LSEBN ODN Board (Main Group)
9th June 2021

In attendance:

- Nora Nugent – ODN Team (Chair)
- Paul Drake – Queen Victoria Hospital
- Gail Murray – NHSE EoE
- Priscillar Batana - NHSE London
- Michael Charalambous – PPV Member
- David Barnes – ODN Team (St Andrews)
- Victoria Dudman – ODN Team (St Andrews)
- Pete Saggers – ODN Team

Joanne Atkins – Chelsea & Westminster

- Daniel Markeson – Stoke Mandeville
- Yasmin Stammers – NHSE South East
- Kathy Brennan – NHSE London
- Lisa Williams – ODN Team (ChelWest)
- Nicole Lee – ODN Team (QVH)

Notes

1 Chair's introduction and apologies

NN welcomes all to the meeting. Apologies have been received from:
Joanne Pope, Jane Hubert, Victoria Osborne-Smith, Julie Hales, Gareth Teakle, Alexandra Murray

NN and NL introduced Michael Charalambous, who has joined the ODN Team as our Public & Patient Voice. MC is a burn survivor, injured at work and treated at St Andrews.

2 Notes of the previous meeting

- ODN Board March 2021
  The notes of the previous meeting were approved, without amendment.

3 Matters arising, not on the agenda

- Peer Review of burn services

  PS explained that the review process had not progressed as expected. As the Quality Surveillance Teams have moved to a regional structure, the discussions between PS and the NHSE team in the East of England have temporarily dropped. PS asked if this could be raised again and reinvigorated. DB noted that this needed to be a national process and supported with appropriate resources.

  Action:
  ❖ **PS will contact Joanne Pope, to agree how Peer Review will be taken forward.**

- Update on proposals for St Andrews > RLH Whitechapel

  DP described the most recent actions on developing arrangements for a burns facility on the Whitechapel site. Focus of attention is the clinical pathway and the financial arrangements. Work is ongoing in both Trusts and it is hoped that a "pilot" would be started in the autumn of this year. PS asked if commissioners were involved at this stage. GM noted that she had been attempting to engage with M&SE Trust and ICS managers. In summary, some progress has been made but work on completing the business case is necessary, before a proper engagement can begin with NHSE commissioners.

- Update on proposals for QVH > Brighton
  NN spoke about a new working group, established to address the planning for a a move of the QVH adult burns service to University Hospital Sussex (Brighton) .

  A Case for Change is being prepared for both Trusts and following that phase, a formal Options Appraisal will be developed. PS reminded the group that NN is working on this project as Clinical Lead for the QVH service, and that at the moment, PS is acting as the network member of the working group.

  PS added that at some future stage, it may become necessary for the network to have clinical representation and DB agreed that he would be happy to be involved.

- Staff Digital Passport

  PS noted the progress being made. Staff names and contact details have been collated from all services, including the hospital locations that staff might work in. PS added that the roll-out requires engagement with Trust HR managers and this is running quicker in Trusts that have already adopted the DSP process. PS is meeting with the NHSE team responsible for the roll-out and further communication with burn services will follow soon.

- Burns Critical Care SOP for Surge & Escalation

  PS announced that the SOP has now been published by NHSE. This is an important document, that includes the arrangements for surge & escalation, the bed bureau and actions to be taken by receiving hospitals for patients turned away / refused. This will need to be implemented properly across the whole network.

  DB noted that many of the service the contact phone numbers are not displayed in the Pathways DOS and that it should be included as a “field” in the DOS system.

  PS noted that it is expected that the DOS system for burns will be redesigned in the very near future. NHSE are keen to see a burns “capacity dashboard”, similar to those already developed for trauma and critical care. The dashboard will continue to be populated from figures in the DOS system, but the grids and reports in DOS will be completely redesigned.

4 LSEBN Performance Reports (Quarter 1 2021-2022)

- Risk Register

  The LSEBN Risk Register includes a number of long-standing issues, related to compliance with burn standards. For Q1, three new topics have been added:

  - Stoke Mandeville: Nurse staffing levels, required to maintain safe & sustainable burn care. PS noted that he has raised the issue with the NHSE SE Commissioner, Yasmin Stammers and YS is keen to work with the network and the Trust to help resolve the issue. DM noted that the main issue is having a safe level of “permanent staff” and that this is a similar position to other specialties in the Trust. A business case has been written but support from the Trust has not been forthcoming. NL added her support for this issue to be resolved, citing instances where nurse cover overnight is not optimal for safe care.

  - Stoke Mandeville: Nominated for Clinical Leadership role. Service clinical leads should have Programmed Activity (PA) time for the management role of a clinical lead. It was noted that there is a “mixed economy” of paid and unpaid PA’s. This has been raised with NHS commissioners and clinical leads need to have PA management time, within their job plan.

