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Collaborative

A Major Trauma Network for South and West Wales and South Powys - Report on Consultation

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Purpose of Document:

This paper provides:

- a brief summary of the rationale for a major trauma network for South and West Wales and South Powys ('the region')
- an overview of the work that has been undertaken to develop recommendations for a major trauma network for the region
- a summary of the resulting recommendations made by an Independent Panel
- a description of the process used to consult on the recommendations
- a description of the framework developed and used for analysis of the consultation responses
- an analysis of the consultation responses, using the framework referred to above
- conclusions drawn from the consultation
- a summary of the financial arrangements for the implementation of a major trauma network
- a recommendation from the Collaborative Leadership Forum to the boards of health boards in the region

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1 Introduction

This paper provides:

- a brief summary of the rationale for a major trauma network for South and West Wales and South Powys ('the region') – Section 2
- an overview of the work that has been undertaken to develop recommendations for a major trauma network for the region – Section 3
- a summary of the resulting recommendations made by an Independent Panel – Section 4
- a description of the process used to consult on the recommendations – Section 5
- a description of the framework developed and used for analysis of the consultation responses – Section 6
- an analysis of the consultation responses, using the framework referred to above – Section 7
- conclusions drawn from the consultation – Section 8
- a summary of the financial arrangements for the implementation of a major trauma network – Section 9
- a recommendation from the Collaborative Leadership Forum to the boards of health boards in the region – Section 10

The recommendation of the Collaborative Leadership Forum (NHS Wales chairs and chief executives acting to oversee the work of the NHS Wales Health Collaborative) is that boards in the region should approve the establishment of a major trauma network for South and West Wales and South Powys, in line with the recommendations of the Independent Panel:

1. A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed.
2. The adults' and children's major trauma centres should be on the same site.
3. The major trauma centre should be at University Hospital of Wales, Cardiff.
4. Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network.
5. A clear and realistic timetable for putting the trauma network in place should be set.

Additional background information and more detailed analysis of the consultation responses is contained in various Supporting Documents (see page 42).

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2 Rationale for a major trauma network

‘Major Trauma’ is the leading cause of death in all groups under 45 years of age and is a significant cause of short and long term morbidity. A trauma network works together to make sure a patient receives the best care for life threatening or life changing injuries. Where there is a major trauma network, it has been shown that more patients will survive and make a good recovery, irrespective where in the region covered by the network they suffer a major trauma.

Organisations such as the National Confidential Enquiry into patient Outcome and Death (NCEPOD), National Institute of Clinical Excellence (NICE), the Department of Health Clinical Advisory Group and the National Audit Office (NAO), have produced several reports which draw attention to poor care and outcomes received by patients resulting from a lack of trauma networks.

South and West Wales and South Powys (‘the region’) is the only region of England and Wales that does not have a major trauma network (MTN) or have access to a designated major trauma centre (MTC). This means that individuals suffering a major trauma in the region are likely to have poorer outcomes and are at greater risk of death.

The development of a major trauma network for the region will represent a significant step forward in the provision of emergency care in Wales and will build on the current model of care, providing greater expertise and resilience to deal appropriately with both individual and mass casualty events. A developing network will lead to enhanced roles for a number of hospitals across the region, but particularly for the University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

The establishment of a major trauma network will also contribute to the delivery of aims of the Wellbeing of Future Generations (Wales) Act 2015, by supporting the delivery of a ‘healthier Wales’ and the goal to “develop a society in which people’s physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood”.

3 Development of recommendations

3.1 Initial work

The work to develop proposals for a major trauma network has been led by the NHS Wales Health Collaborative Team (‘the Collaborative’). The work was undertaken in collaboration with health boards across the region, the Welsh Ambulance Service NHS Trust (WAST), the Emergency

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Medical Retrieval and Transfer Service (EMRTS) and has also involved the third sector and Community Health Councils (CHCs).

In late 2014, the Collaborative was asked by the chief executives in NHS Wales to develop a service model for a major trauma network for the region.

North Wales and North Powys were not included in the project. Betsi Cadwaladr University Health Board is already part of the West Midlands Major Trauma Network, with patients in North Wales having access to the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the West Midlands Major Trauma Network via the trauma unit in Shrewsbury.

A Project Board was established, supported by a Clinical Reference Group (CRG). The service model for major trauma services for adults and paediatrics was developed by the CRG, in line with the standards for major trauma, and approved by the Project Board in May 2015.

3.2 Option appraisal

In June 2015, an option appraisal workshop, led by clinicians, was undertaken which identified the need for a major trauma network with a major trauma centre based in South Wales to support the population of South and West Wales and South Powys.

The workshop included health boards, the Welsh Ambulance Service NHS Trust (WAST) and invited patient representatives from voluntary and charity support groups from across the region. Community Health Councils were also invited to observe. The workshop considered several options:

- Do nothing
- No major trauma centre in South Wales, but patients would access services in England (Bristol)
- One major trauma centre for South Wales based at Morriston Hospital
- One major trauma centre for South Wales based at University Hospital of Wales (UHW)
- Two sites, based at Morriston Hospital and University Hospital of Wales (UHW).

The participants in the workshop determined that the preferred option was **a major trauma centre on a single site based within the region and supported by a number of trauma units.**

The workshop did **not** result in a recommendation on a preferred location for the major trauma centre. However, in identifying the preference for a

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single site, Morriston Hospital, Swansea and University Hospital of Wales (UHW), Cardiff were assessed to be the only two hospitals in the region that could potentially meet the criteria for a major trauma centre, due to the specialist nature of the service and the need for it to be co-located with relevant specialist services.

The workshop agreed that, to support a population of approximately two million (deemed to be the minimum critical mass for sustainability) the network would need to be supported by a major trauma centre located within the region. This ruled out the option of relying on services from the Bristol major trauma centre. The potential for a dual site solution was considered, but eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.

Following the workshop, an equality impact assessment (EqIA) was undertaken and has continued to be revised across the life of the project (Supporting Document 1).

3.3 The Independent Panel

Building on the earlier work, an independent panel of specialists from across trauma and rehabilitation services in the UK ('the Independent Panel') was commissioned by the Collaborative Board (chief executives), on behalf of health boards in the region, to review the information and evidence available and make a recommendation on the preferred location of a major trauma centre in the region.

A formal report (Supporting Document 2) was considered by health boards in the region in January 2017. This report asked boards to note the arrangements for the Independent Panel to consider the evidence regarding the establishment of the proposed major trauma centre and to bring forward a recommendation of a preferred option for public consultation. This was supported by all health boards in the region.

The Independent Panel convened in February 2017, chaired by the National Clinical Director for Trauma to NHS England. The Independent Panel comprised representatives from across major trauma services in the UK. Panel members were selected based on their national and international reputations as experts in trauma care and the development of trauma systems and having previously been involved in the development of regional major trauma systems.

Representatives were invited to attend from health boards, Public Health Wales, the Welsh Government, Community Health Councils (as observers), Emergency Medical Retrieval and Transfer Service (EMRTS), Welsh Ambulance Service Trust (WAST), Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee

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(EASC). The terms of reference and agenda for the day are attached (Supporting Documents 3 and 4).

The Independent Panel was asked to undertake the following:

- Review the service model and specification for major trauma services for adults and paediatrics, across the region
- Consider supporting evidence from Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB for the provision of a major trauma centre at Morriston Hospital, Swansea or the University Hospital of Wales (UHW), Cardiff as part of the major trauma network in south Wales.
- Provide an independent view on the two options for the location of the major trauma centre.
- Provide a view on the phasing of any implementation requirements and priorities for investment within a major trauma centre.
- Advise on the impact on remaining services at Morriston Hospital and UHW Hospital in the event they are not identified as the major trauma centre.
- Advise on the preferred location of a major trauma centre for the region.

4 Recommendations from the Independent Panel for a major trauma network

After considering the evidence, the Independent Panel made the following five recommendations in their report (see Supporting Document 5):

1. A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed.
2. The adults' and children's major trauma centres should be on the same site.
3. The major trauma centre should be at University Hospital of Wales, Cardiff.
4. Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network.
5. A clear and realistic timetable for putting the trauma network in place should be set.

In making their recommendations, the panel identified three main factors that should shape the design of a major trauma network:

- **Clinical interdependencies**, i.e. the services that need to be available at the location of the major trauma centre, as set out in the relevant standards

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- **Critical mass**, i.e. the minimum number of people needed to make a service, in this case major trauma, sustainable
- **Travel times**: The Panel considered the geography of Wales and concluded that, with the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the major trauma centre

The panel concluded that providing specific highly specialist services, such as neurosurgery and paediatric neurosurgery, on the same site as the major trauma centre was the main factor in deciding where to locate the centre. It is important to have these specialist services available immediately if you suffer a major trauma. Providing these services on the same site is a minimum requirement.

Health boards formally received a copy of the report from the Independent Panel alongside their recommendations for consideration at their board meetings in September 2017. They were asked to agree, in principle, to the recommendations from the Independent Panel, and, in doing so, agree to a period of consultation on the recommendations of the Independent Panel (Supporting Document 6). **All health boards agreed, in principle, to the above recommendations of the Independent Panel as the basis for a formal consultation.**

5 Consultation process

As the proposals were deemed as substantial service change, a full consultation of twelve weeks was required. The process was designed in accordance with the 'Guidance on Engagement and Consultation on Changes to Health Services'. The process was considered by the Collaborative Leadership Forum, the six health boards in the region and the six Community Health Councils. As a collaborative process, Health Boards and Community Health Councils (CHCs) agreed that a consistent approach should be taken by all, ensuring equality of opportunity for all populations groups regardless of geographical location.

The consultation process commenced on 13 November 2017 and came to a conclusion on 5 February 2018.

In agreement with the CHCs, the consultation asked for individuals in the region and organisations to consider the following specific questions:

1. Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?
2. Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?

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3. If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?
4. Do you have any other comments?

To ensure a consistent approach was adopted across the region, a task group was established comprising engagement and equality lead officers from each of the affected health boards and a representative of the CHCs. A consultation plan was developed outlining the objectives of the consultation, a stakeholder mapping and the consultation methods to be employed (Supporting Document 7). Plans for local consultation activity, to be undertaken in line with the overall consultation plan, were agreed between each health board and the respective CHC.

The consultation document was made available in various formats via hard copies and a dedicated web page on the Public Health Wales website (as Public Health Wales is the host body of the Collaborative). Public, stakeholder and staff sessions were held and social media was utilised.

Public meetings were scheduled across the region. Formal notes were provided from each consultation meeting, once agreed with the local CHC. A series of additional meetings took place with other professional/recognised groups. Details of the public meetings are attached at Supporting Document 8.

Social media (Facebook and Twitter), was used by health boards to promote the consultation and public meetings. Hywel Dda and Abertawe Bro Morgannwg UHB also engaged in wider discussions via social media.

A mid-way review meeting took place in December 2017, involving all the Health Boards and CHCs, to review the processes and responses received to date in light of national guidance and determine whether any adjustments needed to be made to the consultation for the remaining period. A table setting out the national guidance and how this guidance was applied in the consultation is provided in Supporting Document 9. Emerging themes were also shared with the engagement group.

Following the end of the consultation, the responses were analysed in line with the agreed framework (see Section 6).

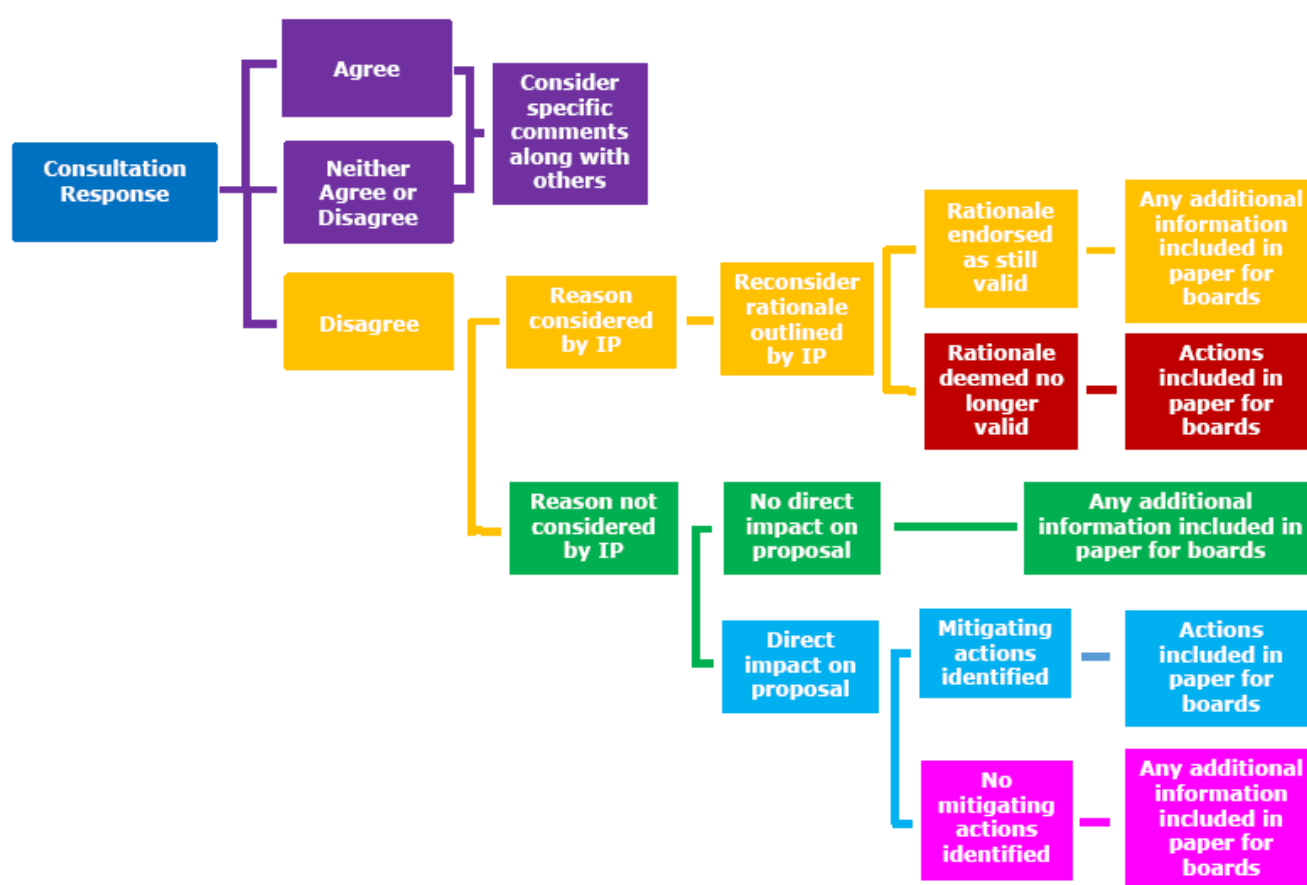
6 Framework for analysis of consultation responses

The Independent Panel considered an extensive suite of information prior to making their recommendations. As a result, health boards agreed, at their board meetings in September 2017, that the basis of the consultation would be the recommendations of the Independent Panel. The framework for analysis of the consultation responses was developed

to assist health boards in their decision making process and an initial version was agreed at the Collaborative Executive Group (formerly the Collaborative Board) in January 2018 (Supporting Document 10).

In February 2018, in considering the initial analysis of responses using the framework, the Collaborative Leadership Forum identified that the framework, as it then stood, could be interpreted as putting the views of the Independent Panel beyond challenge. As a result, the framework was modified to require that, in cases where recommendations had been challenged for reasons already considered by the Independent Panel, the Panel’s rationale should be reconsidered and either endorsed as still valid or deemed to be no longer valid.

The framework is illustrated graphically below:



There are multiple steps to the framework:

- Consider whether an individual/organisation agrees or disagrees with the proposals. If there is no disagreement, any specific comments made are considered, along with comments from other responders, and, where appropriate, identified as issues for consideration during implementation. If there is disagreement, the following steps are applied:

- Consider the reason given by an individual/organisation for disagreeing with the proposals and determine whether the Independent Panel considered the issue.
 - If the issue was considered by the Independent Panel, then the rationale of the Panel is reconsidered and either endorsed as still valid or deemed to be no longer valid (in which case further action is required). In some cases, even though the rationale of the Independent Panel was deemed valid, issues were raised that need to be considered further and/or addressed during implementation. In such cases, the comments are still considered in the thematic analysis (see below). If there is deemed to be a direct impact, then further consideration is given as to whether there are any mitigations for the issue raised and, if so, these are documented.
 - If the issue was not considered by the Independent Panel, then further consideration is given to the issue raised using the following steps:
 - Consider if the issue raised has a direct impact on the proposals. If there is not deemed to be a direct impact, then the comments are still considered in the thematic analysis (see below). If there is deemed to be a direct impact, then further consideration is given as to whether there are any mitigations for the issue raised and, if so, these are documented.
 - Provide information to support boards in their decision making process, including the mitigating circumstances for issues raised.

In applying the framework, care was taken to ensure that all comments made were considered on an equal footing regardless of the format in which they were submitted.

7 Analysis of consultation responses

7.1 Number of responses received

There were 1,041 consultation responses received from across the region, and 254 members of the public engaged in conversation on social media (with potential overlap between these two groups).

Of the 1,041 responses, 999 directly answered the consultation questions asked (60% submitted via the webpage and 40% submitted via post or email). These are shown by health board in the table below:

Health Board	Responses	%
Abertawe Bro Morgannwg UHB	511	51.1%
Aneurin Bevan UHB	38	3.8%

Cardiff and Vale UHB	126	12.6%
Cwm Taf UHB	32	3.2%
Hywel Dda UHB	224	22.4%
Powys tHB	26	2.6%
Not known (no postcode)	38	3.8%
England	4	0.4%
Total	999	100%

There were also 42 other letters and emails received in response to the consultation which did not directly answer the consultation questions, but provided clear views about the recommendations of the Independent Panel. The content of these letters and emails was given full consideration on an equal footing with all other responses and the issues raised are included in the analysis presented in this report and Supporting Documents 11 and 12.

Seventeen public meetings were scheduled across the region and a total of 242 people attended comprising health board employees, local residents, local councillors, an assembly minister and representatives of other organisations. Feedback received in these meetings was captured and analysed and considered on an equal footing with all other responses.

In addition, 254 members of the public engaged in conversation on Facebook and Twitter relating to the consultation (18 in Hywel Dda UHB initiated conversations/threads and 236 in Abertawe Bro Morgannwg UHB initiated conversations/threads). Whilst a number of individuals used these conversations to express their views on the proposal, the conversations were also used by individuals to promote and confirm that they had completed a formal questionnaire to respond to the consultation. The key themes identified from the social media conversations were considered on an equal footing with other responses.

7.2 High level summary of responses to the consultation questions

The following summary is supported by a full numerical and thematic analysis of consultation responses (Supporting Document 11).

Question 1 asked “Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?”

- 92.8%* of responders agreed that a major trauma network should be established for the region
- 4.0% disagreed
- 2.7% neither agreed nor disagreed
- 0.5% provided no response

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*This includes 242 respondents who used a standard 'template' response and who answered 'Yes' to the question (rather than answering 'Agree' or 'Disagree')

Question 2 asked "Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?"

- 34.6% of responders agreed that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel
- 49.4% disagreed
- 14.2% neither agreed nor disagreed
- 1.8% provided no response

The percentage of responders disagreeing that "the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel" varied to a large extent, based on the health board in which responders live.

Those disagreeing accounted for:

- 68.2% of responders from the Abertawe Bro Morgannwg UHB area
- 36.7% of responders from the Hywel Dda UHB area
- 23.1% of responders from the Powys tHB area
- 13.5% of responders from the Cardiff and Vale UHB area
- 9.4% of responders from the Cwm Taf UHB area
- 7.9% of responders from the Aneurin Bevan UHB area

Question 3 asked "If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?"

Question 4 asked "Do you have any other comments?"

The following are the main themes arising from responses to Questions 3 and 4 (with further detail being provided in Supporting Document 11):

- Many respondents took the opportunity to restate and/or expand on their views that:
 - the Major Trauma Centre should be in Murrison/Swansea or should not be at UHW
 - there should be more than one Major Trauma Centre in the region
 - parts of the region should use Bristol (and/or other English centres) as their Major Trauma Centre
- In implementing the network, there is a need to ensure that:

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- improvements are made in EMRTS, air ambulance services and ambulance services to ensure the time taken to transfer patients to the Major Trauma Centre is minimised on a 24/7 basis
- the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the Major Trauma Centre, parking etc.
- there is an adequate focus on the design of the whole network, including the location of trauma units and their facilities and on the entire pathway, including rehabilitation
- there is access to appropriate diagnostic and treatment services at the Major Trauma Centre
- there is excellent communication between professionals and with the public during the implementation and delivery of the network
- implementation proceeds quickly once the decision has been made
- There are concerns about:
 - equity of access in West Wales and other rural areas
 - the impact on existing services at the location of the Major Trauma Centre through additional workload
 - the lack of capacity of estates, facilities and support services at UHW, particularly in relation to views about there being sufficient capacity at Morriston
 - the network's ability to ensure adequate staffing and adequate training for staff
 - the availability of adequate funding to implement the network
 - the downgrading of services away from the Major Trauma Centre
 - lack of co-location with thoracic surgery
 - the potential for the burns unit to move to Cardiff
 - the social and economic impact of further investment in Cardiff at the expense of other areas
 - this being part of a wider agenda to move services from Swansea to Cardiff
 - why it has taken this long to develop proposals for a major trauma network for the region
 - the degree to which the consultation has been genuine and extensive
- Further information would have been welcome in relation to:
 - how well the network is working in North Wales
 - the geographical spread of incidents resulting in major trauma in recent years

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7.3 Themes identified from consultation responses

Themes identified from the consultation (through equal consideration of responses to the formal consultation questions, public and stakeholder meetings, social media, letters and emails received) have been reviewed. The key themes are contained in the Appendix and a more detailed analysis is provided in Supporting Document 12.

A small number of responses cited a lack of clarity in the consultation report and insufficient detail/evidence to enable individuals to respond to the consultation.

7.4 Analysis of reasons given for disagreeing with the recommendations of the Independent Panel

As stated in Section 7.2:

- 4% of responders disagreed with the recommendation that “a major trauma network should be established for South and West Wales and South Powys”
- 49.4% of responders disagreed “that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel”.

The reasons given for disagreement have been analysed and the full analysis is set out in Supporting Document 12, with a summary being provided below.

Reasons for disagreement already considered by the Independent Panel

Most of the reasons given for disagreeing with the propositions in consultation questions 1 and 2 had already been considered by the Independent Panel. These issues are included in those listed in the Appendix (see Supporting Document 12 for a fuller version).

The two main reasons identified for disagreeing with the recommendations were:

- Do not agree with the recommendation for the proposed major trauma centre to be located at the University Hospital of Wales, citing:
 - the major trauma centre should be in Murryston Hospital
 - the report does not sufficiently take into account travel times from West Wales to Cardiff
 - Murryston Hospital is more central to South Wales
- Proximity of South East Wales to Bristol – people living in South East Wales being able to access the major trauma network in Bristol

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The Independent Panel considered clinical interdependencies, critical mass and travel times. The panel made it clear that where there is a major trauma centre you are more likely to survive a major trauma, regardless of the time it takes to travel to the major trauma centre and that, wherever the major trauma centre is located, some people will be a considerable distance from it. The panel did not believe that either Morriston Hospital or University Hospital of Wales as a major trauma centre would have any significant advantage over the other in terms of geography. Rather, the panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre.

The use of the major trauma network centred on Bristol was discounted at the option appraisal in February 2015. The option appraisal workshop agreed that to support a population of approximately two million, the network would need to be supported by a single major trauma centre based within the region (i.e. South Wales). This would include the population of Aneurin Bevan UHB.

Further issues raised, which were considered by the Independent Panel or do not directly relate to the proposals included:

- patient flow and the importance of implementing an automatic acceptance and repatriation policy
- transport and infrastructure requirements (including public transport and road)
- access and support for families and carers.

In applying the framework, the Collaborative Leadership Forum considered carefully all responses, but concluded that the issues raised had been considered by the Independent Panel and that no additional evidence had been produced that would lead the Forum to conclude that the rationale of the Panel was deemed to be invalid. As such, it was concluded that there was no cause, in this stage of the analysis, for the rejection or alteration of any of the specific recommendations of the Independent Panel. There were, however, some aspects of the Independent Panel's recommendations where mitigations were identified to ensure that any negative consequences can be minimised (see section 7.5).

Reasons for disagreement NOT considered by the Independent Panel

There were a number of issues raised in the consultation, which had not been specifically considered by the Independent Panel when making their recommendations. These issues have been considered, are also listed in the Appendix (see Supporting Document 12 for a fuller version) and some of the main points are summarised below:

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- The development of the network will lead to a downgrading of other services
- There should be a Major Trauma Network covering the whole of Wales
- South Wales is big enough to need more than one Major Trauma Centre*
- Parts of the region should make use of the Major Trauma Centre in Bristol*
- Existing infrastructure at the proposed site of the Major Trauma Centre is inadequate
- Existing services at the proposed site of the Major Trauma Centre will be overloaded
- The Major Trauma Centre should be on the same site as thoracic surgery
- There needs to be access to 24/7 interventional radiology services
- There is a lack of 24/7 availability of the Emergency Medical Retrieval Service (EMRTS) or air ambulance
- Transport infrastructure is inadequate
- Concerns about:
 - value for money
 - the availability of adequate funding
 - the recruitment, retention and efficient deployment of staff
 - the consultation process
 - the independence and expertise of the Independent Panel
 - the wider social and economic impact of the proposals

*Note that these issues were addressed during the June 2015 option appraisal (see Section 3.2)

In light of the material presented in the Appendix and Supporting Document 12, it has been concluded that, whilst issues have been raised that need to be considered and addressed or mitigated as part of the implementation of a major trauma network, nothing has been raised that requires the rejection or alteration of any of the recommendations of the Independent Panel.

7.5 Specific mitigations identified

Whilst, as stated above, nothing has been raised through the consultation that requires the rejection or alteration of any of the recommendations of the Independent Panel, there are areas where responders have identified potential negative consequences of the recommendations that can and should be mitigated. These mitigations are included in Supporting

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Document 12 and some are also included in the Appendix. Many of the most important mitigations identified are summarised below:

- South and North Wales will work closely together so they can share best practice and learn from each other. There will be a major trauma and critical care network board which will include both North and South Wales.
- There will be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered by trauma units.
- Where patients currently access the trauma units in England, they will continue to do so.
- A review of services provided at a regional level by UHW will be undertaken to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Proposals for service change would be subject to further engagement.
- Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site.
- Arrangements will be developed to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery.
- Interventional radiology is being addressed on a regional basis between Cwm Taf, Aneurin Bevan UHB and Cardiff and Vale UHB. A plan has been developed to establish a 24/7 rota.
- The neurosurgery service has plans to reduce waiting times through 2018/19, with the support of WHSSC. A review of Neurosciences is due to conclude shortly which will inform longer term planning.
- Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.
- A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.
- Future operational arrangements of EMRTS and the Wales Air Ambulance will be reviewed as part of the planning for the

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implementation of the Major Trauma Network. This will include consideration of both demand and cost/benefit, taking into account any additional survival benefit associated with additional operational hours. Operational hours will be reassessed in the light of this assessment. Further advice about operational procedures will also be taken during implementation, informed by experience elsewhere in England and Wales.

In addition, it should be noted that the development of a major trauma network in the region will be taking place in the broader context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.

7.6 Consideration of equality and human rights issues

In line with the statutory duty placed on each health board under the Wales Public Sector Equality Duty 2011, an equality impact assessment (EqIA) was undertaken on the proposals for a major trauma network for South and West Wales and South Powys. The assessment informed the content of the consultation plan. A revised EqIA evidence document was published at the launch of the consultation and considered as part of the mid way review held in December 2017 (Supporting document 1). At this point, the opportunity was taken to review the responses received to date and identify any particular impacts on groups of individuals due to their protected characteristic and to identify possible ways to minimise or remove these effects. No issues were raised which resulted in changes to the consultation process. The document was available on the consultation website as part of the supporting documentation. In line with the EqIA, public meetings were held across the region about the proposals to give full equality of opportunity to equality and diversity groups to put their views forward on the options. Information was also available on the website and available in braille, audio and British Sign Language, Welsh and sub titled.

On conclusion of the consultation, the responses received and equality monitoring forms were collated and analysed (Supporting Document 11). The responses to the consultation and analysis will be available on the public consultation website at:

www.publichealthwales.org/majortraumaconsultation

715 equality monitoring forms were received as part of the consultation. For each 'protected characteristic' there were a number of respondents who left the question blank.

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There were a number of equality monitoring forms received from organisations, which ticked multiple responses to a single question (e.g. where an age category was required, several age brackets were identified). These forms were acknowledged but were not included in analysis of the monitoring form returns.

The EqIA made an observation that major trauma tends not to be closely associated with particular equality groups; events are not simple to predict on the basis of socio-economic characteristics. However, evidence suggests that should you suffer a major trauma, you are more likely to survive and make a full recovery if you are in a region where there is a major trauma network, regardless of how far you are away from the major trauma centre.

Of the protected characteristics, the EqIA identified that there is potentially no specific impact upon the following protected groups: 'Marriage and civil partnership' and 'Pregnancy and maternity'.

Evidence suggests there are a number of protected groups who may be likely to suffer a major trauma. The EqIA notes that men are at far higher risk of experiencing major trauma than women with age being a risk factor for suffering. It is the leading cause of death for people under 45 years and a significant cause of short and long-term morbidity. There is evidence, of a rising number of falls in the elderly that should be managed within a major trauma pathway and supported with a frail elderly rehabilitation pathway. The conclusion to a study published in 2015 (Emergency Medical Journal, 2015) suggested that the major trauma population in the UK is becoming more elderly and the predominant mechanism that precipitates major trauma is a fall from lower than two metres. Major trauma is more than twice as common in urban areas due to concentration of traffic and people. Moreover, it has been identified that people from Black, Asian and other ethnic minority backgrounds are at a higher risk of incidence and mortality from major trauma, at least in part due to a correlation with concentration in urban areas and the relationship of minorities, deprivation and major trauma incidents¹.

Additionally, trans people must be accommodated in line with their gender expression. Privacy is essential to meet the needs of the trans person and other service users. The wishes of the trans person must be considered rather than the convenience of staff. An unconscious patient should be treated according to their gender presentation. Breaching privacy about a person's Gender Recognition Certificate or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements.

¹ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

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The EqIA also identified responsibility to comply with the Welsh Language (Wales) Measure 2011 and the related health standards. These standards establish the right for Welsh language speakers to receive services in Welsh and for them to be offered communication in their preferred language choice. Meeting the information and communication needs of victims who speak Welsh must be considered. Research has shown these groups cannot be treated safely and effectively except in their first language. The equality monitoring forms identify responses from the following protected groups:

- Age: Age of respondents ranged from the lowest age bracket 16-24 to 75 or over, with the majority of respondents identifying as 45-54 age bracket (141).
- Gender: The response from individuals identifying as female (394) was slightly higher than the number of individuals identifying as male (279).
- Race: Respondents identified as predominately white (642) with a small number of respondents identifying as Asian or Asian British, Black, African, Caribbean or Black British, Mixed or multiple ethnic groups or another ethnic group (26).
- Disability: Majority of respondents identified as not having their day to day activities limited (533). A number of individuals did identify as having day to day activities limited a little (91) or a lot (39).
- Religion or belief: Majority of respondents identified as Christian (371). A small number identified as Buddhist, Hindu, Muslim or other religion (33). A large number identified as no religion (277).
- Sexual orientation: Respondents predominantly identified as heterosexual or straight (586) with a small number identifying as gay or lesbian, or bisexual (37).
- Welsh language: Majority of respondent identified as non Welsh speaking (530) and (139) identified as Welsh speaking.

Following the consultation, the EqIA has been updated (Supporting Document 13).

8 Conclusions drawn from consultation

A range of opinions have been expressed, analysed and considered as part of the consultation exercise. Whilst there was much support expressed for the recommendations of the Independent Panel, there were also counter arguments and objections. Having considered the conduct of the consultation and the analysis of the responses received, the Collaborative Leadership Forum (NHS Wales chairs and chief executives) is content that:

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- the consultation has been conducted in an appropriate manner and in a way that meets the requirements of the applicable Welsh Government guidance
- consultation responses received have been carefully and conscientiously considered
- the Forum has considered all of the arguments and concerns arising from the consultation fairly, rationally, proportionately and transparently
- whilst issues have been raised that need to be considered, addressed or mitigated as part of the implementation of a major trauma network, nothing has been raised that requires the rejection or alteration of any of the recommendations of the Independent Panel (as previously endorsed by boards in the region as the basis for public consultation)
- where required, appropriate mitigations have been identified.

9 Financial arrangements

It is acknowledged that there will be additional capital and revenue costs associated with establishing the major trauma network across the region. Whilst some outline modelling has been undertaken, full assessment cannot be made until such time as the designated site is confirmed.

Where major trauma networks have been developed and designated major trauma centres established in other parts of the UK, investment has been aligned to an agreed incremental implementation programme over a number of years. The first phase of the revenue investment is targeted at addressing the core infrastructure requirements, with initial funding identified for any critical shortfalls and a phased approach to meeting clinical standards over time.

Any capital requirements will also need to be identified and considered in the context of the phased implementation programme, the wider site development plans, interdependencies that exist between trauma services and other clinical services and will be subject to formal business case approval by Welsh Government as appropriate. Should the site of the Major Trauma Centre be confirmed as UHW, the development and submission of the business case will be led by Cardiff and Vale UHB, with the support of other health boards in the region. There would also be likely to be additional costs at Morriston, associated with its proposed lead role for the network, and at all trauma units designated within the network.

The Welsh Ambulance Service NHS Trust has also identified some modest resource implications as a result of the changes to patient flows, the adoption of a new triage model and the anticipated increase in

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requirements for repatriation. Enhanced training requirements for paramedics and the clinical workforce located outside the Major Trauma Centre/trauma units is also likely to require some additional resourcing which will need to be factored into future years Integrated Medium Term Plans (IMTPs).

The experience from other parts of the UK is that the incremental approach to implementation is essential to mitigate unnecessary additional costs and to also ensure that recruitment, training and development of staff is coordinated alongside new care pathways.

The funding mechanisms, in relation to revenue costs, will need to be developed, in detail, as part of the commissioning process. Costs will be benchmarked against the tariff system operational within England and to which Betsi Cadwaladr University Health Board already subscribes in accessing services for its local population. Revenue requirements will be addressed as part of the usual decision making process between health boards and the Welsh Health Specialised Services Committee (WHSSC), factoring in other priorities. This is in line with the core business of WHSSC as a commissioner of specialised services. The agreed revenue requirements will need to be reflected in the IMTPs of all health boards in the region for the period 2019/20 onwards (costs in 2018/19 will be project costs only).

10 Recommendation to boards

Following the consultation process and the analysis and consideration of the responses received, health boards in the region are recommended by the Collaborative Leadership Forum (NHS Wales chairs and chief executives) to **APPROVE the establishment of a major trauma network for South and West Wales and South Powys**, subject to the mitigations identified and in line with the recommendations of the Independent Panel, which were:

1. A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed.
2. The adults' and children's major trauma centres should be on the same site.
3. The major trauma centre should be at University Hospital of Wales, Cardiff.
4. Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network.
5. A clear and realistic timetable for putting the trauma network in place should be set.

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In considering the above recommendation, boards should take into account the views and comments of the Community Health Councils.

Appendix – Analysis of and responses to reasons for disagreement

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Major trauma Network (MTN) structure	The development of the network will lead to a downgrading of other services.	<p>North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency units in North Wales, despite the fact that the Major Trauma Centre (MTC) is based in Stoke on Trent. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients.</p> <p>Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the Major Trauma Centre or receive initial treatment at a trauma unit before being transferred to the Major Trauma Centre.</p> <p>The importance of local access, particularly for the frail and elderly, has been reinforced by the responses received and it is recognised that this should form an important consideration in relevant service models in the future.</p> <p>Under the recommendations of the Independent Panel, Morriston Hospital would have an enhanced role as a large trauma unit.</p>
	We need a major trauma network that covers all of Wales.	<p>North Wales participates in the West Midlands major trauma network and accesses the Major Trauma Centre in North Staffordshire. Patients in North Wales access a large number of their services from England, due to their highly specialist nature, and will continue to do so.</p> <p>The regions will work closely together so they can share best practice and learn from each other. There will be a major trauma and critical care network board which will include both North and South Wales.</p>
	South Wales is big enough to need more than one Major Trauma Centre.	<p>The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2).</p> <p>Under the recommendations of the Independent Panel, Morriston Hospital would have an enhanced role as a large trauma unit.</p>

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Major trauma Network (MTN) structure (continued)	More emphasis should be given to the establishment of the network, including the location of trauma units and the development of rehabilitation pathways, rather than the location of the Major Trauma Centre.	<p>The implementation of the network, including the redevelopment of the whole pathway of care is as important as the location of the Major Trauma Centre.</p> <p>The Independent Panel was asked to make a recommendation on the location of the Major Trauma Centre only, and not the trauma units. Identifying the Major Trauma Centre location first is helpful in informing where to locate the units.</p> <p>The remaining trauma units will need to be identified by individual health boards for their local area.</p> <p>There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered by trauma units.</p> <p>The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.</p> <p>The need to develop appropriate and robust rehabilitation pathways as part of the implementation of the Major Trauma Network is accepted.</p>
	Clarity is required over how Powys will be served by trauma units and the exact geographical definition of the major trauma network in relation to Powys.	<p>Powys secures its secondary care services from neighbouring District General Hospitals. Powys tHB will work with each of these health boards and trusts in relation to trauma unit provision. Powys tHB will also be focusing on the provision of rehabilitation services for people as close to their home as possible.</p> <p>The consultation proposed that where patients currently access the trauma units in England, they will continue to do so. At the boundaries of the network, ambulance crews will assess patients and, if the services of a Major Trauma Centre are required, patients will be taken by ambulance or helicopter to an appropriate Major Trauma Centre, which may be the proposed centre in South Wales or one in England.</p>
	There could be a strong argument for a West Wales Mid Wales or Valleys body to take on the leadership role for the network.	As the biggest unit that was not recommended to be the location of the Major Trauma Centre, Morriston was recommended by the Independent Panel to have a leadership role. The rationale of the Independent Panel has been reconsidered and endorsed.
	Concern model proposed is more of hub and spoke model rather than a network.	The model proposed adopts the arrangements used by major trauma networks across England and Wales.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Location of the Major Trauma Centre	Travelling long distances to the Major Trauma Centre could be detrimental to the health of the injured.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the Major Trauma Centre was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the Major Trauma Centre.
	The Major Trauma Centre should be in Morrison/ Swansea (or should not be in UHW/Cardiff) because of geographic location and travel times.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre. Providing this service on-site is a minimum requirement. The Independent Panel considered isochrone models of travel times for Morrision Hospital and UHW. The Panel considered the geography of Wales and concluded that transfer time to the Major Trauma Centre was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the Major Trauma Centre. Under the recommendations of the Independent Panel, Morrision Hospital would have an enhanced role as a large trauma unit.
	There are concerns about equity of access, particularly in rural/remote areas.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the Major Trauma Centre was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the Major Trauma Centre.
Access and proximity to Bristol	Parts of the region should make use of the Major Trauma Centre in Bristol (or others in England).	The use of the Major Trauma Centre in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a Major Trauma Centre located within the region. This ruled out the option of relying on services from the Bristol Major Trauma Centre.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Existing infrastructure	The Major Trauma Centre should be in Morrison because of room for expansion and facilities at Morryston (inc. a helipad).	This does not call into question the rationale of the Independent Panel in recommending that the Major Trauma Centre should be at UHW. UHW has an existing helipad which provides direct access to the Emergency Unit without the need for an additional transfer. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority.
	The Major Trauma Centre should not be at UHW because of constraints on capacity/ space at UHW.	<p>Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients. Cardiff and Vale UHB is working closely with other health boards on the following:</p> <ul style="list-style-type: none"> • A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public. • Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient’s recovery. Repatriation protocols are being developed to support this work. Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service. <p>Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:</p> <ul style="list-style-type: none"> • a front door Emergency Unit service with a major trauma team leader available 24/7 • increased critical care capacity in line with modelling for additional major trauma activity • additional theatre capacity • creation of a polytrauma unit. <p>There are plans being developed to address each of these, dependent on the outcome of consultation.</p>

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Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Existing infrastructure (continued)	The Major Trauma Centre should not be at UHW because of constraints on capacity/ space at UHW. (continued)	<p>Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site</p> <p>Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.</p> <p>In addition, it should be noted that the development of a major trauma network in the region will be taking place in the context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are broadly committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.</p>
	Neither Murryston or UHW could cope with the extra traffic.	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Infrastructure requirements	<p>Appropriate infrastructure and resources will need to be provided. This will need to cover what facilities and resources will need to be provided at UHW.</p> <p>Has consideration been given to the resources and facilities required including ITU beds, IT infrastructure, support services e.g. radiology?</p>	<p>Morriston Hospital and UHW provided high level costs for each site to meet the designation criteria for a Major Trauma Centre.</p> <p>If supported, UHW will develop a detailed business case which will include an assessment of the resources available and what is required to deliver a Major Trauma Centre. Any additional resources required will be required over a period of time. Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:</p> <ul style="list-style-type: none"> • a front door Emergency Unit service with a major trauma team leader available 24/7 • increased critical care capacity in line with modelling for additional major trauma activity • additional theatre capacity • creation of a polytrauma unit. <p>There are plans being developed to address each of these, dependent on the outcome of consultation.</p> <p>Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site</p> <p>Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.</p> <p>In addition, it should be noted that the development of a major trauma network in the region will be taking place in the context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are broadly committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.</p>

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Infrastructure requirements (continued)	Should the development of the Major Trauma Centre be part of wider discussions regarding the redesign of UHW?	Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site. A Business Case will be submitted to Welsh Government later this year, reflecting a phased development plan.
Existing service provision	The Major Trauma Centre should be on the same site as thoracic surgery.	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site rather than the current two. A subsequent recommendation was made by an independent panel that that the site should be Moriston Hospital. The panel specifically considered the issue of colocation. The issue of colocation of the Major Trauma Centre and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the Major Trauma Centre.
	There is a need to ensure that there is access to 24/7 interventional radiology at the Major Trauma Centre.	This area is being addressed on a regional basis between Cwm Taf, AB UHB and C&V UHB. A plan has been developed to establish a 24/7 rota. This includes some additional appointments, one of which has already been made (start date August 2018). A Business Case is being developed for a hybrid theatre to support the interventional radiology work. In addition to this there is currently work ongoing in Cardiff to finalise the capital plan for an additional single plane interventional suite in order to ensure that there is sufficient room time available across the working week to support regional working. At the point where the major trauma centre is in place there will need to be considerations as to how the rota works to ensure immediate availability of the appropriate staff. This will include extending the on call arrangements for the nurses and radiographers, which has been identified as part of the major trauma case.
	Waiting times for neurosurgery are too long.	Waiting times for Neurosurgery are longer than we want them to be but have been steadily reducing since the Summer supported by improved repatriation and some additional theatre capacity at UHW (201 patients were waiting over 36 weeks at the end of August, down to 81 at the end of January). The service has plans to reduce waiting times further through 2018/19, with the support of WHSSC. A review of Neurosciences is due to conclude shortly which will inform longer term planning.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Existing service provision (continued)	Moving neurosurgery back to Morriston hospital to sit alongside burns unit would not be a major problem.	The location of neurosurgery at UHW was previously the subject of a formal consultation based on the best available evidence.
	How will proposals work given the configuration of burns and plastics and neurosurgery?	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together. Burns and plastics is already a supra-regional service provided from Morriston Hospital. Neurosurgery is already a regional service provided from UHW. Patients are already managed across the two sites relating to their primary needs.
	Concern that the existing Burns and Plastic Surgery service could be moved from Morriston to UHW.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Whilst it is not critical that the burns and plastic centre is on the same site as the major trauma centre, it is important that UHW and Morriston Hospital work together. There are no plans to move Burns and Plastic surgery Services from Morriston Hospital.
	Significant gaps in community neuro-rehabilitation.	Community neuro-rehabilitation will need to be addressed. This issue does not call into question the recommendations of the Independent Panel.
	Concern about impact on local A&E services, including waiting times for local residents needing A&E services at the site of the Major Trauma Centre.	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency units in North Wales. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the Major Trauma Centre or receive initial treatment at a trauma unit before being transferred to the Major Trauma Centre. Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Existing service provision (continued)	Have plans for Hywel Dda have been taken into account, with the proposed closures?	Plans from Hywel Dda may impact on the future configuration of Accident and Emergency units, but will not be material in relation to the overall recommendations of the Independent Panel.
	Need to consider what services could come off the UHW site.	Cardiff and Vale UHB is working closely with other health boards on a review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough which would similarly be subject to further engagement.
	Difficulties with moving patients into community settings within Cardiff and Vale.	Other than through improving survival, the implementation of the major trauma network will not impact on the need for care in community settings in Cardiff and Vale. Patients will be repatriated to their home health board before requiring community based care.
	It may be unclear to the general public the level of accident service hospitals across South Wales presently offer in respect of serious injuries.	To accompany any implementation plan and information for the public on the use of the Major Trauma Centre and major trauma network, clear guidance will be provided outlining the range of Accident and Emergency services available throughout the region.
Financial resources	Whether the anticipated costs of this development are being considered in comparison to other ways of spending the money to support other patient groups, comparing years of quality life added.	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Financial resources (continued)	Concern about whether there is enough money to implement the Major Trauma Network and Major Trauma Centre and to provide 24/7 365 day service provision.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government. See section 9 for further information about proposed financial arrangements.
	Need for detailed costs and to understand what money will health boards contribute towards the Major Trauma Centre and how WG will support this.	WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government. See section 9 for further information about proposed financial arrangements.
	Need a national approach to commissioning, including new SLAs, recognising that this would not all be new work at UHW.	
Workforce requirements	Concern about the network's ability to ensure adequate staffing and adequate training for staff.	A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network. A network provides real opportunities for greater sharing and training across the region.
	Concern about the ability to recruit and retain staff (including doctors) away from the Major Trauma Centre.	One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites. Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.

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Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Workforce requirements (continued)	How will staff be occupied if they are not dealing with a major trauma?	<p>The Major Trauma Centre will meet the service specification set for staffing. It would be up to the Major Trauma Centre how they achieve this.</p> <p>The majority of staff involved in initial trauma care would have other duties in the hospital from which they can be rapidly released when a trauma is admitted.</p> <p>As in other major trauma networks it is likely that some substantial or even full time roles would be required to manage trauma patients - e.g. major trauma practitioners who coordinate and review major trauma patients in the Major Trauma Centre on a daily basis.</p>
	Adequate training, staffing, resources to support air ambulance if they need to make further/longer journeys.	<p>If the proposal is supported, EASC as the commissioner for Welsh Ambulance Service trusts and Emergency Medical Retrieval and Transfer Service will identify detailed training requirements for the workforce. This will then be part of the commissioner intentions for the service.</p>
Transport and infrastructure requirements	Road infrastructure and public transport requirements.	<p>There are various patient transfer options that will be used with the proposed major trauma network. Travel times were considered by the Independent Panel. Public transport is not a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport. Nevertheless, it is recognised that there will be an impact on families and carers who might have to travel further while the patient is being treated in the Major Trauma Centre. It is important to note, however, that patients would typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated.</p> <p>Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.</p>

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Access and support for families	There is a need to ensure that the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the Major Trauma Centre, parking etc.	<p>The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked at the Independent Panel to outline how they would address support for families.</p> <p>Patients will typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated to their local hospital for ongoing care and rehabilitation if required.</p> <p>Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.</p> <p>It should be noted that patients are already transferred to UHW from across the whole region for some highly specialised services and there are arrangements in place to support families where appropriate. This will be considered further as part of the overall implementation of the network and development of the Major Trauma Centre.</p> <p>A new charity-funded building providing accommodation and facilities for families whose children are receiving treatment in UHW has recently been opened. Some accommodation is also available on the UHW site for families of adult inpatients.</p>
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST)	EMRTS/Air Ambulance does not operate 24/7 and cannot operate at night.	<p>At present, the Emergency Medical Retrieval Transfer Services (EMRTS) and Wales Air Ambulance operate a 12-hour service from 8AM to 8PM. If during this time it is dark, the Wales Air Ambulance charity helicopters are able to transfer patients between hospitals where approved landing sites with lights are available. Otherwise a specialist car known as a rapid response vehicle will attend the scene of the incident. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority.</p> <p>Future operational arrangements of EMRTS and the Wales Air Ambulance will be reviewed during implementation. This will include consideration of both demand and cost/benefit, taking into account any additional survival benefit associated with additional operational hours. Operational hours will be reassessed in the light of this assessment. Further advice about operational procedures will also be taken during implementation, informed by experience elsewhere in England and Wales.</p> <p>Any constraints in coverage will apply irrespective of the location of the Major Trauma Centre.</p>

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST) (continued)	The impact of the major trauma network on the WAST and EMRTS.	<p>The rationale outlined by the Independent Panel has been reconsidered and endorsed. WAST and EMRTS presented at the Independent Panel and outlined the impact the Major Trauma Centre would have on them if located at either Morriston Hospital or UHW.</p> <p>If the proposal is supported, EASC as the commissioner for Welsh Ambulance Service trusts will do detailed modelling work which will form part of their future commissioning intentions from health boards.</p> <p>As part of the next phase, further work will be undertaken to develop pathways and the commissioning framework.</p> <p>From an emergency standpoint, these patients already exist and are already managed by WAST and EMRTS/Wales Air Ambulance on a day to day basis. The actual increase in ambulance work is only likely to reflect the small number of patients who travel a short additional distance to reach an Major Trauma Centre, rather than being taken to their local hospital.</p>
	Accessibility of air ambulance when Swansea based helicopter is committed elsewhere.	This is already a constraint and would remain so however trauma services are configured.
	May need to re-assess the way in which ambulance calls are currently prioritised given that the proposal will rely on patients being transferred on occasions from one hospital to another within the network.	This will form part of the implementation plan.
Lack of evidence	Is there sufficient evidence to demonstrate that the current situation disadvantages patients? Major trauma is rare and has been treated well in the present centres.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Consultation process	Politically motivated decision.	Arrangements for an Independent Panel of experienced experts in the field of major trauma (predominantly from outside Wales) were agreed by health boards January 2017 (see section 3.3). The Independent Panel undertook its deliberations and developed its recommendations free from political interference. The decision to consult on the recommendations was taken by health boards and health boards will make final decisions, informed by the report of the consultation.
	The terms of the consultation, might be seen as implying a level of approval by NHS Wales of the recommendations of the expert group. Would have been more appropriate if the public had been invited to comment upon how the expert group had assessed the pros and cons of three options – Bristol, UHW and Morriston.	The report of the Independent Panel was considered by boards in public in September 2017. Boards accepted the recommendations subject to formal public consultation. The use of the Major Trauma Centre in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a Major Trauma Centre located within the region. This ruled out the option of relying on services from the Bristol Major Trauma Centre. The 2015 option appraisal workshop included health boards and the Welsh Ambulance Service Trust. Patient representatives from voluntary and charity support groups from across the region were invited. The CHCs were also invited to observe. A consultation exercise has been conducted that meets the requirements of the applicable Welsh Government guidance.
	Final details for the consultation only became clear in October, concern not widely publicised and great reliance on social media and Christmas period.	The timescale for the consultation was agreed with CHCs. A period of 12 weeks (as opposed to the required eight) was adopted to allow for the impact of the Christmas period.
	Roles of two sites not clearly defined in layman's terms.	The roles of the Major Trauma Centre and trauma units were clearly described in the consultation material.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Consultation process (continued)	Concern about whether the consultation has been genuine and extensive and has complied with the Gunning principles.	In line with the Gunning principles, the consultation process was reviewed against consultation and engagement guidance by health boards and CHCs at mid point. No further changes were advised. Conscientious consideration was given to the outcomes of the consultation process at all relevant times.
	Insufficient information to base a decision on the location of the Major trauma Centre.	Web page provided the technical documents considered by the Independent Panel. All the relevant criteria on which to base the decision were made clear during the consultation process.
	Not enough publicity has been given to the public meetings or the consultation. Request for extension/rerun of consultation process due to poorly advertised/attended public meetings.	Health boards ran a public meeting in each district. Individuals/organisations were able to respond to the consultation via Freepost, online, email. Each health board agreed the local arrangements with its local CHC.
	Should be a decision of the population.	A formal public consultation was undertaken from 13 November 2017 until 5 February 2018, in conjunction with CHCs and in accordance with Welsh Government guidance.
	Further information would have been welcome in relation to the geographical spread of incidents resulting in major trauma in recent years and how well the network is working in North Wales.	It is considered that the information provided during the consultation was adequate.










Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Role of the Independent Panel	Concern that the independent panel was not independent and not in touch with patients.	Arrangements for an Independent Panel of experienced experts in the field of major trauma were agreed by health boards in January 2017. Panel members were selected to provide specific professional expertise It was not part of the role of the panel to be representatives of patients. CHCs were observers at the meeting of the Independent Panel (see section 3.3 for additional information about the Independent Panel and its composition).
	Terms of reference were too limited, requiring the Independent Panel to assess the current clinical capabilities of two hospitals. They should have advised whether South Wales needs to have an Major Trauma Centre and if so to assess where this would be best located in order to complement existing range of Major Trauma Centres in England and so strengthen the major trauma coverage for populations within England and Wales as a whole.	An option appraisal in 2015 agreed that, to support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a major trauma centre located within the region. This ruled out the option of relying on services from the Bristol major trauma centre. The potential for a dual site solution was considered, but subsequently eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.
Needs based decision	Should look at the needs of the community, current services and demographics.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Independent Panel considered evidence compiled across the life of the project, including travel, demographics and service provision.

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Social and economic impact	No political guidance was given regarding the wider strategic direction e.g. should broader economic and social considerations have been taken into account and should Welsh government have chosen to see any major trauma centres sites in south Wales as needing to complement existing chain of Major Trauma Centres operated by NHS England – upon which Welsh residents currently rely.	This was out of the scope of the consultation.
	There are concerns about the social and economic impact of further investment in Cardiff at the expense of other areas.	
Decision making process	Were the options considered subject to a Health Impact assessment (HIA) as part of the work carried out by the panel in arriving at its recommendations. Suggestion that one is carried out before recommendations are progressed.	An Equality Impact Assessment was carried out as part of the consultation process. The establishment of a major trauma network will contribute to the delivery of aims of the Wellbeing of Future Generations (Wales) Act 2015, by supporting the delivery of a 'healthier Wales' and the goal to "develop a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood".

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Implementation of the Major Trauma Network	Concerns about why it has taken this long to develop proposals for a Major Trauma Network for the region.	This was out of the scope of the consultation.
	Whatever service results it is fully accessible for people who are deaf or have hearing loss. The care they receive and co-produce is as dignified and clinically optimal as that of a hearing person. Currently a stream of work going around on accessibility for people with sensory loss in each health board and it is a priority each health board reports back to WG on.	Requirements for equality of access apply to all services. During implementation work will be undertaken to ensure that the specific needs of those with protected characteristics, including the deaf and hard of hearing, are identified and addressed.
	There is a need to ensure that the therapy professions are appropriately involved in the implementation of the network.	Implementation will need to involve professional bodies, as appropriate.
	The Royal College of Midwives should be part of the major trauma network.	

