Response to the proposed changes in health care delivery in the area of the South Wales Health Board

This response has been informed by a focused analysis of the South Wales Programe commissioned by UNISON from Prof Tony Beddow, University of South Wales

Foreword

UNISON is the largest public sector trade union in Wales. In the NHS in Wales, we represent 35,000 members across a very broad spectrum of health related staff including community services, hospitals, acute treatment centres and the ambulance service. UNISON shares the objective of securing safe and sustainable services in the Welsh NHS. The approach we have taken across the reviews being conducted in Wales has been to take a strategic overview of the arguments proposed for change, without becoming engaged in specific local campaigns around individual sites or services. We have taken that same approach in considering the proposals for change presented in South Wales.

Executive Summary

Scope

It is noted that the current proposals for South Wales predominantly focus on three service areas:

- consultant led maternity and neonatal care,
- inpatient care for children,
- emergency medicine.

and UNISON notes these in no way cover the complex range of pressures facing the NHS in this, and other regions of Wales. It is therefore critical to ensure key questions are addressed as the Health Boards now start the work of reforming the NHS.

Indeed our advice would suggest that if the NHS is facing some of the recruitment pressures suggested that significant improvements are required to

our workforce planning arrangements in addition to issues around service configuration.

Further discussion, and reassurance, on the issues identified in this response, will therefore be critical to building confidence in the case for the ongoing reform of the health service in Wales.

Scoring of Options

The proposals emerge from a scoring process which weights various attributes of the changing configuration of services. Based on advice we have received it is not yet clear to UNISON that the proposals being made for Emergency Medicine are yet sufficiently detailed in respect of

- their consequences for other services on these sites, nor
- the experience of patients and users of the NHS.

We believe that the proposals would benefit from further evidence in stress testing elements of the proposals, including the ability of the Universityof Wales Hospital to achieve the service responses anticipated.

Our advice also highlights the assumption that the patient must travel to the clinical specialism but does not consider in great detail the options for medical expertise to travel between sites, or use tele medicine to assist in the delivery of services.

Consistent with our strategic view of the changes proposed UNISON wishes for further discussion to ensure a more holistic view of the changes that will affect our members in the units and geographic area under review.

Our submission also seeks reassurance that the public will understand how they will be expected to access different types of services, as their interests must be fully reflected in the changes proposed.

Financial and Other Demands

The process of change is also based upon costings which indicate the extra expenditure that will be required to deliver these specific proposals, let alone further changes related to the consequent remodelling of services.

UNISON is very aware of the difficult financial climate faced by the Welsh Government, public services and specifically our NHS in Wales. This means we have questions that must be addressed regarding the availability of funds to achieve the changes suggested (current and future unseen proposals) in South Wales.

The analysis UNISON has received also highlights a range of other additional costs that could well fall upon ambulance and other transport services due to the revised pattern of services proposed.

The plans so far presented require significant sums of capital and revenue money at a time when the public purse is under great pressure. Thus these plans are not driven by the straightened times in which public services now operate. Investment in the NHS for the three services mentioned may well be the only option. It does however raise the very obvious question of from where else in Wales is the money to come for what is, clearly, only one part of a major re-shaping of hospital care which in turn will lead to changes in ambulance and primary care – let alone other services.

Timescales

UNISON members will have an interest in seeking further clarity on the timescale of the changes proposed in the review. The union also believes that clarity on such matters will be fundamental to many of the detailed, and essential negotiations that will be required on employees terms and conditions, contracts of employment and to fully understand options and choices as change is progressed. This will include issues around relocation, retraining and career options that will have to be faced as a consequence of any process of change.

However even the information that is available suggests these changes could take over a decade to achieve – which begs some fundamental questions about the pace of proposed change given the scale of the challenge set out in the consultation papers.

To some this may sound a slightly contradictory point. However UNISON firmly believes that when changes are agreed the pace of change, and delivery of revised patterns of service, must be delivered speedily in the light of the challenges we all face.

Conclusion

UNISON submits this response as part of what we hope is an ongoing dialogue about the future of services in the geographic area under review. We reach no firm conclusion at this stage, as the expert advice we have received points to a number of areas in which further evidence, discussion and reassurance are required. This is consistent with our overarching approach in maintaining a strategic approach to the reviews and our members wish to help secure safe and sustainable services for the future.

We also hope that everyone involved in providing strategic political leadership, the management, planning and delivery of services, all staff working in the NHS, the patients and the general public are able to face the scale of challenge facing the NHS in Wales.

As always there are issues which have risen to great prominence during the period of this review including:

- the responses to the Francis report and the agenda around improving nursing care,
- the review of the Welsh Ambulance Service and subsequent response of Welsh Government
- statements on future public spending plans by the UK Coalition Government

which all require careful and strategic consideration alongside these proposals.

The remainder of this report provides the detailed analysis undertaken for UNISON by Tony Beddow, South Wales University.

Detailed submission by UNISON Cymru/Wales on the South Wales Programme

1. Purpose and scope

1.1. The submission firstly sets out to explain the context and origins of the proposals made by the South Wales Health Boards to re-structure the delivery of health (and social care) across South Wales (including parts of Powys) and to assess the strengths and weaknesses of both the proposals and the methods used to develop them. The proposals of the Boards relate at this stage to three specific clinical services: maternal care for higher risk births, inpatient services for children and emergency medicine. Four different options are described in which service delivery for these can be made more resilient and safe for the future. All four concentrate these services on three major sites in Swansea, Cwmbran and Cardiff and either one or two additional hospital sites selected from Prince Charles Merthyr, Princess of Wales Bridgend and Royal Glamorgan, Llantrisant**.**

1.2. No "preferred proposal" is definitively indicated in the consultation document. Instead Boards have sought to explain the issues and then to show how well different options fare in trying to address these. However, one key technical paper "Towards a Preferred Option" reports the results of a detailed exercise done by clinicians, other stakeholders, and members of the public that ranks each of the options by using six criteria. **The overwhelming conclusion of this exercise is that a five hospital solution comprising the three major sites (Swansea Cardiff and Cwmbran) plus Prince Charles**

Merthyr and Princess of Wales Bridgend scores highest when these criteria are applied. (See section 6 for further comment upon this aspect). In this scenario, patients needing care in the three hospital services under debate living in Royal Glamorgan's catchment area would need to travel to one of the remaining five hospitals for care. It is understandable therefore that the public debate has become one of different communities seeking to ensure that "their" hospital will be one that joins the three major units to form either a four or five site network of main hospital services in S. Wales. Across Wales UNISON has maintained a strategic brief on these reviews as we have a paramount interest in helping secure safe and sustainable services and not to become embroiled in 'local' disputes, no matter how, understandably, passionate each local campaign can be.

