NHS HEREFORDSHIRE (Primary Care Trust)
PCT BOARD

Subject:	Proposal for Reconfiguration of Major Trauma Services (NHS West Midlands)
Presented By:	Eamonn Kelly, Chief Executive, West Mercia Cluster

PURPOSE OF THE REPORT:

To outline the proposal for reconfiguration of Major Trauma Care in the West Midlands and the impact upon Herefordshire commissioned services.

KEY POINTS:

- Plans are to be in place for trauma reconfiguration by end of March 2012
- Wye Valley NHST application to be designated a Trauma Unit.
- Full business case awaited but likely to result in increased cost in 2012/13
- Public Consultation in November expected.

RECOMMENDATION TO THE BOARD

The Board is asked to note the content of this report and the impact on commissioning resources in 2012/13

CONTEXT & IMPLICATIONS:

Financial	Costs identified as part of report (Section 4)
Legal	May require HOSC briefing to ensure local awareness raising and Herefordshire impact
Risk and Assurance *(Risk Register/BAF)*	The corporate risk register & the Integrated Commissioning Directorate register are updated regularly to reflect the risks associated with commissioning of services.
HR/Personnel	None
Equality & Diversity	Impact assessments will be undertaken in the event of a significant change.
Strategic Objectives	As outlined and incorporated within the NHS Herefordshire strategic Plan for 2011/12.

Healthcare/National Policy *(e.g. CQC/Annual Health Check)*	Operating Framework 2011/12 QIPP (Quality, Innovation, Productivity & Prevention)
Partners/Other Directorates	Joint working with Herefordshire Adult Social Care & People's Directorate, Wye Valley NHST
Carbon Impact/Sustainability	None identified
Other Significant Issues	None

GOVERNANCE:

Process/Committee approval with date(s) *(as appropriate)*	HHCC Sub-Committee 13th September

NHS HEREFORDSHIRE (PRIMARY CARE TRUST)
Report to Board

Briefing on proposals for reconfiguration of Major Trauma Services (MTS) in the NHS West Midlands

1. Introduction

It is a national requirement in the NHS Operating Framework in England 2011/12 that all regions should be moving trauma service provision into regional trauma systems to make significant improvements in the clinical outcomes for major trauma patients; all regions are now beginning to implement plans for trauma care systems which need to be in place by the end of March 2012. The framework outlines that "all regions should be moving trauma care provision into Regional Trauma Networks configurations in 2011/12" and recommends that designated Major Trauma Centres (MTCs) should be planning the continuous provision of consultant led trauma teams, immediate Computerised Tomography (CT) scan options and access to interventional radiology services for haemorrhage.

2. The current model and the case for change

Since 1988, a number of studies have identified deficiencies in the care provided to severely injured patients in England, There has, however, been little progress in addressing these deficiencies. In 2007, the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) identified the following issues and concerns with the current model of major trauma care in England:

- Almost 60% of the patients receive a standard of care that is less than ideal practice, since they are in the main cared for by organisations which do not have all the required specialties. Therefore, delays are incurred when patients require onward transfer to a more specialist tertiary unit, particularly those patients who need neurosurgical services.
- Of all major trauma cases, currently 27% of patients die as a result of their traumatic injuries.
- As major trauma represents only 0.1% of total Accident & Emergency (A&E) activity, the average Hospital sees less than two patients per week with a larger emergency departments seeing on average one per day.
- The annual cost to the NHS to treat major trauma patients is estimated to be £300-£400 million.
- As a result of the mortality and morbidity associated with major trauma patients, this has been calculated to represent a lost economic output of £3.3 – £3.7 billion per year.
- Deficiencies in both organisational and clinical aspects of care occur frequently. There are difficulties in identifying those patients with an Injury Severity Score (ISS) >15 at the scene or upon admission to the local A&E.
- With large costs involved in both the provision of care and resources for the management of these patients, the current method of identifying the demand for the management of these patients through the Trauma Audit and Research Network (TARN) is not compulsory.

- The organisation of pre-hospital care, the trauma team response, seniority of staff involvement and immediate in-hospital care was found to be deficient in many cases.
- Lack of appreciation of severity of illness, of urgency of clinical scenario and incorrect clinical decision making were apparent.
- Many of these clinical issues were related to the lack of seniority and experience of the staff involved in the immediate management of these patients.
- It was clear that the provision of suitably experienced staff during evenings and nights was much lower than at other times. In the management of trauma, which very often presents at night, this is a major concern.

