South West London & Surrey Trauma Network Operational Policy and Guidelines

Organisation :	South West London & Surrey Trauma Network (SWL&STN)
Document Purpose:	Guidance
Title:	South West London & Surrey Trauma Network Operational Policy and Guidelines
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Description :	The purpose of this document is to outline the operational pathway and guidelines related to the major trauma services in the SWL&STN
Review date:	May 2017

NOTE: The latest versions of the clinical guidelines referred to in this document can all be found on the Network's website

www.swlandstn.com

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1. Network Configuration

The South West London and Surrey Trauma Network (SWL&STN) is part of the London Trauma System. The network is made up of St George's Hospital (the Major Trauma Centre), 7 acute hospitals (Trauma Units) two ambulance services and two air ambulance services. There are also numerous rehabilitation providers within the network's catchment area.

The Trauma Units in London are Kingston Hospital, Croydon University Hospital and St Helier Hospital and in Surrey are, East Surrey, Royal Surrey, Frimley Park and St Peter's Hospitals.

The Network serves a population of more than 2.6 million and has been fully operational since April 2010. Maximum coverage has already been achieved.

In 2013, following the review of Clinical Networks in the NHS, the SWL&STN was given Operational Delivery Network (ODN) status. ODNs are a non-statutory organisational model and within the Networked model commissioners are accountable for the commissioning of services and providers are accountable for the delivery of quality services.

Below is a map showing the Hospitals in the Network and the catchment area.

The network covers two very distinct regions, each with their own particular injury patterns. Road traffic collisions either in a vehicle or as a pedestrian, account for the bulk of the "expected trauma". Interpersonal violence is more prevalent in the London side of the network while rural incidents involving horses account for a significant percentage of the Surrey patients.

A key emerging group is "*Falls less than 2 metres*". This is predominantly older patients who often sustain a significant head injury, especially in the presence of anticoagulants.

The severity of trauma is described using the Injury Severity Score (ISS), an internationally recognised system. This generates a score based on the injuries sustained and is a good indicator of how badly injured the patient is and the probability of surviving the injuries. In the UK this data is collected and validated through national Trauma and Audit Research Network (TARN). Major trauma is defined by an ISS of more than 15. In keeping with predications in the SWL&STN the majority of our patients are in the moderate category with about a fifth minor and a fifth severe.

Below is a table which lists the service providers in the network.

MTC / Trauma Units	**Ambulance Services**	**Rehabilitation Providers**
St Georges Healthcare NHS Trust – MTC	London Ambulance Service	Community Services Wandsworth
Croydon University Hospital, NHS Trust – TU	South East Coast – SECAmb	Sutton & Merton Community Services
Frimley Park Hospital, NHS Trust – TU	London's Air Ambulance	Croydon Community Health Services
Kingston Hospital NHS Trust – TU	Kent, Surrey and Sussex, Air Ambulance	Your Healthcare (Kingston)
Royal Surrey County Hospital, NHS Trust – TU		Central Surrey Health
St Helier University Hospitals NHS Trust – TU		Virgin Care (Surrey)
St. Peter's Hospitals NHS Foundation Trust		First Community Care and Health
Surrey and Sussex Healthcare NHS Trust - TU		Sussex Community Health
		Hounslow and Richmond Community Healthcare
		Spinal cord injury patients are treated at the London Spinal Cord Injury Centre, Royal Orthopaedic Hospital, Stanmore
		<u>Specialised Rehabilitation Services:</u> Wolfson Neurorehabilitation Centre (level 1) Queen Mary's Hospital, Roehampton (level 2a) Bradley Unit, Surrey (level 2b) Royal Hospital for Neuro-Disability, Putney (level 1) Queen Elizabeth Foundation, Banstead (charity) Sussex Rehabilitation Centre, Princess Royal Hospital, Haywards Heath.

		Some patients also access community services in Berkshire & Hampshire: Windsor & Maidenhead East Berkshire Bracknell Forest-Heath hub Southern Health
		Burns patients are treated at Chelsea and Westminster Hospital or Queen Victoria Hospital, East Grinstead

2. Network Governance

The network has both agreed organisational and clinical governance structures. The Clinical Director (Kelvin Wright) has shared accountability for the network with the Network Manager (Leila Razavi).

