MAJOR TRAUMA IN YORKSHIRE AND THE HUMBER: ADDITIONAL INFORMATION FROM LEEDS TEACHING HOSPITALS NHS TRUST

Leeds Teaching Hospitals Trust

Y&H Major Trauma Network information requested by Leeds Health Scrutiny Board 25th January 2012

Overview

- Establishing a major trauma network is mandated by the NHS Operating Framework 2010-11 and the NHS has therefore been committed to change by the Secretary of State for Health and Parliament.

- **Leeds Teaching Hospitals Trust (LTHT) board are committed in principle to supporting this designation** as it will clearly benefit critically ill patients to be treated at LGI, but the board has a duty to ensure that other services and patients are not adversely affected if we are chosen to host the Major Trauma Centre.

- We are still in negotiation about how the NHS can best mitigate the impact of this change. It will require us to find extra capacity at an already busy City centre hospital and extra money to cope with that changing demand. We are hopeful of reaching agreement soon.

Background

The major trauma programme was established in 2009 and has involved all NHS organisations in the region, coordinated by NHS Yorkshire and the Humber. Patients, charities and stakeholders are engaged in the process. The proposals have evolved and they continue to change as issues are addressed in detail and we move, in West Yorkshire, towards opening the network in April (phase 1).

Major trauma data is incomplete and therefore providing definitive major trauma patient numbers is difficult. We have undertaken *activity & financial modelling* work based on the best data available to provide a sensible best estimate. The Regional NHS approach is designed is phases so that changes to patient flows are in (as much as possible) aligned with the available capacity within major trauma centres and do not compromise local trauma services.

LTHT have discussed with the Strategic Health Authority the level of public engagement required which has, to date been co-ordinated at this level by Strategic Commissioning Group (SCG) of Primary Care Trusts. For the West Yorkshire network the main patient movement will be from the surrounding Trauma Units to Leeds General Infirmary.

LTHT is trying to manage this change be ensuring that this increase in complex workload is matched by sufficient capacity to cope so we avoid any impact on Leeds's own trauma patients. To mitigate any risks from activity change a network will actively coordinate existing services with a Trauma Co-ordination team repatriating patients back to local trauma units (based in the District General Hospital's of the Region) as soon as their initial treatment has been completed –

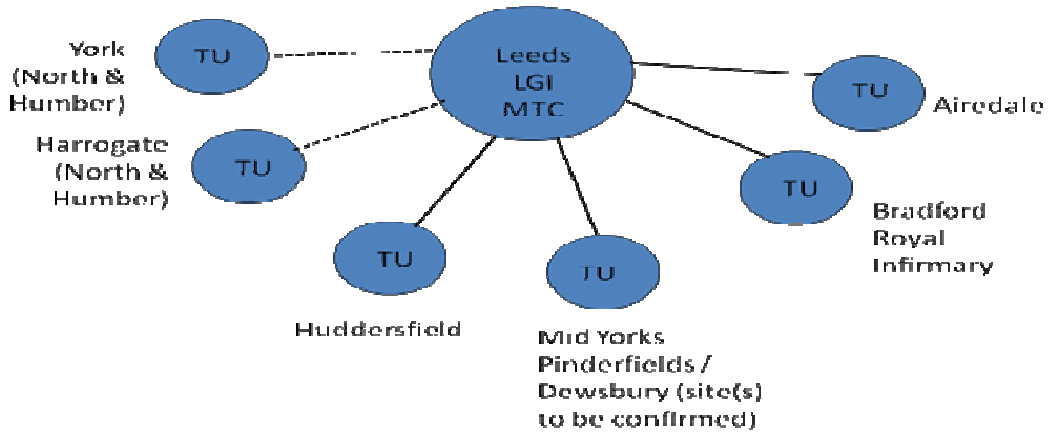
our working assumption is that patients will probably spend the first seven days of their treatment in LGI - though this will depend on the severity of their injury.

This development for West Yorkshire does not see services decommissioned. And, whilst the change to outcomes for an individual patient could be dramatic (return to fully able life rather than life changing disability), the NHS across England does not view this as "significant change" to service.