It is regarded that the outcome of implementing regional trauma networks, based on evidence from overseas is a reduction in mortality of between 15-20% and a reduction in the disability of patients, therefore increasing the number of patients who return to work and pre injury functionality.

3. The new model

It is proposed to transform the care people receive when they suffer major trauma by introducing an improved delivery model across the region. The plans will establish Major Trauma Centres (MTCs) at existing hospitals, where specialist medical teams will provide treatment for major trauma injuries 24 hours a day, seven days a week. MTCs will have all necessary services on site to provide the best possible treatment to patients; these services will include neurosurgery, heart and chest trauma services and urgent rehabilitation services. The creation of new trauma care networks is intended to help patients by increasing survival rates, shortening recovery times and reducing disability from injury. The centres will be supported by Trauma Units (TUs) and Local Emergency Hospitals (LEHs) to create an improved trauma care system for the region. Wye Valley NHS Trust (WVNHST) has applied to be designated as a Trauma Unit as part of this reconfiguration and this application is supported by local commissioners.

The new model of care is based around and facilitated through **Trauma Networks (TN)**; the collaboration between the providers commissioned to deliver trauma care services in a geographical area. A TN should include all providers of trauma care, including: pre-hospital services and rehabilitation services. It will have appropriate links to social care and the independent sector. While individual units retain responsibility for their clinical governance, members of the TN will collaborate in order to provide continuous Quality Improvement.
The model will designate services providing trauma care as either:

- **A Major Trauma Centre (MTC);**
- **A Trauma Unit; (TU); or**
- **Local Emergency Hospital (LEH)**

An **MTC** is a multi-specialty hospital, on a single site, optimised for the provision of Major Trauma care. It is the focus of the Trauma Network (TN) and manages all types of injuries, providing consultant-level care. It also provides a managed transition to rehabilitation and the community. It takes responsibility for the care of all patients with major trauma in the area covered by the Network. The MTC will provide all the major specialist services relevant to the care of major trauma, i.e. general

surgery; emergency medicine; vascular; orthopaedic; plastic; spinal; maxillofacial; cardiothoracic and neurological surgery and interventional radiology, along with appropriate supporting services, such as critical care.
Therefore, the MTC, will receive all trauma patients from its immediate catchment population; and will also receive multiple trauma patients from other hospitals in the system where the standards of care

Present plans begin implementation of a regional trauma care system no later than March 2012. Four options are being considered for the future configuration of trauma care in the West Midlands, as set out below:

1. Three trauma networks – with MTCs at the Queen Elizabeth Hospital in Birmingham, the University Hospital of North Staffordshire and University Hospital Coventry and Warwickshire.
2. Two trauma networks – with MTCs at the Queen Elizabeth Hospital in Birmingham and one at the University Hospital of North Staffordshire.
3. Two trauma networks – with MTCs at the Queen Elizabeth Hospital in Birmingham and one at the University Hospital Coventry and Warwickshire.
4. One trauma Network – with an MTC at the Queen Elizabeth Hospital in Birmingham.

Paediatric Trauma Care will continue to be delivered by Birmingham Children's Hospital.

Option 1) is likely to be preferred, however in order to ensure minimisation of management costs, it is likely that administration of the networks will be jointly managed and options for co-working with the existing Critical Care network are being explored.

4. Costs

The full business case is yet to be finalised. It is expected that across the West Midlands Health Economy the full cost of implementation will be in the range £5.5 million to £7million. **For Herefordshire this equates to a range of £186K to £237K assuming average rates of utilisation.**

5. Next steps and key milestones

Given the relatively constrained timescale for implementation, a number of key milestones occur with the next few months. A putative timescale is set out below:

Development and agreement of PID in reflection of revised scope and mile-stones.	April 2011
Model of Care finalised and Implications agreed by Project Board, Steering Group and Clusters	May 2011
Specification for Integrated Impact Assessment (IIA) and Pre-Consultation	End of May 2011
Completion of IIA and plan for Pre consultation	End of July 2011
Pre Consultation Phase	August/September 2011
Completion of Business Case	September 2011

Multi-Cluster Trauma Unit Selection Panel	8th September 2011
Project Board Appraisal of Trauma system options	End of September 2011
Appraisal document to Clusters, Steering Group & Stakeholders	Early October 2011
SCG preferred option recommendation for consultation	End of October 2011
Stage 1 Gateway Review	October 2011
Public Consultation (subject to HOSCs)	November - February 2012
Final Decision by SCG and Four Tests Review by SHA	February 2012
Commence Implementation	Mid Feb 2012 onwards