PATIENT SAFETY RELATED INCIDENTS

SITUATION

1 The purpose of this brief is to provide an 'at a glance' update of the current patient safety landscape within the Welsh Ambulance Services NHS Trust (the Trust). The key areas focused upon are:

i. Patient Safety Incidents (Internal);
ii. Patient Safety Incidents (External);
iii. Formal Concerns;
iv. Serious Case Incident Forum (SCIF) activity;
v. Serious Incidents reported by the WAST;
vi. Incidents considered at SCIF and passed to the respective Health Boards either as a Patient Safety incident or under appendix b through the Serious Incident Framework;
vii. Potential adverse media attention.

2 It highlights the significant pressures experienced across the wider NHS system and the impact upon WAST service provision. Some of these have resulted in either a catastrophic outcome for patients, or significant harm.

BACKGROUND

3. The Patient Safety, Concerns & Learning Team (inclusive of Putting Things Right teams) continue to see a reduction in the volume of concerns since May 2020. This may relate to a reduction in hospital delays, reduced call demand resulting in an improvement in timeliness.

4. However, Health Boards and Trusts continue to see an increase in the volume of retrospective concerns being registered for investigation, and an anxiety in terms of the anticipated volume for the future. The Head of Patient Safety, alongside the Patient Safety Managers closely monitor the volume of new concerns and incidents being registered, and continue to reduce the volume of concerns in 'backlog'.

ASSESSMENT

5. The impact and consequences of COVID-19 may have significant impact on our patients. Some of these may result in catastrophic or major consequences.

6. The following provides a breakdown of Patient Safety activity:

Patient Safety incidents

The number of patient safety incidents received or reported, of all harm levels, that are ‘a WAST incident only’ and ‘an incident reported by another health board/service about WAST’.

Patient Safety Incidents (Internal)									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	6	5	0	2	5	2	3	7	30
03.08.20	13	4	4	2	6	1	5	5	40
10.08.20	4	5	3	1	7	1	5	3	29
17.08.20	7	5	1	4	2	3	4	8	34

The table below represents the numbers of patient safety incidents reported via the WAST Datix system, but are relating to services provided by another health board or emergency service. The table reflects the total number of incidents reported across the reporting week, and the health board in which they were reported. Currently, without reviewing individual incidents and/or areas it is not possible to identify which health board they refer to, or if/when they were passed to the respective teams.

Patient Safety Incidents (External)									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	6	2	0	0	1	1	2	3	15
03.08.20	6	4	1	1	0	1	2	0	15
10.08.20	7	4	1	1	3	0	3	0	19
17.08.20	8	0	1	4	0	1	4	0	18

Formal and Political concerns

This is the total number of formal and political concerns first received during the reporting date range. The information is drawn from Datix, and is accurate at the time of reporting. These may be subject to change as Early Resolution type concerns may be converted into Local Resolution or Formal thereafter.

Formal Concerns (first received)									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	2	3	0	0	1	1	0	0	7
03.08.20	2	1	4	0	0	0	1	0	8
10.08.20	2	1	1	0	0	0	0	0	4
17.08.20	4	3	0	1	1	0	3	0	12

Of which are Political (first received)									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	0	1	0	0	0	1	0	0	2
03.08.20	0	0	0	0	0	0	0	0	0
10.08.20	0	0	1	0	0	0	0	0	1
17.08.20	1	0	0	0	0	0	1	0	2

Serious Case Incident Forum (SCIF)

Patient safety incident reports with Moderate, Severe or Catastrophic harm indications are reviewed by The Trust Patient Safety Managers. These incidents are then reviewed via SCIF and may result in reporting as a Serious Adverse Incident to Welsh Government. The table below provides a breakdown of incidents discussed SCIF, by health board area in which the incident took place.

Serious Case Incident Forum (cases discussed)									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	0	0	0	2	0	0	0	0	2
03.08.20	2	0	0	0	1	0	0	1	4
10.08.20	5	0	1	0	1	0	0	0	7
17.08.20	5	0	0	1	1	0	3	0	10

Serious Incidents reported by the Welsh Ambulance Services NHS Trust (WAST)

The following table represents the number of Patient Safety Incidents discussed at SCIF which were deemed as reportable to Welsh Government as a Serious Adverse incident (SAI). The figures below are representative of the health board area in which the incidents occurred.

Serious Incidents reported by WAST to Welsh Government (within reporting range)									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	0	0	0	1	0	0	0	0	1
03.08.20	0	0	0	0	1	0	0	1	2
10.08.20	1	0	0	0	0	0	0	0	1
17.08.20	1	0	0	0	0	0	0	0	1

Serious Incident Framework Appendix B Incidents.

Incidents considered at SCIF where the primary causal factor is in relation to the Health Board (i.e. Hospital handover delays). These incidents are passed to the respective Health Boards either as a Patient Safety Incident or through the Serious Incident Framework (Appendix b).

Patient Safety Incidents passed to Health Board under SI Framework (Appendix b).									
H/Board	*ABUHB*	*BCUHB*	*C&VUHB*	*CTMUHB*	*HDUHB*	*PTHB*	*SBUHB*	*111Wales*	*Total*
27.07.20	0	0	0	0	0	0	0	0	0
03.08.20	1	0	0	0	0	0	0	0	1
10.08.20	1	0	0	0	1	0	0	0	2
17.08.20	0	0	0	0	0	0	0	0	0