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Implementation of the Major Trauma Network (continued)	There is a need to ensure that there is excellent communications between professionals and with the public during the implementation and delivery of the network.	The need for a clear communication strategy is accepted and will be included as part of implementation plans.
	Delays in repatriation may be exacerbated by the increased numbers of patients coming to UHW if it were the Major Trauma Centre.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Health boards will need to agree and implement a patient flow policy which supports 'automatic acceptance' at the centre and 'repatriation' as soon as possible.
	There is a need to ensure that digital solutions are used where possible.	The need to make appropriate use of technology in implementing the Major trauma Network is accepted.
	There is a need to ensure that implementation proceeds quickly once the decision has been made.	An appropriate and measured implementation plan will be developed.
	Effectiveness of moving to the model advocated will need to be monitored. Has consideration been given to deriving an appropriate methodology by which this can be done should the network be established. It would be necessary to assess the effectiveness based on outcomes.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. TARN is an outcome based monitoring tool, used for management of major trauma across England and Wales. All health boards subscribe to this.

Supporting Documents

Supporting Document 1	Initial Equality Impact Assessment (EqIA)	 Supporting Document 1 - EqIA.ç
Supporting Document 2	Board Report - January 2017	 Supporting Document 2 - Board
Supporting Document 3	Independent Panel Terms of Reference	 Supporting Document 3 - Indep
Supporting Document 4	Independent Panel Agenda	 Supporting Document 4 - Indep
Supporting Document 5	Independent Panel Report	 Supporting Document 5 - Expert
Supporting Document 6	Board Report – September 2017	 Supporting Document 6 - Board
Supporting Document 7	Consultation Plan	 Supporting Document 7 - Consu
Supporting Document 8	Details of Public Meetings	 Supporting Document 8 - Detail
Supporting Document 9	Consultation Mid Way Review	 Supporting Document 9- Consu
Supporting Document 10	Collaborative Executive Group Paper – January 2018	 Supporting Document 10 - Colla
Supporting Document 11	Numerical and Thematic Analysis of Consultation Responses	 Supporting Document 11 - Num
Supporting Document 12	Analysis of Consultation Responses Against Framework	 Supporting Document 12 - Anal
Supporting Document 13	Post Consultation Equality Impact Assessment (EqIA)	 Supporting Document 13 - Post

NHS WALES HEALTH COLLABORATIVE
A MAJOR TRAUMA NETWORK FOR SOUTH AND WEST WALES AND
SOUTH POWYS

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Revised – October 2017

About this document

This technical document has been produced to provide background evidence to support information provided within the NHS Wales Health Collaborative public consultation on the development of a major trauma Network for South and West Wales and South Powys.

This document is meant as a reference guide, it does not provide exhaustive detail. It aims to provide an overview of our findings to date about what groups within our population may be affected by our proposals and in what way. It is a living document and will be added to by information gathered during consultation and ongoing through all stages up to and including delivery of services where actual impact will be monitored.

1. Background

In late 2014, the Health Collaborative was asked by the Chief Executive Officers (CEOs) to develop a service model for a major trauma network for south Wales. A Project Board was established, supported by a clinical reference group (CRG). Both groups comprised representatives from each of the Health Boards in the region, Welsh Ambulance Service Trust (WAST), Emergency Medical Retrieval and Transfer Service (EMRTS) and Welsh Health Specialist Services Committee (WHSSC). North Wales is already part of the West Midlands Major Trauma Network with the major trauma centre in North Staffordshire. North Powys also participates in the West Midlands Major Trauma Network

The service model for major trauma services for adults and paediatrics was developed by the Clinical Reference Group (CRG) in line with the standards for major trauma and was approved by the Project Board in May 2015. A detailed model for supporting rehabilitation was also

developed through a wide stakeholder group and supported by all Health Boards. The standards for major trauma have been written by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Clinical Excellence (NICE) and say what services should be available for a patient with major trauma: From the response to an accident, transfer to a major trauma centre or trauma units, immediate treatment and urgent surgery, ongoing medical care and further surgery, and rehabilitation. The standards also say what services should be in a major trauma centre, trauma units, and how the network should work.

1.2 The case for change

'Major Trauma' is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity (CAG 2010). Less than 0.2% (2/1000 patients) of the people attending their local emergency department will have a major trauma. In 2016/2017 in South Wales, approximately 1,234 people attended a local emergency department with a major trauma, compared with 617,000 people attending emergency departments in total (www.statswales.gov.wales). Major trauma cases are complex and due to the small number it is a challenge for hospital staff to maintain their highly specialist skills in trauma care. The data used to develop the proposed service model is based on 2014 TARN (The Trauma Audit and Research Network) data. The data available at this time did not cover all south Wales hospitals and Emergency Medical Retrieval and Transfer Service (EMRTS) was not in place and therefore was likely to under-represent the true number of major trauma patients in the region, however it should be noted that numbers are still small.

A number of reports have been produced by organisations such as the National Confidential Enquiry into patient Outcome and Death (NCEPOD), National Institute of Clinical Excellence (NICE), the Department of Health Clinical Advisory Group and the National Audit Office, outlining the provision of trauma care across England, Northern Ireland and Wales. The reports talk about poor care and outcomes received by patients resulting from a lack of trauma networks.

As a result of these reports, England has established trauma networks across its region. North Wales is part of the west Midlands major trauma network and the major trauma centre for the region is in Stoke, North Staffordshire. South Wales is the only region across England and Wales that is not part of a major trauma network nor has access to a designated

major trauma centre. Scotland has made progress in identifying the key components of its trauma network and is moving toward implementation. Across South Wales, major trauma cases are currently managed through informal arrangements across the health boards, with some more complicated cases either admitted directly or transferred to the bigger regional centres – mostly University Hospital of Wales or Morriston Hospital. While this clearly benefits patients, it does not have the proven advantages of an established major trauma network.

A trauma network comprises a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receives the best care for life threatening or life changing injuries and in general includes one major trauma centre (MTC) and several trauma units (TUs) spread across the region. Where there is a major trauma network, it is expected that more patients will survive and make a full recovery, irrespective where in the region they suffer a major trauma.

An established major trauma network can have a significantly positive impact on the population in the region. The key benefits of developing the major trauma network are expected to include:

- Fewer people die: Evidence shows that severely injured patients are 15%-20% less likely to die if they are admitted to a major trauma centre (Clinical Advisory Group, 2010)
- Patients receive the best possible care at the most appropriate site from highly specialised teams, providing 24/7 emergency care with access to the required specialist services
- Patients are less likely to have a long term disability
- Patients require less long-term NHS care
- Patients will have an improved ability to return to work and undertake other activities
- Services meet clinical standards
- The network will enable access to be optimised to services to support patients to return as close to home as soon as possible
- The NHS is able to better plan for and respond to major incidents, improving the care major trauma patients will receive
- Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma

network will facilitate delivery of this, ensuring the best use of resources, making the major trauma centres and trauma units more sustainable

- Local A&E units are less likely to be disrupted by admission of inappropriate major cases that can affect the ability of the department to manage its more routine workload.

1.3 Impact on workforce

Establishing a major trauma network also has significant benefits for the individual organisations who are part of the network:

- It provides an opportunity to develop the skills and expertise of existing staff at the trauma units and local hospital sites through closer working with the highly specialist clinicians and other staff at the major trauma centre
- A network with a clearly identified major trauma centre and trauma units is likely to have a positive impact on recruitment across the network
- The establishment of a network is likely to receive support from the Deanery, meaning it is more likely that trainee doctors will be allocated to hospitals across the network to undertake their training
- Services are delivered within a clinical network which allows improvement to be made through an integrated, whole system approach, resulting in standardisation of services and improved patient outcomes & experience
- Clinical services in south Wales for major trauma align with the rest of the UK and will allow the Welsh NHS to be more effective as part of the national response to major emergencies.

1.4 Equality And Human Rights

Under the Equality Act 2010 we have a legal duty to pay due regard to duties to eliminate discrimination, advance equality and foster good relations between those who share protected characteristics and those who do not.

This means that we need to take into account the needs of people from different groups within our populations who might be affected by our proposals. We must take reasonable and proportionate steps wherever

possible to eliminate or mitigate any identified potential or actual negative impact or disadvantage. Developing a major trauma network also gives us the opportunity to identify and enhance any potential positive impact on protected groups. The Equality Act 2010 gives people protection from discrimination in relation to the following “protected characteristics”¹

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

The Human Rights Act 1998 also places a positive duty to promote and protect rights for all. In Wales, we also have a responsibility to comply with the Welsh Language (Wales) Measure 2011 and All Wales Sensory Loss Standards for Accessible Communication and Information for People with Sensory Loss. We will take all our legal duties into consideration when we make decisions around developing a major trauma network.

¹ Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

Equality Impact Assessment (EqIA)

In Wales, we are required under the Public Sector Equality Duties to undertake Equality Impact Assessments (EqIAs) which will assist us to consider how the decisions we make affect people from protected groups in different ways.

We recognise that consideration of the needs of protected groups helps us to develop and deliver cost-effective services and person-centred care, ensuring that people are treated fairly and equitably.

EqIA is an ongoing process running throughout the course of the decision making process, from the start through to implementation and review. It requires us to consider how the development of a major trauma service, operating within a major trauma network structure for south Wales, south Powys and west Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

EqIAs require analysing impacts on the basis of the above protected characteristics. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a major trauma network and major trauma centre on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence and engagement with key stakeholders has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage.

While socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies.

The report *Transport and Social Exclusion: Making the Connections* (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics.

The proposals under consideration for the establishment of a major trauma network will result in the centralisation of life-saving treatment for a very small number of patients but with the most serious and complex injuries. Trauma units and a comprehensive rehabilitation service will ensure that as a patient's condition improves, responsibility for ongoing care will transfer to healthcare facilities closer to home.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' (those most likely to experience major trauma events) and the sections of the population which are likely to be most affected by the major trauma proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

A literature review was carried out as a first stage of gathering evidence to inform the EqIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders to develop the service model.

2.1 Potential impacts on protected characteristic groups?

The first observation to make is that major trauma tends not to be closely associated with particular equality groups; events are not simple to predict on the basis of socio-economic characteristics. However, evidence suggests that should you suffer a major trauma, you are more likely to survive and make a full recovery if you are in a region where there is a major trauma network, regardless of how far you are away from the major trauma centre.

Evidence suggests there are a number of protected groups who may be likely to suffer a major trauma.

2.1.1 Gender

Men are at far higher risk of experiencing major trauma than women. The NCEPOD report² showed that 75% of major trauma was in men. This is borne out by local data: in 2013, data for University Hospital of Wales, Cardiff, and Morriston Hospital, Swansea, shows that 70% of major trauma was in men.

Young men are at greater risk of being involved in major trauma accidents, typically arising from moving vehicles, tools or work.

2.1.2 Age

Age is a risk factor for suffering major trauma. It is the leading cause of death for people under 45 years and a significant cause of short and long-term morbidity (National Clinical Advisory Group, 2010)³.

There is evidence, of a rising number of falls in the elderly that should be managed within a major trauma pathway and supported with a frail elderly rehabilitation pathway. The conclusion to a study published in 2015 (Emergency Medical Journal, 2015)⁴ suggested that the major trauma population in the UK is becoming more elderly and the predominant mechanism that precipitates major trauma is a fall from lower than 2 metres.

Teenagers and young adults are more likely to need hospitalisation from injuries than other age groups.

² Trauma: who cares? A report of the national confidential enquiry into patients outcomes and deaths (NCEPOD) (2007)

³ NHS Clinical Advisory Groups Report: Regional Networks for Major Trauma (2010)

⁴ The changing face of major trauma in the UK *Emerg Med J* 2015;**32**:911-915

Children under the age of 15 only account for a very small percentage of major trauma and deaths as a result of major trauma.

Potential impact –Involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from.

Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the major trauma network have all the skills required to care for these patients.

There is a need to consider further the transitional needs of young adults aged between 16 and 18 to ensure that they receive appropriate care and rehabilitation in an age-appropriate setting

Young people may also have different needs, and may require facilities to have relatives closer to them, for example in family rooms for patients from further away or more rural areas. When treating children, the service model will additionally follow the standards and criteria outlined for children's services⁵.

2.1.3 Race

Major trauma is more than twice as common in urban areas due to concentration of traffic and people. Additionally, it has been identified that people from Black, Asian and other Ethnic Minority backgrounds are at a higher risk of incidence and mortality from major trauma, at least in part due to a correlation with concentration in urban areas and the relationship of minorities, deprivation and major trauma incidents⁶.

Potential Impact - Engagement with stakeholders on the rehabilitation element of the patient pathway identified that there is a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in their first language. Cultural issues are also important to take into account and a toolkit is available for this purpose.

2.1.4 Disability

Major trauma is the national leading cause of disability for those under 45 years of age. The improved number of survivals in young adults and

⁵ <http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>).

⁶ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

reduced incidences of disability resulting from major trauma will also improve the rate of return to work and socio-economic functioning. Evidence shows that there is a five to fifteen-fold return on the investment made in treatment. As most major trauma patients tend to be of working age, this is an important indicator that given the right care, it is possible for people suffering the most serious injuries to recover sufficiently to go on and have an active working life (NHS East Midlands, 2010)⁷.

Potential Impact - Engagement with stakeholders on the rehabilitation element of the patient pathway identified that Rehabilitation services should give choice to patients with pre-existing mobility issues, for example patient with multiple sclerosis should receive the same options for treatment. Specific patient needs, such as bariatric needs should be considered to ensure the provision of appropriate equipment across boundaries and within social care sector. As well as physical disability, there is a need to consider learning disabilities and mental health. Communication needs in these client groups may be more challenging and care should be adapted accordingly, for example, where there is a need for BSL interpretation services.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss⁸ that apply directly to emergency and unscheduled care (in addition to primary care and other secondary care services) and these outline the staff training requirements, communication systems and equipment and patient needs information which should be provided by health boards. BSL interpreters will be required for the deaf community.

2.1.5 Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

2.1.6 Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

2.1.7 Religion or belief (including lack of belief)

⁷ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

⁶ All Wales Standards for Communication and Information for People with Sensory Loss 2013)

Potential impact - staff need to consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them⁹. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered. As previously a comprehensive cultural awareness toolkit is available for this purpose.

2.1.8 Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, lesbian, gay, bisexual and transgender (LGBT) patients in Wales report significant barriers to health and social care services¹⁰. Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. Inappropriate assumptions are also made about 'next of kin' if they are in a same sex relationship. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks.

Potential Impact - There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall have commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

2.1.9 Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth.

Potential Impact - In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015¹⁹ Trans* people must be accommodated in line with their gender expression. This applies to toilet facilities, wards,

⁹ http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

¹⁰ <http://www.stonewallcymru.org.uk/our-work/research/have-your-say>

outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's Gender Recognition Certificate or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

2.1.10 Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure 2011. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. Whilst we recognise that Welsh and English are Wales' official languages, Wales has many different voices. Like two-thirds of the world's population many people in Wales are bilingual or multilingual. This is particularly important in traumatic situations where people are more likely to need to communicate in their first language.

Potential impact - Service users who prefer to communicate in the medium of Welsh may be required to access highly specialist services which do not have sufficient Welsh speaking staff (this may also be the case for languages other than English). This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account.

The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. However it is important to recognise groups of other individuals who have suffered life changing conditions that may benefit from community through the medium of Welsh. Research has shown these groups cannot be treated safely and effectively except in their first

language (Welsh Language Services in Health, Social Services and Social Care, 2012)¹¹. Our consideration of equality takes account of this.

2. Next Steps

The needs of protected groups will continue to be an ongoing consideration during the consultation process and when implementing the consultation plan, health boards will need to ensure that venues for the public events are accessible and the NHSWCH will need to ensure that information can be provided in a variety of required alternative formats in order to maximise opportunities for participation.

Through the next phase of consultation we will consider what people may tell us about how they will be affected by the proposals in relation to their protected characteristics so that we may seek to eliminate or mitigate any potential disadvantage.

We will continue to update the assessment of impact by taking into account feedback given to us during the consultation.

The health boards will be fully informed of the outcome of the assessment and results will be published for public scrutiny.

¹¹ More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)



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Briefing Paper

Major Trauma

Author: Rachel Jones, Programme Director, Strategic Planning

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Publication/ Distribution:

Abertawe Bro Morgannwg University health Board
Aneurin Bevan, University Health Board
Cardiff & Vale University Health Board
Cwm Taf, University Health Board
Hywel Dda University Health Board
Powys Teaching Health Board

Purpose and Summary of Document:

This paper asks for Health Board to note the process agreed to deliver on making a recommendation for a preferred location of a major trauma centre to cover the region of south Wales, west Wales and south Powys.

The Board/Committee are asked to

Approve

Discuss

Receive

X

1 Introduction

This paper is to provide an overview of the proposed process to identify a preferred location for the major trauma centre (MTC) for south Wales, west Wales and south Powys.

2 Background

An independent panel of specialists from across trauma and rehabilitation services in the UK has been commissioned to review the information available and will make a recommendation on the preferred location for a MTC in the region.

3 Assessment

3.1 The Independent Panel

The Independent panel comprises representatives from across major trauma services in the UK. Panel members were invited on the basis of their national and international reputations as experts in trauma care and the development of trauma systems. All have been involved in the development of regional major trauma systems. The Panel will be chaired by Professor Chris Moran, the National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital and will include experts in key specialities that are essential for managing patients with severe multiple injuries as well as rehabilitation.

3.2 Expectations of the Candidate MTCs

The candidate MTCs are Morriston Hospital, Swansea and University Hospital of Wales, Cardiff. This was confirmed as part of a non financial option appraisal which took place in June 2015 and involved clinicians from across the region. The outcome of the options appraisal was approved by the Collaborative Board in August 2015.

Formal invitations have been sent to the candidate Health Boards, outlining the expectations of the panel in terms of the information provided prior to and on the day.

Each candidate MTC is invited to bring a small team of representatives, including their trauma and rehabilitation lead, to present to the Panel and answer any questions or issues which may arise. The candidate MTCs will be expected to talk about their current services and how they will address the provision of specialist services, including:

- Neurosurgery
- Plastics
- Interventional radiology
- Paediatrics
- Cardiothoracics
- Maxillo-facial
- Critical care capacity
- Rehabilitation

They will also be expected to address their proposals for the service on day one, medium term and longer term and make reference to how relatives and carers will be supported. Each Candidate MTC will also be required to present their TARN data and discuss their response to the major trauma self assessment document.

The major trauma self assessment document is a set of quality indicators developed from the National Service Specification for Major Trauma (NHS England D15/S/a 2013) and the NHS clinical advisory group report on Major Trauma Workforce (CFWI March 2011). They support the NHS England Quality Surveillance programme for major trauma services in England enabling quality improvement both in terms of clinical and patient outcomes. The indicators cover the whole organisation of adult and children's major trauma services including sections for Major Trauma networks, pre-hospital care via ambulance services, Adult Major Trauma centres, Children's Major Trauma centres and Major Trauma units. It is expected that the candidate centres have this information available. They have been advised that no evidence is required to support their answers at this stage, but they should be prepared to discuss their answers during the Panel and may be required to provide supporting evidence at a later stage.

3.3 Structure of the day

Alongside the presentations from the Candidate Health Boards, Public Health Wales will be invited to present on the public health context in which the work is being taken forward and EMERTS/WAST are invited to present on activity levels, current experience when presenting at accident and emergency at either of the candidate sites and the anticipated challenges should either site be identified as the MTC. Members of the forum will be given the opportunity to question the candidate sites on aspects of their presentation in order to facilitate openness and transparency.

3.4 Stakeholder representations

It is proposed that the forum comprises representatives from across the health service in the region alongside other key stakeholders and will include representation from the following:

- Clinical representative from Aneurin Bevan, Cwm Taf, Hywel Dda and Powys Health Boards
- Public Health Wales
- Representation from Health Board Chairs
- Community Health Councils
- EMRTS and WAST
- WHSSC
- EASC

Welsh Government will also be offered the opportunity to have an observer at the event.

3.5 Engagement and consultation

The aim of the Independent Panel process is to assist the Health Boards to identify a preferred option for the development of a Major Trauma Centre for south Wales which will then be the subject of full public consultation.

Alongside the process to identify a preferred option will be a period of wide stakeholder engagement which will focus on raising awareness and understanding of the need for the development of a MTC and the benefits to patients. An engagement document is being developed which will support the process and which will be distributed through established networks within the Health Boards and CHCs.

The engagement process and supporting document will articulate the public benefits, including health outcomes, irrespective of where the MTC is located. Prior to any decisions being made about implementation, a full public consultation exercise will be undertaken by each of the constituent health boards, together with their local Community Health Council in line with Welsh Government guidance.

3.6 Next Steps

Following the Independent Panel event, the independent experts will further review all the evidence provided and presented on the day. Professor Moran as Chair of the Panel will then present a report back to the NHS Wales Collaborative Leadership Group making a recommendation on the preferred location of the MTC for the region.

The recommendation will be then presented to the Health Boards whose populations are affected by the development of the MTC for decision to proceed to public consultation. The Health Boards involved will be:

- Abertawe Bro Morgannwg UHB
- Aneurin Bevan UHB
- Cardiff and Vale UHB
- Cwm Taf UHB
- Hywel Dda UHB
- Powys tLHB

Betsi Cadwalader UHB is not included on the basis that North Wales patients have major trauma services provided from within the neighbouring English Regions.

Each Health Board will be required to consider and agree the recommendation through their individual governance arrangements and make the decision to proceed to public consultation in their Board meeting in public.

On the assumption that agreement is reached by each of the constituent Health Boards to consult on the preferred option arising from the independent panel

process, a full consultation exercise will commence. This is anticipated to take place over the Summer months.

The outcome of the public consultation process will be brought together through the Collaborative Leadership Forum and then reported back through constituent Health Boards through their public meetings for decision. This is likely to be late summer / early autumn 2017.

It should be noted that the decisions to both consult on a preferred option and to ultimately make a decision on the establishment of a Major Trauma Centre to serve the population of south Wales, west Wales and south Powys are reserved for Boards through their individual governance arrangements.

4 Recommendation

The Board is asked to:

- **Note** the arrangements for the Independent panel to consider the evidence regarding the establishment of the proposed Major Trauma Centre
- **Note** the process to bring forward a recommendation of a preferred option for public consultation

Major Trauma Independent Panel

Background briefing

Purpose

This briefing paper provides members of the Independent Panel with background information in support of the meeting being held on 21st February, outlines the additional documentation which panel members will receive, and sets the context for the day. The outputs of the work to date will inform the Independent Panel meeting; this is outlined below. The panel will consider the information and presentations on the day, and will identify a recommendation for the preferred location of the major trauma centre

Introduction

The NHS Wales Health Collaborative, on behalf of the south Wales health boards (Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf, Hywel Dda and Powys) and Welsh Ambulance Services NHS Trust, has been leading a project to develop a model for a major trauma network for the region. In May 2014, the South Wales Health Collaborative Board approved the establishment of project management arrangements to take forward planning proposals. A wide range of work has been completed to support this process across two phases of work, which are detailed in this report.

Process to date

A Project Board and Clinical Reference Group were established, to develop a detailed service model which sets out the standards and requirements for the establishment of a major trauma centre, supporting trauma units and a model for rehabilitation operating within a formal network arrangement.

The first phase of the project concluded in June 2015 with a non-financial option appraisal process to consider the options for delivery of a major trauma centre for south Wales, south Powys and west Wales. This process concluded there should be a one site major trauma centre in South Wales either at Morriston Hospital in Swansea or at the University Hospital of Wales, Cardiff.

The second phase of the work considered the process for reaching a decision on the location of the one centre, supporting trauma units and the model for rehabilitation. This phase of the project is currently being delivered and the outcome of this work will be a suite of information to enable recommendations to Boards on the location of a major trauma centre, which comprises the following:

- The clinical, workforce and financial Impact of a major trauma centre at either of the two shortlisted options
- Review and confirmation of location/designation of trauma units
- Confirmation of Ambulance transfer times/Emergency Medical Retrieval & Transfer Service (EMRTS) Cymru to assess the relative accessibility of both options

- Model for rehabilitation
- Equality impact assessment
- Engagement and consultation requirements

Three rehabilitation workshops have been held and a wide range of stakeholders have been engaged in the work from health boards, Welsh Ambulance Services, local authorities, third sector, patient organisations and patient representatives. This work has focused on the development of a service model for major trauma rehabilitation and the supporting infrastructure and communication requirements to enable the smooth transition of major trauma patients through the pathway, in order to maximise recovery outcomes. The model focuses on the provision of care at three levels – level 1 specialist rehabilitation in current designated units (Rookwood Hospital, Cardiff and Neath Port Talbot Hospital), level 2 rehabilitation at major trauma units, and level 3 rehabilitation in the community setting. Local discussions are ongoing with health boards to identify the requirements for implementation, ensuring alignment with any current models of rehabilitation in place across hospitals and out into the community.

Activity

Major trauma represents a very small proportion of total emergency workload with current and predicted demand (actual and candidate major trauma) at circa 1000-1500 cases per annum or around 0.2% of total A&E activity. The development of a comprehensive Major Trauma Network, a designated Major Trauma Centre and Units does not undermine the viability of the current A&E units across south and mid Wales but will ensure that the most serious cases are admitted for definitive treatment to the MTC with minimum delay or where necessary are appropriately stabilised for onward transfer. A comprehensive approach to rehabilitation will also ensure those patients who require specialist rehabilitation receive it in a timely manner and will be repatriated to local services for ongoing support at the earliest opportunity.

The MTC Project Board have agreed that the baseline activity for each of the current centres should be based on 2014 TARN data. This is outlined below. Data for the remaining hospitals in the system was not available at this time.

Baseline	UHW	Morrison	Total
Major Trauma	251	175	426
Candidate Trauma	221	280	501
Total	472	455	927

The activity to be accommodated by the single centre has been modelled by NWIS on the basis of predicated incidence, LSOA population and travel time. The model assumes a proportion of activity will be treated, and generates different MTC volumes for the Cardiff and Morrison options:

Modelled Activity	UHW	Morrison
Major Trauma	404	387
Candidate Trauma	455	427
Total	859	814

The additional activity that would be treated under each option would therefore be:

Additional Activity	UHW	Morrison
Major Trauma	153	212
Candidate Trauma	234	147
Total	387	359

Panel members will receive a presentation from Public Health Wales as part of the contextual information on the day regarding the demography and geography of Wales. This will be further supported by presentations from the Welsh Ambulance Services NHS Trust (WAST) and the Emergency Medical Retrieval and Transfer Service (EMRTS) regarding travel times and current service provision.

Information in support of the day

To ensure that panel members are aware of the context of the Independent Panel and the work done to date, this document has set out some background information. It will also be accompanied by a suite of documentation, and this is outlined below:

- Agenda for 21st February
- Terms of reference for the Independent Panel
- Panel member biographies
- List of attendees
- Service models developed for the acute major trauma service and rehabilitation
- Service specification for major trauma service
- Equality Impact Assessment – revised January 2017
- Report of the non-financial option appraisal workshop held on 3rd June 2015
- Completed Major Trauma Quality Indicators return from both health boards
- List of services at both candidate MTC sites

In addition, Abertawe Bro Morgannwg UHB Cardiff and Vale UHB, as the two candidate health boards, have been asked to present on the day on the following:

1. How will the Health Board as the MTC address/provide the following service requirements:
 - Neurosurgery
 - Plastics
 - Interventional radiology
 - Paediatrics
 - Cardiothoracics
 - Maxillo-facial
 - Critical care capacity
 - Rehabilitation
2. How will the MT service be developed and what are the staffing issues that will need to be considered?
3. How will trauma ward provision be addressed?
4. What will the service look like on day one, medium term and longer term?
5. How will relatives and carers be supported in the MTC?

Conclusion

This briefing has set out the background information for panel members in support of the Independent Panel meeting. It provides an overview of the additional documentation members will receive in advance of the day, and sets out the information members can expect to receive at the meeting.



Major Trauma Independent Panel

21st February 2017

10am – 4.30pm

Sytner BMW Lounge, SSE Swalec Stadium, Cardiff. CF11 9XR

10.00am	Arrival and refreshments	
10.30am	Welcome and introduction <ul style="list-style-type: none"> • Aims of the day • Welsh Government context • Declaration of interests • What is major trauma? 	Mr Bob Hudson Frances Duffy Prof Chris Moran
11.00am	Overview of demographics and geography in South and West Wales	Mr Hugo Cosh Public Health Wales
11.30am	Pre-hospital care and patient transport: presentation from Welsh Ambulance Services NHS Trust (WAST)	Dr Brendan Lloyd WAST
11.45am	Pre-hospital care and patient transport: presentation from Emergency Medical Retrieval and Transfer Service (EMRTS)	Dr Dindi Gill EMRTS
12.00pm	Presentation from Cardiff and Vale UHB regarding proposals for a Major Trauma Centre at University Hospital of Wales, Cardiff	C&V Reps
1.00pm	Lunch	
1.45pm	Presentation from Abertawe Bro Morgannwg UHB regarding proposals for a Major Trauma Centre at Morriston Hospital, Swansea	ABM Reps
2.45pm	Coffee break	
3.15pm	Observations on the discussions and opportunity for further questions from panel	All
4.15pm	Summary of the day and next steps	Mr Bob Hudson
4.30pm	Close	

Expert review South Wales Major Trauma System

February 2017

Summary

At the request of the Welsh Health Boards, a panel of independent, clinical experts in major trauma met on February 21st, 2017 to consider the structure of a major trauma network in South and West Wales and the potential site of the Major Trauma Centre within this network. The expert panel reviewed information in advance of the meeting and on the day received presentations from Public Health Wales, the Welsh Ambulance Service plus University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

The expert panel was impressed at the high standard of presentation, the enthusiasm from both clinical teams and the clear support demonstrated by the chief executives, medical directors and senior management teams at both centres.

The expert panel unanimously recommends that the Welsh Health Boards consider the following:

1. The rapid development of a major trauma network for South and West Wales with a clinical governance infrastructure.
2. The adult and children's Major Trauma Centres should be co-located on the same site
3. The Major Trauma Centre should be located at University Hospital of Wales, Cardiff
4. Morriston Hospital should become a large Trauma Unit and should lead the major trauma network
5. A clear and realistic timetable for the activation of the Trauma Network should be set.

Introduction

Major trauma is defined as a life-threatening or potentially life-changing injury. Injuries can occur to a single part of the body or at multiple sites and the best treatment requires a coordinated response from the accident site to hospital care and then rehabilitation. International experience has shown that this is best provided by a coordinated network of hospitals that work together to allow the patient to receive treatment in the most appropriate facility in a safe and timely fashion. The system should be designed to save life and prevent avoidable disability, returning patients to their families, work and education.

Trauma and injuries are common but only 1 in a 1,000 patients who arrive at an A&E department will have major trauma. It is impossible for every hospital to provide comprehensive care for all major injuries and so the network should identify these patients and ensure their rapid and safe transfer to a designated Major Trauma Centre (MTC) that has the facilities to provide comprehensive and definitive care for the patient. In general, each network will have one MTC together with a network of hospitals that have the facility to receive and provide early care for these patients, rapidly identify those that require the additional facilities at a MTC and then provide safe, onward transfer.

Patients in Mid and North Wales who suffer major trauma are currently transferred to designated MTCs in England. South and West Wales has a population of 2.2 million and the Welsh Health Boards are planning to develop a network to cover this area, which has a mixed urban and rural geography and some remote rural populations.

South and West Wales has two large teaching hospitals with the potential to develop into a Major Trauma Centre within the trauma network.

The aim of this review was for a group of independent clinical experts in major trauma to assess the available evidence and provide advice to the Welsh Health Boards on the best facility to site the Major Trauma Centre for South and West Wales.

Members

Professor Chris Moran	Professor of Orthopaedic Trauma Surgery, East Midlands Major Trauma Centre Nottingham University Hospital
	National Clinical Director for Trauma NHS-England
Dr. Fiona Moore	Chief Executive, London Ambulance Service
Mr. Tim Chesser	Consultant Trauma and Orthopaedic Surgeon Severn Major Trauma Centre North Bristol NHS Trust
Professor Mark Wilson	Consultant Neurosurgeon and Pre-hospital Specialist North West London Major Trauma Centre Imperial College, London
Professor David Lockey	Clinical Director for Severn Major Trauma Network Consultant in Anaesthetics and Intensive Care North Bristol NHS Trust
Mr. Shehan Hettiaratchy	Clinical Director North West London Major Trauma Centre Consultant Plastic and Reconstructive Surgeon Imperial College, London
Dr. Rachel Botell	Consultant in Rehabilitation Medicine Peninsula Major Trauma Centre Plymouth
Mrs. Sue O’Keeffe*	Critical Care and Major Trauma Network Manager North Wales

* Mrs. O’Keeffe provided the panel with expert advice on network management and the Welsh Health Care System but did not have voting rights on the panel.

Evidence reviewed

The expert panel was provided with a bundle of evidence that included:

- Briefing
- Terms of Reference for independent panel
- Acute service model
- Rehabilitation service model
- Service Specification
- Equality impact assessment
- Major Trauma non-financial options appraisal
- Major Trauma flow – adults
- Major Trauma flow – children
- List of services currently provided at UHW
- ABMU major trauma indicators
- South Wales major trauma project

The presentations received followed the published programme for the day (Appendix-1).

Issues considered

Institutional commitment

Both Trusts gave excellent and well-researched presentations and there was evidence that both planned investment in the concept of hosting a MTC. There was good clinical engagement and support from most specialties in both centres and strong support from the chief executives, medical directors and senior management teams at both hospitals. Some of the proposals were aspirational and they should be strongly encouraged to deliver on their aspirations.

Geography

Public Health Wales and the Welsh Ambulance Service gave excellent and helpful presentations describing the geography of South and Mid Wales together with the population distribution and the estimated road transfer times to each of the proposed MTCs. In addition, the Welsh Emergency Medical Retrieval and Transfer Service (EMERTS) described their role in pre-hospital management and the facility to provide on-scene medical care, accurate triage and rapid air transfer to either of the proposed MTCs.

Morrison Hospital is geographically more central and has better coverage of the West Wales population but some western and eastern areas would be outside of the proposed 60 minute direct transfer time (by land ambulance) and require secondary transfer. University Hospital of Wales is more central to the urban population and a slightly greater percentage of the population would be within 60 minutes direct transport time. It would provide good coverage for the eastern area but a larger number of patients in West Wales would require initial treatment in a designated local hospital before secondary transfer to Cardiff.

Both hospital sites have excellent road access with motorways close by. Both have acceptable air-ambulance landing facilities.

Overall, the panel concluded that both sites give good access to the population and that geographical factors should not be a major issue in designating the site of the MTC.

Facilities

Reception and Resuscitation

Both hospitals have large accident and emergency departments with the facility to receive and resuscitate patients with major trauma. However, neither hospital has a big enough cohort of Emergency Physicians to support their existing workload. Neither hospital supports ambulance offloads as well as they should. University Hospital Wales has both more ED Consultants and marginally better off-load times. Both Trusts accept that this is an area for investment, and both Trusts will need to plan how they provide 24/7 availability of a Consultant led trauma team.

University Hospital Wales has CT scanning within the emergency department and immediately adjacent to the Resuscitation Room. At the present time, Morriston Hospital requires a short transfer to the CT scanner: plans were presented to locate a new CT scanner within the emergency department.

Definitive Care

Neurosurgery

Neurosurgery and neuro-intensive care are key specialties in the management of major trauma as 60% of patients have a head injury and traumatic brain injury is an important cause of death and long-term disability. At the present time, both adult and children's neurosurgery is based at University Hospital of Wales and there is no neurosurgery at Morriston Hospital.

Morriston Hospital described its plan to develop an adult neurotrauma unit based upon the recruitment of six neurosurgical consultants with expertise in neurotrauma and spinal surgery and it was proposed that this would work in collaboration with the main neurosurgical unit in Cardiff. This service model has been used at two MTCs in England (Sheffield and St. Mary's, London) but in both cases the distance between the two units is less than 5 miles. There was no plan to move all of neurosurgery to a single site at Morriston Hospital. The WHSSC representative at the expert review clearly expressed the view that the development of a two-site service for neurosurgery in South Wales was against the strategic plan for the region.

The concerns of the expert panel are:

- Recruiting (good) neurosurgery consultants to a post that is half spinal and half trauma with no other components will be extremely difficult.
- Recruiting an adequate number of juniors who are craniotomy competent (8 for a rota) will be even more difficult, if not impossible.
- A stand-alone neurotrauma unit some distance from the main neurosurgical centre (with no plan to move all of neurosurgery there in a set time frame) may not be sustainable in the long term.
- A stand-alone neurotrauma unit is not a model that has professional support for the Society of British Neurosurgeons (SBNS).
- Interventional neuroradiology is now an integral part of trauma management and it is highly unlikely that South Wales could provide a comprehensive service of two sites.

Plastic surgery

There is an excellent plastic surgery department at Morriston Hospital with a Burns Centre that covers Wales and the South West of England and a high quality orthoplastic service. There is no provision for plastic surgery at University Hospital Wales. However, this specialty on its own would not justify placing the MTC at Moriston.

The most significant risk of Cardiff as the MTC is the lack of plastic surgery and orthoplastics. This is an immediate risk that needs to be resolved before day-1. There are numerous examples in England of offsite plastic surgery and Cardiff would be strongly encouraged to learn from these centres and also work closely with Swansea so that the network (and population of South Wales) gets access to the expertise that has been developed in Swansea.

Interventional Radiology

This is now a key specialty in the management of patients with severe bleeding that would have required life-saving surgery in the past. University Hospital Wales has a comprehensive service that would reach the specification for a MTC. Morriston Hospital has a service, which with some investment, could be expanded to meet this specification. Recruitment into interventional radiology is challenging because of low workforce numbers.

Paediatric Intensive Care

The regional paediatric intensive care unit (PICU) is at University Hospital Wales and there are no plans to develop a second PICU at Moriston Hospital. Thus, locating the Adult MTC in Morriston Hospital requires the development of a separate Children's MTC at University Hospital Wales. The catchment population would be similar to the smallest Children's MTC in England (based at Sheffield Children's Hospital) and so would be viable.

The expert panel does not support the concept of a single Adult and Children MTC at Morriston Hospital with a separate pathway for the most severely injured children that require PICU.

Health Care of the Elderly

Changes in the demographic of the population means that major trauma is becoming more frequent in those over 65 years and this age group now represents 35% of major trauma cases. University Hospital Wales presented plans to increase the number of physicians caring for elderly patients by expanding their current orthogeriatric service and including major trauma.

Rehabilitation

Access to this vital part of the patient pathway was much better thought through and available at University Hospital Wales, with facilities at Rookwood Hospital already in place.

Cardiff seems to have an advanced rehab system and exciting plans for the future. Providing the full pathway of trauma care is vital and it appeared that Cardiff had grasped that concept more completely with plans for coordinated rehabilitation within the acute hospital setting. The consultants in Rehabilitation Medicine already in-reach to the acute wards and 'pull' or signpost patients to the most appropriate rehabilitation service.

The Cardiff team described the new Rehabilitation Centre that would be able to accept all patients, not limited to those with neurological or spinal cord injuries and would include coordinated psychiatry and psychology input, which is key for many of the major trauma patients.

The expert panel was impressed with the dynamic Rehabilitation Lead in Cardiff who will be key in delivering this comprehensive rehabilitation service. They recognized the key role of the rehabilitation network to allow patients coordinated rehabilitation near to home.

Areas of concern

Although Cardiff gave good presentations some of their proposals were aspirational and the Health Boards should strongly encourage them to deliver on their aspirations.

The panel did not support using the air ambulance for repatriation from the MTC. We would encourage the development of a retrieval service with the provision of lit helipads at Trauma Units.

Concerns were raised about the desire and commitment from the orthopaedic department in University Hospital Wales and the impact of major trauma on the daily fracture service (for the local population) has been underestimated. There is a clear need to appoint a number of orthopaedic surgeons with a job-plan focused on trauma: a review of the provision of fracture surgery is essential.

The impact of being a MTC may have underestimated by both parties, particularly on the Emergency Departments and Critical Care Units. Contingency plans need to be in place for escalating critical care when they become full to allow continued reception of major trauma. These need to be formal network escalation plans.

Morriston Hospital presented an excellent vision for the Network. It is essential that the MTC understands its place within the network and we would recommend that the chair of the major trauma network board and the network clinical lead are not based within the MTC.

The Welsh Health Boards should ensure that the network has the power to make sure the promises are delivered if the service is commissioned. This should include accurate and achievable time lines with a requirement for the Rehabilitation Team, Trauma Team Leaders and Multidisciplinary Trauma Service to be in place from day-1.

It is essential that network agreements, protocols and guidelines are in place before the networks become operational and this should include agreement between hospitals, at Chief Executive level, on automatic transfer and automatic repatriation.

Options Considered

1. Combined Adult and Children's Major Trauma Centre at University Hospital Wales.
2. Adult Major Trauma Centre at Morriston Hospital plus Children's Major Trauma Centre at University Hospital Wales.
3. Combined Adult and Children's Major Trauma Centre at Morriston Hospital with an out-reach PICU trauma service at University Hospital Wales for the most severely injured children.

Recommendations

It is the unanimous view of the clinical expert panel that the Welsh Health Boards consider the following:

1. The rapid development of a major trauma network for South and West Wales with a clinical governance infrastructure.
2. The Adult and Children's Major Trauma Centres should be co-located on the same site.
3. The Major Trauma Centre should be located at University Hospital of Wales, Cardiff.
4. Morriston Hospital should become a large Trauma Unit and should lead the major trauma network.
5. A clear and realistic timetable for the activation of the Trauma Network should be set.

The main surgical specialty that will need development at University Hospital Wales is Plastic Surgery, with the formation of an orthoplastic unit. Ideally, this could be achieved by transferring the entire service to Cardiff. However, the panel recognise that this may produce major operational problems in the provision of the burns service for Wales and South West England. If this is not feasible, the panel recommends a collaborative approach between both hospitals. It will take time for this service to develop but it should be possible to put a safe clinical pathway in place so that the activation of the network is not delayed by this development. Joint consultant appointments between the two hospitals could achieve this with the establishment of routine orthoplastic operating lists at the MTC (minimum of two per week) with the appropriate equipment and facilities. Mr. Hettiaratchy is available to provide advice on this as a similar model has been developed in London.

Chris Moran
20th March 2017



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Health Collaborative Report

MAJOR TRAUMA NETWORK DEVELOPMENT

Executive Lead: Bob Hudson, Director Health Collaborative

Author: Rachel Hennessy, Programme Director, Strategic Planning

Purpose of the Report

This paper provides an overview of the work which has been undertaken as part of the major trauma project to facilitate the development of a major trauma network for the population of South and West Wales and South Powys. The paper puts into context the recommendations made by an Independent Clinical Panel regarding the development of the major trauma network, how the major trauma network should be led and the preferred location of the major trauma centre for the region.

Supporting evidence

Supporting documents are attached as a technical appendix to the report

Reference is also made to the following:

- Regional Networks for Major Trauma: NHS Clinical Advisory Group (CAG) Report. September 2010
- NHS England Standard Contract for Major Trauma 2013

	<ul style="list-style-type: none"> • National Audit Office (NAO), Major trauma Care in England February 2010 • Centre for Workforce Intelligence report on Regional Trauma Networks March 2011 • Trauma who cares? A report of the National Confidential Enquiry into Patient Outcome and Death 2007 • SAIL databank https://saildatabank.com/saildata/sail-datasets/emergency-department/
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Engagement – Who has been involved in this work?

The work to support the contents of this report commenced in 2014 and has been developed in collaboration with the following organisations:

- Health Boards across South and West Wales and South Powys, namely: Aneurin Bevan UHB; Cardiff & Vale UHB; Cwm Taf UHB; Abertawe Bro Morgannwg UHB; Hywel Dda UHB; Powys tHB;
- Welsh Ambulance Services NHS Trust (WAST);
- Emergency Medical Retrieval and Transfer Service (EMRTS);
- Collaborative Commissioning Team;
- Welsh Health Specialised Services Commission & Emergency Ambulance Service Commission;
- Regular briefings with Community Health Council Chief Officers;
- Third sector – particularly in relation to rehabilitation model;
- Independent clinical specialists.

Resolution to:

APPROVE	X	ENDORSE		DISCUSS		NOTE	
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MAJOR TRAUMA NETWORK DEVELOPMENT

1. Purpose of the Report

This paper sets out the work which has been undertaken to develop a service model for a major trauma network for the population of South and West Wales and South Powys (henceforth referred to as the South Wales region).

There is a significant body of evidence that demonstrates that patients who suffer a major trauma and are treated within a major trauma network generally have better outcomes and a greater chance of survival. Examples of the benefits of a major trauma system have been demonstrated recently in the terror attacks in London and Manchester where patients were effectively managed across several major trauma centres (MTC) and trauma units (TU). System knowledge and coordination allowed pre-hospital teams to appropriately triage patients and subsequently minimise the number of patients needing secondary transfer to a major trauma centre for ongoing care. In the major trauma centres and trauma units, clinical teams had the expertise and resources to manage critical injuries. For the London attacks, the London Trauma System effectively turned a mass casualty event into several smaller incidents that fell well within the capacity and capability of the receiving hospitals (www.kingsfund.org.uk).

The population of North Wales benefit from Betsi Cadwalader UHB being part of the West Midlands Major Trauma Network that supports the major trauma centre in North Staffordshire. South Wales (including South Powys) is the only region of England and Wales that is not part of a major trauma network; patients do not have access to a designated major trauma centre.

The development of a major trauma network for the region will represent a significant step forward in the provision of emergency care in Wales and will build on the current model of care providing greater expertise and resilience to meet both individual and mass casualty events. The network will lead to enhanced roles for a number of hospitals across the region but particularly for the University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

2. Background

2.1 Establishment of the Major Trauma Project

In 2012 The South Wales Programme (SWP) was established to develop clinically safe and sustainable service models in consultant-led maternity and neonatal care, in-patient children's services and emergency medicine (A&E) for people living in South Wales. The SWP covered Aneurin Bevan, Cardiff & Vale, Cwm Taf, Abertawe Bro Morgannwg and Powys Health Boards. The Programme did not specifically consider major trauma but as part of the work reviewing A&E services, the clinicians identified the need to develop a major trauma network in South Wales as a priority.

Based on advice and guidance in respect of the ability of a trauma network to improve outcomes for patients, in late 2014, the Health Collaborative was asked by the Chief Executive Officers (CEOs) to develop a service model for a major trauma network for the South Wales region. A project board was established, supported by a clinical reference group (CRG). Both groups comprised representatives from each of the Health Boards in the region, Welsh Ambulance Services NHS Trust (WAST), Emergency Medical Retrieval and Transfer Service (EMRTS) and Welsh Health Specialist Services Committee (WHSSC). The scope was widened to include Hywel Dda University Health Board, which had not been involved previously in the SWP.

The proposed service model for major trauma services for adults and paediatrics was developed by the clinical reference group (CRG) in line with the standards for major trauma and was approved by the Project Board in May 2015. A detailed model for supporting rehabilitation was also developed through a wider stakeholder group. The standards for major trauma have been set by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Clinical Excellence (NICE) and identify which services should be available for a patient suffering from major trauma - from the response to an accident, transfer to a major trauma centre or trauma units, immediate treatment and urgent surgery, ongoing medical care and further surgery, and rehabilitation. The standards also specify those services which should be available in a major trauma centre, in trauma units, and how the network should work.

3. Developing the case for change and the Service Model

3.1 Definition of Major Trauma

'Major Trauma' is defined as multiple, serious injuries that could result in disability or death. These might include serious head injuries, severe gunshot wounds or multiple injuries caused by road traffic accidents. It is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity (CAG 2010).

Fewer than 0.2% (2/1000 patients) of the people attending their local emergency department will have suffered a major trauma. In 2016 about 750,000 people across the whole of Wales attended a local emergency department (www.saildatabank.com) (this figure is slightly higher than the data used for modelling purposes (see technical appendix) which was based on 2014 TARN data). The data available at this time did not cover all South Wales hospitals and the Emergency Medical Retrieval and Transfer Service (EMRTS) was not in place and therefore is likely to under-represent the true number of major trauma patients in the region.

Major trauma cases by their very nature are complex. Each individual A&E department will only see 1 or 2 cases a week and due to the small number it is a challenge for hospital staff to maintain their highly specialist skills in trauma care.

In summary, this means that about 1,500 patients attending A&E in Wales in any one year are likely to have suffered a major trauma. This equates to about 20 people each week across South Wales and South Powys.

3.2 Case for Change

3.2.1 Benefits of a Major Trauma Network

In recent years, a number of reports have been produced by organisations such as the National Confidential Enquiry into patient Outcome and Death (NCEPOD), National Institute of Clinical Excellence (NICE), the Department of Health Clinical Advisory Group and the National Audit Office, outlining the provision of trauma care across England, Northern Ireland and Wales. The reports consistently identify that better care and outcomes are achieved when properly constituted formal major trauma networks are in place.

Across the South Wales region major trauma cases are currently managed through informal arrangements across the South Wales Health Boards with some more complex cases either admitted directly or transferred to the bigger regional centres - mostly University Hospital of Wales or Morriston Hospital. Whilst this is clearly beneficial to patients, it does not deliver the proven benefits of an established major trauma network.

A '**major trauma network**' comprises a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receives the best care for life threatening or life changing injuries; it includes one major trauma centre and several trauma units spread across the region.

A trauma network aims to make sure that seriously injured patients can be treated quickly and efficiently by the specialised services that will have all the necessary equipment to hand; provides an infrastructure that will allow a patient to leave the specialist centre and continue their treatment at a hospital closer to home or in the community as soon as possible. Where there is a major trauma network, it is expected that more patients will survive and make a full recovery.

3.2.2 Quality improvement

Treatment of major trauma patients within a designated trauma network delivers significant quality improvements for patients. The network is designed to ensure patients have the best outcomes possible and receive the best possible care as part of an integrated clinical network irrespective of where in the region they suffer a major trauma. The key benefits of developing a major trauma network are expected to include:

- More people survive: Evidence shows that severely injured patients are 15%-20% more likely to survive their injuries if they are admitted to a major trauma centre.
- Patients receive the best possible care at the most appropriate site from highly specialised teams, providing 24/7 emergency care with access to the required specialist services.
- Patients are less likely to have a long term disability.
- Patients require less long-term NHS care.
- Patients will have an improved ability to return to work and undertake other activities.
- Services meet clinical standards.

- The network enables access to be optimised to services that support patients to return as close to home as soon as possible.
- The NHS is able to better plan for and respond to major incidents, improving the care major trauma patients receive.
- Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma network facilitates the delivery of this, ensuring the best use of resources, making the major trauma centres and trauma units more sustainable.
- Local A&E units are less likely to be disrupted by admission of inappropriate major cases that can affect the ability of the department to manage its more routine workload.

Establishing a major trauma network also has significant benefits for the individual organisations which are part of the network:

- It provides an opportunity to develop the skills and expertise of existing staff at the trauma units and local hospital sites.
- A network with a clearly identified major trauma centre, trauma units and defined response at scene is likely to have a positive impact on recruitment across the network.
- The establishment of a network provides a stronger base to support doctors in training.
- Services are delivered within a clinical network, this means that each of the units in the network understand their role and responsibility.
- Clinical services in South Wales for major trauma align with the rest of the UK and will allow the Welsh NHS to be more effective as part of the national response to major emergencies.

4. Service Model for a Major Trauma Network

A major trauma network has one MTC and a network of hospitals, known as trauma units. Emergency departments that are not trauma units will continue to treat any person who is seriously ill or has an injury which does not need the highly specialist services only available at the major trauma centre or the specialist services only available at the trauma units.

99.8% of people who currently attend their local A&E department will still continue to do so even when the major trauma network is established.

The network model is particularly important in managing patients who are further away from the major trauma centre. Patients are more likely to survive a major trauma in a region where there is a major trauma network, regardless of how far they are away from the major trauma centre.

If a person suffers a major trauma, ambulance crews will make an assessment at the scene using triage tools to ensure that those with major trauma are taken directly to a major trauma centre for urgent treatment. The decision making is supported by the on-call clinician at the major trauma centre and may involve bypassing local hospitals so that patients can quickly receive care with access to highly specialist services and equipment and appropriately trained staff. If the distances are long or patients are identified to have time critical pathology which cannot be managed by ambulance transfer patients may have to be taken to their local trauma unit first for stabilisation before onward transfer to the major trauma centre for treatment.

The very nature of the major trauma centre means that they have on-site access to highly specialist skills and services 24 hours a day seven days a week which are normally time critical when managing a patient with acute

major trauma. Some of these services are likely to only be provided in one place for the whole region.

Across the network, there will be a number of hospitals known as trauma units that will have a higher level of specialist services and care available than a local emergency department so they can support the major trauma centre. The trauma units are important in providing immediate life saving services to those patients further away from a major trauma centre or who need stabilising before being transferred to the major trauma centre.

As soon as a patient is well enough to be discharged from the major trauma centre, they may be moved to a trauma unit in their local region to continue their treatment and recovery. A trauma unit will also be able to recognise patients who are beyond their capability to treat and transfer them rapidly to the major trauma centre.

The trauma network will also develop advice on appropriate transport services (both ambulance and Emergency Medical Retrieval) to facilitate rapid assessment and transfer to the major trauma centre or trauma units 24 hours a day.

4.1 Rehabilitation

Rehabilitation is a key component of the major trauma network and is an essential part of good trauma care and good patient outcomes. Rehabilitation needs will be assessed shortly after a patient is admitted to the major trauma centre and will be delivered during the inpatient phase and be continued in a trauma unit or in the local community. Highly specialist rehabilitation services will continue to be provided across South Wales from Rookwood Hospital in Cardiff and Neath Port Talbot Hospital.

4.2 Pre Hospital Care

A major trauma network will also need to be supported by robust pre admission triage. In 2015, the Emergency Medical Retrieval and Transfer

Service was established in Wales (currently operating 12 hours per day) to support the Welsh Ambulance Service Trust in delivering pre admission triage.

5. Appraising the options

5.1 Phase 1 – Project Board / Clinical Workshop

In June 2015 a workshop led by clinicians considered the options available to support the development of a major trauma network in the South Wales region. The workshop comprised representatives from the six Health Boards (Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys) and WAST. Patient representatives were invited through the third sector support groups and geographical coverage was sought. Community Health Councils (CHC) were also invited in an observer capacity. The workshop incorporated the non-financial option appraisal process and concentrated on the clinical benefits of the different options. The options considered included:

- Do nothing.
- No major trauma centre in South Wales with network arrangement into England (Bristol)
- Single major trauma centre for South Wales based in Morriston Hospital.
- Single major trauma centre for South Wales based at the University Hospital of Wales (UHW), Cardiff.
- Dual site solution based upon both Morriston Hospital and UHW.

The options to do nothing and continue with the South Wales area remaining as the only region not being supported by a major trauma network were quickly eliminated. It was also agreed that to support a population of circa 2 million the network would need to be supported by a major trauma centre located within the region. This ruled out the Bristol option.

The potential for a dual site solution was seriously considered but subsequently eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.

The clinician-led process identified that the preferred option was to develop a major trauma network for the South Wales region that contains a number of trauma units supported by a single site major trauma centre.

Morrison Hospital in Swansea and UHW, Cardiff were the only two hospitals in the region identified as having the potential to meet the necessary clinical outcome criteria and the standards, for a major trauma centre. This is due to the specialist nature of the trauma service itself and the need for co-location with other specialist services.

Following the option appraisal an Equality Impact Assessment was completed to support intended engagement with key stakeholders.

Access to the major trauma centre for individual Health Board populations was also considered through the project and a detailed travel times analysis was undertaken. It is acknowledged that a clear consensus was never reached within the Project Board on the best travel metrics to use but in any event the broad conclusions of the travel times analysis hold good for each option. It is clear that Morrison Hospital is more centrally located within the geography of South Wales minimising overall distance to be travelled and UHW is located closer to the centre of gravity of the population distribution across South Wales minimising travel times for a greater number of people and minimising the potential flow of trauma patients out of Wales to Bristol.

