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NHS England

Major Trauma Clinical Network Specification

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Contents

Executive Summary

Major Trauma Clinical Networks support 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 an ambulance service or assessment and stabilisation at a Trauma Unit (TU) followed by rapid transfer.

The Major Trauma Clinical Networks ensure quality standards and networked patient pathways are in place. They also support:

- Cross-organisational working and collaboration.
- Clinical assurance through shared protocols, standards, clinical guidelines, performance and quality audits, clinical dashboards and other tools.
- Consistency in approach to implementation of transfer and repatriation protocols.

Trauma networks play a vital role in Emergency Preparedness, Resilience and Response (EPRR) planning for times of surge/escalation and mass/major incidents.

1. Clinical Networks

Specialised services clinical Networks[1] are a vehicle for specialty level collaboration between patients, providers and commissioners and to drive forward improvements and integration. They should have a clear line of accountability to Integrated Care Boards (ICBs), and NHS England (NHSE) Regional Teams, to ensure local ownership, alignment and a local mandate.

All networks have an important role in delivering the triple aim, supporting:

- better health and wellbeing of everyone,
- the quality of care for all patients, and
- the sustainable use of NHS resources

This specification sets out the appropriate scope for the work of major trauma clinical networks. This will inform the development of the annual workplans developed in conjunction with the network's commissioners. No network will, or could, focus on all aspects of the scope described, at one time.

[1] While some specialised services Clinical Networks have previously been described as Operational Delivery Networks (ODNs), the range of activity undertaken is now significantly beyond that envisaged for ODNs, reaching into non-specialised services, and in some cases primary and community care and prevention. Some are jointly funded as part of national transformation programmes and have accountabilities outside as well as within specialised services. As a result, as a group they are now referred to as specialised services 'Clinical Networks'.

In describing the appropriate scope for networks, these specifications refer to the work of the network board and the network's members, supported by the network team. Networks are not expected to assume the legitimate accountabilities and responsibilities of providers who are accountable for meeting the needs of the Service Specification. However, network responsibilities inevitably overlap with those of providers, because networks aim to improve the ways in which services are delivered operationally and shape how they develop and because providers are members of networks.

2. Major Trauma Strategic Context

In England, trauma is the commonest cause of death in those under 40 years, with survivors often suffering long-term disability. Major Trauma Clinical Networks were established in response to concerns about poor outcomes and a lack of service coordination. The National Audit Office estimated in 2010 that there are 20,000 cases of major trauma per year in England. 5,400 people die of their injuries with many others sustaining permanent disability.

The NCEPOD 2007 report 'Trauma–Who Cares?' raised awareness and was followed by the appointment of the first National Clinical Director for Trauma in 2008. The National Audit Office Report 'Major Trauma Care in England' in 2010 recommended the establishment of regional Major Trauma Clinical Networks.

Trauma care is organised using a networked, tiered model of care that provides a balance between easy access local care for the most patients with highly specialised, centralised services for those with more severe injuries. Pre-hospital teams use triage tools to identify patients who may have suffered severe injuries to determine the appropriate hospital for their care.

Major Trauma Centres (MTCs) provide immediate treatment to people with the most serious injuries 24 hours a day, seven days a week. They have the equipment, facilities and teams of trauma experts to ensure effective diagnosis and early treatment of seriously injured patients. Some provide care only for adults or only for children. Some provide care for both adults and children.

Trauma Units (TUs) treat people with less severe injuries who do not require the input of a major trauma centre. They provide high-quality, ongoing treatment and rehabilitation for all patients. They receive and resuscitate injured patients, and provide expert triage so that where necessary patients are then transferred safely and rapidly to the Major Trauma Centre for definitive care.

Local Emergency Hospitals (LEHs) provide general Accident and Emergency services for their local population, and provide basic trauma care for those who do not need the input of a TU or MTC. While they would normally be by-passed by ambulance services, if they do receive injured patients, they provide expert triage for patients who are then transferred safely and rapidly to the Trauma Unit or Major Trauma Centre for definitive care.

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 pathway, with a key focus on the quality and equity of access to service provision. The networks bring together providers, commissioners, public health and

other stakeholders to assess the needs of the population and plan the provision of trauma care.

All hospitals in the networks contribute mandatory comprehensive patient and system performance data to the Trauma Audit and Research Network (TARN) which provides regular reports on outcomes, network performance and benchmarks the performance of all UK hospitals that receive trauma patients.

3. Network Scope

3.1 Scope

Trauma care is delivered through a networked delivery model which includes all providers of trauma care, including pre-hospital services, other hospitals receiving acute admissions and rehabilitation services along with specialist services.

