Guidance on the 'National Incident Reporting Policy'

7 Minute Briefing

Version 1 - June 2021

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1) What is the new 'National Incident reporting Policy'?

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

The new **National Patient Safety Incident Reporting Policy (the Policy, May 2021**) aims to bring about a number of key changes to national incident reporting.

A New national guidance document has been developed to support the practical application of the Policy, and will be continually updated throughout the development phase.

National reporting of incidents under Phase 1 of the new Policy will commence on **14 June 2021.**

2) What are the key changes?

It is proposed from the **14 June 2021**, the following definition of a nationally reportable patient safety incident applies:
'**A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare'**

- The first obvious change in policy direction is a change in terminology with the **removal of the term 'serious incident'** from the Policy.
- **Greater** local accountability for deciding what needs to be reported using guiding principles and definitions.
- **Greater** emphasis on proportionate investigations, linking with Medical Examiners and mortality reviews where applicable.
- A new more concise list of incidents that need to be reported on an individual basis.
- All such incidents must be reported to the Delivery Unit **within seven working days** from the occurrence, or point of knowledge.
- Specific National Incident Categories.

3) Investigations

Following the notification of a nationally reportable incident, responsible bodies must undertake a proportionate investigation which is appropriate to the severity, and in keeping with NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Proportionality should consider the necessary scope required to undertake a robust investigation, in addition to the most appropriate investigation methodology.

All investigations should seek to establish whether any action or inaction by the responsible body, unintended or otherwise, caused or contributed to the reportable incident.

4) Timeframes and flexible reporting

New Additional Information Required

- Investigation timeframes - At the point of submitting a national incident notification to the Delivery Unit, responsible bodies will now be required to indicate the anticipated investigation timeframe of either **30, 60, 90 or 120 working days** from the incident occurrence or the point of knowledge.
- Whilst responsible bodies will not be performance measured against the anticipated timeframes, quarterly reports, which will be individualised and private to each organisation, will be generated by the Delivery Unit listing how many open incidents the organisation has against the listed timeframes.

5) Applicable Definitions

To facilitate a consistent approach across Wales, the following definitions apply:

Unexpected and avoidable death: A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition.
Severe Harm: An incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care
Permanent Harm: Directly related to the incident and not to the natural course of the patient's illness or underlying conditions, defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual, including psychological harm.
Action: Something done intentionally or unintentionally.
Inaction: Indecision, unnecessary delay, failure to act.
Service user: A person accessing NHS funded treatment or NHS funded care in any setting, including NHS staff accessing treatment and care through fare/occupational health services.

6) Quality Assurance

- ✓ Change to the closure process with accountability for these sitting with HBs/Trusts, Learning outcomes will be reported to the DU for collation of national learning.
- ✓ The removal of the term 'serious' is to support a more just and learning culture where reporting incidents does not feel punitive to staff or organisations.
- ✓ Looking at a range of incidents with different outcomes provides a much broader data set to learn from, and to understand not only what went wrong, but to also start to understand what might have gone right to prevent significant harm outcomes and how we can replicate those practices to improve quality and reduce risk.
- ✓ All incidents should be reviewed to determine those which should be nationally reported.

7) What next?

It is anticipated there will be approximately 12 months of work to allow for adaptation and continuous development. 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 should 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 should 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 will be issued in preparation for all staff to familiarise with in preparation for identified incidents requiring to be reported to the DU.
The forms included:
- Notification form
- Learning from Events form (in development)
- Outcomes form
- Combined pressure ulcer notification and outcomes form
- Downgrading form

Adapted from 7 minute briefing created by Hywel Dda University Health Board