**West Midlands Regional Spine Network**

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**Harms review framework**

**June 2022**

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| **Category** | **Operational Delivery Network policy document** **West Midlands Regional Spine Network (WMRSN)** |
| **Purpose** | **To provide a framework for harms review for long waiting patients** |
| **Version** | **1.0** |
| **Previous versions** | **Nil** |
| **Supporting documents** | **WMRSN COVID-19 documents** |
| **Responsible working group** | **WMRSN Board** |
| **Sign off** | **WMRSN board** |
| **Related networks** | **N/A** |
| **Distribution** | **All WMRSN hospital COO and Medical director****Clinical leads ED / spine surgery / radiology / MSK & Spine triage or interface services****Chair STPs / CCG****Betsi Cadwaladr health board** |
| **Review date** | **1.6.2023** |

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**INTRODUCTION**

The COVID-19 pandemic along with other pressures on the NHS has resulted in significant disruption to elective care and a backlog of patients waiting for outpatient and inpatient care.

This document aims to provide a framework to be used in preventing harm and assessing these patients for harm and reprioritising as required.

Harm in this context is defined as significant or irreversible detriment from prolonged wait OR need for additional procedures as a direct result of prolonged wait.

**PREVENTING HARM**

**PRIORITISING, VALIDATING AND SAFETY NETTING**

As a general principle, all patients referred to spine surgical services should be:

* Appropriately prioritised according to clinical need
* Validated for the need for continued care under spine surgery
* Safety netted with a clear channel of communication especially for patients beyond their anticipated time lines
* Reprioritised as required

To achieve this, there must be adequate administrative support and job planned time for clinicians and other HCP to carry out this work.

The channel for communication could be a generic email address that is regularly monitored or voice mail that is regularly monitored.

**Outpatients – new referrals**

Outpatient referrals to elective services are predominantly directly from primary care and interface services. The urgency prioritisation of the referral must lie with the initial referrer.

**Recommendation:**

* All urgent referrals must be triaged by a clinician or nominated HCP that can assess and confirm priority for that patient.
* Patients with potential cancer diagnosis, infections or potential neurological compromise must be prioritised and flagged for a secure appointment within a specified time frame. Patients inappropriately marked as urgent should be re-prioritised to increase capacity for clinically urgent patients.
* Triage outcomes could be
	+ Assessment by the on call service
	+ Assessment in next emergency clinic slot (less than 2 weeks)
	+ Assessment in elective clinic < 4 weeks
	+ Assessment in elective clinic > 4 weeks
	+ Inappropriate for spine surgical services – divert or reject referral with reason
* If resources are available, the above can be applied to all referrals to the service.

**Outpatients – follow up patients**

A high proportion of patients have breached their planned review date.

**Recommendation:**

* Administrative validation of all long waiting patients to confirm no duplication / incorrect entries
* Consider a validation letter for adult outpatients asking for confirmation from patient that they still need to be seen (provide a generic email address for the response). The letter should encourage contact with the service if the patient feels they have deteriorated.
* Consider a validation clinic whereby patients beyond 52 weeks breach are reviewed by clinician or nominated HCP for flagging:
	+ Those at risk of harm (triggers review - see below)
	+ Those that could be reviewed remotely
	+ Those that no longer require spine surgical care
	+ Those that warrant updated investigations
	+ Those that require F2F appointments
	+ Those that could have a PIFU pathway
	+ Prioritisation category
* Provide a clear channel for patients to communicate with the spine service if they feel they have deteriorated.

**Inpatients**

All patients on a wait list should be listed with a clear prioritisation status as per the FSSA document <https://fssa.org.uk/covid-19_documents.aspx>

The automatic adjustment of prioritisation from P3 to P2 based on time alone is recommended only when capacity allows work flows in keeping with restoration and recovery.

A patient must not be listed for surgery unless they are ready, fit and able for surgery.

**Recommendation:**

* Administrative validation of all long waiting patients to confirm no duplication / incorrect entries
* Consider a validation letter for all inpatients asking for confirmation that they still need surgery (provide a generic email address for the response). The letter should encourage contact if the patient feels they have deteriorated.
* The prioritisation status should be clearly visible to all relevant staff members building theatre lists to ensure the correct patients are prepared for surgery.
* All P1b and P2 patients must be pre-assessed and ready for a list in case of late theatre availability from time of listing.
* Priority for lists must be given to P1, P2 and > 104 week wait patients. The use of pooled lists will facilitate this.
* Any service performing a majority of P3 and P4 patients should be reporting back to the WMRSN to offer support to other units with a significant P2 burden.
* Provide a clear channel for patients to communicate with the spine service if they feel they have deteriorated.
* Patients waiting beyond their anticipated wait time must be contacted by remote consultation for a harms review. Time triggers could be:
	+ P1 patients > 7 days
	+ P2 patients > 8 weeks
	+ P3 patients > 6 months
	+ P4 patients > 52 weeks
	+ All patients > 104 weeks

**HARMS REVIEW**

This process requires job planned time and appropriate administrative resources.