1.3. Although the submission concentrates mainly on the immediate issues contained in the South Wales Plan consultation papers, it does also briefly touch on three broader but important questions.

1.4. **First**, only three clinical services are addressed directly in the consultation and this is because these are the services nearest to imminent collapse – largely because of concerns about staff shortages. If true, this would indicate a major weakness in the arrangements that forecast the needs for clinical staff in Wales and put in place the means for meeting such needs. This weakness should be addressed.

1.5. **Second**, the plans of the South Wales Boards must knit together and must also complement plans for services in West and North Wales – and possibly English plans across the border. This indicates the need for Welsh Government to be satisfied that the key service capacities (general and specialist beds, theatres, admitting departments such as A&E, medical admitting units, and diagnostic services) will be adequate for the loads placed upon them. Specifically, the load to be placed upon the UHW should be fully stress tested so that all are completely confident that, for all revised service profiles required from UHW, these can be safely and physically provided.

1.6. **Third**, the re-organisation of services proposed will take at least a decade to achieve so if the collapse of services is as near as some papers claim, this timescale may prove too long. In the meantime other measures may be needed, including other ways of sharing scarce clinical diagnostic and treatment skills. There is a strong case for enquiring if a different, long term approach has been sufficiently explored –one that assesses the extent to which clinical skills can increasingly be made available to remote sites by maximising the use of distant diagnosis and network support methods. For while there will always be the need for experienced and skilled "direct hands on" treatment in obstetrics and surgery and for other techniques, remote diagnostic and treatment methods are already expanding in many settings (including Wales) and their potential has not been exhausted.

1.7. It should also be noted that all of the proposed options require capital funds (the sources of which are not immediately visible) and additional ongoing revenue funding of £10.6m - £14m to enable them to happen. The papers imply that this sum will not deal with further consequential changes needed to re-balance the service across Wales. Given the unprecedented financial pressure upon the NHS in Wales, making such funds available will not be easily achieved.

1.8. The submission does not attempt to address the inevitable human resource implications of the various changes indicated. Work on this is seen as a further, discrete, piece of work.

2. Structure of the Submission

2.1. The options for change proposed by the Boards rely heavily upon complex – and contested – areas of wider public policy concerning how three key clinical parts of the health care system (primary care, ambulance services, secondary care and tertiary care, and related social care) should now relate one to another whilst still meeting the needs of the public. **The Boards are to be congratulated for the detail that has been placed in the public domain and for the transparency of the arguments deployed.** That said, some of the documentation used to explain the changes appears to be written by, and for, people having knowledge of the terminology and jargon of the NHS. While this is understandable, as the documents are an essential part of the public consultation, more could have been done to help the general reader understand the abbreviations and terms used – for example by providing a glossary in each of the (many) papers.

2.2. The time available for those reading and seeking to absorb the many technical papers has been relatively limited. Within this constraint our submission seeks to analyse the following:

a) the pressures that have prompted NHS across Wales to embark upon a fundamental review of where and how hospital care should be delivered

b) the essential issues that underpin the specific case for change in South Wales

c) the advantages and risks of what is proposed

d) the extent to which other ways could been considered which might have met the challenges facing the NHS

2.3. Section 3 summarises background to the changes, including some of the history that has shaped the present. Section 4 looks at the detail of the changes being proposed for, primarily, three hospital services - those that care for children, those that care for pregnant mothers (and their partners / family), and

those that care for people attending hospital as emergencies with injuries, pain, or other medical conditions that have caused concern to the patient or the family. It should be noted that while the current proposals are limited to these three services, **in UNISON's view it is implicit that these changes will require further alterations to the disposition of other hospital services**. Some existing services at the hospitals that increase their maternity, children's or emergency medicine workload will need to move other work – probably elective - to accommodate incoming services.

2.4. Section 5 addresses transport issues. Section 6 explores the methodology used to compare different options and highlights issues for further consideration. Section 7 draws together a set of questions and issues upon which further clarification or details are sought as part of the ongoing dialogue.

3. Background

3.1. General

3.1.1. The NHS has just celebrated its 65th birthday. As was shown in the Olympic opening ceremony, it has a special place in the life of the UK. However, it is a very different service from that bequeathed to a country ravaged by the Second World War and which, in 1948, was still experiencing food rationing and all the difficulties of switching from a war time economy. Today, the NHS – in the UK generally and in Wales specifically - is facing significant pressures, some of which come from its very success. It is required to look long and hard at how, where and when it delivers its preventive, diagnostic, treatment and after care services. The NHS also has to consider how it wishes its relationship with its key partners - local government, the voluntary sector and commercial companies - to develop. It is against these broader trends that the proposals emerging from the South Wales Health Boards should be judged. These are presented as being limited to the three hospital services mentioned in 2.3 above and considered in more detail in section 4.