5.2 Independent panel

Building on the work of the Project Board and the outcome of the Clinical Workshop, the NHS Wales Health Collaborative Board agreed with the

recommendation for a trauma network to be established with the major trauma centre located in either UHW or Morriston Hospital.

To facilitate the decision on the preferred location of the site for the major trauma centre, the Collaborative Board proceeded to recommend that an independent, expert clinical panel be commissioned to review the available evidence and provide advice. The proposed process for the Independent panel was endorsed through individual (public) Board meetings. CHC Chief Officers were also briefed as part of this process.

The Independent Panel was chaired by Professor Chris Moran, the National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital. With the support of Professor Moran, a group of eight experts were identified to be part of the Independent Panel on the basis of their national and international reputations as experts in trauma care and the development of trauma systems.

The panel was provided with all the relevant information required to enable them to consider the position for the region. A session was also convened with the panel where representatives from across the health service in the region alongside other key stakeholders were invited to attend. This included: Clinical representatives from Aneurin Bevan, Cwm Taf, Hywel Dda and Powys Health Boards; Public Health Wales; Welsh Government; Community Health Councils; EMRTS; WAST; WHSSC and the Emergency Ambulance Services Committee (EASC).

When considering the location of any new service, the Independent Panel determined that there were three main factors that need to be taken into consideration:

- **Clinical interdependencies** (services that must be located together)

The Independent Panel advised that one of the most important factors in effective management of major trauma is the immediate availability of key specialist services. Most of those specialist services are already provided in both UHW and Morriston. However, specialist neurosurgery is only provided in UHW and burns and plastics services only in Morriston.

Given that approximately 60% of major trauma cases require support for head injuries, the panel advised that same-site provision of specialist neurosurgical services (adult and paediatric) is a key requirement for the location of the major trauma centre.

The panel also recognised the importance of the burns and plastics service as part of the trauma network and identified that whilst co-location was not a critical factor, it is imperative that the burns and plastics centre worked very closely with the major trauma centre to make sure patients receive the care they need.

- **Critical mass**

The neurosurgery and burns and plastics services are so specialist they can only be provided from one hospital site for the population of South Wales. The same is true for the establishment of a single major trauma centre for the region.

- **Travel times**

The Panel considered the geography of Wales and made it clear that a major trauma system is expected to improve mortality in all geographical regions of South and West Wales regardless of the transport time to the major trauma centre. It was recognised that irrespective of the location of the major trauma centre at either Morriston Hospital or UHW, some parts of the population in Hywel Dda and Powys will be a considerable distance from the major trauma centre. This is not an unusual situation and most trauma networks in England also support services which are a considerable distance from the major trauma centre. The panel did not believe that either Morriston Hospital or UHW as a major trauma centre

would have any significant advantage over the other in terms of geography.

Working as part of a network, most ambulance services in England operate a bypass system up to one hour. This means that if patients are identified as having suffered major trauma by ambulance personnel they are taken directly to the major trauma centre if it is within one hour travelling time. This can be extended after advice is taken. Patients with more immediate needs will be transported to a trauma unit and stabilised prior to transfer. Only a small proportion of trauma patients require immediate surgery and this is likely to be achieved more rapidly in the major trauma centre mitigating any increase in transport times. The wider network model, (including trauma units, pathways to support direct transfer of a patient to a major trauma centre, EMRTS), has a key role to play in managing patients who may be further away from the major trauma centre.

Taking all three factors into consideration, the Independent Panel produced a report of their findings making the following unanimous recommendations for consideration by the constituent Health Boards:

- **A major trauma network for South and West Wales should be established with the appropriate clinical governance infrastructure.**
- **A clear and realistic timetable for the activation of the trauma network should be set.**
- **The adult and children's MTCs should be co-located on the same site.**
- **The MTC should be located at University Hospital of Wales, Cardiff.**
- **Morrison Hospital should become a large trauma unit and should have the leadership role for the major trauma network.**

It is significant that in making recommendations of the development of the wider network, the Independent Panel recommended that Morriston Hospital should be a large trauma unit. As a large trauma unit Morriston Hospital is likely to be able to manage some conditions that other trauma units will not due to the specialist services it already provides. This means that following clinical assessment a more complex patient may not need to be transferred to the major trauma centre (within agreed protocols) and will continue to be managed within Morriston Hospital. This may be different for other units in the region which do not have such specialist services.

The panel also specified that Morriston Hospital should take the leadership role in the major trauma network. This follows the model in England where the leadership for the network is provided from a hospital other than the hospital where the major trauma centre is located. A lead hospital is necessary to ensure the major trauma network works in a coordinated way and makes sure the patient and the whole patient pathway is the main focus rather than the major trauma centre itself.

6. Financial implications

It is anticipated that there will be additional capital and revenue costs associated with establishing the major trauma network across the region. Whilst some outline modelling has been undertaken, full assessment cannot be made until such time as the designated site is confirmed. Research also suggests that in the longer term the development of an effective trauma network will also deliver wider economic benefits associated with improved clinical and social outcomes.

If Boards approve the development of the network in line with the recommendations of the independent panel, there will need to be an incremental approach to implementation supported by business cases, as appropriate, aligned to IMTPs.

Where networks have been developed in other parts of the UK, such an incremental approach has been successful with initial funding identified for any critical shortfalls and a more phased approach to meeting standards over time.

Any capital requirements will need to be considered in the context of the wider site development plans, interdependencies that exist between trauma services and other clinical services and subject to formal business cases to Welsh Government as appropriate.

WAST has also identified some modest resource implications as a result of the changes to patient flows, the adoption of a new triage model and the anticipated increase in requirements for repatriation. Enhanced training requirements for paramedics and the clinical workforce located outside the major trauma centre/trauma units is also likely to require some additional resourcing which will need to be factored into future years Integrated Medium Term Plans (IMTPs).

7. Next Steps

7.1 Board considerations

The report from the Independent Panel was commissioned to provide advice to support the development of the major trauma network and to recommend a preferred location for the major trauma centre.

The recommendations from the Independent Panel have been reviewed through the Collaborative governance arrangements (Collaborative Executive and Leadership Forum) and the benefits for the population of South Wales associated with developing a major trauma network have been fully considered.

The Collaborative Leadership Forum has agreed in principle to support the recommendations of the Independent Panel and to pass to the constituent Health Boards for consideration.

Health Boards will now need to consider this report and the supporting documents, including the recommendations of the Independent Panel to establish a major trauma network and a major trauma centre for the South Wales region.

In considering this report, Boards are reminded that:

- The evidence is clear that the establishment of a major trauma network (with major trauma units and a major trauma centre) provides better outcomes for patients and saves lives;
- The South Wales region is not currently part of a major trauma network and as such this is a **new service development** for the region;
- The impact on existing hospitals across South Wales is likely to be very small. Based on the data considered as part of this exercise to date the impact on individual A & E departments is likely to be in the order of 1 or 2 patients per week who would, in the proposed new system be treated in the major trauma centre. These will be the most seriously ill or injured patients requiring a very high level of specialist care – many of whom are already transferred to a more specialist centre (often Morriston or UHW) as part of their ongoing care;
- All other patients attending their local A&E will be unaffected by the development of the major trauma centre but will benefit from being part of the network;

It should also be noted that the financial consequences of moving forward with the development of the network and major trauma centre will be subject of business cases that would need to be approved by Boards prior to implementation.

7.2 Consultation

Health Boards in Wales are required to work with their local Community Health Council to consult with the local population on matters of substantial service change.

Given that the proposal to develop a major trauma network is about enhancing services at existing Emergency Departments, it could be viewed that this does not in itself constitute substantial service change requiring public consultation but would certainly require public and stakeholder engagement to ensure a clear understanding of the developments for the future.

However, a major trauma network cannot be established in isolation from the development of a major trauma centre and it is this development that may result in more significant calls for wider consultation. Whilst the evidence cited in this paper has identified that more than 99% of all patients currently attending their local A&E department will continue to do so, even when the major trauma centre is operational, it is important that the public and other stakeholders have a clear understanding of the role of the major trauma centre within the network.

The key issue for consultation will need to focus on the broader pathway for major trauma patients, from incident through to treatment in a trauma unit, the major trauma centre and ongoing rehabilitation.

Any consultation process will be expected to explain how the proposed trauma system will work to the benefit of patients and at the same time help the NHS to best shape pathways to meet patient need.

If Boards accept, in principle, the recommendations of the Independent Expert Panel, immediate discussion will need to take place with the constituent CHCs regarding the mechanism and timescales of any required consultation which would need to commence as soon as possible (Autumn 2017)

Any consultation documentation will be developed by the Health Collaborative team with individual Health Boards engaging with their local Community Health Councils (CHC), to facilitate the local consultation exercise which will seek views on the development of the major trauma system for the South Wales region and the implementation of the recommendations of the Independent Panel.

If, in conjunction with the CHCs, it is agreed that formal public consultation should be undertaken, the consultation questions will need to be framed around the following proposed questions:

- ***We believe there is strong evidence that more lives can be saved and clinical outcomes are improved by establishing a major trauma network – do you agree and are there other considerations you think we should take into account in making the decision to go ahead with this development?***
- ***Based on the recommendations of the expert independent panel, what factors would you want us to take into consideration in the designation of further trauma units and designing the patient pathways between the trauma units and the major trauma centre?***
- ***We believe that rehabilitation as close to home is an important element to an effective major trauma network – do you agree and if so, what key considerations should we take account of in designing such a service?***

It is expected that any consultation will run for between 6 and 12 weeks (to be agreed with the CHCs) with the outcome and subsequent decisions coming to Health Boards for decision, in public, at the end of the calendar year.

8. Conclusion and Recommendations

A considerable amount of work has been undertaken to review the evidence for the establishment of a major trauma network for the South Wales region. This has included significant engagement with key clinicians from constituent Health Boards and independent scrutiny and advice from a panel of UK clinical experts.

This has culminated in a series of recommendations from the Independent Panel (**Appendix 11**) which have been accepted by the Collaborative Leadership Forum.

Health Boards, are asked to:

- **Consider and Discuss** the content of this report and the associated supporting evidence;
- **Accept**, in principle to consult on recommendations of the Independent panel as follows:
 - To establish a major trauma network for the South Wales Region;
 - For the network to be led by the trauma unit at Morriston Hospital
 - For the Major Trauma Centre to be located at UHW
- **Agree** to bring back the outcome of the consultation process for decision by Boards, in public. In reaching a final decision Boards will need also to consider more detailed analysis of the financial and workforce implications of the proposed service model.

Freedom of information status	Open
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Iechyd GIG Cymru
NHS Wales Health
Collaborative

Health Collaborative Report	
MAJOR TRAUMA NETWORK DEVELOPMENT	
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Appendix 2	Service specification
Appendix 3	Service Model
Appendix 4	Rehabilitation service model
Appendix 5	Process for non financial option appraisal
Appendix 6	Outcome report for Non financial option Appraisal
Appendix 7	Financial review of proposed MTC
Appendix 8	Activity modelling
Appendix 9	Isochrones maps
Appendix 10	Independent Panel Terms of reference
Appendix 11	Independent Panel report
Appendix 12	Equality Impact Assessment
Appendix 13	Risk register

South Wales Health Collaborative

Major Trauma Project Board

Draft - Terms of Reference

Purpose

The Major Trauma Project Board will oversee the development of, and provide assurance to the South Wales Health Collaborative Board, on the development of the service model and associated business case for a major trauma network and centre for South Wales and South Powys.

Scope and Definition

The major trauma network for South Wales and South Powys will serve the populations of Aneurin Bevan UHB, Abertawe Bro Morgannwg UHB, Cardiff & Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys tHB.

The service model will address the needs of the most severely injured patients, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from a regional network.

The model for trauma care across the region will be based on a collaborative approach across all stakeholders to plan, provide and manage the treatment of people injured as a result of major trauma and will cover all aspects of trauma care along the whole patient pathway, from the point of injury to rehabilitation.

The trauma network will be a collaboration of the providers delivering trauma care services across the region. The trauma network should include all providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions and rehabilitation services.

The service model will provide a holistic patient-focussed care package. The service will comply with accepted best clinical practice and standards, provide improved patient outcomes and have robust governance arrangements. Consideration will be given as to how this service interfaces with other developments, e.g. Emergency Medical Retrieval and Transfer Service (EMRTS), and impacts on other services such as diagnostics, critical care etc.

Project Structure

The Project Board will be accountable to the South Wales Health Collaborative Board and be supported by a Steering Group and Clinical Reference Group/Task and Finish Groups.

Project Board Membership
(Nominations to be confirmed)

Executive representation from health boards and WAST (one representative from each board, intention to ensure all executive disciplines represented)

Medical Director, Cardiff & Vale UHB

Medical Director, Abertawe Bro Morgannwg UHB

Unscheduled Care Lead, Welsh Government

Welsh Government representative

EMRTS Project Board representative

Wales Deanery

Workforce representative

Ambulance Commissioner

WHSSC representative

BCU Major Trauma Lead

SWHC Team

External independent advisor

The Project Board will be chaired by the Unscheduled Care Lead, Welsh Government.

Members of the Project Board will be responsible for reporting back to their respective organisation and/or their executive peer group.

Project Board Responsibilities

The Project Board will be responsible for:

- Setting the direction for the project
- Overseeing the project arrangements and ensuring that they are fit for purpose
- Approving the project plan and ensuring that the resources needed are made available to the project when required
- Delivery of the project objectives
- Ensuring that project benefits are identified
- Ensuring that risks to the project are identified and managed
- Delegating authority to the SRO to lead the project on a day to day basis
- Reporting progress to the South Wales Health Collaborative.

The outputs of the project are:

- A clinical model for a major trauma centre and network that:
 - meets accepted best clinical practice and relevant standards
 - describes the clinical pathway from pre-hospital care through the acute phase to in-patient and community rehabilitation
 - identifies the relationship, inter-dependencies and inter-face with other specialities and services
 - consider the options available to deliver the clinical model efficiently and effectively

- A description of the workforce model including workforce movement between sites and trainee requirements
- Projected activity and capacity requirements
- Financial framework that tracks and supports the clinical pathway so that no organisation is financially disadvantaged
- A system of audit and assurance that demonstrates clinical quality and safety, including full participation in TARN reporting and monitoring of patient experience and outcomes
- Performance indicators defined by an agreed set of benchmarks
- The production of a business case, the first stage of which will be preparation of a costed service model

The SRO's role is to:

- design and execute the project plan
- deal with issues and manage risks that might affect progress
- manage communications with stakeholders

Frequency of meetings

The Project Board will meet on a monthly basis, to meet the intention of the preparation of a Strategic Outline Case by December 2014.

Accountability

The Project Board is accountable to the South Wales Health Collaborative.

Drafted: May 2014

Revised: 27 August 2014

Agreed: 27 August 2014

For review: December 2014

Appendix 1

Reports, standards and guidance

Following initial review, the following reports, standards and guidance have been identified. This list will be developed through the Steering Group and Clinical Reference Group:

Major trauma care in England: National Audit Office (February 2010)

<http://www.nao.org.uk/wp-content/uploads/2010/02/0910213.pdf>

Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)

<http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf>

Standards of practice and guidance for trauma radiology in severely-injured patients: Royal College of Radiologists (2011)

[https://www.rcr.ac.uk/docs/radiology/pdf/BFCR\(11\)3_trauma.pdf](https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(11)3_trauma.pdf)

The British Orthopaedic Association Standards for Trauma (BOAST)

<http://www.boa.ac.uk/publications/boa-standards-for-trauma-boasts/>

Management of People with Spinal Cord Injury: NHS Clinical Advisory Groups Report (August 2011)

<http://www.mascip.co.uk/sci-roadmap.aspx>

(This report is hosted on the above site – follow link)

Brain Trauma Foundation guidelines for head injury care <https://www.braintrauma.org/coma-guidelines/searchable-guidelines/>

Triage, assessment, investigation and early management of head injury in children, young people and adults: NICE Guideline - Head injury (CG176)

<http://guidance.nice.org.uk/CG176>

Rehabilitation after critical illness: NICE Guideline (CG83)

<http://publications.nice.org.uk/rehabilitation-after-critical-illness-cg83>

Together for Health – A delivery plan for the critically ill: Welsh Government (2013)

<http://wales.gov.uk/docs/dhss/publications/130611deliveryen.pdf>

Note: NICE is developing five pieces of guidance relating to trauma, with expected publication dates in June and October 2015 (to be confirmed). Each piece of guidance will focus on a different aspect of trauma care.

- Complex fractures: assessment and management of complex fractures (including pelvic fractures and open fractures of limbs)

- Fractures: diagnosis, management and follow up of fractures (excluding head and hip, pelvis, open and spinal)
- Major trauma: assessment and management of airway, breathing and ventilation, circulation, haemorrhage and temperature control.
- Spinal injury assessment: assessment and imaging of patients at high risk of spinal injury
- Trauma services: service delivery of trauma services

Major Trauma Quality Indicators

These quality indicators have been commissioned by the National Clinical Director for Major Trauma Chris Moran. They have been developed from the National Service Specification for Major Trauma (NHS England D15/S/a 2013) and the NHS clinical advisory group report on Major Trauma Workforce (CFWI March 2011). They support the NHS England Quality Surveillance programme for major trauma services in England enabling quality improvement both in terms of clinical and patient outcomes. The indicators cover the whole organisation of adult and children’s major trauma services including sections for Major Trauma networks, pre-hospital care via ambulance services, Adult Major Trauma centres, Children’s Major Trauma centres and Major Trauma units. Three relevant sections of this document have been replicated below – reception and resuscitation, definitive care, and rehabilitation.

Abertawe Bro Morgannwg and Cardiff and Vale UHBs are asked to complete the template on the basis of services currently available for a Major Trauma Centre at either Morriston Hospital, Swansea or University Hospital of Wales, Cardiff. This will be submitted to the Independent Panel in advance of the meeting on 21st February. At the meeting, both health boards may be asked to provide further information/evidence, in support of the responses.

Reception and Resuscitation				
Number	Indicator	Descriptor	Yes	No
T16-2B-101/ 201	Trauma Team Leader	<i>There should be a medical consultant trauma team leader with an agreed list of responsibilities who should be leading the trauma team and available 24/7. The trauma team leader should be available in 5 minutes of arrival of the patient.</i>		
T16-2B-102/ 202	Trauma Team Leader Training	<i>All trauma team leaders should have attended trauma team leader training.</i>		
T16-2B-103/ 203	Emergency Trauma Nurse/ AHP	<i>There should be a nurse/AHP of band 7 or above available for major trauma 24/7 who has successfully attained the adult competency and educational standard of level 2 (as described in the National Major Trauma Nursing Group guidance). In units which accept children There should be a paediatric registered nurse/AHP available for paediatric major trauma 24/7 who has successfully attained the paediatric competency and educational standard of level 2 (as described in the National Major Trauma Nursing Group guidance). All nursing/AHP staff caring for a trauma patients should have attained</i>		

		<i>the competency and educational standard of level 1. In centres that accept paediatric major trauma, this should include the paediatric trauma competencies (as described in the National Major Trauma Nursing Group guidance).</i>		
T16-2B-104/ 204	Trauma Team Activation Protocol	<i>There should be a Trauma Team Activation Protocol The trauma team should include medical staff with recognised training in paediatrics and paediatric trained nurses with experience in trauma. The MTC should agree and implement the network imaging protocol for children.</i>		
T16-2B-105/ 205	24/7 Surgical and Resuscitative Thoracotomy Capability	<i>There should be a surgical and resuscitative thoracotomy capability within the trauma team and available 24/7</i>		
T16-2B-106/ 206	24/7 CT Scanner Facilities and on-site Radiographer	<i>There should be CT scanning located in the emergency department and available 24/7. There should be an on-site radiographer available 24/7.to prepare the CT scanner for use.</i>		
T16-2B-107/ 207	CT Reporting	<i>There should be a protocol for trauma CT reporting that specifies:</i> <ul style="list-style-type: none"> • <i>there should be a ‘hot’ report documented within 5 minutes;</i> • <i>there should be detailed radiological report documented within 1 hour from the start of scan;</i> • <i>scans should be reported by a consultant radiologist within 24 hours.</i> 		
T16-2B-108/ 208	24/7 MRI Scanning Facilities	<i>MRI scanning should be available 24/7</i>		
T16-2B-109/ 209	24/7 Interventional Radiology	<i>Interventional radiology should be available 24/7 within 30 minutes of a request Interventional radiology should be located within operating theatres or resuscitation areas. There should be a protocol for the safe transfer and management of patients which includes the anaesthetics and resuscitation equipment.</i>		
T16-2B-110/ 210	24/7 Access to Emergency Theatre and Surgery	<i>There should be 24/7 access to a fully staffed and equipped emergency theatre. Patients requiring acute intervention for haemorrhage control should be in an operating room or intervention suite within 60 minutes.</i>		

T16-2B-111/ 211	Damage Control Training for Emergency Trauma Consultant Surgeons	<i>All general surgeons who are on the emergency surgery rota should be trained in the principles and techniques of damage control surgery</i>		
T16-2B-112 (adults only)	24/7 Access to On-site Surgical Staff	<p><i>The following staff should be available on site 24/7:</i></p> <ul style="list-style-type: none"> • <i>a general surgeon ST4 or above;</i> • <i>a trauma and orthopaedic surgeon ST4 or above;</i> • <i>an anaesthetist ST4 or above;</i> • <i>a neurosurgeon ST2 or above.</i> 		
T16-2B-113/ 212	24/7 Access to Consultant Specialists	<p><i>There following consultants should be available to attend an emergency case within 30 minutes</i></p> <ul style="list-style-type: none"> • <i>emergency department physicians;</i> • <i>a general surgeon; (adults and paediatrics)</i> • <i>an anaesthetist; (adults and paediatrics)</i> • <i>an intensivist; (adults and paediatrics)</i> • <i>a trauma and orthopaedic surgeon;</i> • <i>a neurosurgeon; (adults and paediatrics)</i> • <i>an interventional radiologist;</i> • <i>a radiologist;</i> • <i>a plastic surgeon;</i> • <i>a cardiothoracic surgeon;</i> • <i>a vascular surgeon;</i> • <i>a urology surgeon;</i> • <i>a maxillofacial surgeon;</i> • <i>an ENT surgeon.</i> 		
T16-2B-114 (adults only)	Dedicated Orthopaedic Trauma Operating Theatre	<p><i>There should be dedicated trauma operating theatre lists with appropriate staffing available 7 days a week.</i></p> <p><i>The lists must be separate from other emergency operating.</i></p>		
T16-2B-115/ 213	Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries	<p><i>There should be specialist surgeons and facilities (theatre/equipment) to provide fixation of pelvic ring injuries within 24 hours.</i></p> <p><i>There should be cover arrangements in place for holidays and planned absences.</i></p>		
T16-2B-116/ 214	Trauma Management	<i>The MTC should agree the network trauma management guidelines as</i>		

	Guidelines	<i>specified in T16-1C-107. The MTC should include relevant local details.</i>		
T16-2B-117/ 215	Critical Care Provision	<i>In exceptional circumstances if children are cared for on an adult ITU prior to transfer to a PICU:</i> <ol style="list-style-type: none"> 1. <i>there should be guidelines for the temporary management of children that comply with the minimum standards of the paediatric intensive care society;</i> 2. <i>there should be safe transfer / retrieval pathways;</i> 3. <i>the unit should be part of a paediatric intensive care network.</i> 		
T16-2B-118/ 216	24/7 Specialist Acute Pain Service	There should be a 24/7 specialist acute pain service available for major trauma patients. The MTC should have pain management pathways for: <ul style="list-style-type: none"> • patients with severe chest injury and rib fractures; • early access to epidural pain management (within 6 hours). The MTC should audit the pain management of major trauma patients including patients with severe chest injuries (AIS3+), who were not ventilated and who received epidural analgesia. There should be a 24/7 specialist paediatric acute pain service for major trauma patients.		
T16-2B-119/ 217	Administration of Tranexamic Acid	<i>Patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury and receive a second dose according to CRASH-2 protocol. (Adults)</i> <i>There should be a policy that patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury according to RCPCH guidelines</i>		

Definitive Care				
Number	Indicator	Descriptor	Yes	No
T16-2C-101/ 201	Major Trauma Centre Lead Clinician	<i>There should be a lead clinician for the Major Trauma Centre (MTC) who should be a consultant with managerial responsibility for the service and time specified in their job plan.</i>		
T16-2C-102 (adults only)	Major Trauma Service	There should be a major trauma service led by consultants which takes responsibility for the holistic care and co-ordination of management of		

		every individual major trauma patient on a daily basis.		
T16-2C-103/ 202	Major Trauma Coordinator Service	<i>There should be a major trauma coordinator service available 7 days a week for the coordination of care of major trauma patients. The coordinator service should be provided by nurse or allied health professionals of band 7 or above.</i>		
T16-2C-104/ 203	Major Trauma MDT Meeting	<i>There should be a single daily multi-specialty meeting for the presentation and discussion of all new major trauma patients following admission. The meeting should include:</i> <ul style="list-style-type: none"> • major trauma lead clinician (paediatrics only) • a trauma co-ordinator • a physiotherapist • occupational therapist (paediatrics only) • speech and language therapist (paediatrics only) • youth worker (paediatrics only) • play therapist (paediatrics only) • psychologist (paediatrics only) • safe-guarding representative as required (paediatrics only) • clinical staff for: <ul style="list-style-type: none"> ○ major trauma service (adults only) ○ orthopaedics ○ general surgery ○ neurosurgery ○ critical care ○ radiology <i>Accommodation for the meeting should include facilities for:</i> <ul style="list-style-type: none"> • Video/teleconferencing • PACS 		
T16-2C-204 (paediatrics only)	Identification of Social and Welfare Needs	<i>There should be identified members of the team who are trained to assess the social and welfare needs of the child, family and/or carers following a major trauma event whilst they are resident in the MTC. They should have expertise in dealing with complex discharges and be able to</i>		

		<p><i>identify and support child protection investigations. They should attend the weekly rehabilitation MDT meetings (T16-2D-202) and should include:</i></p> <ul style="list-style-type: none"> • <i>Rehabilitation co-ordinator</i> • <i>Safeguarding Team</i> • <i>Family support services</i> • <i>Paediatrician</i> <p><i>An appropriate needs assessment and outcome measure tool for children admitted to the MTC should be recorded for all complex patients.</i></p>		
T16-2C-105 (adults only)	Dedicated Major Trauma Ward or Clinical Area	<i>There should be a separate major trauma ward or clearly identified clinical area where major trauma patients are managed as a cohort</i>		
T16-2C-106/ 205	Formal Tertiary Survey	<p><i>All major trauma patients should have a formal tertiary survey completed to identify missed injuries.</i></p> <p><i>The survey should be recorded in the patient’s notes.</i></p> <p><i>The major trauma service should audit the implementation of the protocol (paediatrics only).</i></p>		
T16-2C-107/ 206	Management of Neurosurgical Trauma	<p><i>The MTC should have the following neurosurgical provision:</i></p> <ol style="list-style-type: none"> i. <i>on-site neuroradiology;</i> ii. <i>on site neuro critical care;</i> iii. <i>a neurosurgical consultant available for advice to the trauma network 24/7;</i> iv. <i>a senior neurosurgical trainee of ST4 or above;</i> v. <i>all neurosurgical patient referrals should be discussed with a consultant;</i> vi. <i>all decisions to perform emergency neurosurgery for trauma are discussed with a consultant;</i> vii. <i>facilities available to allow neurosurgical intervention within 1 hour of arrival at the MTC.</i> 		
T16-2C-108/ 207	Management of Craniofacial Trauma	<p><i>There should be an agreed pathway for patients with craniofacial trauma which includes joint management with neurosurgery.</i></p> <p><i>Where there are facilities for craniofacial trauma on site they should be co-located with neurosurgery.</i></p>		
T16-2C-109/ 208	Management of Spinal	<i>The MTC should agree the network protocol for protecting and assessing</i>		

	Injuries	<p><i>the whole spine in adults and children with major trauma.</i></p> <p><i>There should be a linked Spinal Cord Injury Centre (SCIC) for the MTC which provides an out-reach nursing and/or therapy service for patients with spinal cord injury within 5 days of referral.</i></p> <p><i>All patients with spinal cord injury should be entered onto the national SCI database.</i></p>		
T16-2C-110/ 209	Management of Musculoskeletal Trauma	<p><i>There should be trauma orthopaedic surgeons who spend a minimum of 50% of their programmed activities in trauma.</i></p> <p><i>There should be paediatric orthopaedic surgeons (paediatrics only).</i></p> <p><i>The MTC should provide a comprehensive musculoskeletal trauma service and facilities to support all definitive fracture care and allow joint emergency orthoplastic management of severe open fractures as specified in BOAST 4 guidelines.</i></p> <p><i>All patients with complex musculoskeletal injuries should have a rehabilitation management plan.</i></p>		
T16-2C-111/ 210	Management of Hand Trauma	<p><i>There should be facilities for the management of patients with hand trauma which include:</i></p> <ul style="list-style-type: none"> <i>• dedicated hand surgery specialists with a combination of plastic and orthopaedic surgeons;</i> <i>• facilities for microsurgery;</i> <i>• a dedicated hand therapist</i> 		
T16-2C-112/ 211	Management of Complex Peripheral Nerve Injuries	<p><i>There should be facilities and expertise for the management of complex peripheral nerve injuries, including brachial plexus.</i></p> <p><i>Where these are not on site the MTC should name the tertiary referral centre.</i></p>		
T16-2C-113/ 212	Management of Maxillofacial Trauma	<p><i>There should be on site maxillofacial surgeons with access to theatre for the reconstruction of maxillofacial trauma.</i></p>		
T16-2C-114 (adults only)	Vascular and Endovascular Surgery	<p><i>There should be facilities for open vascular and endovascular surgery, including EVAR, available 24/7.</i></p>		
T16-2C-115/ 213	Designated Specialist Burns Care	<p><i>Burns care should be managed through a designated specialist burns network.</i></p> <p><i>There should be a clinical guideline for the treatment of burns. This should include the referral pathway to the specialist burns centre where</i></p>		

		<i>the MTC is not the specialist centre.</i>		
T16-2C-116/ 214	Patient Transfer	<i>The MTC should agree the network protocol for patient transfer T16-1C-104</i>		
T16-2C-117 (adults only)	Network Patient Repatriation Policy	<i>The MTC should agree the network policy for the repatriation of patients. T16-1C-115</i>		
T16-2C-118/ 215	Specialist Dietetic Support	<i>There should be a specialist dietician with specified time for the management of major trauma patients.</i>		
T16-2C-119/ 216	24/7 Access to Psychiatric Advice	<i>There should be 24/7 access to liaison psychiatric assessment services.</i>		
T16-2C-120/ 217	Patient Information	<i>The patient and or their family/carers should be provided with written information specific to the MTC about the facilities, care and rehabilitation as specified in the NICE guideline – Major Trauma (NG39)</i>		
T16-2C-121/ 218	Patient Experience	<i>The MTC should participate in the TARN PROMS and PREMS</i>		
T16-2C-122/ 219	Discharge summary	<p><i>There should be a discharge summary which includes:</i></p> <ul style="list-style-type: none"> • <i>A list of all injuries</i> • <i>Details of operations (with dates)</i> • <i>Instructions for next stage rehabilitation for each injury (including specialist equipment such as; wheel chairs, braces and casts)</i> • <i>Follow-up clinic appointments</i> • <i>Contact details for ongoing enquiries.</i> 		
T16-2C-220 (paediatrics only)	Network Patient Repatriation Policy	<i>The MTC should agree the network policy for the repatriation of patients. T16-1C-115</i>		
T16-2C-123 (adults only)	Rate of Survival			

Rehabilitation				
Number	Indicator	Descriptor	Yes	No
T16-2D-101/ 201	Clinical Lead for Acute Trauma Rehabilitation Services	<i>There should be a named lead clinician for acute trauma rehabilitation services who is a consultant in rehabilitation medicine, and have an agreed list of responsibilities and time specified for the role.</i>		

<p>T16-2D-102/ 202</p>	<p>Specialist Rehabilitation Team (adults only)</p>	<p><i>There should be a multidisciplinary specialist rehabilitation team which should include:</i></p> <ul style="list-style-type: none"> • Consultant in rehabilitation medicine • Physiotherapist • Occupational therapist • <i>Speech and language therapist</i> • Dietician • <i>Clinical psychologist /neuropsychologist</i> <p><i>The team should meet at least weekly to discuss and update rehabilitation management plans and rehabilitation prescriptions.</i></p> <p><i>There should be specified contacts for the following:</i></p> <ul style="list-style-type: none"> • <i>pain management specialist</i> • pharmacist • surgical appliance services • <i>orthotic services</i> • prosthetic services • wheelchair services 		
	<p>Specialist Rehabilitation Team (paediatric only)</p>	<p>There should be a multidisciplinary specialist rehabilitation team which should include:</p> <ul style="list-style-type: none"> • lead clinician for rehabilitation • rehabilitation co-ordinator • paediatrician • representation from safeguarding team • representation from family support services <p>Where relevant:</p> <ul style="list-style-type: none"> • play therapist • youth worker • music therapist • physiotherapist • speech and language therapist • dietitian • clinical psychologist / neuropsychologist 		

		<ul style="list-style-type: none"> • neuropsychologist <p>The team should meet at least weekly to discuss and update rehabilitation management plans and rehabilitation prescriptions. There should be specified contacts for the following:</p> <ul style="list-style-type: none"> • pain management specialist • pharmacist • surgical appliance services • orthotic services • prosthetic services • wheelchair services 		
T16-2D-103/ 203	Rehabilitation Coordinator Post	<p><i>There should be a rehabilitation coordinator who is responsible for coordination and communication regarding the patient’s current and future rehabilitation available 7 days a week.</i></p> <p><i>This rehabilitation coordinator should be a nurse or allied health professional at AFC Band 7 or above with experience in rehabilitation.</i></p>		
T16-2D-104/ 204	Specialist Rehabilitation Pathways	<p><i>There should be referral pathways for patients requiring specialist rehabilitation for;</i></p> <ul style="list-style-type: none"> • neurological injuries, including t brain injuries • spinal injuries • complex musculoskeletal injuries • return to work (vocational rehabilitation)for patients with & without brain injury 		
T16-2D-105/ 205	Key worker	<p><i>All patients requiring rehabilitation should have an identified key worker to be a point of contact for them, their carer/s or family doctor.</i></p> <p><i>The key worker should be a health care professional</i></p> <p><i>The name of the patient’s key worker should be recorded in the patient’s notes and on their rehabilitation prescription</i></p>		
T16-2D-106/ 206	Rehabilitation Assessment and Prescriptions	<p><i>All patients should receive a rehabilitation assessment including barriers to return to work. All patients should have a Rehabilitation Prescription initiated within 2 calendar days of admission & the first comprehensive Rehabilitation Prescription completed at 4 calendar days following admission</i></p>		

		<p><i>The prescription should be updated weekly at the rehabilitation MDT meeting until transfer into a designated rehabilitation service (T16-2D-102) and prior to discharge and a copy given to the patient</i></p> <p><i>All patients should be reviewed by a Consultant in Rehabilitation Medicine (or an alternative consultant with skills & competencies in rehabilitation eg: elderly care for elderly patients with multiple co-morbidities) within 3 calendar days of admission</i></p> <p><i>Patients who have Category A or B rehabilitation needs (using the Patient Categorisation Tool) should have a “specialist rehabilitation prescription” completed by a Consultant in Rehabilitation Medicine or their designated deputy. (1)The specialist RP must accompany the patient on discharge from the MTC, with network arrangements to ensure appropriate referral to specialist rehabilitation services</i></p> <p><i>All patients should receive a rehabilitation assessment. Where a prescription is required this should be completed within 72 hours.</i></p>		
T16-2D-107/ 207	Rehabilitation for Traumatic Amputation	<p><i>There should be a rehabilitation program for patients with a traumatic amputation which includes:</i></p> <ul style="list-style-type: none"> • <i>a linked prosthetics centre which provides an out-reach service to see patients with amputation;</i> • <i>pain management of acute amputation, including phantom limb pain;</i> • <i>specialist paediatric psychological services for patients who suffer acute, traumatic amputation. (paediatrics only)</i> 		
T16-2D-108/ 208	Referral Guidelines to Rehabilitation Services	<i>The MTC should agree the network referral guidelines for access to rehabilitation services T16-1C-113</i>		
T16-2D-109/ 209	Clinical Psychologist for Trauma Rehabilitation	<p><i>The trauma rehabilitation service should include a clinical psychologist for the assessment and treatment of major trauma patients.</i></p> <p><i>Inpatient and outpatient clinical psychology services should be available.</i></p>		
T16-2D-110	BSRM Core Standards for Specialist Rehabilitation in the Trauma Pathway	<i>For patients identified as having category A or B needs, & so potentially requiring specialist (Level 1 or 2) rehabilitation, the following datasets should be completed as part of the “Specialist Rehabilitation Prescription”, & should be completed by a Consultant in Rehabilitation Medicine or their designated deputy:-</i>		

		<ul style="list-style-type: none"> • Patient Categorisation Tool or Complex Need Checklist- • <i>RCS-E or RCS-ET (dependent on MTC & Network arrangements)</i> • Northwick Park dependency Score • Neurological & Trauma Impairment Set <p><i>Where specialist rehabilitation is not provided at the MTC, & patients are transferred to TUs or other hospitals, the Specialist RP must be updated at the point of discharge from the MTC</i></p> <p><i>The MTC should also participate in the National Clinical Audit of Specialist Rehabilitation for Patients Following Major Injury.</i></p>		
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**SOUTH WALES HEALTH COLLABORATIVE
SERVICE MODEL OVERVIEW
MAJOR TRAUMA NETWORK**

Version history

Version	Date Issued	Status	Owner
1.0	21.05.15	Final – issued for non-financial option appraisal exercise	RF

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SERVICE MODEL – MAJOR TRAUMA

1. Introduction

This paper describes the proposed service model for a major trauma network to serve South Wales, South Powys and West Wales.

The service model is being developed by the Major Trauma Network Clinical Reference Group, which reports to the Major Trauma Network Project Board, and has clinical representation from all participating health boards and the Welsh Ambulance Services Trust (WAST). The service model's main reference points are the NHS Clinical Advisory Group Report (September 2010): Regional Networks for Major Trauma, the NHS England Standard Contract for Major Trauma (2013), and the Centre for Workforce Intelligence report on Regional Trauma Networks (March 2011) and takes account of other published clinical standards. The process for developing service models is iterative and the model will need to be reviewed on a regular basis.

This service model should be considered in conjunction with service models for emergency medicine, emergency surgery and the Emergency Medical Retrieval and Transfer Service (EMRTS).

This service model is accompanied by, and should be read in the context of, the 'Standards and Guidance for the development of a Major Trauma Network for South Wales' document.

2. The scope, vision, planning principles, service objectives

2.1. Details of the scope, vision, planning principles, service objectives used in developing the service model are provided in this section.

Scope	<p>The major trauma network for South Wales, South Powys and West Wales will serve the populations of Aneurin Bevan UHB, Abertawe Bro Morgannwg UHB, Cardiff & Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys tHB.</p> <p>The service model will address the needs of the most severely injured patients, adults and children, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from a regional network.</p> <p>The model for trauma care across the region will be based on a collaborative approach across all stakeholders to plan, provide and manage the treatment of people injured as a result of major trauma and will cover all aspects of trauma care, along the whole patient pathway from the point of injury to rehabilitation.</p> <p>The trauma network will be a collaboration of the providers delivering trauma care services across the region. The trauma network should include all providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions and rehabilitation services.</p> <p>The service model will provide a holistic patient-focussed care package. The service will comply with accepted best clinical practice and standards, provide improved patient outcomes and have robust governance arrangements. Consideration will be given as to how this service interfaces with other relevant developments and impacts on other clinical and support services.</p>
Vision	<p>To ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable major trauma services at all points along their care pathway from the point of injury to rehabilitation, in line with best practice standard requirements, evidenced by key performance indicators (KPI).</p>
Planning Principles	<p>Some key principles underpin the ongoing planning processes and require that the new service model should describe a system that will deliver:</p> <ul style="list-style-type: none"> • Safe, effective, compassionate and equitable care • High quality, sustainable major trauma treatment and care from the point of injury to rehabilitation – the four key areas are pre-hospital care, acute care, acute on-going care, and rehabilitation

	<ul style="list-style-type: none"> • Timely access for patients to the 'definitive place of treatment' to avoid delays in the patient pathway • Services that meet national clinical and workforce standards • Access to senior medical advice and treatment 24/7 for major trauma patients • Service models underpinned by realistic and deliverable workforce models • Stable medical teams that deliver high-quality patient care in an effective environment in which to train and educate the next generation of doctors • Integration of care and effective relationships with other health professions • An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs • Early access to rehabilitation assessments and to ensure that patients are moved through the system appropriately
Service Aims & Objectives	<p>To improve the quality and safety of care for patients by:</p> <ul style="list-style-type: none"> • Providing a comprehensive system of specialist care for people who have suffered serious injury (major trauma) through the delivery of a regional trauma network • Improving the functionality, health and psychological well-being in those patients who survive their traumatic injuries, increasing their quality of life • Ensuring that services meet agreed national clinical and workforce standards. • Always meeting fundamental standards of care • Valuing patient experience as much as clinical effectiveness • Ensuring responsibility for each patient's care is clear and communicated • Providing effective and timely access to care, including appointments, tests, treatments and moves out of hospital • Ensuring robust arrangements for transferring care are in place • Tailoring services to meet the needs of individual patients, including vulnerable patients • Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment • Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement. • Reducing avoidable deaths in the population of patients who would previously have died of their injuries

	<p>To improve the sustainability of services to patients by:</p> <ul style="list-style-type: none"> • Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate. • Developing clinical roles to provide future workforce flexibility • Ensuring the population has access to major trauma services within a reasonable timeframe • Planning capacity to meet demand and providing appropriate resources across the network • Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies <hr/> <p>To improve access for patients by:</p> <ul style="list-style-type: none"> • Delivering a system based on a pathway of care from the pre-hospital phase through acute care, ongoing care and rehabilitation and a return to socio-economic functioning • Ensuring effective triage and assessment of emergencies to enable conveyance by the most appropriate means to the most appropriate destination according to agreed criteria • Improving information and support to patients and families to encourage them to be active participants in their care
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2.2 National Clinical Standards

Following initial review, the following reports, standards and guidance have been identified. The key publication is the NHS Clinical Advisory Groups Report (September 2010)*

This list will be developed through the Clinical Reference Group:

*Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)

<http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf>

<http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>

Major trauma care in England: National Audit Office (February 2010)

<http://www.nao.org.uk/wp-content/uploads/2010/02/0910213.pdf>

Standards of practice and guidance for trauma radiology in severely-injured patients: Royal College of Radiologists (2011)

[https://www.rcr.ac.uk/docs/radiology/pdf/BFCR\(11\)3_trauma.pdf](https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(11)3_trauma.pdf)

The British Orthopaedic Association Standards for Trauma (BOAST)

<http://www.boa.ac.uk/publications/boa-standards-for-trauma-boasts/>

BOAST 4: The management of severe open lower limb fractures

<http://www.boa.ac.uk/publications/boast-4-the-management-of-sever-open-limb-fractures/>

Management of People with Spinal Cord Injury: NHS Clinical Advisory Groups Report (August 2011)

<http://www.mascip.co.uk/sci-roadmap.aspx> (This report is hosted on this site)

Brain Trauma Foundation guidelines for head injury care

<https://www.braintrauma.org/coma-guidelines/searchable-guidelines/>

Triage, assessment, investigation and early management of head injury in children, young people and adults: NICE Guideline - Head injury (CG176)

<http://guidance.nice.org.uk/CG176>

Rehabilitation after critical illness: NICE Guideline (CG83)

<http://publications.nice.org.uk/rehabilitation-after-critical-illness-cg83>

Specialist rehabilitation in the trauma pathway: British Society of Rehabilitation Medicine (BSRM) core standards version 1.2 (January 2013)

<http://www.bsrn.co.uk/publications/BSRM%20Core%20standards%20for%20Major%20Trauma%2030-5-13.pdf>

Rehabilitation for patients in the acute care pathway following severe disabling illness or injury: BSRM core standards for specialist rehabilitation (October 2014)

<http://www.bsrn.co.uk/publications/Specialist%20rehabilitation%20prescription%20for%20acute%20care%2028%2011%202014%20JA%20%20a%20p1%20redrawn.pdf>

Together for Health – A delivery plan for the critically ill: Welsh Government (2013)

<http://wales.gov.uk/docs/dhss/publications/130611deliveryen.pdf>

Regional Trauma Networks – NHS Clinical Advisory Group on Major Trauma Workforce, Centre for Workforce Intelligence (March 2011)

<http://www.cfwi.org.uk/publications/nhs-clinical-advisory-group-on-major-trauma-workforce/@@publication-detail>

National burn care standards: National Network for Burn Care (Revised 2013)

http://www.britishburnassociation.org/downloads/National_Burn_Care_Standards_2013.pdf

NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013)
<http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>

Note: NICE is developing five pieces of guidance relating to trauma, with expected publication dates in June and October 2015 (to be confirmed). Each piece of guidance will focus on a different aspect of trauma care.

- Complex fractures: assessment and management of complex fractures (including pelvic fractures and open fractures of limbs)
- Fractures: diagnosis, management and follow up of fractures (excluding head and hip, pelvis, open and spinal)
- Major trauma: assessment and management of airway, breathing and ventilation, circulation, haemorrhage and temperature control.
- Spinal injury assessment: assessment and imaging of patients at high risk of spinal injury
- Trauma services: service delivery of trauma services

3. Service Model

3.1 Service overview

The aim of the service is to provide care to major trauma patients, characterised by an Injury Severity Score (ISS) >15 and most patients with moderately severe trauma (ISS >8), from the point of injury to rehabilitation. Calculation of the ISS requires a full diagnostic work-up and so the service is designed around the triage of patients at the point of wounding, to identify “candidate major trauma patients” on the basis of mechanism of injury and assessment of their symptoms and physical signs. The Major Trauma Centre (MTC) will have all the services available to receive and manage seriously injured adults and children. Patients who have been incorrectly triaged to, or have self-presented with serious injury at a hospital within the network, will be rapidly transferred to the MTC. In addition, some patients will need treatment in the MTC which will require transfer in within the first 2 days following injury.

Following assessment and initial treatment at the MTC or TU, children requiring intensive care will be received at the Children’s Hospital for Wales which provides Paediatric Intensive Care Unit (PICU) facilities. See <http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf> - annex 1 for standards for provision of services for children.

The service is designed to deliver high quality specialist care to patients of all ages starting from the pre-hospital phase, through admission to the MTC, with full assessment and diagnostics in the emergency department. This may be followed by operative treatment and an episode in the critical care unit and ward. Rehabilitation will be required for a number for patients, and this rehabilitation will start in the MTC and continue through specialist rehabilitation or local rehabilitation services.

3.2 Clinical service interdependencies:

The table below sets out the key dependencies for the Major Trauma Centre and trauma units:

	Acute phase (continuum into ongoing care and reconstruction)																						
	Emergency radiology in ED	MRI 24/7	Teleradiology between MTC and TUs	General Surgery	Ophthalmology	ICU	Theatres / Anaes	Orthopaedic surgery	Plastic surgery	24/7 Interventional radiology	Vascular/ endovasc surgery – hybrid theatre	Cardiothoracics	Max-facial surgery	Neurosurgery	Spinal injury	Liver surgery	Burns	Emergency Medicine	Ear nose and throat surgery	Transfusion services	Pathology services	Organ donation	
Trauma centre	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Trauma unit	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber

	Ongoing care and reconstruction										
	Radiology – MRI, IR, angiography	Critical care	Clinical psychology	Rehabilitation	Specialist rehabilitation	Specialist acute pain service	Craniofacial trauma support	Haematology	Obs/gynae	Respiratory physiotherapy (for pneumothoraces, chest drain and tracheostomies)	Complex peripheral nerve support
Trauma centre	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Trauma unit	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber

Red	Absolute dependency, requiring co-location on the same hospital site
Amber	Relationship under some circumstances, requiring varying levels of access and contact between specialists but not necessarily co-location

Acute Phase: Defined as the time period immediately after injury and transfer to hospital in which immediately or potentially life or limb threatening problems are recognised, diagnosed and managed utilising damage control principles or definitively where appropriate.

Ongoing Care & Reconstruction: Defined as the subsequent phase in patient care when temporary management is concluded with definitive treatment, integrating rehabilitation, re-ablement and discharge to the community. After the patient's surgical care is complete, this is likely to require transfer for ongoing rehabilitation, possibly involving repatriation to a hospital closer to the patient's home

Major trauma generates complex clinical injuries and problems; successful management involves a number of specialties and agencies. This model will describe how a service which crosses specialty boundaries is delivered to produce a comprehensive trauma service working within a robust governance framework.

3.3 Key characteristics of the major trauma network

Across the network there should be a focus on delivery of patient-centred services which consider all of the health and well-being needs of people who have sustained traumatic injuries. Coordination of medical, nursing and rehabilitation packages of care is crucial and trauma patients should receive appropriate levels of care and rehabilitation at all points along their care pathway. The important role of family and friends should be acknowledged and actively supported.

Rehabilitation should start as soon as is appropriate after admission, typically in the critical care setting, and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential.

Any hospital within the network receiving trauma patients must have associated governance structures in place.

Organisational and network structures should facilitate follow up appointments to take place in the most appropriate setting.

3.4 Service models at each level of care

Service Delivery

Major trauma care is delivered through an inclusive trauma network delivery model. The major trauma network includes all providers of trauma care and, in particular, pre-hospital services, other hospitals receiving acute trauma admissions, and rehabilitation services, and will have appropriate links to social care and the voluntary/community sector.

The major trauma centre (MTC) will provide multi-specialty hospital care to seriously injured patients and manage all types of trauma but specifically will lead the management of major trauma patients, providing consultant-level care and access to tertiary and specialised level services. The MTC takes responsibility for the care of all patients with major trauma in the area covered by the network and provides specialist early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community.

The MTC will be required to work with the ambulance service, other hospitals receiving acute trauma admissions, and specialist and general rehabilitation services, to ensure delivery of the whole pathway including the specialised component and will itself deliver acute care and surgery, on-going care and acute/early phase rehabilitation.

Services will be delivered in line with the standards of the Regional Networks for Major Trauma NHS Clinical Advisory Groups Report (2010), supplemented with KPIs derived from the NHS England Standard Contract for Major Trauma Services(2013).

When treating children, the service will additionally follow the standards and criteria outlined for children's services (<http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf> annex 1).

Patients with an ISS>8 are covered by this service model.

3.5 Pathways of care

Pre-hospital phase

The requirements for pre-hospital care will be developed in conjunction with the EMRTS Project Board. The NHS Clinical Advisory Group report (2010) on major trauma sets out the following recommendations for pre-hospital care:

- A Trauma Triage Tool should be used to identify patients with major trauma
- A paramedic should be present in the Ambulance Control room 24 hours a day. Their role is to identify potential major trauma patients and coordinate the response
- All patients identified as major trauma should be taken to a Major Trauma Centre. Those who are within 45 minutes travelling time from the Centre should be taken there directly, bypassing other units
- Patients who are further away or who are critically unstable should be subject to further guidance on an individual basis
- Patients with major trauma who are taken to a local Trauma Unit should be transferred to a Major Trauma Centre after initial assessment and optimisation in the Emergency Department
- Enhanced care teams should be available 24/7 to provide care to the major trauma patient
- Major trauma patients should be transferred to an appropriate Major Trauma Centre when indicated
- A structured pre-alert should be given to the receiving hospital as early as possible
- On arrival at the hospital a structured handover should be given to the receiving team
- Secondary emergency department transfer to a major trauma centre should be provided by an appropriate trained team
- For time critical conditions, the transfer should be performed without delay
- A structured checklist and standardised documentation should be used and included in the patients' clinical records
- All components of the major trauma network including pre-hospital services should submit data for all major trauma patients to a national trauma dataset (currently TARN)

- Regular audit of the pre-hospital phase of trauma care is essential. Pre-hospital care providers should be given feedback on the patients they manage and should attend audit and other meetings in the MTC and network as part of good clinical governance

Referral

Patients will be triaged to the MTC directly or through a secondary transfer protocol. The MTC will have a policy of automatic acceptance for patients requiring MTC care from within the network. Hospitals within the MTN will work together ensuring patients have seamless access to care and transfer back to their local hospital when medically fit.

Emergency Care and Surgery:

- 24/7 Consultant (trauma team leader) available on the MTC site to receive the trauma patient on arrival (patient to be seen within 5 minutes of arrival)
- The trauma team should be appropriately trained and competent to deliver their role
- Trauma team present 24 hours a day for immediate reception of the patient
- Ability to undertake surgical and resuscitative thoracotomy in the emergency department (ED)
- A protocol to manage massive haemorrhage in place for patients with severe blood loss which includes the administration of tranexamic acid within 3 hours of injury, and transfusion specialist advice should be available 24 hours a day
- 24/7 immediate availability of fully staffed and equipped operating theatres
- All emergency operative interventions performed within the first 24 hours should have consultant involvement, and consultant presence in the operating room for life- or limb-threatening injuries. A consultant will be involved in surgical decision making; Emergency trauma surgery will be undertaken or directly supervised by consultants. There will be a network protocol in place and operational at the MTC for assessing the whole spine in Major Trauma patients.
- Consultants available on site within 30 minutes when required and senior trainees (ST5s and above or equivalent) on site 24/7 for:
 - Neurosurgery;
 - Spinal and spinal cord surgery;
 - Vascular surgery;
 - General surgery (adult or child);
 - Trauma and Orthopaedic surgery;
 - Cardiothoracic surgery;
 - Maxillofacial surgery;
 - Anaesthetics;
 - Interventional radiology;
 - Intensive care
 - Plastic surgery

Diagnostics and Radiology

- Immediate (within 30 minutes) access to computerised tomography (CT) scanning, initial reporting within 15 minutes and detailed reporting within 60 minutes of scan;
- Availability of interventional radiology within 60 minutes of referral
- MRI scanning should be available 24/7
- Tele-radiology facilities in place between all sites within the network

On-going Care and Reconstruction

- Immediate access to critical care or high dependency care (adult or paediatric) when required
- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation co-ordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles
- Access to cross speciality supporting services which will include pain management, rehabilitation medicine (which usually includes management of disturbed behaviour), neuropsychology and neuropsychiatry and psychosocial and mental health care
- A defined ward for major trauma patients
- A ward environment suitable for people with disability to practice and maintain their activities
- A nursing team in the ward, who are able to facilitate practice of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team

Early/Hyper Acute Phase Rehabilitation

- A defined service for early/hyper acute trauma rehabilitation service which meets the needs of patients with ISS >8
- Rehabilitation should start as soon as is appropriate after admission, typically in the critical care setting (and certainly within 72 hours), and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential. A rehabilitation prescription should be provided to all trauma patients with identified needs. This prescription should be reviewed and amended in response to changes in condition.
- The prescription for rehabilitation reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
- All patients to have an initial rehabilitation prescription within 2-4 calendar days of presentation. The prescription may identify no further need for rehabilitation, may recommend monitoring or may require full active engagement of the wider rehabilitation team
- All patients to receive early phase rehabilitation and all other actions identified in the rehabilitation prescription; if action or input cannot be delivered, the reason should be recorded and intervening action to be undertaken
- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. This team will meet weekly to discuss all patients within the scope of this specification in the MTC (Including those in Intensive Care Units)

(ICU) and ward areas); a speciality trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion but a consultant should attend over 80% of meetings and continue to provide supervision and support to the team

Rehabilitation phase (ongoing specialised and local rehabilitation)

- Trauma patients should receive routine screening of rehabilitation needs and appropriate levels of care and rehabilitation at all points along their care pathway
- Network to provide rehabilitation services appropriate the needs of complex trauma patients
- Provider therapy teams should provide access to rehabilitation assessment seven days a week.
- A discharge summary describing the patient's injuries, care received and ongoing needs and plans should be provided at the time of discharge or transfer from a Major Trauma Centre or Trauma Unit. This should include the rehabilitation prescription
- There should be rehabilitation and care coordinator posts throughout the network. Each patient should have an identified key worker to be a point of contact for them, their carers or family doctor and to ensure delivery of their personal prescription for rehabilitation
- Vocational rehabilitation should be a key component of the rehabilitation service
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network's services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients
- Policies for nutritional management should be in place in Major Trauma Centre/s and Trauma Units
- Use should be made of VC/telehealth technology to support the rehabilitation phase enhancing shared care arrangements between generic providers of rehabilitation and the specialist trauma rehabilitation teams
- The needs of families and carers in all phases of major trauma rehabilitation should be considered, including the distances that may be incurred in travelling

Network Delivery

The Major Trauma Network will be led by a Network Director and will take responsibility for the care of all patients referred with major trauma in the area covered by the network, as defined by local protocols and capabilities of other hospitals receiving acute trauma admissions and transfer arrangements to a MTC for under triage and secondary transfer protocols. There should also be the identification of a Network Clinical Lead for Rehabilitation Services to coordinate the development and delivery of rehabilitation services and long-term support in the community, and the delivery of comprehensive and effective rehabilitation to meet the needs of traumatically injured patients, irrespective of their age.

