Pembrokeshire Health Concern August 2012

Assessing the impact: Consequences of removing orthopaedic and emergency services from Withybush Hospital

Introduction

We are currently in a Consultation on healthcare that ends on October 29th 2012. Health Board documents describe local health statistics, descriptions of current services, how these compare against standards, the case for change, the listening and engagement process and their preferred options.

However nowhere in the Health Board documents is there a risk assessment. There is no description of the expected consequences of any preferred options that would involve removal or restriction of services. There is no description of evidence to support improved outcomes from these options. They have indicated, though, that they would assess the potential impact of their options during the consultation.

This document addresses the consequences of three of those preferred options for Withybush Hospital, Haverfordwest:

1. Removal of elective hip and knee replacements
2. Removal of night time and weekend treatment of trauma
3. Removal of night time and weekend emergency surgery

Assuming five days working nine to five, nights and weekends comprise 128 of the 168 hours in the week, or 76% of the time available to take in emergencies. So removing treatment out of hours is over three quarters of the way towards removing it completely.

Some of the comments are based on the inter-dependencies of hospital services, and this topic is expanded in Appendix 1.

Evidence on outcomes is referred to but not discussed in depth. However the lack of support that it provides for the options can be studied further at these links.

Summary

It is shown that each of the three preferred options would lead to unsustainability and progressive deterioration of the remaining services, with ultimately centralisation of the services in Carmarthen.

We expect the Health Board to take account of this in accordance with their stated intent, and in order to ensure safe and sustainable services amend their preferred options to avoid these consequences.

1 Though Technical Document 12 is called 'Assessing for Impact', it contains no text that justifies that title. However on page 28 of that document is the following passage: “It is anticipated that during the Consultation period, a clearer picture of the potential impact of each option currently under consideration will emerge. Together with information contained within this document, evidence gathered during the Consultation will provide the basis for assessing the impact of any service reconfiguration, exploring ways of mitigating any potential adverse impact and maximising any potential positive impact”. In other words, the Health Board have undertaken to assess the impact during the public consultation period that ends on 29th October 2012.


3 In the Consultation Document the phraseology used to describe the preferred options is ambiguous, therefore it is necessary to resolve the ambiguity by referring to the Technical Documents. See Appendix 2 for explanation.

4 http://www.zen142533.zen.co.uk/SWATcontd/traumacentre.html, http://www.zen142533.zen.co.uk/SWATcontd/centralisation.html
1 Removal of elective hip and knee replacements

This would take place as part of the development of a centre for Orthopaedic Surgery at Prince Philip Hospital, Llanelli, that would provide the service for the South of the Hywel Dda area, services in the North remaining at Bronglais Hospital. The benefit of this, it is claimed, would be ring-fencing of beds and theatres, separating elective from emergency work, and reducing the risk of infections. What would remain in orthopaedics at Withybush would be day and short stay surgery (up to two days) and the management of orthopaedic and soft tissue trauma during the daytime.

The consequence would be a problem of staffing. The following questions arise:

- Would there remain a body of Consultant Orthopaedic Surgeons based at Withybush?
- What would be their remit?
- If it is just the service that remains, would it be possible to find a consultant prepared to deal with only minor conditions, excluding the major operations that they have been trained for, appointed to perform, are good at, and find interesting?
- If consultants were given sessions in Prince Philip for elective major surgery, would it be possible to find one prepared to travel repeatedly to and fro the fifty miles between the two hospitals making the pre-operative assessments, performing the surgery, and supervising the post-operative care?
- What happens if a complication occurs?
- Is he or she expected to travel fifty miles to deal with it?
- If not, and a case goes to litigation, how would it look in court if a consultant has to admit he hasn’t been able to see the patient for three days?
- If no consultants were based at Withybush, then would it be possible to find doctors prepared to be based at Prince Philip, but to spend a specified number of days at Withybush?
- If services were to be provided at Withybush only by middle grade doctors, who would be responsible for their supervision, and for appraisal and training?
- Would this be a consultant on the phone up to sixty miles away?
- Would their training be approved by the Welsh Deanery?
- What type of case would they be able to deal with – just simple cases that do not need expert assistance?
- As the current daily 8.30 a.m. Departmental Team meetings for discussion of the previous day’s admissions and imaging would be lost, how great would be the increased risk of missed diagnoses or inappropriate management decisions?
- Who would provide urgent inpatient opinions to other specialties for orthopaedic problems such as falls or suspected spinal problems?

