

**INDEPENDENT INQUIRY INTO THE PROCESSES ON
CONSULTATION AND IMPLEMENTATION OF THE
RECONFIGURATION OF GENERAL SURGICAL SERVICES IN
CARMARTHENSHIRE**

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INTRODUCTION

1. On the 1 February 2007 the Minister for Health and Social Services announced the setting up of an Independent Inquiry to look into the processes on consultation and implementation of the Reconfiguration of General Surgical Services in Carmarthenshire, in particular the decision to close emergency general surgery services at Prince Philip Hospital, Llanelli, Carmarthenshire (the Surgical Services Review). This report summarises the results of the inquiry.
2. The overall aim of the inquiry is summarised above but the more detailed objectives of the inquiry are:
 - Consider the conduct and actions of key stakeholders during the Surgical Services Review, in particular:
 - The Working Group set up by Carmarthenshire LHB in autumn 2005 (comprising Carmarthenshire Community Health Council, the Ambulance Service, Carmarthenshire NHS Trust, Swansea NHS Trust, representatives from Primary Care, Carmarthenshire County Council, the National Public Health Service, and representatives from the Voluntary Sector and the Local Community);
 - Carmarthenshire Local Health Board (the LHB);
 - Carmarthenshire County Council (the Council);
 - Carmarthenshire Community Health Council (the CHC);
 - Carmarthenshire NHS Trust (the Trust); and
 - Welsh Ambulance Services Trust;
 - Consider compliance with Section 11 of the *Health and Social Care Act 2001* and Regulation 18 of the *Community Health Council Regulations 2004*;
 - Include an examination of any contribution officials from the Department for Health and Social Services made in the decision to close emergency surgery services at Prince Philip Hospital;
3. Although the principal content of this report is concerned with events in Llanelli, there are also lessons from these events for NHS leaders across Wales. For that reason the report ends with a commentary and recommendations for the Welsh Assembly Government on the future management of public consultations.
4. The process of undertaking the inquiry included:
 - Review of relevant consultation documentation, correspondence, emails, board and working group minutes and reports of local NHS organisations, the community health council, the Welsh Assembly Government and other organisations.

- Interviews with the leaders of local NHS organisations, the community health council, local government organisations, Assembly Members, Members of Parliament and others during April 2007. A full list of interviewees is provided at Appendix 1.
 - Invitation via newspaper advertisements to members of the public to email evidence to a dedicated website. Five responses were received.
 - Opportunity for the Local Health Board, NHS Trust, Ambulance Trust and Community Health Council to comment on the factual accuracy of the sequence of events section of the inquiry report (paragraphs 9-37).
5. I am grateful to all those who agreed to be interviewed. They gave their time freely and without their cooperation it would not have been possible to complete this inquiry. I am also grateful to Sue Miles and Joanne Gillard who provided me with administrative support in organising the interview schedule; and to Siân Harrop-Griffiths who provided invaluable managerial support.

EXECUTIVE SUMMARY

6. The decision of the LHB and Trust to pursue the centralisation of emergency surgery was reasonable but the consultation process was not presented against a backdrop of a compelling vision and strategy for acute healthcare in Carmarthenshire. In addition, the consultation lacked flexibility and sufficient empathy with and sensitivity to the public and other stakeholders. A history of poor local relationships resulted in too much confrontation and too little collaboration and leadership. Further, the organisational and leadership roles of the NHS Trust and LHB were not clear to external stakeholders.
7. Patient flows and patient preferences should not be determined by NHS structures and systems. Patients should be supported if it is more convenient for them to use emergency or elective services at hospitals other than in Carmarthenshire. The retirement of the consultant vascular surgeon from Prince Philip Hospital was known well in advance and his earlier than planned departure was not linked to implementation of the decision to centralise emergency general surgery. Finally, there is no evidence of pressure being brought to bear by the Assembly Government during the post-consultation decision-making and implementation stages.
8. There are 14 recommendations for the Carmarthenshire NHS and the Assembly Government including: the need for an exciting and compelling vision for the future of Prince Philip Hospital; implementation of the decision to centralise emergency general surgery should be rigorously performance managed by the Trust, LHB, Ambulance Service and CHC, and performance reports made public; NHS organisational and leadership roles require clarification; inter-organisational relationships need improving; the Committee for the Improvement in Hospital Services should clarify its role and governance arrangements; public engagement should be performance managed by WAG; future public consultations across Wales should be quality assured; and all community health councils should have ongoing development support.

BACKGROUND AND SEQUENCE OF EVENTS

9. The changes to surgical services at Prince Philip Hospital, Llanelli in 2006-07 cannot be viewed in isolation. Concerns about safety had been growing for some time. The steps are summarised in Table 1 and although I will not comment on each step in the table I will draw out what I consider to be key issues.
10. The changes to the hospital's accident and emergency services in 2003 have been included because to many stakeholders this is an important historical contextual issue. In summary, the Trust restricted the opening hours of the accident and emergency service at Prince Philip Hospital from 24/7 to 8.00am to 8.pm daily from 1 September 2003 because of increasing clinical risk. It was because of this event that in August 2003 the action group known as the Committee for the Improvement of Hospital Services was formed.
11. Because of the public reaction to the changes to accident and emergency services, an inquiry was initiated by the then Minister for Health and Social Services. The 2003 inquiry (the Marples Report) concluded that there were consultation and communication lessons to be learnt. In September 2004 Prince Philip Hospital's accident & emergency service was restored to 24/7 albeit staffed at night by general practitioners.
12. The January 2004 report from Teamwork management consultancy on the Carmarthenshire health system examined financial control and recovery planning, performance benchmarking, and clinical service re-design. The report concluded, among other things:

'To date the Trust has accepted the principle and practice of operating two general surgical services, two A&E services and two critical care units for a relatively small catchment population of 175,000.

'The natural desire to satisfy individual professional and local emotional and political interests, and to maintain the status quo is understandable but has resulted in providing a poorer service to patients and increased the attendant clinical risks to an unacceptable level.'
13. The 2004 report of the Joint Committee on Higher Surgical Training (2004) recommended, among other things,

'...that general surgical services on both sites should be amalgamated to produce increased training opportunities and to rationalise subspecialty training. This would allow more efficient use of trainees and non-consultant grades across the Trust and allow European working time directive compliant rotas to be constructed.'

Table 1 Summary of key events leading to the cessation of emergency general surgery at Prince Philip Hospital, Llanelli

Date	Event
1 September 2003	Accident & emergency service closed 8.00pm-8.00am
January 2004	Report commissioned by the Mid & West Wales Regional Office from Teamwork Management Services on financial recovery, performance benchmarking and clinical redesign.
September 20-21	Accident & emergency service restored to 24/7.
October	Report to the NHS Trust of the regional visit by the Joint Committee On Higher Surgical Training, Specialist Advisory Committee in General Surgery.
11 February 2005	Preparatory meeting held between the local NHS and non-NHS stakeholders scheduled to meet with the Royal College of Surgeons.
17 & 18 February	Visit of the Royal College of Surgeons of England (RCS) initiated report on the future provision of general surgery.
April	RCS report received by the NHS Trust.
14 September	Multi-stakeholder surgical services working group established by the LHB.
13 December	Health panels launched by the LHB.
16 March 2006	Final report of the surgical services working group considered by the LHB board.
3 April	Public consultation launched by the LHB.
26 June	Public consultation ends.
11 July	CHC council votes (by show of hands) against the proposal for change by 8 votes to 7 giving four reasons of concern.
1 August	CHC and LHB meet to discuss the CHC's concerns.
2 October	Joint LHB/CHC surgical services review facilitated workshop with the Regional Director present to discuss finding a way forward for surgical services.
9 October	CHC workshop and members votes for a second time (by paper ballot) resulting in 8 votes to 5 against the proposal.
31 October	CHC representatives meet Chief Executive of the Welsh Ambulance Service to receive assurances on the outstanding ambulance transport concerns.
21 November	CHC council votes again (by paper ballot) resulting in 8 votes to 7 in favour of the proposal to centralise emergency surgery at West Wales General Hospital.
3 January 2007	First meeting of the surgical services implementation group established and led jointly by the LHB and NHS Trust.
25 January	The Deputy Chief Medical Officer confirms that the immediacy of the decision to move remaining emergency surgical services from Prince Philip Hospital during February 2007 is justified.
1 February	Independent inquiry announced by the Minister for Health and Social Services
2 February	Cessation of emergency general surgery at Prince Philip Hospital.

