# The Scrutiny Panel Report

# On Proposed Service Change Proposals

# At

# Prince Phillip Hospital, Llanelli

## September 2013

**Professor Neena Modi: Expert member for Neonatal Services**

**Dr Jim Wardrope: Expert member for Emergency Care**

**Dr David Salter: Retired former Deputy Chief Medical Officer for Wales**

## Summary of Main Recommendation

**In the Panel's opinion the development of an Emergency Nurse Practitioner led and General Practitioner supported (ENP+GP) model would best serve the people of Llanelli.**

If the panel's recommendations are accepted then this would mean:

- **The hospital would continue to treat most of the patients that go to PPH at present.**

- **The ENP+GP unit would deal with the less serious illnesses and injuries but would be supported by the medical doctors and anaesthetists if patients with more serious conditions arrived unexpectedly.**

- **Patients sent to PPH by their GPs as emergency admissions would be seen directly by specialist medical teams without having to go through A&E and may start their treatment sooner than they would under the existing system.**

- **Patients requiring care by an out of hours general practitioner would be seen in the same unit.**

1. **Replacement of the Emergency Department Service at Prince Phillip Hospital (PPH).**

- The panel strongly support the case for replacement of the "A&E" service at PPH. The case for such a change is supported by the Local Health Board (LHB) and the Community Health Council (CHC).
- As PPH will not have an A&E department, signage should be changed to indicate the scope of the unit. The Panel was not requested to advise on the naming of the new facility. We believe that the naming of such units is subject to discussions across Wales. We advise that the name should make it clear to the public the type of medical and surgical conditions which it can treat. In the meantime, names such as Urgent Care Centre, Urgent primary care and minor injury unit or Urgent GP and minor injury unit are names which could be applied to the type of unit the Panel recommends.
- Traffic signs indicating the "A&E" unit should be removed or replaced.

2. **Safety and benefits of the Emergency Nurse Practitioner (ENP) +General Practitioner (GP) model**

- This model is safe and has many other advantages that work towards NHS Wales' plan of greater use of primary and community care.
- Medical support for the ENPs would result in fewer patients being sent to other hospitals or other departments within PPH and more patients being treated at a single visit.
- Such a model would be able to deal with most of the current workload, given that this is heavily skewed to the treatment of more minor conditions.
- There would be more likelihood of dealing with more patients with more complicated medical needs, such as those with alcohol and drug problems (the overnight GP service already deals with such patients).
- Local GPs working alongside hospital colleagues would improve the way they work together, with better working between community and hospital care.
- It would present a major opportunity for GP training in urgent care giving Hywel Dda Local Health Board a GP workforce with the ability to deal with more complicated urgent medical and surgical problems that occur in primary care and reducing the need to send some patients for hospital care. It would support better screening of the elderly who may be frail and suffering falls, for conditions that can be treated to reduce the recurrence of falls.
- Better co-operation between the Out of Hours service and the new Department would be increased.
- Close working with the similar service provided at Singleton Hospital would be of benefit and possibly increase the opportunities for training and increase the number of doctors available to work in either unit.
- Discussions with the Postgraduate Deanery (responsible for the training of qualified doctors) would highlight these training opportunities and aid the ability to employ doctors in urgent care in the future.

***In the Panel's opinion the development of an ENP led and GP supported (ENP+GP) model would best serve the people of Llanelli and reduce the risks of major increases in patients being sent other units. It would best serve the main strategy of greater emphasis***

***on primary care and better working between hospital and community services. It presents huge opportunities for training and development of GPs to help Hywel Dda LHB provide better community care in the future.***

**3. Safety and benefits of the Emergency Nurse Practitioner model.**

- This model is probably safe but there would be significant limitations on the type of cases that could be handled at PPH alone.
- There would almost certainly be an increase in patients being sent to other hospitals and departments within PPH and there is a risk of a significant increase in patients sent to Morriston Hospital and or an increase in transfers to Glangwili Hospital.
- A major increase in patients sent to already stretched emergency departments would result in a deterioration of quality not only for Llanelli residents but for existing users of services at other hospitals.
- Increased transfer to Glangwili would also cause transport problems for patients discharged after treatment at Glangwili.
- There would be a need for more support from medicine for more patients with difficult problems such as alcohol and drug abuse. These problems are already part of the work done by the acute medicine department but this would increase.

