Publication: **SOP for reporting Issues/Incidents and for initiating investigations and network related Serious Untoward Incidents for the West Midland Operation Delivery Network**
Description: This document described the process for reporting trauma, critical care & burns related issues & incidents to the network office and information about the involvement of the network in serious untoward incidents
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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
21.4.23	Change of risk scoring algorithm, now in line with regional process to escalate risks	S.Graham
31.5.23	Removal of notification form	S.Graham

1.1 Background

The West 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, from here on in they will be referred to as 'issues'.

1.2 Purpose

The purpose of the SOP is to inform every service who are 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*). The process ensures accurate and timely investigation about issues reported to the network offices from any organisation/service within our region and to escalate service risks to governing bodies as described in Appendix 1.

1.3 Scope

Any personnel working for a service within the region served by the MODNs can report issues to the 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 another trust/provider/service, wider training issues, change in practice or pathways etc, reducing risk etc. Whilst it is reasonable to expect all level of personnel to report issues 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 Issues/Incident Reporting Process

a) Issues will be submited to the network office as early as possible via the secure Datix form situated on our website or 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 entries will be added to the purpose-built database within 5 working days and we will initially risk score them using an agreed algorithm appendix 2.

c) The network office will then contact to the person reporting the issue, providing a unique reference number for further correspondence.

d) The Trauma and Critical Care Dashboards also identify any 'open cases' acting as a reminder for those involved in the investigation. The network office will send regular reminders to those investigating too.

e) Upon completion of the investigation the issue will be closed but will remain on the database for auditing purposes or should it be necessary to reopen the case.

1.6 Investigation Process

Many issues are closed quickly following an investigation; often because communication is between one service to another and only requires assistance from the network office. The risk scoring process ensures issues are appropriately escalated and presented/reviewed at network board meetings.

On the dashboard those which are presented as 'red' are more than 6 months old and no investigation has been completed. These issues will be escalated to the **Network Manager & the Regional Leads, who will escalate to the Commissioner of the service and NHSE Quality Team and Integrated Care Board** who will seek further clarification and a process leading to closure of the issue.

Risk score >12: these will be highlighted at network board meetings on a quarterly basis. We will continue to ensure they are properly investigated and therefore any discussions at board meetings must be with caution as the information submitted may not be completely accurate until all sides have reviewed the case. The board may identify learning points/service improvement or further actions as required to allow closure of the issue.

Risk score >12 - The network office will escalate service risks with a score >12 to the Spec Comm Team Single Point of Contact who will assign an appropriate commissioner and manage the issue.

Severity score 5: these are 'catastrophic' cases – whilst rare they do happen and again will be presented at the network board meetings and we will also request that the case be presented by the submitter and investigator at a PAQ Board or equivalent in the other Networks.

1.7 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/Regional Lead & Network Manager who will request a SUI investigation is undertaken or an external review by another network. Appropriate paperwork will be completed.

The West 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.

1.8 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.

1.9 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 trends or themes across services or regions we cover. **No patient identifiable information is kept on the database.**

The database is maintained by the network office.

