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| Agenda Item |
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| Quality Safety and Outcomes Sub-Committee |
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| Incidents and Concerns Report |
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| Dyddiad y Cyfarfod / Date of Meeting | 31/03/2025 |
| 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 |

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|---|-------------------------------|
| 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 | |
|-------------------------------------|---|
| CQC | Care Quality Commission |
| EMRTS | Emergency Medical Retrieval and Transport Service |
| EWN | Early Warning Notification |
| HIW | Health Inspectorate Wales |
| JCC | Joint Commissioning Committee |

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|------|--------------------------------|
| 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 commissioned services to ensure there is a consistent approach to reporting across specialised services, mental health and Ambulance 111. There is data and information gathered in all of these areas, how this is submitted to the JCC and the outcomes and monitoring of these requires further analysis and development.

Following the last meeting Mental Health services Ambulance/111 and any new reportable incident's for the reporting period are included. Data for Ambulance service and 111 reported via the Welsh Ambulance Service Trust is included from December.

The reporting mechanisms for the Emergency Medical Retrieval and Transport Service (EMRTS) is via the host body and reported through to the SBUHB Quality and Safety group forum. Intelligence gathering and reporting is also 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 January to February 2025 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

2.1 New incidents for reporting

In total there have been 3 new nationally reportable incidents reported to the Commissioning teams for Mental Health and Specialised Services over the period January to February 2025. In addition, there have been 2 NHS England notifications and 2 early warning notifications and these are summarised in the following table:

2.1.1 Specialised Services and Mental Health

| Incident date and reference | Reported to JCC | Commissioning Team | Brief Description | Incident Classification |
|------------------------------------|------------------------|---------------------------|---|--------------------------------------|
| INC24-01-036 19/01/25 | 27/01/25 | Cancer & Blood | A Mental Health patient was admitted to the plastics unit for management of an infected wound. The patient had previously been an in-patient on the ward. A risk assessment had been undertaken prior to admission and was not deemed to have any suicidal ideation. The patient was supported on a 1:1 basis with a Health Care support worker who accompanied the patient to an open café area. Unfortunately, he managed to access a staircase leading out to a balcony on the second floor and the patient was found on the ground floor with severe a head injury and tragically passed away at the scene. | Nationally Reportable Incident (NRI) |
| INC25-02-037 03/02/25 | 03/02/25 | Women & Children | A 31 week infant was admitted to Neonatal unit and following a sudden collapse passed away. A possible Medication incident is being investigated. | NRI |
| INC25-02-042 09/04/24 | 21/11/24 | Renal | A patient with an arteriovenous fistula used for dialysis had a catastrophic haemorrhage at home and passed away. | NRI |

| | | | | |
|--------------------------|----------|------------------|---|--|
| INC25-02-038 06/02/25 | 11/02/25 | Women & Children | Wrong route administration of medication given via a parenteral route when intended for enteral administration. | Never Event reported via STEIS (NHS England Strategic Executive Information System) |
| INC25-02-041 29/09/23 | 19/02/25 | Women & Children | Catastrophic hypoxic-ischemic event following a cardiac arrest and sudden collapse following craniofacial surgery of an infant. | Patient safety Incident NHS England delayed reporting to JCC – final report and details are included in this report. |
| INC25-02-040 31/01/25 | 17/02/25 | Renal | 5 cases of Oxa 48 staph (Carbapenmase resistant bacteria) detected on the Nephrology ward since November 2024. Outbreak meetings and an action plan is in place. These are being chaired by Executive Nurse Director. Infection prevention and microbiology team are providing support and guidance. Renal team attending the outbreak meetings. | Early Warning Notification (EWN) |
| INC25-02-043 12/11/24 | 28/02/25 | Mental Health | Serious security breach within a Medium Secure Unit in relation to three patients accessing Wi-Fi. A Wi-Fi dongle device had been concealed and hidden by patient in the back of a stereo and two other patients accessed the internet using this dongle Wi-Fi through a Play Station PS4, an Xbox and a Nintendo Switch. Investigation is ongoing. | EWN |

2.1.2 Ambulance/111

A detailed monthly integrated Quality and Performance report has been received from WAST up until December 2024 which indicated there were 7 NRI's reported in December 2024; details on these are summarised below. Also included 1 further NRI reported for January through the NHS Executive. These are currently detailed separately from the log above as copies of the NRI reports are awaited.

| Incident date and NHS Executive reference | Brief Description | Incident Classification |
|--|--|--------------------------------|
| ID3545 11/12/2024 | Significant delay in attendance of ambulance. Patient subsequently passed away. | NRI |
| ID3546 14/12/2024 | Significant delay in attendance of ambulance. Patient subsequently passed away. | NRI |
| ID3566 21/01/2025 | Significant delay in attendance of ambulance. Patient subsequently passed away. | NRI |
| ID3606 29/12/2024 | Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away. | NRI |
| ID3607 31/12/2024 | Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away. | NRI |
| ID3589 23/12/2024 | Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away. | NRI |
| ID3481 06/12/2024 | Death of patient following control room related ambulance delay. | NRI |
| ID3482 25/12/2024 | Death of patient following control room related ambulance delay. | NRI |