Appendix 1 Clinical Director's job description.

Appendix 2 Network Managers job description

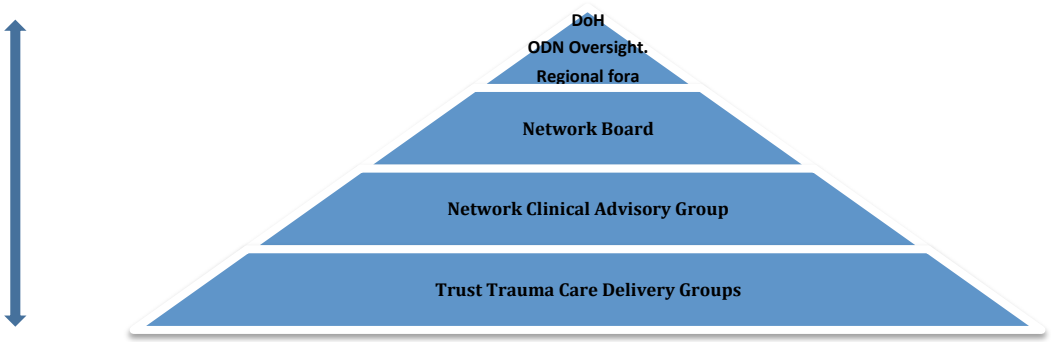
2.1 Organisational governance

In 2013, following the review of Clinical Networks in the NHS, the SWL&STN was given Operational Delivery Network (ODN) status. ODNs are a non-statutory organisational model and within the networked model commissioners are accountable for the commissioning of services and providers are accountable for the delivery of quality services.

National policy outlines the roles and responsibilities of ODNs and indicates that the host organisation (St Georges) assumes performance management responsibility of the network. However in order to effect this responsibility the performance management of the SWL&STN is managed through the network's board.

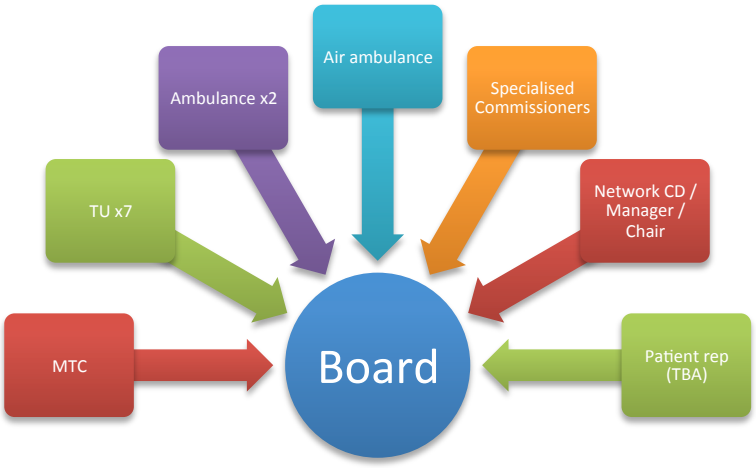
The SWL&STN have both a network board and a clinical advisory group (CAG). The two groups have distinct functions and membership. Due to its location the network also feeds into both the South East Coast and the Pan London ODN oversight groups.

The below represents the organisational governance structure is in place in the SWL&STN



2.1.1 Network Board.

The below stakeholders make up the SWL&STN board



The SWL&STN board is the decision making body for network business and has authoritative power in respect of network activity. The network board determines and develops the network's objectives / strategy within the current network resource ensuring the engagement of network member organisations.

The network board ensures the network operates within an organisational structure which includes providers and commissioners of major trauma care to ensure a co-ordinated and consistent approach to major trauma services.

