HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th June, 2013

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th June, 2013, at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mrs A D Allen, Mr M J Angell, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (3):	Mr L Burgess, Mr J Elenor and Mr R A Latchford, OBE
Labour (2):	Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor A Blackmore, Councillor Mr M Lyons, and Councillor S Spence (one vacancy)

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UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item	Timings
1. Introduction/Webcasting	

2. Substitutes

3. Election of Vice-Chairman

4. Declarations of Interests by Members in items on the Agenda for this meeting.

5. Minutes (Pages 1 - 6)

6. East Kent Hospitals University NHS Foundation Trust Clinical Strategy (Pages 7 - 34)

7. Date of next programmed meeting – Friday 19 July 2013 @ 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

30 May 2013

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 8 March 2013.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr Mrs A Blackmore, Cllr R Davison (Substitute for Ann Allen), Cllr M Lyons, Cllr G Lymer and Mr M J Fittock

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest
(Item3)

(a) Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

(b) Several Members explained that they were diabetics and as diabetes services were on the Agenda they felt this should be made clear.

3. Minutes
(Item 4)

(a) Mr Alan Willicombe requested that the Minutes be amended to reflect the fact he was present at the meeting.

(b) RESOLVED that, subject to this change being made, the Minutes of the Meeting held on 1 February 2013 are correctly recorded and that they be signed by the Chairman.

4. The Francis Report
(Item 5)

(a) The Chairman introduced the item and indicated that Members had before them letters received from Medway NHS Foundation Trust and NHS Kent and Medway on various matters arising from the Francis Report into events at Mid-Staffordshire Hospital. Attention was drawn to the website where Members would be able to access and read the full detailed Report. Given the importance of the Report, the Chairman felt certain this was something the Committee would look at again in the future and asked if Members had any comments. Members proceeded to express a range of views.

(b) One Member identified two of the themes from the Francis Report set out on p.10 of the Agenda as being particularly important, namely the loss of corporate memory from constant reorganisation and the prioritisation of finance and targets over the quality of care.

(c) On the subject of reorganisations, concern was expressed about patients and services potentially being overlooked during the transition from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs). However, the view was also expressed that the constant reorganisations meant little to frontline staff in the NHS as they were continually working and focussed on patients.

(d) There was a discussion over whether the kind of issues identified in the Francis Report were the result of the actions of a tiny minority of staff when the rest were dedicated and hard working, paying tribute to all staff groups including managers, or the result of a broader cultural problem. On this last point, the view was expressed that the NHS was not sufficiently self-critical. Connected with this, the view was expressed that patients felt reluctant to complain about a service they used and that within the NHS the potential penalties for whistle-blowing were too high.

(e) On the subject of Medway NHS Foundation Trust, the view was expressed that the quality of service varied markedly by ward and service. Concern was expressed about what exactly the mortality statistics did and did not include.

(f) It was commented that the Francis Report also had important lessons for patient and public involvement in the future. It was reported that representatives of the Kent LINk had visited the one in Staffordshire to provide support.

(g) Members felt the role of HOSC in maintaining an overview of the actions taken resulting from the Francis Report was a challenging and important one. To this end, there was detailed discussion on the wording of the recommendation. The issue of timing was of particular concern, with the view expressed that not setting a specific time to look at this topic again meant it could slip of the Forward Work Programme, but other views expressed the notion that it was important to wait until the report into Medway NHS Foundation Trust was made available. It was also felt that it would not be possible to ignore the outcomes of the Francis Report.

(h) The Chairman proposed the following recommendation:

- That the Committee recognise the importance of the Francis report and the strength of feeling arising from it and recommends that the HOSC put this item on its forward work programme as a priority.

(i) AGREED that the Committee recognise the importance of the Francis report and the strength of feeling arising from it and recommends that the HOSC put this item on its forward work programme as a priority.

5. Services Overview: a) Diabetes Services; and b) Ophthalmology
(Item 6)

Huw Alban Davies (Patient Advocate Diabetes UK), Dr Abraham George (Assistant Director / Consultant in Public Health), John Nester (Commissioning Manager, NHS Kent and Medway), Carole Eastwood (Commissioning Manager, NHS Kent and Medway), Claire Martin (Diabetes Project Manager, Canterbury and Coastal CCG), Dr Balaji Chalapathy (Dartford, Gravesham and Swanley CCG Board Member), Gerry Clark (Commissioning Programme Manager – Long Term Conditions, Dartford, Gravesham and Swanley CCG), Paula Smith (Commissioning Delivery Manager and Planned Care Lead, Canterbury and Coastal Clinical Commissioning Group), Sean Crilly (Head of Planned Care Commissioning, East Kent Federation of CCGs), Jochen Worsley (Head of Long Term Conditions - East Kent Federation of CCGs), and Ally Hiscox (Head of Commissioning, Swale CCG) were in attendance for this item.

(a) The Chairman introduced the item and NHS colleagues explained that there were representatives of all 7 CCGs present. It was also explained that historical data would necessarily be based on PCT areas, so were not always directly comparable to CCG areas.

(b) Members proceeded to ask a range of questions on diabetes and ophthalmology services, from which several themes arose.

(c) One area of discussion was around diabetes services available at GP practices. The ones available were praised, but it was asked as to the reason why these were not available at all surgeries. It was explained that it depended a lot on the size of the GP practice and the special interests and training of the GPs. The provision of a one-stop shop for diabetes services involved a lot of different disciplines and specialists. This required surgeries of a certain size and for the right estate to be available. Care also needed to be taken not to duplicate secondary services. The way GP practises were being used was also being looked at, with options like one weekday afternoon or a Saturday morning being set aside for diabetes services being considered. The important point was for GPs to know what services were available and how to refer patients to them with a quality service available to all.

(d) Building on this, questions were asked about the future priority which would be given to commissioning and funding diabetes services. Some Members were concerned it could become a ‘Cinderella service’ and the example of the new Pembury hospital not having a diabetes service given as an example, though it was also noted there was a service elsewhere in Tunbridge Wells. On behalf of the East Kent Federation of CCGs it was explained that, working with the Paula Carr Diabetes Trust, an expert commissioner had been employed to produce recommendations by the end of the year. West Kent also treated diabetes services as a priority and were redesigning their diabetes services. There was a focus on addressing the high levels of people with diabetes who had not been diagnosed. The overall aim was to address diabetes early and so free up acute capacity so that Level 3 services with a consultant would be reserved for those with the most need. The comment was made that there was also a need to encourage consultants to let regular patients be treated in the community. The Committee was informed that a one-stop shop would be

coming to Sevenoaks Hospital. This did not mean patients from all over West Kent would need to travel to Sevenoaks. It was a service model being trialled and if successful similar services would be opened elsewhere.

