Annual Report

2017 / 2018

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1. **Clinical Director's opening comments**, by Kelvin Wright, Clinical Director South West London & Surrey Trauma Network (SWL&STN)

I would like to welcome you to this annual report for the South West London and Surrey Trauma Network (SWL&STN). Active as a network now for 8 years we are reaching a landmark time in our story. 2018-2019 will be the end of a decade in a new style of major trauma care and it is worth reflecting back on where we started.

We started this project in 2008 with meetings to determine the nature of the network and all of our stakeholders' key priorities for the future. These meetings shaped us and indeed our early aims of better access, right care in the right place at the right time are all being met. There is still much to be done and we have to maintain the trauma system as a key priority when we all meet with our various contacts. As the NHS faces new challenges it is easy to put 'Major Trauma' into the sorted box yet those of us delivering know full well the extent of the work remaining as well as maintaining the momentum.

Many people make the network function and without their help and passion I could not move this network forward. I would like to thank all stakeholders for their continued support and engagement. The individual support groups across the network and their work on specialist projects remains key. In another year punctuated by uncertainty, terror events and the challenges of the uncertain world we find ourselves in. This report has a section dedicated to the work of the Emergency Planning group who have supported the network with this workstream.

As I look forward to the coming year it will become time to review and revise the five-year strategy. This has guided us previously and although 'no plan ever survives contact' ; it is vital to have a vision that can form a frame with which to progress. The vital areas we chose previously (Head injury, Spinal Injury, Vertebral Column injury, Complex Musculoskeletal injury, Elderly trauma, Public profile, Governance and Research) all remain high on the agenda but there will be new areas to concentrate on. While we do this is it crucial we don't allow those areas in which we have succeeded to slip. As all of our emergency departments are under huge pressure to deliver around targets - the ongoing correct care is an absolute must. We must drive on with our work for identifying elderly trauma and early imaging/triage of these patients.

I hope you will enjoy reading this report and celebrate the success of your network.

2. **Major Trauma Centre update,** Heather Jarman Clinical Director, Major Trauma Centre, St George's Hospital

St George's Hospital has been the Major Trauma Centre (MTC) for South West London and Surrey since 2010. The MTC works as part of both a larger regional (London) and national system of trauma networks that ensures major trauma patients are treated by specialists with training and skills to manage this complex and life-threatening injuries. In 2017 / 18 we provided care to over 2300 of the most severely injured adults and children.

There has been a political and press focus on knife crime over the last year, with an increase in the number of young people being killed or injured with weapons. St George's has been affected by this increase and as part of a strategy across London to reduce the impact of youth violence we have continue to grow our youth work service to support high risk young people. We do this in partnership with Redthread, a charity that supports young people, through youth workers 'embedded' in the Emergency Department and in the major trauma service to provide support during their time in hospital but also following discharge. You can find out more about this important work at www.redthread.org.uk .

It is of course important that staff have the specialist skills and knowledge to care of patients with complex injuries and the last year has seen a number of newly develop opportunities for major trauma centre staff. A number of nurses attended the first UK 'Trauma Care After Resuscitation (TCAR)' course aimed at developing the knowledge base of ward staff, and surgical doctors where are to attend the first TALONS course teaching damage control surgical techniques in the most severely injured patients. This was the first course aimed at doctors in training and involved trainers from across London, including Mr Gary Maytham a vascular surgeon at St George's.

Patients with severe injuries have a complex and often long pathway to recovery and rely on the skills of a huge range of specialists and allied health professions (such as physiotherapy, occupational therapy and dieticians). We continue to support patients and their families through their recovery with access to appropriate services. Following hard work with a number of our patients, staff and development team at Bridges self-management we were delighted to launch a series of self-support tools for major trauma patients and families to support them through their recovery.

