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

To: Health Overview and Scrutiny Committee, 9 September 2011

Subject: Trauma Services in Kent and Medway

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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 regional trauma networks 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.12, 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: Extract from Minutes, Health Overview and Scrutiny Committee, 10 June 2011[8].

Dr Robert Stewart (Medical Director, Kent and Medway Cluster and Chair of the Kent and Medway Trauma and Critical Care Network), Dr Patricia Davies (Locality Director, Dartford, Gravesham and Swanley GPCC and Lead Director for the Kent and Medway Trauma and Critical Care Network), Helen Belcher (Project Manager, East Kent Hospitals University NHS Foundation Trust), Dr Marie Beckett (Deputy Medical Director and Emergency Care Consultant, East Kent Hospitals University NHS Foundation Trust), Karen Barkway (Performance and Governance Manager, NHS West Kent) were in attendance for this item.

(1) The Chairman introduced the item and explained that there were a number of options the Committee could take following the developments of the trauma network in Kent and Medway. As the network did cover two local authority areas, Kent and Medway, the two Committees exercising the health scrutiny function may need to form a Joint HOSC to consider the item if both considered it a substantial variation of service.

(2) Dr Stewart provided an overview of the proposals and the reasons underlying them. There was a need to develop trauma services in Kent and Medway because while there were no Major Trauma Centres in the area, not all patients could be taken to either London (mainly King's) or Brighton within the recommended 45 minutes. A Major Trauma Centre required cardiothoracic, neuroscience and other specialities to hand to provide a full service as well as a certain throughput of patients in order to maintain skill levels. These factors precluded one being established in Kent and Medway, but the development of improved services as well as repatriation for rehabilitative care was possible. The Air Ambulance, although useful, could not be the complete solution as there were too many restrictions on when they could be used. Closer links were being developed with the South East London Trauma Network.

(3) When responding to a major trauma incident, the paramedics assessed the situation and there were three options – taking the patient straight to a Major Trauma Centre, stabilising the patient before transfer, or treating the patient locally. The Kent and Medway Clinical Care and Trauma Network's proposal was to develop three Major Trauma Units across Kent and Medway where additional expertise from consultants would be available and rehabilitation would be coordinated. These Major Trauma units would be linked to Major Trauma Centres which would assist with training and recruitment. The South East Coast Strategic Health Authority and London Trauma Board were supporting the proposals. The proposed sites for the Major Trauma Units were:

[8] Kent County Council, http://democracy.kent.gov.uk/mgAi.aspx?ID=17053

- Pembury Hospital,
- William Harvey Hospital, and
- Medway Hospital

(4) A range of questions were asked by Members over different aspects of the proposals. On the number of patients involved it was clarified that in Kent and Medway each year ½ million patients are seen in Accident and Emergency Departments each year; of these the 200 most severe, major trauma cases, go to King's. The Network stressed the proposals were improvements to existing services and not the downgrading of Accident and Emergency Departments. On the selection of the sites, it was explained that the Acute Trusts had to express an interest but that there were strict criteria around what needed to be provided, such as 24 hour coverage by an Accident and Emergency specialist.

(5) The sites proposed led to Members posing a number of specific questions. One Member suggested that the Pembury and Ashford sites were too close to the other, and specifically in relation to Pembury, it was pointed out that it was not on a motorway and served a large number of people outside of Kent and more information was needed on patient flows from those areas. Following on from this, the lack of any Major Trauma Centre between Brighton and London meant that Pembury was likely to become a hub and this raised questions around whether Pembury had sufficient capacity.

(6) Issues around capacity were also raised around Darent Valley, with the additional pressures caused by the closure of the Accident at Emergency Department at Queen Mary's. It was explained that Darent Valley was not selected as one of the sites as it falls within the 45 minute isochrones for accessing a Major Trauma Centre within London.

(7) Capacity across the entire system was also questioned and the issue rose of where people would be taken if King's was full. It was pointed out that while there was some prediction possible, trauma could not be completely planned for as to when and where it happened. One Member raised the issue of the possible use of private hospitals, such as the one being built in Maidstone.

(8) The representatives attending on behalf of the Network were thanked for providing a succinct overview of the proposals in the time allowed and Members were asked to forward any outstanding questions they had to the Committee Researcher for answering when the Committee returned to the subject.

(9) AGREED that the Trauma Network be invited to return to a future meeting of the Committee and that this meeting be in the form of a Joint HOSC with Medway should the equivalent Committee wish also to explore this matter further.