(e) Several Members of the Committee expressed the view that diabetes services were very good, but there were some concerns around administration and process. One Member explained that he found it odd that HbA1c tests could not be carried out less than 6 months apart and that it had been reported that there were restrictions being placed on making daily test strips available to patients. In response it was explained that evidence showed that daily testing of blood glucose did not lead to more control of the condition, but daily testing was still used where diabetes was not being controlled and/or where a patient was on insulin. HbA1c tests were a much more reliable indicator of how diabetes was being controlled, but that as red blood cells took 180 days to completely renew, it could not be carried out before 6 months had passed.

(f) One point raised by a number of Members was the importance of diagnosing people early and the view was expressed that one reason there were such high levels of undiagnosed diabetes was because diabetes did not always cause people problems and so there was no reason to be tested. In answer to the question of what was being done, NHS representatives explained that along with opportunistic screening, there was the annual health check programme which went a long way to diagnosing the undiagnosed. It was, however, underfunded. In response to a specific question it was explained that the health check programme was commissioned across Kent and Medway through Public Health Departments.

(g) On this theme, it was pointed out that there was a different rationale behind early diagnosis and prevention for Type 1 and Type 2 diabetes. For Type 1 diabetes, which resulted from the body's inability to produce insulin, screening was very important for secondary prevention to ensure the condition was managed appropriately. Early detection of Type 2 diabetes could mean lifestyle changes were recommended to control the condition.

(h) There was a lot of discussion around the lifestyle and socio-economic factors contributing to the current levels of diabetes as well as the possibility of success for preventive health campaigns such as the Change4Life national campaign. Some Members expressed scepticism as to how successful preventive health campaigns could be, but other Members indicated there were examples of turnarounds in social attitudes, such as wearing seatbelts or smoking. NHS representatives explained that it was true to say that it was a very complex area and that there was a big difference between making someone aware of what they should eat and that person changing what they ate. It was often the case that people knew what they should eat but chose to eat otherwise; a person eating fast food to raise their spirits after being made redundant was given as an example. There were also broader cultural challenges, such as parents rewarding children with sweets, which needed to be challenged.

(i) It was explained that there were a variety of different projects underway, and reference was made to the good work the community chef project was doing.

However, some of these projects could be expensive in relation to the benefit gained.

(j) NHS representatives went on to outline some research which had been carried out in the area. As a result of living with different families, 8 different categories of parent in relation to food had been identified, including single-parent families and more traditional approaches which saw meat and vegetables as being necessary with every meal. Each of these segments would need to receive a different message around healthy eating and lifestyle changes. Related to this point, Members felt that sometimes the message dieticians could give could be misleading or sometimes lack the appropriate context for the person being advised. NHS representatives also raised the point that it was important to get the message across that there were not always immediate solutions; weight which had taken 20 year to gain could take as long to lose.

(k) The rise of childhood obesity was a matter of particular concern to Members. A representative from Diabetes UK explained that one worse case scenario had been put forward where the current generation would be the first one to die before their parents due to the health problems being stored up for the future by current lifestyle choices. It was explained that there was the Healthy Schools Programme which aimed specifically at tackling this. Mention was also made of the National Child Measurement Programme which measuring the BMI/weight of children in reception class and in Year 6. This provided useful data about the rate of the rise of obesity. It was further explained that this data was available for each locality through the Public Health Observatory. The importance of cooking lessons at school was also mentioned. An NHS representative noted that however healthy a school was, it could not compensate completely for unhealthy eating outside of school.

(l) One Member raised the possibility of perhaps requiring legislation to tackle the unhealthy food produced by certain companies. There was a discussion on the balance to be struck between these companies as private organisations, the need to give people lifestyle choices and improving health. The ethics of investing in specific companies was also debated. It was reported that there was an ongoing conversation between government, both national and local, public health professionals, food companies and consumers.

(m) In response to a specific question, it was reported that work with the local ambulance service on appropriate patient pathways for diabetics was ongoing.

(n) Moving on to the related subject of ophthalmology, Members concurred that the services delivered were excellent and Maidstone Hospital was named as a centre of excellence. However, concerns were expressed around the administration of the services. Waiting times were reportedly lengthy and there were some irregularities around the appointment system which needed addressing.

(o) NHS representatives undertook to take these concerns to the Service Improvement Group. This group included consultants and so the balance between the priority given to the requests of consultants and those of administrators would be looked at. In East Kent it was explained that the

waiting times had been 13 weeks, but had been reduced to 10 weeks now. To put the Kent situation this in its wider context, it was explained that there was a national shortage of ophthalmologists and that it took 8-9 years to train a consultant ophthalmologist. This was one reason why services needed to be delivered more in the community. Mr Nester undertook to keep the Committee informed on this issue.

(p) Beyond this, NHS representatives explained that with an ageing population there was likely to be an increase in the incidences of glaucoma and increasing pressure on services. The Committee were informed that a tender was coming up for a community glaucoma network to be in place by June. This might involve certain services being available in high street opticians, with referrals to acute hospital consultants only being made for more serious cases. The South Kent Coast CCG envisaged more ophthalmology services being available in the community. Other CCGs might choose different models, but this would allow results to be compared and the spread of best practice.

(q) The impact of Trust Special Administrator's recommendations about South London Healthcare NHS Trust (SLHT) was also discussed. This was important as Darent Valley Hospital accessed ophthalmology services from this Trust's Sidcup site. It was explained that King's College had taken over the ophthalmology services at SLHT but that the details were still being worked out.

(r) Several Members of the Committee made suggestions as to the wording of a possible recommendation.

(s) The Chairman proposed the following recommendation:

- That this Committee thanks its guests for their valuable responses and recognises the fundamental importance of health prevention programmes, and asks this Committee to continue working with the local health sector, the Health and Wellbeing Board, Kent County Council more widely, and central government to understand the best way to effect the necessary changes in lifestyle.

