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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

23 JUNE 2011

TRAUMA SERVICES FOR KENT AND MEDWAY

Report from: Rose Collinson, Director of Children and Adults

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Summary

Members are asked to consider a completed protocol questionnaire received from NHS West Kent in respect of proposals to develop a trauma unit at Medway Maritime Hospital.

1. Budget and Policy Framework

1.1 Under Chapter 4 – Rules, paragraph 22.2 (c) terms of reference for Health and Adult Social Care Overview and Scrutiny Committee has powers to review and scrutinise matters relating to the health service in the area including NHS Scrutiny.

2. Background

2.1. Attached as an appendix to this report is a completed protocol questionnaire, which sets out details of the identification of Medway Maritime Hospital as a site for a trauma unit for Kent and Medway.

2.2. Trauma units provide an 'enhanced' accident and emergency function enabling severely injured patients to be stabilised locally. Where clinically appropriate patients will receive treatment locally, however, transfer to a major trauma centre will be the more usual route.

2.3. In Medway's case there will be no difference to current arrangements as patients would be automatically taken to their nearest hospital. On this basis the changes do not appear to represent a 'substantial' change.

2.4. For some Kent residents there will be a difference to current arrangements in that a patient may bypass an accident and emergency department to be taken to a trauma unit which is more able to meet their clinical needs prior to transfer for specialist treatment within a major trauma centre.

2.5. Kent County Council's Health Overview and Scrutiny Committee considered a report on these changes on 10 June 2011 and for the reasons set out in the paragraph above, requested that the report is brought back to them at a later stage as they considered the changes to be substantial.

2.6. On the basis that it is unlikely to be considered a 'substantial' change for Medway (see paragraph 2.3 above) it is not proposed to hold a Joint Health Scrutiny Committee between the two councils. An invitation will, however, be extended to any member of Medway Council interested in the debate to attend the next debate on the matter at the Kent Health Overview and Scrutiny Committee (see paragraph 5 below).

3. Risk management

3.1. As this is an update report and there are no risk implications at this stage.

4. Legal and Financial Implications

4.1. In July 2003 the Secretary of State issued a Direction about situations when Health Overview and Scrutiny committees (OSCs) are required to establish a joint committee. In cases where an NHS body consults more than one health OSC (because its proposals affect the residents of each of their areas) those Health OSCs that consider the proposals to be "substantial" are required to form a joint committee.

5. Recommendations

5.1. Members are asked to note the attached report and to consider the invitation to attend the Kent Health Overview and Scrutiny Committee as observers when it next considers the trauma services report (date yet to be agreed).

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Background papers - none

Proposal for the Development of Major Trauma Units for Kent and Medway

1. Purpose of this document

This document provides a overview of the Outline Business Case in support of the development of Major Trauma services across Kent and Medway; specifically the development of local Trauma Units to provide enhanced services for patients following major trauma, and links with pathways for rehabilitation for all patients following treatment for major trauma.

The development of Trauma Networks and process per region is a national requirement set out within the revised NHS National Operating Framework for 2010/11 and 2011/12. Within this framework, each region is expected to have Regional and local Major Trauma Networks, and a strategy for delivery in place during 2010/11 with Trauma Units being operationalised by 2012.

It is proposed that three Trauma Units are developed for Kent and Medway based on a full review of data and assessment of Acute Trusts against nationally validated criteria. The three trauma units proposed, therefore, are:

- Maidstone and Tunbridge Wells NHS Trust (Pembury Hospital Site)
- East Kent Hospitals NHS Foundation Trust (William Harvey Hospital Site)
- Medway NHS Foundation Trust

All three Acute Trust CEO (or their designated representatives) and internal clinical leads support the application to become a Trauma Unit.

Emergency Departments not designated a Trauma Unit will continue to receive and treat trauma patients appropriate to the services currently provided within that facility.

The development of these three Trauma Units is based on the reconfiguration of existing services. It is likely that there will be a national tariff structure, but it is unclear at this stage whether this tariff arrangement will be nationally mandated or serves as a guide for local commissioning discussion. It is, therefore, anticipated that for year 1 of the implementation process activity will be paid under the existing Payment by Results (PbR) arrangements.

2. Executive Summary

In order to identify and define the requirements for treating major trauma cases across Kent and Medway, the Critical Care and Trauma Network agreed a set of key principles for local trauma services which supports the development of a hub and spoke model:

- o Kent and Medway do not require a local Major Trauma Centre due to an insufficient number of trauma incidences per year (estimated at 202). National recommendations are that major trauma centres treat 400-650 cases per year, in order to maintain clinical expertise

- o Trauma Units are required to enable appropriate stabilisation of patients, prior to referral to specialist services, which have been shown to reduce mortality from major trauma by 40% by reducing the time to diagnosis and onward referral.

- o Trauma Units will require support from the clinical lead(s) (or Clinical Director on call) at the Major Trauma Centre(s) ensuring effective and appropriate clinical accountability and transfer of patients.

- o Self assessment of each emergency department across Kent and Medway has been undertaken, combined with geographical considerations and review of data, to inform the location of the Trauma Units.

- o Submission of Trauma Audit and Research Network (TARN) data by all Trusts in Kent and Medway has been agreed to enable accurate data collation and review of services going forward

- o Agreement to a focussed review of current rehabilitation pathways, which is key to enabling the effective and efficient use of specialist resources by the appropriate transfer of patients from tertiary centres to clinically appropriate rehabilitation services. In addition this may help to:

  - reduce the length of stay
  - minimise hospital readmissions
  - reduce the use of NHS resources following the initial period of hospitalisation.

These principles were developed following review and discussion of the key national guidance and requirements relating to and referencing Major Trauma. These principles, supported by self assessment of emergency departments, have been the basis for the proposal to develop three trauma units across Kent and Medway.

3. Background

Major trauma is described as serious and often multiple injuries where there is a strong possibility of death or disability; and is identified as the leading cause of death in people under 40. However, in order to identify and address care for all patients suffering trauma injuries the classifications as described by the injury severity score (ISS) have been used within this paper.

