NHS
South Central

Developing Safe and Sustainable acute services in South Central

Stroke, major trauma and vascular surgery engagement document

August 2011

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If you need a copy of this document in a different format or language, please contact the team for the area where you live - details of these are found in Section 10

Executive summary

Which services are involved?

Stroke, major trauma and vascular surgery services are being reviewed by the three Primary Care Trust (PCT) clusters in the NHS South Central region which covers Buckinghamshire, Oxfordshire, Berkshire, Hampshire and the Isle of Wight.

The PCTs have come up with a number of proposals aimed at improving the quality of these services for patients and would like your views.

Why are we doing this?

We believe that by implementing the proposals set out in this engagement document we can save lives and reduce the likelihood of patients suffering long-term disabilities. Our aims are:

- To make sure that the provision of these services is in line with national best practice
- To provide higher quality care and achieve the best results for our patients
- To develop and maintain the expertise of the medical staff who provide these services by providing them with a high volume of patients
- To ensure there are enough of the right medical staff to provide specialist care 24 hours a day
- To ensure the services are financially viable and sustainable
- To ensure patients across the region receive the same high standard of service.

The case for change

- Stroke: Specialist 24 hour centres have been shown to improve outcomes for patients and reduce long term disability. Changes to services are already being made in South Central and improvements being seen.
- Major trauma: Evidence shows dedicated units with expert teams can save more lives
- Vascular surgery: Evidence shows patient outcomes are likely to be better in centres with specialist staff caring for a high volume of patients.

What is a stroke?

A stroke is a type of brain injury caused by a reduced blood supply to the brain. A ‘mini stroke’ (or TIA) has symptoms which do not last as long but many people go on to have a full stoke within a week.

What is major trauma?

Major trauma describes multiple serious injuries that could result in significant physical harm or death such as serious head injuries, gunshot wounds or road traffic accidents.

What is vascular surgery?

Vascular surgeons and interventional radiologists (who provide minimally invasive procedures) specialise in treating the blood vessels of the body, except vessels of the heart. Patients who may need vascular surgery typically suffer from abdominal aortic aneurysms (the main artery in the abdomen becomes stretched and prone to bursting), strokes or poor blood supply to feet and legs.

What changes will I see?

The changes will be different depending on where you live, but in general terms, if you are a stroke, major trauma or vascular surgery patient you will be treated by specialist staff that will be concentrated in a limited number of hospitals. This may mean you will have to travel further than your local hospital to be treated, but in most cases the treatment will be significantly improved and could save your life.

How can I influence the proposals?

We are engaging with local people and interested organisations about the proposals for a six week period running from the end of August to 30th September 2011. You can respond to us online or in writing – details are in section 10. All of the views we receive will be collated into a report which will be considered by the chief executives of the PCT clusters, and at PCT cluster Board meetings, before deciding next steps.

1. Introduction

The three Primary Care Trust (PCT) clusters in the NHS South Central region want to talk to local people about proposals to improve services for those who experience a stroke, major trauma or vascular surgery.

The proposals are to concentrate these services in places where there are specialists and support services available around the clock. National clinical experience shows that this approach saves lives and improves patient recovery.

The three PCT clusters in South Central who would like your views are:

- NHS Buckinghamshire and Oxfordshire
- NHS Berkshire
- NHS Southampton, Hampshire, the Isle of Wight and Portsmouth.

This document explains each of the three services and the proposed changes. Views are being sought as part of a six-week engagement exercise and your feedback will help the PCT clusters decide the best way forward. Details about how you can give us your comments can be found in section 10.

Please note this is not a formal consultation exercise.

2. Background

In 2007 the Department of Health published Our NHS Our Future which set out a vision for improving health services across the country. In 2008 South Central Strategic Health Authority responded to this report by publishing its own vision, Towards a Healthier Future. These documents set out the national and local frameworks within which stroke, trauma and vascular surgery services would be improved.

In order to meet these requirements, we have looked at national best practice with the aim of improving the quality of care for patients in a way that is long lasting.

To implement national best practice each of the services being reviewed would need to be consolidated at various locations across the region to ensure that:

- we can provide higher quality care and achieve the best results for patients
- enough patients are being treated to enable the service specialists to maintain and develop expertise
- there are enough expert medical staff to provide specialist out-of-hours care
- the services are financially viable and sustainable in the long term.

This engagement exercise is focusing primarily on developing the urgent, or emergency, part of stroke, major trauma and vascular surgery.

We are asking you about all three at the same time because they are interconnected. They all require a range of specialist support services including access to specialist theatres, X-ray, scanning, intensive care and interventional radiology around the clock. Interventional radiologists specialise in minimally invasive, targeted treatments which avoid the need for major surgery.

Our proposals have been developed with NHS South Central Ambulance Service (SCAS) to ensure patients are transported to the most appropriate hospital. We will work with SCAS to improve services, and provide training for ambulance staff to assess and treat patients needing specialist stroke, major trauma or vascular surgery care.

2. Background

What is a stroke?

A stroke is a type of brain injury. There are two types of stroke – ischaemic and haemorrhagic. Almost three quarters of all strokes are ischaemic, caused when blood flowing to the brain is blocked. A haemorrhagic stroke is when blood vessels burst.

Strokes usually occur without warning. Both types of stroke reduce the blood supply to the brain which causes brain cells to die, so quick action is needed to stop further brain injury.

What is a 'mini stroke' or TIA?

A transient ischaemic attack (TIA) happens because of a temporary lack of blood to part of the brain and causes short term problems. A TIA is sometimes called a 'mini stroke' but, unlike a stroke, the symptoms do not last and patients recover within 24 hours. However, one in 10 patients will have a full stroke within a week of having a TIA.

What is major trauma?

The term 'major trauma' is used to describe multiple serious injuries that could result in significant physical harm or death. These might include serious head, chest, abdominal and skeletal injuries sustained as a result of accidents, sport or violence. Major trauma is the main cause of death for people under the age of 45 and is a major cause of debilitating long term injuries. More than half of major trauma is caused by road traffic accidents and it is twice as common in urban areas as in rural areas.

What is trauma?

Trauma is less severe and includes injuries such as a fractured hip or ankle or minor head injury. For the purpose of this document we are looking at major trauma.

What is vascular surgery?

Vascular surgeons and interventional radiologists specialise in treating the blood vessels of the body, with the exception of the vessels of the heart. Vascular surgeons work to restore blood flow to an area of the body after trauma, disease or other issues that result in damaged blood vessels. Interventional radiologists specialise in minimally invasive, targeted treatments.

People needing vascular surgery will include:

- People with abdominal aortic aneurysms (AAA): This is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. Timely detection and treatment of abdominal aortic aneurysms prevents later problems with rupture and bleeding, and can be life-saving.
- People with strokes or transient ischaemic attacks (TIAs or mini-strokes): Sometimes, problems with the blood supply to the brain occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes.
- People with poor blood supply to the feet and legs: Some people, particularly those who smoke or have diabetes, can develop narrowings in the blood supply to the legs and feet. This can cause pain on walking, ulceration and infection. Surgical or interventional radiological treatment can improve the blood supply, make walking easier and prevent the serious complications of inadequate blood supply.

3. What have we done so far?

3.1 What have we done so far?

In drawing up our proposals for change we worked closely with clinicians and, in some parts of the programmes, have involved stakeholders, patients and the public. Clinicians developed service specifications for each service working with GP commissioners, Local Involvement Networks (LINks) representatives and a small number of members of the public. A number of charities/voluntary organisations were also involved including the Stroke Association and Headway. They all agreed that it would be better for patients if major trauma, stroke and vascular surgery services were available 24 hours a day, seven days a week, supported by specialists and specialist support services.

