Barking, Havering and MHS Redbridge University Hospitals



The TANQ

Trauma Aggregated News, Queen's



Points of Interest:

- TARN
- TQuINS
- Supplement

Inside this issue: 2: Trauma Call breakdown

The strikes are over and an agreement has been reached. But more importantly, none of the services on the Emergency pathway were disrupted, and patient care was not put at risk.

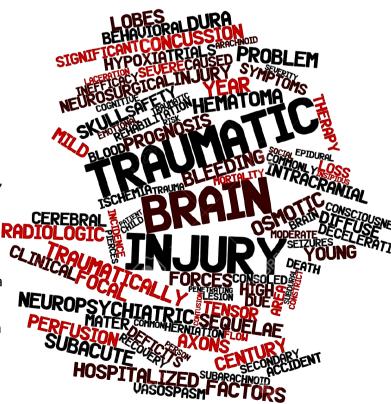
You may be wondering whether the strikes had anything to do with the May issue of the TANQ not being published. If so, be reassured that they had not. The core Trauma Committee at BHRUT have decided to hold the MDT every two months. This allows us more time to analyse the cases presented, and hopefully increases attendance by allowing for other commitments. As a result, the TANQ will be published on alternate months, bringing the total number of issues down to six in a volume.

The focus on the next two months is the Trauma Peer review. Our last review occurred last year and assessed our standards both as a Trauma Unit and a Trauma Centre for isolated head injuries. A number of issues were raised, and we have been steadily working towards improving them.



although our strengths are in the delivery of care to our trauma patients as they come in, our major weakness is in providing a rehabilitation service that is up to the standards that are required by TQuINS. Although this is a problem network wide, the team here at BHRUT are striving hard to remedy it.

In other news, the TARN reports is out for the last quarter of 2015/2016, and there has been some consistent progress. This will hopefully pick up in the first quarter of 2016/2017.



2: TARN Dashboad2: TARN Breakdown3: Peer Review measures

6: Education & Learning

This year's peer review will be on the 14th of July, and will assess our standards as a Trauma Unit. A breakdown of the measures can be found on page 3. You will note that in addition to the National Peer Review standards, there are also Pan-London standards that need to be addressed.

On our self-assessment, it is quite evident that

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The TANQ - up in arms against Trauma



TRAUMA CALLS / Traumatic patients

	Monthly Breakdown 2016						
Month	Total	Home	Admit Queens	To Theatres	Admit Other	DID	Did Not Wait
Мау	27 / <mark>165</mark>	8 / 121	17 / <mark>32</mark>	0 / 0	1 / <mark>1</mark>	0 / <mark>1</mark>	0 / <mark>11</mark>

Developed by a working group of clinicians from Trauma Units Prepared by the Trauma Audit & Research Network 27/05/2016

MAJOR TRAUMA DASHBOARD

Trauma Unit Dashboard Queen's Hospital Essex

Data	0	114.1.1
Data	Qua	IIUV

Duta Quanty											
TU 01 - Quality of patie	nt data submitted to	TARN				TU 08 - Proportion of p	atients with GCS <9 w	vith definitive airway	management withir	1 30 minutes of arrival in ED	
Period	Numerator	Denominator	Trust value (%)	National mean (%)		Rolling	Numerator	Denominator	Trust value (%)	National mean (%)	
15/16 Q4	40.2	44	91.3	94.8	4	Rolling year	Less than 6	Numerator < 6	0	31.4 4	
100 75 50 25 0			flanditi.trinaturaturi	ามรับข้างใหญ่หลาง			all numbers of patient Details of any eligible				
TU 02a - All TARN eligib	le patients submitte	d				TU 09 - Proportion of d	irectly admitted patie	ents receiving CT scan	within 60 minutes o	of arrival at TU	
Period	Numerator	Denominator	Trust value (%)	National mean (%)		Period	Numerator	Denominator	Trust value (%)	National mean (%)	
15/16 Q4	44	156	28.2	69.5	•	15/16 Q4	Less than 6	Numerator < 6	11.1	24.2	
100 75 50 25 0							all numbers of patient Details of any eligible				
TU 02b - All TARN eligil	ble patients submitte	ed within 40 days of (discharge or death (e	xcluding coroner's cases)	TU 10 - Proportion of p	atients with an ISS of	more than 8 that hav	ve a rehabilitation p	rescription completed	
Period	Numerator	Denominator	Trust value (%)	National mean (%)	·	Period	Numerator	Denominator	Trust value (%)	National mean (%)	
15/16 Q4	19	155	12.2	41.7		15/16 Q4	Less than 6	Numerator < 6	0	34.6	
75 50 25 0 Evidence Based Meas							all numbers of patient Details of any eligible				
		E head injury guidelir	nes that receive CT so	an within 60 minutes of	arrival at TU						
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)							
Rolling year	10	12	83.3	57.9							
100 75 50 25 0	T						F	XPFC	TFD ⁻	TARN P	ATIENT
TU 04 - TUs administer	Tranexamic Acid wit	thin 3 hours of incide	nt to patients that re	eceive blood products wi	ithin 6 hours of incident						
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)					2	016	
Rolling year	Less than 6	Numerator < 6	100	53.1	•					•••	
Sm		nts do not allow effec le patients can be fou						Month	Expect	ed Submissions	
TU 05 - TUs deliver Cons	ultant led trauma te	ams within 30 minut	es for patients with a	an Injury Severity Score (greater than 15			January		42	
Period	Numerator	Denominator	Trust value (%)	National mean (%)				February		41	
15/16 Q4	Less than 6	Numerator < 6	0	45				March		45	
		s do not allow effecti		ons.				April		53	
	Details of any eligible	e patients can be four	id in the patient lists.								
System Indicators								Мау		58	

