NOTES: LSEBN Board - Wednesday 5th July 2023

Attended:

David Barnes – St Andrews (Chair and Clinical Lead)
Joanne Lloyd – Network Advisor
Vicky Dudman – Network Lead Therapies
Paul Drake – Queen Victoria Hospital
Victoria Osborne-Smith – NHSE London
Pete Saggers – ODN Manager
Rob Hollingsworth – MDSAS *(Item 3.2)*
Lisa Williams – Network Lead Psychosocial Care
Nicole Lee – Network Lead Nurse
Joanne Atkins – Chelsea & Westminster
Joanne Pope – NHSE East of England
Matthew Lees – Medical Director QVH

1 Chair's introduction and apologies

At the beginning of the meeting, with RH joining to discuss MDSAS, introductions were made.

2 Notes of the previous meeting ODN Board March 2023

The notes were briefly discussed, with a number of issues om today's agenda. The notes were approved as accurate.

3 Matters arising, not on the agenda

3.1 - NHSE QA Peer Review

At the previous meeting, the group had a long discussion about the Peer Review final reports and "factual accuracy checks". It had been agreed that PS would write to HC to express concerns about the reports and their accuracy. At the time of the meeting, no response had been received. DB noted that the reports remain "live" within the context of the Trust governance reporting and the inaccuracies need to be challenged. JP said that she would go back to HC, so that there could be a dialogue with the review team(s) and a response to the letter from PS.

3.2 - TRIPS / MDSAS

RH is attending the meeting to provide a short briefing on the MDSAS tele-referral system. PD spoke about the current position with the TRIPS system. As previously discussed, the TRIPS system was not due to receive any further development upgrades, but PD announced that a new discussion and option appraisal is taking place with the system provider, to look at development opportunities. The options and costs are being discussed PD hopes that further news will be announced later in the summer. The Trust have assurances that the existing system can be maintained. PD agreed to keep DB and PS informed of progress.

NL noted that a number of referring hospitals are refusing to use the TRIPS system, due to concerns about information governance and security. PD responded to confirm that the system meets all of the necessary NHS IG rules and that the issue involves the use of digital cameras or other operational obstacles within the EDs.

With regard to MDSAS, RH spoke about the wider roll-out of the system and technical / security updates. The following issues were discussed:

- Outreach and uploading images from smart phones.
- Patient records available as a PDF for local records.
- Integration with IBID and other reporting systems (PowerBI).
- PS / PD asked about the wider costs of the MDSAS system for other specialties (plastics, trauma etc). RH will resend the analysis of costs to PS, for circulation to services.

Action

- ***It was agreed that C&W would "pilot" the use of the MDSAS system.***
- ***NL will make contact with RH and the MDSAS team.***

PS noted that the LSEBN is seeking to conclude the discussion about tele-referral systems before the year-end and make a decision about staying with TRIPS or seeking a new provider. PS also spoke about NHS procurement rules and DB said that he would be uncomfortable with any decisions proceeding without a full procurement process.

4 Burn Service Update *(Verbal)*
Issues related to activity, performance and staffing

St Andrews

- DB noted that general staffing is much better than previously reported, although the service has recently seen one of the burns consultants leave the Trust. Plans are in place with two locum consultants in post and the permanent job plan is expected to be approved in the next week.
- The service is clinically busy with a number of outlier cases.

Chelsea & Westminster

- JA reported that the service has been very busy in recent months although at the current time, referrals have eased. This is a welcome circumstance as the Trust is planning some engineering work (ventilation) in the burns ICU area, and this may have temporary impact on the ability to accept cases.
- The service is stable with staffing at the moment.
- LW spoke about the long-standing issues with psychology staffing, and noted that discussions have started with the C&W managers about a more flexible approach to staffing.

Queen Victoria Hospital

- PD noted the appointment of two new substantive consultants in the burns team and this is a very welcome addition to the team. Activity remains relatively high, with a significant volume of day-case work.
- PD reported that due to estate problems with the roof / ceiling, the burns ward has had to move location, back to the original location on the QVH site. Engineering renovation work is planned to resolve this situation. There has been no change to the arrangements for critical care (to be discussed later in the agenda).
- With regard to nurse staffing, this remains a difficult issue and the service does not currently have a burns matron in post.

