GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

NHS Wales National Incident Reporting Policy

Implementation Guidance Document (Phase 1)

This policy does not apply to incidents of nosocomial transmission of Covid-19 until further notice

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Introduction

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. 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**).

To manage the transition, this new national guidance document has been developed to support the practical application of the Policy, and will be continually updated throughout the development phase.

Context

In 2021, we find ourselves in a changed healthcare system. The Covid-19 pandemic has challenged traditional organisational and service delivery structures, and re-emphasised the need for ongoing compassionate leadership. The introduction of the Once for Wales Concerns Management System will also help drive a shift towards consistent national incident reporting and better, more intelligent use of incident data. New conceptual approaches to patient safety, in particular the Safety-II approach, require us to think differently, and ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities. To achieve this, processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The first obvious change in policy direction is a change in terminology with the removal of the term ‘serious incident’ from the Policy. This change is not intended to undermine or divert attention away from the fact that some patient safety incidents can have a catastrophic impact on patients, families and our staff, and should in that regard be managed as ‘serious’ incidents. Instead, 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.

Historically, national serious incident reporting systems have focussed on reporting incidents with significant harm outcomes. However, in many cases, the same set of circumstances can lead to incidents with a range of harm outcomes, including no harm. For example, an avoidable patient fall can result in anything from tenderness to significant fracture or head injury leading to death. Historic systems could therefore be said to be affected by outcome bias by only focusing on the worst outcomes. Looking at a range of incidents with different outcomes gives us 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.

The Policy represents a first step in this new approach to incident reporting and management. It recognises a one-size fits all approach does not work, and allows us to think differently about what

should be reported, how it should be reported, and how the collected data is best used to support policy and practice development to help improve quality and reduce risk. The Policy will empower NHS Wales responsible bodies to take more ownership and accountability for incident reporting, changing the relationship and dynamic with Welsh Government.

The Policy has been produced by Welsh Government and sets out, at a strategic level, what needs to be reported. This guidance document sits alongside the Policy and provides the operational detail of how reporting will occur. To ensure this meets the needs of NHS Wales, the guidance document will be collaboratively produced in an ongoing manner with NHS Wales's partners. The Policy and guidance will evolve over time as we increasingly embrace alternative patient safety methodologies and sciences such as Safety-II, systems thinking, and human factors.

Whilst the coordination and production of the document will be overseen by the NHS Wales Delivery Unit, as the shadow form of the NHS Wales Executive, the document is owned by all NHS Wales organisations.

Notwithstanding the need to change traditional approaches to learning from incidents, there remains a requirement to ensure national oversight and focus where significant harm has occurred. The NHS Wales Delivery Unit will fulfil this function as part of its responsibility to manage the national reporting process.

Scope

This guidance document provides the practical detail to support how NHS Wales responsible bodies will implement the Welsh Government's National Incident Reporting Policy.

Together, this document and the Policy will supersede, **from the 14 June 2021**, the Serious Incident section (Section 9) of the Putting Things Right guidance.

Throughout 2021/22, this guidance document will evolve as Phase 1 and 2 are incrementally introduced.

This guidance, as does the Policy, applies to all NHS Wales responsible bodies. A responsible body is defined under the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) as:

(a) a Welsh NHS body

(b) a primary care provider, or

(c) an independent provider.

For the purposes of the Policy and this guidance document, a responsible body includes those who provide or support the provision of NHS healthcare funded through the Welsh NHS, including:

- NHS Wales Health Boards and Trusts
- Services commissioned by NHS Wales Health Boards and Trusts which are delivered in other organisations, including in private healthcare settings, other countries etc.
- Independent contractors who provide services including primary care practitioners (general practitioners, optometrists, dentists, pharmacists)
- Healthcare services provided in prison settings
- Independent healthcare (where care and treatment is commissioned by responsible bodies).

Local Reporting & Investigation Requirements

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.

Organisations should ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of the Policy.

