Incident Reporting
Final Internal Audit Report

June 2024

Public Health Wales NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Contents

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Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

The purpose of our review was to consider the governance and reporting arrangements in relation to the management of incidents.

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- The need for continuous monitoring of unimplemented action plans after incidents have been closed on datix.
- Some key stages and processes within the incident reporting cycle falling behind expectation and within reasonable timelines.
- Retrospective quality reviews of closed incidents be undertaken monthly in line with procedures.
- There is currently no medium through which lessons learnt are being shared across the Trust.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	The Trust has incident management policies and procedures	Substantial
2	Incident reporting and management training arrangements are in place.	Substantial
3	Incidents are captured, responded to and closed down in a timely manner	Reasonable
4	Incidents are reported, monitored and discussed at appropriate forums within the Trust	Substantial
5	There is clear evidence of action being taken and lessons being learned and shared across the Trust	Reasonable
6	Relevant incidents, including nationally reportable incidents, are reported in a timely manner in accordance with national reporting requirements.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Incident management timeliness	3	Operation	High
1	Update of action plans after incident closure on datix	3	Operation	Medium

3	Monthly Retrospective Quality reviews	3	Operation	Medium
4	Sharing of lessons learnt across the Trust	5	Operation	Medium

1. Introduction

1.1 Our audit review of the incident reporting arrangements was completed in line with the 2023/24 internal audit plan for Public Health Wales (the 'Trust').

1.2 The effective application of appropriate incident management policies and procedures are critical to ensuring the safety and operating efficiency of all public sector organisations. NHS Wales organisations should maintain policies and procedures setting out the required actions for all staff and independent members to follow when they identify a potential risk, or an incident has occurred.

1.3 The NHS Wales Executive issued the National Policy on Patient Safety Incident Reporting & Management in May 2023. The policy contextualises the relevance of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the Duties of Candour and Quality regulations which came into effect in April 2023. The aim of the national policy is to set out clear expectations for patient safety incident reporting and management across NHS Wales.

1.4 During 2023 the Trust reviewed and revised it's 'Putting Things Right Incident Reporting and Management Procedure' to ensure alignment with national regulations and guidance. Implementation of the revised procedure will further support the Trust with the timely and robust management of incidents.

1.5 The relevant lead for this review was the Interim Executive Director Quality, Nursing and Allied Health Professionals.

1.1 The potential risks considered for this review were as follows:

- Non-compliance with relevant legislation.
- Patient harm or poor patient experience.
- Financial loss if action is taken against the Trust.
- Reputational damage with decreased public confidence.

2. Detailed Audit Findings

Objective 1: The Trust has incident management policies and procedures in place that are up to date and have been communicated to all staff, and are readily available.

2.1 NHS Wales National Policy on Patient Safety Incident Reporting came into effect in May 2023. It is available on the NHS Wales Delivery unit website with six supporting sections. The purpose of this policy was to set out clear expectations for patient safety incident reporting and management across NHS Wales.

2.2 The Trust has a Putting Things Right (PTR) policy and a PTR incident management procedure available on the Trust's intranet approved respectively in July and December 2023 by the Quality, Safety and Improvement Committee.

2.3 Our review of the Trust's PTR incident management procedure confirmed that it met the requirements of the WG policy and supporting documentation.

2.4 In addition, the Trust has an intranet page where resources regarding incident reporting can be found. The pages include information on:

- Nationally Reportable Incidents (NRIs);
- early warnings;
- never events; and
- access to other relevant policies and procedures.

Conclusion:

2.5 The Trust has an up to date policy and detailed incident management procedure available to staff on its intranet page. We have provided ***Substantial Assurance*** against this objective.

