The College of Emergency Medicine

Patron: HRH The Princess Royal

Churchill House
35 Red Lion Square
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Dear North West Fellows and Members,

Re Major Trauma Networks; FAQs

I recently attended the launch of the Clinical Advisory Group (CAG), chaired by Professor Keith Willett, Oxford Orthopod and National Clinical Director for Trauma. This group will advise on the establishment of trauma networks in England. The initiative is driven by recent evidence of continuing poor outcomes among major trauma victims (MTV) in the UK. EM is well represented in the group, and John Heyworth co-chairs the *Acute Care* subgroup. The likely outcome is that SHAs will commission projects to examine how 'hub and spoke' systems, centred on regional trauma centres (RTC), should be established. *Healthcare for London* set out the model for the capitol, with 4 centres (at Kings, St Mary's, RLH and St Georges) receiving MTV from next year, both by primary transfer, and by secondary transfer after resuscitation at one of a number of Trauma Receiving Units (TRU). The East Midlands health economy has modelled a similar system and has received business cases for RTC status from University Hospital Nottingham and Leicester Royal Infirmary. That system should go live in 2012.

(1) <u>What does this mean for EMNW?</u>
If the common model is accepted then there will be a recommendation for one or more RTCs in our region. Transfer times must be less than 45 min to enable primary transfer (by-passing other EDs) from the scene, otherwise the patient will be taken to the nearest TRU. To qualify as a TRU, incidentally, the ED will have to receive around one major case a week (50-80 pa). While major university teaching hospitals may want to be considered for RTC status, most of us will transform seamlessly into TRUs. Criteria have yet to be determined, but RTCs will have (more or less) all services on site (see section 4) and a major trauma workload (ISS >15) of at least 500 cases per year. There will have to be robust systems for primary and secondary transfer, 24/7 senior-based assessment and resuscitation, imaging and surgery, as well as adequate critical care capacity and rehabilitation infrastructure. RTCs would be expected to participate fully in outcomes audit and be contributing to TARN. Helicopter transfers may not be mandated where reliable ground transportation (<45 mins) is available.

(2) <u>Will my department be 'downgraded'?</u>
Eligible patients for primary or secondary transfer to RTCs represent 0.1% of the activity of most EDs. There should be no perceived threat, rather the need to improve trauma management within TRUs may be seen as an opportunity to gain support for consultant expansion and funding for TARN. The ability to deploy seniors to the floor 24/7 will be a standard of care for any hospital receiving MTVs. A new approach to trauma care in the Northwest could bring a number of benefits, not least a change in approach from the secondary receiving hospitals. The RTC will no longer be able to 'turf' a patient because they lack a (ICU) bed. They will be obliged to take the responsibility find a bed, wherever that may be, from the point of referral. This should bring an end to the 'pass the parcel' experience, familiar to all of us who refer patients for specialist care.

(3) What should I do now?

There is no need for urgent action within the Trusts. The CAG will report to Ministers and the NHS by spring 2010. If the SHAs accept the recommendations then members and fellows will be invited to participate in a major trauma project team commissioned by NHS Northwest. The East Midlands project is at least 2 years ahead of the game and they will not go live until 2012. In the meantime we should look at our own systems and consider how we can improve trauma care. As a minimum we should start to consider ways to secure 24/7 consultant-based trauma resuscitation; either by consultant expansion or confederation of departments at the senior level. And, of course, we should all be submitting data to TARN (www.tarn.ac.uk)

(4) What is meant be 'all services'

I take this to mean 24/7 on-site access to the usual 'staples' of EM, ICM, Surgery and orthopaedics, plus: neurosciences, max-fax, spinal, thoracic, urological, bony pelvis and interventional radiology. Burns, ENT and ophthalmology remains to be determined, and paediatric trauma is the subject of a separate project.

So far as I know there is no trust in the NW that satisfies all criteria; MRI lacks adult neurosurgery and there is no CTC at Preston. None of the Mersey Trusts boast the full complement.

Patrick Nee
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College of Emergency Medicine