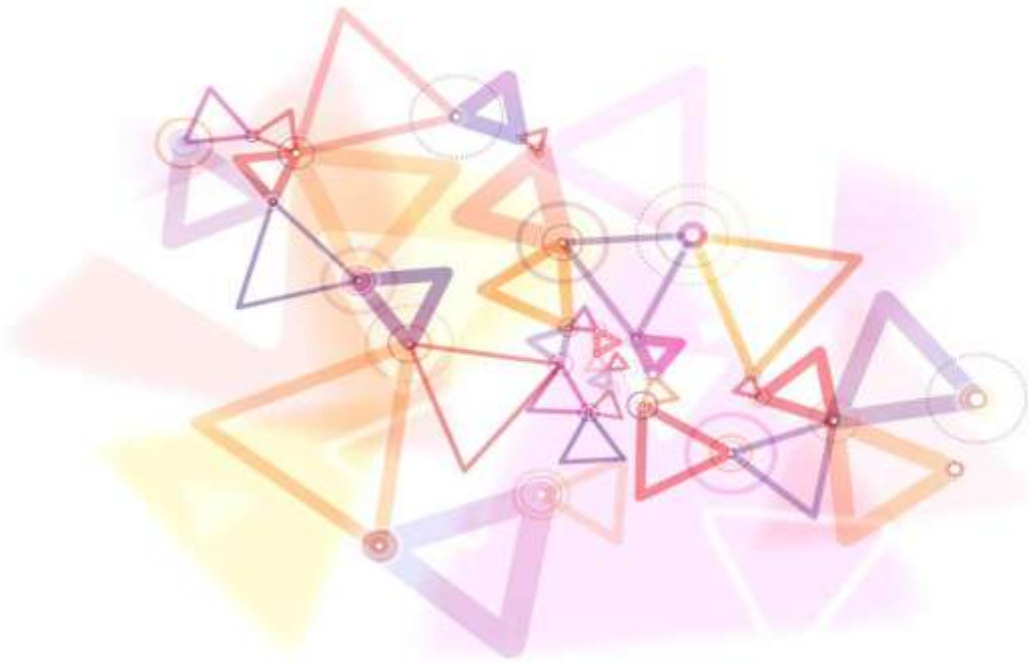
Midlands Critical Care & Trauma Networks NHS

Major Trauma Operational Delivery Networks

Trauma Network Annual Report 2014/15



Classification: General

Organisation	Midlands Trauma Operational Delivery Networks
Document Purpose	Annual Report
Title	Midlands Major Trauma Networks Annual Report
Author	Sarah Vickers, Jeff Osborne, Steve Littleson
Date and Version	1.5.15 V4
Linkages	Network Work Plan Network Operational Policy Midlands Trauma Networks – Trauma Handbook
Circulation	Provider/Acute Trusts Pre-Hospital Providers Commissioner organisations SHA Cluster organisations Senates Operational Delivery Networks Strategic Clinical Networks NHS England
Description	This is the annual report for the year 2014/15
Point of Contact	Sarah Graham, Service Improvement Facilitator
Contact Details	4th Floor, Kings House 127 Hagley Road Birmingham B16 8LD

Foreword

The previous year, our third as a functioning Trauma Network, has seen the provision of trauma care to the West Midlands continue to improve and to be organised in a cohesive cooperative manner.

The challenges faced by the ambulance service, the three adult major trauma centres, the children's major trauma centre and the trauma units remain considerable. The number of Major Trauma patients seen in the Major Trauma Centres is greater than was expected when the network was created. It is well known that the NHS in England is under considerable financial pressure and this places significant challenges on the partners in the Major Trauma Network in delivering the service to patients however we have seen over the last few years considerable innovation in delivering care and step changes in the level of care delivered to patients at every stage of the their major trauma journey.

The success of a Network is sometimes hard to quantify however the West Midlands Trauma network has much to be proud of: developments in the delivery of pre-hospital care that have been recognised as the best in England, innovative new roles for staff in the major trauma centres that are empowering staff to deliver excellence in care, superb collection and analysis of data that is allowing our network to convincingly demonstrate improvements in patient outcomes, high levels of engagement across all parts of the networks in quality improvement, high class education and international conferences supported by the network and offered free to local nurses, paramedics, doctors and other health care professionals and most importantly of all improving survival of major trauma patients.

There are considerable challenges facing the network going forward. It is really important to maintain the momentum generated so far. There are refinements in patient care pathways that the network is continuing to support to further enhance the quality of care patient's experience. Finally there is a need to engage with patients, to understand what patients and relatives want and need from the network and to use their views and stories to further develop the service we provide.

Dr Matthew Wyse
Regional Lead for the Midlands Trauma Networks
and Trauma Lead University Hospitals Coventry and Warwickshire

Contents

Background

The Midlands Trauma Operational Delivery Network is the collective entity for the following trauma networks and the population served:

- Birmingham, Black Country, Hereford & Worcester Trauma Network (BBCHWTN) Approx: 3,129,000
- Central England inc Northamptonshire Trauma Network (CETN) Approx: 1,900,000
- North West Midlands & North Wales Trauma Network (NWM&NWTN) Approx: 2,063,700

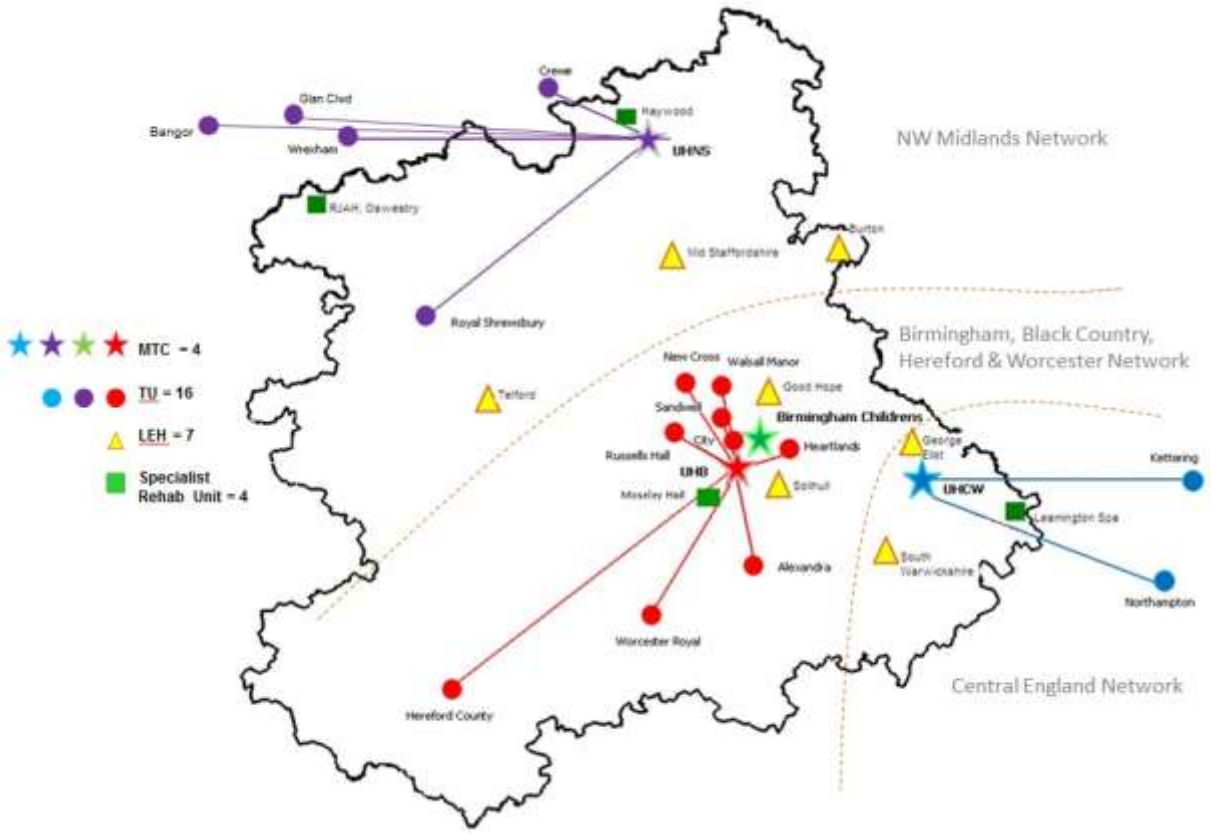
As an Operational Delivery Network (ODN) we focus on operational delivery. ODNs ensure outcomes and quality standards are improved and evidence based networked patient pathways are agreed. We focus on an operational role, supporting the activity of Provider Trusts in service delivery, improvement and delivery of a commissioned pathway, with a key focus on the quality and equity of access to service provision. This will allow for more local determination, innovation and efficiency across the pathway. ODNs support the delivery of 'Right Care' principles by incentivising a system to manage the right patient in the right place.

ODNs are focussed on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise.