Objective 2: Incident reporting and management training arrangements are in place

2.6 The PTR team has responsibility for providing training on incident reporting and investigation. We note that the following training has been undertaken:

- New staff Induction Training: While the workforce team is responsible for organising induction training, the PTR team organises a stall (marketplace) during induction sessions so that new staff can book an incident reporting session. The PTR team also receive an inductee report from workforce which is used to send emails to new staff sharing training times.
- Level 1 datix training delivered monthly by the PTR team on Microsoft teams. There are guides shared to staff during the trainings.
- Level 2 training is undertaken by the investigator. This training has moved away from the Root Cause Analysis (RCA) training and has been refreshed to a system-based training. There are guides shared to staff during the trainings.
- External Training: There were four training sessions provided in 2023 by an external service. This was organised as a result in the gap in the system training - level 2 training. This training is now incorporated into the level 2 training.

Conclusion:

2.7 There are incident management training modules available to ensure staff are adequately equipped. The external training evidence that the Trust ensures there is an improved system in place for the reporting and management of the incident reporting process. We have provided ***Substantial Assurance*** against this objective.

Objective 3: Incidents are captured, responded to and closed down in a timely manner and to the required standard in accordance with the relevant legislation

2.8 Incidents are logged onto Datix and assigned a priority rating of either high, medium or low. Administration of Nationally Reportable Incidents sits with the PTR Team but should be managed within the service area that has initially reported the incident. We note that the PTR team retain full visibility of all incidents and the team meet with service areas to confirm whether or not incidents should be classed as NRIs. Medium and high priority rated incidents are reviewed by the PTR manager to ensure they are accurately reported.

2.9 Given the collaborate nature and interdependency of service provisions across the NHS, circumstances could arise where the accountability/responsibility of an incident could be shared across one or more NHS organisation. Discussions with the PTR Manager confirmed that the Trust has arrangements in place to determine accountability for incidents. If incidents are rated medium/high he Trust's PTR Team would meet with the relevant Health board's Incident Management Team to discuss accountability and agree on actions to be taken to manage the incident.

2.10 We note that currently, the PTR team is working to ensure that the reporting lines for incident management within the Datix system are properly aligned to the Trust's staff and line management structure.

2.11 We tested a sample of incidents recorded on datix to confirm the process undertaken in relation to meetings, investigations, approvals and quality had been undertaken appropriately. We found that investigators had received appropriate training, immediate 'make-safe' actions had taken place, and action plans were in place for all the NRIs where the investigation had been completed. However, we did not see evidence of monitoring actions that were yet to be implemented after the closure of the incident on datix. **(Matter Arising 1 – Medium Priority)**

2.12 We also tested our sample to confirm that the incidents were captured, investigated, quality assured and approved, with evidence retained in Datix. Our testing identified a number of exceptions which included delays in the stages of processing incidents and completion of information fields on datix. ***(Matter Arising 2 – High Priority)***

2.13 In line with the Trust's PTR incident management procedures, the PTR team undertake monthly data validation/quality assurance checks on incident information entered onto the Datix system, although at the time of our fieldwork, it appears that the last exercise was undertaken in December 2023. ***(Matter Arising 3 – Medium Priority)***

Conclusion:

2.14 The importance of service areas, programmes and divisions taking a proactive approach to the documentation and timeliness of the incident reporting process is key. Our sample testing confirmed that the process was followed, however, documentation or information was not always present to support each stage in the process. Some stages within the incident reporting process fell behind reasonable

and established timelines. We have provided ***Reasonable Assurance*** against this objective.

Objective 4: Incidents are reported, monitored and discussed at appropriate forums within the Trust and are escalated where required to provide the required assurance

2.15 On a monthly basis the PTR team produce a performance and insight report which is shared with the Business Executive Team (BET) for information purposes. This highlights NRIs, early warnings and duty of candour information.

2.16 A Performance & Assurance Dashboard (PAD) report is also submitted to BET which is an analysis of incident data for the previous month.

2.17 The PTR team provide a quarterly 'Putting Things Right' report to the Quality, Safety and Improvement Committee (QSIC), which contains incident data for the previous quarter.

2.18 We looked at the governance arrangements relating to reported incidents for Cervical Screening, as it had the highest number of reported incidents. It was reviewed to understand the flow of how incidents are managed, shared and escalated. The Clinical Governance & Quality Assurance Group and Datix Themes and Actions Group (DTA) are the two major groups that are involved in this process. The DTA group also covers lessons learnt from incidents reported. objective.

