Reference:	FOI.11785.23
Subject:	Death and severe harm
Date of Request:	26 May 2023

Requested:

To September 2021 BCUHB accounted for 68% of all Death and Severe harm incidents reported under NR&LS which was NHS and accessible online. Since then, the Once for Wales system has replaced NR&LS.

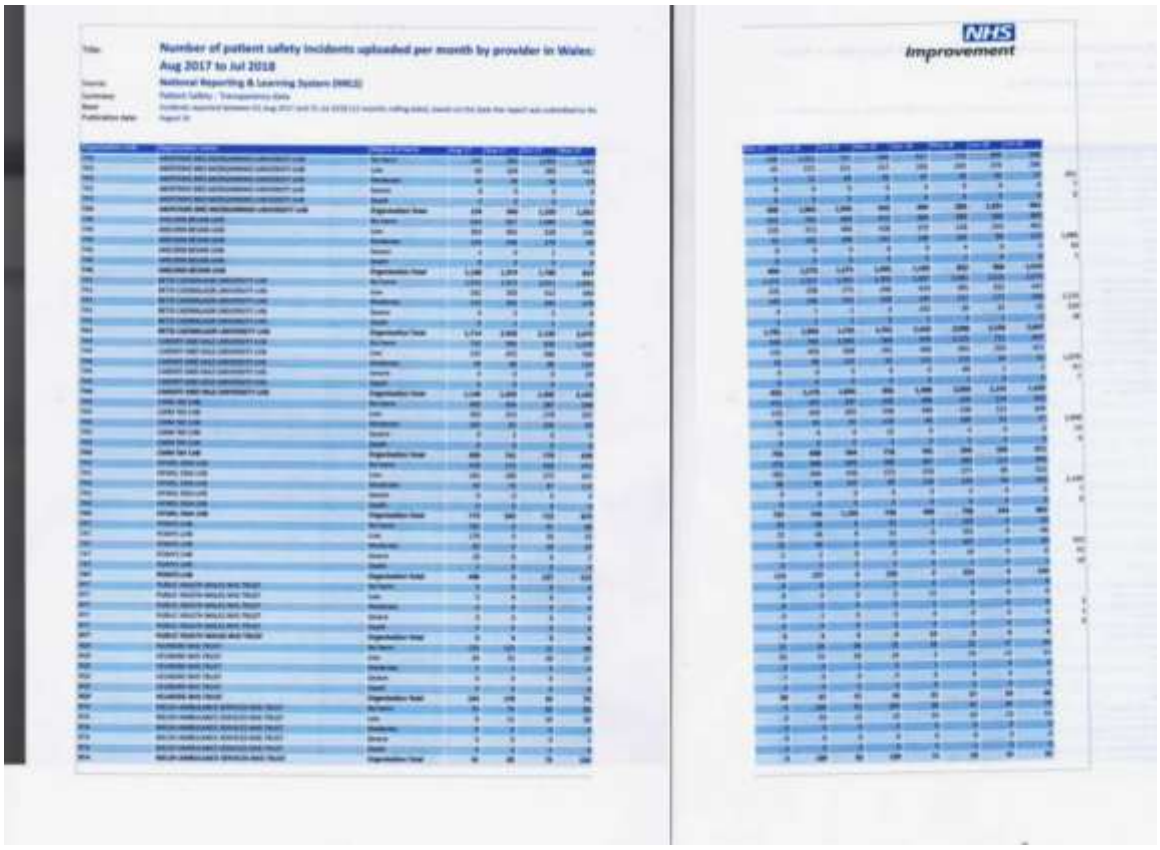
The Wales Shared Services Partnership say each Health Board must supply this individually.

Please accept this as a request under FOI for the equivalent incidents under Once for Wales as Death and Severe harm under NR&LS for your Health Board from October 2021 to Financial Year end 22/23.

Clarified

Patient Safety Incidents please, as per attached excerpt from NR&LS Aug 2017 to Jul 2018.

Only the equivalents of Deaths and Severe Harm.



Response:

Hywel Dda University Health Board (UHB) provides, within the table below, the number of Patient Safety Incidents, during the period 1 October 2021 to 31 March 2023.

Patient Safety Incident	Number
Severe harm	44
Catastrophic/death	26

Additionally, the UHB routinely publishes data regarding severity of incidents in our Quality Assurance report to Quality, Safety and Experience Committee (QSEC). Within the report, investigators are being reminded to ensure that "the grade/severity of an incident should reflect whether the investigation identified any acts or inactions by the Health Board that led to the outcome for the person affected e.g., an expected death in the community was closed as catastrophic by the service and on review no acts or inactions were identified."

Minutes of the QSEC meetings are regularly published on the UHB's website and can be accessed via the link provided overleaf:

Quality Safety and Experience Committee (QSEC) - Hywel Dda University Health Board (nhs.wales)