Over recent years there have been a number of national drivers promoting the review and strengthening of arrangements for the treatment of major trauma cases in order to

reduce death and disability. The 2010 review of Major Trauma Care in England undertaken by the National Audit Office (NAO), highlighted that there had been little progress nationally against recommendations from reviews and audits since 1988. Both the recommendations from the NAO report, and the assertion within Lord Darzi's 2008 NHS Next Stage Review that there were 'compelling arguments for saving lives by creating specialised centres for major trauma' have been supported by the Department of Health through its Regional Trauma Networks Programme and the appointment of the first National Clinical Director for Trauma Care to lead the development of clinical policy. In addition, the continuation of these developments has been reiterated within the National Operating Framework for 2011/12.

The Department of Health's overall national imperative for trauma care is for the development of care models and pathways based on:

- patients' needs;
- local expertise and facilities, and
- geography and transport options,

with ongoing monitoring of performance against professional standards. The Kent and Medway Critical Care and Trauma Network have used these criteria to support decision making for the review of local services.

4. Local context:

Within Kent and Medway, there are four NHS Hospital Trusts, consisting of eight acute hospitals, with seven type 1 Emergency Departments.

Pre-hospital triage is currently undertaken by the Ambulance Trust supported by HEMS where an air ambulance is deemed necessary. Following triage, patients may be transferred directly to a major trauma centre or to a local emergency department dependent on clinical need.

Patients are transferred from the scene of an incident to a local emergency department for stabilisation and assessment; following which a decision is made regarding the location of further treatment. This may be undertaken locally, regionally or within a tertiary (major trauma) centre, and appropriate arrangements for transfer are made.

Patients requiring specialist major trauma intervention may be treated at a number of Major Trauma Centres, including:

- Kings College Hospital NHS Foundation Trust
- Queens Hospital, within Barking, Havering and Redbridge University Hospitals NHS Trust
- The Royal London Hospital, within Barts and The London NHS Trust

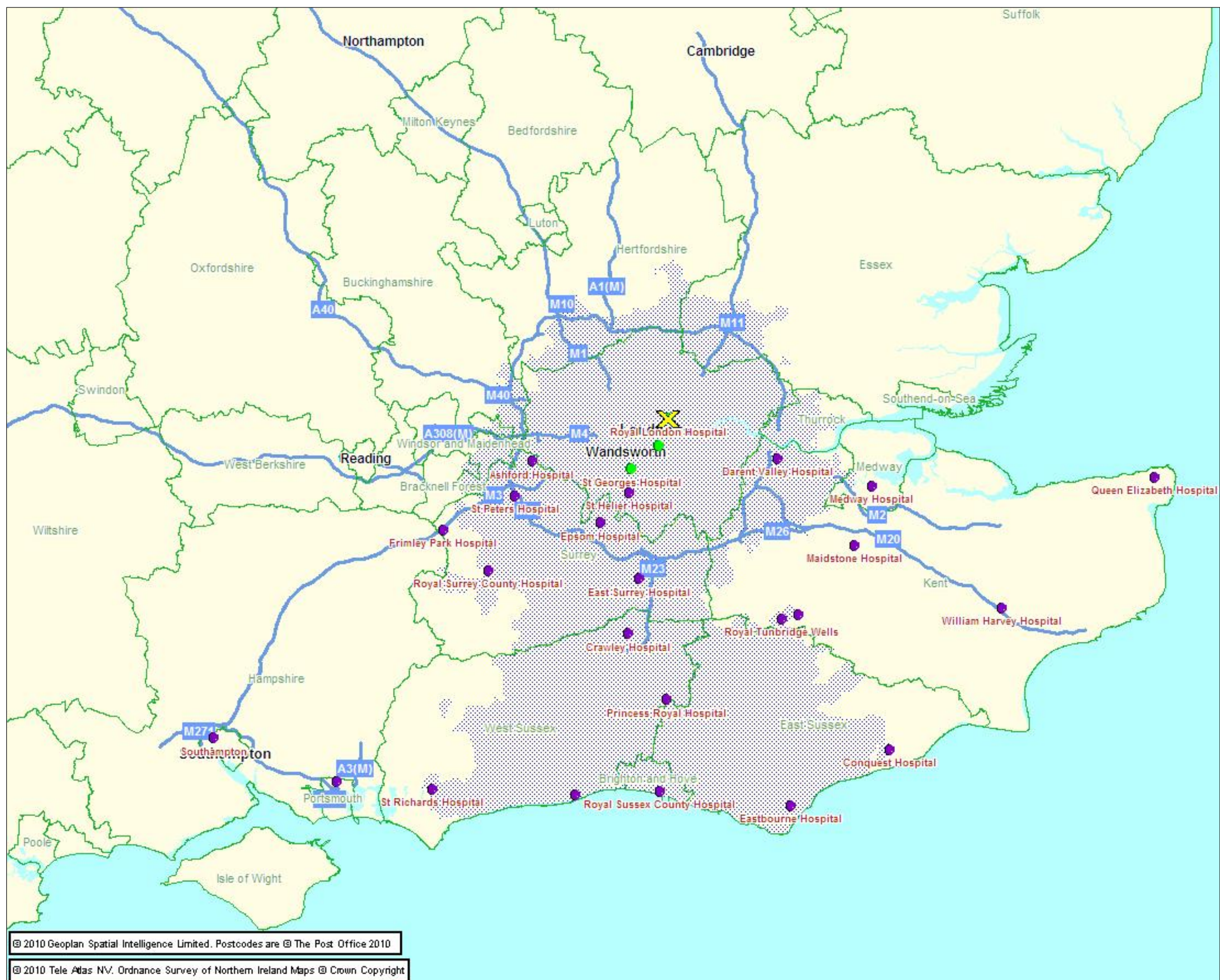
The process for transfer from specialist trauma services into rehabilitative services is currently based on local protocols.