Conclusion:

2.19 The Trust has a structure in place that provides effective mechanisms for monitoring reported incidents from a localised level up to the Board. We have provided ***Substantial Assurance*** against this objective.

Objective 5: There is clear evidence of action taken and lessons learned which are shared across the Trust to minimise future occurrence where deficits are identified

2.20 We note that lessons learnt relating to NRIs are shared within service areas. However, it appears that there is no process to share these lessons more widely across the Trust. ***(Matter Arising 4 – Medium Priority)***

2.21 Our analysis of the Datix system identified that from April 2023 to time of our fieldwork, 1,491 incidents had been reported within the Trust. The majority (1,407 incidents - 94%) were within the Health, Protection and Screening Service Directorate (HPSS), and the Screening Division made up the highest number of incidents reported within HPSS (934 - 66%).

2.22 We reviewed the lessons learnt process for identifying and communicating these within the Screening Division, the HPSS Directorate, and the wider Trust where applicable. We note the following:

- There are groups/forums in place with remits of discussing lessons learnt and taking action to ensure that continuous improvement of processes. We note that some issues with outdated documentation (ToRs), timeliness of

meetings, and lack of documentation of action logs. **(Matter Arising 5 – Low Priority)**

- The Senior Management Team (SMT) from the Screening Division meet each month and review incidents in a bi-monthly basis. ***(See Matter Arising 5 – Low Priority)***
- The SMT feeds into the Health Protection and Screening Services (HPSS) Directorate's Leadership Team group to provide assurance of its business. Assurance is provided through attendance as well as sharing of the minutes. The Directorate looks at numbers rather than the details. Occasionally where they feel incidents will affect other programmes then it would be raised at the SMT.

Conclusion:

2.23 Lessons learnt can be evidenced as shared within incident areas where reporting occurred, however, mechanisms to capture and share incident learnings across the Trust could not be ascertained. We have provided ***Reasonable Assurance*** against this objective.

Objective 6: Relevant incidents, including nationally reportable incidents, are reported in a timely manner in accordance with national reporting requirements

2.24 We selected a sample of closed incidents, which included Nationally Reportable Incidents (NRI) and reviewed the incident reporting, investigation and management phases to confirm that these had been undertaken timely and in line with the target timeframes as set out in the Welsh Government policy. Our findings noted that:

- All incidents, irrespective of their risk priority rating (Low, Medium High) had been inspected by a member of staff within 72 hours of the incident being reported to 'make-safe' (where applicable).
- We identified a number of timeliness issues specifically in relation to the investigation and closing phases of incident management process. ***(Matter Arising 2 - Medium Priority)***

Conclusion:

2.25 There are well defined processes as outlined in the PTR Incident Management procedure, while the timeliness of some of the incident reporting stages were appropriate, we identified some stages delays in the processing time. We have provided **Reasonable Assurance** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Update of action plans after incident closure on datix (Operation)			**Impact**
A datix incident can be closed even when some actions have not been fully implemented. It was not certain how action plans (saved on datix) are updated, and ongoing monitoring undertaken following the submission of the outcome form to the NHS Executives and closure of the incident on datix. We note that some health boards have recently adopted a new software tool, AMaT, to enhance the continuous monitoring of action plans raised after the closure of the datix incident.			Potential risk of: • Reoccurrence of incident. • Failure to update the action plan following the closure of the incident on datix.
Recommendations			**Priority**
1.1	The Trust should ensure there is a system in place that would ensure the continuous monitoring of action plans after the incident has been closed on datix.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	A Digital Audit Management Tool is to be procured by Public Health Wales. This will support the updating and completion of action plans during and post incident closure. A data log of all closed incidents with outstanding action plans will be compiled by the PTR team and the use of action module within Datix will be used to update and remind of outstanding actions.	Awaiting procurement date September 2024	Quality, Safety and PTR Manager, PTR Managers

