NHS South West

South West Strategic Health Authority

Briefing for Overview and Scrutiny Committees: Establishment of Networks of Trauma Care

1. Purpose of the report

1.1 The aim of this paper is to provide Overview and Scrutiny Committees with information about plans to establish Regional Networks of Trauma Care in line with international clinical practice and clinical recommendations which have informed national policy. Specifically, the paper sets out the proposed model of trauma networks in the geographical area covered by NHS South West and outlines the process for designating Major Trauma Centres. This will augment standards of quality and enhance the level of trauma care already provided.

1.2 The proposals presented here will:

- improve the quality of trauma services across the region;
- improve the coordination of trauma care across the Networks and ensure patients are treated in the hospital best equipped to deal with their injuries;
- reduce the length of stay in hospital and help to ensure patients receive appropriate rehabilitation in a setting close to home;
- increase survival rates and improve clinical outcomes over time.

1.3 These proposals have been endorsed by the steering group who advised NHS South West on how trauma networks should be configured, by the clinicians who provide trauma services and the managers who commission them, and by Professor Keith Willett, National Clinical Director of Trauma Care at the Department of Health.

1.4 Chairs of Overview and Scrutiny Committees and Local Involvement Networks have previously received a verbal briefing on these proposals from the Deputy Director, Policy and Business Projects at the South West Strategic Health Authority.

2. Decisions/actions requested

2.1 Overview and Scrutiny Committees are asked to:

- receive and review the information concerning the establishment of Trauma Networks and designation of Major Trauma Centres;
- note the improved quality in service and care that patients will receive;
- note the involvement of clinicians and service managers in the development of proposals thus far and the intention to involve patients and the public in the plans for service improvement;

- comment on the proposals and plans for patient and public engagement.

3. Background

3.1 Major trauma describes serious and often multiple injuries that could cause death or serious disability. It is the leading cause of death in people aged between one and forty and is a significant Public Health issue.

3.2 In England, the most common cause of major trauma is a road accident. This is of particular significance in the South West where the level of car ownership is high due to large areas of rural geography and where accidents are one of three big killers alongside circulatory disease and cancer.

3.3 Despite all of this, major trauma represents a small percentage of the work of most hospital accident and emergency departments which will see less than one case of major trauma each week. Because of this, not all hospitals have the equipment and specialist doctors required to treat major trauma effectively. This means that patients will sometimes need to be transferred to a Major Trauma Centre where they can be operated on immediately if necessary and where there is a full range of specialist skills available. This requires coordination and effective communication between hospitals that provide trauma care to ensure that patients get to the right place at the right time for the right care. This involves:

- identifying the severity of the injury as soon as possible, ideally at the scene of the incident;
- if this is not possible, then investigations such as scanning should take place immediately on arrival at the first hospital to which the patient is taken;
- if the injuries require specialist care, then the patient should be transferred to a Major Trauma Centre as quickly as possible;
- patients should receive appropriate rehabilitation to assist their recovery.

3.4 All of this requires better organisation of trauma services and it is for this reason that Strategic Health Authorities have been asked by the Department of Health to set up Regional Networks of Trauma Care. This will ensure that patients with life-threatening injuries are taken to a specialist hospital where expert staff are available around the clock. It is estimated that 450 to 600 lives could be saved in NHS hospitals every year by doing this.

4. Current service arrangements – what happens now?

4.1 Trauma services are currently provided by a wide range of hospitals within NHS South West. Specialist care is provided at larger acute hospitals, with high-end complex care provided in Bristol and Plymouth.

4.2 Although there are arrangements in place between hospitals for the transfer of patients to more specialist services, these arrangements are not formally coordinated across the region.

4.3 Establishing trauma networks will mean that major trauma centres and hospitals will work together with ambulance services to ensure that patients are taken to the hospital that is best equipped to deal with their injuries.

5. Proposed service development – what will change?

5.1 The need to make trauma care a priority was highlighted by Lord Darzi in his Next Stage Review of the NHS in 2008. This was reinforced in a report into *Major Trauma Care in England*[1] published by the National Audit Office in February 2010 which was highly critical of how trauma care is currently provided and concluded that the NHS is not providing value for money in relation to trauma services.

5.2 The report highlighted the need for well-established systems and processes to deal with the low incidence but high complexity of major trauma and recommended the development of regional trauma networks. A commitment has been given to Parliament that Trauma Networks will be operational by 1 April 2012.

5.3 The role of a Trauma Network, led by a Major Trauma Centre at the heart of it, is to take responsibility for all major trauma patients injured within its area by working to co-ordinate and improve the care that patients receive. Strategic Health Authorities have been charged with determining how many Trauma Networks and how many Major Trauma Centres should be established to serve their populations in line with the geography of the region and the number of cases of major trauma hospitals treat each year.

5.4 The Government's response to the NHS Futures Forum published in June 2011 stresses the importance of clinical networks in supporting the commissioning and provision of healthcare.

