GIG CYMRU NHS WALES | Y Weithrediaeth Executive

***Changing the picture** of quality & safety - for the NHS by the NHS*

Note: The intention to provide a high level summary overview of NRI data, showing both organisation-specific and All-Wales data, that can be shared with your Quality & Safety Committee (or equivalent) to support and embed a consistent approach to the use of NRI data across NHS Wales

Public Health Wales NHS Trust quarterly Nationally Reported Incident (NRI) Overview and Learning Report
NRIs reported Q4 2022/23 (1 January 2023 – 31 March 2023)

Prepared by Q&S Team

1. Overall NRI reporting rate

Figure 1.1 – NRIs reported by PHW between 14 June 2021 – 31 March 2023

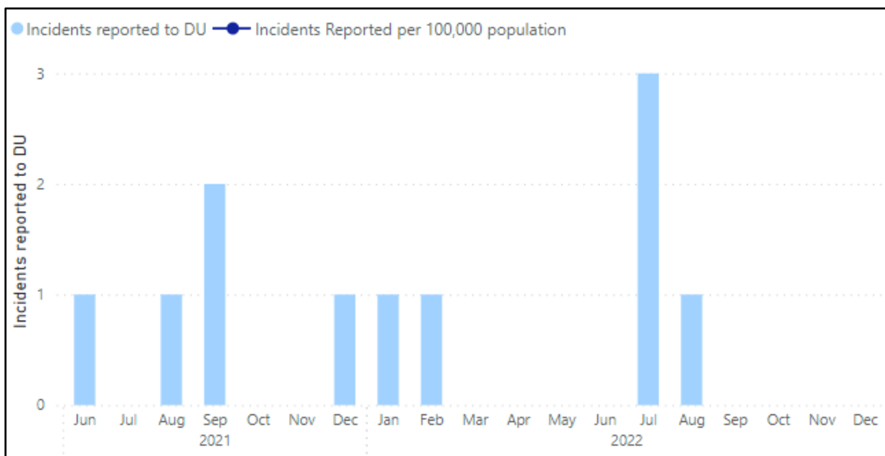
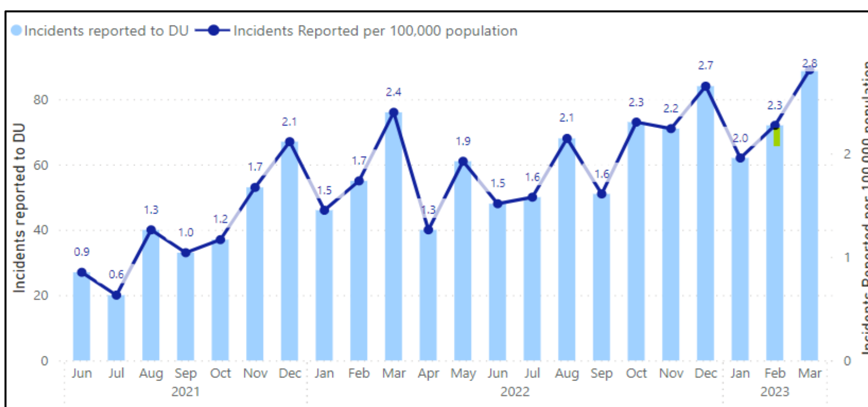


Figure 1.2 – All-Wales NRIs reported between 14 June 2021 – 31 March 2023 and rate per 100,000 population

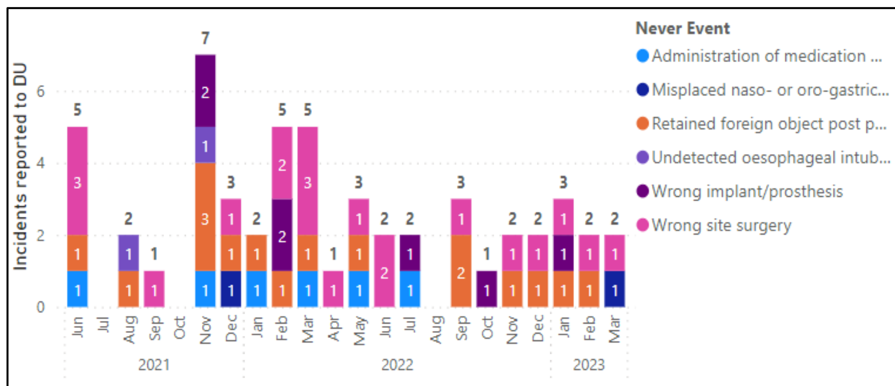


2. Never Event reports

Figure 2.1 – Never Events reported by PHW between 14 June 2021 – 31 March 2023

Nil to report

Figure 2.2 – All-Wales Never Events reported between 14 June 2021 – 31 March 2023



