Birmingham, Black Country, Hereford & Worcester Trauma Network

Board Meeting

30th March 2017, 13:30 – 16:30

Meeting Room, Crown House, 123 Hagley Road, Birmingham B16 8LD

Approved Minutes

Attendees:

Jon Hulme - Chair	JHu	Consultant - Intensive Care Medicine/Anaesthetics	SWBH
Steve Littleson	SL	Network Data Analyst (minutes)	MCC&TN
JJ Lee	JL	Major Trauma Fellow	QEHB
Keith Porter	KP	Professor of Clinical Traumatology	QEHB
Ian Roberts	IR	MERIT / RTD Support Officer	WMAS
Clare Brown	CB	Therapy Manager	RHH
Rita Rai	RR	Directorate Manager, T&O	DGoH
Dan O'Carroll	DOC	Trauma Lead	Walsall
Nick Turley	NT	Trauma Lead	Worcester

Apologies:

Sarah Graham	MCC&TN
Jane Wallace	HoEFT
Peter Burdett-Smith	WVT

Adrian Simons	RWH
Kay Newport	BCH

Item	Description
1	Welcome and Introductions
2	Apologies noted above
3	Minutes of previous meeting held on 1/1/17 reviewed and approved
4	Outstanding actions from previous minutes:

	From which meeting?	Original action No	Description	Responsible person
a	18/5/16	2	Arrange Network M&M meeting at Walsall Manor Hospital (TN also has a case she would like to present there) ***30th Mar update*: *this is still required (also see AOB in item 8)***	**SG** to arrange with DOC
b	18/5/16	3	Heartlands Peer review still outstanding. ***Update since meeting: SG met with Heartlands contingency on 13th Apr. Pragmatic decision made to shelf the outstanding peer review, and concentrate on getting things ready for the next round of reviews, where Heartlands will be reviewed first. SG has been invited back to***	**Closed**

			their peer review development meeting 18th May	
c	28/9/16	2	Arrange M&M with Hereford for TRID case 1405. ***Mar 30th update: KP met with PBS, and this TRID has now been closed off***	**Close**
d	28/9/16	3	NB to see if the discharge framework Steve Sturman was developing could be beneficial with discharge process. 11th Jan update: Reverse NoRSE being worked up. TU's should ensure it is a mutually beneficial system for both sides, and contact QEHB with any issues. QEHB trying to integrate with internal tracker system, but will need up-to-date contacts. ***30th Mar update: All stakeholders invited to 'Reverse NORSe showcase' taking place at QEHB on 27th Apr.***	**Close**
e	28/9/16	4	QEHB governance department are not happy with rehab prescriptions going out as editable text, but SL said that their systems should have a way of recording the date it was sent to a TU and therefore could attach a workable document, along-with with the PDF version	**Close**
f	28/9/16	8	MTC unable to access original ePRF for patients "scene to TU journey". 11th Jan update: Project team are looking into this. 30th Mar update: KP met the project team on 10th Mar. System needs some software tweaks.	**KP** to update on progress
g	16/11/16	7.3	Trauma Nurse Training Level 2 - KP agreed to speak with Rob Pinate, Chair of the National Major Trauma Nursing Group about this and how units can be supported as it won't just be our network who is struggling. 11th Jan update: BCH proving in-house competencies, based on best aspects of other paediatric units. Query need to take a more 'network' approach though. SWBH had identified additional funds, but it was still going to be a very costly exercise, given the 3 days 'out' as well as course costs, and queried whether a 'train-the-trainer' would work better across the network. Worcs had a 2 year plan to train staff up, with the Trust prepared to provide extra funding, but there would still be issues filling gaps in the rota. DGoH have a programme, although not accredited. TC to write a short overview on the course, and the Board to look at what it needs to 'top-up' to level 2 accreditation. Could it be module-based, rather than a block 3 day course. ***30th Mar update:*** **KP reported QEHB have a level 2 model that was developed by Tracey**	**Tom Clare** to write a short overview of their existing course **SG** to distribute the level 2 standards to the Board, and also the QEHB course model