5.5 An analysis of a range of data from different sources carried out by the South West Public Health Observatory concluded that there should be either one Major Trauma Centre or two to deal with around 1,000 cases of major trauma in the region each year. Both of these options were considered by a group of expert clinicians (the Clinical Advisory Group) involved in the care of trauma patients in the South West, alongside guidance published by the Royal College of Surgeons which sets out national standards for trauma services[2].

5.6 The guidance states that a Major Trauma Centre needs to be able to provide all the major specialist services relevant to the care of major trauma, i.e. general, vascular, orthopaedic, plastic, spinal, maxillofacial and cardiothoracic surgery, neurosurgery and interventional radiology, along with appropriate supporting services, such as critical care. Only two hospitals in the south west can do this without significant changes to their infrastructure – they are Frenchay Hospital (which will be superseded as a Major Trauma Centre by the newly developed Southmead Hospital when it opens in 2014) in Bristol and Derriford Hospital in Plymouth.

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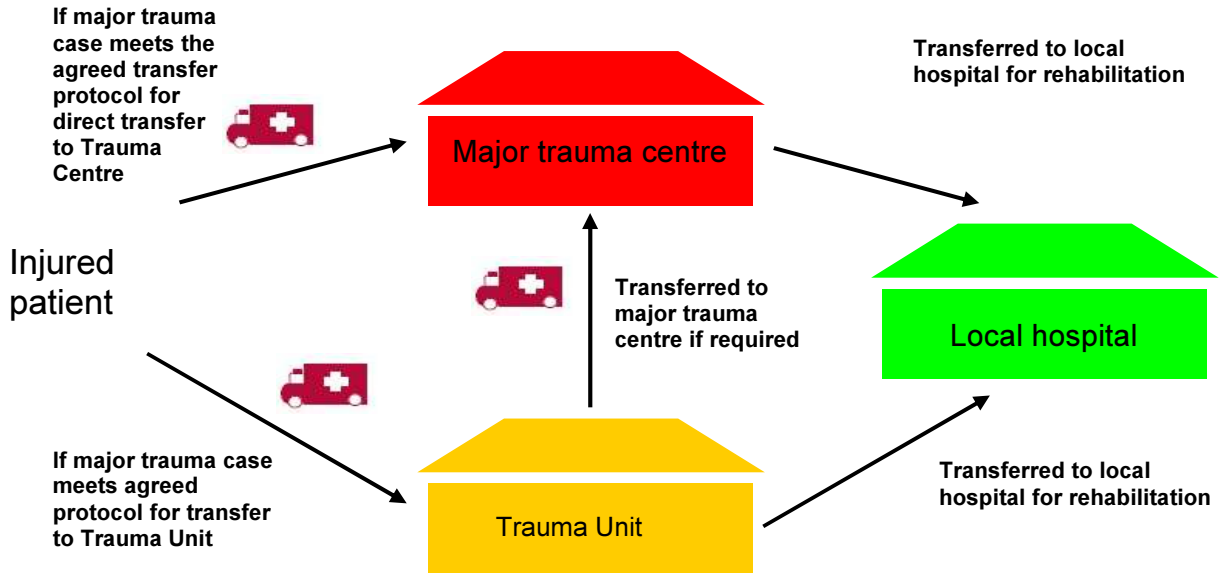
[1] National Audit Office (February 2010). Major Trauma Care in England. http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

[2] The Intercollegiate Group on Trauma Standards (December 2009). Regional Trauma Systems: Interim guidance for commissioners

5.7 Having only one Major Trauma Centre in the South West was discounted because of the long journey times involved for the many people who would live too far away from the specialist service to benefit from being taken there. Instead, the Clinical Advisory Group recommended that there should be two Major Trauma Centres in the south west and that these should be established at Bristol and Plymouth where complex trauma care is already managed. It was also agreed that a Trauma Network should be formed around each of the two Major Trauma Centres.

5.8 The diagram below shows the pathway that trauma patients would follow within each Network and where they would be treated dependent on the severity of their injuries:



5.9 Using Hospital Episode Statistics data, it is estimated that there are between 1110 and 2764 cases of major trauma in the South West each year. For a typical acute hospital, this equates to between one and five patients per week, dependent on the size of the hospital. The only change in patient flows as a result of these proposals is that a small number of severely injured patients will be taken directly to a Major Trauma Centre. Evidence shows that any increase in travel time would be more than outweighed by the reduction in mortality and morbidity achieved by treating these patients at a hospital where specialist care is available around the clock. Since approximately 44% of trauma cases occur over one hour's travel time away from Bristol or Plymouth, more than half of trauma patients will continue to be taken to their local hospital for treatment. Overall, it is estimated that any changes in patient flows will be less than two patients per hospital per week. It is estimated that 30-40 lives could be saved in the South West each year as a result of the improvements in the coordination of care that will be achieved via the establishment of Trauma Networks.

5.10 NHS South West will work with potential trauma units, that is, those hospitals whose A&E departments receive trauma patients, to ensure they meet the highest clinical standards to provide life saving services to patients. Some Trauma Units will continue to provide specialist services such as those for the treatment of burns, plastics and spinal injuries. In such cases these hospitals (Salisbury and the Royal Devon and Exeter respectively) will take responsibility for making their services available to patients in the Network who need them. It is important to note that accident and emergency services will remain unchanged.

