

**Agenda Item**

5.4

**Quality Safety and Outcomes Sub-Committee**

**Incidents and Concerns Report**

<b>Dyddiad y Cyfarfod / Date of Meeting</b>	02/06/2025
<b>Statws Cyhoeddi / Publication Status</b>	Open/ Public
	Not Applicable
<b>Awdur yr Adroddiad / Report Author</b>	Adele Roberts, Head of Quality and Patient Care
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<b>Noddwr yr Adroddiad / Report Sponsor</b>	Carole Bell, Director of Nursing and Quality

<b>Pwrpas yr Adroddiad / Report Purpose</b>	For Noting Choose an item.
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<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome</b>
	Click or tap to enter a date.	Choose an item.

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

<b>Acronyms / Glossary of Terms</b>	
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 (JC) covering Specialised Services Mental Health and Ambulance/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 JCC from provider and commissioned services covering April to May 2025 with the exception of the Ambulance and 111 service which covers the period February /March in line with the WAST reporting period The Emergency Medical Retrieval and Transport Service report is also taken through to the SBUHB Quality and Safety group forum.

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.

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 Executive HIW/CQC 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 nce 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 & 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 5 new nationally reportable incidents reported to the Commissioning teams over the period April/ May 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
INC25-04-001 22/05/24	08/04/25	Cardiac	A patient died whilst on the cardiac surgery waiting list. The patient was seen in University Hospital Wales by Cardiac Surgeon in May 2023 with a plan for cardiac surgery in the next 3-4 months. It was noted in February 2025 when arrangements were being made to contact the patient prior to surgery that they had sadly died; cause of death Ischaemic Heart Disease.	Nationally Reportable Incident (NRI)
INC25-04-004 09/04/25	15/04/25	Women & Children	An extreme pre-term baby born at 23+1 weeks gestation experienced a hypoglycaemic event after being started on an infusion of insulin for hyperglycaemia. Blood sugars were not checked hourly as required It is too early to determine whether this has caused any long term neurological impairment.	NRI
INC25-04-005 13/02/25	16/04/25	Women & Children	Twins arrived at Princess of Wales Special Care Baby Unit (SCBU) on 13th February 2025 from Neonatal Intensive care unit, University Hospital of Wales. On the evening of their admission twin 2 received the incorrect expressed breast milk (EBM) via orogastric tube (OGT).	NRI

Incident date and ref	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC25-04-006 29/08/24	28/04/25	Renal	A patient received 3 chest X-rays as part of assessment for fitness for kidney transplantation between September 2023 and August 2024. It is under review whether the suspicious lesions were visible in any other x-rays prior to August 2024 as patient subsequently diagnosed with adenocarcinoma.	NRI
INC25-04-007 15/12/2024	28/04/25	WAST	Delay in treatment of a dialysis patient following contacting 999 and 111, 6 times over 4 hours. Patient was pronounced deceased on attendance of ambulance.	

### 2.2.2 NHS Executive Weekly Patient Safety Briefing Report

Since the beginning of the year the NHS Executive publish a Weekly Patient Safety Briefing Report

The report is published by the Quality & Safety Team within the Performance & Assurance Division of the NHS Executive and aims to gather and triangulate intelligence of issues reported by individual Health Boards and Trusts from 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 17 NRI's reported relating to WAST that have not previously been reported and are summarised below. JCC are currently working with WAST to further understand their