The MTC will:

- Be responsible for all stages of care, including the rehabilitation and transfer aspects of the patient's pathway
- Provide clinical advice to other providers within the network. This will include pre-hospital treatment, patients awaiting transfer to the MTC for definitive treatment, and following acute care when the patient is discharged to on-going specialised and local rehabilitation services
- Accept the secondary transfer of major trauma patients in accordance with the clinical condition of the patient
- Be actively engaged and contribute to the operational requirements, training, governance and audit within and across the MTN

- Deliver care and access to treatment in line with locally agreed network protocols and guidelines

Discharge planning, continuing care and rehabilitation

Patient transfer

- There should be cross network agreements and adequate resources to ensure that once specialist trauma care has been completed, patients can be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs
- There should be a formal handover back to the local therapy team (including ALAS) via an identified therapy lead at the provider unit. The responsibility should be on the local team to 'pull' patients back to local services. This must be achieved in a timely manner with adequate notice to plan and support transition. The local therapy team should visit the patient at the provider unit as part of transfer planning. The transfer should be followed up with a visit from the provider therapy team following transfer
- A discharge summary must be provided to support the patient's transfer to an alternative healthcare setting or the community.
- Ongoing access to advice from provider therapy teams as required.

Communication

- There will be effective communication between all those responsible for the patient's care, the patient and where appropriate their family and other carers.
- Patients will be provided with a full range of condition-specific information in appropriate formats
- A directory of services and resources should be developed relating to rehabilitation and ongoing care to facilitate referral and access to these services. Links with the local authorities and third sector are integral to the rehabilitation model

Audit, data management, governance and quality improvement

- Full data submission to TARN within 25 calendar days following a patient's discharge
- The Major Trauma Network will be responsible for drawing down its report from TARN and ensuring the ISS is confirmed
- The Major Trauma Network will be responsible for clinical governance and collaborate with other hospitals in the network in reviewing and learning from TARN data
- There should be a review of the applicability of the UK National Dataset for Specialist Rehabilitation Services to all Major Trauma patients.

Representatives from hospitals within the networks will meet regularly to examine performance through formal governance processes. Performance improvement will be undertaken through regular mortality and morbidity meetings which will generate action plans for improvement.

3.6 Key risks

There are a number of risks associated with the development of the Major Trauma Network and Major Trauma Centre/s:

- Failure to identify and plan co/inter-dependencies
- Inconsistency of data across hospital sites to inform service modelling

- Lack of regional clinical consensus on service model
- Lack of stakeholder commitment to process
- Uncertainty regarding service changes
- Failure to fully capture capital and revenue implications, lack of affordability and failure to get agreement on funding flows
- Failure to fully capture staffing implications
- Failure to agree and implement network arrangement may adversely affect clinical recruitment and retention
- Clarity on commissioning arrangements
- Inadequate communications
- Failure to deliver informatics solutions at implementation

4. Workforce

The proposed service model is based on the following workforce-related principles:

- Services to meet national clinical and workforce standards
- Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate
- Access to senior medical advice and treatment 24/7 for major trauma patients
- Service models underpinned by realistic and deliverable workforce models
- Stable medical teams that deliver high-quality patient care in an effective environment in which to train and educate the next generation of doctors
- Integration of care and effective relationships with other health professions
- An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
- Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment
- Developing clinical roles to provide future workforce flexibility

The service model and standards describe some specific workforce requirements:

- The Major Trauma Network will be led by a Network Director
- There should be identification of a Network Clinical Lead for Rehabilitation Services
- Enhanced care teams should be available 24/7 to provide care to the major trauma patient
- 24/7 consultant (trauma team leader) available on the MTC site to receive the trauma patient on arrival
- Trauma team present 24 hours a day for immediate reception of the patient

- All emergency operative interventions performed within the first 24 hours should have consultant involvement, and consultant presence in the operating room for life- or limb-threatening injuries. A consultant will be involved in surgical decision making; emergency trauma surgery will be undertaken or directly supervised by consultants.
- Consultants available on site within 30 minutes when required and senior trainees (ST5s and above or equivalent) on site 24/7 for specified specialities
- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation co-ordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles
- A nursing team in the ward, able to facilitate practise of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. A speciality trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion
- There should be rehabilitation and care coordinator posts throughout the network
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network's services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients

5. Specialised Tertiary & Networked Services

- Paediatric Intensive Care (PICU) will remain at Children's Hospital for Wales
- Paediatric burns services will be delivered by Bristol
- Paediatric rehabilitation model will need to be considered by WHSSC
- Need to consider capacity requirements on WAST for secondary transfers

6. Key Performance Indicators

(To be completed in implementation phase)

7. References

- Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)
- NHS England Standard Contract for Major Trauma (2013)
- Centre for Workforce Intelligence: Report on Regional Trauma Networks (March 2011)

SERVICE MODEL - REHABILITATION

1. Introduction

This paper describes the proposed rehabilitation service model for a major trauma network to serve South Wales, South Powys and West Wales.

The rehabilitation service model is being developed by the Major Trauma Network Rehabilitation Workstream, which reports to the Major Trauma Network Project Board. It has been developed via a series of three workshops with participants in the workshops nominated through members of the Major Trauma Project Board and included representatives from a broad spectrum of professionals within each Health Board – Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys, Welsh Ambulance Service Trust – Third Sector partners and Local Authorities. Invitations were also extended to Community Health Councils, Welsh Health Specialised Services Committee and patient representative groups.

The trauma service model has been developed by the Major Trauma Network Clinical Reference Group which is described in a separate document entitled, [Clinical Model, May 2015, Final](#).



[3. Clinical Model -
May 2015 - Final.pdf](#)

Throughout the work to develop the model, rehabilitation has consistently been highlighted as a key part of the patient pathway, commencing at admission, continuing through the inpatient phase to discharge from the major trauma centre or unit out into the community and is a true enabler to achieving the best outcomes for the patient.

2 Scope

Scope	<p>The rehabilitation model will align with the major trauma network for South Wales, South Powys and West Wales and will serve the populations of Aneurin Bevan UHB, Abertawe Bro Morgannwg UHB, Cardiff & Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys tHB.</p> <p>The service model will provide a holistic patient-focussed treatment package. The service will comply with accepted best clinical practice and standards, provide improved patient outcomes and have robust governance arrangements. Consideration will be given as to how this service interfaces with other relevant developments and impacts on other clinical and support services.</p>
Vision	<p>To ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable trauma rehabilitation services at all points along their care pathway from the point of injury to rehabilitation, in line with best practice standard requirements.</p>
Planning Principles	<p>Key underpinning principles are the :</p> <ul style="list-style-type: none"> • British Society of Rehabilitation Medicine, Specialist Rehabilitation in the Trauma pathway: core standards (version 1.4 – October 2013); • Regional Networks for Major Trauma: NHS Clinical Advisory Group Report (September 2010) recommendations for Early/Hyper Acute Phase Rehabilitation and the Rehabilitation phase (ongoing specialised and local); • The Initial Management of Adults with Spinal Cord Injuries, Advice for Major Trauma Networks and SCI Centres on the Development of Joint Protocols: National Spinal Cord Injury Strategy Board (May 2012); • National Spinal Cord Injury Database; and • NICE Guidelines on Major Trauma - no: 37, 38, 39, 40 and 41 (February 2016).

<p>Service Aims & Objectives</p>	<p>To improve the quality of rehabilitation for patients by:</p> <ul style="list-style-type: none"> • Providing a comprehensive system of specialist and local rehabilitation for people who have suffered serious injury (major trauma) through the delivery of a regional trauma rehabilitation network; • Improving the functionality, health and psychological well-being in those patients who survive their traumatic injuries, increasing their quality of life; • Ensuring that services meet agreed national clinical and workforce standards; • Always meeting fundamental standards of care/treatment; • Valuing patient experience as much as clinical effectiveness; • Ensuring responsibility for each patient’s care is clear and communicated; • Providing effective and timely access to rehabilitation at all levels; • Ensuring robust arrangements for transferring treatment are in place; • Tailoring services to meet the needs of individual patients, including vulnerable patients; • Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment; and • Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement.
	<p>To improve the sustainability of services to patients by:</p> <ul style="list-style-type: none"> • Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate; • Developing clinical roles to provide future workforce flexibility; • Ensuring the population has access to major trauma services within a reasonable timeframe; • Planning capacity to meet demand and providing appropriate resources across the network; and • Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies.

	<p>To improve access for patients by:</p> <ul style="list-style-type: none"> • Delivering a rehabilitation system based on a pathway of care from acute care, ongoing care and rehabilitation and a return to socio-economic functioning; and • Improving information and support to patients and families to encourage them to be active participants in their rehabilitation.
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3 Service Model

Network Delivery

There will be a Network Clinical Lead for Rehabilitation Services to coordinate the development and delivery of rehabilitation services and long-term support in the community, and the delivery of comprehensive and effective rehabilitation to meet the needs of traumatically injured patients, irrespective of their age.

Discharge planning, continuing care and rehabilitation

Patient transfer

- There should be cross network agreements and adequate resources to ensure that once specialist trauma care has been completed, patients can be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs.
- There should be a formal handover back to the local therapy team (including ALAS) via an identified therapy lead at the provider unit. The responsibility should be on the local team to 'pull' patients back to local services. This must be achieved in a timely manner with adequate notice to plan and support transition. The local therapy team should visit the patient at the provider unit as part of transfer planning. The transfer should be followed up with a visit from the provider therapy team following transfer.
- A discharge summary must be provided to support the patient's transfer to an alternative healthcare setting or the community.
- Ongoing access to advice from provider therapy teams as required.

Communication

- There will be effective communication between all those responsible for the patient's care, the patient and where appropriate their family and other carers.
- Patients will be provided with a full range of condition-specific information in appropriate formats.
- A directory of services and resources should be developed relating to rehabilitation and ongoing care to facilitate referral and access to these services. Links with the local authorities and third sector are integral to the rehabilitation model.

Audit, data management, governance and quality improvement

- Representatives from services within the rehabilitation network will meet regularly to examine performance through formal governance processes.
- A central database is required to monitor and measure rehabilitation outcomes.
- Use of the Network rehabilitation prescription will be mandated.

Workforce

- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation coordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles.
- Able to facilitate practice of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team.
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.

- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. A specialty trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion.
- There should be rehabilitation and care coordinator posts throughout the network.
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network’s services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

Specialist rehabilitation is the total active care of patients with complex disabilities by a multi-professional team who have undergone recognised specialist training in rehabilitation led/supported by a consultant trained and accredited in rehabilitation medicine (Ref BSRM standards).

The aim of the rehabilitation service is to provide rehabilitation appropriate to the level of injury in the right setting. It will start in the Major Trauma Centre and continue through specialist or local rehabilitation services. To provide a holistic pathway of care, service requirements are as follows:

Early/Hyper Acute Phase Rehabilitation

- | |
|---|
| <ul style="list-style-type: none"> • A defined service for early/hyper acute trauma rehabilitation service which meets the needs of patients with ISS >8. |
| <ul style="list-style-type: none"> • All patients have an initial rehabilitation prescription within 2-4 calendar days of presentation. The prescription may identify no further need for rehabilitation, may recommend monitoring or may require full active engagement of the wider rehabilitation team. |
| <ul style="list-style-type: none"> • Rehabilitation starts as soon as is appropriate after admission, typically in the critical care setting (and certainly within 72 hours), and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential. |

- The prescription for rehabilitation reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient.
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
- All patients receive early phase rehabilitation and all other actions identified in the rehabilitation prescription; if action or input cannot be delivered, the reason is recorded and intervening action is undertaken.
- All patients needing rehabilitation input or monitoring are under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation.
- This team meets weekly to discuss all patients within its scope. A consultant attends over 80% of meetings and continues to provide supervision and support to trainees and the team.

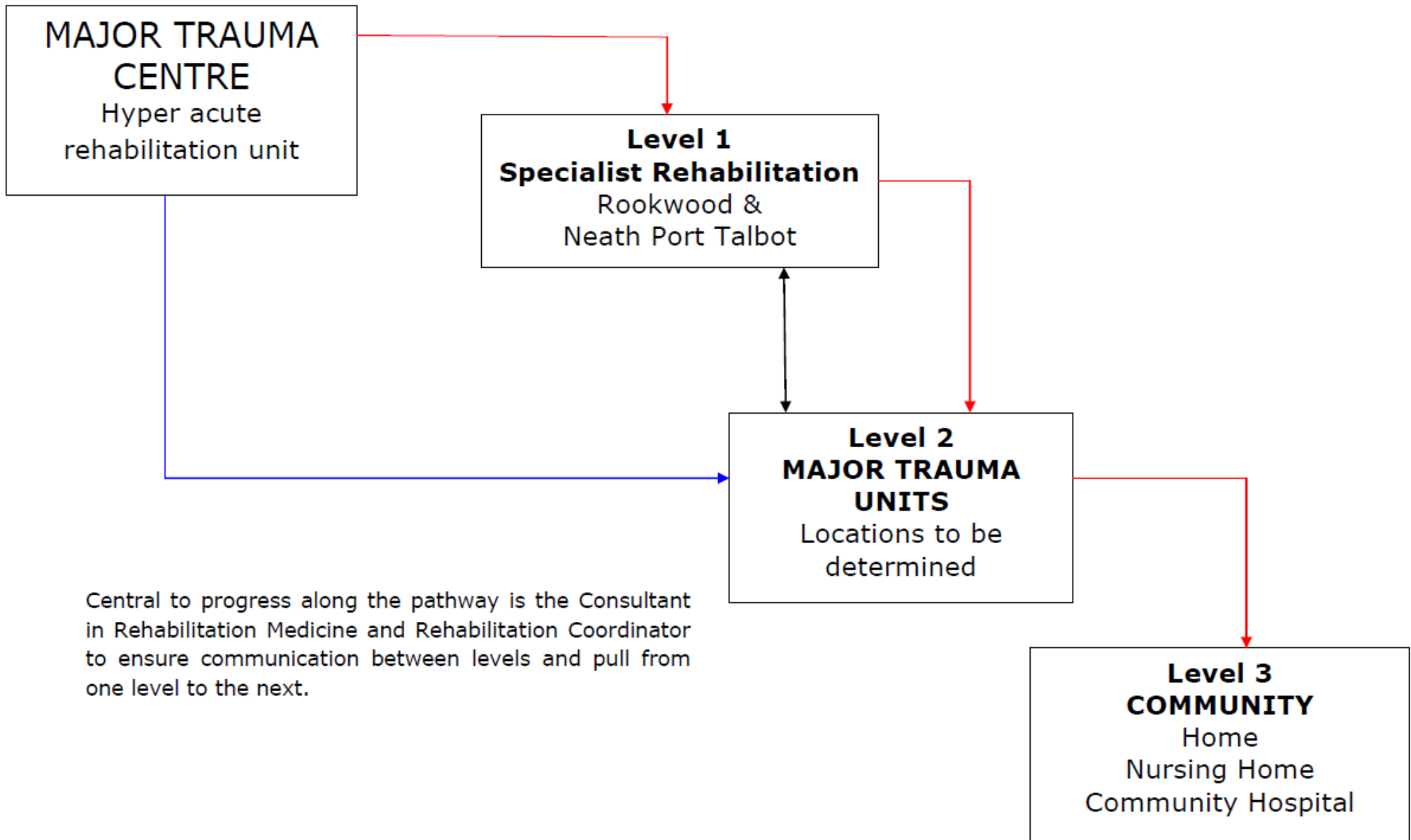
Rehabilitation phase (ongoing specialised and local rehabilitation)

- Trauma patients receive routine screening of rehabilitation needs and appropriate levels of care and rehabilitation at all points along their care pathway.
- Provider therapy teams provide access to rehabilitation assessment seven days a week.
- A discharge summary describing the patient's injuries, care received and ongoing needs and plans are provided at the time of discharge or transfer. This includes the rehabilitation prescription.
- There are rehabilitation and care coordinator posts in place. Each patient has an identified key worker to be a point of contact for them, their carers or family doctor and to ensure delivery of their personal prescription for rehabilitation.
- Vocational rehabilitation is a key component of the rehabilitation service.
- There is an adequately skilled and resourced multi-disciplinary rehabilitation team. Multi-disciplinary team includes: physiotherapists, occupational

therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients.

- Policies for nutritional management are in place.
- Use is made of VC/telehealth technology to support the rehabilitation phase, enhancing shared care arrangements between generic providers of rehabilitation and the specialist trauma rehabilitation teams.
- The needs of families and carers in all phases of major trauma rehabilitation are considered, including the distances that may be incurred in travelling.

South Wales, South Powys and West Wales Rehabilitation Service Model



Description of Rehabilitation Levels

Hyper Acute rehabilitation

Rehabilitation should start as soon as is appropriate after admission, ideally in the critical care setting and in line with NICE Guidance: Rehabilitation after Critical Illness in Adults; (Reviewed February 2014). The hyper-acute service enables early rehabilitation input to patients who have intensive rehabilitation needs. Patients with poly-trauma, head injuries, spinal injuries or multiple fractures maybe co-located within a designated ward/unit area within the Major Trauma Centre site allowing enhanced co-ordination from the multi-disciplinary team involved in their care.

Level 1 – Specialist Rehabilitation

A small number of very complex trauma patients will require the skills and facilities of a level 1 specialist rehabilitation facility. These patients will typically present with complex disabilities and a range of medical, physical, sensory, cognitive and behavioural problems. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, psychology and ALAS (list not exhaustive).

Specialist rehabilitation input will be initiated early during the patient's journey. This may commence when the patient is in the intensive therapy unit ('ITU') and will continue beyond this phase of treatment. Rehabilitation input will commence with the initiation of a rehabilitation prescription within 72 hours. The prescription will be a standard form template in an electronic format to enable ongoing edit and revision. The prescription should be completed by a specialist in rehabilitation, including an allied health professional or therapist (band 7). Access to specialist rehabilitation will be provided by a rehabilitation consultant, through a specialist rehabilitation prescription.

The designated Major Trauma Centre will incorporate hyper acute rehabilitation provision in order to provide rehabilitation to patients who also require ongoing acute medical treatment. This will enable patients to access relevant medical specialties. The facility will accommodate patients with tracheostomies and naso-gastric tubes. This could be provided on a medical ward or a dedicated major trauma ward and the Team will follow the patient.

When the patient is ready to move from a hyper acute rehabilitation facility, they may be transferred to a level 1 facility according to their needs. The patient may not necessarily need to move through a pathway transferring to a lower level acute facility and then into the community. Where onward transfer to another facility is required, communication with the receiving unit will be proactive and clear. GPs will also receive information on the rehabilitation that the patient has received or been prescribed. Support from neuro-psychiatry will be provided as clinically required.

Continuity of care will be prioritised throughout the patient's journey. The patient will be allocated a key worker and will have access to a single point of contact (either a nurse or therapist) to enable them to raise queries at any point. Where patients are treated on a medical ward, the trauma team will be expected to work with the medical specialties to ensure that the provision of rehabilitation alongside medical treatment is seamless.

The patient and their family will be informed of relevant information throughout their time in rehabilitation. This will include the provision of an information booklet and an option to keep a patient or family diary. Support to families will also be prioritised and consideration should be given to providing facilities such as on-site accommodation where families travel long distances. Open visiting has also been identified as a priority, factoring in patient feedback. Early links with appropriate third sector agencies should be established.

Level 2 – acute ongoing rehabilitation – Major Trauma Units

For the majority of patients whose needs will be less complex and at a lower level, acute and ongoing rehabilitation will be provided within a Major Trauma Unit which will be more localised to their area of residence. They may be directly admitted to the Major Trauma Unit or via the Major Trauma Centre. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, psychology and ALAS (list not exhaustive).

Rehabilitation input will commence with the initiation of a rehabilitation prescription within 72 hours and will be overseen by a Consultant in Rehabilitation Medicine. The prescription will be a standard form template in an electronic format to enable ongoing edit and revision. The prescription should be completed by a specialist in rehabilitation, including an allied health professional or therapist (band 7).

The Major Trauma Unit will enable patients to access relevant medical specialties and could be provided on a medical ward or a dedicated trauma ward.

The patient may not necessarily need to move through a pathway transferring to a lower level acute facility and then into the community. Where onward transfer to another facility is required, communication with the receiving unit/community will be proactive and clear. GPs will also receive information on the rehabilitation that the patient has received or been prescribed. The Major Trauma Unit Rehabilitation team will have the capacity and skill set to advise the community teams and local rehabilitation hospitals to outreach to local hospitals or units for patients with ongoing rehabilitation needs.

Continuity of care will be prioritised throughout the patient's journey. The patient will be allocated a key worker and will have access to a single point of contact (either a nurse or therapist) to enable them to raise queries at any point. Where patients are treated on a medical ward, the trauma team will be expected to work with the medical specialties to ensure that the provision of rehabilitation alongside medical treatment is seamless.

The patient and their family will be informed of relevant information throughout their time in rehabilitation. This will include the provision of an information booklet and an option to keep a patient or family diary. Support to families will also be prioritised and consideration should be given to providing facilities where families travel long distances. Open visiting has also been identified as a priority, factoring in patient feedback. Early links with appropriate third sector agencies should be established.

Level 3 – ongoing rehabilitation – Community

As patients improve and no longer require care within an acute setting they will be transferred into a community setting to continue their rehabilitation. The model of which will be determined by the local model of care which may be different across the network area depending on rural or urban localities and will contain vocational/social participation and third sector support as necessary. The Consultant in Rehabilitation Medicine will maintain an overview and patients will be reviewed and managed within the community. There will be links with GPs, the wider Primary Care Team and third sector organisations. Specialist Community Teams such as those working in Acquired Brain Injury and Spinal Injury will support primary care teams with a seamless approach between community and Level 2/specialised care.

To enable a seamless approach Community areas (to be determined) require:-

- a) A Community rehabilitation co-ordinator equivalent to MTU Co-ordinator.

- b) Early notification of patient injury (via coordinator?), to enable the appropriate people to be involved in planning care journey/ involve families where appropriate.
- c) Regular meetings and updates on patient progress to enable informed decisions to be made early in the care journey e.g. modifications/ adaptations of property requires intervention as early as possible due to long lead in.
- d) Pathways should be in place such that the same standard of treatment and care is provided pan Wales.
- e) Sharing of data across HBs, Social Care and Agencies.
- f) Knowledge of services available within the community (Directory – Dewis Cymru website with resource directory/database).
- g) Clarity around “maintenance” of patients i.e. where one service ends / starts for lifelong support.

Paediatric Rehabilitation

The paediatric rehabilitation model requires further discussion with WHSCC in light of the acute paediatric rehabilitation services model and fixed points such as the Paediatric Intensive Care Unit remaining within the Children’s Hospital for Wales and Paediatric Burns Centre services provided by Bristol. It is recommended that a pan Health Board Task & Finish Group is established to develop and/or confirm pathways based on the acute paediatric rehabilitation model outlined and agreed by WHSCC.

SOUTH WALES HEALTH COLLABORATIVE

MAJOR TRAUMA NETWORK DEVELOPMENT

PROCESS FOR NON FINANCIAL OPTION APPRAISAL EXERCISE

May 2015

PURPOSE

The purpose of this paper is to describe the process for undertaking the non financial option appraisal for the future delivery of a major trauma centre as part of the major trauma network to serve South and West Wales and South Powys.

INTRODUCTION

The service model for the major trauma network has been developed through the Major Trauma Network Clinical Reference Group (CRG) and Project Board.

The option appraisal will be to:

- Consider the number and siting of a major trauma centre to serve the population of South and West Wales and South Powys.

It is assumed that consultant-led emergency departments will act as the ‘trauma units’ within the major trauma network structure. Standards for a major trauma centre and trauma units have been defined through the work of the CRG, substantially informed by the NHS Clinical Advisory Group ‘Regional Networks for Major Trauma’ report (2010) and with reference to the NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013).

The workshop will need to consider:

- The infrastructure requirements for the number and siting of a major trauma centre, based on the agreed service model and the proposed activity that will be centralised in a major trauma centre;
- The co-located and interdependent services that will be needed in a major trauma centre; and
- Scoring of each option against each of the six benefit criteria.

SERVICE MODELS – THE INITIAL LIST OF OPTIONS

The aim of the service is to provide care to major trauma patients, characterised by an Injury Severity Score (ISS) >15 and most patients with moderately severe trauma (ISS>8), from the point of injury to rehabilitation. Calculation of the ISS requires a full diagnostic work-up and so the service is designed around the triage of patients at the point of wounding, to identify “candidate major trauma patients” on the basis of mechanism of injury and assessment of their symptoms and physical signs. A trauma triage tool will be used to identify patients with major trauma. Patients will be triaged to the major trauma centre directly or through a secondary transfer protocol. The major trauma centre will have a policy of automatic acceptance for patients requiring major trauma centre care from within the network. Hospitals within the major trauma network will work together ensuring patients have seamless access to care and transfer back to their local hospital when medically fit.

An initial “long list” of potential service models for the future delivery of a major trauma centre as part of the major trauma network to serve South and West Wales and South Powys is:

Option 1 – Do nothing

This option describes the current situation and clinical pathway delivery and is used as the baseline comparator. There is currently no major trauma network serving South and West Wales and South Powys and no hospitals have been designated as ‘major trauma centres’ or ‘trauma units’.

Option 2 – Single site – University Hospital of Wales

This option would propose the development of a single-site Major Trauma Centre at the University Hospital of Wales Cardiff. This would mean the designation of the University Hospital of Wales as the major trauma centre serving South and West Wales and South Powys with all other consultant-led emergency departments acting as the ‘trauma units’ within the major trauma network structure, some of which may provide specialist services.

Option 3 – Single site – Morriston Hospital

This option would propose the development of a single-site Major Trauma Centre at the Morriston Hospital, Swansea. This would mean the designation of Morriston Hospital as the major trauma centre serving South and West Wales and South Powys with all other consultant-led emergency departments acting as the ‘trauma units’ within the major trauma network structure, some of which may provide specialist services.

Option 4 – Dual site

This option would propose the development of a Major Trauma Centre that would be delivered across two sites: University Hospital of Wales and Morriston Hospital. This **does not** mean that the full requirements for a major trauma centre would be provided on each site. This would mean the requirements for a major trauma centre serving South and West Wales and South Powys would be provided across the University Hospital of Wales and Morriston Hospital, one of which would need to be the designated lead for the major trauma network. Some specialist services would need to be provided from Morriston to UHW (e.g. burns and plastics) and from UHW to Morriston (e.g. neurosurgery) through emergency outreach clinical teams. The remaining consultant-led emergency departments would act as the ‘trauma units’ within the major trauma network structure.

Option 5 – Outsourced service- no Major Trauma Centre in South Wales

This option would propose that a Major Trauma Centre is not established within South Wales but that this service would be commissioned from a provider partner outside Wales. This would mean the designation of a major trauma centre in England serving South and West Wales and South Powys with the consultant-led emergency departments in South and West Wales acting as the ‘trauma units’ within the major trauma network structure, some of which may provide specialist services.

AGREED SERVICE MODEL

The service model for the major trauma network has been developed through the Clinical Reference Group (CRG) and has been informed by a thorough review of the recommendations of the Clinical Advisory Group Report (2010) and with reference to the NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013) .

BENEFIT CRITERIA – NON FINANCIAL OPTION APPRAISAL

The financial and non financial criteria for this option appraisal have been informed by that previously agreed and used in the South Wales Programme (SWP) and other developing South Wales or all Wales business cases.

In order to assess each of the potential options for the number and siting of a major trauma centre, the benefit criteria, coverage of issues to be considered within each criterion, and the weighting, have been agreed by the CRG and the Project Board. The method of determining the weighting has been to give each criterion a value which, when all added together, equals 100. The agreed benefit criteria, coverage and weighting are:

Benefit Criteria	Definition / coverage	Weighting (%)
Quality & Safety	Meets agreed clinical, quality and safety standards; Compliance with legislation, regulations and accreditation standards / performance; Supports rapid adoption of best practice; Clinical effectiveness, including:- <ul style="list-style-type: none"> • Delivers improved outcomes for patients; • Supports R&D; • Improves consistency in clinical practice. 	35
Equity	Service meets potential differential impact on protected groups Timeliness of access to specialist care for all patient groups / improvements in standards for specific patient groups	10
Strategic fit	Services delivered within network of integrated care; In line with outcomes of the SWP and other emerging service models. Does not destabilise other clinical services / developments;	15
Sustainability /Future proof	Availability of appropriately trained and skilled workforce; Service provided by a workforce which is “fit for purpose”, re EWTD and clinical training standards;	25

	Attracts and retains an excellent workforce across all staff groups; Delivers the critical mass required to achieve full benefit from resources and investment; Does not destabilise other clinical services / developments; Provides business continuity and service contingency in the event of a major incident, etc.	
Access	Access to services is optimised Service capacity will meet demand in a timely way Service will be delivered in an appropriate environment Suitable and timely transport for transfers between the major trauma centre and trauma units; Avoidable transfers minimised.	15
	Total	100

PROCESS

The non financial option appraisal will be undertaken through a stakeholder workshop.

The workshop will be independently chaired and will be facilitated by the South Wales Health Collaborative. Workshop participants, clinical and managerial, will be invited from each of the six health boards (Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys) and the Welsh Ambulance Services NHS Trust. Each health board and WAST will be allocated a maximum number of attendees (for health boards calculated as 2 representatives per 100,000 population and with 5 representatives from WAST) and will be expected to manage their representation across a range of specialities/disciplines directly involved in or supporting a major trauma centre service. Patient representatives will be invited through third sector support groups and fair geographical coverage will be sought. The CHCs will be invited to attend the workshop in an observer capacity.

Given the expected number of participants at the workshop, attendees will be allocated to one of six groups on arrival. This will be to ensure as much of a balance as possible on each of the groups between organisations, specialities and disciplines. Each group will then subsequently consider in detail a selected number of the above benefit criteria.

Before undertaking the detailed non financial option appraisal scoring, the workshop will:

- Receive a presentation to:
 - Describe the process to develop the service model, highlighting the infrastructure requirements and co-interdependencies
 - Explain the benefit criteria and weighting
 - Set out the options for the configuration of the major trauma network
 - Confirm the process for scoring
 - Describe how the results will then be collated and how the sensitivity analysis will be undertaken, as a post-workshop activity.

Scoring

The workshop will then need to undertake the detailed non financial option appraisal, through a scoring exercise. This will be as follows:

Each of the options being appraised will need to be allocated scores relating to how well or not it fulfils or delivers against each of the agreed criteria. To do this, each of the main, key benefit criteria above will be considered in detail through a range of “sub criteria”, with each option being appraised then scored either 0, 1 or 2 for each of these sub criteria: 0 will indicate that the option does not deliver the relevant sub benefit at all, 1 partially delivers it and a score of 2 delivers this fully. These scores will then be averaged for each of the main key benefits, resulting in each being scored out of a total of 2, to give an unweighted total out of 10, for each option. Where possible, this will be informed by hard data and be evidence based and objective, although it is inevitably also going to include a degree of professional judgement. **Appendix 1** provides an example of the detailed and, consolidated scoring sheet following this exercise.

Each of the six groups will focus on a selected number of the main benefit criteria and will only score each of the options, for each of the sub benefits as above for each option, for these. This will be as follows, grouped to ensure that the weighted criteria are as equally spread across all of the participants as possible:

- Groups 1&2 – Quality and Safety;
- Groups 3&4 – Equity and Sustainability/future proofing
- Groups 5&6 – Strategic Fit and Access

The scoring for each of the options and categories being considered by each of the groups, for each of the relevant benefit criterion being considered, will need to be provided by each group, based on a consensus view. To assist in this, scoring sheets will be provided and each group will include an independent member to assist in facilitating this scoring.

POST WORKSHOP

When averaged and then consolidated, each of the above scoring for each benefit for each option being appraised will then have the above agreed weighting applied (by multiplying the average scores for each benefit by the weighting) to enable both a weighted and un-weighted outcome to be determined. This will then confirm a preferred option from a non financial appraisal point of view, and also how all of the evaluated options rank and how close any of them are between each other, in meeting the benefit criteria. All this will be vital information to use in conjunction with the subsequent financial appraisal in determining the overall preferred option. This will then be consolidated and completed to feed back to the Project Board, at which it is also expected that a consistency check of the outcomes of the scoring exercise will be undertaken. This will also then be shared with all participants of the workshop, as soon as possible.

Following the completion of this stage of the process, the outcomes will also be tested further through a sensitivity analysis, designed to assess how sensitive the outcome is to changes in some of the input criteria and data. As a minimum, this will review the outcome by:

- Reverse weighting: this will test how sensitive the outcome is to the weighting that has been applied to the benefit criteria. It does so by completely reversing the weighting, so that the highest weighted criteria becomes the lowest, the second highest the second lowest and so on.
- Equal weighting: similar to the above in terms of testing the sensitivity of the weighting applied, this will assume an equal weighting for each of the criteria, and what the resulting scores and ranking of options would therefore be.
- Reviewing the 2nd ranked option: this tests the sensitivity of the preferred option, through potentially two additional analyses. Firstly, it adds a marginal increase in score (typically 5-10%) to each and every criteria for the 2nd ranked option, to see if this would affect the preferred option outcome. If it does not, it then also goes on to test what increase in such scoring would be required to affect this.

All of this will also be undertaken in preparation for the Project Board meeting, to feed into this discussion and also inform the subsequent required financial appraisal. Subject to a final non financial option appraisal outcome at this stage, the detailed financial appraisal will then be undertaken, following any further sub option appraisal focussing on the whole major trauma network and pathway, to determine the overall preferred option.

The results will be fully captured in the resulting business case.

Appendix 1

South Wales Health Collaborative

Major Trauma Network Project

Draft proposed scoring mechanism for non financial option appraisal

Proposed scoring for each sub / detailed benefit:-

- 0 Option does not deliver benefit
- 1 Option partially delivers benefit
- 2 Option fully delivers benefit

Main benefit criteria	Detailed benefit being appraised / scored within each	Scores					
		Option 1 Do nothing	Option 2 Single site - UHW	Option 3 Single site - Morriston	Option 4 Dual site - networked service	Option 5 Outsourced	
Quality & Safety (35)	Meets agreed clinical, quality and safety standards						
	Compliance with legislation, regulations and accreditation standards / performance						
	Supports rapid adoption of best practice						
	Clinical effectiveness, including:-						
	Delivers improved outcomes for patients						
	Supports R&D						
	Improves consistency in clinical practice						
	Sub total Quality & Safety gross score	0	0	0	0	0	
	Number of sub benefits	0	0	0	0	0	
	Average Quality & Safety score for weighting (out of a maximum of 2)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Equity (10)	Service meets potential differential impact on protected groups						
	Timeliness of access to specialist care for all patient groups						
	Improvements in standards for specific patient groups						
		Sub total Equity gross score	0	0	0	0	0
		Number of sub benefits	0	0	0	0	0
	Average Equity score for weighting (out of a maximum of 2)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Strategic Fit (15)	Services delivered within network of integrated care						
	In line with outcomes of the SWP and other emerging service models						
	Does not destabilise other clinical services / developments						
		Sub total Strategic Fit gross score	0	0	0	0	0
	Number of sub benefits	0	0	0	0	0	
	Average Strategic Fit score for weighting (out of a maximum of 2)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Sustainability / Future proof (25)	Availability of appropriately trained and skilled workforce						
	Service provided by a workforce which is "fit for purpose", re EWTD and clinical training standards						
	Attracts and maintains an excellent workforce across all staff groups						
	Delivers the critical mass required to achieve full benefit from investment						
	Does not destabilise other clinical services / developments						
	Provides business continuity and service contingency in the event of a major incident, etc						
		Sub total Sustainability / Future proof gross score	0	0	0	0	0
	Number of sub benefits	0	0	0	0	0	
	Average Sustainability / Future proof score for weighting (out of a maximum of 2)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Access (15)	Access to services is optimised						
	Service capacity will meet demand in a timely way						
	Service will be delivered in an appropriate environment						
	Suitable and timely transport for transfers between major trauma centre/s and trauma units						
	Avoidable transfers minimised						
		Sub total Access gross score	0	0	0	0	0
	Number of sub benefits	0	0	0	0	0	
	Average Access score for weighting (out of a maximum of 2)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Total gross unweighted scores		0	0	0	0	0	
Total average unweighted scores (out of a total of 10)		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

Appendix 1 (cont'd)

South Wales Health Collaborative

Major Trauma Network Project

Draft proposed scoring mechanism for non financial option appraisal

Summary

Benefit criteria	Option 1 – Do nothing			Option 2 – Single site - UHW			Option 3 – Single site - Morriston			Option 4 – Dual site - networked service			Option 5 – Outsourced		
	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score
Quality & Safety	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!
Equity	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!
Strategic Fit	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!
Sustainability / Future proof	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!
Access	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!
Total (out of 10 / 200)	#DIV/0!	100	#DIV/0!	#DIV/0!	100	#DIV/0!	#DIV/0!	100	#DIV/0!	#DIV/0!	100	#DIV/0!	#DIV/0!	100	#DIV/0!

CONFIDENTIAL REPORT**Major Trauma Independent Panel****High level draft financial information****Purpose**

This briefing paper provides members of the Independent Panel with high level draft financial information.

Introduction

In order to support the NHS Wales Health Collaborative (NHSWC) to develop an option appraisal for the location of the South Wales Major Trauma Centre (MTC) both potential sites have undertaken an initial assessment of the revenue and capital consequences of providing the MTC.

It should be noted that finance and clinical colleagues, from both potential MTC sites and the NHSWC have worked closely and collaboratively to prepare these financial assessments.

Summary of Draft Financial Assessments

Both potential MTC sites have assessed their additional investment requirements for both capital and revenue.

Capital – assessed costs

At this stage it is possible to predict the capital impact of accommodating the MTC only in indicative terms. The indicative capital costs of both sites are summarised in the table below:-

Indicative Capital costs £m	
UHW Cardiff	£23m
Morrison Swansea	range from £9.9m - £12.8m with additional £3.1m if CT required

Revenue – assessed costs

Using the assessed additional capacity requirements both potential MTC sites have estimated their additional investment requirements:-

- a) To fully meet the standards of a Major Trauma Centre; &
- b) As an essential investment against each of the standards to accommodate the additional activity (until such time as funding is available to fund full standard compliance).

Indicative Revenue costs	Essential Minimum Assessed cost of Change £m	Meets standards Assessed cost of Change £m
UHW Cardiff	7.6	10.7
Morrison Swansea	9.1	11.8

Patient Activity Levels

The MTC Project Board has agreed that the baseline activity for each of the current centres should be based on 2014 Trauma Audit & Research Network (TARN) data. This is outlined below. Data for the remaining hospitals in the system was not available at this time.

Baseline	UHW	Morrison	Total
Major Trauma	251	175	426
Candidate Trauma	221	280	501
Total	472	455	927

The activity to be accommodated by the single centre has been modelled by NHS Wales Informatics Service (NWIS) on the basis of predicated incidence, Lower Super Output Areas (LSOA) population and travel time. The model assumes that a proportion of patient activity will be treated, and generates different MTC volumes for the Cardiff and Morrison options:

Modelled Activity	UHW	Morrison
Major Trauma	404	387
Candidate Trauma	455	427
Total	859	814

The additional activity that would be treated under each option would therefore be:

Additional Activity	UHW	Morrison
Major Trauma	153	212
Candidate Trauma	234	147
Total	387	359

Capacity Requirement Assumptions

The NWIS model included length of stay assumptions for general ward and ITU stays and bed occupancy, based on current practice. These assumptions have been applied to the additional activity flowing to each of the sites in order to estimate the additional capacity requirements.

Financial Assessment – Revenue costs

Using the additional capacity requirements (outlined above) both potential MTC sites have assessed their additional investment requirements:-

- a) To fully meet the standards of a Major Trauma Centre; &
- b) As an essential investment against each of the standards to accommodate the additional activity (until such time as funding is available to fund full standard compliance)

These additional requirements have been costed, and the key resource impacts are summarised in the table below:-

Assessed Revenue costs	Morrison Swansea	Morrison Swansea	UHW Cardiff	UHW Cardiff
	Meets Standards £000's	Essential £000's	Meets standards £000's	Essential £000's
24 hr Consultant Cover	919	390	919	393
Trauma Training	10	10	10	10
24/7 Trauma Team	428	428	256	256
24/7 Theatre	1,593	774	1,664	808
Neurosurgery	1,125	885	0	0
Spinal	172	172	0	0
Vascular	0	0	0	0
General Surgery	0	0	0	0
T&O	240	240	288	242
Cardiothoracic	0	0	0	0
OMF	52	52	0	0
Anaesthetics	1,352	510	1,352	608
Interventional radiology	206	206	540	270
Plastics	120	120	640	192
ITU	1,558	1,558	1,138	1,138
Admin Support	179	118	168	168
Trauma Ward	2,172	2,172	2,859	2,684
Trauma Ward Therapies	796	621	0	0
Psychology	91	0	0	0
TARN	59	59	69	69
Non Pay	735	735	759	759
Total	11,807	9,050	10,662	7,597

Financial Assessment – Capital costs

At this stage it is possible to predict the capital impact of accommodating the MTC only in indicative terms.

For Morriston, Swansea a range of scenarios have been worked up to provide the additional capacity modelled from the activity flows and assumed Length of Stays and the assessed costs of these options are included in the table below:-

Morriston Swansea – indicative capital cost options

	Additional Capacity £000	CT Option £000	Total £000
Option 1	12,837	3,087	15,924
Option 2	14,307	3,087	17,394
Option 3	9,880	3,087	12,967

For UHW, Cardiff the estimate is that circa £23m capital resources could be required. This estimate is specific to the site at UHW and attempts to be realistic given the context of other changes and capital works, which are underway at the current time or being planned. If UHW was designated as an MTC then the solution and resultant costs could be quite different.

Report from the Major Trauma Project Team in relation to the confirmation of Baseline Major Trauma activity figures in Wales

Introduction

At its meeting dated 11th May 2016, the MTC Project Team received a verbal report and discussed the options in relation to the assessment of the baseline patient activity levels, noting the discussion at the Project Board on 25th April. Discussions were also held at the Joint Workstream meeting on 11th May and the Clinical Reference Group on 19th May.

Initial Baseline Assessments

As part of the options appraisal process carried out in June 2015, the following figures were presented as the baseline estimates of average annual Major Trauma activity by TARN Injury Severity Score (ISS) at the University Hospital of Wales (UHW) and Morriston Hospital respectively.

Site	ISS 9-15	ISS >15
UHW	160	189
Morriston	220	127

These figures were based on official TARN returns for the period January 2012 to June 2014.

Proposed Revised information as at 25th April 2016

Subsequent to the initial options appraisal process, Cardiff & Vale UHB and Abertawe Bro Morgannwg UHB (ABMU) were asked to produce detailed impact assessments around the establishment of a Major Trauma Centre at UHW and Morriston respectively. This process involved estimating the requirements in terms of staff, beds and infrastructure to meet the standards and expected uplift in demand at those sites from their current baseline if they were to become a Major Trauma Centre. This led to some closer scrutiny of the initial baseline estimates, especially those in relation to UHW, where the view from Cardiff & Vale UHB was that these represented a significant understatement of current major trauma activity levels.

To this end, Cardiff & Vale UHB subsequently proposed a revised set of baseline estimates, based on more up to date TARN information (Calendar Year 2014), with additional grossing factors applied, taking into account the following:

- 1) the % of admissions which had not been clinically coded, and thus not possible to be categorised as trauma or not, and
- 2) the % of admissions with a trauma clinical code that were unable to be located in order to be reviewed by the TARN co-ordinator, and thus unable to be sent to TARN

In order to ensure comparability between UHW and Morriston, ABMU Health Board were requested to produce their own set of revised estimates using the 2014 date period and the same grossing methodology employed by Cardiff & Vale UHB.

Preliminary figures were then discussed at the Major Trauma Project Board meeting on the 25th April 2016. However, these figures were presented in the form of very detailed spreadsheets, with no

accompanying explanatory guide to the figures, and without a clear summary of the results. As a consequence, some specific and important issues relating to this data were not discussed.

A decision was taken by the Project Board to use the original data and uplift by 12%/13% across the bands of complexity with a need to describe the assumptions and the broad levels of risk associated with this calculation.

Summary and Context

A summary of the various baseline estimate options are shown:

	Original TARN-based estimates (Jan 12 - Jun 14)		Admissions-based TARN (2014)		Non admission-based TARN (2014)		TARN Total (2014) as @ PB 25/04/16		TARN Total (2014) May 2016		Grossed-up Admissions-based TARN		Grossed-up TARN (2014)	
	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15
ISS	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15	9-15	> 15
UHW	160	189	209	213	10	26	219	239	221	251	225	243	235	269
Morrison	220	127	288	142	0	32	288	174	280	175	292	144	292	176
UHW + Morrison	380	316	497	355	10	58	507	413	501	426	517	387	527	445
UHW incr			31%	13%					38%	33%			47%	42%
Morrison incr			31%	12%					27%	38%			33%	39%
UHW + Morrison			31%	12%					32%	35%			39%	41%

Key to table

The figures in amber show the baseline estimates that would be arrived at using the methodology proposed by Cardiff & Vale UHB (based on 2014), which include a grossing-up of the admission-based TARN figures. The figures in red are those which were agreed following discussions at the 25th April 2016 Project Board meeting. However, in reaching this decision, it should be noted that most of those discussions were focussed on whether or not to gross up the admissions-based TARN figures in the way suggested by Cardiff & Vale UHB, meaning that certain other matters were rather overlooked.

Having reviewed the figures, the project board agreed that baseline estimates should be revised such that they were based on the calendar year 2014 rather than the Jan 12 – Jun 14 period. As the unadjusted admissions-based TARN figures for 2014 were 12-13% higher than the original baseline estimates for ISS>15 and 31% higher for ISS 9-15, the project board decided that this represented a sufficient increase and that no additional grossing-up factors were required. However, what was rather overlooked was the fact that official TARN figures also include a significant element of non admissions-based activity, for example where a patient is attended to in an Emergency Department, but is not admitted to that hospital (due to death in ED or a transfer to another hospital), and through their recommendations, the project board, possibly unknowingly, were excluding this activity from the baseline figures. This represented a significant change to the methodology from what was used to compile the original baseline estimates.

The figures in green are the official 2014 TARN figures. These use a methodology which is consistent with that used for the original baseline estimates methodology. This would result in a revised baseline estimate shown in green in the table above, and shows increases of 33% and 38% for UHW and 38% and 27% for Morrison for ISS>15 and ISS 9-15 respectively.

It should be noted that there has been a suggestion that 2015 data is applied. Whilst 2015 data is available, it is incomplete and, as a consequence, it is felt to be unreliable at this point.

Conclusion

After reviewing the options, the Project team concluded that the use of the official **green** 2014 TARN figures is:-

- Consistent with the methodology that was originally agreed and used for the initial options appraisal process;
- Clear and easy to understand and would provide a consistent methodology for future data analysis and reporting

Recommendation

The Project Team recommends that the official 2014 TARN figures (green**) are used as the baseline activity.**

Project Board is asked consider this recommendation and confirm its position in respect of the baseline activity.

MTC Project Team -May 2016

Appendix 9a–Isochrones Maps Major Trauma Scenarios – UHW as MTC

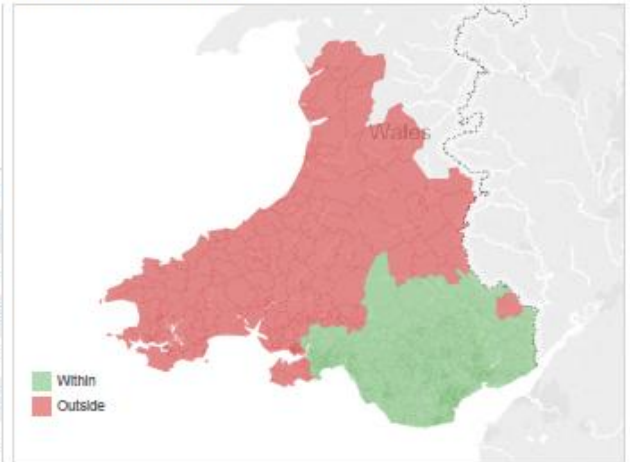
Choose Major Trauma Centre(s)
University Hospital Of Wales

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

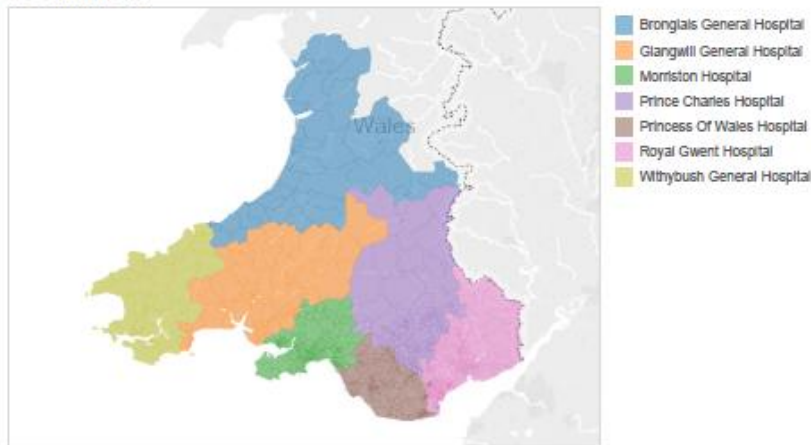
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	13	23	14	11	24	430	12	536
Candidate Major Trauma	11	16	28	16	13	28	477	14	803
Major & Candidate Major Trauma	21	29	51	30	24	52	907	27	1,139
Head	9	12	21	12	10	22	390	11	488
Non Head	12	17	29	17	14	30	517	15	652
Secondary Transfers In	0	0	0	0	0	0	123	0	123
Secondary Transfers Out	11	15	27	16	13	27	0	14	123
Beds	0.6	0.8	1.4	0.8	0.7	1.5	42.8	0.8	49.4
ICU Beds	0.1	0.1	0.2	0.1	0.1	0.2	5.6	0.1	6.5

MTC 60 minute isochrone

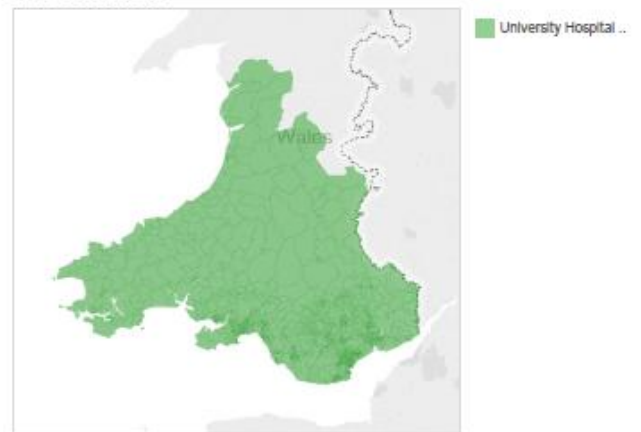


	Population	% Population
Within	1,886,846	80.09%
Outside	468,929	19.91%

TU Catchment



MTC Catchment



Appendix 9b–Isochrones Maps Major Trauma Scenarios – Morriston as MTC

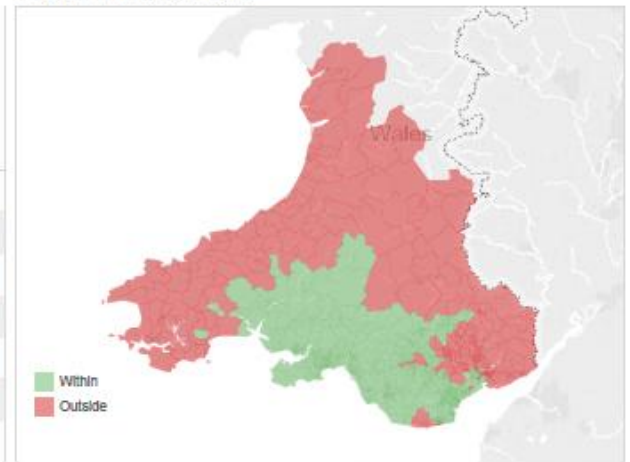
Choose Major Trauma Centre(s)
Morriston Hospital

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

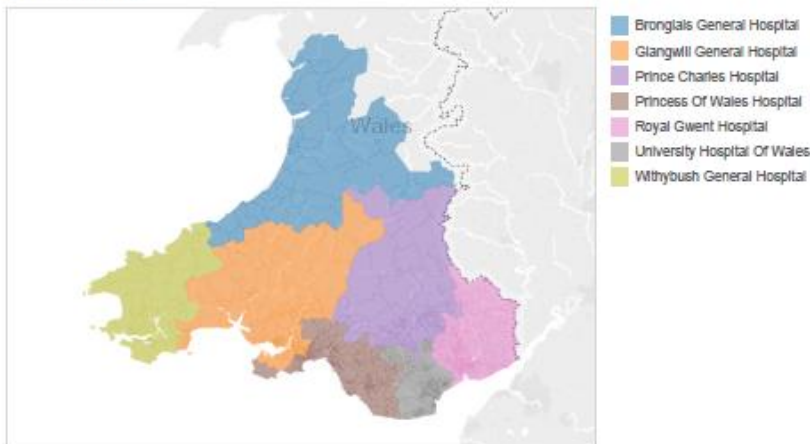
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	11	422	15	15	38	29	12	553
Candidate Major Trauma	11	13	460	18	18	46	35	14	615
Major & Candidate Major Trauma	21	25	882	33	32	84	64	27	1,168
Head	9	10	382	14	13	35	27	11	502
Non Head	12	14	500	19	19	49	37	15	666
Secondary Transfers In	0	0	151	0	0	0	0	0	151
Secondary Transfers Out	11	13	0	18	17	44	34	14	151
Beds	0.6	0.7	41.8	0.9	0.9	2.4	1.8	0.8	49.8
ICU Beds	0.1	0.1	5.5	0.1	0.1	0.3	0.2	0.1	6.6

MTC 60 minute isochrone

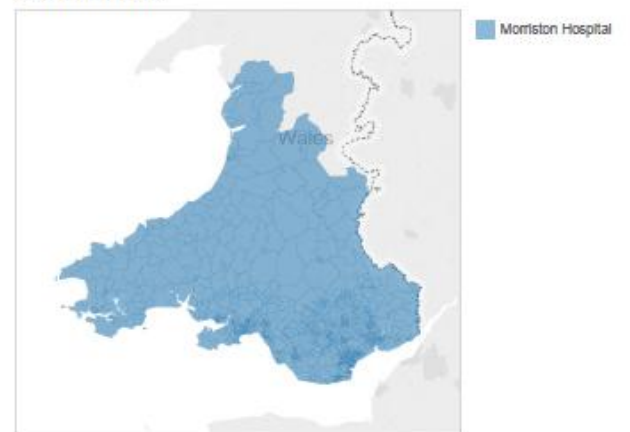


	Population	% Population
Within	1,612,535	68.45%
Outside	743,240	31.55%

TU Catchment



MTC Catchment



MAJOR TRAUMA INDEPENDENT PANEL TERMS OF REFERENCE - FINAL

1. PURPOSE

An independent panel has been commissioned by the NHS Wales Health Collaborative to provide a view on the development of a major trauma network across south Wales, south Powys and west Wales and to make a recommendation on a preferred model for the region. The recommendation will be advisory and will be used by the NHS Wales Health Collaborative to make a formal recommendation on the preferred site of the major trauma centre in the region

2. OBJECTIVES

The major trauma independent panel will be required to undertake the following:

- Review the service model and specification for major trauma services for adults and paediatrics, across the region
- Consider supporting evidence from Abertawe Bro Morgannwg UHB (ABM) and Cardiff and Vale UHB (CAV) and for the provision of a major trauma centre at Morriston Hospital, Swansea or the University Hospital of Wales (UHW), Cardiff as part of the major trauma network in south Wales.
- Provide an independent view on the two options for the location of the major trauma centre.
- Provide a view on the phasing of any implementation requirements and priorities for investment within a major trauma centre.
- Advise on the impact on remaining services at Morriston Hospital and UHW Hospital in the event they are not identified as the major trauma centre.
- Advise on the preferred location of a major trauma centre for the region.

