Pembrokeshire Health Concern (PHC).

May 2012. Proposed plan for reconfiguration of Health services in Hywel Dda

Introduction

We agree that owing to demographic change, technological developments and recruitment issues, no change is not an option. However we disagree with many aspects of the Health Board’s “Your Health Your Future” options. We believe that it is the responsibility of the Health Board to ensure both equality of access to services as far as possible, and equality of hospitals so that they are all seen as attractive places to work. Many of the options so far suggested would not fulfil these criteria.

The Health Board’s "listening exercise" finished on 30th April 2012. However, the Longley report which is a crucial determinant of reconfiguration was not made public until the second week of May. Therefore we expect both the Health Board and the Welsh Assembly Government to “listen again” before coming up with their announcements – to our proposals influenced by that report.

Accordingly we lay out in this document our plan and in the Appendices the principles behind it, and elaboration of certain aspects. The essence is the conservation of Bronglais and Withybush Hospitals as traditional District General Hospitals though with enhanced organisational culture, the conversion of Glangwili Hospital to a Specialist Hospital, though without all the Core Services that are so necessary in the more remote areas, and the removal of Prince Philip Hospital from Hywel Dda to Abertawe Bro Morgannwg in order to commence a fruitful partnership with Morriston Hospital, Swansea while continuing to serve Hywel Dda.

Our proposals

1. Enhanced Community Support, use of Telemedicine and Videoconferencing, Avoidance of Unnecessary Hospital Admission and Delayed Discharge.
   These are all aspirations of the Hywel Dda Health Board with which we heartily agree. Because up to 40% of patients in hospital at any one time probably do not need to be there, but lack adequate community support, this is probably the single most important factor that can reduce the excess costs of healthcare, and will allow for development of world class quality in the local hospital services.

2. Bronglais and Withybush Hospitals to retain Core Services, namely Accident and Emergency, Emergency Surgery, Trauma and Orthopaedics, Obstetrics and Gynaecology, Paediatrics, Elective General Surgery, General Medicine, Diagnostics including Laboratory and appropriate Radiology facilities, Intensive Care, all 24 hour consultant–delivered.
3. **Glangwili Hospital, Carmarthen and Prince Philip Hospital, Llanelli to retain Urgent Care Centres**: patients requiring full Accident and Emergency services would be taken either to Morriston Hospital or, in the Western end of the county, to Withybush Hospital. While this would not be considered ideal by the local population, the number of people inconvenienced would be the minimum possible, and every person would be within four minutes of the “Golden Hour” accessibility to an Accident and Emergency Department (see Appendix 4). Additionally the Llanelli area should be removed from Hywel Dda and placed under the Abertawe Bro Morgannwg Health Board in Swansea. Prince Philip and Morriston Hospitals would then function as a two-site hospital with facilitation of staff sharing, education training and facilities. Glangwili would remain as a Specialist Hospital serving the whole of Hywel Dda with certain facilities for which centralisation is evidence-based (see below), and the other 91,000 residents of Carmarthenshire with basic facilities.

4. **Hyperacute Stroke Centre to be established at Glangwili Hospital**. This is strongly evidence-based (see Longley report). Patients from the most distant parts of the Hywel Dda area would only be required to spend approximately three days there prior to return to their base hospital. This approach has been shown to improve outcomes including survival.

5. **Vascular Surgery to be developed at Glangwili Hospital**. There is already a significant service that rotates with the Morriston centre and it would make sense for this to continue. This implies development of:

6. **Interventional Radiology at Glangwili**. Huge advances in this sub-specialty have made it applicable across a number of disciplines including Vascular Surgery. There is currently a big requirement for these skills which can save lives and avoid operations.

7. **Urology at Glangwili and Prince Philip Hospitals** as currently practised.

8. **Benign Upper Gastro-intestinal surgery at Glangwili Hospital**. Cancers of the stomach and oesophagus have already been centralised to Cardiff but there remains a significant load of surgery for benign conditions, such as obesity surgery, for which the skills are already available in Carmarthen. This can be developed for the benefit of the whole Hywel Dda population.

