Response to South Wales Programme Public Consultation

On behalf of RCT Welsh Liberal Democrats. June 2013

RCT Welsh Liberal Democrats submitted a fairly substantive response to the initial round of public engagement in which we stated:

"In much of the over-arching theory behind these proposals there is little to argue with. Nobody could disagree with having centres of excellence for major trauma and highly specialised services. – If the patient's need is that urgent and severe then they need to be in the place where they will receive the best treatment and their survival rate is greatest.

However, there is some way to go in educating the public, and also in ensuring that the community based services which are referred to are actually provided to an acceptable standard."

During the consultation stage we have attended public meetings, held discussions with various healthcare professionals, and spoken to many members of the public.

Overall we are still of the opinion that, under the circumstances in which the Welsh NHS finds itself there have to be changes made as the current situation is not sustainable.

It is disappointing, though, that the feedback from the public engagement and the subsequent public consultation process has failed to answer a number of the questions which many people have in relation to the programme, and indeed in some instances has raised more.

As with our earlier response, we will divide this into two sections, firstly the over-arching programme and comments on the proposals and secondly addressing the issue of the various options and our support for Option 4 which includes the Royal Glamorgan.

OVERALL PROPOSALS

STAFFING ISSUES

As we have said previously, we accept the argument that for training purposes doctors want and need to train in busy departments where they can gain specialist knowledge. It must be said, however, that this state of affairs is not new, and it is disappointing that the Welsh Government have failed to come to terms with the situation across Wales in relation to this.

The BMA was recently quoted in the press as saying

""We recognise the difficulties involved in attracting doctors to Wales in certain shortage specialities but that does not account for all the vacancies we see in Wales, many of which are a result of deliberate vacancy control policies by health boards.

"The difficulties in recruiting junior doctors are well known and a fresh approach in making the quality of training and experience for trainees in Wales a top priority must be pursued."

The recruitment figures being quoted in order to implement the new programme of services effectively are quite frightening, and the historic inability to recruit anywhere near the number of senior doctors and specialist nurses needed in Wales does not fill us with confidence.

The public need to be assured not only that these recruitment targets can be met and so there will be a better level of patient care in an emergency, but that staffing shortages will not prevent the non-critical care services from being effectively delivered. That the A&E departments who are not chosen as one of the major centres can deal with the patients who go there and do not end up like the Minor Injuries Units in the area, with limited opening hours and patients needing to make an appointment to go there..

We know that there are insufficient neonatal cots in Wales now, and that staffing shortages were responsible for the downgrading of the unit at the Royal Glamorgan in 2008. What happens if the required number of senior and specialist staff are not found to cover the five centres proposed?

It is claimed that the new specialist care centres will be more attractive to doctors, and they will receive better training and be able to specialise more readily, and we can see the logic of this. Yet surely the flip side of this is that the hospitals who are not amongst the five major centres will find it harder to recruit staff?

Will the quality be maintained in non consultant led maternity units? Will there be the paediatric staff to keep outpatient care going? Will staff want to work in a basic level A&E unit that does not provide critical trauma care?

The National Assembly's Children & Young People Committee produced a report into neonatal care in September 2012. It highlighted the fact that staffing shortages are a major problem across Wales. Can we be assured that if these changes go ahead and fewer units are spread across the area that those units will be adequately staffed? Will there be the overall increase in neonatal cots that has been identified as a need?

The Committee report states

"Although the local health boards have stated that they are taking the increasing birth

rate into consideration in their future planning, given that local health boards are already facing staffing shortages and capacity issues, the Committee is apprehensive that unless these issues are dealt with effectively they will intensify in the future."

Can we be assured that the planned changes will take this into account?

Looking at the wider picture the ambulance service will have a crucial role to play in the success of the proposed critical care centres. Yet we are hearing reports that that service too is suffering from staff shortages, and that stations are having to be shut down on occasion because there are insufficient staff due to sickness, staff being on leave, or cutbacks in personnel.

