Paper 6.5

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
30 June 2016

AGENDA ITEM NUMBER	7.6	
TITLE OF PAPER	Trauma Unit Annual Report	
Confidential	**NO**	
Suitable for public access	**NO**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Trauma Delivery group		
STRATEGIC OBJECTIVE(S):		
Best outcomes	√	To ensure safe delivery of care for all patients presenting with Trauma related injury
Excellent experience	√	To ensure patients have an optimum experience throughout their whole journey
Skilled & motivated teams	√	To ensure optimum clinical expertise and response
Top productivity		
EXECUTIVE SUMMARY	.	
	This document outlines ASPH Trauma Unit Operational Delivery (2015/6) in preparation for the National Major Trauma Peer Review Process (planned for 2nd Aug 2016).	
RECOMMENDATION:	Note the Annual Report	
SPECIFIC ISSUES CHECKLIST:		
Quality and safety	To ensure patients receive immediate care by skilled clinicians through-out their journey	
Patient impact	To ensure patients are supported particularly for those where trauma related injury has resulted in life changing care needs	
Employee	Tis ensure staff have the right skills to assess where major trauma care is required (at Major Trauma Unit) and where appropriate manage patients with the TU	
Other stakeholder	Carers, SGH	

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Equality & diversity	To ensure patients receive the same level of expert care irrespective of age, gender, race, culture etc
Finance	To ensure where appropriate staff are given the opportunity to attend essential skills based Trauma courses to ensure they are able to deliver the highest standard of care
Legal	To mitigate against injury
Link to Board Assurance Framework Principle Risk	
AUTHOR NAME/ROLE	Lorraine Knight, Interim Chief Operating Officer Claire O'Brien, Head of Emergency Planning & Resilience)
PRESENTED BY	Lorraine Knight, Interim Chief Operating Officer
DATE	27 June 2016
BOARD ACTION	Receive

Ashford & St. Peters NHS Foundation Trust
Trauma Unit

Annual Report

2015/16

Organisation	Ashford & St. Peters NHS Foundation Trust (ASPH)
Document Purpose	Overview of Trust Trauma Unit status and priorities for 2016/7
Title	Annual Report
Author	Claire O'Brien (Head of Emergency Planning & Resilience)
Date and Version	June 2016, Version 5
Linkages	Network Peer Review Report and Action Plan
Circulation	Trauma Network Group & Trust Board Directors
Description	This document outlines ASPH Trauma Unit Operational Delivery (2015/6) in preparation for the National Major Trauma Peer Review Process (planned for 2nd Aug 2016).
Point of Contact	Claire O'Brien (Head of Emergency Planning & Resilience)

Foreword

Ashford and St Peters Hospitals NHS Foundation Trust serves a population of over 410,000 people and provides a wide range of services from two hospital sites – Ashford Hospital near Hounslow and St Peters in Chertsey. The quality of services continues to be developed and the Trust won the national Quality of Care Award from CHKS in 2016.

Our strategy is to develop integrated care for the local population and deliver high quality specialist services in Surrey. The Trust Board therefore recognises the value of delivering effective trauma services (as part of the Major Trauma network) and the benefits this brings the local population. ASPH is committed to ensuring that key service improvement and governance recommendations (as described within the network strategy) are given priority; ensuring high quality, safe and compassionate care for our patients.

Contents

Background

Ashford and St Peter's NHS Trust (ASPH) is a member of the South West London and Surrey Trauma Network (SWL&STN). The Network was established in 2010 in response to the National Confidential Enquiry into Patient Outcomes & Death (NCEPOD) report – Trauma: 'who cares' which highlighted significant deficiencies in organisational and clinical aspects of trauma care. St Peter's Hospital (SPH) acquired Trauma Unit (TU) Status in 2011.

SPH receives trauma predominantly from South East Coast Ambulance Service (SECamb) and self-presentations. Major trauma is taken directly to the Major Trauma Centre (MTC) at St George's Hospital (SGH). All trauma patients presenting to SPH are discussed with the MTC and where appropriate are transferred to SGH. Patients considered stable and suitable to be managed within a TU will be assessed and where appropriate admitted to St Peter's under the care of the most relevant specialty.

