ODN Board meeting September 2020
Attachment 02

LSEBN ODN Summer MDT Audit
Thursday 9th July 2020
Video-Conference software platform - GotoMeeting
Short Notes of the meeting

In attendance, for all or part of the meeting:

Annette Kempster	*Chelsea & Westminster*	Catherine Spoors	*St Andrews*
Ellen Paton	*Chelsea & Westminster*	David Barnes	*St Andrews*
Hodan Abdi	*Chelsea & Westminster*	Karen Cook	*St Andrews*
Isabel Jones	*Chelsea & Westminster*	Louise Kierons	*St Andrews*
Jorge Leon-Villapalos	*Chelsea & Westminster*	Michael Wiseman	*St Andrews*
Kate Atrill	*Chelsea & Westminster*	Nicole Lee	*St Andrews*
Katherine Elworthy	*Chelsea & Westminster*	Odhran Shelley	*St Andrews*
Lisa Williams	*Chelsea & Westminster*	Rachel Wiltshire	*St Andrews*
Richard Mcdonald	*NHSE East of England*	Vicky Dudman	*St Andrews*
Julie Hales	*NHSE South East*	Alexandra Murray	*Stoke Mandeville*
Kathy Brennan	*NHSE London*	Beth Angell	*Stoke Mandeville*
Dan Markeson	*Oxford John Radcliffe*	Claire Harris	*Stoke Mandeville*
Siji Joseph	*Oxford John Radcliffe*	Clara Upson	*Stoke Mandeville*
Claire Tait	*Queen Victoria Hospital*	Fadi Issa	*Stoke Mandeville*
Denise Lancaster	*Queen Victoria Hospital*	Helen Hine	*Stoke Mandeville*
Nora Nugent	*Queen Victoria Hospital*	Kaneka Bernard	*Stoke Mandeville*
Simon Myers	*Royal London*	Liz Pounds-Cornish	*Stoke Mandeville*
		Pete Saggers	*Burns Network*

1 Introduction

1.1 JL-V welcomed members of the burns MDT to the burn's network summer audit meeting, held as a video-conference meeting for the first time. The audit meeting was held in two sessions, morning and afternoon. A copy of the meeting agenda is provided at *Appendix A*.

1.2 JL-V noted the arrangements and the following principles for the meeting:

- This is a video-conference audit meeting and is for NHS staff involved in specialised burn care.
- The video and audio content of the meeting will be recorded. The recording will be encrypted and stored securely.
- Each service will present all deaths and all Serious Incidents (SI's), for the period October 2019 to March 2020.
- The meeting will agree the cases that will move forwards to the National Audit meeting (2020)
- If time allows, each service will present a case-analysis for an unexpected survivor.
- Screen presentations, related to individual patients, will be provided and the content must not be shared with others.

1.3 In addition to the audit presentations, JL-V suggested that at the end of the meeting, there were a number of other, burns network-related, issues that he would like to share with members of the wider MDT.

2 Service Audit Presentations

2.1 **Process**

Each service is required to present activity and cases analysis, for the period October 2019 to March 2020, using the nationally approved template. The presentation includes:

- A summary of referred activity
- An analysis of paediatric resus cases
- All Serious Incidents (SIs),
- All mortalities and;
- One morbidity / non-mortality case.

This audit peer-review process is intended to identify those cases that would be of interest to a wider audience at the national audit meeting. It is expected that the cases presented to the national audit meeting will be mortality cases with a low Revised Baux score or cases that have interesting or unusual clinical aspects.

2.2 The following hospital burn services participated in the audit and presented activity figures and cases;

- St Andrews Broomfield Hospital (centre-level adults and children)
- Chelsea & Westminster Hospital (centre-level adults and unit-level children)
- Queen Victoria Hospital (unit-level adults and facility-level children)
- Stoke Mandeville Hospital (unit-level adults and children)
- Oxford John Radcliffe (facility-level adults and children)
- Royal London Hospital Whitechapel (facility-level adults)

2.3 **Note of the discussion:**

The LSEBN M&M audit is a closed meeting, where no formal minutes are taken, to provide a suitable 'space' for openness and honesty for clinicians to share and learn. M&M audit is a requirement of the NHS England service and network specification and all burn services are required to present all mortality cases and all serious incidents. All of the cases have been discussed previously at service and Trust audit meetings. The purpose of the audit is to add an additional layer of governance and scrutiny to the existing service audit function, and to support services across the whole network in sharing experiences and good practice, with the aim of improving patient outcomes and quality of care.

No individual cases were identified as requiring further action or investigation.

