By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 10 June 2011

Subject: Trauma Services

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1. Background

(a) Selected key facts about major trauma[1]:

- Major trauma = serious/multiple injuries where there is the strong possibility of death or disability.
- Blunt force causes 98% of major trauma, mainly through car accidents and falls. Gunshots, knife wounds and other penetrating injuries account for 2%.
- It's the leading cause of death in England for those aged under 40.
- Major trauma accounts for 15% of all injured patients.
- Major trauma admissions to hospital account for 27-33 patients per 100,000 population per year and represents less than 1 in 1,000 emergency department admissions.

2. Regional Trauma Networks

(a) Over the years, there has been a growing body of evidence concerning the need to improve trauma services. In 2007, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a report entitled *Trauma: Who Cares?* This found "Almost 60% of the patients in this study received a standard of care that was less than good practice. Deficiencies in both organisational and clinical aspects of care occurred frequently."[2]

(b) A National Audit Office report, *Major trauma care in England* (published 5 February 2010), made the following overall findings:

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[1] Key facts extracted from a) National Audit Office, *Major trauma care in England*, 5 February 2010, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx b) The Intercollegiate Group on Trauma Standards, *Regional Trauma Systems. Interim Guidance for Commissioners*, December 2009, http://www.rcseng.ac.uk/news/docs/Regional_trauma_systems.pdf

[2] NCEPOD, *Trauma: Who Cares?,* 2007, p.10, http://www.ncepod.org.uk/2007report2/Downloads/SIP_report.pdf

- "Despite repeated reports identifying poor practice, the Department and NHS trusts have taken very little action to improve major trauma care."

- "Survival rates for major trauma vary significantly between hospitals, reflecting variations in the quality of care."

- "As major trauma is a relatively small part of the work of an emergency department, optimal care cannot be delivered cost-effectively by all hospitals."

- "Evidence shows that care should be led by consultants experienced in major trauma, but major trauma is most likely to occur at night-time or at weekends when consultants are not present in emergency departments."

- "The delivery of major trauma care lacks coordination and can lead to unnecessary delays in diagnosis, treatment and surgery."

- "Information on major trauma is not complete and quality of care is not measured by all hospitals."

- "Ambulance trusts have no systematic way of monitoring the standard of care they provide for people who have suffered major trauma and opportunities for improving care may be missed."

- "The availability of rehabilitation varies widely across the country, and services have not developed on the basis of geographical need."

- "The costs of major trauma are not fully understood, and there is no national tariff to underpin the commissioning of services."[3]

(c) The need for specialist trauma services formed part of the 2008 NHS Next Stage Review[4]. On 1 April 2009, Professor Keith Willett was appointed as the first National Clinical Director for Trauma Care and his team assists strategic health authorities (SHAs) in developing regional trauma networks[5].

(d) The NHS Operating Framework for 2011/12 stated the following:

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[3] National Audit Office, *Major trauma care in England*, 5 February 2010, pp.6-7, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

[4] Department of Health, *High Quality Care For All. NHS Next Stage Review Final Report*, June 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

[5] Department of Health, National Clinical Directors, http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/Nationalclinicaldirectors/DH_101369

- "All regions should be moving trauma service provision into regional trauma network configurations in 2010/11. Tariff changes will be introduced from April 2011 that are designed to recompense for the complexity of multiple-injury patients. Designated Major Trauma Centres should be planning the continuous provision of consultant led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage"[6].

3. Injury Severity Score (ISS)

(a) An anatomical scoring system, the injury severity score, is used to classify trauma. The score goes from 0 – 75 and a score of 16 and over is classed as major trauma.

Table: Injury severity score group and mortality[7]

injury severity score	**percentage of major trauma patients**	**percentage mortality of this injury severity score group**
16-25	62.6	10.5
26-40	28.9	22.1
41-74	7.7	44.3
75	0.8	76.6

[6] Department of Health, *NHS Operating Framework 2011/12,* 15 December 2010, p.43, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

[7] National Audit Office, *Major trauma care in England*, 5 February 2010, p.11, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

Appendix: Selection from Minutes, Health Overview and Scrutiny Committee, 5 February, 2010[8].

