# Cyngor Gwledig
# LLANELLI
# Rural Council

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*Fy nghyf:* *My ref:* C/KPH
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26 October 2012

Mr T Purt
Chief Executive
Hywel Dda Health Board
Merlins Court
Winch Lane
Haverfordwest
Pembrokeshire
SA61 1SB

Dear Mr Purt

**YOUR HEALTH YOUR FUTURE – CONSULTING OUR COMMUNITIES CONSULTATION ON HEALTH CARE SERVICES IN HYWEL DDA HEALTH BOARD**

This letter supports the Council's formal response to the health board's consultation questionnaire. The letter should be read in conjunction with the completed questionnaire, which is attached.

The Council welcomes the opportunity to respond to the consultation exercise and to providing its views about Hywel Dda's response to 'Together for Health', the Welsh Government's five year vision for health services in Wales, published in November 2011.

## 1. INITIAL COMMENTS

The Council has attempted over the last eight months to diligently participate in Hywel Dda's engagement and consultation process whilst being as constructive as it possibly can when corresponding with the health board.

Naturally, the Council's number one priority has been the safeguarding of key services at Prince Philip Hospital (PPH), Llanelli, especially the A & E unit.

Indeed, during the listening and engagement stage of the process the Council made its position perfectly clear to the health board. To recap, the Council along with the rest of the Llanelli community wanted to have A & E services at PPH fully reinstated. It did not support the notion of having an urgent care centre which was being advocated at the time. Indeed, the Council commented that it was disappointed to discover that none of the potential options being displayed at the various public health events provided for an A & E service being delivered from PPH. This was and is still unacceptable.

The Council requested the health board to review its position so that it included an option which supported the full suite of A & E services being restored at PPH and that it be taken forward to the formal consultation stage. Regrettably this request was not taken up by the health board. Despite not having a fully functional A & E service operating from PPH at the present time it is difficult to comprehend why this is not the case given the Llanelli area's infrastructure, demographics, unemployment levels linked to poor health and its deprived electoral areas. Given the major industry in the area the demand for the full suite of services is clear for all to see.

More recently Dyfed Powys Police's main custody unit has been set up in Llanelli. Having the custody unit in Llanelli puts more pressure on local health services; for example, the condition of some of the people held in custody is heavily influenced by alcohol and drugs. These people can and do sustain injuries whilst in custody. A police officer commented on a recent case where a person was held in custody and had sustained a head injury in the cell. This necessitated two police officers accompanying the individual to Glangwili for treatment because PPH could not deal with the injury, taking up valuable hours of their time. If services were provided at PPH then the injured person could have been assessed and treated quickly thereby releasing the police officers to get on with more important duties. If the A & E service is downgraded then this example will become a fairly common occurrence and will put considerable strain on police resources. Surely, the setting up of the custody unit in Llanelli further supports the argument for doctor led A & E services at PPH?

During the listening and engagement stage, the Council informed you that it intended to engage management consultants to help formulate counter proposals for future delivery of A & E services at PPH. In facilitating this, the Council sought an assurance from the health board that it provide more specific data promptly on request. The Council criticised the engagement process and felt it was flawed. It was vital the debate was informed with reliable analysis of both the potential economic and healthcare outcomes, both of which were lacking in the engagement process. The approach should have been patient led and built up from an assessment of patient needs: specifically a detailed patient-level analysis of the current and projected needs and outcomes of Llanelli's ageing population.

The Council previously challenged the health board to inform the engagement/consultation process with sound relevant analysis and make this available to the Council for examination. It has also asked the health board for patient data on three separate occasions so that the same could be forwarded to its advisers for appropriate scrutiny and re-modelling in order to put forward counter proposals; sadly all to no avail as no information was provided. I will revisit this point later.

The listening and engagement documentation placed great emphasis on best patient outcomes and providing care closer to home; these are points which the Council generally supports. However, with regard to the potential A & E options: the health board's preferred option for emergency and urgent care in Hywel Dda is the consultant led major emergency department

in each of the three counties of Carmarthenshire, Pembrokeshire and Ceredigion. This preference was based on an option appraisal of six options carried out in 2011. Bearing in mind the Longley Report 'The Best Configuration of Hospital Services for Wales; the report refers in the case of emergency care, there is now a generally accepted minimum set of acute services required on site to provide a safe emergency service department, which incidentally PPH fully complies with as a service model. The question therefore is why didn't the health board consider the option of basing the Carmarthenshire major emergency department in the town with the largest population namely Llanelli instead of Carmarthen? Surely this would help to achieve its published aim of providing 80% of health services closer to home!