Matter Arising 2: Outcome of Incident Reporting Management Review (Operation)	**Impact**
We obtained a report from the Datix system listing all incidents that had been closed (fully actioned) between March 2023 to February 2024 and tested a sample of 23 incidents, including three NRIs to confirm that the incidents were captured in good time, investigated, quality assured and approved with evidence retained in Datix. As part of our testing we reviewed the key stages of the administration and management of incidents. We note the following: **Nationally Reportable Incidents** Incident management/reporting We identified the following matters in relation to timely reporting: • One incident took almost six weeks to report an incident after it occurred. All incidents are required to be reported as soon as possible so as to avoid any further harm. • Two incidents took between 7-22 weeks to be closed on Datix after the investigations had been completed. The Trust's PTR incident reporting and management procedure requires a timescale of 30 days from the incident report date to the closure date. • For one incident, the early notification to the NHS Wales Executive took 10 working days, which was three working days longer than the requirement. • For one incident, the outcome Form was sent to NHS Wales Executive two weeks after the expected submission date. Datix data recording • For two incidents, a number of required data fields within the external reporting section of Datix were not complete. Document retention/evidence • For one incident – While the NRI notification form had been submitted to the NHS Wales Executive, it was not documented on Datix.	Potential risk of: • Patient harm or poor patient experience. • Financial loss if action is taken against the Trust.

Non NRIs

Incident management/reporting

- Three incidents were reported up to 6-15 weeks after the incident had occurred. Incidents should be reported as soon as possible to ensure proper and timely incident management.
- For five incidents, management review did not start until more than three weeks after the incident was initially reported, with the longest taking over more than nine weeks.
- For two incidents, the investigation took between 14 to 17 weeks.
- For eight incidents, incidents were closed on Datix between 3-24 weeks after the investigation had been completed.

Datix data integrity

- For one incident, the management review took more than seven weeks. This could be as a result of how dates are entered. Management end date and investigation start date fields are not always entered on Datix.
- For one incident, the investigation start date had not been recorded.
- For three incidents there were no progress notes.
- For four incidents, lessons learnt were not clearly documented.

Document retention/evidence

- For one incident, the necessary documentation was not saved to Datix as required.
- For 3/4 incidents that required action plans did not have their action plan uploaded onto Datix.

Segregation of staff duties

For two incidents, the reporter, incident manager, investigator and person responsible for closing the Datix incident was the same person. In ensuring objectivity and transparency it is best practice to involve more than one member of staff in the process for reporting, investigating and managing incidents.

Recommendations		Priority
2.1	Management should ensure that incidents are processed within the expected timeframes and reported as stated in the Welsh Government policy, Welsh Government supporting documents and Health Board policy and procedure. Where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays.	**High**
2.2	The Trust should ensure where lessons learnt have occurred improvement plans are completed and supporting documents continue to be uploaded on datix.	**Medium**
2.3	There should be segregation of staff duties. More than one staff should be involved in the incident manage cycle from the point of reporting to closure on datix.	**Medium**
2.4	Management should ensure key incident reporting fields are completed on datix.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	The importance of timescales and the timeliness of reporting will be further emphasised in the investigator training. As part of the PTR team initial reviews the timeliness of reporting will be examined and discussion had with the reporter if there has been a delay to understand why. The findings of this audit will be presented by the Executive Director Nurse at the Business Executive Team (BET) meeting to raise aware of the management of incidents across Public Health Wales.	July 2024	Putting Things Right Managers
2.2	Revision of Datix investigator training will support investigators in documenting learning and the associated evidence to support it. Emphasis on uploading of all documentation will be delivered through all training the PTR team deliver.	August 2024	Quality, Safety and PTR Manager, PTR Managers

	PTR team will work with the Datix leads to undertake quality reviews of closed incidents to review the compliance of document uploads.		
2.3	Updates will be provided to the Datix superuser network as well as via training on the appropriate persons to open, investigate and close the incident form	August 2024	Quality, Safety and PTR Manager, PTR Managers
2.4	Reintroduction of the Quality Reviews to support identification of data entry issue and the outcomes to be shared at Datix networks and quality meetings.	August 2024	Quality, Safety and PTR Manager, PTR Managers

