



Agenda Item
4.4

Quality Safety and Outcomes Sub-Committee

Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	03/02/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
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Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	Choose an item.

Acronyms / Glossary of Terms	
CQC	Care Quality Commission
EWN	Early Warning Notification
HIW	Health Inspectorate Wales
JCC	Joint Commissioning Committee
MDT	Multidisciplinary Meeting

NHS	National Health Service
NRI	Nationally Reportable Incident
SOP	Standard Operating Procedure
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 (JCC) across our commissioned services. Whilst we acknowledge that these predominantly relate to the specialised services, work is in progress to ensure that there is consistent approach to reporting in the future. Intelligence gathering and reporting is also intrinsically linked and supported by the reporting mechanisms published by the Quality & Safety Team within the Performance & Assurance Division of the NHS Wales Executive.

This report aims to gather and 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 JCC from provider and commissioned services covering the period October 2024 to December 2024 and 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 that 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.

Triangulation of the data submitted through the commissioning routes alongside intelligence from reporting received from the NHS Executive and HIW/CQC enables identification of new or ongoing concerns such as repeated IP&C incidents

and supports the sharing of good practice and data collection / dashboard initiatives and learning through commissioned services with Health Boards.

Intelligence and reporting is also received through NHS England meetings such as Director of Nursing meetings for specialised services and through National reporting from the National Meetings such as the NHS England National Quality and Governance Meeting. Details of any information received and of relevance will be shared in the commissioning team reports and within this report.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.2 New incidents for reporting

In total there have been 11 new nationally reportable incidents reported to the Commissioning teams over the period October 2024 to December 2024. In addition, there have been 2 Datix notifications and these are summarised in the following table:

2.2.1 Specialised Services and Mental Health

Incident date and reference	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC24-10-021 26/09/24	10/10/24	Cancer & Blood	Delay in genetic testing with a family history of X-linked hypophosphatemic rickets. Delay in labs processing the samples, this should have been 42 days but was approximately 150 days.	Nationally Reportable Incident (NRI)
INC24-10-022 08/10/24	17/10/24	Women & Children	Cerebral function monitoring was placed on an infant with a suspicion of an hypoxic event. The infant attended an MRI scan and the needle used to enable the CFM was found to be still in situ rather than having been fully removed despite the probe wire having been cut.	NRI
INC24-10-023 14/10/24	14/10/24	Cardiac	Never Event reported re medication administration. It was noted that the medication drawn up and administered was oral Oxycodone and not Oxycodone for subcutaneous use.	NRI
INC24-10-024 01/04/24	17/10/24	Renal	Patient passed away following a Catastrophic haemorrhage from an aneurysmal Arteriovenous Fistula used for renal dialysis treatment.	NRI

INC24-10-025 16/11/23	17/10/24	Cardiac	Patient transfer to tertiary centre for management of a cardiac event and for consideration of primary angioplasty procedure late in the evening. Treatment and management delayed overnight which resulted in a further cardiac episode. Patient underwent a primary angioplasty but delay thought to have resulted in the patient developing further long term cardiac morbidity issues.	NRI
INC24-11-028 16/07/24	29/10/24	Cardiac	8 patients were implanted with Cardiac Implantable Electronic Devices (CIED's) that had exceeded their expiry dates.	NRI
INC24-11-029 05/10/24	04/11/24	Cardiac	Coronary Artery Bypass graft surgery delay for over 10 days with a further cardiac episode resulting in death.	NRI
INC24-11-030 11/10/24	11/11/24	Women & Children	MRSA infection outbreak. Delay in receiving NRI form. JCC already attending outbreak meetings.	NRI

INC24-12-033 18/11/24	20/12/24	Cardiac	WAST staff contacted Tertiary unit to arrange for Primary PCI for a patient who was having a Myocardial infarction at 02.30hrs. WAST staff advised to take the patient directly to the cardiac catheter Lab however on arrival at the cardiac catheter lab it was locked. Just after 05:00 WAST staff were advised that they could return to the catheter lab where the patient underwent complex PPCI They went into cardiogenic shock during procedure and unfortunately died on ITU the following day.	NRI
INC24-12-034 24/11/24	23/12/24	Cardiac	The patient was awaiting transfer to the Cardiac Centre for a TAVI procedure. TAVI CT completed by the referring hospital on 29/10/2024, and the patient accepted on the general cardiology list on 30/10/2024. Patient suffered a cardiac arrest on 24/11/2-24, and sadly died while still awaiting transfer to the specialist centre.	NRI
INC25-01-035 10/01/25	10/01/25	Women and Children	Wales Online and potentially the Sun newspaper intend to run a story about a child who receives joint care between Cardiff and Vale, Cwm Taff Morgannwg and Bristol Childrens Hospital. The story centres around concerns raised by family members that surgery is being denied to this child by Bristol Children's Hospital	Early Warning Notification

