Cheshire & Mersey
Major Trauma Network

Governance Framework

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To be read in conjunction with:	**Cheshire & Mersey Major Trauma Network: Standard Operation Procedure** **Cheshire & Mersey Major Trauma Network: Transfer Guidelines**	
Target Audience:	All specialities dealing with Major Trauma across Cheshire & Mersey Major Trauma Network (MTC's, TU's and other Participating Organisations).	
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Executive Summary

The Clinical Governance Framework serves as a comprehensive structured approach to ensure the delivery of safe, effective, and high-quality patient care within the Cheshire & Mersey Major Trauma Network. This summary highlights key components of the policy:

1. **Incident Reporting:**
    - Sets the expectations of Participtaing Organistaions and the Network
    - Establishes a standardised incident reporting process to promptly identify and investigate all adverse events, near misses, and incidents, to devleop a culture of transparency and continuous improvement.

2. **Rapid Review of Deaths in Emergency Department and Theatres:**
    - Implements a streamlined process for the rapid review of deaths occurring within the Emergency Department and Theatres.
    - Provides Network oversight and alllows for timely analysis, identification of contributing factors, and implementation of corrective actions to enhance patient safety and outcomes.

3. **Mortality Review:**
    - Sets the expectations of Participating Organisations and the Network
    - Outlines a the approach to sharing mortality reviews, in alignment with national guidelines, that examine the circumstances surrounding patient deaths, identify opportunities for learning and improvement, and highlights where targeted interventions may be required to prevent future adverse outcomes.

4. **Excellence Feedback:**
    - Outlines the approach to highlighting excellence in trauma management
    - Allows the opportunity to recognise excellence in ones own organisation or recognise excellence in others..

By adhering to the principles outlined in the Clinical Governance Framework, Cheshire & Mersey Major Trauma Network demonstrates its commitment in compliance with the Major Trauma Clinical Network Specification 2023, improving patient outcomes, quality of care and reducing avoidable deaths.
The intention is not to replace already existing governance frameworks within participating organisations, but to aid in identifying and tackling network-specific challenges. This, in turn, ensures quality assurance and encourages improvement through collaborative learning processes.

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1. Introduction

Cheshire & Mersey Major Trauma Network supports the delivery of the high-quality care for all trauma patients across the pathway of trauma services.
Trauma care is organised using a networked, tiered model of care.
The aim of networked trauma care is to ensure that major trauma patients receive their care at the most appropriate hospital and those requiring specialist care receive their care at a Major Trauma Centre (MTC) following triage by North West Ambulance Service (NWAS) or assessment and stabilisation at a Trauma Unit (TU) followed by rapid transfer. However, it is acknowledged that a significant proportion of patients may receive all their treatment within the Trauma Unit, it is therefore vital that Cheshire & Mersey Major Trauma Network ensure quality standards and networked patient pathways and policies are in place.

A core function of the Cheshire & Mersey Major Trauma Network is to have established governance and reporting processes in place that allow oversight of flow, quality, safety, experience, and outcomes.

1.1. Network Objectives

As defined in the Major Trauma Clinical Network Specification 2023, clinical network objectives include:

- Improving outcomes, reducing avoidable deaths, and increasing the quality of life and return to functioning for patients surviving their injuries.
- Improving the quality of care and patient and family experience.
- Ensuring that services meet the service specification and standards.
- Ensuring common referral, care and transfer pathways and other policies, protocols, and procedures are used across the network.
- Ensuring that as much care and treatment is provided as close as possible to home.
- Ensuring robust collection, analysis and reporting of data on outcomes, quality of care and patient and family experience.
- Ensuring efficient and appropriate flow of patients along the pathway, managing system capacity
- Improving equity of access to trauma services.
- Improving productivity and efficiency across the network
- Improving service resilience and the ability to respond to incidents.

2. Scope

The framework covers clinical governance of all major trauma patients within the Cheshire & Mersey Major Trauma Network. It replaces and supersedes any previous Clinical Governance Framework and process covering Cheshire & Mersey Major Trauma Network and is applicable to adults and children.