In addition to our clinical services, we are active in a number of research areas around the care of major trauma patients. This is an important part of the MTC work and ensures that care and treatment is as up to date and innovative as possible. Some of the areas we are researching

are elderly trauma outcomes, major traumatic bleeding, visitors experiences of intensive care and head injury.

We said a sad 'goodbye' this year to Lucy Silvester, our major trauma consultant therapist, who has relocated with her family out of London. She will be missed for her dedication and leadership to the therapy services for major trauma.

I would like to personally thank all the clinical leads for the specialties that make up the major trauma service for their hard work and commitment. The expertise of our staff at St George's is recognised through representation at both national and regional level in a number of advisory groups developing major trauma care. All those working with major trauma patients at St George's are justifiably proud of the work of the MTC and the dedication to excellence for patients and staff.

3. Network updates

In year five of our strategy it is good to celebrate success. During a time of bed pressures and challenges in the Emergency Department we have reduced our length of stay for rib fractures as a network contributing to the greater success of the system as a whole. Based on national data from TARN we have seen the length of stay fall from 2014 figures of a mean of 11 days (6-20 range) to 2017 figures of a mean of 7 days (5-15 range). It is not just about length of stay. We want to see a clinical improvement and the same data shows that in the same period we have reduced mortality from rib fractures. In the under 65 years of age we have reduced mortality from 8.9% to 3.7% across the network and in the over 85 – a key group for the strategy we have reduced it from 37% to 17.6%. This has however shown us that we may well need to redefine 'elderly' in order to bring success to the group between 65 and 85 years of age.

Research is a way of forming the future. The network participated in the Pan London TriBAL study which looked at head injury management. These results were presented at the conference and it became clear just how many head injuries are looked after, very effectively in Trauma Units. Something, I suspect, many of us knew from our day to day lives. Opportunities for research in major trauma tend to be very major trauma centre focussed and it is to the credit of all our stakeholders that they engage in these projects when opportunity arise for trauma units to also participate.

Education across the network is an important part of what we do. In 2017 we ran a network Trauma Intermediate Life Support (TILS) instructor day to facilitate TILS training across the network. All of our stakeholders are carrying out education be it Advanced Trauma Life Support, Advanced Trauma Nursing care, European Trauma Course or local teaching. 2018-2019 must be a year in which we join up these efforts and try and develop a network educational plan. This will not detract from individual hospitals own plans but help collaboration, increase faculty sizes, allow for a multidisciplinary approach and generally show a cohesive framework to learning.

2017 saw our 4th Biannual Conference. A wide range of speakers covered topics across the whole trauma agenda and reinforced the multidisciplinary nature of our work. Trauma Co-ordination, Rehabilitation – a patient journey that moved the entire audience as well as Major Incident updates together with a rather co-incidental opportunity to practice in chemical protective suits continued to make this one of the must attend events in our calendar. An ever growing range of external delegates shows the network as a leader in the local and regional health system.

The network awards also formed part of the conference. This was the network's chance to say thank you to the teams on the ground for their day to day support to the network
It was also an opportunity to say goodbye and thank you to two individuals who had worked to deliver the network's agenda. Jackie Thompson, Network Nursing Lead, and Lucy Sylvester, Rehabilitation Director, have both worked with the network for many years and had helped form the current state of the Network.

Communication is absolutely key for the network. The availability of information both routine and in a crisis can make all the difference and the year saw a complete overhaul of the network website – www.swlandstn.com. Updated protocols based on local and national learning provides end users with crucial information at their fingertips, in the bed space.

One of the important areas is disaster planning. The website dedicates a whole section to this with resources from national sources as well as local guides for those 'on the ground'. Network representatives have been responsible for both leading and delivering on Regional Emergency Planning for our network and the capital.

Support for staff was highlighted as an important area for those involved in the tragic events of 2017 and led the network to hold a Trauma Risk management (TrIM) study day. This gave us the chance to explore means of supporting staff at times of crisis – particularly after major incident type events but also in our day to day lives. We hope the key learnings from will from part of local plans and processes.