Hospitals interested in becoming specialist centres for stroke, major trauma and/or vascular surgery were then invited to submit plans showing how they would meet the service specifications. These plans were assessed at review panels which included independent clinical representatives and specialists in stroke, major trauma and vascular surgery. The proposals outlined in this document are the result of these reviews.

3.2 The financial picture

The same amount of money will continue to be invested in these services, because they are paid for at a set national price. We expect that by changing these services the money spent on them will be used more efficiently. However, this will depend on the final design for each of the three services – for example how many patients, and what treatments they have.

QUESTION: Do you agree that NHS South Central should follow national guidance and establish specialist stroke, major trauma and vascular centres for patients?

4. Stroke

Stroke is the third largest cause of death in England; 110,000 people in England have a stroke each year and there are 900,000 people living in England who have had a stroke. 25% of strokes occur in people who are under 65. 20 – 30% of people who have a stroke die within a month, and a third of people who have a stroke are left with a long term disability. The risk of recurrent stroke within five years of a first stroke is 30% – 43%.

4.1 Why do we need to change the way stroke services are provided?

The National Stroke Strategy, published in November 2007, aimed to improve the quality of stroke services and patient experiences and outcomes throughout England. The strategy recognised the potential benefits for all patients if effective early treatment and fast rapid access to acute stroke services were provided.

The mantra of the strategy is "**Time is Brain**":

- Brain cells are dying every minute a stroke goes untreated. Every stage of the journey until treatment is received is therefore time critical.
- The first steps to accessing emergency treatment is a rapid response to a 999 call for suspected acute stroke; rapid assessment by the ambulance crew and blue light transfer with pre-alert to a receiving hospital able to offer hyper-acute services with appropriate 24-hour expertise.
- Thrombolysis, used to dissolve blood clots, is a key treatment for ischaemic stroke patients. The sooner it is given the better because it can help prevent disability. After four and a half hours of the start of symptoms the benefits of thrombolysis reduce significantly.

In South Central the time between having a stroke and being admitted for suitable treatment has generally been too long, meaning that clot-busting drugs could not be administered. Furthermore, many patients were not being admitted to specialist stroke wards when they got to hospital. This can result in longer hospital stays with limited access to therapies such as physiotherapy, speech therapy and occupational therapy. Ultimately, this has meant that patients did not recover as quickly or as well and that is why we are changing the way stroke services are provided.

We also want all stroke patients in South Central to be provided with the same standard of high quality care wherever they live.

4. Stroke

In London, the changes proposed have already been implemented resulting in a significantly improved service for patients (See diagram on page 14).

4.2 What improvements have already been made or are being proposed?

South Central was one of the worst performing regions for stroke services and, for that reason, has already begun to address the urgent need to improve patient care in this area. Changes to stroke services have already been implemented in Southampton and South West Hampshire, Portsmouth, Buckinghamshire, Berkshire and Oxfordshire resulting in significant improvements in care for stroke patients. (See diagram on page 14).

South Central is now one of the best performing regions as a result of the changes we have made.

For example, clot-busting drugs can only be administered after doctors have done an urgent brain scan. With the implementation of new stroke services, hospitals have 24-hour access to brain scans and stroke specialists ensuring that more patients can be treated with thrombolysis.

Under the changes being made, everyone who has suffered a stroke or TIA across the South Central area should have access to a fully integrated acute stroke service for patients which would:

» Improve outcomes for stroke patients by reducing the level of death and disability
» Reduce the length of stay in hospital
» Improve access to stroke services
» Ensure equity for patients across South Central.

Under these changes stroke care service provision is being organised into four levels of care:

1

Hyper acute stroke units – these highly specialised units:
» provide clot-busting drugs 24/7 to patients within four and a half hours of the onset of a stroke
» provide 24/7 rapid access to brain scans and diagnosis
» provide specialist stroke doctors 24/7
» ensure 95% of patients requiring clot-busting drugs are treated within 60 minutes of arriving at hospital
» **provide all the services at 2 and 3**

2

Acute stroke units – these units, which provide care for new stroke patients 24/7:
» receive patients directly if the onset of stroke is greater than four and a half hours
» receive patients who have been treated in hyper acute stroke units whose condition is now less serious
» provide 24/7 access to brain scans and diagnosis
» provide 24/7 stroke specialist nurses
» provide specialist stroke doctors from 9am to 5pm
» have 24/7 access to neurosurgical facilities, neuro-critical care and interventional radiology
» have access to vascular surgeons either direct or via technology
» provide acute stroke inpatient care and rehabilitation services.
» **provide all the services at 3**

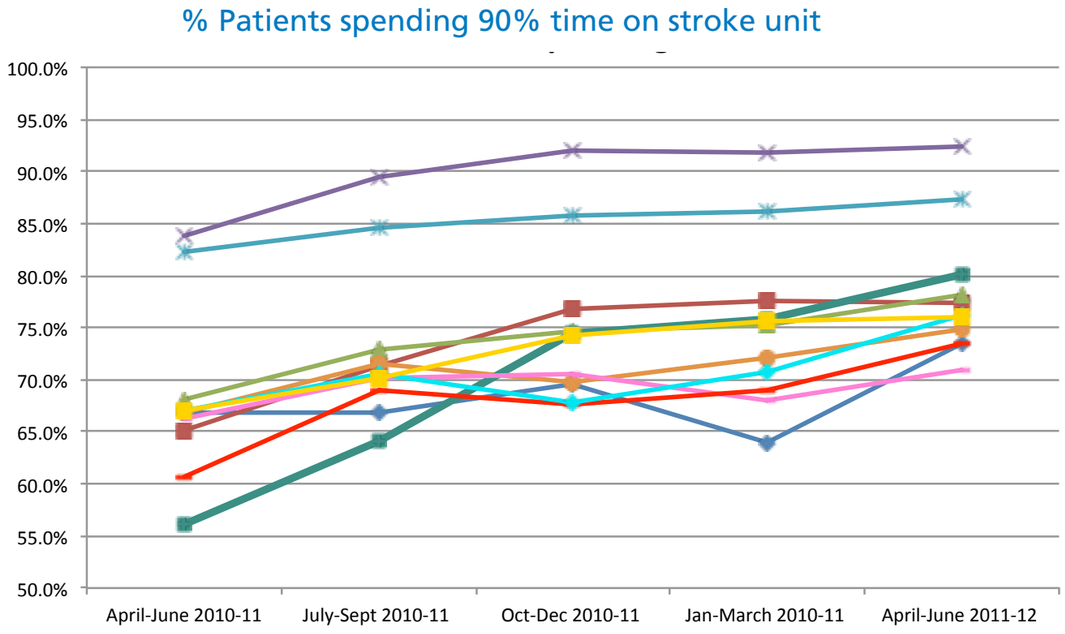
3

c) Rehabilitation stroke units – these units would:
» receive stroke patients from hyper acute or acute stroke units
» provide comprehensive rehabilitation services provided by a multidisciplinary team of health care professionals – stroke physicians; stroke trained nurses; physiotherapists; speech and language therapists and occupational therapists.

4

d) TIA services – Access to TIA services is important in reducing the risk of patients going on to have a stroke. Patients are assessed as either high or low risk. High risk patients are seen within 24 hours and low risk patients within seven days of the patient contacting a health professional. All TIA service improvements have now been made across South Central.