2.4 A number of themes emerged from the case discussions, including:

- Frailty as a predictor of morbidity / mortality;
- The potential for frailty scoring in adults under 65
- Indicators from previous medical history (history of drug / alcohol misuse or obesity)
- Positive collaboration between

2.5 **Confirmation of cases for National Audit meeting (2020)**

From the service presentations, four cases will go forward to the national audit meeting, expected to be held in Autumn 2020.

3 Other issues

3.1 <u>Pandemic and Covid-19</u>

JL-V spoke briefly to pay tribute to members of the burns MDT, for their efforts and dedication during height of the pandemic period. It was also recognised that the LSEBN had contributed very significantly to the national resilience planning for Covid-19, including IJ and PS joining a newly formed Burns National Covid Group, advising NHS England and developing the national burns escalation plan.

As part of this national plan, the clinical and management leaders at St Andrews Broomfield Hospital approved a proposal to ring-fence burns ICU capability, to provide a service "of last resort" for England and Wales, in the event of all other burn's ICU capacity being overwhelmed by Covid-19 patients.

3.2 NHS 111

During the pandemic period, the LSEBN became aware of an issue about advice to callers on the NHS 111 service. It became apparent that wrong advice was being issued for minor burn injuries and that as a result of pressure on the 111 service, some callers were being asked to wait 3-4 hours for a call-back. After early communication between Dr Gareth Stuttard, *National Clinical Lead for Urgent and Emergency Care*, JL-V, NN and NL have held a very productive meeting with Darren Worwood, *Deputy Clinical Director for NHS Pathways*. During the meeting, it was agreed that the LSEBN would collaborate with the NHS 111 service, to provide educational input into the protocols for burns and first aid advice.

3.3 Network-wide MDT

- The meeting briefly reflected on the recent Network MDT meeting, held on Tuesday evening, 30th June. This was a very productive meeting, held in the style of a "Grand Round" and focusing on patients in the burn's ICU. Notable areas of discussion were:
  - *Major trauma, assessment and early treatment;*
  - *Referral criteria for specialised burns;*
  - *Network guidelines for initial assessment and management*
  - *Network guidelines for surgery before transfer to a burns service;*
  - *Training / education for non-burns clinicians;*
  - *Hyperthermia guidelines;*
  - *ICU management.*

The next meeting will be hosted by the team from St Andrews and a confirmed date will be circulated shortly.

3.4 Opioids

The meeting briefly discussed a video / audio presentation on the current crisis regarding the use of prescription opioids. This is a 23-minute presentation and it was felt more appropriate to look at holding a separate education event, perhaps through a lunch-time webinar, organised by the LSEBN. NL and PS will discuss this further, at the earliest opportunity.

Close of Meeting:

JL-V and PS thanked everyone for their input during the meeting, whether as a presenter or observer. No date has been agreed for the next winter audit meeting but this will likely be during the second week of December 2020.

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Appendix A – Audit Meeting Agenda

LSEBN ODN Summer MDT Audit **Tele- / Video Conference**
Thursday 9th July 2020 **Part 1 – 10.30 to 12.30**
Part 2 – 13.30 to 15.30

Note for attendees.

- *This is a video-conference audit meeting and is for NHS staff involved in specialised burn care.*
- *Each service will present all deaths and all Serious Incidents (SIs), for the period October 2019 to March 2020.*
- *If time allows, each service will present a case-analysis for an unexpected survivor.*
- *Screen presentations, related to individual patients, will be provided and the content must not be shared with others.*
- *During the meeting, and unless you are speaking, please ensure your microphone is muted.*

1	*10.30*	**Chairs Introduction** • Aims and Objectives • Actions and next steps	*JL-V* *NN*
		Part 1	
2	*10.35 to 12.30*	**Network Mortality & Morbidity Audit 2019** • St Andrews • Royal London Whitechapel • Queen Victoria Hospital ▪ *Unexpected survivor cases*	*Service leads from each hospital / service*
		12.30 – 13.30 Meeting paused for one hour Reconvene at 13.30	
		Part 2	
3	*13.30*	**Network Mortality & Morbidity Audit 2019** • Stoke Mandeville • Oxford John Radcliffe • Chelsea & Westminster • *Unexpected survivor cases*	*Service leads from each hospital / service*
4	*15.15*	**Confirmation of cases moving forwards to National Audit meeting (2020)**	
5	*15.25*	**Future Audit topics** - Network / professional groups - Proposals for National audit topics	*All MDT members*
6	*15.30*	**Any other issues not discussed** **Close of meeting**	*JVL / NN*

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