Birmingham, Black Country, Hereford & Worcester Trauma Network

Network Meeting

Wednesday 28th September 2016, 13:30 – 16:30

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

Approved

Attendees:

Jon Hulme - Chair	JHu	Consultant - Intensive Care Medicine/Anaesthetics	SWBH
Keith Porter	KP	Professor of Clinical Traumatology	UHB
Shane Roberts	SR	Head of Clinical Practice	WMAS
Nicola Bartlett	NB	MTS Manager	UHB
Diba Shariat	DS	Consultant Rehabilitation Medicine	BHCH
Steve Littleson	SL	Network Data Analyst (minutes)	MCC&TN
Adrian Simons	AS	Consultant Orthopaedic Surgeon	RWH
Rita Rai	RR	Directorate Manager, T&O	DGoH
Karen Hodgkinson	KH	Major Trauma & Rehab Co-ordinator	BCH

Apologies:

Nick Turley	NT	Trauma lead A+E	WORCS
Sarah Graham	SG	Service Improvement Facilitator	MCC&TN
Vandana Kalia	VK	Clinical Effectiveness Projects Facilitator	SWBH
Jane Wallace	JW	Trauma Nurse Practitioner	HoEFT
Alison Lamb	AL	Consultant Nurse	RJAH
Tina Newton	TN	Consultant in Emergency Medicine	BCH
Alastair Marsh	AM	Consultant Orthopaedic Surgeon	QEHB
Dan O'Carroll	DO'C	Consultant in Emergency Medicine	Walsall

Item	Description
1	Welcome and Introductions
2	Apologies noted above
3	Minutes of previous meeting held on 6/7/16 reviewed and approved
4	Outstanding actions from previous minutes – see last page for actions list.
5	**Governance** Network TRID Presentations/discussions: • TRID 1392 – Multiple issues, mainly around; contacting CTC, NoRSE referral system, UHB following own protocols, hyperacute transfer pathway. NoRSE is already on the network risk register and part of the workplan. KP to send internal report to JHu. Hyperacute transfer pathway being addressed at Tri-Network Forum this month • TRID 1222 – NoRSE and hyperacute transfer pathway being addressed. Closed

	• TRID 1405 – Multiple issues, mainly around ownership, capacity, and communication. Outstanding action was for Rivie to contact Hereford to arrange M&M for this case • TRID 1415 – Delay from initial 'heads-up' call, till arrival of patient. Chronology of events examined, and all felt that timings were acceptable. Closed • TRID 1435 - NoRSE and hyperacute transfer pathway being addressed. Closed <u>Triage Tool accuracy where motorcycle involved</u>: SL presented network data since go-live (10,725 TARN submissions) showing that RTC's make up about a fifth of all TARN submissions for the network, and motorcycles are involved in around a quarter of the RTC's, so motorcycles as MOI around 5% overall. • There have been 14 motorcyclist deaths since April '12 – all taken direct to MTC as tool +ve's. No TU deaths • 5 tool +ve's taken to TU's required subsequent transfer (3 for >RR, and 2 for <SBP) • 11 tool +ve's taken to TU were managed there (5 with slight <GCS initially, 4 with slightly >RR, 2 with slightly <SBP. 8 of these 11 patients had an ISS <15. All were either chest injuries (rib #'s), or limb fractures • 17 tool -ve's that required transfer to MTC. 11 had an ISS<15. Only 5 had an AIS>3 injury. Mostly open lower limb fractures, pelvis fractures and chest injuries Summary: No indication from the data that motorcyclists being discriminated by triage tool
6a 6b	**Business:** Regarding repatriations, a few discussion points came out: • Should there be a 'discharge checklist' that has to be completed and accepted by both sides before the 48hr clock starts? NB to see if the framework Steve Sturman was developing would be useful here • Rehab prescriptions still being sent out as pdf's, which the TU can't then carry on using. KP to check whether can go as editable text, with a pdf record stored internally to avoid any governance issues down the line • If a transferred patient develops complications, who is 'accountable'. The board felt if the TU could deal with the complication they should do – if not, re-refer. Either way, these patients should be highlighted for network M&M's to share learning The changes to the flow of paediatrics to the Alexandra was discussed, and whether they were now no longer a functional TU for paediatrics. Subsequent to the meeting, SL has reviewed TARN data, and there were only a couple of teenagers who presented out-of-hours last year, so the hope would be that the impact would be negligible for the trauma network. This will be closely monitored in conjunction with WMAS data, TARN data and TRID's

