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Date: 29 January 2010

Dear Member

HEALTH OVERVIEW AND SCRUTINY COMMITTEE - FRIDAY, 5 FEBRUARY 2010

I am now able to enclose, for consideration at next Friday, 5 February 2010 meeting of the Health Overview and Scrutiny Committee, the following reports that were unavailable when the agenda was printed.

Agenda No	Item
4.	**Dover Healthcare (Pages 1 - 16)**
5.	**Emergency Care Pathways (Cardiac, Stroke, and Trauma) (Pages 17 - 30)**

Yours sincerely

Peter Sass
Head of Democratic Services & Local Leadership

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East Kent Hospitals University NHS
NHS Foundation Trust

NHS
Eastern and Coastal Kent

Liz Shutler
Executive Director of Strategic
Development and Capital Planning

Amanda Harrison
Director of Assurance and
Strategic Development

DOVER HEALTHCARE

Update on Progress made since 30th September HOSC

1. On October 19th 2009 an independently facilitated stakeholder event was held in Dover with a broad range of invited stakeholders including the local MP, members of the public, stakeholders previously involved in discussions on Dover, representatives of patient and local interest groups, councillors and officers from DDC, representatives from the Environment Agency (EA), East Kent Hospitals University Foundation Trust (EKHUFT) and the local Practice Based Commissioning (PBC) consortium. The meeting was asked to evaluate each site against the previously agreed criteria, there was also an open question and answer session which allowed people to express their views on the potential sites (Appendix 1).

2. This session enabled us to re-evaluate all the sites previously considered, the mid-town site, the existing Buckland Hospital site and potential sites at Whitfield, to take in to account any changes which had occurred since the original evaluation. .In addition two further sites potential sites were identified. These were Buckland Mill and the Charlton Green/Post Office site in the centre of Dover as illustrated in Appendix 2.

3. Using information gained from the stakeholder event the above five site options have been considered in greater detail against each of the criteria outlined above. The outcome of this analysis is shown in Appendix 3.

4. A report was submitted to the Board meeting of the NHS Eastern and Coastal Kent on the 18th November 2009 asking for the earlier recommended site proposal be amended, as a consequence of the high risks now associated with the mid town site and the advice that it would not pass the sequential planning test as there were appropriate, reasonably available alternative sites for the development in a lower flood risk zones.

5. The Board of NHS Eastern and Coastal Kent was informed that although Dover District Council remain confident that the flood risk on the mid town site can be addressed indications from the Environment Agency are that where similar work has been carried out elsewhere it has taken a number of years to deliver and that if planning permission were sought for the hospital development on this site without clear plans for mitigating all aspects of the flood risk then they would appeal the decision resulting in a referral to the Secretary of State for consideration. Proceeding with a development on this site must therefore be considered high risk.

6. The Board agreed that in order to move forward as rapidly as possible it was necessary to balance the risks and opportunities of each site. Whilst a full

assessment will be carried out in the Outline Business Case (OBC) and Full Business Case (FBC) as developed by EKHUFT in support of the development it is clear that some sites should be ruled out at this stage to avoid delay. The Board of NHS Eastern and Coastal Kent agreed that from the evaluation of the Mid Town, Charlton Green and Buckland Mill sites it was clear that these sites carry significant risks without conferring significant advantages over the other sites under consideration.

7. Whilst there are limitations with all sites considered both the potential Whitfield sites and the current Buckland Hospital site were considered by the Board of NHS Eastern and Coastal Kent to provide appropriate, reasonably available sites for the development in lower flood risk zones. It was agreed that both these options would meet the health needs of the people of Dover and provide the opportunity for a timely development. The NHS Eastern and Coastal Kent Board noted that the development would be undertaken by EKHUFT and therefore it would be for the Board of EKHUFT to make a decision about which of these sites offered the best option in respect of rapid delivery and affordability. The Board decision was as follows:

   It was resolved that the Board recommends a new community hospital be developed by EKHUFT through a proper process of Outline and Full Business Case Development to deliver Dover Practice Based Commissioning intentions; that in developing the business case EKHUFT considers the most appropriate site for development utilising the information already gathered in the Board report and further assessing the potential sites against the criteria given with a priority on delivering the most affordable and rapidly deliverable option; that EKHUFT ensures that there is an ongoing process of engagement with all stakeholders to ensure they are kept informed of the progress of the development (NHS Eastern and Coastal Kent Board minutes, November 2009).

8. In addition to the process which EKHUFT will lead to develop a business case for the estate development, the PCT will continue to work with PBC to develop the required commissioning intentions for services to be delivered from the site and elsewhere in the Dover locality. Throughout this process the PCT will ensure that there is appropriate and ongoing stakeholder engagement by EKHUFT and the PCT and that all business cases and commissioning intentions are supported by the required Equality Impact Assessments and relevant action plans.

9. The EKHUFT Board met on the 27th January to agree their position on the development of a new Community Hospital in Dover. The Board considered the OBC which identified the preferred option as a new build at Buckland Hospital. As detailed in the Trust's unconfirmed minutes, it was agreed that:

   "Given the economic downturn and the financial position of the Trust, it is recommended that the preferred option is supported and that the case continues to be developed to FBC stage, for review by the Board of Directors as planned.

   This will be subject to confirmation of the availability of capital to support the development and the other priorities within the Trust's wider capital programme."

Outstanding Issues

10. In the last year the commissioning intentions of the Dover and Aylesham Practice Based Commissioning Consortium (see Appendix 5) have continued to be refined and further developed. It is expected that this will be an ongoing and continuous process as the PCT and PBC respond to local health needs and the challenges of improving quality, productivity and patient experience. EKHUFT will through the development of an OBC and FBC for the development need to ensure that it is financially viable and continues to provide a robust and flexible solution for the estates required to deliver the services that the PCT and PBC wish to commission. There is a risk that the business case demonstrates the development is unaffordable. Mitigating this risk will require an ongoing dialogue as the business cases are developed and ratified by the EKHUFT Board. It will be important to continue to develop an understanding of the levels of activity and costs of services which will be delivered from the site and the impact as many/most of these services are transferred from their current delivery sites to better meet the needs of the Dover population. The PCT and EKHUFT will need to take action to ensure the development is affordable this will include the potential of the site to be a location for services commissioned from a range of providers.