14. In the light of the comments made by Teamwork management consultants and the Trust's increasing clinical governance concerns about emergency general surgical services, the LHB and Trust took the decision to seek an independent view from the Royal College of Surgeons of England (RCS). The RCS visit was well publicised and well known to non-NHS stakeholders, many of whom were interviewed as part of the review. The three RCS reviewers visited on 17 and 18 February 2005 and concluded:

'The proposal to split emergency and elective procedures and to centralise emergency general surgery at West Wales General Hospital appears to be the only solution. The review team did not encounter any person or organisation who would disagree with this and no-one could supply an alternative to the plan. The volume of emergency general surgery admissions at Prince Philip Hospital is actually in the order of one per day and so the review team conclude that this service is uneconomical and unsustainable. If the proposals are implemented well, there is scope to attract elective work from the Swansea hospitals to PPH and to attract emergency work from Haverfordwest and Aberystwyth to the WWGH. This will make both hospitals more sustainable and viable and appropriate funding and resources should follow.'

15. The RCS report made 10 recommendations, a number of which focused on the need for effective consultation and communication processes, the establishing of clinical networks, transport arrangements, and the elective surgical mix to be provided at PPH by considering expanding ear, nose & throat surgery, urology, gynaecology and ophthalmology.
16. In addition to the 2003-04 changes to accident and emergency services influencing stakeholders' views about the management of the local NHS, the Mid and West Wales consultation on acute services, was another critical factor in shaping public opinion. This consultation also commenced on 3 April 2006 and the main proposal was that the Mid and West Wales region would be configured in terms of three acute service delivery units (hospital networks) and one networked service delivery unit (Powys) of community and hospital services. This would be achieved through either:
- the development of a new single acute hospital in South Dyfed, located mid-way between Haverfordwest and Carmarthen to replace Withybush and West Wales General Hospitals; or
 - the development of West Wales General Hospital as the main acute hospital site networked with Withybush and Bronglais, both of which would operate on a linked service basis.
17. The consultation proposals went on to say that Neath Port Talbot and Prince Philip hospitals would have an integral role to play within the hospital networks. They would continue to provide acute emergency medical services and a full range of diagnostic and outpatient services. However, they would expand to specialise in providing more elective surgery for the region.
18. If the proposals went ahead then Prince Philip Hospital would retain its key function as a centre for emergency medical assessment and treatment for the

local population and would be further developed as a dedicated centre for elective treatment supporting both Dyfed and Swansea with the following services:

- Minor injuries/local accident centre receiving patients with minor injuries/illnesses
- Medical assessment unit
- Medical inpatient services (generally non-specialist)
- High dependency care (with capacity for short term ventilation) plus coronary care facility
- Range of elective inpatient services
- Broad range of day-case surgery
- Full outpatient services
- Extensive diagnostic services
- Midwifery-led maternity service and/or extended day paediatric investigation and treatment service where locally indicated
- Diagnostic services

19. The outcome of the consultation was that although there was little support for the proposals there was recognition that change was needed. The Minister asked that a planning forum be established to develop further proposals for change. This has been established across the Carmarthenshire, Ceredigion and Pembrokeshire local health board and NHS trust areas and has met twice.
20. The public consultation on Carmarthenshire's surgical services was preceded by the LHB establishing a surgical services working group. It met for six months between September 2005 and March 2006 and was chaired by the LHB's director of public health. Membership was wide-ranging and inclusive, for example, it included the CHC, the ambulance service, general practitioners and the Committee for the Improvement of Hospital Services. The overall objective of the group was, *'To review the existing organisation and delivery of surgical services for Carmarthenshire residents and develop a strategy to drive improvement.'*
21. At its meeting on 10 October 2005 the working group considered the options available for the delivery of surgical services. On 14 November the minutes record that further detailed discussion took place including the options of maintaining the status quo and the provision of emergency surgery at either Prince Philip or West Wales General hospitals. The minutes also record that, *'The potential for other options...were considered, but no additional options were put forward by the Surgical Services Working Group.'*
22. At the 20 December meeting, working group members discussed whether there was further evidence or information relating to the risks and benefits of the available options but no issues were identified. The group recommended that the most favourable option would be to relocate all emergency general surgical activity to West Wales General Hospital, with increased elective capacity at Prince Philip Hospital. The three months public consultation began on 3 April 2006 based on the working group's assessment of the benefits and risks of the three options that had emerged from the group's discussions (see Table 2).

Table 2 Summary of the options for emergency general surgical services

Option and benefits	Risks
1. Maintaining the status quo <ul style="list-style-type: none"> No change in service delivery 	<ul style="list-style-type: none"> Not sustainable Clinical governance agenda Impact on training posts
2. All emergency surgery directed to Prince Philip Hospital <ul style="list-style-type: none"> 24 hr service geared towards Llanelli 	<ul style="list-style-type: none"> No CEPOD theatre No emergency surgical activity between Bronglais and Llanelli Increased ambulance activity
3. All emergency surgery directed to West Wales General Hospital <ul style="list-style-type: none"> All other surgical specialties located at WWGH Dedicated CEPOD Theatre at WWGH main A&E Dept for Carmarthenshire located at WWGH Increased elective work at PPH Increased training posts 	<ul style="list-style-type: none"> Increased numbers of Llanelli patients to Swansea NHS Trust Increased ambulance activity

23. The consultation document recorded that two other options were put forward by the working group but dismissed:
- All emergency general surgery directed to Morriston Hospital: dismissed due to hospital situated outside Carmarthenshire, the consequential risk to staff in Carmarthenshire and excess travelling times.
 - New hospital build: dismissed due to cost and outside the review of general surgical services.
24. The consultation document also included an appraisal of the options against a range of criteria undertaken by the working group (see Table 3); a travel times analysis; and a statement that the recommendations could be implemented on a cost neutral basis.
25. Information was included in the document on the resource implications of providing an 'ideal' general surgical service, namely:
- Provision of an MRI scanner at West Wales General Hospital: costed at £2m (for equipment and accommodation) and which could be operational within 18 months of approval of funding.
 - Critical care facilities: no additional resource/capacity identified.

- Provision of a purpose built day surgical/endoscopy facility at Prince Philip Hospital: costed at £10.4million and taking two years from date of approval to completion.

Table 3 Appraisal of the surgical service options

Criteria	Options		
	Maintain the status quo	All emergency surgery to PPH	All emergency surgery to WWGH
Acceptability to stakeholders:			
• Users of the service	√	√	√
• GPs	√	√	√
• Consultants	X	X	√
Evidence of safety of these units	√	√	√
Are measures to ensure clinical governance in place or being implemented?	√	√	√
Accessibility	√	X	√
Equitable	√	X	√
General surgical staffing and availability			√
Informed choice	√	√	√
Continuity of care	√	√	√
Quality of care	√	X	√
Cost	±	±	±

Key: √ positive point; X negative point; ± equivocal

26. No further detail is contained within either the consultation document or the final report of the surgical services working group on the above issues.
27. The consultation document contained details of three proposed public meetings, which were part of a programme of 17 meetings held during the consultation period. During these meetings the Trust's clinical staff as well as the LHB played a prominent role in explaining the proposals to the public, their elected representatives and other stakeholder organisations.
28. Following the cessation of public consultation and their first vote against the proposal the Carmarthenshire CHC had four concerns, which were identified at a meeting with the Local Health Board on 1 August 2006 (see Table 4). These were resolved to the CHC's satisfaction between 27 September and 21 November 2006.
29. Given the concerns about the possible impact of the proposal on the ambulance service on 14 September 2005 the surgical service working group requested information from the ambulance service on the number of calls for emergency surgery patients to be taken to Prince Philip and West Wales General hospitals

and also on the number of inter-hospital transfers. On 14 November information was presented concerning abdominal admission for each hospital; and the Trust clarified reasons for transporting patients to each hospital and stressed the expertise and training of ambulance staff.

Table 4 CHC concerns post-consultation

Concern	When resolved
1 Diminution of services increased risk to patients	Resolved at CHC workshop held on 27 September 2006
2 Downgrading of service and a downgrading of Prince Philip Hospital	Resolved at CHC workshop on 27 September 2006
3 Lack of confidence in emergency ambulance service	Resolved following meeting with Welsh Ambulance Service NHS Trust Chief Executive on 31 October and report to CHC meeting on 21 November 2006
4 Distance for relations and carers to travel when visiting patients who may have emergency procedures	Resolved following meeting with Welsh Ambulance Service NHS Trust Chief Executive on 31 October and report to CHC meeting on 21 November 2006

30. Ambulance services were discussed again on 14 January 2006. Working group members highlighted the need to consider the resource implications on ambulances transferring patients and dealing with 999 calls. Discussion by the surgical service working group indicated that the option of centralising emergency surgery at Prince Philip Hospital could mean increased activity for the ambulance service. Also, centralisation at West Wales General Hospital meant that there was a potential risk on the increased number of patients potentially needing to access surgical services at Swansea hospitals.

