# Thames Valley Local Office – Revalidation Team

**Incident Reporting (Formerly Exception Reporting)**

**Purpose of reporting**

Triangulation of concerns, ensure resident doctor is declaring involvement (via the Form R) and that we are aware in order to:

* Support the resident doctor
* Review reflection and learning by the resident doctor (primarily via review at ARCP)
* Make appropriate revalidation recommendations
* Highlight any trends within training areas or with individuals (e.g. multiple incidents of the same theme across Trusts for one individual)
* Take any other action as may be required including passing on information to the next Trust

Following discussions during 2024, amendments were made to the reporting requirements to reflect the changes brought in by the Patient Safety Incident Response Framework. Below are the revised ‘criteria’ and the reporting form has also been updated.

We also changed the name from Exception Reporting to avoid confusion with the reporting process used in Trusts for working hours etc.

**What to report**

When a resident doctor is named in or significantly[[1]](#footnote-2) involved in:

Any confirmed patient safety incident that requires a mandatory PSII. There is a detailed national list[[2]](#footnote-3) for these but in summary:

* Deaths thought more likely than not due to problems in care
* Never Events
* Maternity and neonatal incidents meeting Health Services Safety Investigations Body (HSSIB) and Maternity and Newborn Safety Investigations Special Health Authority (MNSI) criteria
* Child Deaths
* Deaths of persons with Learning Disabilities
* Safeguarding incidents (as per criteria)
* Screening programme incidents
* Deaths of patients detailed under MHA or where MCA applies
* Deaths in custody where health care is provided by NHS
* Mental Health and Domestic Homicides

**Or** any of the following:

* Formal complaints
* Claims (clinical negligence)
* Human resources / professional standards investigations
* Coroner inquests
* Criminal investigations
* GMC referrals that the employer has made or aware of

**Or** any other situation not listed above which has led to concern about the doctor’s involvement.

**When**

Notification needs to be on **a real time basis** with updates as and when appropriate. Retrospective reporting (e.g. 6 monthly) does not support the revalidation process.

**How**

Complete template as fully as possible including:

* Resident Doctor name, programme and GMC number
* Date of incident and a reference e.g. Ulysses or other system ID
* Type of concern (e.g. PSII category or complaint)
* What happened
* What the impact for was patients / service users
* Status/Outcome of investigation
* Identified actions and when completed or due for completion

Inform resident doctor that the Incident Report is being submitted and provide them with a copy.

Upload to our secure SharePoint which has been set up specifically to receive these reports.

If you or another colleague need access granting to the folder, please email [england.revalidation.tv@nhs.net](mailto:england.revalidation.tv@nhs.net)

**Follow up**

In addition to an initial review by the Revalidation Team, Incidents Reports are sent to the relevant Head of School and provided to the resident doctor’s next ARCP panel to enable reflection to be reviewed and the revalidation section of the ARCP outcome form to be completed appropriately.

Please ensure we are updated on ongoing incidents/concerns – we will be chasing this up also.

The resident doctor also needs to be updated, where necessary (e.g. if left training or rotated prior to end of any investigation/outcome) we are happy to facilitate this.

**Trust processes for identification of incidents involving resident doctors**

Information should be obtained from your organisation’s clinical governance systems (e.g. Complaints/Risk Management/Patient Safety Teams, Incident Reporting systems and HR/Workforce) rather than from individual educational supervisors.

It is for each Trust to decide how best to arrange this in line with their own structures and processes, but we have included some suggestions below to assist.

* Relevant teams briefed to notify DME of any incidents that meet the criteria above. This could now include the medical examiners/teams.
* Regular meetings with the above may assist.
* Addition of resident doctor check box on internal reporting systems to allow automated alerting of relevant incidents to DME or a reporting function to accommodate this.

**Levels of involvement**

Incidents that meet the criteria described above and where resident doctors have been named (or identified) and are significantly involved should be reported.

Significant involvement includes:

* Directly providing the care related to the incident or that led to the incident.
* Communicating with the patient or relative in detail.
* Making decisions about diagnosis / treatment including reviewing scans/blood results.
* Prescribing medication.

Examples

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| --- | --- | --- |
| **Incident Type** | **Description** | **Incident Report to NHSE TV?** |
| Never Event | Guidewire left in situ by resident doctor after insertion of a chest drain. Discovered the same day by different registrar upon removal of chest drain. | YES - first doctor only (although both likely to be part of investigation) |
| Patient Safety Incident | Doctor was called to see a patient, with a diagnosis of dementia, on ward following a fall. She, along with another resident doctor, attended promptly, examined the patient thoroughly and put in a detailed management plan, including clear instructions for the nurses to monitor the patient’s condition and to call for medical attention should there be additional clinical need. There was no indication at that stage that the patient had suffered a fracture. It transpired later, from further clinical signs and from the nurses following the agreed monitoring plan that the patient had a fracture, uncertain if this was from the specific fall or any subsequent injury that the team were not aware of. | NO - Unless identified that the doctor was previously involved with the care of the patient prior to the fall. |
| Never Event | Resident doctor in endoscopy (working independently at time of incident.) Patient with dementia brought into the procedure room incorrectly after answering to another patient’s name. Identification band not checked by Nursing staff. WHO checklist not available in admission pack - therefore not completed. Gastroscopy was performed by Doctor. Patient was not fasted and error was identified. Patient had unnecessary gastroscopy. No pathology identified. Patient and family notified of this - appropriate actions taken. | YES – doctor themselves also needed to confirm correct patient |
| Complaint | Complaint directed towards the team, where doctor was specifically mentioned. This complaint was initially sent to PALS by the relative of a patient who was seen by resident doctor and registrar in clinic and discussed with the on-call consultant. The crux of the complaint was that the relative felt unhappy that the patient was not admitted following this encounter when they felt they would be unsafe at home. There had been no medical or surgical indication to admit and the patient was referred for local follow-up as a 2WW | YES – doctor was specifically mentioned in complaint and had seen the patient. |
| Complaint | Emergency Department. Resident doctor clerked and discharged a patient whilst on a medical take on call shift. The patient made a complaint about their care in the ED department focussing on the nursing staff's behaviour towards her. Resident doctor was not formally identified in the complaint but was asked by the PALS team to answer some questions about her medical care during her stay in the ED. | NO |

All of the above incidents should still be declared by the resident doctor on their Form R.

1. Definitions and examples can be found at the end of this document. [↑](#footnote-ref-2)
2. Appendices A and B in the NHS England Patient Safety Response Framework supporting guidance: Guide to responding proportionately to patient safety incidents, v1.1, September 2022 available at <https://www.england.nhs.uk/wp-content/uploads/2022/08/b1465-3.-guide-to-responding-proportionately-to-patient-safety-incidents-v1.2.pdf> [↑](#footnote-ref-3)