11. The business cases will need to take into account any additional cost relating to each site including:

    - Site purchase
    - Legal fees
    - Installation of utilities
    - Costs of addressing planning issues e.g. flood risk

12. There is a significant risk that delaying the delivery of the development any further will impact on the potential for EKHUFT to take the development forward through capital investment. The development is part of a planned programme of capital investment in the EKHUFT estate over the next three to five years which includes developments on the main acute sites in order to provide single rooms for in-patients. EKHUFT have indicated that currently the Dover development is still part of its overall programme but that it will need to complete within two years to ensure it does not impact on other elements of the programme.

13. Many of the sites have potential time delays which will need to be addressed as the OBC and FBC are developed. These include:

    - Planning issues
    - Flood risk with potential mitigation not currently defined or delivered (see appendix 6)
    - Site acquisition where sites are in multiple ownership
    - Legal issues

Appendix 1

Public views expressed at the meeting on 19th October:

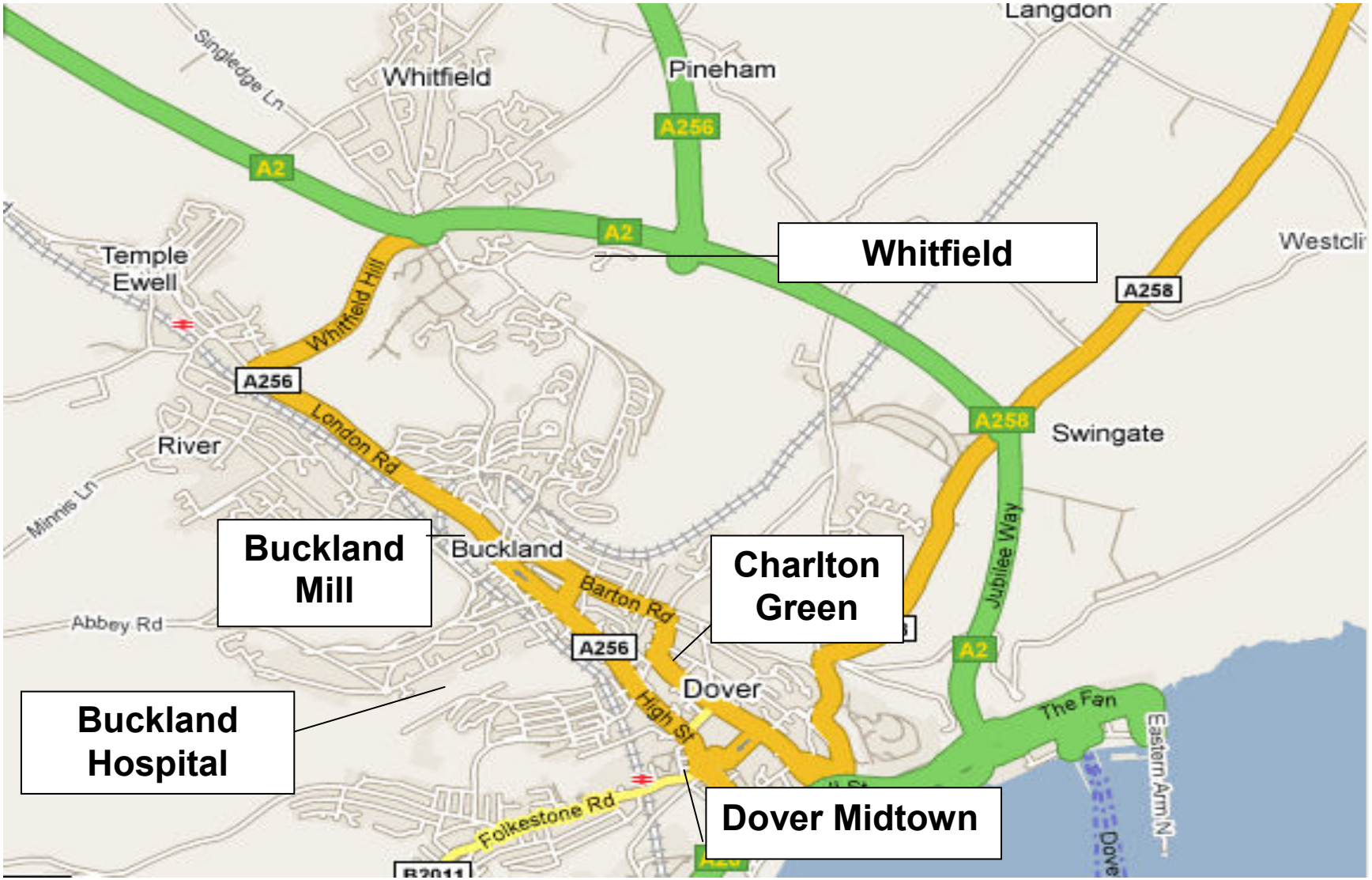
Buckland: + within area of high deprivation, probably no flood risk, deliverable
- access constrained, parking difficult, possibly contaminated site

Whitfield: + potential for expansion, easier access for rural communities, access could be improved
- remote from areas of greatest need, poor access, possible planning constraints

Midtown: + would meet local needs, in centre of areas of deprivation, access good
- flood risk will impact on delivery timescale, car parking, little expansion

Buckland Mill: + access, site size adequate, car parking,
- land may be prohibitively expensive, flood risk possible

Charlton Post Office:+ central Dover site, in centre of areas of deprivation
-site size constrained, land in multiple ownership, parking


Langdon
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Temple Ewell
Whittfield Hill
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A258
Westcli
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Swingate
River
London Rd
Minnis Ln
Buckland Mill
Buckland
Barton Rd
Charlton Green
Abbey Rd
A256
Jubilee Way
A2
Dover
High St
The Fan
Buckland Hospital
Folkestone Rd
Dover Midtown
Eastern Arm N
B2011

SITE	MID TOWN	WHITFIELD	BUCKLAND	CHARLTON GREEN	BUCKLAND MILL	COMMENTARY
CRITERIA						
Commission-ing Intentions	YES	YES	YES	YES	YES	All sites have the ability to deliver commissioning intentions but there are risks associated with all options.
Car parking	YES - site would include parts of the existing DDC and PCT owned car parks but additional space would be made available as part of the scheme at William Muge House	YES - dependant on the size of the site purchased	YES - would impact on the amount of land available for sale	YES – but parking on site limited; could utilise William Muge House but further away and therefore less accessible	YES - but limited with no realistic options elsewhere	
Accessibility	56.2	30.7	34.3	49.3	43.1	KCC data - % of households able to access the site within 30 minutes by public transport or on foot
Flexibility/ Future Proofing	Potential for future expansion including on health centre site	Potential for future expansion	Potential for future expansion	Restricted site with limited options for future expansion	Limited site area with correspondingly limited opportunities for expansion	

