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To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: Drivers for Change: a) Emergency Surgery Standards, b) Trauma Networks, and c) European Working Time Directive

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Introduction

(a) In the report submitted to the Health Overview and Scrutiny Committee by East Kent Hospitals University NHS Foundation Trust for the 3 February 2012 meeting, a number of 'key drivers of change' behind their clinical strategy review were outlined.[1] This background paper provides additional information on several of these. It is for use with both Items 7 and 8 of this Agenda.

(b) At the previous meeting of the Committee on 7 September 2012, the issue of the impact of the European Working Time Directive (EWTD) was raised and discussed and the hope expressed that this be an issue which could be returned to. Additional information on the EWTD is included for Member's background information.

Part A – Emergency Surgery Standards

1. Introduction.

(a) In February 2011, the Royal College of Surgeons of England produced the document *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*.[2] This had the aim of providing information and standards on emergency surgical service provision for both adult and paediatric patients.

(b) The following provides a summary of the report.

2. What is emergency surgery?

(a) The report explains that an emergency surgical service is not one that simply operates out of hours. Instead, six elements are outlined:

1. Undertaking emergency operations at any time, day or night.

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[1] East Kent Hospitals University NHS Foundation Trust, *Clinical Strategy Review,* Health Overview and Scrutiny Committee 3 February 2012, https://democracy.kent.gov.uk/documents/s29810/Clinical%20Strategy%20Briefing%20from%20East%20Kent%20Hospitals%20NHS%20University%20Foundation%20Trust.pdf

[2] The Royal College of Surgeons of England, *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*, February 2011, http://www.rcseng.ac.uk/publications/docs/emergency-surgery-standards-for-unscheduled-care

2. The provision of ongoing clinical care to post-operative patients and other inpatients being managed non-operatively, including emergency patients and elective patients who develop complications.

3. Undertaking further operations for patients who have recently undergone surgery (i.e. either planned procedures or unplanned 'returns to theatre').

4. The provision of assessment and advice for patients referred from other areas of the hospital (including the emergency department) and from general practitioners. For regional services this may include supporting other hospitals in the network.

5. Early, effective and continuous acute pain management.

6. Communication with patients and family members/others providing support.[3]

(b) For most surgical specialties, providing emergency surgical care works out to around 40-50% of the workload. This varies according to the speciality; for example, in neurosurgery over half the admissions are non-elective and account for 70-80% of the workload.

3. The case for change and common issues:

(a) A number of reasons for changing the way emergency surgical care is delivered are given:

- "Patients requiring emergency surgery are among the sickest treated in the NHS.

- Outcome measurement in emergency surgery is currently poor and needs to be developed further.

- Current data show significant cause for concern – morbidity and mortality rates for England and Wales compare unfavourably with international results.

- It is estimated that around 80% of surgical mortality arises from unplanned/emergency surgical intervention.[4]

- The NHS has to reduce its costs significantly over the coming years – savings can only be delivered sustainably through the provision of high quality and efficient services. The higher complication rate and poorly defined care pathways in emergency surgery (when

[3] Ibid., p.7.
[4] Meaning 80% of those deaths which result from surgery.

compared to elective surgery) offer much greater scope for improvement in care and associated cost savings.

- The reduction in working hours for doctors and the focus on elective surgical care has changed the level of experience and expertise of trainees when dealing with acutely ill surgical patients.

- Patients expect consultants to be involved in their care throughout the patient pathway.

- Evidence from a survey of general surgeons indicated that only 55% felt that they were able to care well for their emergency patients.

- At least 40% of consultant general surgeons report poor access to theatre for emergency cases." [5]

(b) A number of common issues to be addressed are outlined in the report[6]:

- Priority and timeliness of surgery.

- Understanding quality and outcome issues.

- Teamworking.

- Organisation of staff.

- Organisation of facilities.

- Clinical interdependencies.

- Communication with patients and family members/others providing support.