Matter Arising 3: Monthly Retrospective Quality Reviews (Operation)			**Impact**
The PTR incident management procedure states: *'Quality Reviews Upon Closure of an incident, a monthly retrospective sample_of incidents are subject to a quality review process involving the PTR Managers and the Quality & Clinical governance manager. Quality reviews look at the quality of the investigation, provide feedback where necessary and good practice is recognised. Themes and trends are monitored and shared as required.'* This review was last undertaken in December 2023.			Potential risk of: • Missed opportunity to contain or capture errors and inadequacies.
Recommendations			**Priority**
3.1	In line with the procedures, As a form of good practice management should resume the monthly quality review checks or the procedure is updated to reflect how often these reviews would be undertaken periodically.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Monthly quality reviews of a sample of closed incidents will commence in July 2024. These reviews will then be shared with the Quality Leads, Heads of Divisions/Programmes and the Investigators. Opportunity for further understanding of the quality reviews to be discussed at the Datix networks/ Quality meetings with lessons/outcomes shared anonymously.	July 2024	Putting Things Right Managers

Matter Arising 4: Sharing of lessons learnt across the Trust (Design)			**Impact**
NHS Wales National Policy on Patient Safety Incident Reporting & Management requires NHS organisations to ensure they have robust systems and processes in place to support the extraction and dissemination of learning from incident investigations throughout the organisation. We understand that lessons learnt are shared within directorates and divisions, but it appears that there is no process to share lessons, which may affect the Trust as a whole, more widely.			Potential risk of: • Reoccurrence of incidents
Recommendations			**Priority**
4.1	Management should ensure there are mediums through which lessons learnt can be shared and circulated to staff on a Trust wide basis.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Public Health Wales are in the process of implementing a Quality Oversight Group. The purpose of the Quality Oversight Group (QuOG) is to oversee and monitor arrangements around quality to ensure the achievement of safe and clinically effective outcomes for service users, maintaining positive service user and carer experience, equitable and inclusive services in line with the requirements for the Health and Social Care (Quality and Engagement) Act (Wales) 2020: Identify and act on learning from patient safety incidents, concerns, complaints and claims and that these, together with good practice are shared across the organisation; the impact of learning should be measured. Facilitate the thematic analysis of learning from patient safety incidents, concerns, complaints and claims. Assurance to Business Executive Team and Quality, Safety and Improvement Committee.	September 2024	Quality, Safety and PTR Manager

Matter Arising 5: Screening Division & the reinstatement of the Cervical Screening Datix, Themes and Actions Group (Design)	**Impact**
The DTA group is expected to meet quarterly. However, it met in March 2023 but did not meet again until January 2024. This group was scheduled to meet again in May. The ToR for the DTA group is reviewed annually, and at the time of our fieldwork this review was ongoing. We read the group's action notes and identified actions in relation to training in 2023. However, the 2024 actions from the January 2024 meeting had incomplete fields. For example, the service improvement identified, the start date and progress comments.	Potential risk of: • Inability to monitor progress of agreed meeting actions • Inconsistent meeting leading Inability to achieve the purpose of the group

Recommendations		**Priority**
5.1	Acknowledging that steps have been taken to reinstate this group, management should ensure that the ToR and action notes are updated and meetings continue to be held quarterly.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	ToR – discussed, updated and circulated after the meeting on the 24th January to ensure everyone in the DT&A group was happy with the decisions. And to bring the ToRs back to the next meeting for final approval - agreed at DT&A meeting 24th May 2024. Action notes – from January 2024 were discussed at the next meeting (24th May) so that time is provided to those individuals to allow for tasks to be completed. The action notes were updated during the meeting on the 24th May 24 with some actions carrying forward as not completed. Dates booked – 24th May 2024, July 2024 and October 2024. The meeting in April 24 was rearranged for the 24th May.	Completed	Quality Lead, Cervical Screening Wales

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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