31. Given the above concerns and issues it is worthwhile replicating here the minute of the discussion by working group members at their meeting on 8 February. Of particular note to this inquiry is the concern about interpretation of the working group report by people outside the group and the local NHS:

The document had been circulated electronically to all members. Dr Thomas stated it had been important to look at the way issues were addressed and to have an evidence based document. A concise summary had been included at the beginning and the document would be presented to the LHB and NHS Trust in this format.

It was agreed it was an excellent report, giving an accurate account of the work involved and it was easy to read.

Dr Thomas stated there would be an amendment to Fig. 8 on page 36 reference General Surgery Cases Going to Theatre. It was expected the document could be amended before presentation to the LHB.

A number of concerns were raised on the interpretation of the report by people from outside the Surgical Services Working Group/Health Service. These were:

- The division of provision of services at Prince Philip Hospital and West Wales General Hospital*
- The view of members of the public that they are losing services rather than gaining an improved service*
- Information and costs and funding for the options*
- The benefits of change and how it will be phased in*
- Need to anticipate questions from the public in order to have the answers ready, particularly the 'what if this happens to me'*
- The ability to support the document at the LHB meeting when the public would be present*
- Support systems to give reliable and seamless care of patients regardless of the geographical site of the hospital*
- Clear and concise statements within the document relating to the service from the patients' point of view*
- Patients to be referred to the appropriate hospital for treatment*
- Educating the general public on the need for change and the advantages or benefits to everyone*
- Additional distance to travel*

PH (Paul Harries) was concerned about the reaction of member of the public, particularly within the Llanelli area. It was possible they would see the transfer of services to West Wales General Hospital as detrimental to the area, overlooking the benefits of the changes on elective services.

Members were reminded this was a Draft Document for the LHB and NHS Trust to consider. Subject to their approval/changes this would then become a consultation document and at that time it would be relevant to include information regarding the above points either as part of the document or an appendix. Specific questions could be forwarded to Dr Thomas for inclusion in the consultation document. This would then allow for the relevant answers to be compiled. An implementation plan could also be included at the consultation stage.

The document as presented by the Surgical Services Working Group met the brief and gave preferred options. It was important the Working Group should not provide information which may prejudice a situation. The information would also be used by the Trust to support applications for funding from the Welsh Assembly Government to implement the changes. Applications for funding had already been made for certain areas.

Cllr Sian Thomas stated once the LHB and NHS Trust had approved the document for consultation, should more information be required then it could be added as an Appendix.

PH asked about the provision of helicopter services for use in trauma cases etc for the transfer of patients from incidents and to other hospitals either within or outside the area.

Discussion took place on this item. The estimated cost was £750k plus for providing landing facilities at Prince Philip Hospital. However emergency procedures were already in place with landing areas agreed at both hospitals should the need arise. The ambulance service had vehicles which allowed for three support staff and two others to travel with patients when it was necessary to provide this type of service.

The money required for a helicopter would have opportunity costs elsewhere in the Health Service. The use of the Air Ambulance Service was an alternative option.

The report was a Review of General Surgical Services in Carmarthenshire and gave an important opportunity to improve services for Elective Surgery which would benefit Carmarthenshire.

The provision of a helicopter service was an item for Mid and West Wales as a whole rather than Carmarthenshire, and should be addressed by the Acute Services Review.

32. The Carmarthenshire CHC met on three occasions to vote on the outcome of the public consultation. The final vote took place on 21 November 2006, when CHC members decided to support the LHB's recommendation that emergency general surgery should cease to be available at Prince Philip Hospital and be centralised at West Wales General Hospital.
33. The decision was transmitted to the Welsh Assembly Government (WAG) via an email dated 22 November 2006 from the Regional Director, Mid & West Wales Health and Social Services Regional Office. The Regional Director also emailed WAG on 1 December saying that a surgical services implementation group would manage implementation of the decision, the date of which would be 1 February 2007. Finally, the Regional Director sent a detailed briefing note dated 17 January 2007 to the Chief Executive of NHS Wales covering the contextual history, consultation process and implementation.
34. Because of the concerns voiced during the inquiry about the choice of implementation date it is worth providing some background detail. February 2007 was chosen for implementation by the local NHS and multi-disciplinary surgical services implementation group because this coincided with the change over of junior medical staff that was planned to take place the same month; however, there were also historical consultant on-call rota issues that needed addressing if a safe service was to be provided.

35. Historically, the consultant surgeon on-call rota was one-in-four weeks at PPH and one-in-six weeks at WWGH. However, in order to maintain these rotas with only nine consultant surgeons the fourth slot at PPH had been filled on an ad-hoc basis by other consultants and middle grade surgical staff every Thursday and every fourth weekend. On the retirement of the consultant vascular surgeon from PPH in January 2007 a locum was appointed who took up his slot in the rota, but the emergency cover was now being provided by three consultant surgeons, two of whom were locums in vascular and breast surgery. The fourth slot continued to be filled on an ad-hoc basis.
36. The only substantive consultant surgeon at PPH at that time was due to take annual leave for the period 12 February to 2 March, thereby leaving only the two locum consultants to maintain the rota. Consequentially, a staged implementation to the reconfiguration of medical staffing rotas was therefore agreed by the local NHS as follows:
- On 2 February a one-in-eight consultant rota was introduced at WWGH and the rotas of middle grade doctors were revised to: support the emergency take at WWGH with resident cover; and provide an additional level of non-resident on-call for PPH out-of-hours by senior staff grade doctors on a one-in-four rota for any surgical opinions required by the physicians or for any post-operative elective surgical complications.
 - On 7 February the changeover of junior doctors took place and the new starters were incorporated into the rotas.
 - Between February and April exposure to emergency surgery patients was incorporated into existing work plans for four first year foundation doctors¹ at WWGH.
 - From 1 April the junior doctors' rota was revised to incorporate foundation trainee doctors and house officers.
37. Finally, in the light of the above surgical staff rota changes, the withdrawal of emergency general surgery from Prince Philip Hospital and centralisation at West Wales General Hospital took place in February 2007.

INQUIRY FINDINGS

38. On the face of it, the LHB approached the challenge of the surgical services issue in an open and engaging way, for example the surgical services working group had wide NHS and non-NHS representation including the CHC and the non-statutory Committee for the Improvement of Hospital Services. In addition, the LHB endeavoured to reach local people during the consultation using different types of engagement events such as public meetings and health panels. However, it is clear from my discussions that the local NHS, in the shape of the LHB and Trust, failed to reach the hearts and minds of local people and their representatives both before and during the consultation on surgical services. This begs questions about the quality and flexibility of the

¹ The start of postgraduate medical education in the UK. Foundation years comprise a two-year, structured training programme that bridges the gap between medical school and specialist and GP training.

LHB's engagement framework outlined in its final report of the review of general surgical services.

39. The issues that emerged from my discussions can be grouped around four themes, each of which is explored below.
- The quality of the consultation process.
 - Relationships and trust.
 - The role of the community health council.
 - Implementation of the decision.

The quality of the consultation process

40. The consultation can be divided into two discrete parts: first, the pre-consultation process, which included the work of the surgical services working group, preparation of the consultation document and planning of the management of the consultation; and second, the formal public consultation including media management.

Pre-consultation

41. It must have been clear during the work of the surgical services working group that the option of withdrawing emergency surgery from Prince Philip Hospital was likely to be contentious and challenged, even more so as the 2007 date of elections to the National Assembly for Wales, known well in advance, drew nearer. Therefore it should have been realised by local NHS leaders that that there was a real risk of the public consultation and its possible ramifications becoming a major issue in the pre-election period up to election day on 3 May 2007.
42. The poor timing of the consultation in the context of the forthcoming 2007 election was acknowledged by some in the local NHS and other stakeholders. As one Assembly Member succinctly put it, *'The timing could not have been worse'*. Consequently, it should not have been a surprise that prospective Assembly members and the local media conflated the NHS consultation and the forthcoming elections with the result that the general surgical services did become a very significant issue for almost everybody with an interest.
43. The poor timing of the consultation was also exacerbated by the concomitant consultation on the reconfiguration of acute hospital services across Mid and West Wales, which was commented on by three respondents to the consultation:

'The Council would wish to await the outcome of the Acute Services Review before any reconfiguration of general surgery in Carmarthenshire takes place'
(Llanelli Rural Council)

'Makes little sense to consider this review when the Acute Services Review remains ongoing...'
(Catherine Thomas AM)

'This review should be considered following the resolution of the Acute Services Review' (Committee for the Improvement of Hospital Services)

44. Many stakeholders saw the fact that the two consultations proceeded at the same time as confusing and some in the local NHS viewed running the two public consultations as particularly challenging given the increasingly emotionally charged views from non-NHS stakeholders about the proposed change to Prince Philip Hospital's surgical service. However, notwithstanding the process difficulties of running two consultations, the proposal for the future use of Prince Philip Hospital is virtually the same in both consultations and therefore it was reasonable, notwithstanding the above views, for the Carmarthenshire LHB to make a decision about emergency general surgery.