Specific information requested by Leeds OSC

Details of the proposed networks / patient flows - including projected patient numbers

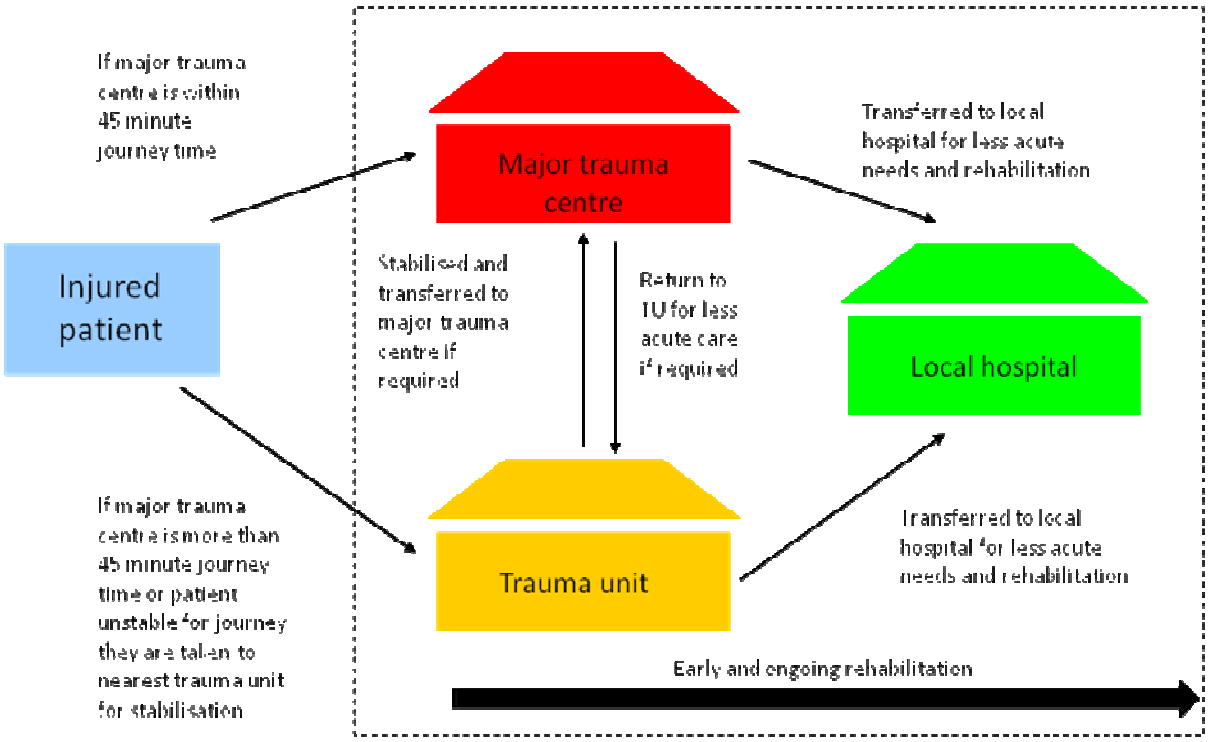
The West Yorkshire network has LGI as the Major Trauma Centre (MTC) with a number of Trauma Units (TUs) in the district general hospitals surrounding the city.



Details on the implications / benefits for patients

What will the network mean for patients who sustain major trauma?