JP asked how the services are managing through periods of industrial action. DB responded to note that generally speaking, cover for junior doctors has been challenging but consultants have been able to maintain service access. There is an inevitable impact on elective care and there are questions about sustaining this position over the longer term. This position was echoed across all services.

Standing Item: Network Performance Reports

5 LSEBN Performance (Quarter 4 2021-2022)

5.1 Issues Log (ODN Risk Register)

- The register has been updated to note the issues arising from the QA peer review visits.
- A number of issues are to be discussed at today's meeting.
- It was agreed that the current issues and classification of "risk" should remain on the report.

5.2 Quality Dashboard

- This report relates to the data collected through IBID. The report highlights areas of "non-compliance".
- DM commented on the way that data is collected and spoke about the way compliance is measured. As an example, DB said that it was entirely possible to treat patients with a resus-sized injury, but without resorting to fluid resuscitation. This type of case "skews" the figures and can be misleading.
- NL asked if the counting of OP cases was causing some services to struggle with compliance. It is possible that the figures at St Andrews are skewed by the inclusion of OP activity. This will need to be checked with IBID.
- NL also asked about the Burns Rehab Prescription and PROMS. PS responded to say that the Burns RP, in its current guise, had been approved by the CRG some years ago. There is clearly a problem with the current format and all networks/services are raising this as an issue that needs to be revisited.
- DB reiterated concerns about the IBID dashboard reports, saying that whilst some of the quality dashboard indicators are good, there are a number of issues where the quality dashboard indicator is less than good, citing frailty scores as an example.

5.3 Refusals (Referrals turned away)

- The quarterly report now analyses the cases split by age-group.

5.4 Pathways DOS Sit-Rep Bed Availability, OPEL Status and Occupancy

- The report provides the most recent figures from the DOS record. The analysis now includes a table showing the cause of OPEL 2 closures.
- JL noted that services closed due to beds being "full" is often caused by difficulties with staffing.

5.5 Network Team Budget

- PS reported that the final year-end figures have now been confirmed by Chelsea & Westminster and the sums to be carried forward into 2023 are also confirmed. Since the previous meeting, and within the 2022-23 financial year, all services submitted invoices for the network training & education budget, meaning that the amount carried forward into 2023-24 is less than the amount discussed at the March meeting. The sum is confirmed as £28,498.00. The FY budget for 2023-24 is confirmed by NHSE as £181,100.
- As discussed at the March meeting, it is proposed that the staff budget is increased to reinstate the second clinical lead post (as "deputy clinical lead") and to add an informatics & data lead for the network team.
- The network education and training budget for 2023-24 is £32,000. PS asked services to submit invoices at the earliest opportunity.
- The change to the clinical leadership roles is caused by the new NHSE specification for Burn Networks and the requirement for the Network Board to have an independent external Chair. The meeting discussed how the role of Chair would be filled and the possible candidate options, including people from an ICB or from another acute discipline (such as trauma or ED).

6 Referral and acceptance thresholds

Queen Victoria Hospital:
To discuss the proposed acceptance threshold and mitigations for Adult Burns

- Following the discussion at the March Network Board, QVH have developed proposals for the upper threshold for adult in-patient care. PD has provided a description of the proposals in a short written report and flow-chart.
- PD noted the following issues:
  - The situation with access to critical care remains an issue and reduces the capability of the service to admit large or complex cases.

- Along with other exclusion criteria, it is planned that a threshold of 20% TBSA is put into place.
- It was noted that setting a written definition for what is included and excluded is a difficult task and there will inevitably be a "case-by-case" assessment above or below the 20% target.
- The flow-chart begins with a clear statement about the cases that should be referred to a burn centre (St Andrews or ChelWest) and provides a referral schematic view of the type of cases (cause and size of injury) that QVH would expect to receive, including a low-threshold for facial burns.