Our pre-hospital colleagues have been busy. The Kent, Surrey & Sussex Air Ambulance Trust (KSSAAT) has recently commissioned the first of two new AW 169 helicopters into service. They are the first Helicopter Emergency Medical Service (HEMS) in the world to operate these aircraft in this role although others are now following their lead. The medical interior has been specifically designed by the KSSAAT team to allow patient interventions to take place in the cabin, which is a first in the UK, and they are hopeful that they might be able to undertake some of these interventions in flight eventually. The helicopters have far greater endurance, speed and lift than those KSSAAT used to operate and these capability enhancements are already have a significant positive impact on trauma patient care.

We also welcomed Fionna Moore as the new medical director at SECAMB along with Daren Mochrie as the chief executive. Fionna has been a longstanding member of the network from her time as the lead for the London Trauma System and her work in the London Ambulance Service. Since being in post SECAMB have launched a new pre-hospital triage tree. The development of new isochromes and pathways can only improve our patient's pathway.

2018-2019 must be the year of Rehabilitation. The network owes a huge debt of thanks to Lucy Sylvester for all her work as our Rehabilitation Director. Her profiles regionally and nationally are a credit to herself, St Georges and the Network. The passion of the rehabilitation group owes so much to her as well as the individual members who drive it Kate Galloway has taken over the role of Rehabilitation Director. Kate has been active with the network for many years and this represents a natural progression for her as she leads the Rehabilitation agenda across the Network. Kate will be working with the Rehabilitation group to launch the new network wide template rehabilitation prescription – more in the rehabilitation section.

All in all, it has been an extremely busy year, with much achieved and still much to do. 2018 - 2019 promises to be just as busy.

4. Network Data and Governance

As ever we have maintained and used our governance log to guide our process and improve the care of our patients. In the last year there has been no serious network incidents reported and no incidents of harm. The main issues reported have been related to communication, image exchange and some referral issues relating to understanding and using the right the pathway. Through our clinical advisory group (CAG) and the network board these have all been discussed and resolved. Where needed policy revisions have been made to strengthen our pathways'. The discussions around these cases at both forums have are always interesting provide some useful insights and robust learning for all. The commitment from all of the stakeholders continues to strengthen our governance.

TARN is still the public face of major trauma data and this is why so much effort has been put into supporting our data teams and enabling trusts to use their TARN data as a way of driving service improvements. The chart below shows our year on year data from the TARN website.

Hospital Name	Case ascertainment 2015 %	Case ascertainment 2016 %	Case ascertainment 2017 %
Ashford and St. Peter's Hospitals NHS Trust	**81 - 95**	**55 - 65**	**85 - 100**
St Peters Hospital Chertsey			
Croydon Health Services NHS Trust	**58**	**64 - 80**	**42 - 49**
Croydon University Hospital			
Epsom and St Helier University Hospitals NHS Trust	**77**	**70 - 80**	**56 - 65**
Epsom General Hospital			
St Helier Hospital			
Frimley Health NHS Foundation Trust	**88 - 100+**	**89 - 100+**	**100+**
Frimley Park Hospital			
Kingston Hospital NHS Trust	**65 - 76**	**73 - 85**	**64 - 75**
Kingston Hospital			
Royal Surrey County Hospital NHS Trust	**78 - 91**	**85 - 100**	**92**
Royal Surrey County Hospital			
St George's Healthcare NHS Trust	**81**	**80 - 97**	**87 - 100+**
St George's Hospital			
Surrey and Sussex Healthcare NHS Trust	**67**	**100+**	**100+**
East Surrey Hospital			

A case ascertainment of greater than 85% is crucial as this enables meaningful statistical conclusions to be drawn. Monthly feedback and reports from TARN together with advice re case selection and locating suitable cases for entry has assisted in the improvement across the network as well as the efforts from dedicated individuals within trusts who have worked to deliver on this network target. The network continues to work with those areas below 85% to help them reach the set level.