The Major Trauma Clinical Network responsibility includes all aspects of trauma care, for both adults and children.

The network's scope includes concern for the whole pathway of care from point of injury to rehabilitation and discharge, and for injury prevention within the geographical area covered by the network.

Dedicated major trauma rehabilitation services are in scope but while networks have a role in the oversight and co-ordination of the pathway links to general rehabilitation services, the commissioning and delivery of general rehabilitation services is out of scope.

The specialised element of the service is described in detail in the following Service Specifications:

- Major Trauma Service (All Ages) (D15/S/a)

The geographical boundaries of the networks are based around pathways of care for taking account of the tiered service model. This may not be co-terminus with commissioning boundaries so strong links with adjacent networks will need to be developed.

Out of Scope

Burns

3.2 Population Covered

Every Major Trauma Centre, Trauma Unit, and Local Emergency Hospital in England will be a member of one of 22 networks which cover the country. The networks are:

NORTH EAST AND YORKSHIRE
Northern
North Yorkshire and Humberside
West Yorkshire
South Yorkshire

NORTH WEST
North West Children's
Lancashire and South Cumbria
Cheshire and Mersey
Greater Manchester

MIDLANDS
Birmingham, Black Country, Hereford and Worcester
Central England
North Midlands and North Wales
East Midlands

EAST OF ENGLAND
East of England

LONDON AND EAST OF ENGLAND
North East London and Essex

LONDON
North West London

LONDON AND SOUTH EAST
South West London and Surrey
South East London, Kent and Medway

SOUTH EAST
Sussex
Thames Valley

SOUTH EAST AND SOUTH WEST
Wessex

SOUTH WEST
Peninsula
Severn

Wales and Scotland: While some residents of Wales and Scotland receive their care in England, hospitals in these countries are not part of these networks, except for north Wales where the hospitals are part of the North Midlands and North Wales network.

Networks in England will work with colleagues in Scotland and Wales to offer mutual aid as appropriate at times of service pressure.

Crown Dependencies: Residents of the Channel Islands and the Isle of Man receive their care in England and for this reason hospitals in these territories are also part of these networks.

Northern Ireland: While some residents of Northern Ireland receive their care in England, hospitals in Northern Ireland are not part of these networks.

4. Network Aims and Objectives

4.1 Network Aims

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 an ambulance service or assessment and stabilisation at a Trauma Unit (TU) followed by rapid transfer.

Trauma Clinical Networks support effective clinical flows through:

- capacity planning and activity monitoring with collaborative forecasting of demand, and matching of demand and supply
- developing a whole system collaborative approach to supporting patient flow, including repatriations and monitoring delayed repatriation
- focussing on quality and effectiveness by agreeing and implementing standard pathways and protocols, benchmarking, audit and other clinically focussed improvement activities

4.2 Network Objectives

The main objectives of Major Trauma Clinical Networks 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 incidents

4.3 Network Functions

Service delivery: *the network's role in planning and managing capacity and demand*

- Ensure efficient and appropriate flow of patients along agreed pathways of care through clinical collaboration of networked provision of services.
- Plan capacity and monitor activity with collaborative forecasting of demand, and matching of demand and supply.
- Plan and co-ordinate the provision of a comprehensive system of specialist care for people who have suffered serious injury to ensure access to specialist major trauma care, including preparing and agreeing a plan guiding the response to major incidents and other surges in demand.
- Co-ordinate patient pathways across the whole network from the pre-hospital phase including rehabilitation and a return to socio-economic functioning.
- Monitor day to day capacity across the network, agreeing and working to an agreed escalation plan (with agreed thresholds for escalation triggers) for both within network and across network to monitor and manage surges in demand.
- Ensure services are able to respond effectively to major incidents involving injured patients.
- Work with other networks and NHSE regional teams to develop mutual aid agreements to support capacity management and escalation in times of crisis.

Resources: *the network's role in stewardship of resources across whole pathway and minimising unwarranted variation*

- Support improved productivity and increasing efficiencies across the network
- Support work to more accurately cost pathways of care and more efficient utilisation of resources.
- Reduce unwarranted variation in pathways and processes that lead to inefficiencies.
- Work with other related networks and teams, flexing use of resources to find efficiencies, target resources for best effect and share insight and experience.

***Workforce:** the network's role in ensuring flexible, skilled, resilient staffing*

- Assess future workforce needs for provision of trauma services across the network taking into account projected demand.
- Support providers to develop and implement innovative and extended roles for non-medical staff groups, through training and development and network wide policies and procedures.
- Assess training needs for the network (including baseline skills audit and network maturity assessment) and networked services.
- Develop and agree a network training plan that meets the needs of the network both in the delivery of care and in the functioning of the network.
- Agree with commissioners and providers how the planned training will be resourced and delivered.
- Monitor delivery and assess the effectiveness of the agreed training.
- Promote workforce resilience through:
    - mutual aid agreements.
    - staff passporting or equivalent.
    - health and wellbeing support for staff.