- DB noted that the proposals would need to be supported and approved by the relevant NHSE commissioners.
- NL asked about the cases that do move up to ChelWest of Chelmsford and a process for step-down and repatriation, once a patient no longer needs centre-level care.
- NL also mentioned the funding arrangements for the "bigger" cases.
- JP asked about the arrangements for ambulance transfers, to avoid inappropriate transfers. PD noted that the referral pathway for trauma & EDs will remain unchanged and the decision to accept or refuse cases should rest with the burns clinicians.
- DB noted the statement in the document that refers to "aspirational" standards and suggested that this should be reworded. The document will need to be officially formatted with the QVH "header" and signed-off by the Trust Board.
- JA asked again about an adjustment for the funding arrangements to recognise this formal change to the referral pathway for patients with large or complex injuries.
- ML reiterated the issue for QVH related to critical care staffing.

Actions:

- ***The Network supports in principle, the proposals detailed in the papers from QVH.***
- ***The proposals should now be reformatted into a formal Trust "headed" document and be signed-off by the Trust.***
- ***The next step is to have commissioner (NHSE South East) approval.***
- ***PS will make contact with the NHSE SE commissioners to ensure they are informed of the discussion today.***

QVH have submitted a second paper for discussion at the Network Board, related to the QA visits, compliance with the BBA Burn Care Standards (2018) and mitigations in place to address areas where standards are not met. The following issues were noted:

- DB mentioned the QA report and the recommendation that there should be an action plan for the areas not compliant with the requirements for co-located services. The aim is to support the service and Trust in mitigating the position, whilst a longer-term solution is sought for specialised burn care in the Southeast region.
- DB described a number of areas where further detail or clarification is needed:
  - 24 hour staff-grade cover
  - Impact of the outreach service, related to the lack of MTU colocation
  - Local Trust support for areas including urology, Obs & Gynae etc
  - Paediatric issues for non-IP care
- PD responded on these topics as follows:
  - It is noted that for QVH, it is rare to require access to the co-located services.
  - On-site consultant medical cover is provided through on-site respiratory services but this is not available as 7 day or 24 hour cover. The burn service relies on the on-site practitioner and ICU out-of-hours team (anaesthetics and intensivists) for medical cover. This includes medical emergency calls for trauma and burns and for deteriorating patients.
  - If a medical consultant is needed out-of-hours, then a call / referral is made to Brighton. The Trust is engaging with other local Trusts to make the partnerships more appropriate to where the patient lives. In addition, remote access can be a useful addition to the service, when urgent advice is needed. This is particularly helpful where scans have been done and specialist advice is required to look at the results remotely. It is possible to get a clinician over to QVH within 60-90 minutes in an emergency situation.

- ML added a comment for the support from the Trust for SLAs with multiple local hospitals. A new CEO is in post and supports these initiatives.
- With regard to the Medical Emergency Teams and Critical care out-reach (site practitioners but with more than one role), this includes ward staff from the burns and plastics team., with any concerns escalated to the on-call burns consultant.
- The burns outreach team is led by a senior burns nurse, visiting peripheral hospitals where patients have a burn injury and another unrelated condition or trauma. This is essentially out-reach wound care and dressings. Additionally, there is a plastics team in Brighton, with 5 consultants (burns aware) and 2 clinical nurse specialists (burns trained). This team supports patients in the Brighton MTC with a burn injury (with or without other trauma). With poly-trauma, the burn surgery takes place at Brighton.
- DB asked if all of this detail is included in the SOP for burns, and PD responded to say no.
- NL asked if there could be an update with nursing team, bearing in mind current vacancies.