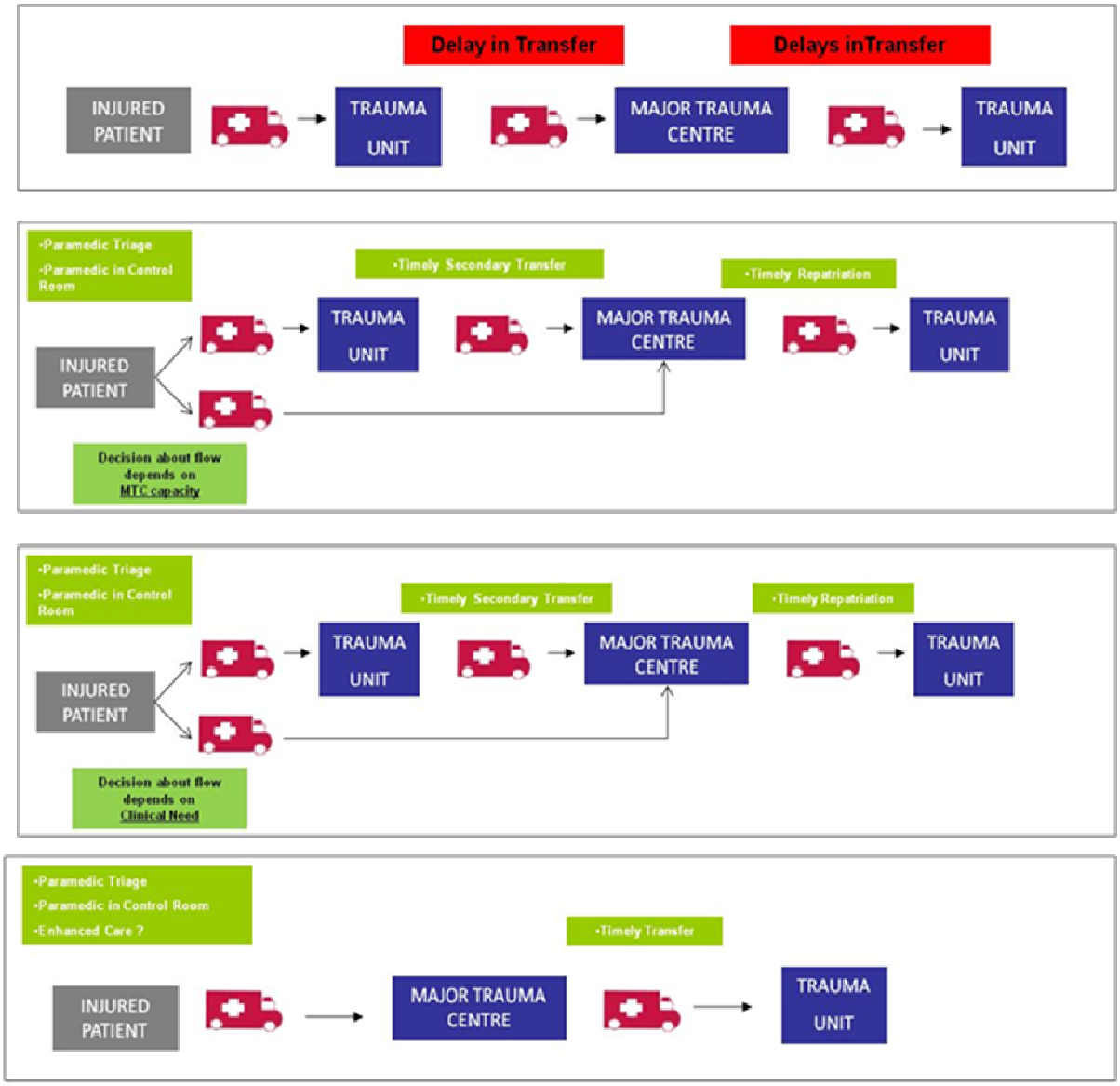
- Major trauma patients will be assessed immediately and taken directly to the Major Trauma Centre. If they arrive first at a Trauma Unit (TU) there will be no delay in transferring them to receive the specialist care they require. Many of these patients will currently be taken to a major trauma centre, but only after having initially being taken to their local hospital and then potentially delayed waiting for tests and a transfer for the more specialist care they urgently require
- As soon as it is clinically appropriate to do so patients will be transferred back to their local hospital for follow up care and to begin their rehabilitation. Our working assumption on this is up to seven days at LGI.
- The impact of this improved coordination will mean quicker diagnosis and specialist treatment for patients resulting in a better change of avoiding death or long-term disability and access to highest grade of treatment available in the Region's Teaching Hospital.



A phased approach will be taken to implementation to help ensure that demand meets capacity within the system.

The phasing described in the diagram below will run from 1 April 2012 to 2014. It is proposed that phase 1 commences in April 2012 with the implementation of a senior paramedic in the ambulance control room who will liaise directly with the paramedic on scene and the Major Trauma Centre to determine the clinical needs of the patient and the most suitable destination based on an assessment of clinical condition and Centre capacity.

As a result of these changes small numbers of extra patients are expected in the first phase. The main impact of this phase is to bring patients who already access the facilities of Leeds earlier in their pathway and repatriate them to local hospitals in a timely manner. Funding does remain an issue which needs agreement, however, we remain committed in principle to supporting the move to centralisation is this is at all possible and believe that an equitable solution can be found before we move to full implementation.