Introduction

As part of the on-going National Peer Review program and performance initiatives each trauma network undertakes assurance visits of the Trauma Units within their network. A network panel including external representatives will visit ASPH on 2nd August 2016.

This year there are two sets of measures against which ASPH will be assessed:
1) National Trauma Measures (TQUINS)
2) Pan - London Trauma Unit Standards.

A self-assessment and evidence of compliance against these standards is required. This includes evidence of an operational policy, annual report and work plan.

In addition information is expected to be submitted in advance of the visit and includes:

- Evidence of institutional commitment
- Evidence of TARN data completeness
- Evidence of governance and risk management
- Evidence of inpatient care and inpatient pathways
- Evidence of transfer of care processes
- Evidence of on-going rehabilitation practices

The last review in 2014 identified gaps in effective trauma delivery:

Where were we?	Where are we now?
Poor closure of governance reviews following M&M meetings and the absence of a specific risk register with institutional risk (eg only one CT scanner)	The Trust has reviewed its governance reporting structure to ensure a more robust mechanism of scrutiny relating to the management of Trauma patients (**see fig 1 below**). SPH now has 2 CT scanners. A recent audit showed that patients were seen within the expected response times (1 hr to CT + 1hr for reporting. Where there were delays identified most were due to delays in booking due to missing initial need for a CT or where there were delays in transfer from ED to CT
A number of patients waiting more than 30 minutes to see a doctor	A recent audit of trauma patients shows that the majority of patients are seen within 30mins of presentation. There is a still a risk in response for the older person as they are a high percentage of our major trauma without mechanism.

Inconsistent recording of the level of doctors attending trauma calls.	The Trauma record book has been updated to include whether a trauma call was triggered. A recent education programme in ED has re-launched requirement to complete the log as previously there were gaps in documentation
Trauma team activation criteria review	During Aug 15 – May 16, 92% of all patients identified with Trauma had a Trauma call activated.
Increased consultant cover on the shop floor when new consultant posts are recruited	Rapid Assessment & Treatment (RAT) was designed to address senior review. However this has not been able to be sustained due to senior clinician staffing short-falls. There is a need to develop a more robust pathway for the identification of trauma in the older person.
Increase administrative support for trauma governance	Since April 16 there is designated additional admin to support TARN and a Trauma Coordinator role which is helping to refocus the group
Demonstrate cross organisational learning from trauma M&M reviews	Fortnightly M&M meetings have been set-up to review all Trauma patients. This group focuses on all TARN patients as well as others where there has been any cause for concern
Governance log to show progress against action and current status	There is a TARN standardised governance log. The TDG are developing a log which will capture the whole of the patients journey for auditing purposes
Direct referral pathway from SGH to St Peters community beds needed	The Trust Rehab coordinator supported by therapies ensures that patients are transferred to a rehab bed at the point of repatriation
Continued engagement with the MTC for more complex cases.	Our newly appointed COE Trauma lead and our lead therapist are joining the virtual board rounds set-up by SGH to discuss complex cases where additional support on the longer-term management maybe required

Trauma Delivery Group

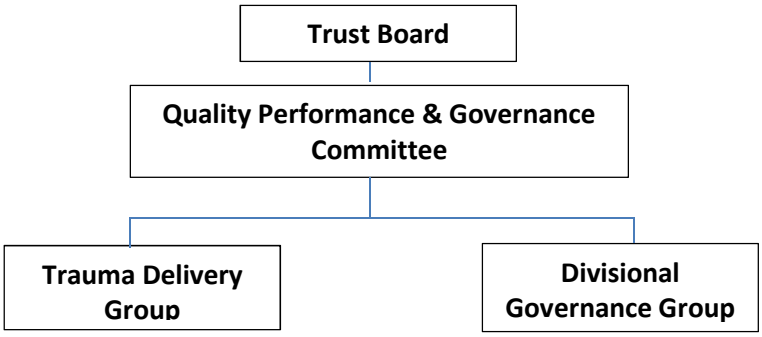
The Trauma Delivery Group (TDG); made up of multi-disciplinary senior clinicians and managers was set-up in 2011. The group refreshed its clinical leadership and membership in March 2016. This group currently meets fortnightly to discuss key actions relating to effective care of trauma patients presenting/admitted to ASPH. The group terms of reference were last reviewed and revised in March 2016 (**See appendix 1).**