These questions cannot all be readily answered, but need asking of the Health Board who do not appear to have considered them. This is despite the fact that, we understand, at least one Carmarthen orthopaedic surgeon gave up elective surgery at Llanelli citing lack of infrastructure support and the distance he had to travel (22 miles). It is clear that the sustainability of the remaining services at Withybush would be in doubt.

Put succinctly, broken bones in Pembrokeshire would end up having to be treated in Carmarthenshire, even minor orthopaedic surgery would become unsustainable, it would become impossible to obtain urgent orthopaedic opinions for inpatients admitted under other specialties, and there would be loss of recognition for training of the medical staff. With loss of recognition, it would become impossible to recruit.

Put even more succinctly, the service would become unsustainable..
2 Removal of night time and weekend treatment of trauma

The Health Board envisage developing what is described in the Consultation Document as a “24/7 full emergency service” that implies the availability of skilled medical assistance on site round the clock. However, at night and during weekends, this medical assistance would take the form of the management of only minor conditions by middle grade doctors who would provide a ‘stabilise and transfer’ service to Glangwili Hospital for anything more serious. There would be developed at Glangwili Hospital a ‘trauma centre’ for this purpose.

The claim is that providing this so-called ‘trauma centre’ would produce better outcomes due to a greater degree of specialisation, lower cost per patient, and with fewer staffing problems. However, evidence is lacking that such an arrangement will achieve any of these things.

There is a danger that lay people hearing the term will be inclined to accept the claimed benefits, because of the use of the phrase ‘trauma centre’. This is because there has been publicity about the benefits of trauma centres. But these major trauma centres are different from what is proposed, and it would be a case of the public having been misled. This is explained as follows:

- The evidence is excellent that the use of ‘major trauma centres’ improves the survival of the tiny proportion of trauma patients who have multiple life-threatening injuries. These should bypass the local hospital in favour of a major trauma centre that has all (or nearly all) specialties on site, i.e. in South Wales that means either Swansea or Cardiff. However, as indicated above, evidence is lacking for developing a so-called ‘centre’ for the majority of patients who do not need this type of care. That is what the Health Board are referring to, and what may be misunderstood.

The consequence of loss of trauma treatment at night and weekends would be as described in the final two paragraphs of section 1 above.

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3 Removal of night time and weekend emergency surgery

Similarly to the arrangement for trauma management, the Health Board favours an arrangement whereby there would be no emergency surgery facility at night and weekends, though there would be a 24 hour ‘assessment’ facility provided by a middle grade doctor. Any patient requiring surgery would be stabilised and transferred to a new ‘centre’ at Glangwili Hospital. Patients requiring observation but not immediate surgery would presumably be admitted for observation (in Withybush as in most hospitals, about half of emergency surgical admissions actually end up having emergency surgery, and the remainder settle down without that). Presumably if an indication for surgery developed at night or during a weekend (which is likely, because those periods comprise 128 of the 168 hours in the week), the patient would be transferred to Glangwili. If it developed during the day, logistics might still result in a transfer. The Health Board’s justification for this option is discussed below (Appendix 3).

The consequences of this arrangement are even more alarming than those for trauma and minor orthopaedic surgery, because they are potentially fatal. Therefore they are described below in some detail.

1. Surgical emergencies from the western and northern parts of Pembrokeshire would no longer have access to treatment within one hour. For some conditions, such as a rapidly bleeding rupture of the spleen, this may have fatal consequences.