(t) AGREED that this Committee thanks its guests for their valuable responses and recognises the fundamental importance of health prevention programmes, and asks this Committee to continue working with the local health sector, the Health and Wellbeing Board, Kent County Council more widely, and central government to understand the best way to effect the necessary changes in lifestyle.

6. Date of next programmed meeting – Friday 7 June 2013 @ 10:00 am
(Item 7)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 June 2013

Subject: East Kent Hospitals University NHS Foundation Trust Clinical Strategy.

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the East Kent Hospitals University NHS Foundation Trust Clinical Strategy.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The HOSC has considered the development of East Kent Hospital University Foundation Trust's (EKHUFT) clinical strategy on two occasions previously. These were:

- 3 February 2012
- 12 October 2012.

(b) A number of 'key drivers for change' behind their clinical strategy review have been identified by the Trust and this report provides additional information on some of these.

2. The Trust

(a) EKHUFT was formed in 1999. It was awarded University NHS Hospital status by the University of London (Kings College) in 2007 and became an NHS Foundation Trust on 1 March 2009. As a teaching Trust it is involved in the education and training of doctors, nurses and other healthcare professionals, working closely with local universities and Kings College University in London.

(b) It is one of the largest hospital Trusts in England, serving a population of c.759,000 people. Its main sites are:

- Kent and Canterbury Hospital, Canterbury
- Queen Elizabeth the Queen Mother Hospital, Margate
- William Harvey Hospital, Ashford
- Buckland Hospital, Dover
- Royal Victoria Hospital, Folkestone

(c) It also provides health services from other locations across Kent.[1]

3. Emergency Surgery Standards

(a) In previous reports submitted to the HOSC, EKHUFT have identified two recent publications as being key policy and service drivers underpinning the clinical strategy review.

(b) The first publication identified is a report by the Association of Surgeons for Great Britain and Ireland (ASGBI), *Emergency general Surgery: The Future.* This 'Consensus Statement' was produced as a result of a conference in February 2007. Some of the main points made in the conclusion are as follows:

- There is wide variation in the quality of emergency general surgery (EGS).
- EGS is one of the most common reasons for admission to a surgical bed in Britain.
- All Trusts which receive emergency general surgical admissions should have a named surgeon responsible for the clinical leadership of this service.
- Emergency admissions should have dedicated resources and senior surgical personnel readily available.
- There must be a clear and identifiable separation of delivery of emergency and elective care.
- Timely access to diagnostic services (particularly radiology), interventional radiology and emergency theatre time is necessary.
- The assessment, prioritisation and management of emergency general surgical patients should be the responsibility of accredited General Surgeons.
- The largest component of the emergency general surgical case-mix is gastrointestinal.
- ASGBI recognises the case for regional trauma centres.
- It is clear from trends within the specialty and training that separation of vascular surgery from general surgical practice in the UK is inevitable. Similar arguments apply to breast surgeons.[2]

(c) In a later document, *Issues in Professional Practice, Emergency General Surgery*, the following explanation of the term 'general surgery' is provided:

"General surgery is a historical term, the spread of which currently includes gastro-intestinal surgery, endocrine surgery, torso trauma and

[1] Information for this section sourced from: East Kent Hospitals NHS University Foundation Trust Annual Report 2011-12, http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/annual-reports-and-business-plans/ and EKHUFT website, http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/, accessed 13 May 2013.
[2] ASGBI, *Emergency General Surgery: The Future*, February 2007, http://www.asgbi.org.uk/en/publications/consensus_statements.cfm

hernia surgery. In some hospitals, breast, transplant and vascular surgeons still undertake some general surgery and may contribute to EGS, although these disciplines are increasingly separate. This separation has been driven by a desire for improved outcomes through specialisation, although neither the provision of specialist on-call cover nor the impact of withdrawal of manpower from EGS has been cleanly resolved."[3]

(d) The other publication is the Royal College of Surgeons of England produced document *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*.[4] This had the aim of providing information and standards on emergency surgical service provision for both adult and paediatric patients. This was published in February 2011.

(e) 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.

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.[5]

(f) 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.

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[3] ASGBI, *Issues in Professional Practice, Emergency General Surgery*, p.8, May 2012, http://www.asgbi.org.uk/en/publications/issues_in_professional_practice.cfm

[4] 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

[5] Ibid., p.7.

(g) 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.[6]
- 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 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." [7]

(h) 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.

4. Trauma Networks

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

[6] Meaning 80% of those deaths which result from surgery.
[7] Ibid., p.13.

- 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.

(b) 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]

(c) The need for regional trauma networks formed part of the 2008 NHS Next Stage Review.[10]

(d) 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."[11]

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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

[10] Department of Health, *High Quality Care For All. NHS Next Stage Review Final Report*, June 2008, p.20, http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdfn

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

(e) 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."[12]

(f) 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.[13] This was consolidated in *The NHS Operating Framework for 2011/12*:

- "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."[14]

(g) *The NHS Operating Framework* for 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-

[12] 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

[13] 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/digitalasset/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

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

quality care and facilitate the move to trauma care being delivered in designated centres."[15]

(h) The NHS Outcomes Framework is based around five domains. Within each are a number of overarching indicators and areas of improvement. One of the improvement areas of Objective 3, 'Helping people to recover from episodes of ill health or following injury', is 'Improving recovery from injuries and trauma', with the indicator being 'Proportion of people who recover from major trauma.'[16]

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

(j) A map showing the location of the 22 centres is at Appendix 1 (page 17).[18]

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[15] 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

[16] Department of Health, *The Mandate. A Mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015,* November 2012, p.15, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127193/mandate.pdf.pdf

[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

(k) The NHS Clinical Advisory Groups Report, *Regional Networks for Major Trauma*, contains a number of key definitions. These are found in Appendix 2 (pages 19-20).[19]

(m) 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

5. South East London Kent and Medway (SELKaM) Trauma Network

(a) A letter from King's College Hospital NHS Foundation Trust providing information on the South East London Kent and Medway (SELKaM) trauma network is included in this Agenda (pages 21-23). The appendix to this letter provides information on the sites forming the SELKaM trauma network (page 25).

(b) The Kent and Medway element of the South East London, Kent and Medway Major Trauma System went live on 8 April 2013. This information has been submitted to HOSC to provide additional background and context to the discussion of EKHUFT's clinical strategy and no representatives of the Network will be present at the meeting. The report from King's College Hospital NHS Foundation Trust explains that "an analysis of the first six months data will be undertaken by the SELKaM Trauma Network in conjunction with partner organisations to understand the changes in patient flows and the effects on patient outcomes." A copy of this report will be presented to the Kent HOSC.

6. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from East Kent Hospitals NHS University Foundation Trust.

[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

Appendices

Appendix 1: Major Trauma Centres, April 2012. Page 17.

Appendix 2: Trauma Definitions. Pages 19-20.

Reports for this Item

Report from King's College Hospital NHS Foundation Trust. Pages 21-23.

Appendix to above report. Page 25.

Report from East Kent Hospitals NHS University Trust. This is a copy of the paper from East Kent Hospitals NHS University Trust included in the Agenda for the HOSC meeting of 12 October 2012 and provides useful background. Pages 27-34.

Representatives from EKHUFT will deliver a presentation at this meeting.

Background Documents

Agenda, Health Overview and Scrutiny Committee 3 February 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3977&Ver=4

Agenda, Health Overview and Scrutiny Committee 12 October 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3983&Ver=4

Contact Details

Tristan Godfrey
Research Officer for the Health Overview and Scrutiny Committee
tristan.godfrey@kent.gov.uk
Internal: 4196
External: 01622 694196

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Major Trauma Centres

April 2012

Adult and Children's Major Trauma Centres

1. Addenbrooke's Hospital Cambridge
2. Frenchay Hospital Bristol
3. James Cook University Hospital Middlesborough
4. John Radcliffe Hospital Oxford
5. King's College Hospital London
6. Leeds General Infirmary
7. Queen's Medical Centre Nottingham
8. Royal London Hospital
9. Royal Victoria Infirmary Newcastle
10. St Mary's Hospital London
11. St George's Hospital London
12. Southampton General Hospital

Adult Major Trauma Centres

13. Derriford Hospital Plymouth
14. Hull Royal Infirmary
15. Northern General Hospital Sheffield
16. Queen Elizabeth Hospital Birmingham
17. Royal Preston Hospital
18. Royal Sussex County Hospital Brighton
19. University Hospital Coventry
20. University Hospital of North Staffordshire Stoke on Trent

Children's MTCs

21. Alder Hey Children's Hospital Liverpool
22. Birmingham Children's Hospital
23. Royal Manchester Children's Hospital
24. Sheffield Children's Hospital

Collaborative

25. Manchester Collaborative MTC
    a) Salford Royal NHS Trust
    b) Manchester Royal Infirmary
    c) University Hospital South Manchester
26. Liverpool Collaborative MTC
    a) Aintree University Hospital
    b) Walton Centre
    c) Royal Liverpool University Hospital

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1 Case for change

This section lays out the CAGs case for change. It defines the components of a regionalised approach to trauma care, examines the overall need for reform in the NHS context and then examines the rationale for change at each stage of the trauma care pathway.

1.1 Definitions

In this document the definitions used are as follows.

Clinical Advisory Groups (CAGs) – Five clinical advisory groups were established in order to produce this advice, each covering a separate aspect of the care pathway as follows:

- Pre-hospital and inter-hospital transfers
- Acute Care and Surgery
- Ongoing Care & Reconstruction
- Rehabilitation
- Network Organisation (incl. governance)

Major Trauma – NHS Choice defines 'Major Trauma' as multiple, serious injuries that could result in disability or death. These might include serious head injuries, severe gunshot wounds or road traffic accidents. Major Trauma is defined in the scientific literature using the Injury Severity Score (ISS), which assigns a value to injuries in different parts of the body and totals them to give a figure representing the severity of injury. An ISS greater than 15 is defined as Major Trauma. This would include serious injuries such as bleeding in the brain or a fracture of the pelvis and cases of multiple injuries; however, this definition does not include all those who should benefit from the regionalisation of trauma care.

This document refers to severely-injured patients, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from regional networks. Psychosocial consequences of such injuries are common but patients suffering such symptoms in isolation without injury as a result of a "traumatic experience" are not covered.

Inclusive Trauma System – An Inclusive Trauma System (ITS) describes a model in which commissioners; providers, public health representatives and other stakeholders of trauma care in a geographical region collaborate to plan, provide and manage the treatment of people injured as a result of Major Trauma.

The ITS is responsible for all aspects of trauma care, from the point of injury to rehabilitation, as well as for injury prevention. Each ITS comprises of one or more 'Trauma Networks' (see definition below). The ITS also features:

- a population-based approach to the assessment of need and the provision of treatment.
- a role for every hospital and provider of care.
- provision for the speedy transfer of patients between facilities, particularly where the severely injured have been under triaged away from the Trauma Centre.
- a quality assurance structure that penetrates across the region and to each stage of care, which underpins providers' clinical governance processes, identifies inadequate performance in order to support its correction and ultimately can apply sanctions where this does not occur. It also informs commissioners about the quality of care being delivered.

The Royal College of Surgeons advises that the ITS should have in place a plan which sets out the

detail of the 'Trauma Care Pathway' (TCP) for the region.

Trauma Care Pathway – This is the process through which care is provided for patients who have suffered Major Trauma; specifically, it describes the 'the location and capability of each trust/hospital within the ITS and outlines ambulance bypass protocols and thresholds for transferring patients to more specialist units'.

Trauma Network – A Trauma Network (TN) is the name given to the collaboration between the providers commissioned to deliver trauma care services in a geographical area. At its heart is the 'Major Trauma Centre'. A TN should include *all* providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions (Trauma Units), and rehabilitation services. The TN has appropriate links to the social care and the voluntary/community sector. While individual units retain responsibility for their clinical governance, members of the Network collaborate in a Quality Improvement programme.

Major Trauma Centre – A Major Trauma Centre (MTC) is a multi-specialty hospital, on a single site, optimised for the provision of trauma care. It is the focus of the Trauma Network and manages all types of injuries, providing consultant-level care.

- It is optimised for the definitive care of injured patients. In particular it has an active, effective trauma Quality Improvement programme. It also provides a managed transition to rehabilitation and the community.
- It takes responsibility for the care of all patients with Major Trauma in the area covered by the Network. It also supports the Quality Improvement programmes of other hospitals in its Network.
- It provides all the major specialist services relevant to the care of major trauma, i.e. general, emergency medicine, vascular, orthopaedic, plastic, spinal, maxillofacial, cardiothoracic and neurological surgery and interventional radiology, along with appropriate supporting services, such as critical care.