Governance and Risk Management

A new Trauma lead has been appointed and the governance arrangements have been redesigned. **(See fig 1 for updated governance structure).**

Fortnightly MDT M&M meetings are used to review patients presenting with an Injury Severity Score (ISS) >15 and discuss governance issues relating to the management/outcome of these patients. Results from key local audits are presented by specialties to the divisional governance meetings. Key learning will now be included in bi-annual reporting to Quality Governance Committee (QGC) and to Trust Board. Learning from audits is shared in educational meetings such as Quality and Safety Half Days (QuASH Days). Divisional Governance leads assist the TDG to maintain a governance log and risk register. Trauma Datix incidents are logged and investigated.

Fig 1:



Trauma Audit and Research Network (TARN)
Data Completeness for the 9 months 01 April 2015 to 31 December 2015 was 70.4 – 86% and accreditation 97.1% (**See appendix 2**)

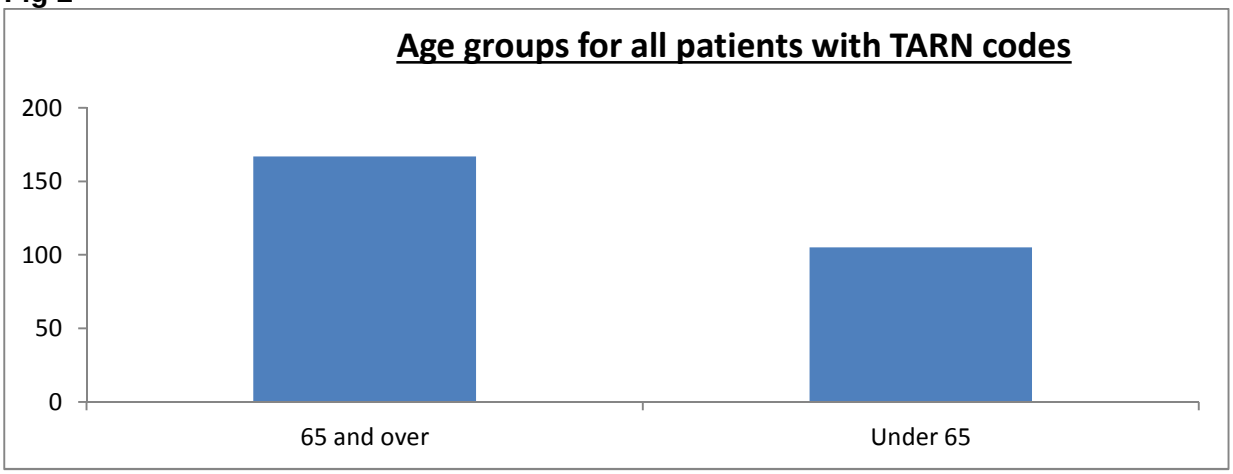
Developments

Traumatic Brain Injury (TBI)
For many years TBI patients have suffered from the lack of a dedicated service beyond the initial resuscitation and surgical intervention. ASPH has improved links with community services to provide timely transfer to a rehabilitation setting following discharge from the MTC and for those patients requiring acute transfer back to ASPH patients are where possible fast-tracked to Ashford Hospital which provides dedicated neuro rehab care or to an acute Care of the Elderly (COE) bed. Following repatriation, the requirement to isolate patients for infection has led to a delay for some patients to get to the right bed at the right time. The Trauma group is working closely with the Infection Control Team to ensure that where possible patients are isolated within an appropriate specialty bed base on transfer.

Spinal Cord Injuries (SCI)
Spinal cord injury patients are a complex patient group who are often associated with long waits in acute beds in the network (both MTC's and TU's) while waiting a rehabilitation placement at a Spinal Cord Injury Centre. ASPH are working to ensure all senior clinicians/therapists are American Spinal Injury Association (ASIA**)** trained to ensure best quality spinal cord assessment.