   - Research conducted by Gary Hicks and Henry Jones of the former Pembrokeshire Community Health Council using AA Route Planner and updated to 2011 population figures, demonstrates that, if the nearest emergency access is Glangwili Hospital in Carmarthen, about 13,300 people would have over 70 minutes driving time there, with a further 17,700 people taking between 60 and 70 minutes. The sum of those is over 25% of the current population of Pembrokeshire.

      - These calculations do not take into account all the other time-consuming parts of the process of obtaining care, such as the time taken for an ambulance to reach the patient, neither do they take into account the increase in population due to tourism which in the summer is from 118,000 to about 200,000 (an increase of about 70%) using 2011 population figures. Conversely, perhaps ambulances go faster than AA Route Planner, or perhaps occasionally helicopter transport is available. There are, therefore, imponderables. But it is probably a reasonable estimate that roughly 25% of the population at any time would be over one hour away from life-saving facilities, and a significant number of those a good deal more than that.

2. There would be a downgrading of the standard of service to inpatients who develop surgical emergencies. This would apply to not only medical admissions who develop surgical problems, but also emergency surgical admissions who develop an indication for surgery later, and patients who develop complications following elective surgery.

   - Some of these patients will have immediately life-threatening conditions that preclude any sort of transfer, except immediately to the operating theatre on site. Such patients would die. An example is acute upper gastro-intestinal haemorrhage.

3. Because of 2, it would no longer be safe to deal with certain categories of patient, even though they probably will not require emergency surgery. This would drastically downgrade the ability of the hospital to deal with a comprehensive range of conditions. Here are some examples:

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6 The Pembrokeshire CHC Transport Study can be found at the following URL: http://www.zen142533.zen.co.uk/OldSWATStuff/SWATlinksOld.htm#chcstuff
• Upper gastro-intestinal haemorrhage. This is a common condition, responsible for admissions on most medical intakes. Most settle down without surgery. The small number who don't would suffer a greater mortality than if operating facilities were available immediately on site.

• Elective major colorectal surgery. This is complex surgery that cannot be practised safely without access to 24 hour emergency surgical facilities on site.

  o The Withybush colo-rectal unit is one of the pioneers in Wales in the management of colorectal cancer using enhanced recovery techniques and laparoscopic surgery. National audit data depict its excellent performance. The surgery is complex, with a significant rate of complications requiring return visits to theatre (even in world class units). Accordingly it requires 24 hour access to intensive care and emergency facilities including specialist anaesthetic skills and theatre. The Health Board has acknowledged the pre-eminence of Withybush Hospital in this field, by recommending that it should be the Hywel Dda centre for laparoscopic surgery. However, they do not appear to have acknowledged the corollary of that, which is the need for adequate supporting infrastructure. Should 24 hour emergency facilities be withdrawn, the colorectal surgeons would no longer be willing to undertake that type of surgery at Withybush, on the ground of safety. They would resign, and go elsewhere.

• Gastro-intestinal endoscopy. Currently Withybush Hospital has a large and busy Endoscopy Unit for examination of the stomach or colon. In addition to providing diagnostic and therapeutic procedures, the unit participates in the National Bowel Cancer Screening Programme. Gastroscopy is used for patients with upper gastrointestinal bleeding, and frequently succeeds in controlling it with the use of injection techniques. The occasional failure requires surgery, and the requirement may be extremely urgent. Colonoscopy has a recognized complication rate of bowel perforation of about 1:800, which equates to about two per year at Withybush. For this reason the supervisory body the British Society of Gastroenterology advises access to surgery in a timely manner. Removal of out of hours emergency surgery may compromise the ability to support the endoscopy unit and the standards, thereby putting at risk future approval of the unit for both practice and training.

4. Since most hours in the week – 128 of the 168 - would no longer contain an emergency workload, there would be a drastic reduction in emergency experience for surgical trainees, resulting in loss of recognition for training.