In addressing the above, the panel will take into consideration DH guidelines for the establishment of regional networks for major trauma and NICE guidance for major trauma; these guidelines are based on the evidence of best practice and include a number of recommendations which are central to establishing a major trauma centre.

3. ASSUMPTIONS

- A non financial option appraisal has identified that only one trauma centre is viable to support a population of 2.2million (the population in south Wales, south Powys and west Wales)
- The major trauma centre for the region should be located in South Wales
- Morriston Hospital Swansea and UHW Cardiff are the only options for provision of a major trauma centre in Wales, due to the potential ability to meeting major trauma standards

- Key stakeholders from across the region will be invited to attend the Independent Panel in order to facilitate openness and transparency. A list of the stakeholders invited is attached.

4. RESPONSIBILITIES

The remit of the independent panel is as follows:

- Review data sets available to support major trauma centre in south Wales, south Powys and west Wales, to include:
 - a. Contextual information
 - b. Transport times
 - c. Activity models
 - d. Equality Impact Assessment
 - e. Standards for major trauma
 - f. Non financial option appraisal
 - g. Service models for rehabilitation and acute service
 - h. UK Standards for the management of open fractures
- Receive and consider the self assessments against peer review standards and TARN data from ABMU and CAV representatives.
- Hear and consider presentation from ABM and CAV in response to the following questions:
 - a. How will the MTC provide all the service required?
 - b. How will the Health Board as the MTC address the following service requirements:
 - Neurosurgery
 - Plastics
 - Interventional radiology
 - Paediatrics
 - Cardiothoracics
 - Maxilla-facial
 - Critical care capacity
 - rehabilitation
 - a. How will the MT service be developed and what are the staffing issues that will need to be considered?
 - b. How will trauma ward provision be addressed?
 - c. What will the service look like on day 1?
 - d. How will you address the infrastructure requirements in medium and long term?
 - e. How will relatives and carers be managed in the MTC?
- Provide challenge to Health Boards when considering the presentation/information provided
- Receive and consider the views of EMRTS/WAST, in relation to a major trauma network in Wales
- Advise on the ability of Morriston Hospital and UHW to meet the primary requirements of a major trauma centre as recommended by the NHS Clinical Advisory Group (CAG) 'Regional Networks for Major Trauma' report.
- Advise on gaps in service at Morriston Hospital and UHW Hospital in the event they are identified as the major trauma centre

- Make recommendations to the NHS Wales Health Collaborative for the preferred location of the MTC
- Produce a report for the NHS Collaborative advising on the major issues which need to be considered to determine the most appropriate site for a MTC in Wales

5. MEMBERSHIP

The Independent panel comprises representatives from across major trauma services in the UK.

Panel members were invited on the basis of their national and international reputations as experts in trauma care and the development of trauma systems. All have been involved in the development of regional major trauma systems. The panel includes experts in key specialties that are essential for managing patients with severe multiple injuries.

The Independent panel will be chaired by Professor Chris Moran, the National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital. He has led the development of major trauma networks in England, which have increased the probability of surviving major injuries by 25%.

The membership of the panel is as follows:-

Professor Chris Moran	National Clinical Director for Trauma to the NHS in England and Professor of Orthopaedic Trauma Surgery	Nottingham University Hospital
Fionna Moore	Chief Executive	London Ambulance Trust
Tim Chesser	Consultant Trauma & Orthopaedics	North Bristol, NHS Trust
Mark Wilson	Consultant Neurosurgeon and pre hospital care specialist	Imperial college, London
David Lockey	Clinical Director for Severn Major Trauma Network, Consultant Anaesthetist and critical care Medicine	North Bristol NHS Trust
Shehan Hettiaratchy	Consultant and Honorary Lecturer	Imperial College, London
Rachel Botell	Consultant Rehabilitation Medicine.	Plymouth Hospitals NHS Trust
Sue O'Keeffe	Critical Care and Trauma Network Manager, North Wales	North Wales Major Trauma Network

It should be noted that Sue O’Keeffe will provide support in relation to the Welsh context only. She will not have a vote on the panel.

6. TIMESCALES

The Major Trauma Independent Panel will take place 21st February 2017.

The report outlining findings from the Independent panel will be submitted to the NHS Wales Health Collaborative within four weeks following the Independent Panel.

7. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

The major trauma Independent Panel will:

- Report their initial finding and advice at conclusion of the day to all attendees.
- Provide a report outlining their findings to Bob Hudson, Director NHS Wales Health Collaborative, on behalf of the NHS Wales Health Collaborative Board.

Drafted: December 2016

Agreed: January 2017

Date: 12.01.17

Attachment 1.

Representation from ABM and CAV:

- Chief Executive Officer
- Medical Director
- Lead Clinician for Trauma Care
- Lead for acute rehabilitation
- Planning lead

Other invited key stakeholders

- Chief Executive Officer Public health Wales
- Ministerial representative
- Community Health Councils
- Patient representative from ABM and CAV
- Lead clinician from Hywel Dda, Cwm Taf, Aneurin Bevan, Powys
- Director NHS Wales Health Collaborative

Expert review South Wales Major Trauma System February 2017

Summary

At the request of the Welsh Health Boards, a panel of independent, clinical experts in major trauma met on February 21st, 2017 to consider the structure of a major trauma network in South and West Wales and the potential site of the Major Trauma Centre within this network. The expert panel reviewed information in advance of the meeting and on the day received presentations from Public Health Wales, the Welsh Ambulance Service plus University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

The expert panel was impressed at the high standard of presentation, the enthusiasm from both clinical teams and the clear support demonstrated by the chief executives, medical directors and senior management teams at both centres.

The expert panel unanimously recommends that the Welsh Health Boards consider the following:

1. The rapid development of a major trauma network for South and West Wales with a clinical governance infrastructure.
2. The adult and children's Major Trauma Centres should be co-located on the same site
3. The Major Trauma Centre should be located at University Hospital of Wales, Cardiff
4. Morriston Hospital should become a large Trauma Unit and should lead the major trauma network
5. A clear and realistic timetable for the activation of the Trauma Network should be set.

Introduction

Major trauma is defined as a life-threatening or potentially life-changing injury. Injuries can occur to a single part of the body or at multiple sites and the best treatment requires a coordinated response from the accident site to hospital care and then rehabilitation. International experience has shown that this is best provided by a coordinated network of hospitals that work together to allow the patient to receive treatment in the most appropriate facility in a safe and timely fashion. The system should be designed to save life and prevent avoidable disability, returning patients to their families, work and education.

Trauma and injuries are common but only 1 in a 1,000 patients who arrive at an A&E department will have major trauma. It is impossible for every hospital to provide comprehensive care for all major injuries and so the network should identify these patients and ensure their rapid and safe transfer to a designated Major Trauma Centre (MTC) that has the facilities to provide comprehensive and definitive care for the patient. In general, each network will have one MTC together with a network of hospitals that have the facility to receive and provide early care for these patients, rapidly identify those that require the additional facilities at a MTC and then provide safe, onward transfer.

Patients in Mid and North Wales who suffer major trauma are currently transferred to designated MTCs in England. South and West Wales has a population of 2.2 million and the Welsh Health Boards are planning to develop a network to cover this area, which has a mixed urban and rural geography and some remote rural populations.

South and West Wales has two large teaching hospitals with the potential to develop into a Major Trauma Centre within the trauma network.

The aim of this review was for a group of independent clinical experts in major trauma to assess the available evidence and provide advice to the Welsh Health Boards on the best facility to site the Major Trauma Centre for South and West Wales.

Members

Professor Chris Moran	Professor of Orthopaedic Trauma Surgery, East Midlands Major Trauma Centre Nottingham University Hospital
	National Clinical Director for Trauma NHS-England
Dr. Fionna Moore	Chief Executive, London Ambulance Service
Mr. Tim Chesser	Consultant Trauma and Orthopaedic Surgeon Severn Major Trauma Centre North Bristol NHS Trust
Professor Mark Wilson	Consultant Neurosurgeon and Pre-hospital Specialist North West London Major Trauma Centre Imperial College, London
Professor David Lockey	Clinical Director for Severn Major Trauma Network Consultant in Anaesthetics and Intensive Care North Bristol NHS Trust
Mr. Shehan Hettiaratchy	Clinical Director North West London Major Trauma Centre Consultant Plastic and Reconstructive Surgeon Imperial College, London
Dr. Rachel Botell	Consultant in Rehabilitation Medicine Peninsula Major Trauma Centre Plymouth
Mrs. Sue O’Keeffe*	Critical Care and Major Trauma Network Manager North Wales

* Mrs. O’Keeffe provided the panel with expert advice on network management and the Welsh Health Care System but did not have voting rights on the panel.

Evidence reviewed

The expert panel was provided with a bundle of evidence that included:

- Briefing
- Terms of Reference for independent panel
- Acute service model
- Rehabilitation service model
- Service Specification
- Equality impact assessment
- Major Trauma non-financial options appraisal
- Major Trauma flow – adults
- Major Trauma flow – children
- List of services currently provided at UHW
- ABMU major trauma indicators
- South Wales major trauma project

The presentations received followed the published programme for the day (Appendix-1).

Issues considered

Institutional commitment

Both Trusts gave excellent and well-researched presentations and there was evidence that both planned investment in the concept of hosting a MTC. There was good clinical engagement and support from most specialties in both centres and strong support from the chief executives, medical directors and senior management teams at both hospitals. Some of the proposals were aspirational and they should be strongly encouraged to deliver on their aspirations.

Geography

Public Health Wales and the Welsh Ambulance Service gave excellent and helpful presentations describing the geography of South and Mid Wales together with the population distribution and the estimated road transfer times to each of the proposed MTCs. In addition, the Welsh Emergency Medical Retrieval and Transfer Service (EMERTS) described their role in pre-hospital management and the facility to provide on-scene medical care, accurate triage and rapid air transfer to either of the proposed MTCs.

Morrison Hospital is geographically more central and has better coverage of the West Wales population but some western and eastern areas would be outside of the proposed 60 minute direct transfer time (by land ambulance) and require secondary transfer. University Hospital of Wales is more central to the urban population and a slightly greater percentage of the population would be within 60 minutes direct transport time. It would provide good coverage for the eastern area but a larger number of patients in West Wales would require initial treatment in a designated local hospital before secondary transfer to Cardiff.

Both hospital sites have excellent road access with motorways close by. Both have acceptable air-ambulance landing facilities.

Overall, the panel concluded that both sites give good access to the population and that geographical factors should not be a major issue in designating the site of the MTC.

Facilities

Reception and Resuscitation

Both hospitals have large accident and emergency departments with the facility to receive and resuscitate patients with major trauma. However, neither hospital has a big enough cohort of Emergency Physicians to support their existing workload. Neither hospital supports ambulance offloads as well as they should. University Hospital Wales has both one ED Consultants and marginally better off-load times. Both Trusts accept that this is an area for investment, and both Trusts will need to plan how they provide 24/7 availability of a Consultant led trauma team.

University Hospital Wales has CT scanning within the emergency department and immediately adjacent to the Resuscitation Room. At the present time, Morriston Hospital requires a short transfer to the CT scanner: plans were presented to locate a new CT scanner within the emergency department.

Definitive Care

Neurosurgery

Neurosurgery and neuro-intensive care are key specialties in the management of major trauma as 60% of patients have a head injury and traumatic brain injury is an important cause of death and long-term disability. At the present time, both adult and children's neurosurgery is based at University Hospital of Wales and there is no neurosurgery at Morriston Hospital.

Morriston Hospital described its plan to develop an adult neurotrauma unit based upon the recruitment of six neurosurgical consultants with expertise in neurotrauma and spinal surgery and it was proposed that this would work in collaboration with the main neurosurgical unit in Cardiff. This service model has been used at two MTCs in England (Sheffield and St. Mary's, London) but in both cases the distance between the two units is less than 5 miles. There was no plan to move all of neurosurgery to a single site at Morriston Hospital. The WHSSC representative at the expert review clearly expressed the view that the development of a two-site service for neurosurgery in South Wales was against the strategic plan for the region.

The concerns of the expert panel are:

- Recruiting (good) neurosurgery consultants to a post that is half spinal and half trauma with no other components will be extremely difficult.
- Recruiting an adequate number of juniors who are craniotomy competent (8 for a rota) will be even more difficult, if not impossible.
- A stand-alone neurotrauma unit some distance from the main neurosurgical centre (with no plan to move all of neurosurgery there in a set time frame) may not be sustainable in the long term.
- A stand-alone neurotrauma unit is not a model that has professional support for the Society of British Neurosurgeons (SBNS).
- Interventional neuroradiology is now an integral part of trauma management and it is highly unlikely that South Wales could provide a comprehensive service of two sites.

Plastic surgery

There is an excellent plastic surgery department at Morriston Hospital with a Burns Centre that covers Wales and the South West of England and a high quality orthoplastic service. There is no provision for plastic surgery at University Hospital Wales. However, this specialty on its own would not justify placing the MTC at Moriston.

The most significant risk of Cardiff as the MTC is the lack of plastic surgery and orthoplastics. This is an immediate risk that needs to be resolved before day-1. There are numerous examples in England of offsite plastic surgery and Cardiff would be strongly encouraged to learn from these centres and also work closely with Swansea so that the network (and population of South Wales) gets access to the expertise that has been developed in Swansea.

Interventional Radiology

This is now a key specialty in the management of patients with severe bleeding that would have required life-saving surgery in the past. University Hospital Wales has a comprehensive service that would reach the specification for a MTC. Morriston Hospital has a service, which with some investment, could be expanded to meet this specification. Recruitment into interventional radiology is challenging because of low workforce numbers.

Paediatric Intensive Care

The regional paediatric intensive care unit (PICU) is at University Hospital Wales and there are no plans to develop a second PICU at Moriston Hospital. Thus, locating the Adult MTC in Morriston Hospital requires the development of a separate Children's MTC at University Hospital Wales. The catchment population would be similar to the smallest Children's MTC in England (based at Sheffield Children's Hospital) and so would be viable.

The expert panel does not support the concept of a single Adult and Children MTC at Morriston Hospital with a separate pathway for the most severely injured children that require PICU.

Health Care of the Elderly

Changes in the demographic of the population means that major trauma is becoming more frequent in those over 65 years and this age group now represents 35% of major trauma cases. University Hospital Wales presented plans to increase the number of physicians caring for elderly patients by expanding their current orthogeriatric service and including major trauma.

Rehabilitation

Access to this vital part of the patient pathway was much better thought through and available at University Hospital Wales, with facilities at Rookwood Hospital already in place.

Cardiff seems to have an advanced rehab system and exciting plans for the future. Providing the full pathway of trauma care is vital and it appeared that Cardiff had grasped that concept more completely with plans for coordinated rehabilitation within the acute hospital setting. The consultants in Rehabilitation Medicine already in-reach to the acute wards and ‘pull’ or signpost patients to the most appropriate rehabilitation service.

The Cardiff team described the new Rehabilitation Centre that would be able to accept all patients, not limited to those with neurological or spinal cord injuries and would include coordinated psychiatry and psychology input, which is key for many of the major trauma patients.

The expert panel was impressed with the dynamic Rehabilitation Lead in Cardiff who will be key in delivering this comprehensive rehabilitation service. They recognized the key role of the rehabilitation network to allow patients coordinated rehabilitation near to home.

Areas of concern

Although Cardiff gave good presentations some of their proposals were aspirational and the Health Boards should strongly encourage them to deliver on their aspirations.

The panel did not support using the air ambulance for repatriation from the MTC. We would encourage the development of a retrieval service with the provision of lit helipads at Trauma Units.

Concerns were raised about the desire and commitment from the orthopaedic department in University Hospital Wales and the impact of major trauma on the daily fracture service (for the local population) has been underestimated. There is a clear need to appoint a number of orthopaedic surgeons with a job-plan focused on trauma: a review of the provision of fracture surgery is essential.

The impact of being a MTC may have underestimated by both parties, particularly on the Emergency Departments and Critical Care Units. Contingency plans need to be in place for escalating critical care when they become full to allow continued reception of major trauma. These need to be formal network escalation plans.

Morrison Hospital presented an excellent vision for the Network. It is essential that the MTC understands its place within the network and we would recommend that the chair of the major trauma network board and the network clinical lead are not based within the MTC.

The Welsh Health Boards should ensure that the network has the power to make sure the promises are delivered if the service is commissioned. This should include accurate and achievable time lines with a requirement for the Rehabilitation Team, Trauma Team Leaders and Multidisciplinary Trauma Service to be in place from day-1.

It is essential that network agreements, protocols and guidelines are in place before the networks become operational and this should include agreement between hospitals, at Chief Executive level, on automatic transfer and automatic repatriation.

Options Considered

1. Combined Adult and Children’s Major Trauma Centre at University Hospital Wales.
2. Adult Major Trauma Centre at Morriston Hospital plus Children’s Major Trauma Centre at University Hospital Wales.
3. Combined Adult and Children’s Major Trauma Centre at Morriston Hospital with an out-reach PICU trauma service at University Hospital Wales for the most severely injured children.

Recommendations

It is the unanimous view of the clinical expert panel that the Welsh Health Boards consider the following:

1. The rapid development of a major trauma network for South and West Wales with a clinical governance infrastructure.
2. The Adult and Children’s Major Trauma Centres should be co-located on the same site.
3. The Major Trauma Centre should be located at University Hospital of Wales, Cardiff.
4. Morriston Hospital should become a large Trauma Unit and should lead the major trauma network.
5. A clear and realistic timetable for the activation of the Trauma Network should be set.

The main surgical specialty that will need development at University Hospital Wales is Plastic Surgery, with the formation of an orthoplastic unit. Ideally, this could be achieved by transferring the entire service to Cardiff. However, the panel recognise that this may produce major operational problems in the provision of the burns service for Wales and South West England. If this is not feasible, the panel recommends a collaborative approach between both hospitals. It will take time for this service to develop but it should be possible to put a safe clinical pathway in place so that the activation of the network is not delayed by this development. Joint consultant appointments between the two hospitals could achieve this with the establishment of routine orthoplastic operating lists at the MTC (minimum of two per week) with the appropriate equipment and facilities. Mr. Hettiaratchy is available to provide advice on this as a similar model has been developed in London.

Chris Moran
20th March 2017

NHS WALES HEALTH COLLABORATIVE
MAJOR TRAUMA NETWORK DEVELOPMENT

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Revised – January 2017

Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a major trauma network to serve South Wales, South Powys and West Wales.

The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics¹ and requires Welsh public bodies to demonstrate how they pay ‘due regard’ when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating ‘everyone the same’, but recognising that everyone’s needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely

¹ Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)². Our consideration of equality takes account of this.

EIA requires us to consider how the development of a major trauma service, leading to recommendations for the location of a major trauma centre, supporting trauma units and a comprehensive rehabilitation pathway, operating within a major trauma network structure for south Wales, south Powys and west Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

This document is not intended to be a definitive statement on the potential impact of the major trauma development on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

The NHS Wales Health Collaborative, on behalf of Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys health boards, and the Welsh Ambulance Service NHS Trust (WAST), has been coordinating the development of proposals for a major trauma service for south Wales, south Powys and west Wales. The project is being led through the South Wales Major Trauma Network Project Board, which is overseeing the work, and is supported by a clinical reference group and a number of workstreams. The work will lead to recommendations for the location of a major trauma centre, supporting major trauma units and a comprehensive rehabilitation pathway, operating within a major trauma network structure for the region.

Through the project board, clinical reference group and rehabilitation workstream, clinicians and stakeholders have been working together to examine national standards and guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for

² More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

the most seriously injured patients, who need to be seen at a specialist major trauma centre operating within an integrated major trauma network.

Rationale

The report 'Regional Networks for Major Trauma' (National Clinical Advisory Group, 2010)³ compiles key recommendations from national reports and international guidance including from the American College of Surgeons to deliver standards for the care of major trauma patients. The evidence is consistent that the best outcomes are achieved within inclusive trauma systems with major trauma centres and trauma units.

The NCAG report comments that major trauma is a serious public health problem; it is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity.

Internationally, the establishment of trauma systems has been founded on trauma centres. These hospitals specialise in, and are designated for, the treatment of the severely injured. They see such patients with sufficient frequency to gain expertise in their management. Over several decades the evidence that this model improves trauma outcomes has become substantial. Their effect has been assessed using several methodologies and a consistent picture has emerged. Severely injured patients are 15-20% less likely to die if admitted to a major 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 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. The benefits of trauma systems may take 3 years or more to be realised and depend upon an iterative process of needs analysis, service organisation and quality improvement.

At present, there is no major trauma network or designated major trauma centre operating across or within south Wales, south Powys and west Wales. Evidence demonstrates that the introduction of a major trauma centre supported by trauma units and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The vision for the major trauma service is to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable major trauma services at all points along their care pathway from the point of injury to rehabilitation, in line with best practice standard requirements, and evidenced through key performance indicators.

³ Regional Networks for Major Trauma: National Clinical Advisory Group (2010)

The proposal is to establish a major trauma centre operating within an integrated major trauma network for south Wales, south Powys and west Wales. This will provide direct access for patients with very serious and often multiple injuries to the right level of service 24 hours a day, 365 days a year. The major trauma centre will be supported by a network of trauma units, delivered through designated consultant-led accident and emergency (A&E) departments, and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing at admission, continuing through the inpatient phase to discharge from the major trauma centre or trauma unit into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

Emergency departments across the region see and treat many thousands of patients, approximately 750,000 over a year. Approximately 1500 patients will have, or be suspected to have had, a major trauma which is a very small proportion of the total number of patients (0.2%). When patients with a serious and complex injury need to come to hospital we want to have senior clinicians available to see them as soon as they arrive, whatever time of day or night. This means they will get the right diagnosis, start the right treatment quicker and get better faster. We need to offer everyone the sorts of medical advances which mean people involved in serious accidents have the best chance of survival. This kind of medicine should be delivered by teams of doctors, nurses and therapists who have specialist skills, which they use day in and day out so they remain experts in what they do. It can't be provided in every hospital because they wouldn't be able to keep up their skills because they wouldn't be seeing enough patients.

The NCAG report provides advice on delivering treatment for everyone which is based around the needs of individuals irrespective of where they suffer their injuries; transports the patient as rapidly and safely as possible to the hospital that can manage the definitive care for their injuries either directly or by expedited transfer to the major trauma centre; and moves the responsibility for definitive patient care from the receiving clinical team to the trauma network, when appropriate. The NCAG structures the patient pathway from pre-hospital care through to acute care to ongoing care and reconstruction to rehabilitation.

The NCAG report, together with the NHS England Standard Contract for Major Trauma (2013)⁴, have been the main reference points for the development of the service model for south Wales, south Powys and west Wales. The British Society for Rehabilitation Medicine standards have been an additional key reference point in the development of the rehabilitation model.

⁴ NHS Standard Contract for Major Trauma Services (All ages) D15/S/a: NHS England (2012)

People with a severe injury would be assessed by ambulance staff or assessed and treated by the Emergency Medical Retrieval and Transfer Service/EMRTS Cymru at the scene of the incident. They would then be taken by road or air ambulance directly to the major trauma centre if it was safe to do so, accessible within 60 minutes (NICE guideline, 2016)⁵ and the patient did not need stabilising. At the major trauma centre patients would be cared for by an on-site consultant-led team. If the patient needed to be stabilised first, he or she would be taken to the nearest trauma unit, and once stabilised, transferred to the major trauma centre. Once the patient's specialist trauma care has been completed, patients will be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs. This may be to a local hospital or for specialist rehabilitation

Rehabilitation services will be provided in the most appropriate setting for the level of injury and phase within the recovery process and is modelled on three levels. The model proposes improved communication for patients, across the system, with the implementation of a rehabilitation prescription which will identify the patient's needs, and ensure these are delivered throughout the pathway. Rehabilitation, delivered more locally will have positive impacts for patients, especially if there is equity of provision across the whole region, and the rehabilitation model aims to ensure that patients receive the highest quality, appropriate rehabilitation, irrespective of their location.

Who is affected?

Patients with major trauma are those with serious, often multiple injuries who require 24/7 emergency access to a wide range of clinical services and expertise. The term 'major trauma' is used to describe the most severe single injuries or multiple injuries. It can include major head injury, limb amputation, severe knife and gunshot wounds, multiple injuries or spinal injury and is often defined as an Injury Severity Score (ISS)⁶ greater than 15. The definition of 'trauma services' generally includes less severe injuries such as fractured hip or ankle or minor head injury.

Major trauma patients require complex diagnostic, integrated and intensive early treatment from a wide range of specialities. Often multiple specialist resources are required with no or little delay, and access to the right service at the right time may be critical to survival.

The estimated incidence for major trauma cases is 185 per million and the estimated incidence of moderate trauma (ISS 9-15) is estimated at 220 per million per year. Modelling undertaken to assess the potential number of patients within the region who would need to be seen and treated within the major trauma network structure has estimated the number of cases as approximately 1500 per year, which would include secondary transfers between

⁵ Major trauma: assessment and initial management: NICE guideline (February 2016)

⁶ Those who are injured may have one or many injuries and the Injury Severity Score (ISS) is an anatomical score that measures the overall severity of injured patients. A major trauma is defined as the ISS being greater than 15. Moderate trauma is an ISS between 9 and 15: Trauma Audit and Research Network (TARN)

hospitals. This is a very small percentage of A&E workload, (0.2%), but these patients often have complex needs.

Where are we now?

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation and review.

This paper defines the proposal for change and the rationale, sets out the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.

Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

The case for change is founded on firm clinical evidence and guided by national and international good practice. Numerous studies have documented the benefit of organised, regional major trauma care. The findings of an independent audit published in 2013 showed that 20 per cent more patients were surviving severe trauma since the introduction of Major Trauma Networks in 2010 in England (Trauma Audit and Research Network, n.d.)⁷.

In 2012, Professor Marcus Longley conducted a review (Longley, 2012)⁸ of the evidence about the best configuration of acute hospital services in Wales. Prof Longley's report provided an objective analysis of the key issues facing the future of the NHS in Wales.

In respect of safety and quality, and on the basis of the available evidence, Prof Longley suggested there are several specialties for which we can be reasonably sure that we know how services should be configured included within which were major trauma services:

Major trauma Services: There is evidence of significant outcome benefits for patients with major trauma when treated in a dedicated major trauma centre. In a typical year around 1,000 patients in Wales have major trauma:

- Regionalisation of care to specialist trauma centres reduces mortality by 25% and length of stay by four days
- High volume trauma centres reduce death from major injury by up to 50%
- Time from injury to definitive surgery is the primary determinant of outcome in major trauma (not time to arrival in the nearest emergency department)

⁷ Trauma Audit and Research Network (TARN)

⁸ The best configuration of hospital services for Wales: a review of the evidence: Professor Marcus Longley, Welsh Institute for Health and Social Care (2012)

- Major trauma patients managed initially in local hospitals are 1.5 to five times more likely to die than patients transported directly to trauma centres
- One centre might typically serve a population of three to four million people.

The King's Fund published a report in November 2014⁹ which set out the evidence for the reconfiguration of clinical services. This paper aims to help those planning and implementing major clinical service reconfigurations ensure that change is as evidence-based as possible. It investigates the five key drivers – quality, workforce, cost, access and technology – across 13 clinical service areas, summarising the research evidence and professional guidance available in each. Reconfiguration of trauma services was one of the clinical service areas reviewed.

The King's Fund summarised the evidence that should be taken into account when reconfiguring trauma services as:

- Formalised systems of trauma care, in which care for the most complex patients is centralised into a small number of trauma centres, improves patient outcomes
- Trauma centres need 24/7 access to fully staffed theatres and diagnostics, including CT, MRI and pathology. They also need comprehensive critical care and neurosurgical support

As referenced under the Rationale above, the report 'Regional Networks for Major Trauma' (National Clinical Advisory Group, 2010) compiles key recommendations from national reports and international guidance including from the American College of Surgeons to deliver standards for the care of major trauma patients. The evidence is consistent that the best outcomes are achieved within inclusive trauma systems with major trauma centres and trauma units.

In terms of access to healthcare, there is an increasing evidence base that, when given the facts, patients and carers will prioritise excellence and quality over convenience when it comes to their healthcare treatment, particularly for major treatment interventions and life-threatening conditions. A Welsh Confederation survey (YouGov, 2011) sought to establish the level of awareness about the management of the NHS in Wales, perceptions of quality and views on areas of policy including the future for hospital services. The survey found people in Wales say they don't mind travelling for specialist services if it means the care will be of higher quality, although there is no definition of what a specialist service is and, overall attitudes to concentrating services in fewer, larger hospitals are negative with most people opposing this and believing their local hospital should provide every type of service.

⁹ The reconfiguration of clinical services: What is the evidence?: King's Fund 2014

What are the potential impacts on protected characteristic groups?

EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a major trauma network and major trauma centre on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a major trauma network will result in the centralisation of life-saving treatment for a relatively very small number of patients but with the most serious and complex injuries. Trauma units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' (those most likely to experience major trauma events) and the sections of the population which are likely to be most affected by the major trauma proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that major trauma tends not to be closely associated with particular equality groups; events are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to experiencing major trauma. However, a few groups are certainly key to consider in this assessment.

A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Gender

Women are not a high risk group in terms of major trauma. Men are at far higher risk of experiencing major trauma. The NCEPOD report¹⁰ showed that 75% of major trauma was in men. This is borne out by local data: in 2013, data for University Hospital of Wales, Cardiff, and Morriston Hospital, Swansea, shows that 70% of major trauma was in men.

Young men are at greater risk of being involved in major trauma accidents, typically arising from moving vehicles, tools or work. Death from trauma is higher in men than it is in women, believed to be because males are much more willing to engage in risk-taking activities.

Age

Age is a risk factor for suffering major trauma. It is the leading cause of death for people under 45 years and a significant cause of short and long-term morbidity (National Clinical Advisory Group, 2010)¹¹. Children under the age of 15 only account for a very small percentage of major trauma and deaths as a result of major trauma. Teenagers and young adults are more likely to need hospitalisation from injuries than other age groups.

Whilst the elderly are infrequent victims of major trauma, their clinical outcomes including survival rates may not be as good as in the young. There is evidence, however, of a rising number of falls in the elderly that should be managed within a major trauma pathway and supported with a frail elderly rehabilitation pathway. The conclusion to a study published in 2015 (Emergency Medical Journal, 2015)¹² suggested that the major trauma population in the UK is becoming more elderly and the predominant mechanism that precipitates major trauma is a fall from lower than 2 metres.

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the major trauma network has all the skills required to care for these patients.

There is a need to consider further the transitional needs of young adults aged between 16 and 18 to ensure that they receive appropriate care and rehabilitation. Young people may

¹⁰ Trauma: who cares? A report of the national confidential enquiry into patients outcomes and deaths (NCEPOD) (2007)

¹¹ NHS Clinical Advisory Groups Report: Regional Networks for Major Trauma (2010)

¹² The changing face of major trauma in the UK *Emerg Med J* 2015;**32**:911-915

also have different needs, and may require facilities to have relatives closer to them, for example in family rooms for patients from further away or more rural areas.

Race

Major trauma is more than twice as common in urban areas due to concentration of traffic and people. Additionally, it has been identified that black people and ethnic minorities are at a higher risk of incidence and mortality from major trauma, at least in part due to a correlation with concentration in urban areas and the relationship of minorities, deprivation and major trauma incidents¹³.

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that there is a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability

Major trauma is the national leading cause of disability for those under 40 years of age. The improved number of survivals in young adults and the reduced disability will also improve the rate of return to work and socio-economic functioning. Evidence shows that there is a five to fifteen-fold return on the investment made in treatment. As most major trauma patients tend to be of working age, this is an important indicator that given the right care, it is possible for people suffering the most serious injuries to recover sufficiently to go on and have an active working life (NHS East Midlands, 2010)¹⁴.

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that:

Rehabilitation services should give choice to patients with pre-existing mobility issues, for example patient with multiple sclerosis should receive the same options for treatment. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector.

As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they

¹³ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

¹⁴ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

¹⁵ All Wales Standards for Communication and Information for People with Sensory Loss 2013)

came from. Communication needs in these client groups may be more challenging and care should be adapted accordingly.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss¹⁵ that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards.

Improved service will reduce the rates of disability and increase socio-economic functioning.

Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)

It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them¹⁶. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report significant barriers to health and social care services¹⁷ . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patient' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall have commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of

¹⁶ http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

¹⁷ <http://www.stonewallcymru.org.uk/our-work/research/have-your-say>

staff and their patients. Health boards should continue to seek to make progress in this area.

Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015¹⁹ Trans* people must be accommodated in line with their full-time gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's GRC or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the major trauma centre within the major trauma network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)¹⁸.

¹⁸ More than just words: Strategic Framework for welsh language services in Health, Social Services and Social Care (2012)

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, it is particularly relevant in relation to the protected characteristics. There is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies.

The report *Transport and Social Exclusion: Making the Connections* (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

As a group, and with regard to risk of major trauma, it would be expected that individuals living in deprived areas would be over-represented as pedestrians and under-represented as car occupants in road traffic accidents.

There is a strong relationship, particularly with children, between social deprivation and the incidence of injury and some evidence that the disadvantaged are less likely to survive (The Trauma Audit & Research Network: an overview).

What are the potential impacts on NHS staff?

Proposals to establish a major trauma network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a major trauma network and centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of major trauma services in south Wales, south Powys and west Wales are on a par with the structures in the rest of the UK.

Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the major trauma development?

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence*, are of particular relevance and potential impact to the development of proposals for a major trauma network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service for major trauma, with the most complex care provided from a major trauma centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a major trauma network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family.

This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

United Nations Convention on the Rights of the Child

Children under the age of 18 are protected by the United Nations Convention on the Rights of the Child (UNRNC). Healthcare providers have a duty to protect, promote and fulfil the rights of the child. The UNRNC should be considered in conjunction with the Human Rights Act and the duty to promote fairness, respect, equality, dignity and autonomy. Due regard must be given to the specific needs of a person of his/her age, and in particular the right to maintain contact with family members. This could apply to a child as a patient or a child/sibling of a patient. The convention recognises that children themselves, not adults, are entitled to be involved in decisions that affect them.

Initial summary conclusion

The introduction of a major trauma network, including rehabilitation and the designation of a major trauma centre and major trauma units, is intended to improve patient care and outcomes for major trauma:

- Time to access: time from injury to definitive trauma care is the primary determinant of outcome in major trauma
- Quality of outcome: regionalised trauma systems show a continuous improvement in results over time with reductions in morbidity and mortality
- Equality: standardisation of regional services, including rehabilitation with protocols should improve equality of access and reduce inequalities

The service redesign intends to standardise transfer for life-saving treatment to a specialised major trauma centre within a major trauma network which will reduce inequalities in outcome. Providing rehabilitation on a network model standardises the approach across the three levels of care and improves local access.

The proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups. At this stage, this assessment indicates that there are relatively few cases of major trauma and among them the equality groups are mostly under-represented, since, from national evidence and research, the majority occur in working age men although there are growing numbers of older people needing major trauma care. Assuming, in the majority of cases, major trauma leads to a 999 call, there should not be any particular equality-group impact in terms of access to the new services.

In certain geographic areas, there may be groups that will experience travel times longer than the target 60 minutes travel time for definitive care at a specialist major trauma centre. Consistent with major trauma structures across the UK, and in accordance with NICE guidance, major trauma units are an integral part of the network structure and provide for stabilisation of a patient's condition before onward transfer to the major trauma centre.

For those visiting major trauma victims whilst being cared for at a major trauma centre, longer and more complex journeys are likely to be necessary for some. Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people from equality groups, especially older people and disabled people. It is these groups who are more likely to experience problems with communication and understanding. Journey times will be considerably increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a 'local' hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South Wales Major Trauma Network Project Board, Clinical Reference Group and a number of workstreams, is continuing to plan for a major trauma service, leading to recommendations for the location of a major trauma centre, supporting major trauma units and a comprehensive rehabilitation pathway, operating within a trauma network structure for south Wales, south Powys and west Wales. The EIA will continue to be reviewed to further develop and refine this assessment and to ensure consideration is given to mitigate any identified negative impacts. Feedback from a planned awareness raising and engagement process will be incorporated into the next draft.

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Appendix 13 – Risk Register

Major Trauma Risk Log: Revised March 2017

Ref	Domain	Date risk identified	raised by	Risk	Cause	Effect	Controls	Owner	Risk Rating initial			Risk Rating current			Date of last update	Status	Comment
									I	L	Risk Score	I	L	Risk Score			
R7	adverse publicity/reputation	26.05.15		Delay in progressing the development of the MT network model because of lack of knowledge around MT as a result of not engaging openly with key stakeholders including CHCs	failure to communicate openly with stakeholders	delay in progressing development of the trauma network	monthly briefing following project board Regular update with Chief Officers Engage Chief Officers in developing further briefings	Project Board	4	4	16	4	4	16	26.05.17	open	
R25	business objectives/projects	16.03.17		delay in progressing the network model as a result of the unsuccessful candidate MTC site not engaging in developing a networked model	unhappy with proposal	delay in progressing development of the trauma network	Independent clinical advice taken help support a recommendation on a preferred site	Health Boards	4	3	12	4	3	12	26.05.17	open	
R24	business objectives/projects	16.03.17		Delay in progressing the network model as a result of unsuccessful candidate MTC site challenging the outcome	unhappy with proposal	delay in progressing development of the trauma network	Independent clinical advice taken help support a recommendation on a preferred site	Health Boards	4	4	16	4	2	8	26.05.17	open	Does this need to be closed?
R23	adverse publicity/reputation	16.03.17		Public perception of the major trauma network and the location of the centre is inaccurate due to incorrect information being made public	only select pieces of information shared	stakeholders do not have a complete picture of the case for change	Work with CHCs to develop overarching supporting documents HB to work with CHCs to cascade information through their networks Work with the BBC media to ensure a balanced story is given	Project Board	4	4	16	4	4	16	26.5.17	open	work on engagement has been postponed due to the General election on 8th June and purdah
R22	business objectives/projects	16.03.17		The major trauma network model is not progressed as a result of the public not accepting the case for a major trauma network for south Wales during the consultation phase	public do not agree with case for change and MT as a priority	MT network model is not progressed	Work with CHCs to develop overarching supporting documents HB to work with CHCs to cascade information through their networks Work with the BBC media to ensure a balanced story is given	Health Collaborative/Health Boards	4	3	12	4	3	12	26.5.17	open	
R21	business objectives/projects	16.03.17		The recommended preferred location for the MTC based on advice from Independent Panel and wider information is not accepted by public	unhappy with proposal	delay in progressing development of the trauma network	formal challenge to the proposal	Health Collaborative/Health Boards	4	3	12	4	3	12	26.5.17	open	
R20	business objectives/projects	16.03.17		The recommended preferred location for the MTC based on advice from Independent Panel and wider information is not accepted by some individual Health Boards	unhappy with proposal	delay in progressing development of the trauma network	formal challenge to the proposal	Health Collaborative/Health Boards	4	4	16	4	3	6	26.5.17	open	Formal report is intended to go to Leadership forum in June, following which it will go to individual Health boards for consideration
R19	business objectives/projects	16.03.17		The recommended preferred location for the MTC based on advice from Independent Panel and wider information is not accepted by Collaborative Board	unable to reach as consensus on MTC location	delay in progressing development of the trauma network		Project Board	4	3	12	4	2	8	26.5.17	open	suggested this is now closed
R12	finance	26.05.15		Individual Health Boards will not receive appropriate payment for out of area patients as there is no commissioning model in Wales to support the flow and payment of patients across health Boards	lack of commissioning framework	organisation incur significant cost no incentive to repatriate patients to local TU	Commissioning work group to be established to progress the commissioning model formal discussion to be held with WHSSC, Collaborative Commissioning body to determine options available	Project Board	4	3	12	4	3	12	26.5.17	open	a commissioning T&F group is being established to develop a recommended commissioning model
R26	business objectives/projects	16.03.17		Delay in progressing the network model of MT because of lack of commitment from HB developing the model	lack of engagement from Health Boards	delay in progressing development of the trauma network	CEO's mandated NHSWCHC to undertake the work	Health Boards	4	3	12	4	2	8	26.5.17	open	Executive Board approved development of the network at Board 23.5.17 does this now need to be closed?
R26	adverse publicity/reputation	29.03.17		Population of south Wales continue to have worse outcomes following a major trauma and more deaths than the rest of the UK as a result of a major trauma network not being implemented	no major trauma network in south Wales	more deaths and worse outcomes than the rest of UK (including north Wales)	Independent clinical advice taken help support a recommendation on a preferred site	Health Boards	5	5	25	5	5	25	26.5.17	open	
R27	adverse publicity/reputation	29.03.17	Ruth Alcolado	Population of south Wales continue to have worse outcomes following a major trauma and more deaths than the rest of the UK as a result of the decision on the location of the major trauma network being delayed	delay in agreeing location of MTC and Tus	more deaths and worse outcomes than the rest of UK (including north Wales)	HB to work with CHCs to cascade information Health Collaborative to continue to engage with CHC and Health Boards Leadership forum established to support decision making process and recommendations	Health Boards	4	4	16	4	4	16	26.5.17	open	
R28	service/business interruption	29.03.17		the development of the network facilitates uncertainty and unsustainable services outside of the centres (MTC and Tus)	the main sites are able to attract key clinical posts and are supported by trainees via the deanery which may make it difficult to recruit to posts in the non trauma units/mtc sites	vacancies in hospitals outside the major sites, which may lead to difficulties providing a clinical safe and effective service		Project Board	4	3	12	4	3	12	26.5.17	open	
	Finance	29.03.17		Delay in implementation of the major trauma network due to no commissioning framework in Wales to support cross Health Board management of patients	No agreed framework for managing patients across health boards	new service model not implemented	Commissioning work group to be established to progress the commissioning model formal discussion to be held with WHSSC, Collaborative Commissioning body to determine options available	Health Collaborative	4	3	12	4	3	12	26.5.17	open	a commissioning T&F group is being established to develop a recommended commissioning model
	Quality	11.04.17	Brendan Lloyd	Primary scene management & transfers are managed may not be managed as well as possible due to staff not undertaking the required training to support the new service model	insufficient training of WAST staff	patients managed inappropriately resulting worse outcomes Patients not being transferred appropriately	training requirements to be identified and plan developed as part of the next phase of the programme	Project Board/WAST	5	5	25	5	5	25	26.5.17	open	
	Finance	11.04.17	Brendan Lloyd	Delay to implementation of the major trauma network due to insufficient training of WAST staff to support the change in service model as a result of insufficient funding	insufficient training funding not identified to support training requirements	delays in implementation of the service model patients managed inappropriately	Need for financial implications associated with delivering WAST training and operational costs to be included in the commissioning framework	Project Board/WAST	4	3	12	4	3	12	26.5.17	open	
	Quality	29.03.14	Phil Kloer	Some patients have a worse outcome as the major trauma occurs more than 60 minutes away from the nearest TU or MTC	it is not possible for all areas across South Wales, West Wales and South Powys to be within 60 minutes of the MTC or a TU	potential for patients to have a worse outcome Delay in patients reaching an appropriate centre for treatment	Investment has been made in EMRTs to support transfer of major trauma cases in Wales to an appropriate centre It is recognised across the UK that there will be areas more than 60minutes away from a TU and MTC	Project Board	3	3	9	3	3	9	26.5.17	open	



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NHS Wales Health
Collaborative

Major Trauma Network Consultation Plan

Author: Rachel Hennessy, Programme Director

Date: 13th November 2017

Version: 4

Publication/ Distribution:

- www.publichealthwales.org/majortraumaconsultation

Purpose and Summary of Document:

This document summarises the plan for the proposed consultation on major trauma.

1. Introduction

This paper sets out the framework to support a consultation exercise on the provision of a major trauma network for South and West Wales and South Powys, hereafter referred to as South Wales. People living in North Wales benefit from Betsi Cadwaladr UHB being part of the West Midlands major trauma network that supports the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the West Midlands major trauma network. South Wales is the only region of England and Wales that does not have a major trauma network or have access to a designated major trauma centre. This means that if you suffer a major trauma in south Wales, you are likely to have poorer outcomes and are at greater risk of death.

The development of the major trauma network for the region will represent a significant step forward in the provision of emergency care in Wales and will build on the current model of care providing greater expertise and resilience to meet both individual and mass casualty events. A developing network will lead to enhanced roles for a number of hospitals across the region but particularly for the University Hospital of Wales, Cardiff and Morriston Hospital, Swansea.

The work to develop proposals for a major trauma network has been done in collaboration with health boards across the region, Welsh Ambulance Service Trust, Emergency Medical Retrieval and Transfer Service and also involved third sector and Community Health Councils.

2. Background/context

In late 2014, the Health Collaborative was asked by the Chief Executive Officers to develop a service model for a major trauma network for the south Wales region. A Project Board was established, supported by a clinical reference group. The service model for major trauma services for adults and paediatrics was developed by the clinical reference group in line with the standards for major trauma and approved by the Project Board in May 2015. In June, a non financial option appraisal was undertaken which identified the need for a major trauma network with a major trauma centre based in the region to support the population.

Building on this work, approval was given for an Independent Panel to review the evidence available and advice on the development of the major trauma network and to recommend a preferred location for the

major trauma centre. The recommendations from the Independent Panel have been reviewed through the Collaborative governance arrangements (Collaborative Executive Group and Leadership Forum) and the benefits for the population of South and West Wales and South Powys associated with developing a major trauma network fully considered. Health boards have considered and agreed in principle to the recommendations and for a period of consultation, in their public Board meetings in September.

Health boards in Wales are required to work with their local Community Health Council to engage and consult with the local population on matters of substantial service change. Given that the proposal to develop a major trauma network is about enhancement of existing services at existing emergency departments, it could be viewed that this does not in itself constitute substantial service change requiring public consultation but would certainly require public and stakeholder engagement to ensure a clear understanding of the developments for the future. Any consultation process will be expected to explain how the proposed trauma system will work to the benefit of patients and at the same time help the NHS to best shape pathways to meet patient need. Further advice has been sought from the Community Health Councils on the process and length of a consultation.

3. Scope of Consultation

To ensure the consultation process is meaningful, consideration needs to be given to key messages to be shared with the public and the evidence available to support the proposed development of a major trauma network.

The key messages include:

- 'Major Trauma' can be defined as multiple and serious injuries that could result in disability or death. These might include serious head injuries, multiple injuries cause by road traffic accidents, industrial accidents, falls, mass casualty events, attempted suicide, knife and gunshot wounds
- A major trauma network is a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receive the best care for life threatening or life changing injuries
- You are more likely to survive and make a full recovery if you have a major trauma in a region where there is a major trauma network, regardless of how far you are aware from the major trauma centre
- Good trauma care involves getting the patient to the right place at

the right time for the right care; having the seriousness of the injury identified as early as possible ideally at the scene of the incident; with detailed investigation taking place immediately on arrival at the trauma unit

- A major trauma network normally has one major trauma centre supported by a number of trauma units. Rehabilitation is a key component of the major trauma network and is an essential part of good trauma care and good patient outcomes
- A local emergency department does not routinely receive patients who suffer a major trauma. You will continue to go to the local emergency department if you are seriously ill or have an injury which does not need the highly specialist services
- An independent panel of expert clinicians working in major trauma were asked to look at the evidence and provide advice on the best hospital site for the major trauma centre. The Independent Panel produced a report making the following recommendations:
 - The rapid development of a major trauma network for South and West Wales and South Powys with a clinical governance infrastructure
 - The adult and children's major trauma centres should be co-located on the same site
 - The major trauma centre should be located at University Hospital of Wales, Cardiff
 - Morriston Hospital, Swansea should become a large trauma unit and should have a leadership role for the major trauma network
 - A clear and realistic timetable for the activation of the trauma network should be set
- The remaining trauma units (if any) will need to be identified by individual health boards for their local population
- Once the location of the major trauma centre has been agreed, further work will be required to identify the full costs of the major trauma centre and the trauma units.

In light of the key messages, the consultation will ask people to respond to three questions:

1. Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?
2. Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?

3. If we develop a major trauma network for South and West Wales and South Powys is there anything else we should consider?

4. Consultation Plan

This section of the document outlines the objectives of the proposed consultation, the stakeholders, proposed method of consultation and the proposed consultation and post consultation phase. A detailed table outlining the proposed events will be developed and attached.

4.1 Objectives

The consultation plan outlines the methods and proposed process for the consultation that will support delivery of the following objectives:

- Ensure awareness and information about the consultation reaches the majority of our key stakeholders, by the close of the consultation exercise
- Provide a full range of opportunities, taking account of accessibility, for our staff and key stakeholders to give their views by the close of the consultation exercise
- To raise awareness to the general public of the consultation and provide opportunities for feedback.

4.2 Stakeholders

There are a number of stakeholders which will need to be considered in this consultation and a variety of methods which will be employed. A stakeholder mapping exercise has been undertaken and a detailed list of stakeholders is attached. Key stakeholder groups will include the following:

NHS Wales Staff

This includes: board members; general practice; dentist; optometry; pharmacy; commissioners; Welsh Ambulance Services Trust; Emergency Medical Retrieval Transfer Service and staff working across the NHS in south and west Wales and south Powys region.

Community Health Councils

Health boards will undertake consultation with their local community health council in line with guidance

<p>General public</p>	<p>(Regulation 27 of 'The Community Health Councils Constitution, Membership and Procedures Wales')</p> <p>Health boards will be responsible for undertaken consultation with the general public within their region, which will include public meetings in each district.</p>
<p>National bodies/organisations</p>	<p>A list of national bodies/organisations will be drawn up by the health Collaborative and a copy of the consultation and supporting documents will be sent to these organisations by the Health Collaborative. This includes: Local Medical Committee; Local Optometry Committee; Local Pharmacy Committee and Local Dental Committees; Royal Colleges.</p>
<p>Third sector</p>	<p>Third sector organisations will be engaged through the Wales Council for Voluntary Action (WCVA) by the Health Collaborative and through local County Voluntary Councils (CVCs) by the engagement leads.</p>
<p>Local authorities and elected members (Councillors, Assembly Ministers, Members of Parliament)</p>	<p>Local authorities, through the Welsh Local Government Association (WLGA); Welsh Assembly Cabinet Members; Children's Commissioner; Older Persons Commissioner will be engaged by the Health Collaborative. Health boards will engage with Town and Community Councils.</p>
<p>People with protected characteristics</p>	<p>An Equality Impact Assessment (EqIA) has been undertaken to consider how the major trauma proposal impacts on individuals with protected</p>

characteristics. Groups with the following protected characteristics will be engaged with which include: Welsh Language group; equality groups; 50+ forum; women's equality network Wales; Lesbian and Gay Christian Movement Cymru; Welsh Refugee Council and Black Voluntary Sector Network Wales (BVSNW).

Other Stakeholders

This will include a number of specialist groups who may have an interest in major trauma: universities; Police; Fire service; search and rescue. Health Boards will also engage with other stakeholders including; youth councils; carers groups and GPs. In line with Guidance on Engagement and Consultation on changes to Health Services, this will include as a minimum

- Stakeholder Reference Group
- the Health Professional Forum
- the Partnership Forum
- Public Services Board
- Regional Partnership Boards

4.3 Consultation methods

A number of methods of engagement will be employed throughout the consultation.

Launch of consultation	Subject to approval by health boards in their public board meetings in September the consultation will commence 13 th November 2017.
	Health boards, Welsh Ambulance Service Trust, Emergency Retrieval and Transfer Services, Welsh Government, Community Health Councils will receive an email briefing providing the start date for the consultation and confirming closing date.
	Following launch of the consultation, all documentation will be made available via public health Wales website at

	<p>www.publichealthwales.org/majortraumaconsultation and a press release/briefing will be compiled by the Health Collaborative prior to launch day and shared with Welsh Government, health boards (engagement, Communication leads, planning leads), Community Health Councils.</p>
Distribution to NHS Wales staff	<p>Staff will be directed to the consultation documents via the Public Health Wales website at www.publichealthwales.org/majortraumaconsultation. There is no expectation regarding cascading of this information, therefore accessing information on the website will be at the discretion of individuals.</p>
Distribution of consultation document to National organisations	<p>The consultation document will be shared with national organisations by the Health Collaborative via email and hard copies provided where requested. Groups will be signposted to local public meetings to be held by health boards across the region.</p>
Distribution of consultation documents to local organisations	<p>Consultation documents will be shared through local health board networks on line and hard copies provided where appropriate.</p>
Public sessions	<p>Public sessions will be held across each Health Board. A list of planned activity is attached to this document. Details on the proposed public sessions will be available on the website www.publichealthwales.org/majortraumaconsultation and also available on individual health board websites.</p>
Presentation	<p>A PowerPoint presentation will be compiled and made available for health boards to show at public events.</p>
Animated film	<p>A short film will be produced which will outline the key elements of the consultation. This will be made available on the websites, alongside other consultation documentation and will be available to show at public events.</p>
Questionnaires	<p>Hard copies of the surveys can be returned to a freepost address or scanned and returned via a dedicated email address. This will be coordinated by the Health Collaborative</p>

Online response	Individuals or organisations can respond to the consultation questions online at www.publichealthwales.org/majortraumaconsultation
Frequently Asked Questions	An initial list of frequently asked questions will be available as a technical document on the website. This list will be updated on a weekly basis pending further frequently asked questions.
Social Media	Social media may be used where health boards already use this method of engagement with the public. Questions or queries which relate to an area of interest for the wider public or the development of the wider major trauma network, should be referred to the Health Collaborative to log and coordinate a response, which will then be uploaded to the FAQs.

4.4 Consultation Phase

It is anticipated that the consultation period should last a period of 12 weeks subject to agreement with the Community Health Council's and approval at public health board meetings.

Assuming a consultation period of 12 weeks, the consultation will commence 9am, Monday 13th November and end 9am Monday 5th February 2018.