The health board has also previously stated during the engagement stage that none of its emergency departments comply fully with Royal College standards. Furthermore, it does not have senior doctors on site at all times in any of its four acute hospitals. Indeed it was revealed by your Mr Paul Williams, at an organised event for Town and Community Councils in Carmarthenshire, held in St Peters Hall, Carmarthen in March of this year, that none of the health board's A & E departments complied with Royal College staffing requirements. He stated that four A & E consultants were needed at each hospital site and yet the health board only had four A & E consultants across the health board's entire region. This begs the question about the clinical safety argument. How can the health board argue a case for the three other district general hospitals having an A & E department under the proposed options and yet PPH is excluded? This would need twelve A & E consultants according to the Royal College so how can the health board justify providing cover for the three hospitals with just four A & E consultants whilst at the same time ignoring the case for including PPH?

## 2. HYWEL DDA'S CONSULTATION PROCESS AND ITS PREFERRED OPTIONS

The first thing to say is the Council fully understands the issues generally affecting the health service throughout Wales. Indeed the issues and challenges being experienced by the health board are common to other health boards across the country, notwithstanding of course, the size and rurality of the health board's catchment area which for the most part brings its own particular challenges.

### Changing population

The health board refers to its changing population; by the year 2026 the amount of over 75s in the area will double to 70,000. Indeed this age group represent 10% of the population of Hywel Dda. As people live longer demands on services increase. Furthermore, patients aged over 75 occupy 70% of acute hospital beds. Expanding upon this point the health board refers to 'virtual wards' and the shift from bed based hospital care to community based delivery. The health board states its present base of 1,279 beds would realise a 20% reduction over time as a consequence of focussing and caring for people, particularly the elderly in their preferred environment – their own home in their own locality!

However, as being witnessed in England, the Royal College of Physicians claim hospitals could be on the brink of collapse. The Royal College has said the triple effect of rising demand, increasingly complex cases and falling bed numbers was causing problems. If we are not careful, the same could happen in Hywel Dda. Advances in medicine had led to people living longer, but this meant they were increasingly developing complex long term conditions. Therefore the focus on community care should not be interpreted as a panacea. By cutting beds there is a real danger hospitals in Hywel Dda will be seriously under

resourced and won't be able to cope with future demand to deal with acute and chronic conditions common to frail and elderly patients.

**Health inequality**

The health board states there is a measurable gap between the life expectancy of people living in different parts of Hywel Dda and it needs to ensure that all of its population receives the same standard of care they deserve. As far as Llanelli is concerned and in terms of receiving the same standard of care then surely the hospital services model advocated for PPH conflicts with this statement? How can Llanelli residents expect to receive the same standard of care when a 24/7 local accident centre is being proposed for PPH? Whereas, Bronglais, Glangwili and Withybush will have 24/7 emergency departments to serve their resident population!

The Council is aware of the health board's initial work on its equality impact assessment as part of its legal obligations under the Equality Act 2010. The Council notes however that further work is needed and that a full impact assessment is required and this will be compiled during the consultation period. Points that clearly need to be considered as far as Llanelli residents are concerned are:

- Transportation issues associated with Hywel Dda's preferred option for hospital services at PPH and the knock on effect of having to travel elsewhere.
- Llanelli's deprived electoral areas.
- The high levels of unemployment linked to poor health.
- An ageing population.
- Its local industry and urbanised infrastructure.

The Council expects all of the above to be assessed at a local level and not at a general level across the Hywel Dda catchment area as otherwise this will dilute/distort the overall assessment when it comes to matching need to the best patient outcomes for people living in the Llanelli area.

**Developing the options**

The consultation document states the development of the options has been subject to a robust clinically led process to develop benefit criteria and weighting. The purpose of this was to ensure that uniform assessment of the options could be carried out. The highest waiting score (22%) has been allocated to safety criteria. Furthermore, any options that did not meet clinical and other criteria were discounted in advance of the listening and engagement exercise. Moreover, potential options were measured against the relevant criteria with only those clinically safe and operationally deliverable options being put forward to consultation.

Clinicians at PPH have challenged the health board's preferred option for PPH, stating the proposal is unsafe. Given that the highest waiting score of 22% was allocated to safety then how can the health board's preferred option for A & E services at PPH be considered as a viable proposal when the health board's own workforce has stated the option is unsafe? Furthermore, the National Clinical Forum (NCF) needs to be made aware of this worrying development. It clearly needs to consider the views of the clinicians based at PPH. Their claims clearly contradict the statement made in the consultation document that the NCF indicated in June 2012, the proposed options were clinically appropriate and safe? This definitely does not seem to be the case for PPH and you have to question the scale and

integrity of the vetting process and the role performed by NCF. This situation is very worrying indeed.