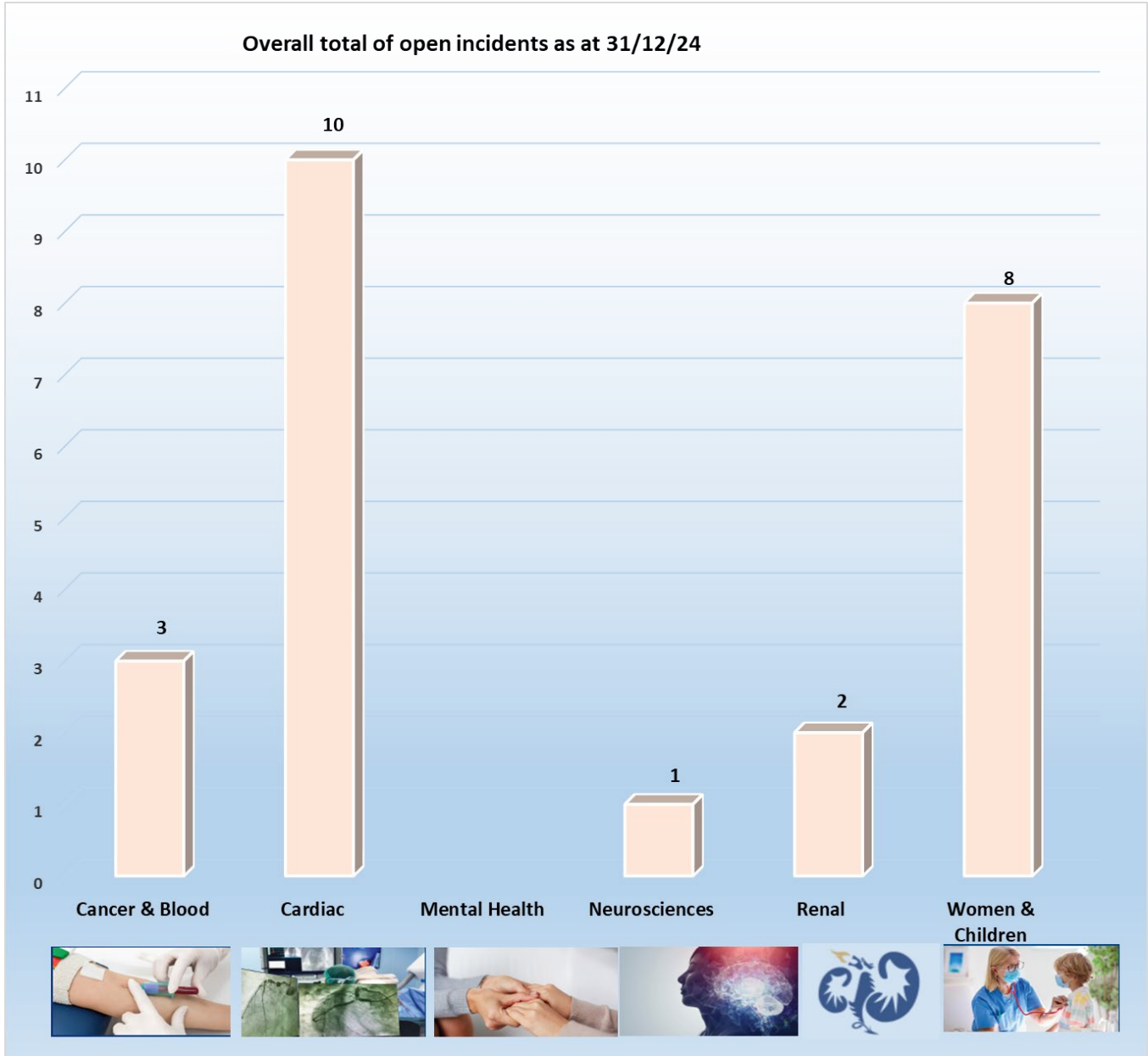
INC24-10-027	24/10/24	Mental Health	Incident occurred within a medium secure unit with one patient, involving a significant episode of violence and aggression where 7 staff were injured. Awaiting outcome and learning.	DATIX
INC24-12-031 09/10/24	05/12/24	Cancer & Blood	Datix submission re patient from acute kidney injury following specialised medication treatment for a Neuroendocrine tumour at Royal Free London.	DATIX