We work in partnership with acute hospitals providers, commissioners, rehabilitation and pre-hospital providers who jointly review, plan, commission and develop critical care and trauma services within the Network whilst working to agreed service specifications.

Our website www.midlandscriticalcarenetworks.nhs.uk is an initiative commissioned in 2009 to share information, promote discussion and provide a secure platform for communicating with individuals in both clerical and medical roles. The MCC&TNs is operated by the network office based on the Hagley Road, Birmingham.

Network Map



Introduction

The overall purpose of the ODN is to provide support for the delivery of the strategic direction and the network work objectives/work plan. The ODN will focus on operational delivery, ensuring outcomes and quality standards are improved an evidence based networked patient pathways are agreed. The ODN works to a service specification and has an operational role in supporting the activity of Provider Trusts in service delivery, improvement and delivery of a commissioned pathway. The ODN is made up of many trusts and individuals who are committed to sharing best practice whilst being open and transparent by sharing data that can improve the service it provides to patients. The ODN supports the delivery of 'Right Care' principles that lead to the management of the right patient seen in the right place at the right time, first time.

Our key functions are to:

- provide a clear network structure
- ensure there are shared governance arrangements
- embed a performance management framework which monitors all aspects of the system
- continually develop communication at all levels, engaging clinicians across organisational and geographical boundaries
- facilitates effective rehab
- promote good team working for the good of the patient. Patient centred care

We continue to be hosted by Queen Elizabeth Hospital Birmingham and are funding stream is via top-sliced CQUIN money. Our financial report will be available at the end of this financial year, around April 2015. Suffice to say our current financial prediction ensures we are with-in budget and we do not predict any changes to this by the end of the financial year.

Our network teams consist of the following members:

Network Management Team:

Network Manager	Jeff Osborne
Service Improvement Facilitator & Governance Lead	Sarah Vickers
Data Analyst	Steve Littleson
Network Administrator	Juliet Brown
Network Regional Clinical Lead	Dr Matthew Wyse
Network Regional Rehabilitation Lead	Dr Alex Ball

Birmingham, Black Country, Hereford & Worcester Trauma Network (BBCHWTN)

Queen Elizabeth Hospital Clinical Lead	MTC	Professor Sir Keith Porter
Birmingham Children's Hospital Clinical Lead	MTC	Dr Tina Newton
Hereford	TU	Dr Jules Walton & Dr Peter Burdett-Smith
Worcester Royal	TU	Dr Steve Graystone & Dr Paul Shone
Alexander, Redditch	TU	Dr David Gemmell
Heartlands	TU	Dr David Raven
Dudley	TU	Mr Alastair Marsh
Walsall	TU	Dr Fazle Alam
Wolverhampton	TU	Dr Adrian Simons
City, Birmingham	TU	Dr Cliona Magee
Sandwell	TU	Dr Jonathan Hulme
Good Hope	LEH	Dr David Raven
Solihull	LEH	Dr David Raven
Moseley Hall Rehabilitation Hospital		Dr Zacc Falope

Central England inc Northamptonshire Trauma Network (CETN)

University Hospital Coventry & Warwickshire Clinical Lead	MTC	Dr Matthew Wyse
Birmingham Children's Hospital Clinical Lead	MTC	Dr Tina Newton
Northampton	TU	Dr John Hare
Kettering	TU	Dr Linda Twohey
South Warwickshire	LEH	Dr Julie Nancarrow
Central England Rehabilitation Hospital (CERU)		Dr Derar Badwan & Sue Bleasdale

North West Midlands & North Wales Trauma Network (NWM&NWTN)

Royal Stoke University Hospital Clinical Lead	MTC	Dr Peter Oakley
Birmingham Children's Hospital Clinical Lead	MTC	Dr Tina Newton
Leighton, Crewe	TU	Dr Paul Knowles
Shrewsbury	TU	Dr Mark Prescott
Bangor	TU	Dr Rob Perry
Glan Clywd	TU	Dr Mark Anderton
Wrexham Maelor	TU	Dr David Southern
Telford	LEH	Mr Adrian Vreede
County	LEH	under review
Burton	LEH	Dr Alina Paunescu
Haywood Rehabilitation Hospital		Dr Alex Ball

Pre-Hospital Provider Leads

West Midlands Ambulance Service	Shane Roberts
East Midlands Ambulance Service	Ian Mursell
North West Ambulance Service	Roger Jones
Midlands Air Ambulance Charity	
The Air Ambulance Service	
North West Air Ambulance	

Summary of activity and key achievements

Operational Delivery

Review of patient pathways / Protocols in Trauma Handbook

An annual review of the Trauma Handbook was completed by network colleagues leading to version 4 being circulated both manually and via electronic methods to each organisation. The Trauma Handbook is available on the networks website. www.midlandscriticalcarenetworks.nhs.uk

Peer Review

Work had started by the network where we had updated the current trauma standards to ensure they were fit for purpose & reflective of current guidance. However, during this period we were informed that Peer Review would be undertaken and delivered by the National Peer Review Team. The Network has continued to assist the national team with regards to the visits proposed for our Trauma Units. At the end of these visits we will identify a programme for continued performance monitoring and evaluation including engagement and involvement of our CCGs.

Data Activity Monitoring

Activity & Performance monitoring

Performed by our Network Data Analyst, analysing local KPI data, reviewing reports produced by Trauma Audit & Research Network (TARN) and providing timely outcome monitoring reports for each of our network organisations. See information provided below.

ISS >15 patients that remain in Trauma Units - Each Trauma Unit is sent a list of patients every six months showing all the ISS>15 patients not transferred. They are manually reviewed by the clinical members in the network office first, to try and guide TU clinicians towards the cases that might require local review.

Improving the TARN submissions levels from the Trauma Units - Each TU has been visited, and new filtering software (developed by the Networks Data Analyst) has been introduced for the majority of them. This filters their local ICD10 data to isolate the TARN eligible cases. This has saved them from manually having to find the cases. The system is working well, but there are limited resources available locally to increase the whole time equivalent (w.t.e) of the data clerks. They now *have* the cases that require submission, but are struggling with resource allocation. This report will include the data analysis to evidence to what extent this software filter has improved the reporting process (to be completed by the end of March 2015).

Data quality monitoring - Units with low data accreditation scores are contacted to (a) make them aware, and (b) point out how they could improve. The data accreditation score compiled by TARN only covers several metrics, but we also monitor key fields such as Triage Tool, Incident Postcode, Glasgow Outcome Score, Rehab prescriptions, etc.

Key performance indicators for the TU's - A core set of KPI's have been agreed and TU TARN data was passed through the template to produce their local KPI's. These were initially only for 'local eyes', to help teams identify where improvements had to be made. More recently, we have been circulating amalgamated information, with the aim of getting everyone more used to being open and completely transparent with their data. A sample will be included in the appendices.

Using the data to inform - The data analyst has been able to supply data for, and be involved in, many local audits:

- Abdominal injuries data (with liver subset) to inform MTC's specialists on activity trends
- Analysis of 'lost' BPT for the MTC's
- Year-on-year activity comparisons

- Lot's of analysis on 'silver trauma' to see the impact they have, and to find ways of improving their journeys
- Business case development for an MTC wanting to open a Level 1 acute rehab unit in-house
- Analysis of AIS3+ head injuries that remain in the TU's for the network rehab lead
- Analysis of the Welsh patients that would have by-passed a TU, was this system to be put in place
- Pre-hospital observations as an indicator for trauma alerts
- Breakdown of network meeting attendance
- Monitoring the delays in and out of specialist rehab centres for trauma patients
- Business case development for a rehab centre wanting to expand beds
- Analysing the impact of no resident overnight Consultant at an MTC

Use information in a smarter way - The data analyst has been able to develop a wide-range of software to this end:

- The policies which form the network trauma handbook have been combined into a single digital document, which can be saved to smartphones/tablets and accessed offline. This may be developed into an interactive app in the future.
- The rehab directory is hosted and maintained on a publically-accessible section of our website. Any user can simply enter a postcode, tick what services they are looking for, and see what is available (and how far), with contact details / hyperlinks for any provider they want to pursue. Other networks have shown an interest and we are now exploring whether to try and expand this to a national directory.
- Development of a TRauma Issues Database (TRID) allows Trusts to submit issues with any part of the trauma system. The database operator can easily track progress, as all communications are captured, and it is used for case discussion at the bi-monthly governance meetings and also to generate closure letters.
- Development of the filtering software designed to help the TU's find their patient list for TARN submission. It is envisaged we will be able to use this in the LEH's to help them identify their trauma patients with high ISS's or who are poly-trauma, without the need for them to submit any data to TARN.

Improved Quality & Standards of Care

Rehabilitation Network Programme

Rehabilitation work programme activities/work streams/work group outcomes, listed below.

Overview

One of the recommendations from the redesign of major trauma services in England was the appointment in each network of a 'Director of Rehabilitation'. The West Midlands Trauma Network responded to this via the appointment of a 0.2 WTE Clinical Lead for Rehabilitation, a post held by a Consultant in Rehabilitation Medicine since the Network's 'Go-Live' date of March 2012.