National Reporting Requirements (Phase 1)

Overarching national reporting requirements

From 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 above definition of an incident is applicable to all NHS funded services, regardless of speciality, delivered in all secondary or primary care settings, including community based services (see also the “Scope” section).

When considering whether to report an incident, the following should be applied:

- a patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is **assessed or suspected** 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 **caused or contributed to severe harm**

- as it will not always be possible to determine the extent to which a patient safety incident caused or contributed to the harm or death of a patient within seven working days, responsible bodies should report in line with the criteria where it is known, and/or suspected, that a patient safety incident has caused or contributed to harm or death. In this scenario, for clarity, the responsible body should specify on the form that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date as set out later in this guidance.

- all such incidents must be reported to the Delivery Unit **within seven working days** from the occurrence, or point of knowledge.

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N.B. It is important to note that acts or inactions can also result from technical failure or delays in systems and processes, as well as human interactions.

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

Policy Term	Applicable Definition
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 welfare/occupational health services

Specific National Incident Categories

The following incidents will also be nationally reportable from 14 June 2021. Whilst these fall under the broad definition of a nationally reportable incident as set out above, they have been drawn out in the policy to ensure clarity on expectations around national reporting.

1. Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months

2. In-patient Suicides

All completed in-patient suicides of any service user, in any clinical setting, will be reportable. The requirement extends to all service users, not just those being treated for mental health needs either within a Mental Health setting or otherwise.

Detained Mental Health patients on authorised/agreed leave away from the clinical setting who complete suicide, or are suspected to have completed suicide whilst away, regardless of the agreed leave timeframe, will be reportable as in-patient suicides.

3. 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. These incidents will be nationally reportable from the 14 June 2021.

Other maternal deaths such as 'Indirect' and 'Late Maternal Deaths' will be considered as part of phase 2 reporting criteria – further guidance will be provided in due course.

4. 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

The Never Event list cannot be added to by responsible bodies in any way. Responsible bodies should ensure the term 'Never Event' is used only in reference to the current national list, or any revisions to the national list at later dates.

5. Incidents where the number of patients affected is significant

such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure

The key wording in this reporting requirement is "the number of patients affected **is** significant". The word 'is' has been purposely included to prevent unnecessary reporting where emerging issues, which could have resulted in harm, were avoided through corrective action or risk mitigation.

Where any incident has, or is likely to have caused an unexpected or avoidable death, and/or severe harm, this should reported as a national incident within seven days from the point of knowledge that harm has been caused (regardless of timeframe). It should be reported by the body responsible for coordinating the affected patient's/patients' care and treatment, regardless of whether the underlying incident was within that organisation's control. Reporting organisations can identify at the time of reporting who the appropriate investigating organisation should be where the incident is considered beyond their control. Organisations will remain responsible for coordinating and liaising with other organisations in relation to joint investigations. Also see 'Joint investigation' section.

All other incidents which do not meet national reporting thresholds should be reported and managed locally with consideration of submitting an 'early warning notification' at the appropriate time.

6. Unusual, unexpected or surprising incidents

where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial

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.

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. This is in keeping with the spirit of the policy that a mature approach to assessing and reporting incidents should allow organisations to make decisions and, following assessment, report any such incidents they feel should be reported.

There is therefore an expectation that, as part of the systems and processes specified above, responsible bodies will consider all incidents, and where an incident of significant concern occurs, will report those incidents nationally even if they do not strictly meet the criteria set out in the Policy.

Whilst it is a decision for each organisation about serious patient safety incidents reported in this way, advice can be sought from the NHS Wales Delivery Unit to support decision making.

Special Reporting Arrangements

The following special reporting arrangements will be effective from the 14 June 2021 pending completion of the roll out of Phase 2. To provide clarity, this guidance document will be iteratively updated as these areas are resolved during Phase 2 work.