4. Models of care.

(a) Within the clinical interdependencies which exist, a number of models of care are outlined in the report:[7]

- Consultant-based care.

- Separating elective and emergency care.

- Surgical assessment units.

[5] Ibid., p.13.
[6] Ibid,. pp.8-12.
[7] Ibid., pp.13-16.

- Clinical networks.
- Extending the working day.
- Outcomes and quality indicators.

(b) The report is not prescriptive as to which model of care should be adopted, and the bulk of the report consists of describing the standards underpinning unscheduled surgical care applying to both paediatric and adult patients.

Part B – Trauma Networks

1. Background

(a) Selected key facts about major trauma:[8]

- Major trauma = serious/multiple injuries where there is the strong possibility of death or disability.
- Blunt force causes 98% of major trauma, mainly through car accidents and falls. Gunshots, knife wounds and other penetrating injuries account for 2%.
- It's the leading cause of death in England for those aged under 40.
- Major trauma accounts for 15% of all injured patients.
- Major trauma admissions to hospital account for 27-33 patients per 100,000 population per year and represents less than 1 in 1,000 emergency department admissions.

2. Regional Trauma Networks

(a) Over the years, there has been a growing body of evidence concerning the need to improve trauma services. In 2007, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a report entitled *Trauma: Who Cares?* This found "Almost 60% of the patients in this study received a standard of care that was less than good practice. Deficiencies in both organisational and clinical aspects of care occurred frequently."[9]

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[8] Key facts extracted from a) National Audit Office, *Major trauma care in England*, 5 February 2010, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx b) The Intercollegiate Group on Trauma Standards, *Regional Trauma Systems. Interim Guidance for Commissioners*, December 2009, http://www.rcseng.ac.uk/news/docs/Regional_trauma_systems.pdf

[9] NCEPOD, *Trauma: Who Cares?,* 2007, p.10, http://www.ncepod.org.uk/2007report2/Downloads/SIP_report.pdf

(b) The need for regional trauma networks formed part of the 2008 NHS Next Stage Review.[10] On 1 April 2009, Professor Keith Willett was appointed as the first National Clinical Director for Trauma Care.[11]

(c) A National Audit Office (NAO) report, *Major trauma care in England* (published 5 February 2010), found there was:

- "unacceptable variation in major trauma care in England depending upon where and when people are treated…. Care for patients who have suffered major trauma, for example following a road accident or a fall, has not significantly improved in the last 20 years despite numerous reports identifying poor practice, and services are not being delivered efficiently or effectively."[12]

(d) The NAO report was warmly welcomed by the Royal College of Surgeons of England which supported its recommendation to introduce regional trauma centres. The Royal College's report *Regional Trauma Systems. Interim Guidance for Commissioners*, published in December 2009, identified the following priorities in trauma care:

- "identifying major trauma patients at the scene of the incident who are at risk of death or disability;
- immediate interventions to allow safe transport;
- rapid dispatch to major trauma centres for surgical management and critical care;
- coordinated specialist reconstruction; and
- targeted rehabilitation and repatriation."[13]

(e) A series of commitments around developing regional trauma networks was made by the Department of Health at a hearing of the House of Commons Public Accounts Committee on 22 March 2010.[14] This was consolidated in *The NHS Operating Framework for 2011/12*:

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[10] Department of Health, *High Quality Care For All. NHS Next Stage Review Final Report*, June 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

[11] Department of Health, *National Clinical Director for Trauma Care*, http://www.dh.gov.uk/health/about-us/people/ncd/ncdtc

[12] National Audit Office, *Major trauma care in England*, 5 February 2010, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

[13] The Intercollegiate Group on Trauma Standards, *Regional Trauma Systems. Interim Guidance for Commissioners*, December 2009, p.10, http://www.rcseng.ac.uk/news/docs/Regional_trauma_systems.pdf

[14] Summarised in: Department of Health, *Establishment of Regional Networks of Trauma Care*, 16 September 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/di

