

## Clinical Audit and Research Steering Group

### Minutes

Thursday 30th November 2017, 13.30 – 16.30

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The Mezzanine, Waterloo Action Centre

#### Present:

Neil Thomson (Chair)	NTn	Interim Deputy Medical Director	LAS
Fenella Wrigley	FW	Medical Director	LAS
Rachael Fothergill	RF	Head of Clinical Audit & Research	LAS
Joanna Shaw	JS	Clinical Audit Manager	LAS
Lynn Sugg	LS	Quality Manager	LAS
Tina Ivanov	TI	Deputy Director Clinical Education and Standards	LAS
Mark Faulkner	MF	Advanced Paramedic Practitioner	LAS
Natalie Tiech	NT	Patient Representative	LAS Patient's Forum
Mary Halter	MH	Senior Research Fellow	St. George's, University
Heloise Mongue-Din	HM-D	Research Manager	LAS
Gurkamal Francis	GF	Assistant Head of Clinical Audit & Research	LAS
Jasmine Palmer	JP	R&D Co-ordinator	LAS

(Minutes)

#### Observers:

Johanna Hughes	JH	Paramedic Research Fellow	LAS
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#### Apologies:

- Douglas Chamberlain
- Benjamin Woodhart
- Fiona Moore
- Julia Williams
- Julian Sutton
- Will Glazebrook
- Rebecca Salter
- Anu Mitra

## **Minutes of the Previous Meeting**

The group ratified the minutes of the last meeting.

### **Matters Arising:**

The following actions were completed:

MF fed back to FW regarding the group's agreement that IV Paracetamol should be included and Ibuprofen excluded for the Paediatric Pain Re-audit.

NTn spoke to Procurement regarding the possibility of obtaining an education grant from a commercial funder and reported that commercial education grants could be sought so long as the bidding process is not tendered.

EC amended the clinical audit work plan for 2017/18 and added ideas to the proposed audit work plan for 2018/19.

EC added an audit on alternative responses (NETs, taxis & referrals to 111) to the proposed 2018/19 clinical audit work plan.

HM-D incorporated CARSG comments into the point of care troponin testing trial. HMD updated that Philips were not able to provide an adequate number of devices so project would not go ahead.

JH placed notices on drugs lockers of PARAMEDIC-2 active stations reminding crews to phone EBS after recruiting a patient.

MW provided a clinical opinion on the PRFs of the three patients enrolled into PARAMEDIC-2 who received standard adrenaline after broken syringes were found part way through resuscitation.

FW liaised with John Goldie and establish the timeline for recruiting a dedicated team leader to conduct VAS/PAS CPIs. MF updated that Richard Harpin was to make a business case for a full time position.

EC incorporated areas of low compliance with the NICE Quality Standards into the clinical audit work plan in 2017/18.

EC emailed a summary of the findings to FW & Paul Gibson regarding IROs/dates and CADs to enable feedback.

MF reported that an internal business case for additional funding to support the Trauma registry had been prepared and sent to FW for action. The London Trauma Network was opposed to closing the registry but were unable to commit to full or part funding for its continuation. RF informed that funding had been secured to develop the new ARP registries which meant the Trauma registry was not at risk this financial year. Furthermore, if the ARP funding could be continued, the Trauma registry would be able to continue into next year.

NTn reported that regarding provisions for virtual attendance for CARSG meetings, the Trust's current priority is meeting the IT requirements for ARP. The Trust is introducing Skype for Business but this is unlikely to feature access external to the LAS.

#### **Research Update:**

HM-D presented the Research Update. Details for specific projects are available in the resource pack but the following remarks were added:

- CARSG member Mark Faulkner was the top recruiting clinician for PARAMEDIC-2 having enrolled 92 patients into the trial.
- Research Paramedic Heather Cole is on Maternity Leave and her position is being covered by Research Paramedic Helen Werts. Heather will not be coming back to CARU once her leave is finished.
- MH reported that a final report for PHED had been drafted and approved for limited dissemination by the funder.

HM-D updated that additional funding of £9k had been awarded from North West London Clinical Research Network (NWL CRN) following a business case made by the LAS.