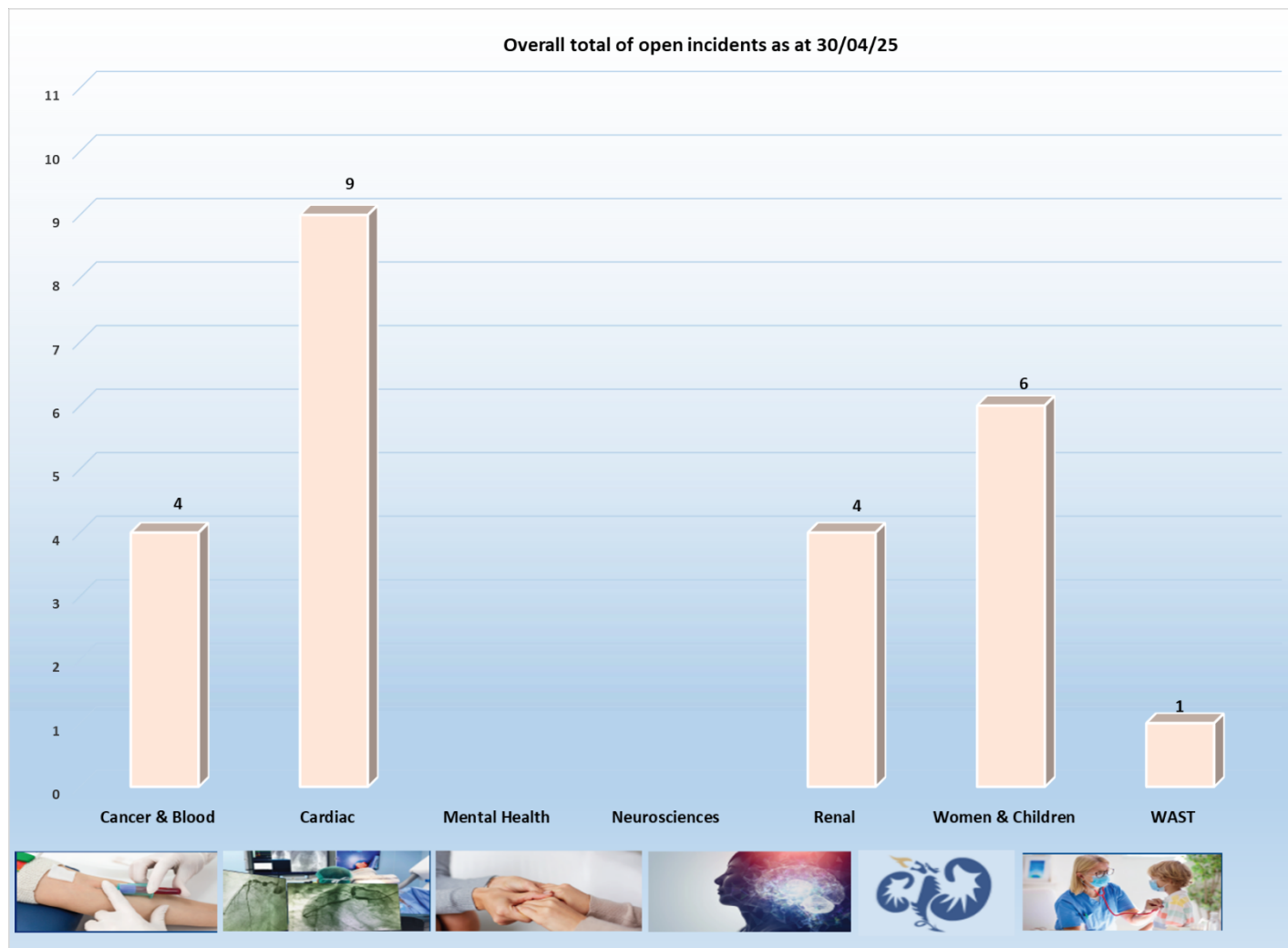
reporting mechanisms and monitoring of actions taken. This will be covered in the deep dive which is being presented at todays committee meeting.

<b>Incident date and NHS Executive reference</b>	<b>Brief Description</b>	<b>Incident Classification</b>
ID3415 11/11/2024	Inappropriate call grading, resulting in delayed attendance of ambulance crew. Patient subsequently passed away 6 days later in ITU.	NRI
ID3661 10/12/2024	Missed allocation of resource resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3678 10/12/2024	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3679 08/01/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3708 31/12/2024	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3731 23/12/2024	Delay in stroke treatment because of ambulance delay. Patient subsequently passed away in hospital.	NRI
ID3732 06/12/2024	Significant delay in attendance of ambulance. Patient was sadly pronounced deceased at home.	NRI
ID3727 05/09/2023	Significant delay in attendance of ambulance. Patient was sadly pronounced deceased at home.	NRI
ID3729 04/02/2025	Missed diagnosis of fractured neck of femur on initial ambulance attendance. Patient subsequently admitted to hospital.	NRI
ID3747 21/08/2024	Inappropriate care and discharge of patient at scene of emergency.	NRI
ID3748 25/07/2024	Inappropriate care and discharge of patient at scene of emergency.	NRI

ID3776 21/12/2024	Significant delay in attendance of ambulance. Patient was sadly pronounced deceased at home.	NRI
ID3777 26/12/2024	Significant delay in attendance of ambulance. Patient was sadly pronounced deceased at home.	NRI
ID3753 30/01/2025	Unexpected death of patient on arrival to hospital. Concerns raised by one crew member of inappropriate treatment provided to patient.	NRI
ID3781 27/09/2024	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3783 22/12/2024	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
ID3782 14/01/2025	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 shared with the committee. This does not include the 17 from WAST as this stage as work is ongoing re the threshold for 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 as the incidents due to internally sign off through the relevant governance processes within the health Board/ Trusts in the first instance

## 2.4 Closed Incidents

A total of 5 incidents have been closed in this reporting period, 4 from the Women and Children's commissioning team and one from the Cardiac commissioning team:

- INC23-05-012 Women & Children Commissioning Team
- INC24-02-075 Cardiac Commissioning Team
- INC24-03-084 Women & Children Commissioning Team

- INC24-10-022 Women & Children Commissioning Team
- INC25-03-045 Women & Children 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

## 2.4 Complaints

4 new complaints have been received in the reporting period, two 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
HCP25-04-001	05/04/25	Women & Children	JCC	IVF Eligibility Concern	Open
AM25-04-066	10/04/25	Neurosciences	JCC Walton	Spinal Surgery Delay	Open
HCP25-04-002	30/04/25	Women & Children	JCC/IPFR Policy	IVF Eligibility Concern	Closed
AM25-03-065	24/03/2025	Women & Children	JCC	IVF Policy Concern	Closed

The WAST report received for this month includes a high level of complaints received and are themed into the following categories:

- Access - 40% related to being unable to access care when people felt they needed this
- Clinical Treatment and Assessment - issues around individualised care not being understood and non-conveyance features
- Appointments - Timelines around non-emergency transport handover delayed transfer and competing priorities

Once again work is ongoing to establish and agree the threshold for reporting from a commissioning perspective fully understanding that there are established processes within the provider for monitoring and reporting to their Board.

The CCAPS system captures any complaints relating to framework commissioned services a summary of which is included in the Mental Health & Vulnerable Groups report. Any serious complaints would be reported in the section above. As a newly

established organisation work is ongoing to support a robust and consist approach to reporting across the three commissioned portfolios,

## **2.5 Ombudsman**

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

The JCC received a response from the Ombudsman has now been completed and the complaint has not been upheld. The outcome has been shared with The Director of Nursing for the Health Board of residence and the case can be closed.

## **2.6 Safeguarding**

There was one safeguarding referral received on the 3<sup>rd</sup> February relating to Mental Health Services.

Allegation of Neglect- Patient is an inpatient is a secure unit (Elysium Ty Glyn Ebwy) under a section 3. Failure to respond appropriately to a medical emergency leading to potential further harm.

A professional Strategy Meeting was held on the 11<sup>th</sup> April. The group were satisfied that all remedial action had been taken by the provider, no further action was required and the case was closed. The Safeguarding Team from the Health Board of residence were present at the meeting

## **3. Changes to National Legislation**

### **3.1.1 Putting Things Right**

It has been reported that there is a delay in the implementation of the regulatory framework due to translation issues. There is an intention for the revised guidance to be considered before the summer recess in preparation for a Senedd debate in Sept 2025. It is proposed that implementation will be 1<sup>st</sup> April 2026 renaming it '*Listening to People - A Complaints, Incidents & Redress Framework*'. A New strategic Oversight Group will meet from this month however the Strategic Reference Group will continue until the regulations are passed.

### **3.1.2 NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2025**

The first meeting of the National Strategic Oversight Group as referenced above took place on Wednesday 21<sup>st</sup> May 2025. The terms of reference were agreed with work proposed for an implementation structure and Quality Impact Assessment (QIA)/ Regulatory Impact Assessment to support the regulations. The roadmap was shared with the group. The date of the next meeting is to be determined.

## **4.0 ASSESSMENT**

### **Objectives / Strategy**

<b>Dolen i Nod (au) Strategol CBC</b> <b>Link to JCC Strategic Goal(s)</b>	Choose an item.
<b>Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals</b> <a href="#">150623-guide-to-the-fg-act-en.pdf</a> <a href="#">(futuregenerations.wales)</a>	A Healthier Wales
	If more than one applies please list below:
<b>Dolen i Hwyluswyr Ansawdd</b> <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <a href="#">(Duty of Quality Statutory Guidance (gov.wales))</a>	Learning, Improvement & Research
	If more than one applies please list below:
<b>Dolen i Feysydd Ansawdd</b> <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <a href="#">(Duty of Quality Statutory Guidance (gov.wales))</a>	Safe
	If more than one applies please list below: Effective Efficient Timely Patient centred Equitable
<b>Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)</b>	No - Not Applicable
	If more than one applies please list below:

<b>Impact Assessment</b>		
<b>Ansawdd</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below:

<i>Have you undertaken a Quality Impact Assessment Screening?</i>		Assessed as part of the Health Board investigation process
<b>Cydraddoldeb</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: As above
<b>Cyfreithiol / Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw da / Reputational</b>	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
<b>Effaith Adnoddau</b> <i>(Pobl /Ariannol) /</i> <b>Resource Impact</b> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

## 5. RECOMMENDATIONS

The Quality Safety Outcome Sub Committee is asked to:

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

## 6. NEXT STEPS

Further updates will be provided at future meetings.