Clinical Harm Review Process for Waiting List Management

Policy

Domain	Governance, Incident & Risk Management		
Lead author	Head of Quality & Risk		
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Responsible committee	Clinical Governance Committee	HCRG Care Group Executive Sponsor	Chief Operating Officer
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2	August 2023	V1.2 – April 2021 (updated Feb 2022)	

Policies and procedures are applicable to colleagues employed by and/or working for and/or delivering services to or on behalf of HCRG Care Group:

"HCRG Care Group" refers to each of the various entities that make up HCRG Care Group as a group. This includes HCRG Care Group Holdings Limited and its subsidiaries (as defined in section 1159 of the Companies Act 2006), as well as Peninsula Health LLP.

This policy / procedure applies to the following group(s) of colleagues:

	Required level of acceptance	
Colleague group	Awareness	Read
HCRG Care Group corporate colleagues	✓	
Clinical colleagues	✓	
Non-clinical colleagues in business units / clinical service	✓	
All colleagues	✓	
Specific colleague group(s) (if applicable, please state) Regional Directors, BU Heads & Operational Managers Quality, Governance & Improvement Leads		✓ ✓

Contents

1. Policy statement

HCRG Care Group, referred to as "the organisation" has aligned this Clinical Harm Review Process for Waiting List Management to the Clinical Governance Policy which supports the delivery of safe and high-quality care for all service users.

This document details the process to be adhered to when business units are conducting harm reviews into waiting lists which is an NHS England (NHSE) requirement.

This Process should be read in conjunction with the organisation's policy suite and with specific local policies and procedures.

2. Introduction

Harm reviews are defined as:

A review of the state of the health of a patient, undertaken by a clinician, in order to ascertain if harm has occurred due to the increase in waiting caused by not meeting mandated and contracted standards. Harm can be both physical and/or psychological.

Patients may be harmed not only by clinical treatment, but also as a result of the need to be on a waiting list for clinical treatment over the agreed time (as determined by each service) as this may result in deterioration of their physical or psychological condition (this does not need to be a formal diagnosis of a psychological condition).

NHS England have set expectations that such waiting list delays should be expected to trigger a review process, so that providers can understand the causes of these long waits and put in place processes to avoid them in future. Harm Reviews are critical for an organisation and service to learn from delays caused by any reason (can be due to the effect of various disruptions on business-as-usual waiting lists as well as any delays due to the management of the waiting lists for any reason.)

Given the nature of the services offered nationwide it is acceptable for Services to use the Clinical Harm Review Process approved within their local Health Systems and or Specialist areas however all governance process regarding learning and reporting must be adhered to as per this document.

3. Aims

The purpose of this Process is to identify a standardised approach to Harm Reviews for all Business Units and Services within the organisation in relation to waiting list management which then supports the organisation's governance and assurance processes and maintains practice in line with national expectations.

Successful implementation of this process with robust governance will also provide assurance to external bodies that the organisation understands the risks that waiting for and/or delays in treatment can pose to patients and is taking steps to mitigate against these risks which may include further reviews and operational actions.

There is no requirement for either prospective or retrospective harm reviews to be routinely carried out rather they should be undertaken in response to an identification that patients and service users are waiting longer than is mandated/contracted for a treatment.

4. Definitions

4.1 Harm

Definitions of harm will differ according to the circumstances which are being reviewed, e.g., Referral to Treatment (RTT) pathway, or Cancer pathway.

However, NHSE have suggested definitions for the different levels of patient harm that may occur for these pathways, as demonstrated in the table below. There will be other condition-specific factors that could be used to contribute to the definition of harm at a specialty level. Each speciality must determine these definitions of harm within their local SOP (located on the Intranet).

Example Definitions of Harm –52-week RTT pathway

Severe	Irreversible progression of disease Death on the waiting list from index condition
Moderate	Increase in symptoms Increase in medication or treatment
Low	Prolongation of symptoms

Example Definitions of Harm – Cancer pathway

Severe	Delayed diagnosis Progression of cancer Death on the waiting list from index condition
Moderate	Increase in symptoms Increase in medication or treatment
Low	Prolongation of symptoms

For patients suffering from moderate or severe harm it is a legal requirement that the duty of candour process must be followed as per the Duty of Candour Policy. For the latter group the Patient Safety Incident Response Framework (PSIRF) and associated policy and plan, should also be followed in conjunction with the Management of Incidents Policy.