The Royal College of Surgeons cite research advising that such centres should admit a minimum of 250 critically injured patients per year

Trauma Unit – A Trauma Unit (TU) is a hospital in a Trauma Network that provides care for most injured patients and:

- is optimised for the definitive care of injured patients. In particular, it has an active, effective trauma Quality Improvement programme. It also provides a managed transition to rehabilitation and the community.
- has systems in place to rapidly move the most severely injured to hospitals that can manage their injuries.
- may provide some specialist services for patients who do not have multiple injuries (e.g. open tibial fractures). The Trauma Unit then takes responsibility for making these services available to patients in the Network who need them. Other Trauma Units may have only limited facilities, being able to stabilise and transfer serious cases but only to admit and manage less severe injuries.

Local Emergency Hospital (not designated as TU) – The Local Emergency Hospital (LEH) is a hospital in a Trauma Network that does not routinely receive acute trauma patients (excepting minor injuries that may be seen in an MIU). It has processes in place to ensure that should this occur patients are appropriately transferred to an MTC or TU. It may have a role in the rehabilitation of trauma patients and the care of those with minor injuries.

Update on the Kent and Medway Major Trauma Project

1. Summary

- The Kent and Medway element of the South East London, Kent and Medway Major Trauma System went live on 8 April 2013.
- It was agreed with Clinical Commissioning Groups that the Medway Maritime Hospital and the Tunbridge Wells Hospital would be designated as Trauma Units.
- It was also agreed with the Clinical Commissioning Groups that the William Harvey Hospital would be designated as an interim Trauma Unit until the completion of East Kent Hospitals University Foundation Trust's (EKHUFT) clinical strategy review.
- Initial feedback on the go-live has been positive and a six month post go-live report will be presented to the Kent and Medway Clinical Commissioning Groups and the HOSC and HASC.
- The SELKaM Trauma Network is setting up Clinical Reference Groups to continue to drive improvements to the major trauma pathway and inform future commissioning intentions with regards to major trauma.

2. Background

Major trauma may typically occur because of a road accident, a violent incident, or a serious fall. Although the number of major trauma patients is relatively small, less that 0.2% of hospital emergency work, their injuries are often complex and they are seriously at risk of death or disability. For example, somebody who has been in a road traffic accident might have both chest and head injuries. In order to improve chances of survival it is imperative that care is based on the individual needs of each patient and the expertise is available when they need it.

The need to improve care for major trauma patients was highlighted in a National Audit Office report (2010). It stated that there were unacceptable variations in care for this most severely injured group of patients and made recommendations to improve standards. A nationwide programme to form regional trauma networks was set up by the Department of Health following a recommendation from Lord Darzi that Major Trauma Centres would save lives. Networks are based on a hub and spoke model whereby a Major Trauma Centre works in partnership with several Trauma Units and pre-hospital care providers.

3. Kent and Medway aspect of the SELKaM Trauma Network

The South East London, Kent and Medway (SELKaM) Trauma Network is made up of:

- King's College Hospital Major Trauma Centre;
- Six trauma units including the Medway Maritime Hospital and the Tunbridge Wells Hospital;
- An interim trauma unit at the William Harvey Hospital; and
- Two local emergency hospitals at Darent Valley Hospital and the Queen Elizabeth the Queen Mother Hospital.

(See Appendix 1).

The Kent and Medway Trauma Network were unable to continue in its own right as it did not have a Major Trauma Centre. King's College Hospital was identified as the most appropriate Major Trauma Centre for Kent and Medway patients in order to build on pre-existing high standards of care, patient pathways and patient flows. An agreement was reached that as of the 1 April 2012 the South East London Trauma Network and the Kent and Medway Trauma Network would join to establish a new network.

The newly formed SELKaM Trauma Network supported NHS Kent and Medway as it worked with partner organisations and the then emerging Clinical Commissioning Groups (CCGs) in Kent and Medway. The aim was to develop high quality trauma units across Kent and Medway to work in partnership with the Major Trauma Centre.

Designation visits took place at the Medway Maritime Hospital and the Tunbridge Wells Hospital in September 2012. The visiting panels were impressed with the progress against the trauma unit criteria that both hospitals had made, particularly with regards to Trauma Audit and Research Network (TARN) data collection and analysis, education and training, governance, and pathways. The panel therefore recommended to the Clinical Commissioning Groups that both hospitals should be designated as Trauma Units.

Discussions with East Kent University Foundation Trust (EKHUFT) regarding the development of a Trauma Unit in East Kent resulted in an agreement that any final decision on which site/s should be Trauma Unit/s should be taken after the completion of EKHUFT's Clinical Strategy Review. The panel therefore recommended that the William Harvey Hospital be designated as an interim Trauma Unit until the completion of the clinical strategy review.

This was because the William Harvey Hospital was in a position to meet the Trauma Unit criteria.

The Clinical Commissioning Group's majority decision supported the visiting panel's recommendations and the major trauma system successfully went live in Kent and Medway on 8 April 2013. As with all new pathways there have been occasional deviations from the agreed pathway however overall the implementation has gone smoothly and issues are being managed through an agreed governance route.

An analysis of the first six months data will be undertaken by the SELKaM Trauma Network in conjunction with partner organisations to understand the changes in patient flows and the effects on patient outcomes. A copy of the resulting report will be presented to the Kent and Medway Clinical Commissioning Groups and the Kent County Council and Medway Council Health and Scrutiny Committees.

4. Future focus

The SELKaM Trauma Network is committed to improving the end to end major trauma pathway in collaboration with partner and commissioning organisations. Clinical Reference Groups are therefore being set up to identify and resolve issues at specific points on the major trauma pathway. These include:

- Emergency Department CRG
- General surgery and orthopaedics CRG
- Head Injury CRG
- ICU CRG
- Major Transfusion CRG
- Orthoplastics CRG
- Paediatric CRG
- Pelvic CRG
- Pre-hospital care CRG
- Rehabilitation CRG
- Spinal Cord Injury and Vertical Cord Injury CRG

The outcomes from these Clinical Reference Groups will inform commissioning recommendations to the Clinical Commissioning Groups.