9. **Major Trauma**. Improved triage and retrieval at the site of accident will result in bypassing of the local hospital and transfer directly to major trauma centre at either Morriston or University of Wales Hospital, Cardiff. This is strongly evidence-based, more lives of the most severely injured patients will be saved in this fashion. There is no evidence that a centralisation of trauma services at a lesser “centre” without full support on site (as suggested by the Hywel Dda Health Board) will improve outcomes, and that would be associated with the loss of the “Golden Hour” and attendant risks for the remaining hospitals. The majority of trauma cases do not need major centre care, but some may lose their life or suffer unnecessary permanent disability if not treated within one hour.
10. **Breast Cancer Centre at Prince Philip Hospital, Llanelli.** There is already a new charitably funded centre there. The current excellent service at Withybush would eventually cease with the retirement of the distinguished Breast Surgeon there, the Llanelli service can be built upon for the benefit of everybody in the Hywel Dda area.

11. **Complex Orthopaedic Centre at Prince Philip Hospital, Llanelli.** By complex orthopaedic surgery is meant anything other than elective primary hip and knee replacements and routine minor procedures, which would remain at the base hospitals, together with routine trauma management (simple broken bones and soft tissue injuries). Examples would be revision joint replacements, hand surgery etc.

12. **Colorectal Cancer Centre at Withybush Hospital.** This would build upon the already well-developed Laparoscopic (“keyhole surgery”) and Enhanced Recovery service at Withybush Hospital. Enhanced video-conferencing bringing in surgeons at Bronglais and Glanwgili Hospitals would enable appropriate cases to be managed at the local hospitals, more complex cases would be brought to Withybush. This would have the advantage of allowing retention of emergency surgical skills in each hospital, so essential because of its remote location. We stress that colorectal surgery is complex surgery and requires the support of 24 hour consultant-delivered Emergency Surgery on site.

13. **Staffing issues.** We would anticipate improvement in recruitment as soon as uncertainty is stopped with announcement of definitive plans. More controversial, but we believe viable in the long run, would be derogation from the European Working Time Directive. In the case of General Surgery, for example, the Royal College of Surgeons in conjunction with the Association of Surgeons in Training has been negotiating with the UK Government for this for several years. They have produced a model 65–hour rota which fulfils all the requirements for rest and greatly enhances opportunities for training (for more on EWTD see [http://www.zen142533.zen.co.uk/OldSWATStuff/EWTD/EWTDlinks.htm](http://www.zen142533.zen.co.uk/OldSWATStuff/EWTD/EWTDlinks.htm)). With political will this would be achievable in most of the specialties. Since the number of doctors needed to cover a 24 hour rota is directly related to the maximum number of hours they can work, replacing a 48 hour rota with a 65 hour one would reduce medical staff requirements by a factor of 48/65, while enhancing training.

14. **Funding.** The Welsh Assembly Government to incorporate unavoidable excess costs of which a significant component is degree of rurality, in a fashion similar to that used by the Scottish Health Service ([http://www.nrac.scot.nhs.uk/](http://www.nrac.scot.nhs.uk/)). This would result in approximately 4% increase in funding for our rural area, and would be the first time ever that the principle of equity has been fulfilled for our local people.
Appendix 1. Recruitment problems

With the exception of national problems such as Radiology, Accident and Emergency, prior to the current prolonged period of uncertainty Withybush had minimal recruitment issues. An examination of events resulting in the removal of Histopathology services from Withybush shows that Hywel Dda did not advertise for a replacement for 17 months, then took a further 6 months to interview suitable applicants and then appointed them for Carmarthen. In the process the two remaining consultants at Withybush had resigned, and two excellent locums who could have replaced them, were driven away (one of these did work at Carmarthen for about a year but subsequently resigned, to a job in Bury St Edmunds). Subsequently the Health Board have complained of difficulties in recruitment, but this was clearly a problem created by them, that could have been avoided. PHC have repeatedly highlighted this issue in order to alert the public to the possibility of the employers trying to behave in the same way with other specialties. Other aspects of recruitment and staffing are dealt with in Appendix 2, section 5.

Appendix 2. Principles behind PHC plan.

1. Core Services. These are services that a) are needed for immediate saving of life, and b) depend on one another. Removal or restriction of one will lead to disintegration of the others. Because of the remote location of Bronglais and Withybush Hospitals, there is no safe alternative to retaining their Core Services. However, retention of Core Services is not necessary in Carmarthenshire because of ready access to Morriston Hospital via dual carriageway and motorway. Various factors that reinforce this view include the high rate of road traffic accidents in Pembrokeshire (http://www.wales.nhs.uk/sitesplus/922/page/49928), the presence of more tourist and industrial activities than in Carmarthenshire, and studies demonstrating increased mortality with increased distance to hospital. Recently the Withybush Consultant and local management body combined have confirmed these views in their response to the Health Board’s “listening exercise” that is now in the public domain. It reasserts what Core Services are and that they should remain at Withybush. PHC have made this document available at http://www.zen142533.zen.co.uk/SWATcontd/campaign_documents/Withybush%20response%20CSS%20version%2004.2%20final%20draft.pdf, and a one page version from the Consultant body that was sent to the Chief Executive: http://www.zen142533.zen.co.uk/SWATcontd/campaign_documents/MSC%20view%20of%20core%20services.pdf. The latter is expressed in absolutely clear terms and additionally advises that some services in Carmarthen should be downgraded.

