Agenda Item
5.4

Quality Safety and Outcomes Sub-Committee

Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	04/08/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Adele Roberts, Head of Quality and Patient Care
Cyflwynydd yr Adroddiad / Report Presenter	Carole Bell, Director of Nursing and Quality
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
	Click or tap to enter a date.	Choose an item.

Acronyms / Glossary of Terms	
ABO	Blood Group System
BAPM	British Association of Perinatal Medicine
CAMHS	Child and Adolescent Mental Health Services
CQC	Care Quality Commission
CT	Computed Tomography Scan

Acronyms / Glossary of Terms	
EWN	Early Warning Notification
HIW	Health Inspectorate Wales
HMC	His Majesties Coroners
HTA	Human Tissue Authority
IPFR	Individual Patient Funding Request
MRI	Magnetic Resonance Imaging
NEWS	National Early Warning Score
NHSBT	National Health Service Blood and Transplant
NICU	Neonatal Intensive Care Unit
NRI	Nationally Reportable Incident
NWJCC	NHS Wales Joint Commissioning Committee
OCD	Obsessive Compulsive Disorder
ODT	Organ Donation and Transplantation
PSOW	Public Service Ombudsman Wales
SBUHB	Swansea Bay University Health Board
UAC	Umbilical Arterial Catheters
WAST	Welsh Ambulance Services University NHS Trust

1. SITUATION/BACKGROUND

The purpose of this report is to provide an update on the incidents and complaints reported to the Joint Committee covering Specialised Services, Mental Health, Learning Disabilities and Vulnerable Groups and Ambulance Services and 111.

This report aims to triangulate issues reported by individual Health Boards and Trusts from a variety of sources. The report includes a summary of concerns and incidents reported to the NHS Wales Joint Commissioning Committee (NWJCC) from provider and commissioned services covering 01/05/2025 – 08/07/2025 with the exception of the Ambulance and 111 service which covers the period April/May in line with the Welsh Ambulance Services University NHS Trust (WAST) reporting period. The Emergency Medical Retrieval and Transport Service report is also taken through to Swansea Bay University Health Board's Quality and Safety Group.

Reporting will cover the following areas:

- Reportable incidents, those recently reported to the NHS Executive, NHS Wales
- Serious incident notifications received from NHS England and actions taken
- Early warning notifications reported to Welsh Government commissioned/provider services and the NWJCC
- Closed reportable Incidents and outcomes/learning from these
- An update of ongoing open incidents and concerns
- Any new concerns received by provider/commissioned services over the last Quarter
- Any concerns referred to the Ombudsman

The report does not cover DATIX incidents related to commissioned services categorised as low harm or no harm. Monitoring of such takes place at a local level by each of the providers with the expectation themes and trends are monitored and reported as necessary aided by the following:

- Regular assurance and reporting meetings held with the provider.
- Quality visits/ audit outcomes and reporting within data submissions.
- Dashboard data and monitoring submitted by Health Boards and NHS England.

More emphasis is being placed on ensuring that the triangulation of data from a variety of sources is gathered and evidenced to prevent duplication ensuring consistency in reporting. Intelligence from the NHS Wales Performance and Improvement, Health Inspectorate Wales/Care Quality Commission as well as internal data sources enables identification of new or ongoing concerns as well as benchmarking across services and providers.

Intelligence and reporting from NHS England is also gathered through relevant forums, National Quality & Governance Group and National databases. Further work is required in the ability to access Model Hospital within NHS England to gain access to their data collection and reporting system.

Gathering evidence is vital in the commissioning cycle is pivotal in ensuring the services commissioned meet the Health and Care Standards. It enables the early identification, monitoring and reporting of new or ongoing concerns and supports the sharing of good practice and learning through commissioned services.

Details of any information received and of relevance will be shared in the commissioning team reports and covered within this report.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.2 New incidents for reporting

In total there have been 14 new nationally reportable incidents, 1 DATIX and 2 early warning notifications reported to the commissioning teams over the period 01/05/2025 – 08/07/2025. These are summarised in the following table:

2.2.1 Specialised Services and Mental Health

Incident date and ref	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC25-06-009 26/04/2025	28/05/2025	Women & Children	Neonatal death on day 8 of life, preterm infant born at 24 +3 weeks gestation. Expected mortality as extreme risk within the British Association of Perinatal Medicine (BAPM) Framework.	Nationally Reportable Incident (NRI)
INC25-06-010 02/05/2025	28/05/2025	Women & Children	Neonatal death on day 3 of life, preterm infant born at 23 +3 weeks gestation. Expected mortality as extreme risk within the BAPM Framework.	NRI
INC25-06-011 28/04/2025	30/05/2025	Renal	The administration of ABO blood group system compatible products delayed the completion of incompatible kidney donation.	NRI
INC25-06-012 08/04/2025	03/06/2025	Cardiac	Frequency of observations not undertaken in accordance with National Early Warning Score (NEWS). Patient subsequently had a cardiac arrest.	NRI
INC25-06-013 14/05/2025	03/06/2025	Cardiac	Thirteen confirmed Norovirus positive patients across three Cardiac service wards. This has had an impact on service provision in the Cardiac Unit.	NRI
INC25-06-014 23/05/2025	11/06/2025	WAST	31+3 week gestation infant born at home via peri-mortem section. Baby transferred to Singleton Neonatal Intensive Care Unit (NICU). Evidence of a severe hypoxic ischaemic brain injury with abnormal neurology and this was confirmed on Magnetic Resonance Imaging (MRI) brain scan. Following confirmation of the findings on MRI brain the family agreed for compassionate withdrawal of intensive care treatment.	NRI

Incident date and ref	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC25-06-016 21/05/2025	17/06/2025	Women & Children	Admission to the neonatal unit for vascular access as part of standard preterm care. Two umbilical arterial catheters (UACs) were mistakenly left in the umbilicus Intravenous fluids were infused via the arterial line leading to vasospasm and discoloration of the left lower limb resulting in vascular compromise.	NRI
INC25-06-017 17/05/2025	17/06/2025	Renal	A patient with extensive peripheral vascular disease underwent 5th renal transplant. Clinical findings initially did not suggest vascular compromise, but limb ischaemia developed overnight requiring revascularisation the next day and subsequent above knee amputation due to non-viable tissue. Some concerns also raised on the reporting of a computed tomography (CT) scan taken post-operatively and the use of systemic heparin under review for fact-finding.	NRI
INC25-06-018 29/04/2025	19/06/2025	Women & Children	Neonatal death on day 2 of life, preterm infant born at 22 +2 weeks gestation. Expected mortality as extreme high risk within the BAPM Framework.	NRI
INC25-06-019 13/05/2025	19/06/2025	Renal	Vascular patient awaiting transfer and surgery; the patient died unexpectedly after transfer from a local unit to a regional centre. On reviewing the patient's care it was identified that NEWS score had been calculated incorrectly and observations were not undertaken in line with guidance.	NRI

Incident date and ref	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC25-07-020 06/05/2025	02/07/2025	Mental Health	A child and adolescent mental health service (CAMHS) patient was admitted due to escalating obsessive compulsive disorder (OCD) symptoms to a paediatric ward. Discharge was delayed twice due to ongoing safety concerns. Young person mental health further escalated requiring rapid tranquilisation and detention under the Mental Health Act. A Tier 4 assessment requested was delayed beyond the 48-hour target, prolonging detention in an unsuitable setting.	NRI
INC25-07-021 25/06/2025	02/07/2025	Women & Children	A fetal medicine scan identified fetal abnormalities. At 34 weeks +1 day gestation the infant was delivered at a regional centre resuscitation was unsuccessful and the baby sadly passed away. Case has been referred to the coroner.	NRI
INC25-07-022 18/06/2025	02/07/2025	Renal	A data quality issue has been identified in transplant referral records across multiple centres, including Cardiff and Vale University Health Board. Automated data submissions from renal IT systems have led to inconsistent capture of key clinical details, notably dialysis status, in national transplant systems and affects patient prioritisation under the 2019 NHS blood and transplant (NHSBT) allocation policy	NRI
INC25-07-025 29/06/2025	08/07/2025	Mental Health	Patient was subject to assault, by way of inappropriate restraint all necessary investigative and disciplinary actions will be taken.	NRI
INC25-07-024 01/07/2025	01/07/2025	Women & Children	Inappropriate storage of colostrum.	DATIX

INC25-06-015 12/05/2025	10/06/25	Cardiac	Since the 12th of May 2025, there have been thirteen confirmed Norovirus positive patients across three Cardiac service wards. This has had an impact on service provision in the Cardiac Unit.	Early Warning Notification (EWN)
INC25-07-023 07/07/2023	03/07/25	Women & Children	This case concerns an investigation into events between 2nd and 7th July 2023. The Coroner raised a number of concerns as a result which will be considered by the Health Board.	EWN