The latest review has promised changes, but will these be adequate, and will they take place in time for the implementation of the SWP?

It seems that no satisfactory answers have been forthcoming and that a lot of the plans are based on supposition and even a degree of wishful thinking.

Your workforce modelling technical document does nothing at all to allay any concern with regard to future staffing.

The level of up-skilling of nursing staff required is substantial, and questions must be raised over whether it is achievable, given that these skill shortages have existed for some time and the Welsh Government seems to have done little to address the problem. Where will these staff suddenly appear from? Will the training programmes be in place?

The on-going problems with regard to the recruitment and retention of junior doctors are highlighted, although this seems to have been played down both in the main consultation document and in the public meetings.

As stated in the workforce document

- Reducing training posts combined with the inability to appoint sufficient permanent or temporary middle-grade level speciality doctors may result in existing paediatric rotas becoming unsustainable before the South Wales Programme consultation on reconfiguration of acute, inpatient paediatric services is completed

- Wales continues to be seen as an unattractive place for junior doctor training. This would not alleviate the current recruitment difficulties.

Such statements do not instil confidence in the ability of the Programme to deliver, and it would seem that there is a substantial amount of work still to be done.

FINANCE

The SWP and Health Board representatives have been adamant from the start that this is not a money saving exercise, but that, on the contrary, the reorganisation will cost money.

However, it is stated in the consultation documents and was confirmed at the Pontypridd public meeting that there is no information available as to the capital expenditure that will be involved. Revenue costs have been estimated but not capital costs. These will apparently be worked out during the 'implementation stage' because it is not known at this point which option will be finally chosen.

It appears incredulous that at no point during this extensive exercise has anyone sat down, looked at the current estates and put together at least basic, approximate capital costs for each option, especially when the SWP has effectively ruled out all but two of those options. How can the scheme have progressed this far with no consideration given to building / remedial / remodelling works that will need to be undertaken?

Will there be substantial differences in capital costs depending on which option is chosen? Where will the money come from? What if it simply is not there? Where is the business case for these proposals? We think there should be input from the Welsh Government which addresses these questions prior to any changes being made to critical care services.

Money should not be the deciding factor in any changes which affect the health of the people of South Wales, but the financial position cannot be ignored either. It has to be a consideration, and this consultation process is flawed in not including an analysis of it.

You cannot simply state that the *"capital funding is likely to be requested from the Welsh Government's capital programme"* without some indication of how much that is likely to be and when this request would be made and the money expected to be available. The Government capital programme is much in demand, and we all know the state of Health Board budgets.

THE SCCC AT LLANFRECHFA

Every option in these proposals centres around three 'fixed points' which include the proposed new SCCC in Cwmbran. Yet work on this has not even started yet, it is way behind its original time scale and doubt has been cast over whether it will happen at all.

The Cwmbran SCCC was planned by Gwent Health Authority way before the current plans came into being. According to their initial plans it should have already been built. Back in 2006 the then Welsh Health Minister said building would start in 2009, then in 2011 it was said that it would start by 2013. **At the time of writing the new Health Minister has said that he is still considering an outline business case.**

When questioned in the Assembly Chamber by Welsh Liberal Democrat leader Kirsty Williams on 5th June 2013 as to when the hospital may be built, the First Minister said that *"It is tied up with the issue of the programme board, and the results of any consultation."*

So we are left with huge uncertainty over this centre, the projected costs of which are rising all the time. There is also a body of opinion which says that it is too small to cater for the needs of the population it is intended to serve.

This centre is one of the cornerstones of this whole project. If it does not go ahead then there will be six centres across South Wales still, not the planned five which we are being told is the maximum number that is acceptable and able to offer safe services to the public.