Formal public consultation

45. The content of the consultation document is based on the final report of the surgical services working group. I have read the consultation document a number of times and although it contains relevant and valuable information, overall it tends to read like a management report than a document written for the public. In fact the document is referred to as a report in the Foreword.
46. In my view the document is too technical in content and style. This is because it is an edited version of the working group's final report rather than the result of a fresh approach to drafting a new document specifically for public consumption.
47. Although the LHB's working group identified a number of pertinent issues to be addressed prior to the consultation commencing (see paragraph 31 above), the document does not focus on how services will be improved as a result of the changes proposed; it gives the strong impression of services being taken away rather than articulating an overall vision for the future of Prince Philip Hospital. There was ample opportunity to do this, given the LHB and Trust acknowledged during the LHB's working group before and during the inquiry that their plan was to develop the hospital as a centre for elective surgery for Carmarthenshire and areas beyond such as Swansea, reflecting the aforementioned proposals for the organisation of acute services across Mid and West Wales.
48. NHS leaders in Swansea confirmed during the inquiry that they could treat emergency surgical patients from the Llanelli area and the Swansea LHB said there was potential benefit for their residents from Prince Philip Hospital being developed as an elective surgical centre. This would continue the trend of previous decisions taken by the Trust, for example the centralisation of the majority of elective orthopaedic surgery at Prince Philip Hospital. Centralising elective surgery reflects the UK-wide trend of splitting emergency and elective sites for surgery with consequential benefits for patients such as reductions in waiting times and cancelled operations through better management of hospital resources (see paragraphs 92 to 106 below).
49. In addition to a lack of vision, specific examples of where I believe the document is lacking include:

- Many technical and erudite terms, such as ‘literature review’, ‘epidemiological needs assessment’, ‘CEPOD’² and ‘CEPOD theatre’, ‘upper quartile’ and ‘basket day case activity’ are insufficiently explained.
 - The examples quoted of the organisation of surgical services elsewhere in Wales lack comparative detail - such as activity, inter-hospital distances and transport arrangements - to make them meaningful to readers wanting to understand the relevance to Carmarthenshire.
 - The travel analyses make no reference to public transport and demographic data on car ownership, which is surprising given that the proportion of households in the *Communities First*³ areas of Llanelli with no cars or vans is in the range 35-44% compared to the Wales average of 26%; in addition, the travel analyses are somewhat difficult to interpret and understand.
 - There is a lack of financial analysis, particularly the costs of the options; it is not sufficient to assert in a consultation document that *‘surgical services could be reorganised...and remain cost neutral’* without providing supporting financial data.
 - The document did not provide a proposed framework of questions and issues to help guide individuals and organisations wishing to respond to the consultation.
50. Above all else the document needed bringing to life for the public, for example by the use of patient case studies to exemplify how a range of clinical cases would be diagnosed and treated under the new proposals for emergency general surgery. Three comments summarise the feelings of non-NHS stakeholders:

‘I did not feel that the views of Llanelli people had been taken on board’
(AM/MP)

‘Attempts were made to involve people but they were ham-fisted’ (AM/MP)

‘Travelling was not fully taken into account’ (GP)

51. Much of the above comment and advice about the importance of style and drafting more user-friendly content aimed at the general public is reflected in

² Dedicated emergency theatre. The surveys of the National Confidential Enquiry into Patient Outcome and Death (NCPOD) review clinical practice and identify potentially remediable factors in the practice of anaesthesia, surgery and other invasive medical procedures. In 1991-92 it was recommended that dedicated emergency operating and recovery rooms should be provided. Prince Philip Hospital does not have such facilities.

³ The Assembly Government’s Communities First Programme exists to provide local people with opportunities to play an active role in shaping the future of their community. The programme is embedded in 140+ communities and brings together people from a range of backgrounds within those communities. The activities taken forward have helped give people a sense of common purpose, a sense of hope and a sense of belonging.

WAG guidance, *WHC (2004) 84 Shaping Health Services Locally*, issued in January 2005.

52. In addition to a lack of vision, the document also contains no implementation plan for developing Prince Philip Hospital as an elective surgical centre. Many external stakeholders commented on this, saying that although they understood this was the intention of the local NHS, the lack of a coherent and clearly spelt out plan in the consultation document resulted in a missed opportunity and a considerable public relations gaffe. As two interviewees said:

'There was a good story to tell but the packaging should have been much cleverer, much better' (Councillor)

'The benefits were undersold' (AM/MP)

53. The need for benefits to sell during the consultation was seen as necessary to counteract the prevailing view from some external stakeholders that centralising emergency surgery at West Wales General Hospital was likely to be interpreted as a loss of another public service from Llanelli. A number of Llanelli non-NHS organisations and individuals expressed the strong view that historically, the management of public services had been centralised at Carmarthen having previously been based in Llanelli. However, other stakeholders said this view needed to be balanced against the considerable regeneration investment that has been made in Llanelli. Nevertheless, the historical sense of loss felt by some stakeholders influenced their views about proposed changes to local health services.
54. Some comments were made about the organisation of the public meetings held during the consultation, for example they were inaccessible in terms of times and locations and also that the format, with a panel sitting at a top table, was felt to be non-user friendly and potentially intimidating.
55. There were also comments made about patients being forced to go to West Wales General Hospital when for many it would have been convenient for them and their relatives to go to hospitals in Swansea. The view is summed up by a councillor, *'The Trust has not explained or justified why Carmarthen [rather than Swansea]'*.

Media Management

56. Media management was also an important issue during the consultation. Although the CHC proposed in September 2006 that the local NHS should plan a media exercise to help ensure accurate media reporting of the proposals, I could find no evidence of a media management strategy other than references to hold a number of public meetings during the consultation.
57. A review of local newspaper articles about the consultation would seem to indicate that the local NHS was forced into a reactive and defensive position. Also, media management was not helped by the NHS Trust's retired consultant vascular surgeon choosing not to publicly support the proposed change to emergency general surgical services. However, there was nothing that the Trust, as the surgeon's former employer, could have done about this.

58. It is very clear that the media climate within which the local NHS had to conduct the consultation was extraordinarily challenging and exacerbated by the mounting opposition to the consultation proposals. I found no evidence of a change of approach to media management during the consultation by the local NHS, led by the LHB, as the increasingly challenging media climate intensified. The following two comments underscore the challenge of the NHS and its media management:

'The Carmarthenshire NHS is seen as reactive rather than proactive in the media' (CHC member)

'The Trust and LHB do not have a systematic approach to media management' (NHS observer)

59. There would have been a number of ways for the local NHS to pursue a more proactive approach to publicising the positives of the proposed change and to dispel the negative rumours that emerged during the consultation, for example:

- direct leafleting of the general public, NHS staff, NHS contractors such as GPs, and pharmacists, and other public service organisations;
- the taking out of newspaper advertisements;
- the commissioning and use of polling to test public opinion; and
- securing television and radio interviews for senior NHS staff.

60. However, with some justification, there was criticism of the media by the local NHS and others, as the following comments indicate:

'The Llanelli Star did not print the positives about the proposals' (NHS member of staff)

'The climate being created [by the media] prevented the ability to have a rational discussion' (AM/MP)

61. I note that on 20 March 2007 the chairs and chief executives of seven public service organisations, including the LHB and NHS Trust, wrote to the Editor of the Carmarthen Journal to seek an improved relationship, expressing *'growing concern at the negative, often factually inaccurate reporting that appears to be a regular feature of your papers.'*

62. During the inquiry there was frequent mention of a public petition of some 30,000+ signatures against the surgical service changes. Comments were made about the organisation and motivation behind the petition that questioned its validity and generated suspicion, for example: people being asked to sign the petition more than once; the reason for the petition being the possible closure of the whole of Prince Philip Hospital; and the petition not being presented to the local NHS at the end of the consultation.

63. Petitions are a legitimate form of public protest but I am not in a position to comment on the validity or otherwise of this petition. I understand that the

petition was organised by the Committee for the Improvement in Hospital Services and it was not presented during the consultation. I further understand that this was because the Committee anticipated the eventual decision about surgical services being elevated to WAG, when the Committee hoped to be able to present the petition at that level. Given the speculation about the petition's accuracy, size and validity it would have been prudent to have presented it to the LHB, as the statutory consulting body, at the end of consultation when it could have been taken into account in decision-making. To continue to dangle it over the ongoing consultation discussions, in the manner of the sword of Damocles, seemed unfair to local people, the LHB and the CHC.