3.1.2. Pressures upon the NHS arise from a number of causes:

- The financial constraints under which the NHS operates in Wales, in part because of the UK –wide restrictions on government spending and in part because of the way that the Barnett formula delivers a sum for health spending in Wales that does not fully match current operating costs for NHS Wales[1]

[1] The Barnett formula allocated to Welsh Government about £5 for every extra £100 that English spending departments whose functions are devolved to Wales (health, education etc) obtain in the annual spending round. These cash sums are then aggregated to form the revised "block vote" from which Welsh Government funds all its services. NHS Wales has traditionally cost more to run than its English equivalent (for reasons that are argued about); hence the sum for health given to Wales by Barnett has, in the past, been augmented by using money derived from other services – often those run by local government. This approach was no longer possible in 2012/13.

- Continuing demands for health care from an ageing population where life expectancy is still rising; the increase in dementia (which hardly gets a mention in the papers) is one consequence of this trend
- Technological changes that alter treatment methods and require new approaches to the delivery of care, in part because the increased specialisation of medical staff inevitably leads to a greater concentration of services upon fewer and fewer sites
- Difficulties in recruiting or retaining key senior medical staff both in certain specialties such as paediatrics and emergency medicine or in certain parts of Wales
- The need to deliver services that are consistent, safe, and which deliver good outcomes.

3.1.3. All Health Boards in Wales, in line with long standing strategic aims, are conducting similar exercises. Some have given greater prominence to features that, at first sight, appear to be missing from the South Wales plans. In particular, the long standing wish to see demand upon hospitals diminish by better prevention, screening and self care, improved anticipatory primary care, and better alternatives to hospital referral and admission (especially for the elderly patients) are referred to but fleetingly in the South Wales plan. Plans by the Hywel Dda Board for example give these aspects more attention. In contrast the South Wales plans concentrate upon three "problem" specialties and this arises because these are the services to which Boards have given priority to counter shortages of senior medical cover and which threatens their continued operation.

3.2. South Wales strategic direction

3.2.1. The strategic intent underpinning the proposals of the Health Boards is set out in a paper issued in May 2013 titled *The South Wales Programme: Consultation Document*. This main paper is amplified in numerous technical papers which can be found at http:// www.wales.nhs.uk/SWP/supporting-documents**. The detail placed in the public domain is commensurate with the importance of the topic and the Boards are to be congratulated for making such detail available.** This allows the general public and others to probe the case made for change and to test how the proposals serve interests of the tax paying public rather than any vested interests (however honourable) of parts of the NHS or Government.

3.2.2. The papers make clear that the Boards are seeking to balance six factors judged important to service provision. These are:

- safety
- quality
- sustainability
- access
- equity and
- strategic fit

To show how these factors have been described, weighted, and tested with different audiences, technical papers explain work undertaken with both professional and other groups. The issues arising from this part of the process exercise are described in section 6 of this report. The overriding impression given by the papers is that the main impetus for change now arises from the difficulties Boards foresee in attracting and retaining sufficient, skilled, senior doctors to provided adequate round- the- clock coverage of the present number of (seven) hospital sites providing the three services. This challenge arises from a natural desire to have competent and skilled doctors available at the bed side. It then links to the way that doctors in training, and their numbers and career choices, have to be accommodated within the wider staffing arrangements that the service makes. (UNISON notes that no similar concerns appear to exist for any other key clinical staff, e.g. anaesthetists, radiologists, specialist nurses or midwives – but would seek reassurance on whether this is the case?).

3.2.3. The main features of the Boards' plans concentrate on improving the long term resilience of only three important hospital inpatient and related services. These are described as consultant – led maternity and neo-natal care, inpatient care for children, and emergency medicine (A&E). A key concern running through the plans is to ensure that services are safe. Further, high quality clinical care has to be delivered consistently over time and made accessible to the communities served. This is likely to require further complementary changes in due course to how other hospital services are delivered and also has significant implications for how road and air ambulance services are provided. Lastly, whatever service configuration emerges from this process has to be resilient (that is, capable of being resourced with people and money) in the light of foreseeable future pressures over, probably the next decade.

3.2.4. Arising from the analysis undertaken by the Boards, their preferred course of action is to reduce the number of their hospital sites along the South Wales M4 corridor (as far North as South Powys) from which the full range of care in the three hospital services cited above is offered. Their analysis compares the coverage and resilience of different combinations of hospitals providing these three services. The underlying assessment is that one, or possibly two, of the hospitals currently offering the three services must relinquish them if NHS Wales is to offer high quality services in the future. In every option three sites are seen in due course as housing the three specialties reviewed – Morriston Hospital, UHW and the new hospital proposed for Cwmbran[2]. To these three sites might be added either one or two more. The Princess of Wales Hospital Bridgend, Prince Charles Merthyr, and the Royal Glamorgan Llantrisant, contend for this task. **Implied, but not overly stated or explored, is the notion that**

[2] This will replace Nevill Hall and Royal Gwent Hospitals which will however remain in some form as a "local" hospital. Morriston Hospital will in due course host obstetric services presently at Singleton Hospital. Neither of these sites will provide these services for at least five years – and probably longer in the case of Cwmbran.

experienced medical skills cannot be adequately made available to all current sites by remote access for advice and guidance, or by "flying teams", for hands on care / intervention.

3.2.5. Whilst services relating to both expectant mothers and in patient children's services are largely well understood, **it is not immediately clear precisely what services are meant to be covered by the term "emergency medicine (A&E)".** For in respect of medical care (that is care of people – often elderly - who require the skills of physicians rather than surgeons for conditions such as diabetes, heart chest and gastric conditions, dementia, or a combination of chronic conditions that come with ageing) the papers signal that further work needs to be done to clarify which inpatient and assessment services can safely be placed at which locations. Clearly for patients to use any new services pattern properly, they must fully understand what each hospital is meant to be doing – and not doing. **Such understanding is not helped if the service itself is still unclear about the remit of major hospitals or the language with which this is described. These matters are addressed in section 4.1.2. of the report.**

3.2.6. Finally, the plan makes it clear that, while it has not been possible to indicate in any detail how the bed, theatre and other service capacities needed at these hospitals to cope with incoming work will be made available, one likely consequence is that some clinical services presently provided at these hospitals will need to be moved elsewhere in order to free up space.