1. Pressure damage

Retrospective reporting arrangements for pressure damage will continue as outlined in the Welsh Health Circular (WHC) (2018) (051). Please refer to the below link for further details;

https://gov.wales/sites/default/files/publications/2019-07/welsh-health-circular-on-revised-pressure-ulcer-reporting-including-the-reporting-of-serious-incidents.pdf

N.B. An updated reporting and closure form is available (see “Revised forms” section below) and should be used from 14 June 2021.

2. Unexpected deaths in the community of patients known to MH&LD Services

All unexpected deaths of service users known to Mental Health & Learning Disabilities (MH&LD) services, including Drug and Alcohol Services, within 12 months immediately prior to their death, should be reported and proportionally investigated by responsible bodies.

As it is not possible to provide guidance for all eventualities of an unexpected death in this particular regard, the following is provided as broad guidance for responsible bodies to follow:

All deaths of MH&LD patients that are unexpected, i.e. not as a result of a diagnosed terminal illness, or end of life integrated pathway/care plan, should be reported locally in the first instance. An exception to this would be an unexpected death where there is clear indication at the point of knowledge that the death is related to a particular incident such as a road traffic collision, unless suicide is suspected.

All deaths of MH&LD patients will however always be locally reportable where the exact cause of death is not immediately known, or where an acute medical event such as a heart attack has occurred. This is to ensure firstly there is a broader data set for unexpected deaths for this category of service user, whether nationally reportable or not, and secondly to ensure responsible bodies then conduct a proportionate investigation to understand whether care and treatment over the service user’s course has caused or contributed in any way to the death.

Local investigation methods should ensure that examination is given to factors in the service user’s care which identifies things that could or should have been done differently, representing key opportunities for learning and improving service delivery. Local investigations must consider and review physical healthcare (where appropriate) in conjunction with MH&LD delivered services and therapies.

From 14 June 2021, where local investigations assess 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 death, responsible bodies must report as an individual national patient safety incident within 120 working days from knowledge of death.

Incidents of this nature should be reported using the general incident reporting and outcomes forms (i.e. there is no specific form for this category of incidents). It is acceptable for notifications and outcomes forms to be submitted together.

3. Safeguarding

Safeguarding incidents should be reported and managed in keeping with national safeguarding procedures and requirements. Safeguarding incidents should only be reported nationally to the DU, where it is **assessed or suspected** 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 **caused or contributed to severe harm**. In all other instances, responsible bodies should consider submission of an 'early warning notification'.

4. Procedural Response to Unexpected Death in Childhood (PRUDiC)

PRUDiC incidents should be reported and managed locally in line with national PRUDiC requirements. PRUDiC incidents should only be reported nationally to the DU, where it is **assessed or suspected** 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 the **death**. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

5. Abuse / Suspected Abuse

Abuse incidents should be reported and managed locally. Abuse incidents should be reported nationally to the DU, where it is **assessed or suspected** 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 **caused or contributed to severe harm**. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

6. Healthcare Acquired Infections (HCAIs)

HCAI incidents should be reported and managed locally. HCAI incidents should only be reported nationally where it is **assessed or suspected** 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 **caused or contributed to severe harm**. HCAIs which appear on death certificates will by their nature be considered causative or contributory to the death, and will be classed as nationally reportable within seven days of point of knowledge. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

N.B. This requirement does not apply to nosocomial transmission of Covid-19 until further notice. Organisations should continue to maintain local records in this regard, and refer to separate requirements set out in the National Framework for the Management of Patient Safety Incidents from Nosocomial Transmission of Covid-19.

7. Commissioned Services

As set out in the policy, most NHS organisations will commission services from other organisations, including from WAST, neighbouring HBs/Trusts and outside of NHS Wales.

The policy sets out the general principles for consideration in relation to incidents occurring within commissioned services. A key fundamental principle is that responsible bodies are responsible for the health of their population, not just in relation to the care that they directly provide. Therefore NHS organisations have an explicit obligation to ensure appropriate mechanisms for following up incidents which affect members of their population even if they did not directly provide care themselves.