64. In summary, the reasons for the concerns of the local NHS about surgical services reflected prevailing professional clinical views about the safety and effectiveness of services, and consequentially I find that it was reasonable for the local NHS to pursue the centralisation of emergency general surgery. However, the preparation and management of the consultation lacked flexibility and sufficient empathy with and sensitivity to the public and influential external stakeholders such as councils and the public's elected representatives.

Relationships and trust

65. There is a history of poor inter-organisational relationships between the Trust and LHB, which was acknowledged by the two organisations themselves and was also well known to external stakeholders. Some non-NHS stakeholders commented that it was not uncommon for one NHS organisation to comment critically about the other to third parties. Ongoing disagreements about the apportionment of historical financial deficits between the two organisations are an example of a lack of joint ownership of issues.
66. The new chairs of the Trust and LHB are aware of this history and acknowledge the need for a more positive inter-organisational relationship. The chairs know that they have an important leadership role in ensuring that their boards and their chief executives reflect the new style and tone of inter-organisational working required if they are to create 'one Carmarthenshire NHS'.
67. The LHB and Trust also have a mixed quality relationship with local politicians and local councils although this is being addressed through, among other things, mechanisms such as the appointment of joint posts between local NHS organisations and the County Council.
68. The vast majority of external stakeholders did not trust the local NHS (principally the Trust) to consult, lead and manage change because of the historical events surrounding Llanelli's accident and emergency service changes during 2003-04. Many stakeholders, such as local councils and politicians, approached the surgical services issue with a feeling of mistrusting local NHS leaders. As one councillor said, *'Trust is at the root of the problem, we need trust and transparency'*. The Trust and LHB should have been much more aware of both this issue and the aforementioned feelings about the history of public services in Llanelli (paragraph 53), and reflected these feelings in their preparation and management of the public consultation.

69. Some members of the Welsh Assembly commented that they were frequently *'fobbed off'* (sic) with middle managers when they met with one of the local NHS organisations. Conversely, one NHS organisation said no matter how hard they tried, they were unable to meet with one of the prospective members of the Assembly. What ever the truth of these situations, they unfortunately reflect poor relationships and do not serve the people of Llanelli well. Leaders of public service organisations and elected representatives must, irrespective of personal differences, develop an ongoing, open and trusting relationship in order to discuss issues of potential concern to the people they serve.
70. Although the LHB is the statutory body responsible for leading public consultations on NHS change issues, the vast majority of non-NHS stakeholders saw the Trust as the NHS body leading the consultation, which is perhaps understandable given the public role played by the Trust's consultant staff in the consultation. Nevertheless, one council described the LHB as, *'...having no leadership...a toothless animal that is dictated to by the Trust'*. This and similar comments reflect, in my view, public confusion about the organisational and leadership role of the LHB, and its inter-organisational relationship with the Trust.

The role of the Community Health Council

71. The Carmarthenshire Community Health Council was formed on 1 April 2006 by the merger of two previous CHCs (Llanelli and Carmarthenshire). The new CHC, with some fifty percent of new membership, had to immediately engage with the public consultation on general surgical services. There was further potential organisational stress in September 2006 when there was a change of chief officer at a time when the new CHC had already taken the first of three votes and was actively considering its post-consultation concerns.
72. The CHC met on three occasions to vote on the outcome of the public consultation. Table 5 summarises – anonymously – attendance by members at each of the three meetings when voting took place. The table shows that contrary to an opinion expressed during the inquiry, the majority of members were present for the final vote that took place on 21 November 2006, well over the one third of members required for meetings to be quorate. It was at this meeting that CHC members decided to support the LHB's recommendation that emergency general surgery should cease to be provided at Prince Philip Hospital and be centralised at West Wales General Hospital.
73. The protracted time for decision-making of the CHC, necessary whilst they explored their four post-consultation concerns, summarised in paragraphs 28-30 above, generated three issues expressed during the inquiry:
- 1 Questions from non-NHS stakeholders about the legitimacy of paper ballots for voting as opposed to a show of hands.
 - 2 Heightened emotions in the CHC because of suggestions that some members had been bullied and harassed during the voting period, which was further exacerbated by a particularly personal and public poster campaign focusing on, among others, the CHC chair.

- 3 Suggestions of pressure being applied to the CHC from the Welsh Assembly Government to support the proposal for the cessation of emergency general surgery at Prince Philip Hospital.

Table 5 CHC members' attendance at voting meetings

CHC member	Attendance at meetings when voting took place		
	11 Jul 2006	9 Oct 2006	21 Nov 2006
1	√	√	√
2	√	√	√
3	√	√	√
4	√	√	√
5	√	√	√
6	√	√	
7	√	√	√
8	√	√	√ (part)
9	√	√	√
10	√	√	√
11	√	√	√
12	√	√	√
13		√	
14			√
15	√		√
16	√		√
17	√		√
18	√		
19			√
20			
21	√		

74. Suggestions of harassment and bullying and intimidating personal poster campaigns are wholly unacceptable. They are not only stressful for the people concerned but also do little to convince local people that mature and considered debate is taking place about the future of their public services. The CHC's constitution states quite clearly: *All questions put to the vote shall, in the first instance, be determined by a show of hands. A secret (written) ballot may be held at the request of members.*
75. Given the emotional and highly charged atmosphere within which the CHC was being asked to make their decision it is understandable that some members wanted the anonymity and safety of a paper ballot, which is accepted practice in UK electoral systems. Since their experience of voting on the emergency general surgery issue I have noted CHC proposals to amend their standing orders (including the one in the preceding paragraph) as follows: ... *A secret (written) ballot may be held at the request of members or if the Chief Officer or Chairman has been approached by Members who feel harassed and/or bullied by another member or members of the Council.* Given the history I would support this amendment to the CHC's standing orders.
76. I also found no verbal or written evidence to support the suggestion of pressure being exerted on the CHC by officers, politicians or advisors of the Welsh

Assembly Government. I believe there is some confusion here because of emails and correspondence between the CHC and officials at WAG, such as the Head of Public and Patient Involvement Branch. I have seen this correspondence and it is clear that the CHC was seeking advice on process and procedure. This was not unreasonable given the context of the CHC and its chief officer being relatively new and the climate surrounding their decision-making.

77. However, I believe there are three issues emerging from the CHC's experience that are worthy of reflection in this inquiry:
 - 1 The additional challenges flowing from the CHC being a new organisation and having to play a critical and deciding role in an important and emotionally highly charged issue so soon after being constituted.
 - 2 The extent to which CHCs and their chief officers are supported in terms of personal and organisational development including keeping up-to-date on the increasingly changing and complex policy and clinical context of acute healthcare (see paragraphs 92-106 below).
 - 3 Whether the CHC should have taken three votes or waited for the answers to all its post-consultation queries and concerns before voting once only.
78. The first two issues raise questions about the general development of CHCs and the extent to which they are helped in their preparedness for participating in difficult scenarios. This is important and I have therefore included it in the recommendations in paragraph 125 for action by the Assembly Government.
79. There is no clear answer to the question about the third issue of how the CHC voted. However, given the environment outlined above within which the CHC was expected to reach a view about emergency general surgery, with hindsight it may have been more appropriate for the CHC to have waited for responses to its four post-consultation concerns before taking a single vote.
80. Finally, although outside my terms of reference it would be remiss not to comment on the role of the Committee for the Improvement of Hospital Services. This is because the Committee is seen by many stakeholders as a prominent player in health service issues in Llanelli. As stated previously the Committee was formed as a result of events in 2003 regarding accident and emergency services. The Committee said that they were encouraged by a former health minister to continue in their role to – as their written submission to this inquiry states - *'remain in being and to be vigilant over the health service in Carmarthenshire'*. However, the impression from the local NHS is that the Committee focuses on Llanelli only.
81. The role of the Committee appears to conflict with the statutory role of the Carmarthenshire CHC, which exists to represent the interests of the public in health services across Carmarthenshire. In my discussions with NHS and other stakeholders there was uncertainty about the current role of the Committee and the extent to which it is seen to reflect the opinion of a significant proportion of

the local population rather than continuing – as some stakeholders believed – to be more politically motivated.

82. The success of pressure groups like the Committee depends on the extent to which they can shift public opinion and the ability to directly influence statutory organisations. Influence can be developed by establishing effective and trusting relationships with the organisations concerned, in this case the LHB, Trust and CHC. It was evident during the inquiry that these relationships are lacking. Although I am not in a position to make recommendations about the Committee, because it is a non-statutory body, I believe if it continues in existence then it would be helpful for the Committee to;
- clarify its role and governance arrangements; and
 - reflect on how best to influence and work with the statutory health bodies responsible for decision-making on behalf of local people, particularly the CHC.