2.2.3 Ambulance/111

Work is ongoing with WAST to agree a process of reporting through to the JCC. Members will note the recent significant pressures across the urgent and emergency care system, including the declaration of a critical incident by the Welsh Ambulance Services University NHS Trust (WAST) on 30 December 2024, which has continued into January. The commissioning team will continue to work with WAST and health board colleagues to understand the level of harm within the system. Serious Case Incident Forums (SCIF) themes consistently relate to delayed response and call categorization, predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme. All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team within WAST, who will consider the requirement to enact the Duty of Candour and contact patients and families as appropriate.

2.3 Open Incident Log

The graph below provides details on the incidents which remain open within the Commissioning teams.



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 as the incidents have to be signed off internally through the relevant governance processes with the organisations in the first instance.

2.4 Closed Incidents

A total of four incidents have been closed in this reporting period and are summarised as follows:

2.4.1 INC23-03-062 Cardiac Commissioning Team

Patient was admitted with a myocardial infarction, following the cardiothoracic multi-disciplinary team meeting, surgery was deemed the best option for treatment. The patient attended an outpatient appointment in January 2023 and scheduled to have cardiac surgery in early February 2023 which was cancelled. The patient subsequently attended his GP with worsening cardiac symptoms on late February 2023, where he was seen in the Medical Assessment Unit the same afternoon and discharged. Later the same day, the patient was found deceased. The review of this incident highlighted several issues and lessons for learning from the incident which has been shared with the teams:

Learning identified:-

- The Escalation processes for chest pain reviewed within the emergency department and acute medicine in agreement with cardiology to ensure appropriate review safe treatment and appropriate discharge.
- A review of the workload, roles and responsibilities of the cardiology registrar on-call to enable the prioritisation of acute patients.
- Improve Consultant Connect process by implementing second tier calls to go via the directorate management team who would take a message from the GP and pass this directly to the consultant on-call.
- When patients present to EU, or MAU, any referral letters that they bring with them or which are communicated electronically must be actioned and documented within the medical notes.
- All patients who attend EU/MAU with potential cardiac symptoms should have an ECG and troponin as standard, this must be reviewed in person by a senior doctor before discharge
- There needs to be a robust process to ensure that medically expected patients receive an appropriate senior review prior to discharge. The cardiology directorate also needs to establish a process so that they are aware of medically expected patients, with cardiac symptoms, to ensure they receive an appropriate in-person review.

The patient's son was notified of the review process and any questions will be answered within the investigation. The incident occurred prior to 1st April 2023, therefore formal Duty of Candour processes were not triggered.

The delay in investigating the incident was acknowledged due to clinical commitments and operational pressures.

2.4.2 INC23-10-046 Neurosciences Commissioning Team

As part of a follow up for a patient with longstanding neurosurgical problems it was noted that there was an increase in the size of the aneurysm in 2017. Management at this time was for the patient to be discussed and reviewed within the MDT and a follow up offered, which does not appear to have been undertaken. In August 2023 the patient collapsed at home and a CT head scan showed a large intraventricular haemorrhage (a bleed within the area of the brain that contains spinal fluid) with a build-up of fluid in the brain. The patient was referred to the neurosurgical team at the University Hospital of Wales (UHW) for their opinion however the patient passed away before she could be further reviewed by the Neurosurgical team.

Issues identified during investigation:

- The patient did not receive follow up after the multidisciplinary team (MDT) meeting in September 2017.
- Gaps in the neurosurgical and interventional neuroradiology consultant establishment left the service under resourced.
- There was no data monitoring metric in place to capture all patients discussed at the MDT meeting in 2017.
- A full review of roles and responsibilities within the neurovascular MDT has taken place. Job descriptions have been updated and the neurovascular MDT Standard Operating Procedure (SOP) has been revised to demonstrate accountability of actions.
- All vacancies aligned to neurovascular service have been recruited to and the current consultant body within the neurovascular service as a whole has increased since 2017 with the addition of two whole time equivalent clinical nurse specialists.
- There has been an increase in administrative support throughout the neurovascular service.
- All commissioned services are bench marked when funding support is requested from JCC.
- An updated neurovascular database has been established since 2017. Allowing for timely documentation of patient outcomes, recommendations following MDT discussion, and tracking of planned diagnostics surveillance scans etc. Audit trails of the system are regularly reviewed.