NN suggested that a more formal approach be made by the network, to write to the Trust to highlight both of the issues raised at Stoke Mandeville. PS noted that the Memorandum of Understanding (MOU) had been written to ensure that Trusts were "signed-up" to the position of burn services within the network, and that implicitly included burn standards, for staff engaging in network activities.

JA asked whether this was also an issue in other parts of England and that there should be some transparency in understanding how this topic was being tackled.

It was noted that Trusts "cap" PA time at different levels.

Action:

- ❖ **NN and NL will draft a letter to the Buckinghamshire Healthcare Chief Executive, to highlight concerns about the current nurse staffing levels.**
- ❖ **PS will raise the issue of PA time at the NBODNG and seek to undertake a survey of burn services in other networks.**

- TRIPS Telemedicine. This issue is being discussed, later in the meeting.

- Quality Dashboard

The Burns QD for 2020-2021 Quarter 4, was circulated to members with the agenda. The figures used are extracted from data submitted to services through IBID. In the report tables, figures highlighted in pink, are for indicators where compliance has not been met. There are a number of known anomalies, that are being investigated by IBID and the burns service, including "pain scores" at St Andrews and children's in-patient activity at QVH.

DB reiterated that the QD effectively automates the collection of data, to support evidence for good outcomes, whereas a peer-review process would add a more realistic view point.

- Centre-Level Care Refusals / Referrals turned away

PS has collated the figures related to "centre-level" referrals that have been turned away or refused by the burn centre. Both St Andrews and ChelWest collect the details of patients refused, and PS extracts a subset of cases that are true referrals. Excluded cases include patients refused, but with agreement to accept later the same day, or referrals for plastic surgery or referrals for cases where burn care in not necessary.

The analysis reported to the ODN indicates that the vast majority of "refused cases" are transferred to another service within the LSEBN area, but a small but significant number of patients are transferred out of area, mainly to Birmingham (3 children) or Swansea (4 Adults). The following issues were discussed:

- JA asked if other networks were experiencing similar levels of refusals as LSEBN. PS responded to say that there is evidence that this is not the case.
- DB commented on the general position with the staffing levels, access to bank nurses and levels of sickness, all potentially linked to the impact of the pandemic.
- NL emphasised the need to keep working on the training packages for ICU staff, to work in burns.
- LW noted that anecdotally, the figures suggest that the numbers of cases refused seems to be much higher than previously experienced.

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

PS has created a national archive of figures taken from the Pathways DOS system and the graphs and tables will grow, as the year progresses.

The report only relates to actual burn care activity, and burns bed occupancy for "non-burns" activity is excluded, for all levels of care (ICU, HDU and Ward care). The report does not explain the number of actual patients, but rather the occupancy levels as an indicator of how "busy" the services have been.

- Burn Service Update – issues related to activity and performance

PS explained that this will become a standing item on the ODN Board agenda, to give services the opportunity to talk about the current situation, from the perspective of the service.

Chelsea & Westminster *(Jo Atkins / Lisa Williams)*
- General comment about how busy the last year has been, with a significant impact on staff.
- Consideration being given to adding a new (6th) consultant post to the team.
- Access to admin support a problem (no secretarial or support staff).
- The team got through the pandemic very well, with lots of flexibility from the staff.
- Higher than normal levels of limb amputations, associated with a higher than normal level of complex or unusual injuries.

St Andrews *(David Barnes)*
- Very difficult year, with some very complex burn injuries but also across the whole service and pathway.
- Complex discharge arrangements and follow-up.
- Immigration issues and liaison with Home Office.

Stoke Mandeville *(Dan Markeson)*
- Also very busy. Covid had a clear impact at the beginning of 2020 but normal business returned in the summer last year, and now all trauma services are seeing extraordinary levels of injuries.
- A higher than normal spate of scald injuries, from hot liquids spilled on children and older adults.

Queen Victoria Hospital *(Nora Nugent)*
- A similar position in QVH, although not directly involved with the pandemic, there was a high number of "non-burns" patients.
- Recent C-Diff outbreak impacted on all levels of care.
- Looking at consultant cover for weekday sessions.

DM asked whether there were any actions that the LSEBN can take, to help reduce the number of injuries. Prevention initiatives through the ODN, or professional groups (BBA, BAPRAS etc) do not necessarily reach the target audience.
- NL noted that the steam inhalation project is being presented at BBA conference, next week. This will include a note of the number of people that the campaign reached through @twitter. NL added that linking the local hospital into the "tweet", increased markedly the reach of the message.
- It was acknowledged that celebrity endorsement would help promote public health messages.
- MC spoke about the London Fire Brigade twitter account which has 222,000 followers and linking campaigns with them, and other areas, would extend the reach of the message.
- JA commented that a fundamental issue was the difficulty in reaching the lower socio-economic group, and families where parents do not have English as a first language. Education in schools (PHSE) for accident prevention and first aid.