- "All regions should be moving trauma service provision into regional trauma network configurations in 2010/11. Tariff changes will be introduced from April 2011 that are designed to recompense for the complexity of multiple-injury patients. Designated Major Trauma Centres should be planning the continuous provision of consultant led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage."[15]

(e) *The NHS Operating Framework* for the current year, 2012/13, set out that the scope of the Payment by Result (PbR) tariff would be extended to:

- "introduce a 'quality increment' which may apply to patients being treated at regional major trauma centres, designed to reward high-quality care and facilitate the move to trauma care being delivered in designated centres."[16]

(f) A network of 22 new major trauma centres was announced by the Department of Health on 2 April 2012:

- "Working alongside local hospital trauma units, 22 Major Trauma Centres will operate 24 hours a day, seven days a week and be staffed by consultant-led specialist teams with access to the best state of the art diagnostic and treatment facilities.

- "Previously, patients who suffered major trauma were simply taken to the nearest hospital, regardless of whether it had the skills, facilities or equipment to deal with such serious injuries. This often meant patients could end up being transferred, causing delays in people receiving the right treatment.

- "The new network means ambulances will take seriously injured patients directly to a specialist centre where they will be assessed immediately and treated by a full specialist trauma team. Patients who have suffered a severe injury often need complex reconstructive surgery and care from many professionals, and so the trauma team includes orthopaedics, neurosurgeons,

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gitalasset/dh_119423.pdf. Uncorrected transcript of Public Accounts Committee hearing, 22 March 2010 available at: http://www.publications.parliament.uk/pa/cm200910/cmselect/cmpubacc/uc502-i/uc50202.htm

[15] Department of Health, *NHS Operating Framework 2011/12,* 15 December 2010, p.12, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

[16] Department of Health, *NHS Operating Framework 2012/13*, 24 November 2011, p.38, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

radiologists, physiotherapists, occupational therapists and speech therapists."[17]

(g) A map showing the location of the 22 centres is at Appendix 1.[18]

3. Key Definitions

(a) The NHS Clinical Advisory Groups Report, *Regional Networks for Major Trauma*, contains a number of key definitions. These are found in Appendix 2.[19]

(b) An anatomical scoring system, the **injury severity score (iss),** is used to classify trauma. The score goes from 0 – 75 and a score of 16 and over is classed as major trauma.

Table: Injury severity score group and mortality[20]

injury severity score	percentage of major trauma patients	percentage mortality of this injury severity score group
16-25	62.6	10.5
26-40	28.9	22.1
41-74	7.7	44.3
75	0.8	76.6

Part C - European Working Time Directive and Medical Training

1. Introduction[21]

(a) The European Working Time Directive (EWTD) became law for most British workers on 1 October 1998, with an extension of up to 12 years to prepare to introduce it for doctors in training. The hours junior doctors were allowed to work were limited to 58 hours per week since August 2004, 56 since August 2007 and 48 hours since August 2009. Some rotas were allowed time-limited derogation to operate at 52 hours per week. Money was allocated to Primary Care Trusts to support implementation.

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[17] Department of Health, *New major trauma centres to save up to 600 lives every year*, 2 April 2012, http://mediacentre.dh.gov.uk/2012/04/02/new-major-trauma-centres-to-save-up-to-600-lives-every-year/

[18] Sourced from: NHS Choices, *Major Trauma Centres,* April 2012, http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Documents/2012/map-of-major-trauma-centres-2012.pdf

[19] Sourced from: NHS Clinical Advisory Groups Report, *Regional Networks for Major Trauma*, September 2010, pp.5-6, http://www.excellence.eastmidlands.nhs.uk/welcome/improving-care/emergency-urgent-care/major-trauma/nhs-clinical-advisory-group/

[20] National Audit Office, *Major trauma care in England*, 5 February 2010, p.11, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

[21] Introduction sourced from: Medical Education England, *Time for Training. A Review of the impact of the European Working Time Directive on the Quality of Training*, May 2010, pp.64-69, http://www.mee.nhs.uk/pdf/JCEWTD_Final%20report.pdf.