The West Midlands Trauma Network comprises three clinical Major Trauma Networks (Central England (CETN), Birmingham, Black Country, Hereford and Worcester (BBCHW) and North West Midlands and North Wales (NWMNW). This covers a vast geographical area and over 23 Clinical Commissioning Groups (CCGs). Whilst the original aim for a Director of Rehabilitation was to facilitate the rehabilitation pathway and patient flow across the entire Network, this has not been practicable, due to the size and complexity of the service. The major role of the Rehabilitation Lead to date has thus been to advise the Network on rehabilitation strategy and bring together a group of rehabilitation clinicians from the various trauma services as a 'rehabilitation sub-network'.

A Trauma Rehabilitation work programme has been developed, regularly reviewed and reported to the Network's Performance and Quality (PaQ) Board. Main items on the work programme are summarised below, with future actions identified where applicable. During the first year following 'Go Live', two education and information sharing events / workshops were held in Birmingham and were well attended by a wide trauma rehabilitation audience from around the region and beyond. A database of contacts has been developed in response to the workshops, such that information can be easily disseminated to a growing number of relevant clinicians and managers.

Rehabilitation Prescription

A working group was established to reach consensus on the format of a paper or web-based standard Rehabilitation Prescription (RP). Modification of the DoH template, originally circulated by Keith Willets, with input from a number of clinicians across the region, led to the creation of a West Midlands version, comprising 'Core' and 'Supplementary' sections to cater for two groups of complexity, as well as a modified version for children.

With minor local modification, this RP is in use in all four MTCs and sent out across the region. Initial development was linked to national work, including that of Professor Derick Wade, the British Society of Rehabilitation Medicine (BSRM) and the National Major Trauma Clinical Reference Group (CRG). In addition, scope for linking to existing TARN data collection has been explored.

Next actions:

- Ongoing modification of West Midlands version to reflect learning and developments in trauma service
- Continued sharing externally and development of web-based / IT solutions for generation of RP
- Consider incorporation into TARN database if / when 'real-time' TARN data entry becomes a reality
- Enhance functionality of RP as a patient-held document (user feedback ideally)
- Gap analysis of uptake of RP recommendations outside the MTC (as per original aim)

Embed RP generation and delivery across all trauma units and other providers of trauma rehabilitation, including community rehabilitation services where they exist.

Directory of Rehabilitation Services

Initially to be hosted by Birmingham Community Foundation NHS Trust (as a project within the West Midlands Rehabilitation Centre), the database development now rests with the Midlands Critical Care and Trauma Network (MCCTN). A standardised information template has been agreed and organisations contacted to invite inclusion, with follow up contacts made. A web design organisation has been tasked with delivering the on-line Directory which will be accessed via a direct link from the MCCTN website.

Next actions:

- Publicise across the region and externally
- Implement and maintain robust monitoring and updating processes

Specialised Rehabilitation

The Specialised Rehabilitation Capacity group was launched in 2013 as a rehabilitation sub-group, initially designed to assess the impact of the redesigned major trauma service on specialised rehabilitation unit (SRU) capacity.

Inpatient specialised rehabilitation in the West Midlands is provided by five NHS England-commissioned units: Central England Rehabilitation Unit (CERU) in Leamington Spa, the neuro-rehabilitation ward of University Hospital of Coventry and Warwickshire, the Inpatient Neurological Rehabilitation Unit (INRU) at Moseley Hall Hospital in Birmingham, The Neurological Rehabilitation Unit at West Park Hospital in Wolverhampton and the North Staffordshire Rehabilitation Centre at the Haywood Hospital in Stoke on Trent. There are no specialised rehabilitation units in North Wales currently. In addition, several non-NHS providers, including the Brain Injury Rehabilitation Trust (BIRT) unit in Birmingham and the Hunters Moor Unit, offer highly specialised inpatient rehabilitation.

All units were invited to attend the group meetings and submit activity data for analysis. The mandatory UKROC (UK Rehabilitation Outcomes Collaborative) data provided the necessary information for the submitting units. Analysis demonstrated that major trauma redesign per-se had not impacted upon capacity, but that longstanding issues of delayed discharge were more likely to be of significance.

A further focus of the group was the group of patients whose needs are so complex that they cannot be met within existing NHS England commissioned units. This highlighted an apparent anomaly in the commissioning structure, whereby funding for specialist placements for such patients (currently exclusively non-NHS provided)

falls to the local CCG. This is the cause of widespread confusion and lengthy delay in patient pathway and is a nationally recognised problem. Any solution rests on education and engagement of CCGs. It was suggested by the group that an agreed set of criteria could be developed, to provide assurance to the CCGs whenever funding requests of this type are made. This could be preceded by a register of all patients in this category across the region. This was widely supported by providers of specialised rehabilitation but requires CCG engagement to be progressed and implemented.

Future direction of the group is to be in combination with the rehabilitation subgroup of the Midlands Strategic Clinical Network for Neurology, chaired by Professor Adrian Williams. The two key priorities for the groups, to be taken forward as Task and Finish groups over a 12-month timescale, were agreed as:

- Provision of specialised rehabilitation for patients with respiratory and ventilatory problems
- Provision of community-based specialist brain injury services

Trauma Unit Rehabilitation Pathway

Development of defined trauma rehabilitation pathways within the 16 Trauma Units (TU) (including the 3 hospitals in North Wales) across the network has failed to progress, despite the specific requirements for TU designation outlined in Network agreed standards. No TU to date has in post a functioning Rehabilitation Coordinator or dedicated trauma rehabilitation sessional input from a Consultant in Rehabilitation Medicine. No rehabilitation prescriptions are being generated within TUs.

Rehabilitation provision and interest varies between TUs and is greatest in units with traditional links with Rehabilitation Medicine services that pre-date the trauma service redesign. Some initial progress has been made during 2014 in securing contracts for rehabilitation medicine input in two of the region's TUs.

The lack of rehabilitation pathways within TUs has a direct and severe impact on patient flow and care closer to home (repatriation), leading to significant pressures on MTC capacity which require addressing urgently.

Next actions:

- Full engagement with TU Peer Review process to ensure rehabilitation specifications are robustly assessed and clear recommendations made, with timescales and consequences for non-compliance.
- Analysis of TU TARN data to examine prevalence of injuries likely to result in significant rehabilitation need to highlight importance of structured rehabilitation provision
- A Network response in combination with efforts to tackle the problems of transfers out of MTCs.
- Assistance with the production of business cases for TUs to develop in-house rehabilitation services and Level 3 rehabilitation pathways.

Neuropsychological Provision

A subgroup was convened in 2013 to reach expert consensus on the most appropriate screening tool for neuropsychological problems resulting from acquired brain injury. Meetings were well attended and a wide range of viewpoints debated. The conclusion reached was that the Neuropsychological Assessment Battery (NAB) was the most appropriate tool for MTC use and could be administered by appropriately trained Occupational Therapists where no clinical psychologists were available.

Next actions:

- Obtain and disseminate findings of working group
- Task group with making formal recommendations about post-traumatic amnesia (PTA) management if appropriate

Musculoskeletal Rehabilitation

Lack of a defined rehabilitation pathway and more importantly dedicated rehabilitation beds for patients with musculoskeletal trauma has always been recognised as a major issue for trauma services. Its main impact in the Network is via its effect upon patient flow and transfers out of MTCs, although no robust data has been collected to illustrate this.

Some trauma rehabilitation teams, such as that at University Hospital of North Midlands (UHNM), have clinicians with a special interest in musculoskeletal rehabilitation, but this is unusual.

Next actions

- Data collection by individual MTCs to evaluate and define gaps in musculoskeletal service provision
- Link with general rehabilitation pathway work across trauma units

Sharing Events

The delivery of a joint trauma and critical care annual sharing event, sharing best practice, improved knowledge & skills was held on 24th June 2014. The programme looked at the benefits of scrutiny and service improvement, the benefits to service users, the affect of seven day working, emergency and mass casualty planning as well as many break-out sessions covering – violence prevention, non-medical prescribing, governance and new research in sepsis. We had excellent representation from a wide range of personnel with over 150 delegates.

Education and Training

We currently produce an annual programme of study days to enhance and improve the knowledge & skills of trauma staff. This is a list of training held by trusts and the network which is regularly updated and disseminated.