6c	JHu raised the question of mid to long-term objective planning. Network office just finalising the current workplan, which can be shown at subsequent meetings, and added to accordingly
6d	Questions raised around the types of vascular injuries Walsall are accepting and refusing, based on some HALO feedback. JHu will discuss the exact nature of this with DO'C, looking at SOP's / SLA's and feedback to board
	Network Feedback
6e	– SG reviewing all the TOR's for the boards and will be sending out requests for deputy chairs
6f	– Peer review process went well and draft reports have been circulated, along with concern letters to Chief Executives. AS discussed his frustration about having a serious concern raised against New Cross, without anyone being able to give any clear advice how to address it. This was picked up by the network team after the meeting, and it was down-graded to a general concern, in line with how it was raised with most other TU's. AS was contacted and apologised to.
6g	**WMAS Feedback** – SR said the roll-out of the ePRF was going well, but if there were any issues, the development team were keen to hear about them. WMAS now require the unique 'case number' to investigate any issues. This replaces the PRF number
6h	**QEHB Feedback** - QEHB are planning to expand the SAU to try and free-up capacity in ED, and deflect from the wards
6i	**BCH Feedback –** No clear update on internal rehab business case, but formalising pathway to Central England Rehab Unit for adolescents. Whilst there are limited facilities out there for paediatrics, the commissioners have been impressed by what has been achieved locally
6j	**TU Feedback –** RR said DGoH were looking around the network for example models of how they can deliver rehab prescriptions. Network office forwarded on
6k	**Spinal Centre Feedback –** Ongoing issues with lack of access to national data. Subsequent to the meeting, this was taken up by KP. National team are looking at ways to feedback to units, and it is on their current workplan.
7	**AOB** 1. SL discussed videoconferencing and the benefits it could bring now the office can support the wifi speed required to run it. All in support, as would extend the capability to the peripheral units to become more involved again 2. TRID database will be overhauled to allow for fortnightly report to be circulated showing how has outstanding actions, and how long they have been unanswered
8	**Date of next meeting:** Wed 16th November, 13:30-16:30, Crown House, 123 Hagley Rd

Outstanding actions by date

From meeting on 16.3.16

1. Patients being taken to Sandwell / City / QEHB. KP previously mentioned that there has been cases taken to QEHB (as a TU) rather than Sandwell and that this is causing problems with access to Social Services in other commissioning areas. KP previously mentioned that Andrew McKeirgan is looking into this. SR mentioned that the crews will go to the nearest hospital based on their GPS system, unless there is a specialist pathway involved. SR stated that if this needs to change it will need to be agreed by the commissioners. SL provided a review of the data he did when the City informed us of their TU status changing. SL said that the new data shows that most cases are for orthopaedics and that the numbers are like what we thought they would be.

From meeting on 18.5.16

2. QE are using a NORSe type system for Hand referrals: AM said they are rolling this out network-wide for all on-line type referrals. AS felt there are still problems with NORSe and improvements are still required in order to make it work better for the TU's e.g. the login for referrals. AM mentioned the generic login used by Russell's Hall that works extremely well, AS said he would discuss this again with RWH, the network offered to provide support on this matter if required. SL mentioned the Share facility on NORSe that can be reviewed by any consultant no matter who initiates the referral**. Action: SG to chase Graham Flint about the changes requested at the board meeting.**

3. Open fractures of patients who had motorcycle accidents. Are they being under-triaged? SR agreed to put out a notice to crews to be more aware of motorcycle injuries and a better appreciation of the 'speed' at which these vehicles travel. SL did provide some data on the lower limb open fractures, only 3 were motorcycle incidents. Again it reiterated that if units feel patients are being under triaged they should notify the trauma desk as soon as reasonably possible and TRID. **Action: SL agreed to find out the numbers involved and if they were appropriately triaged. – Presented today within governance section**

4. Arrange Network M&M meeting at Walsall Manor Hospital. **SG to arrange with DOC.**

5. Improving engagement at board meetings. Further discussions were had. AM said that we need to ensure the Leads are given the PA session that is part of the Peer Review standards. **Action – SG to contact TU non attendees.**

From this meeting 28th September:

1. KP to send JHu internal report around the events of TRID 1392

2. Rivie to contact Hereford to arrange M&M for TRID case 1405

3. NB to see if the discharge framework Steve Sturman was developing could be beneficial

4. KP to check whether rehab prescriptions can go out as editable text

5. Network to present workplan at meetings to set mid to long-term objectives

6. JHu to discuss vascular injuries with DO'C, to ensure no conflict as a TU

7. SG to send out for deputy chair

8. SL to procure videoconferencing equipment

9. TRID overhaul