(b) The definition of working time includes job-related training, working lunches, paid and some unpaid overtime, time spent on-call in the workplace. As a result of a European Court of Justice ruling (in the SiMAP case), on-call time when a doctor is obliged to be resident in a hospital counts as working time even when time is spent asleep.

(c) The EWTD also includes a range of rest and break entitlements such as 11 hours continuous rest in every 24-hour period. The Jaeger case ruling by the European Court of Justice means that compensatory rest for missed rest must be taken immediately the shift ends and not aggregated to be taken later.

(d) Individual doctors can opt-out of the EWTD, but cannot be made to do so and may opt back in. Rotas cannot be planned on the basis of doctors opting out but must be planned as if the EWTD applied.

(e) In addition doctors in training have been covered by the New Deal (the employment contract) since 1991. Working hours must comply with the EWTD and New Deal. All trainees have been limited to 56 hours per week since August 2003; various restrictions apply depending on the rota pattern worked. Trusts are required to monitor the working arrangements of their doctors in training; this ensures they are placed in the correct pay band.

2. Impact of the EWTD – Temple Report.[22]

(a) Following the full implementation of the EWTD in 2009, the Secretary of State for Health asked Medical Education England to commission an independent review of its impact on the training of dentists, doctors, healthcare scientists and pharmacists. Professor Sir John Temple was appointed as the Independent Chair.

(b) Key findings:

- Headline:
  High quality training can be delivered in 48 hours.
  This is precluded when trainees have a major role in out of hours service, are poorly supervised and access to learning is limited.

- Specific findings

  - Gaps in rotas result in lost training opportunities

  - The impact of EWTD is greatest in specialties with high emergency and/or out of hours workloads

  - Traditional models of training and service delivery waste learning opportunities in reduced hours

[22] Full report: Ibid.

- Consultant ways of working often support traditional training models
- EWTD can be a catalyst to reconfigure or redesign service and training

(c) Recommendations:

- Implement a consultant delivered Service
- Service delivery must explicitly support training
- Make every moment count
- Recognise, develop and reward trainers
- Training excellence requires regular planning and monitoring

3. Recent Developments

(a) The House of Commons Health Committee considered junior doctors' training in its 2012 report, *Education, training and workforce planning*, and produced the following recommendation:

- "While we recognise that introduction of the European Working Time Directive has had a significant impact on working and training practices, we do not feel any rose tinted nostalgia for a system which used to rely on over-tired and under-trained junior doctors. We have received a broad basis of evidence which shows how it is possible to reconcile reasonable hours for junior doctors with high quality training and, most importantly, high standards of care for patients."[23]

(b) The Government response to the Health Select Committee report stated that the *Better Training Better Care* programme had been developed to enable the delivery of the key recommendations of the Temple report along with the findings of Professor John Collins' report

[23] House of Commons Health Select Committee, *education, training and workforce planning*, 15 May 2012, p.22, http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/6i.pdf

Foundations for Excellence.[24] This project currently has 16 pilot sites, including East Kent Hospitals University NHS Foundation Trust.[25]

[24] Department of Health, *Government Response to the House of Commons Health Select Committee First Report of Session 2012-13: Education, Training and Workforce Planning*, p.9, https://www.wp.dh.gov.uk/publications/files/2012/09/CM8435-Government-response-to-HSC-inquiry-on-ETWP.pdf; Medical Education England, *Foundation for Excellence An Evaluation of the Foundation Programme*, October 2010, http://www.mee.nhs.uk/pdf/401339_MEE_FoundationExcellence_acc_FINAL.pdf

[25] Health Education England, *BTBC Pilot Sites,* http://www.hee.nhs.uk/work-programmes/btbc/btbc-pilot-sites/