• This would be superimposed on the current major training problem in surgery that has developed as a result of the European Working Time Directive that restricts the working week to 48 hours. This would sound the death knell for Basic Surgical Training, and recognition for training would be withdrawn by the Royal College of Surgeons and the Welsh Deanery.

• This would exacerbate junior staff recruitment problems.

5. Since less surgery would be performed, together with removal of elective hip and knee replacements, there would be less requirement for anaesthetists and intensive care.

• Ultimately it may become difficult to justify the need for enough anaesthetists to support a rota for the intensive care unit. Since acute medical care requires intensive care too, an already restricted service may become unsustainable.

Again, ultimately the service would become unsustainable.

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8 http://www.zen142533.zen.co.uk/OldSWATStuff/EWTD/BulRCS%20Sept%202012.pdf
Appendix 1. Inter-dependency of services

Many sources attest to the fact that hospital services are inter-dependent, including the recent Longley Report that was commissioned for the Welsh Government. Here are some of them.

- The Royal College of Physicians recommend that, for acutely ill medical patients, the following services are required on site: Accident and Emergency, Acute General Surgery, Resident Anaesthetic cover, Intensive Care, Cardiac Care.

- The Scottish NHS Remote and Rural Steering Group defines a Rural General Hospital as one which "undertakes management of acute medical and surgical emergencies and is the emergency centre for the community, including the place of safety for mental health emergencies." A detailed description is given of the conditions and procedures that would be managed in these hospitals, and the facilities required; these are similar to those currently provided in Withybush Hospital (Figs. 1 and 2).

<table>
<thead>
<tr>
<th>Unscheduled</th>
<th>Planned</th>
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<tbody>
<tr>
<td>Nurse led Urgent Care service managing minor injury and minor illness;</td>
<td>Management of patients with stroke;</td>
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<tr>
<td>Ability to resuscitate patients;</td>
<td>Rehabilitation and step-down;</td>
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<tr>
<td>Ability to manage acute surgical and medical admissions;</td>
<td>Post-op step down, rehabilitation and follow-up;</td>
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<tr>
<td>Initial fracture management and manipulation of joints;</td>
<td>Management of patients with long term conditions, including haemodialysis, and cancer care as part of a network;</td>
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<tr>
<td>Midwife led maternity service;</td>
<td>Provide ambulatory care for children within the locality;</td>
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<tr>
<td>Neonatal resuscitation;</td>
<td>Routine elective surgery;</td>
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<tr>
<td>Capability to diagnose and initially manage acutely ill or injured child;</td>
<td>Visiting services.</td>
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<td>Capability to manage patients requiring a higher dependency of care before transfer;</td>
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<tr>
<td>Clear and appropriate retrieval and transfer arrangements.</td>
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<tr>
<th>Diagnostic</th>
<th>Support</th>
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<tbody>
<tr>
<td>Diagnostic capability, including: Imaging: Digitised image capture, Ultrasound and CT scanning; Laboratories: Limited range of Biochemistry, Haematology and cross match blood; Endoscopy: Upper and lower GI, Cytoscopy; Surgical intervention: e.g. biopsy of lesion Cardiac Investigation including: Stress testing and Echocardiography.</td>
<td>Clinical decision support via e-health links to other centres; Pharmacy support.</td>
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<table>
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<tr>
<th>Emergency Surgical Workload</th>
<th>Planned Surgery</th>
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<tbody>
<tr>
<td>Appendicectomy;</td>
<td>Biopsy of lesions;</td>
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<tr>
<td>Caesarean Section;</td>
<td>Cholecystectomy and/or exploration of common bile duct;</td>
</tr>
<tr>
<td>Endoscopy (including injection of varices);</td>
<td>Circumcision;</td>
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<tr>
<td>Evacuation of retained products of conception;</td>
<td>Endoscopy;</td>
</tr>
<tr>
<td>Lacerations;</td>
<td>Nail bed procedures;</td>
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<tr>
<td>Initial fracture management and joint dislocations;</td>
<td>Peri-anal procedures;</td>
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<tr>
<td>Repair of perforated ulcer;</td>
<td>Resection and anastomosis of bowel;</td>
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<tr>
<td>Control of haemorrhage (including splenectomies);</td>
<td>Simple undescended testes repair;</td>
</tr>
<tr>
<td>Resection and anastomosis of bowel;</td>
<td>Scrotal surgery including varicoectomy;</td>
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<tr>
<td>Ruptured ectopic pregnancy surgery;</td>
<td>Varicose veins surgery;</td>
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<tr>
<td>Chest drain;</td>
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<tr>
<td>Drainage of pericardium injury (for cardiac tamponade) plus suturing of penetrating injury.</td>
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Figs. 1 and 2. Scottish definitions of services required in a Rural General Hospital

