Midlands Critical Care & Trauma Networks NHS

Central England Trauma Network

Minutes of Board Meeting
22nd March 2017
Central England Rehabilitation Unit
Approved Minutes

Approved by Chair: 27/3/17

Present:

John Hare (Chair)	JH	Consultant Anaesthetist	NGH
Steve Littleson (minutes)	SL	Data analyst	MCC&TN
Linda Twohey	LT	Clinical Lead	KGH
Derar Badwan	DB	Rehabilitation Consultant	SWFT
Caroline Leech	CL	Consultant Emergency Medicine	UHCW
Aimee Taylor	AT	Major Trauma Acute Coordinator	UHCW
Kathy Wagstaff	KW	Lead Nurse	CERU
Philippa Gibbs	PG	Coventry Airbase Manager	TAAS
Nicola Dixon	ND	Major Trauma Therapy Lead	UHCW
Tina Newton	TN	Consultant in Emergency Paediatric Medicine	BCH
Ian Mursell	IM	Consultant paramedic	EMAS
Shane Roberts	SR	Head of Clinical Practice, Trauma Management	WMAS

Apologies:

Sarah Graham	SG	Service Improvement Facilitator	MCC&YN
Jonathan Young	JY	T&O Consultant	UHCW
Tristan Dyer	TD	Consultant Emergency Medicine	NGH
Sue Bleasdale	SB	General Manager	CERU, SWFT
Sharon Ryan	SR	TARN Coordinator	NGH
Julie Nancarrow	JN	Consultant Emergency Medicine	Warwick
Matthew Wyse	MW	Clinical Lead	UHCW

Item	ACTIONS
1. Welcome and Introductions	
2. Apologies The apologies were noted (see above).	
3. Approval of Minutes The minutes of the meeting held on 18.01.17 were approved as an accurate record.	
4. Outstanding actions from last meeting (updates from todays in **bold)** • Prophylaxis required for embolization? The issue about spleens in the November minutes is whether they have pneumovax/lifetime antibiotics if embolized which Matthew has been reviewing. There is currently no national consensus. **UHCW**	

plan to circulate a survey monkey to canvas what other centres do	**MW to update**
• JN was asked to review the cases that went to SWFT and whether they were appropriate to be taken to an LEH. JN reported that many of the cases involved chest injuries and were hard to identify. Many resulted from cycle / motorcycle incidents. She thought a more thorough assessment should take place in some cases to distinguish between patients who were walking at scene, and those that had moved themselves out of danger. MW requested the network to go back to the ambulance service with specific cases to discuss. **SL demonstrated a filter tool which could be used to extract all TARN eligible cases from an LEH (without requiring a TARN clerk), and also the subset that should be presented at governance – ISS>15 and poly-trauma, who remained in an LEH. The cases identified could easily be passed back through ED systems to establish arrival method, i.e ambulance. This would obviously depend on an 'invite' from SWFT…**	**JN to discuss the concept internally, and if OK'd, SL to be put in touch with informatics**
• Network Hyper-Acute Transfer Policy. MW updated that this proved to be a very good discussion at the regional clinical forum meeting on 12.10.16. Displayed were the CETN transfers currently taking around 6 hours, which the Network aims to improve. The problems in the BBCHWTN when trying to transfer neuro patients into the MTC, they will now use the principal of send and call and will not use the NORSe which slows down the transfer. NORSe will be updated afterwards. Imaging in TU's - if they are done by the TU they must be good quality images. MW & Jon Hulme have revised some sections of the policy which will be circulated in due course. Needs slight amendments made to reflect the differences in the trauma system setup in North Wales. Sue O'Keeffe and Jonathon Hulme working on this, and will be brought to next Board. **Amendments to reflect the differences in the Welsh system have been incorporated, and were shown. CL felt that there possibly needed to be more clarity around the roles and expectations within this policy, with the feeling that the ED TTL may now face lengthy periods liaising with neurosurgeons, or that junior staff may try to refer inappropriate patients. The Board felt that the queries and examples given were covered within the policy, and it has been approved, although CL and UHCW will discuss it at an internal meeting on May 2nd, and will feedback at next Board. SL suggested commencing a prospective audit of the types of patients being referred via this pathway, including referrers grade, etc**	
• PEGs - UHCW now have Rachel a Dietician working within the MTS and is reviewing the pathway issues. She is reviewing risks and talking with the PEG team in order to make some improvements. She is also linking with the national dietetics teams. **No update today**	**UHCW to update**
• SR has been reinforcing the roll of the RTD. DN re-issued the memo to staff at EMAS and is trying to strengthen/encourage the use of the trauma tool, work in progress. MW asked if EMAS are sorting out their trauma support system but DN said there have been no further discussions about an RTD and the CAD are limited on the advice they can provide, there is very little organisational support. o **WMAS – SR said that part of the issue was that local crews felt they were going to the right destination anyway, so why the need to call the RTD. There has been an engagement process with supervisors and mentors to reinforce the message as to the importance of the RTD. Biggest issues seem to have been within the regions of Coventry & Warwickshire and Staffordshire**	**Update when ready**

