Title:	**CLINICAL INCIDENT REPORTING**
Reference number	**PD-0DN-03**
Main Author (s)	**Kelly Harvey**
Target Audience	**All Local Neonatal Units within the North West Neonatal Operational Delivery Network**
Ratified by:	**SMT**
Date Ratified:	**6.10.21**
Review Date:	**6.10.24**
Version:	**Final**
Document status:	**Circulated via CEG October & November & uploaded to website 6.10 21** **Only 1 minor change to original document regarding units outside of ODN**

North West Neonatal Operational Delivery Network
Clinical Incident Reporting Process

1. **Introduction**

The North West Neonatal Operational Delivery Network (NWNODN) encompasses three localities: Greater Manchester, Cheshire and Mersey and Lancashire and South Cumbria. The guiding principle of all providers within the NWNODN is to provide safe, effective care of the highest standard to babies and families.

Due to the nature of neonatal care and the need for transfers and care by more than one provider clinical incidents may be identified by one provider having occurred within another provider. If this is the case and there has been harm to the patient or near miss of potential harm, the identifying provider has a responsibility to report this and ensure investigation has been carried out. It is appropriate that such clinical incidents are highlighted via the NWNODN, via a robust governance process to ensure timely and appropriate escalation of clinical incidents is undertaken and responses/outcomes are tracked.

2. Purpose

Describe and illustrate a process for reporting a clinical incident identified at another provider via the NWNODN.

3. Scope

Applies to all providers of neonatal care in the North West Neonatal Operational Delivery Network.

4. Responsibilities

4.1. Providers:

- To engage with all NWNODN governance processes and highlight any clinical incidents identified at other providers.
- Follow the process of clinical incident reporting via the NWNODN.
- Review any clinical incident highlighted within own unit and feedback to the NWNODN via the clinical incident form when requested.
- Adhere to time frames for response.

4.2. Connect North West (CNW):

- To engage with all NWNODN governance processes and highlight any clinical incidents identified at another provider.
- Follow the process for clinical incident reporting via the NWNODN
- Adhere to timeframes for responses.
- Review any clinical incident highlighted within CNW by another provider and complete incident reporting form as appropriate.

4.3. NWNODN Team:

- Facilitate clinical incident reporting between individual providers.
- Track clinical incidents and ensure timeframes for response are adhered to where possible.
- If an incident occurs during care provided outside of a NW neonatal provider to refer the incident to the relevant network/transport service for local review, sharing this process in support.

- Identify incidents where further review may be required such as multi-provider review/independent review.

5. Clinical Incident reporting Criteria:

- Any incident identified as causing harm or potential harm (near miss) to a patient where the act/omission occurred whilst in another providers care.

6. Clinical incident reporting process:

- Flow chart to describe process in Appendix 1.
- Clinical incident identified which has occurred within another provider.
- Clinical Incident form completed – ensuring no patient identifiable data is on the form (badger ID only) – and sent to K. Harvey (Governance QILN).
- Incident is assigned a NWNODN reference number and forwarded to the provider/s involved in the clinical incident, with a date for response set.
- The clinical incident will have suggested action identified such as local governance review/CEG review as high-level incident/need for multi-provider review.
- Provider responds within the timeframe with details of local review/lessons for sharing or with details of why local investigation not yet complete (i.e. if an RCA not yet complete).
- Outcome agreed by provider and NWNODN and forwarded to reporting provider.
- Lessons learnt shared at appropriate locality CEG only when outcome agreed.

7. References

- NHS England. (2012). Serious Incident Framework: Supporting learning to prevent recurrence: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
- NRLS (2012) Grading of Harm within as clinical incident, Learn from patient safety events (learn-from-patient-safety-events.nhs.uk)

