



## [Response to the report 'The Best Configuration of Hospital Services for Wales' by Professor Marcus Longley.](#)

We welcome and applaud the thoughtful contribution to the national debate on the most efficacious configuration of hospital services in Wales which has been produced by Professor Marcus Longley, a greatly respected contributor in this field.

Professor Longley repeatedly emphasises in his report that evidence is "frustratingly vague, inconclusive, contradictory, or simply non-existent" and does not always point to a single answer. "Readers therefore have to weigh the evidence for themselves, taking into account the interpretations placed upon it, and applying their own common sense."

We would reiterate our contention that whilst 'no change' is not an option, 'wrong change' would be the worst possible outcome for future generations within Wales.

Professor Longley notes that only six of the thirteen Accident and Emergency Departments in Wales have provided data.

The Hywel Dda Health Board is one of those which has failed to supply such data, and Prince Philip Hospital, Llanelli is not recognised as even possessing an A&E department, despite assurances to the contrary from the Minister for Health and Social Services.

The data is therefore incomplete and not reflective of the situations prevalent in the Llanelli, Carmarthen, Haverfordwest and Aberystwyth hospitals and their medical provision.

In any event, Professor Longley notes that "all of these data are beset by a variety of definitional and quality issues, and all should be treated with caution". He also states ".....experts are not always right, and their opinions should be treated with caution".

For Major Trauma Services it is noted that the time from injury to definitive surgery is the primary determinant of outcome, not the time to arrive at the nearest emergency department. "Major trauma patients managed initially in local hospitals are 1.5 to 5 times more likely to die than patients transported directly to trauma centres." "One centre might typically serve a population of 3-4 million."

The current population of Wales is estimated to be just over 3 million. We would suggest that the implication is therefore clear: Wales could be effectively served by one centre to deal with major trauma, supported by its own independent air transport to transfer patients rapidly from any point in the country to the Major Trauma Unit within 20 - 30 minutes. Such a unit would need to be supported by, but independent from any of the existing LHBs and would operate autonomously.

Professor Longley notes that in General Trauma and Emergency Care it is not the size of the unit that matters but rather the compliance with clinical standards within the unit, whatever it's size. Indeed, he observes that "smaller hospitals often show better compliance" but that outcomes are better "where senior doctor cover is available 24/7".

We would suggest that our strategy, as set out in our document 'An Alternative View', of establishing Centres of Excellence in all of the Hywel Dda hospitals to support parallel A&E and Urgent Care Centres sits well with Professor Longley's observations.

Another approach would see the merit in situating major fully functional A&E and Urgent Care Centres in the three major centres of Bronglais, Withybush and Prince Philip Hospitals. A Community Hub based at Glangwili Hospital would cater for minor injuries within the small rural community it serves.

Professor Longley's observations regarding Stroke Care are critical as the incidence of Stroke within our increasingly aged population becomes greater.

In areas such as Maternity and Paediatrics he finds no evidence in the published research of a consistent relationship between outcomes and size of unit.

There is good evidence to link positive patient outcomes after surgery with individual surgeon volume rather than hospital volume and the concept of clinical networking is supported, again in line with our 'An Alternative View' proposals.

In considering the relationships between other determinants than volume in considering patient outcomes, Professor Longley concludes that "Many of these factors are unrelated to hospital size; others can be correlated with hospital size, sometimes inversely....hospital configuration....is never sufficient in itself".

In all, we would argue that this report supports our argument that the headlong rush towards centralising Hywel Dda services in Glangwili is unwise, unwarranted, unwanted and unnecessary.

We have argued our case for reducing rather than extending the distances that patients and visitors have to travel. Professor Longley is unequivocal:" The location of services - and therefore travel time .....can literally be a matter of life and death".

He goes on ".....the issue with the greatest impact for most patients is the adequacy of non-emergency transport.....for patients and.....their visitors". We have ourselves highlighted this issue and suggested strategies to meet the needs.

It was not in Professor Longley's remit to consider the interface between medical and social services and we would value his views on our proposals regarding the provision of on-site convalescence / rehabilitation units and community support for the elderly but we are satisfied that our holistic proposals fit well with Professor Longley's overall observations and extend his general philosophy into the broad community.

We would reiterate that, all the way through his report, Professor Longley asks readers to make their own judgments in order to find a solution and does not make a recommended solution himself.

Finally it should be acknowledged that due to its remit the report, excellent as it is, only addresses the provision of services from the hospitals and not in the wider community where in fact the greater impact is to be felt from the fallout of change.

We would further recommend the earliest possible government action to bring all relevant parties together with a view to establishing an holistic solution to an increasingly nationwide problem, whereby the organisation, management and funding of care for the elderly is molded into a single cohesive and effective strategy, removing those patients who neither want nor need to be trapped within the hospital system into a more appropriate situation, initially in a convalescence / rehabilitation unit and then on to long term care management either, ideally at their own home, or if necessary at a community care home.