4. Stroke



New hyper acute stroke unit at Wycombe Hospital improves services for patients across two counties

The hyper acute stroke unit at Wycombe Hospital, which opened in June 2011, covers the population of Buckinghamshire and Berkshire East.

Close working with the ambulance service and A&E staff at both Stoke Mandeville and Wexham Park hospitals has been critical to the success of this new service. All stroke patients from Buckinghamshire are now taken directly to Wycombe Hospital where they can receive the immediate specialist care and treatment they need. All patients from east Berkshire who would benefit from thrombolysis are also taken to Wycombe Hospital.

Additional staff have been employed at Wycombe Hospital and nursing ratios increased to allow for a duty stroke nurse to be available 24/7. The duty stroke nurse receives calls from GPs, A&E and the ambulance service which enables them to give advice or receive prior warning of patients being taken to the unit.

The restructuring of emergency stroke services in Buckinghamshire has resulted in the number of patients achieving a 90% stay on a designated stroke ward increasing from approximately 54% in April 2011 to 90% in July 2011. In addition, the numbers of patients being given thrombolysis has increased around three fold due to the 24/7 availability of stroke consultants.

Consultants and imaging services have worked closely together at Wycombe Hospital to ensure 100% of patients are scanned within 24 hours and 50% are now scanned within one hour compared to 14% back in April, this year.

A stroke early supported discharge service was introduced across Buckinghamshire this month (August 2011) which allows those stroke patients who are medically able to leave hospital to receive intensive rehabilitation in their own homes.

4. Stroke | Case study

Meet Joseph and Harry. Both are 59 years old, married, working full-time and aiming to go on working until they are 65. One day Joseph and Harry become ill at home… and this is where their similarity ends. Joseph lives in an area where stroke services have not been modernised. Harry lives in an area where stroke services have been developed to provide new and faster track routes into care. Both have slurred speech and weakness on the left side.

Joseph

Joseph's wife is concerned but Joseph says he is ok - he'll be fine in a minute.	Joseph's wife is increasingly concerned and calls her GP who recognises from her description that this is a stroke and calls an ambulance. It is too late for clot-busting drugs...	Joseph is transferred to a general medical ward with some stroke expertise but no specialist team.	Joseph's stroke is identified as an ischaemic stroke. Some physiotherapy, occupational therapy and speech therapy are offered but this is from a non-specialist team and is limited.	Joseph is still on the ward. He is put on a long waiting list for rehabilitation.	He is transferred to a community hospital. He has some therapy but no therapy goals are set and no specialist therapy provided.	After three weeks therapy starts at the rehabilitation centre but the outlook for recovery is now reduced. Joseph is still in a wheelchair. His speech is still slurred. His wife will need to provide support with his care in the long term. Joseph is realising that a return to work is distant now.	A year later Joseph begins his return to work part-time.

Harry

Harry's wife has seen the FAST campaign on telly and calls 999. The ambulance arrives and within an hour Harry is in a hyper acute stroke unit.	Harry is admitted direct to the hyper acute stroke unit and seen by a full stroke specialist team immediately. His stroke is identified as an ischaemic stroke. Clot-busting drugs are administered within four and a half hours of the stroke.	Harry is settled on the unit and is receiving medical care from staff with specific expertise in stroke.	Harry gets a visit from the stroke adviser who offers support. Physiotherapy, occupational therapy and speech therapy start to be provided by staff specially trained in dealing with stroke patients.	After seven days Harry is transferred to a specialist stroke rehabilitation community hospital. His therapy continues as before.	Harry is discharged to home. He has some speech difficulties and is walking with a stick. The Community Communication Support Service and Return to Work Service are helping him.	Harry returns to work, initially part-time. His speech has progressed considerably and his walking has strengthened.	Harry is working normally.

4. Stroke

4.3 What improvements have already been made in your area and what are the future plans?

A map on page 21 shows the arrangement below.

Southampton

Southampton General Hospital is already providing the full pathway of stroke care for patients, acting as both a hyper acute and acute stroke unit, as well as providing rehabilitation services. Southampton is also providing a high and low risk TIA service seven days a week.

Lymington New Forest Hospital provides a high and low risk TIA service on weekdays. At the weekend, high risk TIA patients are able to be seen at Southampton General Hospital.

Isle of Wight

It is proposed that St Mary's Hospital would provide hyper acute services and also seven day high and low risk TIA services. It is likely that the provision of hyper acute services would be facilitated via technology with a mainland hospital. The hyper acute services are expected to be implemented in the day time in autumn 2011 and 24/7 early in 2012.

Portsmouth City

Queen Alexandra Hospital already provides a hyper acute unit and seven day high and low risk TIA services.

Hampshire

South West
Patients in South West Hampshire (including the New Forest) have access to hyper acute services from Southampton General Hospital, and continue to have the option of rehabilitation at Lymington New Forest Hospital.

North
The proposal is that all North Hampshire stroke patients go to the Royal Hampshire County Hospital in Winchester for the first three days because it is already a hyper acute unit. Basingstoke and North Hampshire Hospital would be an acute unit and Lymington New Forest Hospital is already a rehabilitation unit and will not receive acute patients.

It is also proposed that the Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital would each provide seven-day high and low risk TIA services.

Lymington New Forest Hospital provides a weekday high and low risk TIA service. At the weekend, high risk TIA patients would be able to be seen at Southampton General Hospital.

North East
Frimley Park Hospital in Surrey (outside of the South Central region) would provide hyper acute services and seven day high and low risk TIA services.

QUESTION: Do you agree with our proposals for Hampshire and the Isle of Wight?

4. Stroke

Berkshire

The Royal Berkshire Hospital in Reading has a hyper acute unit and also provides a seven-day high and low risk TIA service.

Doctors from both Wycombe Hospital and Wexham Park Hospital in Slough are working together providing 24/7 hyper acute stroke services from Wycombe Hospital for patients eligible for thrombolysis. Wexham Park Hospital provides acute services and Heatherwood Hospital in Ascot provides rehabilitation services. High risk TIA patients are seen at Wycombe Hospital; low risk TIA patients are seen at Wexham Park.

Frimley Park Hospital in Surrey (outside of the South Central region) provides hyper acute services and seven-day high and low risk TIA services for patients in the Bracknell area.

Oxfordshire

The John Radcliffe Hospital in Oxford provides hyper acute services. The Horton General Hospital in Banbury provides acute and rehabilitation services and Abingdon and Witney Community Hospitals provide rehabilitation services.