Period	Numerator	Denominator	Trust value (%)	National mean (%)	
15/16 Q4	7	9	77.8	55.1	• •
- Rapid access to specialist MTC care - patients transferred to MTC within 12 hours of referral request					
- Rapid access to	specialist with care-				
			T	AL 11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
Period	Numerator	Denominator	Trust value (%)	National mean (%)	

Small numbers of patients do not allow effective national comparisons. Details of any eligible patients can be found in the patient lists.



June	41
July	60
August	60
September	47
October	67
November	52
December	49



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PRID



National Peer Review Programme

TQuINS

Trauma Quality Improvement Network System

"PEER REVIEWS 2016"

RECEPTION AND RESUSCITATION MEASURES

Indicator	Descriptor	Descriptor Magnified
T16-2B-301	Trauma Team Leader	There should be a trauma team leader of ST3 or above or equivalent NCCG, with
110-20-301	frauma ream Leauer	an agreed list of responsibilities available within 5mins, 24/7.
		There should also be a consultant available in 30 minutes.
		The trauma team leader should have been trained in Advanced Trauma Life
		Support (ATLS) or equivalent.
		There should be a clinician trained in advanced paediatric life support available
		for children's major trauma.
		There should be a nurse/AHP available for major trauma 24/7 who has
T16-2B-302		successfully attained or is working towards the adult competency and
110-20-302	Emergency Trauma Nurse/ AHP	educational standard of level 2 as described in the National Major Trauma
		Nursing Group guidance.
		In units which accept children;
		There should be a paediatric registered nurse/AHP available for paediatric
		major trauma 24/7 who has successfully attained or is working towards the
		paediatric competency and educational standard of level 2 as described in the
		National Maior Trauma Nursing Group guidance
Indicator	Descriptor	Descriptor Magnified
T16-2B-303	Trauma Team Activation Protocol	There should be a trauma team activation protocol
		The trauma team should include medical staff with recognised training in
		paediatrics and paediatric trained nurses with experience in trauma.
	Agreement to Network Transfer Protocol from	The trauma unit should agree the network protocol for the transfer of patients
T16-2B-304	Trauma Units to Major Trauma Centres	from trauma unit to major trauma centre.
	radina onici to major radina centres	
746 00 005		There should be CT scanning available within 60 minutes of the trauma team
T16-2B-305	24/7 CT Scanner Facilities	activation.
T16-2B-306	CT Reporting	There should be a protocol for trauma CT reporting that specifies there should be
110-20-300	er keporting	a provisional report within 60 minutes.
T16-2B-307	Teleradiology Facilities	The trauma unit should have an image exchange portal that enables immediate
T16-2B-308	24/7 Access to Surgical Staff	image transfer to the MTC 24/7.
		The following staff should be available within 30 minutes 24/7:
Indicator	Descriptor	Descriptor Magnified
T16-2B-309	Dedicated Orthopaedic Trauma Operating	There should be dedicated trauma operating theatre lists with appropriate
116-28-309	Theatre	staffing available 7 days a week. The lists must be separate from other emergency operating.
		energency operanily.
T16-2B-310	24/7 access to Emergency Theatre and Surgery	There should be 24/7 access to a fully staffed and equipped emergency theatre.
		Patients requiring acute intervention for haemorrhage control should be in an
		operating room or intervention suite within 60 minutes.
T16-2B-311	Trauma Management Guidelines	The trauma unit should agree the network clinical guidelines specified in T16-1C-
		107 The trauma unit should include relevant local details
		The trauma unit should include relevant local details.
		There should be a protocol for the management of massive transfusion in
T16-2B-312	Transfusion Protocol	patients with significant haemorrhage.

