Birmingham, Black Country, Hereford & Worcester Trauma Network

Network Meeting

Wednesday 16th November 2016, 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
Keith Porter	KP	Professor of Clinical Traumatology	QEHB
Shane Roberts	SR	Head of Clinical Practice	WMAS
Steve Littleson	SL	Network Data Analyst (minutes)	MCC&TN
Adrian Simons	AS	Consultant Orthopaedic Surgeon	RWH
Rita Rai	RR	Directorate Manager, T&O	DGH
Karen Hodgkinson	KH	Major Trauma & Rehab Co-ordinator	BCH
Nick Turley	NT	Trauma lead A+E	WORCS
Sarah Graham	SG	Service Improvement Facilitator	MCC&TN
Tina Newton	TN	Consultant in Emergency Medicine	BCH
Janet Hallam	JH	Clinical Lead Physiotherapist	QEHB

Apologies:

Vandana Kalia	VK	Clinical Effectiveness Projects Facilitator	SWBH
Jane Wallace	JW	Trauma Nurse Practitioner	HoEFT
Alison Lamb	AL	Consultant Nurse	RJAH
Alastair Marsh	AM	Consultant Orthopaedic Surgeon	QEHB
Dan O'Carroll	DO'C	Consultant in Emergency Medicine	Walsall
Nicola Bartlett	NB	MTS Manager	QEHB
Diba Shariat	DS	Consultant Rehabilitation Medicine	BHCH
Kay Newport	KN	Trauma Rehabilitation Coordinator	BCH
Abdul Jalil	AJ	Consultant Emergency Medicine	Worcs
Corine Ralph	CR	tbc	BCHT

Item	Description
1	Welcome and Introductions
2	Apologies noted above
3	Minutes of previous meeting held on 28/9/16 reviewed and approved
4	Outstanding actions from previous minutes – see last page for actions list.
5	**Governance** 1. Network TRID Updates: Nil for discussion today. 2. SL is doing some work with the QEHB and their tracker looking at patients not being repatriated back to the TU's in 48hours, to help quantify the delays and any patterns etc. **Action - SL will present at the next meeting including how long they then stay in the TU.** AS agreed this would be beneficial to review. 3. New Case Presentations - Details provided by Russell's Hall Hospital. Case from 02/10. Un-helmeted 74-year-old travelling down-hill at approx. 20mph, hit van door which was

	opened on him. Should the patient have been taken to the TU? The Board felt that the injuries described were not time critical but would have liked to know how big was the subdural haematoma and the initial GCS (possibly <15 but not specified how low). In summary, they felt that the patient went to the right place and that some of this was about the dissatisfaction over the lack of beds. **Action - SL will track down the TARN submission.** JHu mentioned his pending TRIDs where patients were not accepted by the MTC, KP reiterated that a lack of ITU beds should not be the reason for not accepting a patient. SL said the network is not being informed when the QEHB have no capacity. SL is trend reporting, so in future rather than 10 separate TRIDs SL will pull them into Trends reports for presentation.
6	**Network Data** SL presented the Q1 April-June Dashboards. Russell's Hall is little bit behind with their data collection but Heartlands is catching up. NGH is the only TU achieving 100%, SL has asked their TARN Coordinator to a show and tell about her process and how she has been able achieve 100%. SL provided clarity around some of the measures, the TU's deliver grade STR3 or above led trauma team on arrival – the metric is unhelpful and some MTC's and TU's have issues e.g. consultants not being called in. TN felt it is more important to get trauma activation correct than worrying about ISS. Walsall are doing well to get patients into CT within 60 mins of arrival. **Action - SL to sort TXA Ph-ED**. **Action - SL was asked to do a summary for RWH so they can review their figures.** **Post meeting update from SL – the metric around ST3+ trauma teams clouded by the fact TARNs denominator includes ambulance pre-alerts not actually subsequently seen by the trauma team. Moving forward SL will add on a line in the dashboard isolating only those patients seen by a trauma team**
7	**Business Updates:** 1. BBCHWTN Objective setting – SG presented the MCC&TN Work Plan which led to further discussions about some BBCHWTN 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. 2. Peer Review Update – SG provided feedback from the 2016 visits, a report is being written. Both KP and SG reiterated the discussion held at the PaQ meeting regarding 2017 Peer Review process, we know the process helps move things forward but it can be timely and may not provide any more benefit by doing actual visits again in less than 12months time. Therefore, the PaQ Board agreed that instead of visits the Network Office will use a Network Board meeting to perform evaluation and feedback. BBCHWTN Board members were in full agreement with this idea.