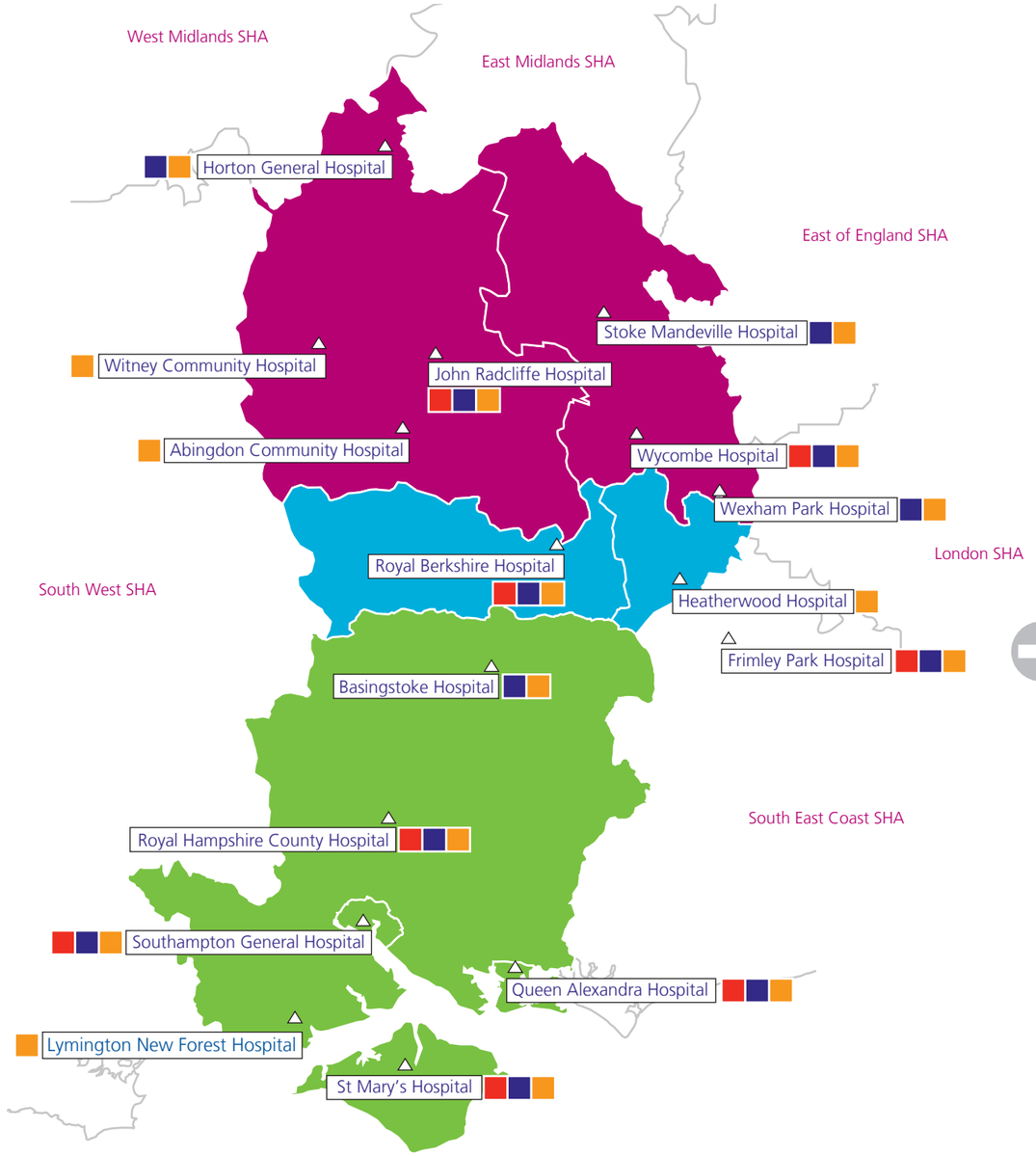
The John Radcliffe provides seven-day high and risk TIA services, the Horton General provides five-day high and low risk TIA services. At the weekend, high risk TIA patients are seen at the John Radcliffe.

Buckinghamshire

All Buckinghamshire patients go to Wycombe Hospital for the first three days. Some patients would then be transferred to Stoke Mandeville Hospital for acute and rehabilitation services. Wycombe Hospital provides a seven-day high and low risk TIA service. Stoke Mandeville provides a five-day low risk TIA service.

There may be a change to these arrangements following a consultation on 'Better Healthcare in Buckinghamshire' which is due to start in October 2011.

New arrangements for stroke



5. Major trauma

Major trauma is the biggest killer of people under 45 in this country. Overall in England, there are 5,400 deaths due to major trauma per year and many more than that suffer permanent disability as a result.

5.1 Why do we need to change the way major trauma services are provided?

There are approximately 900 major trauma patients (children and adults) across South Central each year. Whilst this is a relatively small number from a population of four million, major trauma patients have complex injuries and need expert care to have the best chance of surviving and recovering.

Whilst all hospitals with A&E departments across the South Central area treat both adults and children involved in major trauma, good patient outcomes in South Central are lower than in healthcare systems in equivalent western economies (National Audit Office Report, 2010). In many of the hospitals currently providing major trauma care, there is insufficient clinical cover and activity levels do not allow staff to maintain the expert skill levels required to treat these patients. There is a frequent need to transfer patients to more specialist centres which can result in an unacceptable delay in treatment.

5.2 What happens now?

Currently all hospitals with emergency departments (A&E) across South Central treat children and adults with major trauma, although many are transferred to more specialised centres for further treatment.

The majority of people who have a major trauma injury are taken to their local hospital where there can be a delay in receiving all the care they require. Two thirds of major trauma patients end up being transferred because their local hospital is unable to provide all the expert care needed.

5.3 What is being proposed?

It is proposed that there is a major trauma system in South Central which would provide high-quality specialist trauma care and rehabilitation across the region. The proposed system would consist of two major trauma centres and a number of trauma units.

Under the new proposals there will be a much better chance of surviving and recovering from a major trauma injury. Patients would have direct access to specialist teams and state-of-the-art equipment to ensure they receive immediate treatment, 24 hours a day, seven days a week.

We believe our plans will save lives, reduce long term disability and improve standards of care. We will also be better able to plan for, and respond to, major incidents under these proposed changes.

People with a severe injury would be assessed by ambulance staff at the scene of the incident. They would then be taken by ambulance direct to one of two major trauma centres if it was safe to do so and the patient did not need stabilising. At the major trauma centre patients would be cared for by an on-site team including experts in diagnostic tests, trauma injuries and brain surgery.

If the patient needed to be stabilised first, he or she would be taken to the nearest trauma unit.

For less severe injuries, patients would be taken to the nearest trauma unit or A&E.

We believe patients will benefit from the shared knowledge of clinicians in the major trauma network. For major trauma patients spending a little extra time getting to a hospital which provides the right team of specialists is more important than getting to the nearest hospital. Specialist treatment at a major trauma centre has a greater impact on journey time (i.e. the time spent in an ambulance) on medical outcomes and can increase survival rates by 20% (National Audit Office Report, *Major Trauma Care in England* 2010).
Levels of care for adults and children involved in major trauma have been improved in other countries within integrated trauma networks. Our plan is to achieve this in South Central through hospitals, ambulance and rehabilitation services working better together as a whole system with clear access and processes in place to meet the needs of these patients, leading to better patient outcomes and a more sustainable system.

Introducing a major trauma network across South Central would:

- **Improve patient outcomes**
  - Long term disability would be reduced by improving outcomes for adults and children involved in major trauma
  - The duration of NHS treatment would be reduced for major trauma patients
  - Patients would have an improved ability to return to work and undertake recreational activities.
- **Lower mortality rates**
  - The major trauma mortality rate would be reduced.

5. Major trauma

- **Create better and stronger clinical teams**
  - To ensure best outcomes for major trauma patients, hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. A major trauma network would help with this.
- **Reduce costs and improve use of resources**
  - Having major trauma centres and units specialising in major trauma would be a more cost effective way of caring for major trauma patients.
- **Create sustainable services**
  - The introduction of a major trauma network would ensure the best use of resources, making the major trauma centres and trauma units more sustainable.

Major Trauma Centre

A major trauma centre (MTC) is part of a major trauma network. It is a specialist hospital responsible for the care of the most severely injured patients involved in major trauma. It provides 24/7 emergency access to consultant-delivered care for a wide range of specialist clinical services and expertise. A hospital which is a designated major trauma centre will have an A&E department.