○ **EMAS – IM reported EMAS are going through a restructuring process at the moment, which has been the priority**	
5. Review Current Network Related TRIDs **1513** – No update today from either UHCW Neurosurgeons, or KGH. Clarification sought on the correct RTD telephone number for hyperacute transfers **1512 -** IM said there had been recognition of the suspected spinal injuries, and that they had triggered the tool. The decision to fly had been made to give a smoother journey over that by road. It was however acknowledged that there had still been delays over decision making. The Board felt it was an incorrect perception that air offers a smoother journey, and that these primary transfer should be prompt, and by road. Both EMAS and WMAS to send out a notice to such effect and to reinforce. **CLOSE** **1507 –** SR fed back that an ASO spoke to crew. Low mechanism of injury, so not fully assessed against major trauma. **CLOSE** **1492** – The Board sought reassurance that this case had been managed optimally, and have requested IM and LT to have a closer look at the notes and bring to next Board for reassurance **1489** – IM fed back that ePRF shouldn't have been done, as out-of-area. Their new system is being finalised though and relaunched. The aim is for 100% acceptance of the ePRF. **CLOSE** **1486 –** This is being investigated by EMAS as a 'high level incident' **1460** – Case presented by AT. Patient was equidistant from Warwick and Coventry, with an iGel in situ - ? should have gone straight to Coventry. SR said there was RTD and ASO involvement, and the crew felt that after ROSC they didn't feel happy to wait for MERIT, so moved to closest unit. Board felt that was a reasonable decision. **CLOSE** **1416** - Feedback from LT. Spinal injury was originally missed on Radiolology report. ED management was acceptable, based on the scan report. Scans must be reported on more timely and in conjunction with plain films. If there are discrepancies, they must be discussed with Orthopaedics. KGH learning points: any returns <72hrs must be reviewed by someone more senior than previous. Datix should have been completed. **CLOSE**	**SL to clarify** **IM and LT to update** **IM to update**
6. Data CETN Data Presentation for CL ‹ SL showed the networks TARN data completeness as being above the 80% figure, and also outlined a project to try and show data from LEH's. This would probably be one of the few networks in the country that would have a good handle on ***all*** their trauma patients and their pathways. Positive Ws figure for the network, equating to the modelled number of additional survivors per year, although Kettering has a negative Ws. Examples shown of how the quality of submitted data can easily affect this though. Cases reviewed, and no clinical concerns. Transfers out of KGH and NGH shown, by age group and MOI, and the	

same done for those that remained within a TU. Transfers into UHCW shown, with detailed breakdown of patients from Warwick.	
7. Business i) Network Board Terms of Reference. These were reviewed and accepted Network updates- • **KGH**: Having ongoing issues with TARN clerks, which is having a knock-on effect to the case-mix capture, and the quality within • **NGH**: Theatre staff will no longer be onsite after 0200, and there will be the expectation to be able to return within 30mins, as per for the Consultants • **CERU**: Operationally, things have been tight recently. SB should be returning soon though • **EMAS:** Restructuring programme once again • **TAAS**: Nothing to update • **WMAS**: Updating the dispatch system to get medical support to patients quicker. TRIDs will now be managed centrally, to hopefully enable a faster resolve • **UHCW**: Running the HECTOR course in May, which places are free for. The next round of the 'transfers into UHCW' audit will be presented at May's Board. Elderly fallers with chest injuries are having non-contrast CT's and are being admitted and having aggressive treatment	**SL to work data up**
8. AOB • Regarding the networks mass casualty exercise, it was felt that there could have been quicker confirmation of who was going, so that rota's, etc, could be managed better. • Board members queried that Trauma Care attendance seemed lower than previous, and wondered whether the very late acknowledgment had anything to do with this. There will be feedback sought from all those who attended, and the network want to survey all the 'no shows' to try and ascertain why no, and what can be learned • There will be a tri-network sharing event across Critical Care, Trauma and Burns taking place in October. Anyone wishing to participate, or who would like something covered, should get in touch with the network office asap • After another round of interviews, the position of network manager has been offered to an existing network manager from elsewhere in the country. No start date has been outlined yet	**SL to take to next network team meet** **Network office to update** **Network office to update**
9. Date, Time, Venue of next meetings 17th May 2017, 0900-1200, UHCW CSB	