Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	28 October 2015				
Report Title:	Action Plan for the Serious Concerns Post Major Trauma Peer Review				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X			x		
Prepared by:	Dr. Alexandra Danecki Clinical lead for Major Trauma				
Executive Sponsor (presenting):	Stacey Hunter, Director of Operations				
Appendices (list if applicable):					

Purpose of the Report
To set out the progress update action plan in response to the 5 serious concerns raised at the major trauma peer review on the 24th March 2015

Action required by the Board of Directors
To review and approve the update action plan.

Key points for discussion

The 5 serious concerns along with actions are detailed in the action plan

1. Significant delays in assessing CT scans for trauma:
   - 5 actions all completed with audit data showing figures are better than those quoted in the peer review document
2. No agreed Network trauma management guidelines:
   - One action – completed - All guidelines now available on the West Yorkshire Major Trauma Network website
3. No overall trauma coordinator service:
   - 4 actions – 2 completed. One amber one red – both relating to changes required to S1
4. Trauma Audit Research Network data incomplete:
   - 2 actions – one completed one amber – relating to recruitment of post in November
5. No dedicated specialist rehabilitation services locally:
   - 4 actions – 2 completed and one amber – relating to S1 updates

Action required by the Board of Directors

To agree and accept the updated action plan

WYMTN – PR: Update on Response to Notification of Serious Concerns (12/10/2015)

Serious Concern	Immediate action	Progress update	Evidence to be presented to EAG	Lead	timescale	Risk Rating
The team acknowledged significant delays in accessing CT scans for trauma. The TARN data shows a median time from arrival to CT for all trauma patients of 3.1 hours and for those meeting NICE head injury criteria of 1.9 hours which is outside the NICE guidelines. A local audit undertaken by the team demonstrated only 2 out of 62 patients received CT scan within 30 minutes of request and less than 50% of patients within 60 minutes of request. Furthermore, the local audit demonstrated that only 70% had provisional CT report available within 60 minutes. Delays in undertaking CT scans on major trauma patients may lead to significant adverse outcome for these patients.	**AD** to further scrutinize audit data from January and February 2015, although acknowledge that data may not be sufficiently robust for the measures being assessed (previously no way of recording time of CT request).	**Complete**.	Appendix 1: Retrospective review of trauma CT audit data from January/February 2015. Submitted to EAG 16.4.15	AD	16.04.15	2x2=4
	30/3/15 – **AD** met with **GR** and **MC** to devise audit protocol running from 1/4/15 looking specifically at the 2 assessed TU measures.	**Complete**: audit (n72) demonstrates 78% of patients having their CT within 30minutes of request, and 92% of scans reported within 60minutes. This is a considerable improvement on the quoted figures from the TARN data.	Appendix 2: CT Audit April 15. Preliminary data. Submitted to EAG 16.4.15. Appendix 8: CT Audit April 15. (please note: the datasheet does not appear fully complete as secondary analysis being done to review other aspects of trauma care at AGH)	AD	20.5.15	
	MC and **GR** to review internal systems in radiology for ensuring that ED CT reporting is flagged to the appropriate radiologist and dictation verified and available within 60minutes.	**Complete**.	Appendix 3: Assurance from radiology department that ED trauma CT scans (including isolated head) will be reported and verified within 60minutes of scan completion 24/7. Submitted to EAG 16.4.15	GR	16.4.15	1x2=2
There are **no agreed network trauma management guidelines** and in their absence there is no evidence of local guidelines. The reviewers were significantly concerned that in the absence of network or local	**AD** to liaise with WYMTN ODN regarding the anticipated timescale for production of network guidelines. Once network guidelines adopted will need to go through AGH trauma governance group to be agreed	**Complete.**	All guidelines available at www.wymtn.com	AD	6 months	1x1=1

guidelines there may be a variation of clinical practice that could compromise the quality of patient care and outcomes.	at Trauma Unit level.					