Key issues for consideration within Kent and Medway:

- The NHS Clinical Advisory Groups Report into Regional Networks for Major Trauma (September 2010) reiterated the imperative for patients involved in major trauma to be transferred to a Major Trauma Centre within 45 minutes. However, the Clinical Advisory Group also acknowledges that for many areas transfer within this 45 minute isochrone is not possible, and local trauma units will therefore be required to provide stabilisation prior to onward transfer to a Major Trauma Centre. Due to the geography of Kent and Medway, the majority of emergency departments fall outside the 45 minute isochrones for Major Trauma Centres (see Figure 1).

<u>Figure 1: Major Trauma Centres (London and Brighton)</u> – Area of Kent and Medway Not Covered by Major Trauma Facilities*

(* Shaded area represents approximate 45-minute road travel times by Ambulance to/from King's College Hospital, London and Royal Sussex County Hospital, Brighton)



The proposed trauma unit locations were based on the ability for all areas of Kent and Medway to be within 45 minutes of either a Major Trauma Centre (as is the case for the Dartford and Gravesham areas proximity to King's College Hospital) or a

trauma unit. Figure 2 demonstrates the coverage of services within 45 minutes for Kent and Medway following implementation of the proposed Trauma Unit sites:

Figure 2: Major Trauma – 45-Minute Ambulance Road-Travel Isochrone around SEC Major Trauma Centres and Kent and Medway (potential) Trauma Units*
(* Shaded area represents approximate 45-minute road travel times by Ambulance to/from KCH, London; RSCH, Brighton; WHH, Ashford; MMH, Gillingham; Pembury, Tunbridge Wells)

- Whilst there is a high potential for major incidents within the Kent and Medway area – due to the high volume of international traffic using the multiple motorways within the region, air corridors and the channel tunnel – this is not borne out by data modelling
- Multiple transfers increase morbidity rates and therefore clear pathways for the transfer of patients from incident to suitable locations for diagnosis and treatment are vital

5. Trauma Units

Nationally a Trauma Unit is defined as a unit that 'provides care for most injured patients' (NHS Clinical Advisory Group recommendations to the Department of Health) 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.'

Due to the geographical constraints within Kent and Medway and the proximity of the nearest Major Trauma Centre, as described above, the Critical Care and Trauma Network have deemed it necessary to develop local trauma units. This is to ensure adequate and appropriate services locally which meet the needs of seriously injured patients, both in terms of treatment for some patients where the required clinical expertise is available locally and for stabilisation of patients prior to transfer to a Major Trauma Centre for specialist treatment.

Emergency Departments not designated a Trauma Unit locally will continue to receive and treat trauma patients appropriate to the services currently provided within that facility. Network wide protocols will define the clinical criteria for each unit, and be developed to support full implementation of trauma services across Kent and Medway.

6. Proposal for Kent and Medway Trauma Units

The Critical Care and Trauma Network have proposed the development of three Trauma Units across Kent and Medway, as fully described within the Outline Business Case. This decision was based on:

1. review of trauma incident data and Trust data available

2. review of the geographical constraints within Kent and Medway, and the ability for patients to be transferred from the scene of an incident to trauma services within the recommended 45 minute time window. For the majority of patients within Kent and Medway it is not possible for patients to be transferred to a London Major Trauma Centre within this time frame. Trauma Units, providing services to stabilise and, where possible, treat patients prior to transfer to specialist services are therefore deemed necessary.

3. review of Trusts self assessment against Trauma Unit Designation Criteria.

The Network has therefore identified the following hospitals for development as trauma units:

- Maidstone and Tunbridge Wells NHS Trust (Pembury Hospital Site)
- East Kent Hospitals NHS Foundation Trust (William Harvey Hospital Site)
- Medway NHS Foundation Trust

Dartford and Gravesham NHS Trust was deemed not to require a trauma unit due to its proximity to Kings College Hospital, and the ability of patients to be transferred to the Major Trauma Centre within the recommended 45 minute timeframe. This proposal is fully supported by clinical leads and Acute Trusts.

As patients meeting specific pre-hospital triage criteria will continue to be directly transferred to a major trauma centre, it is proposed that major trauma centre services will continue to be commissioned from a range of providers. This will include both London providers (as outlined above), and with the Major Trauma Centre in Brighton when this service 'goes live' in 2014. This will enable the needs of the Kent and Medway population to be met both in terms of geographical location, and therefore time to transfer for specialist services, and specialist services available at each provider. This will require the development of clearly defined service level agreements, service specifications and clinical processes for the transfer (to and from specialist services) and rehabilitation.

7. Benefits

The key benefits to the development of local Trauma Units are:

- Local health economy:
    - Reduction in death and disability for patients suffering major trauma due to the reduction in time to diagnosis and treatment or transfer to specialist services.
    - Ensuring clinical quality for trauma patients
    - Enables care to be provided local to the patients where this is clinically

appropriate

    - Efficient and effective use of NHS resources, both in terms of use of Major Trauma Centre specialist services and local services.
- Trusts:
    - Designation results in a higher profile
    - Training and education opportunities
    - Deanery recognition for training
    - Tariff attached for major trauma patients
    - Benefits for all Trusts with the transfer of patients to local services for rehabilitation when specialist services are no longer required

8. Payment Structure for Multiple Trauma

The development of Trauma Units will be based on the reconfiguration of existing local services.

A revised payment structure for multiple trauma patients, which uses two scores based on diagnosis and treatment, has been released by the Department of Health for 2011/12. However, it is unclear whether this will be mandated and therefore on which local tariffs will be based.

Trusts will need to consider that there are no additional monies available for the development of Trauma Units. Costs attributable to becoming a Trauma Unit will only be apparent following a detailed review against the Trauma Unit Designation criteria and these will therefore differ by the requirements at each site.

However, based on the experience within the London Trauma System, the main changes required to meet these criteria relate to governance arrangements, staffing rotas, and development and implementation of protocols. This work will be supported by the Network.