TARN data also shows that overall the network has a positive survival rate (WS score. On average there is 1 to 2 additional survivors per hundred patients across the network .

Peer reviews of all seven trauma units were also carried out by the network in 2017. The national quality indicators (TQUINS) and the Pan London standards for trauma units were both used. The visits supported by local CCGs and again showed high levels of engagement and motivation across the network. No areas of clinical concern were raised. Some process issues like time to CT for patients with head injuries were identified as were issues with TARN data collection. These concerns formed the focus points for the six month follow up visits and action plan development.

The visits were also a chance for the trauma units to show case areas of innovation. Several trauma units are trying new ways of working within their EDs as a way of delivering good quality trauma care, this includes paramedics working alongside the nursing staff in the emergency departments.

The network was also self-assessed against the network TQUINS. Due to the work done by the CAG all of the required protocols and pathways are now in place. This meant the network was is complaint against all of the TQUINS.

Governance around the elderly patient with trauma has been a key objective for the network. The need to identify this group of patients early has been a significant area of work in the last year and continues. Initiatives at Croydon and Kingston have driven national triage tree development and pan London policy. These units are to be congratulated for their work here and keeping their hospitals and the network at the forefront of policy development.

In summary, the network remains proactive in all areas of governance and continues to perform at a high standard.

5. **Elderly trauma developments,** by Croydon University Hospital and Kingston University Hospital

The Trauma Audit Research Network (TARN) report into elderly trauma was published in April 2017 and placed a large focus on enhanced triage processes to identify patients with elderly trauma. The typical major trauma patient in the TARN database has changed from being young and male to being older with a lower degree of male predominance. A fall of less than 2metres is the commonest mechanism of injury in older patients.

Pre-hospital triage systems do not accurately identify older major trauma patients. As such they are brought to Trauma units, such as Croydon and Kingston university hospitals, instead of a Major Trauma Centre. The report highlighted that they are managed by a junior doctor and have delays in imaging, diagnosis and care.

Working with ED practice educators Croydon and Kingston have developed their own triage tool (based on pre-hospital tools in the literature) to identify potential major trauma in elderly patients who have had a fall from standing. If a patient triggers on the tool they have an urgent Primary Survey assessment by an SpR or Consultant and early delivery of analgesia, imaging and necessary management. The clinician may also trigger an in house trauma team assessment or a full Trauma team activation.

Croydon and Kingston are the first two trauma units in London using such a triage tool to identify elderly trauma patients. The education surrounding its implementation have qualitatively enhanced management of elderly trauma patients in the ED at both Croydon and Kingston. Significant reductions in the rates of missed injuries have been achieved and improvements in process measures such as time to imaging and initial assessment by a doctor can be seen. This has occurred within the constraints of departmental pressures that include factors such as ambulance offload times/ exit block that have heavily impacted on these projects.

Elderly Trauma: Can We Identify Those With Moderate or Severe injury?

Dr Y. Graichen[1], Dr H. Tucker[2], Dr D. Peel[1]

1 Emergency Department, Croydon University Hospital 2 Emergency Department, Kingston Hospital NHS Foundation Trust

Aim

To develop and implement an in-hospital emergency department trauma triage tool to identify moderate/severe traumatic injuries in patients over 65

Background

- An older person suffering a fall from standing is now the typical injury mechanism on the TARN database[1].
- Elderly patients with moderate/severe trauma often present to, and are managed in, Trauma Units rather than Major Trauma Centres.
- Current pre- and in-hospital triage does not always detect injuries in this population, leading to delayed injury recognition and treatment and increased mortality.

Methods

A triage screening tool was developed[2,3], based on existing non-validated tools. Those who triggered on the tool received an early, senior doctor, primary survey at triage, appropriate early imaging, and timely management.

