

PAPER FOR NORTH YORKSHIRE COUNTY COUNCIL

SCRUTINY OF HEALTH COMMITTEE

24 September 2010

Transforming Trauma and Orthopaedic Surgery

1 Purpose

- To inform the committee about national discussions on the provision of trauma services (physical injuries caused by events such as falls, accidents or violence) services and proposals for the future management of patients requiring treatment for orthopaedic trauma from Hambleton and Richmondshire in line with best clinical practice and to seek the Committee's views on these changes.
- To set out proposed further engagement with key stakeholders and the public on taking forward these proposals.
- To invite comments from NYCC OSC on the proposed approach to public engagement, as set out in appendix 1 to this report.

2 Background

Currently orthopaedic and trauma services (patients who have suffered multiple or severe injury) are delivered at both FHN and JCUH as largely independent services delivered by separate teams. At FHN the service delivers a trauma service (with the exception of major trauma cases and children who are diverted to JCUH) and an elective orthopaedic service, both from Gara Ward.

In 2009/10, 5908 patients were admitted to JCUH and 3284 to FHN. Of these patients:

- 1709 patients required emergency surgery at JCUH and 537 at FHN;
- 2797 patients had elective surgery at JCUH and 2175 at FHN;
- 1403 patients were admitted but did not require an operation at the time of admission at JCUH and 572 at FHN.

FHN has a busy orthopaedic department but one which sees a small amount of trauma work. This raises concerns about the Trust's ability to offer the best service and to achieve the best outcomes for patients given current developments in standards and the pressures on the service.

Trauma centres

There is a national debate about how trauma services are organised given the poor outcomes achieved in the UK and the benefit of designating trauma centres which deal with the most severe cases to address this.

This discussion is being taken forward by clinicians, commissioners and managers across the North East SHA as part of the work to develop a proposal to implement the "Our Vision, Our Future" Strategic Report initially produced in spring in 2008 as a result of Lord Darzi's report on the NHS.

The recommendation to Chief Executives across the North East is that there should be the designation of two regional centres to serve the North East - in Newcastle and at JCUH - dealing with the most severe cases of trauma. This recognises the extensive skills and facilities which already exist at JCUH. These skills include not just dedicated orthopaedic trauma consultants but cardiothoracic surgery, neurosurgery and other relevant specialties so that all the skills to deal with severe injury are available rapidly. The centre will work with other hospitals so that patients who have sustained serious injury are delivered safely and rapidly as possible to the hospital with the necessary specialists.

As well as reflecting the high level of expertise which currently exists within JCUH, this also means that the service will further develop its skills in the management of trauma. The clinical team believe that all trauma management should be provided at JCUH to ensure that patients benefit from this service and that this is in line with best practice nationally and internationally.

Standards of trauma care

The creation of trauma centres represents a leap forward in the delivery of major trauma services, but there have been significant changes in the delivery of all aspects of orthopaedic care. These include sub specialisation - doctors practising in very specific areas such as lower limb surgery or hand surgery - and the recognition of the correlation between case volumes and outcomes.

Best practice for trauma cases is for patients to be treated by a team of specialists since the knowledge and skills of the team outweigh those of a single surgeon however experienced. Maintaining case volume when activity is split between two sites is difficult, particularly for trauma (a sub specialist trauma service at JCUH is currently provided but not at FHN). Surgeons at FHN may not see sufficient cases to maintain their skills and ensure best outcome for patients.

Best practice for elderly patients who suffer a fractured neck of femur (a common fracture in elderly people following a fall) is for them to be admitted under the joint care of a geriatrician and an orthopaedic surgeon. Minimising pre-operative delays and reducing the overall length of stay is critical to ensuring patients achieve the best recovery. Early diagnosis and assessment by an ortho-geriatrician and anaesthetist, within 48-72 hours of admission, enables the operation to go ahead as early as possible and for rehabilitation on a dedicated hip fracture unit to start immediately post-operation. As with trauma, only a large hospital such as JCUH will have the volume of patients to ensure that it has the necessary geriatricians and dedicated facilities to deliver the best practice pathway and achieve the best outcomes.

Experience elsewhere, for instance at the Holland Orthopaedic and Arthritic Centre in Canada which exemplifies international best practice, has shown that separating elective care from emergency trauma care can bring significant benefits. Health care acquire infections can be reduced through ring-fenced beds for elective admissions and length of stay can be reduced.