Implementation of the decision

83. Once the decision had been made to cease emergency general surgery many people thought that the implementation was rushed and badly managed by the LHB and Trust. Further, the timing of the implementation was seen to be exacerbated by the retirement of a consultant vascular surgeon at Prince Philip Hospital. However, the retirement of the surgeon was publicly well known for some time, for example he wrote to local general practitioners on 14 December 2006 advising them of his retirement on 31 March 2007.
84. The specific concern raised during the inquiry focused on the surgeon actually retiring earlier, on 2 January, which many people saw as a provocative act by the NHS Trust designed to force the issue of implementing the decision. However, I have explored the reasons for the earlier leaving date and I am satisfied that they are not at all related to the changes to general surgical services at Prince Philip Hospital.
85. The now vacant consultant surgical post is currently being advertised for a replacement by a consultant vascular surgeon who will work at Prince Philip Hospital and be professionally linked to the vascular surgery centre at Morriston Hospital, Swansea. This clinical networking-based model built around specialist centres reflects the growing clinically driven policy context for general and specialist acute hospital services (see paragraphs 92-106 below). Consequentially, the quality of vascular surgical services available to the people of Llanelli and Carmarthenshire should be enhanced.
86. There have were also suggestions during the inquiry of a close relationship between WAG and the local NHS and CHC during the post-decision period with sub-textual suggestions of pressure being applied to decision-making and planning of the implementation by the local NHS. I have covered the CHC element of this in paragraph 76 above.
87. It is true that post-decision there was a lot of activity between the local NHS and the Assembly Government, for example a meeting between the Regional

Director, NHS Trust and LHB on 18 January to discuss the implications of an exchange between the Minister and the then Llanelli AM in the Assembly the previous day. Given ministerial accountability for the NHS it was not unreasonable for him, in the light of the Assembly discussion, to request further information about the proposed implementation.

88. The Regional Director also met with WAG's legal advisor; the Cabinet Health & Social Policy Adviser, Mark Drakeford to brief him on the implementation; and also the Deputy Chief Medical Officer, Dr David Salter who, at the Regional Director's request, would be meeting the Trust's consultants on 24 January 2007 to consider their compelling reasons and urgency for change to emergency general surgical services.
89. Dr Salter summarised his assessment in an email to the Regional Director dated 25 January 2007. He said, *'...that the basis of the decision seems to fall into two parts and is based on patient safety issues: an immediate issue and a cumulative risk issue.'* The immediate issue was precipitated by the aforementioned consultant vascular surgeon whilst the cumulative issue stems from increasing difficulty with surgical and anaesthetic staffing rotas and the decreasing exposure of all staff to emergency surgery and the consequential de-skilling effect. Dr Salter concluded in his written assessment that, *'...the retirement [of the consultant surgeon] has precipitated the need to withdraw emergency surgery from PPH as the service was already breaching reasonable patient safety and governance standards.'*
90. During the next few days there were further exchanges of emails between Dr Salter, the Minister and the Chief Medical Officer exploring the surgical staffing issues at Prince Philip Hospital. The general conclusion was that with the implementation rapidly approaching no alternative action could be taken. The Chief Medical Officer however did make the point, *'It seems that the alternative vision for elective/breast/day surgical services at Llanelli needs to be articulated positively, with investment and the commitment of surgeons rather than struggling to achieve quality standards for an acute service with the risk of adverse outcomes.'*
91. I find nothing untoward with this activity and exchange of emails. Given that the NHS is part of the wider political system and accountability of local NHS organisations to the Assembly Government, it is perfectly reasonable for the latter to seek reassurances about local process and timescales for action. The testing of the quality of decision-making of local NHS organisations when tackling difficult and controversial issues should be neither a surprise nor interpreted by observers as pressure for decisions to be changed.

THE POLICY CONTEXT FOR ACUTE HEALTHCARE

92. The findings and recommendations of this inquiry into events in Llanelli need to be considered in the context of the key policy issues facing the organisation of acute clinical services in Wales. These are summarised below.
93. The challenges facing NHS organisations in Wales are considerable. There is an ambitious agenda of health and healthcare initiatives from the Welsh

Assembly Government. The main policy driver for NHS Wales is *Designed for Life*, published in 2005. The strategy outlines how WAG will achieve its ambition to transform the NHS in Wales to become a truly world class service by 2015.

94. *Designed for Life* outlines that care and services will be provided at four levels across the NHS: home and in the community; local acute; specialist and critical care; and tertiary and highly specialist services. Service, financial and workforce planning will need to reflect care based on these levels, enabling patients to pass between the levels as their condition requires. Some of the key aspects of the policy relevant to the future structure of local health services across Wales include:
- User-centred services to be created that will require wholesale service transformation to be achieved.
 - Service improvements required will only be achieved through a combination of investment and reform.
 - Planning and commissioning will be strengthened so that they increasingly integrate prevention, demand management, and rapid access to high quality services and ensure that services meet the needs of local populations.
 - Local provision of the hospital services used frequently such as outpatients and routine surgery.
 - Service commissioning will be driven by clear and rigorous standards of clinical and of professional guidance.
 - Chronic disease management services will be remodelled to develop a care programme approach within an integrated chronic disease framework.
 - Better health education and preventive programmes.
 - Stronger and more responsive primary care provided 24 hours a day.
 - Immediate access to appropriate emergency care and hospital beds.
95. The approach of *Designed for Life* reflects recent reports by other bodies. The Kings Fund report, *Ideas to Make a Supplier Market Work in Healthcare* (June 2006), The Institute for Public Policy Research's, *The Future Hospital, The Progressive Case for Change* (January 2007) and the English Department of Health's *Strengthening Local Services: The Future of the Acute Hospital* (March 2006) all highlight the challenges and dilemmas facing NHS trusts and health systems in achieving the highest standards of care in local settings for local people.
96. All reports promote centralising highly specialised care as well as decentralising services and treatments, coupled with the strengthening of clinical networks in order to both improve access and reduce inequalities while at the same time raising standards. The IPPR report provides a case for redefining the purpose of hospitals offering insights into how services might be defined, managed and delivered in the future.
97. *The Future of the Acute Hospital* provides guidance on outline how hospitals might work in a sustainable way in the future, endorsing high levels of cooperation and integration that promotes, among other things, quality and

patient choice. Under these proposals, sustainable acute services would consist of:

- A commissioned network of hospitals working with community based services as part of a whole system.
 - An integrated approach to primary care, ambulance services and out-of-hours services, social care and mental health services.
 - Accident & emergency services supported by a minimum set of acute care key services to ensure safety and beyond key services a variety of models would be possible.
98. Where hospitals could not sustain stand-alone services they would need to operate as part of a sustainable network, examples include trauma and emergency surgery, specialist surgery, paediatrics, and obstetrics and gynaecology. Although elective and diagnostic services would, in the English policy context, be most likely to generate competition they should not be allowed to de-stabilise urgent and emergency care networks. The *Future of the Acute Hospital* also proposes that increasingly specialist staff and service specific assets would be provided by networks and collaborative ventures rather than by hospitals.
99. Managing services through networks is not new to the NHS. Managed clinical networks already operate in Scotland and have played a major role in improving cardiac and cancer outcomes in England in recent years. They promote seamless working across primary, secondary and community care and enable best use of scarce resources. However, the arrangements promoted by *The Future of the Acute Hospital* are significantly different in terms of scope and design, which recognise the increasing focus on quality and improving outcomes irrespective of setting.
100. The English policy document, *Our Health, Our Care, Our Say* describes a vision for a new type of community hospital that provides truly integrated care closer to where people live. It cites examples of care that have traditionally been provided in acute hospital settings in England but which are routinely provided in locality based establishments in other countries.
101. *Our Health, Our Care, Our Say* refers to care in several European countries where specialist services are provided outside of hospital in medical care centres. Kaiser Permanente in the US is also quoted as operating with fewer beds relative to the population served. It has 3.5 fewer bed days for the eleven leading causes of admission in the NHS. Lower utilisation of bed days is achieved through integration of care and active management of patients, the use of intermediate care and medical leadership.
102. The key features of new community hospitals would include some or all of the following: a specialist workforce; a wide range of diagnostic facilities and other equipment; operating facilities; and day surgery and outpatient facilities. Units serving populations of 100,000 or more would also undertake a more specialist range of services, including complex surgery requiring general anaesthetic and accident and emergency facilities. They would incorporate:

- Generalist and specialist clinicians
- Training for other health professionals
- Intermediate facilities
- Peer support
- Integrated health and social care resource
- Links with other more specialist centres

103. The development of 21st century community hospitals offers real opportunities for revolutionising the way acute care is delivered and for providing a catalyst in the way patient care is actively managed.
104. In summary, more than at any other time in the history of the NHS there are a wide range of organisational models available for NHS and non-NHS organisations to pursue innovative ways of providing accessible and cost-effective NHS services to local communities. These models also make it easier to pursue joint ventures with social care and voluntary organisations that are likely to be attracted to creating new forms of organisational forms to deliver services.
105. The approach of the planning forum established after the public consultation on acute services for Mid and West Wales reflects much of the above policy direction for the future organisation of acute hospital services. The forum will look at how services provided in the four hospitals serving the three counties across Mid and West Wales can work together more closely. It will also look at how community services can be further developed to respond more effectively to people's needs.
106. The planning forum's emphasis will be on services, not hospitals; on improving and integrating services, not on beds or buildings; and on delivering more services to patients in the community. Hospitals in the future will have different roles and will need to work together in clinical networks alongside primary care to provide the best care and clinical expertise for each patient. It is against this strategic backdrop that a sustainable future for Prince Philip Hospital needs to be agreed.