Acutely short of breath
Uncontrollable major haemorrhage
Severe pain

ANATOMY OF INJURY

- Significant Injury to >= 2 Body regions
- Suspected head or spinal injury
- Suspected chest injury
- Suspected Pelvic injury

PHYSIOLOGY

- Systolic BP <110MMHg
- Heart Rate >90bpm
- GCS<15 (even if baseline)

Lactate >2 or BE < -2

OTHER

- Patient on anticoagulant medication or has a bleeding disorder

Fig 1. Amber criteria (extract from triage tool)

The primary outcome was rate of secondary imaging/missed injuries.
Secondary outcomes were times to initial assessment, senior assessment, and imaging.

The tool was initially trialled retrospectively on 200 case notes of patients over 65, presenting with a fall. It triggered more trauma calls and reduced the missed injury rate.

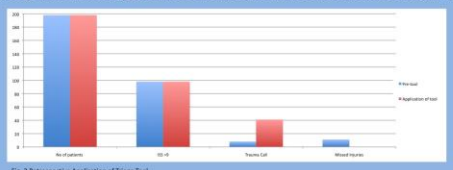

Fig. 2 Retrospective Application of Triage Tool

IMPLEMENTATION

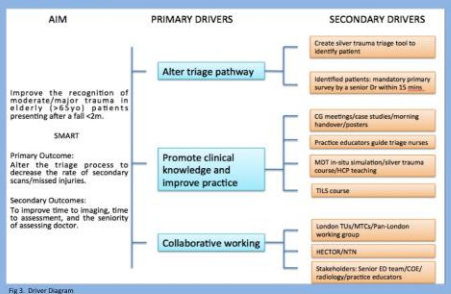

Fig 3. Driver Diagram

Simultaneous QIP's at two trauma units followed 4 cycles of Plan, Do, Study, Act (PDSA) methodology, with extending hours of implementation.

References:

1. Major Trauma in Older people, Trauma Audit Research Network, April 2017
2. London Major Trauma System, management of elderly major trauma patients, Feb 2017
3. Heartlands Elderly Care Trauma and Ongoing Recovery Programme course manual, v1.0, 2017
4. Wierman HA, Erskine T, Caterino J, et al. Members of the Trauma Committee of the State of Ohio EMSB. Development of statewide geriatric patients trauma triage criteria. Prehosp Disaster Med 2011;26:170–9

Results

Implementation of an elderly trauma triage tool reduced the incidence of secondary imaging in those over 65 presenting with a fall from standing.

Pre-implementation mean CT scan rate was 23%. Post implementation the mean rate was 13% if the tool was used and 44% if no tool was used.

Use of the tool reduced the time to initial assessment, the time to assessment by a senior decision maker, and time to initial, appropriate, imaging.

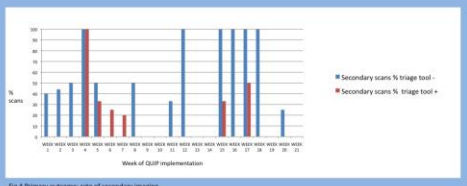

Fig 4 Primary outcome: rate of secondary imaging

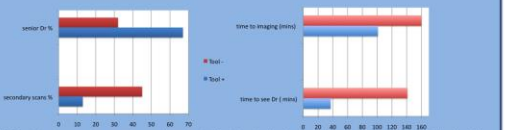

Fig. 5. Secondary outcomes: senior assessment, secondary imaging rates; time to imaging, time to senior decision maker assessment pre- and post-implementation

The sensitivity of the tool was 90%. The specificity was 40%. PPV: 71% NPV: 90%

Multivariable analysis of tool criteria: heart rate, pain score, VIEWS, anticoagulants, pelvic injury, and injury to greater than two regions: all significantly, independently, associated with ISS >9.

Discussion

The triage tool enabled earlier imaging and detection of traumatic injuries. This facilitates earlier appropriate management of moderate and severe injuries, with patient, hospital and trauma system benefits.