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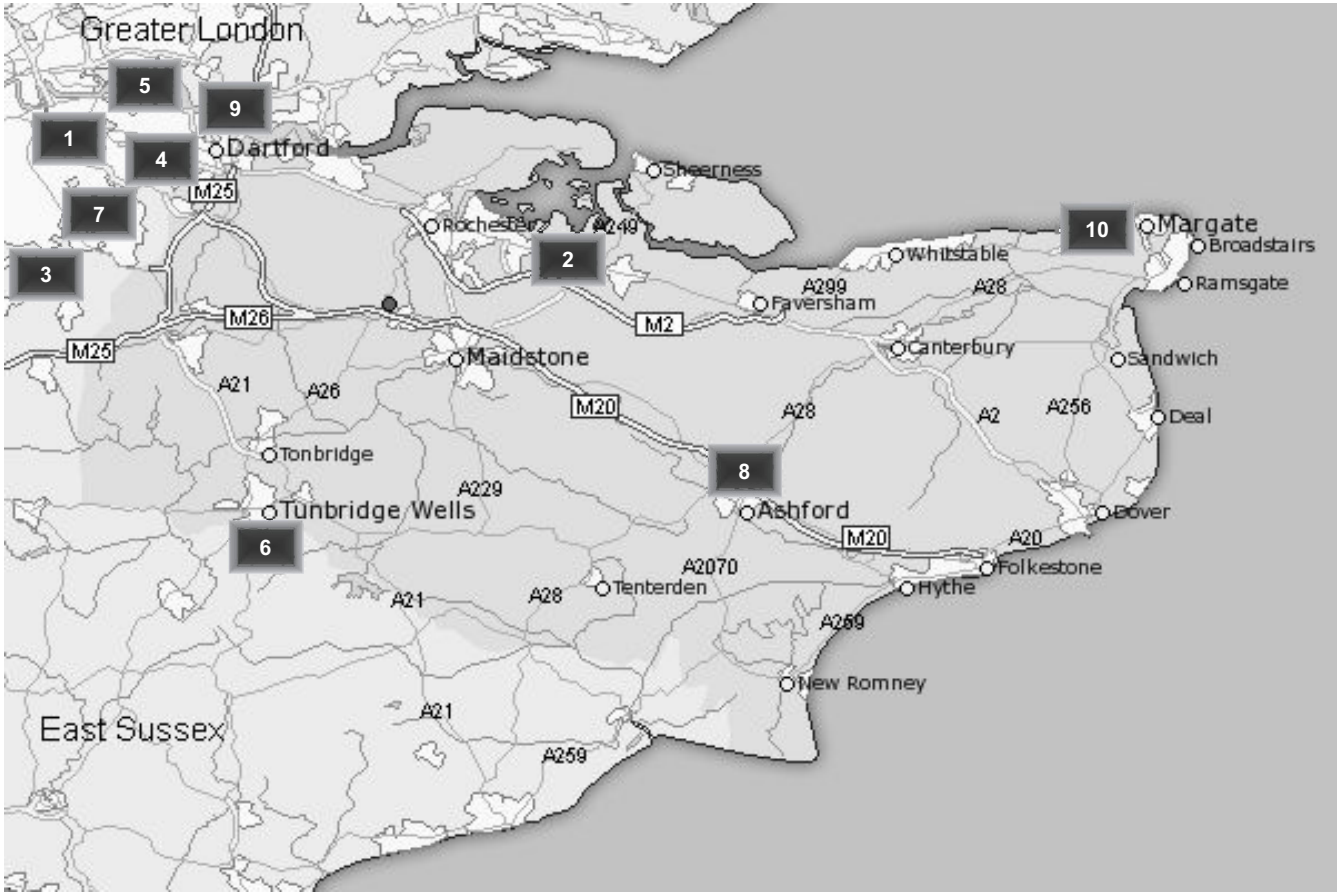
Appendix 1

SELKaM Trauma Network



Major Trauma Centre

1. Kings College Hospital London

Trauma Units

2. Medway Maritime Hospital, Gillingham
3. Princess Royal University Hospital, Bromley
4. Queen Elizabeth Hospital, Woolwich
5. St Thomas' Hospital London
6. Tunbridge Wells Hospital, Pembury
7. University Hospital Lewisham, Lewisham
8. William Harvey Hospital, Ashford

Local Emergency Hospital

9. Darent Valley Hospital, Dartford
10. Queen Elizabeth the Queen Mother, Margate

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East Kent Hospitals University NHS
NHS Foundation Trust

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

CLINICAL STRATEGY: UPDATE

1. Introduction

1.1 East Kent Hospitals University NHS Foundation Trust (EKHUFT) has earned its enviable record for safety and performance by its continued search for improvement and better results for patients. As we strive to achieve the best for people in East Kent and whilst we recognise that our staff work extremely hard to deliver a safe and high quality service, we know that we can do better.

1.2 Although we achieve good outcomes for patients, we need to continue to improve. We recognise that improved treatments require improved facilities and we need to ensure that we make the best use of the resources that we have. The Trust like every NHS Trust in the country is expected to plan services to make them sustainable, drive efficiency and deliver high quality care.

1.3 As part of this improvement process the Trust has been working on developing a clear strategy for its clinical services, since the end of 2010.

1.4 The process began with discussions with our clinicians and other stakeholders, to draw on their knowledge and experience of advancements in treatments, technologies and standards and that has shaped the current thinking around the Trust's Clinical Strategy.

1.5 At this stage we have not taken any decisions or ruled anything in or out and we are seeking to establish the viability of the suggestions that have come forward from our clinicians.

1.6 That being said, we cannot promise that everything will stay the same for ever. Advances in technology and science will lead to change over a period of time.

2. Purpose of paper

2.1. The purpose of this paper is to provide the members of the Health Overview and Scrutiny Committee with an update from the latest thinking relating to the Trust's Clinical Strategy that have resulted from our discussions as we continue to engage with staff and other stakeholders across the health economy.

2.2. It also summarises the activities that have taken place to date as part of the initial communication and engagement phase which was launched at the end of October 2011 and highlights how we plan to engage further with staff and other external stakeholders so that we can further test the validity of the ideas so far.

3. The key policy and service drivers behind the work

3.1 The key policy and service drivers that have led the Trust to undertaking a Clinical Strategy review are the following:

a. Recent publications from both the Association of Surgeons for Great Britain and Ireland (ASGBI) *"Emergency General Surgery: The Future"* and the guidelines from the Royal College of Surgeons (RCS) on *"Standards for Emergency Surgical Care"* outline that outcomes for patients requiring out of hours surgery i.e. at night and at weekends, are relatively poor, as opposed to those treated during "normal" working hours on weekdays.

