Freedom of Information Request: Our Reference CTHB_386_18

You asked:

Under the freedom of information act please provide the following information with reference to document below, which outlines the 'serious incidents' system.

http://www.wales.nhs.uk/sitesplus/documents/1064/Handling%20Serious%20Incidents%20Guidance1.pdf

The incidents are graded according to severity, which comes with various timescales for investigation / action.

Please provide copies of the documents sent by your health board under the above scheme for the financial years 2008/9, 2009/10, 2010/11, 2011/12, 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18 and 2018/19 to date.

If the reporting system has changed, please provide the details of incidents reported under any new system.

I do not wish to see the personal details of the individuals who made the reports or any personal details of the individuals involved and understand these may have to be redacted for privacy purposes.

However please ensure the brief description of what happened, the location and speciality, action taken and reports made to other organisations are included.

Also, please provide:

A summary of the number of incidents reported using this system in each financial year from 2008/9 to the current year thus far.

Please break the above summary down to include which location and speciality in which the incidents occurred.

For example:

2008/9
Hospital 1
7 incidents, 3 in emergency department clinic, 4 in outpatient clinic A

Medical centre 1
2 incidents, 1 in GP surgery, 1 in fracture clinic

Etc.

Alternatively, should such a summary database / table not exist, please advise as to how incidents are recorded and analysed for trends.

For example, if several incidents are reported over several months or years involving the same patient or staff member, how they are collated / referenced in the reporting system.

Please also detail any audit processes that are in place to ensure reporting of this nature is done appropriately, with relevant referrals made in a timely manner.

Our response:

Whilst all incidents are reported via the Datix system, it was not until April 2017 that the additional information relating to incidents reported to WG was captured on the system. Prior to this these incidents where recorded on a excel spreadsheet, which is not conducive to running reports. This would require a manual count. Since April 2017, this information is all contained within Datix and a number of reports can be provided, for example, the table attached. To provide this information for previous years would require a manual trawl of excel spreadsheets for each year and cross reference to Datix. To provide you with this information, would significantly exceed the 18 hours' time and £450 cost limit set out within Section 12 of the Freedom of Information Act.

With regards to the attached spreadsheet – please note the following:-

- The majority of Serious Incidents (SI) relate to pressure damage sustained by individuals living in their own home.
- Mental Health Services - These cases related to either suicide or accidental death while under care of community and or in-patient mental health services.
- As part of the look back exercise in maternity services there were an additional 11 cases that were reported locally but not reported to WG. These were retrospectively reported and therefore not included in the above numbers. These cases are included in the numbers recently proactively communicated in public.

Information relating to the number of serious incidents reported to WG is contained within the Health Board's Annual Concerns Report from 2011 onwards. Please see link provided below:
http://cwmtaf.wales/how-we-work/plans-and-reports/annual-concerns-reports/

To provide copies of the forms submitted to WG would require a manual trawl of individual records to retrieve the detailed information required,

which would exceed the cost of compliance, and to which we would apply a Section 12 exemption.

Further information relating to serious incidents is also available in our Board papers under - Concerns (Complaints, Claims And Patient Safety Incidents) – Update On High-Risk Events. Please see link to board papers provided below:

http://cwmtaf.wales/we-are-cwm-taf/board-papers/

Welsh Government Serious Incidents by Directorate and Category 2017/2018

	Slip, Trip or Fall	Absconding	Admission / Transfer / Discharge	Aggressive/ Threatening Behaviour/Abuse	Communication	Delays	Equipment	Food Safety	Infection	Maternal Event	Neo-Natal Event	Organisational - Staffing Levels	Patient injury	Physical Assault	Pressure Damage	Radiological Investigations	Self Harm	Treatment Error	Unexpected Complications	Unexpected or Trauma Related Death	Total
Acute Medicine and A&E	29	0	1	0	1	4	0	2	4	0	0	0	0	0	9	0	0	1	1	0	**52**
Anaesthetics, Critical Care & Theatres	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	1	1	**5**
Child & Adolescent Mental Health Service (CAMHS) - In-Patient	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**5**
General Surgery, Trauma & Orthopaedics and Urology	9	1	0	0	0	0	0	0	0	0	0	0	0	0	18	0	0	0	0	0	**28**
Head and Neck, Eyes, ENT, Oral and Maxillofacial	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**3**
Medical Records and Outpatients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Mental Health	5	6	0	1	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	16	**31**
Merthyr & Cynon Locality	10	0	0	0	0	0	0	0	0	0	0	0	1	0	59	0	0	0	0	0	**70**
Obstetrics and Gynaecology	0	0	3	0	0	0	0	0	0	1	2	1	0	0	0	0	0	0	1	0	**8**
Patient Care & Safety Unit	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	**4**
Radiology	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	5	0	0	0	0	**8**
Rhondda & Taff Locality	4	0	0	0	0	0	0	0	0	0	0	0	0	0	71	0	0	0	0	0	**75**
Total	**58**	**11**	**4**	**2**	**1**	**7**	**1**	**2**	**4**	**1**	**2**	**1**	**1**	**1**	**162**	**5**	**3**	**1**	**3**	**20**	**290**

Footnote 1: The majority of Serious Incidents (SI) relate to pressure damage sustained by individuals living in their own home

Footnote 2: Mental Health Services. These cases related to either suicide or accidental death while under care of community and or In patient mental health services

Footnote 3: As part of the look back exercise in maternity services there were an additional 11 cases that were reported locally but not reported to WG. These were retrospectively reported and therefore not included in the above numbers. These cases are included in the numbers recently proactively communicated in public