Reference was made earlier to PPH being the major emergency department for Carmarthenshire and we believe the option should be put to the NCF for independent comment and assessment; acute services at PPH support Professor Longley's model for emergency care; PPH has the necessary infrastructure.

**Working with other health boards**

Hywel Dda has taken the decision to work separately from the South Wales Programme Board (SWPB) and yet the impression given in the consultation document is Hywel Dda is working with health boards across the M4 corridor. The SWPB has decided to take a different approach emphasising greater public engagement and consultation prior to formal consultation yet Hywel Dda has set about a separate and divorced consultation programme ahead of the other affected health boards that make up the SWPB. Surely there must be a degree of uniformity in order to attempt to address nationwide issues and challenges? Why does Hywel Dda consider itself to be unique from other health boards in this regard?

**Specific themes highlighted during the engagement process**

Addressing the issue of transport is of great concern particularly if the health board's preferred service model for PPH is adopted as more patients will be referred elsewhere. The health board has correctly identified that families and carers sometimes have to travel long distances for visits and that over 90% of people find their own way to hospital appointments. There is no overnight provision for family members to stay near hospitals. Furthermore, at weekends, public, community, social care and non-emergency patient transport is not as readily available. Llanelli patients referred to Glangwili Hospital will readily testify to this under existing service arrangements. Llanelli residents referred to Glangwili A & E but then not admitted or discharged have had great difficulty arranging transport home during late at night or during the early hours of the morning. If they were fortunate enough to find a taxi (prepared to take them home) the taxi fare was astronomically expensive. How can this be regarded as acceptable and sustainable? Car parking is also a major issue: Glangwili is overstretched where PPH has ample car parking!

**Emergency patient transfers**

The health board states it has discussed its plans with the Welsh Ambulance Services NHS Trust (WAST). If this is the case why is it that WAST has been reluctant to comment on the proposals publically? The health board claims it is working with WAST to develop clinical protocols to ensure patients are taken to the right place. If this is true then these working protocols should have been included in the consultation bundle to demonstrate the emergency transfer of patients under any of the preferred options has been appropriatly risk assessed and deemed safe.

The Council has failed to get any sort of information or comment from WAST on health board proposals other than receiving a copy of its Operational Directive 41 which was published in 2007! There is a great concern that no recent or up to date information has been made available by WAST or indeed indirectly by the health board as part of its supporting technical evidence. Instead the health board states prior to any potential service reconfiguration within Hywel Dda, an assessment of the impact on emergency transport

provision will be undertaken, implying this will follow later. The issue is, how do other stakeholders arrive at an informed decision over patient logistics if the information is not available to support the different options during the consultation stage? This is not acceptable. Given the current transport issues encountered by Llanelli patients then this will only get worse if PPH's A & E service is downgraded to a nurse led/delivered service. More patients will inevitably have to be transferred elsewhere and this will present a huge problem for self-presenting patients admitting themselves to PPH and then perhaps needing emergency transport to another hospital.

Since 2009 the number of intra-hospital transfers for 999 emergencies from PPH to other hospitals has virtually doubled from 164 to 324 in 2012. This correlation would rise exponentially if PPH had a 24/7 ENP service. This is not an improvement in the way the current A & E service functions and will not lead to better patient outcomes nor a safer service.

**Community care and care closer to home**

The provision of primary care and community care will be primarily led through the local GP service, the new Community Resource Centres and through social care services delivered by Carmarthenshire County Council. This is the health board's strategy for changing the way health services are delivered in the future. There are two main concerns with this proposed change. The first and obvious concern is the robustness of the existing community infrastructure to deliver future health care in the way the health board has described. Putting this right will take a great deal of time and will carry a significant cost burden which is the second issue. How and who will meet this cost burden? There should be no hospital changes until the infrastructure has been independently tested for robustness and more importantly the funding is in place to deliver a safe and sustainable service. However, once you commit to the strategy there is no going back and to approach it in this way presents a very significant risk. The health board refers to an Implementation Board to oversee the changes. The Council advocates that this Board is, in the main, made up of non-health board members and representatives. Also the Council feels that once the system has been rigorously tested, taking into consideration patient experiences as the main indicator, that the old and the new systems run in parallel for a year with the old model gradually being phased out over an agreed timeframe. This may take many years to achieve!