2.2.2 NHS Executive Weekly Patient Safety Briefing Report

Since the beginning of the year NHS Wales Performance and Improvement publish a Weekly Patient Safety Briefing Report. The report is published by the Quality Safety Assurance Team within the Performance & Assurance Division of NHS Wales Performance and Improvement and aims to gather, and triangulate intelligence of issues reported by individual Health Boards and Trustsfrom a variety of sources. The report includes a summary of:

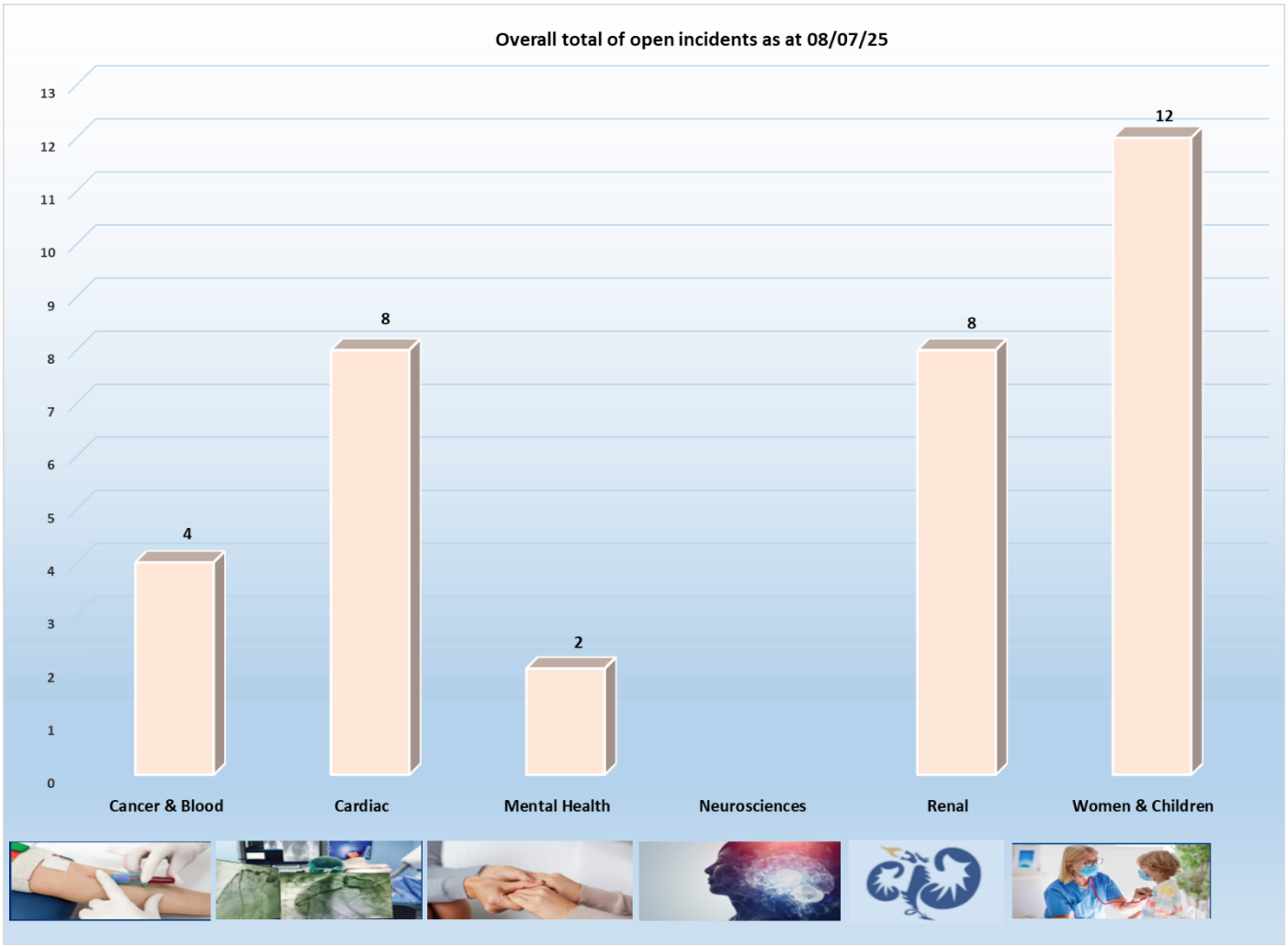
1. Nationally reported incidents received in the previous 7 days
2. Early Warning Notifications received from Welsh Government in the previous 7 days
3. High Level External Reports published in the previous 7 days to include but not limited to;
   - Public Service Ombudsman Wales (PSOW)
   - Healthcare Inspectorate Wales (HIW)
   - Human Tissue Authority (HTA)
   - His Majesties Coroners (HMC)
4. Weekly news and media reports relating to NHS Wales

In addition to the reports already received there are 10 NRIs reported relating to WAST that have not previously been reported and are summarised below.

