North West Children's Major Trauma Network
Always Children First

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Table of Contents

- **Introduction**

Major Trauma Clinical Networks ensure quality standards and networked patient pathways are in place. They support the management of capacity and demand, improvement and delivery of a commissioned pathways, with a key focus on the quality and equity of access to service provision.

The North West Children's Major Trauma Operational Delivery Network was formalised in 2021. The Network is unique in being the only designated Children's Operational Delivery Network for Major Trauma in England. The Network is cohosted by Royal Manchester Children's Hospital (RMCH) and Alder Hey Children's Hospital (AHCH) with the financial envelope held within Manchester University NHS Foundation Trust

The Network provides a service to the conurbations of Cheshire and Mersey, Greater Manchester, Lancashire and South Cumbria, North Wales, and the Isle of Man. The current population for children aged less than 16 years old served by the Network is c.1.4 million (19.1% of the total NW population).

A key challenge for the Network is the wide geographical area it serves with a mix of urban and remote rural populations with considerable distance for some populations from the MTCs in Liverpool and Manchester. For some children with major trauma their injuries are time critical, and it is essential that they are transferred as quickly as possible into the MTCs. Across the network several hospitals have over 1 hours travel from the MTC with Furness General and Nobles Hospital having over a 2-hour travel time into their designated MTC of Alder Hey.

The key functions of the Network are to:

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

This policy will support the Network in addressing these core functions by ensuring that the Network has a robust governance process to ensure quality, safe and sustainable Major Trauma services for children across the Network.

Aims and Objectives

This policy aims to ensure effective governance processes are in place to allow opportunities for learning and to maximise the quality of children's major trauma services. To provide quality assurance and improvement, the Network has a responsibility to ensure that lessons are learned from;

- Case reviews of unexpected deaths and unexpected survivors
- Serious Untoward Incident case reviews
- Incident reports
- MTC PROMs reports
- Network National Major Trauma Registry (NMTR) data including clinical reports
- Morbidity and Mortality reviews

The Network will communicate themes and incidents through the Clinical Effectiveness Group (CEG) with overall responsibility through the Governance board.

Network Leadership Team

The Network has a responsibility to oversee the incident reporting & governance process across the Northwest Children's Major Trauma Operational Delivery Network and acts as the impartial body to ensure that efficient investigations take place and subsequent feedback is provided.

Any lessons learned will be shared with all stakeholders at the CEG to ensure that actions can be agreed to reduce risk of recurrence and improve the quality, equity and safety of major trauma services for children, young people and their families across the Network.

Emergent themes will be identified by the Network and incorporated within quality improvement plans. Where issues cannot be resolved at Network CEG level, these will be escalated via the Network Board for arbitration and agreement of actions.

Providers

All member organisations have a responsibility to share and report to the Network the following:

- NMTR Data
- MT clinical audit findings
- MT Network pathway incidents
- Internal incidents relating to MT patients with a risk score of 12 or above or when local action is insufficient to alleviate or remove the concern, or repeated occurrences of the same or similar concerns occur
- Peer review findings and response to action plans
- MT Morbity and mortality case reviews
- Complete the Major Trauma Governance Report Quarterly (see section 4)

To ensure learning in a timely manner and to facilitate the use of the above for informed decision making, providers have a responsibility to ensure that data, incident reporting and case reviews are completed accurately and timely.

Major Trauma Governance Report

To support elements of the governance process, an agreed governance report will be submitted to the Network by the MTCs and TUs on a quarterly basis.

This report will be reviewed by the Network Leadership Team and reports presented by exception by the MTC/TU Trauma Lead at the CEG meeting.

A summary report including themes identified will be reported by the Network twice yearly to the ODN board, where appropriate escalated to the ICB and any actions included within Network Improvement plans.

National Major Trauma Registry

All providers of major trauma care are required to contribute to the mandatory comprehensive patient and system performance data the NMTR which provides regular reports on outcomes, network performance and benchmarks the performance of all UK hospitals that receive trauma patients. All providers must ensure that their submissions to NMTR are accurate and timely to ensure confidence in their data validity. This will enable the Network to review clinical reports, data and dashboards to identify key themes, good practice and outliers for trauma care.

If concerns arise from the NMTR data the Network will meet with the individual centre to discuss concerns and develop an action plan to support improvement in trauma standards.

Major Trauma Incident Reporting

In the event that an organisation has a major trauma incident or a governance concern that requires reporting into the Network the process below should be followed to ensure consistency of reporting and governance:

- Incident raised via trust incident reporting system (e.g. Datix)
- Notification email including incident reference number to be sent to Network via NorthWest.Children's.MajorTrauma.Network.ODN@mft.nhs.uk
- Receipt of incident acknowledged by network leadership team and incident recorded into network governance database.
- Incident investigation and feedback to be led by reporting Trusts Governance Team with feedback managed by recipient site. Investigation and feedback timescales as per figure 1.
- Feedback should be provided to the reporting trust and network once a reply is received.
- Incident/report and actions to be discussed at local TU /MTC quality meeting
- Network is informed the incident is completed and database updated.
- Any remedial action and lessons learned recorded and shared as applicable at Clinical Effectiveness Group by Chair.
- Incident closed by reporting site.
- Summary of emerging themes reviewed and reported to CEG and Governance Board.
- **Criteria for discussion at Clinical Effectiveness Group**

- All Patient Safety Incidents, incidents with a consequence score of 4/5 (Major / Catastrophic), regardless of likelihood score and all high-risk incidents as defined by a risk matrix score of 8 and above.