INQUIRY FINDINGS AND RECOMMENDATIONS

Summary of findings

107. The following summary of findings flow from the analysis in paragraphs 38 to 91 above:
- I. The decision of the LHB and Trust to pursue the centralisation of emergency surgery was reasonable given the history of concerns about clinical safety, which is underscored by external reviews over a number of years, and the UK policy context for acute hospital services.

- II. Whilst the LHB led consultation process followed WAG guidance⁴ it was not presented against the backdrop of a compelling vision and strategy for acute healthcare. Consequentially, the case for changing surgical services was not sold to local people.
- III. The management of the general surgical services consultation was not helped by conflating it with the bigger, more complex consultation on acute services for the whole of Mid and West Wales.
- IV. The preparation and management of the consultation lacked flexibility, and sufficient empathy with and sensitivity to the public and influential external NHS stakeholders such as councils and the public's elected representatives.
- V. The consultation document was of poor quality because it was an edited version of the surgical services working group's final report rather than the result of a fresh approach to drafting a new document specifically for public consumption.
- VI. There was no media management strategy resulting in the local NHS reacting to, rather than proactively managing, media relations.
- VII. Although there were a series of public meetings arranged during the consultation, in which the Trust's clinical staff played a strong and positive role, it is unclear how the meetings formed part of the LHB's strategy for public engagement.
- VIII. Poor relationships across the local NHS and between the local NHS, other public service organisations and Assembly Members resulted in too much confrontation and too little collaboration and leadership, which was a weak basis for conducting the consultation.
- IX. The respective organisational and leadership roles of the NHS Trust and LHB during the consultation were not clear to all external stakeholders.
- X. The voting arrangements of the CHC were not ultra vires and were reasonable given the circumstances of it being a new organisation with a change of chief officer, and the climate within which it was expected to deliberate and vote.
- XI. The retirement of the consultant vascular surgeon from Prince Philip Hospital was known well in advance and his earlier than planned departure was not a provocative act by the Trust linked to implementation of the changes to general surgical services.
- XII. Patient flows and patient preferences should not be determined by NHS organisational structures and administrative systems. If patients and/or their

⁴ Specifically, Section 11 of Health & Social Care Act 2001, which places a duty on LHBs and Trusts to involve and consult the public on service planning, developing proposals for change and in decision-making; whilst section 18 places a duty on LHBs to involve CHCs in these issues.

relatives decide it is more convenient for them to access acute emergency or elective healthcare at hospitals other than in Carmarthenshire then they should be supported in doing so unless there are compelling clinical reasons against it, for example the location of specialist services.

- XIII. Although the CHC satisfied itself about travel times and ambulance service support between Llanelli and West Wales General Hospital, non-NHS stakeholders remain to be convinced.
- XIV. There is no evidence of inappropriate action or pressure being brought to bear by the Assembly Government on either the local NHS or CHC during the post-consultation decision-making and implementation stages.

Recommendations

108. The following recommendations are derived from the above findings:

- I. Against the backdrop of the strategic proposals for acute services across Mid and West Wales, an exciting and compelling vision for developing Prince Philip Hospital as an elective surgical centre for West Wales and beyond should be agreed by the LHB and Trust with stakeholders as soon as possible and signed off by all. The vision should be supported by an investment strategy with timescales and costs, and the vision and strategy should be widely publicised to local people. This process should be led by the LHB.
- II. NHS organisations, their clinical staff and supporting financial and operational management systems should be aligned to support freedom of choice of hospital (where clinically appropriate) by patients and local people requiring emergency and elective surgery.
- III. Implementation of the decision to withdraw emergency general surgery from Prince Philip Hospital and centralise the service at West Wales General Hospital should be rigorously performance managed by the Trust, LHB and Ambulance Service in terms of:
 - clinical governance and the clinical service impact on local people;
 - patient access to general surgical services in Carmarthenshire as evidenced by changes to waiting times, reductions in cancelled admissions and operations; and
 - transport and ambulance journey times.

The LHB should coordinate agreement of the performance management process and format with the Trust, Ambulance Service, GP representatives and CHC; and make the reports available to all stakeholders and the public on a regular basis. Quarterly would be reasonable.

- IV. The LHB needs to develop its external leadership role so that the public, politicians and other public service organisations understand that it, rather than the NHS Trust, is the statutory leadership body responsible for taking decisions about the commissioning and the future strategic direction of local

NHS services. The LHB could raise its public profile by, among other things, leading an ongoing programme of public engagement so that local communities are more informed about how healthcare provision is changing because of developments in clinical practice.

- V. The Trust and LHB need to establish a more effective working relationship and accept joint ownership of local NHS issues and challenges such as strategic development and big operational issues such as financial management. This should be led by the chairs of the LHB and Trust, supported by their chief executives and boards. Collectively they should lead a process of stronger inter-organisational engagement and discussion, and the development of mutually supportive and effective inter-personal relationships across the two organisations.
- VI. The Chair of the LHB should lead a process for him and the Chair of the Trust to meet regularly with AMs and MPs to discuss healthcare matters of concern to themselves and local people.
- VII. In the context of Carmarthenshire being a pilot for implementing the Beecham report⁵ the chairs of the LHB and Trust should agree with other public service leaders how best they can develop effective inter-personal and inter-organisational working relationships over and above the structural requirements set out by Beecham.
- VIII. If the Committee for Improvement in Hospital Services continues in existence then it would be helpful to the NHS and external stakeholders if it could clarify its role and governance arrangements; and reflect on how best to influence and work with the statutory health bodies responsible for making decisions on behalf of local people, particularly the CHC.

LESSONS FOR NHS WALES

109. There are six key lessons from analysing events in Llanelli:
- 1 The need for ongoing, meaningful and effective processes of public engagement.
 - 2 The need for high quality public consultation processes, publications and decision-making.
 - 3 The need for effective media management.
 - 4 The need for sustainable, trusting and effective inter-organisational relationships within and beyond the NHS.
 - 5 The need for clear organisational and individual accountabilities and responsibilities.
 - 6 The need to develop and support community health councils
110. It does not need this inquiry to remind NHS leaders, the public and their elected representatives that pursuing change to the structure of local health services is

⁵ *Making Connections – Delivering Beyond Boundaries: Transforming Public Services in Wales* is a specific action plan for gaining improvement in public services with a core requirement being citizen focus. One of its five themes is local service organisations establishing Local Service Boards.

increasingly controversial and challenging. The history of health service changes in Llanelli underscores this all too well. The changes that have been made to Prince Philip Hospital reflect the difficulties in balancing the accountability of statutory bodies for providing high quality and safe services with the expectations of increasingly knowledgeable and consumer orientated local people that public services will be readily accessible when they need them. For many people, hospitals and other healthcare facilities are seen not only as essential components of their local social and community infrastructure but also, like schools and other public buildings, a manifestation of the reason they pay taxes.