	Event	Date	Time	Venue	Place No.s	Trust Only (TO) or Open to other Networks (ON)
1	Spinal Injury	9 May	All day	Walsall Hosp		
2	Transfer Training	19 May	All day	TBC		
3	Ultrasound Guided Vascular Access Course	19 May or once a year	All day	Worcester Royal Hospital	12	National
4	Sharing Event	24 June	All day	Birmingham City FC		ON
5	Coventry Adult Transport Course	12 Sept	All day	University Hospital Coventry and Warwickshire (UHCW)		ON
6	Nursing Management of Acute Trauma Patients - ***NEW***	18 Sept	All day	Network Office, Birmingham		ON
7	Transfer Training	16 Oct	All day	Walsall Hosp		ON
8	ATLS	18-20 Nov 2014	All day	Ysbyty Glan Clywd, Rhyl		ON
9	Advanced Respiratory Interactive Workshop – ***NEW***	20 Nov 2014	All day	Network Office, Birmingham		ON
10	ATLS	10 Dec 2014		Alexandra Hospital	**FULL**	ON
11	ATLS	22-24 October 2014	Two days	Royal Wolverhampton NHS Trust	20	ON
12	Advanced Trauma Simulation Course (ATSC)	23 Oct 2014	All day	QEHB		ON
13	European Trauma Course (ETC)	17 -19 Sep 14 18 -20 Nov 14	3 days 3 days	QEHB QEHB		
14	ATLS	12-14 Nov 2014	3 days	QEHB		
15	RSI Assistant course	11 Jun 21 Aug 9 Sep 27 Oct 20 Nov		QEHB		Both
16	ATLS	3-5 Dec 2014	3 days	Wrexham Maelor Hospital	**FULL**	ON

West Midlands Ambulance Triage Tool Review

Our West Midlands Ambulance Service representative, Shane Roberts recommended that the service review the current triage tool in line with American Triage Tool Recommendations. This review was undertaken by the Performance and Quality Board. The Board agreed to the recommendations and work is underway to implement the new version of the tool by January 2015.

Major Haemorrhage Protocol Audit

The network performed an audit to establish with if the MTC's and TU's had a protocol in place, what version they used and if it varied to the version supplied in the Trauma Handbook to establish if there were any discrepancies in the protocols currently being used. An audit was completed in September 2014 and the final report will be finalised by the end of this financial year. Units will be informed of any recommendations regarding any alterations to their protocols on a one to one basis. Initial review of this audit did not raise any concerns over the localised protocols being used.

Emergency Planning and Resilience

The network has been working with the Local Area Teams in the region to develop a strategic plan for the West Midlands in time of mass casualty / surge. Much of the preliminary work has been completed around casualty regulation & capability, which was done by our West Midlands Ambulance Service representatives. A West Midlands Strategic Response Framework has been written and a Casualty Regulation & Integrated Health Response event took place in June 2014 with over 100 delegates from various organisations.

Work has been put on hold since October due to the reorganisation of the Local Area Teams and NHS England however, we plan to formalise the next steps in due course, these will include:

- Performing a table top exercise
- Performing a command post exercise
- Develop network recovery plans
- Disseminate all relevant information e.g. plans/frameworks
- To work with organisations to ensure their plans align with this Framework

<u>Partnership Development</u>

Patient & Public Involvement (PPI)

A workshop was held on the 1st October 2013 for our network organisations & members, the focus was to provide tools that would assist trauma colleagues in securing patient and public involvement. There was good engagement on the day which has led to a better understanding by some organisations. The network has recently identified a number of 'former' patients who are keen to work with the networks in responding to their perception of how the trauma service can be improved..

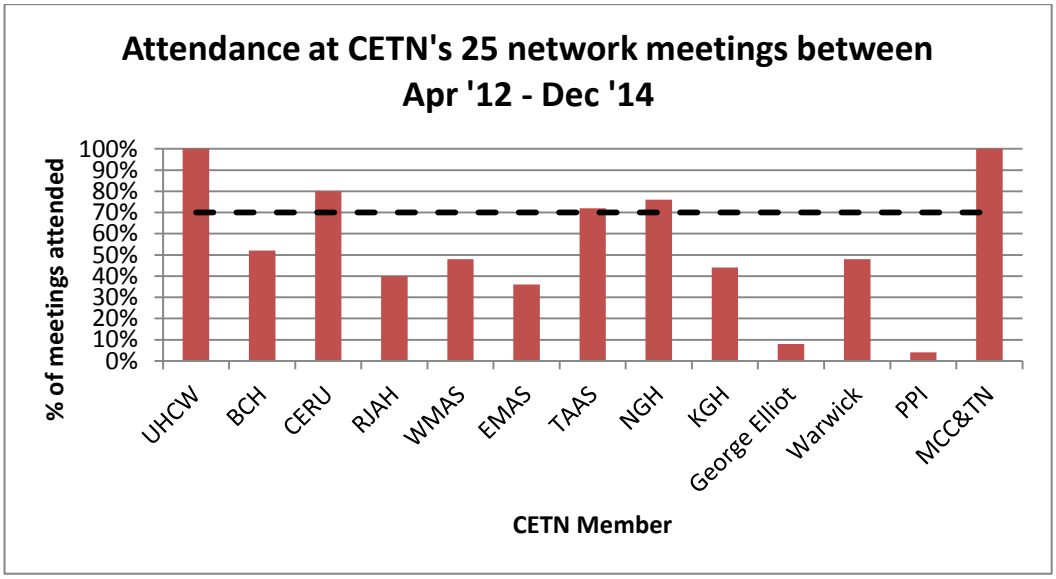
Re-engage with the Private/Independent sector

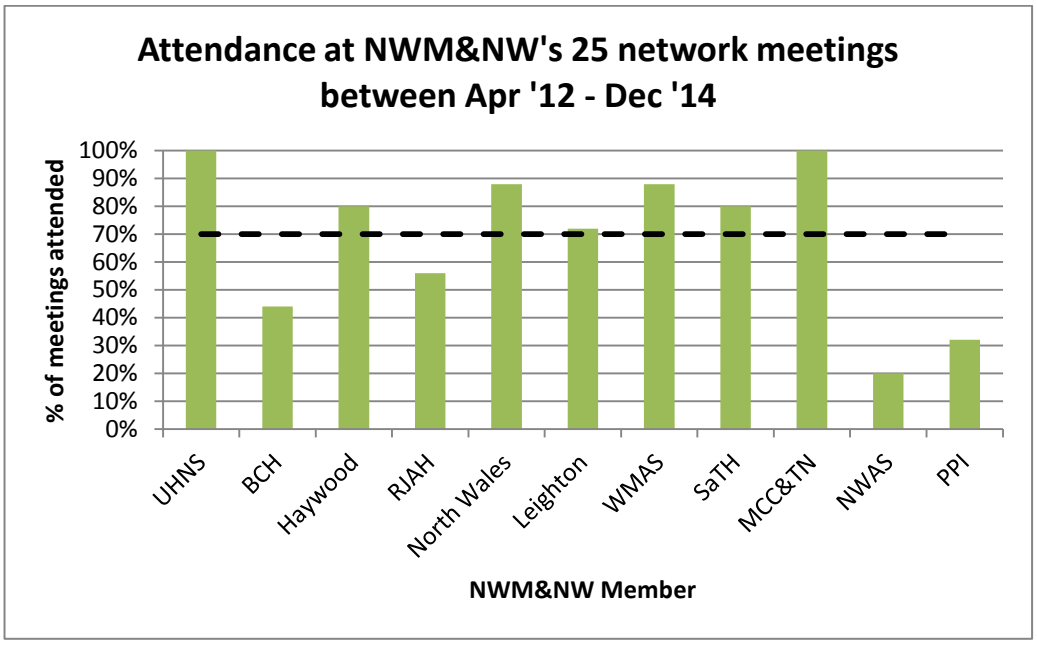
We currently have good engagement and active participation within the network with our independent air ambulance services who provide regularly attend network board meetings. We are also fortunate to have good working relationships with independent specialised rehabilitation providers despite limited NHS referrals.

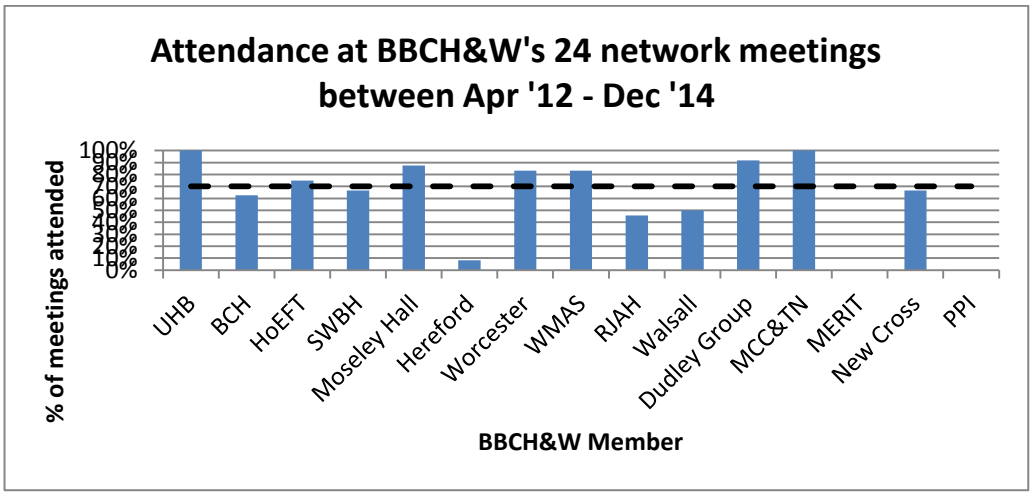
Network Board Meetings

Each Network has pre-arranged monthly meetings, hosted by hospital trusts and/or the network office.

