GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Agenda Item
5.6

Quality Safety and Outcomes Sub-Committee

Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	06/10/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Adele Roberts, Assistant Director of Nursing and Quality, NWJCC
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	
CQC	Care Quality Commission

Acronyms / Glossary of Terms	
EWN	Early Warning Notification
HIW	Health Inspectorate Wales
HMC	His Majesties Coroners
HTA	Human Tissue Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
NRI	Nationally Reportable Incident
NWJCC	NHS Wales Joint Commissioning Committee
OCD	Obsessive Compulsive Disorder
ODT	Organ Donation and Transplantation
PET	Positron Emission Tomography
PSOW	Public Service Ombudsman Wales
SBUHB	Swansea Bay University Health Board
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 NHS Wales Joint Commissioning Committee (NWJCC) 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 andincidents reported to the NWJCC from provider and commissioned services covering 14/07/2025 – 31/08/2025 with the exception of the Ambulance and 111 service which covers the period June/July in line with the WAST reporting period. Work is currently under way to review the NWJCC operating model to align the reporting with other provider organisations. 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 NWJCC
- 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 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.

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

2.1 New incidents for reporting

In total there have been 4 new nationally reportable incidents, 2 DATIX and 1 early warning notification reported to the Commissioning teams over the period 14/07/2025 – 31/08/2025. These are summarised in the following table:

2.1.1 Specialised Services and Mental Health

Incident date and ref	Reported to JCC	Commissioning Team	Brief Description	Incident Classification
INC25-07-028 02/07/25	06/08/25	Cancer & Blood	Late diagnosis of sarcoma leading to amputation.	Nationally Reportable Incident (NRI)
INC25-08-029 13/07/25	07/08/25	Women & Children	Neonatal death.	NRI
INC25-09-032	24/06/25	Women & Children	Infant death due to cardiac disease, on the waiting list for Cardiac surgery	NRI
INC25-09-033 22/08/25	03/09/25	Women & Children	On routine screening 2 infants tested positive for MRSA.	NRI
INC25-07-026 18/07/25 - 21/07/25	18/07/25	Mental Health	Multiple DATIX submissions for the same patient: escalation of behaviour with significant risk to themselves and others, along with property damage.	DATIX
INC25-08-031 24/01/25	29/08/25	29/08/2025	Paediatric hereditary anaemia wrong number of blood cells given.	DATIX
INC25-07-027	23/07/25	Cancer & Blood	Suspension of PET radiopharmaceutical production.	Early Warning Notification (EWN)

2.1.2 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 and Assurance Division of NHS Wales Performance and Improvement 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:

- Nationally reported incidents received in the previous 7 days
- Early Warning Notifications received from Welsh Government in the previous 7 days
- 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)
- Weekly news and media reports relating to NHS Wales

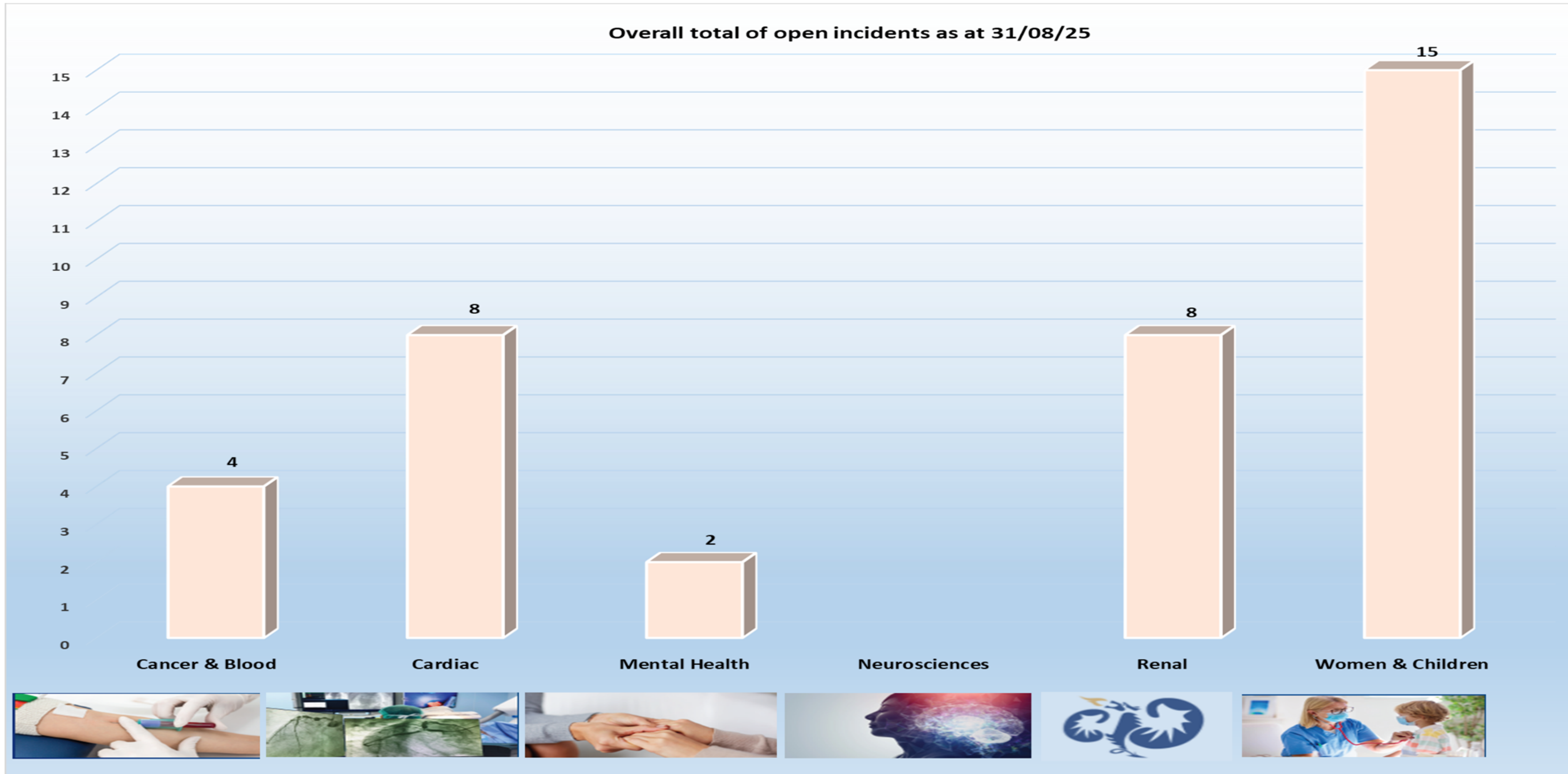
In addition to the reports already received there are 5 NRIs reported relating to WAST which have not previously been reported and are summarised below.