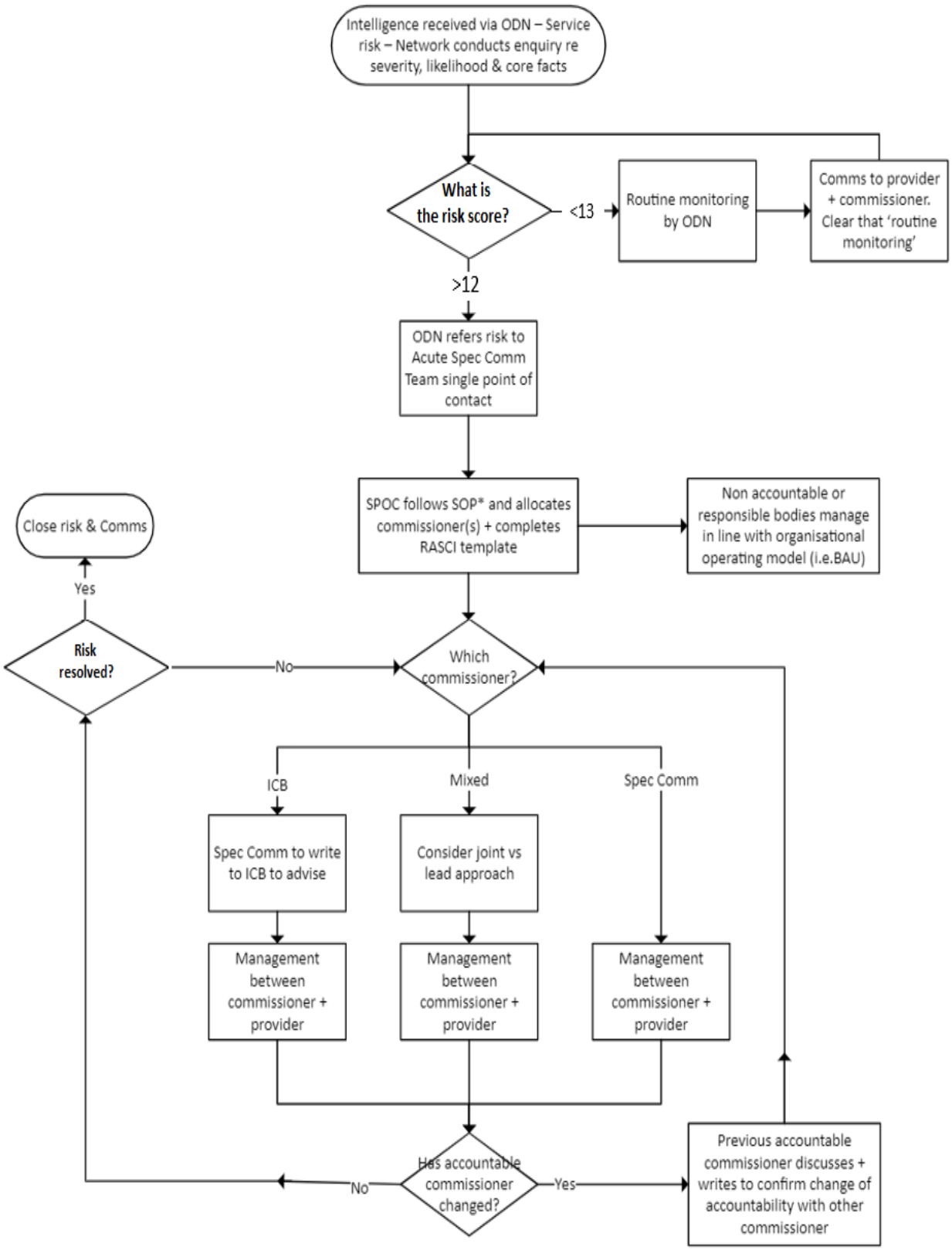
1.10 Abbreviations

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

1.11 Appendices

Appendix 1	Service Risk Escalation Flowchart
Appendix 2	Risk scoring algorithm

Appendix 1 Service Risk Escalation Flowchart



Appendix 2 – Risk Scoring Algorithm

Instructions for use

- Use Hazard Impact Descriptors to determine the consequence score for the potential adverse outcome relevant to the risk being evaluated.
- Use Likelihood Descriptor to determine the likelihood score for those adverse outcomes.
- Calculate the risk score the risk multiplying the consequence by the likelihood.

Impact Score	Hazard Impact Descriptors	Likelihood Score	Likelihood Descriptor
1	**Negligible** - Minor poor experience of patient(s) - Occasional complaints of poor patient experience - No serious Incidents - No or minimal breech of guidance, standards and/or policies - L1 Routine monitoring (MH) – Managerial/Operational Issue with low level short term risk	1	Likely (>50% chance) to be less than one year/no or minimal mitigations required
2	**Minor** - Minor physical or psychological harm/injury (recoverable) to patients, - Multiple formal complaints of poor patient experience - Service Loss / interruption > 8 hours, including ongoing low staffing level reducing service quality - Limited evidence of non compliance with guidance, standards and/or policies - Local media coverage – short-term reduction in public confidence in part of system organisation/pathways - L2 Routine Monitoring (MH) - Managerial/Operational issues with low level risk	2	Likely (>50% chance) to be at least once a year / short term mitigations identified and in place
3	**Moderate** - Single significant physical or psychological harm, or permanent injury - Single serious complaint (including concerns raised by healthcare staff) that requires reporting to or investigation by regulators - Service loss / interruption > 24 hours, including ongoing unsafe staffing - Reduced CQC rating/ recommendations. - Single non-compliance with guidance, core standards and/or policies - Local media coverage – loss of public confidence in a system organisation/pathway (short/ medium term) - L3 Enhanced Monitoring (MH) - Safeguarding concerns; Never Event with moderate impact	3	Likely (>50% chance) to be at least every six months / mitigation plan in place and on track
4	**Serious** - Multiple significant physical or psychological harm/injury (<10), - Multiple serious complaints (including concerns raised by staff) that requires reporting to or investigation by regulators - Service loss / interruption > 48 hrs including uncertain delivery of service due to lack of staff. - Reduced CQC rating/Challenging recommendations. - Evidence of non-compliance with core standards and/or policies - Local media coverage. Significant loss of public confidence in a system organisation or pathway (long term) - L3 Enhanced monitoring (MH) - Multiple safeguarding concerns; Never Events with moderate impact	4	Likely (>50% chance) to be at least quarterly / mitigations unlikely to prevent risk within next quarter
5	**Severe** - 1 avoidable/unexpected death or multiple significant physical or psychological harm/injury (>10) - Service loss / suspension / interruption > 1 week, including due to lack of staff - CQC enforcement action/Critical report and low rating. - Major non-compliance with core standards and/or policies - National media involvement likely. Significant loss of public confidence in a system organisation or pathway (long term)	5	Likely (>50% chance) to be monthly / insufficient mitigations in place and/or significantly off track.
6	**Critical** - 2 or more avoidable/unexpected deaths - Permanent loss of service/facility, including non- delivery of service due to lack of staff. - Prosecution / Severely critical report by regulator - Significant and immediate infringement of process/systems which results in loss of critical service and/or risk to service users - National media coverage inevitable. Total loss of public confidence in system organisations and/or pathways.	6	Likely (>50% chance) to be daily / insufficient mitigations identified and minimal reduction in risk impact expected