			Clatworthy. This has been shared with SG for distribution	
h	16/11/16	7.4a	The RTD is unable to directly task ambulances from CAD. 11th Jan update: SR chasing relevant EOC person to check phone exchanges. JHu said that the RTD staff have found a pragmatic approach whereby they simply pass the paper referral they have made, on to staff on the normal CAD desk. 30th Mar update: SR found out from management there is already a direct-line. There will be a memo to WMAS staff that the RTD will task, to save duplication	**Close**
i	16/11/16	8.3	QEHB night time helipad - KP to meet with SR and B Steele to sort this out, in-particular the emergency planning aspect. ***30th Mar update: KP met with SR and Becky Tinsley, and it seems there is no reason why the QEHB helipad can't be 24/7. There is charity money available, and KP has asked SR to identify cases that had to land on secondary sites for conveyance by road to QEHB to add weight to the proposal***	**KP** to update **SR** to identify cases for KP
j	16/11/16	7.1	SG presented the work plan which led to further discussions about some work-streams, a) Injury Prevention raised by SR after listening to the presentation from the Redthread Organisation who are situated in some London MTC's and helping to reduce violent crime by speaking with victims. b) More training for ambulance crews around trauma patient assessments e.g. a series of pod casts about different assessments. ***30th Mar update: SR to work up a clearer concept of what he would like to achieve; scope, platform, costs, etc. IR to investigate what MAA have available***	**SG** so send out template **SR** to develop case **IR** to update
k	16/11/16	7	Patient Stories – a concept for future meeting, to have stories presented at board meetings, a more positive approach what we are doing well and how we are helping patients and making improvements is trauma care. ***30th Mar update: Board felt this should be moved to a standing agenda item, and a prompt should be included in the email when the Board papers are circulated***	**SG** to action

l	16/11/16	7	Also, a new item for the agenda could be progress reports for MTC and TU's from Peer Review concerns and issues.	**Board to discuss**
m	11/1/17	e	DOC noted that from a NORSe perspective, he felt that the response they were getting was getting worse. Taking into account historical TRIDs, issues previously discussed at Board and transfer data on severe head injuries, Chair to draft a letter of concern to David Rosser at QEHB (Neuroscience)	**JHu to action**

5	**TRIDS** **1530 -** The QEHB specialist hand pathway will be re-written to include 'or near' amputation, and to try and build in an element of common sense. As well as being refreshed on the website, we wil try to develop systems whereby all the RTD / MERIT / BASICS teams are aware of these 'additional layer' pathways that aren't always triage tool positive. Close **1526 –** Additional details to be provided by Ian Roberts (photos, ? RTD involvement, etc). IR **1524 -** With unique cases where there is no specialty pathway in place, there may be occasions where 'split sites' may request an alternative destination. If the patients ABC's are stable enough, then this should be accommodated where there are good organisational reasons. If not, the patient should be taken to the original unit for assessment and stabilisation, then rapidly transferred to the other TU or MTC - whichever is deemed to be in the patients best interest. Above all, there should remain an element of pragmatic, common sense on all sides. Close **1515 -** Board members could easily see both sides. Not a regular pattern. Close **1511 –** Ongoing issues with ortho. Raised as an issue internally. RCA notes requested. DOC **New Cases:** Steve Goodyear asked for a case to be discussed, which Nick Turley presented. Issues were: 1. **Elderly patient who fell down full flight of stairs, and who wasn't alerted by WMAS**. *Patient never met any of the stage 1 to 3 triggers on the triage tool either pre-hospital, or indeed on arrival in ED, so this would never have prompted a call to the regional trauma desk. The Midlands Silver Trauma Group are looking to put a silver trauma 'safety net' in place at the RTD to give a heightened awareness of certain patients. [Update from SL since meeting: One of those would be an SBP of <110 (rather than 90 as per the triage tool). Unfortunately, this patient still wouldn't have triggered, as their lowest SBP was 115. Patients found at the bottom of the stairs are a challenging group, because it's often not known exactly how far they have fallen].*