Elderly Trauma
An increasing amount of our seriously injured patients; with an Injury Severity Score (ISS) of >15 are the elderly fallers from standing who do not appear as major trauma in the classical sense. These patients often present with a seemingly insignificant mechanism but can have serious injuries. With the population ageing this has also been recognised nationally. (**See fig 2**)

Fig 2



Data has shown that 'Falls<2 metres' (a fall from standing) has a significant injury pattern associated with it. Patients admitted in Jan 2016 stayed a range of 1-74 days (**See fig 3**). The majority of these patients were frail elderly admitted to the Clinical Decisions Unit (CDU) to the Emergency Department (ED) for 24-48hrs supervision or to the Acute Medical Unit (AMU) (**See fig 4**)

Fig 3

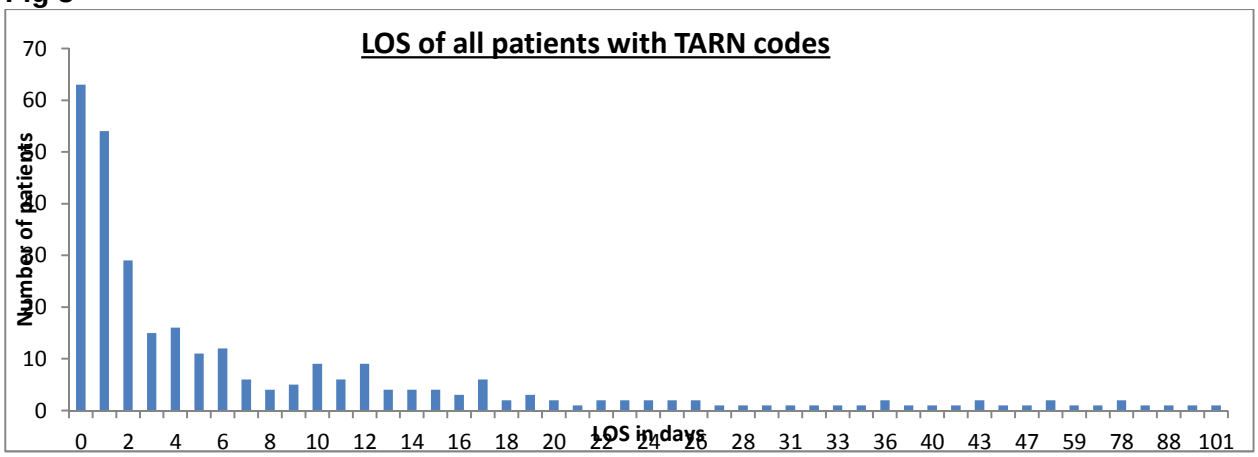
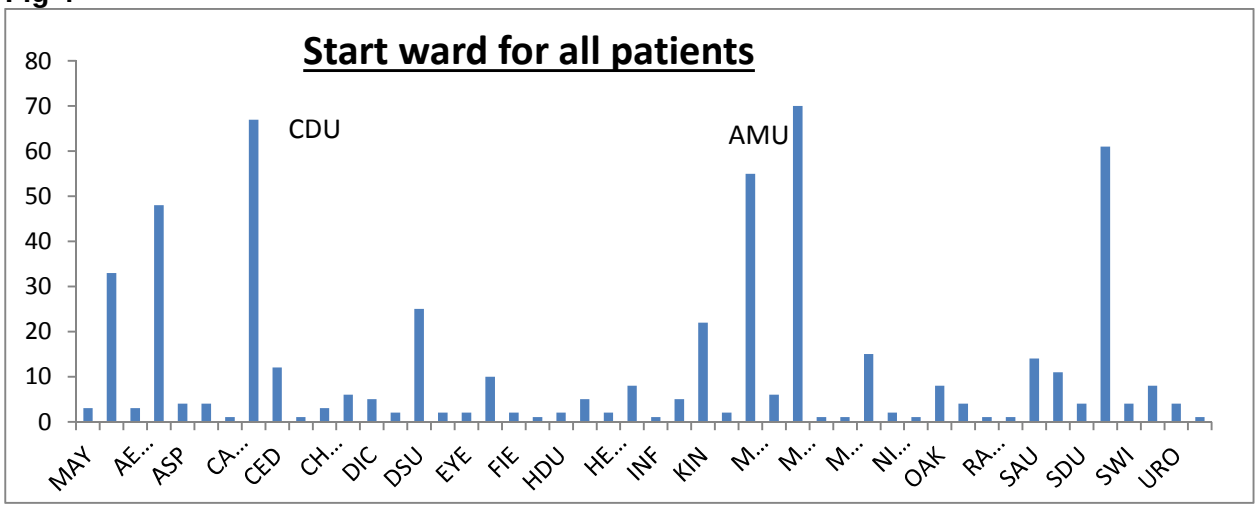