The following groups of patients should be formally assessed for harm:

* Patients contacting service to self-report deterioration
* Patients breaching their urgent outpatient time
* Patients waiting > 52 weeks for their outpatient follow up
* P1 patients > 7 days
* P2 patients > 6 weeks
* P3 patients > 6 months
* P4 patients > 52 weeks
* All patients > 104 weeks
* Patients identified by the clinician as requiring a harm review

All harms reviews should be clearly documented and have managerial as well as clinician oversight.

All harms reviews actions should be followed through.

Appropriate governance mechanisms need to be triggered as appropriate via a Datix and following usual Trust policy.

Harms reviews can be remote consultations with outcome as urgent F2F appointment.

Where the clinician feels the first review requires a F2F appointment, this should be accepted.

The aim for a harms review is to:

* prevent harm
* identify harm
* re-prioritise as necessary
* learn from the review

The level of harm must be recorded:

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| --- | --- |
| **Level of Harm** | **Descriptor** |
| **Catastrophic** | Death due to progression of the disease whilst on the waiting list from index condition. |
| **Severe** | Irreversible progression of disease, therapeutic window missed with respect to timing such that surgical opportunity is lost or the severity of surgery is increased significantly, disease no longer remedial with original intended treatment. |
| **Moderate** | Significant change to treatment and/or surgical plan needed. |
| **Low** | Prolongation of symptoms, minor increase in medication, minor changes in surgical difficulty but same procedure. |
| **No harm** | No evidence of change in the clinical condition, clinical impact and surgery difficulty. |

As well as the Datix, the immediate clinical action from the review should also be recorded:

|  |  |
| --- | --- |
| **Action** | **Descriptor** |
| **Urgent re-prioritisation** | Risk of causing harm is high or harm has happened but can be mitigated by clinical reprioritisation |
| **Urgent re-assessment** | Further assessment / investigations required urgently to assess – should be complete < 6 weeks. This may include F2F assessment to change procedure and re-inform patient |
| **Re-assessment required** | Further assessment / investigations required to assess – should be complete < 3 months |
| **Continue – no change required** | No harm or risk of harm identified – continue original plan |
| **Discharge from service** | Patient no longer requires spine surgical service  |

The outcome from all harms reviews must be clearly recorded and the actions followed through.

The harms reviews should be repeated if the criteria for review are reached again.

This is a framework for consideration. Individual services may develop their own harms review process. The West Midlands Spine Surgery ODN board feel that this is an appropriate guidance for the population of patients we manage.

Appendix 1

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| --- | --- |
| **Patient Identifier** | PID - Age:  |
| **Incident Report Form number** | Uxxxx |
| **Date scoping completed** | dd/mm/yy |
| **Scoping completed by** | Name - Role |
| **Speciality/Division/Site** | Specialty / Division / Site |
| **Incident description**  | The incident was reported on dd/mm/yy. Details of the incident form were:*“to include description of the incident ”* |
| **Incident Timeline**Highlight key events, interactions,interventions pertinent to the case | Timeline: |
| **Harm review** |

|  |  |
| --- | --- |
| **Patient’s diagnosis** |  |
| **Initial proposed Surgery/Treatment** |   |
| **Initial Expected Prognosis/Outcome** |  |
| **Date procedure agreed** |   |
| **Initial Priority Score** |  *- Please include date agreed* |
| **Was the patient's condition reviewed whilst on the waiting list** |  *- Please detail key reviews/discussions* |
| **Current Priority Score** |  *- Please include date agreed* |
| **Current proposed Surgery/Treatment** | * *This is to identify for example if due to delays, the surgical plan needed to be reviewed which may affect prognosis/outcome*
 |
| **Current Expected Prognosis/Outcome** |  |
| **Were alternative treatments considered?** *If not please provide further details* |  |
| **Any other contributing factor** |   |

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| **What is the actual/suspected level of harm**  |

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| --- | --- | --- |
| **Level of Harm** | **Tick relevant box** | **Descriptor** |
| **Catastrophic** |  | Death due to progression of the disease whilst on the waiting list from index condition. |
| **Severe** |  | Irreversible progression of disease, therapeutic window missed with respect to timing such that surgical opportunity is lost or the severity of surgery is increased significantly, disease no longer remedial with original intended treatment. |
| **Moderate** |  | Significant change to treatment and/or surgical plan needed. |
| **Low** |  | Prolongation of symptoms, minor increase in medication, minor changes in surgical difficulty but same procedure. |
| **No harm** |  | No evidence of change in the clinical condition, clinical impact and surgery difficulty. |

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| **Rationale for the level of harm** |  |
| **Summary of concerns issues identified** |  |
| **Sign off by the Division**  |
| **Reviewed by** | Name - Role |
| **Review date** | dd/mm/yy |
| **Level of Harm approved** | **YES/NO** |
| **Comments** |  |