Working to agreed Trauma Network protocols, designated Trauma Units are likely to see an increase in activity owing to treating/stabilising a number of trauma cases that would otherwise have been treated initially at another DGH. It is not anticipated that these numbers will be high particularly for the first year of implementation, as there is not expected to be an increase in the case load, which is currently being managed within existing services. However, this will be monitored through TARN and reviewed by the Network. Payment for patients will be made under the PbR mechanism route.

For Trusts not identified as a Trauma Unit, there is a potential for patients to bypass the emergency department. Based on national data, estimates of local Acute Trust attendances of all significant trauma cases have been reviewed. This review has identified that, potentially, up to approximately 80 trauma cases per annum of ISS 9 or above (major trauma cases are considered to be ISS 15 or above) currently treated at Darent Valley Hospital could, under Trauma Network protocols, be treated at a Major Trauma Centre either directly or via a Trauma Unit. However, this data is based an approximation and, on review by clinical leads, is considered to be an over estimate.

Evidence from the London Trauma System suggests that concerns on the part of those hospitals that do not become Trauma Units (i.e. in respect of the potential financial impact of losing major trauma cases) is largely unfounded, as major trauma cases represent a very small proportion of their caseload. It is estimated that c.90% of emergency departments see less than one major trauma case (ISS 15 or above) per week and c.75% have less than one per fortnight. Any financial losses associated with this reduction can be recouped via participation in rehabilitation pathways, and ensuring that patients occupying Major Trauma Centre critical care beds unnecessarily can be appropriately repatriated within local services.

9. Major Trauma Networks

The NHS Clinical Advisory Group recommended that Major Trauma Networks, consisting of all providers of trauma care, should be in place within each region, centred around a Major Trauma Centre. In order to implement this recommendation, the Kent and Medway Critical Care and Trauma Network have agreed to further develop links with South East Coast Trauma Network with a view to becoming part of this Network.

Further work on this arrangement is required including:

1. commitment from the Major Trauma Centre and local Trusts regarding the appropriate and swift transfer of patients to the most appropriate service
2. arrangements for the provision of 24/7 advice and guidance on the management of local major trauma patients by a Major Trauma Consultant
3. review and development of operational policies from South East London Network for implementation across Kent and Medway

In order to address local issues, it is expected that the current Kent and Medway Critical Care and Trauma Network Board will continue as a subgroup of the South East London Network. In addition, a forum for commissioning discussion and decision making will be identified – dependent on the confirmation of national commissioning arrangements for major trauma.

10. Rehabilitation

It is acknowledged that not only is rehabilitation essential to ‘address the physical and psychosocial needs’ of patients following major trauma, there are generally limited facilities for providing this service (NHS Clinical Advisory Group 2010). Patients who do not receive rehabilitation are unlikely to return to their maximum levels of function; with implications for individuals, carers and society as a whole.

In order to enable provision of appropriate rehabilitation for individuals, and efficient use of specialist resources, arrangements for the transfer of patients from tertiary trauma centres to local, or specialist, rehabilitation services will be reviewed. This work will be undertaken as part of the closer links with South East London Trauma Network, and by the Kent and Medway Critical Care and Trauma Network.

11. Conclusion

The development of local Trauma Units within Kent and Medway is required in order to ensure:

- That death and disability is reduced for Kent and Medway patients suffering major trauma
- Swift diagnosis, treatment and transfer of patients to specialist centres is enabled, as clinically required
- High quality clinical care is provided
- Effective and efficient use of NHS resources

The Kent and Medway Critical Care and Trauma Network has reviewed the options in relation to the development of such units and deemed that, at this stage, three hospitals be developed as Trauma Units. The location of these units were based on the ability of patients to be transferred to a Major Trauma Centre within the 45 minute target time, review of incident data and Trust self assessment against Trauma Unit designation criteria.

In addition to the development of Trauma Units, the Network will continue to actively link with Major Trauma Centres to ensure that protocols, policies and procedures to facilitate the diagnosis, treatment, transfer and rehabilitation of major trauma patients are implemented across Kent and Medway.

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12. References / Guidance Documents:

- Major Trauma Care in England; National Audit Office, February 2010.
- Revision to the Operating Framework for 2010/11; published 21st June 2010
- NHS Operating Framework 2011/12; published December 2010.
- The Operating Framework for the NHS in England 2010/11 (DH, 2009)
- The Operating Framework for the NHS in England 2011/12 (DH, 2010)
- Healthier People, Excellent Care (South East Coast SHA, 2008)
- Regional Networks for Major Trauma (NHS Clinical Advisory Groups Report, September 2010)
- Major Trauma Care in England (National Audit Office, February 2010)
- Implementing trauma Systems: Key Issues for the NHS. (Ambulance Service Network and the NSH Confederation. August 2010)
- Modeling Trauma Workload – A Project for the Department of Health from the Trauma Audit and Research Network (TARN) – South East Coast Trauma Activity.
- London Trauma Office – Designation Criteria for Trauma Units v 3.4. (June 2010.)
- Regional trauma systems, interim guidance for commissioners. (The Intercollegiate Group on Trauma Standards. December 2009.)

Substantial development or variation of health services in Medway – protocol for NHS bodies to work with Overview and Scrutiny Committees

1. Introduction

This protocol establishes a framework for consultation by NHS bodies with Medway Council's Overview and Scrutiny Committees (OSCs) on proposals under consideration for any substantial development of the health service in or affecting the community in Medway or any proposal to make any substantial variation in the provision of such services. The protocol has been discussed with the Strategic Health Authority, NHS Medway (the PCT), Medway NHS Foundation Trust, Kent and Medway NHS and Social Care Partnership Trust, the South East Coast Ambulance Trust and the Local Involvement Network (LINK).