Representation has been monitored and only a very small number of trusts are not as visible as others. Where there are geographical and staffing issues that limit attendance at board meetings the network chairs and management team have visited these organisations to offer support and to clarify the level of commitment required and the responsibilities of being part of a network. The network data analyst and the network governance lead regular monitor attendance – see report below.







The first years Network Trauma Board meetings were primarily focussed on establishing the pathways and building working relationships. Following a review of the board activity the schedule was revised for 2014 to reflect the view that governance was a significant priority and therefore would require more frequent meetings. See example schedule below:

Gov/Bus	Date	Time
Governance	January	09.30-11.30
Governance	February	09.30-11.30
Business/Data	March	09.30-11.30
Governance	April	09.30-11.30
Governance	May	09.30-11.30
Business/Data	June	09.30-11.30
Governance	July	09.30-11.30
Governance	August	09.30-11.30
Business/Data	September	09.30-11.30
Governance	October	09.30-11.30
Governance	November	09.30-11.30
Business/Data	December	09.30-11.30

Further consultation was sought prior to the 2015 meetings scheduling and after much deliberation boards agreed to alter the format to the following schedule as the focus on the governance components had been significantly addressed in 2014.

Gov/Bus	Date	Time
Governance	January	09.30-11.30
Business/Data	March	09.30-11.30
No meeting	**April**	
Governance	May	09.30-11.30
Business/Data	June	09.30-11.30
No meeting	**July**	
Governance	August	09.30-11.30
Business/Data	September	09.30-11.30
Tri-Network Trauma Clinical Forum	October	ALL DAY
Governance	November	09.30-11.30
Business/Data	December	09.30-11.30

Governance Agenda - As well as the trauma related issues TRauma Issues Database (TRID) and case presentations, there was work to reformat the governance meetings that would also focus on presenting examples of audits, research & posters developed by each organisation. Some examples have been:

- A rehabilitation poster and rib fixation audit developed by Royal Stoke University Hospital
- Head injury audit completed by Moseley Hall Rehabilitation Hospital
- An NHS.net repatriation address process developed by Russell's Hall Hospital, Dudley

- Trauma Call Audit abstract, Paediatrics CT Head radiation exposure article, poster at Hong Kong international EM conference - Pelvic trauma audit & pre-hospital diagnosis and NIHR-HECTOR underway at HEFT 1st Sept all from Heartlands Hospital, Birmingham.

Business & data meetings – continued along the same format with input from all organisations; Pre-hospital, Trauma Units, Major Trauma Centres, Rehabilitation, Network and data reports and audits provided by the data analyst regarding work previously requested by colleagues or reports generated from TARN data. Whilst there are standard general items board members are invited to submit any other agenda items for general discussion or data sharing. The board uses this format to feedback to pre-hospital providers.

T14-1C-103 Examples of data activity including MTC direct admissions, hyper-acute secondary transfers, urgent transfers and ISS>15 held in TUs covering are provided in the appendix 5, pages 9, 10 & 11 .

Performance & Quality Board *(PaQ)*
The Performance and Quality Improvement Board is part of the governance structure of the Midlands Trauma System. The Trauma Performance and Quality Board will be responsible for providing assurance to stakeholders that appropriate governance and operational arrangements are in place across the Midlands Trauma Networks. This is achieved through the monitoring of Performance and Quality information, reviewing policies and procedures, and overseeing Death Panel Reviews across the system. The PaQ may review individual cases where considered appropriate or may deal with overall summary information. The PaQ through its work will ensure that there is continuous improvement in the delivery of trauma care.

Meetings are scheduled on a monthly basis and are extremely well represented from members of all three networks and often including individuals or organisations that have invited by the group to present ideas or discuss problems facing provision, some of these have included the Regional Trauma Desk & trauma unit leads. PaQ also review audit and research requests such as the provision of pre-hospital of blood products and the development of a web based e-learning pre-hospital paediatric training package.

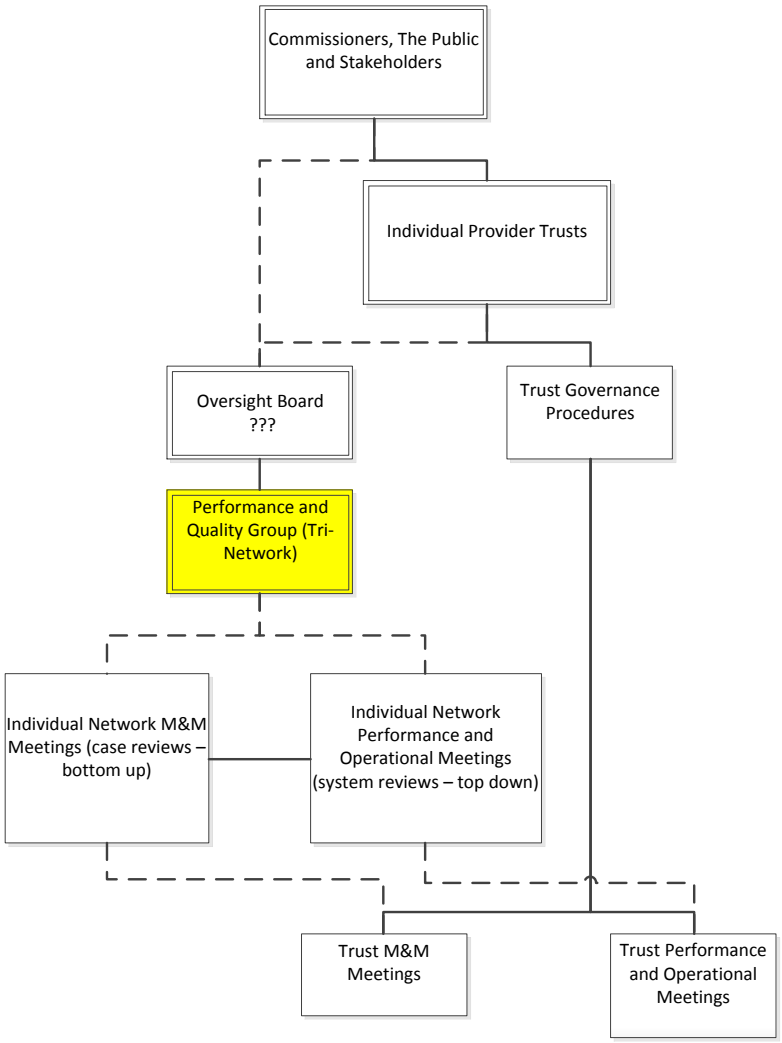
Sub Groups
There are a number of sub groups who meet as and when required, they include:
- Major Haemorrhage Work Group – who meet to discuss on-going and emerging issues e.g. training and education, blood products, stock availability, application of the major haemorrhage protocol etc. A representative of the National Blood Transfusion Group attends these meetings.
- Specialist Rehabilitation Services Group – meet to discuss capacity issues, staffing, data and service provision. The group are currently working on data accuracy and will reconvene in March 2015 to ensure data quality accurately reflects their current case load and performance. This should then lead to a clearer understanding of where pathway bottlenecks are occurring.

Management Team Meetings
Meetings are held on a regular basis each month where we review the team's work capacity and work plan, discuss outstanding actions, general management issues and plan forthcoming events.

Accountability

Annual Report
The network provides an annual report at the end of each financial year that provides a detailed account of quality outcomes, work plan achievements and a financial report.

Governance Framework
As detailed in the section Network Board Meeting, governance is a priority topic for the networks. The Midlands Trauma ODNs have adopted the principles outlined in the National ODN Governance Framework.



Regional Oversight Board

The Trauma Care System was fully supported in its implementation phase by a Trauma Programme Board. Once the networks were established the Trauma Programme Board had fulfilled its commitments, produced a closure report and therefore disbanded in October 2013 with the expectation that they would be superseded by an appropriate body.

In consultation with the Network's Host organisation it was recognised that the most appropriate body to support all of the Host's Operational Delivery Networks (Major Trauma, Adult Critical Care & Burns) would be an Oversight Board. The Host Organisation assumed the responsibility for identifying Board membership and establishing an Oversight Board to service the three ODNs.

At the time of writing this (draft) report (December 2014) the Trauma Networks have not been informed of any progression on this outstanding issue.

Trauma Newsletter

A quarterly trauma newsletter is produced and sent to all our colleagues across the Networks. The newsletter highlights any service development, reconfiguration, good news, training and awards and topics of general interest.

