AGENDA ITEM
2.1.5

QUALITY & SAFETY COMMITTEE

NHS WALES NATIONAL INCIDENT REPORTING POLICY

Date of meeting	09/08/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director, Quality, Safety & Safeguarding
Presented by	Louise Mann, Assistant Director, Quality, Safety & Safeguarding
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Medical & Nursing Executives ILG Leadership Teams	(14/06/2021)	SUPPORTED

ACRONYMS	
	All explained in the report

1. SITUATION/BACKGROUND

1.1 National incident reporting in NHS Wales has changed. Historically, the focus of incident reporting at a national level has been to examine in detail specific Serious Incidents as set out in the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, primarily through the use of Root Cause Analysis investigation.

1.2 The new National Patient Safety Incident Reporting Policy aims to bring about a number of key changes to national incident reporting (See Appendix 1).

1.3 National reporting of incidents under Phase 1 of the new Policy will commence on 14 June 2021. In brief there are changes in the definitions and terminology previously used, most notably the removal of the term *'serious incident'* from the Policy. There is greater local accountability for deciding what needs to be reported using guiding principles and definitions. Greater emphasis on proportionate investigations, flexibility around timeframes for completion of investigation and linking with Medical Examiners and mortality reviews where applicable; reducing duplicative reviewing processes. There is a new more concise list of incidents that need to be nationally reported on an individual basis. All relevant incidents must be reported to the Delivery Unit within seven working days from the occurrence, or point of knowledge with specific National Incident Categories.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 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]). However, 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 incidents meeting the new National Reporting criteria, and those incidents under the previous reporting criteria that still require Integrated Locality Group (ILG) / HB level oversight and investigation.

2.2 Until further clarity is achieved via the DU national workshops, CTMHB have taken an approach to the changes that maintains effective central oversight of patient safety incidents. The CTMHB guidance ensures that all new and previously reportable *serious patient safety incidents* must continue to be reported to the appropriate ILG governance team for initial approval, and then submitted to the Central Patient Safety inbox to provide oversight and assurance for executives and Board members.

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

2.4 Incidents that previously have been considered *serious incidents* will continue to be investigated with Root Cause Analysis tools within a 60 day timeframe. This will be until proportionate investigation tools and a common understanding of incident management has been agreed nationally.

2.5 New DU notification forms are now in use and available to colleagues on SharePoint.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 It is anticipated there will be approximately 12 months of work to allow for adaptation and continuous development in relation to policy implementation. The Policy will be implemented in two phases:

- Individual reporting of the most serious incidents occurring in healthcare (Phase 1), and
- Thematic reporting of healthcare incidents based on common factors regardless of the harm outcome (Phase 2)

All incidents will continue to be reported and investigated locally in line with local policies and procedures. This may include escalation through other national frameworks (e.g. multiagency safeguarding processes) where appropriate.

All incidents will be subject to timely review to ensure immediate make safes are identified and actioned, to reduce future risk of patient harm where applicable, and to determine necessity for national reporting to the DU in keeping with policy timeframes.

New Revised Forms from 14 June 2021, a new suite of "Nationally Reported Incident" forms have been issued and being used within CTMHB.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Introduction and implementation of a new policy in relation to incident reporting. Potential risk of reduced reporting and central assurance.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Safe Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Interim position
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 That Committee Members **CONSIDER** and **ENDORSE** this interim approach (Appendix 2) to the implementation of the new policy in relation to incident management. This could be considered a cautious approach to ensure that there remains a good line of sight on the occurrence of harmful patient safety incidents, make safes, investigation and learning, and for good central governance, scrutiny and assurance.