If reassurances cannot be given over something as major as this then how can we be sure that the rest of the scheme will follow on*?*

SUPPORT SERVICES / PRIMARY CARE

There is still a major concern that there will be an amalgamation of services across fewer hospital sites with none of the promised increase in community based services. A&E units are often over-burdened because patients simply cannot access treatment for minor injuries and ailments elsewhere in a timely manner.

If the proposed changes are to go ahead then, as stated in the consultation documents, an improvement is needed in primary care and community based services along with a publicity drive to ensure people know where they should go for the most appropriate treatment.

There is confusion over which is the best course of action now – MIU, GP or A&E. Someone who has slipped in the street and hurt their ankle doesn't know if it is broken or not – that is why they seek medical advice. Yet under the current system they can turn up at the MIU in, for example Cwm Rhondda – after phoning for an appointment and waiting until the allotted time of

course – only to be told that they do not deal with breaks there, and they have no X Ray facilities, so they have to go to A&E.

If the new plans are put into operation then there will be an added layer, and along with that more confusion, especially given some of the misinformation that is being put around in certain quarters.

A greater number of community outreach nurses would help alleviate pressure on neonatal units as more babies could be discharged earlier. Will this be put into place? The fear is that due to staff shortages this will not happen and we will merely end up creating increased pressures on fewer hospitals.

Where are the proposals and business plans for the strengthened Primary care services? It cannot be looked at as a separate issue, health services should be fully integrated. What of the extra staff and facilities needed to support patient care in the community, where will they come from, when will they be put into place, how much will they cost and where is the money coming from?

FUTURE CHANGES

On 11th June Health Minister Mark Drakeford launched the delivery plan for the critically ill. It made for stark reading, and yet again painted a bleak picture of another section of the Welsh NHS.

There are 3.2 critical care beds in Wales per 100,000 of population, below that in the rest of the UK. Worryingly it states that “"unknown number of patients who should receive critical care (are) being denied access due to capacity shortages".

In some instances there is over 100% occupancy, and 111,377 critical care bed hours were lost due to patients awaiting discharge to ward beds in 2012/13.

Yet again as part of the solution it is recommended that “care would be better if spread across fewer hospitals than the current 17 in order to concentrate expertise.”

The SWP consults on a small number of critical care services, but this plan makes it clear that there could be more changes to follow shortly. If the number of centres offering critical care beds were to be reduced then undoubtedly the centres chosen would be the ones being talked about to provide consultant led specialist services now.

This makes it all the more essential that the right choice is made now.

Notwithstanding the reservations expressed above, if the changes are to go ahead then we strongly believe that the right choice is option 4, which includes the Royal Glamorgan as one of the five centres, along with Prince Charles.

The case for retaining critical care services at the Royal Glamorgan

(OPTION 4)

ACCESSIBILITY

Whilst patient safety, care and health outcomes must be of paramount importance then we also need to consider issues of accessibility which we would argue are integral to achieving this. Whilst the majority of patients accessing the services under discussion may travel by ambulance, their families won't. Those families provide an important support network in the case of patients with severe injuries, those with life threatening illnesses or events, paediatric cases, and babies needing special care. The extra strain put on families is an important consideration.

Transport links are so poor as to be virtually non-existent in some instances – public transport is not as good as it should be, and road links and traffic problems mean there is considerable difficulty in travelling from the Rhondda across to Bridgend or Prince Charles. During the winter months harsh weather often leads to road closures which greatly affect travel time, and this has not been taken into consideration in the analysis of the options put before us.

The Royal Glamorgan is generally speaking far more accessible than the Princess of Wales, with a better road network in the vicinity. It is minutes from the M4, and a dual carriageway links the motorway and the hospital. From the Bridgend area it is accessible from either the motorway or several 'A' roads. People from the Rhondda travel down the A4119, and from the Pontypridd area there is the new by pass.

We believe the data presented in the consultation documents does not make a strong enough case for one hospital over the other, and would dispute the journey times given in many cases. The 'as the crow flies' distances may give a false impression, as there are numerous 'B' roads around the Princess of Wales, and along the shortest routes from the Rhondda.