***In the Panel's opinion many of the added advantages of the ENP+GP model would be lost and does not support this option over the ENP+GP model.***

4. **Out of Hours Service**

- The barrier between the Out of Hours Centre and the existing "A&E" department is artificial. Patient in the "A&E" needing GP care have to telephone to obtain an appointment in the Unit across the same corridor. This seems contrary to good patient care and efficient use of resource. The reasons for such barriers should be explored and ways found that remove barriers to patient care introduced.

***There should be an easy means for patients to go from one department to the other.***

5. **Access to primary care/ GP hospital referrals.**

- There were many comments especially from the CHC about patients' poor access to their GPs in some areas, resulting in increased Emergency Department (ED) attendance. The CHC was planning a survey of patients attending the ED to provide evidence of the magnitude of such problems. This is a worrying finding and likely to be a significant bar to the LHB strategy of greater use of community services. Some patients referred for urgent or emergency admission to hospital are directed through the existing "A&E" rather than seeing doctors from specialist departments first. This can lead to delays in starting the most appropriate care.

***If the CHC survey confirms problems with access to primary care, then action should be taken to remove such barriers. Patients referred by their GP to specialties should not have to go through the ED unless there were systems in place to assess such patients with a view to preventing admission.***

# Technical Documents Supporting the Advice and Recommendations

## Context and Rationale

Hywel Dda Local Health Board (HD LHB) has carried out a consultation on the re-organisation of ED services in West Wales. Part of that plan was to replace the current part time ED with a Local Accident Unit (LAU). The Community Health Council had considered these plans but had asked that the LAU which would be mainly nurse led, should have GP support and be named an Urgent Care Centre (UCC).

The decision had been referred to the Minister for Health of the Welsh Assembly by the CHC. The Minister has sought external advice on the proposals by the LHB and the CHC by means of a Scrutiny Panel.

## Current Emergency Department Services in West Wales

The current provision of services is well described in the supporting documents, provided by the LHB and the CHC. West Wales presents challenges for Emergency Care provision due to the large distances and relatively poor transport links in a rural setting. There are currently three Type 1 EDs providing 24 hour care and one Type 2 department at Prince Philip Hospital (PPH) Llanelli. It is the future of PPH that is the subject of this Scrutiny.

## Services at PPH

- The ED is staffed by Emergency Medicine doctors 8am to 10 pm seven days per week and overnight the department is staffed by GPs with a special interest in A&E.
- The department sees 30,000 new patients per year with 3,000 ambulance attendances and a 10% admission rate. There are a number of protocols in place that divert ambulances with general surgical conditions, children, major trauma and other conditions to other hospitals.
- The ED is supported by acute medicine, imaging and laboratory services. There is a small ITU/HDU. There are fracture clinics during the week and elective orthopaedics on site. There is no general surgery or paediatrics on site.
- There is a co-located Out of (OOH) facility run from the Fracture Clinic next to the ED. However there is no common triage mechanisms and there are artificial barriers to access that prevent primary care patients moving easily from the ED to OOH.

## Case for change

- The EDs in the area are struggling to maintain staffing, a problem in Emergency Medicine (EM) throughout the whole of the UK. However with only two substantive EM consultants, no EM middle grade trainees and a few substantive non consultant middle grade doctors, the Emergency Medicine staffing in Hywel Dda is severely stretched and is very far removed from any current guidelines for staffing A&E departments. The maintenance of the service is highly dependent on the hard work and good will of a few individuals. The situation should

be regarded as a major clinical and organisational risk. There is no prospect of improvement in this situation in the medium or longer term with the current need to staff 4 A&E departments. This is not sustainable, desirable or safe.

- Problems in EDs have been widely publicised and NHS England is undertaking a whole systems review to try and address the issue. The staffing issue in Wales is even more acute.
- Advances in treatment of some conditions have led to concentration of specialist services with patients travelling far longer distances to receive better care.
- The back-up services available at PPH, while capable of sustaining a safe ED taking selective ambulance patients, is not ideal. The department does not function as an ED at night.

