National Major Trauma Nursing Group

Monday 14th September 2015
10:00 – 16:00
Midlands Trauma Network Meeting Room
4th Floor Kings House, 127 Hagley Road, Birmingham, B16 8LD

Approved Minutes

Present:

Robert Pinate (Chair)	Nurse Consultant, Kings College Hospital London
Sarah Graham (Minutes)	Service Improvement Facilitator, Midlands Critical Care Network
Sue Booth	University Hospital of Newcastle
Gabby Lomas	Matron/Emergency Medicine, Salford Royal
Mark Dawes	Trauma Nurse Practitioner, New Cross Hospital
Mandie Burston	Trauma Co-ordinator, Royal Stoke University Hospital
Andrea Hargreaves	Practice Development Nurse, University Hospital of Coventry
Jane Owen	Major Trauma Service Lead, University Hospital of Coventry
Sharon Sanderson	Major Trauma Case Manager, Nottingham University Hospital
Josephine Merrifield	Nottingham University
Laura Walker	A and E Educator, Nottingham University Hospital
Rosalind Palfrey	Major Trauma Co-ordinator, University Hospital Southampton
Bruce Armstrong	Lead Clinical Educator, University Hospital of Southampton
David McGlynn	New Queen Elizabeth Hospital, Scotland
Jill Windle	Salford Royal Foundation Trust

Apologies:

Professor Chris Moran	National Clinical Director for Trauma, Professor of Orthopaedic Surgery, Nottingham.
Anne Taylor	Consultant anaesthetist, Royal Stoke University Hospital
Jonathan Jones	Consultant in A and E, Leeds Teaching Hospital
Simon Davies	Trauma Co-ordinator, Royal Stoke University Hospital
Karen Wood	Sister in A and E, South Tees Hospitals Foundation Trust
Sue Murphy	A and E Manager, South Tees Hospitals Foundation Trust
Professor Rob Crouch	Consultant Nurse and Visiting Professor, University Hospital Southampton and University of Surrey

1. Welcome and introductions:

Introductions were made round the table. RP welcomed the group and thanked colleagues for attending.

2. Apologies:

Recorded as above

3. Minutes of the last meeting 1.7.15

Approved as an accurate record.

4. Matters arising:

a) Chair position and Vice-Chair

Since last meeting SD felt he was unable to commit to the position of Chair. As RP agreed to be Vice Chair he asked if anyone wished to put them self forward however everyone was happy for RP to take up the position as Chair. No-one present volunteered the Vice Chair position, RP will circulate the request to all the contacts with when the minutes are circulated.

RP presented the aims and objectives, the link into the CRG, and that what appeared in the peer review documents was the catalyst for the meeting which was to address the meaning of the word 'equivalent' in the standards.

It has been agreed that we will have the equivalent question dealt with by December 2015 and a set of competencies ready by Jan 2016. Which we will review today.

b) Admin support

The Midlands CC and Trauma Network will continue to provide refreshments and room facilities.

Prof Moran will receive the minutes and papers so we can establish who we are accountable to as a national body.

5. Terms of reference – discuss/finalise:

a) Membership

We need to establish a definitive list by network and agree numbers per-network. RP presented the contacts broken down by each network. RP will update them and circulate after the meeting. We also need representation from those not represented, e.g. Welsh representation. Everyone agreed to contact all those they already know in those networks.

DMc mentioned that the Scottish Government had agreed that from next year there will be 4 MTC's, together with TU's. Although policy has been set out there had been no discussions as to who is running the networks, cohort arrangements etc. DMc will be taking back what is required of the ED requirements. RP asked for reps from Dundee, Aberdeen and Edinburgh.

b) Quorate

We need to agree how many members from each network we will require, what is a reasonable number? Mel Kynaston (MK) mentioned that their group sent requests to their professional bodies e.g. ICC. We will need to consider a patient rep on the group.

Group agreed 2 people as a minimum, and no more than 3 from each network but we will require a cross section from MTCs and TUs. GL agreed to contact a patient rep she knows.

The medical workforce representation can be covered by Prof Chris Moran, Prof.Sir. Keith Porter and current medical membership (Dr Jonathan Jones (Leeds and RCEM Trauma Group Chair) and Dr Jackie Gregson (Northumbria)) which would help us in the future especially regarding emergency nursing and clinical practice, it would be important to have their engagement however we would need to be mindful of the total numbers on this nursing group.

We do not have anyone from Health Education England (HEE) which is really important if we want to commission this group in the future and to highlight the way forward for Peer review.

We will need to have national standards so that commissioners actually commission them. MK said that they got their competencies written into the service specification and that the HEE were really not that interested for critical care, neither were the NMC. However, since it's been to the CRG it has been agreed as a standard. JW said she had been in contact with the HEE in the past but just so they knew what they were doing.