The consultation document and supporting consultation pack will be cascaded by the Health Collaborative to key stakeholders as identified in the attached stakeholder analysis and Health Board engagement leads.

The Health Collaborative will be responsible for ensuring the consultation document and supporting documentation is uploaded to the Public Health Wales website.

Health Board engagement leads will be responsible for ensuring the consultation is signposted on their health board website and the documentation is made available across their region.

There will be a period of planned activity, led by health boards in each region. This will provide the opportunity for staff, stakeholders and the wider public to find out more about the proposals for a major trauma network in South Wales as well as providing opportunities to feedback on the proposals in the consultation document.

A list of representatives to lead planned events will need to be agreed. It is anticipated that WAST and EMRTs representatives will participate in the planned activity alongside health boards. Health boards will also identify a clinical lead and executive lead to take forward the public sessions.

Administrative support to public sessions will be supported by individual health boards. Feedback from each event will be captured on a standardised meeting record sheet to ensure consistency across Health Boards. Notes will be shared and agreed between the health boards and local Community Health Councils prior to being sent to the NHS Wales Health Collaborative to log. Notes from other local meetings will be sent directly to the NHS Wales Health Collaborative to log.

Emerging themes from the planned events will be identified by the Health Collaborative and shared with engagement and Community Health Councils leads.

A formal review meeting will be scheduled for approximately six weeks into the consultation to review response to the consultation and address any issues of concern. This will be coordinated by the NHS Wales Health Collaborative and include the health boards and Community Health Councils chief officers.

Where there is interest from the media, the Health Collaborative will coordinate formal responses as appropriate, engaging with Welsh Government and Health Board Communication leads. Queries relating to local context and issues will be addressed through individual health boards communication leads. A Press Strategy has been developed and shared with individual health boards.

3.5 Post consultation Phase

The NHS Wales Health Collaborative will receive and log responses to the consultation. This will be shared with health boards and the Community Health Councils for consideration and response.

Responses will be analysed by the NHS Wales Health Collaborative and themes identified. This information will be shared with Community Health Councils to enable production of a formal response.

A report will be produced which will include the findings of the consultation. This will be considered by health boards in their public Board

meeting in March 2018.

3.6 Timelines

The consultation period is anticipated to last for a period of 12 weeks, commencing 9am Monday 13th November 2017 to 9am Monday 5th February 2018. A final report, detailing the response to the consultation will be produced for consideration by health boards in public meetings in March 2018.

4. Risks

The consultation on major trauma spans several organisations and regions across south Wales and is therefore complex in nature. There are a number of risks associated with delivering the planned range of activity within the identified time frame.

- Ensuring consistency in delivery of key messages across the region, where there are differing local priorities
- Opposition from one or a number of stakeholders
- Media interest
- Adverse publicity
- Misunderstanding regarding key messages, principles or emerging recommendations
- Confusion with any other potential stakeholder consultation processes which may run concurrently, for example thoracic services
- Availability of adequate resource to manage and run a comprehensive consultation process at health board and from within the Health Collaborative.

A risk register has been developed and will continue to be reviewed and updated throughout the course of the consultation.

Health Board	Title	Template received	06/11/2017	13/11/2017	20/11/2017	27/11/2017	04/12/2017	11/12/2017	18/12/2017	25/12/2017	01/01/2018	08/01/2018	15/01/2018	22/01/2018	29/01/2018
Cwm Taf University Health Board	Rhondda Valleys Public Forum	X		15/11/2017 09:30											
Cwm Taf University Health Board	Hospital Medical Staff Committee	No		17/11/2017											
Cwm Taf University Health Board	Cynon Valley Public Forum	X			22/11/2017 09:30										
Cwm Taf University Health Board	Local Medical Committee	Meeting cancelled			23/11/2017										
Cwm Taf University Health Board	Taff Ely Public Forum	X				27/11/2017 1pm									
Cwm Taf University Health Board	Merthyr Tydfil Public Forum	X				29/11/2017 2pm									
Cwm Taf University Health Board	Working in Partnership Forum	No										11/01/2018			
Cwm Taf University Health Board	Health, Social Care & Wellbeing Forum	No					06/12/2017 circ. Electronically								
Cwm Taf University Health Board	Equality & Welsh Language Group	No						13/12/2017							
Cwm Taf University Health Board	Stakeholder Reference Group	Meeting cancelled						14/12/2017 cancelled							
Cwm Taf University Health Board	CHC Service Planning Committee	HC Development session - no template completed										12/01/2018			
Cwm Taf University Health Board	Medical Leadership Forum	Meeting cancelled												24/01/2018	
Cwm Taf University Health Board	Healthcare Professionals Forum	Virtual sharing of information													
Cwm Taf University Health Board	Meeting with staff directly involved with trauma services	No attendees													
Cwm Taf University Health Board	Health Board	No template completed													31/01/2018
Cardiff and Vale University Health Board	Joint UHB Stakeholder Reference Group and Healthcare Professionals Forum	X				30/11/2017 09:30 - 12									
Cardiff and Vale University Health Board	UHB Local Partnership Forum	X						13/12/2017 10-12							
Cardiff and Vale University Health Board	Cardiff and Vale CHC members via full CHC council meeting											08/01/2018 6 - 7pm			
Cardiff and Vale University Health Board	General Public - Vale	X										09/01/2018 6:30 - 8pm			
Cardiff and Vale University Health Board	General Public - Cardiff	X										10/01/2018 6:30 - 8pm			
Cardiff and Vale University Health Board	Cardiff Public Services Delivery Board				24/11/2017										
Cardiff and Vale University Health Board	Vale Public Services Delivery Board					30/11/2017									
Cardiff and Vale University Health Board	Staff engagement	X													
Abertawe Bro Morgannwg University Health Board	Disability Reference Group									29/12/2017 12pm					

Abertawe Bro Morgannwg University Health Board	Stakeholder Reference Group			17/11/2017 10am											
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Swansea	X					04/12/2017 2 - 6:00pm								
Abertawe Bro Morgannwg University Health Board	Public Meeting - Swansea	X					04/12/2017 6 - 8pm								
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Neath	X					05/12/2017 2 - 6:00pm								
Abertawe Bro Morgannwg University Health Board	Public Meeting - Neath	X					05/12/2017 6 - 8pm								
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Port Talbot	X						12/12/2017 2 - 6:00pm							
Abertawe Bro Morgannwg University Health Board	Public Meeting - Port Talbot	X						12/12/2017 6 - 8pm							
Abertawe Bro Morgannwg University Health Board	Stakeholder Reference Group											10/01/2018 10am			
Abertawe Bro Morgannwg University Health Board	ABM Youth														
Abertawe Bro Morgannwg University Health Board	Bridgend Equality Forum	X				22/11/2017 2pm									
Abertawe Bro Morgannwg University Health Board	Swansea Bay LGBT Forum												17/01/2018 2pm		
Abertawe Bro Morgannwg University Health Board	CHC Members						28/11/2017 10am								
Abertawe Bro Morgannwg University Health Board	CHC Members													23/01/2018 10am	
Abertawe Bro Morgannwg University Health Board	Local Advisory Medical Group					23/11/2017 6:30pm									
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Bridgend	X										19/12/2017 2 - 6:00pm			
Abertawe Bro Morgannwg University Health Board	Public Meeting - Bridgend	X										19/12/2017 6 - 8pm			
Abertawe Bro Morgannwg University Health Board	Traumatic Brain Injury Service	X													
Hywel Dda University Health Board	Public Drop in Session - Haverfordwest	x										12/12/2017 3-7pm			
Hywel Dda University Health Board	Public Drop in Session - Carmarthen	x										13/12/2017 3-7pm			
Hywel Dda University Health Board	Public Drop in Session - Aberystwyth	x											16/01/2018 3-7pm		
Powys Teaching Health Board	Drop in Session					16/11/2017 10 - 12:30									
Powys Teaching Health Board	Drop in Session						27/11/2017 & 28/11/2017 All day events								
Powys Teaching Health Board	Drop in Session	x											05/01/2018 10 - 12:30		
Powys Teaching Health Board	Drop in Session	x												09/01/2018 10 - 12:30	
Powys Teaching Health Board	Drop in Session	x												12/01/2018 10 - 12:30	
	Brecknockshire Committee	X													
Powys Teaching Health Board	Full council meeting of the CHC													09/01/2018	
Aneurin Bevan University Health Board	Public Meeting - Newport													08/01/2018	
Aneurin Bevan University Health Board	Public Meeting - Caerphilly													09/01/2018	

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GUIDANCE FOR ENGAGEMENT AND CONSULTATION ON CHANGES TO HEALTH SERVICES

SECTION 5: SUBSTANTIAL CHANGE

<p>A key issue to be determined as to whether formal consultation is required is whether the change is substantial or not.</p> <p>It is expected that staff who lead on citizen engagement will work closely with their counterparts in other LHBs and the Trusts to promote consistency in dealing with such cases. As part of this analysis, the CHC and other stakeholders, in assessing proposals and participating in discussions about consultation, should be conscious of the potential to compromise the LHB's ability to maintain a full service for the whole population it serves</p>	<p>In discussion with CHCs the proposal for a major trauma network is subject to a period of consultation to last 12 weeks.</p>
<p>Where it appears likely that a formal consultation could take place, it is proposed in future that this should be conducted on a two stage basis. The first stage is for NHS organisations to undertake extensive discussion with all the key stakeholders, to include:</p> <ul style="list-style-type: none">• the Stakeholder Reference Group• the Professional Forum• the Partnership Forum• the Community Health Council• the Local Service Board• staff and their representative bodies• other key partners as appropriate. <p>The purpose of these discussions will be to explore all the issues, to refine the options and to decide and agree on which questions will be set out in the consultation. Only when it is satisfied that this first stage has been properly conducted, should the NHS organisation proceed to formal consultation</p>	<p>Prior to the decision to go to consultation, work was undertaken in collaboration with key stakeholders. In June 2015 a workshop led by clinicians looked at the options available to support a major trauma network in south Wales. The workshop comprised representatives from the Health Boards and Welsh ambulance services Trust (WAST). Patient representatives were invited through the third sector support groups and geographical coverage was sought. CHCs were also invited in an observer capacity.</p> <p>Following this workshop a period of engagement was planned and documentation was developed. However, this was delayed and instead a single period of consultation was taken forward.</p> <p>To facilitate the decision on the preferred location of the site for the major trauma centre an independent, expert clinical panel was commissioned to review the available evidence and provide advice on the best facility to locate the major trauma centre for the region. Representatives from across the health service in the region alongside other key stakeholders were invited to attend the panel. This included: Clinical representatives from Aneurin Bevan, Cwm Taf, Hywel Dda and Powys Health Boards; Public Health Wales; Welsh Government; Community Health Council; Emergency Medical Retrieval Transfer Service (EMRTS); WAST; Welsh Health Specialist Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC).</p> <p>The development of the consultation documentation and questions was done in collaboration with health boards and the community health</p>

	councils. The initial questions were revised on discussion and agreement by the community health councils.
A formal consultation period of a minimum of 6 weeks should be sufficient in most cases if the issues have already been fully explored during the first stage and if the CHC agrees.	The major trauma consultation period is for 12 weeks, 13 th November 2017 – 5 th February 2018
<p>A number of issues should be considered right at the start, because they will impact on decisions to be taken at various stages throughout the formal consultation process. These include:</p> <ul style="list-style-type: none"> • what is the respective responsibility of each of the local NHS organisations? • has there been any previous consultation carried out on the same or a previous related or similar issue, e.g. for local authority services? • who should be consulted, on what and how? • will these issues affect users of other NHS services in particular those with sensory loss and disabilities? • are there issues affecting other Welsh or English areas? • what resources are needed and available? • how will any conflict/complaints be dealt with? • how will the outcome feed into the decision making process? • when and how will decisions be made? • how will results be fed back to patients, staff and citizens who have been involved, either directly or indirectly? will they be published through the media to inform a wider public? • what evaluation of the consultation is going to be undertaken, and how? • when to complete a full equality impact assessment • what is the timetable for both the involvement and consultation process? • what is the impact on associated services? 	<p>The majority of these issues are covered within the consultation document and a number of additional supporting documents</p> <ul style="list-style-type: none"> • Consultation plan • Media and communication plan • Equality Impact Assessment <p>These documents have been developed in conjunction with engagement leads from individual health boards, WAST and EMRTS and have been viewed by the CHCs.</p> <p>The Health Collaborative will be responsible for ensuring the consultation document and supporting documentation is uploaded to the Public Health Wales website and distributed to national organisations. Health Board engagement leads will be responsible for ensuring the consultation is signposted on their health board website and the documentation is made available across their region. Public sessions will be held across each health board.</p> <p>A stakeholder mapping exercise has been undertaken and a detailed list of stakeholders produced. The consultation documents have been by the Health Collaborative and to local organisations through local health board networks.</p> <p>The major trauma consultation period ends 5th February 2018. During the consultation the NHS Wales Health Collaborative will receive and log responses and this will be shared with health boards and the Community Health Councils for consideration and response.</p> <p>Responses will be analysed by the NHS Wales Health Collaborative and themes identified. This information will be shared with Community Health Councils to enable production of a formal response.</p> <p>A report will be produced which will include the findings of the consultation. This will be considered by health boards in their public Board meeting in March 2018.</p>

	<p>Processes have been agreed for sharing responses to the consultation, media enquiries and information from public sessions.</p> <p>The Health Collaborative team have been identified as the point of information in the consultation documents and will be collating and analysing the responses.</p>
<p>In managing the process, the Welsh Assembly Government will expect that:</p> <ul style="list-style-type: none"> • senior clinicians will take a lead role in presenting and supporting the proposed change; • the NHS body leading the consultation will work in partnership with its counterparts in other local NHS bodies • NHS bodies will invest sufficient resources to manage the process from start to end effectively, openly and transparently; and • the Local Service Board partners will be fully involved to ensure that proposals are seen and addressed within the context of the “whole system” of public service provision. 	<p>The NHS Wales Health Collaborative has:</p> <ul style="list-style-type: none"> • worked with Health Board engagement, communication and equality leads and with Community Health Councils • public sessions are being led by clinical and managerial representatives in each area supported by representatives from WAST and EMRTS • production and translation of consultation document is being undertaken by the Health Collaborative for use throughout the consultation. • There will be communication with: <ul style="list-style-type: none"> • Stakeholder Reference Group • the Professional Forum • the Partnership Forum • Local Service Board
<p>Consultation documents should:</p> <ul style="list-style-type: none"> • explain why change is necessary and provide clear evidence; • include a clear vision of the future service; • explain the consequences of change or of maintaining the status quo, on quality, safety, accessibility and proximity of services • include information on outcomes for patients and service users; • in the case of changes relating to hospitals, demonstrate how services will in future be provided within an integrated service model; • set out clearly evidence for any proposal to concentrate services on a single site; • include the evidence of support from clinicians for any proposed change; • in the case of changes prompted by clinical governance issues, show how these have been tested through independent review; 	<p>The consultation document outlines the case for change and recommendations of an Independent Panel.</p> <p>It has been signed off by all Health Boards and is supported by a number of additional documents</p> <ul style="list-style-type: none"> • Consultation plan • Media and communication plan • Equality Impact Assessment • Technical documents available on the website www.publichealthwales.org.uk/majortraumaconsultation Inc. FAQs and Risk Register <p>cover the majority of these issues</p> <p>The service model for a major trauma network was developed through a clinical reference group. An Independent clinical panel was appointed to make further recommendations based on clinical expertise.</p> <p>Once the location of the major trauma centre has been agreed, further work will be required to identify the full costs of the major trauma centre and the trauma units.</p>

<ul style="list-style-type: none"> • show which options were considered during the engagement phase - the NHS needs to ensure that, if a preferred option is specified, this will not be seen as a 'fait accompli'; • explain any risks and how they will be managed; • give a clear picture of the financial implications of the different proposals; • spell out who will be affected by the proposed changes and how their interests are being protected; • explain how any change and benefit will be evaluated after implementation; • be available in a range of formats, such as "Easy Read", large print, Braille and BSL or audio; • be signed off by the Board • set out how sustainable staffing levels are to be achieved. 	<p>A video of Professor David Lockey, Transitional Lead for the South Wales Neonatal Network is available on the website and has been shared with engagement leads for presenting at public and other meetings</p> <p>The consultation document is bilingual and available in</p> <ul style="list-style-type: none"> • Easy Read • Braille • Audio • BSL <p>There is also a contact email and phone number should other formats be required.</p>
<p>The NHS body should develop media contacts and work with them to explain the changes and their impact in ways in which citizens will understand. The process of consultation should be genuine and transparent. There should be an open discussion with citizens, NHS staff, staff representative and professional bodies, stakeholders, third sector and partner organisations right through the process.</p>	<p>A media and comms plan has been produced and a log of media enquiries and cuttings updated on an ongoing basis.</p> <p>All media enquiries are being managed centrally through the Health Collaborative in line with the agreed media plan.</p> <p>Prior to commencing the consultation, a press briefing was issued to local press across the region.</p> <p>The consultation document has been distributed electronically by the Health Collaborative to national organisations. Health Boards have distributed the document to an agreed set of local organisations.</p> <p>Public sessions will be held across each Health Board. There will also be communication with:</p> <ul style="list-style-type: none"> • Stakeholder Reference Group • the Professional Forum • the Partnership Forum • Local Service Board
<p>The primary task of CHCs is to assess the impact of proposed changes on health services not to take a partisan role. If a CHC considers that there are other options to the proposal to be consulted upon by the responsible NHS body it should inform the NHS body at the earliest stage. The NHS should provide assistance to the CHC in considering such options.</p>	<p>Advice was sought from the CHCs on the process, the consultation questions and length of a consultation. The consultation questions were amended on guidance from the CHCs.</p>
<p>At the end of the consultation period, the CHC should have the opportunity to consider all comments received and record its own observations on</p>	<p>The Health Collaborative will receive and log responses to the consultation. This information will be shared with health boards and the CHCs for</p>

them.	consideration and response.
<p>If the CHC agrees to the proposals in the consultation, the NHS body may proceed to implement its proposals subject to any other approvals or consents that may be required.</p> <p>The Welsh Assembly Government, local Assembly Members, the local council(s) and local Members of Parliament should be informed of this and a notice inserted in the local press informing the public that the proposals are to be implemented following CHC agreement. In normal circumstances it is considered that this stage should be reached within 4-6 weeks after the end of the public consultation period.</p>	Not applicable at this stage
<p>Where a CHC is not satisfied that proposals for substantial changes to health services would be in the interests of health services in its area or believes that consultation on any such proposal has not been adequate in relation to content or time allowed, it may take further action as set out in Section 7 below.</p>	Not applicable at this stage
<p>NHS bodies should consider with CHCs how well the consultation process worked and whether it met the expectations of those who participated in it. They should assess this against the measures identified at the planning stage. They should also give feedback to stakeholders about the results of consultation.</p>	Not applicable at this stage

National Principles for Public Engagement in Wales – this is supported by the Major Trauma Consultation Plan

<p>Engagement is effectively designed to make a difference Engagement gives a real chance to influence policy, service design and delivery from an early stage.</p>	<p>Engagement questions developed and agreed in conjunction with CHCs.</p>
<p>Encourage and enable everyone affected to be involved, if they so choose The people affected by an issue or change are included in opportunities to engage as an individual or as part of a group or community, with their views both respected and valued.</p>	<p>Prior to commencing the consultation, a press briefing was issued to local press across the region.</p> <p>The consultation document has been distributed electronically by the Health Collaborative to national organisations. Health Boards have distributed the document to an agreed set of local organisations.</p> <p>Public sessions will be held across each Health Board. There will also be communication with:</p> <ul style="list-style-type: none"> • Stakeholder Reference Group • the Professional Forum • the Partnership Forum <p>Local Service Board English and Welsh websites developed. Public sessions being held across the region.</p>
<p>Engagement is planned and delivered in a timely and appropriate way The engagement process is clear, communicated to everyone in a way that's easy to understand within a reasonable timescale, and the most suitable method/s for those involved is used.</p>	<p>Major trauma consultation plan developed in conjunction with health board engagement leads. Timescale for consultation in outlined in consultation document, consultation information, board papers.</p>
<p>Work with relevant partner organisations Organisations should communicate with each other and work together wherever possible to ensure that people's time is used effectively and efficiently.</p>	<p>Work on the consultation document, consultation plan and supporting information has been developed in conjunction with health board engagement leads, CHC to ensure consistency. EMRTS/WAST providing additional support to public sessions.</p>
<p>The information provided will be jargon free, appropriate and understandable People are well placed to take part in the engagement process because they have easy access to relevant information that is tailored to meet their needs.</p>	<p>Consultation document has gone through 'plain English' and achieved a crystal mark. Easy read version has been commissioned and published. Alternative formats are available on the website and at request. The consultation document is bilingual and available in</p> <ul style="list-style-type: none"> • Easy Read • Braille • Audio • BSL

	As EqIA has been completed which has been used to underpin the consultation plan
Make it easier for people to take part People can engage easily because any barriers for different groups of people are identified and addressed.	Responses are welcomed via email, hard copy or through on line form available on the website.
Enable people to take part effectively Engagement processes should try to develop the skills, knowledge and confidence of all participants.	As above
Engagement is given the right resources and support to be effective Appropriate training, guidance and support are provided to enable all participants to effectively engage, including both community participants and staff.	Engagement leads are leading the process through health boards Health Collaborative is providing support, facilitation and developing central consultation documents and collating responses.
People are told the impact of their contribution Timely feedback is given to all participants about the views they expressed and the decisions or actions taken as a result; methods and form of feedback should take account of participants' preferences.	A report will be written with the response to the consultation and made available for health board meetings in March 2018. Health Boards will keep CHCs exec and full councils informed on the consultation progress The final report will be published on the Public Health Wales website following Health Board meetings in March 2018.
Learn and share lessons to improve the process of engagement People's experience of the process of engagement should be monitored and evaluated to measure its success in engaging people and the effectiveness of their participation; lessons should be shared and applied in future engagements.	A mid way review is being undertaken to review current response to the consultation and identify any changes, further work required in the second phase of the consultation. It is anticipated a document outlining lessons learned will need to be produced on completion of the consultation phase.



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Major Trauma Network Consultation Proposed framework for making recommendations

Author: Rachel Hennessy, Programme Director

Date: January 2018

Version: 0

Publication/ Distribution:

- Executive Group

Purpose and Summary of Document:

This paper outlines the processes, which have taken place leading up to the major trauma consultation and presents the framework that will be used to guide Health Boards through the recommendations being made following the period of consultation on the proposed development of a major trauma network for South Wales.

The Board/Committee are asked to

Approve

X

Discuss

Receive

1. Introduction

This paper outlines the processes, which have taken place leading up to the major trauma consultation and recommends a framework that will be used to guide Health Boards through the decision-making processes in relation to the recommendations made by the Independent Panel for a major trauma network for South Wales and the proposed location of the major trauma centre. .

2. Background

In late 2014, the Health Collaborative were asked by the Chief Executive Officers (CEOs) to develop a service model for a major trauma network for the south Wales region. A Project Board was established, supported by a clinical reference group (CRG). The service model for major trauma services for adults and paediatrics was developed by the CRG in line with the standards for major trauma and approved by the Project Board in May 2015. In June 2015, a non-financial option appraisal was undertaken which identified the need for a major trauma network with a major trauma centre based in South Wales to support the population of South and West Wales and South Powys.

North Wales and North Powys, were excluded from the project. Betsi Cadwalder is already part of the West Midlands Major Trauma Network with patients in North Wales having access to the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the West Midlands Major Trauma Network via the trauma unit in Shrewsbury.

Building on this work, an independent panel of specialists from across trauma and rehabilitation services in the UK were commissioned by the Collaborative Board, on behalf of Health Boards, to review the information and evidence available and make a recommendation on the preferred

location of a Major trauma centre in the region. A formal report to health boards in January 2017 asked them to note the arrangements for the Independent Panel, the expectations from the panel and to note the process to bring forward a recommendation for public consultation (appendix 1. Appendix 2 and 3 are the terms of reference for the Independent Panel and a list of the evidence considered.) This was supported by all health boards.

The Independent Panel took place in February 2017. Following the event, the independent experts further reviewed the evidence provided and presented on the day and provided a formal report to the Health collaborative. The independent panel report made the following recommendations:

- A major trauma network for South Wales with a clinical governance infrastructure should be quickly developed
- The adults' and children's major trauma centres should be on the same site
- The major trauma centre should be at University Hospital of Wales, Cardiff
- Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network
- A clear and realistic timetable for putting the trauma network in place should be set.

Health Boards formally received a copy of the Independent Panel report, and their recommendations for consideration at their board meetings in September 2017. Health boards were asked to agree in principle to the recommendations from the Independent Panel, and in doing so; agree to a period of consultation on the recommendations of the Independent Panel. All health boards agreed to these recommendations and a twelve-

week period of consultation commenced 13th November 2017 and is due to conclude 5th February 2018.

The main consultation document, response form and covering letter was written by the Health Collaborative and formally approved by health boards. The Consultation questions were formulated with guidance from the CHC. In line with guidance and best practice, the document was available in a variety of formats. An English and Welsh website was developed and accessed via Public Health Wales. A number of planned sessions are being led by health boards in each region, supported by WAST and EMRTS to provide the opportunity for staff, stakeholders and the wider public to find out more about the proposals as well as providing opportunities to feed back. People and organisations are encouraged to respond to the consultation using email, online via the website or to return their response using a FREEPOST address.

Following the consultation, the responses will be analysed by the health collaborative and a recommendation made to the Collaborative Leadership Forum for consideration at its meeting on 21st February for onward consideration by the constituent health boards in March 2018.

3. Framework for making the recommendations

Health Boards have already agreed (as outlined above) that the basis for public consultation would be the recommendations made by the Independent Panel.

The consultation questions were developed in conjunction with health boards and CHCs and asked respondents (individuals and organisations) to consider the following three questions:

- Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys? (give a reason)
- Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel? (give a reason)
- If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?

Respondents were asked to either: agree; disagree; neither agree nor disagree, and give a reason for their answer.

It is always challenging to evaluate the narrative provided in consultation responses to demonstrate that due consideration has been given to all views presented. This is further complicated by the need to determine whether the rationale underpinning the response has already been considered by the independent panel in generating their recommendation for consultation in the first place.

It is therefore proposed that a systematic framework is adopted to analyse the responses to the consultation, which is intended to support the Collaborative Leadership Forum in considering the recommendation that will be made to Health Boards for decision in March 2018. The proposed framework (Attachment 4) will assist the evaluation of consultation responses against the recommendations of the Independent Panel with a view to deciding whether they are accepted as the basis for future service redesign and development.

The proposed framework would require the consultation responses to be considered in line with 5 key steps as follows:

Step 1.

For each question on the consultation response form, responses will be collated and divided into:

- Agree
- Neither agree nor disagree
- Disagree

Where responses 'agree' or 'neither agree nor disagree' with a question, no further analysis will be undertaken.

Further consideration will need to be given to the response from individuals who disagree with a consultation question.

Responses, which disagree with the recommendation, will progress to Step 2 of the analysis.

Step 2.

Where there is a reason given for disagreeing with the recommendations of the independent panel, those reasons will be further grouped into two categories:

- Reasons considered by the Independent Panel in arriving at their recommendation
- Reasons **not** considered by the Independent Panel in arriving at their recommendation

Issues that were considered by the Independent Panel, and identified as either not material to the clinical outcomes of a patient will not be considered further.

Issues, which not considered by the Independent Panel will progress to Step 3 of the analysis.

Step 3.

An assessment will be made of any issue progressing to this stage of the analysis to determine if the concern raised has any direct impact on the decision about the establishment of the network or location of the Major Trauma Centre

- If not, then no further consideration will be given to the issue
- If there is a direct correlation with the proposal then the analysis will progress to Step 4.

Step 4.

If an issue raised has not been addressed by the independent panel and directly relates to the development of a major trauma network, it will be necessary to consider if there are any reasonable steps that can be taken to mitigate the issue.

- Where it is possible to put in place mitigating actions, these will need to be identified and included as evidence to be presented to Boards to factor into their decision-making
- Where no clear mitigating actions can be identified, the issue will progress to Step 5 of the analysis.

Step 5.

Where an issue raised cannot be mitigated, the analysis will need to include any further information that might be helpful to Boards in their decision making.

Consideration of other methods of responding to the consultation

Similar consideration will need to be given to any other issues or themes evolving from general responses to the consultation and feedback from public sessions and social media, and the same methodology will need to be applied.

4. Timeframes for Consultation

Appendix 5 outlines the proposed timeframes for responding to the consultation. It is anticipated that following the conclusion of the consultation, the initial response to the consultation will be considered by the Leadership Forum.

The Community Health Councils will then receive the response to the consultation to discuss the findings and recommendations. This will be considered by the Executive Group for each CHC and will then ratified by full committee.

It is anticipated that a formal briefing will then be required for Assembly Members. Following discussion with the CHC Chief Officer representative at the regular engagement team meeting, he has confirmed the preference for a formal briefing to the wider CHC prior to the report being considered by individual Health Boards as the statutory bodies.

Health Board meetings are scheduled to take place in March, whilst the majority are scheduled for 29th March, Aneurin Bevan and Powys are scheduled for 21st March. Correspondence is taking place with Board Secretary to look at either aligning board meetings or setting an exceptional meeting to consider the response to the major trauma consultation.

5. Conclusion

The methodology for generating the preferred location for the Major trauma centre for South Wales and the development of the wider network, was approved by all constituent Health Boards as being the Independent Panel process with the recommendations from the Independent panel forming the basis for consultation

This process was agreed as an objective recommendation based on the available evidence as assessed by impartial experts in the field of major trauma. In arriving at their decisions, health boards will need to consider how stakeholders have responded to the consultation and whether any of the consultation responses raise concerns about the recommendations made by the Independent Panel that cannot be mitigated and which would therefore materially impact on their ability to endorse the recommendations made.







To support health boards in considering the response to the consultation the proposed framework will provide a clear basis against which consultation responses have been considered and enable health boards to make a clear decision for responding in relation to the recommendations made by the Independent Panel.

6. Recommendation

The Executive Group are asked:

- To agree to use the proposed framework to support making a recommendation on the implementation of a major trauma network for South Wales
- To agree to use the proposed framework to support making a recommendation on acceptance or otherwise of the recommendations made by the Independent Panel.
- To note the timeframe following the consultation.

- To note the requirement by CHCs for a formal briefing following the consultation.
- To determine whether a formal briefing for Assembly Members should take place following the consultation

Appendix 1.	January 2017 Public Board Paper	 <p>MT public Board paper - January 2017.</p>
Appendix 2.	Independent Panel Terms of Reference	 <p>Document 3 - Terms of Reference Independen</p>
Appendix 3.	<p>Agenda for Independent Panel event</p> <p>List of evidence considered by the independent panel</p>	 <p>Doc 2 - Final Agenda for Independent Pane</p>  <p>Major Trauma Independent Review C</p>
Appendix 4.	Framework for making a recommendation	 <p>MAJOR TRAUMA - APPENDIX - DECISION</p>
Appendix 5.	Timeframe for responding to consultation	 <p>Proposed draft response timeline 221</p>



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Major Trauma Consultation Numerical and Thematic Analysis of Responses

Author: Jacqui Davies, Planning Manager

Date: 13 March 2018

Version: 1 (Final)

Purpose and Summary of Document:

This document contains a detailed numerical and thematic analysis of the responses received during the consultation on proposals for a major trauma network for South and West Wales and South Powys.

The paper contains an analyses of:

- the written responses received to the consultation questions (Section 2)
- the views expressed at stakeholder meetings, including formal public meetings (Section 3)
- social media comments (Section 4)

An equality monitoring analysis is also provided (Section 6).

1 Overview

There were 1,041 consultation responses received from across the region, and 254 members of the public engaged in conversation on social media (with potential overlap between these two groups).

Of the 1,041 responses, 999 directly answered the consultation questions asked. During the consultation period 24 stakeholder meetings were reported to the Collaborative.

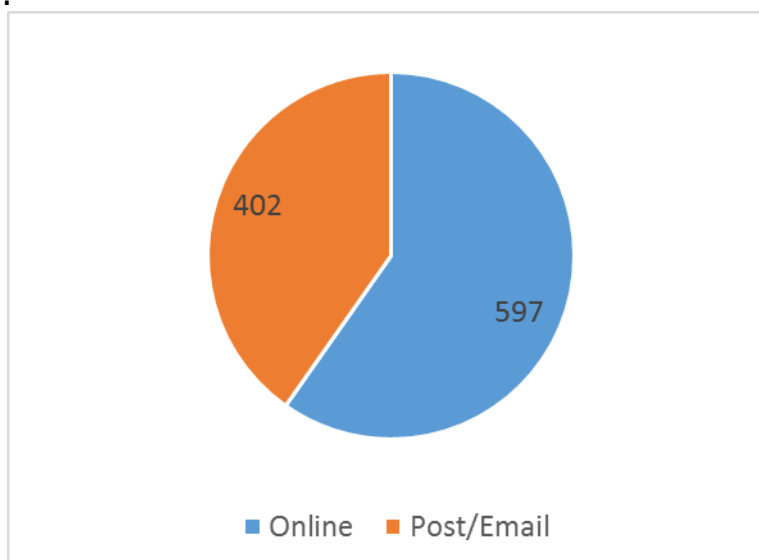
Comments received through all of the above means were considered on an equal footing.

2 Response to questions

2.1 Format of responses received

A total of 999 responses were received directly answering the questions asked.

60% (597) of the responses were submitted online through the Major Trauma Consultation webpage and 40% (402) were received either through post or email.



Of the 402 responses received either through post or email:

- 141 (35.1%) used formal consultation responses forms
- 126 (31.3%) were on a standardised template
- 116 (28.9%) were on a standardised email
- 12 (3.0%) were in a standardised letter
- 7 (1.7%) were independent responses

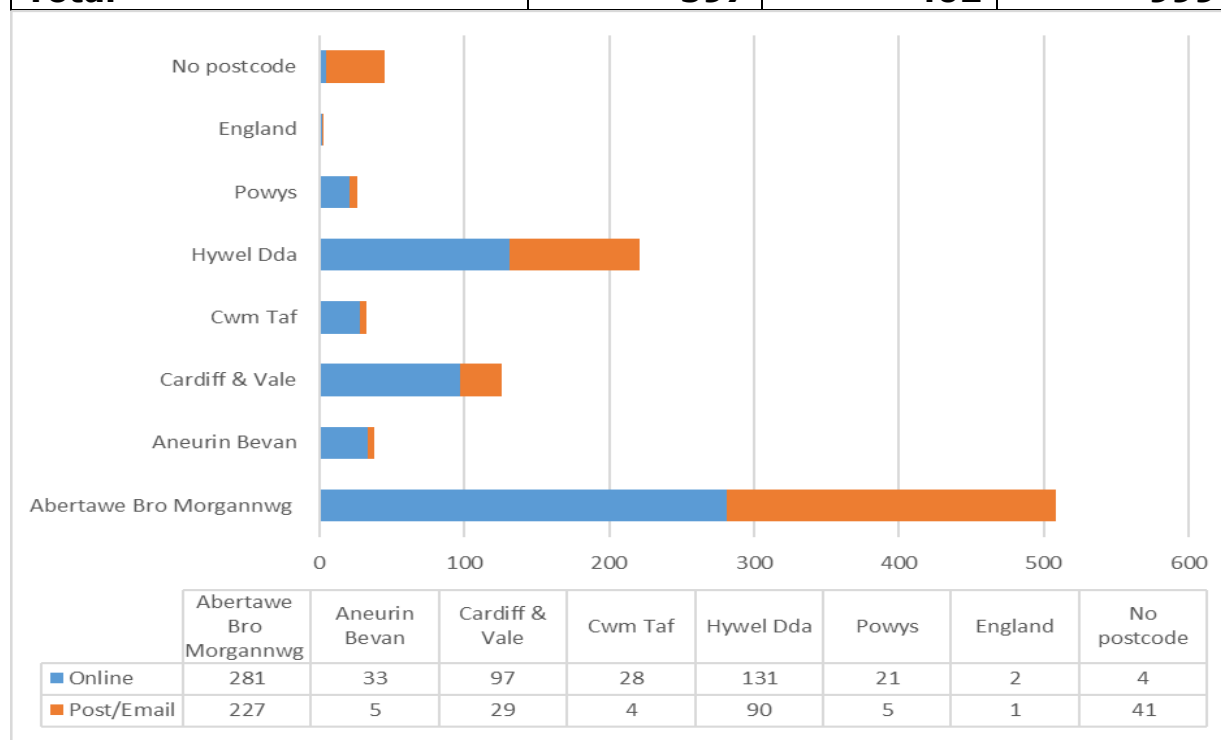
Whilst the majority of responses were in English, 15 Welsh responses were received and two used 'easy read' English.

2.2 Distribution of responses by area

Illustrated below is the distribution of the 999 responses directly answering the consultation questions:

- 73.5% of responses were from West Wales
- 19.6% of responses were from South Wales
- 2.6% of responses were from Powys
- 4.2% of responses were from England/No postcode

	Online	Post/Email	Total
Abertawe Bro Morgannwg	281	230	511
Aneurin Bevan	33	5	38
Cardiff & Vale	97	29	126
Cwm Taf	28	4	32
Hywel Dda	131	93	224
Powys	21	5	26
England	2	2	4
No Postcode	4	34	38
Total	597	402	999



254 people submitted standardised responses, either in the form of a template, an email or a letter.

2.3 Organisational responses

A total of 100 responses were said to be representing the views of organisations. However, nine were discounted as they had listed the organisation as either “NHS” or an individual health board (not consultees). The organisations referenced are as illustrated below:

<p>Abertawe Bro Morgannwg</p> <p>Aberavon Constituency Labour Party ABMU Local Medical Advisory Group Brackla Dental Surgery Briton Ferry Town Council Cilybebyll Community Vouncil Hawthorn Court Care Ltd, Swansea Llanfair Grange Care Home Llanfair Surgery Morgannwg LMC</p> <p>Ogmore Constituency Labour Party Pencoed Town Council Primary Care Communities Unit ABMU Socialist Health Association, Cymru Wales Stroke Association Swansea Council Swansea Council for Voluntary Service The Old Vicarage Nursing Home, Neath The Vale of Neath Practice Three Cuffs Dementia Care Home ABMU Brain Injury Service UNITE Retired Members Swansea Area Branch</p>	<p>Specialist Neurological Occupational Llanelli Town Council Llanelli Rural Council Mid and West Wales Fire and Rescue Service Llandyfaelog Community Council Cylch Ferwig Llandysilio-go-go Community Council Llanllwchaearn Community Council Mynachlog-ddu and Llangolman Community Council</p> <p>Jobcentre Plus, Haverfordwest Carmarthen Town Council Llangeodmor Community Council Llanrhian Community Council Mathry Community Council Clwb Gwawr Llandeilo HM Coastguard Division 5 Wales & NI St Oswalds VA School Cylch Methrin Cei Newydd Cylch Methrin Crymymch Gelli Mor Ltd</p> <p>Cwtsh Y Clos Nuersery</p>
<p>Cardiff & Vale</p> <p>Care & Repair Cardiff and the Vale</p> <p>Barry Town Council Royal College of Anaesthetists Glamorgan Voluntary Services (GVS) Vale of Glamorgan 50+ Strategy Forum Simon Thomas AM Occupational Therapy Service Cardiff and Vale UHB</p> <p>The Chartered Society of Physiotherapy (CSP) in conjunction with the Association of Trauma and Orthopaedic Chartered Physiotherapists (ATOCP) Royal College of General Practitioners Cardiff 50+ Forum Royal College of Nursing Wales</p>	<p>Hywel Dda</p> <p>Cylch Meithein San Cler Blaenmarlais Care Ltd Cylch Meithrin Felinfoel Tenby Town Council Shelter Cymru Rural Issues Freystrop Community Council</p> <p>Narbeth Surgery</p> <p>Cyngor Cymuned Beulah Ceredigion</p> <p>Cenarth Community Council Carmarthenshire Federation WI Eglwysrwrw Community Council</p>
<p>Cwm Taf</p> <p>RGH Hospital Medical Staff Committee, Cwm Taf University Health Board Heads of Nursing Forum, Cwm Taf Health Board National Orthotic and Podiatry Standing advisory group Physiotherapy Service Cwm Taf UHB Old Radnor Community Council</p>	<p>Dinas Cross Community Council</p> <p>Clwb Gwawr Glannau Teifi</p> <p>Ilangeitho Community Council Cyngor Tref, Ceredigion Cyngor ??</p>
<p>Powys</p> <p>DYFI U3A Tawe Uchaf Community Council Glascwm Community Council Presteigne and Norton Town Council Felinfach Community Council</p>	<p>Llangunnor Community Council Cardigan Hospital and Community League of Friends 75 or over Llanfar-ar-y-Bryn Community Council Headway Pembrokeshire Committee</p>
<p>England</p> <p>The Disabilities Trust/ Brain Injury Rehabilitation Trust The Royal College of Emergency Medicine Wales (RCEM Wales) Headway - the brain injury association BMA Cymru</p>	<p>Royal College of Surgeons of Edinburgh</p> <p>Royal College of Anaesthetists Welsh Board S Wales Police</p>

2.4 Responses to consultation questions

Question 1 - Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?

- 92.8%* of respondents agreed with the proposition that a major trauma network should be established for South and West Wales and South Powys
- 4.0% disagreed
- 2.7% neither agreed nor disagreed
- 0.5% did not provide any response

* This includes 242 respondents who used a standard 'template' response and who answered 'Yes' to the question (rather than answering 'agree' or 'disagree')

		Agree	Disagree	Niether agree nor disagree	No Response	Total
Abertawe Bro Morgannwg	Online	261	14	5	1	281
	Post	224	4	2	0	230
	Total	485	18	7	1	511
Aneurin Bevan	Online	30	1	2	0	33
	Post	4	1	0	0	5
	Total	34	2	2	0	38
Cardiff & Vale	Online	88	8	1	0	97
	Post	25	2	2	0	29
	Total	113	10	3	0	126
Cwm Taf	Online	27	1	0	0	28
	Post	3	0	1	0	4
	Total	30	1	1	0	32
Hywel Dda	Online	119	5	7	0	131
	Post	89	1	3	0	90
	Total	208	6	10	0	224
Powys	Online	16	1	4	0	21
	Post	4	1	0	0	5
	Total	20	2	4	0	26
England	Online	2	0	0	0	2
	Post	2	0	0	0	2
	Total	4	0	0	0	4
No Postcode	Online	4	0	0	0	4
	Post	29	1	0	4	34
	Total	33	1	0	4	38
Total	Online	547	30	19	1	597
	Post	380	10	8	4	402
	Total	927	40	27	5	999

Respondents were also invited to provide a narrative supporting their decision.

The main reasons for **agreeing** with the proposition contained in Question 1 are set out below:

Theme	
Access (208 references to)	Access to best possible care
	Availability of all major services and expertise on one site
	Best patient outcomes
Recognised need for a MTN (92 references to)	Needed in South Wales
Equity (40 references to)	Equity across the UK
	Equity across Wales
Evidence based (17 references to)	Based on evidence
Current Provision (11 references to)	A strategic solution to the problems experienced with the current arrangements and infrastructure
	Benefit existing emergency departments
	Consideration of the existing framework
	Free up other hospital facilities
	MTC and network well overdue for Wales
	Natural development
	Need for formal plan
	Reduce strain on local A&E departments
Uncertain of current service provision	
Current reliance on England (3 references to)	Currently Wales has no MTC, but relies upon services from NHS England e.g. Bristol.
	Currently the nearest trauma unit is Bristol
	Bristol too far away so lives may be lost
Communication and Engagement	Improved communication between HBs
Other comments generally supportive of network proposals	Unaware MTN not already established
	Agree with Panel recommendations
	Recruitment and retention
	Best use of public service resources
	Essential/sensible/well founded
	Needed to augment other hospitals
	Spread the diversity of specialisation throughout Wales
	Supportive of advantages
	The area should have its own infrastructure to form a major trauma network
	Best Practice
Trauma Networks make a difference	

Other comments generally supportive of network proposals (continued)	We need to be working together
	Widely reachable
	Would provide an industry leading service to South Wales
	Has the potential to recognise and build on existing good practice
	Has the potential to formalise and develop the relationships between the teams and services that contribute to the outcomes delivered along the major trauma care pathway
	Has the potential to ensure that all staff and carers contributing to the major trauma care pathway are supported to maintain and develop competencies and have access to the resources they need to deliver consistently high quality care
	Has the potential to relate a community of practice that can support the ongoing development of the existing trauma workforce, offer quality practice-based learning opportunities to develop the trauma workforce of the future, and produce high quality research outputs that address questions arising from practice in this area
	Looks like wide consultation and examination of the issues
If an independent expert panel has considered the evidence and made that recommendation I will agree with them, subject to funding being available.	

A number of respondents who **agreed** with the proposition in Question 1 went on to make comments that were not direct justifications of their agreement. Almost all of these comments related to the proposed location of the Major Trauma Centre:

- 22 responders who agreed with the proposition in question 1 went on to make comment indicating that they thought there should be an MTC in Morriston/Swansea
- 8 further responders indicated that easy access is needed from West Wales
- 8 further responders indicated that Cardiff is too far away from West Wales to be the location of the only MTC in the region
- 13 responders either suggested that South East Wales should receive major trauma services from Bristol or believed that was already the current position
- 4 responders indicated that there should be improved trauma services in South Powys
- 3 responders indicated that there should be an MTC further West than Swansea

Two responders had concerns that the concentration of expertise at the major trauma centre might deplete the current trauma capabilities of the local units

Of those responders **disagreeing** with the proposition in Question 1:

- 6 responders made comments indicating that there should be two or more MTCs covering the region
- 4 further responders indicated that the MTC should be in Morriston/Swansea
- 4 further responders indicated that UHW is too far away to serve West Wales
- 2 further responders expressed concerns about the accessibility of services to West Wales

Other reasons for **disagreeing** with the proposition contained in Question 1 are set out below:

Responses
Additional funding needs to be allocated to allow hospitals to operate effectively
Disbelieve the significant amount of evidence quoted
Disruption of established skilled teams
Emergency services cannot all be centralised
Hospital in Wales are at a pressure point where you are just going to create a bigger problem
Insufficient evidence to suggest poor care at present
Major trauma is rare and has been treated well in the present centres
Need a MTN that covers all of Wales
Removing major trauma from West Wales will damage all other complex care teams
Service should be for the WHOLE of Wales
South Wales is big enough to need more than one centre
The physical infrastructure at any of the hospitals would not be able to cope unless there is radical thought as to what moves out of any of the hospitals that will be involved in the network
There is a need for specialist units with the right teams for life saving treatment
Travelling long distances could be unrealistic and detrimental to the health of the injured
We should invest in the trauma services available in Bristol
A major trauma network should not be established if it is designed to substitute effective ongoing A&E services within 60 minutes of communities in south west Wales. A major trauma unit must only be considered as an additional service

Question 2 - Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?

- 34.5% of respondents agreed
- 49.3% disagreed
- 14.3% neither agreed nor disagreed
- 1.8% did not provide any response

The table below illustrates the distribution of responses received:

		Agree	Disagree	Niether agree nor disagree	No Response	Total
Abertawe Bro Morgannwg	Online	77	141	60	3	281
	Post	13	205	5	4	227
	Total	90	346	65	7	508
Aneurin Bevan	Online	28	2	3	0	33
	Post	3	1	1	0	5
	Total	31	3	4	0	38
Cardiff & Vale	Online	74	12	11	0	97
	Post	22	5	2	0	29
	Total	96	17	13	0	126
Cwm Taf	Online	21	2	5	0	28
	Post	2	1	1	0	4
	Total	23	3	6	0	32
Hywel Dda	Online	44	47	39	1	131
	Post	41	34	11	4	90
	Total	85	81	50	5	221
Powys	Online	10	6	4	1	21
	Post	5	0	0	0	5
	Total	15	6	4	1	26
England	Online	2	0	0	0	2
	Post	1	0	0	0	1
	Total	3	0	0	0	3
No Postcode	Online	0	3	1	0	4
	Post	2	34	0	5	41
	Total	2	37	1	5	45
Total	Online	256	213	123	5	597
	Post	89	280	19	13	401
	Total	345	493	142	18	999

The expertise and independence of the Independent Panel were the main reasons for **agreeing** with the proposition in Question 2, as illustrated below:

Theme	
Independent Panel (75 references to)	Fairer and no hidden agendas or possibility of other influence
	Reassurance that the decisions are being made for the benefit of the people
	Ability to consider the clinical issues effectively
	Balanced and informed views
	Best people to make the decision
	Best way to get results
	Carefully considered the options
	Clear process, lines of governance and transparency
	Evidence based
	Expertise
	Fairest outcome
	Follows a democratic process
	Given the work that has been done to reach this conclusion the answer is categorically yes
	Independent view
	Non political
	This report has not thought out lightly
	Unbiased Panel
	Why have an independent otherwise
UHB's are signed up to IP decision	
Wide consultation and examination of the issues	
Access (4 references to)	Availability of specialist services on UHW site
	Availability of the best resources, staff and having good access
	Greater provision of care across south wales
Location (4 references to)	
Existing Services (3 references to)	Cardiff has neurosurgery and the paediatrics hospital to support the service and excellent transport links.
	Obvious and probably only choice available to build on the current facilities and skilled workforce.
	Siting is at UHW where most tertiary services are based currently including tertiary Paediatric surgery, neurosurgery
Other	MTN beneficial to south wales

A number of respondents who **agreed** with the proposition in Question 2 went on to make comments that were not direct justifications of their agreement:

- 8 respondents made comments indicating that they understood that the Independent Panel had not yet produced its recommendations
- 4 respondents expressed general concerns about access
- 3 respondents disagreed with the recommendation the only MTC in the region should be at UHW

The main theme emerging from the reasons for **disagreeing** with the proposition in Question 2 related to location. 249 respondents disagreed with the panel's claim that:

"Neither Morriston Hospital or University Hospital of Wales as a major trauma centre would have any significant advantage over the other in terms of geography. Cardiff is within an hour of Bristol's Major Trauma Centre. This means that the Major Trauma Centre should be in Swansea not Cardiff"

Theme	
Independent Panel (20 references to)	Council leaders and AM's should have been included
	Decision seems to be made already
	Decision should be made by those in the medical profession with 1st hand experience
	Disadvantages residents in West wales
	Do not believe the panel have given sufficient recognition to the impact of the geography of Wales and appreciated just how poor the road network is outside of the M4 corridor, particularly to West Wales
	Don't trust the independent panel
	How independent is the IP?
	Independent Panel has poor knowledge of current issues
	It should take all recommendations into account from wherever they are received
	Make-up and qualifications of the IP
	Panel is not seeing the wider future picture
	Do not agree with recommendation of IP
Location (390 references to)	Disagree with the panel's claim that "Neither Morriston Hospital or University Hospital of Wales as a major trauma centre would have any significant advantage over the other in terms of geography." Cardiff is within an hour of Bristol's Major Trauma Centre. This means that the Major Trauma Centre should be in Swansea not Cardiff
	Do not agree with the location for the MTC
	Major trauma centre should be in Morriston
	Too close to Bristol
	Trauma centre should be on the same site as thoracic surgery
	Proximity to SCCC
	Neither hospital have all specialisms in place

Location (continued)	Existing pressures at Morriston and UHW
	Needs to be a major trauma services in South Wales that gives equal access to all patients in South Wales The plans to centralise the MTC in Cardiff will negatively impact on many other surgical and non-surgical service west of Cardiff
	Footprint of UHW site
Needs based decision (14 references to)	Should look at the needs of the community current services and demographics
	Should be based on NHS need, budgets and live saving timeframes
	Should be what's best for most of the population of South Wales
	Should be based on population opinion
Other	Wider consultation needed
	Emergency services cannot all be centralised
	Political choice
	poorly thought out
	putting lives at risk
	Elevating one alone to the status of trauma centre will almost inevitably result in the down-grading of the other
Recruitment of a range of general medical posts may be affected so that GP services may also be affected	

Question 3 – If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?

and

Question 4 – Do you have any other comments?

The following are the main themes arising from responses to Questions 3 and 4:

- Many respondents took the opportunity to restate and/or expand on their views that:
 - the MTC should be in Morriston/Swansea
 - the MTC should not be at UHW
 - there should be more than one MTC in the region
 - parts of the region should use Bristol (and/or other English centres) as their MTC
- In implementing the network, there is a need to ensure that:
 - improvements are made in EMRTS, air ambulance services and ambulance services to ensure the time taken to transfer patients to the MTC is minimised on a 24/7 basis

- the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the MTC, parking etc.
- there are adequate facilities at sites in the network other than the MTC
- there is an adequate focus on rehabilitation (including minimising waiting times)
- there is access to 24/7 interventional radiology at the MTC
- appropriate decisions are made about the location of trauma units
- there is excellent communications between professionals and with the public during the implementation and delivery of the network
- the therapy professions are appropriately involved in the implementation of the network
- digital solutions are used where possible
- implementation proceeds quickly once the decision has been made
- There are concerns about:
 - equity of access in West Wales and other rural areas
 - the impact on existing services at the location of the MTC through additional workload
 - the network's ability to ensure adequate staffing and adequate training for staff
 - the availability of adequate funding to implement the network
 - the downgrading of services away from the MTC
 - the ability to recruit and retain staff away from the MTC
 - the capacity of estates, facilities and support services at UHW, particularly in relation to the situation at Morriston
 - lack of co-location with thoracic surgery
 - the potential for the burns unit to move to Cardiff
 - the social and economic impact of further investment in Cardiff at the expense of other areas
 - this being part of a wider agenda to move services from Swansea to Cardiff
 - why it has taken this long to develop proposals for a major trauma network for the region
 - the degree to which the consultation has been genuine and extensive
- Further information would have been welcome in relation to:
 - how well the network is working in North Wales
 - the geographical spread of incidents resulting in major trauma in recent years

2.5 Narrative submissions

In addition to the above responses, 42 narrative submissions were received during the consultation period. Of which 12 were responses on behalf of organisations, illustrated below:

Aberavon Constituency Labour Party
Blaehonddan Community Council
Ciybebyll Community Council
Glascwm Community Council
Hearing Loss Cymru
Older People Commissioner for Wales
Pencoed Town Council
Presteigne and Norton Town Council
St Dogmaels Community Council
Tawe Uchaf Community Council
The Royal College of Midwives
The Royal College of Pathologists

The following table illustrates the emerging themes from these submissions:

Theme	
Access	Whatever service results it is fully accessible for people who are deaf or have hearing loss. The care they receive and co-produce is as dignified and clinically optimal as that of a hearing person. Currently a stream of work going around on accessibility for people with sensory loss in each health board and it is a priority each health board reports back to WG on
	Importance of continuing cross border services into England for residents of East Radnorshire who are long distances from proposed units and presently access much of their hospital care in England
Financial resources	Additional financial resources need to be made available to prevent health boards from suffering further financial pressure
MTN Structure	UHW and Morriston should have equal status
	RCM should be part of the major trauma network (leading cause of death in people under the age of 45)

MTN Structure (continued)	Concern model proposed is more of hub and spoke model rather than what may be understood by a network
	Has consideration been given to the provision of sufficient number of ITU beds. Has this been modelled?
	How will proposals work given the configuration of burns & plastics and neurosurgery?
	Are there any plans to have a trauma unit within Powys? Powys is sadly lacking any major medical unit or A&E department
Population based	Consideration should be given to the disposition of population throughout the region and not only in urban areas
Consultation Process	Insufficient information to base a decision on the location of the MTC
	Extension/rerun of consultation process due to poorly advertised/attended public meetings
	Were the options considered subject to a Health Impact assessment (HIA) as part of the work carried out by the panel in arriving at its recommendations? Suggestion that one is carried out before recommendations are progressed
	Information received on engagement and consultation with older people
Current Service Provision	Develop a new department for neurosurgery and paediatric major trauma aligned to a centre in Morriston
	How will the recent decision to centralise thoracic surgery in Morriston impact?
	Fear Burns & Plastics unit move from Swansea
Workforce Requirement	Negative impact on recruitment and retention in Morriston
	Important to understand the implications for attracting doctors in training to Wales as a result of the proposals and to quantify if this means trainee posts being relocated from some hospital sites
	Adequate training, staffing, resources to support air ambulance if they need to make further/longer journeys
	Need for additional staff resources will need to be considered. Need to ensure rotas are drawn up and suitably staffed. Seek assurance this has been modelled

Location of MTN	Geographical position of Swansea
	Has consideration been given to the alternative proposition of joining south east Wales to a major trauma network centre located in Bristol with more western parts of south Wales served by a major trauma network that is based on a major trauma centre located in Swansea
	Proximity to Bristol
Travel Times	Vital response time for victims from western end of region cannot be safely met by locating MTC at Cardiff
	Travel times
	Need to be within one hours drive of treatment
	Road links in Swansea and links to M4 mid south Wales
Impact on EMRTS/ Air Ambulance	Accessibility of air ambulance when Swansea based helicopter to committed elsewhere
	Has appropriate consideration been given to the provision of sufficient ambulance capacity and has this been modelled to support the decision
	May need to re-assess the way in which ambulance calls are currently prioritised given that the proposal will rely on patients being transferred on occasions from one hospital to another within the network
Implementation of MTN	Effectiveness of moving to the model advocated will need to be monitored. Has consideration been given to deriving an appropriate methodology by which this can be done should the network be established? It would be necessary to assess the effectiveness of the network on outcomes from the moment of trauma occurring rather than simply the time of arrival at the relevant hospital
Infrastructure	Appropriate infrastructure and resources will need to be provided. Modelling work should be undertaken in sufficient detail ahead of taking a decision to progress with the proposed trauma network and not left to be worked out until after the decision has been taken. This will need to cover what facilitates are resources will need to be provided at UHW. It may also need to be determined if other facilities/services may need to be relocated to free up space for facilities required for the MTC. This should be understood before any decision is finalised
	Capacity to expand at Morriston Pressure on UHW for mainstream treatment
	Swansea has a purpose built helipad

Communication	The need for a clear communication strategy once a decision is taken on the way forward. Effective programme for informing communities in region how the proposals will work and what they will mean to them in practice.
Other	Unanswered questions relating to social and welfare aspects for patients and relatives

3 Stakeholder meetings

During the consultation period a total of 17 public meetings and/or drop in sessions were held across South and West Wales and South Powys. In addition, the Collaborative received feedback from a further seven meetings.