There was a delay in the completion of the investigation due to the reviewer undertaken this report alongside their operational duties. Operational pressures impacted completion.

2.4.3 INC24-04-003 Cancer & Blood Commissioning Team

Adult Patient transferred to the Welsh Centre for Burns at Morriston hospital with a self-harm injury from CTMUHB Mental Health ward which required surgery and a skin graft. Patient was not subject to any restrictions under the MH act therefore was not accompanied or supported by a MH practitioner. Following surgery the patient was found in the bathroom toilet area asphyxiated after having accessed a computer cable from the clinical area. An investigation was undertaken with the review and support of the MH team.

Learning identified included:

- Ligature assessments on ward areas to include the wiring on portable computers so that access cannot be easily gained.
- Development of a fully documented referral pathway for patients referred to The All Wales Centre for Burns & Plastic Surgery, from outside of the Health Board.
- Referral pathway to include; where patients are in the care of mental health services and require transfer to The All Wales Centre for Burns & Plastics Surgery (and it is intended that they return to the care of mental health services), there should be accompanied by an appropriately trained mental health practitioner.
- Consideration to be given to the development of a mental health nursing role within The All Wales Centre for Burns & Plastics Surgery.
- Development of additional mental health training for staff working in The All Wales Centre for Burns & Plastics Surgery, in order to support patients who, have self-harmed and to recognise any deterioration.
- Wards to have ligature cutters able to cut cables, available.
- Development of a Standard Operating Process to support staff in escalating patients, where they have concerns about mental health.

2.4.4 Liverpool Heart and Chest/Alder Hey

The JCC became aware of a cyber-incident relating to Alder Hey and Liverpool Heart and Chest Hospital. The incident stemmed from a cyber-criminal accessing the Trust network via a compromised generic user account which was used to access the remote Citrix gateway and therefore to the network. Correspondence with the services have provided assurance that there was no compromise or access made to any clinical systems or databases e.g. Electronic Patient Record System. This incident was supported by a national and regional approach and the incident response was stood down on 12th December 2024. In terms of risk and harm, the Trust has assessed any adverse impact to the data subjects as 'some adverse effect'. What was accessed was the name / address and hospital number details and date of procedure. Whilst data has been stolen and a small volume published on the dark web by the cyber-criminal, and some media attention, there has been minimal contact or concern raised by patients regarding the incident. From LHCH there have been 5 patients which were notified of the data breach incident in writing, and 2 out of the 5 patients are Welsh. The Welsh patients we also know the Health Boards have been informed BCUHB and Powys. The incident was reported to the Information Commissioners Office on 29th

November 2024 and the Trust has engaged with the ICO to provide regular updates and assurance of measures taken to manage the incident. The ICO closed this incident on 14th January 2025 confirming there is no further action to be taken by the ICO i.e. regulatory or enforcement action.

2.5 Complaints

One new complaint has been received in the reporting period and is summarised below which has been closed.

Log number	Date received	Commissioning team	Health Board /JCC/Independent provider Response required	Concern	Open/closed
HCP24-11-013	11/11/2024	Women & Children	JCC	IVF Eligibility Concern	Closed

There are no outstanding complaints reported to JCC.

It should be noted that WAST have reported an improvement in complaints timescales continues. The provider is exceeding the minimum target of 75% 30 working day compliance for the first time in several years. In addition acknowledgement of formal complaints is also fully compliant with the national timescales. It is anticipated that 30 working day compliance will begin a temporary decrease as the team begins to focus on resolving long-standing complaints and the total number of open cases.

2.6 Ombudsman

There have been no new referrals to the Ombudsman for this reporting period. In addition the JCC is yet to receive feedback from the ongoing referral following gender reassignment surgery.

3. 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	A Healthier Wales
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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 <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:	If no, please include rationale below: 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	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: As above

<i>Have you undertaken an Equality Impact Assessment Screening?</i>		
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.

5. NEXT STEPS

Further updates will be provided at future meetings.