**National Standards and Welsh Government Policy**

- NHS Wales has set out its five year vision in "Together for Health". The main policy direction is better access to primary care and better local services. Services must be put on a strong basis to ensure long term sustainability while keeping services as local as possible. It acknowledges the challenges of staffing in some specialties and financial pressures.
- The College of Emergency Medicine (CEM) sets out standards for ED staffing. There should be a consultant in Emergency Medicine available at all times and a doctor of ST4 level or above in the department at all times. HD LHB fails to meet these standards in its EDs. The national workforce problem is not going to improve in the foreseeable future. All avenues have been tried to solve this problem including the recruitment of overseas doctors.
- If HD LHB is to provide a safe ED network then there is an overwhelming case for concentrating resources in fewer units.
- The pattern of work and case mix in PPH ED is not ideal to support Emergency Medicine training.

**Sustainability**

- There is strong evidence that the current ED framework in Hywel Dda is not sustainable. PPH is not an ED at night. Other departments struggle to provide safe staffing. In order to try and provide a long term sustainable ED network hard decisions need to be made.

**Best practice**

- It appears that many of the best clinical practice decisions have been made with centralisation of services for heart attack, major trauma, general surgery and paediatrics. This has left PPH with the bare minimum of clinical support for the ED. While the support is within CEM guidelines, it is not the ideal configuration for support services.
- Staffing problems will mean that it is impossible to provide an up to date EM service and the case mix is far from ideal for EM training.

**HD LHB proposals**

- The proposal is to continue an acute medical take with a medical receiving unit (currently the model at night) and an Emergency Nurse Practitioner led minor injury unit (or Local Accident Unit).

**Results of the consultation process**

- There appears to have been a large consultation process with staff, the general public and the CHC.
- There also appears to be general support for change and that the current model is not sustainable but there are a number of important documented objections that need to be considered.
- The main counter proposal by the CHC is that the ED should be replaced with an "Urgent Care Centre" that would have 24 hour GP support.
- Acute physicians at PPH have expressed their main concerns as that with a nurse led model, they, as physicians, would be asked to provide support out-with their competence in the areas of paediatrics, orthopaedics and general surgery. There are also concerns about the care needed by patients brought by the police.
- Local primary care (LMC) agrees that the current situation at PPH is not sustainable. They have reservations about a nurse practitioner led unit but also about capacity in primary care to take up increased community care.
- The National Clinical Forum of leading clinicians agrees that the situation in Hywel Dda is not sustainable. They think that even greater consolidation of services would provide a more sustainable solution.

**Developments subsequent to the consultation**

- PPH clinicians, local primary care and PPH management have engaged in an exercise to explore the type of services that would replace the "A&E" Service at PPH. They have set up five work streams to provide options for consideration.
- These work streams include forward thinking plans for the development of services. Perhaps those for acute medicine and for the management of the frail elderly are most advanced. Given the highly selective nature of the current workload, these plans will probably provide a safe and sustainable solution for the acute medical patients attending PPH from cardiac arrest to ambulatory care for medical conditions. The work on the care of the frail elderly patient has the potential to improve care for this very important group of patients.
- There are two models offered for the care of minor illness and minor injury. One is staffed only by emergency nurses practitioners (ENP), the other uses the same ENP model augmented by a GP with special interest in urgent care (ENP+GP). The ENP+GP model seemingly has been introduced with great success at Singleton Hospital in Swansea. In Singleton they apparently have no problem in recruiting GPs to staff the model.
- While a full impact analysis is not complete on these two models, it is clear that the acute physicians continue to be concerned about the safety and effectiveness of the ENP model and clinical opinion is firmly behind the ENP+GP model. The ENPs the Panel met voiced

a clear preference for the ENP+GP model; they think this would make them more effective.

**General points made by CHC members, at their meeting with the Panel**

- Hywel Dda is a large and largely rural community with poor transport links and long transport times
- Bronglais Hospital is isolated and serves a large area to the north and is thus strategically important.
- Llanelli is more of an urban area with stronger links to Swansea both culturally and in terms of transport and referral patterns.
- The use of data and statistics by the LHB including population health needs assessment was either poor or missing completely.
- There was a perception that the LHB was advertising locum posts rather than substantive posts.
- There was agreement that new ways of working were going to be required, "creative solutions that would tackle rurality".