3. Aims & Objectives

The aims and objectives of this framework are to define:

- The Network Incident Reporting and Response process, detailing the responsibilities of both the Network and provider organisations.
- The Network Major Trauma Death: Rapid Review process, to provide the Network with timely oversight of all Major Trauma related deaths that meet set criteria for review, that occur in the Emergency Departments or in Operating Departments.
- The Network expectations with regards to Mortality Reviews of those patients who would have met criteria for submission to the National Major Trauma Registry (Previously TARN) who have died as inpatients or within 30 days of discharge.
- The Network Excellence Feedback process, to be used as a conduit of celebrating and sharing excellence from any point of the major trauma patient's pathway.

4. Network Incident Reporting and Response

Cheshire & Mersey Major Trauma Network (CMMTN) is committed to ensuring that a robust incident reporting system is in place as part of its requirements to meet the Major Trauma Clinical Networks Specification 2023, but also to provide assurance that the Network maintains appropriate oversight, identifies trends, and takes positive action to prevent or minimise the likelihood of the errors or incidents recurring in the future, to the following bodies:

- Cheshire & Mersey Joint Specialised Services Clinical Network (SSCN) Board
- Cheshire & Mersey Integrated Care Board
- NHS England Specialist Commissioning.

The aim is that CMMTN and organisations who provide care for Major Trauma patients in the region will promptly identify and investigate all adverse events, near misses, and incidents relating to major trauma, to promote a culture of transparency and continuous improvement.
Incidents may occur at any point in the major trauma patient's pathway and may be clinical or non-clinical in nature.

All Patient Safety Incidents should be reported via local reporting procedures in conjunction with local PSIRF guidelines.

4.1 Reporting Criteria

Examples of events that may require completion of a Network Incident Report include:

- Patient safety incidents (previously known as *Serious Incidents).*
- Deviation from Network agreed pathways or policies.
- Delays to treatment.
- Delays to, or difficulties in agreed referral processes.

4.2 Incident Reporting & Response Submission & Review Process

If an organisation wishes to raise a major trauma related incident, the following process should be followed:

1. Clinical incident or governance concern is discussed with local Major Trauma Lead prior to submission of ***Incident Reporting & Response Form*** (Appendix 1).

2. Completed Cheshire & Mersey Major Trauma Network (CMMTN) Incident Reporting & Response Form to be sent via NHS.NET or GOV.IM email to CMMTN Quality Improvemnet (QI) Lead calum.edge@nhs.net or if sent via NHS.UK email account, this should be encrypted.

3. Acknowledgement of receipt of completed form along with allocation of SSCN Log number will be provided to the reporting organisation.

4. Request for investigation and a response will be facilitated by CMMTN QI Lead via the Trauma Lead and/or Major Trauma Nurse of the responding organisation.

5. Response will be provided within 14 days of receiving the incident report and is sent to CMMTN QI Lead for review.

6. Response shared with reporting organisation.

7. Network Incident Database updated by QI Lead, including RAG Rating and Risk Matrix scoring.

8. Depending on the incident and the level of response provided, the following may take place:
    a. Opportunity for reporting organisation to request further information
    b. Independent subject matter expert opinion sought, as and when required.
    c. Incident highlighted for discussion at next CMMTN Clinical Group & Governance meeting (criteria for discussion outlined below)
    d. Ad-hoc multi-agency meeting facilitated by the Network to address any serious concerns
    e. Meeting between organisations facilitated by the Network if resolution of incident likely to be protracted or not achievable following standard processes.

9. Incident closed

10. Annual report of all Major Trauma Incidents to be compiled by CMMTN QI Lead and presented to Clinical Group and incorporated into CMMTN Annual Report.

11. Provider organisations should discuss all incidents (submitted or responded to) in their Major Trauma Assurance/Working Group meetings, a summary should be provided as part of each organisations Annual Report and be included in any future Peer Review presentations.