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9 Professor Marcus Longley, "The best configuration of hospital services for Wales" is at the following four URLs: [http://www.wales.nhs.uk/sitesplus/863/opendoc/190933..190935..190936..190937](http://www.wales.nhs.uk/sitesplus/863/opendoc/190933..190935..190936..190937)


• Longley refers to several sources including the Royal College of Physicians and the Royal College of Surgeons in describing inter-dependency in several places in his report:

  o (Summary p.16): A table is given depicting those needed to support an emergency department (it is referenced in the Quality and Safety document page 23 as from the NHS National Leadership Network). The contents of the table are: “On-site: Acute Medicine, Level Two Critical Care, Non-interventional Coronary Care Unit, Essential Services Laboratory … Diagnostic Radiology … Supported by 24 Hour Local Multi-Hospital Network Access (not necessarily on-site) to: Emergency Surgery, Trauma and Orthopaedics, Paediatrics, Obstetrics and Gynaecology, Mental Health, Supervised Surgery, Interventional Radiology”.

  o (Quality and Safety page 11): “In considering service change in Wales, particularly in relation to acute hospital services, it should be recognised that it will be important that hospitals are not considered as assemblages of discrete and completely separate services. There are important inter-dependent relationships within and between hospitals and primary and community based services that will need to be considered in setting out the case for change”; (page 22): “There is strong evidence to support this position”, referring to the Royal College of Physicians: “seriously ill medical patients require a facility which can provide … Acute general surgery, A&E department, Resident anaesthetic cover, Intensive care”; (page 28) “unselected medical [in]take without the ability to provide on-site surgical opinion is unsafe, e.g. for patients presenting with severe gastro-intestinal haemorrhage.”

Regarding the references above to “Level Two Critical Care” and “Multi-Hospital Network Access”, the following comments are appropriate. Much of the care currently provided in the Withybush Intensive Care Unit is Level Three, and many of the patients receiving this care are Medical patients. I would interpret the Royal College of Physicians use of the term “Intensive Care” as referring to Level Three care rather than Level Two. This is an inconsistency that is not resolved in Professor Longley’s Summary document.

With regard to “24 hour local multi-hospital network access”, while that idea may work adequately with two urban hospitals a few miles apart, it is not feasible for two hospitals thirty-two miles apart, with only nine of those miles as dual carriageway, i.e. Withybush and Glangwili.

• The Withybush Consultants and Managers response "to the Health Board Engagement exercise, “Demonstrating the Interdependencies, Securing the Future”, depicts repeatedly the interdependencies. Here are several quotes from that document:

  o “All specialties require consultant and middle grade cover to provide a safe on call service 24/7 for acute and emergency admissions.”.

  o “an integrated medical service supported by a general surgical service and critical care and anaesthetics in partnership with an integrated emergency and urgent care centre is essential for the safe local provision of care at Withybush.”.

  o “General surgery remains a core service and supports emergency and urgent care, general medicine and orthopaedics. … Health Board Colorectal service developed and progressed around Withybush laparoscopic model. Endoscopy and GI bleeding service progressed with Physicians. Consultant led 24 hour emergency service maintained in support of Colorectal and other hospital services.”