The board meets on a quarterly basis and is responsible for reviewing the network's risk register, TARN data and compliance against the network's transfer of care protocol. The board also support the CAG in ratifying new polices, protocols and clinical pathways

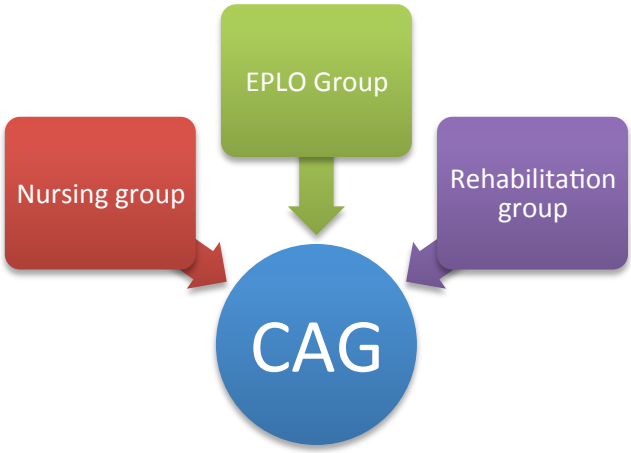
Appendix 3 TOR for the network board

2.1.2 Network Clinical Advisory Group (CAG)

The clinical leads for trauma from the major trauma centre, the 7 acute hospitals (trauma units) two ambulance services and two air ambulance services are all members of the network CAG. The three network subgroups (nursing, rehabilitation, emergency planning) also feed into the CAG. The CAG is chaired be the Network Clinical Director.

The CAG ensures delivery of the optimal trauma pathway across the SWL&STN by overseeing assigned functions of clinical governance/ patient safety, clinical audit, clinical outcomes, data collection and analysis (via both TARN and local audits), research, training and development of the trauma workforce and the management of clinical risk.

The CAG is the clinical decision making body of the Network. It agrees and implements clinical policies, procedures, systems and practices across the SWL&STN which support the optimal trauma pathway.



Appendix 4. TOR for the Network CAG

2.1.3 Network Nursing Group

The network nursing group provides clinical experience and expertise in major trauma nursing to identify components that require a consistent approach across the network. The group reports directly into the network CAG, and also feeds into other groups (pan London nursing group, other specialist nursing groups and national forums). The purpose of the group is to share best practice, learning tools and devise agreed protocols for trauma nursing to be used across the network

Appendix 5. TOR for the Network Nursing Group

2.1.4 Network Emergency Planning Group (EPLO Group)

The EPLO group provides assurance to the SWL&STN CAG with regards to emergency preparedness of the SWL&STN. Membership comprises of emergency planning representatives from all network stakeholder organisations. The group provides the operational focus on all aspects of emergency planning, resilience and business continuity across the SWL&STN in order to ensure that emergency response is coordinated across the network. The group is responsible for ensuring that appropriate strategies, frameworks and structures are in place across the Network and for ensuring continual improvement in these areas.

Appendix 6. TOR for the Network EPLO Group

2.1.5 Network Rehabilitation Group

The network rehabilitation group is chaired by the network's Rehabilitation Director and reports directly into the network CAG and also the London Trauma Rehabilitation Group (LTO). The group represents the views of all therapy disciplines working within each representative's organisation. The group provides forum to discuss the major trauma rehabilitation pathway and ensures the delivery of the optimal rehabilitation pathway for trauma by overseeing, network rehabilitation task groups (as required), clinical audit and outcomes, performance criteria, milestones and deliverables, data collection and analysis, research and education. The group is also responsible for maintaining the network's rehabilitation directory of service

Appendix 7. TOR for the Network Rehabilitation Group and Rehabilitation Directory of Services

2.1.6 Network Risk Register

All risks (threats and opportunities) associated with network's service delivery and patient care are recorded and monitored.

Members of the SWL&STN board and the CAG have visibility of the register and are responsible for raising risks via the network clinical director and / or the network manager. Risks are identified from a variety of sources, including the board, the CAG and local trauma group meetings held by network stakeholder organisations

The register is managed by the network manager. The Network Manager, supported by the Clinical Director, are responsible for checking the register on a regular basis and completing the risk assessments. This includes impact and probability analysis as well as the risk scoring, which will determine the risk response category and risk response.

The risk tolerance are:

- 0-3 – not on risk register
- 4-6 discussed and managed by CAG
- 8-15 escalated to trauma board
  16 and escalated to trauma board and other 3rd party organisations ie CCGs

Advice and support in specific specialist areas may be obtained. Risk owners will be asked to provide the network manager with updates. The risk register is tabled at the quarterly trauma board meetings and also feed into the network's strategy and work plans.