There will be occasions where a full investigation may not be required. These incidents will relate to a no patient harm event. These incidents will be discussed with the responding organisation and logged on the incident database to monitor ongoing trends, at which point a more formal review may be requested.

All incidents received relating to children will be shared by CMMTN QI Lead with the North West Children's Major Trauma Network (NWChMTN), where further information may be requested by the NWChMTN Lead Nurse.

4.3 Criteria for discussion at Cheshire & Mersey Clinical Group & Governance Meeting

- All Patient Safety Incidents
- All high-risk incidents as defined by a risk matrix score of 8 and above.
- All incidents with a *Consequence* score of 5 (Catastrophic), regardless of *Likelihood* score
- Incidents where-by resolution is unlikely to be achieved under normal reporting and response process.
- Incidents where there is evidence of emerging themes
- Any incident that the reporting or responding team request to be discussed at the Clinical Group and Governance meeting.

5. Network Major Trauma Death: Rapid Review Process

While the number of Major Trauma related deaths in the Emergency Departments across the region are low, and lower in those who have required Damage Control Surgery (DCS) or have died in the Operating Theatre / Theatre Recovery Departments, it is important that the Cheshire & Mersey Major Trauma Network have oversight of these cases in an appropriate time frame. To achieve this, it is requested that all organisations report any of deaths that meet the criteria to the Network via the ***Rapid Review Form*** (Appendix 2).

Completion of the Major Trauma Death: Rapid Review Form should take place within five working days after the event where possible.

The criteria for completion of the form have been defined as:

- Traumatic Cardiac Arrests
- Resuscitative Thoracotomy
- Pregnant patients / Resuscitative Hysterotomy
- Patient undergoing Damage Control Surgery / Intraoperative deaths
- All paediatric deaths

5.1 Problem in Healthcare Identified

If a problem in healthcare is identified as part of the Major Trauma Death: Rapid Review Process, the local team must highlight this through their internal governance structures and appropriate investigation must take place as per the organisations '*Learning From Deaths Policy'.*

A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm'. To identify the problems in healthcare, teams should consider what an acceptable standard of healthcare would be for a patient and articulate how the healthcare they received fell below this acceptable standard (whether through omission, delay, or incorrect actions).

5.2 Submission and Review Process

Once completed the form should be submitted to the Cheshire & Mersey Major Trauma Network (CMMTN) via email the Quality Improvement Lead: calum.edge@nhs.net. This should be sent from an NHS.NET or GOV.IM email account or encrypted if from NHS.UK email addresses.

The Network database will be updated by CMMTN QI Lead

A review will take place and information will be shared with CMMTN Medical Lead and Specialised Services Clinical Network (SSCN) Director as required.

The Network team will decide if an urgent review meeting is required, if so the CMMTN QI Lead will facilitate this. If an urgent review meeting is not required, feedback will be shared at the next scheduled CMMTN Clinical Group & Governance meeting.

Annual report of all Major Trauma Death: Rapid Reviews to be compiled by CMMTN QI Lead and presented to Clinical Group and incorporated into CMMTN Annual Report.

All participating organisations should review all submitted Rapid Reviews in their Major Trauma Assurance/Working Group meetings and implement actions to reduce any possibility of recurrence of identified issues. A summary of Rapid Reviews should be provided as part of each organisations Annual Report and be included in any future Peer Review presentations.

All rapid reviews received relating to children will be shared by CMMTN QI Lead with the North West Children's Major Trauma Network (NWChMTN), where further information may be requested by the NWChMTN Lead Nurse.

6. Network Mortality Review Process

The Mortality Review Process is essential to examine the circumstances surrounding patient deaths, identify opportunities for learning and improvement, and implement targeted interventions to prevent future adverse outcomes.

Participating organisations should have an established process for identifying patinets who have sustained traumatic injuries and subsequently died.