DEFINITIVE CARE MEASURES

Indicator	Descriptor	Descriptor Magnified
T16-2C-301	Major Trauma Lead Clinician	There should be a lead clinician for major trauma, who should be a consultant with managerial responsibility for the service and a minimum of 1 programmed activity specified in their job plan.
T16-2C-302	Trauma Group	The TU should have a trauma group that meets at least quarterly.
		The membership should include:
		🛽 major trauma lead clinician;
		2 executive board representation;
		I ED medical consultant
		2 ED nurse
		representation from:
		🛙 radiology
		2 surgery
		2 anaesthetics
		🛙 critical care
		Itrauma orthopaedic surgeons
Indicator	Descriptor	Descriptor Magnified
T16-2C-304	Management of Spinal Injuries	The trauma unit should agree the network protocol for protecting and assessing
110-20-304	Management of Spinal Injuries	the whole spine in adults and children with major trauma.
		There should be a linked Spinal Cord Injury Centre (SCIC) for the MTC which
		provides an out-reach nursing and/or therapy service for natients with spinal

DEFINITIVE CARE MEASURES

Indicator	Descriptor	Descriptor Magnified
T4C 2C 200	Trauma Unit Agreement to the Network	
T16-2C-308	Repatriation Policy	The trauma unit should agree the network repatriation policy T16-1C-115
		There should be a protocol in place for identifying a speciality team to accept the
		patient. The protocol should include the escalation process in the event of there
		not being access to a specialty team.
T16-2C-309	Patient Experience	The MTC should participate in the TARN PROMS and PREMS
T16-2C-310	Discharge Summary	There should be a discharge summary which includes:
		A list of all injuries
		Details of operations (with dates)
		Instructions for next stage rehabilitation for each injury (including specialist
		equipment such as; wheel chairs, braces and casts)
		Pollow-up clinic appointments
		Contact details for ongoing enquiries.
T16-2C-311	The Trauma Audit and Research Network (TARN	N
10-20-511	The Hadma Addit and Research Network (TARK	The trauma unit should participate in the TARN audit.

REHABILITATION MEASURES

Indicator	Descriptor	Descriptor Magnified
		There should be a rehabilitation coordinator who is responsible for coordination
T16-2D-301	Rehabilitation Coordinator	and communication regarding the patient's current and future rehabilitation
		including oversight of the rehabilitation prescription.
		This rehabilitation coordinator should be a nurse or allied health professional.
T16-2D-302	Access to Rehabilitation Specialists	There should be the following allied health professionals with dedicated time to
		support rehabilitation of trauma patients:
		🛙 physiotherapist
		I occupational therapist;
		Ispeech and language therapist
		🛙 dietician
		There should be specified referral and access pathways for
		 rehabilitation medicine consultant
		• pain management
		 psychology/neuropsychology assessment (1)
		mental health/psychiatry
		 specialised rehabilitation
		 specialist vocational rehabilitation
		 surgical appliances
		 orthotics and prosthetics
		wheel chair services.
		All patients should receive a rehabilitation assessment including barriers to
T16-2D-303	Rehabilitation Prescriptions	return to work. Where a prescription is required this should be completed within
		72 hours.