EFFECT ON OTHER HOSPITALS

There is a great deal of concern locally that if services re removed from the Royal Glamorgan then other hospitals will not be able to cope with the increased demand.

Some have argued that the SWP figures do not take into account natural patient and travel flows. They say that, for instance, many people would naturally choose to travel down to UHW for services rather than across to Bridgend or up to Prince Charles as the road network makes that easier. This would put more strain on services at UHW than has been accounted for.

They also point to the fact that parking is a problem at UHW and that there is a cost involved in parking there which is not the case at the Royal Glamorgan or other hospitals.

Several people have been putting this argument forward, and whilst there may be some merit in it, as undoubtedly the natural traffic flow would take people in that direction, we also think it may be adding to the overall confusion.

We have made the point previously that public education is essential if this reorganisation is to have any chance of delivering an improvement in patient care. People have to know exactly what level of treatment and what services they can expect to be available at any particular hospital / health care centre.

As we understand it then the proposals are such that the majority of patients requiring these critical care services would be travelling by ambulance and would have no choice as to where they were being taken. However, there would be a percentage who would still turn up by car and the assumptions being made about patient numbers need to take into account the natural flow of traffic and where that would take them. Would UHW be able to cope with the extra numbers?

The Royal Glamorgan currently acts as the overflow hospital for UHW, and the centre used if A&E there has to be closed for any reason. Removing consultant led services from the Royal Glamorgan would have a seriously detrimental effect for a large number of residents in West Cardiff and parts of the Vale of Glamorgan.

THE LOCAL POPULATION - DEPRIVATION AND HEALTH

It has to be borne in mind that there is a substantially higher number of elderly people in the Rhondda than the Wales average. STATS Wales places it at 23.45% of the population as opposed to a Welsh average of 22.83%.

The percentage of older people with limiting long term disabilities across all three constituencies – Rhondda, Cynon and Pontypridd – is given as 64.84% against an average of 54.81%. They are more likely to require access to A&E services generally and specifically to critical care services.

There is no end of research which suggests that deprivation and poverty are linked with a significantly higher incidence of low birth weight babies and premature births. Teenage mothers are more likely to give birth to low birth weight babies, and to deliver before full term, and Rhondda Cynon Taff has amongst the highest teenage pregnancy rate in Wales, along with neighbouring authority and Cwm Taf partner Merthyr.

Looking at the Lower Super Output Area divisions as used by Stats Wales, out of the 152 in Rhondda Cynon Taff 27 are amongst the top 10% most deprived in Wales. 20 of these are in the 'catchment area' of the Royal Glamorgan. Patients and families would have to travel further if Option 3 were taken forward, and so would be unfairly disadvantaged.

The latest stats for the 1896 LSOAs in Wales show that with regards to health deprivation Bridgend has 34 LSOAs in the top 500. RCT has 75 of which 53 are in the Rhondda and Pontypridd constituencies residents from which would presently attend the Royal Glamorgan.

With regard to the top most deprived 10% according to health indicators RCT has 23.7% of its LSOAs in that band whilst Bridgend has 15.3%.

To quote from the SWP's own Equality Impact Assessment (EIA):

"Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways."

"The EIA will help us answer the following questions:

- *Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?*
- *Is there potential for, or evidence that the proposed changes will affect different groups differently?*

"Some will be affected more than others. For example:

- *New parents of seriously ill new born babies and the babies themselves. Relatives of the baby who want to offer support to the parents and to visit the baby in hospital.*
- *Older people, disabled people or people with other health conditions or impairment that might result in more frequent use of emergency and the inpatient children's services described.*
- *Service users who rely on public transport.*
- *Service users in lower socioeconomic groups."*

The EIA thoroughly outlines the issues involved and the potential service groups who could be disadvantaged, but does not then appear to take the next step of adding in any weighting because of the socio-economic factors in the area.