Trauma unit

A trauma unit is a hospital that is part of the major trauma network providing care for all except the most severe major trauma patients.
When it is not possible to get to the major trauma centre within 45 minutes, or where the patient needs to be stabilised quickly, the patient would be taken to the nearest hospital with a local trauma unit for immediate treatment and stabilisation before being transferred on to the major trauma centre.

Once discharged from a major trauma centre, local trauma units also provide on-going treatment and rehabilitation for patients.

A hospital which is a designated trauma unit will have an A&E department.

A&E departments

Hospitals that are not a major trauma centre or trauma unit but have an A&E department will manage patients with injuries that need urgent treatment but do not require specialist services.

Case study

5.4 Case study

Meet Tomas and William. Both are 21 years old and recently started in full time employment. One day Tomas and William are involved in a serious car crash. A passer-by stops and calls 999… and this is where their similarity ends. Tomas lives in an area where major trauma services have not been modernised. William lives in an area where major trauma services have been developed to provide new faster track routes into specialist care. Both have serious, life threatening injuries.

Tomas	William
An ambulance arrives and the crew recognises that Tomas has a life threatening head injury. A doctor is requested but no doctor is available. Tomas is transferred to the nearest A&E.	An ambulance arrives and the crew recognises that William has a life threatening head injury. An enhanced care team arrives shortly after. They sedate William and he is put on a breathing machine. William is then transferred to a Major Trauma Centre where he receives a rapid assessment.
Tomas has a brain scan and the results are sent to the regional neurosurgical registrar. Tomas is transferred by ambulance to the regional neurosurgical centre where he is operated on four hours after William, and kept sedated.	William has a brain scan and is transferred to the neurosurgical operating theatre for an operation. He is kept sedated.
After five days Tomas is allowed to wake up from his sedation. He is not fully conscious, unable to speak and his left arm and leg are not fully functioning. Tomas stays on the neurological ward for one month before being transferred to the neuro-rehabilitation ward.	After two days, William is allowed to wake up from his sedation. He is conscious, can hold a conversation and has normal leg and arm movement. After four days he is transferred back to his local hospital for rehabilitation.
After six months Tomas prepares to go home. His parents have modified their house to enable 24-hour care to continue including support from the local rehabilitation team.	William goes home after 10 days in hospital; he has community- based rehabilitation. Within four months William is back to work and continues to receive support from the rehabilitation team.

5. Major trauma

5.5 What are the plans for your area?

A map on page 29 shows the proposals.

In South Central, only the John Radcliffe Hospital in Oxford and Southampton General Hospital have the full range of surgical and supporting specialties required for hospitals to be major trauma centres.

These include the ability to be able to carry out brain surgery and cardiothoracic surgery – surgery on organs inside the chest, usually the heart and lungs. The proposed centres would be supported by, and linked to, a number of trauma units, which would be based at other major hospitals across the region.

QUESTION: Do you agree that the John Radcliffe Hospital in Oxford and Southampton General Hospital should be the major trauma centres?

It is proposed that the following hospitals within South Central are trauma units:

Stoke Mandeville Hospital, Aylesbury (which will also continue to provide specialist spinal care)

Wexham Park Hospital, Slough

Royal Berkshire Hospital, Reading

Basingstoke and North Hampshire Hospital (which will also continue to provide specialist pelvis and liver care)

Queen Alexandra Hospital, Portsmouth (which will also to continue to provide specialist orthopaedics and renal care as well as plastic surgery)

St Mary's Hospital, Isle of Wight.

QUESTION: Do you agree that these hospitals should be trauma units?

Southampton, Hampshire, the Isle of Wight and Portsmouth

The proposal is that adults and children who suffer major trauma in Southampton, Hampshire, the Isle of Wight or Portsmouth are taken directly to a major trauma centre at Southampton General Hospital, rather than to the local A&E.

Patients would stay in Southampton General until they were stable. They would then be transferred to a dedicated local trauma unit closer to home or other appropriate, specialist rehabilitation location for on-going care. This could be within Southampton General Hospital, at the Queen Alexandra Hospital in Portsmouth, St Mary's Hospital on the Isle of Wight or Basingstoke and North Hampshire Hospital.

The Help Charity has already donated £3 million to Southampton General Hospital to build a new helipad on the site. This will mean major trauma patients are taken to Southampton as fast as possible.

Berkshire, Buckinghamshire and Oxfordshire

The proposal is that adults and children who suffer major trauma in Berkshire, Buckinghamshire or Oxfordshire are taken directly to the major trauma centre at the John Radcliffe Hospital in Oxford, rather than to the local A&E.

Patients would stay in the John Radcliffe until they were stable. They would then be transferred to a dedicated local trauma unit closer to home or other appropriate, specialist rehabilitation location for on-going care. This could be within the John Radcliffe Hospital, at the Horton Hospital in Banbury, the Royal Berkshire Hospital in Reading, Wycombe Hospital, Stoke Mandeville Hospital in Aylesbury or Wexham Park Hospital in Slough.

The John Radcliffe Hospital already has a helipad

5. Major trauma

In some cases the changes will mean patients travelling longer in the ambulance to a major trauma centre than they would have done if they were being taken to their local A&E.

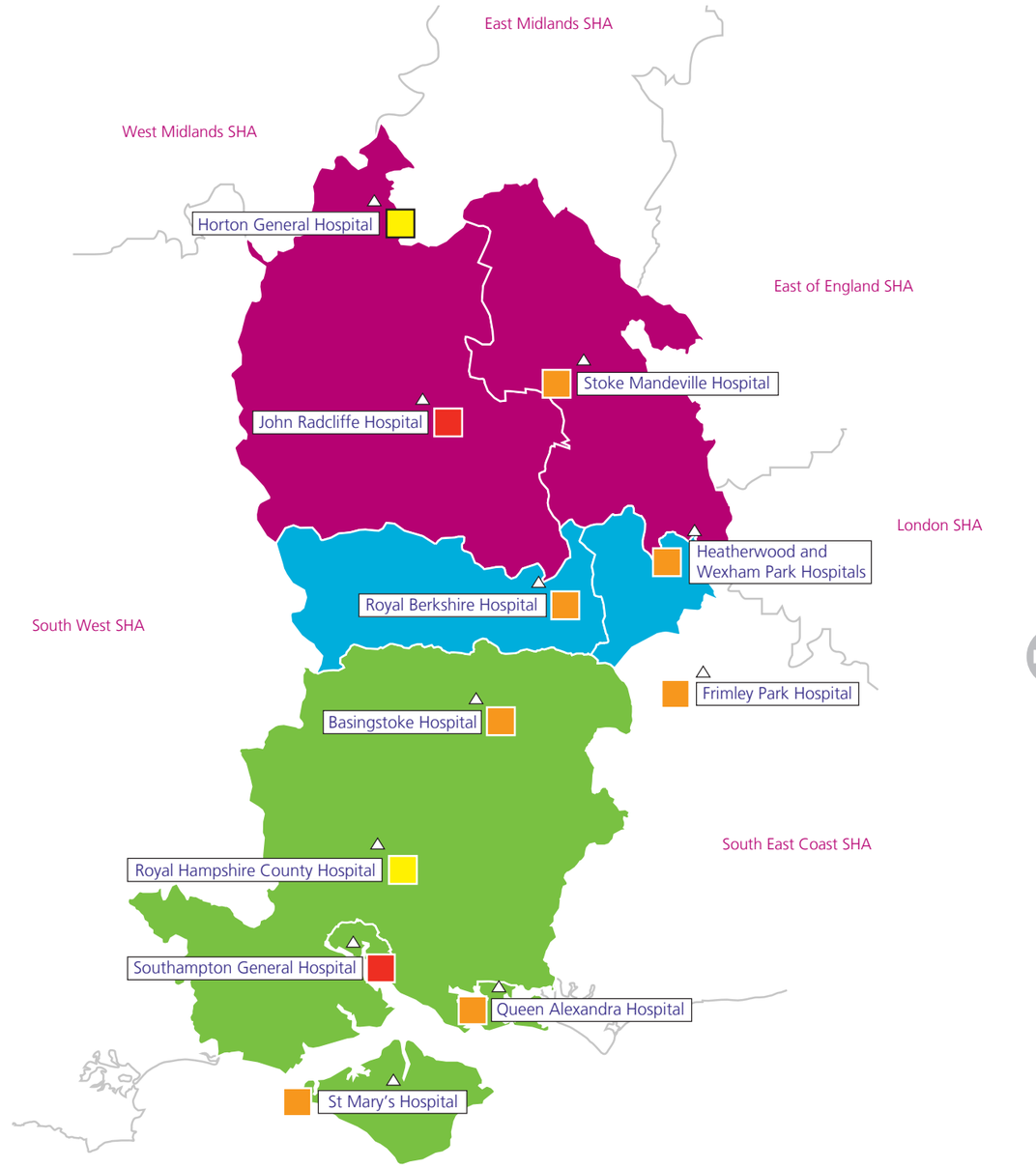
However, the journey is very unlikely to be longer than 45 minutes and it means patients would be treated in a specialist centre with all the facilities and expertise they may need. They would not need to be transferred from a local hospital or trauma unit which would incur delays to treatment and could have adverse effects on survival.