SITE	MID TOWN	WHITFIELD	BUCKLAND	CHARLTON GREEN	BUCKLAND MILL	COMMENTARY
CRITERIA						
Deliverability	Site in Public Sector ownership (including William Muge House) All utilities available on site. Adjacent to site currently used for health services	Site in Private Sector ownership. Change of planning use required, , likely to cause delay, public transport realignment required	Site in Public Sector ownership – EKHUT. All utilities available on site. Site used for health provision currently	Site in multiple ownership. Acquisition likely to be complex. All utilities available on site	Site part of larger redevelopment. All utilities available	
Value for money	Potential for additional build costs in relation to flood risk and building in developed area Site purchase costs within public sector partnership	Site costs unknown but will be at open market rate. Potential for costs associated with installing utilities and road infrastructure	No site purchase cost but new build on this site may limit value of remaining land	Site costs unknown but will be at open market rate.	Site costs unknown but initial discussions have suggested these will be high	
Adjacencies with other health services	Close to majority of GP surgeries and dentists. Pharmacies nearby	Distant from majority of existing GP surgeries. Pharmacy near by.	Close to some existing GP surgeries. Pharmacies near by	Close to majority of GP surgeries and dentists. Pharmacies nearby	Close to some existing GP surgeries. Pharmacies near by	See Map 2 and 3
Location	In centre of wards with highest health need and deprivation	Outside areas of deprivation	Good access from St Radigund's ward one ward with high	In centre of wards with highest health need and deprivation	Good access from St Radigund's ward one ward with high	See Map 4

SITE	MID TOWN	WHITFIELD	BUCKLAND	CHARLTON GREEN	BUCKLAND MILL	COMMENTARY
CRITERIA						
Flood/EA Risk Assessment	YES.	YES	NO	YES	YES	See Appendix 3 for initial views from the EA on each of the five sites
Wider considerat-ions	Likely to have positive impact on regeneration	Moves services away from centre of regeneration	No positive impact on regeneration	May have some impact on regeneration	May have some impact on regeneration	
Risk rating	HIGH	MEDIUM	LOW	HIGH	HIGH	

DECISION MAKING PROCESS – ACTIONS AND COMMUNICATION Appendix 4

Date/	2010		
Organisation	**January**	**February**	**March onwards**
NHS Eastern and Coastal Kent	27th		PCT and EKHUFT consider/discuss implications of EKHUFT OBC and impact on financial and commissioning decisions.
NHS Health Overview and Scrutiny Committee		5th NHS ECK and EKHUFT to report progress and confirm site to HOSC along with rationale. EKHUFT leads subsequent communication as required	
East Kent Hospitals University Foundation Trust	27th Board considers OBC EKHUFT leads communication with stakeholders in advance of the meeting. Media messages agreed with PCT		

Dover and Aylesham PBC Consortium

Please reply to: Dover PBC Consortium c/o The High Street Surgery
100 High Street Dover Kent CT16 1EQ
Tel. 07891 620079

Date: **19th October 2009**

A Statement

From: The Dover & Aylesham Practice-based Commissioning (PbC) Consortium

Re: The development of a new healthcare facility for Dover

This statement confirms the current position of the Dover PbC Consortium.

The Consortium completed a comprehensive Commissioning Intentions document for health services for Dover in July 2008. This document has been compiled with help from, and the full support of, NHS Eastern and Coastal Kent Commissioning Team and received the approval of the NHS Eastern and Coastal Kent Board in 2008.

The commissioning intentions are underpinned by the need for and development of locally accessible and appropriate healthcare facilities. The effective delivery of health and wellbeing services in Dover is dependent on the building of a significantly improved healthcare facility. It is anticipated that this will require a new Dover hospital.

The primary concern of the Dover PbC Consortium is to ensure that any new build enables us to implement our commissioning intentions as soon as possible.

The main criteria agreed by the Consortium as prerequisites for a healthcare facility site are that it must:-

1. Be easily accessible to the majority of the Dover District population, including the more economically deprived areas – 'accessibility' to mean not only transport, but also hours of clinical service and a comprehensive range of services that deliver care locally.

2. Support current services and enable the development of additional and improved services.

3. Be served by comprehensive and efficient public transport links and provide appropriate car-parking for patients and staff.

The Consortium, at present, does not have a preferred location for the facility but it is clear that the current Buckland Hospital buildings are not fit for purpose.

We are committed to commissioning intermediate care beds on one site with a preference that they are integrated or co-located on the new hospital site.

Statement ends.

November 2009

Dover Alternative Hospital Sites

We have looked at all of the sites suggested for locating your new medical facility and have put together a brief summary of our requirements for each location. We have highlighted the broad environmental constraints we can see at each of the sites.

Once you choose your preferred site, we will be able to provide a more detailed understanding of the constraints and opportunities related to the specific design and siting of your development.

We would be happy to look at any assessments prior to any planning application being submitted to the Council, so that we can offer advice and guidance on any areas of concern.

The sites:

1. Buckland Mill

Requirements: Flood Risk Assessment/Drainage Strategy
Land Drainage Consent (possible)
Scheme to address contamination (possible)
Ecological Assessment (possible)

Flood Risk

A site specific Flood Risk Assessment was completed to accompany an outline planning application at this site. You could use this assessment as a starting point for your own investigations if you chose to take this site forward. This Assessment confirmed some areas of the site to be in Flood Zone 1[1] although others parts would be in Flood Zones 2 and 3. The site also has some Areas Susceptible to Surface Water Flooding.

The best location for the hospital would be in the lower risk parts of the site (to the north) and providing access to Crabble Hill so there would be a dry escape route. If the hospital was located entirely within Flood Zone 1 all we would require would be a Flood Risk Assessment focussing on drainage (Drainage Strategy). The Sequential and Exceptions Tests[2] would not be required if the site was located to the north in Flood Zone 1, entirely out of Flood Zones 2 and 3.

