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

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[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]

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[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

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