***Quality:** the network's role in improving quality, safety, experience & outcomes*

- Ensure that services meet the service specification and national standards
- Participate in comparative benchmarking and audit across the network through the national major trauma audit (TARN)
- Ensure the quality of the network is monitored and subject to a process of continuous quality improvement through the national clinical audit
- Improve the collection, analysis and reporting of data on outcomes, quality of care and patient and family experience, including TARN data collection (including case-mix standardised outcomes linked to outcomes framework).
- Use data to improve outcomes, experience and quality of care for patients.
- Manage risks to the delivery of the network's annual work programme.
- Identify service issues and risks and ensure they are managed through regional and system quality structures following agreed escalation processes. Providers or commissioners may ask networks to facilitate the response to risks, but providers and commissioners remain accountable for their services' risks.
- Ensure the provision of high-quality information for patients, families, staff and commissioners, standardised across the network.

***Collaboration:** the network's role in promoting working together across organisations at local, system and national level*

- Work collaboratively to share learning, experiences, knowledge, skills and best practice for the benefit of all within the network.
- Share best practice with the other Major Trauma Clinical Networks.

- Work collaboratively with all other Major Trauma Clinical Networks to agree and achieve national goals.
- Participate in the national Major Trauma Network group
- Link into Local Resilience Fora to ensure effective Emergency Preparedness, Resilience and Response (EPRR) arrangements.
- Develop and implement a Public and Patient Engagement strategy.

Transformation: *the network's role in planning sustainable services that meet the needs of all patients*

- Develop, agree and implement common referral, care and transfer pathways and other policies, protocols, and procedures across the whole pathway, to reduce variation in service delivery
- Regularly review network configuration, capacity and compliance with standards, advising and agreeing a plan with commissioners to assure sustainable services that meet the needs of all patients.
- Facilitate and promote trauma research and development initiatives undertaken by trauma professionals across the Trauma Clinical Network.
- Support the early and systematic adoption of innovation and research across the network.
- Implement nationally agreed commissioning policies and products.

Population health: *the network's role in assessing need, improving inequalities in health, access, experience and outcomes*

- Improve access and equity of access to trauma services
- Development and involvement in injury prevention programmes.
- Work with commissioners to understand the needs of the population for trauma services.
- Review service delivery across network against need and identify gaps and variation in services – gaps in overall provision, quality, geographical distribution - and deliver improvements to network services to address these issues.
- Develop specific proposals which mitigate inequalities for the vulnerable groups identified.

4.4 Annual workplan

The network board will agree an annual workplan with its commissioners (usually through the joint strategic commissioning committee). This will reflect national, regional and local priorities, taking account of the resources available to support delivery. The workplan will describe its expected deliverables and benefits.

The network board will publish an annual report detailing its activities, accounts and delivery against the agreed annual plan.

5. Governance

5.1 Accountability

Hosting

Major Trauma Clinical Networks will be hosted by a named organisation from within the local geography determined by the network's commissioners, but will operate at arm's length, for the benefit of the network and not the host organisation.

Accountability and responsibility

Network footprints reflect patient flows, provider scale and catchments so will often cut across commissioner boundaries (ICB and regional). Governance arrangements must provide clear accountability to commissioners at system level (with links to all relevant ICBs) and region as appropriate for both network delivery and commissioning responsibilities. Local arrangements to achieve this should be clearly documented within the network's terms of reference.

Networks will be responsible to ICBs for the management of local pathways and delivery of locally agreed targets. This should be set out in memoranda of understanding between ICBs, providers and the network.

The network will be accountable to the regional team of NHSE via the appropriate board within the Region including any multi-ICB decision bodies established.

Network plans and deliverables should be agreed with all ICBs within the network's geography and signed off by the region. Networks will be expected to provide regular reports and have regular reviews with NHSE regional teams.

The network's authority to act on behalf of its commissioners and members will be set out clearly within the network memorandum of understanding and where necessary clarified within the agreed annual plan.

5.2 Network governance and architecture

Members and stakeholders

Networks are required to have a formally constituted governing body or board, which is accountable to the network's commissioners for delivery of the network's agreed programme, with a line of sight to all ICBs whose patients use the services of providers within the network.

Network boards should include balanced representation from member organisations and other relevant stakeholders, including patient representatives and third sector organisations.