By introducing a major trauma network we will:

- **Significantly improve the numbers of major trauma patients making a recovery to a "non-dependent" life.** Currently 75% are left with a significant long-term disability.
- **Save lives** (an estimated 15% reduction in lives lost), in Yorkshire and the Humber we estimate that we can save an additional 30 lives a year (Source: Cost Effectiveness of Regional Networks for Major Trauma in England 2011)
- **Improve access to specialist services regardless of where in the region** they are injured – reducing variations in treatment and outcomes
- **Reduce Length of Stay** (LOS) by an estimated 4 days due to earlier transfers, more rapid and definitive care and fewer complications (Source: NCEPOD Regional trauma system guidance for commissioners 2009)
- **Improve access to rehabilitation services for all**

Details on the likely impact on other LTHT hospital based services

Modelling from the Yorkshire & Humber Observatory (YHO) indicates an annual shift of 521 major trauma patients from the TUs to LGI, an increase of 68%, taking the total number of major trauma patients treated in Leeds from 758 to 1279 a year.

The 758 patients LGI currently treats in a year include patients that are currently received as secondary transfers from other trusts within the sub-region. It is likely that a proportion of the additional 521 patients would also have been received by LTHT as secondary transfers from other trusts.

However, there are concerns over the accuracy of the modelling and the impact of over-triage (patients diverted to the MTC from scene of incident when their injuries do not require this level of intervention) has yet to be fully understood. Experience from London suggests for every major trauma patient, two more suspected MT patients arrive in the Emergency Department who thankfully do not require MT specialist care. The unanticipated impact of these patients could have a significant impact on the Emergency Department, plus have a knock-on effect on other services as these patients are treated before being sent to their local Trauma Unit. The sub-region will therefore work very closely with Yorkshire Ambulance Service (YAS) during phase 1 to understand and mitigate the impact.

LTHT are establishing the Clinical Governance / Quality Improvement programme for the sub-region, with the first meeting scheduled for January 2012. During this phase, preparatory work will be undertaken to ensure the network is ready for direct transfer of patients and also improve the current provision of major trauma care for patients that are already transferred between trusts as secondary transfers.

Monthly meetings for clinicians and managers will focus on:

- Development of cross organisational patient pathways that ensure timely and efficient secondary transfer and repatriation
- Development of protocols that ensure consistent clinical management and improved patient experience
- Development of Key Performance Indicators
- Cross organisations clinical governance meetings, analysis of morbidity and mortality, outcome data
- Establish data capture to inform Activity and Finance monitoring
- Establish sub regional infrastructure to support the management of the Major Trauma Network.

It is proposed that from April 2012 we will receive direct transfers to Leeds General Infirmary (LGI) based on clinical need. We have a way to go to reach agreement about this with our commissioner. There is still a disagreement about the number of patients we can realistically treat. The level of clinical need is yet to be determined and until this is, there is a risk to this phase.

We believe that in the first phase this will be a small number of patients with severe major trauma, such as head injuries, who would probably already be transferred to LGI as secondary transfers under the current model.

From April 2012 LTHT will also accept secondary transfers from Trauma Units (TUs) within 2 days of initial request. As stated previously, LTHT already receive a number of major trauma patients from local TUs as secondary transfers. The requirement to receive them in a timely manner will make having robust repatriation and discharge protocols in place critical to avoid having a negative impact on LTHT's ability to manage existing activity; this work will be developed through the Clinical Governance / Quality Improvement Forum.

Early calculations about what it will cost to implement the phase 2 suggest that LTHT could need to find up to £5.3 million above the tariff being currently offered for this service. Phase 3 extends this to the provision of comprehensive long-term rehabilitation which, so far, has not been accounted for in any of the financial modelling.

There will also be financial pressures felt by Trauma Units (based in the district general hospitals in the rest of West Yorkshire) if they lose activity but are unable to remove any of their fixed costs there will be financial consequences.

LTHT and the rest of the Western sub-region network have therefore only agreed to progress to phase 2 once the financial issues are resolved. Moving into this phase will require agreement by all Trust Boards within the sub-region.

LTHT board are committed in principle to supporting this designation as it is the best thing to do for critically ill patients, but we also must ensure that our other services and patients are not adversely affected.

Impact on other related services and/or organisations (e.g. YAS, Embrace)

- We have been informed that an analysis of the ambulance service business case for implementing the major trauma network has been undertaken and a "confirm and challenge" process, led by senior managers and clinicians has tested the plans.
- YAS do want consistency in approach across their operating region - we support this call.
- The Network structures are being designed to ensure a whole system view is taken into account allowing any cross boarder issues to be identified and addressed early than at present.

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January 2012