(a) *Professor Roche, Medical Director (South East Coast Strategic Health Authority). Ms Evans, Head of Business Planning and Strategy, and Mr Reynolds, Head of Business Development (South East Coast Ambulance Trust), Ms Thomas, Director of Service Redesign (NHS West Kent) and Andrew Cole, Head of Commissioning Urgent and Continuing Care (NHS Eastern and Coastal Kent) were present for this item.*

(b) (22) Mr Roche referred to the major trauma report that had today been issued by the National Audit Office. Major trauma was not currently a success story, the UK was just starting to look at major trauma services. In Kent one of the issues was logistics, in 2008 66 people in Kent died in road traffic accidents, and most of these were in the coastal area away from the major road network. Patients with complex trauma need to be rapidly assessed by ambulance crews. Approximately 60% of those with complex trauma had head injuries. Many patients from Kent were taken to King's College Hospital, London. However King's could not accept transfers by air ambulance at night. It was recognised that there was a problem with trauma treatment in Kent and a review had already been commissioned across the Strategic Health Authority area. Trauma Leads had been appointed in Brighton and Kent who would form the basis of a trauma board. The message was that major trauma patients like heart attack patients needed a 24/7 service available with senior staff and urgent access to further services if necessary. He stated that he was determined to come back to the Committee in the future with a success story for trauma.

(c) (23) The Chairman stated that he was encouraged that Mr Roche had approached this Committee at this early stage to seek the Committees views as representatives of the layperson.

(d) (24) In relation to a question from Councillor Blackmore seeking clarification on the air ambulance and night flying, Mr Roche explained that only police pilots could fly at night, but another issue was the affect of adverse weather on the air ambulance. Accidents involving major trauma were more likely to occur in poor weather conditions.

(e) (25) Councillor Lyons asked whether there were likely to be a number of dedicated centres in Kent or whether there would be a shared facility with Sussex. Mr Roche explained that 600 – 700 patients a year were needed to support a fully equipped trauma centre. It was anticipated that Kent would produce less than 100 patients a year and therefore it was very unlikely Kent could host a centre. In Kent the issue was logistics and there was a need to ensure that

[8] Kent County Council, http://democracy.kent.gov.uk/mgAi.aspx?ID=11160

patients were assessed, any immediate problems resolved and then were able to access good pathways to appropriate care in a timely manner. It was then necessary to repatriate and properly rehabilitate these patients. This needed to be put in place across Kent to ensure the best outcomes for the patient.

(f) (26) In response to a question from Mr Cooke, Mr Roche confirmed that the most significant number of road deaths in Kent occurred outside of the M25 and M20 corridor, along class "A" roads and in the coastal areas. The aim was to provide the best possible service and not disadvantage people because of where they lived or where an accident occurred.

(g) (27) Mr Daley asked whether when Pembury Hospital was open it would be able to deal with aspects of the major trauma services that patients currently had to go to Brighton or London to receive. Mr Roche replied that patients with brain or chest injuries would still need to go to other centres. He stated that Kent was to be congratulated in centralising its heart treatment, which had been done by clinicians working together to provide a service that was best for patients and he was keen that the same principle would drive the reconfiguration of acute trauma.

(h) (28) In response to a question from Mr Lyons, Mr Roche confirmed that the trauma leads would inform him of relevant organisations to seek views from, However, the service would be developed around the benefits to the patients and not any vested interests.

(i) (29) In answer to a question from Mr Kendall, Mr Roche stated that very few cyclists were killed in Kent but that there was evidence from America that the use of helmets reduced injuries for cyclists.

(j) RESOLVED That the Committee supports the developments taking place in emergency care pathways and health colleagues be thanked for bringing the paper on trauma to this Committee to enable Members to have an input at an early stage.