We would argue strongly that the statistics referred to above with regard to health and deprivation when taken into consideration as part of a thorough equality impact assessment tip the balance in favour of the retention of services at the Royal Glamorgan.

CAPACITY ISSUES / DEMAND FOR SERVICES

The All Wales Neo-Natal Network report of 2012 stated that a significant part of the intensive care capacity problems relate to inappropriate distribution of critical care cots, resulting in some being under used whilst there are extreme pressures in other areas.

The demand is evident in the RCT area. The same Neo-Natal report gives the combined occupancy figures for high and low dependency cots. At the Princess of Wales in Bridgend the occupancy level was only 20.5% in 2011, whilst at the Royal Glamorgan the occupancy level is given as 174.5%.

So it would seem that if the plan is going to take into account demand and the provision of services where they are more convenient for the largest number of users then it would seem that an expansion of the service at the Royal Glamorgan would be sensible.

Stats Wales figure for occupancy of paediatric beds 2011 – 12 shows the following:

	Beds available	Average %occupancy (number of beds occupied)
Roy Glam	56	35.3 % (19.77)
POW	30	57.1 % (17.13)

Simple maths shows that the Princess of Wales does not have the extra 20 beds on average that would be necessary to incorporate the Royal Glamorgan patients without an expansion of the unit there, whilst the Royal Glamorgan has the existing capacity. It is surely not practical or cost effective then to close the larger unit.

In January 2013 the Children & Young People's Committee at the National Assembly for Wales undertook an inquiry into neonatal capacity.

Mark Drayton, Clinical Lead, Wales Neonatal Network presented a report which stated:

"There has been a major increase in demand for neonatal intensive and high dependency care in South Wales between 2011 and 2012.

The South Central and South East Communities have experienced large increases in the extremely preterm birth-rate between 2011 and 2012 while there has been a modest fall in the South West, in the same period.

The increase in activity experienced by units in South Wales appears to be attributable to the significant rise in the extremely preterm birth-rate.

Increased numbers of babies have been cared for outside their own Health Community in South Wales. Cwm Taf units have continued to provide some ongoing neonatal intensive care outside the context of a NICU, and without this, the need to transfer babies out of Wales would have been even higher.

"An additional 4 IC cots are required to meet the substantial deficit in provision that is evident in the South Central Health Community".

So yet again we have more evidence of the higher demand which exists in the South Wales Central area, which includes RCT. Also of the invaluable service which has been provided by the Royal Glamorgan.

THE STATISTICAL EVIDENCE PRESENTED

We have some concerns about the statistical evidence presented and the conclusions reached.

The focus groups seem to be very small indeed considering the catchment areas they cover – and, as stated in the 'Towards a preferred option' document, *"forums cannot be certified as statistically representative samples of public opinion."* Residents of the West of the Vale of Glamorgan were invited to the Bridgend group, but what about those from other parts of the Vale of Glamorgan who use the Royal Glamorgan of choice?

There were admitted variations in how the scoring was carried out, with some respondents using the RAG data and others just, it appears, going on gut instinct or their own experience. How can this give valid feedback? On issues such as safety and quality of service how can such opinion based 'evidence' from people with no clinical expertise be valid? It is surely just a subjective opinion?

There were 44 responses from the Abertawe Bro Morgannwg Health Board (out of a possible 47) but only 25 from Cwm Taf (out of a possible 34). It is not clear whether there was any weighting allowed for the difference in number of responses.

With regard to staff from individual specialities then it is interesting to note that Option 4 came out ahead in at least two of the specialities under discussion.

To quote Mark Twain, *"facts are stubborn things, but statistics are pliable."* It appears to the uninitiated that these statistics are indeed pliable.

In conclusion we would just like to add that the Royal Glamorgan is the newest hospital in the region, it was supposed to offer improved facilities for the people of the area. It is ludicrous to suggest that this should not be one of the five centres chosen to provide critical care services.

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