[1] Flood Zones are defined in Annex D of Planning Policy Statement 25. The overall aim of decision makers is to steer new development to Flood Zone 1.
[2] The Sequential and Exceptions Tests are also explained in Annex D of Planning Policy Statement 25.

Government policy strongly encourages a sustainable drainage system (SUDS) approach, and we would recommend the inclusion of sustainable drainage at this site particularly as part of the site is in an Area Susceptible to Surface Water Flooding.

A Flood Risk Assessment would still be required for this site if it was in Flood Zones 2 or 3, and the assessment would have to include the results of both a Sequential and Exception Test (PPS 25).

Please keep in mind that Land Drainage Consent may be required if any construction or other works was proposed near or in the River. We can advise you at a later stage, if this site was taken forward.

Groundwater and Land Contamination

This site is a brownfield site and therefore there may be land contamination as a result of the previous use of the site. The site is also partially located in a Source Protection Zone 3.

You may need to submit a scheme to address the risks associated with potential contamination of the site. The components of that scheme are explained in Appendix A. However, previous planning applications have been submitted for this site with schemes to deal with the contamination. Therefore, you may be able to use any previous assessments to inform your development choices, and/or some remediation may have already taken place? It would be wise to get confirmation from Dover on the status of the site and their requirements.

Biodiversity

The Buckland Mill site sits adjacent to the River Dour which is a natural chalk stream. There are opportunities at this site to further improve the River and it's surrounds for biodiversity and improve access to the River for the public.

However, the location of your medical facility on the Buckland Mill site, and associated works will determine whether there are any impacts, or opportunities for enhancement.

If the proposed facility was adjacent to the River, we would want confirmation of the developments impact on the wildlife and habitats of the River. We are aware that previous planning applications have been submitted for this site, including ecological assessments, therefore it would be wise to explore these permissions to find out what assessments, and work have already been undertaken.

2. Charlton Green Sorting Office

Requirements: Flood Risk Assessment
Scheme to address contamination

Flood Risk

There are flooding problems at this site, and Dover District Council's Strategic Flood Risk Assessment (SFRA), says that part of the site is within Flood Zone 3A. This is the area fronting Charlton Green road. The site is also partially located in an Area Susceptible to Surface Water Flooding. Dover District Council wrote in their SFRA that surface water flooding occurred along Charlton Green in 2003. Their SFRA concludes that the site should be considered "high risk".

A Flood Risk Assessment would be required for this site, and the assessment should include the results of both a Sequential and Exception Test. However, given that a significant part of the site is within Flood Zone 1, and it is likely a dry escape route can be achieved from Frith Road and Salisbury Road, it is possible this site could be considered acceptable in terms of flood risk. However, it would be useful to consider the design, including flood mitigation at an early stage.

Groundwater and Land Contamination

This site is a brownfield site and therefore there may be land contamination. The site is also located in a Source Protection Zone (SPZ) 1. We designate Source Protection Zones to protect drinking water supplies from pollution. Source Protection Zone 1 is the Zone closest to the drinking water supply abstraction point.

You would need to submit a scheme to address the risks associated with potential contamination of the site, particularly the risks posed to the drinking water supply. The components of that scheme are explained in Appendix A.

3. Whitfield

Requirement: Flood Risk Assessment/Drainage Strategy

Flood Risk

Your suggested site at Whitfield is in a Source Protection Zone 3, as well as Flood Zone 1.

Any development site greater than 1 hectare, particularly on a Greenfield site, would require a Flood Risk Assessment focussing on drainage. This is because the proposed scale of the development could present risks of flooding on-site and/or off-site if surface water run-off were not effectively managed. The Assessment is an opportunity to show how the surface water drainage would be managed.

Government policy strongly encourages a sustainable drainage system (SUDS) approach, and we believe a good surface water drainage scheme would not be hard to achieve.

The site also lies on clay with flint deposits that in turn overlie the upper chalk formation; this is classified as a non-aquifer overlying a major aquifer. This means that your design will have to take account of the chalk aquifer, and the height of the groundwater table.

4. Buckland Hospital

Requirements: Scheme to address contamination

Flood Risk

Our Flood Map shows Buckland Hospital is located in Flood Zone 1. I understand you propose to build on the car parking area of the existing hospital, and having measured this area it appears to be less than 1 hectare in size. For developments less than 1 hectare in Flood Zone 1, the main flood risk issue to consider is usually the management of surface water run-off.

As the site appears to be less than 1 hectare we would not require a Flood Risk Assessment. However, if the site to be developed is extended to over 1 ha we would require a Flood Risk Assessment to be submitted with any planning application. The

Flood Risk Assessment would have to demonstrate how surface water drainage was to be managed to avoid any flood risk.

Land Contamination

This site is a brownfield site and therefore there may be land contamination associated with its use, or previous uses. You would need to submit a scheme to address the risks associated with potential contamination of the site. The components of that scheme are explained in Appendix A. The preliminary risk assessment would identify if there was potential contamination at the site.

5. Midtown Site

Requirements: Flood Risk Assessment
Land Drainage Consent (possible)
Scheme to address contamination
Ecological Assessment (possible)

Flood Risk

The entire site available for the hospital is within Flood Zone 3. We would require a Flood Risk Assessment for this site, and the assessment should include the results of both a Sequential and Exception Test as explained in Planning Policy Statement 25 (Development and Flood Risk).

As part of the Flood Risk Assessment you would also have to demonstrate how you would achieve a dry escape route, and dry access to the site in the event of a flood, as well as appropriate flood mitigation or protection. Unfortunately, no reports we have seen previously have been able to demonstrate these, so it is important that these issues are a priority for investigation if you were to proceed with this site.

As well as being in a Flood Zone, the site is also located in an Area Susceptible to Surface Water Flooding. Southern Water Services have also identified the site as being at risk to flooding from the combined foul sewerage system.

Land Contamination

This site is a brownfield site and therefore there may be land contamination associated with its use, or previous uses. You would need to submit a scheme to address the risks associated with potential contamination of the site. The components of that scheme are explained in Appendix A. The preliminary risk assessment would identify if there was potential contamination at the site.

Biodiversity

The site sits adjacent to the River Dour which is a natural chalk stream. There are opportunities at this site to further improve the River and it's surrounds for biodiversity and improve access to the River for the public.