4. Aim of the review and key principles

4.1 As work has progressed on the Clinical Strategy Review, key themes have emerged around quality of care, patient safety, financial pressures, trends in care provided by primary care (GP surgeries), community services and location of services.

4.2 As part of this review all the services provided by the hospital were examined and taking account of the emerging themes, the Trust agreed some principles. Relating to our vision for services in East Kent these were:

a. The highest priority for the Trust is "emergency care". This means that patients, who are cared for and/or treated in our hospitals as an emergency, receive high quality, safe care every day of the week, around the clock.

b. The Trust also provides a wide range of other clinical services across its five hospitals and it was also agreed that there needed to be a clear strategy for "planned care" and specialist services. The Trust wants to ensure that if a patient needs a referral to hospital for care or treatments, for example (for an operation or for investigations) they would be happy to "choose" one of our hospitals to treat and look after them.

c. The geography of East Kent and the current pattern of service provision also dictate the need to develop improved community services, in line with national best clinical practice. The Trust also wants to increase the types of care and treatments that it can provide for patients as either daycase procedures or in short stay facilities as opposed to inpatient care.

4.3 In agreeing these principles it was recognised that services need to be clinically safe, affordable and provide equity of access for patients and their families. So our current focus is on areas that we know we need to change and improve:

a. Planned Care
b. Outpatient Care
c. Emergency Care (across all specialties)
d. Trauma Care

5. Details of current service provision and performance in the areas being explored

5.1 The following section outlines the current service provision and performance in the areas being looked at. As part of this work the Trust has agreed the following. The Trust will continue to:

a. provide emergency medical services from all three of its acute sites; WHH at Ashford, KCH at Canterbury and the QEQMH at Margate. This will require on site general surgical support;
b. provide acute inpatient care of the elderly services from the WHH, KCH and the QEQMH;
c. provide inpatient acute services for gynaecology and paediatrics from the WHH and the QEQMH;
d. provide acute inpatient fractured hip (neck of femur) and non complex trauma services from the WHH and the QEQMH; and
e. take into account the recommendations from the Royal Colleges, particularly the Royal College of Surgeons.

5.2 So taking note of these agreements the "Case for Change" for specific clinical areas is as follows:

Short Stay Care – Reasons for change

5.3. We recognise that patients spend considerable time within hospital and waiting for care. This time could be better spent if care were provided in other ways; day care; ambulatory care and short stay admissions.

So what might it look like?

5.4. In line with best practice nationally we need to treat 70% of all unexpected admissions as "short stay" or be discharged within one day. This type of care could utilise both hospital and community facilities. To help us achieve this we are exploring new and innovative ways to use technology to deliver medical services and we are looking at different ways of treating over forty clinical pathways.

Outpatients - Why do we need to make changes?

5.5. The Trust recognises that its outpatient department (clinics) are the front window of its clinical services and first impressions which form part of the patients experience are made around choice, quality, patient safety, privacy and dignity. We acknowledge that a number of our outpatient facilities need modernising so that they provide a welcome environment for our patients and relatives and importantly, support the proposed new models of care.

5.6. Currently we provide outpatient services from 22 sites across East Kent. We have acknowledged that the ways in which the clinics are currently organised are not providing the best service to our patients.

5.7. Although there is a large number of geographical areas where we run clinics we know that we still have a fair number of patients travelling more than 20 minutes drive time for their hospital clinic appointment and patients are often required to visit multiple sites for their assessment and treatment and "***we think our patients deserve better".*** We also know that only a few specialities are offered from some of those sites.

So what might it look like?

5.8. We want to provide a wider range of services across six sites and ensure that over 90% of patients can access outpatient services within a 20 minute drive time. We also want to improve diagnostic and treatment facilities that will allow for a "one stop clinic" approach and maximise the use of clinics by providing early evening clinics as well as possible clinics on a Saturday morning which will better meet the needs of our population. To support this work we plan to rebuild the facilities at Dover to provide up-to-date, modern facilities.

5.9. We plan to, over the next few years, improve our other four outpatient facilities. We are already improving our appointment systems. We want to try the new technology available that will allow us to communicate with GPs and patients directly preventing, where appropriate, an appointment for a hospital visit. We want to discuss this more widely with the public to make sure that we get this right and we will, of course, have to discuss this with staff groups who will potentially be asked to work differently. Finally we will have to link this with other planned changes to ensure that there is the best use of professional staff time.

5.10. One outstanding area is the location of the site for the North Kent Coast. Work continues to assess the opportunities for this location.

5.11. The Trust is also looking at opportunities to expand other forms of care, such as radiotherapy and is discussing whether we could extend this in East Kent to the QEQMH site. In addition, our focus is to extend where possible, specialist emergency outpatient services such as ophthalmology to new sites, again such as QEQMH.

Emergency Paediatrics – What do we want to improve?

5.12. We want to prevent children having to wait unnecessarily in an Emergency Department (ED). If they do arrive in an ED, we want to make sure that they are seen in a child-friendly environment with an assessment by child trained nurses and doctors. We need children to be seen rapidly as their conditions can change quickly and we need fast, expert decisions, especially at peak times of the day.

What might it look like?

5.13. By introducing a "GP hotline to a paediatric consultant" we will ensure access to direct clinical settings. We want to introduce this as soon as we can. We also want Paediatric doctors (consultants and middle grades) and nurses to be allocated to the ED, during peak activity hours and alongside this we want to create a dedicated Children's Emergency area as part of the ED.

Emergency Gynaecology - **What do we currently provide?**

5.14. Currently many women regularly attend the ED and then are referred to the Gynaecological team to be seen in the early pregnancy service the next day. There are three early pregnancy clinics on three sites, WHH, QEQMH and KCH. If women attend the ED, they may have to wait a long time because the doctors are responsible for providing cover to the Maternity for (labour ward) and Gynaecological services.

So how might it look like in the future?

5.15. The aim is for women to avoid the ED altogether, except for out-of-hours and if clinically unstable. By providing a combined early pregnancy / emergency gynaecology service during core activity hours at the WHH and the QEQMH seven days a week and by maintaining the early pregnancy service at KCH, we believe that women will have direct access to the care they need. We also have plans to extend the current emergency gynaecology service at the QEQMH and launch the same service at the WHH.