	Action – KP will inform Prof Chris Moran, National Lead for Trauma. 3. Level 2 Nurse Training (Peer Review Measure) – All TU's in the Network are struggling to achieve this measure. The Board felt other training platforms need consideration as the cost of some courses and the time to allow staff to attend training is a major factor in them not being able to achieve it. There is also a high level of turn-over of staff in a lot of units**. Action 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.** 4. Hyper-acute transfer policy review – JHu presented draft V2 and that the policy was discussed recently at the tri trauma network clinical forum, the challenges and the current process and to reaffirm what is required to expedite the transfer of time critical injured patients. JHu went through each section and reiterated that we will use the send and call / package and call approach, that there should be a clear 'stop' indicator required by the MTC when they want to stop any further care. The new red section recommends that for immediate/hyper acute transfers that NORSe should not be used and that a call to the MTC ED be enacted. There were further discussions and a recommendation that the TU's will not continue to use NORSe until improvements are made. Agreed by the Board. QEHB and WMAS to take to their boards. **Action – SR stills need to deal with the issue that the RTD is unable to directly task ambulances.** SL presented some network data - no transfer, transfers in and the timelines. The MTC need to find a way to audit how well it is working and TU's need to raise a TRID when it's not. Needs a short review. **Action - JHu will talk with Matthew Wyse and SG has added this to the CETN Board meeting agenda for next week's meeting. SG will disseminate to the NWM&NW TN for discussion and to seek agreement.** **Action - The final version to be circulated and implemented by end of December 2016.** TN said BCH are behind this protocol. It will be interesting to see how well it works. 5. 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. Also, a new item for the agenda could be progress reports for MTC and TU's from Peer Review concerns and issues. 6. Deputy Chair – **Action SG to speak with Dan O'Carroll.** 7. Worcester Hospital Neuro pathway – Send the pathway to KP who will deal with this with his colleagues as we need to adhere to this pathway. The network feel it should not be changed. SL looked at the data, majority of neuro cases are going to Coventry.

	Action – KP to reiterate the adherence to the neuro pathway with colleagues.
8	**AOB** **1.** RWH AS asked colleagues if they were aware of any facilities that could care for a patient who requires help with physical conditions/daily nursing care requirements as well as the need for some psychological support. There is a facility in Birmingham called Hunters moor, who may know of a facility who could help. This needs high level interjection by the TU. **Action** - **JHu will find out where their patients go for ETC testing.** 2. RHH – RR asked if anyone knew if the new Metropolitan Hospital would affect any other hospital boundaries? This will need some mapping. WMAS will probably be looking at this so will JHu. 3. WMAS SR – informed the Board that the Air Ambulance is currently flying until in the hours of darkness until 9pm. QEHB have daylight access only. The MAA charity have offered to pay for the Porters to make it a functional helipad and more importantly this would affect Emergency Planning, especially if incidents happened at night. **Action - KP to meet with SR and BSteele to sort this out, in-particular the emergency planning aspect.** 4. WMAS SR asked that WMAS be involved in future plans if decisions are made to move BCH to the QEHB site, KP said this could be many years away. 5. KP congratulated Simon Davies from UNHM who has been appointed Network Manager. Hopefully starting around March/April 2016.
9	**Date of next meeting:** Wed 11th January, 13:30-16:30, Crown House, 123 Hagley Rd Birmingham
	Outstanding actions by date 16.3.16 meeting: Patients being taken to Sandwell / City / QEHB. KP previously mentioned that there have 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 considering 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. Update today 16.11 – still no further forward, things may improve with the inclusion of Heartlands Hospital. It was agreed that this Board is unable to assist with the issues regarding CCG boundaries. SL mentioned the number of CCG's this network deal with, in the excess of 60. Closed. 18.5.16 meeting: **1.** 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 to make it work better for the TU's e.g. the login for referrals.