Fig 4



A COE Trauma lead has now been appointed to support elderly patients presenting with Medical Trauma related injury (e.g. Head Injury). There is enhanced focus by the site management team to ensure these patients get to an appropriate bed on initial presentation or following repatriation. A new COE Consultant has been appointed who is looking to further develop the care given to trauma patients. Therapies support tracking and coordination of specialist care and where appropriate patients are flagged & transferred to a COE or Neurology bed.

Areas for Improvement:

Adherence to the Network Transfer of Care Policy:
Requirement to isolate patients for CPE screening (following repatriation) impacts on patient placement due to the demand for side room capacity within most specialty wards. Many patients are admitted to the Acute Medical Unit (AMU) introducing delay in being admitted to the specialty ward and consistent access to COE clinical teams and therapeutic treatments

Trauma Criteria: Differences in SECamb Trauma triggers for initiating a Trauma inbound call to SPH can result in a delay in Trauma assessment and has been noted

Neurology bed base/capacity: Following repatriation the ability to place acute post-operative patients in a neurology bed is a challenge. If ASPH are successful in the bid to manage stroke services for the locality a pathway review will be required to ensure elderly trauma patients receive the right level of specialist COE input.

Summary and Way Forward

For 2016 the TDG will focus on the following priority areas:

1. **Patient's experience**: Critiquing the patient's journey is seen as an opportunity to identify gaps in service provision. Assessing patients experience is a powerful tool to improving care/practice. A patient representative will be invited the join the TDG

2. **Identification and implementation of training recommended by the London Trauma network:** A recent nursing and doctor training needs analysis has revealed gaps in training. It is recognized that the ability to release staff to attend external training (Advanced Trauma Nurse Course (ATNC) is limited. In-house training has therefore been developed to ensure nursing staff have the basic skills/competence to manage trauma presentations. Appropriate grade doctors with Advanced Trauma Life Support (ATLS) cover ED 24/7, with the ability to escalate to a senior Consultant OOHs if there are greater than 2 Trauma presentations

3. **Management of the older person following trauma:** It is recognized that some elderly patients have a missed diagnosis of Trauma as the initial history is often poor on presentation. Since the introduction of our COE Trauma lead the TDG are very keen to ensure that elderly patients get to the right bed in order to ensure they receive appropriate functional and cognitive specialist care.

4. **Trauma Call attendance:** A recent audit of Trauma call response has revealed that there is patchy response from certain specialties. The ability to measure effective trauma call response has been compromised with the withdrawal of switchboard contact when an alert is sent. It is recommended that the test Trauma call be responded to by all specialties in order to be sure bleeps are being held and working

Actions arising from the assurance visit in August will also be incorporated into the work plan above.

Conclusion:
The Trust continues to improve its ability to manage Trauma and is keen to learn and embrace any change which puts the patients at the very heart of the service we provide. There is still work to do to ensure adherence to recommended best practice trauma pathways thereby ensuring effective clinical outcomes for all patients.

Appendix 1

TRAUMA DELIVERY GROUP
Terms of Reference

Constitution

Clinical Governance Committee: to ensure robust clinical governance review process are in place for all trauma patients, managed within ASPH or transferred out to the Major Trauma network

Trauma Delivery Group: to ensure adherence to recommended best practice trauma pathways thereby ensuring effective clinical outcomes for all patients

Authority

The Group is authorised by the committee to instigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group.