2. Duties placed upon NHS bodies to consult

Each local NHS body has a duty to consult the relevant OSCs set up by Medway Council on any proposal it may have under consideration for any substantial development of the health service in or affecting Medway or on any proposal to make any substantial variation in the provision of such services. This is additional to any discussions that NHS bodies will have with the Council, as distinct from the OSCs about service developments, especially where they link to services provided or commissioned by the Council. The duty to consult relevant OSC Committees is also additional to the duty placed upon NHS bodies to consult and involve patients and the public.

The NHS body will discuss any proposals for service change with the relevant OSC committee at an early stage as part of the Committee's work programming process in order to agree whether or not the proposal is substantial and at this point there will be discussion about how consultation with the OSC will be undertaken. The local NHS body will make it clear when the consultation period will end and will allow sufficient time for the OSC to consider the matter and reach a view. Government guidance on consultations states that full consultation should last for a minimum of 12 weeks although it is recognised that in some circumstances the consultation period may have to be shorter.

In Medway, responsibility for the overview and scrutiny of health and social care services for adults rests with the Health and Adult Social Care OSC. Responsibility for overview and scrutiny of health and social care services for children rests with the Children and Adults Overview and Scrutiny Committee. The Health and Adult Social Care OSC has principal responsibility for matters bridging services for children and adults.

3. Identifying who is the consulting body

Where an NHS Trust plans to vary or develop services locally it will discuss the proposal with the relevant Medway OSC to determine whether the proposal is substantial. If the outcome of the discussion is that the proposal is a substantial development or variation the Trust must consult the OSC.

Where a NHS Foundation Trust intends to vary its authorisation and the variation would result in a substantial variation of goods and services provided by the Trust to NHS patients and commissioned locally by PCTs, it must consult relevant OSCs. If an OSC considers it should refer the issue referral would be to MONITOR (the independent regulator of Foundation Trusts) and not to the Secretary of State.

NHS Medway (the PCT in Medway) is responsible for consulting on the planning and commissioning of services for the local population. However another "lead" PCT may be responsible for consultation on any substantial variation or development where a number of PCTs commission services from an acute or other type of NHS Trust.

Guidance from the Centre for Public Scrutiny (CfPS) suggests that PCTs should have mechanisms in place to ensure that joint consultation takes place where there is no lead commissioning PCT, or if a proposal relates to services across more than one PCT. The relevant OSCs in Medway will rely on NHS Medway to ensure that this happens. This could involve coordination of the consultation by a Strategic Health Authority.

It is important for the OSCs to have a clear understanding of which body will be responsible for considering the responses to consultation and taking the final decision on a substantial service development or variation.

4. Gathering Information about potential proposals for "substantial" change

NHS bodies will be requested to make information about planned reconfiguration activity available to the relevant OSCs at their meetings clearly identifying service developments and variations on which OSCs will be consulted either formally (because they are "substantial") or informally. This will enable each Committee to create capacity within work programmes to respond to forthcoming consultation and to respond to issues that arise during the year.

5. Defining a "substantial" variation or development

A "substantial variation or development" of health services is not defined in regulations. ***Department of Health guidance and good practice indicate that in deciding whether a proposal is substantial, the following issues should be considered:***

- ***Changes in accessibility of the service. For example, both reductions and increases on a particular site or changes in opening times for a particular clinic. There should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location.***

- ***Impact of the service on the wider community and other services, including economic impact, transport and regeneration.***

- ***Number of patients/service users affected. Changes may affect the whole population (such as changes to accident and emergency) or a small***

group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial.

- ***Methods of service delivery eg moving a particular service into a community setting from an acute hospital setting.***

National guidance encourages OSCs and NHS bodies to agree a method of evaluating the need for formal consultation. In line with guidance issued by the Department of Health, CfPS and the Independent Reconfiguration Panel (IRP). Medway OSCs will expect the relevant NHS Trust to ***notify the relevant OSC of every proposed service development or variation and to take into account the guidance set out above and the questions set out in Appendix 1 when evaluating whether or not a proposed service development or variation should be defined as "substantial" and thereby subject to formal consultation with the relevant OSC. Appendix 1 provides a clear indication of where it is likely that the relevant OSC would challenge a decision not to define a change as "substantial". The template at Appendix 2 will be used by the NHS bodies to ensure that relevant information is consistently supplied to the OSCs.***

6. Changes that result from national policies for service modernisation

When significant changes are proposed about how NHS organisations are structured, they do not automatically constitute substantial variations or developments. Changes that either alter the delivery of management or administrative functions of NHS bodies, or the number of NHS bodies, are not substantial variations or developments as outlined in the exemptions within the relevant Regulations. OSCs will be consulted along with other stakeholders in these circumstances and the power of referral to the Secretary of State is not available.

However where proposals involve specific changes to service delivery, which impact upon patients, carers and the public in Medway, NHS Trusts will be expected to enter into discussions to identify whether the issue is substantial and to consult OSCs as set out in this protocol.

Likewise, the establishment and development of an Independent Treatment Centre (ITC) is not initially a substantial variation or development as it is the establishment of a new service provider. However if the commissioning PCT proposes changes to services received by patients as a consequence of the establishment of an ITC it should discuss the proposals with the OSC to agree whether or not these proposals are substantial.

7. Handling disagreements about what is “substantial”

If the relevant NHS body and the OSC cannot agree whether an issue is "substantial” the NHS body will provide the OSC with information and reasons why they consider the issue is not substantial and the OSC may seek views from other NHS bodies **such as the SHA**. If it proves impossible to reach an agreement, the

OSC and NHS body may ask the Independent Reconfiguration Panel for informal advice on whether the issue should be regarded as substantial.

If agreement still cannot be reached and the OSC believes the issue is substantial it may refer the matter to the Secretary of State on the basis of inadequate consultation. At this point it would be for the Secretary of State, and then potentially the Courts, to determine whether it is substantial.

8. Scrutiny of specialised services

The commissioners of NHS services that are highly specialist and provided across a large geographical area are required to consult all OSCs that consider any proposed variations or developments to be substantial. The Medway OSCs will rely on NHS Medway to alert them to any proposed change to specialised services where the proposed change affects Medway residents. NHS Medway will identify the body responsible for consultation with OSCs across the area affected. This may be a commissioning group established through a number of PCTs, a specific Trust or a national commissioning group.