4. Proposed changes by care group and their justification

4.1. Overall Context

4.1.1. Section 3 described the main drivers that NHS Boards (and Welsh Government) have to take into account when reviewing service delivery. This section now looks in more detail at the three hospital services being considered for changes. In this respect the author's view is that the issues relating both to high risk maternity services and in patient children's services have been clearly described.

4.1.2. However in respect of Emergency Medicine, the terminology used, and the further work that remains to be done (which the papers acknowledge), leads UNISON to believe, that, for this key service, the proposals are less clearly developed. More explicit and user-friendly descriptions of the range of services to be offered at each hospital under the aegis of "emergency medicine (A&E) service" are required if the general public are to play their part in using these services as the NHS intends. This is particularly important as members of the public will be expected to understand how the health care system seeks to manage the assessment and treatment stages of care for a variety of conditions if they are to use the right services in the most efficient way. For example "local emergency care" will take minor injuries, may take "selected acute medical

cases" but are not expected to handle flu, diarrhoea and vomiting, dizziness, urinary tract infections, and constipation. The obvious question that arises is: how does a lay member of the public know which label to place on his/her pain and discomfort? This is further addressed in section 4.4 below.

4.1.3. There is also the overall policy framework of analysis applied by the Boards to the weighting of the different factors involved. UNISON is advised to have some concerns about the Boards' attitude towards "safety". It is not as clear as it could be whether this particular attribute is seen as one of six and able to be adjusted to accommodate the remaining five factors – or whether is has an irreducible minimum component, or "given", that sets it apart from the other five. Clinical technical papers imply the latter. The implications of this are explored further in section 6.

4.1.4. Finally, although the three services are the main thrust of the proposals, within the detail of the papers, one major issue and two important caveats are to be noted.

4.1.5. The major issue is that, at a time of unprecedented financial pressure on the Welsh Government's budget and thus upon health spending, the plans require an increase in spending of at least £14m per year. This is rightly described as a small part of the huge health budget. But it is still a claim for more cash when even current levels of spending cannot be funded from the agreed budget. (Were the current disposition of services kept -and the papers indicate that this option is there for comparative purposes only rather than being considered feasible - this would require an extra £21m each year including £3.3m to improve the ambulance service).

4.1.6. The first caveat (as papers make clear) is that **little work has been done on key capacities at each of the four/ five sites destined to host the three services to show how these can be housed**. Two of these sites (Morriston and Lllanfrechfa Grange) are future developments perhaps 10 years away. A third is UHW which, some papers note, is landlocked and already congested. The second caveat is that although only three services are now under consultation, it seems inevitable that further service changes will be needed - perhaps at UHW, Princess of Wales, and Prince Charles- to move currently provided services (probably elective ones) to make room for the incoming services.

4.1.7. The three service areas currently under consultation are now briefly described and commented upon.

4.2. Consultant led maternity and neonatal care

4.2.1. The proposals

4.2.1.1. The Boards promise that community delivered services, antenatal clinics, early pregnancy clinics and midwife led birthing centres "will continue to be available in all hospitals as now"[3]. However, for pregnancies deemed higher risk right from the start, or those that become complicated during labour, services will be concentrated upon a fewer number of sites. It is made clear that this is to be done to ensure that "skilled and experienced doctors are available to support the labour ward 24/7". The intention therefore is that, for about 1,251 women, their time in labour and the 48 hours thereafter, will take place in a hospital that is further away from their home than is currently the case. The number of women to be cared for in "the larger birthing units" is forecast to rise from 22,708 to 23,531 –probably as a result of an increase in the number of women of child bearing age rather than changes in the proportion of births taking place at home and in other low risk settings.

4.2.1.2. As in the other two services (for children and emergency medicine), the work that has been done is driven by the wish to identify the impact of different hospitals **LOSING** services as a result of operating from fewer sites. Although four options are described, the thrust of the evidence presented is that removing high risk pregnancies from the Royal Glamorgan hospital would mean that about 1,743 births now taking place there would, in future, be shared between other hospitals. About 622 births low risk births are predicted to remain at Royal Glamorgan.

4.2.1.3. In selecting the hospital to lose services it is clear that this choice is not to be made by comparison of the relative clinical attributes of the current hospital services. Rather the main driver would appear to be an assessment of how the people of South Wales (and South Powys) can – given the geography - be given broadly equal access to such services. Simply put, using the weighted criteria offered by the Boards, Royal Glamorgan Hospital is located in the part of South Wales that the analysis suggests can most easily be covered by the hospitals North, West, East and South of it.

4.2.1.4. If implemented, it is predicted that the withdrawal of Royal Glamorgan from caring for higher risk pregnancies will lead to 3023 mothers having travel times of over 30 minutes compared with 2,197 currently. Of these 791 would be residents of deprived areas – 200 more than would be the case if the Princess of Wales had been the one unit to lose this service. However, were services

[3] It is assumed that this promise, for Swansea, means that in due course Singleton Hospital will no longer offer any of these services once the planned transfer of services to Morriston Hospital have occurred. In respect of Aneurin Bevan Local Health Board, Unison will wish to confirm what maternity services will remain at Nevill Hall and Royal Gwent once the new hospital at Llanfrechfa Grange Cwmbran is operational.

retained at both Royal Glamorgan and Prince Charles hospitals, it is predicted that only 2153 births would occur at the latter – 350 less than the minimum number deemed necessary by professional opinion.

4.2.1.5. To accommodate the proposed changes, the Boards propose to improve the way that this service operates. Changes would include the flexible deployment of the clinical workforce and an increase in the number of consultants covering out of hours and week end shifts. No increase in beds is predicted overall. However, an additional 28 doctors (the highest number of extra staff and 22 more than the option needing the least increase in staff (retaining Royal Glamorgan only alongside the Swansea, Cwmbran and Cardiff sites) are said to be required if both Prince Charles and Princess of Wales are kept.