4.2 Patient Cohorts

This process is concerned with clinical harm reviews of the following patient cohorts:

Prospective	Patients who have waited over the prescribed required time period
Retrospective	Patients who appear to have been affected by waiting for access to a service, as above and may have been highlighted through incidents, complaints, feedback etc and those patients who have been apparently lost to follow up

The prospective harm review patient cohort concerned with 'Current long waiters of concern / breaching agreed wait time threshold' will be *defined by each specialty* and detailed in the BU/Service Process.

4.3 Harm Review Cohorts

The service will determine those service users who are within the cohort as per section 4.2.

4.4 Desktop Harm Review

The clinician assesses the identified "harm review" patient cohorts for their specialty i.e., 52- week breaches using records available. A harm review assessment is made based on this information i.e., no, low, moderate, or severe harm. This can be for prospective or retrospective reviews (see section 5.1.2).

4.5 Clinical Harm Review

The clinician conducts a more detailed assessment of identified harm review patient cohorts i.e., 52-week breaches which may involve reviewing patient records in more detail, contact with the patient's GP and/or an appointment with the patient. This can be for prospective or retrospective reviews (see section 5.1.2).

4.6 Risk Stratification

The clinician identifies and predicts which patients are at a high risk or likely to be at a high risk and prioritises the waiting lists accordingly to mitigate potential harm and maximise all available capacity. This includes:

- Triaging referrals for new patients and addressing key questions such as 'is the clinical need urgent or routine?', 'which specific specialty does the patient require an appointment in?', 'does the patient require any tests prior to their appointment?'

- Reviewing overdue follow up patients addressing key questions such as 'does the patient still require a follow up appointment?', 'is the clinical need urgent or routine?', 'can the patient be seen by an alternative clinician – nurse, allied health professional, or doctor?'

5. Standards and Practice

5.1 Prospective versus retrospective clinical harm reviews

As per national guidance, there are two categories of clinical harm reviews for waiting list management:

5.1.1 Prospective reviews

A review which aims to ascertain what the risk is of a patient coming to harm.
Categories include:

- Patient waiting over 52 weeks
- New outpatients waiting over 24 weeks with or without an appointment
- Overdue follow ups over 6 months

Method required:

- Service to agree local thresholds (maximum acceptable waiting times for the conditions that they treat or procedures that they carry out taking into account contracted performance requirements) and incorporate this information into the SOP for their specialty
- Desktop review of patients using information available, assignment of 'level' of harm and subsequent actions taken
- 2nd clinical review to confirm level of harm as required (if either further clinical opinion / information is required and/or if harm review has initially assessed as either moderate or severe harm)
- Escalation and exception reporting of any cases of potential moderate harm or above
- Themes of findings from harm reviews reported through BU governance and management committees and quarterly to Clinical Governance Committee

5.1.2 Retrospective reviews

A review which ascertains the level of harm a patient has suffered and whether this was as a result of their increased waiting time.
Categories include:

- Emergency admissions on an outpatient waiting list
- Emergency admissions with a future booked appointment
- The requirement of further/more extensive treatment as a result of the delay
- Deaths on an outpatient waiting list (unless it is clear the death was not connected to any condition the patient was on the pathway/wait list for).

Method required:

- Review of episode where harm may have occurred (i.e. ED attendance) and 'level' of harm assigned
- Policy for incident reporting followed including Duty of Candour/ being open requirements completed and recorded
- Escalation and exception reporting of any cases of potential moderate harm or above
- Themes of findings from harm reviews reported through BU governance and management committees and quarterly to Clinical Governance Committee

6. Communications

It is not usually necessary to inform the patient and their GP of the result of harm reviews with an outcome of no or low harm unless a benefit in doing so can be demonstrated or the review has been undertaken in response to a complaint or other concern. This is to avoid causing unnecessary distress or upset, however, should always be considered as this is good professional practice.

For patients who have been deemed to have suffered moderate or severe harm, this should be communicated to them and their GP in line with the Duty of Candour Policy & Procedure and investigated in accordance with the Patient Safety Incident Response Framework (PSIRF) and associated policy and plan.

7. Governance and Assurance

An overview of the results of all clinical harm reviews will be reviewed at the next available Quality Governance Meeting (or similar) for the BU as well as local service quality meetings. All actions must be agreed by the service and be SMART with clear ownership and timescales. Action plans must be monitored to completion by the BU Quality Governance Meeting, or accountability for monitoring must be agreed within the BU if this is assigned to another group.

Learning from clinical harm reviews must be shared in all quality reporting for the BU and the Service must ensure all colleagues are able to review the learning.