Access to services and best use of resources

Under the current model of trauma and orthopaedic surgery, both FHN and JCUH provide the full spectrum of services. The low volume of trauma surgery undertaken at FHN means that the current arrangements for trauma at FHN are inherently inefficient. There are on average 10 trauma patients a week at FHN based on 2009/10 data. To provide a safe service for these patients requires consultant and other senior medical staff to be available twenty four hours a day and theatre lists to be set aside exclusively for trauma cases. The requirement for a dedicated on call consultant at all times means that, in addition to these poorly utilised theatre sessions, sessions are lost each week because the consultant has to be available to respond to trauma cases and cannot undertake elective operations. The on call arrangements are the same between JCUH and FHN – one consultant covers each site although volumes at JCUH are much higher – 1709 cases at JCUH in 2009/10 and 537 at FHN.

These arrangements mean that consultant time and theatre time is being under used even though Orthopaedic referrals have increased by over 30% in the last five years and continue to increase across all PCTs despite investments in musculoskeletal triage and GPs with specialist interests (GPwSis). From 2008/09 to 2009/10 elective surgery increased from 2670 to 2885 spells (an 8% increase). In 2009/10 only 78% of patients were treated within the 18 week target. While this has improved in 2010/11, referrals have continued to increase and the orthopaedic department needs to use all available capacity as efficiently as possible to ensure it offers patients timely access to services.

3 Proposed Service Model

To respond to these pressures and modernise the service to meet best practice guidance the proposed service model would see the development of a fully integrated orthopaedic and trauma service across both sites. Trauma care would be centralised at JCUH while FHN would become an orthopaedic treatment centre for elective procedures – the volume of orthopaedic activity undertaken at FHN will increase as a result of the change as more elective work than currently undertaken will be carried out at the hospital. There will be more integrated working between JCUH and FHN with JCUH based consultants running clinics and undertaking lists at FHN.

Major trauma cases attended by the ambulance service would be transferred direct to JCUH. All other trauma patients whose natural catchment is FHN would initially be seen in A&E at the Friarage for assessment. Those requiring emergency surgery would be transferred to JCUH by a twice daily ambulance service; those not requiring emergency surgery would be treated in A&E and either admitted as non-surgical cases or discharged with referral for elective surgery or out-patients clinic if necessary. The model is shown diagrammatically in appendix 1.

Patients transferred to JCUH would be returned to FHN after surgery for part of their post operative care. We envisage Fracture neck of femur patients being returned to FHN after 48 hours – the length of stay for other cases will be very short.

Based on historic trauma activity it is estimated that on average ten patients a week would transfer to JCUH. Occasional difficulty in providing an on-call service at FHN (in part because of short notice deployment of military doctors) has resulted in trauma patients being transferred to JCUH for a week at a time on occasions over the past twelve months. The numbers of patients transferring during these weeks has been on, average, one per day, which suggests that fewer patients than historic information indicate may be affected.

The benefits of the proposed reconfiguration are:

- it would address the current concerns about the low volume of trauma work being carried out FHN and the sustainability of this service model;
- it would allow compliance with best practice guidance for fractured neck of femur with orthogeriatrician input which would not be possible at FHN;

- it provides the potential for a strong, sustainable role for the hospital as an elective centre for orthopaedics. The availability of sub specialisation on site (eg hand surgery) is being improved to give patients access to services which were previously only available at JCUH;
- it allows for full utilisation of theatres and beds at FHN;
- it allows the Trust to improve the delivery of trauma care by more effective use of consultant time;
- it would allow the Trust to release poorly used theatre capacity, and, with the appointment of planned additional consultants puts the Trust in a much stronger position to sustain and improve delivery of waiting times (which remain a constitutional guarantee) for all commissioners.

4 Stakeholder and Public Engagement

- **PCT**

The Trust has been working with the PCT on these proposals which will be discussed at the Clinical Executive at the end of September.

The PCT and South Tees Hospitals Foundation Trust has already begun discussions with key stakeholders to brief them on the proposal and gather views, which to date have been positive.

- **GP Commissioners**

GP lead commissioners have been briefed on the proposals and have discussed the proposed change to the care pathway with clinicians and managers from South Tees Hospitals Foundation Trust.

The Practice Based Commissioning Board and the Local Medical Committee will be asked to formally support the proposed change during their meetings in September, both meet just prior to the Overview and Scrutiny Committee.

- **Ambulance**

The Trust has discussed the pathway with NEAS and Yorkshire Ambulance Service (YAS) who have identified the additional resource required to provide patient transfers and the Trust has built the cost of these changes into its plans.

- **Public and Patient Engagement**

The aim of the engagement is to inform key stakeholders and patient groups why a change to the care pathway is proposed and what this will mean for the future provision of services and to invite their comments.