We would want an assessment to be submitted with any planning application, emphasizing the development's impact on the wildlife and habitats of the River, as well as mitigation, compensation or enhancement measures that might subsequently be proposed. However, the location of any buildings or associated works will determine whether there are any significant impacts, or opportunities for enhancement.

Appendix A

Components of a Scheme to Address Contamination.

1. A preliminary risk assessment which has identified:
    - all previous uses
    - potential contaminants associated with those uses
    - a conceptual model of the site indicating sources, pathways and receptors
    - potentially unacceptable risks arising from contamination at the site.
2. A site investigation scheme, based on (1) to provide information for a detailed assessment of the risk to all receptors that may be affected, including those off site.
3. The site investigation results and the detailed risk assessment (2) and, based on these, an options appraisal and remediation strategy giving full details of the remediation measures required and how they are to be undertaken.
4. A verification plan providing details of the data that will be collected in order to demonstrate that the works set out in (3) are complete and identifying any requirements for longer-term monitoring of pollutant linkages, maintenance and arrangements for contingency action.

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Kent Health Overview & Scrutiny Committee

Emergency Care Pathway Review

SECAmb Report

1. **How will the public's experience of the ambulance service change as a result of the development of 24/7 specialist units?**

   Direct access to specialist centres is designed to improve patient outcomes in line with best practice. Whilst initial journey times to the specialist units may be longer than currently, this should negate the need for patients being transported to hospital, and then subsequently requiring a secondary transfer to a specialist unit. For patients, this means that they should receive the specialist care that they require sooner.

2. **How will the training and job descriptions of paramedics be changing to take account of these changes?**

   The Trust has plans in place to train more paramedics at post-registration level, in both primary and critical care. These are called Paramedic Practitioners and Critical Care Paramedics. The Trust's workforce plan considers wider workforce change, with various different grades of operational staff, linked to service delivery to meet patient need.

3. **How else will the ambulance service be changing in light of these service developments?**

   The Trust will continue to work to ensure that staff are equipped with the appropriate education, skills and understanding of complex conditions, including being aware of the impact of longer journey times.

   SECAmb are undergoing wide workforce change, with a wider ranging skill mix being introduced, linked to patient need.

   Work will be undertaken in conjunction with specialist centres and networks to review and audit the outcomes on an ongoing basis.

4. **How will it be decided where to take a particular patient?**

   Appropriate pathways and parameters will be agreed in close liaison and negotiation with clinical networks and commissioners. This information will be cascaded to staff, enabling them to take the patient to the most appropriate receiving unit. The use of modern technology will assist in ensuring the patient is taken to the correct specialist centre. All vehicles will be equipped with a telemetry system that allows the patients details to be sent to the receiving hospital which allows them the time to set up the necessary teams for the immediate treatment required upon the arrival of the patient.

5. **How is this decision communicated to the patient, where possible?**

As with current procedures, crews will endeavour to keep patients, as well as relatives and carers, informed as to where they will be taking them, recognising that this may not be to the nearest hospital.

6. What is Protocol C?

Protocol C is a more effective method of CPR that involves giving 200 chest compressions before delivering a shock from a defibrillator, followed by a further 100 compressions after the shock. This is in contrast to the previous method of resuscitation, which saw alternating breaths and compressions given before delivering a shock. From a clinical outcome perspective, this method has delivered improved levels of Response of Spontaneous Circulation (ROSC) for patients, leading to more lives being saved.

7. What information can you provide about the ambulance service travel times to these specialist centres from different parts of Kent?

We have undertaken an analysis of travel times using GIS software to map and model one year's activity for Kent PPCI patients, to identify potential ambulance implications. The implications of additional travel to a primary specialist centre will be similar for stroke, as it is for PPCI, though the centres might be different.

However, as mentioned above, the main issue is not necessarily the additional travel times to a specialist centre, but that the patient will be directly transferred to the most appropriate receiving unit. This will potentially lead to an improved outcome for the patient, at a centre that is best equipped in terms of staff skills and resources. In the case of stroke and PPCI in particular, time is a significant factor for good outcomes.

22 December 2009

NHS South East Coast

Regional strategy *Healthier people excellent care*

Healthier people, excellent care builds upon our ongoing work in the region to improve health and care including the *Regional Health Strategy*, the *Health Inequalities Strategy*, *Creating an NHS Fit for the Future* as well as the national Next Stage Review, *Our NHS, Our Future*.

Our vision has been discussed and refined over two years and after extensive consultation. Clinicians, experts from social care, and the voluntary sector worked in eight clinical pathway groups. They identified good practice throughout the region, examined gaps or barriers and described what needed to happen locally and nationally to deliver optimal care.

More than 100,000 staff, service users and organisations were informed about or involved in developing the vision and more than 2,500 people and groups provided feedback or took part in consultation events. Our consultation document was widely distributed throughout the region. The ensuing 15 week consultation involved more than 2,000 people and organisations.

We are building *Healthier people, excellent care* into the core business of the NHS across the region. The tools for implementation are the NHS South East Coast Operating Framework, and primary care trust Strategic Commissioning and Operational Plans.

Our focus is on three key areas – quality, innovation and productivity – and how we as a strategic health authority and regional headquarters of the NHS, empower the local NHS to drive change through clinicians on behalf of patients and the public. Developing leadership within the NHS is critical through which quality, innovation and productivity will flow.

The NHS is busier than ever before, treating more patients more quickly and to higher standards, at a time when economic challenges demand better value from public services. As demand for healthcare increases, the local NHS has to ensure it can meet patient needs and provide high quality services within the context of a changing society with increased expectations. Local services must be delivered in a way where advances in medical treatments, technology and research are being introduced at an accelerated pace.

We have been working on restructuring the strategic health authority, re-aligning roles, functions and structures, so that we can deliver our vision and its new priorities. NHS South East Coast has established a Quality Board to measure quality and improve care across our region.

The Quality Board is led by NHS South East Coast Chief Executive Candy Morris and includes senior regional NHS leaders, local clinical leaders and local government and patient representatives. The Board will push forward our vision and ensure commitment to our pledges to improve the quality of care, experience of patients and productivity of services across the region. To

support the Quality Board, a Quality Observatory has been established to monitor information describing the quality of services, their efficiency and evidence of how they might be improved.

Clinical pathway leaders, assisted by networks of clinicians, will oversee care pathway re-design, gather evidence of best practice and report on reviews of guidelines, service evaluations and outcomes. This work will be supported by the Quality Observatory and the clinical leads will inform and liaise with the primary care trusts' quality programmes.