It is recognised that the commissioning organisation is unlikely to be able to directly investigate an incident occurring on the premises of another organisation and will usually rely on the provider organisation undertaking the investigation on their behalf. It is therefore expected that as part of the commissioning arrangements, consideration is given to how incidents which occur during commissioned services will be investigated by the provider organisation with the commissioner kept informed. The commissioning organisation must have systems and processes to assure themselves of the suitability of commissioned services.

Where an incident occurs during commissioned services and is nationally reportable to another authority (e.g. an incident which occurs in the English NHS will be reportable via STEIS), there is no requirement to duplicate report to the NHS Wales Delivery Unit. Responsible bodies should consider the submission of an ‘early warning notification’ where appropriate. An appropriate summary reporting mechanism for incidents of this nature will be developed during Phase 2.

From 14 June 2021, where an incident which occurs during commissioned services in Wales meets the national incident threshold, this should be reported in line with the Policy by the organisation responsible for the patient’s care and treatment at the time the incident is identified.

8. Externally Reportable Incidents

There is no requirement within the Policy for responsible bodies to routinely generate a national incident report for matters which are already reportable to external organisations, regulators and national audits, such as the Human Tissue Authority (HTA), or Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE). These national reporting requirements, and any associated requirements relating to review and taking corrective or preventative actions, must still continue in line with the external organisation’s requirements.

Responsible bodies should only report an incident of this nature as a national incident as well where the incident is **assessed or suspected** 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 severe harm or death. In all other instances, responsible bodies should consider submission of an ‘early warning notification’ where appropriate.

Reporting Process

From the 14 June 2021, all nationally reportable incidents will be submitted to the NHS Wales Delivery Unit at the earliest opportunity, but no later than seven working days following occurrence or point of knowledge. All forms will continue to be submitted via email until such time that Once for Wales Concerns Management System processes allow for electronic submission. All forms will be sent to NationalSIreports@wales.nhs.uk.

1. Revised Forms

From 14 June 2021, a new suite of “Nationally Reported Incident” forms will be issued and should be used for all new incidents reported to the DU. These forms will be available on the DU’s website: https://du.nhs.wales/patient-safety-wales/patient-safety-incidents/

The forms include:

- Notification form
- Learning from Events form (in development)
- Outcomes form
- Combined pressure ulcer notification and outcomes form
- Downgrading form

In keeping with existing process, all forms must receive Executive sign-off prior to submission. Forms not reviewed and signed by a responsible Executive will be returned and not recorded.

2. 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. The purpose of this reporting is to ensure good governance both on the part of the Delivery Unit, responsible for the national reporting process, and individual organisational governance responsibilities in keeping with NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

- **Level of Investigation** – At the point of submitting a national incident notification to the Delivery Unit, responsible bodies will now be required to indicate what level of proportionate investigation they intend to undertake. The plan in due course is to align the category of available investigation levels with the Once for Wales Concerns Management System implementation and roll out across Wales.