Making a Difference – the Patient Story

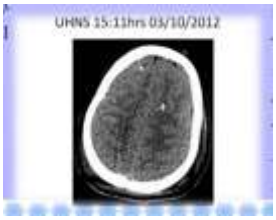
On 1st October 2012 BCUHB changed providers for Major Trauma. On the 2nd October 2012 there was a serious road traffic accident near Dolgellau . The 17 year old occupant of the car was seriously injured—she was taken by RAF SeaKing to Ysbyty Gwynedd and then transferred to the Major Trauma Centre, now known as the Royal Stoke University Hospital. Megan spent 44 days in ICU and over 8 months in hospital…….this is Megan's Story

Injury to Interview—Megan's Story

Hello, my name is Megan Jones. I was born a week before Christmas in 1994 and grew up in a loving Christian family in the mountains of North Wales. Being the third of four girls, Mum always said that being born was the easiest thing I did – everything else was hard work from then on! I was a mischievous, extremely strong - willed little girl who knew her own mind, and if there was ever trouble at our house, I was sure to be found out the main culprit! I did well at school, became head girl in year 11 and left my local school in Dolgellau with 9A*s and 2As - at that time my dream was to become a doctor. In 2011, I moved school to study for my A-levels as my previous school didn't have a 6th form. That winter, after doing my grade 8 piano exam and passed with distinction, I turned 17. Passing my driving test was very high on my list of priorities and I loved driving. I passed my test on July 31st, 2012 with only 2 minors. Feeling ecstatic and rather proud of myself, when the examiner said *"I am obliged to tell you that a high percentage of young people who've passed their test have accidents - let's hope you won't be one of them."* I nodded my head, but never considered for a second that I would be one of those 'young people'. Two months later, on October 2nd 2012, I went to school like any usual Tuesday, and afterwards Dad and I went for a haircut. I needed to borrow the car that evening to go to a job interview I had at a local hotel at 6:30pm. Mum met us at the hairdressers with the Clio I was insured to drive. She warned me there was a lot of water on the road due to awful rain we'd had that day, and to drive carefully. I replied *"Yeah, aquaplaning!"* rolling my eyes, like I knew all about it. I went to the job interview after visiting my Grandmother and got the job. Walking out of the hotel door is the last thing I remember...I was on my way home when I had the accident. An eyewitness account from a following vehicle said that I was driving at about 40-45mph when I hit water and a large spray rose on both sides of the car. The rear passenger side spun around 1800 and the car hit the kerb on the other side of the carriageway, spun in mid air, went over the metal fence of the adjoining field and barrel- rolled down a steep ravine. I was found hanging upside down out of the driver's window, the

engine was out of the car about 10 meters away and there was a round, dented, cracked circle where my head had collided with the windscreen even though I was wearing a safety belt. They thought I was dead when they saw me. I don't remember anything of that day (except strangely the job interview) and remember nothing of the following 7 weeks. The previous day (October 1st) April Jones had gone missing in Machynlleth and a crew of Mountain Rescuers were on their way down to search for her. They were the first on the scene with medical equipment and got me out of the car through the sunroof and gave me some adrenaline because my pulse was very weak.. My GCS was 8 on scene and paramedics soon realised that this was a serious incident and called for an air ambulance. An RAF Sea King helicopter was in the air above Dolgellau at the time – dropping troops off to go and search for April - and was at the scene of the accident within 15 minutes of me initially losing control of the car. I was airlifted to Ysbyty Gwynedd, and was in hospital within the 'golden hour'. After being sedated & scanned I was then transferred to Stoke-on-Trent as the first major trauma victim from North Wales. The contract between Betsi Cadwalader and UHNM had only been signed the day before. My story is a credit to our emergency services who were so efficient that night. I had critical injuries which included:

1. Closed fracture LEFT temporal bone
2. Fracture floor LEFT orbit
3. Intracerebral haemorrhage
4. Contusions LEFT frontal & RIGHT parietal lobes
5. Diffuse axonal injury
6. Tentorial haematoma
7. Cerebral oedema
8. Fracture RIGHT posterior arches C3 & C4
9. Fracture body C5



10. Facet joint widening
11. LEFT lung contusion
12. Laceration RIGHT elbow
13. Contusion over RIGHT distal humerus
14. Laceration to LEFT hand over 3rd and 4th metacarpophalangeal joints
15. Liver laceration

The total of my *Injury Severity Score* was 43. As news of my accident circulated people at home and abroad began to pray. I received the best possible care by the Critical Care Team in UHNM. I was placed in an artificial coma by the use of thiopentone in the hope that my Intracranial Pressure would lower because it was sky high due to my brain swelling from the shake in the car accident. An ICP monitor was inserted in my skull and my condition was stabilised to the best of the Trauma Team's ability. I came very close to having a craniotomy to relieve the pressure, but thankfully it never stayed too high for long enough, even though it was 50+ at times. For the first couple of weeks in Critical Care, things were getting worse, not better. Doctors described it as taking one step forward then three steps back: **October 7th**: My condition was deteriorating rapidly and no one knew why. A nurse called Vicky was working that shift with the consultant Chris Thompson - she had cared for me from the very beginning and is an excellent nurse. My abdomen had swollen massively and my condition was too unstable to be taken for a scan and Vicky thought I might be going into cardiac arrest..In the end things got so bad that the Doctors had to take the risk of moving me and taking me in for a scan in order to see what was happening. In the meantime my family were told to come and say goodbye to me because they didn't know how the scan was going to go. My family came to see me for what everybody thought might be the last time, as the staff were rushing the bed through the corridor.

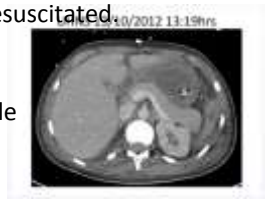
The scan revealed that the majority of my small intestine had become ischaemic. The surgeon came to tell my family the news and said he would have to operate to remove the ischaemic bowel that was poisoning me, and if more than two thirds was ischaemic I would not survive. In the early hours of the morning Surgeons undertook the task of removing the dead bowel . Over two thirds of my small intestine was removed – all who were in the theatre that night expected me to die on the operating table, but miraculously, I survived. **October 8th**: Because they had done the minimum amount of work needed to keep me alive the previous night, I was taken back into theatre to finish the operation. The plan was to fit a stoma, but there wasn't enough bowel left to do this. Surgeons had to join both ends together and hope for the best. **October 9th**: The thiopentone was stopped and my family were told if I were to regain consciousness it would be in 24-48hrs. I had 10-12ltrs of excess fluids in my body and weighed 11st or more.

October 10th: I had full blown Clostridium difficile - now my large intestine was suffering. This was near enough inevitable with the stress my body was under and all the medication I was on. I think the most important fact to highlight here is that nobody else in the unit has contracted C.diff. which goes to show how well the team managed the infection, and informed my family and visitors of the necessary requirements when visiting me (i.e. hand washing, gloves & apron etc).

October 11th: Mum was keeping a diary from the day of the accident and wrote on this day - *"No change, this is hard Meg."* I still wasn't responding even though the thiopentone had been stopped 48hrs ago.

October 12th: I suffered a brief asystolic arrest for no apparent reason, and had to be resuscitated.

October 13th: I had been running a very high temperature for days and even though numerous tests had been taken, no result indicated why it was so high; therefore they decided to scan me. The plan was to scan my abdomen but the 'happened' to scan a little lower and found that I had two, very large, deep vein thrombosis in my iliac veins. To prevent the clots from travelling to my lungs and killing me, a filter was placed in my vena cava. It was also discovered that there was a little collapse at the bottom of my left lung.



October 15th: *"It might not get any better than this."* Doctors prepared my family that I could possibly remain in a permanent vegetative state because I still wasn't showing any signs of response. Things were not looking good, I was still alive, assisted by the work of the amazing staff and machines. But gradually things did improve: **October 16th**: I opened my eyes a tiny bit. My eldest sister had bought a relaxing piano CD and was playing it in my room in ICU. Whenever it was played my ICP went up.

October 17th: I moved my right arm a little bit on my own for the first time, but my left side was paralysed for quite a while.

October 18th: One of my best friends, Joseff and his Mother, who is also a very close friend, came to see me. Before they left Siân she said "*Right Meg, I'm not leaving here until you've given me some 'A's on your ventilator machine."* Sure enough 3 'A' for 'assisted' [breathing] appeared on the ventilator.

October 20th: I opened my eyes and gave the weakest smile ever. Even though I was conscious now, I don't remember anything. Doctors still warned Mum and Dad that they were most likely to have a severely handicapped daughter, and they wouldn't have the same 'Megan' back. My Parents started considering a house move that would be better adapted for a disabled person.

October 25th: According to my parents Dr Brian Carr is a wonderful Doctor whom I hope to meet one day so I will be able to thank him for his work. He had been very concerned about my condition from the beginning. Whenever he saw my parents and Mum in particular, he would look so concerned and say things like *"I can't imagine what you're going through."* Mum had not once seen him smile. But on this day, when Mum saw Dr Carr, he smiled! She knew that I had turned some sort of a corner and was a little better.