6. Presentation from Angela Himsworth & Mel Kynaston on how they developed their competencies for ITU

AH provided information about CC3N group and the competencies. AH felt it is important to ensure every trust knows about this group to ensure work is not being developed elsewhere / duplicated. Be clear as to this groups function and remit. For Critical Care there were no national standards, the group produced some minimum content and competencies to go with them. AH confirmed that there is no funding for CC3N, so where the group do not incur travelling costs they put towards lunch etc. or have reps to cover the cost of lunch but there are no funds for publishing either, so they asked network managers and reps for funds. RP presented the group with the booklets produced by CC3N and how they got to that stage and how we could learn from them.

Further discussions regarding the Higher Education Institutions (HEI) and why CC3N chose this way forward. MK said that there was so much disparity with other courses they had to review each of them to ensure they had transferable awards. The drive was getting the academic part sorted which they got the national bodies to endorse.

RP asked about HEI's and if we should look at them? MK, they had the same problem, but they have seen a move to these competencies by hospital trusts. We need to have some dialogue with the Universities so they understand what they need to provide and the reasons why. Some trusts are using the competencies as part of their job descriptions, but all this is because they are part of the national criteria. CQC have also picked up on them and are asking if trusts are using them, which is very positive. The competencies can help support staff or can be used for performance management purposes.

JW: said the Faculty of Emergency Nursing (FEN) competencies were being revalidated off which would include some trauma elements. There are many trauma ones already written elsewhere so we will need to decide what is core or essential, and how other variances could be matched.

MK also worked with Skills for Health so they could see which of the national occupational health standards could be mapped over which made it easier for the assessors to sign-off the competencies as they were standardised.

AH mentioned the importance of Mentors and assessment tools.

MK mentioned that as part of the new revision they have separated the skills and the knowledge, this has been kept in step 1 but steps 2 and 3 they have been brought together due to a lot of repetition.

MK said there was no supernumerary competencies identified which we may want to do. Mentors have found it very useful.

There had been new sections in the new revision like revalidation, quantifying the steps to their CPD in hours and they also built in some reflective practice. MK

presented the type of things that are as a result of the revision process e.g. learning contracts, the group agreed we should have this. Title to include 'Registered'? However some trusts have ODP's, paramedics etc. so need to consider this. Reflective practice documentation – taken from the nursing code of conduct and the NMC revalidation check list.

RP mentioned the section about the assessors, CC3N included who they should be and the skills they require. They stipulate how much time they will require on the assessments. The group agreed we also need to do this but it will be a challenge. Will need some investment to get these assessors up to scratch especially in the TU's however this could also be done via other routes e.g. scenario based training which would be acceptable especially as some units don't see much trauma.

Modalities of assessment need to be included. They don't re-assess throughout the document. They will become working documents that will require on-going development.

JM agreed to speak to TARN to see if they can produce some data and host a website.

All agreed that the CC3N steps should be given to trauma nurses if they also do additional critical care work so they can do the specific competencies.

The group agreed to inform CC3N when they have the work completed and we may want to ask military personnel to look at the competencies too.

MK will send RP the revised version when ready.

RP invited Angela and Mel to work closely with the group in future when we begin to consider the major trauma critical care nursing competencies.

7. What does equivalence mean – how do we define it?

RP highlighted to the Trauma Peer Review team who visited his network why is the nursing component in the TQuINS a sub section in Trauma Team Leader and why nursing doesn't have a section of their own. RP showed what the Pan-London group are using and the nursing section as set out in the South East London Kent and Medway (SELKaM) TU and MTC criteria.

<u>Equivalence is?</u>

The group went through the training currently available:

- ATNC: does fulfil the leadership standard, but difficult to set up and runs alongside ATLS course.

- TNCC: International, formal assessment process on trauma scenario, demonstrates knowledge, how to articulate and manage a trauma call, OSCE, written paper testing knowledge, can demonstrate competency in leadership.
    - BA felt that any training course not provided in the document glossary should be brought back to the group for discussion and approval.

  Group agreed, equivalent to ATNC.

- ETC – if full candidate only, OSCE pass/fail element, no written exam paper element. But can still be a provider for leadership element. Every 4 years.

  Group agreed, equivalent to ATNC.

- TILS – lower level, for those in departments as a 'stepping stone'/introduction to emergency care, in no way is it an equivalent. Something that would be for staff that may not stay in trauma full time/long term. Includes critical decision making. Junior staff, skills focused. Running 4 years, not profitable, can be modified, accountable to the local MTN. Group agreed – not equivalent to ATNC.
    - RP said it is important to ensure it is shown at the appropriate level.

