to meet the needs.

It was not in Professor Longley's remit to consider the interface between medical and social services and we would value his views on our proposals regarding the provision of on-site convalescence / rehabilitation units and community support for the elderly but we are

satisfied that our holistic proposals fit well with Professor Longley's overall observations and extend his general philosophy into the broad community.

A problem of this scale requires a solution that meets the needs of the Clinicians, provides for the safe and economical delivery of essential services to the Stakeholders and suits the needs of society including ease and speed of access to unplanned needs as in the case of Accident and Emergency Services.

It is our view that this truly all Wales problem requires an all Wales solution and that piece-meal introduction of inadequate measures to individual Health Boards precludes a satisfactory outcome for all parties concerned.

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.

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

There are four District General Hospitals located in the Hywel Dda area for good reason. It is because the demographics have required this in the past. Current housing and social mobility surveys underline that there is a clearly established trend towards an increasing urban population in the east of the region with a steadily decreasing rural population elsewhere.

Llanelli (PPH) has been in the vanguard of changes that are proposed throughout the NHS, particularly in 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.

Over one thousand patients from Llanelli and Burry Port have had their provision moved at short notice in an exercise which was 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.

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

However, the flawed centralisation policy that has been imposed on the large urban population of Llanelli means that they are in the position of actually getting a reduced service under the guise of improvements.

'Centralisation' should, of course, take into account population levels and not just geography!

Failure of the Operational Delivery

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.

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.

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 how links across to the Surgeries, GPs, the Private or Public Sectors could be achieved in terms of staffing, resources or funding.

CIHS / SOSPPAN Proposals

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. 31% of the Population lives in an Urban Environment whilst the remaining 69 % live in Rural Areas.

The Building Blocks

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.

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.

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.

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.

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.

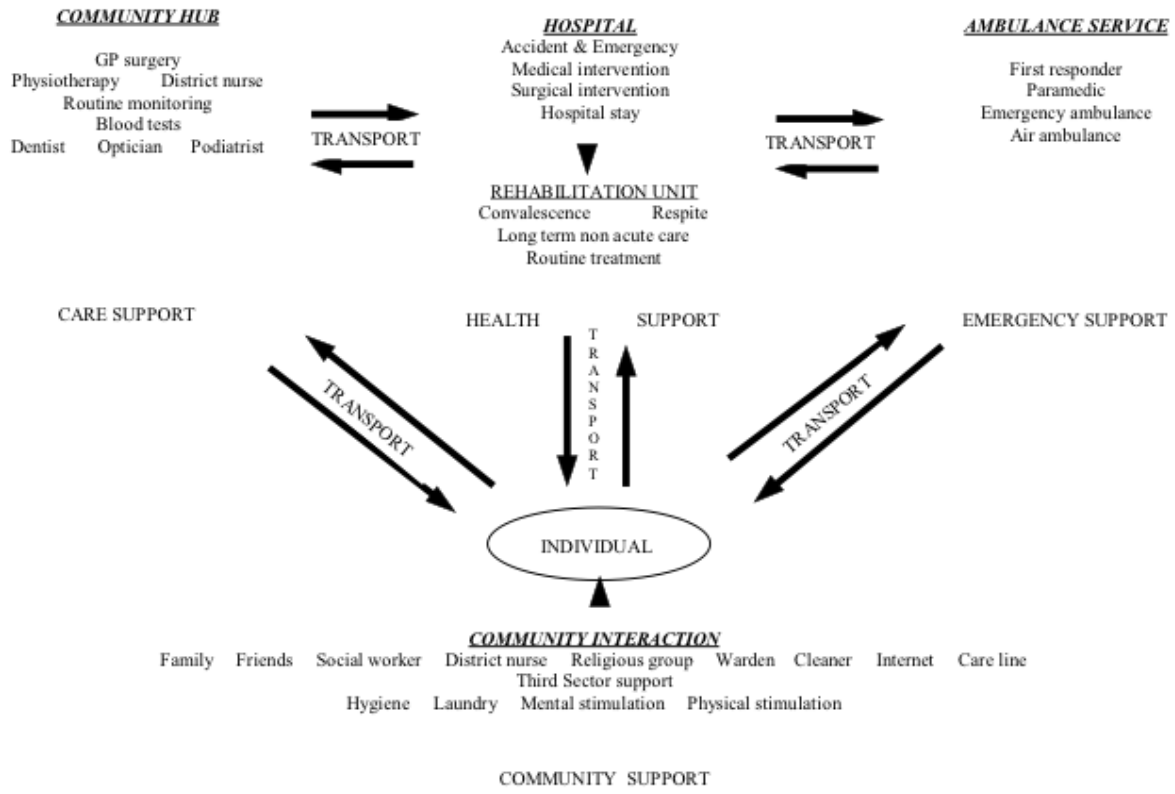
F. Community Hubs (and Surgeries)

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.

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

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.



Savings / Economies

Obvious money saving exercises are no doubt being carried out regarding reduction of super-numerate 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.

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.

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. This is included in the full document, available on our website: sosppan.co.uk.

We fully support the concept of "No Change is not an Option"

We would only qualify that with

"Wrong Change is not an Option".

As a first step towards an acceptable solution CHIS / SOSPPAN is committed to seek the reinstatement of an Unplanned Emergency Care Service at Prince Philip Hospital commensurate with the needs and demands of the large urban population of Llanelli, Burry Port and the surrounding district which encompasses areas recognised on a European scale as suffering some of the highest levels of social deprivation in the land.

The Committee for the Improvement of Hospital Services

Hydref 2012 **October 2012**

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