2. Evidence. All changes must be evidence-based.

1. Here we do not refer to patients with severe injuries for whom it has been shown that correct triage and direct transfer to a major trauma centre is indicated, bypassing the local hospital. We refer to various conditions including trauma that do not need a major trauma centre, but whose lives would be put at risk without rapid access to emergency treatment. Below are two studies demonstrating this.


3. **Current services.** Services that are already good should be built upon in a way that benefits the whole of the Hywel Dda area, and not swept away in favour of political dogma. Services that are sub-optimal or difficult to sustain require evidence-based solutions that will vary from service to service.

4. **Centralisation.** While there is evidence favouring centralisation of certain services, often those that require improvement would benefit, not from centralisation into fewer facilities, but from grass-roots application of robust, sustainable and reviewable protocols and infrastructure. This is stressed in the Longley report.

5. **Recruitment.** Significant contributors to current recruitment problems are a) the prolonged period of uncertainty caused by the Health Board and the Welsh Assembly Government, b) the European Working Time Directive which has seen doctors’ hours reduced to 48 per week, in the face of opposition from many of those whom it was supposed to benefit – the junior doctors themselves, c) immigration restrictions that have stifled the flow of doctors from Asia, d) occasionally, specific actions of the Health Board (see item on Histopathology above). Realisation of this leads to commonsense solutions.

6. **Capacity.** Historically Ceredigion and Pembrokeshire have always played second fiddle to Carmarthenshire because of decisions in Cardiff; this has led to a significant excess of inpatient bed capacity in Carmarthenshire per head of population, which cannot be justified on the basis of equity of access to care. Furthermore, Bronglais Hospital in Aberystwyth takes a significant proportion of its patients from outside the area (Powys and Gwynedd), which magnifies the effect (see [http://www.zen142533.zen.co.uk/SWATcontd/engagement.html#carmarthenprepared](http://www.zen142533.zen.co.uk/SWATcontd/engagement.html#carmarthenprepared)) 45. Acceptance of this fact will affect capacity decisions through the three counties.

7. **Funding.** Historically the Welsh Government has not accounted for the known unavoidable increase in expense of running a healthcare service in a rural area. This is in contradistinction to Scotland. If the principles used by the Scottish Government had been applied in Wales, Pembrokeshire would have received over 4% greater funding for its health service (see Powerpoint presentation at [http://www.zen142533.zen.co.uk/OldSWATStuff/Rurality%20in%20Wales%20and%20Pembrokeshire.pps](http://www.zen142533.zen.co.uk/OldSWATStuff/Rurality%20in%20Wales%20and%20Pembrokeshire.pps) and the updated Scottish system at [http://www.nrac.scot.nhs.uk/](http://www.nrac.scot.nhs.uk/)). Similar considerations apply to Hywel Dda as a whole.

On the above basis, our plan would centralise services in two hospitals i.e. Withybush and Bronglais. Services that are already good would be built upon in all three counties. The hospitals in Carmarthenshire would serve as centres for certain specialties for which evidence shows that centralisation will be beneficial for the whole population of the Hywel Dda area. Should our plan exceed the funding available, then the area to introduce further economies will be the hospitals and services in the East, because neither Pembrokeshire nor Ceredigion people can safely endure the risks of further cutbacks in their areas.

---

4. We are grateful to the Hywel Dda Community Health Council for allowing the use of their bed count figures.

5. Excess capacity at Glangwili Hospital at the expense of the three other acute hospitals is also identified independently by SOSPPAN: see [http://www.sosppan.co.uk/upload/Proposals%20Rev15.pdf](http://www.sosppan.co.uk/upload/Proposals%20Rev15.pdf) pages 3–4.
Appendix 3. Road infrastructure – some considerations.

Llanelli the largest town in Carmarthenshire is only 12.6 miles from Morriston Hospital, six of them on motorway. Carmarthen is only 27 miles from Morriston via dual carriageway (the last eight on motorway).

Haverfordwest to Glangwili Hospital, Carmarthen is 32 miles via mainly A road congested in summer and is not uncommonly blocked by accident (3 in 1 month recently) or snow etc. The road is only dualled for the last nine miles.