4.2.1.6. In respect of neonatal intensive care, three sites are to continue to be sustained and it is indicated that these are to be co-located with regional / specialist obstetric services in UHW and, in due course, Morriston Hospital and the new service at Cwmbran. Further work (not detailed) is to be done to "reduce the number of babies needing to travel outside of Wales for this highly specialised care". High dependency services will complement the other two sites offering care for higher risk pregnancies.

4.2.2. Comments upon the proposals

There are several issues that emerge from the documentation.

4.2.2.1. Although the papers say that there will be increased flexibility in the use of medical staff there is little evidence of any serious examination of more radical approaches to making maximum use of scarce medical skills. Remote consultant support via video link and "flying cover" from networked teams might have been considered an alternative to the traditional static base approach that has applied to consultant cover. Given that many deliveries can have a degree of pre-planning, such options - especially with an increase of 28 staff – should at least have been explored and demonstrably discounted. Is it possible to treat the units at Royal Glamorgan and Prince Charles as one using more mobile staff rostered differently?

4.2.2.2. As noted in 4.2.1.1. it is predicted that about 1,251 people will travel an increased distance to access these services. It is acknowledged that the Boards (and ORS) have undertaken a considerable amount of work to explore with patient groups how women **might** react to different combinations of hospital services for higher risk births. This work informs projected flows, were changes to be made. However, the detailed work done, in our advisors view, must be treated with some caution as a predictive tool. First, within the proposed arrangements mothers will continue to be able to choose where they can deliver their baby unless specific clinical exclusion criteria apply. Faced with the actuality of service change, mothers to be might make different choices to those indicated when

change was only a theoretical possibility. Second, the sampling used to predict behaviour was skewed. Mothers attending UHW for antenatal care were not sampled, no one from the Swansea area responded, and the two thirds of the replies (about 340 people) came from Neath Port Talbot, RCT and Bridgend areas.

4.2.2.3. Only three of the current services have the levels of work (2,500 births) required to sustain acceptable services, although Princess of Wales at 2463 births and Royal Glamorgan at 2,365 are close to the minimum level and may attain it given the forecast increase in population. In the future, if the proposed five site option is pursued, all five sites are predicted to exceed this minimum level with UHW and the new Cwmbran / Llanfrechfa Grange units catering for 7,193 and 6,004 births respectively, with Singleton and Princess of Wales caring for 4,301 and 3,347 respectively. However, Prince Charles is predicted to be only marginally above the minimum level at 2,686 births. IF this level is as critical as is suggested to long term sustainability, a judgement is needed as to whether the populations served by this hospital are likely, in the future, to remain at their current levels and thus generate a sufficient workload. This highlights the importance of the reliance that can be put upon the forecast usage of this particular hospital, for it would take only a modest drop in population and / or births to bring it below the recommended safe level.

4.2.2.4. It is noted that total caesarean section rates vary from 21% of total births at UHW to 31% at Prince Charles hospital – a variance of about 50%. The elective caesarean rate as a percentage of total births also varies from 9% at the Royal Gwent to 15% at the Royal Glamorgan – again a variance of over 50%. Such variances may be the result of differential case mix or different socio economic groups served by each hospital, different clinical practice in each unit, or some other factor. Taking normal births and elective deliveries together, on current practice about 70% of the workload would appear to be capable of being managed in a paced/anticipated way. Could this be supported by the flexible staffing arrangements suggested but not fully explored? It might be useful for further work to be done to identify what rates of both emergency and elective caesareans are judged to be appropriate in each setting, given the many factors in play.

4.2.2.5. Given the increased travel times forecast by any changes, and the relatively short notice of the need to transport women in labour to hospital at any time and in all weathers, there is certain to be consequential demands for both the skills and capacity of the road (and air) ambulance cover to be made more resilient. It is noted that a capital sum of £1.1m and a revenue sum of £5m is identified to enhance “clinical conveyance” (ambulance services) capacity. However, the methodology behind this calculation is opaque. **UNISON seeks further discussion on the assumptions for these costs given the existing pressures on the Welsh Ambulance service.**

4.3. In patient children's services

4.3.1. The proposals

4.3.1.1. In many respects, the proposals for in patient hospital services for children follow closely the same arguments as for consultant led maternity care. Currently in patient care is based in seven acute sites. **Admissions** total some 14,438 per year with 3,328 at UHW, 2,624 at Morriston and 1,550-1,719 at Royal Glamorgan / Princess of Wales and Prince Charles. Royal Gwent and Nevill Hall together admit 3,612. Total **attendances** at all sites are 36,630 ranging from 8,695 at UHW to 3,709 at Prince Charles (and 3,526 at Nevill Hall).

4.3.1.2. One objective of the proposals – based on professional opinion of the numbers needed to ensure safe high quality services - is to have "a minimum of 4,400 attendances presenting to the Paediatric Department each year". (It is not immediately clear from the papers seen how this requirement is defined – see 4.3.2.1 below). As with obstetric care, the major driver of change is the need to ensure a resilient cadre of senior medical staff able to provide high quality care round the clock care on a daily basis.

4.3.1.3. Again, as with maternity and emergency medicine, the same set of criteria are used to balance safety, resilience and access with the result that the technical paper "Towards a preferred Option" supports services concentrated upon the five hospital sites at Morriston Swansea, UHW Cardiff, Prince Charles Merthyr , Princess of Wales Bridgend and the proposed hospital at Llanfrecha Grange.

4.3.2. Comments upon the proposals

4.3.2.1. The proposals are based in part upon a need for Paediatric Departments to have 4,400 "attendances" presenting each year. The definition of "attendance" is not given in the Clinical and Service Planning Framework technical document. It may mean all attendances including outpatient, emergency medicine visits and both urgent and elective inpatients. It may include some neonates. Table 2 on page 28 of the Clinical and Service Planning Framework technical document shows that currently Nevill Hall, Royal Glamorgan Prince Charles and Princess of Wales hospitals fall below 4,400 "attendances". (For example Royal Glamorgan is shown as having only 4,293 attendances even with 1719 admissions). The five site option is predicted to have over 6,000 attendances at the least busy unit (Princess of Wales), over 10,000 attendances at UHW and a range of 6,500 – 7,000 attendances at the other three sites. If the predictions are broadly robust, none of the proposed units teeter on the edge of viability against the attendance criteria laid down.