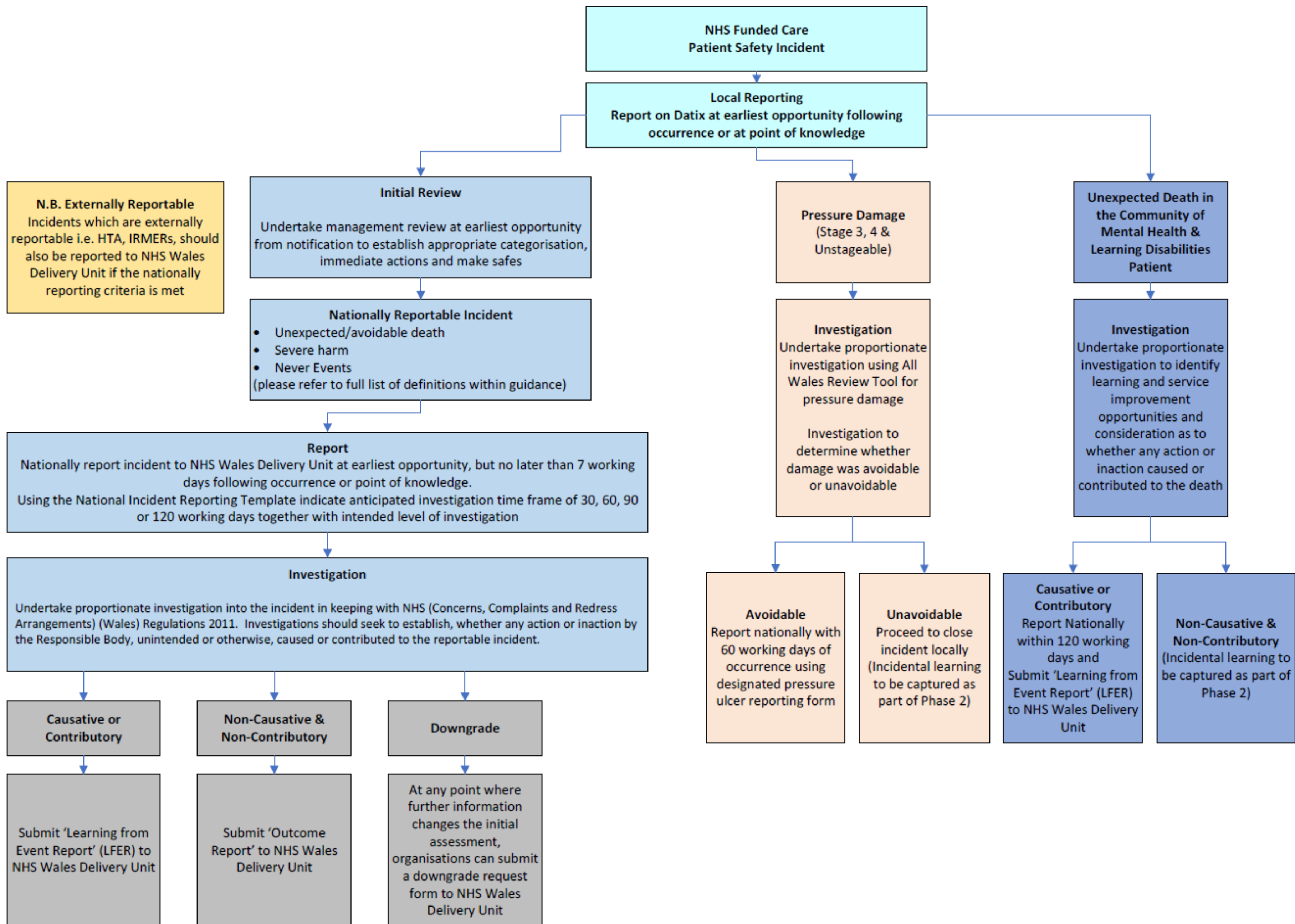
3. Notifications in relation to incidents involving Multiple Organisations

Where an incident is to be jointly investigated, only one notification in relation to the incident needs to be made. The organisations involved in the joint investigation should agree the lead organisation for reporting purposes.

4. Near-miss Incident Reporting

There is a strong desire to receive learning and information from significant near miss incidents, however it is recognised that it would not always be appropriate to require near misses to be reported as national incidents. The mechanism for near miss reporting will be nationally agreed as part of Phase 2. In the interim, responsible bodies can share learning from near miss incidents to the national reporting inbox clearly identifying the incident circumstances and learning identified.

National Incident Reporting Flow Chart (Phase 1)



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.

For pressure damage incidents, responsible bodies should complete the All Wales Pressure Damage Review Tool as set out in the relevant Welsh Health Circular, and complete more in depth investigations where required.

Joint Investigations

Joint investigations are essential when multiple organisations are involved in an incident. The Putting Things Right Guidance should be followed and responsible bodies should also be mindful of their obligations under General Data Protection Regulation in respect of the processing and sharing of data.