November 2nd: My eldest sister, Alaw, and Mum were in the room with me, and for some reason they had a biro. I made a motion for them to give me the biro and when they did, I clicked frantically it so that the tip went in and out at lightning speed! They were so excited that I knew what a pen was, and gave me some paper to see what I would do. I scribbled something that didn't look like writing at all – but Mum could make out my initials – MAJ.

November 3rd: I wrote my name with a heart "Megan <3" Dr Chris Thompson who had assessed me the previous day was surprised to say the least!

November 13th: Siân came again and before she left this time she said *"Next time I come and see you I'll bring you a gift. What can I get you? A bit of bling or something?*" I still couldn't speak because I had a tracheostomy in, but wrote down on a piece of paper *"Siân's engagement ring."*. Now Siân has a beautiful engagement ring, with a large amethyst and diamonds around it! I don't remember asking for this, but Siân teases me that I knew exactly what I was doing! When my rehab consultant, Dr Alex Ball, saw that I'd written this, she knew that my recovery would be good – I'd come to a conscientious decision about what I wanted, drew a picture of the ring and it involved some humour too.

November 14th: I had coughed blood some days before, and I had an endoscopy to see why. Dr Lao discovered I had ulcers in my oesophagus, stomach and duodenum. The worst ulcers were clipped to prevent bleeding, but it was discovered that I also had an oesophageal stricture about 6cm long which apparently is common in Critical Care patients and the problem is usually sorted after one or two stretches. I was being fed via a Naso-Gastric tube at this time. Dr Lao did say at the time *"I think I'll have to do this again."* How prophetic were his words! I had the first stretch to the stricture in my oesophagus on this date.

November 16th: I moved from Critical Care onto a Neuro Ward…….I was in critical care for six and a half weeks in total, but I don't remember any of it. I was having some crazy hallucinations like being a drug addict riding a motorbike around the country, filling my petrol tank at different stations then driving off without paying! I had a line in my hand to inject the drugs and didn't want to hand cash over the till and reveal that I was a drug addict!

When I was discharged from Critical Care, Simon Davies – one of the Major Trauma Co-ordinators and a great guy – wrote that I was a *"Complex admission with several complications."* I believe this was putting it kindly! My first 'proper' memories are in the Neuro Ward. Like many patients post ICU I didn't feel safe on the ward, but despite this I felt a calmness that I cannot put into words. I still wasn't myself for many months, but I knew what had happened - that I was in hospital after a car accident. I felt that this all had happened for a reason – I wasn't sure of that reason yet but I knew deep down that God had kept me alive and worked miracles for a reason and surprisingly, I didn't feel resentment or bitterness about the situation.

One night I was having a nightmare (about a nurse!) and I pulled my tracheostomy out. I vaguely remember bells ringing and people rushing in – there was a panic because I couldn't breathe, until I vomited everywhere and could breathe again. When Mum came in the next morning and saw there was no trachy, just a gauze over the hole, she said *"I didn't know they were taking the trachy out!"* I wrote - *Took it out myself, it was a drama!"* Even though the trachy was out I made no effort to speak. This was causing concern that the brain injury might have affected my speech. But on November 22nd I whispered my first word when a nurse asked if I knew what month it was, in a weak voice I replied *"November"*. I was only on the neuro ward for 10 days, and then transferred to Haywood Hospital to a Specialist

Rehab ward – this would be my home for the next 4 months. I went to Haywood on November 27th and loved it at Broadfield Ward. I got on well with all the staff, the atmosphere was calm and quiet there and I could trust them. As a result, I've made some life long friends, and I've also been back to visit a couple of times.

I had my 18th Birthday on Broadfield, and it was such a special day. The fact that I was still here to celebrate my Birthday was a miracle, but everybody went to such an effort to make it extra special. I had my first bath since the accident (one of my favourite nurses made sure of that!) and that bath was the best yet. My Parents gave me an iPhone –the link to the outside world was great and I could now access the social media sites 24/7! In the evening some close friends arrived and I was allowed the day room to myself to have a 'party'! Christmas was a week later, and even though it was like no other Christmas we've had as a family before, this day again was also extra special. Mum went to Waitrose (a treat!) and bought food for a cold buffet and staff had laid out tables in the day room, so the six of us could eat together as a family.

On the subject of food, sometime during my time in Critical Care I was given an N.G. tube so that I could be fed (I pulled it out a few times when I was in Critical Care – I'm glad I don't remember that!). Earlier on in December the tube had been taken out in Haywood, and I was expected to start eating again. But I wasn't swallowing my own saliva, let alone eating food. I was assessed by a S.A.L.T. who thought that my swallowing was fine but when I ate I would regurgitate the food. Doctors thought my ability to swallow had been affected by the brain injury. I still wasn't a 100% myself; all I knew was that I couldn't/didn't want to swallow. I was taken back to UHNM Endoscopy Unit for investigations, it was discovered that the stricture had closed up tight, therefore explaining the regurgitating and lack of swallowing. On discharge form UHNM I had a Neuro Consultant – the wonderful Italian - Ms Erminia Albanese. I was also under Dr Alex Ball, who is equally wonderful, and was my rehab consultant but, at that time, I did not have a GI consultant. During my time in Haywood, I was in a vicious circle of NG's being taken out, trying my best and struggling to eat; I couldn't even drink I regurgitated everything that went down back up, a new NG being placed to 'feed' me and then Haywood contacting the Endoscopy Unit at UHNM. Then, I'd be taken to the Endoscopy for a stretch and be back at Haywood the same day, and the whole circle happened again. I was meant to be there to gain strength and do physiotherapy, but because I couldn't eat I was weak and underweight and I rarely had enough energy to do much exercise, it was a vicious circle. In the end I was placed under the care of bariatric consultant Mr Cheruvu, who ensured me that he wouldn't be performing gastric bypass surgery on me! He thought the best way to progress would be to move on from the stretching with a balloon, and to try a different method. He used rods to open the stricture, and this was a lot more painful and the stricture closed up faster than the balloon method. He considered removing my oesophagus and stretching my stomach up but after considering the state of my bowel he ruled against it. He contacted other gastro consultants up and down the country but nobody had any answers, they all agreed that he had a problem on his hands. The next move was to place a stent in my oesophagus; this was done on March 20th, 2013. I was taken back to Haywood on the same day, and for the next five days I vomited countless times. I couldn't even keep water down, and was placed on IV fluids. But my veins were so bad by this point that cannulas would stop working after less than a day! After the vomiting had continued for 4 days, I was x-rayed and it became obvious that the stent had slipped down and was holding the sphincter muscle of stomach open hence all the vomiting! The decision was to take me back to UHNM to sort out the slipped stent, Dr. Alex Ball insisted that I stayed under the Gastro Team until my complicated oesophagus was fixed! I missed Haywood terribly but I knew that Alex had made the best decision. I was in UHNM for the last two months of my time in hospital mainly under the care of Dr Lao and Dr Glass (two wonderful gastro consultants). During this time stents were fitted and clipped in place, slipped, and then another placed. One stent did stay in the correct place for four weeks, but this was a month of the worst pain I've ever endured so far. I was on oramorph, voltarol and other strong painkillers, but these only scratched the surface of the pain. I would get a spasm up my oesophagus so that I would double over in pain, and when these spasms occurred they would travel right up through my teeth to the front of my forehead. I was given several x-rays to see if the stent had slipped therefore causing so much pain, but it was still in place. The pain was a mystery. I didn't eat anything and relied entirely on my NJ tube for nutrition, but I did drink ice cold fluids that would give my hurting oesophagus some relief. After four weeks I was still struggling to drink. I needed another endoscopy; the next thing I knew, Dr Lao and Dr Glass' heads appeared through the curtain that was pulled around my bed. An unexpected slot had appeared and they were taking me down for an endoscopy right this minute. It was discovered that a membrane of skin had grown over the top and bottom of the stent. The stent that had caused me so much pain came out and I've kept it as a souvenir! A new one was placed and although I was in moderate pain, it didn't compare with the pain I was in before. The next day Mr Cheruvu came over to see how I was doing and found me sitting up in bed, eating some