HM-D reported that CARU education initiatives were continuing and gaining increased support, including evidence for practice sessions and EOC new starters training. Additionally, the LAS has networked with university partners including Kings College London and Anglia Ruskin to deliver training to Paramedic and Data Science students, increasing the LAS' future research capabilities. TI reported she has received phenomenal feedback from students and staff at Anglia Ruskin University, with numerous students applying to the LAS because it is research active. The meeting congratulated CARU for such productive efforts.

RF & HM-D raised concerns that the capacity of CARU was limited and the Patient's Forum had in its annual report recommended that CARU undertake research into complaints in relation to shift time and CAT- A response time, and that no consultation with CARU had taken place. The group noted that the LAS already publishes patient experiences data, and that this doesn't fall within CARU's remit. Furthermore, the proposed project on CAT-A calls may be rendered redundant by the introduction of ARP. NT was tasked to feed back to Malcolm Alexander, Chair of the Patients Forum.

#### **CRN Performance:**

JP presented on the LAS performance against CRN targets in Quarters 1-2 of 2017/18, particularly that the LAS has six active portfolio studies compared to 4 in the same period last year. We are required to ensure 80% of studies recruited the correct number of participants within the contractually agreed timeframe. The LAS performance is 100%. The LAS was set a target of 653 patients to recruit in 2017/18 , we have exceeded this by recruiting 289% of the required patients. JP also reported that we expected to close the year having met 100% of the CRN speciality recruitment target.

## Research Projects in Development

### MATTS (Major trauma Triage Tool Study)

HM-D presented MATTS (Major trauma Triage Tool Study) led by the University of Sheffield. The project aims to develop and prospectively validate a universal trauma triage tool for ambulance services. Funding is being sought from NIHR HTA Programme. RF is a co-applicant on the funding application. MF is a steering group member for the project. The training requirements were discussed; extensive and face to face training could be necessary and there should be appropriate funding in place.

### RAPID-2

HM-D presented RAPID-2 - the prehospital administration of Fascia Iliaca Compartment Block (FICB) for hip fractures. Noting that RAPID-1 had been run successfully in the Welsh Ambulance Service, this study seeks to expand the methodology across multiple Services. The group noted that training would be extensive. TI reported that APPs have protected in-hospital training time and it was agreed the Urgent Care APPs may be the most appropriate group for this project. FW and MF were concerned that as the prehospital focus for such patients is rapid extraction, FICB procedure may lengthen on scene time. Additionally, as many older fallers need to be moved from a warped position in order to access the FCIB administration site, pain relief would need to be administered before FCIB. The meeting concluded that CARU should pursue this study as it focuses on low acuity patients and is in line with LAS' objectives.

### ARREST Trial Update:

JH presented the ARREST trial that is due to start in early January 2018. A synopsis was made available in the resource pack sent before the meeting. The trial will be delivered in a phased rollout, with St. Thomas', Kings College London and St. Georges HACs. Westminster and Waterloo ambulance stations will be first to go live.

RF raised an issue with having to share CRN accruals with other Trusts. The LAS is funded by the Department of Health, through the CRN, based on the number of accruals we make each year. An accrual is counted as each patient recruited and consented to a trial. When negotiating trial set up with NHS partners, some Trusts ask for accrual sharing where there is no corresponding activity. In the case of ARREST, EDs demanded 50% of our accruals for patients transported to their ED or else they would pull out of the trial. The EDs are already to be compensated £147 for each patient taken to them as part of the trial. The requested accruals would be in addition to this. RF was concerned that LAS research activity was going unrecognised and would be under-funded because of such proposed arrangements. The meeting agreed that CARU should seek to reduce accrual sharing agreements. FW and NTn requested that RF attempts to renegotiate accrual sharing agreements for the ARREST Trial.

**Action 1: RF to attempt to renegotiate accrual sharing agreements for the ARREST Trial**

### **Annual Clinical Audit Review**

NT presented the findings of her annual review of clinical audit working practices in the LAS, she noted that the standard of the audit was high, all criteria were met and the department had passed the review with no recommendations for improvement. In particular of the four clinical audits she reviewed: the reports were accessible, the posters and infographics were bespoke and addressed the specific findings of the clinical audit.

NT congratulated CARU on a good review.

RF thanked NT for all her work in supporting CARU and undertaking independent review. .