3.1 Public meetings

A total of 242 people attended public meetings, attending as health board employees, local residents, representatives of organisations, local councillors and Assembly Ministers.

- In ABM 4 people attended 4 meetings
- In Cardiff & Vale 26 people attended 2 meetings
- In Cwm Taf 134 people attended 4 meetings
- In Hywel Dda 47 people attended 3 meetings
- In Powys 31 people attended 4 meetings

Consistent with approaches in other Health Boards, Aneurin Bevan University Health Board organised five public meetings which were to be clinically led and managerially supported (one per Unitary Authority area). Only five people registered across all five proposed meetings, three of whom were staff, one a local councillor and one a member of the public. In agreement with the Aneurin Bevan Community Health Council, all five individuals were contacted, talked through the document, sent the video and offered a direct conversation with a lead clinician for any questions. As a result, there was no attendance at the public meetings and they were cancelled. Despite cancellation, members of staff from the health board attended each venue at the relevant time in case any members of the public turned up without registering. No further attendees presented.

Abertawe Bro Morgannwg

Number of public meetings/ drop in sessions	4
Dates	4 – 19 December 2017

Venues	
Number of attendees	4
Chaired by	Information not provided
Presentation by	Hamish Laing, Medical Director Joanne Abbott-Davies, Assistant Director of Strategy Sian Harrop-Griffiths, Director of Strategy
In attendance	Information not provided

Attendees were at 'drop-in' sessions, where they were provided with information about the consultation. Attendees were asked if they preferred to feedback at the meetings or subsequently submit written responses. All agreed to submit written responses.

Cardiff & Vale (C&V) University Health Board (UHB)

Number of public meetings/ drop in sessions	2
Dates	9th & 10 th January 2018
Venues	Cardiff & Barry
Number of attendees	26
Chaired by	Malcolm Latham (CHC member) Alan Brown (CHC, Vice Chair)
Presentation by	Graham Shortland (Medical Director) Leigh Davies (Deputy Clinical Lead for Major Trauma) Abigail Harris (UHB Director of Strategy and Planning) Melissa Rossiter (UHB Clinical Lead for Major Trauma)
In attendance	David Rawlinson (Clinical Informatics Manager, EMRTS) Len Richards (UHB Chief Executive) Linda Donovan (UHB Head of Strategic and Service Planning) Anne Wei (Strategic Planning and Partnership Manager) Daniel Price (CHC Deputy Chief Officer) Wendy Orrey (CHC Business Manager) Jonathan Whelan (WAST Assistant Medical Director and EMRTS Consultant)

	Bob Tooby (WAST Assistant Director of Operations) Maria Battle (UHB Chair) Rebecca David (EA to Director of Strategy and Planning)
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In response to Question 1 - Establishment of a Major Trauma Network for South and West Wales and South Powys, a number of issues were discussed including:

- Not with-standing the increased survival rates though establishing a MT Network, whether the anticipated costs of this development are being considered in comparison to other ways of spending the money to support other patient groups, comparing years of quality life added
- Concern raised about the Ambulance Service not taking notice of the cards that provide instructions on how to deal with a patient
- How a single MTC, covering a wide geographical area, will take the needs of families into consideration including accommodation, such as newly opened at the Children’s Hospital for Wales
- Whether the plans build in room for increased numbers coming to an MTC, as the figures in the presentation and documentation show that the numbers expected to come to an MTC have already increased since the issue was first looked at
- The proportion of people ending up in a Major Trauma Centre (MTC) as compared to being dealt with in other trauma units
- The numbers coming to an MTC in the presentation suggest that there might be 3 or 4 patients coming a day, and this would not happen evenly across every day. So when an MTC is operational, how staff are occupied if they are not dealing with a major trauma
- How the location of a single centre for Thoracic Surgery will relate to the MTC
- Support the proposals but query whether there is funding to pay for the developments
- Funding for what might need to be an increase in the number of air and road ambulances to support more transfers within a MT Network
- Why Wales is so far behind the rest of the UK in establishing a MT Network
- Concerned that it is such a complicated system that it won’t work and that smaller hospitals often provide the best care
- Whether the development of Trauma Units will lead to the closure of minor hospitals that might be seen as ‘surplus to requirements’
- How successful we will be in securing funding for this development.

Issued discussed with regards Question 2 - whether the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel, include:

- Issues for UHW as a specialist centre in managing to repatriate patients to local hospital, given historical problems with getting other hospitals to take patients back
- The numbers of people expected to come to a Major Trauma Centre (MTC) and the impact on capacity at UHW
- Meeting the needs of the next of kin whose family are being cared for in the MTC
- The importance of training of staff across the Network so that when patients go back to their local hospital, staff of all disciplines have the necessary skills to deal with the patients
- Whether the frustrating experience of long delays in repatriation might be exacerbated by the increased number of patients coming to the UHW if it was the MTC
- The importance of looking at what services could come off the UHW site, recognising that travel to the site was a problem, in particular those relying on public transport.

Cwm Taf

Number of public meetings/ drop in sessions	4
Dates	15 th – 29 th November 2017
Venues	Rhondda and Cynon Valleys, Taf Ely and Merthyr Tydfil.
Number of attendees	134
Chaired by	Community Health Council
Presentation by	Allison Williams, Chief Executive, Ruth Alcolado, Deputy Medical Director Lisa Williams, Clinical Director, Trauma & Orthopaedics
In attendance	Informed not provided

Those who attended the public meetings were in support of the established of a Major Trauma Network but questioned the location of the Major Trauma Centre.

The audience felt there were a number of issues that needed consideration should a Network be established, these included:

- Call for greater multi-agency working to support successful implementation of the Network e.g. the road network is crucial in ensuring patients get to the MTC in a timely manner.

- How many Air Ambulances do we currently have? During what hours can they fly? What happens at night in the proposed model if you need to be transferred to the Major Trauma Centre?
- Where will the Trauma Units be?
- What changes will be required to WAST and EMRTS in order to implement the Network and how will these be funded?
- Will you increase the number of ambulances in operation or reduce waiting times for ambulances outside A&E in order to ensure there are sufficient ambulances available?
- Will EMRTS be able to operate at night and in fog?
- If EMRTS can't fly at night, then patients from West Wales would have a very long journey by ambulance to Cardiff
- What about the "Golden Hour"? There is so much traffic on the road – do we need more funding for EMRTS so that we're not reliant on ambulances on the road?
- Do we need motorbike ambulances?

In addition, a number of additional comments/Questions were asked:

- Suggestion that a similar approach is taken to the Children's Hospital for Wales and the Noah's Ark appeal to raise money to support the development of the Network. Felt we couldn't rely solely on NHS funding
- Welsh Government support for the proposal was queried and how WG are engaging in the project to ensure it is delivered
- Air Ambulances should be funded from core NHS budget not reliant on a charity
- Will the burns service move from Morriston if the Major Trauma Centre is at UHW?
- How is EMRTS funded?
- Why are we reliant on charitable funding for such an important service?
- The thoracic surgery engagement is based on a similar case. Is that why they're being considered at the same time? Will those services be based in the same place?
- Is everything in place in UHW to manage major trauma? If there's minimal additional activity to go to UHW then why do we need to develop the Network and the Major Trauma Centre?
- Will the Major Trauma Centre at UHW be a new build?
- Do ambulance have a police escort to aid quicker travel?

- Is the Major Trauma Network about wider services and rehabilitation? This would make it a better quality service.
- If 1,200 patients per day are affected has does this equate to 2 per day at the Major Trauma Centre?
- Are the surgeons working exclusively in the NHS or are some also doing private work?
- Why are we so behind in this area? All other regions have a Major Trauma Centre.
- What's the budget for the Network? Will it call on already stretched resources or will Welsh Government identify additional funding?
- Will there be any know on implications for Prince Charles Hospital?

Hywel Dda

Number of public meetings/ drop in sessions	3 drop in sessions
Dates	12 th December - 18 th January 2018
Venues	Haverfordwest, Carmarthen and Aberystwyth
Number of attendees	47
Chaired by	Information not provided
Presentation by	
In attendance	

Across the three sessions there was broad agreement that a Major Trauma Network should be established for South and West Wales and South Powys and people felt that it long overdue. However, there was a view that basing it on UHW, Cardiff was too far East and that the preferred option would be to base the service on Morriston, Swansea.

In respect of whether development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel, Concerns were raised related to:

- the long term viability of Swansea as a major centre if Cardiff is selected
- services in Cardiff seem to have extremely limited understanding of the issues of rurality and difficulty of patients and relatives to travel to Cardiff
- the independence of the "Independent Panel"
- the effect on the ability of A&E Department in Cardiff to cope with the volume of work

Those present raised a number of issues that should be considered should a Network be developed this included:

- Family support

- Travel and Accommodation for relatives
- Concern was expressed that Swansea, Burns and Plastics Unit would be transferred to Cardiff/UHW as an enabler and would therefore further degrade local services in the West.
- In developing a Major Trauma Network further delay should be avoided.
- The MTN should include Paediatric Trauma.
- EMRTS would need expansion to 24/7 capability for inter-hospital transfers.
- Supporting hospitals would require considerable expansion and staffing and capability to rule in/rule out at locality level to avoid swamping the Trauma Centre.
- Dangers of reduction of services and quality of services with removal of resource
- “Stabilisation” in Glangwili General Hospital is a worry
- Worries that there is a lack of 24/7 advance pre-hospital service
- Doubts that there will be an ability for Withybush General Hospital to stabilise patients too unwell to go direct to UHW
- Given the proposed expansion of Morriston, will the decision over MTC to Cardiff prevent this?
- 24 hour Air Ambulance provision to make Major Trauma Network work for rural health boards such as Hywel Dda
- Effective networking to enable local ongoing rehabilitation and what will be the arrangements for rehabilitation.

In addition, a number of additional comments/Questions were asked

- Will this affect A&E 24 hour availability?
- Distance to travel
- 12 hour air ambulance. Who pays?
- Worried about cost
- Availability of beds in Cardiff
- Hywel Dda context – not explained
- Cynicism that this won't result in cuts in local services
- Does UHW really have the capacity to expand (real estate!!) for the influx?
- Why can't Bristol contribute to the Network – meaning Swansea could be MTC?
- Why can't Withybush helipad be used at night? Why does the airport need to be used?

- Major concerns about sub-centralisation of services to Glangwili (they won't cope)
- Is this a stepping stone to removal of Cardiothoracic Surgery from Swansea in favour of Cardiff?!
- Concerns over timing of consultation – over Christmas, likelihood of engagement lower!
- Is there capacity at UHW? (number of beds etc.)
- How is rehabilitation and social care to be commissioned? – People are stuck in hospital
- EMRTS 24/7?
- What happens next in the consultation process?
- What are the timescales for the introduction of the network?
- Concerns about the difficult traffic access to UHW
- Want clarity regarding geographical boundary between the North Wales network and the South Wales network
- What discussions have there been between the Trauma Network and the Mid Wales Collaborative?
- Has the Ambulance services been engaged since the beginning?
- Concern that Cardiff has not got capacity? But neither does Morriston
- Cardiff need to make it work
- Will the Major Trauma Centre have any consequence for other services?
- A&E targets are not good in Cardiff

Additional Comments were also submitted from the CHC:

- If the Major Trauma Centre is to be moved even further south access is vital and so I spoke to a representative from EMRTS who confirmed there are three Air Ambulance Helicopters in Wales operating 8am – 8pm, but this is limited in the winter months by darkness. The Air Ambulance does from time to time call on the Coastguard 'Sea King' helicopter to fly at night or in poor weather conditions when the Air Ambulance (AA) is unable to fly. The Air Ambulance can only operate between certain hospitals at night.
- All three of the AA helicopters have a consultant on board and I was reassured that the patient depending on the trauma i.e. head injuries would naturally go to Cardiff, Burns would go to Morriston and some to Stoke where the patient would receive the best treatment. This person thought this would not change if the Major Trauma service was to move to Cardiff. North Wales Health Board use Stoke, Alder Hay (Children's), Liverpool Trauma Hospitals so they are not really affected by this consultation apart from patients on the South Border and Powys patients.

- If the Major Trauma service was moved to Cardiff I feel Hywel Dda patients would be affected the most, not only would the Welsh Government need to properly fund the Air Ambulance 24/7 but also ensure there were always consultants on board. If there is poor weather or during the night (currently) the Air Ambulance does not run and therefore transfer times are hugely increased with an additional hour travel time on top of an already very long journey from the remoteness of North Mid & West Wales.
- I was told that the Welsh Air Ambulance pilots are training to fly at night and this will be complete by the end of 2018, however without funding from WG and the assurance of employing consultants on a 24 hour rota this will increase travel times by ambulance (if available) greatly.
- If the Major Trauma Unit does move to Cardiff then Morryston should retain its Burns Trauma unit and Welsh Government will have to provide proper funding for WELSH AIR AMBULANCE and CONSULTANT'S 24/7 in my opinion.
- Bristol Trauma unit is very close to Cardiff and would this affect patients being flown there in the future?

Powys

Number of public meetings/drop in sessions	3 drop in sessions
Dates	5 th – 12 th January 2018
Venues	Ystradgynlais, Brecon and Crickhowell
Number of attendees	31
Chaired by	Information not provided
Presentation by	
In attendance	

At each of the sessions there was agreement and support for the development of a major trauma network for South and West Wales and South Powys.

Whilst the benefits of locating the Major Trauma Centre at the University Hospital of Wales were recognised, there were concerns that some services may be lost or downgraded at Morryston, having an impact on patients follow up appointments, waiting times and whether staff may be downgraded or moved to another location. There was particular reference to the Burns and Plastics Unit.

At one session it was felt strongly that the major trauma centre could be situated in Morryston particularly when there is already a major trauma centre in Bristol. Reference was also made to the need for west Wales to get its own major trauma centre.

A number of issues that needed consideration should a Network be established were raised by the audience, these included:

- Will repatriation/ step down to the major trauma unit be smooth enough to help with flow?
- Which exact geographical area will the network cover, it is difficult to plan more until we know that?
- The opportunities to develop the real estate are better at Morriston than they are at UHW.
- The helipad at Morriston should be upgraded to accommodate larger choppers.
- is there enough money to develop a major trauma centre and to maintain it 24/7/365?
- who will have the overall say on whether this scheme is approved, surely this will sit higher than the NHS Wales Collaborative?
- it is a long way to travel from south west Wales and some areas of south Powys to Cardiff. Public transport can be difficult and timely to access but from some areas in south Powys, public transport links are non existent, from here it is proven that it is more difficult to travel to the University Hospital of Wales than it is to Morriston Hospital
- will there be facilities in place at the major trauma centre for families to stay on site?
- will there be adequate allocated parking to ensure that families are able to park easily given the nature of their visits
- Are there enough staff to run this service in one place or will they need to be relocated?
- There needs to be a clear plan of how existing A&E units will be maintained.
- It is well documented on the news and social media how stacked up ambulances are at our hospitals; will this get worse if this service is consolidated to UHW?

A number of additional comments/Questions were also asked:

- Based on the information in the consultation document, it sounds like the decision has already been made.
- Given that the major trauma consultation comes on the back of the future shape of thoracic surgery services in South Wales engagement period, this feels that there is a bigger plan already in place and we are slowly being 'drip fed' information for a plan that has already been agreed and is based in University Hospital Wales.
- There seems to be lots of stuff missing from the consultation document.

- It feels like the Ystradgynlais valley is being 'stitched up' and will lose vital services in Morriston that the valley people have campaigned hard for, particularly burns and plastic services.
- Currently, how many Powys patients receive treatment at major trauma centres?
- Why does everything have to happen in Cardiff?
- Can the consultation period be extended?
- Can we have a public meeting with senior representatives from NHS Wales Collaborative, ABMUHB, PTHB.
- Will Morriston be downgraded?
- Will the SCCC have any impact on the major trauma centre?
- It comes across that you have been very ambiguous in the consultation document.
- In future, please share relevant/ current health issues like this in local newspapers.
- In regard to the difficulties that could be experienced for families in travelling from South Powys to the major trauma centre, Crickhowell Volunteer Bureau has in excess of 30 volunteers, all of whom drive on a regular basis. The team support WAST on a Mon-Fri 9-3 basis but could consider 24/7 coverage to ease the pressure on patients and their families; there are other community car schemes available across Powys who may also be open to operating 24/7 to cover emergencies.
- Can arrangements be put in place for improved transport, accessibility, overnight accommodation etc. when loved ones spend a long time in recovery a long way from him - particularly as family and friend contact can aid recovery.
- Location of MTC a less critical issue than the location of the Trauma Units and the rehabilitation pathway - health boards in South Wales must work together to agree a pattern of TUs that serves the whole of South Wales and not just individual Health Board resident populations, particularly as Powys does not have an acute hospital within the health board area
- Poor road infrastructure in rural mid Wales
- Geography and coverage of the proposed network not clearly defined - what is "South Powys" and where does it finish? Is there a clear strategy for trauma network coverage for the whole of Wales.
- Role of EMRTS and Air Ambulance is critical and could be strengthened further.
- Why is the proposed MTC located so far south rather than somewhere more accessible to more of South Wales.

3.2 Other meetings

As a minimum and in accordance with consultation guidance the following groups received information on the consultation process either via an established meeting, electronically or in hard copy and were invited to participate in the consultation process:

- Public Services Board
- Working in Partnership Forum
- Healthcare Professionals Forum
- Stakeholder Reference Group

Abertawe Bro Morgannwg

Meeting Title	Bridgend Equality Forum
Date	22 nd November 2017
Number of attendees	13
Presentation by	Joanne Abbott-Davies, Assistant Director of Strategy.

During the forum individuals/constituent organisations agreed to submit comments direct on the consultation. They enquired whether UHW are still charging for parking as they felt this may have an effect on where it should be based as it may put people off.

Meeting Title	Traumatic Brain Injury Service
Date	16 th January 2018
Number of attendees	14
Presentation by	No formal presentation was provided but the major trauma video was played.

The Group agreed that a major trauma network should be established for South and West Wales and South Powys, supporting the concept of a MTN because it will improve mortality rate - although this needs to be accompanied by investment in services to enable people with severe disability and their families to have a long-term quality of life.

However, they did feel additional information is required to inform this judgment and that the infrastructure required to successfully implement the rehabilitation network is currently lacking in South West Wales.

Additionally, the Group agreed, in principle that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel but further information on funding is needed.

Should a Network be developed they group felt there were a number of issues to be considered:

- There are concerns about the lack of medical leadership and poor resources for neuro-rehabilitation in South West Wales. In order for the model to succeed the network needs access to medical leadership from a Consultant Neurologist based at Morriston Hospital.
- This model does not take into account road travel from the furthest areas of South West Wales and South Powys to the proposed Centre at Cardiff (UHW) – this will continue to be a challenge for patients and families. There is minimal difference in travel times for patients travelling from West Wales to Cardiff or Bristol. How will traffic movement be managed? Need to consider the logistics of travelling by road to Cardiff at peak times, as well as travel costs, support, parking costs for families visiting patients at UHW.
- Are there sufficient ambulances available? More investment required and the funding available is unclear. There are concerns about the pressure for ambulance crews to provide “pre-hospital” or “roadside” care – more medical staff on-road to give assistance? Does this form part of the model?
- There are currently problems with discharge planning for patients repatriated from the Specialist Neuro-rehabilitation Unit at Neath Port Talbot Hospital to local district general hospitals and into the community (ABMU & HD). These issues have been ongoing for many years and there is a danger of re-creating these problems on a larger scale at Morriston Hospital.
- It will be important that patients are repatriated onto an appropriate ward with the correct skill mix and staff who understand and have knowledge of complex brain injury, as well as other injuries. There is a general lack of knowledge and understanding of head injury. There is a difference in “medically safe” for discharge and “safe” for discharge (and communication with relatives is key to safe discharge)
- Communication is currently poor between hospitals, GPs and neuro-rehabilitation services across South Wales.
- Investment will be required to improve clinical systems between Health Boards and Trauma Centres/Units. These costs need to be factored into the model.
- There are significant gaps in community neuro-rehabilitation services covering ABMU and HDUHB. There are long waiting times and the service in ABMU only has the resources to accept patients with moderate/severe brain injuries with active rehabilitation goals (not patients with severe brain injuries who require long-term psychosocial support). There are insufficient resources to provide any hospital in-reach services and patients are likely to wait several months post discharge to access specialist community neuro-rehabilitation.

- There will need to be investment in MDT community resources to deal with the increase in complex patients anticipated with the implementation of the network, otherwise there will be problems with delayed discharges and re-admissions.

A number of additional questions were asked:

- Where is the Financial Information? There is no cost-benefit analysis available in this consultation document to make an informed opinion on the model proposed.
- Who were the members of the Independent Panel that made the decision to locate the MTC in Cardiff?
- What is meant by Critical Mass? How was this calculated? How was it assessed? What guidelines were used for monitoring/assessing patients living in rural area?
- Where is the funding for implementing the Network coming from? Will the current financial problems impact on this?
- Insufficient information on rehabilitation within document.
- Where is the business plan?
- How will this new service be staffed given the problems with multidisciplinary recruitment in this speciality?
- Why was there no-one from the TBIS involved in any pre-consultation discussions? In ABMU there have been no brain injury specialists or expert patients involved in shaping this model.
- Issues specific to the Traumatic Brain Injury Service based at Morriston
- 60% of Trauma cases involve head injury.
- TBIS currently do not have medical staff within the MDT at Morriston. This cover was mainly provided by the Consultant in A&E but he recently retired and the post has not been replaced.
- The main medical problem post TBI is epilepsy but the current pathway to access neurology is problematic as many patients have to be referred back to the Consultants in Rehabilitation Medicine and they have to refer patients to Neurology.
- TBIS has an established business plan to include Neurology sessions in the community service. To date this plan has not been funded but funding neurology as part of a hospital in-reach neuro rehabilitation service will be crucial to the implementation of this trauma model for South West Wales. Having neurology embedded in the specialist community neuro rehabilitation team is consistent with the in-reach community model in North Wales.
- The ABI service in ABMU has the lowest MDT resources per population in Wales. If the current service has a long waiting list – what will be the

impact of the new trauma services? Complex brain trauma patients often require input for the rest of their lives.

- There is no designated lead/ward for brain injuries at Morriston. Services are fragmented and chaotic. Many patients fall through the net and are unable to advocate for themselves. There are problems with repatriation of patients from Cardiff – patients can be placed anywhere within ABMU, this has implications for other patients and staff. Few staff have the experience and knowledge of the neuro behavioural problems that can occur with a TBI. This may have implications for managing risk.
- Since Neurosurgery moved to Cardiff circa 2009 the cases of unsafe early discharges have increased. There is a waiting time to access TBIS. This service does not have the resources to intervene at short notice or in a crisis.
- There is a general lack of expertise in this specialist area across South West Wales (postcode lottery) and a historical under investment in services. It is highly likely that there will be problems recruiting.
- There are also concerns about the delayed discharges and occasionally inappropriate admissions to the Specialist Inpatient Neuro rehabilitation Unit at Neath Port Talbot Hospital. This causes problems for the patients/families and community teams. These challenges may be compounded if a Trauma Unit is developed before the problems are resolved.

Cardiff & Vale

Meeting Title	Stakeholder Reference Group and Healthcare Professionals' Forum
Date	30 th November 2017
Number of attendees	9
Presentation by	Leigh Davies, Deputy Clinical Lead for Major Trauma Abigail Harris, Director of Strategy and Planning

There was agreement with the establishment of a Network and it was felt that:

- The sooner the network is in place the better because of the reduced morbidity and 20% predicted increase in survival rates
- The financial costs are far outweighed by the societal benefits of introducing the network
- Although the creation of a network will be an additional cost, if morbidity rates are reduced as a consequence then long term costs may actually decrease. Getting the right treatment quickly and starting rehabilitation early will reduce long term disability.

- More emphasis should be given to the establishment of the network rather than the issue of the location of the centre, as the service model is about the whole patient pathway.

There was also agreement that the Network should be established on the recommendations of the Independent Panel noting that these have come from an independent panel of experts who have experience of what works and what benefits result from establishing a network.

The group felt that the following needed to be considered should the Network be developed:

- An evaluation process should be agreed and described.
- Transport issues will have to be addressed for people visiting patients in the major trauma centre. It was noted that the panel had not considered access for visitors to be a major consideration in recommending the location of the major trauma centre as in principle patients would remain in the centre for as short a time as possible before transferring to other parts of the network.
- The Third Sector must be included as key partners in the network as they will have a big role to play in rehabilitation.
- The ability of the Welsh Ambulance Services NHS Trust (WAST) to support the running of the network is crucial

Meeting Title	Local Partnership Forum
Date	13 th December 2017
Number of attendees	14
Presentation by	Jenny Thomas (Consultant in Rehabilitation) Melissa Rossiter (Clinical Lead for Major Trauma) Leigh Davies (Deputy Clinical Lead for Major Trauma) Abigail Harris (Director of Strategy and Planning)

In respect of question 1 there was discussion on the need for work on detailed costs and plans to be developed depending on the outcome of consultation. Other issues raised relating to:

- cost of developing networks in England
- anticipated national approach to commissioning
- opportunities for reorganising existing resources
- the fact that this would not all represent new work for C&V UHB as a lot of polytrauma patients require neurosurgery and already come to UHW, so this is an opportunity to consolidate what they're already providing.

Questions asked relating to Question 2 include:

- Whether any capital work that would be needed to establish a Major Trauma Centre at UHW would be part of discussions with Welsh Government about the redesign/rebuild of UHW.
- How establishment of a Major Trauma Centre at UHW would affect staffing.

Meeting Title	Staff Engagement Session
Date	13 th December 2017
Number of attendees	59
Presentation by	Jenny Thomas (Consultant in Rehabilitation) Melissa Rossiter (Clinical Lead for Major Trauma) Leigh Davies (Deputy Clinical Lead for Major Trauma) Abigail Harris (Director of Strategy and Planning)

A number of issues were discussed:

- How quickly a Major Trauma Centre (MTC) would be operational if approved following consultation.
- The impact of establishing a MTC at UHW on other specialities and their involvement in work to date and on implementation going forward.
- The funding arrangements and how the UHB could be assured that it would receive the appropriate remuneration for all the additional work.
- Whether becoming an MTC would lead to recruitment of more trauma surgeons and anaesthetists or whether there was an expectation that existing teams would pick up the work.
- The impact of establishing an MTC on support structures and whether there would be additional resources to ensure adequate capacity particularly in overstretched teams such as physiotherapy.
- The nature of the proposed network lead role for Morriston.
- The additional patients UHW might expect to see if it became the MTC.
- How the development of an MTC would impact on theatre and critical care capacity and whether it would require a remodelling of ward environments.
- What was happening on moving elective work off the UHW site.
- The feasibility of repatriating children in light of the changes taking place as a result of the South Wales Programme which is bringing more specialist children's services to Cardiff.
- Whether an MTC would be a specific new building.

Cwm Taf University Health Board

The relevant stakeholder groups were invited to respond directly to the consultation process using the variety of response mechanisms available and therefore any responses will be included within section 2.4 of this report

Hywel Dda UHB

Meeting Title	Stakeholder Reference Group
Date	10 th November 2017
Number of attendees	22
Presentation by	Dr Phil Kloer, Medical Director

Issues raised include:

- The document is only 10 pages long. It does not look to provide full detail for such a big issue.
- What money will the Health Board need to contribute towards this Major Trauma Centre? Would Welsh Government help the Health Board?
- Aberystwyth are overreliance on the Air Ambulance. The patient is transported by air to hospital however family/carers are about 4-5 hours behind and at times arrive too late. How can you help those individuals left behind?

Powys Teaching Health Board

Meeting Title	Brecknockshire Committee
Date	24 th January 2018
Number of attendees	11
Presentation by	Matthew Dorrance, Chair Dr Karen Gully, Medical Director Mandy Mills, Engagement Officer

Questions asked by the Committee include:

- There has been a lot of talk around downgrading District General Hospitals and creating the SCCC. How does this proposal fit in with the other proposals?
- Will it be in a separate place?
- Cardiff is 25/30 miles away from Bristol (Frenchay), is it that the location is convenient for the consultants, and that's fine if it is the case but what about Burns and Plastics at Morriston. The Ystradgynlais do have concerns about this?
- What is the role of the Police given that they will often be involved in major trauma?
- What about NAS (National Air Support)?

- Will the staffing levels be a plentiful supply of clinicians?
- Will this affect the coordination?
- What role are the CHC playing in the consultation?
- Could you explain how important it is for patients to have these centres of excellence.

4 Social media

In addition, 254 members of the public engaged in conversation on Facebook and Twitter relating to the consultation (18 in Hywel Dda initiated conversations/threads and 236 in ABMU initiated conversations/threads). Whilst a number of individuals used these conversations to express their views on the proposal, the conversations were also used by individuals to promote and confirm that they had completed a formal questionnaire to respond to the consultation. The key themes identified from the social media conversations were considered in line with the agreed framework.

Theme	
Location of MTC	Unhappy with proposals for the MTC in the south of Wales (Swansea or Cardiff)
	All major towns need this located at their A&E
	Interested to see if the plans for Hywel Dda have been taken into account, with the proposed closures it is likely to put added stress on other major hospitals in the area.
	Why shouldn't it come to West Wales? - Carmarthen would be better for West Wales
	West Wales suffers whilst Carmarthen has major hospitals close by
	Why not change Neath Port Talbot hospital to major trauma/orthopaedic unit leaving Morriston, Singleton and Bridgend to deal with the rest. Neath is a beautiful hospital with not a lot or no A&E
	Morriston should be the Major Trauma Centre
	<ul style="list-style-type: none"> • easily accessible by road/close to motorway • excellent surgeons • covers burns • probably more land to expand than at UHW • more central for West Wales • easy to get to from north Wales

Location of MTC (continued)	In London, they have trauma units in most of their hospitals. Time is important. It would mean a lengthy journey from Bridgend, It is important for Wales to have their own trauma unit. It would save a lot of lives Response from individual: People need to understand the difference between MTC and TU. There are only 4 MTCs in London serving 12 million. Wales has a population of 3 million
	Why can't there be two major trauma hospitals in Wales?
	People of South West Wales need to be treated locally
	Cannot believe in 2018 we do not have a trauma unit
	Wales cannot support 2 Burns & Plastic or 2 neurosurgery dept. or PICU someone will have to move.
	Proximity of Bristol: <ul style="list-style-type: none"> • There is a trauma centre in Bristol Cardiff & East Wales can easily access. • Why have two major trauma units so close together • Wales was looked at in isolation and did not include the hospitals in Bristol
Current Service Pressure	Morrison cannot cope with the demands on A&E as it is and if POW is moved then it will only make things worse
	Neither site could cope with the extra traffic. They need to improve roads and parking first
Current Service Provision	Aberystwyth needs a nurse led walk in centre
	Concern unable to staff Hywel Dda at present
	Upgrade Bronglais; we need better hospitals to cope with treatments, operations and emergencies before major trauma units sited miles away Response from individual: The major trauma unit is separate to A&E. this is to concentrate expertise. Plastics already go to Morrison, brain injuries to Cardiff. There is no way we could have this expertise in Bronglais
	Morrison doesn't have enough neurosurgeons. Major trauma patients need them the majority of the time. Cardiff has neurosurgeons

Current Service Provision (continued)	All this for an event that may never happen. We have patient needing operations now that should be the priority
	How does this help stroke patients needing urgent treatment. Response from individual: MTCs don't treat strokes, thrombolysis is carried out in all DGH. You cant pack all DGS with tertiary specialists
	Neurosurgery needed back in Murryston. Paediatric HDU as well
	If the proposed closure of Worthybush and Glangwilli go ahead there will be a lot of deaths
Access and support for families	Not just about the patient but their family – parking at UHW/Expenses for relatives
Consultation process	General enquiries regarding the time and location of the public meetings - why hold the public session in the week and not weekend days - Not enough publicity given to this consultation
	Difficulties responding to the online consultation
	It has already been decided
	All these consultations are costing money. If it's not broke why are you fixing it?
	Discussion thread regarding completion and submission of consultation forms
Financial resources	Is it necessary? This money could be better spent improving services in existing premises
Political Decision	Political argument from a London-centric point of view
Other	Cutting bed and centralising specialities does not work for the benefit of the population
	Are we having a helicopter for this service wherever it is located
	get rid of all management and bring back ward matrons

5 Receipt of late/damaged responses

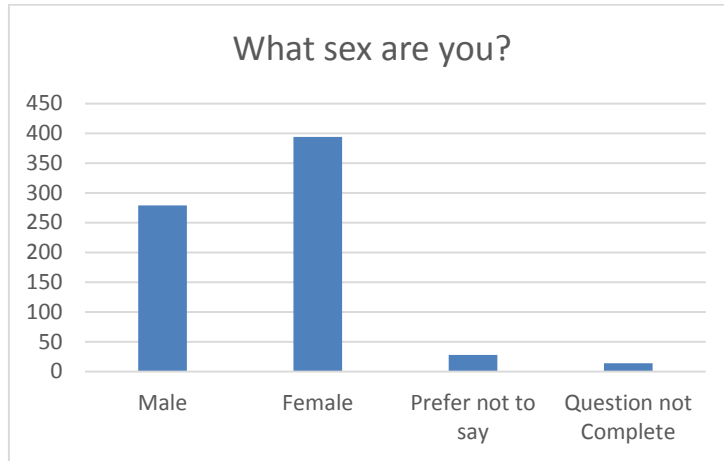
- Following closure of the consultation a further 13 responses were received in the post and 6 via email. These have not been included in the analysis.
- The Collaborative received notification from Royal Mail of failure to deliver a package. However, the date documented was outside of the consultation window.
- An empty, damaged envelope was received.

6 Equality monitoring

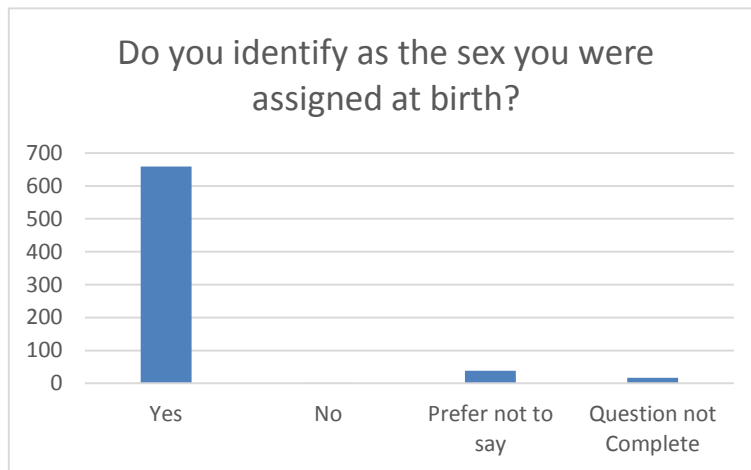
Equality monitoring questions accompanied the formal consultation response forms as well as the online response questionnaire. There were 715 completed equality monitoring forms returned as part of the consultation process.



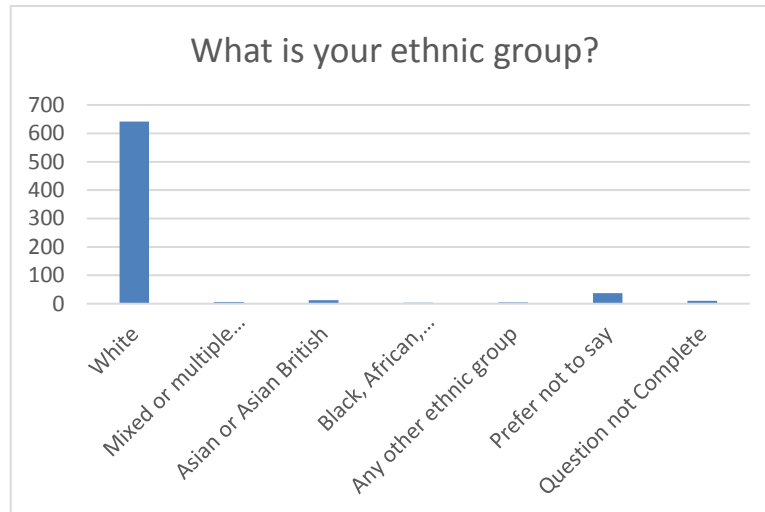
Category	Number of Respondents
16 to 24	17
25 to 34	85
35 to 44	117
45 to 54	148
55 to 64	141
65 to 74	109
75 or over	45
Prefer not to say	38
Question not complete	15
Total	715



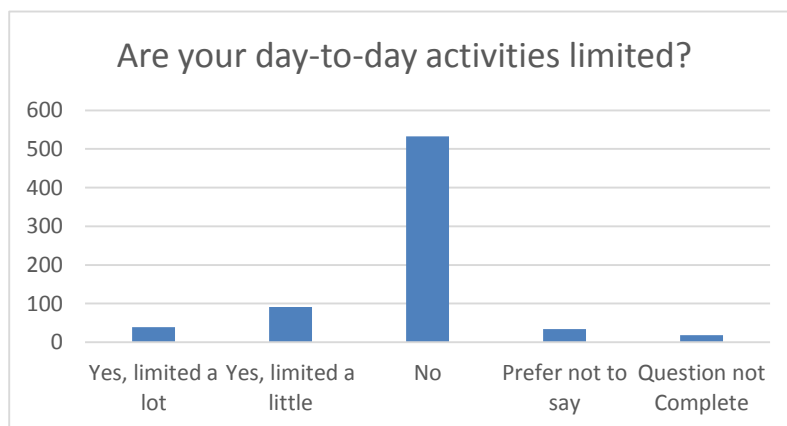
Category	Number of Respondents
Male	279
Female	394
Prefer not to say	28
Question not complete	14
Total	715



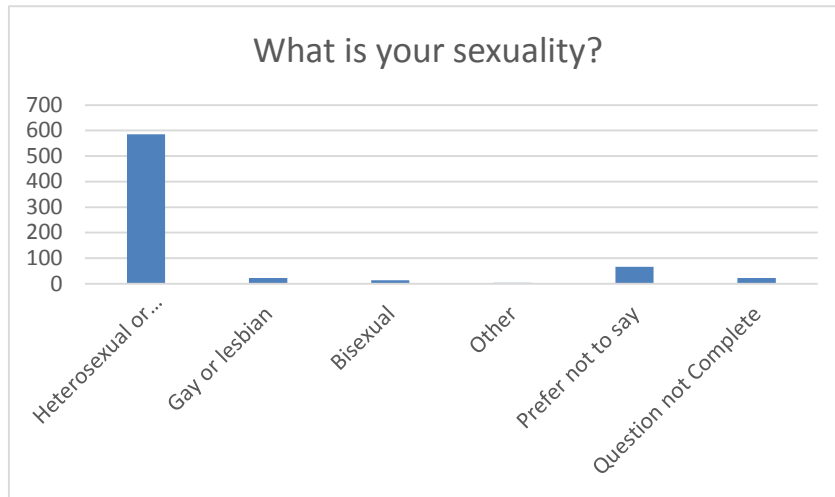
Category	Number of Respondents
Yes	659
No	1
Prefer not to say	38
Question not complete	17
Total	715



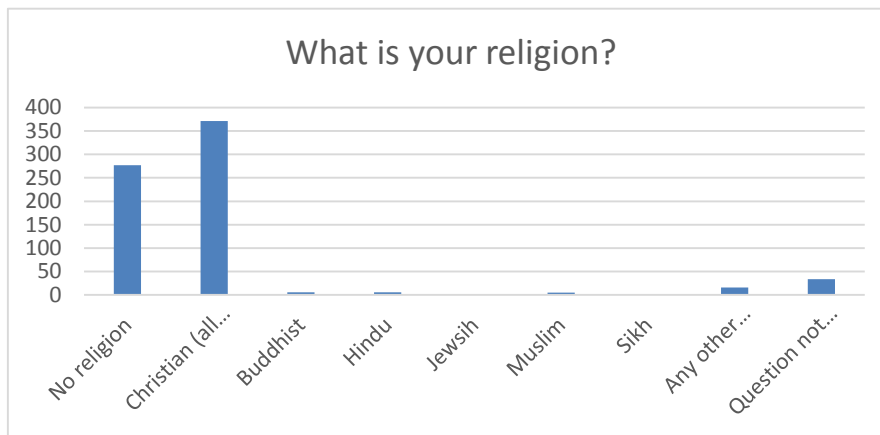
Category	Number of Respondents
White	642
Mixed or multiple ethnic groups	6
Asian or Asian British	12
Black, African, Caribbean or Black British	3
Any other ethnic group	5
Prefer not to say	37
Question not complete	10
Total	715



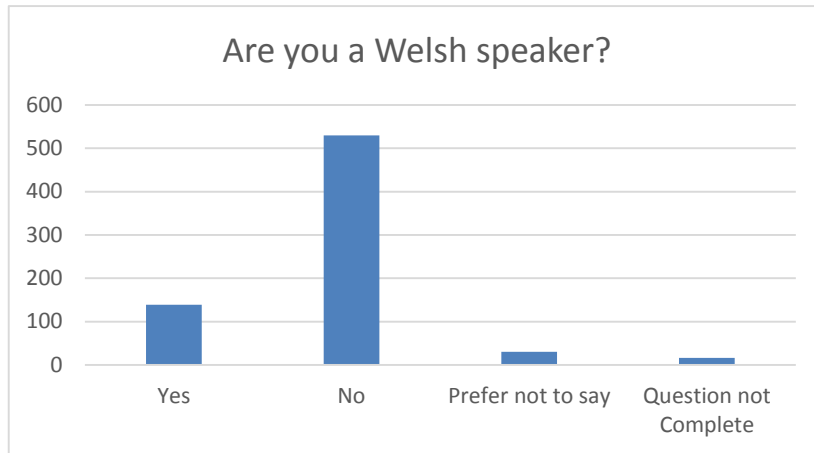
Category	Number of Respondents
Yes, limited a lot	39
Yes, limited a little	91
No	533
Prefer not to say	34
Question not complete	18
Total	715



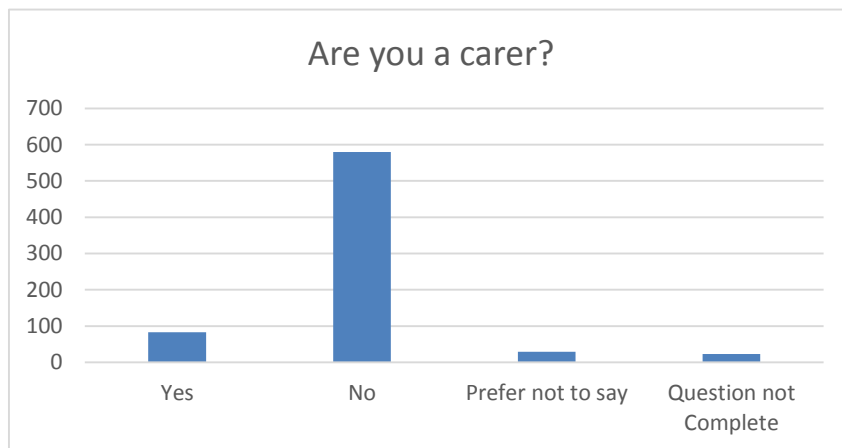
Category	Number of Respondents
Heterosexual or straight	586
Gay or lesbian	23
Bisexual	14
Other	3
Prefer not to say	66
Question not complete	23
Total	715



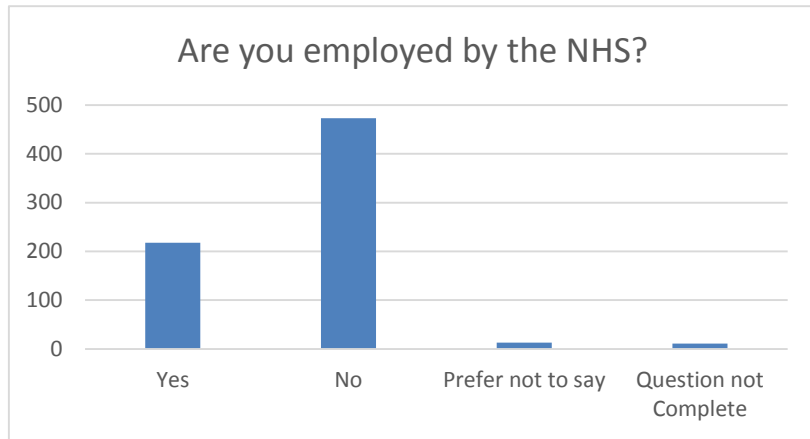
Category	Number of Respondents
No religion	277
Christian (all denominations)	371
Buddhist	6
Hindu	6
Jewish	0
Muslim	5
Sikh	0
Any other religion	16
Question not complete	34
Total	715



Category	Number of Respondents
Yes	139
No	530
Prefer not to say	30
Question not complete	16
Total	715



Category	Number of Respondents
Yes	83
No	580
Prefer not to say	29
Question not complete	23
Total	715



Category	Number of Respondents
Yes	218
No	473
Prefer not to say	13
Question not complete	11
Total	715



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Major Trauma Consultation Analysis of Responses against Framework

Author: Rachel Hennessy, Programme Director

Date: 16 March 2018

Version: 1a (Final)

Purpose and Summary of Document:

A framework for analysis of the consultation responses was developed to assist health boards in their decision making process. Consultation responses were analysed in accordance with the framework. This paper contains the resulting analysis of:

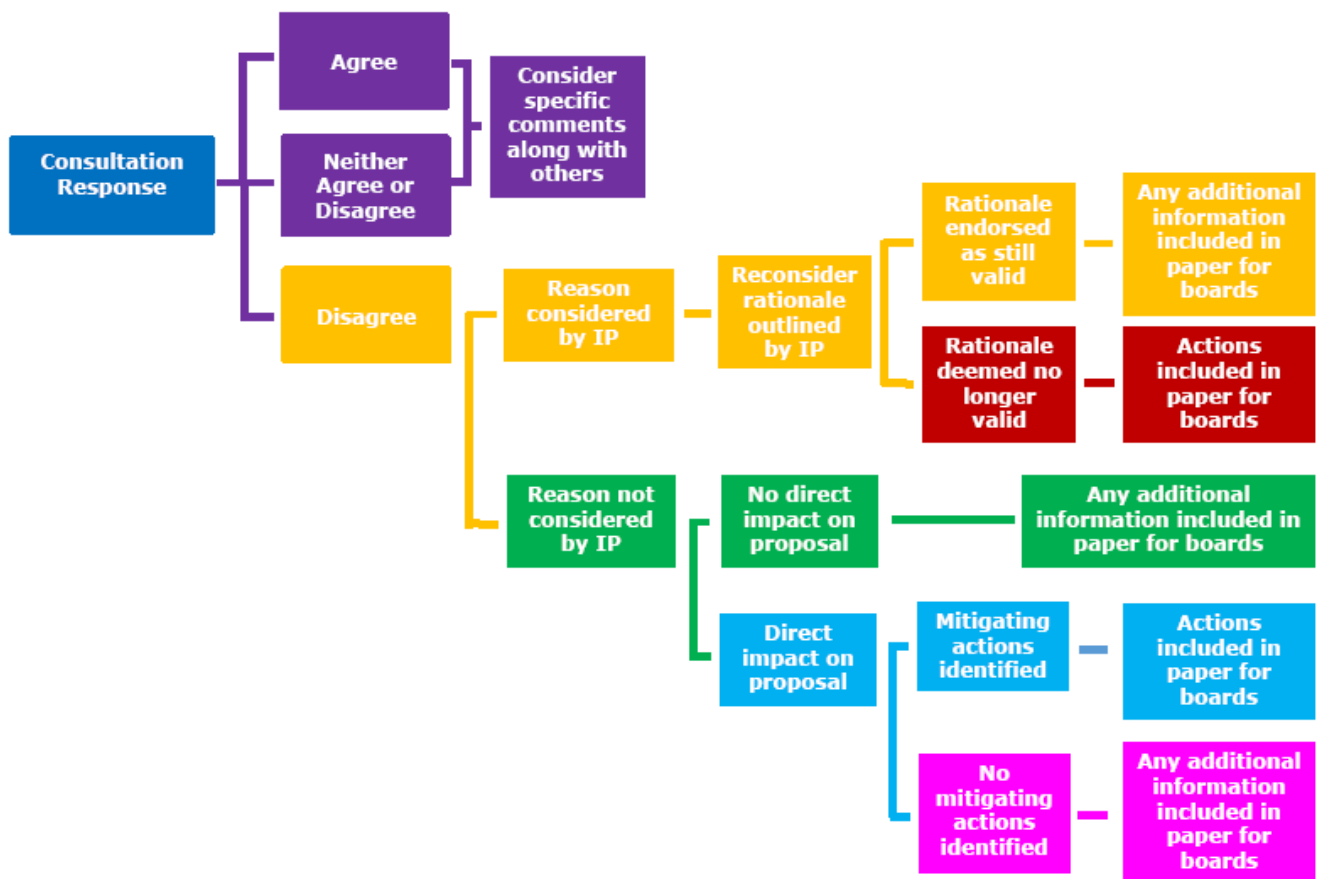
- comments made in response to consultation questions 1, 2 and 4 (Sections 1, 2 and 3)
- comments made in public meetings (Section 4)
- comments made in other formal groups and meetings (Section 5)
- other consultation responses received (Section 6)

Introduction

The Independent Panel considered an extensive suite of information prior to making their recommendations. As a result, health boards agreed, at their board meetings in September 2017, that the basis of the consultation would be the recommendations of the Independent Panel. The framework for analysis of the consultation responses was developed to assist health boards in their decision making process and an initial version was agreed at the Collaborative Executive Group (formerly the Collaborative Board) in January 2018.

In February 2018, in considering the initial analysis of responses using the framework, the framework was modified to require that, in cases where recommendations had been challenged for reasons already considered by the Independent Panel, the Panel’s rationale should be reconsidered and either endorsed as still valid or deemed to be no longer valid.

The framework is illustrated graphically below:



In applying the framework, care was taken to ensure that all comments made were considered on an equal footing regardless of the format in which they were submitted.

1 Consultation Question 1

The reasons given by individuals/groups for not agreeing with question 1 have been collated into themes outlined below and considered in line with the agreed framework.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Major trauma network (MTN) structure	The development of Trauma Units will lead to the closure of minor hospitals that might be seen as 'surplus to requirements'.	No	Direct	Yes	<p>North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency (A&E) units in North Wales, despite the fact that the Major Trauma Centre (MTC) is based in Stoke on Trent.</p> <p>If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients.</p> <p>Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the MTC or receive initial treatment at a trauma unit before being transferred to the MTC.</p> <p>The importance of local access, particularly for the frail and elderly, has been reinforced by the responses received and it is recognised that this should form an important consideration in relevant service models in the future.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Major trauma network (MTN) structure (Continued)	Need a major trauma network that covers all of Wales.	No	Indirect	Yes	North Wales participates in the West Midlands major trauma network and accesses the MTC in North Staffordshire. Patients in North Wales access a large number of their services from England, due to their highly specialist nature, and will continue to do so. The regions will work closely together so they can share best practice and learn from each other. There will be a major trauma and critical care network board which will include both North and South Wales.
	South Wales is big enough to need more than one centre.	No (but considered by the 2015 option appraisal)	Indirect	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	Travelling long distances could be unrealistic and detrimental to the health of the injured.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the MTC was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the MTC.
Access and proximity to Bristol	There should be investment in the trauma services available in Bristol.	No (but considered by the 2015 option appraisal)	Indirect	N/A	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
Lack of evidence	Is there sufficient evidence to demonstrate that the current situation disadvantages patients?	Yes	N/A	N/A	The rationale outlined by the Independent Panel has been reconsidered and endorsed.
	Major trauma is rare and has been treated well in the present centres.	Yes	N/A	N/A	There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	Location of a single centre for Thoracic Surgery will need to relate to the MTC.	No	Indirect	No	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site rather than the current two. A subsequent recommendation was made by an independent panel that that the site should be Moriston Hospital. The panel specifically considered the issue of colocation. The issue of colocation of the MTC and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the MTC.
Existing infrastructure	Physical infrastructure of any of the hospitals would not be able to cope unless there is radical though as to what moves out of any of the hospitals involved in the network.	No	Indirect	Yes	Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure (Continued)	Physical infrastructure of any of the hospitals would not be able to cope unless there is radical thought as to what moves out of any of the hospitals involved in the network. (Continued)	No	Indirect	Yes	<p>Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.</p> <p>In addition, it should be noted that the development of a major trauma network in the region will be taking place in the context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are broadly committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.</p> <p>Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work. Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Financial resources	Whether the anticipated costs of this development are being considered in comparison to other ways of spending the money to support other patient groups, comparing years of quality life added.	No	Indirect	N/A	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process.
Workforce requirements	How staff will be occupied if they are not dealing with a major trauma.	No	Direct	Yes	The MTC will meet the service specification set for staffing. It would be up to the MTC how they achieve this. The majority of staff involved in initial trauma care would have other duties in the hospital from which they can be rapidly released when a trauma is admitted. As in other MTNs it is likely that some substantial or even full time roles would be required to manage trauma patients - e.g. major trauma practitioners who coordinate and review major trauma patients in the MTC on a daily basis.