**Issues specific to PPH made by CHC members**

- The CHC acknowledged that professional opinion had stated that the current situation was not sustainable.
- The CHC preferred model was for an "Urgent Care Centre" with ENPs working with doctor support 24/7. The reasons for this model were provided in the referral documents and are noted above.
- The model of the GP unit at Singleton hospital was said to be successful.
- There were significant issues about the transfer of patients to Glangwili Hospital. If these patients were discharged in the evening and at night, there could be major problems with transport home as the public transport links were not good.
- There were concerns expressed about capacity at Glangwili and Morriston A&E.
- There was an opinion that the hospital had been built with public subscription and that the population will always go to the hospital.
- There were a number of demographic reasons why PPH should continue to provide a doctor led service, including high levels of deprivation, a high immigrant population, high drug and substance misuse, the proximity of the police cells, and a different culture between Llanelli and Carmarthen.
- The CHC had been assured that any solution would be clinically led.
- There was a comment that the signs to an A&E department were potentially misleading, especially to visitors.
- There were a number of comments that access to primary care was poor in some areas leading to increased ED visits. Also there was some evidence that GP emergency admissions had to go through the "A&E" department.
- The Panel was careful to clarify that the CHC agreed the model of care that had been suggested. They confirmed that they are proposing an acute medical receiving unit and an Urgent Care Centre with ENP and GPs working 24 hours per day. They agreed this model was not an A&E department.

**Conclusions**

The College of Emergency Medicine has a position statement on reconfiguration of services and how these should be judged. Dr Wardrope has adapted these tests to apply to the local situation.

1. **Safe, effective and accessible delivery of emergency care must lie at the heart of all decision making in reconfiguration.**

*Opinion*

- Either the ENP or ENP+GP model would provide safe health care.
- The ENP model would probably provide less effective and less accessible healthcare with more patients being transferred to other services.
- The ENP+GP model is likely to lessen the need for transfer and lessen the impact on already stretched EDs especially at Morriston.
- The acute physicians have voiced concern about the ENP model in that they would be asked to provide clinical advice for orthopaedics, paediatrics and O&G. There are the plans for PPH that the orthopaedic presence will actually be enhanced. Major trauma will be taken to Morriston Hospital and moderate isolated limb injury would again be taken by ambulance to other Emergency Medicine departments.
- The Nurse Practitioner will be well trained in the management of minor trauma and able to recognise the need for transfer. There will be orthopaedic doctors on site who should be able to provide occasional orthopaedic advice
- There may be a vanishingly small number of patients that walk in with an injury that needs immediate intervention. There should be sufficient orthopaedic and anaesthetic back up and it is hard to see why acute medicine should be involved.
- Regarding the care of a sick child, there are already systems in place to provide anaesthetic support (with the staff updated in the care of children). The aim would be to stabilise and transfer to more appropriate care. Children with minor illness may need referral to either GP services or to another ED.
- The same would apply to general surgical patients.
- There are issues surrounding the care of patients with alcohol or drug intoxication. PPH has a work stream looking at the care of such patients. The details are not yet finalised but given adequate resource, planning and training it should be possible to deal with these patients effectively. Indeed there are opportunities to improve the on-going care of these patients.

**2. Commissioners must fully understand the complexity of the emergency care case mix and its distribution over a 24 hour period.**

There is evidence the commissioners understand the case mix although the CHC voiced concerns about some of the statistics and a health needs assessment.

**3. The competencies and skillsets of the clinical decision makers in the emergency care system must be considered before any reconfiguration proposals are allowed to proceed.**

*Opinion*

- The commissioners have considered the skills required of nurse practitioners but perhaps overestimate the confidence of the ENPs to handle some conditions without medical support.
- The numbers of ENPs trained/ in training is currently not sufficient to run a 24/7 service.
- There are already a number of GPs working at nights that have very significant experience of ED work. These numbers will have to grow if the ENP+GP model is accepted. Experience at Singleton Hospital indicates that there is no shortage of GPs willing to undertake such work. However recruitment, training and CPD of these GPs will require careful planning.

**4. Close collaboration with local clinical experts are vital in any discussions.**

Local experts in Emergency Medicine, Acute Medicine have been actively involved as have GPs. The views of the clinicians who will have a direct role in service delivery are very important.

**5. Any proposed models for care delivery must be clinically led.**

The ENP+GP model has significant clinical support by the acute physicians, the ENPs and it is believed, local primary care.

The ENP model has some support from EM.