Emergency Medicine - What happens now?

5.16. We all recognise that patients need to see expert doctors and nurses as soon as possible. At the Trust many patients can be referred direct to the Clinical Decisions Unit (CDU) which is managed by the Acute Physicians who are the specialist doctors who are able to effectively manage many patients in emergency medicine.

5.17. Within our Emergency Department we have difficulties recruiting consultants and middle grade doctors and the Emergency Care Intensive Support Team (ECIST) has stated that we need to provide a consultant led service, providing strong leadership for 16 hours each day at both the WHH and the QEQMH sites.

What might it look like in the future?

5.18. Our plan is to develop a model so that we have a consultant led service 7 days a week between 8 am and midnight.

5.19. Additional consultants would need to be recruited to the Trust and rotated between the WHH and the QEQMH.

5.20. Nurse consultants will provide additional support to the clinical teams and further enhancements to the current service would be met by the further extension of the GP service (Integrated Urgent Care Centre) and the maintenance of the Emergency Care Centre Model with Acute Physicians.

5.21. The suggested improvements for Emergency Medicine are supported by the Royal College of Emergency Medicine and it is believed that it will address the recruitment issues.

Surgery – Reasons why we need to change

5.22. The increase in sub-specialisation means we can no longer rely on some surgeons to provide general surgical emergency services. For example, vascular surgeons no longer form part of the general surgical rota and a question has arisen as to how appropriate it is for breast surgeons to continue to work on the general surgical emergency service.

5.23. We also believe that junior doctors should not be unsupervised when making major decisions in emergency pathways. With small teams of general surgeons at two sites, a consultant is not always available in an emergency and this may cause delays for some patients.

5.24. General Surgery emergency services are currently delivered from two acute sites (WHH and the QEQMH).

How might it look in the future?

5.25. Emergency care is the Trust's highest priority and we need to ensure consultants deliver medium and high-risk surgery appropriately and with the best possible outcome. This means having dedicated general surgery teams without conflicting duties.

5.26. The options that have come forward to date that deliver these aspirations are modelled on a ***"Hub and Spoke"*** principle.

5.27. In this instance:

a. ***"HUB****" is a Centre for medium and high risk colorectal and general surgical cases. This means that one team of general surgeons would be available every day and night with consultant led decision making and involvement in all complex cases; .*

b. ***"SPOKE"*** *would mean that Consultants are on site Monday to Friday during normal working hours. Weekends and out-of-hours general surgical advice would be provided by the resident middle grade doctors.*

The suggested location options are shown in table one and are as follows:

Table One

Option 1	*Hub WHH – 1 spoke at QEQM; assumes KCH remains largely unchanged.*
Option 2	*Hub at KCH – 2 spokes; WHH and QEQM*
Option 3	*Hub QEQM & WHH (continue as now but increase workforce to meet improved professional standards and service improvements).*

6. Trauma Services

6.1. Evidence shows that survival rates and recovery for patients suffering major trauma are improved if patients receive immediate treatment and transport to a specialist centre.

6.2. The Kent and Medway Critical Care Trauma Network has indicated that they would wish to develop three trauma units in Kent - at Pembury, Medway and WHH, Ashford. EKHUFT has responded by making it clear that it is not in the best interests of the whole community to redesign part of the emergency services in isolation and is not therefore intending to make any decision regarding trauma until it concludes its overarching Clinical Strategy.

6.3. We need to consider the provision of major trauma in our clinical strategy and it will need to be provided from a site with a trauma team.

7. Stakeholder Engagement Events and Key Findings from Events that have taken place to date

7.1 On the 27 October 2011 EKHUFT launched the initial engagement and communication process for the Trusts Clinical Strategy Review, highlighting the emerging themes and key drivers for change.

7.2 At the launch a series of presentations to the hospital staff across the main hospitals sites was undertaken. This was followed by an afternoon session with the Clinical Commissioning Groups (CCGs) and GPs in East Kent.

7.3 Since January 2012 the Trust has undertaken a series of engagement presentations to help ensure wider engagement amongst key stakeholders. These included:

a. CCG Board meetings and CCG consortia meetings;
b. The East Kent Commissioning Federation – Whole System Delivery Group;
c. HOSC;
d. Local Borough Councils (Thanet and Ashford);
e. Council of Governors;
f. Hospital League of Friends (QEQMH);
g. MPs;
h. Staff Committee and presentations at the Trust's Chief Executive Forum; and at the
i. Patient Group at QEQMH (Urgent Care and Long Term Conditions Division)

7.4 Following the CCG / GP Stakeholder Engagement Event which was held on 25 July 2012, which was attended by GP leaders from Ashford, C4G (Canterbury), Thanet and Swale CCGs, it was clear that they were vital to the process. Both parties agreed and said they were committed to work in partnership to jointly agree any short and long term strategies for a sustainable future.

7.5 There were three key actions that were jointly agreed by all participants:

a. A commitment to establish a Group to reflect on the longer-term needs and to examine and build up what this might look like for the health economy for the sustainable future.

b. A commitment to establish a small group to reflect on the current meeting structures to ensure that they are ***"fit for purpose***" for the long-term. From these groups it is paramount that the objectives and outputs are consistent and also take account of the vision and any future strategies for the long term. Confirmation has now been given that the current meeting structure is "fit for purpose".

c. To meet with the East Kent Commissioning Federation (and Swale CCG) and the local National Commissioning Board (NCB) to identify a new radical approach to engagement, so that a wide array of key stakeholders across Kent are engaged in the process.

8. Plans for further strategy development and engagement

8.1 As an iterative part of the engagement process the Trust is now developing the second phase of its engagement process and will meet again with staff and other key stakeholders to share the latest thinking. It is planned that phase two of the engagement process will continue to take place over the next few months.

8.2 The next steps are to:

a. test our plans with the long term commissioning plans; and to
b. take independent advice from the Royal College of Surgeons on the surgical options and appropriate clinical adjacencies (a visit from the RCS is due in late November).

9. Timeline of the Process

9.1 Timelines will need to be agreed with the CCGs. It is anticipated that in the event of public consultation this can only take place in 2013 after the Trust and the East Kent CCGs have had the opportunity to engage with stakeholders across the health and social care economy.