What was the rationale behind the HPEC recommendation?

For acute care, the key recommendation is that by 2010 all appropriate heart attack, stroke and major trauma patients would receive the care from 24/7 specialist units.

This recommendation was based on evidence from the National Confidential Enquiry into Patient Outcome and Death Report[1] and evidence from the Trauma Audit Research Network (TARN) which identified the need for specialist care in order to optimise patient outcomes.

Similarly, national and international evidence indicates that the management of stroke is best delivered in units that have the capacity to perform urgent brain scans, administer thrombolytic (clot dissolving drugs) and provide patients with specialist assessment and support[2].

In the case of heart disease, thrombolysis is now being replaced by primary angioplasty wherein a fine tube is passed through the arterial system into the coronary arteries and the blocked artery is opened and sometimes supported with a metal stent. Again, this requires the co-ordinated services of a specialised unit [3].

What service changes have taken place across the region, and what changes are planned, in order to provide these 24/7 specialist units?

Stroke

Each acute provider now has a dedicated stroke unit that employs specialist staff trained in the management of stroke. These operate on a 24/7 basis. Each PCT has systems for delivering acute thrombolytic therapy (clot-bursting drugs) that have shown to have a beneficial effect on long-term outcomes for people who have suffered a stroke. NHS East Kent has commissioned a 'telemedicine' model from East Kent Hospitals University NHS Foundation Trust that uses the system to undertake investigation and assessment of

[1] (Trauma: who cares? National Confidential Enquiry into Patient Outcome and Death, November 2007)
[2] (The National Stroke Strategy for England, Department of Health 2007)
[3] (Boyle R. Mending Hearts and Brains: Clinical Case for Change; Department of Health, 2006)

stroke patients remotely from where the patient presents. NHS West Kent has commissioned a 'rota system' from Dartford & Gravesham NHS Trust and Maidstone & Tunbridge Wells NHS Trust who operate the rota between the 4 hospitals to provide a full 24hr/7 day a week service between them. This rota includes Medway NHS Foundation Trust. The formidable success of the 'telemedicine' system, (it recently won a national award) which has supported the effective treatment of high numbers of patients, has prompted NHS West Kent and NHS Medway to replace the current rota system with a telemedicine solution.

Cardiac

This has also been a significant success in Kent. The commissioners and providers have come together to make a single site for Primary Angioplasty which is shortly to be commissioned. This represents a significant achievement for commonsense, practical thinking and collaborative work and is something of which Kent can be proud.

An acute angioplasty service will be based in Ashford, at the William Harvey Hospital, which can be reached in less than the requisite 2 hours from anywhere in Kent. It will be opened in 2010 and will be the first unit to meet the HPEC pledge

Trauma

The management of serious trauma and head injury in the UK is sub optimal with mortality 40% higher than those countries which have networked organised trauma services. Kent is challenged because of its geography and demography. Major trauma and head injury should be sent directly to a regional centre, which for Kent has meant Kings College Hospital or St. Barts and the London Hospital as there is currently no centre in the South East Coast region.

Resolution is difficult because the preferred solution is to network Trauma units (TUs) with Major Trauma Centres, (MTCs) and the latter require a population of 2-4 million so a unit for Kent would not to be viable. The changes in London, (see below) will reduce our links with our traditional tertiary services and this is providing an impetus to resolve this. West Kent PCT is taking the lead in bringing together Kentish commissioners and providers to produce a viable solution. This is being supported at regional level by the SHA which will take a much more directly strategic approach in pressing for innovative solutions.

What is the definition of the different levels of trauma service, including 'poly-trauma'?

The severity of trauma is calculated based on an injury severity score (ISS) which reflects the severity of injury to various areas of the body. Generally, patients with scores of greater than 15 are regarded as having major trauma. It should be noted that in the National Confidential Enquiry into Perioperative Death, 62% of the 795 multiple trauma cases reviewed included head injury

Most trauma, whether affecting a single organ, such as a head injury or multiple organs, (poly-trauma) should be managed in local Trauma Units, (population 500,000), based in Hospitals provided with consultant led teams round the clock, with access to immediate scanning, theatre time and ITU facilities. These should be networked to an MTC, (population 2-4 million) with additional resources including; helicopter pad, cardiothoracic, neuro, vascular, maxillo-facial and plastic surgery s well as sufficient ITU facilities for those patients with severe trauma, (ISS>16) or GCS <9. The important message is that a network of hospitals linked to a major trauma centre can span the spectrum of severity. These systems lead to a reduction in multiple trauma mortality of 8% and a 50% reduction in overall avoidable deaths[4]

Can the SHA provide a map indicating where, across the region, these specialist units are located, or where they are planned to be located in the future?

Specialist stroke units are situated at:

Darent Valley Hospital, Dartford. (shared rota)

Kent & Canterbury Hospital, Canterbury (24hr)

Queen Elizabeth, the Queen Mother Hospital, Margate (24hr)

William Harvey Hospital, Ashford. (24hr)

Kent & Sussex Hospital, Tunbridge Wells. (shared rota)

Maidstone Hospital. (shared rota)

For each of these locations can you name the services provided and indicate whether they are available 24/7?

As mentioned above all the acute providers have a stroke unit that can provide dedicated stroke care from admission onwards. The Acute Stroke Units provide dedicated and specialist stroke care including thrombolysis. They provide rapid, early expert intervention and early rehabilitation for the acute stroke patient through a comprehensive pathway of care. Patients are looked after by an extensive multi-disciplinary team overseen by a specialist stroke consultant.

All major trauma centres, when fully online, will offer 24/7 care. As defined by Healthcare for London, a major trauma centre provides treatment to people with the most serious injuries 24 hours a day, seven days a week. These centres will have the equipment, facilities and teams of trauma experts to ensure effective diagnosis and early treatment of seriously injured patients.

[4] Nathens AB, Jurkovic GJ, Cummings P, Rivara FP, Maier RV. The effect of organised systems of trauma care on motor vehicle mortality. JAMA 200; 283: 1990-1994.

Patients in major trauma centres would then be transferred to local hospitals for ongoing care

The numbers of patients defined as having suffered 'major trauma' is low, being in the region of 300 per year (compared with around 1,600 per year in London). The volume of major trauma cases or potential major trauma cases work does not justify a major trauma centre development in Kent & Medway.