**Other general observations**

The main consultation document and supporting technical documentation had a number of omissions and gaps. Indeed this point was raised by the Council at the Town and Community Council event held in Carmarthen on 13 September, 2012. The Council found itself having to write to the health board for further clarification and explanation. It posed 21 additional questions to help define various statements contained in the main consultation document more clearly. This was put to the panel of representatives; the gist of the health board's response was 'it was a case of striking the right balance for the reader in terms of the amount of information to include'! The Council understands the need to make public consultation documents readable, succinct and understandable but the information sought by the Council should have been included in the supporting technical documents if the health board felt it was too detailed to be included in the general document, but this wasn't the case.

Furthermore it would have been helpful if the factsheet produced by Hywel Dda over preferred options for PPH had been included in the main consultation document from the

very outset. This would have saved a lot of time for consultees and it would have clarified better understanding over what is to be delivered under the health board's preferred service model: option B. Many people will not be aware of these documents and will have been put at a distinct disadvantage when responding to the consultation questionnaire.

The other point to mention here is the semantic changes as to who will lead the 24/7 local accident centre option proposed for PPH under option B. The description in the main consultation document states the service will be provided by skilled emergency nurse practitioners and provide a **similar** level of service to the current department.

Recent email clarification received form the health board's Director of Planning confirmed that the service in PPH will be nurse **delivered** with remote consultant cover and leadership. The Council up until recently had been under the misapprehension the service will be nurse **led**, not nurse delivered. Indeed, however, the consultation questionnaire refers to a nurse **led** service and people are asked if they support this as an option by ticking the option B box. This is clearly misleading and in the Council's view undermines the consultation process because the service description does not match what is stated in the main consultation document nor indeed does it support the comments received from the Director of Planning! A nurse led service is quite different from a nurse delivered service with the support of doctors irrespective of that support being provided remotely.

The Council has previously referred to three failed attempts to obtain the necessary patient data from the health board. The Council has also commented in earlier correspondence with the health board about the timing of its formal consultation process. The launch of the consultation in early August did not help the Council to accomplish what it hoped to achieve in formulating a robust counter proposal backed up by patient analysis and data. The Council was in recess during August; like most other public bodies who consider themselves stakeholders in the consultation process so it effectively lost a full month to prepare its case. On top of this further questions needed to be asked of the health board to clarify understanding of definitions of services; all adding to delays and eating into valuable consultation time. This effectively presented the Council with an 8 week and not a 12 week window of opportunity to constructively participate. This was far from satisfactory and it has hindered the Council's preparations and plans. Realistically, there simply wasn't enough time to turn something around via the assistance of the Council's management consultants. This became even more apparent when Bellis-Jones Hill, Healthcare Management Solutions had identified further information gaps in the technical documentation supporting the consultation process in its latest letter to the Council. The Council feels this has been poorly handled by the health board and the patient data requested by the Council should have been made available at a much earlier stage of the process when the options were being developed. The matter has been further compounded with WAST's unhelpful and evasive stance in not supplying relevant and important information about the preferred service options and the impact on its services. Again this is unacceptable and is a significant concern.

## 3. THE COUNCIL'S POSITION AND PREFERENCES

### A & E service model

The Council does not support the health board's preferred option for PPH, it prefers other alternatives, which will be addressed later. However, the Council is pleased that the health board will locate doctor led Emergency Medical Admission Units (EMAU) at its four main hospital sites. In the case of PPH this reflects what was garnered during the listening and

engagement stage of the process. Unfortunately this does not go far enough to satisfy local need for a 24/7 emergency department and accident centre at PPH in addition to EMAU.

The Council wants PPH to enjoy parity with the other three main hospital sites and this can be easily achieved because PPH's current service infrastructure matches that advocated by Professor Longley in his report 'The Best Configuration of Hospital Service for Wales'. The service is able to support a doctor led emergency service from PPH albeit with 24 hour offsite support via local multi-hospital network access for:

- Emergency surgery;
- Trauma and orthopaedics;
- Paediatrics;
- Obstetrics and gynaecology;
- Mental health;
- Supervised surgery; and
- Interventional radiology.

Of course, these specialities could be provided directly from PPH if it was selected as the main consultant led major emergency department for Carmarthen and this is the Council's preferred option. However, if this is not possible then the Council's second preference is for PPH to have a doctor led emergency department working alongside emergency nurse practitioners with a fully supporting EMAU but with 24 hour access to the services described above. These services could be provided from within the health board (Glangwili hospital) or from outside the health board (Morriston hospital).

The Council feels strongly about PPH having its own A & E department especially as the number of patients using the current service has exceeded 33,000 per annum for the last four years. This is on a par with Glangwili and Withybush and is significantly more than Bronglais, although in the case of Bronglais the unit serves a smaller population base.