**6. The training and education of the emergency care workforce must lie at the heart of the service to help optimise the quality of care delivered**

Training and education of the ENPs is being given prominence.

The ENP+GP model gives a golden opportunity to provide a novel and effective learning environment for GP trainees. This has the potential to increase the long term sustainability of urgent care workforce in Hywel Dda.

**7. A high quality clinical governance and risk management programme must be built into any proposed reconfiguration with a set of metrics that can be shared between all relevant stakeholders to ensure the pursuit of excellence in emergency care.**

It is not entirely clear what the clinical governance arrangements are going to be. Until the final model is decided this will be difficult and the management team are very aware of the need for this infrastructure.

**8. The unit must have a cohesive 24/7 support service structure from key specialties and services including acute medicine, intensive care/anaesthesia, diagnostic imaging and appropriate laboratory services.**

PPH has the services required to support a selective emergency medical take.

**9. Ideally paediatrics, general surgery and orthopaedics should also be on site. If they are not, then safe care pathways with robust governance processes linked to corporate responsibilities must be in place for the management and safe transfer of patients.**

The PPH management team seem very aware of these issues and already procedures are in place to deal with general surgical, paediatric and orthopaedic patients. These systems will have to be reviewed before service change.

**10. Detailed modelling of the potential impact of any reconfiguration proposal on the local population and healthcare economy is vital.**

The impact assessment and modelling of patient flows is work in progress. It is likely that the ENP+GP service would not result in major changes in patient flows. The frailty work and the acute medical plans could expedite patient care in some instances and may prevent admissions.

The ENP model may result in significant onward referral to other services. This could have significant impact on Morriston hospital. An increase in patient attendances at Morriston could have a major impact on the safety of patients, not only of those from HD area but also those from other Health Boards.

# Appendix 1

**Terms of reference**

The following Terms of Reference for the Scrutiny Panel have been agreed:

Taking account of relevant national standards, sustainability, best practice and the Welsh Government policy context set out above, to examine the proposals for service change put forward by Hywel Dda Health Board; and the objections and alternative proposals put forward by Hywel Dda Community Health Council for:

- A&E services at Prince Philip Hospital in Llanelli; and

- Neonatal services, specifically in relation to Glangwili (Carmarthen) and Withybush (Haverfordwest) Hospitals.

To provide detailed advice and recommendations to the Minister for Health and Social Services on whether the Health Board's proposals should proceed, or be modified to take account of the Community Health Council's objections and alternative proposals.

# Appendix 2

**Documents examined**

Together for Health
College of Emergency Medicine Standards for Reconfiguration of Services
College of Emergency Medicine: The Way Ahead
Changing Care and Improving Quality
Key submission: A&E service in Prince Philip Hospital Llanelli- Hywel Dda Health Board
Supporting information in relation to the Hywel Dda Community Health Council Referral
Document: A&E Department at Prince Philip Hospital
National Clinical Forum Response

# Appendix 3

**Meetings with Hywel Dda Health Board and with representatives from PPH Hospital**

Trevor Purt - CEO
Sian-Marie James - Vice Chair
Kathryn Davies - Director of Planning, Strategic Integration, Therapies and Health Sciences
Paul Williams - Assistant Director of Strategic Planning
Dr Sian Lewis - Consultant Haematologist & Assistant Director of Clinical Services
Jeremy Williams - Consultant, Emergency Medicine
Sharon Burford - Project Manager, Planning Dept & Primary Care Out of Hours Manager
Mansell Bennett - Programme Manager, PPH Unscheduled Care Programme
Dr Robbie Ghosal - Consultant Respiratory Physician & Lead for Acute Medicine Work stream
Dr Granville Morris - Consultant Gerontologist and Lead for Frailty Work stream
Dr David Samuels - Clinical Leadership Fellow & Lead for Substance Abuse and Mental Health Work stream
Ann Marie Lewis - ENP, PPH
Laura Parkinson - ENP, PPH

**Meeting with Community Health Council 15th August**
Tony Wales - Chair
Gabrielle Heathcoat - Deputy Chair
Ashley Warlow - Chief Officer
Sam Dentten - Deputy Chief Officer
Helen Pinnell Williams - Secretary
Ray Hine
Paul Hinge
Ruth Howells
Peter Milewski
Pamela Parsons
John Philips
Chris Slader
Janet Waymont