When it is not possible to get to the major trauma centre within 45 minutes, patients would be taken to the nearest hospital with a local trauma unit for immediate treatment and stabilisation before being transferred on to the major trauma centre.

Patients with less serious injuries, urgent or emergency care needs would continue to be treated by their local A&E, Minor Injury Unit or GP.

QUESTION: Do you agree with our proposals for the south and the north of the region?

Major Trauma: proposed future configuration



6. Vascular surgery

Vascular disease increases with age and is the major cause of morbidity in diabetes patients. Over 40% of patients admitted to hospital under the care of vascular teams have diabetes. Smoking is a major cause of vascular disease and over 80% of vascular patients are current or ex smokers.

The overall mortality from a ruptured aneurysm is about 85%. Eight to ten thousand patients die each year from a ruptured aneurysm in England and Wales.

Around 20% of the population over 60 years of age have poor blood supply to the feet and legs. It is particularly high amongst smokers, diabetics and patients with coronary artery disease.

The latest clinical evidence shows that patients with a vascular condition do better if they are treated by a vascular specialist. It also shows that if an aneurysm does rupture the person has a better chance of survival if they are operated on by a vascular specialist.

6.1 Why do we need to change the way vascular surgery is provided?

There is strong national clinical consensus that patients requiring vascular surgery receive better quality care when they are treated by specialists who deal with a high volume of patients and who, therefore, have significant expertise in this field. This is the case even for patients travelling up to 60 minutes for treatment. Under our proposals no one in South Central would be more that 60 minutes from a local vascular centre.

Outcomes for patients are also improved where there is a strong multi-disciplinary vascular team including interventional radiologists. Nationally there are a limited number of vascular surgeons and interventional radiologists so in order to make best use of their services we are proposing to concentrate them in specialist centres.

In 2009, the South Central Vascular Surgery Group commissioned a report to assess the provision of vascular surgery across the region. The report, Delivery of Vascular Surgery, made recommendations as to how services could be developed to ensure good outcomes for patients. Key points from the report were:

» **Better patient outcomes**
Even though patients may need to travel further for treatment, evidence shows that outcomes are likely to be better in centres which have a high volume of vascular patients, as vascular teams would be more experienced and better practised as a result.

» **Lower patient mortality**
Clinical evidence shows that specialist vascular teams have lower patient mortality rates. Essentially, the more surgeons perform a particular type of surgery, the better they get.

» **Better and stronger clinical teams**
To ensure best outcomes for patients, hospitals carrying out specialist vascular surgery need to have specialist doctors, interventional radiologists and clinical support staff available at all times.

» **24 hour access**
Vascular teams need enough specialists to ensure sufficient surgical and medical cover 24 hours a day, which is not always possible in smaller hospitals.

» **Reduced costs**
Having larger units specialising in vascular surgery is a cost effective way to treat patients.

» **Sustainable delivery**
The cost of having surgeons and clinical support staff available 24 hours a day for vascular surgery is significant. For smaller units with low number of patients this is unsustainable. Larger units treating a high number of patients not only means the expertise of the surgeons is improved, but the cost per patient is lower. This makes larger units more sustainable.

6.2 What happens now?

At the moment, vascular surgery takes place in local hospitals where appropriate services are available. The operations may sometimes be undertaken by general surgeons rather than vascular specialists and some patients who would benefit from a less invasive procedure are not always able to have this treatment because interventional radiologists are in short supply.

Currently, there are also a variety of arrangements shared across hospitals for treating patients who need emergency vascular surgery. This means that there is not a vascular surgeon available in all parts of the region 24/7.

6. Vascular surgery

6.3 What is being proposed?

Before developing our proposals a service specification was put together by local health service commissioners and expert clinicians based on national best practice. Hospitals were then asked to submit proposals illustrating how they would meet the service specification for vascular surgery in South Central. These proposals were considered by a specialist panel which included clinicians who work inside and outside our region. Their unanimous decision was that the best outcomes for the population would be met if there were three units providing 24 hour emergency and complex inpatient vascular surgery and that these should be at:

- John Radcliffe Hospital, Oxford
- Frimley Park Hospital, Surrey,
- Southampton General Hospital.

The reasons these hospitals were chosen were:

- We are proposing that the John Radcliffe and Southampton General become major trauma units and they will, therefore, be best placed to undertake complex emergency surgery around the clock.
- They already have specialist vascular surgery teams which can be built upon to provide a high quality service for all vascular surgery patients in South Central
- Geographical location.

The intention is that patients would have pre-operative assessments carried out locally and only travel to the John Radcliffe, Southampton General or Frimley Park for complex surgical procedures. In most cases the vascular surgeon who assesses the patient locally before their operation would then travel with the patient to the John Radcliffe, Southampton General or Frimley Park where he or she would be supported by an expert vascular team.

Patients would then return home to their local hospital for on-going care/ rehabilitation as appropriate. However, it is estimated that 85-95% of patients will be discharged directly home from the vascular centre hospital.

If we did nothing to change complex vascular surgery in South Central patients would continue to receive a service which does not reflect national best practice and, therefore, is not the best quality service we could provide.

QUESTION: Do you agree with our proposal to establish three units at the John Radcliffe, Frimley Park and Southampton General Hospitals?

6.4 What are the plans for your area?

A map on page 35 shows the arrangements below.

Basingstoke and North Hampshire

The proposal is that Frimley Park Hospital and St Peter's Hospital, both in Surrey and outside of the South Central region, would provide emergency and elective complex inpatient vascular surgery for the population of Basingstoke, North Hampshire and the rest of the Surrey Vascular Network . North Hampshire and Basingstoke Hospital would retain its vascular teams for day cases, diagnostics and local outpatient provision.