### **Clinical Audit Update**

JS updated the meeting on the LAS clinical audit work plan reporting that since the last meeting 4 clinical audits had been released, 9 were underway and 5 were to be started. The exercise portion of the Exercise Unified Response (EUR) clinical audit had been abandoned due to difficulties matching paperwork after the event. A lessons report had been written to provide learning for any such future audits.

*Post meeting note: As a result of recent vacancies within CARU, and the resulting capacity issues, the clinical audit work plan was revisited at a Medical Directorate Forum (18/01/18), chaired by the Medical Director. The priority of clinical audits yet to be undertaken was discussed and re-scoring undertaken by the Clinical Audit Manager, the highest two scoring topics were put forward for completion 2017/18. These two projects are: Missed Spinal Injuries and Obstetric Emergencies. The remaining projects that have not yet started will be carried over for consideration in the 2018/19 work plan which will be reviewed at the next CARSG meeting.*

CPI feedback rates were variable, however as new Team Leaders had been recruited and were being trained by CARU, an upward trend was expected in future months.

After being sent to CARSG for comments, the Hypovolemic Clinical Audit will be re-written as a case series and not as a clinical audit due the very small sample size.

JS reported that CARU had to redesign the continuous re-contact clinical audit for 2015-17, as a significant error in the data extract query provided by the LAS Business Intelligence (BI) Team resulted in missing data for approximately 1,300 patients treated and discharged by the clinical hub CHUB or referred to 111. CARU does not have the capacity in this work year to redress the balance. This issue does not affect data and analysis for the year 17/18 which will be done in full.

The meeting was concerned that such a mistake had been made and in particular that it was not picked up by BI, as the LAS relies on their data for assurance of clinical safety and decision making.

FW asked that RF enquire what had been done by BI to escalate the erroneous continuous re-contact query issue and prevent future incidents.

TI and NTn proposed, and the meeting agreed, that the incident should be reported on Datix. The incident report was to act as a notification to the Trust that its quality assurance for 2015-17 is limited and not as robust as had been thought.

**Action 2: RF to find out what had been done by BI to escalate the erroneous continuous re-contact query issue and prevent future incidents**

**Action 3: JS to raise an incident on Datix regarding the erroneous continuous re-contact query issue**

### **Clinical Audit Project (Ondansetron)**

JS presented findings from the clinical audit on the anti-emetic Ondansetron that was introduced to the Service in 2013. Two incidents had been reported where patients were given double the recommended dosage but no harm was reported.

403 PRFs were audited, 13 of which were sent for clinical review as it was uncertain if administration of Ondansetron was clinically indicated.

It was reported that 10 patients were given the incorrect dose. MF indicated disparities between UK guidelines, International standards and manufacturer recommendations, may account for incorrect dosage.

JS noted that when given intravenously, ondansetron should be administered slowly over two minutes; however 25% of patients (n=79) were given another IV drug within two minutes, meaning ondansetron was given faster than recommended. MF and FW cautioned that care must be taken in this assertion as nothing in the guidelines precludes a clinician stopping an ondansetron IV to administer other drugs and then restarting ondansetron afterwards.

TI suggested and the meeting agreed a recommendation should be made that training for ondansetron be altered in particular that training should be in real time over 2 minutes in order to help paramedics gauge the administration time.

### **Clinical Audit Project (Dexamethasone)**

JS presented the findings and recommendations of the dexamethasone Clinical Audit, triggered as this is a newly introduced drug in 2013.

Lack of equipment was reported in 10 of the 34 cases where the oxygen saturation level was not recorded. MF noted that some patients are too small to fit the standard equipment. NT countered that therefore there should be specialist equipment.

In 53% of cases dexamethasone was given for a 'seal bark cough' which is not an indication in the national guidelines. MF proposed, and NTn seconded, that the recommendation that the Medicines Management Group should be asked to consider withdrawing dexamethasone should be removed. The meeting discussed that it may be a documentation issue whereby clinicians note the main

indication, and it has never been made explicitly clear to crews that they should document other indications. Explicit guidance should be given to crews and a re-audit conducted.