	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. Complete. Very brief feedback received.** Update today 16.11 – KP provided an update regarding plans to modify NORSE so that recipients are available to reply to referrals in a timely manner, there are also some staff changes taking place. It is hoped the modifications will immediately flag up acute head injuries and certain triggers like extradurals that will initiate a quick response. They are working towards a 30min response time. Some of the modifications will hopefully help inform referring hospitals when they should call the QEHB for a more rapid response. SG read out the reply from Graham Flint, which doesn't provide any real feedback about progress. 2. Arrange Network M&M meeting at Walsall Manor Hospital. **SG to arrange with DOC. Outstanding. TN has a case she would like to present at Walsall.** **3.** Improving engagement at board meetings. **Action – SG to contact TU non-attendees.** The Chair asked the Board if they found the current agenda useful? TN felt that the meetings are worthwhile and appreciates how difficult it can be to get to each meeting. TN mentioned that her colleagues are having problems claiming back travelling expenses. SG offered help from the Network, if there is any way to support them. SR agreed that even after 4 years there is still lots to do as there always things changing and evolving. SR is happy to visit all the TU's with someone from the Trauma Desk to do some training around the system, their roles/responsibilities and how to deal with issues. It was noted that both Hereford and Heartlands TU's are completely disengaged. KP has been invited to speak with Hereford colleagues and will address this issue. We need to address this with the TU's and it's hoped that the video conferencing will help with this. We still need to do Heartlands Peer review but it was noted they are making improvements with their TARN completeness. **Action - KP will chase Kevin Bolger after SG receiving no reply.** 28th September meeting: **1.** KP to send JHu internal report around the events of TRID 1392. 16.11 – still with Rivie Mayele, KP will chase. **2.** Rivie to contact Hereford to arrange M&M for TRID case 1405 – Outstanding. **3.** NB to see if the discharge framework Steve Sturman was developing as it could be beneficial. KP will chase. **4.** KP to check whether rehab prescriptions can go out as editable text. QEHB Governance department are not happy with this, 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 with the PDF version. **5.** JHu to discuss vascular injuries with DO'C, to ensure no conflict as a TU. 16.11. JHu to chase. **6.** SG to send out for deputy chair – SG sent the email but no interest received. SG was asked to speak with Dan O'Carroll who is an active participative member if he would consider the role **7.** TRID overhaul – 16.11 SL presented the new outstanding TRID report, they are chased every 2 weeks for updates which will hopefully speed up the process of closing TRIDs in a timely manner. There were not many outstanding for this network. For WMAS TRIDs they will be raised on their internal system which will direct them to the most appropriate person, leading to a quicker resolution. QEHB also doing the same. SWBH TRIDs now go to a direct email address where someone then directs them to the right people in the Trust rather than them all going to the TU Lead. Close. **8.** EPR – SR spoke with the project team about secondary access to reports and they are dealing with this. E.g. patient who goes to TU initially and is then transferred to an MTC. SL said the

	new EPRF's are helping with TRID investigations. Close. From 16.11.16 meeting: 5.2 QEHB Tracker/Repatriations review - SL will present at the next meeting including how long they then stay in the TU. 5.3 Case presentation by Russell's Hall Hospital. SL will track down the TARN submission. 6.0 Network data - a) SL to sort TXA Ph-ED. b) SL was asked to do a summary for RWH so they can review their figures. 7.2 2017 TU Peer Review – KP will inform Prof Chris Moran, National Lead for Trauma of our process for next year. 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. 7.4 Hyper-acute transfer policy review – a) SR stills need to deal with the issue that the RTD is unable to directly task ambulances. b) JHu will talk with Matthew Wyse and SG has added this to the CETN Board meeting agenda for next week's meeting. c) SG will disseminate to the NWM&NW TN for discussion and to seek agreement. d) The final version to be circulated and implemented by end of December 2016. 7.6 Deputy Chair – Action SG to speak with Dan O'Carroll. 7.7 Worcester Hospital Neuro Pathway - KP to reiterate the adherence to the neuro pathway with colleagues. 8.1 Information for Adrian Simons - JHu will find out where their patients go for ETC testing. 8.3 QEHB night time helipad - KP to meet with SR and BSteele to sort this out, in-particular the emergency planning aspect.