	2. **Internal trauma call not placed and c-spine # missed clinically and radiologically.** *Noted new trauma alert policy implemented Aug '16. Head and neck CT reported on TARN as having "marked spondylotic changes with fused vertebral end-plate osteophytes between C3 and C7. No fracture or malalignment. No other abnormality". Post mortem showed displaced lower cervical vertebral # though, with spinal cord injury, although NT informed the group the patient had shown no neurological signs, and had been moving all 4 limbs (even after CRP following an arrest a few days later). [Update from SL since meeting: patient had a plain film of elbow recorded on TARN as they had been c/o pins and needles in arm, and were querying a fracture].* 3. **?displacement of unstable C-spine # as a consequence of CPR on 22/5, with respiratory compromise following this.** Patient initially ambulatory, but developed respiratory complications. Arrested and died as a consequence of respiratory complications (pulmonary contusion noted on initial chest CT). KP asked whether there had been a PE, cardiac event, pneumonia or rib #'s, but NT said "No". He said the only thing missed was documentation around problems moving the neck, to which KP said they would have (at QEHB) probably moved the patient to HDU for more intensive input.
6	**Network Data** SL gave an overview of the data completeness and survival figures from the most recent TARN clinical report. Network submissions are the best they have been, and the only outlier is Heartlands, who have had issues with data collection recently. This is slowly being addressed though, and there is confidence they will soon be back to their previously good submission level. Regarding additional survivors, there are circa 36 a year for this network, which is several more than originally calculated as part of the 'pre' trauma network baseline assumptions. The 2 Worcestershire TU's are outliers in-that they are showing more deaths than expected (and they have both submitted complete case-mixes). SL showed that the difference between the observed survivors and the expected survivors was less than 1 in each unit though, but went on to tease out the data within the 90-95% bands for probability of survival to show several cases where patients had not survived. The Trust should ensure these have been looked at through M&M's and are satisfied with the clinical aspects. Transfers around the network were then looked at, including where there was a transfer from a TU to a TU, rather than to an MTC. There was then an overview on the types of patients remaining in a TU with an ISS>15. *The presentation is included below as a PDF, but if you require any 'source data' or additional queries, please just ask*  BBCHW Data Presentation Mar 2017.pdf TARN have agreed to increase the time from admission to dispatch date from 6 to 12 weeks, which will allow more cases to be included on the TU dashboards, which is fantastic news
7	**Business Updates:**

	Russells Hall: Keen to get level 2 trauma training up and running. Will collate the details Tom had previously mentioned, and send them to SG. CB said the Trust have now decided to support the rehab co-ordinator post, and has requested any similar business cases from other Trusts (SG has since sent out this request) ***Worcs:*** Improving ED nurse training in April, with TILS, which will only leave a 0.5wte gap in having a L2 trained nurse 24/7. New internal trauma team activation criteria implemented. Problems engaging specialty colleagues, who often leave quickly – query who the patient is then admitted under. Also issues with poor attendance at trauma call training. ***QEHB*** – Date has been set for a major incident event – Sep 13th. JL will send round the link for further details. Network approached for cadaveric course funding [update from COB Board – this was approved] ***SWBH*** – Historical dysfunctional trauma group has now been resolved, and there is now exec buy-in ***Regional Trauma Desk –*** Changed the model of air ambulance personnel training and taken on more full time staff being trained, and rotated around RTD/AA/MERIT. Several 'new' people on desk. Also increasing coverage of Dr on aircraft which should allow a second team more readily available from the next few months onwards
8	**AOB** 1) It was felt that network M&M meetings should still take place, with each unit undertaking 1 a year, and rotating around all units. We could use TARN data to help identify cases if units wished 2) Specialty trauma to QEHB discussed. Hands sorted, but no clarification on BOAST4 yet 3) Network Board TOR to rollover to next mwwting
9	**Date of next meeting:** Wed 24th May 2017, 13:30-16:30. Venue tbc