Pan-	London Measures
Evidence of Institutional Commitment	
Evidence of institutional commitment	Named senior lead to attend Network Board (75% attendance required)
	Named clinical lead to lead both locally and be part of the network group (1 PA
	required. 75% attendance required)
	Named clinical lead for elderly trauma to lead locally
	Named rehab lead to attend Network rehabilitation group (75% attendance
	required)
	Named TBI and Spinal champions to lead locally (requirement 75% attendance)
	EPLO representation at network EPLO group (75% attendance required)
	Nursing representation at network nursing group (75% attendance required)
	Named clinical lead for other network subgroups
	Named management support for clinical lead
	Evidence of local trauma delivery group meetings with MDT attendance
	(minimum quarterly)
	Evidence of dedicated resources that support TARN data entry.
Evidence of TARN data completeness	TARN requires minimum of 80% for data to be statistically significant
Pan	London Measures
Fail-	London Measures
Evidence of Governance and risk managemen	nt
	Evidence of effective clinical incident management for trauma (governance log)
	-Evidence of clinical governance meeting (M&M meetings) which MT nationts an
	-Evidence of clinical governance meeting (M&M meetings) which MT patients an -Evidence of local review of patients with ISS greater than 15 (minimum nuarter(h)
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	-Evidence of local review of patients with ISS greater than 15 (minimum quarterly) Evidence of risk register related to delivering major trauma care / services and routine reporting to Divisional or Trust governance and risk board Evidence of a structured action plan for reviewing trauma governance and risk
Evidence of inpatient care and pathways	 Evidence of local review of patients with ISS greater than 15 (minimum quarterly) Evidence of risk register related to delivering major trauma care / services and routine reporting to Divisional or Trust governance and risk board Evidence of a structured action plan for reviewing trauma governance and risk management (from ED to rehab) is structured within the Trust Confirmation of lead speciality and pathway for the management of admitted
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Evidence of transfer of care processes	Evidence of local review of patients with ISS greater than 15 (minimum quarterly) Evidence of risk register related to delivering major trauma care / services and routine reporting to Divisional or Trust governance and risk board Evidence of a structured action plan for reviewing trauma governance and risk management (from ED to rehab) is structured within the Trust Confirmation of lead speciality and pathway for the management of admitted trauma patients with: Multiple injuries Isolated head injuries Spinal injuries Elderly trauma patients Evidence of a trust wide process for accepting patients transferred back from the MTC Evidence of compliance with network and Pan London standards of transfers within 72 hours (includes 24 hours pre-alert) for the last 12 months
Evidence of transfer of care processes Evidence of on-going care rehabilitation	Evidence of local review of patients with ISS greater than 15 (minimum quarterly) Evidence of risk register related to delivering major trauma care / services and routine reporting to Divisional or Trust governance and risk board Evidence of a structured action plan for reviewing trauma governance and risk management (from ED to rehab) is structured within the Trust •Confirmation of lead speciality and pathway for the management of admitted trauma patients with: Multiple injuries Isolated head injuries Spinal injuries Elderly trauma patients Evidence of a trust wide process for accepting patients transferred back from the MITC Evidence of compliance with network and Pan London standards of transfers within 72 hours (includes 24 hours pre-alert) for the last 12 months Description of trauma co-ordination care service (roles and evidence of engagement) Evidence of agreed Referral pathways/directory of services and documentation
Evidence of transfer of care processes	Evidence of local review of patients with ISS greater than 15 (minimum quarterly) Evidence of risk register related to delivering major trauma care / services and routine reporting to Divisional or Trust governance and risk board Evidence of a structured action plan for reviewing trauma governance and risk management (from ED to rehab) is structured within the Trust Confirmation of lead speciality and pathway for the management of admitted trauma patients with: Multiple injuries Isolated head injuries Spinal injuries Elderly trauma patients Evidence of a trust wide process for accepting patients transferred back from the MTC Evidence of compliance with network and Pan London standards of transfers within 72 hours (includes 24 hours pre-alert) for the last 12 months

		provides an out-reach nursing and/or therapy service for patients with spinal cord injury within 5 days of referral.
74.0 20 205		There should be network agreed local management guidelines for the
T16-2C-305	Management of Multiple Rib Fractures	management of multiple rib fractures including:
		Pain management including early access to epidural;
		I access to surgical advice.
T16-2C-306	Management of Musculoskeletal Trauma	There should be guidelines for:
		Isolated long bone fractures;
		early management of isolated pelvic acetabular fractures;
		peri-articular fractures;
		☑ open fractures.
		The guidelines should include:
		accessing specialist advice from the MTC;
		Imaging and image transfer;
		Indications for managing on site or transfer to the MTC.

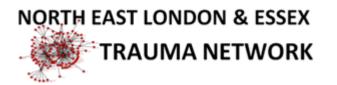
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PRIDE

Education, Training & Professional Development





- TILS @ Queen's to be announced
- Trauma Talks @ RLH 9 June 2016 (Neuro Rehab)
- Advance Trauma Life Support (ATLS) 14—16 September 2016
- **TARN (Data Collection) Manchester 29 July 2016**

Useful websites for trauma:

www.bhrhospitals.nhs.uk | www.tarn.ac.uk | www.c4ts.qmul.ac.uk | www.nice.org.uk | www.trauma.org | www.aftertrauma.org | www.tquins.nhs.uk | www.rcseng.ac.uk | erc.europa.eu



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