Incident date and NHS Executive reference	Brief Description	Incident Classification
Ref: ID4026 08/01/2024	Incorrect address recorded by call handler resulting in delay in treatment of patient who subsequently passed away.	NRI
Ref: ID4034 08/04/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
Ref: ID4079 27/05/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
Ref: ID4080 22/05/2025	Inappropriate call assignment grade resulting in delay in treatment of patient who subsequently passed away.	NRI
Ref: ID4081 20/12/2024	Incorrect address recorded by call handler resulting in delay in treatment of patient who subsequently passed away.	NRI

Following a meeting on the 18 September with WAST it has been established that the category that is recorded on the report is not a WAST categorisation and is a broader/generic categorisation. As a result it has been agreed that a meeting will be set up to review this in more detail for a more accurate reporting picture in the future. In addition, NHS Wales Performance and Improvement are going to undertake a national assurance exercise relating to joint investigations and enactment of the Duty of Candour / NRI reporting. This review aims to provide an integrated picture of intelligence and it will include aggregated data, contributions from multiple teams and directorates, and provide a holistic understanding of regional strengths and any concerns. This approach to compiling and triangulating our organisational data is a new approach to assurance and learning for the Trust.

2.2 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. This does not include the 5 from WAST at 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.

2.3 Closed Incidents

1 incident has been closed in this reporting period:

- INC22-11-027 Cancer & Blood 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 learning has been undertaken.

2.4 Complaints

6 new complaints have been received in the reporting period, 4 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
HCP25-07-012	21/07/25	Cancer & Blood	JCC	Paediatric burns closure concern	Closed
AM25-07-068	29/07/25	Cancer & Blood	BCUHB	Burns care concern	Closed
AM25-07-069	05/08/25	Neurosciences	The Walton	Walton referral delay concern	Open
HCP25-08-013	07/08/25	WAST	JCC	Ambulance categories concern	Closed
HCP25-08-014	15/08/25	Women & Children	WFI/JCC	WFI concern	Closed
AM25-09-070	26/08/25	IPFR	BCUHB/JCC	Plastics IPFR concern	Open

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

2.6 Mental Health
The Commissioning Care Assurance and Performance System (CCAPS) system captures complaints and incidents relating to framework commissioned Services, a summary of which is included in the Mental Health & Vulnerable Groups report. These are reported through to the Health Board of residence through the CCAPS system and access to reviewing these is undertaken by the mental health care coordinator in the Health Board for those residents in framework provider commissioned placements. A clinician within the Mental Health team also reviews these daily. CCAPS reports incidents through the same categories as the Datix classifications. No Harm / Minimal harm / Moderate Harm /Severe Harm / Catastrophic. Any serious incidents or complaints would be reported in the section above for JCC commissioned patients.

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

3.0 ASSESSMENT

<table>
<tr><th colspan="2">Objectives / Strategy</th></tr>
<tr><td rowspan="2">Dolen i Nod (au) Strategol CBC
Link to JCC Strategic Goal(s)</td><td>Choose an item.</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">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)</td><td>A Healthier Wales</td></tr>
<tr><td>If more than one applies please list below:</td></tr>
<tr><td rowspan="2">Dolen i Hwyluswyr Ansawdd
(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /
Link to Enablers of Quality
(Duty of Quality Statutory Guidance (gov.wales))</td><td>Learning, Improvement & Research</td></tr>
<tr><td>If more than one applies please list below:</td></tr>
</table>

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

Impact Assessment		
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: ☐ Outcome:	No: ☒ 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) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

4. RECOMMENDATIONS

The Quality Safety Outcome Sub Committee is asked to:

- **Note** the Incidents and Concerns report