Organisations should continue to use existing joint investigation frameworks / arrangements where applicable. In keeping with single organisation reporting requirements, organisations must liaise and coordinate the investigative response when more than one organisation is involved, to decide who will assume responsibility and oversight.

Outcome Process

For incidents reported on or after 14 June 2021, the previous closure process will change. From the 14 June 2021, responsible bodies will have three options following the reporting and proportionate investigation of an incident, as set out below. The key overarching change is that full accountability and responsibility for closure of investigations will sit entirely with the responsible bodies. The information submitted to the Delivery Unit will not be used as a method of agreeing closure.

Organisations will still be expected to submit good quality information in a timely manner which evidences the suitability of investigation undertaken. This will be monitored though the NHS Wales Delivery Unit processes including Quality Assurance. Regular feedback will be provided directly to organisations including as part of regular interface Quality and Safety meetings.

Option 1 Causative or Contributory - will apply where investigations have determined an act or inaction, unintended or otherwise, has caused or contributed to the reportable incident.

In this instance, at the conclusion of the investigation, responsible bodies will be required to complete and submit a Learning from Events report to the Delivery Unit.

Option 2 Non-causative / Non-contributory - will apply where investigations have determined an act or inaction, unintended or otherwise, did not cause or contribute to the reportable incident.

In this instance, at the conclusion of the investigation, responsible bodies will be required to submit an Outcome Report to the Delivery Unit.

Option 3 Downgrade - At any point where further information changes the initial assessment, responsible bodies can submit a downgrade request form to the Delivery Unit.

Governance & Assurance Requirements

Responsible bodies should ensure they continue to have robust systems and processes that ensure the following requirements are met:

- Internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off of national incident notification and outcome forms (for all three options)
- Clear and demonstrable lines of reporting to relevant Committees and the Board
- Ensure processes which enact the policy in all areas of the organisation (including e.g. Primary and Community Services, Prison services etc.)
- Mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate
- All incidents should be reviewed to determine those which should be nationally reported. These systems and processes should focus on a multi-disciplinary approach to decision making within an appropriate governance framework. Whilst advice and support can be sought from the NHS Wales Delivery Unit, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy
- Ensure robust mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes
- Ensure robust mechanism for demonstrating shared learning
- Ensure robust mechanisms for ensuring patient and family engagement where appropriate, in line with Being Open arrangements and in active preparation for the incoming Duty of Candour.

Transitional Arrangements

For all current open Serious Incidents, including incidents reported up to and including 13 June 2021, the previous 'Serious Incident' policy applies. Accordingly responsible bodies must continue to investigate and close such incidents using the existing closure or downgrading forms as follows:

- For incidents reported to Welsh Government (WG) on or before 30 March 2020, please submit a closure form directly to WG ImprovingPatientSafety@gov.wales
- For incidents reported to WG after 1 April 2020, or to the Delivery Unit thereafter, please submit a closure form directly to the DU NationalSIreports@wales.nhs.uk

All closure forms will be reviewed with confirmation of closure confirmed directly to organisations.

Early Warning Notifications

Early Warning notifications are independent of incident reports and will replace 'No Surprise' reports from the 14 June 2021.

Historically the No Surprise Reporting and Serious Incident reporting processes became interlinked, primarily because they were both communication channels into Welsh Government. With the NHS Wales Delivery Unit taking on responsibility for national incident reporting, as the shadow form of the NHS Executive, these communication channels are now much more clearly separated as they serve two distinct purposes.

As set out in the policy, Early Warning notifications are replacing No Surprise Reports and should only be used as a rapid communication channel to give an urgent notification to Welsh Government of a potential area of interest. Early Warning notifications should be sent as soon as practicable to ImprovingPatientSafety@gov.wales

In some cases, an incident may require both an Early Warning notification being sent to Welsh Government, and an incident report being sent to the NHS Wales Delivery Unit. Although these may contain elements of the same information, the detail of the report and the reporting timescales will often be different.