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12 NHS National Leadership Network 2006 Local Hospitals Project
13 Level Two Critical Care is defined by the (British) Intensive Care Society by a number of criteria that appear to exclude invasive ventilation (i.e. requiring endotracheal intubation specifically for ventilation) which would be Level Three see their document from 2009 “Levels of Critical Care for Adult Patients”.
14 http://www.zen142533.zen.co.uk/SWAtcontd/campaign_documents/Withybush%20response%20CSS%20version%204.2%20final%20draft.pdf
• The Health Board themselves have identified the services that are required as ‘essential backup’ for any hospital with an Accident and Emergency Department. These are listed by Dr Jeremy Williams on their DVD as “Critical Care, Acute Medicine, Laboratory services, Diagnostics, Orthopaedics, Paediatrics and General Surgery”.

• Finally, attention is drawn to two real life examples that demonstrate the loss of services that follows restriction of Core Services.
  o The first is the now well-publicized loss of cardiac services from Rochdale Infirmary in 2011. A promise had been made in 2006, prior to removal of various other services such as Obstetrics and Accident and Emergency, that the department would be built up into a centre of excellence for cardiac services. However this promise was reneged upon, and that decision confirmed by a College inspection in early 2011, that produced a report that there were insufficient supporting services.
  o The second is the also well-publicized loss of 999 Emergency Medicine from Neath Port Talbot Hospital. This was due to inability to recruit following withdrawal of approval for training from the medical unit. This hospital has been without a full set of Core Services for some years, leading to restriction in the conditions that it is safe to manage on the medical unit, and corresponding restriction in training experience. Hence the removal of training approval.

Both examples show that it can be months or years before the actual loss of services occurs. Thus, if Hywel Dda proposals were fulfilled, things would appear to be satisfactory for some time, public interest would fade away, and the actual cuts would come later.

15 http://www.zen142533.zen.co.uk/SWATcontd/rochdale.html#rochdalecardiology
Appendix 2. Interpretation of Hywel Dda Health Board’s plans for Emergency and Unplanned Care

The plans

These are contained in the Consultation Document made public on August 6th 2012.

The Health Board’s ‘preferred option’ is to be found under “What we need your views on” on page 39: “24/7 Emergency Departments and Accident Centres providing a full emergency department service including medical, surgical and trauma assessment and appropriate treatments.”.

Most lay readers will accept this as indicating that the current range of emergency services provided throughout the twenty four hour period will remain. However, lack of clarity and text elsewhere suggests otherwise.

Difficulties accepting this option at its face value

1. “appropriate treatments” is not defined, so the possibility of only minor ones being appropriate is not excluded, all major work to be transferred (which would be a downgrading from the current service)

2. Elsewhere in the document is stated the plan to remove all but day case and short stay Orthopaedics despite the fact that this is described as one of the essential backup services for an Accident and Emergency Department in the Health Board’s own DVD.

3. There are two statements in the preceding section “What we will do” on page 38 of the document that indicate an intention to centralise emergency surgery and trauma services within Hywel Dda, viz.:
   a. Statement 5: “Develop network protocols for complex cases and complex major trauma to be treated in specialist unit(s) where full sub-specialty services are readily available within the next 12 months”
      o The phrase ‘complex major trauma’ does not refer to the small minority of patients who have multiple life-threatening injuries and need transferring out of Hywel Dda, because they are dealt with in Statement 1 of the section. Currently there is no ‘specialist unit’ within Hywel Dda for emergencies. The implication is that such a unit would be developed for Hywel Dda. Serious cases that are currently dealt with in each of the three counties, would be centralised to one of the three counties. There is ample evidence that the Health Board would see Carmarthenshire as that county.
   b. Statement 9: “We will move towards … services delivered from specialist centres for the more serious conditions to be developed in the next 12-18 months”
      o Again, this statement clearly suggests an intention to centralise within Hywel Dda some emergency services that are currently not centralised.