Incident date and NHS Executive reference	Brief Description	Incident Classification
ID3823 21/01/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3893 26/04/2025	Inappropriate care provided to patient at scene of emergency.	NRI
ID3895 04/05/2025	Patient sustained burns to his face after lighting a cigarette whilst left unattended on high flow oxygen.	NRI
ID3896 19/02/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3903 30/01/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3923 18/03/2025	Inappropriate call assignment grade resulting in delay in treatment of 17-month-old baby who subsequently passed away.	NRI
ID3924 04/05/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3928 11/03/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3937 11/02/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3992 06/11/2024	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI

2.3 Open Incident Log

The graph below provides details on the NRI incidents which remain open within the Commissioning teams which have previously been shared with the committee. Thisdoes not include the 10 from WAST as this stage as work is ongoing regarding current and updated reporting through to the commissioner.



An updated position is available on the data log and progress is discussed with the various provider as part of the contracting process between the quality leads. As previously stated, there is sometimes a delay in the closure of the incidents due to internal sign off through the relevant governance processes within the Health Board/Trusts in the first instance.

2.4 Closed Incidents

A total of 2 incidents have been closed in this reporting period, both from the Cardiac commissioning team:

- INC24-08-017 Cardiac Commissioning Team
- INC24-10-023 Cardiac Commissioning Team

Evidence within the closure forms of learning and development have been noted. Within the assurance meetings with the Health Boards/ Trusts and Quality forums further reference to these will continue to support evidence that implementation of the learning has been undertaken.

2.5 Complaints

10 new complaints have been received in the reporting period, 3 of which have been closed. These are summarised below:

Log number	Date received	Commissioning team	Health Board /JCC/ Independent provider Response required	Concern	Open/ closed
HCP25-06-003	23/05/2025	Neurosciences	Betsi Cadwaladr University Health Board	Cochlear Concern	Closed
HCP25-06-004	27/05/2025	Cardiac	NWJCC Swansea Bay University Health Board	Cardiac Services Quality Monitoring Concern	Open
HCP25-06-005	02/06/2025	Mental health	NWJCC	Placement Concern	Closed
HCP25-06-006	20/06/2025	Neurosciences	NWJCC Cardiff and Vale University Health Board	DBS Concern	Open
HCP25-06-007	23/06/2025	IPFR	NWJCC/Individual Patient Funding Request (IPFR) Policy	Access to Burosumab	Open
HCP25-06-008	26/06/2025	IPFR	NWJCC/IPFR Policy	Access to Burosumab	Open
AM25-04-067	26/06/2025	Renal	Cwm Taf Morgannwg University Health Board	Renal Unit Concern	Closed
HCP25-06-009	24/06/2025	Renal	Powys Teaching Health Board	Patient Behaviour Concern	Open

HCP25-06-010	30/06/2025	IPFR	NWJCC/IPFR Policy	Access to Burosumab	Open
HCP25-07-011	17/06/2025	Neurosciences	NWJCC Provider – consent sought from patient	Information Governance Concern	Open

2.6 WAST Inquest Outcome

WAST recently outlined some of the learning they have taken forward following an inquest held in June 2025 from the death of a young woman in February 202O. The patient died of sepsis within a few hours of being admitted, the Coroner addressed the issue of the ambulance crew not having issued a pre-alert to the hospital.

Learning for WAST has included the introduction of an electronic patient clinical record, which enables crews to capture patient's information on an iPad in order to pre-alert healthcare partners prior to a patient's arrival at hospital and share the documentation of clinical assessment and care given. Outcomes of this will be monitored through the commissioning team.

No new reports regarding Quality and Safety have been received this month from WAST, these are updated on a quarterly basis.

2.7 Ombudsman

There have been no new referrals to the Ombudsman for this reporting period.

3.0 ASSESSMENT

Objectives / Strategy	
Dolen i Nod (au) Strategol CBC Link to JCC Strategic Goal(s)	Choose an item.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr	Learning, Improvement & Research

Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Effective Efficient Timely Patient centred Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken a Quality Impact Assessment Screening?		Assessed as part of the Health Board investigation process
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: As above

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATIONS

The Quality, Safety and Outcomes Sub-Committee is asked to:

- **Note** the report; and
- **Receive** the report for assurance.

5. NEXT STEPS

Further updates will be provided at future meetings.