When Medway OSCs are consulted directly by a NHS body outside Medway about changes to specialised services, or invited to be part of a joint OSC involving several other local authorities, the relevant Overview and Scrutiny Coordinator will seek a view from NHS Medway and the Medway LINK so that PCT and LINK advice about potential local impact is taken into consideration by the relevant Medway OSC in its response or in its contribution to the work of a joint committee.

9. Joint Overview and Scrutiny Committees

Where there are proposals for substantial variation or developments to services affecting more than one OSC area the consulting NHS body has a duty to consult all the OSCs affected. In these circumstances the law requires the affected local authorities to establish a joint committee for the purpose of responding to the consultation. In some circumstances affected OSCs may delegate the power to respond to one OSC.

In line with CfPS guidance the NHS body leading the consultation should provide sufficient information about the proposal, the evidence used to require the action proposed, and the anticipated impact of the variation or development upon existing and future patients and carers to each of the affected OSCs at an early stage.
It is important for sufficient time to be allowed for OSCs to decide whether the proposal would be substantial for the people within its local authority area or not.

10. Variations in services provided by NHS Foundation Trusts

The rules governing consultation by NHS Foundation Trusts with OSCs are different to those covering other NHS bodies. NHS Foundation Trusts must consult the relevant OSC if they propose to apply to MONITOR to substantially vary the provision of protected goods or services in Medway. Protected goods or services are those goods and services provided to NHS patients and commissioned locally by PCTs.

Medway's OSCs will have regard to CfPS guidance which says an application by a Foundation Trust could be considered "substantial" where the application asks to provide additional or reduced services compared to the current services provided. If the OSC is not satisfied with the level or timing of consultation or where it considers that the proposed application would not be in the interests of health services in Medway it may report to MONITOR in writing. There is no power of referral to the Secretary of State in relation to NHS Foundation Trusts.

11. Changes in independent healthcare provision

The powers and duties associated with health overview and scrutiny apply to all services provided by or for the NHS and include independent providers in primary care eg GPs, dentists, pharmacists. For NHS commissioned services and independent sector providers who are contracted to provide NHS services the commissioning body is responsible for any consultation with OSCs. The OSC may invite a representative from the provider to supply information and attend meetings but cannot require attendance as these organisations are not subject to the requirements placed upon NHS bodies in relation to health scrutiny.

12. Identifying and using expert witnesses

In line with CfPS guidance Medway OSCs may call witnesses who can provide a specialist , objective or independent view of the issues when gathering evidence for their response to NHS proposals. Consideration will be given to drawing on advice and evidence from a range of organisations including service user groups, the LINK, professional organisations, academic institutions and the NHS.

13. Responding to consultations and preparing a response

Where time permits the relevant OSC will respond to the consulting NHS body by the given deadline with its comments and views in writing and will explain the process it has followed, the evidence it has considered and identify any witnesses that have contributed. The written response will summarise any areas of disagreement between the OSC and NHS body and include recommendations and suggestions for reaching a concensus.

The OSC may request a report on the outcome of all the consultation undertaken by the NHS body on the proposed service variation or development in order to take a view on how the consulting body has responded to the views it has received to ensure that the final decision is in the interests of local people.

14. Receiving the NHS response

At the end of the consultation an OSC may conclude that the consultation has not been adequate or that the proposal is not in the interests of the local health service in Medway. If local resolution cannot be reached the OSC may refer the issue to the Secretary of State or in the case of a Foundation Trust to MONITOR where they are not satisfied:

- with the content of consultation or the time allowed

- that the reasons given for not carrying out adequate consultation are reasonable

- that the changes are in the interests of the health service in Medway.

Referral will be a last resort after every effort has been made to reach agreement locally, **noting that the Strategic Health Authority has expressed its willingness to contribute to any discussion to resolve a local dispute about the scale of change or its impact**. The relevant OSC will notify the NHS body if it is minded to make a referral and provide a copy of the referral.

Signed on behalf of:

Organisation	Name and Designation	Signature	Date
Medway Council	Julie Keith, Head of Democratic Services		
NHS South East Coast			
NHS Medway			
Medway NHS Foundation Trust			
South East Coast Ambulance Trust			
Kent and Medway NHS and Social Care Partnership Trust			

Appendix 1

Definition of a health service development or variation as "substantial" and therefore subject to consultation with relevant Overview and Scrutiny Committee (OSC) - Checklist for NHS bodies and OSCs

It is a matter for the lead NHS body to decide if a proposed service variation or reconfiguration is “substantial” and therefore subject to formal consultation with the relevant Overview and Scrutiny Committee (OSC). OSCs will wish to understand why a change is being proposed and what the intended and likely outcomes will be for patients and the public in Medway.

Key questions for NHS bodies	Circumstances in which the relevant OSC may challenge a decision not to designate a change as “substantial” and not to formally consult
1.What is the reason for the proposed service development or variation?	• Failure to brief the OSC on the proposed change and the range of options considered • Perception of change being driven by financial considerations over and above benefits to patients
2. How extensive, inclusive and adequate is the consultation process?	• Lack of evidence of adequate consultation with patients and the public in planning and developing the proposals for change • Lack of evidence of adequate consultation with other key stakeholders (such as voluntary sector and social services) • Lack of evidence of account being taken of patient, public and stakeholder views in the development of the proposed change • Strong opposition to change as consequence of patient and public consultation
3. How will access to services be affected?	• Lack of evidence of assessment of impact of change on Medway patients, their carers and the public • Lack of evidence that local health needs assessments or health equity audits have been taken into account • Particular communities will experience greater adverse effects of change than others and in particular vulnerable people (now and in the future) • Absence of transitional arrangements to ensure no loss of access during period of change
4. What demographic assumptions have been made in formulating the proposals?	• No evidence that demographic projections have been taken into account • Failure to address future patient flows and/or catchment areas for services • Disagreement about assumptions made on catchment areas for new national or regional centres of excellence and future patient flows particularly for specific groups of patients eg children, people with particular conditions