A summary of findings and lessons learned will be presented at the next available Clinical Governance Committee and Quarterly Business Review (or similar).

8. Organisational arrangements and responsibilities

The Executive Team has overall accountability at Executive level within the organisation, with responsibilities including for operational performance, clinical quality and safety as outlined below.

8.1 Executive Team

The Executive Team will be responsible for effective operation of the policy as outlined in the Clinical Governance Policy with the Chief Operating Officer holding executive responsibility for Clinical Safety, supported by the Chief Nursing Officer.

8.2 Chief Nursing Officer

Responsible for:

- Ensuring there is a robust process for all BUs to follow to undertake appropriate harm reviews for waiting list management
- Seeking assurance from BU Heads/Regional Directors that all those undertaking harm reviews are suitably qualified and experienced
- Ensuring that there is a clear governance process for the reporting of harm reviews, management of action plans developed post harm reviews and providing assurance to the Executive Team and Board regarding the harm reviews

8.3 Head of Quality and Risk

Responsible for:

- Developing a robust process for all BU to follow to undertake appropriate harm reviews for waiting list management and ensure it is reviewed as required with a maximum 3 years
- Supporting the Quality Leads in all business units when required when they are undertaking or monitoring harm reviews/waiting lists

- Ensuring that all harm reviews are reported to the Clinical Governance Committee quarterly with an update on all relevant action plans

8.4 BU Heads/Regional Directors and Functional Directors/Heads of Function

Responsible for:

- Overseeing the implementation of the harm review for waiting list management process within their BU/Service
- Ensuring that those undertaking harm reviews are provided with all necessary data to enable Harm Reviews to be completed.
- Ensuring that the process for the notification of results of the completed clinical harm reviews are communicated to the patient and their GP as appropriate, and that any escalations are made internally in line with existing policies and procedures.

8.5 BU Quality Leads

Responsible for:

- Ensuring the process is followed in undertaking appropriate harm reviews for waiting list management and participate in review of the process with the Head of Quality and Risk where directed
- Supporting those undertaking clinical harm reviews in their business units
- Reporting all harm reviews to the Clinical Governance Committee and Quarterly Business Review (or similar) quarterly with an update on all relevant action plans
- Ensuring there is a governance process within the business unit for the reporting of harm reviews, management of action plans developed post harm reviews and providing assurance to the Senior Leadership Team within the BU

8.6 All Colleagues

Responsible for:

- Carrying out their duties in accordance with instructions.
- Reporting incidents/accidents and near misses in accordance with the organisation's procedures for the reporting and management of incidents.
- Being familiar with and complying with all appropriate policies and procedures.
- Being accountable for providing safe standards of clinical practice through compliance with the regulations of appropriate professional bodies.
- Escalating any concerns relating to clinical harm from waiting list management.

9. Key committees and working groups

The committees with responsibility for monitoring outcomes of harm reviews for waiting list management are detailed within the organisation's governance structure including agreed terms of reference which are reviewed annually. Formal reporting systems and a common membership within all committees supports the clinical governance process.

9.1 Executive Team

The Executive Team is responsible for overseeing operation of the business, including management of the corporate risk register, and for providing regular reports to the Board.

9.2 Clinical Governance Committee

Clinical Governance Committee reports to the Quality Committee and is responsible for oversight of clinical governance including systems to manage and mitigate clinical risk. The Clinical Governance Committee is supported by its reporting committees/working groups, namely the Infection Control Committee, Medicines Governance Group, Safeguarding Governance Group and Striving for Better Committee.

9.3 Quarterly Business Review/Integrated Performance Committee

The Quarterly Business Review/Integrated Performance Committee will be responsible for performance management of all BU Operations and monitoring action plans where waiting times have exceeded expectations and harm reviews are required. Clear trajectories for improvement will be monitored here.

10. Stakeholders

The organisation recognises the importance of involving their stakeholders in control of risk and will engage in consultation and discussion to agree and monitor key areas.

Appendix 1 Version Control

Version	Date	Main author(s)	Individuals/ groups consulted	Significant changes	Legislation/national guidance /best practice etc. reflected
1	Dec 2020	Cath Marsland	Quality Leads	New	
1.1	September 2021	Cath Marsland	Chief Medical Officer Ash Capel	Change to wording of section 6.3	
1.2	February 2022	Ash Capel		Rebranded. Amended 'Ops Board' to 'Quarterly Business Review'	
2	July 2023	Ash Capel – Head of Quality & Risk Beth Galley – Deputy Quality Lead (DaSH)	Quality Performance Group		