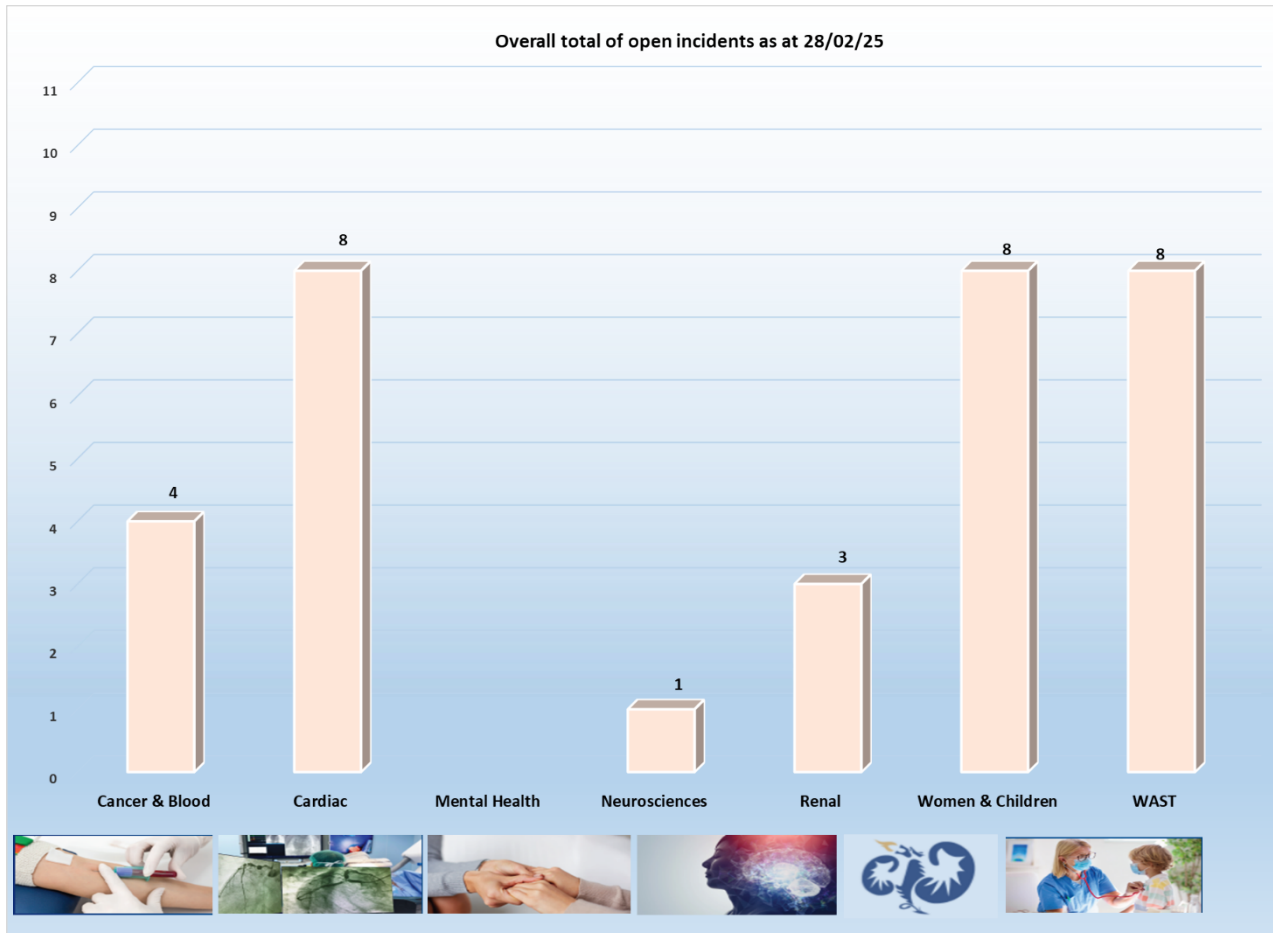
Over the last 6 months through the WAST report there appear to have been a total of 25 reported NRI's. Further details around the NRIS's need to be established. Data received from WAST for December report there were 30 overdue NRI's. Further work is required in fully understanding the reporting mechanisms. It is proposed that the WJCC will attend their serious case Incident Panel and this will be shared and considered in future reporting.

2.1.3 Coroner Cases

Recent data received for December 2024 is at 20 requests. Themes from inquests relate to delays in providing a response in the community. 2 regulation 28 prevention of Future death reports within this theme have both been responded to within 56 day time frame.

2.2 Open Incident Log

The graph below provides details on the NRI incidents which remain open within the Commissioning teams which have been shared or detail obtained within the JCC.