The following key messages will be given when communicating and engaging on the proposals:

- To explain the aim of the proposed changes to Trauma and Orthopaedic services.
- To set out what the services are (high level) and how they are currently provided and how patients access them.
- To explain why the current services need to change.
- To explain what the proposed change is.
- To explain the differences between the current care pathway and what is proposed, detailing who will be affected and how.
- To explain what the benefits are and how outcomes for patients will improve and how the patient experience will change.

- To explain when the change will take place.
- Comments on the proposed change are welcome, we want to understand any concerns which will inform planning about the proposed change and whether there is support for the proposal.

The PCT has developed a public engagement plan. A draft is appended which the Overview and Scrutiny Committee is asked to comment on.

5 Summary

These changes aim to improve the quality of orthopaedic services to meet current best practice and to put them in the best possible shape to for the future.

The Overview and Scrutiny Committee is asked to:

- Consider and comment of the proposed changes.
- Consider and comment on the proposed public engagement process about the changes in the trauma service

**Prepared by Jill Moulton, Director of Planning
September 2010**

Transferring orthopaedic surgery engagement plan:



NYY PCT Trauma
Engagement Plan.doc

Trauma Care Pathway



Trauma Pathway.doc

Public Engagement Plan – Trauma / Orthopaedic Services

Appendix 1

Meetings arranged by PCT				
Date	Event	Process	Key people to attend	
	<ul style="list-style-type: none"> • CMB 21st July 2010 • PBC Board 15th September 2010 • ICE 24th September 2010 • OSC 24th September 2010 papers H&R LMC 21st September 2010 	<p>Paper with Briefing to Directors, ICE, OSC, PCT Board</p> <p>PBC – part of TARGET</p>	<p>Internal PCT – A Brown and Mikki Golodnitski, Adrian Jones and Graham Dickinson, Abi Tebbs</p> <p>External A Brown, Jill Moulton, Grahame Dickinson, Adrian Bergin, Adrian Jones</p>	
Local Councils				
	<p>Richmondshire District Council</p> <p>Hambleton District Council</p> <p>North Yorkshire County Council</p> <p>Town Councils (Northallerton, Thirsk, Stokesley, Richmond, Leyburn, Hawes, Bedale, Easingwold, Colburn, Catterick)</p>	<p>Letter with Briefing inviting comment</p>	<p>Amanda Brown</p>	
Letters to stakeholders -				
	<p>William Hague MP</p>	<p>Letter with information</p>	<p>Chair/CEO letter</p>	
	<p>Ann McIntosh MP</p>	<p>Letter with information</p>	<p>Chair/CEO letter</p>	
	<p>Julian Sturdy MP</p>			



	MOD – Catterick & RAF base	Letter with information inviting comment	A Brown	
21 st September	Local Medical Committee & PBC, Northallerton Division	Letter with information inviting comment plus attendance at meeting	A Brown, G Dickinson	
	NYCMHS	Briefing	A Brown, Jan Aspinall, Alison Woodhouse, Jill Moulton	
	H&R Strategic Review – Unscheduled Care	Update	A Jones, Grahame Dickinson	
	Local Organisations <ul style="list-style-type: none"> • Ham & Rich Carers Centre • Age Concern • Stokesley Carers Centre • Broadacres Link to LTC • Dalecare, St John's Centre • North Yorks Forum Voluntary Organisation (to cascade to other community groups) • 'Hop A Long' Group FHN 	Letter with briefing document inviting comment	Suggest joint letter from: A Brown Jill Moulton GP Clinician	
	NYCC – Adult and Children Services	Letter with information inviting comment	A Brown	
	SHA <ul style="list-style-type: none"> • Yorks & Humber • North East 	Letter with information advising engagement underway	A Brown, Jill Moulton	
	LSP – Hambleton & Richmondshire	Letter with Briefing Paper as an agenda item	A Brown	
	North Yorkshire LINKs + LINKs groups for Richmondshire and Hambleton	Letter with Briefing inviting comment	A Brown, Sandra Donoghue	

	NYY Overview and Scrutiny (Health) Committee	Briefings and Papers	Clinicians, Jill Moulton	
	YAS / Air Ambulance/NEAS	Agreement to pathway and operational consequences.	A Brown, R Clayton, Medical Director	
Media				
	Local Media	Briefing pack, proactive media briefing, press releases, interviews, PCT web site	STFHT and PCT Commissioning teams	

Pathway for Trauma Patients Presenting at the FHN and Requiring an Orthopaedic Opinion