- HEI – varies.
    - JO said its needs to be clear about the components e.g. leadership
    - PR asked if it should include a pass / fail component.
    - Faculty is prepared, assessors prepared. There is something about ensuring appropriate people are providing this training, need to have appropriate teaching skills.
    - Narrow list for 'Leadership' and the range of courses that can be accessed.
    - Need to define what is an acceptable standard course or level of training. Set time scale for achieving the standard.

- BATLS: parallel to ATLS, recognition of team, defined curriculum, but not for everyone, team assessment (really important), valid for 4 years. Clear leadership component. Need in date. Ticks the box as pass/fail. OSCE and written paper examination. Cost free for military. Group agreed, equivalent to ATNC.

- APLS:
    - Written paper/OSCE may not be trauma related, leadership component, but may not be competent in Trauma.
    - Given above issues not able to agree equivalence to ATNC.

- Diploma in Immediate Medical Care:
    - Approved by RCSEd, examiner goes on a course, multidisciplinary, clear leadership, pre-hospital element, high decision making, observer, clear curriculum/OSCI.
    - Does it fit within resus/reception environment? It won't cover everything, and may not be fit everyone, fits with pre hospital environment, but if you have the skill set it could be accessible. E.g. retrieval skills, PHEM trainees.
    - Syllabus, then exam. £680.
    - For consideration but not agreed as equivalent at this stage.

- TTM/TTL Day
    - No pass/fail, build up portfolio, no national standard. Seen as an important part of the trauma education portfolio but not equivalent to ATNC.

Group discussed common themes which may assist in the assessment of equivalence:

- Curriculum must include:
    - Skills and knowledge acquisition in the reception, resuscitation and initial management of the major trauma patient.
    - Curriculum must be nationally and/or internationally recognised.
    - Courses must be consistent in content and delivery. This includes assurance of faculty training to deliver the course.
    - Demonstration of leadership skills of the trauma team/members.
    - Candidates must be required to successfully pass an examination through the use of OSCE and/or written paper.
- Will eventually be up to networks to decide which modality they use.

8. Workshop:

To begin drafting/pulling together National standards - three items in particular

a. Adult ED trauma competencies:

b. Paediatric ED trauma competencies:

c. Education pathway – agree levels:

Essential criteria – TU rewrite of what is in the TQuINS paperwork.

Rob's GROUP

Three stage approach with competencies for each level.

3. Expert = Advanced Clinical Practitioner In addition to standards below.	National curriculum of competency assessment with specific trauma aspects recently published – RCEM/HEE
2. Advanced = Current TQuIN level ATNC or equivalent Attainment of advanced level trauma competencies in addition to standards below.	24/7 availability of one nurse to attend trauma call trained to this standard.
1. Foundation = Orientation to trauma. TILS/TTM/ATLS observer/ETC observer/nurse role, etc. Attainment of foundation level trauma competencies.	90% of staff or 100% of nurses looking after trauma patients – for discussion and agreement

Developing the competencies: sit and go through them all to map them.

Gabby's Group

Very similar as above

Competencies – separate the clinical skills from the knowledge.

Careful about the language used as different equipment for example are used from trust to trust. Could always leave space to put in your own equipment.

How descriptive do we go e.g. tools for assessors. Needed more for the practical skills. Definitely need guidance and standardisation.

Passport type document that is transferrable.

List what needs to be done in each year of your training.

Andrea's Group

Agreed with all of above but need more on non-technical side especially with Paediatrics

Actions:

- Send RP any local documents that units have developed.
- Next meeting first thing on the agenda will be to go through the boxes in more detail.

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3. AOB

- TARN – Group discussed if possible to ascertain a baseline of training from TARN. Currently TARN does have the functionality to input nurses attending and their training but not a mandatory field. However, courses included in drop down menu is limited to ATLS, ETC and APLS only.

Action:

GL/JM to liaise with TARN to request/discuss if nurses attending trauma calls and their competency/educational level could be mandated for entry to TARN.

- Website for this group – TARN – discussed whether they could/would support website development/hosting.
- Links to Health Education England – discussed
- Vice Chair – Jill Windle – put out in covering email for invitation to put name forward.

4. **Date of next meeting**:

Friday 6th November, 10 – 4pm, Midlands Trauma Network Office, 127 Hagley Road, Birmingham, B16 8LD

Summary of actions

Actions	Lead
Contact Patient Representative for inclusion on this group	GL
Hosting and Data set question to TARN to see if they can produce some data and host a website.	GL/JM
Send RP examples of trauma competency documents ahead of the next meeting	All
Draft ToR for tabling at the next meeting	RP
Draft competency document and educational standards for emergency nurses for tabling at next meeting	RP
Draft 'equivalence' paper for tabling at the next meeting	RP