At the Fit for Future 'Galaxy' conference in July 2007 it was agreed that major trauma services for Kent and Medway patients would continue to be provided from the tertiary centres in London - principally Kings College Hospital and the Royal London. NHS London's 'Healthcare for London' consultation sought views on the model of trauma services in 2009 and confirmed these hospitals (with the addition of two other centres) will be the major trauma providers for London.

NHS London and London providers are currently working through the standards and pathways to ensure standards and networks are established.

What should a specialist stroke unit contain, what services should it provide and what hours should it be open for?

Each acute provider now has a dedicated stroke unit that employs specialist staff trained in the management of stroke. These operate on a 24/7 basis. Each PCT has systems for delivering acute thrombolytic therapy (clot-bursting drugs) that have shown to have a beneficial effect on long-term outcomes for people who have suffered a stroke. NHS East Kent has commissioned a 'telemedicine' model from East Kent Hospitals University NHS Foundation Trust that uses the system to undertake investigation and assessment of stroke patients remotely from where the patient presents. NHS West Kent has commissioned a 'rota system' from Dartford & Gravesham NHS Trust and Maidstone & Tunbridge Wells NHS Trust who operate the rota between the 4 hospitals to provide a full 24hr/7 day a week service between them. This rota includes Medway NHS Foundation Trust. The formidable success of the 'telemedicine' system, (it recently won a national award) which has supported the effective treatment of high numbers of patients, has prompted NHS West Kent and NHS Medway to replace the current rota system with a telemedicine solution. A business case is being prepared and funding has been agreed through the SHA Innovation Fund.

SEC Ambulance Service NHS Trust have provided extensive training for all call centre staff and have adapted their response for stroke calls to ensure an appropriate 'category A with transport' response is deployed in order to transfer patients to the closest operational acute stroke centre as quickly as possible.

The 2008 National Sentinel Stroke Audit generally showed improvements in care across Kent from the previous audit in 2006.

Darent Valley Hospital went from the middle half to the bottom quartile nationally. A complete pathway service improvement initiative has since led to subsequent improvement in a repeat local audit.

Kent & Canterbury Hospital went from the middle half to the top quartile nationally.

Queen Elizabeth The Queen Mother Hospital went from the lower quartile to the middle half.

William Harvey Hospital went from the lower to upper quartile.

Kent & Sussex Hospital stayed in the lower quartile. A series have improvements have since been initiated. A repeat audit is planned for January 2010.

Maidstone Hospital went from the lower quartile to the middle half.

Please provide an overview of the 3T development in Brighton and the impact of these changes on the people of Kent, including which areas are likely to be more affected than others.

Overview of the 3Ts development in Brighton

The Outline Business Case (OBC), approved last year by NHS South East Coast and currently under review by the Department of Health involves a proposed capital investment of £420 million, over the period 2010-2020, to deliver the Regional Centre for Teaching, Trauma and Tertiary Care at the Royal Sussex County Hospital site in Brighton. This is known as the 3Ts programme.

The aims of the programme are fully aligned with national, regional and local priorities and the commissioning intentions of the local primary care trusts. It is also a top priority for the SHA, and a key enabler for the region-wide NHS vision for healthcare and wellbeing across Kent, Surrey and Sussex - *Healthier people, excellent care*.

Investment objectives of the scheme

The investment objectives include:

- Replace the wards and other clinical accommodation currently in the Barry and Jubilee buildings on the Royal Sussex County Hospital (RSCH) campus with accommodation that is 'fit for purpose' and meets standards of privacy and dignity, in line with existing and emerging national priorities;

- Transfer the Regional Centre for Neurosciences from Hurstwood Park (on the Princess Royal Hospital site in Haywards Heath, some 15 miles from Brighton) and expand its capacity, in line with the Sussex-

wide *Tertiary Services Commissioning Strategy* (2008) and other commissioning intentions. This will allow patients from Sussex who currently have to travel to other centres (mainly in London) to be treated closer to where they live;

- Develop and expand non-surgical cancer services, in line with the Sussex Cancer Network's *Service Delivery Plan* and the Sussex *Tertiary Services Commissioning Strategy*. This will allow patients across Sussex to receive radiotherapy and chemotherapy treatment closer to where they live and will enable the Network to continue to meet national waiting times standards;

- Develop the Royal Sussex County Hospital as the Level 1 Major Trauma Centre for Sussex and the South East, as set out in the NHS' region-wide vision for healthcare in the South East Coast - *Healthier people, excellent care* (2008) and in line with Lord Darzi's report, *High Quality Care for All* (2008);

- Develop teaching, training and research activities within the Trust, in partnership with the Brighton & Sussex Medical School; Kent, Surrey & Sussex Deanery; and the Universities of Brighton and Sussex – again in line with Lord Darzi's vision of high quality teaching and research supporting high quality care.

Principle Benefits

- responds directly to the future strategic direction of the NHS by providing services and facilities that will support high quality patient care for all;

- responds to the regional strategy for developing specialist centres and a Level 1 Major Trauma Centre;

- responds directly to the future plans of the PCT commissioners across Sussex in providing capacity for local people to receive cancer, neurosciences and major trauma care locally;

- responds to the local need for providing modern, fit for purpose inpatient and diagnostic facilities for the people of Brighton & Hove;

- will provide the opportunity to further develop facilities for teaching and research and magnify the radiated benefits of this for the whole of the NHS across the South East for the next 20 years and beyond.

The 3Ts development will deliver tangible patient focused benefits, for example:

- fit for purpose accommodation - using evidence-based design to substantially improve the patient environment, maintain patient safety and reduce hospital-acquired infections;

- the 3Ts programme will provide almost 70% of its inpatient accommodation in single rooms – currently only around 5% of the services that form part of the programme are in single rooms;

- improved services for patients with stroke through the co-location of neurology and stroke inpatient services with good access to diagnostic imaging and treatment facilities;

- providing care closer to home: the 3Ts programme will provide the necessary capacity for neurosurgery and cancer care, with appropriate imaging and treatment support to allow many patients who currently have to travel out of Sussex for treatment to have that treatment closer to where they live;

- the 3Ts programme will also provide expanded capacity within the Sussex Cancer Network to continue to meet waiting times standards and allow patients to be accommodated and treated on the Royal Sussex County Hospital campus rather than having to travel daily to London centres for treatment

- extra capacity in specialist and tertiary care closer to where patient lives and a reduction in the number of people who have to travel to other centres, mainly London, for this care;

- the 3Ts programme will enable the Trust to become a Level 1 Major Trauma Centre at the hub of a Trauma Network for Sussex and the wider region. Key to this is the relocation of the Regional Centre for Neurosciences from Hurstwood Park and the development of appropriate capacity and treatment facilities on the Royal Sussex County Hospital campus.