Berkshire, Buckinghamshire and Oxfordshire

We are proposing that the John Radcliffe Hospital in Oxford would provide all emergency and elective complex inpatient vascular surgery except in Buckinghamshire where it is proposed that Wycombe Hospital would continue to carry out vascular surgery on stroke and TIA patients.

The Royal Berkshire Hospital in Reading, Wycombe General and Wexham Park Hospital in Slough would retain their vascular surgeons for day case, diagnostics and local outpatient provision. These surgeons would travel to the John Radcliffe Hospital as part of an emergency rota to cover the north of the region and to carry out elective complex inpatient surgery on their local patients.

6. Vascular surgery

Portsmouth, Winchester, Southampton and the Isle of Wight

The proposal made by the specialist panel is that Southampton General Hospital provides emergency and elective complex inpatient vascular surgery for the population of Portsmouth while continuing to provide this service for the people of Southampton, Winchester and the Isle of Wight.

This would increase the volume of vascular surgery patients at Southampton, increasing the surgeons' expertise and thereby improving the service for patients. However, the Portsmouth Overview and Scrutiny Panel asked us to consider alternative options which we have done and they are as follows:

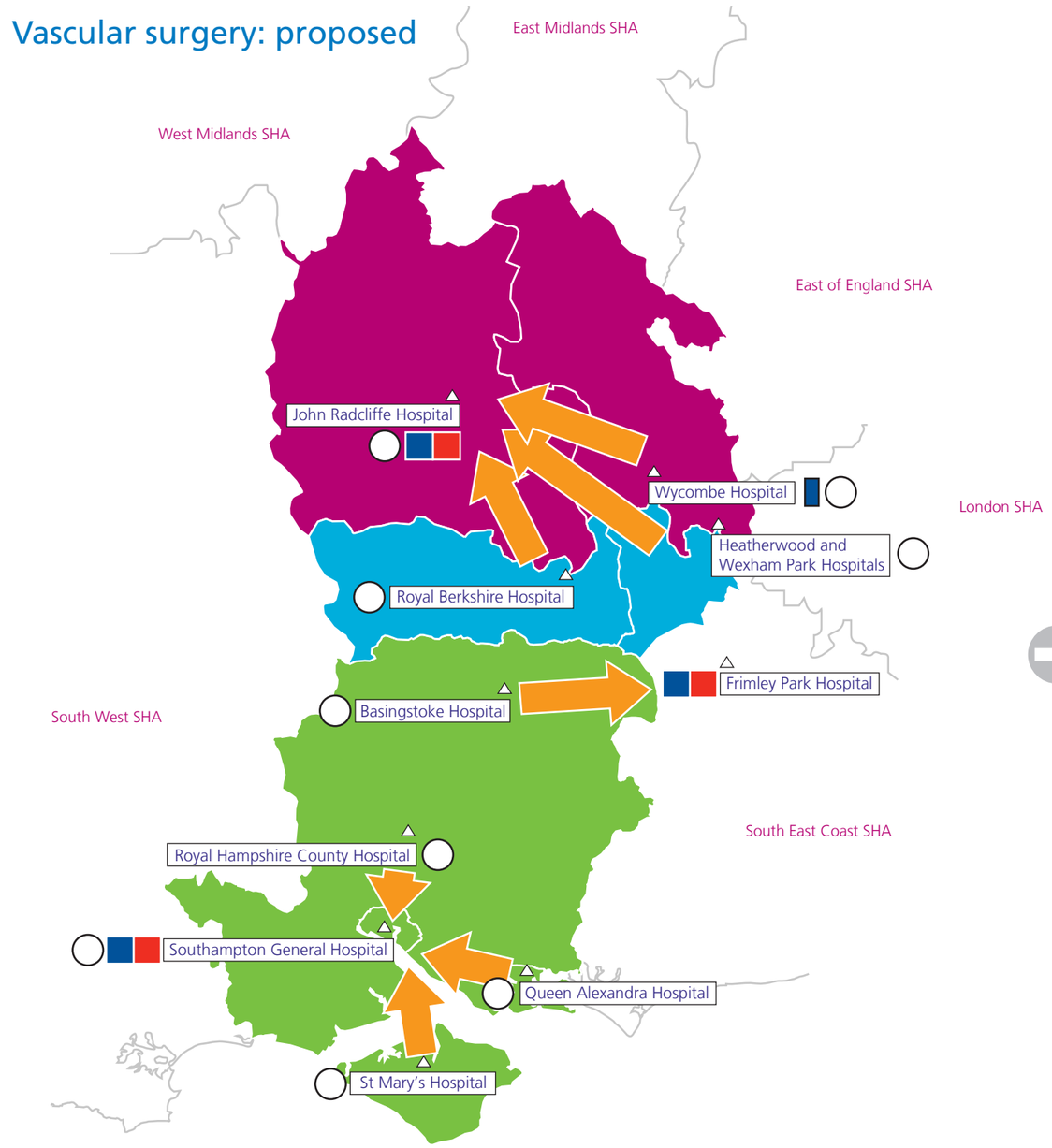
» The Queen Alexandra Hospital in Portsmouth provides emergency and elective complex inpatient vascular surgery for their current population and also for the population of Chichester which is in the South East Coast region. South East Coast providers are currently reviewing vascular surgery in Sussex. If a proposal involving Chichester and Portsmouth were to be favoured by the Sussex Review, we would need to make sure it met the South Central specification for vascular surgery.

» Some elective complex vascular surgery is retained at Portsmouth. This would have to be agreed between the Queen Alexandra and Southampton General hospitals, and with local commissioners. If a proposal was forthcoming, we would need to be sure it meets the South Central specification for vascular surgery.

We want to gather initial views on these options and work with Sussex on their plans for vascular surgery before deciding the next steps with local Overview and Scrutiny Committees/Panel.

QUESTION: Do you agree with the proposals for your area as set out above?

Vascular surgery: proposed



7. Equality Impact Analysis

Public sector bodies are required to demonstrate equality across all strands, including age, sexual orientation and religion or belief. This builds on the existing duties relating to disability, gender and race, and improves the coverage in relation to gender reassignment. Equality impact assessments have been developed for all three specialities covered in this engagement document and can be requested by contacting your area as outlined in the Have your say page in section 10.

8. Glossary and abbreviations

Health outcomes - this describes how quickly and to what extent patients recover from health issues.

South Central Strategic Health Authority (SHA) - there are 10 SHAs in England which are responsible for enacting the directives and implementing policy as dictated by the Department of Health at a regional level. Each SHA area contains various NHS Trusts which take responsibility for running or commissioning local NHS services. The SHA is responsible for strategic supervision of these services.

Local Involvement Networks (LINks) - set up to give communities a stronger voice in how their health and social care services are delivered. The LINk promotes involvement and finds out what people think about the services, monitors the care provided by services and uses LINk powers to hold services to account.

FAST - to help people recognise the symptoms of stroke quickly, the Stroke Association funded research into FAST, which requires an assessment of three specific symptoms of stroke:

Facial weakness - can the person smile? Has their mouth or eye drooped?
Arm weakness - can the person raise both arms?
Speech problems - can the person speak clearly and understand what you say?
Time to call 999.