Key questions for NHS bodies	Circumstances in which the relevant OSC may challenge a decision not to designate a change as "substantial" and not to formally consult
5. What provisions are being made for the effects on patient flow of initiatives around choice and commissioning?	• Insufficient indication of whether the proposed change will generate a significant decrease or increase in demand for a service arising from patient choice, payment by results and practice based commissioning • Absence of contingency plans for financial "cushioning" if any additional capacity in the proposals is not taken up
6. What is the clinical evidence on which proposals are based?	• Insufficient information to satisfy OSC that the proposal will lead to just as good or preferably improved outcomes and experiences for Medway patients supported by robust clinical evidence • Absence of *local* evidence that the proposals will lead to good clinical outcomes for patients/evidence of disagreement between clinicians • Likelihood that particular groups will be less well off even where the majority will have better outcomes • Lack of evidence about how the proposal will contribute to achievement of national and NHS priorities/targets in Medway
7. How will the proposed reconfiguration contribute to joint working?	• Failure to consider how patient pathways across health and social care will improve to provide a more "seamless service" as a consequence of the change.
8. How will the proposal help the NHS achieve its health improvement goals and reduce inequalities?	• Lack of information about how the proposed change will contribute to NHS Medway's achievement of targets relating to health improvement and reduction in health inequalities • The proposal has the capacity to increase inequalities for any groups of the population
9. **What infrastructure will be available to support redesigned or reconfigured services?**	• Failure to consider transport and infrastructure issues in the context of sustainable transport policies, public transport routes and frequency of transport services

Appendix 2

MEDWAY COUNCIL
Gun Wharf
Dock Road
Chatham ME4 4TR

Health Overview and Scrutiny

Health Service development or variation - assessment form

In order that the relevant Health Overview and Scrutiny Committee can assess whether it agrees that a proposed service change or development is "substantial" please provide the following details.

A brief outline of the proposal with reasons for the change and timescales

The proposal in relation to the development of Trauma Units within Kent and Medway will enable patients with severe injury (major trauma) to be assessed and stabilised prior to receiving treatment within the Trauma Unit, if clinically appropriate, or transfer to a Major Trauma Centre for specialist treatment.

The proposed sites for Trauma Units within Kent and Medway were reviewed following self nomination by Trusts and the final shortlist has been determined by:

- The overall caseload of major trauma cases across the region
- The proximity to a major trauma centre, and therefore the timescales for transfer for specialist treatment – for the majority of Kent and Medway patients this is Kings College Hospital.
- Assessment of a hospitals ability to meet the designation criteria for a Trauma Unit

Medway FT has been identified as a site for a Trauma Unit.

The development of such Trauma Units is in response to (1) a number of reviews of Trauma Care within the UK, which determined that significant improvements are required; and (2) national requirement and commitment within the NHS National Operating Framework for 2010/11 and 2011/12 for the development of Major Trauma Networks by 31st December 2011.

Extent of consultation

(a) Have patients and the public been involved in planning and developing the proposal?
(b) List the groups and stakeholders that have been consulted
(c) Has there been engagement with the Medway LINK?
(d) What has been the outcome of the consultation?
(e) Weight given to patient, public and stakeholder views

Consultation on the proposal has to date been limited to stakeholders within

the Kent and Medway Critical Care and Trauma Network, Trust and PCT Boards, and South East Coast SHA.

Further consultation with patients and the public will be undertaken via LINKs, Health Networks and other patient groups going forward.

Effect on access to services

(a) The number of patients likely to be affected
(b) Will a service be withdrawn from any patients?
(c) Will new services be available to patients?
(d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

(a) The number of patients experiencing major trauma across Kent and Medway is low (in February 2010, the National Audit Office cited this to be 0.2% of the total activity of emergency departments for hospitals across England). Full data analysis is planned, which will be supported by local NHS Trusts data submissions to the Trauma Audit and Research Network (TARN) which all Trusts have committed to contribute to. Data analysis is currently limited due to difficulties in identifying patients with major trauma within the current datasets – therefore submission to TARN is vital to support ongoing review and development of local services.

(b) no services will be withdrawn from any patient – this proposal is concerned with the appropriate transfer of patients to locations which are clinically able to provide the best care to meet their needs.

(c) Trauma Units will provide an 'enhanced' accident and emergency function enabling severely injured patients to be stabilised locally. Where clinically appropriate patients will receive treatment locally, however, transfer to a major trauma centre will be the more usual route. The only difference to current arrangements is that a patient may bypass an accident and emergency department to be taken to a Trauma Unit who is more able to meet their clinical needs prior to transfer for specialist treatment within a major trauma centre. NB patients will not be transferred away from a major trauma centre i.e. a patient injured in Gravesend will be transferred directly to Kings College Hospital as the major trauma centre and not to Medway FT prior to onward referral – unless clinically this is more appropriate to enable stabilisation of a patient before transfer therefore improving survival / recovery.

(d) Patients eligible for transfer to a Trauma Unit will be identified based on clinical need by the attending clinician (usually air or road ambulance service) based on protocols to be developed in conjunction with the Major Trauma

Centre. Patients will not self refer to a 'Trauma Unit'. Patients requiring attendance at A&E departments locally will be able to attend departments as per current services via self referral, air ambulance, road ambulance, GP referral and other existing routes of referral.

Demographic assumptions

(a) What demographic projections have been taken into account in formulating the proposals?
(b) What are the implications for future patient flows and catchment areas for the service?