2 Consultation Question 2

The reasons given by individuals/groups for not agreeing with question 2 have been collated into themes outlined below and considered in line with the agreed framework.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	There should be more than one centre.	No (but considered by the 2015 option appraisal)	Indirect	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).
Access and proximity to Bristol	Proximity of South East Wales to Bristol – people living in South East Wales have access to the Network in Bristol.	No (but considered by the 2015 option appraisal)	Direct	No	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	Disagree with the location of MTC – the MTC should be in Swansea/Morrison. Report does not take into account travel times from West Wales and South Powys to Cardiff.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre. Providing this service on-site is a minimum requirement. The Independent Panel considered isochrone models of travel times for Morrison Hospital and UHW. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.
Strategic direction for Wales	Report fails to take into consideration access to English MTCs.	No (but considered by the 2015 option appraisal)	Indirect	Yes	The 2015 option appraisal agreed that, to support a population of approximately two million, the network would need to be supported by a major trauma centre based within the region. All major trauma networks in England and Wales maintain appropriate links with one another.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing Infrastructure	<p>Existing pressure on Morriston Hospital and UHW</p> <ul style="list-style-type: none"> • Existing pressure on UHW in relation to capacity required for the MTC. • Morriston has already purchased further land which could accommodate the MTC 	No	Direct	Yes	<p>Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if the University Hospital of Wales (UHW) becomes the MTC. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.</p> <p>Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:</p> <ul style="list-style-type: none"> • a front door Emergency Unit service with a major trauma team leader available 24/7 • increased critical care capacity in line with modelling for additional major trauma activity • additional theatre capacity • creation of a polytrauma unit. <p>There are plans being developed to address each of these, dependent on the outcome of consultation. Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing Infrastructure (Continued)	<p>Existing pressure on Morriston Hospital and UHW</p> <ul style="list-style-type: none"> Existing pressure on UHW in relation to capacity required for the MTC. Morriston has already purchased further land which could accommodate the MTC (Continued) 	No	Direct	Yes	<p>This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site.</p> <p>Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.</p> <p>Cardiff and Vale UHB is also working closely with other health boards on arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	Access and support for families.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked at the Independent Panel to outline how they would address support for families. Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST)	The impact of the major trauma network on the WAST and EMRTs.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. WAST and EMRTS presented at the Independent Panel and outlined the impact the MTC would have on them if located at either Morryston Hospital or UHW.
	EMRTS/Air Ambulance does not operate 24/7 and cannot operate at night.	No	Direct	No	At present, the Emergency Medical Retrieval Transfer Services (EMRTS) and Wales Air Ambulance operate a 12-hour service from 8AM to 8PM. If during this time it is dark, the Wales Air Ambulance charity helicopters are able to transfer patients between hospitals where approved landing sites with lights are available. Otherwise a specialist car known as a rapid response vehicle will attend the scene of the incident.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST) (continued)	EMRTS/Air Ambulance does not operate 24/7 and cannot operate at night. (continued)	No	Direct	No	Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority. Future operational arrangements of EMRTS and the Wales Air Ambulance are currently under review. Any constraints in coverage will apply irrespective of the location of the MTC. Further advice about operational procedures will be taken during implementation, informed by experience elsewhere in England and Wales.
Consultation process	Politically motivated decision.	No	N/A	N/A	Arrangements for an Independent Panel of experienced experts in the field of major trauma (predominantly from outside Wales) were agreed by health boards January 2017 (see section 3.3 of the main report). The Independent Panel undertook its deliberations and developed its recommendations free from political interference. The decision to consult on the recommendations was taken by health boards and health boards will make final decisions, informed by the report of the consultation.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Role of the Independent Panel	Concern that the independent panel is not independent and not in touch with patients.	No	N/A	N/A	Arrangements for an Independent Panel of experienced experts in the field of major trauma were agreed by health boards in January 2017. Panel members were selected to provide specific professional expertise. It was not part of the role of the panel to be representatives of patients. CHCs were represented at the meeting of the Independent Panel (see section 3.3 for additional information about the Independent Panel and its composition).
Population based decision	Should be a decision of the population.	No	N/A	N/A	A formal public consultation was undertaken from 13 November 2017 until 5 February 2018, in conjunction with CHCs and in accordance with Welsh Government guidance.
Needs based decision	Should look at the needs of the community, current services and demographics.	Yes	N/A	N/A	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Independent Panel considered evidence compiled across the life of the project, including travel, demographics and service provision.
Patient flow	Delays in repatriation may be exacerbated by the increased numbers of patients coming to UHW if it were the MTC.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Health boards will need to agree and implement a patient flow policy which supports 'automatic acceptance' at the centre and 'repatriation' as soon as possible.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Transport and infrastructure requirements	Road infrastructure and public transport requirements.	No	Indirect	Yes	<p>There are various patient transfer options that will be used with the proposed major trauma network. Travel times were considered by the Independent Panel. Public transport is not a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport. Nevertheless, it is recognised that there will be an impact on families and carers who might have to travel further while the patient is being treated in the Major Trauma Centre. It is important to note, however, that patients would typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated.</p> <p>Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.</p>

3 Consultation Question 3 and 4

The comment made in response to questions 3 and 4 have been collated into themes outlined below and considered in line with the agreed framework.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	The MTC should be in Morriston/Swansea	Yes	Direct	No	<p>The rationale outlined by the Independent Panel has been reconsidered and endorsed. The panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre. Providing this service on-site is a minimum requirement.</p> <p>The Independent Panel considered isochrone models of travel times for Morriston Hospital and UHW. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.</p>
	The MTC should not be at UHW				

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Major Trauma Network structure	There should be more than one MTC in the region	No (but considered by the 2015 option appraisal)	Indirect	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).
	There is a need to ensure that appropriate decisions are made about the location of trauma units	No	Direct	Yes	<p>The implementation of the network, including the redevelopment of the whole pathway of care is as important than the location of the MTC.</p> <p>The Independent Panel was asked to make a recommendation on the location of the MTC only, and not the trauma units. Identifying the MTC location first is helpful in informing where to locate the units.</p> <p>The remaining trauma units will need to be identified by individual health boards for their local area.</p> <p>There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered (e.g. in Powys).</p> <p>The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and proximity to Bristol	Parts of the region should use Bristol (and or other English centres) as their MTC	No (but considered by the 2015 option appraisal)	Indirect	N/A	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST)	There is a need to ensure that improvements are made in EMRTS, air ambulance services and ambulance services to ensure the time taken to transfer patients to the MTC is minimised on a 24/7 basis	No	Direct	No	At present, the Emergency Medical Retrieval Transfer Services (EMRTS) and Wales Air Ambulance operate a 12-hour service from 8AM to 8PM. If during this time it is dark, the Wales Air Ambulance charity helicopters are able to transfer patients between hospitals where approved landing sites with lights are available. Otherwise a specialist car known as a rapid response vehicle will attend the scene of the incident. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority. Future operational arrangements of EMRTS and the Wales Air Ambulance are currently under review. Any constraints in coverage will apply irrespective of the location of the MTC. Further advice about operational procedures will be taken during implementation, informed by experience elsewhere in England and Wales.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	There is a need to ensure that the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the MTC, parking etc.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked at the Independent Panel to outline how they would address support for families. Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.
Existing service provision	There is a need to ensure that there are adequate facilities at sites in the network other than the MTC	No	Direct	No	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency units in North Wales. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the MTC or receive initial treatment at a trauma unit before being transferred to the MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision (Continued)	There is a need to ensure that there is access to 24/7 interventional radiology at the MTC	No	Direct	Yes	<p>Interventional radiology is being addressed on a regional basis between Cwm Taf, AB UHB and C&V UHB. A plan has been developed to establish a 24/7 rota. This includes some additional appointments, one of which has already been made (start date August 2018). A Business Case is being developed for a hybrid theatre to support the interventional radiology work. In addition to this there is currently work ongoing in Cardiff to finalise the capital plan for an additional single plane interventional suite in order to ensure that there is sufficient room time available across the working week to support regional working.</p> <p>At the point where the major trauma centre is in place there will need to be considerations as to how the rota works to ensure immediate availability of the appropriate staff. This will include extending the on call arrangements for the nurses and radiographers, which has been identified as part of the major trauma case.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	There are concerns about equity of access in West Wales and other rural areas	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the MTC was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the MTC.
Existing infrastructure and services	There are concerns about the impact on existing services at the location of the MTC through additional workload	No	Direct	Yes	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if the University Hospital of Wales (UHW) becomes the MTC. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients. Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service: <ul style="list-style-type: none"> • a front door Emergency Unit service with a major trauma team leader available 24/7 • increased critical care capacity in line with modelling for additional major trauma activity

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure and services (Continued)	There are concerns about the impact on existing services at the location of the MTC through additional workload (Continued)	No	Direct	Yes	<ul style="list-style-type: none"> • additional theatre capacity • creation of a polytrauma unit. <p>There are plans being developed to address each of these, dependent on the outcome of consultation. This work is being progressed within the context of an overall refurbishment and internal service reconfiguration programme for the UHW site. This will be subject to submission of a Business Case to Welsh Government. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.</p> <p>Cardiff and Vale UHB is also working closely with other health boards on arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce	There are concerns about the network's ability to ensure adequate staffing and adequate training for staff	No	Indirect	Yes	<p>A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.</p> <p>A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.</p>
	There are concerns about the ability to recruit and retain staff away from the MTC				

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Financial resources	There are concerns about the availability of adequate funding to implement the network	No	Indirect	N/A	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process.
MTN structure	There are concerns about the downgrading of services away from the MTC	No	Direct	Yes	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency (A&E) units in North Wales, despite the fact that the Major Trauma Centre (MTC) is based in Stoke on Trent. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the MTC or receive initial treatment at a trauma unit before being transferred to the MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure (Continued)	There are concerns about the downgrading of services away from the MTC (Continued)	No	Direct	Yes	The importance of local access, particularly for the frail and elderly, has been reinforced by the responses received and it is recognised that this should form an important consideration in relevant service models in the future
Existing infrastructure	There are concerns about the capacity of estates, facilities and support services at UHW, particularly in relation to the situation at Morriston	No	Indirect	Yes	Cardiff and Vale UHB is working closely with other health boards on the following: <ul style="list-style-type: none"> • A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public. • Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure	There are concerns about the capacity of estates, facilities and support services at UHW, particularly in relation to the situation at Morriston	No	Indirect	Yes	Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.
Existing service provision	There are concerns about lack of co-location with thoracic surgery	No	Indirect	No	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site (Morriston Hospital), rather than the current two. The issue of colocation of the MTC and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision (Continued)	There are concerns about the potential for the burns unit to move to Cardiff	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together. Burns and plastics is already a regional service provided from Morriston Hospital.
Social and economic impact	There are concerns about the social and economic impact of further investment in Cardiff at the expense of other areas	No	Indirect	No	This was out of the scope of the consultation.
	There are concerns about this being part of a wider agenda to move services from Swansea to Cardiff				
Consultation process	There are concerns about the degree to which the consultation has been genuine and extensive	No	Indirect	No	The consultation process was reviewed against consultation and engagement guidance by health boards and CHCs at mid point. No further changes were advised. Conscientious consideration was given to the outcomes of the consultation process at all relevant times.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process (Continued)	Further information would have been welcome in relation to how well the network is working in North Wales	No	Indirect	No	It is considered that the information provided during the consultation was adequate.
	Further information would have been welcome in relation to the geographical spread of incidents resulting in major trauma in recent years	Yes	Indirect	No	
Implementation of the Major Trauma Network	There is a need to ensure that there is an adequate focus on rehabilitation (including minimising waiting times)	Yes	Direct	No	The need to develop appropriate and robust rehabilitation pathways as part of the implementation of the Major Trauma Network is accepted.
	There is a need to ensure that there is excellent communications between professionals and with the public during the implementation and delivery of the network	No	Indirect	No	The need for a clear communication strategy is accepted.
	There is a need to ensure that the therapy professions are appropriately involved in the implementation of the network	No	Indirect	No	Implementation will need to involve professional bodies, as appropriate.
	There is a need to ensure that digital solutions are used where possible	No	Indirect	No	The need to make appropriate use of technology in implementing the Major trauma Network is accepted.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Implementation of the Major Trauma Network (Continued)	There is a need to ensure that implementation proceeds quickly once the decision has been made	No	Indirect	No	An appropriate and measured implementation plan will be developed.
	There are concerns about why it has taken this long to develop proposals for a major trauma network for the region	No	Indirect	No	This was out of the scope of the consultation.

4 Responses from public meetings

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	The location of the trauma units and rehabilitation pathway is more critical than the location of the MTC.	No	Direct	Yes	<p>The implementation of the network, including the redevelopment of the whole pathway of care is as important than the location of the MTC.</p> <p>The Independent Panel was asked to make a recommendation on the location of the MTC only, and not the trauma units. Identifying the MTC location first is helpful in informing where to locate the units.</p> <p>The remaining trauma units will need to be identified by individual health boards for their local area.</p> <p>There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered (e.g. in Powys).</p> <p>The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.</p> <p>The need to develop appropriate and robust rehabilitation pathways as part of the implementation of the Major Trauma Network is accepted.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Clarity required over the exact geographical location of the major trauma network – relates to Powys.	Yes	Indirect	No	At the boundaries of the network, ambulance crews will assess patients and, if the services of a Major Trauma Centre are required, patients will be taken by ambulance or helicopter to an appropriate Major Trauma Centre, which may be the proposed centre in South Wales or one in England.
	Impact of the MTC and MTN on other hospital sites including SCC, Morriston, Prince Charles Hospitals.	No	Indirect	No	Fewer than 1% of the treatment provided in emergency departments is major trauma.
Existing services	Waiting times for neuro surgery are too long.	No	Indirect	Yes	Waiting times for Neurosurgery are longer than we want them to be but have been steadily reducing since the Summer supported by improved repatriation and some additional theatre capacity at UHW (201 patients were waiting over 36 weeks at the end of August, down to 81 at the end of January). The service has plans to reduce waiting times further through 2018/19, with the support of WHSSC. A review of Neurosciences is due to conclude shortly which will inform longer term planning.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing services (Continued)	Difficulties with moving patients into community settings within Cardiff and Vale.	No	Indirect	Yes	Other than through improving survival, the implementation of the major trauma network will not impact on the need for care in community settings in Cardiff and Vale. Patients will be repatriated to their home health board before requiring community based care.
	The waiting time for residents needing local emergency department services if the Major Trauma Centre comes to the University Hospital of Wales or Morriston Hospital.	No	Direct	No	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing services (Continued)	Need to look at what services could come off the UHW site, recognising that travel to the site was a problem.	No	Direct	Yes	Cardiff and Vale UHB is working closely with other health boards on a review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.
	Concern that Burns and Plastics will be moved from Morriston.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Whilst it is not critical that the burns and plastic centre is on the same site as the major trauma centre, it is important that UHW and Morriston Hospital work together.
	Clear plan of how existing A&E units will be maintained.	No	Direct	No	Fewer than 1% of the treatment provided in emergency departments is major trauma. The implementation of the recommendations for a major trauma network will not change the role of local emergency units that are not designated as trauma units within the network.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Role of EMRTS/WAST	Role of EMRTS and air ambulance needs is critical and needs to be strengthened.	Yes	Direct	Yes	As part of the next phase, further work will be undertaken to develop pathways and the commissioning framework.
	The impact on ambulances if the service is consolidated to UHW.	Yes	Indirect	No	From an emergency standpoint, these patients already exist and are already managed by WAST and EMRTS/Wales Air Ambulance on a day to day basis. The actual increase in ambulance work is only likely to reflect the small number of patients who travel a short additional distance to reach an MTC, rather than being taken to their local hospital.
Patient flow	Delays in repatriation/step down resulting in issues with patient flow.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Health boards will need to agree and implement a patient flow policy which supports 'automatic acceptance' at the centre and 'repatriation' as soon as possible.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Financial resources	Need to consider if there is enough money to develop the MTC and ensure cover 24/7 365 days.	Yes	Direct	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Proposed financial information was provided by both candidate sites. WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	Staffing available to support the proposal or will they need to relocate.	No	Indirect	Yes	<p>A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.</p> <p>A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	Need to ensure that there is adequate allocated parking to ensure that families are able to park easily and facilities at the MTC for families to stay on site.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Independent Panel requested candidate sites to answer this question. Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.
Transport and road infrastructure requirements	Need for improved public transport.	No	Indirect	Yes	There are various patient transfer options that will be used with the proposed major trauma network. Travel times were considered by the Independent Panel. Public transport is not a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport. Nevertheless, it is recognised that there will be an impact on families and carers who might have to travel further while the patient is being treated in the Major Trauma Centre. It is important to note, however, that patients would typically only spend a short period of time in the MTC itself, before being repatriated. Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.

5 Responses from other formal groups/meetings

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN Structure	More emphasis should be given to the establishment of the network rather than the location of the MTC and identifying the location of the trauma units as soon as possible to provide reassurance to the public.	No	Direct	Yes	<p>The implementation of the network, including the redevelopment of the whole pathway of care is as important as the location of the MTC.</p> <p>The Independent Panel was asked to make a recommendation on the location of the MTC only, and not the trauma units. Identifying the MTC location first is helpful in informing where to locate the trauma units.</p> <p>The remaining trauma units will be identified by individual health boards for their local area, although there will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered.</p> <p>The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and proximity to Bristol	Locating the service at UHW appears illogical from a geographical (travel time perspective) when Bristol is such a short distance from Cardiff.	No (but considered by the 2015 option appraisal)	Direct	N/A	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
Existing service provision	Significant gaps in community neurorehabilitation across the region (ABM).	No	Indirect	No	Community neuro-rehabilitation will need to be addressed. This issue does not call into question the recommendations of the Independent Panel.
	Problems with hospital flow, communication and discharge processes from regional neurorehabilitation unit based at Neath port Talbot Hospital. Need for significant investment into an in-reach community rehabilitation service.	No	Indirect	No	This issue will need to be addressed. This issue does not call into question the recommendations of the Independent Panel.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	How are problems with interventional radiology being addressed.	No	Direct	Yes	Interventional radiology is being addressed on a regional basis between Cwm Taf, AB UHB and C&V UHB. A plan has been developed to establish a 24/7 rota. This includes some additional appointments, one of which has already been made (start date August 2018). A Business Case is being developed for a hybrid theatre to support the interventional radiology work. In addition to this there is currently work ongoing in Cardiff to finalise the capital plan for an additional single plane interventional suite in order to ensure that there is sufficient room time available across the working week to support regional working. At the point where the major trauma centre is in place there will need to be considerations as to how the rota works to ensure immediate availability of the appropriate staff. This will include extending the on call arrangements for the nurses and radiographers, which has been identified as part of the major trauma case.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Infrastructure requirements	Should discussion around capital work for UHW be considered as part of wider discussions with Welsh Government regarding the redesign of UHW.	No	Indirect	Yes	Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and expansion internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site. A Business Case will be submitted to Welsh Government later this year, reflecting a phased development plan.
Financial resources	Need for detailed costs and to understand what money will health boards contribute towards the MTC and how WG will support this.	No	Direct	Yes	WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government.
	National approach to commissioning, new SLAs, recognising that this would not be all new work for C&V.	No	Direct	Yes	WHSSC has been identified to lead the development of a commissioning framework for the major trauma network.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	The impact of the MTC and the MTN on the ability to recruit and retain staff across the network, training requirements, placements for defence, improve skill sets, rotation of staff across sites.	No	Direct	Yes	<p>A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.</p> <p>A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.</p> <p>Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	Support for families of patients being transferred by air ambulance who will arrive 4-5 hours later.	No	Direct	Yes	Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC. A new charity-funded building providing accommodation and facilities for families whose children are receiving treatment in UHW has recently been opened. Some accommodation is also available on the UHW site for families of adult inpatients.
Transport and road infrastructure requirements	Transport issues will need to be addressed for people visiting the MTC.	No	Indirect	Yes	Patients will typically only spend a short period of time in the MTC itself, before being repatriated. Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.
Insufficient information	Insufficient information about the plans and investment available to support this development. More detail to inform how the panel felt this could be delivered, infrastructure changes and additional investment in staff.	No	Indirect	Yes	If the proposals are agreed, the next level of detail will be developed as part of detailed implementation plans.

6 Additional responses to the consultation (social media, letters and emails)

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location of MTC	Geographical position of Swansea.	Yes	Direct	No	<p>The rationale outlined by the Independent Panel has been reconsidered and endorsed. Information considered by the Independent Panel included the geography and demographics of Wales and the panel concluded that transfer time to the MTC was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network</p> <p>The Independent Panel concluded that with the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the major trauma centre.</p>
	Swansea has a purpose built helipad.				
	Road links in Swansea and links to M4 Mid South Wales.				
	Capacity to expand at Morriston.				
	Vital response time for victims from western end of region cannot be safely met by locating MTC at Cardiff, services should be within the 'golden hour' - within one hours drive of treatment.				
Consideration should be given to the disposition of population throughout the region and not only in urban areas.					

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Proximity to Bristol	Locating the service at UHW appears illogical from a geographical (travel time perspective) when Bristol is such a short distance from Cardiff. The population of the south east have access to the MTN and centre in Bristol.	No (but considered by the 2015 option appraisal)	Indirect	No	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
	Has consideration been given to the alternative proposition of joining south east Wales to a major trauma network centre located in Bristol with more western parts of south wales served by a major trauma network that is based on a major trauma centre located in Swansea. Should be a formal relationship with Bristol network.				
MTN structure	There could be a strong argument for either West Wales Mid Wales or Valleys body to take on the leadership role but this appears not to have been explored.	No	Indirect	No	As the most major unit that was not recommended to be the location of the MTC, Murryston was recommended by the Independent Panel to have leadership role. The rationale of the Independent Panel has been reconsidered and endorsed.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Why not change Neath Port Talbot hospital to major trauma/orthopaedic unit leaving Morriston, Singleton and Bridgend to deal with the rest. Neath is a beautiful hospital with not a lot or no A&E. Carmarthen would be better for West Wales. All major towns need this located at their A&E.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Morriston Hospital in Swansea and University Hospital of Wales, Cardiff were the only two hospitals in the region that could maybe meet the criteria for a major trauma centre. This is due to the specialist nature of the service and the need for it to be located with other specialist services.
	Further clarity required regarding the exact scope and number of trauma centre [units] - is not clearly described in the consultation document. Are there any plans to have a trauma unit within Powys? Powys is sadly lacking any major medical unit or A&E department.	No	Direct	Yes	The remaining trauma units will need to be identified by individual health boards for their local area. Powys secures its secondary care services from neighbouring District General Hospitals. Powys tHB will work with each of these health boards and trusts in relation to trauma unit provision. Powys tHB will also be focusing on the provision of rehabilitation services for people as close to their home as possible. The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Advice from the group be further tested by 1. Assessing the reliance of an England and Wales chain of MTUs comprising Morriston rather than UHW 2. looking further at the accessibility indicators for both road and air conveyed patients from S Wales if Morriston was relied upon.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Information considered by the Independent Panel included the geography and demographics of Wales. The Independent Panel concluded that there should be an MTU within the region and that this should be at UHW.
	UHW and Morriston should have equal status.	Yes	Direct	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).
	Concern model proposed is more of hub and spoke model rather than what may be understood by a network.	No	Indirect	No	The model proposed adopts the arrangements used by major trauma networks across England and Wales.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Has consideration been given to the resources and facilities required including ITU beds, IT infrastructure, support services e.g. radiology	No	Direct	Yes	Morrison Hospital and UHW provided high level costs for each site to meet the designation criteria for a MTC. If supported, UHW will develop a detailed business case which will include an assessment of the resources available and what is required to deliver a major trauma centre. Any additional resources required will be required over a period of time.
	How will proposals work given the configuration of burns & plastics and neurosurgery.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together. Burns and plastics is already a regional service provided from Morrison Hospital. Neurosurgery is already a regional service provided from UHW. Patients are already managed across the two sites relating to their primary needs.
Existing service provision	May be unclear to the general public the level of accident service hospitals across South Wales presently offer in respect of serious injuries.	No	Indirect	Yes	To accompany any implementation plan and information for the public on the use of the MTC and major trauma network, clear guidance will be provided outlining the range of Accident and Emergency services available throughout the region.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision (Continued)	Moving neurosurgery back to Morriston hospital to sit alongside burns unit would not be a major problem if other factors were judged to be more strategically important. Develop a new department for neurosurgery and paediatric major trauma aligned to a centre in Morriston.	No	Indirect	No	The location of neurosurgery at UHW was previously the subject of a formal consultation based on the best available evidence.
	Fear that accident services to west of Bridgend will increasingly struggle to recruit senior consultants and nursing staff leaving West Wales hospitals.	No	Indirect	Yes	A workforce plan, including any arrangements for staff rotation across the network, will be developed as part of the business case for the major trauma centre and network. The establishment of the network will improve the ability of NHS Wales to recruit and retain relevant staff.
	Importance of continuing cross border services into England for residents of East Radnorshire who are long distances from proposed units and presently access much of their hospital care in England.	No	Direct	Yes	The consultation proposed that where patients currently access the trauma units in England, they will continue to do so.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	Concern that Burns and Plastics will be moved from Morriston.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together.
	How will the recent decision to centralise thoracic surgery in Morriston impact.	Yes	Indirect	No	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site (Morriston Hospital), rather than the current two. The issue of colocation of the MTC and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	Interested to see if the plans for Hywel Dda have been taken into account, with the proposed closures it is likely to put added stress on other major hospitals in the area.	No	Indirect	No	Such plans may impact on the future configuration of Accident and Emergency units, but will not be material in relation to the overall recommendations of the Independent Panel.
	Upgrade Bronglais; we need better hospitals to cope with treatments, operations and emergencies before major trauma units sited miles away.	No	Indirect	No	View to be shared with Hywel Dda Health Board.
	Aberystwyth needs a nurse led walk in centre.	No	Indirect	No	View to be shared with Hywel Dda Health Board.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure	Not clear the impact on UHW, it is already a congested site, this may increase pressure on UHW for mainstream treatment for the local population.	No	Direct	Yes	<p>Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.</p> <p>Cardiff and Vale UHB is working closely with other health boards on the following:</p> <ul style="list-style-type: none"> A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure (Continued)	Not clear the impact on UHW, it is already a congested site, this may increase pressure on UHW for mainstream treatment for the local population. (Continued)	No	Direct	Yes	<ul style="list-style-type: none"> Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work. Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.
	Morrison Hospital has acquired further land upon which additional clinical capacity can be placed and already has it helicopter landing site within its grounds.	No	Indirect	No	This observation does not call into question the rationale of the Independent Panel in recommending that the MTC should be at UHW. UHW has an existing helipad which provides direct access to the Emergency Unit without the need for an additional transfer. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure (Continued)	Neither Morriston or UHW could cope with the extra traffic. Morriston cannot cope with the demands on A&E as it is and if Princess of Wales were to move then it will only make things worse	No	Direct	No	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.
Infrastructure requirements	Appropriate infrastructure and resources will need to be provided. Modelling work should be undertaken in sufficient detail ahead of taking a decision to progress with the proposed trauma network and not left to be worked out until after the decision has been taken. This will need to cover what facilitates are resources will need to be provided at UHW. It may also need to be determined if other facilities/services may need to be relocated to free up space for facilities required for the MTC. This should be understood before any decision is finalised.	No	Direct	Yes	Morriston Hospital and UHW provided high level costs for each site to meet the designation criteria for a MTC. If supported, UHW will develop a detailed business case which will include an assessment of the resources available and what is required to deliver a major trauma centre. Any additional resources required will be required over a period of time.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and Support for Families	It is not just about the patient but also their family: e.g. Cost of parking at UHW/Expenses for relatives.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked to outline how they would address support for families at the Independent Panel. Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.
Strategic direction for Wales	No political guidance was given regarding the wider strategic direction e.g. should broader economic and social considerations have been taken into account and should Welsh government have chosen to see any major trauma centres sites in south Wales as needing to complement existing chain of MTCs operated by NHS England – upon which Welsh residents currently rely.	No	Indirect	Yes	Out of scope - Wales is a devolved nation.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Scope of Independent Panel	Terms of reference were too limited – effectively requiring the Panel to assess the current clinical capabilities of two hospitals. They should have advised whether South Wales needs to have a MTC and if so to assess where this would be best located in order to complement existing range of MTCs in England and so strengthen the major trauma coverage for populations within England and Wales as a whole.	No	Direct	Yes	An option appraisal in 2015 agreed that, to support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a major trauma centre located within the region. This ruled out the option of relying on services from the Bristol major trauma centre. The potential for a dual site solution was considered, but subsequently eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.
Data issues	Data about incidence and volumes of major trauma shows equal activity at Morriston and UHW.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed.
	Travel time data needs to be in the public domain in much more detail.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Travel time was not the primary consideration in recommending UHW as the MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Financial resources	Additional financial resources need to be made available to prevent health boards from suffering further financial pressure.	No	Direct	Yes	Proposed financial information was provided by both candidate sites. WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government.
	The financial and opportunity cost of creating a south wales unit for what is a small number of people who may receive a higher level of care than they presently get from Bristol because of their distance from Bristol needs to be weighed against all other current unmet demands upon existing scarce NHS resources.	No	Indirect	No	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process. The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	Additional staff resources will need to be considered; rotas need to be drawn up and suitably staffed. Needs to be reassurance this has been modelled.	No	Direct	Yes	<p>A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.</p> <p>A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.</p> <p>Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.</p>

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	Adequate training, staffing, resources to support air ambulance if they need to make further/longer journeys.	No	Direct	Yes	If the proposal is supported, EASC as the commissioner for Welsh Ambulance Service trusts and Emergency Medical Retrieval and Transfer Service will identify detailed training requirements for the workforce. This will then be part of the commissioner intentions for the service.
	Important to understand the implications for attracting doctors in training to Wales as a result of the proposals and to quantify if this means trainee posts being relocated from some hospital sites; possible loss of trainees from Morriston should the MTC go to UHW.	No	Direct	Yes	A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network. A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements (Continued)	Important to understand the implications for attracting doctors in training to Wales as a result of the proposals and to quantify if this means trainee posts being relocated from some hospital sites; possible loss of trainees from Morriston should the MTC go to UHW. (Continued)	No	Direct	Yes	Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.
Impact on EMRTS/Air Ambulance	Accessibility of air ambulance when Swansea based helicopter to committed elsewhere.	No	Direct	No	This is already a constraint and would remain so however trauma services are configured.
	Has appropriate consideration been given to the provision of sufficient ambulance capacity and has this been modelled to support the decision.	No	Direct	Yes	EMRTS presented at the Independent Panel. Most patients already require transfers by ambulance or a rapid response vehicle. WAST has considered the impact of the changes from the proposal. If the proposal is supported, EASC as the commissioner for Welsh Ambulance Service trusts will do detailed modelling work which will form part of their future commissioning intentions from health boards.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Impact on EMRTS/Air Ambulance (Continued)	May need to re-assess the way in which ambulance calls are currently prioritised given that the proposal will rely on patients being transferred on occasions from one hospital to another within the network.	No	Indirect	Yes	This will form part of the implementation plan.
Decision making Process	Were the options considered subject to a Health Impact assessment (HIA) as part of the work carried out by the panel in arriving at its recommendations. Suggestion that one is carried out before recommendations are progressed.	No	Direct	No	For consideration at next stage of the project. The establishment of a major trauma network will contribute to the delivery of aims of the Wellbeing of Future Generations (Wales) Act 2015, by supporting the delivery of a 'healthier Wales' and the goal to "develop a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood".

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process	SHA concerned the terms of the consultation, might be seen as implying a level of approval by NHS Wales of the recommendations of the expert group. This perception is aided by the apparently unintended public release of the conclusions of the expert group. Would have been more appropriate if the public had been invited to comment upon how the expert group had assessed the pros and cons of three options – Bristol, UHW and Morriston.	No	Indirect	No	The report of the Independent Panel was considered by boards in public in September 2017. Boards accepted the recommendations subject to formal public consultation. The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC. The 2015 option appraisal workshop included health boards and the Welsh Ambulance Service Trust. Patient representatives from voluntary and charity support groups from across the region were invited. The CHCs were also invited to observe. A consultation exercise has been conducted that meets the requirements of the Welsh Government guidance.
	Final details for the consultation only became clear in October, concern not widely publicised and great reliance on social media and Christmas period.	No	Indirect	NO	The timescale for the consultation was agreed with CHCs. A period of 12 weeks (as opposed to the required eight) was adopted to allow for the impact of the Christmas period.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process (Continued)	Roles of two sites not clearly defined in layman's terms.	No	Indirect	No	The roles of the MTC and trauma units were clearly described in the consultation material.
	Concerns regarding the Gunning principles.	No	Direct	Yes	In line with the Gunning principles, the consultation process was reviewed against consultation and engagement guidance by health boards and CHCs at mid point. No further changes were advised. Conscientious consideration was given to the outcomes of the consultation process at all relevant times.
	Insufficient information to base a decision on the location of the MTC.	No	Direct	Yes	Web page provided the technical documents considered by the Independent Panel. All the relevant criteria on which to base the decision were made clear during the consultation process.
	Unanswered questions relating to social and welfare aspects for patients and relatives.	No	Indirect	No	To be considered as part of implementation. Requirements are set out in a Welsh Health Circular, as for other tertiary services.
	Not enough publicity has been given to the public meetings or the consultation. Request for extension/rerun of consultation process due to poorly advertised/attended public meetings.	No	Direct	No	Health boards ran a public meeting in each district. Individuals/organisations were able to respond to the consultation via Freepost, online, email. Each health board agreed the local arrangements with its local CHC.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process (Continued)	Information received from the older persons commissioner on engagement and consultation with older people.	No	Direct		Information noted. Consultation process was considered to be appropriate.
Implementation of the MTN	Whatever service results it is fully accessible for people who are deaf or have hearing loss. The care they receive and co-produce is as dignified and clinically optimal as that of a hearing person. Currently a stream of work going around on accessibility for people with sensory loss in each health board and it is a priority each health board reports back to WG on.	No	Indirect		Requirements for equality of access apply to all services.
	The Royal College of Midwives should be part of the major trauma network (as trauma is the leading cause of death in people under the age of 45).	No	Indirect	No	Implementation will need to involve professional bodies, as appropriate.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Implementation of the MTN	Effectiveness of moving to the model advocated will need to be monitored. Has consideration been given to deriving an appropriate methodology by which this can be done should the network be established. It would be necessary to assess the effectiveness of the network on outcomes from the moment of trauma occurring rather than simply the time of arrival at the relevant hospital.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. TARN is an outcome based monitoring tool, used for management of major trauma across England and Wales. All health boards subscribe to this.
	The need for a clear communication strategy once a decision is taken on the way forward. Effective programme for informing communities in region how the proposals will work and what they will mean to them in practice.	No	Indirect	No	The need for a clear communication strategy is accepted.
Other	Are we having a helicopter for this service?	Yes	Direct	No	The Emergency Medical Retrieval and Transfer Service (EMRTS), are supported by the Air Ambulance and have been included through the project



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Major Trauma Network for South and West Wales and South Powys Equality Impact Assessment Evidence Document *Post Consultation Analysis*

Author: Rachel Hennessy, Programme Director

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Purpose and Summary of Document:

This technical document has been produced to provide background evidence to support information provided within the NHS Wales Health Collaborative public consultation on the development of a major trauma Network for South and West Wales and South Powys.

This document is meant as a reference guide, it does not provide exhaustive detail. It aims to provide an overview of our findings to date about what groups within our population may be affected by our proposals and in what way. It is a living document and will be added to by information gathered during consultation and ongoing through all stages up to and including delivery of services where actual impact will be monitored.

This document builds on the initial EqIA developed prior to the consultation and includes the post consultation analysis and considers findings from the consultation exercise which commenced 13th November 2017 and concluded the 5th February 2018.

1 Background

In late 2014, the Health Collaborative was asked by the Chief Executive Officers (CEOs) to develop a service model for a major trauma network for south Wales. A Project Board was established, supported by a clinical reference group (CRG). Both groups comprised representatives from each of the Health Boards in the region, Welsh Ambulance Service Trust (WAST), Emergency Medical Retrieval and Transfer Service (EMRTS) and Welsh Health Specialist Services Committee (WHSSC). North Wales is already part of the West Midlands Major Trauma Network with the major trauma centre in North Staffordshire. North Powys also participates in the West Midlands Major Trauma Network

The service model for major trauma services for adults and paediatrics was developed by the Clinical Reference Group (CRG) in line with the standards for major trauma and was approved by the Project Board in May 2015. A detailed model for supporting rehabilitation was also developed through a wide stakeholder group and supported by all Health Boards. The standards for major trauma have been written by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Clinical Excellence (NICE) and say what services should be available for a patient with major trauma: From the response to an accident, transfer to a major trauma centre or trauma units, immediate treatment and urgent surgery, ongoing medical care and further surgery, and rehabilitation. The standards also say what services should be in a major trauma centre, trauma units, and how the network should work.

1.1 The case for change

'Major Trauma' is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity (CAG 2010). Less than 0.2% (2/1000 patients) of the people attending their local emergency department will have a major trauma. In 2016/2017 in South Wales, approximately 1,234 people attended a local emergency department with a major trauma, compared with 617,000 people attending emergency departments in total (www.statswales.gov.wales). Major trauma cases are complex and due to the small number it is a challenge for hospital staff to maintain their highly specialist skills in trauma care. The data used to develop the proposed service model is based on 2014 TARN (The Trauma Audit and Research Network) data. The data available at this time did not cover all south Wales hospitals and Emergency Medical Retrieval and Transfer Service (EMRTS) was not in place and therefore was likely to under-represent the true number of major trauma patients in the region, however it should be noted that numbers are still small.

A number of reports have been produced by organisations such as the National Confidential Enquiry into patient Outcome and Death (NCEPOD), National Institute of Clinical Excellence (NICE), the Department of Health Clinical Advisory Group and the National Audit Office, outlining the provision of trauma care across England, Northern Ireland and Wales. The reports talk about poor care and outcomes received by patients resulting from a lack of trauma networks.

As a result of these reports, England has established trauma networks across its region. North Wales is part of the west Midlands major trauma network and the major trauma centre for the region is in Stoke, North Staffordshire. South Wales is the only region across England and Wales that is not part of a major trauma network nor has access to a designated major trauma centre. Scotland has made progress in identifying the key components of its trauma network and is moving toward implementation. Across South Wales, major trauma cases are currently managed through informal arrangements across the health boards, with some more complicated cases either admitted directly or transferred to the bigger regional centres – mostly University Hospital of Wales or Morriston Hospital. While this clearly benefits patients, it does not have the proven advantages of an established major trauma network.

A trauma network comprises a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receives the best care for life threatening or life changing injuries and in general includes one major trauma centre (MTC) and several trauma units (TUs) spread across the region. Where there is a major trauma network, it is expected that more patients will survive and make a full recovery, irrespective where in the region they suffer a major trauma.

An established major trauma network can have a significantly positive impact on the population in the region. The key benefits of developing the major trauma network are expected to include:

- Fewer people die: Evidence shows that severely injured patients are 15%-20% less likely to die if they are admitted to a major trauma centre (Clinical Advisory Group, 2010)
- Patients receive the best possible care at the most appropriate site from highly specialised teams, providing 24/7 emergency care with access to the required specialist services
- Patients are less likely to have a long term disability
- Patients require less long-term NHS care
- Patients will have an improved ability to return to work and undertake other activities
- Services meet clinical standards

- The network will enable access to be optimised to services to support patients to return as close to home as soon as possible
- The NHS is able to better plan for and respond to major incidents, improving the care major trauma patients will receive
- Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma network will facilitate delivery of this, ensuring the best use of resources, making the major trauma centres and trauma units more sustainable
- Local A&E units are less likely to be disrupted by admission of inappropriate major cases that can affect the ability of the department to manage its more routine workload.

1.2 Impact on workforce

Establishing a major trauma network also has significant benefits for the individual organisations who are part of the network:

- It provides an opportunity to develop the skills and expertise of existing staff at the trauma units and local hospital sites through closer working with the highly specialist clinicians and other staff at the major trauma centre
- A network with a clearly identified major trauma centre and trauma units is likely to have a positive impact on recruitment across the network
- The establishment of a network is likely to receive support from the Deanery, meaning it is more likely that trainee doctors will be allocated to hospitals across the network to undertake their training
- Services are delivered within a clinical network which allows improvement to be made through an integrated, whole system approach, resulting in standardisation of services and improved patient outcomes & experience
- Clinical services in south Wales for major trauma align with the rest of the UK and will allow the Welsh NHS to be more effective as part of the national response to major emergencies.

2 Equality and Human Rights

Under the Equality Act 2010 we have a legal duty to pay due regard to duties to eliminate discrimination, advance equality and foster good relations between those who share protected characteristics and those who do not.

This means that we need to take into account the needs of people from different groups within our populations who might be affected by our

proposals. We must take reasonable and proportionate steps wherever possible to eliminate or mitigate any identified potential or actual negative impact or disadvantage. Developing a major trauma network also gives us the opportunity to identify and enhance any potential positive impact on protected groups. The Equality Act 2010 gives people protection from discrimination in relation to the following “protected characteristics”¹

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

The Human Rights Act 1998 also places a positive duty to promote and protect rights for all. In Wales, we also have a responsibility to comply with the Welsh Language (Wales) Measure 2011 and All Wales Sensory Loss Standards for Accessible Communication and Information for People with Sensory Loss. We will take all our legal duties into consideration when we make decisions around developing a major trauma network.

3 Equality Impact Assessment (EqIA)

In Wales, we are required under the Public Sector Equality Duties to undertake Equality Impact Assessments (EqIAs) which will assist us to consider how the decisions we make affect people from protected groups in different ways.

We recognise that consideration of the needs of protected groups helps us to develop and deliver cost-effective services and person-centred care, ensuring that people are treated fairly and equitably.

EqIA is an ongoing process running throughout the course of the decision making process, from the start through to implementation and review. It requires us to consider how the development of a major trauma service, operating within a major trauma network structure for south Wales, south

¹ Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

Powys and west Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

EqIAs require analysing impacts on the basis of the above protected characteristics. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a major trauma network and major trauma centre on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence and engagement with key stakeholders has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage.

While socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics.

The proposals under consideration for the establishment of a major trauma network will result in the centralisation of life-saving treatment for a very small number of patients but with the most serious and complex injuries. Trauma units and a comprehensive rehabilitation service will ensure that as a patient's condition improves, responsibility for ongoing care will transfer to healthcare facilities closer to home.

A literature review was carried out as a first stage of gathering evidence to inform the EqIA, which identified potential impacts of the proposal on protected characteristic groups. There was also engagement with stakeholders to develop the service model.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' (those most likely to experience major trauma events) and the sections of the population which are likely to be most affected by the major trauma proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

3.1 Potential impact on protected characteristic groups?

This section of the document, recognises the potential impact on protected characteristic groups prior to the consultation exercise and the first observation to make is that major trauma tends not to be closely associated with particular equality groups; events are not simple to predict on the basis of socio-economic characteristics. However, evidence suggests that should you suffer a major trauma, you are more likely to survive and make a full recovery if you are in a region where there is a major trauma network, regardless of how far you are away from the major trauma centre.

Evidence suggests there are a number of protected groups who may be likely to suffer a major trauma.

3.1.1 Gender

Men are at far higher risk of experiencing major trauma than women. The NCEPOD report² showed that 75% of major trauma was in men. This is borne out by local data: in 2013, data for University Hospital of Wales, Cardiff, and Morriston Hospital, Swansea, shows that 70% of major trauma was in men.

² Trauma: who cares? A report of the national confidential enquiry into patients outcomes and deaths (NCEPOD) (2007)

Young men are at greater risk of being involved in major trauma accidents, typically arising from moving vehicles, tools or work.

3.1.2 Age

Age is a risk factor for suffering major trauma. It is the leading cause of death for people under 45 years and a significant cause of short and long-term morbidity (National Clinical Advisory Group, 2010)³.

There is evidence, of a rising number of falls in the elderly that should be managed within a major trauma pathway and supported with a frail elderly rehabilitation pathway. The conclusion to a study published in 2015 (Emergency Medical Journal, 2015)⁴ suggested that the major trauma population in the UK is becoming more elderly and the predominant mechanism that precipitates major trauma is a fall from lower than 2 metres.

Teenagers and young adults are more likely to need hospitalisation from injuries than other age groups.

Children under the age of 15 only account for a very small percentage of major trauma and deaths as a result of major trauma.

Potential impact –Involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from.

Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the major trauma network have all the skills required to care for these patients.

There is a need to consider further the transitional needs of young adults aged between 16 and 18 to ensure that they receive appropriate care and rehabilitation in an age-appropriate setting

Young people may also have different needs, and may require facilities to have relatives closer to them, for example in family rooms for patients from further away or more rural areas. When treating children, the service model

³ NHS Clinical Advisory Groups Report: Regional Networks for Major Trauma (2010)

⁴ The changing face of major trauma in the UK *Emerg Med J* 2015;**32**:911-915

will additionally follow the standards and criteria outlined for children's services⁵.

3.1.3 Race

Major trauma is more than twice as common in urban areas due to concentration of traffic and people. Additionally, it has been identified that people from Black, Asian and other Ethnic Minority backgrounds are at a higher risk of incidence and mortality from major trauma, at least in part due to a correlation with concentration in urban areas and the relationship of minorities, deprivation and major trauma incidents⁶.

Potential Impact - Engagement with stakeholders on the rehabilitation element of the patient pathway identified that there is a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in their first language. Cultural issues are also important to take into account and a toolkit is available for this purpose.

3.1.4 Disability

Major trauma is the national leading cause of disability for those under 45 years of age. The improved number of survivals in young adults and reduced incidences of disability resulting from major trauma will also improve the rate of return to work and socio-economic functioning. Evidence shows that there is a five to fifteen-fold return on the investment made in treatment. As most major trauma patients tend to be of working age, this is an important indicator that given the right care, it is possible for people suffering the most serious injuries to recover sufficiently to go on and have an active working life (NHS East Midlands, 2010)⁷.

Potential Impact - Engagement with stakeholders on the rehabilitation element of the patient pathway identified that Rehabilitation services should give choice to patients with pre-existing mobility issues, for example patient with multiple sclerosis should receive the same options for treatment. Specific patient needs, such as bariatric needs should be considered to

⁵ <http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf>).

⁶ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

⁷ Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

⁶ All Wales Standards for Communication and Information for People with Sensory Loss 2013)

ensure the provision of appropriate equipment across boundaries and within social care sector. As well as physical disability, there is a need to consider learning disabilities and mental health. Communication needs in these client groups may be more challenging and care should be adapted accordingly, for example, where there is a need for BSL interpretation services.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss⁸ that apply directly to emergency and unscheduled care (in addition to primary care and other secondary care services) and these outline the staff training requirements, communication systems and equipment and patient needs information which should be provided by health boards. BSL interpreters will be required for the deaf community.

3.1.5 Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

3.1.6 Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

3.1.7 Religion or belief (including lack of belief)

Potential impact - staff need to consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them⁹. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered. As previously a comprehensive cultural awareness toolkit is available for this purpose.

3.1.8 Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, lesbian, gay, bisexual and transgender (LGBT) patients in Wales report significant barriers to health and social care services¹⁰. Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. Inappropriate assumptions are also made about 'next of kin' if they are in a same sex relationship. This makes LGBT people feel anxious about accessing health or social care and

⁹ http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

¹⁰ <http://www.stonewallcymru.org.uk/our-work/research/have-your-say>

creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks.

Potential Impact - There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall have commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

3.1.9 Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth.

Potential Impact - In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015¹⁹ Trans* people must be accommodated in line with their gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's Gender Recognition Certificate or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

3.1.10 Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure 2011. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. Whilst we recognise that Welsh and English are Wales' official languages, Wales has many different voices. Like two-thirds of the world's population many people in Wales are bilingual or multilingual. This is particularly important in traumatic situations where people are more likely to need to communicate in their first language.

Potential impact - Service users who prefer to communicate in the medium of Welsh may be required to access highly specialist services which do not have sufficient Welsh speaking staff (this may also be the case for languages other than English). This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account.

The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. However, it is important to recognise groups of other individuals who have suffered life changing conditions that may benefit from community through the medium of Welsh. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)¹¹. Our consideration of equality takes account of this.

4 The Consultation process

A consultation plan was written to ensure there was a consistent approach to the consultation across the region and to provide a full range of opportunities taking account of accessibility for staff and key stakeholders to give their views and equality of opportunity to respond.

In developing the consultation plan consideration was given to the variety of methods which would need to be employed to give equality of opportunity to stakeholders to respond to the consultation. In order to facilitate this, standard documentation was produced and made available in a variety of formats including: easy read in English and Welsh; British Sign language; audio English and Welsh; sub titled presentation; and Braille.

The main consultation was produced as a bilingual document and a crystal mark was achieved which recognised the achievement of plain English in the document.

Alongside the main consultation document which was available electronically or via hard copies, the follow other methods for sharing information during the consultation were employed:

A website for the consultation was developed and accessed via Public Health Wales at the following address:

www.publichealthwales.org/majortraumaconsultation.

¹¹ More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

There is both an English and Welsh website. The consultation document and supporting documents were available on the website in a variety of formats as detailed above.

An animated short film was produced outlining the key elements of the consultation. This was filmed in English and Welsh with BSL overlaid.

The Clinical Lead for Major Trauma also provided a session talking about major trauma, the benefits and proposed model. His session was also available with Welsh translation.

Across the consultation period, each health board scheduled public meetings in each district within their region. This was to provide the opportunity for staff, stakeholders and the wider public to find out more about the proposals for a major trauma network in South Wales as well as providing opportunities to feedback on the proposals in the consultation document. The presentation was available in English and Welsh and British Sign language interpreters were made available where required. A series of additional meetings took place with other professional/recognised groups.

People and organisations are encouraged to respond to the consultation using the following methods: Hard copy via a FREEPOST address; Email via a generic email address; or online in their preferred language of choice.

Social media (Facebook and Twitter), was used by health boards to promote the consultation and public meetings. Hywel Dda and Abertawe Bro Morgannwg UHB also engaged in wider discussions via social media.

Prior to the formal launch of the consultation, a bilingual press release was sent under embargo to local media across the region. A further press release was issued to local media at the mid-point of the consultation reminding the public of the consultation and the date by which to respond. Requests were made from several local radio stations, as well as BBC Wales for interviews with the Transitional clinical Lead for Major Trauma.

5 Outcome from consultation

On conclusion of the consultation, the responses received and equality monitoring forms were collated and analysed. The responses to the consultation and analysis will be available on the public consultation website at:

www.publichealthwales.org/majortraumaconsultation

There were a total of 1041 response to the consultation received from across the region.

Seventeen public meetings were scheduled across the region and a total of 242 people attended comprising health board employees, local residents,

local councillors, an assembly minister and representatives of other organisations. Feedback received in these meetings was captured and analysed and considered on an equal footing with all other responses.

In addition, 254 members of the public engaged in conversation on Facebook and Twitter relating to the consultation (18 in Hywel Dda UHB initiated conversations/threads and 236 in Abertawe Bro Morgannwg UHB initiated conversations/threads). Whilst a number of individuals used these conversations to express their views on the proposal, the conversations were also used by individuals to promote and confirm that they had completed a formal questionnaire to respond to the consultation. The key themes identified from the social media conversations were considered on an equal footing with other responses.

Alongside the response to the consultation proposal, there were 715 completed equality monitoring forms received. On analysis of the equality monitoring forms, for each 'protected characteristic' there were a small number of respondents who left each question blank. There were also a number of equality monitoring forms received from organisations, which ticked multiple responses to a single question (e.g. where an age category was required, several age brackets were identified). These forms were acknowledged but were not included in analysis of the monitoring form returns.

Outlined below is an overview of the response to the equality monitoring forms.

- Age: Age of respondents ranged from the lowest age bracket 16-24 to 75 or over, with the majority of respondents identifying as 45-54 age bracket (141).
- Gender: The response from individuals identifying as female (394) was slightly higher than the number of individuals identifying as male (279).
- Race: Respondents identified as predominately white (642) with a small number of respondents identifying as Asian or Asian British, Black, African, Caribbean or Black British, Mixed or multiple ethnic groups or another ethnic group (26).
- Disability: Majority of respondents identified as not having their day to day activities limited (533). A number of individuals did identify as having day to day activities limited a little (91) or a lot (39).
- Religion or belief: Majority of respondents identified as Christian (371). A small number of respondents identified as Buddhist, Hindu, Muslim or other religion (33). A large number identified as no religion (277).

- Sexual orientation: Respondents predominantly identified as heterosexual or straight (586) with a small number identifying as gay or lesbian, or bisexual (37).
- Welsh language: Majority of respondent identified as non Welsh speaking (530) and (139) identified as Welsh speaking

As recognised earlier in this document, the EqIA notes that while socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, which impact on their ability to access health services.

Analysis of the consultation responses identified the following areas which may affect individuals identifying with low economic status and as such consideration needs to be given to how these can be mitigated for this group of individuals: major trauma network infrastructure; road infrastructure and public transport; and access and support for families;

- Major trauma Network Infrastructure – The need to consider the establishment of the wider network, including the location of trauma units and the development of rehabilitation pathways, rather than the location of the Major Trauma Centre was emphasised in the consultation. The structure of the proposed network is likely to impact on this group of individuals.

The implementation of the network, including the redevelopment of the whole pathway of care is as important than the location of the Major Trauma Centre. It is proposed that patients will typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated to a trauma unit closer to home for ongoing care and rehabilitation if required.

To support this, it is accepted that appropriate and robust rehabilitation pathways will need to be in place as part of the implementation of the Major Trauma Network.

The Independent Panel was asked to make a recommendation on the location of the Major Trauma Centre only, and not the trauma units. Identifying the Major Trauma Centre location first is helpful in informing where to locate the units. The remaining trauma units will need to be identified by individual health boards for their local area. There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered by trauma units (in line with national standards and guidelines).

- Road infrastructure and public transport is likely to impact on this group of individuals, in particular for those living a distance from the major trauma centre. It is recognised that the proposals for a major trauma centre at University Hospital Wales, may mean some individuals will live a distance from the Major trauma centre.

However, patients will be taken to the major trauma centre by 'blue light ambulance' or the air ambulance and would typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated to a trauma unit closer to home as soon as possible. Therefore public transport should not be a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport.

However, in order to mitigate the impact the location of the major trauma centre appropriate arrangements will need to be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre to support families and carers.

- Access and support for families and carers, including parking, accommodation and information (including translation into Welsh and other languages), at the major trauma centre is an area likely to impact on this group of individuals.

It is recognised that there is a need to ensure that the relatives of patients are adequately supported and informed during the time at the major trauma centre. It is accepted that in order to mitigate the impact on families and carers, appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.

In the current service model for Wales, some patients are already transferred to UHW from across the whole region for some highly specialised services and there are arrangements in place to support families where appropriate. This will be considered further as part of the overall implementation of the network and development of the Major Trauma Centre.

In addition, a new charity-funded building providing accommodation and facilities for families whose children are receiving treatment in UHW has recently been opened. Some accommodation is also available on the UHW site for families of adult inpatients.

There were a number of responses received from individuals/organisations representing individuals with protected characteristics such as representative of the deaf and hard of hearing and the Older persons Commissioner for Wales. These responses referenced the importance of giving consideration to the needs of individuals with protected characteristics, ensuring the service that is implemented is fully accessible and the care received and opportunities for the involvement in co-production are equitable across all stakeholders.

6 Next Steps

The needs of protected groups will continue to be an ongoing consideration during the planning and implementation phase of the project and Health boards will need to ensure that stakeholders are engaged throughout, venues for the public events are accessible and information is provided in a variety of required alternative formats in order to maximise opportunities for participation wherever required.