All trauma deaths that occur in the Emeregncy Departmnet or Theatre environment should have had a Rapid Review completed as soon as possible after the death of the patient. These should be followed up with a formal mortality review, discussion at local M&M meetings and completion/submission of a Network Mortality Review Form (appendix 3)

Whereby historically a Mortality Form was completed on confirmation of the Injury Severity Score (ISS) and Probability of Survival Score (Ps), as provided by the Trauma Audit & Resesarch Network (TARN), this led to delays in submissions and therefore a lack of Network oversight of emerging themes and trends.
Once functionality is established, the National Major Trauma Registry (NMTR) which has replaced TARN, will provide participating organistaions with identified patinets and their ISS & Ps, howvere it is imperitive that submission of a Network Mortality Review Form is completed at the earliest opportunity following identifcation of the death of the patinet and review in local M&M meetings, regardless of if the ISS or Ps has been provided by the NMTR.

Any death where there has been a ***potential problem in healthcare identified*** (see point 5.1) should be highlighted through internal governance structures and appropriate investigation must take place as per the organisations '*Learning From Deaths Policy'.*

6.2 Submission and Review Process

Once completed the Mortality Review Form should be submitted to the Cheshire & Mersey Major Trauma Network (CMMTN) via email the Quality Improvement Lead: calum.edge@nhs.net. This should be sent from an NHS.NET or GOV.IM email account or encrypted if from NHS.UK email addresses.

The Network database will be updated by CMMTN QI Lead

A review will take place and information will be shared with CMMTN Medical Lead and Specialised Services Clinical Network (ODN) Director as required.

The Network team will decide if an urgent review meeting is required, if so the CMMTN QI Lead will facilitate this. If an urgent review meeting is not required, if criteria for discussion at the Network Clinical Group & Governance Meeting, the case will be scheduled for discussion at the next meeting.

Annual report of all Major Trauma Mortality Reviews to be compiled by CMMTN QI Lead and presented to Clinical Group and incorporated into CMMTN Annual Report.

CMMTN QI Lead will be responsible for updating ISS and Ps to the Network Database once available from the National Major Trauma Registry.

6.3 Criteria for discussion at Cheshire & Mersey Clinical Group & Governance Meeting

- All deaths where there has been a corresponding Patient Safety Incident reported
- All deaths where there has been a corresponding Network Incident reported
- Deaths where there has been a problem in healthcare identified
- All paediatric deaths
- All pregnant trauma deaths
- Death(s) relating to emerging themes/trends
- Any death that the treating team request be discussed

All mortality reviews received relating to children will be shared by CMMTN QI Lead with the North West Children's Major Trauma Network (NWChMTN), where further information may be requested by the NWChMTN Lead Nurse.

All participating organisations should review all submitted Motility Reviews in their Major Trauma Assurance/Working Group meetings or dedicated M&M meetings and implement actions to reduce any possibility of recurrence of identified issues. A summary of Mortality Reviews should be provided as part of each organisations Annual Report and be included in any future Peer Review presentations.

7. Network Excellence Feedback Process

The *Network Excellence Feedback Form* should be used to highlight and share examples of excellent practice.
This can be relating to your own organisation, an external organisation or a combination of collaborative working that resulted in excellence at any point in the patient's pathway and regardless of the overall outcome.

Examples:

- *Early recognition of need for rapid conveyance to the MTC or TU by pre-hospital providers.*
- *Reception and resuscitation of a severely injured patient who could not bypass a Trauma Unit.*
- *Code red trauma team activation at the MTC, with timely sequence of events, excellent teamwork and communication.*
- *A multi-organisational response to the management of a patient*

Feedback for an external organisation will be shared with their trauma Leads and Excellence Forms will be discussed in the CMMTN Governance meeting

Appendix 1 – Network Governance Incident Reporting & Response Form

Network Governance Incident Reporting V2

Appendix 2 – Major Trauma Death: Network Rapid Review Form

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Appendix 3 – Major Trauma Mortality Review Form

Network Mortality Review Form V2.0 Feb

Appendix 4 – Network Excellence Feedback Form

Network Governance Excellence Reporting