5.11 All hospitals wishing to provide trauma services within the Networks will be reviewed against national standards. They will be asked to submit evidence for how each standard can be met and how any gaps in service specification will be addressed over time.

5.12 Prospective Major Trauma Centres will be reviewed by a panel that will include clinicians, managers, the ambulance service and lay representatives. The panel will review the evidence submitted and carry out a visit to the hospital to evaluate trauma services and ensure plans are in place to meet national standards prior to their official designation.

5.13 Those hospitals wishing to become Trauma Units will also be assessed against national standards and will be asked to develop business plans in conjunction with their local commissioners to demonstrate that they can meet the standards required for designation. It will be the responsibility of the Trauma Networks and commissioners of trauma services to agree an appropriate number of Trauma Units to ensure an appropriate range of trauma services is provided in line with the needs of the local population in each Primary Care Trust area.

5.14 A series of “confirm and challenge” events will be held before the end of the calendar year to facilitate the process of Trauma Unit designation. At these events, a review panel comprising clinicians, business managers, commissioners and a patient representative will test the plans of prospective Trauma Units to ensure that they can deliver quality trauma services that are sustainable. The review panel will make a series of recommendations to the trusts and highlight any gaps that will need to be addressed before achieving Trauma Unit status. Primary Care Trusts will seek to engage Overview and Scrutiny Committees following these confirm and challenge events when they will be provided with a briefing on the outcomes and proposed configuration of trauma services in each Network. Designation will need to take place before 1 April 2012 when the Networks will become operational.

6. Expected benefits from the proposed service development

6.1 Establishing Major Trauma Centres in Bristol and Plymouth means that trauma services in NHS South West will remain largely unchanged. Accident and emergency services in hospitals will be unaffected. Patients will continue to be taken to their local hospital for treatment and, if they require specialist care, they will be transferred to a Major Trauma Centre in Bristol or Plymouth as is current practice. Trauma patients from Dorset will continue to go to Southampton General Hospital for their care and patients in parts of Wiltshire will continue to go to the John Radcliffe Hospital in Oxford. Both of these hospitals are aiming to become Major Trauma Centres in the South Central Strategic Health Authority which borders the South West.

6.2 What will change as a result of the Trauma Networks being established is that patients whose injuries are severe enough to warrant them being taken directly to the nearest Major Trauma Centre will be taken there without delay so that they receive the specialist care they need as quickly as possible from experts who will be available around the clock.

6.3 All hospitals wishing to become Major Trauma Centres and Trauma Units will need to meet national standards for the provision of trauma services. This will result in quality improvements. **The proposals for establishing two Trauma Networks in NHS South West will therefore serve to enhance the levels of trauma care that already exist in the region and improve the quality of services for patients**.

6.4 As a result of establishing Networks of Trauma Care, patients will also benefit from:

- reduced delays in receiving definitive care and treatment;
- reduced lengths of stay in hospital and ongoing care in settings closer to home where clinically appropriate;
- reduced variation in outcomes depending on where and when a person receives treatment;
- appropriate rehabilitation in a setting close to home
- increased exchange of skills and best practice between hospitals in the Networks and improved education and training of staff to ensure that high quality standards of trauma care are maintained.

7. The engagement process

7.1 In line with the principle of “no decision about me without me” patients and the public will be closely involved in the establishment of Trauma Networks. Their views will be sought in relation to proposals at stakeholder events and there will be patient involvement in the designation of Major Trauma Centres and Trauma Units.

7.2 In terms of seeking the views of patients and the public, two events are planned to which all relevant stakeholders will be invited. The first will be held in Bodmin, Cornwall on 20 September 2011. The second will be held in Bath, Avon on 22 September 2011. Specifically, people's views will be sought in relation to existing standards of trauma and rehabilitation services, the care pathway for patients, and the support that is available and/or required for patients and their families or carers. Overview and Scrutiny Committees will be invited to attend along with members of Local Involvement Networks and relevant voluntary organisations.

7.3 In relation to their future role in commissioning of services for patients, the views of general practitioners will also be sought. NHS South West will write to the leads of emerging Consortia to inform general practitioners about the establishment of trauma networks and engage them in the work programme. General practitioners will also be invited to attend the stakeholder events.

7.4 There will be a named Primary Care Trust cluster engagement contact that will work with NHS South West and offer a local point of contact and co-ordination during this process. This will assist the local impact assessment process.

8. Current timescales

8.1 The evaluation visits to prospective Major Trauma Centres are due to be held in early October, with designation by the end of the calendar year (2011) to allow for Trauma Networks becoming operational by 1 April 2012.

9. Conclusion and Recommendations

9.1 Overview and Scrutiny Committees are asked to:

- receive and review the information concerning the establishment of Trauma Networks and designation of Major Trauma Centres;
- note the improved quality and safety of service that patients will receive;
- note the involvement of clinicians and service managers in the development of proposals thus far and the intention to involve patients and the public in the plans for service improvement;
- comment on the proposals and plans for patient and public engagement.