5 Network Tele-referral System

To consider the future for a network or national tele-referral system

PD attended the meeting, to give an update on progress with the development of TRIPS. A copy of the PPT will be circulated with the notes of the meeting. Key issues noted are:

- Background to the original system development.
- Utilisation for burns and other services, with "hubs" hosted on the QVH site and over 200 referral sites.
- Funding arrangements through commissioning (£104,000).
- System lacks mobile device (smart phone) support.
- The new MDSAS system; how it operates and uses mobile phone technology to upload images to the desk-top system.
- New TRIPS could be expanded to use a web and mobile app, based on MS Teams, including text and photo / video.
- Costs – Proof of Concept at £37,000
- Costs – Project Management at £66,000
- Costs – Full development initial capital £159,750
- Costs – on-going annual costs £57,828
- Opportunity that NHS contracts for cloud hosting and license fees might reduce these sums substantially.
- Each of the burn "hubs" (St Andrews, ChelWest and SMH) should be contributing £15,000 each for the system, but QVH have never invoiced this in the past.
- Dans Fund are considering offering financial support for the project.

The meeting discussed the issue and noted the following:

- PS noted that the "hub" funding of £15,000 can be traced back to 2013, when NHSE took up the new commissioning arrangements. Since then, like at QVH, the amount will have been subsumed within the overall contract tariff.
- PS asked about the "scalability" of the system, if it were rolled-out across the whole country. PD responded that there would be little additional costs involved and that the cloud-based environment supported expansion, almost without limit. Wider expansion would also generate income for QVH.
- PD noted that he was unable to explain the comparison costs of MDSAS for non-burns referrals. PS explained the background to funding for MDSAS and agreed that the MDSAS team were reluctant to give any details of the costs involved for non-burns referrals.
- DM spoke about the positive experience with the existing TRIPS system and asked whether a new TRIPS would have any effect on the MDSAS project. PD spoke about the benefit of having a single, unified referral system and PS noted that this was an issue identified by the NHSE EPRR team as a desirable objective.

PS said that despite all of the benefits that this new TRIPS would give to burn care, the financial analysis suggested that the new system was not affordable, without the application of significant industry discounts or external investment. This would also be the case for the adoption of MDSAS, because although it is "free" for burns, there will be additional costs for using this for non-burns referrals.

NN noted that QVH use the existing TRIPS system more for the non-burns referrals than burns, and adopting MDSAS would bring a significant cost to them. The alternative of running two systems side-by-side, was not an optimal solution. It is important that we understand the MDSAS costs better than we currently do and making it difficult to make a decision about how to move forward.

Action:

- ❖ **PS will write to MDSAS and ask for a more detailed analysis of the cost profile for using MDSAS.**

PS added that the discussion about TRIPS and MDSAS was as a result of three issues:

- MDSAS promoting their system, at the beginning of the pandemic and rolling-out their referral system across the South West network. The SWUK network did not have a pre-existing system in place, so adopting MDSAS was a more simple process and decision.

- The LSEBN already has TRIPS, so the pressure to take MDSAS is less, than experienced in the south west. However, QVH have indicated that they may potentially be experiencing a storage issue, as hardware ages and sustainability comes into question.

- From the perspective of a major incident, the benefit of having a single referral system, across all burn services and networks.

These three things had converged last autumn, and we had invited MDSAS to come to the ODN meeting and give a presentation. A decision is needed nationally, about adopting a single system and this leads the conversation towards the development of a system specification and invitation to tender. PS added that without this, there was little prospect of there being a national system, which would lead the LSEBN network to retain the existing TRIPS system.

PD mentioned conversations he was having with NHSX. They have responsibility for setting national policy and developing best practice for NHS technology, digital and data, including data sharing and transparency. They have indicated an interest in this sort of project and this might be a system they might support, moving forwards.

NL noted that the system because the TRIPS (and MDSAS) system is used by burns and many other specialities and the costs could be shared across a much wider group of stakeholders.

PS concluded the discussion, suggesting there is no immediate need to resolve this issue. Without a national instruction, there is no necessity to move from the existing TRIPS system. The issue should be raised at the next NBODNG meeting, to further explore the concept and support for a national system.

Action:

❖ **PS will add this topic to the agenda for the next NBODNG meeting.**

6 Service delivery issues

Bed capacity and capability for all levels of care

- Intensive care for adults and children

PS had prepared a presentation, provided as a “discussion document”, looking at a case for change for increased ICU & HDU bed capacity and capability in the London & South East network. A copy of the PPT will be circulated with the notes of the meeting.

