

Agenda Item

4.6

Quality Safety and Outcomes Sub-Committee
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Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	15/12/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
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Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting.
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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	
CQC	Care Quality Commission

Acronyms / Glossary of Terms	
CT	Commissioning Team
EWN	Early Warning Notification
HB	Health Board
HEFA	Human Embryology Fertility Authority
HIW	Health Inspectorate Wales
HMC	His Majesties Coroners
HTA	Human Tissue Authority
IPFR	Individual Patient Funding Request
JCC	Joint Commissioning Committee
MBRRACE	Mother and Babies Reducing Risk through Audits and Confidential Enquiries
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
NRI	Nationally Reportable Incident
OCD	Obsessive Compulsive Disorder
ODT	Organ Donation and Transplantation
PMRT	Perinatal Mortality Review Tool
PSOW	Public Service Ombudsman Wales
WAST	Welsh Ambulance Service Trust

1. SITUATION/BACKGROUND

The purpose of this report is to provide an update on the incidents and complaints reported to the Joint Commissioning Committee covering Specialised Services, Mental Health and Ambulance/111. The report includes a summary of concerns and incidents reported to the JCC from a provider and commissioned services perspective covering the period 1/09/2025 – 31/11/2025.

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 JCC.
- Closed reportable Incidents and outcomes/learning from these.
- An update of ongoing open incidents and concerns.
- Any new concerns received by provider/commissioner 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.

Gathering evidence is vital in the commissioning cycle in ensuring the services commissioned meet the Health & Care Quality 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.

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 across the systems. Intelligence from the NHS Wales Performance and Improvement, HIW/CQC as well as internal data sources enables identification of new or ongoing concerns as well as benchmarking across services and providers. In addition, intelligence and reporting from NHS England is also gathered through relevant forums, National Quality & Governance Group and National databases.

Details of any information received and of relevance are shared and discussed in the relevant commissioning team reports and summarised in the following section of the report.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 New incidents for reporting

In total there have been 4 new nationally reportable incidents, 1 DATIX and 1 early warning notification reported to the Commissioning teams over the period 01/09/2025 – 31/11/2025. These are summarised in the table below:

2.1.1 Specialised Services and Mental Health

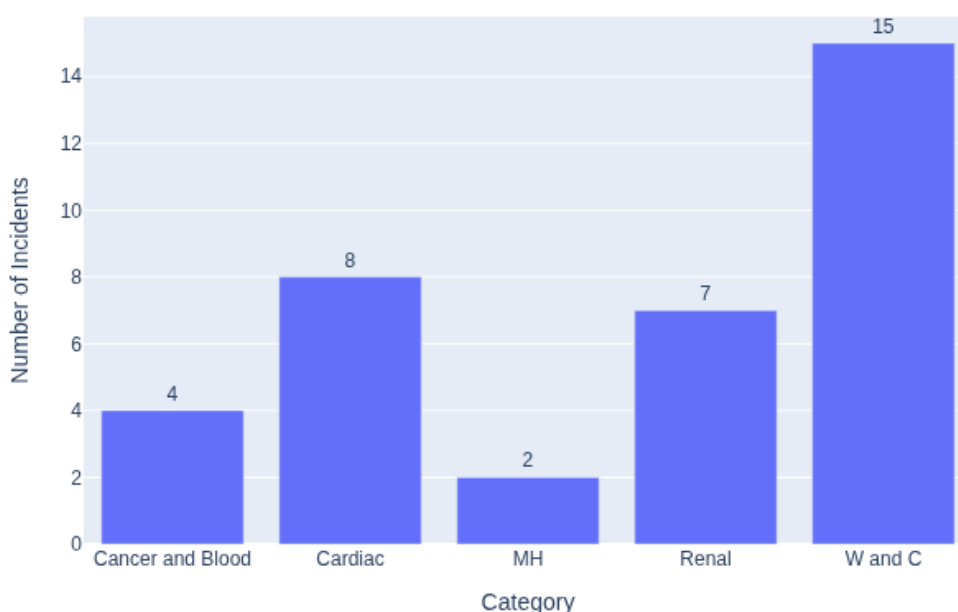
Incident date and ref	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC25-09-033 22/08/25	03/09/25	Women & Children	On routine screening two babies tested positive for MRSA	Nationally Reportable Incident (NRI)
INC25-10-034 28/09/25	01/10/25	Women & Children	Neonatal death.	NRI
INC25-10-035 29/09/2025	10/10/25	Cardiac	Death of a patient on a Cardiology waiting list.	NRI
INC25-10-036 26/02/2025	13/10/25	Women & Children	Neonatal death.	NRI
INC25-09-034	23/09/2025	Renal	Death of a Renal patient whilst undergoing dialysis	DATIX
INC25-10-031 13/10/25	15/10/2025	Women & Children	Human Fertilisation and Embryology Authority (HFEA) received an anonymous complaint	Early Warning Notification (EWN)

The two neonatal deaths highlighted above are also reported as NRI's through the MBBRACE and PMRT review mechanisms noting the extreme prematurity of the babies. In a recent escalation meeting with the Children's Hospital for Wales a detailed summary of each of the MRSA cases was provided and assurance given regarding the classification of each case which are not directly related no warrant declaration of an outbreak within the unit. Final investigation reports will be received for all of the above cases and reported accordingly.