4.3.2.2. It does however appear strange, at first sight, to have as a benchmark for these services one driven by the number of children attending hospital, when

all recent policy guidance has been designed to avoid the need for children to come to hospital. Child proof medicine storage to prevent accidental overdosing, play area safety features, and preventive care in primary and community care settings are all examples of initiatives aimed at avoiding the need for hospital care.

4.3.2.3. If the argument is that senior doctors need to see enough poorly children to maintain their skills, then this might be possible by rotating doctors between the very busy units (UHW/ Morriston) and the less busy (Princess of Wales and Prince Charles). If the argument is that Wales simply does not have enough senior doctors in this specialty, then attention should perhaps turn to the adequacy of the planning processes by which the service and the profession predict the numbers required. If the argument is that Welsh paediatric posts are not attractive, is it clear which features lessen their attraction, and are these unattractive features going to be designed out of the revised services? Again, as for maternity care, there is little evidence that alternatives to service concentration to ensure the availability of skilled consultant advice or intervention have been explored, and actively discounted for well argued reasons. UNISON would consider that similar considerations could arise in other service areas.

4.4. Emergency Medicine

4.4.1. The proposals

4.4.1.1**.** As with services for expectant mothers and children, many of the issues by now familiar to the reader arise in respect of Emergency medicine (A&E). Trade offs between safety, resilience, and quality of service are being assessed and made. However, the precise scope of the service covered by this term remains ill defined in the papers (see for example 4.4.1.5. below). As a consequence, the suggested way forward is more tentative and has the appearance of “work in progress”. This is addressed in more detail in section 4.4.2.

4.4.1.2. The document “South Wales Programme Overview of planning process and emerging proposals” sweeps across the raft of changes. It notes that “traditional A&E services are no longer fit for purpose”. There are “more acute / general medicine patients attending than injuries”. A&E services are “still regarded as the main front door to the NHS but (it) becomes a bottleneck”. The service is however “still seen as (the) easiest service to access for care which can often be provided differently and more appropriately”. It is a pity that the South Wales consultation does not explore this further – as is the case in, for example Hywel Dda’s review of services which appears more fully to recognise that the NHS is predominantly a service for older people where needs – though now met by referral to and admission into hospital – may be better met in non-acute care settings .

4.4.1.3. Unlike maternity and children's services where a minimum workload is given as a key driver of change, in emergency medicine the driver is the need to provide a level of consultant cover meeting the standards set by a professional body, in this case the College of Emergency Medicine. (Given that the total number of users of the emergency medicine service is 676,932 per year, it is unlikely that shortage of work is an issue). These standards are 16 hours (in the day) for an "emergency department" and 24 hour cover for a trauma unit[4]. Patients needing admission are to be assessed by a senior doctor within two hours[5]. Medical rosters will need to meet European Working Times Directive, New Deal, and Deanary training requirements. **UNISON notes that in maternity and children's services little concern is expressed about the availability of other skills – for example those of anaesthetics, radiology, and nursing**. UNISON seeks further reassurance on these matters.

4.4.1.4. Key principles and assumptions underlying the changes are:

- flexible deployment of the clinical workforce and services that are attractive to doctors seeking employment
- an increase in enhanced / advanced nurse practitioner led and delivered services in local and regional units (no concerns are signalled here about lack of staff or the unattractiveness of posts)
- the development of more non training grade roles
- a greater integration between minor injuries, GP out of hours, and acute medicine in local hospitals
- paramedics are to have direct access to specific services using agreed care pathways[6] (which the author interprets as meaning they will be trained and empowered to assess and diagnose some conditions / patient needs in their own right)
- adequate primary and community care capacity will be available 24/7.

4.4.1.5. The South Wales Programme Overview paper refers to "local emergency care" which is to include:

- nurse –led minor injuries (including paediatric ones)
- stabilisation skills and facilities
- selected acute medical intake and rehabilitation BUT "work (is) ongoing to define this"
- high dependency unit
- out of hours co-located primary care.

[4] Given the firm evidence on safety that runs through documents, it may be puzzling to some to note care given in a third of the day can safely be left in the hands of less senior staff.

[5] It might be assumed that the numbers to be seen within two hours will greatly exceed the numbers admitted as presumably only a senior doctor assessment can safely discern those who do NOT need admission from those that do.

[6] Here the author assumes it is intended that some patients whose needs are fairly obvious, and for whom neither the assessment/diagnostic or in patient capabilities of the hospital will add much to the care plan, will be taken to other care settings – or indeed have relevant care brought to them at home.

4.4.1.6. Services in the four / five regional hospitals will treat:

- all children under one year old and all paediatric illnesses
- the majority of unscheduled surgical admissions
- patients requiring critical care which includes complex elective surgery
- chest pain and myocardial infarction
- poisonings and (non alcohol) overdoses
- major illnesses, for example strokes

4.4.1.7. Certain patients will go direct to hospital in patient specialties and others to a primary care service. Speciality bound cases will include patients with post operative complications, allergies, acute asthma or diabetes, and PV bleeds, and obstetric cases. Primary care is to take patients with flu, diarrhoea / vomiting, dizziness, skin conditions, urinary tract infections, blocked catheters and constipation**. It is not clear whether the diagnosis that determines the patient destination is intended always to be done in either the local or regional emergency medicine department, or whether others (e.g. GPs and paramedics) will be able to make some diagnoses.**

4.4.1.8. As in inpatient care for children and higher risk pregnancy, the thrust of the proposals is to concentrate services on fewer sites – Morriston, Cwmbran and UHW supported by either one, or two, hospitals out of Prince Charles, Princess of Wales and Royal Glamorgan. Application of the same weighted criteria results in two hospitals - Princess of Wales and Prince Charles joining the three larger sites as the preferred option.