Actions:

- ***The Network supports in principle, the mitigations as described in the report from QVH and the discussions today.***
- ***The report should be expanded to include reference to the Medical Emergencies team, QVH outreach and the arrangements for plastics and trauma at Brighton.***
- ***The report should be officially approved by the QVH Board.***
- ***There should be a discussion / meeting between the QVH team, the Network and NHSE South East Commissioners, to ensure that the arrangements have consensus across the three organisations.***

St Andrews:
To discuss the proposed, revised Threshold Matrix for Paediatric referrals

- In 2015, new arrangements were put in place to create a pathway for children with the most severe and complex injuries to be potentially transferred for treatment at Birmingham Children's Hospital. A scoring "risk matrix" assessment tool was developed for cases referred to St Andrews. Following the QA visits, recommendations have been brought forward to improve the arrangements with BCH and Great Ormond Street.
- JL spoke about the proposal, noting the following:
  - Most children referred to St Andrews are accepted and treated at St Andrews. A very small number require support from PICU and depending on the circumstances and need for burn care, these cases are currently treated in collaboration with GOS or BCH.
  - The paediatric matrix is essentially an "organ failure" tool and is simple to use, with additional references to age/weight, size of the burn injury and requirement for ventilation.
  - A meeting has been held with the paediatric transfer services (CATS, PaNDR and KIDS) it was agreed that the first contact from St Andrews should be with PaNDR (Paediatric and Neonatal Decision Support and Retrieval Service) based in Cambridge. The transfer is managed by PaNDR no matter which destination service is chosen.
  - The new document sets out the referral procedures and processes.
  - At the moment, the 'matrix scoring" leads to only a handful of cases being discussed with BCH and only 1 or 2 cases have actually resulted in transfer to Birmingham.
- JP noted another PIC related workstream at St Andrews, with Teresa Tredoux working on the assessment of nursing qualification and skills, against the new PIC standards. The conclusion of this project will be followed up with joint work with the PICU network.
- PS asked about the decision process for transfer, as the new document seems to move away from BCH/KIDS being involved in the decision. DB responded to say that the proposed model clarifies the position with regard to the need for PICU, with or without burn care. JP suggested that the referral procedure should be amended to include reference to discussions with PIC consultant colleagues.

- PS added that the original "matrix" had been developed in response to recommendations from the Burns Clinical Reference Group (CRG) and asked whether this new proposal should also be passed through the Major Trauma & Burns CRG.
- JP suggested that the CRG might better be involved once the other work (staffing, skills and PIC nursing standards).

Actions:

- ***The Network supports in principle, the revised St Andrews Paediatric Matrix.***
- ***A small edit will be added to the referral procedure, to describe the early communication with PIC consultants.***
- ***A final version will be circulated for e-approval and sign-off.***

7 NHSE Commissioning for burn care networks

To discuss the new NHSE Burn Network Specification

PS introduced the new (draft) NHSE specification for the burns networks. The specification sets out the scope, aims & objectives and operational governance arrangements within a standard NHSE format for all networks. The new arrangements cover issues and topics that are already covered within the existing arrangements for the LSEBN, including Terms of Reference, Work Plans and Memorandum of Understanding.

One new issue that will need to be resolved (mentioned at 5.5 above) is the requirement to appoint an external Chair for the network board. At the moment, our Network Clinical Lead is also Network Chair but this arrangement will end under the new specification. PS asked how NHSE London is managing this situation with other clinical networks. VO-S replied to say that other networks are contemplating the same question. The trauma networks already have external chairs and they are usually "close partners" who are not officially part of the network (for example pre-hospital clinicians or ambulance). Other networks are looking towards the new ICBs. VO-S said that it was important that the Chair was someone who really understands the service (burn care). PS said that due to the wide geography and multiple organisations within the LSEBN area, finding the right person was going to be a challenge.

In conclusion it was agreed that the focus of attention should be about the "type" of person needed for the role, rather than where that person is from. A person specification will be needed and then a process for seeking expressions of interest.

8 LSEBN Work Plan 2023

NHSE London (Host) Programme

The 2023-24 Work Plan was circulated to the meeting, but not discussed in any detail. It was noted that the work plan is being scrutinised by NHSE London and work programmes are shared with ICB commissioners.

Action

- **VO-S will ensure liaise the other NHSE regions (covering the LSEBN area) on the burn network work programme.**

<u>Date of next ODN Board meeting(s)</u>

<u>Confirmed dates</u>

Thursday 5th October 2023

- *LSEBN Network Board (Main Group)*
- *LSEBN M&M Audit*

Tuesday 9th January 2024

- *LSEBN Network Board*