2.1.7 Network Quality Assurance

Trauma and Audit Research Network (TARN)

Data entry into the national Trauma and Audit Research Network (TARN) is mandatory for major trauma centres (MTCs) and trauma units (TUs). This allows detailed analysis of performance criteria and outcomes for injured patients. The network places a high emphasis on this data entry as it is a marker of quality and performance and is valuable in the public domain.

As with all statistics, data quality is crucial. The network has built improving data quality into its five-year strategy and this is discussed at both the network trauma board and CAG. Currently pre-hospital providers are not required to subscribe to TARN.

It should be noted that not all patients who are trauma called are eligible for TARN. For example only patients who stay in hospital more than 3 days are eligible for inclusion. In some cases where the mechanism of injury or condition of the patient triggers the pre-hospital decision tree, the injuries turn out to be fairly minor. Identification of those patients who are TARN eligible is key to improving completeness figures.

Network Performance reviews

Performance visits and peer reviews are part of the network's ongoing governance and performance agenda.

The network carries out regular reviews of the TUs. From 2016 the network has become accountable for conducting reviews of the TUs in line with the national peer review program. The TUs will be assessed against the national trauma quality standards (TQUINs). In addition to these a set of Pan London Trauma Unit standards will also be used.

Part of the TU reviews will include a visit. The panel consists of Network Clinical Director (or deputy), Network Rehabilitation Director, Network Manager, Network Chair (lay), Clinical Commissioning Group (CCG) representative, External representative from another trauma network and a member of the Trust's Non Executive team. Formal feedback reports and recommended actions are sent to the Trust CEO and local CCG.

The network is also assessed against a set of network related TQUINs

ISS greater than 15 reviews.

Each trauma unit is required to conduct a regular review of patients with an ISS greater than 15 who were not transferred to the MTC. This includes looking at if the case was discussed with the MTC and the conclusion of the review. A network template for these reviews is used and is submitted to the network manager. These case reviews are discussed at both local trauma group meetings and presented at the Network CAG.

2.1.8 Information sharing agreement

The network has an information sharing agreement between all stakeholder organisations. This information sharing agreement is compliant with the general principles for the legal information sharing and has been signed off by the Caldicott Guardian at each organisation.

Appendix 8. Network's information sharing agreement

2.2 Clinical Governance

The network's Clinical Director is responsible for clinical governance across the network. The network's Clinical Director chairs the network CAG, which is the clinical governance forum for the network.

Incidents / Issues are logged via the network manager and entered onto the network's governance log. Investigations will be initiated by the network manager and network clinical director. All stakeholders are encouraged to log issues relating to major trauma service delivery and patient care.

All handlers are responsible for investigating the incident assigned to them and providing updates via the network manager.

Open Incidents / issues are tabled and discussed at the CAG meetings. Trend analyses form part of the network's annual report and strategy. Learning from closed incidents are also shared at this forum.

The Network has a joined up investigation system in the event of serious incident (SI) occurring. This system does not change how serious incidents are investigated locally nor does it remove control of the investigation from trusts. It prevents multiple reports being released and enables whole network learning.

Appendix 9. Network's SI protocol

3.0 Network Trauma Management Guidelines

The following clinical management guidelines are in place in the SWL&STN. Copies of the latest versions of all of the guidelines referred to below are on the network's website for clinical staff to refer to and download (www.swlandstn.com)

3.1 Trauma Documentation

A branded standardised patient documentation booklet is used throughout the network. This includes spinal clearance checklist and flowchart. The network uses the Intensive Care Society's checklist for all urgent transfers.

3.2 Secondary transfer protocol

Agreed secondary transfer protocol for adults and children has been operational since go live in 2010.