4.4.1.9. If this course of action is agreed upon, the number of "regional" cases attending the five sites is given as UHW 33,457 – an increase of 14%; Morriston 27,789 – an increase of 3%; Princess of Wales 18,408 – an increase of 50%; Prince Charles 18886 – an increase of (47%) and Cwmbran 26,382 – (no comparable figure given).

4.4.1.10. Were the indicated change to come about 9,338 "regional" patients are predicted to have an increased journey time of 15 minutes or more and 11,621 patients would have a journey taking longer than 30 minutes (it is not stated as such but it is assumed that this assumes a journey by road or air ambulance and not private car or public transport)[7].

[7] If 11,621 patients have journey times in excess of 30 minutes, if the time between an incident occurring and the 999 call being made is five minutes ,and if response times are 10 minutes to arrive and 5 minutes to make an assessment of the situation , then the time for arrival at major unit will be on the limit of the "golden hour". This implies a need for a greater capacity for diagnosis and stabilisation and care at the scene and en route.

4.4.2. Comments

4.2.2.1. Unlike high risk maternity cases and in patient children's services, the total intended future loads upon both the "local" and "regional" emergency medicine departments are not clearly discernible. Predicted attendance figures shown in 4.4.1.9. total 124,922 cases. Given that the total load currently is nearly 677,000 (all cases) it is not clear how many "local" cases will be added to the work of the "regional units" and if these can be easily accommodated.

4.4.2.2. It has been clear for some time that A&E services and medical assessment / admission units have been the route of choice or necessity for patients (or their GPs) for whom unaided care at home is not sensible. Often the local A& E service is all that is available at the time of day or night when a crisis occurs; hospitals become a stopping off point of safety whilst more appropriate care is organised – often weeks hence. It is laudable then that this expensive hospital resource is to be reserved for patients whose condition is not known and for whom a good diagnosis requires the assessment and diagnostic skills found in hospital. However, whilst the current plans "assume" a range of alternative care is available to which paramedic staff and GPs can direct / take patients, current evidence is that such care is not in abundant supply. Some reassurance is needed that plans to remedy this are close to fruition.

4.4.2.3. The absence of firm plans to deal with the heavy load of often elderly patients suffering from medical conditions is worrying. A&E departments often play a role in assessing such patients if medical assessment / admission units are not operative or have been avoided. It is not clear whether GPs, the out of hours service, and paramedics are to have an increased role in assessing such patients instead of using emergency medicine departments. If so, patients could access acute inpatient care (if needed and available at the local or regional hospital), or alternative services such as immediate care and support at home, or care in another setting without entering the emergency department.

5. Transport Issues

5.1. Transport issues are recognised as arising from the proposed changes. It is inevitable that if journey times are increased for obstetric and accident and emergency patients, then more transport capacity will be needed. Further, if distances are increased, more patients may need to rely upon ambulance services rather than public transport or private cars, and increased travel times might require increased use of the air ambulance service to enable patients to reach regional centres sufficiently quickly. (Transport needs of family and other visitors will also emerge).

5.2. It is also implied that there will be increased ambulance journeys resulting from patients who have been admitted to regional centres for their initial care being transferred back to local hospitals or other settings for ongoing care.

5.3. The ambulance service is already under great pressure – in part because its vehicles spend too much time acting as overflow emergency treatment bays in the car parks of major A&E departments. The financial plan shows revenue and capital sums set aside to address “clinical conveyance”. For the indicated option of five regional centres revenue and capital sums of £5m and £1.1m respectively are set aside. Interestingly, a revenue sum of £3.3m is shown as required even if the current disposition of services is kept. Given that the current pattern of services, by definition, does not alter the nature of “clinical conveyance” this sum seems to equate to an acknowledged current level of under funding which should be rectified anyway. UNISON’s advisor is not convinced that including this in the sums needed for additional costs for the current service is appropriate – especially if the inefficient use of ambulance resource made necessary by service weaknesses elsewhere in the system were overcome. **We seek clarity on this point.**

5.4. It is clear from preceding paragraphs that merely increasing the numbers of road vehicles (and air ambulance flying time) will not in itself be sufficient. Implicit in the proposals is a requirement for responding units to play a greater role in assessing what is wrong, deciding where to take the patient, and providing active care for the patient en route. **UNISON made this very point in its submission to the recent McClelland Review into the Welsh Ambulance Service and we are pleased to note that to a large extent this point was accepted in the McClelland recommendations.**

6. The methodology used to compare options

6.1. The methodology used to compare the options employs a standard approach of listing key criteria, attributing weights to those criteria, and then scoring or otherwise assessing each of the options in terms of how well they meet such criteria. This approach in itself is not controversial. It is however noted that the criteria used in South Wales are not the same as the criteria used in Hywel Dda for its future planning process. While this in itself may be justifiable, if the NHS in Wales is meant to offer a similar level of service, one might expect that, across Wales, its re-shaping would be being driven by a common agreement upon its key attributes – even if these are then weighted differently in different parts of Wales to reflect local circumstances.

6.2. Six weighted criteria have been used and weighted as follows; quality 21, safety 22, access 20, equity 9, sustainability 20, and strategic fit 8 (total 100).
There are several weaknesses readily acknowledged in the papers. One is that the terms used are felt by many to be overlapping or imprecise – for example access and equity are closely related as are safety and quality. Another is that the scores applied give four of the six features almost identical marks. Further, different players involved in the weighting exercises understood the terms in different ways.

6.3. However, a more fundamental issue is whether all of the criteria should have been weighted at all. The technical papers make it clear that "safe services should be provided as locally as possible; local services should not be provided as safely as possible". **This understandable view makes "safety" a required feature.** Put another way, all proposed services have to be safe; it is a discerning and absolute feature that all options must possess. This being the case, it is hard to see why it is then weighted. Rather, only options that are clearly "safe" should be weighted and scored, using whatever criteria and scores are judged right..