111. Against this backdrop, the pursuance of changes to public services by statutory organisations and their leaders requires an increasingly sophisticated approach at the core of which is effective public engagement. However, effective and sustainable public engagement is rarely, if ever, created when the public are seen to be engaged for the first time over proposals for significant change to their local health service.
112. As politicians and other publicly elected representatives tend to know, at the heart of effective public engagement is an ongoing and sustainable relationship between them and the people they serve, which like all good relationships needs to develop over time so that trust and mutual respect can develop. Trust is crucial to the development of effective public engagement; it is an action-based concept and people are trusted on the basis of what they do, rather than on the basis of what they say they are going to do.
113. If there is a programme of ongoing engagement over a period of time then there is the greater probability of this forming a more solid basis for sustainable dialogue over the more effective handling and mutual resolution of difficult and contentious issues when they arise, such as proposals for change to local public services.
114. I have considered the effectiveness of the Welsh Health Circular WHC (2004) 84: *Shaping Health Services Locally: Guidance for Involving and Consulting on Changes to Health Services*. Part two of this guidance provides much excellent advice in the shape of frameworks and procedures for involving and consulting with stakeholders on service change.
115. I have also looked at guidance available in other UK countries such as England and Scotland. The most recent additional guidance has been issued by the Chief Executive of the NHS in England, which does not change legislation but reaffirms the importance of good practice in engaging with the public and other stakeholders before and during public consultation. A theme running through much of the guidance across the UK is the need for good processes of ongoing⁶ engagement – in terms of quality, time and regular contact - with the public, their representatives and other statutory public bodies. As the guidance for Scotland says, '*end process consultation is not acceptable*'.

⁶ My emphasis

116. There are seven steps in part two of WHC (2004) 84: *A basic framework for involving and consulting people*, as follows:

<u>Step</u>	<u>Task</u>
1	Identify the need for change
2	Develop options for change
3	Plan the consultation
4	Consult on options
5	Evaluate outcomes
6	Give feedback
7	Continue involvement and consultation

117. The guidance for Scotland and England can, along with general guidance on engaging and involving local communities in discussions about their public services, be used to audit the guidance for Wales. This inquiry report will not do that in detail but I will make a few key recommendations for consideration by the Welsh Assembly Government, reflecting the importance of good public engagement and the themes that emerged from the analysis of events in Llanelli.

118. **Recommendation 1: sustainable public engagement**

Against the backdrop of its policies for healthcare, such as *Designed for Life*, WAG should satisfy itself that all local health boards have ongoing processes for sustainable public engagement about local health services. These processes and the areas for actions arising from the engagement should be performance managed.

119. **Recommendation 2: quality assuring future consultations**

WHC (2004) 84: *A basic framework for involving and consulting people* should have an additional process step inserted at the end of the preparatory phase, between steps 3 and 4 called 'Quality assuring the consultation', which would serve two purposes. First, it would provide the opportunity for NHS and non-NHS stakeholders and organisations involved in formulating proposals for consultation to pause, take stock and decide if they are content to move forward to the public consultation phase. Ensuring that there is a process for pausing and taking stock should be the lead responsibility of local health boards.

120. Second, in order to increase the quality of public consultations, all future consultation processes and documents should be quality assured before the consultation commences. This could be a role for the regional offices supported by small panels comprising people with direct experience of planning, managing and participating in consultation events such as senior managers from NHS and public service organisations, CHC chief officers and members, trade union representatives, voluntary organisations and members of the public. These panels would peer review consultation proposals and to optimise experience, membership should be drawn from across Wales and possibly elsewhere. Further, in order to maintain momentum, the panels should meet and report within pre-determined timescales. Above all else, all public consultations should spell out clearly the vision and benefits of the proposals for change.

121. Pausing and taking stock does not mean all stakeholders signing up to the preferred recommendation(s) of the proposed consultation but it would be reasonable for them to be assured:
- about how the proposed public consultation process would be undertaken;
 - that all options for change are seen to be receiving equal consideration in the context of the local NHS having a preferred option for change; and
 - that there will no surprises emerging from the local NHS during the consultation, such as unannounced additional information, analysis or changes of view.
122. Should the majority of stakeholders involved in the pre-public consultation phase not be content about moving to the public consultation phase, then the LHB, if it cannot address the concerns, will need to assess the risks of proceeding to public consultation. This would be a particular responsibility of the LHB board led by the chair and chief executive, who would also need to be mindful of managing upwards by informing, and if necessary seeking advice from, the regional office.
123. **Recommendation 3: media management**
The Assembly Government should issue guidance to all NHS organisations on effective media management and/or incorporate media management guidance in WHC (2004) 84: *Shaping Health Services Locally: Guidance for Involving and Consulting on Changes to Health Services*. In addition, the guidance should be drafted with input and advice from the media, other public service organisations, politicians, CHCs and the public.
124. **Recommendation 4: developing inter-organisational relationships**
The Assembly Government should satisfy itself that local NHS organisations are playing a full and active part in the development of effective inter-organisational relationships both between themselves in local health systems and with other public service organisations and elected representatives. Where necessary, WAG should performance management the implementation of processes for developing these relationships.
125. **Recommendation 5: clarifying accountabilities and responsibilities**
WHC (2004) 84 guidance should be tightened to clarify and emphasise the responsibilities of individual NHS organisations, such as the role of LHBs as the statutory NHS bodies with principal responsibility for leading strategic development, commissioning services for patients and accounting to the public for the standard, quality and delivery of their local health service. As far as is practicable, accountabilities should be assigned to single organisations and individuals only; accountabilities for process, delivery and decision-making divided across organisations and individuals may lack clarity and consequentially confuse the public and stakeholders.
126. **Recommendation 6: supporting community health councils**
Community health councils and their chief officers should have annual organisational development programmes for, among other things, supporting their understanding of the potential implications of emerging healthcare policy

and trends in the clinical development of services. The Board of Community Health Councils in Wales could be remitted by the Assembly Government to undertake this work.

The Assembly Government should also establish inter-CHC learning networks, again perhaps led by the National CHC Board, so that CHCs and their chief officers can share their experiences of being involved in challenging issues. One outcome from these learning networks could be the production of examples of good practice to form the basis of guidance for use by CHCs across Wales.

LIST OF INTERVIEWEES

Assembly Members**

Helen Mary Jones	AM for Mid and West Wales
Catherine Thomas	AM for Llanelli
Rhodri Glyn Thomas*	AM for Carmarthenshire East & Dinefwr and Chair of Health & Social Services Committee

Carmarthenshire Community Health Council

Carol Jones	Chief Officer
Cllr Sian Thomas	Chair**
10 members	Interviewed at two separate meetings

Carmarthenshire County Council

Cllr Mary Gravel *	Leader
Mark James	Chief Executive
Martin Morris	Deputy Leader and former Chief Officer, Carmarthenshire CHC

Carmarthenshire Local Health Board

Alan Brace	Chief Executive
Alison Gittins	Head of Corporate Services
Jane Jeffs	Vice-Chair and Chair of Patient & Public Involvement Committee
Ken Jones	Chair
Karen Preece	Head of Modernisation
Dr Michael Thomas	Director of Public Health
Dr Mark Vaughan*	Former Chair and Llanelli general practitioner
Mary Williams	Divisional Manager, Surgical Services

Carmarthenshire NHS Trust

Paul Barnett	Chief Executive
Huw Beynon	Deputy Chief Executive
Mr Hugh Evans	Retired consultant vascular surgeon
Monica French	Acting Chair
Dr Ben O'Donohoe	Clinical Director, Anaesthetics
Mrs Margaret Price	Former Chair
Mr Martin Taube	Clinical Director, Surgical Services
Dr Peter Thomas	Medical Director
Dr Jeremy Williams	Director of A&E

Committee for the Improvement of Hospital Services

Glyn Davies	Chair
Paul Harris	Secretary

Dyfed Powys Local Medical Committee

Dr Alan Williams*	Member
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Dr Helen Morris* Member

Llanelli Rural Council

Mark Galbraith Clerk to the Council
Cllr Jim Jones Leader

Llanelli Town Council

Lynn Davies Clerk to the Council
Cllr Carl Lucas Leader

Media

Robert Lloyd Editor, Llanelli Star and Carmarthen Journal

Members of Parliament

Nia Griffith MP for Llanelli

Mid & West Wales Regional Office

Graham Williams Regional Director

Neath Port Talbot & Bridgend Local Health Boards

Andrew Goodall Chief Executive

NHS Confederation in Wales

Mike Ponton* Director

Swansea Local Health Board

Sue Heatherington* Chief Executive

Swansea NHS Trust

Calum Campbell Acting Chief Executive
Mr Colin Ferguson Consultant Vascular Surgeon
Robert Royce Director of Planning, Estates & Facilities

Trade Union

Wendy Evans Branch Secretary, UNISON

Welsh Assembly Government

Dr Brian Gibbons Minister for Health and Social Services**
Mrs Ann Lloyd Head of Department of Health and Social Services/ Chief Executive NHS Wales
Dr David Salter* Deputy Chief Medical Officer
Mark Drakeford* Cabinet Health & Social Policy Adviser

Welsh Ambulance Services NHS Trust

Wayne Evans* Locality Officer
Alan Murray* Chief Executive
Huw Phillips* Locality Officer
Andy Roughton* Regional Director

(* telephone interview; ** at the time of the Inquiry)