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.

2.3 Closed Incidents

A total of 7 incidents have been closed in this reporting period and 1 downgrade form. The WJCC are satisfied that the level of investigation undertaken by the provider has been robust and any lessons learnt from the incidents have been actioned and dealt with accordingly with robust action plans in place. The Duty of Candour has been considered in all cases. Any lessons are shared with the relevant networks for wider learning They are summarised as follows:

- INC24-04-004 Cardiac Commissioning Team
- INC24-03-086 Cardiac Commissioning Team
- INC25-02-041 Women & Children Commissioning Team
- INC24-06-013 Women & Children Commissioning Team
- INC24-11-030 Women & Children Commissioning Team - Down grading of an MRSA outbreak to increased incidence on the neonatal Intensive care unit. Following robust testing it is highly unlikely that transmission between the babies had occurred. The clinical area will continue to actively review all results and encourage parents to hand wash and be updated on infection prevention principles.
- INC25-02-042 Renal Welsh Kidney Network - Subsequently, the renal network are taking this forward with WG and NHS Executive.
- INC24-10-020 Neurosciences Commissioning Team
- INC24-12-033 Cardiac Commissioning Team Downgrade Form

2.4 Complaints

4 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 |
|--------------|---------------|--------------------|--|-------------------------|--------------|
| HCP25-01-014 | 10/01/25 | Women & Children | JCC | IVF Eligibility Concern | Closed |
| HCP25-02-015 | 25/02/25 | Women & Children | JCC | IVF Policy Concern | Open |
| HCP25-02-016 | 25/02/25 | Cancer & Blood | JCC | PSMA PET Concern | Open |
| AM25-03-063 | | Cancer & Blood | JCC | PET Concern | Open |

WAST have reported an improvement in complaints timescales the provider is exceeding the minimum target of 75% 30 working days. 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. Details of themes and trends reported within the complaints recorded for the data available are for Quarter 3 and include:

- Appointments – same day cancellation
- Access to services delays alternative transport and asked to self-convey.

- Communication reference call back or welfare calls
- Clinical treatment and assessment – advice or care plans
- Attitude and behaviour.

Details of the breakdown of these to core services for Ambulance and volume are reported within data from WAST for Q3 include:

- 111 – 29
- Ambulance Care service -152
- 999 Coordination – 110
- Emergency Medical Services - 53

Mental Health have their own reporting system within CCAPS but work to establish how the reported criteria for JCC commissioned services is being developed to support consistency within reporting.

2.5 Ombudsman

The Ombudsman has issued two public interest reports relating to ambulance commissioned services which are summarised below:

2.5.1 202302966 and 202307480

A public Interest report was issued following the investigation of a complaint against Welsh Ambulance Services University NHS Trust and Swansea Bay University Health Board. The complaint raised concerns regarding the lack of care and treatment provided to a relative in September 2022. The Ombudsman's investigation considered whether the triaging of the emergency calls, and the priority they were allocated by the Trust, was reasonable and appropriate. The investigation also considered whether the advice provided by Trust staff during the calls was reasonable and appropriate. The Ombudsman upheld some of the complaints and made a number of recommendations, which the Trust accepted. These will be considered by the commissioning team and improvement monitored.

2.5.2 202306104

A report by the Public Services Ombudsman for Wales Case: 202306104 where a relative complained about a lack of care and treatment by the Welsh Ambulance Services University NHS Trust. The Ombudsman's investigation considered the handling of 2x 999 calls, the standard of record keeping by the attending paramedic, and whether the earlier arrival of Trust staff would likely have affected Mr B's outcome. The Ombudsman upheld all three aspects of the complaint. The Ombudsman made a number of recommendations, which the Trust accepted. These will be considered and discussed with the provider with an action plan in place to monitor improvement for future care.

3.0 ASSESSMENT

| Objectives / Strategy | |
|--|---|
| Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(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 Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales)) | 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 (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 | Yes: <input type="checkbox"/> | No: <input checked="" type="checkbox"/> |

| | | |
|---|--|---|
| <p><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></p> | <p>Outcome:</p> | <p>If no, please include rationale below: Assessed as part of the Health Board investigation process</p> |
| <p>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></p> | <p>Yes: <input type="checkbox"/></p> | <p>No: <input checked="" type="checkbox"/></p> |
| | <p>Outcome:</p> | <p>If no, please include rationale below: As above</p> |
| <p>Cyfreithiol / Legal</p> | <p>There are no specific legal implications related to the activity outlined in this report.</p> | |
| <p>Enw da / Reputational</p> | <p>There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.</p> | |
| <p>Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i></p> | <p>There is no direct impact on resources as a result of the activity outlined in this report.</p> | |

4.0 RECOMMENDATIONS

The Quality Safety Outcome Sub-Committee is asked to:

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

5.0 NEXT STEPS

Further updates will be provided at future meetings.