Key Facts:

The Trust‘s preferred option is estimated to have a capital cost of £420 million. The preferred option has been developed in three stages over the period 2010 – 2020. The stages proposed are as follows, and it should be noted that these are subject to Department of Health approval following the review process that is currently ongoing:

Stage 1 (£319 million)

Trauma
Neurosurgery
Fit for purpose hospital accommodation

This stage is proposed to commence in 2010 and complete in 2014.

Stage 2 (£88 million)

Oncology
Fit for purpose patient accommodation
Teaching facilities

The stage is proposed to commence in 2015 and complete in 2018.

Stage 3 (£13 million)

Complete site rationalisation and car parking.

This stage is proposed to commence in 2018 and complete in 2020

The proposed development presents a unique opportunity to strengthen tertiary/specialist and secondary care services. It will significantly enhance the Trust's reputation for excellence as a University Teaching Hospital, providing opportunities for an ever closer partnership with the Brighton & Sussex Medical School and the Universities of Brighton and Sussex. Most importantly, it will provide significant improvements in access and clinical outcomes for the local populations of Brighton & Hove and for patients across Sussex and the South East.

Impact of these changes on the people of Kent, including which areas are <u>likely to be more affected than others</u>

The Trust and its local commissioners established a Sussex Trauma Network to look at the potential to develop a Level 1 Major Trauma Centre in Brighton. They worked with South East Coast Ambulance Trust (SEC Amb) and the emerging major trauma networks established through the Healthcare for London work.

The PCT and Trust at a meeting with Kent HOSC were asked for an estimate of the likely number of Kent residents which might fall within the trauma centre catchment and which wards these represented. The Trust used South East Coast Ambulance Service road ambulance travel times to model the equidistance between the Royal Sussex County Hospital and the next nearest major trauma centres, being the Royal London, St. George's Hospital, King's College Hospital and Southampton University Hospital. They then used population data at individual ward level to identify a logical catchment area. The analysis also included projected population growth to 2014. The Trust estimated the total workload of around 360 cases per annum in major trauma to be drawn from a catchment of 1.49 million.

The road travel times showed the catchment for the Sussex Trauma Network overlapping slightly with the West Kent and Eastern & Coastal Kent Primary Care Trust boundaries (and therefore with the Kent County Council boundary). The Trust modelling suggested that the following wards could fall within the Sussex Trauma Network catchment:

- Tunbridge Wells Borough excluding the northern wards of Paddock Wood, Frittenden & Sissinghurst, Capel, Southborough and Brenchley;

- Ashford Borough, but only including the wards of Oxney and Rolvenden & Tenterden West;

- Shepway Borough, but only including Lydd and part of Romney Marsh wards.

The Trust estimated that by 2014 there would be a population of around 100,000 in these areas which could translate to around 25 cases per annum – so quite a small proportion of the overall total. These were however planning estimates. The decision where to take a particular patient will be clinically driven and will depend upon the acuity of the patient.

What assessment has been made of the impact of the implementation of new major trauma and stroke services in London on care pathways for the population of Kent?

NHS South East Coast has commissioned its Acute Care Lead, Dr Steve Pollock to examine the management of serious head injury within the South East Coast Strategic Health Authority region. Extrapolating from national data, it is suggested that the SHA population of 4.2 million would generate around 76 moderate and 236 severe head injuries per annum as part of the multiple trauma toll. The report recognises that there is a need for clear referral pathways to tertiary centres that provide the range of care that these patients need, included specialist intensive care as well as neurosurgery. Furthermore, there is a need to develop appropriate rehabilitation pathways for these patients following acute intervention.

The distribution of severe or fatal road traffic accidents as documented by the Department of Transports research[5], shows that there is a wide geographic spread of these patients within Kent and that not all of the patients have ready access to the tertiary centre at King's College Hospital. In view of this, the Strategic Health Authority is proposing to establish a musculoskeletal network and to examine the options for the appropriate management of these patients in trauma units prior to referral to a major trauma centre.

In terms of stroke overall there will be no negative impact on stroke management in Kent. The dispersed telemedicine model adopted by South East Coast Strategic Health Authority may well prove superior to the centralised London model and the only downside will be for those very few stroke patients who require neurosurgery.

There are already problems of access for Kentish patients to neurosurgery beds in London. This is due to both the geographical distances particularly in

[5] source: Broughton and Buckle 2006

East Kent, the heavy local demand on the south London service, and to the peaks and troughs in the nature of major trauma. We are keeping closely in touch with developments in London, alongside our specialist commissioners. The final picture about London configurations is not clear at this point, but we need to anticipate that local patients are likely to receive priority in whatever emerges.

Are there any regional or local workforce issues which could delay the introduction of these specialist units?

Specialist stroke care units and specialist cardiac care units have been in place for some time and are well developed. Locally, as is the case nationally, there are some workforce issues regarding recruitment to stroke consultant posts and a high turnover of band 5 nurses. Having made so much progress we want to assure sustainability and are supporting the combined efforts of The Providers and Kent Cardiovascular Network in an ongoing recruitment process. The SHA in its system management and assurance role works with PCTs to assure the quality of workforce planning and development throughout the SHA area. This in turn support the SHA in its stewardship, on behalf of the SEC community, of medical and professional education and training funds (approx £250m) for services delivered through contracts with Higher Education Institutes and placement contracts with NHS providers.

What part do the air ambulance services play in these changes?

Kent air ambulance is an independent / charitable organisation which has 2 helicopters covering Kent. Kent air ambulance has 6 doctors and 12 paramedics (9 of whom are seconded from SECAMB). The majority of their work involves transferring patients to specialist centres following major trauma. They occasionally do transport patients following stroke if there are difficulties with roads or getting patients quickly to stroke centres.

Helicopters are an important component of rapid access to distant MTCs. However they can only fly in daylight and alternative methods of rapid transit, already in place for paediatric ITU, need further examination for adults. Transport of patients is a component of the 3T project in Brighton.

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