fish and chips. He exclaimed – *"Look at her!"* pointing at me, *"She is a different woman! You can go home tomorrow young lady!"* That word – '*home'!* My discharge had been planned twice previously but didn't happen; this time I was not going to raise my hopes only to be disappointed again. I didn't think I was well enough to leave hospital, because I was weak, underweight and still receiving treatment for my oesophagus. On a gloriously sunny day on June 7th, 2013, Mr Cheruvu strolled into the bay and announced that I was to go home and come to into the endoscopy unit to remove the stent after 6 weeks or whenever needed. Mum and I packed my many belongings - after such a long stay in hospital I had collected quite a stash - three trolleys full, this included a supply of feed, giving sets etc and meds! So it was after 8 months and 5 days in hospital, I was finally allowed home permanently! I had been granted ward leave on several weekends from March to May, but those weekends felt like a holiday and by the Sunday night, I wanted to go back to hospital! It sounds bizarre saying that now, but I felt secure in the hospital and it was what I was used to after recovering from the coma, I suppose I had become institutionalised. The original plan to return to Stoke for a visit after 6 weeks at home didn't quite go to plan. After a few days home, I could feel my oesophagus closing up like it had in the past. I groaned inside thinking I would have to go back into hospital full time. I had the direct number to endoscopy, so we called and arranged to go back the next day. Sure enough, the stent had slipped; it was taken out and *replaced with a new one. Thankfully, it was only a day trip and I returned home after having a new stent fitted* the same day. For the next 6 months, I returned to the Endoscopy Unit in Stoke numerous time, every two weeks or so. In total I had six stents fitted and they all slipped. Dr Glass and Lao retreated back to the original form of dilatation using a balloon. I didn't enjoy eating and relied heavily on my Nasojejunal tube which had been in since May. Food hurt after I swallowed and I had to drink a lot of water to wash anything I swallowed down. As my stricture was completely 'unique' medics didn't have a clear plan of what to do, but had to 'play it by throat' (mind the pun!). I knew my oesophagus so well by now, that I could tell when it was time for a dilatation. Around October 2013, Dr Lao had a brainwave. He thought of injecting the steroid 'kenalog' intramuscularly into the stricture itself would reduce inflammation and prohibit the formation of fibrous scar tissue, therefore aiding the healing. This was done late October and the results have been fantastic. On December 20th, 2013, my NJ tube was removed because it was thought I could manage without it. My face felt naked for weeks without it, and I looked like a 'normal' person now! Since this, things have been getting **better and better**. In February 2013, I was discharged from the neuro perspective by Ms Albanese who couldn't believe the extent of my recovery and the fact I am still the same girl I was before and can still play the piano! In September last year I started school again part time and did my AS year again to see how I would cope. Things went well, and I remembered all of the work I had done! There I was, sitting in class thinking *"I remember all this! What's the point?!"* I'd have to remind myself that it was a miracle I was even alive, let alone being back at school and remembering all the work! Things could have been very different. As the weeks passed, I was regaining strength and going for physio (although doing the exercises at home rarely happened!). In September this year I returned to school full time to finish my A-levels with a clear ambition in sight. I want to become a nurse. Having received such excellent care from so many different individuals, I have been inspired to care for others in the same way I liked to be cared for. To work for the NHS would be an honour after it has done so much for me and I would feel so privileged to care for others. Instead of playing the victim of a terrible car crash and a horrific past two years, I can channel the insight I gained to being a patient and all the countless things I learned in hospital, into something positive that would aid others! I submitted my UCAS application to study nursing in November and have received three offers to come for an interview, I'm still waiting to hear from Edinburgh University. On December 11th, I attended Keele School of Nursing for an interview; it seemed to go much better than what I'd imagined. I will know if I've been successful in 2-3 weeks. It would be amazing not only for me, but also for those who cared for me in Stoke (and the Haywood), to see me doing my nurse training at the hospital where I was a patient for so many months! I have an interview in Southampton for dual nursing (adult&child) on January 9th and in Swansea on the 23rd of January – I'll be sure to let Sue [O'Keeffe] know how they've gone! Working for the NHS would be something so worthwhile to do with my life after being given a second chance, and I'd love to give something back. I have told my story at numerous events over the past 18months, one of which included a Major Trauma Event in St Asaph, organised by Sue. After I had finished presenting, Sue announced a surprise; a man came up and gave me a big hug. Sgt Paul (Haz) Hunter was the paramedic who was in the Sea King helicopter with me on the way to Bangor–I almost burst into tears in front of everyone. It was amazing to see another individual who had played a crucial role in my story, and then to be able to thank him in person. Many people who participated in saving my life are yet still to be met and thanked, but I am so, so grateful to each and every one of them.

I still have to go back to Stoke for dilatations, but as a result of the steroid injections, the stricture is closing much slower. A year ago I was going back for stretches every fortnight – I've now gone without and dilatation for 12 weeks, which is just fabulous! Eating is much improved, and less water is needed to 'wash the food down'. When I do go back, I try and

arrange it so that I'll be on the propofol list. I've had 35 endoscopies and a side-effect of having midazolam so often is that I've built a resistance to it.!! That's my story so far...I'm so excited; hopefully there will be more to add in the future. I hope you're inspired by it - it proves that the work you do in the healthcare profession does change lives for the better, and I admire you all so much for what you do. I cannot thank the trauma team, specialist rehab team and the NHS enough. We are **so** privileged to have the NHS, people are all too quick to criticise it instead of appreciating it. Whilst it is important to acknowledge mistakes and learn from them, I think it is also important to focus on the positive aspects and changes. As Helene Donnelly (ambassador for cultural change in the NHS) said *"There is no room for negativity now."* I will continue to share my story and give the NHS, Trauma and Rehab team the praise they deserve. By the grace of God, and your hard work I am alive and I am so happy that I can share my story with you. *Yours, Meg.*

Ongoing Key priorities for the future

Effective collecting and reporting of TARN and other appropriate data sources

We will continue to deliver a high standard of quality and performance monitoring and reports through appropriate forums and boards. We will utilise existing data sources for Trauma to compare and contrast provider organisations performance and provide service users and commissioners with relevant performance reports that demonstrate where improvements should, can and have been made against nationally and locally agreed standards. We will continue to deliver open transparent data analysis and review using areas of best practice, to support under performance thus raising the overall level of service provision.

Annual work plan for the ODN to deliver the national strategy and outcomes.

We will continue to develop an annual work plan with our network that will reflect national strategy, local issues and areas identified within the ODN service specification. The plan will be reflective of the needs of our network colleagues and their feedback over the past year as well as addressing future requirements.

Providing professional and clinical leadership across the networks.

We will continue to provide advice, guidance and leadership for respective professional disciplines across the ODN's. Ensuring that all professional disciplines with Trauma have access to relevant 'clinical leaders' to promote and support them including regional support. There are a very small number of trusts personnel who are planning to hand-over clinical leadership over the next year and we will continue to support them during this time of change.

Trauma Issues Database

A TRauma Issues Database (TRID) will be maintained, but we hope to enhance the visibility and access to it by installing the report form on our website that we hope will improve the reporting mechanism. We will provide 'trend' reports to our trusts/organisations and use it to identify potential service improvements.

Review existing Policies, guidelines and protocols

We will continue to ensure our trauma handbook is both current and reflective of best practice and national/international policy. Where required develop new policies, guidelines and protocols that are fit for purpose and embedded in practice.

Education and Training

We will maintain the level of training and education currently provided and where necessary enhance and support learning within the network that exceeds the minimum requirements and strives towards the aspirational as detailed in the Trauma Handbook reference number 54.

Effective linkage into local Clinical Commissioning Groups (CCGs)

We remain positive that we will establish collaborative working with CCG leads for their commissioned services, ensuring services are fit for purpose or where required remedial plans are developed to resolve any performance related issues. The Peer Review programme for 2015 and subsequent reports should act as leverage in commissioner engagement.

New Key priorities for the future

Oversight Board
Our governance and accountability framework will be greatly enhanced by an Oversight Board and as previously stated we eagerly await the final develops of this Board by our Host organisation.

Network capacity reporting will be managed through the NHS Pathways DoS.
Recently implemented the capacity monitoring through the 'national' system will enable capacity reports and compliance reporting to appropriate organisations. We will follow National recommendations on escalation/surge monitoring and reporting via DoS and use archived and current activity data coupled with national intelligence to identify pressures in the system and support local and national colleagues in managing demand. We will ensure that escalation plans fit with local and national requirements and include partner networks e.g. Burns.

Reviewing work-load within Trauma services
Utilising current data sources to identify and action any evidence relating to work-load impacting on quality of care, any outliers or exception in activity data will be reviewed and analysed to ascertain the impact work-load may have had.

Partnership Development and Collaborative Working
We aim to work more collaboratively with the other ODN's and/or SCN's and related sub-groups and stakeholders. We will develop better opportunities to engage with patients and third sector organisations that will contribute to service development.

Support and promote clinical research
The network will promote, support and encourage any current emerging or clinical research as appropriate including injury prevention programmes, innovations & publications.

Pre-Hospital TARN reporting
The Network will work with all Pre-Hospital providers to facilitate the capture of trauma related pre-hospital deaths.

Summary and Way Forward

Since our last national peer review much work has been done by the network management team to streamline the processes, meeting formats and work plan activities we use so that they are coherent and work for all 3 networks in our region when and where required.

There is much more work to be done over the next year to address some specific activities in our region. Our key topics include:

a) Patient and public involvement.
b) Care closer to home and rehabilitation provision across the region.
c) Network accountability to an Oversight Board.
d) Effective links with CCGs.
e) Emergency and Resilience Planning with trusts, pre-hospital providers and area teams.

There are some new and exciting developments on the horizon e.g. a Paediatric Training – E-learning Package being developed by Birmingham Children's Hospital.

Finally, we will continue to share best practice, learning from each other, share data, improve communication between organisations and strive for any and all opportunities to enhance the trauma care we provide in our region.