The Council does not support a nurse led/delivered local accident centre with remote consultant led support via the use of telemedicine. Professor Longley states in his report that in the case of general trauma and emergency care there is increasing evidence that outcomes are better when there are more senior doctors on site 24/7.

Furthermore, the Council does not agree with the health board's argument that four A & E consultants can support emergency departments at the three other hospital sites to the detriment of PPH as stated previously in this response. If the health board feels it can juggle the four A & E consultants amongst the other hospitals then surely PPH can also be included under the same umbrella of cover resulting in one A & E consultant covering each hospital with additional on-site support from other senior doctors.

I referred earlier to the Council engaging management consultants to help formulate counter proposals. Formulating robust counter proposals has not been achieved because of the difficulty in obtaining patient data from the health board in a timely manner. Instead the management consultants have given an opinion and advice on the health board's options and supporting evidence and have put forward three approaches for taking matters forward. The letter forms part of the Council's formal submission and is appended to this response. It identifies concerns with the service model being advocated by the health board, it also identifies gaps in the data sets, which if provided might have helped the Council to make a

stronger argument on behalf of Llanelli residents and also for other residents living further afield but who rely on PPH as their main hospital.

The consultants' letter refers to the requirement for a risk assessment for Llanelli residents routed to Glangwili within the 'Golden Hour'. Their analysis of option 3 in Technical Document 5 – 'Emergency and Urgent Care' (three emergency departments but UCC at PPH) indicates as might be expected that 22% will take longer than 60 minutes. This is a significant risk. The health board states it has the ability to achieve the golden hour for 100% of the population but its data **does not** agree with this.

The management consultants have commented that while the option for PPH may be convenient for Hywel Dda 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. They suggest the analysis be carried out or at least reviewed by an independent panel of experts. In the Council's opinion this should have been done before going out to consultation. The previous options and work endorsed by the NCF does not satisfy a full and rigorous analysis as quite clearly the physicians at PPH have now recently come out and declared the proposal as unsafe! The Council agrees with Bellis-Jones Hill, Healthcare Management Solutions when it states that the onus is on the health board to make its case in the 'court of public opinion'; something that it is yet to do convincingly! For these reasons alone the consultation process should be deferred for the health board to prove its case.

The Council does not accept any of the A & E options being advocated for PPH and fully supports the Llanelli based physicians. The Council demands either a consultant led major emergency department for PPH or failing that a 24/7 doctor led A & E service as previously described. The residents of Llanelli deserve nothing less.

**Community hospitals**

The Council would like Mynydd Mawr Hospital (MMH) to be retained in service. Patients greatly value the hospital and by the health board's own admission MMH has been fantastic for patients from the Gwendraeth and Llanelli areas over the past 20 years (and in different ways in the past).

Is it feasible to co-locate the planned Community Resource Centre on the hospital grounds instead of Cross Hands?

Could telemedicine be used given there are no investigations or doctors on site 24 hours per day at MMH? This might alleviate the number of journeys taken by very frail patients with them being put in ambulances at any time of day or night for transfer back to PPH or, even worse, Glangwili Hospital.

The Council understands that perhaps some of the patients should not be accommodated at MMH. It has been suggested that some patients would be better off recovering in convalescence homes (run by Carmarthenshire County Council). However, there is a lot to be said for better patient experience and MMH does an excellent job in this regard. By dispensing with MMH the obvious concern is the proposed new infrastructure will not match current service standards. More pressure will be brought to bear on community care services adding to rising costs and yet no additional money has been identified to bolster services.

Closing MMH will also mean the loss of 28 beds with the domino effect on bed allocation at PPH; compounding the overall loss of beds in the hospital. From the English experience there are numerous cases appearing up and down the country of serious bed shortages in hospitals. Why would we wish to follow suit, surely it must be wise to learn the lessons from this experience?

Co-locating the planned CRC at MMH will help bring together services using existing infrastructure to boost sustainability for community care services going forward.

**Other hospital services**

The Council supports the planned new short stay surgical unit for PPH provided the reconfiguration of beds has no detrimental impact on other key services.

The Council also supports the Orthopaedic Centre of Excellence planned for the south of Hywel Dda being located at PPH. This is seen as a positive service enhancement.

With regards to the proposal to develop a Paediatric High Dependence Unit, alongside the health board's level 2 Neonatal Unit, the Council feels that whilst supporting the merits of creating the unit, greater collaboration and advice should be sought from the SWPB in terms of developing options going forward.

This concludes the Council's consultation response and we trust that the Council's points will be fully published by ORS and duly considered by Hywel Dda Health Board.

Yours sincerely

Mark Galbraith

Clerk to the Council

Enc