In addition to the above the Weekly Patient Safety Briefing Report published by NHS Wales Performance and Improvement is used by the NWJCC to cross reference and triangulate reportable incidents. In addition to the incidents reported above there are 9 NRI's reported relating to WAST relating to Inappropriate Call Assignment which, could have been a factor contributing to patient harm. These are in addition to those that have been reported to the committee previously and as a result the NWJCC Director of Nursing has written to NHS P&I expressing concern and asking for clarity and further work to be undertaken to fully understand the position and actions being taken. A meeting with NHS P&I took place on the 5 December 2025 and have been informed that a detailed piece of work is being undertaken which will be shared with ourselves and WAST on completion. The Commissioning Team will consider the findings and any actions reported to the committee in future reports.

2.2 Open Incident Log

Open incidents up until 31/10/25



The graph above provides details on the NRI incidents which remain open within the Commissioning teams which have previously been shared with the committee. Updates are provided through regular contact with the providers and are summarised on the data log which is available on request. Closure is often delayed due to delays in Health Boards either from an investigation or governance process perspective.

2.3 Closed Incidents

4 incidents have been closed in this reporting period and are summarised below:

- INC24-12-034 Cardiac Commissioning team
- INC24-09-019 Cardiac Commissioning Team
- INC23-11-052 Cancer and Blood Commissioning Team
- INC24-10-024 Renal

Whilst the two Cardiac Incidents are from the same Health Board they are not related in terms of origin and presentation. No linked themes or trends have been identified for wider sharing and the Commissioning Team were fully assured of the robustness of the final investigation report received.

The Cancer and Blood incident is from a small bespoke service within the commissioning portfolio and again there are no relatable issues to other services within this area.

The renal closure form does relate to ongoing work within the Renal portfolio re line access and fistula management the detail of which is reported in the separate renal report received by the committee. The renal team have had the findings from this incident presented nationally to support learning and development within this clinical area.

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. Key themes which are often seen through all Quality assurance reporting remain re communication and the follow up and implementation of learning. These areas are as highlighted above are also addressed within the Quality meetings held with every Health Board within the Quality meetings held with every Health Board.

2.4 Complaints

6 new complaints have been received in the reporting period and are summarised below:

Log number	Date received	Commissioning team	Health Board /JCC/ Independent Provider Response required	Concern	Open/ Closed
AM25-07-069	05/08/25	Neurosciences	The Walton	Walton referral delay concern- this is awaiting a Health Board	Open
AM25-09-070	26/08/25	IPFR	BCUHB/JCC	Plastics IPFR concern. This is being investigated jointly by the JCC and HB	Open
HCP25-09-015	04/09/25	IPFR	BCUHB/JCC	Legal concern re care management at the Christie	Open
HCP25-10-013	13/10/25	Women and Children	CTUHB	Access to fertility Treatment and immigration status. Legal advice currently being sought has been sought	Open
HCP25-10-018	15/10/25	Women and Children	C&V	As above	Open
HCP25-10-019	19/08/25 initial concern re opened due to legal advice received	Women and Children	C&V	As above	Open

In addition, two complaints have been received relating to commissioned services which have been passed to the relevant provider for investigation and are summarised in the following table:

21/11/25	Mental Health & Vulnerable Groups	C&V	Concern from patients family regarding Adult Gender Services. This will also feed into the planned wider review of the service	Open
19/11/25	Women and Children	C&V	Concerns raised regarding the MDT for audiology services	Open

2.6 Ombudsman

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

3.0 ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Ensure Quality
	Improve Equity and Population Health
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
	A More Equal Wales
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research Leadership
Dolen i Feysydd Ansawdd	Safe
	Efficient

(<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Effective Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental / Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?</i> / Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	Assessed as part of the Health Board Investigation Process
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?</i> / Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	Individual Equality Impact Assessments are carried out as necessary and can be requested.
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 (<i>Pobl / Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	There is no direct impact on resources as a result of the activity outlined in this report.	

4. RECOMMENDATIONS

The Quality Safety Outcome Sub Committee is asked to:

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