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Version control and record of amendments

Date	Amendment	Lead
3.1.19	Layout of information	S.Graham
11.3.20	Title of the document – developed into an SOP	S. Graham

1. Background

The Midlands Operational Delivery Networks (MODN) for Trauma, Critical Care & Burns operate an incident reporting system which is part of their governance process. Each has its own title; Trauma is the Trauma Related Issues Database (TRID), Critical Care is the Critical Care Related Issues Database (CCRID) and Burns is the Burns Incident Log (BIL).

The system is used to report trauma, critical care & burns related issues/incidents respectively, but can be used to report risks & preventable deaths. Its purpose is to ensure accurate and timely investigation about issues reported to the network offices from any organisation/service within our region.

1.2. Purpose

The purpose of the SOP is to inform every service who is part of the MODNs the process for reporting issues to the network office, the investigation process and escalation of network related Serious Untoward Incidents (SUIs), (*other similar terms may be used*).

1.3. Scope

Any personnel working for a service within the region served by the MODNs can report issues to their network office. These services will include Major Trauma Centres, Trauma Units, Local Emergency Hospitals, Critical Care Units, Ambulance Service Providers, Spinal Centres & Rehabilitation Hospitals, Burns Centres, Burns Units & Burns Facilities.

1.4. Responsibilities

All Trusts will continue to use their internal governance and reporting systems e.g. Datix system however, we recognise that there are some issues that will require peer support and investigation by the ODN as it may relate to wider training issues, change in practice or pathways etc, reducing risk etc.

It is reasonable to expect any level of personnel from the services mentioned to report issues however, some individuals may wish to request that these be reported via their nursing or medical lead, senior personnel or governance leads.

It is the responsibility of the MODNs to ensure that this SOP is adhered to and to instruct personnel of its use, allowing the network to examine issues through this formal process.

1.5. Procedure

1.5.1. Issues/Incident Reporting Process

a) Services will submit issues to the network office as early as possible **via secure email** using either the report form (appendix 1) or via the Datix style form found on our website via
Trauma = ***www.mcctn.org.uk/trid.html***
Critical Care = ***https://www.mcctn.org.uk/ccrid.html***

Burns = ***https://www.mcctn.org.uk/issue-log.html***

b) The network office will enter the details of the issue onto the purpose-built database within 2 working days and will be risk scored using an agreed algorithm appendix 2.

c) The network office will reply to the person reporting the issue within 3 working days, providing a unique reference number for further correspondence and to inform them of the investigation route to be taken, described in 1.5.2. a) or b)

d) Upon completion of all investigation the issue will be closed but will remain on the database for auditing purposes or should it be necessary to reopen the case. All those involved in the investigation will be sent a closing letter providing details of the agreed outcome within a week of closure.

1.5.2. Investigation Routes

There are 3 routes of investigation:

a) **Internal only,** where communication is between one service to another. Most issues can be dealt with in this manner and closed off quickly with assistance from the network office.

b) **Network Board meetings,** where peers from trauma, critical care or burns meet on a regular basis and will be presented with an in-depth case study presentation of the issue, leading to discussion and a resolution. The board may identify learning points/service improvement or further actions as required to allow closure of the issue.

If a resolution cannot be agreed in a timely manner, the issue will be followed up by the -

c) **Network Manager, Medical Lead of respective network and the Commissioner of the service** who will seek further clarification and a process leading to closure of the issue.

1.5.3. Serious Untoward Incident Investigations

On occasion there is a need for a more formal review of an issue or when a SUI is reported to the network.

a) *SUI requested by a service* – the service initiates it themselves and the network is asked to be involved in the investigation to offer the support of external clinicians or provide a second opinion by a trained individual or brought to the respective network board meeting.

b) *Following submission of an issue and subsequent risk scoring* - the case is escalated to the Network Medical Lead & Network Manager who will request a SUI investigation is undertaken or an external review by another network. Appropriate paperwork will be completed.

The Midlands Network is in the fortunate position to work with 3 trauma networks and 3 critical care networks, each will be used as external reviewers to the other, should it be deemed necessary.

1.6. Timescales

Timely investigation is imperative. Those involved in any investigation are required to:
a. Respond within 14 days of initial notification of the issue.
b. Investigate the issue within 8 weeks of receiving the notification and when unable to meet the deadline to immediately notify the Network office.

1.7. Issues Database

The database is used to record the details provided on the report form and entries are retained for reporting purposes but are also used for identifying particular patterns or themes across services or regions we cover. **No patient identifiable information is kept on the database.**

Reminders are sent to anyone who has outstanding actions on a monthly basis and following agreement to close an investigation, the date is recorded, and the details of the issue are sent via a closing letter to all involved in the investigation.

The database is maintained by the network office.

1.8. Abbreviations

TRID	Trauma Related Issues Database
CCRID	Critical Care Related Issues Database
BIL	Burns Incident Log
MCCTODN	Midlands Critical Care & Trauma Operational Delivery Network
MBCODN	Midlands Burn Care Operational Delivery Network
SOP	Standard Operating Procedure
PaQ	Performance & Quality
SUI	Serious Untoward Incident

1.9. Appendices

Appendix 1	Issues/Incident Report Form v5 (can be adapted for any service)
Appendix 2	Risk scoring algorithm

Appendix 1

Issues/Incident Report Form V5

Please use this form to notify the Network of an adverse event as soon as possible

via secure email to stephen.littleson@nhs.net using the report form or complete online via appropriate web link

Part 1 - Notification

Datix or Other Trust Reference Number: Reporting Clinician: Reporting Organisation: Date of notification:

Part 2 – Patient Details – Only used when sending via secure email above. This information will not be entered onto the TRID database.

Patient name	
Date of Birth	
NHS Number	

Part 3 – Pre-hospital Details

If the issue is pre-hospital related please provide the **case number** found on the top of the Patient Report Form (PRF) - not the PRF number. This will speed up the investigation process.	

Part 4 – Case Details

	Issue 1	Issue 2	Issue 3
Date the issue occurred?			
Time the issue occurred?			
Trust / organisation the issue is about?	Choose an item.	Choose an item.	Choose an item.
Other, if not on above list			
Issue location	Choose an item.	Choose an item.	Choose an item.
Other, if not on above list			
Issue Type	Choose an item.	Choose an item.	Choose an item.
Other, if not on above list			
Issue Team	Choose an item.	Choose an item.	Choose an item.
Other, if not on above list			
Issue Description? – please provide as much detail as possible inc time-lines			
What actions have been taken to date?			
What actions are outstanding?			
Please indicate if you wish to discuss this case at your Network Board Meeting			

Appendix 2

Risk Scoring

Instructions for use

- Use table 1 to determine the consequence score for the potential adverse outcome relevant to the risk being evaluated.
- Use table 2 to determine the likelihood score for those adverse outcomes.
- Calculate the risk score the risk multiplying the consequence by the likelihood.

Table 1:

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Table 2:

Consequence Score	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1 – 3 Low risk	4 – 6 Moderate risk	8 – 12 High risk	15 – 25 Extreme

Guidance Information Only	**Consequence score (severity levels) and examples of descriptors**				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to

		for patient safety if unresolved Reduced performance rating if unresolved	Repeated failure to meet internal standards Major patient safety implications if findings are not acted on		meet national standards

Risk Scoring Algorithm

Green	**Report themes to the network office**
Yellow	**Network Board presentation and discussion**
Amber	**Service led SUI for reporting back to the network office**
Red	**External network SUI investigation**