Challenges:

- Unexpected disruptions/interpretations/non-compliance with change
- Senior-decision maker and staff fatigue
- Need to identify champions and key stakeholders to ensure sustainability
- Change in the context of departmental pressures and other demands
- Improving process measures in the context of departmental pressures
- Low tool specificity leading to high over-triage rates and team fatigue
- Tool must be introduced alongside education and staff awareness

Next steps:

- Improve specificity to reduce over-triage rate and resource fatigue
- Further prospective validation of logistic regression analysis of criteria
- Extrapolation to other units/pre-hospital viacollaborative research networks

Conclusions

- **Introduction of an elderly trauma triage tool alongside an MDT education program reduces the rate of secondary imaging and missed injuries**
- **It leads to early senior decision making, appropriate early imaging, and timely management, thus improving the care of elderly trauma patients**

Acknowledgements:

Dr Mayank Agarwal, EM Consultant, Croydon University Hospital
Dr Robert Lee, FY2, Croydon University Hospital

6. Patient stories

The patient stories below are extracts from the '*Bridges to recovery after trauma'* book, coproduced with Bridges Self- Management, St Georges MTC and their patients and families

Millie:

I was in hospital for a total of nine weeks, in which I had seven operations. When I woke up, my brother and sister-in-law were there. It was Friday and I was in intensive care.

When I woke up, I was unsure whether they had taken my leg and avoided looking down. Later that day, I asked a nurse and they told me...

At that point, I slightly lost it.

The next thing I heard was that I needed to have more major surgeries for my other injuries - in the lead up to my second surgery I thought I was going to die, I was paranoid that something was going to go wrong.

When I came back up from that surgery, I was moved to the high dependency unit. I was in a lot of pain at that point and they tried me on different painkillers. I remember having a night of hallucinating. After a couple of nights, they moved me to the ward and I think that week they sorted out the pain and things got better.

In hindsight, I didn't really know what was going on during the first week or two in the hospital. My head was all over the place. It was all a bit of a blur.

I lost my mum. I think the painkillers de-sensitised me to everything and it maybe didn't really sink in at that point.

After they had sorted out my pain, I was kind of okay for a few weeks. I had my family and friends coming to see me most days, which was very important.

When I came off the painkillers, reality hit, I woke up crying every day for about two weeks.

After being in hospital for nine weeks, I was unable to start rehab straight away. I had a month out until my fractures healed.

My family wanted me to stay in hospital until I was ready to start my rehab, as none of their houses were set up for me in a wheelchair. I felt very lonely. I was beside myself and didn't sleep.

As far as I was concerned I didn't need to be there because I wasn't sick anymore. At the end, I went home for a few days, then I went to stay with a friend and went back to my dad's house from time to time.

I hated the rehab centre. I hated to see other people with stumps, it was so quiet there - I flooded with tears.

After my rehab, I went on holiday for a week and then came back to work full-time. Going back to work was the most important thing for me. I felt that I had way too much time not doing anything.

I was really lucky in that I haven't really had issues with my stump, so working was no problem.

After a year, I felt emotional generally as I was dealing with a lot on my own, I didn't want to be that person, so I saw a counsellor and that helped.

I wanted to do a sport that I did before and I knew it was possible to ski. I wasn't any good at first, but after some time I got it. I really love skiing. My ultimate aim is to do a sport where no one can tell whether I have an amputation.

David:

In hospital:

After my fall from a ladder, the operations and the discomfort afterwards were intensive for a while. It helped me to move around from bed to bed meeting different people – both patients and staff. The social side of being in hospital was very important. I spent most of my time talking or doing some work on my laptop. I had the accident on a Friday and emergency operation on Friday evening. I run a small business and it was important to try to keep that running, so, I was already working by the Sunday.

Getting home:

We got ramps so I could get into the kitchen and dining room which was really important to me.