The following transfer levels of care definitions are followed:

Type of transfer	Definition	Examples (Please note the examples given are designed to be illustrative not exhaustive).	Notes and actions
TIME CRITICAL	Needs to be transferred for immediate life or limb saving intervention. By definition has been under-triaged / self presented to a trauma unit or determined to be in need of immediate TU intervention in order to survive journey to MTC.	Uncontrolled haemorrhage, ischaemic limb, expanding intracranial bleed	-These require the first available double manned ambulance, same priority as 999 call. -The initial ambulance may stay to transfer the patient onwards. -These are blue light transfers. -TU Team leader will have phoned MTC ED Consultant. - Require suitable escort with appropriate training from the TU defined by the patient's clinical need. -The escorting team/crew should pre-alert when approx. 15 mins away from MTC - Require re-Trauma Call in the MTC
URGENT SECONDARY: ED TO ED **(to be at MTC at <12 HRS FROM INJURY)**	These patients need to be in the MTC. They are not in imminent danger of catastrophic event. They should be identified in the TU by the trauma team leader, who will refer to the ED Consultant at the MTC. They will be transferred to the ED at the MTC where they will be re-trauma called.	Open fractures with no vascular or imminent limb threat, Stable children being transferred for observation in a paediatric surgical unit,	-TU Team leader will have phoned MTC ED Consultant. -The TU should inform the MTC when the patient is leaving and give an estimated time of arrival. If this changes then the clinicians will be contacted by the ambulance service Emergency Operations Centre. - Require suitable escort with appropriate training from the TU defined by the patient's clinical need. -These are not blue light transfers. -The ambulance should be booked for within 2 hours at the TU -These patients are received in the ED at the MTC
SECONDARY TRANSFER (FROM WARD SPECIALITY TO SPECIALITY)	These are stable trauma patients referred by an admitting team in the TU to a speciality team in the MTC. They will be isolated injuries in a body region with no element of life or limb threat.	Stable Pelvis cases	-Non blue light transfers. These may be transferred through the Trusts PTS contract. -Transferring and Admitting teams should clearly hand over the case and document in the notes any pre-transfer plans. -May be transferred to a ward at the MTC and not the ED -Should be transferred to the MTC within 2 calendar days of acceptance The ambulance staff for these will be Band 2/3 ambulance care assistants capable of delivering oxygen and entonox. Higher clinical care will need to be supported by the Hospital trust by means of escorts.

3.3 Head injuries

The network has an agreed adult and paediatric isolated head injury protocol.

All patients with a server head injury (AIS3+) are discussed with the neurosurgical department at the major trauma centre. Decisions to transfer are based on clinical needs and surgical intervention requirements.

Poly-trauma involving the head is managed as “time critical or urgent secondary” transfers.

3.4 Spinal injuries

The network has an agreed adult and paediatric spinal injury protocol.

Spinal clearance checklist and flowchart can be found in the network’s trauma booklet.

All spinal cord injuries are transferred to the major trauma centre in their acute phase. A multidisciplinary team ASIA assessment is completed. The network’s objective is to complete this within 24 hours.

In accordance with national standards all spinal imaging should be reported by a consultant radiologist withinb 24 hours of admission.

The network’s linked spinal cord injury centre is Stanmore and has agreed protocols for resuscitation and acute management including skin care, gastric, bowSel and bladder care and neuro-protection.

3.5 Open fractures

The network has an agreed open decision tree which was issued by the major trauma centre and provides the trauma units with guidance on the management of open fractures.

3.6 Massive transfusion

Each trauma unit has a major haemorrhage policy. The network has issued an overarching protocol for mass haemorrhage in trauma patients and supports the use of1:1 bloo, FFP and the use of Tranexamic acid.

3.7 CT

The network and all trauma units have agreed with local radiology department the use of Pan-scanning in poly-trauma cases. This is incorporated in individual trauma units local policies.

The network has also issued guidelines on the imaging of children.

3.8 Teleradiology facilities

Teleradiology facilities (IEP) are in place across the network in order to allow immediate transfer of images between the major trauma centre and the trauma units.

The Network has agreed set of standards for radiology image transfer. Adherence is monitored via the clinical governance log.

Standards of care.

- A written radiology report will accompany all trauma patients having been transcribed into the trauma booklet or printed direct from the referring institution radiology system.
- A Trauma pro-forma (tick box) form may be part of this report but since it is designed to point out gross findings only, it is not acceptable as the report in total.
- The written copy should have a name of the reporting radiologist clearly documented.

- A means of contacting that doctor for clarification should also be provided eg. mobile number, via switchboard or via designated bodies such as Nighthawk
- All images will be transferred with a report via IEP to enable merging with PACS at the major trauma centre.
- When the patient leaves prior to the report being ready ie emergency transfer then a report will still be issued in accordance with 1-4 above and sent via IEP as soon as it is prepared.