(a) Incidence of major trauma cases is not expected to increase with the implementation of Trauma Units across Kent and Medway – some hospitals may see a small change in the numbers of such patients but this is likely to remain static within the overall Kent and Medway health economy. Once TARN data for local Trusts becomes available this data will be reviewed to more accurately determine the impact of local increases in population – however, this will be in conjunction with the review of increases in the numbers of patients accessing (or likely to access) all emergency services within the area.
(b) As an emergency service there will be no specific catchment area for the Trauma Unit, any eligible patient requiring major trauma services and local review / stabilisation will be conveyed to the nearest Trauma Unit who can clinically meet their needs. Patient flow will therefore be dependent on clinical need. Once the specialist major trauma element of a patients treatment has concluded they will be transferred back to a local hospital (or other appropriate facility) for continuation of treatment and rehabilitation as required.

Can you estimate the impact this will have on specific groups?

(a) What will be the impact on children?
(b) What will be the impact on people with disabilities?
(c) What will be the impact on older people?
(d) Has an equalities impact assessment been carried out of this proposal?

(a, b, c) This proposal is specifically based on clinical need. As such the impact on patients will not be based on specific groupings as described above. Patients will be transferred to the most appropriate facility based on the severe injury sustained at that time and not age or other factor. The only exception will be where children may be more appropriately treated within a specialist children's centre rather than a major trauma centre. However, work is being undertaken nationally to review major trauma services for children and further work will therefore be undertaken locally following the implementation of the overall major trauma service in Kent and Medway.

(d) The full business case includes an equality impact assessment.

Choice and commissioning

(a) Will the change generate a significant increase or decrease in demand for a service arising from patient choice, payment by results and practice based commissioning?

(b) Have plans been made for “financial cushioning” if additional capacity is not taken up?

(c) Is the proposal consistent with World Class Commissioning and reflected in NHS Medway commissioning plans?

(a) As an emergency service, attendance within the Trauma Unit for major trauma patients is not based on patient choice but on clinical need. A new HRG and payment structure for major trauma patients has recently been released. Payment by results will continue to be the current source of income for Trauma Units.

(b) not applicable – no additional capacity is being implemented.

(c) All PCTs across Kent and Medway were required, as part of the development of the Assurance Statement for the Annual Operating Plan for 2011/12, to provide assurance of the development of appropriate major trauma services consistent with national requirements. This proposal meets these requirements.

Clinical evidence

(a) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?

(b) Will any groups be less well off?

(c) Will the proposal contribute to achievement of national and local priorities/targets?

(a)

There have been multiple reviews and evidence in relation to major trauma services in England / UK since 1988 – all of which have identified deficiencies in the delivery of care for these patients. Examples of evidence include:

- Evidence as presented by the National Audit Office (February 10) identified a 20% higher in-hospital mortality rate for trauma patients in England compared to the US.
- In addition, the NHS Clinical Advisory Groups report on Regional Networks for Trauma expanded on this data:
  - In 1992, for example, the UK Major Trauma Outcomes Study (MTOS) of almost 15,000 patients, showed continued unsatisfactory care
    - In 2007 the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a major report on major trauma.

Internationally, the establishment of Trauma Systems (which the proposed Trauma Units would be part of) has been founded on Trauma Centres. Severely injured patients are 15-20% less likely to die if admitted to a Trauma Centre than if admitted to other hospitals. A Trauma System should have regard to the needs of all injured persons in its area. Benefits to the whole

injured population will derive from an Inclusive Trauma System (ITS) that provides for the needs of all injured patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units.

(b) no groups are expected to be less well off – indeed an improvement in services for all trauma patients is likely, over time, to be seen.

(c) Implementation of Major Trauma Systems (Networks) is a priority outlined within the NHS Operating Framework for 2010/11 and 2011/12

Joint Working

(a) How will the proposed change contribute to joint working and improved pathways of care?

In order to ensure that death and disability is minimised for severely injured patients, joint working is vital to enable appropriate identification, treatment, transfer and rehabilitation. As such the Kent and Medway Critical Care and Trauma Network consists of colleagues (clinical and managerial) from all Acute Trusts across the region, the Ambulance Trust, Major Trauma Centre, PCTs. Pathways for these patients will cross organisational, as well as geographical boundaries, and therefore effective joint working, communication and pathway development is key.

Health inequalities

(a) Has this proposal been created with the intention of addressing health inequalities and health improvement goals in this area?
(b) What health inequalities will this proposal address?
(c) What modelling or needs assessment has been done to support this?
(d) How does this proposal reflect priorities in the JSNA?

(a) no specific health inequalities have been considered as part of this proposal – the key aim is to reduce death and disability for all patients following major trauma.
(b) Not applicable
(c) Modelling of the numbers of patients based on reporting of data to the Trauma Audit and Research Network has been undertaken to identify potential numbers of patients impacted by this change. The data has been included

Wider Infrastructure

(a) What infrastructure will be available to support the redesigned or reconfigured service?

(b) Please comment on transport implications in the context of sustainability and access

(a) NHS Trusts nominated themselves for designation as a Trauma Unit, those who have been selected will be required to demonstrate how they are able to meet the designation criteria, identify gaps and action plans to bridge these gaps. Experience within the London Trauma System (which has been in existence since April 2010) is that much of the changes required are around effective governance arrangements / clinical rotas. There are no additional funds available, nationally or locally, to develop trauma units.

(b) There will be no additional transport implications for patients who will be conveyed by road or air ambulance to the most clinically appropriate location.
There may be some additional air ambulance traffic – arrangements are currently under review to enable night flying to major trauma centres. This will replace road conveyance.
For the majority of patients, this proposal will not alter the location of treatment, but may enable local stabilisation, enhance specialist major trauma support to local units and facilitate rapid transfer of patients to and from the major trauma centre for treatment and rehabilitation.

Do you believe the outlined proposal is a substantial variation or development?

The proposal is not a substantial variation to existing emergency care services – predominantly the changes will be improved flow and coordination of patients across the major trauma system. However, these improvements are likely to have an impact on the potential for death and extent of disability following major trauma.

Is there any other information you feel the Committee should consider in making its decision?

This proposal, including the site of the Trauma Units, has been led by and fully approved by clinical leads from all NHS Trusts within Kent and Medway.