The first day I was home, my family took me for a trundle to the park. It was an exciting day out. After a week, we went to a restaurant. It meant a lot to me to be able to enjoy something like that. There they asked me; "'Would you like to use the lift, sir?" It's amazing how some people take an interest and care about making things easier for you!

Setbacks and worry:

The cage was taken off my leg. Two days later, when I was getting in the car, that leg broke. Back in hospital for an operation I was worried whether I would ever walk properly again or even lose the leg.

Life now and measuring progress:

As a Chartered Building Surveyor, I spend the whole day walking around an estate somewhere. I am getting on with my normal activities as best as I can. Last September was the first time I was able to do archery.

I measure my recovery through seeing people's lack of reaction to me. I went to a meeting and I was the last to turn up. They saw me parking and it was the first time nobody had said; "How is it going? – How are your legs? – You're walking better." It was like normality had returned. All of a sudden, you feel you can take on challenges and you're able to feel how you have improved.

7. **SWL&STN meeting - Emergency planners,** Kristel McDevitt, Chair and Emergency Preparedness Manager at St Georges University Hospitals NHS FT.

The SWL&STN Emergency planners group continue to meet on a quarterly basis, with the strength of this group attributed to an open and honest discussion by members on the challenges we may face, the sharing of best practice, whether from a declared Major incident and / or Business continuity incident, or from exercises (trust and multi-agency) that we can usefully adopt within our own organisations. We also review guidance published by the NHS England Emergency Preparedness, Resilience and Response (EPRR) teams in National, South and London offices.

In the 2017/18 NHS England EPRR Core Standards assurance, and review of Strategic Assets - Major Trauma Centre, it was highlighted as an area of continuing good practice that we showed: '*Full integration and leadership within the South West London and Surrey Trauma Network*'.

The main focus of 2017/18 has been on Mass casualty work streams, and the learning from 2017 terrorist incidents. The group is fully committed and engaged in workshops and briefing events that have occurred and we fully support the work taken forward by Kelvin Wright and Leila Razavi on the SWL&STN Major incident and Mass casualty guidance.

We are also pleased to note that on 3rd July 2018 the SWL&STN will be hosting a trauma network exercise, **Exercise Buzzard,** which we hope will be an excellent opportunity for trusts to test their Major Incident / Mass Casualty response and how this supports a wider network response.

The objectives of the exercise, as laid out by NHS England, are to review the immediate response of Trauma Centres, Trauma Units and Emergency Departments to a mass casualty incident, explore the network command, control, communication and coordination procedures in response to a mass casualty incident and identify any learning for future development and improvements to inform the production of a Network Mass Casualty distribution plan

We look forward to carrying on the good work into 2018/19 and imbedding lessons identified from this exercise and as we move forward, exploring a closer link with other trauma networks in London and across the UK.

8. **Network Rehabilitation Group Update** , Kate Galloway, Rehabilitation Director, South West London & Surrey Trauma Network

The network rehabilitation group continues to be dynamic, pro-active and engaging. We actively share best practice and ideas surrounding major trauma rehabilitation, including clinical practice, research and service improvement. In the previous year, our head and spinal champions within the network have continued to strive towards best practice, including local MDT training and pathway development. A first version of a network- based rehabilitation prescription has been created with fantastic engagement of my wider rehabilitation colleagues in it's use. Tools have also been created to help assist in this process. Links with TU TARN co-ordinators have strengthened with our rehabilitation colleagues, thereby broadening our knowledge in the wider trauma field. Training continues to be a strong feature within each of the units across the network and clinicians are actively involved in audit and service improvement, including a review of outcome measures. There was a study day hosted by the MTC in external fixation and audits have included investigating the effects of TBI on vestibular impairment, leading to the development of screening tools. 15 patients made use of the complex MSK rehabilitation beds and there has also been early development of a repatriation pathway from MTC straight to rehabilitation, without the need for TU transfer.