These statements do not fit with the impression given by the preferred option to maintain "24/7 Emergency Departments and Accident Centres providing a full emergency department service including medical, surgical and trauma assessment and appropriate treatments.”.

4. In the Consultation Summary which appeared on the Hywel Dda website after the original documents is the following statement (p.7):
   “Subject to the final model, to develop the Hywel Dda Health Board emergency surgery and trauma centre(s) to ensure an operating theatre and team is available at Bronglais, Glangwili and Withybush Hospitals during daylight hours wherever possible”

5. When asked recently at an staff meeting in Withybush where conditions such as appendicitis and fractures would be treated, Mr Tony Chambers, Director of Operations, replied that he did not know.

Pending explicit assurances from the Health Board, these statements must be assumed to indicate an intention to centralise services for the more serious emergencies at Glangwili Hospital.

The implication is that these would no longer be treated at Withybush and Bronglais Hospitals, which would therefore mean a downgrading of the services there.

It is highly likely that this would be followed by a closure of services at night and weekends. Since these comprise 128 of the 168 hours in the week, that would be over three quarters of emergency capability lost.
Appendix 3. Rebuttal of Health Board's justification for removing emergency surgery out of hours

The justification for this is described in Technical Document 3, summarized in the following paragraph: "Having three separate surgical intakes across Hywel Dda means that surgeons do not see enough of any one type of emergency to be able to develop their expertise and it is not possible to achieve true specialisation in surgery. The service in Carmarthenshire achieves sub-specialisation more easily than the other counties and has accredited surgeons in some sub-specialties. Resources are generally spread too thinly and therefore the Health Board cannot deliver timely emergency surgery services with dedicated and ring-fenced resources such as theatres."

- Dealing with each sentence separately, to an experienced consultant general surgeon, the first is misleading:
  - "Having three separate surgical intakes across Hywel Dda means that surgeons do not see enough of any one type of emergency to be able to develop their expertise and it is not possible to achieve true specialisation in surgery."
    - No British consultant would get through an appointments panel without fully adequate training and experience in emergency surgery. That includes, of course, recognizing what he/she or the department can't cope with and needs to transfer. In fact that's a major part of training - understanding what you can't do, as opposed to what you can do. The phrase 'true specialisation in surgery' presumably refers to specialisation in Emergency Surgery – but there is no such specialty. There is easily enough emergency work at Withybush for the consultants to maintain their expertise (average of six emergency surgical admissions daily). However any lay reader will see that sentence as indicating that currently in Hywel Dda the consultant surgeons are no good at dealing with emergency surgical on call, except at Glangwili. This is not true.

- Re the second sentence in that paragraph, the reference to 'sub-specialisation' and 'accredited surgeons in some specialties' is also misleading:
  - "The service in Carmarthenshire achieves sub-specialisation more easily than the other counties and has accredited surgeons in some sub-specialties."
    - In Withybush, the consultant general surgeons are accredited - and that means having the appropriate post-Fellowship training and College Accreditation with certificates to prove it - in either Colorectal Surgery or Breast Surgery. In Glangwili, they are accredited in Colorectal Surgery, Upper Gastro-intestinal Surgery, and Vascular Surgery. There is no such thing as accreditation in Emergency Surgery. The Health Board are implying that there is, and that the Glangwili surgeons have it, and the others don't. That's untrue. What is true is that certain complex emergency surgical problems may require dealing with elsewhere and it is the job of the experienced general surgeon to assess and transfer appropriately – often to a regional centre in Swansea or Cardiff. But the vast majority of emergency surgical problems fall well within the expertise of a fully trained general surgeon, most are colorectal actually, as long as he/she has the facility on site.

- The third sentence is partially correct. Though there was for many years a dedicated theatre (Theatre 1) at Withybush, successive health authorities failed to staff it.