Transient Ischaemic Attack (TIA) - a TIA is sometimes referred to as a mini-stroke. It occurs when a blood vessel supplying brain tissue becomes temporarily blocked, causing a short term loss of blood supply to part of the brain. The symptoms of a TIA are the same as a stroke, but as the blood supply is restored before permanent damage to brain cells is caused, the symptoms fully resolve. In some cases symptoms may last for just a few minutes, in other cases it may be several hours – but to be considered a TIA (rather than a stroke), symptoms must be fully resolved within 24 hours. A TIA is an important warning sign that someone is at risk from suffering a complete stroke – with the risk being greatest in the first month or so after the TIA. Strokes can be prevented, and immediate medical review is therefore vital.

Pathway - a way of describing the different stages that a patient may go through during their contact with health services.

Thrombolysis - used to dissolve blood clots that could cause serious, and possibly life-threatening, damage if they are not removed. Research suggests that when used to treat stroke, thrombolytic therapy can prevent or reverse paralysis and other problems that otherwise might result.

9. References

Department of Health *Our NHS Our Future* (2007)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079078

Towards a Healthier Future
http://www.southcentral.nhs.uk/wp-content/uploads/2010/02/Towards-a-Healthier-Future.pdf

Royal College of Physicians' *National Clinical Guideline for Stroke* (2008)

British Association of Stroke Physicians' *Stroke Service Standards* (2010)

National Institute for Clinical Excellence *Quality Standards Programme: Stroke* (2010)

Department of Health's *National Stroke Strategy* (2007)

NCEPOD Trauma: *Who Cares?* (2007)

National Audit Office *Major trauma care in England* (2010)

The Intercollegiate Group on Trauma Standards *Regional trauma systems interim guidance for commissioners*, (December 2009)

The Vascular Society of Great Britain & Ireland, (2007). *The provision of emergency vascular services.*

The Vascular Society of Great Britain & Ireland, (2009). *The provision of services for patients with vascular disease*.

AAA Screening Programme – *Commissioning guidance – Version 2* (28/09/2009)

10. Have your say

We would like to hear from local people and organisations who may be affected by, or have views on, these changes. Your feedback will help further inform any changes we decide to make.

Please let us have your comments by **Friday 30th September 2011**.

You can respond to our questions or make general comments online or in writing. If you are reading this document online and would like a paper version please contact the team for the area where you live, or the area you represent, as detailed below. These teams can also be contacted if you need this document translated or in a different format.

We will be talking to groups and meeting with people with an interest in this work during late August and September and any public events will be advertised locally.

For Southampton, Hampshire, Isle of Wight and Portsmouth write to:

Communications Team
Freepost RRYC-AUHZ-EHKE
NHS Southampton City
Trust HQ
Oakley Road
Southampton
SO16 4GX

To comment online visit www.hampshire.nhs.uk You will be asked to register before you can get all the information.

Phone: 02380 296229

Email: communications@scpct.nhs.uk

For Berkshire write to:

Communication and Engagement Team
Freepost RRLX-SZAY-LTKX
(Safe and Sustainable services engagement)
NHS Berkshire
57 - 59 Bath Road
Reading
RG30 2BA

To comment online visit www.berkshirewest-pct.nhs.uk You will be asked to register before you can get all the information

Phone: 0118 982 2782

Email: ppi.team@berkshire.nhs.uk

For Buckinghamshire and Oxfordshire write to:

Communications & Engagement
FREEPOST RRRKBZBTASXU
NHS Oxfordshire
Jubilee House
5510 John Smith Drive
Oxford Business Park South, OXFORD OX4 2LH

To comment online visit www.oxfordshirepct.nhs.uk You will be asked to register before you can get all the information.

Phone: 01865 334636

Email: talking.health@oxfordshirepct.nhs.uk

Please respond by 30th September 2011

10. Have your say

We are keen to receive your feedback on the proposals and invite you to complete the following questions – you may answer as few or as many as you wish.

Confidentiality

Responses from individuals will be shared with consulting PCTs to enable them to consider respondents' views fully, but will otherwise by kept confidential. Your name will be kept confidential and will not be disclosed except as may be required by law.

Personal details

We would be grateful if you could provide personal information as it will enable us to identify trends. However, all consultation responses will be fully taken into account when decisions are made, irrespective of whether or not you provided personal details. If you provide us with your details we will let you know the outcome of this work.

Please note if you would prefer you can respond online via your local NHS website. You will be asked to register first – this is a quick process and should take no more than a couple of minutes. Details of how to respond online are given on page 40.

QA Please tell us your name

.....

QB Are you:

- ○ Providing your own response
- ○ Submitting on behalf of an organisation (go to QI)

QC How old are you?

- ○ Under 25
- ○ 25 - 34
- ○ 35 - 44
- ○ 45 - 54
- ○ 55 - 64
- ○ 65 or over
- ○ Prefer not to say

QD Are you?

- ○ Male
- ○ Female
- ○ Prefer not to say

QE Which ethnic group do you consider yourself belonging to?

- ○ White
- ○ Mixed
- ○ Asian or Asian British
- ○ Black or black British
- ○ Chinese

  Other: .....
- ○ Prefer not to say

QF Do you consider yourself to have a disability? By disability we mean 'All physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities' (Disability Discrimination Act 2005)

- ○ Yes
- ○ No
- ○ Prefer not to say

QG Please can you write in your full postcode below. This will be used to assess whether we are receiving responses from across South Central

.....

QH Do you work for the NHS?

- ○ Yes
- ○ No

QI Details of your organisation

Please complete the following section if you are responding on behalf of an organisation. If you are submitting a personal response please go to **Q1** (one).

What is the name of the organisation you are submitting this response on behalf of?

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QJ Please tell us who the organisation represents and where applicable how you assembled the views of members

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Q1 Do you agree that NHS South Central should follow national guidance and establish specialist stroke, trauma and vascular centres to change services for patients?

- ○ Yes
- ○ No
- ○ If no, why not?

.....

.....

Stroke

Q2 Do you agree with our proposals for Hampshire?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q3 Do you agree with our proposals for Isle of Wight?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Major trauma

Q4 Do you agree that the John Radcliffe Hospital in Oxford, and Southampton General Hospital should be major trauma centres?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q5 Do you agree that the following hospitals within South Central should be trauma units? (Please circle)

Yes / No Stoke Mandeville Hospital, Aylesbury

Yes / No Wexham Park Hospital, Slough

Yes / No Royal Berkshire Hospital, Reading

Yes / No Basingstoke and North Hampshire Hospital, Basingstoke

Yes / No Queen Alexandra Hospital, Portsmouth

Yes / No St Mary's Hospital, Isle of Wight

- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q6 Do you agree with our proposals for Southampton, Hampshire, the Isle of Wight and Portsmouth?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q7 Do you agree with our proposals for Berkshire, Buckinghamshire and Oxfordshire?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Vascular

Q8 Do you agree with our proposal to establish 3 units providing 24 hour complex vascular surgery at the John Radcliffe Hospital, Oxford; Frimley Park Hospital Surrey and Southampton General Hospital?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q9 Do you agree with our proposals for Basingstoke and North Hampshire?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q10 Do you agree with our proposals for Portsmouth, Winchester, Southampton and the Isle of Wight?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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Q11 Do you agree with our proposals for Berkshire, Buckinghamshire and Oxfordshire?

- ○ Agree
- ○ Disagree
- ○ Don't know

If you disagree or have an alternative proposal please include details here

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If you have any other comments please indicate below

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Next steps

The results of this engagement exercise will be presented to a meeting of the PCT chief executives and meetings of their Boards, and they will decide how best to proceed based on the feedback received.

Please mail your completed questionnaire to the address nearest to where you live, or where your organisation is located, shown on page 40.

The closing date for responses is Friday 30th September and please allow time for postal delivery.