8. Monitoring Systems **Monitoring and or Audit**

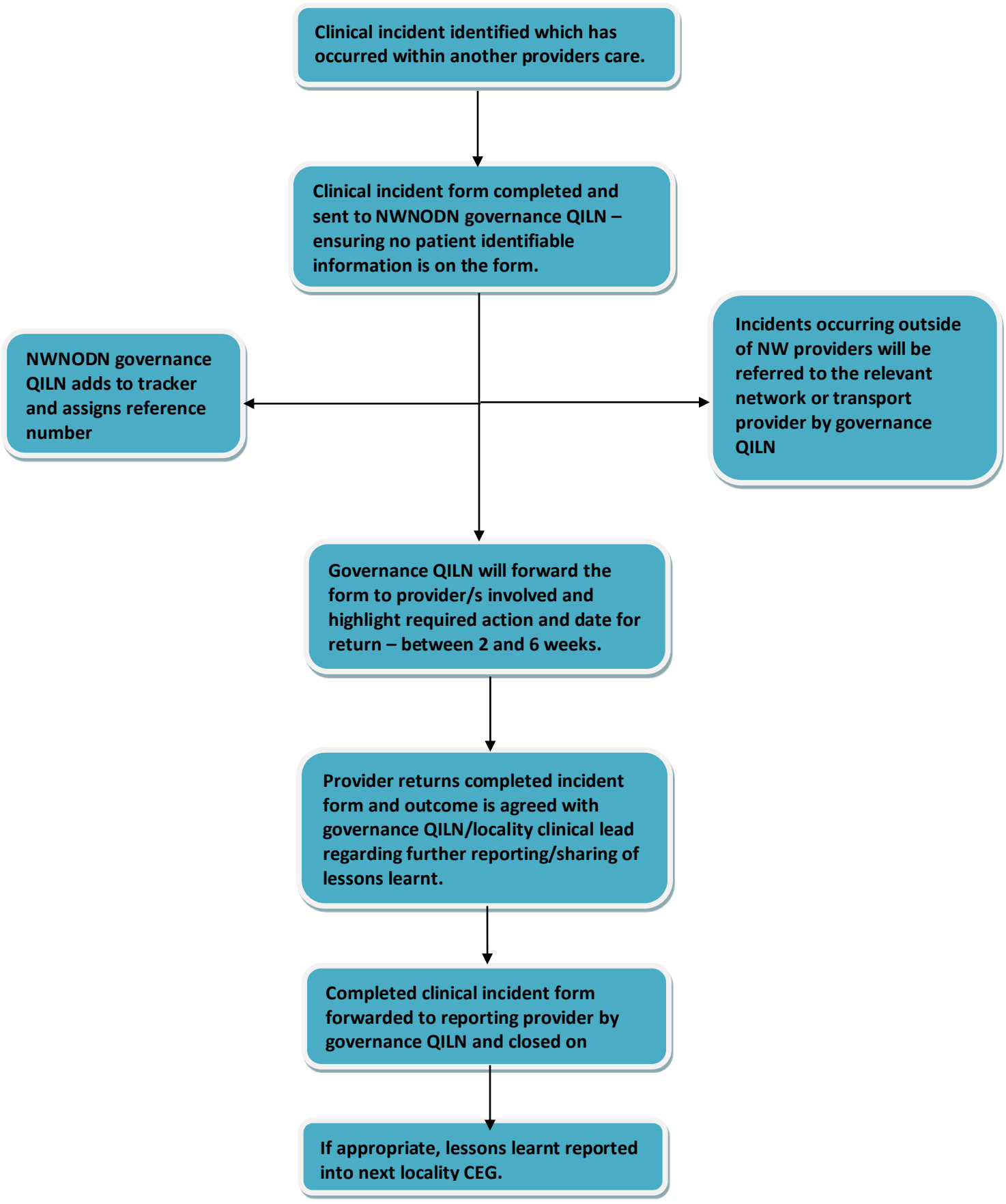
Monitoring and Audit	Frequency	By Whom	Reported to
	Annually	**NWNODN Team**	**SMT & NSGs**

9. Equality and Diversity Assessment Box

Equality and Diversity Assessment	**18/06/2018 & 30/09/2021**
Impact Assessment Completed by	**K. Harvey**
Date completed	
Relevance Shown	**none**
Action plan completed	
Nominated Lead for Action Plan	
Completed Assessments held by	**North West Operational Delivery Network**

Appendix 1:

Clinical Incident Reporting Process



Appendix 2 - Clinical Incident Reporting Form -

CLINICAL INCIDENT IDENTIFIED AT ANOTHER/MULTIPLE PROVIDERS			
NO PERSONAL IDENTIFIABLE INFORMATION TO BE USED IN ANY PART OF THIS FORM.			
Date of Incident:		**NWNODN Reference:**	
Providers involved: (Please include any known badger ID)	**1.** **2.** **3.**		
Type of incident:		**Level of Harm:** (See Key)	
Brief details of incident (fact only no personal opinion to be included)			
Issues identified by reporting provider – please make clear here why you have assigned level of harm.			
Action taken by reporting provider			
Date referred to additional providers	**1.** **2.** **3.**	**Action requested:** (Share internal review, report to CEG if identified as high level)	
Provider response (please attach details of local review here if complete)			
Date of response to NWNODN:		**Date forwarded to reporter:**	
Outcome: (i.e. appropriate local review no wider learning or reported lessons learnt to CEG or Multi-provider review requested. If RCA complete please include action plan)			

Levels of Harm:

No Harm/near miss- Potential harm avoided but lessons could be learnt

Low - Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons

Moderate- Any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.

Severe- Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.

Death- Any unexpected or unintended event that caused the death of one or more persons.

As per NRLS grading of harm: Learn from patient safety events (learn-from-patient-safety-events.nhs.uk)