Milford Haven to Glangwili is 39 miles, 7 more miles on congested A Road.

St David's / Fishguard to Glangwili is 47+ miles, 15 more miles on twisty A road and even worse for Ceredigion.

This leads to inequities of access, should patients require to be taken to Carmarthen for Accident and Emergency services (see Appendix 4 below for a more detailed examination of this).

Appendix 4. Population and other demographic considerations

The following considerations demonstrate that far fewer patients in Hywel Dda would be inconvenienced or put at risk by removing full Accident and Emergency facilities from Glangwili Hospital than from Withybush. Additionally this would mitigate against adverse environmental effects and cost from excess travel using fossil fuels.

There are about 93,000 people resident in South East Carmarthenshire who can reach Morriston Hospital more quickly than Glangwili, and the Health Board has admitted that in 2010, 1100 ambulances took patients from the Llanelli area to Morriston in preference to Glangwili. If this population is subtracted from the Carmarthenshire total the effective catchment population for Glangwili at about 91,000 would be only slightly higher than Ceredigion – but Bronglais not only serves Ceredigion with its population of 84,000 but also neighbouring areas of Powys and Gwynedd, accounting for an unspecified number, perhaps 20,000 (we await a definitive number from Aberystwyth managers).

When these factors are placed against the population of Pembrokeshire at 119,000 that swells to about 200,000 in the summer, it is easy to show that far fewer people would be inconvenienced – or put at risk – by a downgrading of Glangwili Hospital with loss of Accident and Emergency – than if Withybush were the hospital to be downgraded. This was worked out by Henry Jones and Gary Hicks (members of the Pembrokeshire Community Health Council) in 2006. If Glangwili were downgraded, about 9,200 people in Carmarthenshire would have a travel time to their nearest A&E of between 60 and 64 minutes, whereas if Withybush were downgraded, 21,000 would have a travel time of over 60 minutes of which 12,000 would be over 70 minutes (see http://www.zen142533.zen.co.uk/OldSWATStuff/SWATlinksOld.htm#chcstuff). Translated to today’s population figures, that would become 10,200 versus 23,200 with 13,300 people over 70 minutes.
Other facts that contribute to the case for retaining full services in Haverfordwest are:

- within a nine mile radius of Haverfordwest there are 89,000 people whereas around Carmarthen there are only 42,000, of whom 17,000 are in the overlapping nine mile radius around Llanelli.
- the population of Tenby swells from 5,000 in the winter to 95,000 in the summer.
- throughout the year there are 300,000 visitors to St David’s Cathedral.

In Pembrokeshire there are more county assets that require healthcare than in Carmarthenshire due to tourism and industry and other activities both on land and at sea – oil terminals, LNG, coastal path walkers, theme parks, marinas, two army bases. Additionally there is an exceptionally high rate of deaths from road traffic accidents in Pembrokeshire (http://www.wales.nhs.uk/sitesplus/922/page/49928). While this could be alleviated by preventive measures and better triage with direct transfer to major trauma centres in Swansea or Cardiff, the majority of injuries which are not in the category requiring major trauma centre care, would be put at risk of death or permanent disability by not having access to a nearby emergency facility. Increasing road traffic by centralising facilities in Carmarthen would further increase the risk of accidents in Pembrokeshire.

**Further reading.** We recommend the Longley report which forms much, but not all, of the basis for our recommendations: http://www.welshconfed.org/WHSCpapers.htm.

**Who are Pembrokeshire Health Concern?**

We are a small group of people formerly associated with SWAT (Save Withybush Action Team). We decided that we could not continue with that group when without our agreement a policy was announced that included the closure of Glangwili Hospital. We felt that this clearly will not happen and as such the idea is more a political manoeuvre than a sensible option.

We have developed this plan in the hope of achieving the best possible result for all three counties, with two District General Hospitals at the periphery where they are needed, a Specialist Hospital nearer the centre, and the other one transferred to a mutually beneficial relationship with the Abertawe Bro Morgannwg Health Board, while able to continue to serve Hywel Dda.

We realise that our proposals contain three suggestions that (at least in Wales) are radical. These are derogation from the European Working Time Directive, funding to account for the rural nature of our area, and the transfer of one of our hospitals into a different Health Board area. We justify these on the basis that radical problems require radical solutions.

---

6. Figures obtained from Councillor Peter Stock
7. Quoted by Dr George Middleton of St David’s
8. Reference provided by Heather Scammell