3.9 Abdominal trauma guidelines

The network has agreed guidelines which give an overview of blunt and penetrating trauma including investigation recommendations

3.10 Emergency Anesthetic guidelines

The network has agreed guidelines to allow for the safe induction of emergency anesthesia in the resus room.

3.11 Surgical airways in adults and children

The network has agreed guidelines of the safe way to manage airways as part of a failed incubation drill.

3.12 Thoracic trauma guidelines

The network has agreed guidelines on managing rib fractures, chest drains, analgesia and thoracotomies in the ED

3.13 Vertebral Column Injuries standards (VCI)

The network undertook a review of the services available for patients with VCI. From this a set of standards has been developed to guide both the MTC and the TUs when treating patients with VCIs.

4.0 Network Transfer of Care

The network has an agreed transfer of care protocol for patients being transferred out of the major trauma centre back to their local trauma unit.

The protocol is based on the assumption that in order to maintain flow across the network and into the major trauma centre patients requiring transfer back to their local trauma unit should be transferred within 48 hours of notification. Senior points of contacts within each of the trauma units are notified of any transfer delays exceeding the 48 hour target. Compliance against the protocol are monitored and reported to the network board.

Appendix 10. Network Transfer of Care Protocol flow sheet

5.0 Network Rehabilitation

The Network has a funded rehabilitation director post. The Rehabilitation Director is responsible for delivering the agreed strategic direction, leadership and vision to the SWL&STN and has the prime role in the development of rehabilitation services in the SWL&STN. They are the chair of the network's rehabilitation group.

Appendix 11. Network Rehabilitation Director's job description

The Network has a Directory of rehabilitation services. This is regularly updated by members of the Network Rehabilitation Group

The network has issued referral guidelines for access to rehab services

Appendix 12. Network referral guidelines

All patients transferred out of the major trauma centre to either trauma units or rehabilitations services have a completed rehabilitation prescription and MDT report.

6.0Network Emergency Planning

The network's EPLO group oversee the emergency preparedness for the SWL&STN.

In line with the NHS regulations each acute Trust is assessed in relation to their emergency preparedness. Major trauma is covered by the requirements to provide evidence of arrangements to respond to major incidents and mass casualties.

The network also has a major incident framework to supplement existing multi agency emergency preparedness arrangements in South West London and Surrey, to ensure that South West London and Surrey Trauma Network (SWLSTN) can meet the national and local planning assumptions in relation to a major incident/s

In response to the Pan London Mass Casualty Plan (2016), this is available on the network's website. The network has issued some key planning assumptions and associated guidance.

Appendix 13: SWL&S trauma network Mass Casualty Key considerations

South West London & Surrey Trauma Network
Operational Policy and Guidelines
Appendices

Appendix list:

Appendix 1: Network Clinical Director's job decription

CD Major Trauma JD 100210.doc

Appendix 2: Network Manager's job description

Network Manager JD May final 2013.doc

Appendix 3: TOR for Network Board

South West London Surrey Trauma Netwc

Appendix 4: TOR for Network CAG

TOR Clinical Advisory Group.doc

Appendix 5: TOR for Network Nursing Group

SWL and Surrey MT Nursing ToR FINAL.dc

Appendix 6: TOR for Network Emergency Planning Group

SWLSTN EP ToR September 2014 (Fina

Appendix 7: TOR for Network Rehabilitation Group and Rehabilitation Directory of Services

Network Rehab Group TOR.doc Jan 2

Network DoS v.5.doc

Appendix 8: Information Sharing Agreement

Trauma Network Information Sharing A

Appendix 9: Network SI protocol

South West London and Surrey Trauma N

Appendix 10: Transfer of care protocol flow sheet (full protocol also available)

SWL and Surrey Trauma Network. Tra

Appendix 11: Network rehabilitation job description and job plan

Trauma Network rehab Director JD FII

Job Plan - April 2016.docx

Appendix 12: Network referral guidelines

Rehabilitation and Referral Guidelines v1

Appendix 13: SWL&S trauma network Mass Casualty Key considerations

SWLSTN Mass Cas Key Conderations.pdf