**Action 4: JS to amend the Ondansetron and Dexamethasone clinical audit recommendations in line with CARSG comments**

**Clinical Quality Update:**

GF presented on the requisite proposed changes to clinical quality monitoring the Ambulance Quality Indicators (AQI's) from April 2018 as part of resulting from adoption of the Ambulance Response Programme (ARP) from April 2018. RF & GV are working with NHSE to develop the new national indicator set.

**Cardiac:**

The cardiac measures will continue with ongoing monthly AQI data submissions. While the existing quality measures remain unchanged, the overall ROSC group measure will no longer be required (though CARU will continue to monitor this as part of internal reporting). Two new clinical indicators will be introduced: (1) the number of all cardiac arrests each Service attends regardless of resuscitation attempt and (2) compliance to a post- ROSC care bundle. A new systems indicator of time to CPR is also required, but needs further work at this stage.

**STEMI:**

Data submissions will be required for one month from each quarter, although the month is yet to be determined. It is proposed that the time to PPCI measure is amended to time to angiography, and for the care bundle that the sample is based on patients confirmed as STEMI at hospital and not by Ambulance Service clinicians. Both of these changes have been discussed with MINAP as they rely on the quality of outcome data to be improved, and it has been suggested that Ambulance Services are provided access to data from the British Cardiovascular Intervention Society (BCIS) registry as it may be more reliable. However, this requires further discussions as the linkage required will take time and therefore it is likely that these measures will not be changed immediately.

**Stroke:**

As per the STEMI indicators, data submissions will be required for one month from each quarter, although the month is yet to be determined. The sample for the measures will be based on patients confirmed to have a stroke at hospital and relies on access to outcomes from the SSNAP (Sentinel Stroke National Audit Programme) dataset, though there are linkage and IG issues to overcome. If successful, the time measure will move from measuring arrival at hospital to time to CT scan/treatment but the elements of the care bundle remain unchanged.

**Sepsis:**

A new Sepsis AQI is proposed and data will be required for one month of each quarter. The sample will be based on adult patients, but pregnancy and neutropenic sepsis will be excluded. The expected care bundle is: observations documented, site of infection recorded, O<sub>2</sub> administered, IV/IO attempted and pre-alert. MF queried whether site of infection was required as it is not always

obvious. GF clarified that the requirement is to document either the site of infection or that an attempt to locate it was made.

Staffing for the development of a new registry to support the AQI is being funded by the LAS as part of the ARP programme until the end of March 2018, with the expectation that these roles will become permanent.

Elderly Falls:

This new AQI will focus on patients on the floor and time to appropriate response (measured as the time to attend or to dispatch a falls service). The meeting discussed concerns that the LAS was disadvantaged in this measure as there is not a falls network in London as there are in other parts of the country. This measure is proposed as a systems indicator to be populated by the Business Intelligence functions, with potential that clinical aspects of care will be included at a later date.

**AOB:**

RF highlighted that following recommendations from consultants KPMG's audit, new terms of reference will be published and sent to CARSG for comment and approval with the minutes of this meeting.

RF reported that the group needs to approve the ToRs - these will be circulated with the minutes for approval.

RF thanked external CARSG members for their valuable input.

**Action 5: JP to send revised CARSG TOR to members for comment and approval**



Actions from Previous Meetings:

Action No.	Agenda item	Action details	Date Generated	Respons Office
1.	<b>8. Clinical Audit Update</b>	CH-S to investigate how feedback could be given to emergency responders	Mar-17	CH-S

Actions from this meeting

Action No.	Agenda item	Action details	Responsible Officer
1.	<b>ARREST Trial Update</b>	RF to attempt to renegotiate accrual sharing agreements for the ARREST Trial	RF
2.	<b>Clinical Audit Update</b>	RF to find out what had been done by BI to escalate the erroneous continuous re-contact query issue and prevent future incidents	RF
3.		JS to raise an incident on Datix regarding the erroneous continuous re-contact query issue	JS
4.	<b>Clinical Audit Project (Ondansetron) &amp; <u>Clinical Audit Project (Dexamethasone)</u></b>	JS to amend the Ondansetron and Dexamethasone clinical audit recommendations in line with CARSG comments	JS
5.	<b>AOB:</b>	JP to send revised CARSG TOR to members for comment and approval	JP