Clinical representation should cover the whole multi-disciplinary team and pathway of care.

The network should develop an approach to working with patients and families that ensures patient views inform its whole work programme and ensure optimal service provision for patients.

The Board

The board should meet on a regular basis and operate under the oversight of a suitable chair with agreed terms of reference.

The chair will be an appropriately experienced, impartial leader who is credible across the whole network and will be appointed through a fair and open process.

- The chair should not be the network clinical lead, and ideally should not have the same main employer as the Network Clinical Lead in order to mitigate the risk of (real or perceived) conflicts of interest.

- They could be a board member or senior clinician from one of the provider organisations in the network (ideally not the host, to underpin the collective nature of these arrangements) or a patient representative where a suitable candidate is available.

5.3 Risk Management and risk sharing

Networks do not manage risk independently but within a system of national, regional and system level arrangements. Networks support risk identification, assessment, mitigation and may facilitate any agreed response.

Specific local risk management arrangements and governance processes should be managed locally through MOUs/ SOPs etc which are clear and signed off. Escalation processes for risks within a system should be clear and explicit, with any quality concerns escalated through agreed systems and regional processes.

5.4 Interdependent Relationships

- Burns Clinical Networks
- Adult Critical Care Clinical Networks
- Local resilience fora

6. Resources

Network funding provided to the host is ring-fenced for the network programme of work.

Each network should have a team to support its work that provides clinical leadership, management and administrative support. Networks should also have arrangements for analytical and business intelligence support. Commissioners must ensure as part of the annual planning process that the scale of resource made available to networks is sufficient to support the agreed programme of work. The capacity of the network to deliver its programme of work does not reside solely in the network team but also in the support of all network members including its commissioners.

As part of the annual planning process, commissioners must ensure that:

- the scale of resource made available to networks is sufficient to support the agreed programme of work
- networks have access to the data they need and the analytical capacity and capability to turn this into actionable improvement programmes

Roles such as administration, network management and analytical support may be appropriately combined across networks, with further opportunities: to increase the value from these investments, share learning across networks and improve the sustainability of networks, through the provision of a pool of staff to support specialised services and Clinical Networks across a region.

7. Deliverables, Service Indicators & Outcomes

Indicators and metrics of network performance come from three principal sources:

1. Generic indicators of a well set up, well-functioning network

- There is an appropriate network management team in post with the skills to deliver the specification
- The network board meets at least three times per year, is quorate, and minutes, actions and risks are recorded
- As appropriate to the network spec, there are regular network specialist Multi-Disciplinary Team (MDT) meetings (or equivalent)
- There are IT facilities in place that enable communication across the network, supporting image transfer and remote participation in the MDT.
- There is an annual workplan agreed with the network's commissioners
- There is an agreed plan for PPV engagement
- There is an analysis of the service needs of the population served by the network, a gap analysis and a plan, agreed with the network's commissioners to meet those needs
- There are network agreed patient pathways, procedures and protocols
- There is an analysis of workforce requirements and a plan, agreed with network members to meet these requirements
- There are arrangements (for example passporting) that enable workforce flexibility between providers within the network.
- There is an analysis of training needs, and an annual network training plan agreed with network members
- There is an analysis of the networks data and information needs and a plan, agreed with network members to meet these requirements
- There is a network agreed research strategy including access and participation in clinical trials
- The annual workplan includes at least one quality improvement initiative
- An annual report is produced, summarising the work of the network and its outcomes. The report includes a financial statement
- The network participates in the national network of networks

2. Nationally agreed indicators and outcomes for all networks of this specialty, for example as defined by a national transformation programme, or included in the service specification and delegated to network leadership.

National network requirements are:

- There is a network governance group
- There is a network agreed transfer and repatriation protocol
- There are network agreed pathways in place
- There is an emergency preparedness plan
- There is a network clinical lead for rehabilitation
- There is a network strategy for training education

Common networks metrics are:

- 12hr secondary transfers TU to MTC
- 48hr repatriations
- TARN submission rates
- TARN data quality indicator

3. The network's individual locally agreed annual workplan, which should build in metrics and indicators for each element.

The network board will agree an annual workplan with its commissioners which will include the expected in year deliverables along with the indicators that will demonstrate effective network operation.

8. Further support and information

Major Trauma Care in England, National Audit Office, 2010 available here:
https://www.nao.org.uk/reports/major-trauma-care-in-england/
The full suite of materials covering what clinical networks do, commissioning of specialised services clinical networks and the clinical networks operating model together with model materials for use by networks and their commissioners can be found on the Future NHS website here:
https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=34094320
Access requires membership of the site and permission to access the workspace. This is straightforward for all NHS employees.