In summary, the report indicated that there is an inequitable distribution of ICU beds across the four networks, when compared with the catchment population. The report shows that the LSEBN serves almost 41% of the population of England and Wales, but only has 20% of the commissioned baseline of ICU beds.

Further analysis included

- Number of days services at OPEL 2 (closed to referrals)
- Number of days the network was at OPEL 3.
- Number of days bed occupancy exceeds normal business levels (surge)
- A comparison of LSEBN with the other networks.

It was noted that when St Andrews is closed for adults (OPEL 2), then the network is closed OPEL 3 for children's centre-level referrals.

In summary, the analysis provides evidence of a mis-match of populations and utilisation for burns ICU. The LSEBN is more likely to be at OPEL 3 than any other network and as a result, patients are "refused" and transferred to burn services in other parts of the country.

As noted earlier in the meeting, it is sub-optimal for patients to be transferred away from the LSEBN and this should be a rare occurrence.

The report makes a number of recommendations.

- ***There should be an urgent and detailed review of the current levels of activity and demand for burn care, in the L&SE network, to ascertain whether the current situation is temporary and short-term, or a longer-term, permanent trend.***
- ***This work should aim to describe the expected bed capability and need for burn care, for the next 8-10 years.***

- ***Commissioners should validate the current, funded and commissioned baseline capacity and capability for burn care.***
- ***Commissioning arrangements should be in place to support burn services, to respond to increased demand and reduce the number of patients being transferred out of the network.***

- ***The LSEBN should develop a network protocol for mutual aid between centres, units and facilities in the network.***
- ***This should include "step-down" and "step away" arrangements for on-going acute burn care and rehabilitation.***
- ***Commissioning arrangements should be organized to ensure that services are appropriately remunerated for additional work undertaken.***

- ***There should be an urgent review of the NHS Pathways DOS system, to add further utility, regarding the notification of bed availability and capability to accept referrals. This would include the development of a "live" burns dashboard.***

The group discussed the topic:

- Establishing the baseline bed capacity and the situation related to block contracts.
- Consequences on the planning arrangements for sustainable capability, and the number of beds and staff establishment.
- Figures suggest that a national discussion is needed.
- Changes to commissioning and move to population-based funding, and recognising the fact that patients who are refused and transferred out of the network, are generally the complex and expensive cases.
- Potential to use Public Health England and NHSE data resources to look at the activity in more detail.
- Analysis clearly shows the need to look at ICU capacity and improve access.
- Need to take a longer view of activity, to assess what the actual need / demand profile is, for the population.
- Need to look at the entire pathway and how the network operated collectively, including step-down and outreach.
- Need to look at other data sources, to have a more complete view of the position.
- Using the IBID system to provide detailed information of previous years.
- The need to look at this as a whole network, across commissioning boundaries.

Action:

- ❖ **PS will make arrangements for a meeting with the London, EoE and South East commissioners, to discuss how to take this forward.**

The meeting was over-running and the following issues were not fully addressed.

7 Post Pandemic Reflection

Discussion document – impact of the pandemic on staff and service activities

Following a discussion at the previous meeting, the ODN team (LW, VD, NL and PS) had met in early May, to discuss the impact of the pandemic on the delivery of care, with the following highlighted topics:

- The acute care pathway
- Out-patient care
- Step-down
- Staff well-being and recovery
- Follow-up care and elective surgery

Work on a survey of waiting lists for elective burn surgery and non-surgical interventions was incomplete and the expected report (attachment 08) was not circulated to members. The report was not discussed in detail and will come back to the next meeting.

Action:

- **PS will send the draft report to ODN members.**

8 Future arrangements for Specialised Service ODNs

Governance, oversight, and accountability

Not discussed.

9 Network ODN Issues for information:

ODN Team Budget: Month 12 outturn

PS reported the final end of year position for the network team budget. There is an underspend indicated, largely caused by due invoices for staff secondments or training and education not being processed.

There was a discussion about whether the budget underspend could be carried forward. KB confirmed that it is possible and NHSE can make the necessary arrangements. PS suggested that because of the way that ChelWest manage the budgets internally, the underspend was probably overstated and it although this might be beneficial in future years, it probably wasn't necessary for 2020-2021.

The report also provides the proposed budget for the new financial year 2021. This includes the network training and education budget, amounting this year to around £40,000 PS asked that an early decision is made on how the funding would be utilised.

Action:

- **PS will write to service clinical leads about how the training & education budget will be used in the new financial year.**

Date of next ODN Board meeting(s)

Confirmed dates

- *LSEBN ODN Board (Main Group) and M&M Audit Thursday 7th October 2021*
- *LSEBN ODN Board (Core Group) Tuesday 7th December 2021*
- *LSEBN ODN Board (Main Group) and M&M Audit Wednesday 16th March 2022*