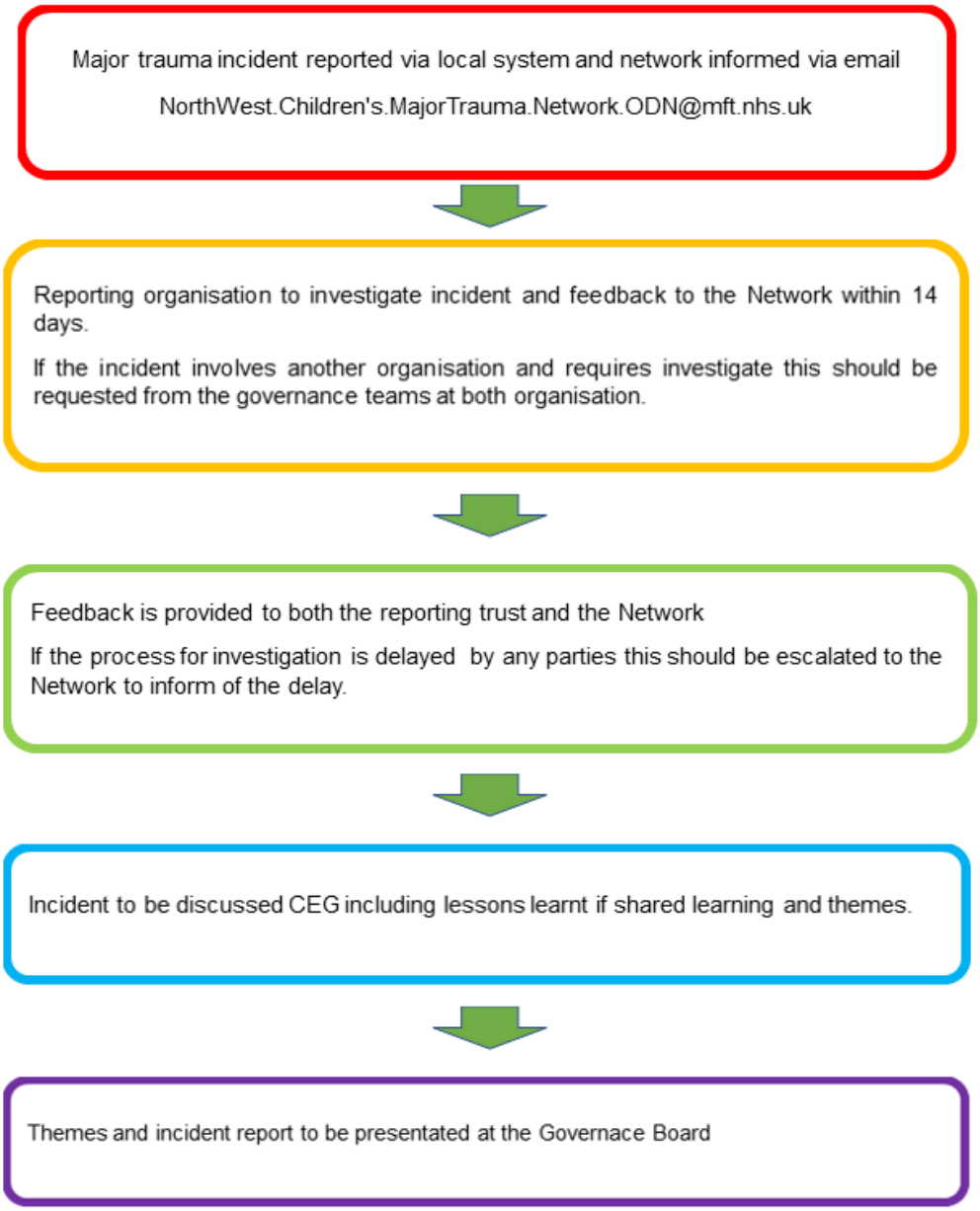
- Incidents where-by resolution is unlikely to be achieved under normal reporting and response process.
- Incidents where there is evidence of emerging themes
- Any incident that the reporting or responding team request to be discussed at the Clinical Effectiveness Group

Criteria for discussion at Governance Board meeting

A 6 monthly incident governance report will be provided to the Governance Board 6 monthly. The report will include:

- Themes
- Lessons learnt
- Any incidents not resolved at provider source or CEG

Incident Reporting Flow Chart



Appendix

C&M

L&SC Internal incident and email that have placed and incident with brief details

GM GM-MTN-Incident-reporting-Proforma-vs-3.1.pdf