Major trauma rehabilitation continues to be a strong priority both nationally and within our network strategy. Our recent focus surrounds the implementation of rehabilitation prescriptions network-wide. The NHS Clinical Advisory Group for Major Trauma recommends every patient should receive high quality rehabilitation, with their rehabilitation needs assessed and documented through a rehabilitation prescription ensuring services can be planned and implemented. It reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient. It is an extension of a discharge/transfer summary and should include on-going health and social care plans. In particular, it should ensure that patients' needs, and the plans made to address these, are clear as patients move from one setting to another. The prescription should allow the identification of any unmet needs and the reasons for this to enable system evaluation and targeted service development. Fundamentally, our patients should receive a copy and be central to the rehabilitation plan. Furthermore, the patient's GP and CCG should also hold a copy to help plan on-going rehabilitation, especially on discharge from the acute sector and to help support the need for funding for more specialist rehabilitation services.

This project is a challenging area for all therapists and although there is much work to be done, we have started to make progress. Our goals in the coming year are to ensure rehabilitation prescriptions are used network wide, across all specialities within major trauma and to ensure our patients receive a copy. We are also working to ensure accurate and consistent rehabilitation data collection within TARN to highlight the lack of more specialist rehabilitation services. We also need to engage with our local GPs and CCGs to ensure they understand the importance of the rehabilitation prescription.

I would like to thank my colleagues in the rehabilitation group for their hard work and on-going support and enthusiasm.

9. **Network Nursing Group Update**, Christine Nkansah and Francesca Hole, Network Nursing Lead

Although the network nursing group did not formally meet in 2017 / 18 the nurses continued to be strong advocates for the trauma network, becoming increasing involved in supporting TARN data and speaking at national conference 'For Nurses, by Nurses' conference at Arsenal's Emirates Stadium attended by 400 nurses

This year we plan to reinvigorate the nursing group and over the coming months we will be visiting all of the network hospital so we can learn about the good work that is being done and the challenges being faced. We hope collectively as a network we can work to reduce these. For example, by setting up a directory of all of the trauma related training and education available to nursing staff and other AHPs across the network. The aim will be to have courses running at consistent times of the year so that nursing off duty can be planned in advance, so that course places could be utilised to the maximum. This would help improve nursing retention, as individual nurses would feel valued by their hospital trusts. Our long term aim would be to set up a network nursing faculty which would ensure a comprehensive and academic standing for learning.

We also feel that nurses have a vital role to play in the transfer of patients back from the MTC to their local hospital and plan to establish a single point of contact model to help improve the communication and ultimately reduce the time it takes to get patients back to their local hospital

We are both delighted to be appointed in this role and look forward to working with our nursing and AHP colleagues across the network

10. **Chairs closing comments** by Adrian Bell, Chairman, SWL and Surrey Trauma Network, Chief Executive, KSS Air Ambulance

Yet again this has been a year of continued evolution and development within the Network and I remain hugely grateful to all who make this momentum possible, especially Kelvin Wright and Leila Razavi.

A significant part of this development has been the appointments of Kate Galloway as the new Rehabilitation Director and Christine Nkansah and Francesca Hole as the new Network Nursing leads. These appointments underscore the Board's unswerving commitment to the Network, its strategic development and, most importantly, its undiminished desire to support patient care as fully as possible.

I thoroughly enjoyed the network's conference. Once again the venue was full and it was great to see so many faces both internal and external. The patient story was particularly interesting as it also highlighted how the legal system can support patients and their families on the road to recovery and get them access to the necessary rehab, which the NHS isn't always able to provide. The major trauma signposting service that is offered to patients at the MTC is the first if this kind and a real credit to the network and our patients / families. The mass casualty session was also of particular interest as we were able to hear and learn from those involved in the tragic events of last year.

Planning for our 2018/19 TU reviews has just started. I am very much looking forward to as it offers a prime opportunity to hear at first hand the success and challenges in each and every Trust and also what is expected of, and needed from, the Board and CAG in terms of help and support.

Thank you.