6.4. If this approach were taken, then a factor that might come to the fore is the potential of any option to become unsafe – a feature that is perhaps close to the criteria "sustainability" and which might in turn alter the weights given to remaining criteria. One feature of the emerging preferred option – the predicted number of births at Prince Charles Hospital - is only just above the level deemed appropriate. Approaching the weighting of criteria as outlined in 6.3. might have produced a different result.

7. Summary of key Issues

The foregoing has indicated that the changes proposed to health services operating in South Wales arise from very real pressures upon the NHS. It is clear that before UNISON can decide how to react to the proposed changes we need to further understand fully the following key issues.

7.1. Safety of services: two matters arise.

7.1.1. Are all services safe now? If not, action is needed sooner than the plans suggest (10 years if the new Cwmbran Hospital and the transfer of services from Singleton to Morriston Hospitals are needed to make safe services currently unsafe). This can only be by closing them down or by overcoming the reasons why they are unsafe.

7.1.2. If safety is a fundamental (a given) the inclusion of this factor as one of six criteria to be weighted to allow the various options to be compared is contentious. The alternative methodology would have been to require all options to show that they would offer safe services, and then differentiate options by applying to them other factors.

7.2. Have the drivers for change been well tested?

7.2.1. Different arguments have been deployed to justify the changes being proposed. In respect of high risk deliveries and in patient children's services, the main arguments used relate to professional opinion of the minimum workloads needed to ensure quality services – 2,500 births and 4,400 attendances respectively. These workloads would be needed irrespective of the number of

doctors available. However, in emergency medicine, the issue is not work load but the availability of senior cover (and how that cover is made available within current legislation, acceptable lifestyles for clinical staff, and their perception of the attractiveness of posts on offer).

7.2.2. As has been suggested earlier, two immediate challenges arise for the service from these different positions.

7.2.3. First, if skills have to be gained and retained by seeing adequate numbers of cases, does this require the patient always to come to the doctor rather than the doctor going to the patient? Is modern medicine now moving to a position where senior and scarce skills should expect to serve a wider geographical area within which they work, by rotation, both busy units where they refresh their skills, and less frenetic units where skills remain well honed until they need to be refreshed by returning to the high case load units?

7.2.4. Second, if there is a shortage of medical staff through either the training of insufficient numbers or the inability to make posts sufficiently attractive, can these challenges be overcome in other ways? It cannot be the case that staff can both complain of overwork /stress at the same time as not having enough work to maintain their skill levels. Other factors must be at work and perhaps need further exploration. Continued further specialisation, no doubt driven by laudable professional motives, left unchecked, must inevitably lead to further requests for centralisation of services to the point where only one or two sites in South Wales can be staffed and equipped to the levels desired. One of the challenges faced by the NHS in 1945 was that of spreading scarce, high quality skills to all parts of the UK. Many measures were taken to temp experienced staff away from major London teaching hospitals and from general practice in well off areas. Even then, some thirty years later Julian Tudor Hart was still able to point his finger at the persistence of the Inverse Care Law.

7.3. Timescales

7.3.1. There are a number of issues relating to timescales which are not made clear in the papers. First, the date when the new hospital at Cwmbran becomes operational, and the roles of Royal Gwent and Neville Hall change, is not clear – although it is predicted to be at the end of the decade. Second, the timing of the switch of Obstetric and midwifery services from Singleton hospital to Morriston hospital is not indicated and it is not clear how the capital money for this will be Provided or the capacity actually created on the Morriston site. Thus for perhaps the next seven years, current services will still need to be provided from the current hospital network. If the preferred medium term option of UHW/ Morriston and Cwmbran plus Prince Charles and Princess of Wales is confirmed as the way forward, it is of course possible to take early steps to change the role of the Royal Glamorgan Hospital.

7.3.2. Other changes to elective services at UHW, Prince Charles and Princess of Wales Hospitals are indicated if the preferred – or other – options proceed. The timescale for these is unclear. Further, the precise arrangements for the care of people suffering from medical conditions remains opaque and again no timetable for coming to a view of this is indicated.

7.4. Service capacities

7.4.1. UNISON is advised on some concerns about the impact upon service capacities in a number of key NHS services. Here, capacity is defined as both an adequate number of resources / services and an adequate competency of those. The plans will require shifts in patient flows to hospitals and although much work has been done to predict how these might alter, less work appears to have been done to describe the resultant capacity that NHS services will need – and the intensity at which these will be required to operate.

7.4.2. Key hospital services affected include:

- space and staff in A& E / Medical Assessment Units and other similar services to which patients arrive unannounced and with a variety of injuries and medical conditions (including mental illness)
- in patient capacity, especially for older patients admitted with medical conditions but also including in patient surgical capacity
- operating theatre capacity to ensure that changes to emergency flows which increase the amount of urgent unscheduled surgery can be accommodated without too much interruption to elective operating lists
- supporting specialist accommodation in ITU, coronary care units and other high dependency services – again in part to ensure elective work is not hindered; specific issues relating to the care of neonates also arise.

7.4.3. Finally, in respect of ambulance care, it is clear that an increased load and responsibility will be placed upon both road and air cover, both because of increased travel times and/or distances to hospital and because of increased inter-hospital transfers. The extra travelling time associated with each option has been indicated, but in the time available to study the plans, it is not clear how increased transport capacity is to be provided or funded.

7.5 Finance

7.5.1 The plans so far presented require significant sums of capital and revenue money at a time when the public purse is under great pressure. Thus these plans are not driven by the straightened times in which public services now operate. Investment in the NHS for the three services mentioned may well be the only option. It does however raise the very obvious question of from where else in Wales is the money to come for what is, clearly, only one part of a major re-

shaping of hospital care which in turn will lead to changes in ambulance and primary care, and possibly much else?

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http://teams.unison.org.uk/regions/CymruWales/organising/Health/DB-UNISON response to the South Wales NHS Programme.doc