3. Top 10 NRI types

Figure 3.1 – NRIs reported by PHW in Q4 2022/23, by NRI type

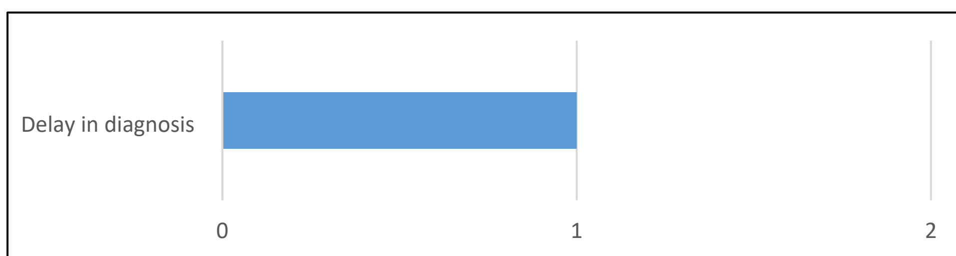
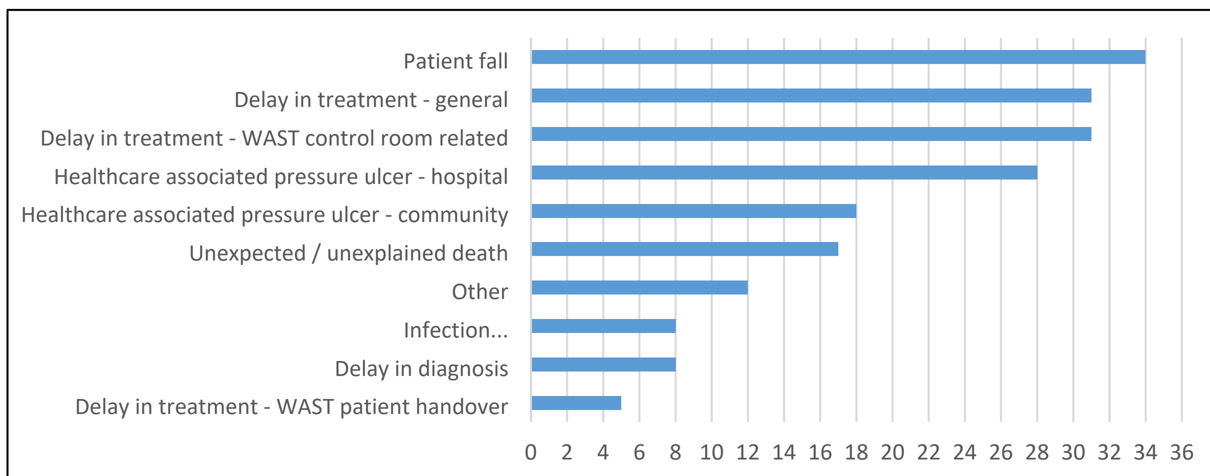
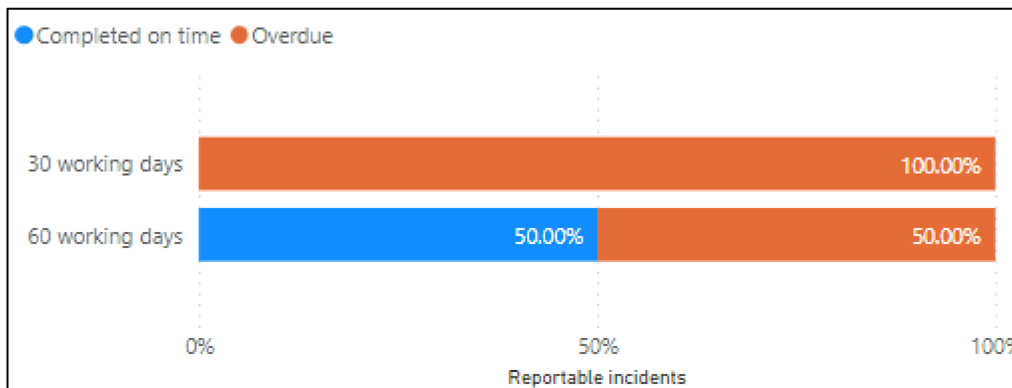


Figure 3.2 – All-Wales NRIs reported in Q4 2022/23, top 10 NRI incident types



4. Timeliness of sharing investigation outcomes

Figure 4.1 – proportion of NRIs where investigation outcomes have been submitted (*note*: snapshot data as at 5 June 2023. Excludes any retrospectively reported NRIs e.g. pressure ulcers)



5. Top NRI themes for NRIs reported by PHW in Q4 2022/23:

- Nil to report

6. Key national learning message for Q4

Increases in many waiting lists for clinical services have led to national conversations about how best to prioritise patients in terms of clinical risk, as well as the 'right' processes for undertaking harm reviews in relation to patients who are experiencing long waits for clinical assessments and interventions, including diagnostics. While NRI data can help inform these conversations, it is not fully clear whether all patient safety incidents where significant harm has occurred are being nationally reported. Accordingly:

- NHS Wales organisations must ensure that they are undertaking harm review processes where relevant

- The harm review format can be useful for across all service areas and specialties for other patients who exceed the recommended timescales for assessment or treatment. Examples from national reporting include its use in ophthalmology services

- Organisations must ensure that their harm review processes are fully aligned with PTR and that assessments are made as to whether the Duty of Candour is triggered. Harm review processes should also include the need to record identified harms as patient safety incidents and nationally report incidents where significant harm has been identified.

Health Board/Trust response:

The NHS Wales Executive Quality & Safety Team have provided the above NRI data to all Health Boards and Trusts to support and embed a consistent approach to the sharing and utilisation of NRI data across NHS Wales.

The intention is that this data is shared with each organisation's Quality & Safety Committee (or equivalent) and that the Health Board/Trust use this as an opportunity to describe to the Committee any actions being taken within the organisation in response to the NRI data. This supports internal assurance systems that NRI data is being considered and used within the organisation to improve patient safety, outcomes and/or experience.

You may wish to use the space below to describe how your organisation has interpreted and is responding to the NRI data. The data and accompanying narrative can then be easily incorporated into your Committee's report template.