The NHS Delivery Unit (DU) have issued a new framework, guidance and suite of notification forms in respect of Health Board incident reporting and investigation (NHS Wales National Incident Reporting Policy Implementation Guidance Document [Phase 1])**. Further work is required to establish how HB's will safely manage this transition to ensure that there is consistency of approach and oversight of those meeting the new National Reporting criteria, and those incidents under the previous reporting criteria that require ILG / HB level oversight and investigation. Therefore until further notice the following guidance will apply within CTMUHB, and all new and previously reportable *serious patient safety incidents* must continue to be reported to the appropriate ILG governance team for approval. Once approved by the ILGs, reports must be submitted to the Central Patient Safety inbox at** CTHB_Patient_Safety@wales.nhs.uk

The Central Patient Safety Team will then disaggregate those that require notification to the Delivery Unit and will forward as appropriate.

To support the implementation of these interim arrangements:-

- ✓ New notification forms must be used and are available at: http://ctuhb-intranet/dir/Cons/psi/SitePages/Home.aspx
- ✓ Notifications of all serious patient incidents must be made to the appropriate ILG governance team for approval.
- ✓ ILG's to report all serious patient safety incidents to the central inbox at: CTHB_Patient_Safety@wales.nhs.uk to provide oversight and assurance to the executive team and Health Board members.
- ✓ The central patient safety team administrator will forward nationally reportable incidents to the DU.
- ✓ All serious patient safety incidents will require RCA investigation within a 60 day timescale until agreed proportional investigation tools are available.

If colleagues are unsure about the new reporting requirements please contact your ILG governance team or the central patient care & safety team for further guidance:

Central Patient Safety Team CTHB_Patient_Safety@wales.nhs.uk

RTE Governance Team CTM.RhonddaTaffElyILG.Governance@wales.nhs.uk

Bridgend Governance Team BridgendILGGovernanceComplaints@wales.nhs.uk

MC Governance Team CTM.MerthyrCynonILG.Governance@wales.nhs.uk

NATIONALLY REPORTABLE INCIDENTS – Reported to the Delivery Unit (via the Central Patient Safety Team).

Incident type	Supporting Narrative
Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months.	
In-patient Suicides	All completed in-patient suicides of any service user, in any clinical setting, will be reportable.
Maternal Deaths	The national reporting requirement is confined to 'direct maternal deaths': the death of a woman while pregnant, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes..
Never Events	Reporting arrangements for Never Events will remain as outlined in the Welsh Health Circular (WHC) (2018) (12). Please refer to the below link for further details; https://gov.wales/sites/default/files/publications/2019-07/never-events-list-2018-and-assurance-review-process.pdf
Incidents where the number of patients affected **is confirmed to be** significant	Such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure. **Investigate locally and report nationally if patients are confirmed to be affected.**
Unusual, unexpected or surprising incidents	Where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial. The purpose of including this category within the policy was to enable organisations to report an incident they consider should be reported, even where the national reporting criteria cannot be met.

CTMUHB INCIDENT REPORTING GUIDANCE FROM 14th JUNE 2021

***The nature of patient safety incidents makes it impossible to define a list to which all reportable incidents would comply – this is one of the problems observed with traditional 'category based' reporting methods. All organisations will have incidents occur that do not strictly meet the criteria set out in the policy or this guidance, but should still be reported. This may be because the incident was a significant near miss or because the circumstances of the incident make it impossible to determine a level of harm with any certainty. Whilst it is a decision for each organisation about serious patient safety incidents reported in this way, advice can be sought from the Central Patient Safety Team.**

LOCALLY REPORTABLE INCIDENTS – Reported to the Central Patient Safety Team.

Incident type	Supporting Narrative
Pressure Damage	Reported and investigated locally for all incidents. If **Avoidable** Grade 3, 4 or unstageable – **report nationally**. If **Unavoidable** – continue to manage with local standards.
Unexpected deaths in the community of patients known to MH&LD services.	All unexpected deaths of service users known to MH&LD services, including those under the care of Primary MH and Drug & alcohol services, within 12 months prior to death to be reported and investigated locally. **Causation or Contributory – report nationally.** **Non-causation or Non-contributory –** report locally.
Safeguarding	Safeguarding incidents should be reported and managed in keeping with national safeguarding procedures and requirements. **See additional information below ****
Procedural Response to Unexpected Death in Childhood (PRUDiC)	PRUDiC incidents should be reported and investigated locally in line with national PRUDiC requirements. **See additional information below ****
Abuse or Suspected Abuse	Abuse should be reported and managed locally. **See additional information below ****
Healthcare Acquired Infections (HCAIs)	**See additional information below **** HCAIs which appear on death certificated will by their nature be considered causative or contributory to the death and will be classed as nationally reportable. This requirement does not apply to nosocomial transmission of Covid-19 until further notice.
Commissioned Services	Complex requirements, therefore refer to policy. Additional support can be provided by the Central Patient Care and Safety Unit.
Externally Reportable Incidents	Although local reporting is required at present, there is no requirement to nationally report matters which are reportable to external organisations, regulators and national audits, such as Human Tissue Authority (HTA), or Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries (MBRRACE). **See additional information below ****

**Where it is assessed or suspected that an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or contributed to severe harm, this should be nationally reported to the DU. In all other instances, responsible bodies should consider submission of an 'early warning notification' to WG.

DATIX

To support implementation of the revised National Incident Reporting Process the Datix system has been updated to ensure the external and internal requirements continue to be met.

The WG screen within the incidents module has been renamed to Nationally Reportable Incident Information. The terminology has also been updated to reflect the role of the Delivery Unit and update documentation i.e. LFER / Outcome reports.

In order to assurance robust tracking the type field now includes a number of options:

- ✓ **Serious Incident** – these are all serious incidents that were reported to the WG/DU prior to the 13.06.21
- ✓ **Nationally Reportable Incident** – all incidents that meet the criteria for reporting to the DU after 14.06.21
- ✓ **Locally Reportable Incident** – this will include incidents that would previously have been considered a Serious Incident, that although no longer meet the NRI criteria, but must be reported internally via the central inbox. Reduced fields will appear to reflect this for internal monitoring only.
- ✓ **Pressure Ulcer Incidents** – for stage 3, 4 and unstageable that require investigation within 60 days and reporting to the DU if deemed avoidable on conclusion of the investigation.

- ✓ **Unexpected death in the community of mental health and learning disability patient -** incidents that require investigation and reported to the DU if deemed causative or contributory.
  Pressure ulcer incidents and unexpected death in the community of mental health and learning disability patients do not require a DU notification on identification, but an outcome report to should be submitted on conclusion of the investigation. The appropriate type will be selected on initial review and whilst a date for completion will be entered, the notification fields will not appear when these options are selected. This will support the monitoring process and ensure those that require national reporting on outcome are not missed.
- **Externally reportable incident only** – this will include incidents that are reportable externally such as HTA, IRMER, MHRA and Safeguarding.

If colleagues are unsure about the new reporting requirements please contact your ILG governance team or the central patient care & safety team for further guidance.