Chair:

Consultant Orthopaedic Surgeon – Lead for Trauma, supported by the EPLO lead

Membership

Clinical Lead for Trauma – Orthopaedic Consultant

Accident and Emergency Clinicians – Consultant – Vice Chair (Adult & Paeds)

Accident and Emergency Department - Matron & Senior Nurse (Adult & Paeds)

Service Manager Accident and Emergency

Resuscitation Officer

Operating Department Practitioner

SECAMB Representative

Clinical Governance Manager

Paediatric Matron

Trauma and Orthopaedics - Matron/Trauma lead nurse

COE lead Consultant

Therapy lead

EPLO Lead

Management Support

TARN auditor

By Invitation

Chief Operating Officer

Consultant Surgeon

Consultant Anaesthetist

Trauma Surgeon

Radiologist

Clinical Site Nurse Practitioner (for patient pathway management)

Quorum

Meeting can only go ahead with 6 or more members are present.

Frequency and Conduct

The group will meet monthly for 1.5 hours for the first 6 months, from March to August 2016. Thereafter meetings will be bi-monthly

Function

- The development and implementation of strategy, operational plans, policies, regarding management of trauma patients, including Paediatrics
- Review of recommendations of the TARN data and quarterly reports and implementation of quality improvements.
- Review of individual cases and the dissemination of learning through quarterly trauma forum and presentation at divisional Educational Half Days
- Review of the Hot Trauma Transfer arrangements as per Trauma Network Guidelines
- Ensure there is a patient perspective and measure patient and carer experience

Key Responsibilities

- Improvement of the management of trauma patients and implementation of the trauma network guidelines.
- Identification and implementation of training recommended from the London Trauma network.
- Monitoring of national and local guidelines.
- Fulfillment of Trauma Unit designation criteria.
- Evidence of effective governance and risk management processes
- Evidence of inpatients/transfer of care pathways
- Structured action plan for reviewing trauma governance/risk management
- Evidence of training methods and log of training needs analysis/evidence

Reporting Lines

Local Trauma Network Meeting

Reporting progress as part of emergency Medicine Clinical Governance Report twice yearly

Clinical Advisory Group (CAG)

Quality Performance & Governance Committee – (QPGC)

Appendix 2

The Trauma Audit & Research Network

Data Completeness & Accreditation

If data completeness is low then the analysis in the rest of the report may not be reflective of true practice.

Trust / Hospital	01 April 2014 to 31 March 2015			01 April 2015 to 31 December 2015		
	Submissions n	Completeness %	Accreditation %	Submissions n	Completeness %	Accreditation %
Ashford and St. Peter's Hospitals NHS Trust	**280**	**74.9 - 89.7**	**95.8**	**202**	**70.4 - 86**	**97.1**
Croydon Health Services NHS Trust	159	58.9 - 66.4	96.3	70	35.5 - 40.1	86.3
Epsom and St Helier University Hospitals NHS Trust	285	77.7 - 89	83.9	159	55.4 - 63.5	90.3
Epsom General Hospital	80	80 - 97.8	80.3	45	54.9 - 67.1	86.2
St Helier Hospital	205	76.8 - 85.9	85.3	114	55.6 - 62.2	91.9
Frimley Health NHS Foundation Trust	350	88.4 - 100+	95.0	288	93.2 - 100+	94.9
Kingston Hospital NHS Trust	151	54.7 - 66	89.3	101	47.4 - 57.2	92.1
Royal Surrey County Hospital NHS Trust	229	65.1 - 78.5	92.9	201	77 - 92.9	92.8
St George's Healthcare NHS Trust	934	62 - 74.8	93.3	863	71.8 - 86.6	92.5
Surrey and Sussex Healthcare NHS Trust	235	54.3 - 68.1	91.8	85	26.5 - 33.2	93.1

Data completeness
This is displayed as a percentage range and represents the number of patients submitted to TARN compared to the number of patients expected based on the Hospital Episode Statistics (HES) dataset. The range represents the variance seen in the accuracy of the HES data.

Accreditation
This is the proportion of key fields used in this report that are filled in for each patient submitted to TARN.