Finally in this paragraph and indeed in all their documents, the Health Board have ignored the recommendations of both the Royal College of Surgeons of England and the Welsh Assembly Government to take account of the rural nature of some hospitals. Because of the importance of these considerations, we quote:

17 Technical Document 3 "Acute Surgery and Surgical Specialties" pp.31-2
18 Royal College of Surgeons of England 2006, "Delivering High-quality Services for the Future"
19 Welsh Assembly Government 2009 "Rural Health Plan: improving integrated service delivery across Wales" p.46
Hospitals serving a population of 150,000 or less are found in many geographically remote parts of England and Wales. Advice offered regarding the organisation of services usually centres around the hospital working in close partnership with adjacent services to make use of those specialist services not available on site. During the working party's health-system visits it became clear that this advice, while well intentioned, is not always practical. Hospitals do work closely with other units within the Trust wherever possible, but often there are such distances between sites that networking is not possible, and providing outreach services to different hospitals within the Trust is difficult. There is a potential conflict between the trend toward managed clinical networks and contestability. Also, outreach services are costly to provide and do not help with running a competitive service. However, outreach services may help to generate new referrals and thus potential income in an era of patient choice. Rural hospitals will now also face the difficulties of competition, contestability and new funding arrangements. Where more centrally located units will have the option of closing down services on one site to be provided on another, the rural units do not have such inherent flexibility. Furthermore, in many cases, the Trust must provide, for example, A&E services on each site and have no hope, therefore, of lowering their reference cost. This means that rural units will be severely disadvantaged in the world of PBR and contestability. The siting of ISTCs near to rural hospitals will seriously compromise their already fragile income base. The College would strongly urge the government to consider the plight of rural hospitals and act accordingly to protect them. Multi-site rural hospitals may have some flexibility when it comes to centralising onto a single site but this flexibility may be impaired by clinical or political factors. In addition, there are limitations on the extent to which patients in a rural setting can exercise choice. The larger urban areas of the country will offer a more accessible choice of service provider. Rural areas with a smaller population density are less attractive to independent sector providers entering the market. This, combined with the distance to the neighbouring acute Trust, may restrict patients' ability to access a choice of service providers.

(p.39): “Centralisation based on clinical need. As with any method of service configuration, there are advantages and disadvantages to the centralisation thesis. The College does not support the wholesale centralisation of services for a number of reasons, not least of which is the difficulty of repatriating patients to their local hospital and community service. However, where there is evidence to suggest a positive relationship between large volumes of activity and clinical outcomes, as is the case for some highly specialised surgical interventions, then the centralisation of services must take place. Research has shown that patients are willing to travel to access specialist care. However, because of the method of strategic planning and governance within the NHS, centralisation based on clinical need has often been difficult to achieve, despite professional evidence on safety and cost having been provided. Identified benefits should be considered when designing services and the relationship between volume and outcome should not always be used to support the centralisation of services – a critical mass of patients can also be met using the managed clinical network approach across geographical areas. For example, centralisation of specialist services has occurred with regard to the surgical management of a number of cancers. Such decisions have not always adequately taken into account the knock-on effect on the provision of surgical services to patients with benign and emergency conditions. In addition, the creation of specialist centres can lead to de-skilling of surgical teams in peripheral hospitals.”

.. and 19 (p.46): “a totemistic adherence to critical mass cannot be justified.”

The upshot is that the Health Board want to centralise emergency services at Glangwili because they claim that is the only way they can fulfil guidelines - and that is understandable. But here are the four things that constitute their failure to bolster that case:

1 They have made misleading statements about surgeons and specialisation.
2 They have failed to take account of relevant comments in the guidelines by adopting a “totemistic adherence to critical mass” (see above).
3 They have failed to point to any evidence that the proposed centralisation will make any difference to mortality and morbidity. In fact there is no compelling evidence 5.
4 They have failed to consider the knock-on effects on the services that remain having removed some to centralization, and potential mortality as a result.