NMTRG Minutes 26/4/2018

Points for discussion:

1. Introductions

Everybody introduced their selves and Stephen Friend introduced himself as the current chair of the Group.

The background to the set-up of the NMTRG was provided included the e-mail conversation with Chris Moran summarised – NICE scoping document summarised (https://www.nice.org.uk/guidance/gid-ng10105/documents/final-scope) and request from the DOH to develop rehabilitation after trauma guidelines. Defined Trauma from scoping document. Discussed the guidance of focus for the trauma rehabilitation guidelines and specialities required in rehab. Explained the role of the NMTRG as a signposting document for NICE.

Stephen disseminated information about the possible link up with the National Major Trauma Clinical Psychology group – who will be meeting next week.

We also discussed the differing needs of the Paeds and Adults service at present and the NMTRG will need to split at some point into Adults and Paeds.

2. Timings of future meetings, travel plans / teleconferencing

Timing for future meetings was discussed. Consensuses decided that 1000-1300 for the sub-group meeting was appropriate and continue to meet every 3 months. A thought of teleconferencing was raised and it was to be utilised for today's sessions. We decided we may need an etiquette protocol if we were going to use it in the future.

3. TARN / Rehab Prescriptions (30 min ?)

The role out of the new RP and the new BPT was discussed. There seemed to be vast differences in practice across the MTC's and even what Major Trauma leaders and TARN have been expecting. Discussion was had around every body's individual RP and it was decided we would upload our RP to the NMTRG webpage for other MTC's to review. A variety of methods of providing information to patients on DC was provided and how this information was recorded with TARN.

Discussion was had around if posting the RP out to patients was included in BPT. Stephen reported he had written confirmation from TARN that sending out the RP is included ifr BPT. This information will be disseminated. There was also questions around the sign off of the RP and if the RP has to be written and completed by a Band 7 or above or just reviewed and signed off by a Band 7 or above. This was debated and no final decision was made. The plan moving forward was for Nicola Dixon to draft a statement of questions to be discussed and unifying answers provided which can be disseminated at the next NMTRG meeting. It was advised Nicola may want to contact Hannah Farrell as she has been tasked with creating a TARN / RP BPT Q&A document.

4. NICE plans for Major Trauma / Feedback for ToR / Statement of Purpose (?)

Feedback about the NICE scoping document. The ToR was disseminated and changes were planned. Stephen will complete this and bring with him to the next meeting in July. It was decided we do not require a statement of porpose and a ToR as they are all covered by the ToR.

5. Capabilities – **The ability of an organisation / group to achieve its objectives / a broader approach**

Capabilities were discussed as a forward move for the group – there were some some concerns about using this title as in some areas capabilities were used for failing or underperforming staff members. We decided the name of the process was not as important at present as the process. It was decided we would look at standards and professional skill sets in relation to injuries to begin with. We can then encompass local guidelines as required and the documents are not there to be a test but to encourage equality of treatment throughout the MTC network. We set a time frame of 12 months to complete the Professional skillset documentation.

6. Structure and possible alignment with Advanced Clinical Practice (https://www.hee.nhs.uk)

    a. Clinical practice
    b. Leadership & management
    c. Education
    d. Research

This underlying structure was agreed and it will sit with the Advanced Clinical Practice plan from NHS for staff members over the next few years.

7. Structure of the Capabilities

    a. TARN specific grouping
    b. ? Poly/Complex MSK UL/Complex MSK LL etc?

The drivers were from the initial conversation surrounding availability or unavailability of service provision for major trauma patients (paeds or adults) at the MTC and in TU's. We needed a way forward to scope the service provision and to ask what would be 'blue sky' treatment from the available services. We also presented the possible need for >65 or a specific frailty model being needed.

The best way we decided to achieve this would be to assess individual disciplines involvement against a small set of injuries and report what treatments would be offered, what we would like to offer but are unable (for whatever reason) and ideally what onward treatment our major trauma patients would receive in and ideal world. From this we can then create ideal MDT professional skillsets with the correct MDT involvement and treatments for each set of injuries, but would allow local guideline use (i.e. collar / brace guidelines). It should then lead to more complex and polytrauma rehabilitation professional skillsets being developed.

These professional skill sets would be underpinned by the four pillars of clinical practice, leadership & management, education and research.

The longer term aim of the rehab guideline is to highlighting educational needs for trusts and services to then

introduce local / national educational resources teaching to make every trauma admission irrespective of the hospital as uniform as possible. It should encompass all starting points and level of clinical experience.

The areas of interest we identified are:

1. Simple UL / LL fractures
2. Complex UL / LL fractures
3. Amputee UL
4. Amputee LL
5. SCI
6. VCI
7. Chest wall and lung injury
8. Abdominal injury
9. Pelvic / Sacral injuries (? inclusive of bladder)
10. TBI
11. Head & Neck
12. Neurological injury outside the cord
13. Vascular
14. Bladder
15. Burns / Degloving / Internal Degloving / Friction Burns

With the aim to gather feedback on Abdominal, chest and Simple UL / LL fractures initially for feedback by the end of June and discussion at the next meeting.

8. Allocate working groups
    a. With specific injury area of focus (for adults / paeds)
    b. Benchmark existing standard / guidelines
    c. Capability Development in working groups

    d. Clinical educational development
    e. Educational information / resources for patients (collate)
    f. Development of PPI / Trauma Peer Network ? (later down the line)

Each representative from a hospital will collect data and present initially back by the end of June. Caire Horsfield will comprise a document for initial data collection, disseminate to the group for feedback and it will then be sent out for data collection. We will review the data as a group at the next session, look for trends and decide about ongoing needs.

We will reconvene on 19th July for the next meeting.