There is **no overall trauma co-ordinator service** to ensure that all major trauma patients in the Trust have their multiple needs managed throughout the care pathway, including current and future **rehabilitation**. This includes the transfer and repatriation of patients to and from the Major Trauma Centre and associated specialist services. This could affect the treatment and outcomes for patients.	Standard reviewed on 09.04.15 and following actions agreed:					2x2=4
	a) Trauma rehabilitation coordinator agreed	**Complete**	Named Trauma Rehabilitation Coordinator – Cath Gregson	CG	16.04.15	
	b) Work with IT to develop icon to identify trauma patients from point of admission on Systmone	**In progress**: ongoing work with IT to scope what is required to add icon. Concerns regarding additional demands on ED reception staff	Changes in staffing and role allocation has resulted in this not being actioned. **AD** to chase	AD	6 months	
	c) Pathway to demonstrate coordination of trauma patients from admission to discharge	**Complete**	Appendix 4: Flowchart to demonstrate pathway coordination. Submitted to EAG 16.4.15	CG/SL	16.04.15	
	d) Audit of identified trauma patients to identify if rehabilitation needs met	**Incomplete**: This can only be done once systems in place to flag trauma patients across the trust (see b)).	Update in 6 months	CG/AD	6 months	

TARN data for the TU is incomplete and consequently inadequate to provide robust clinical and management information to the service and the Trust. The absence of adequate data capture and entry has resulted in there being insufficient information available to provide assurance to the Commissioners and the Trust on the quality and safety of the current service or to allow	31/3/15 **AD** met with **LT** to discuss current TARN process in detail. Significant issues highlighted including 1. problems with eligible patient capture via clinical coding. 2. completion of data by multiple operators with important clinical information not entered resulting in multiple errors on submission. 3. Transparency and adequacy of HES data.	**Complete**			09.04.15	5x2=10
	13/4/15 meeting arranged to	**In progress**: shortlisting	Appendix 9: Final Job description	ER	1	

effective planning for the future.	discuss the above between **AD, LT, PB, ER, JS**. Decision made that this needs to be a new dedicated role (15hrs pw)	scheduled for 13/10/15. Interviews to follow. 6 applicants to date. Temporary member of staff working to address backlog of work pending formal appointments.	with banding		month	

There are no **dedicated specialist rehabilitation** services for trauma patients locally therefore patients are being admitted to general wards where they will not receive the specialist rehabilitation support required. Lack of dedicated facilities and defined rehabilitation pathways co-ordination may seriously compromise the quality and outcome of patient care.	Standard reviewed on 09.04.15 and following actions agreed:					2x2=4
	a) Flowchart to describe specialist rehabilitation pathways including onward referral to community services	**Complete**	Flowchart to demonstrate pathway coordination (see action 3c/appendix 4). Submitted to EAG 16.4.15	CG/SL	16.04.15	
	b) Description of seven day rehabilitation services available to trauma patients to include the role of the Consultant in Rehabilitation	**Complete**	Appendix 7: Description of seven day rehabilitation services available to trauma patients Submitted to EAG 16.4.15	CG/SL	16.04.15	
	c) Work with IT to enable access for therapy to input on-going rehabilitation needs in discharge summary (rehabilitation prescription)	**In progress: CG** met with IT to scope best system – rehab prescriptions included in discharge letter (ICE) on ward 5. Working with IT to replicate in Systmone trust wide.	Update in 1 month	CG/SL	1 month	
	d) Amend operational policy for Physiotherapy on-call to include trauma patients	**Complete**	Appendix 11: updated operational policy	SL	1.6.15	

AD – Alex Danecki
GR – Girish Raghunathan
MC – Martin Cobley
LT – Laura Taylor
PB – Phil Browne
JS – Julia Spencer
ER – Ercy Radi

CG – Cath Gregson
MD – Mary Dickinson
SL – Sara Lewis