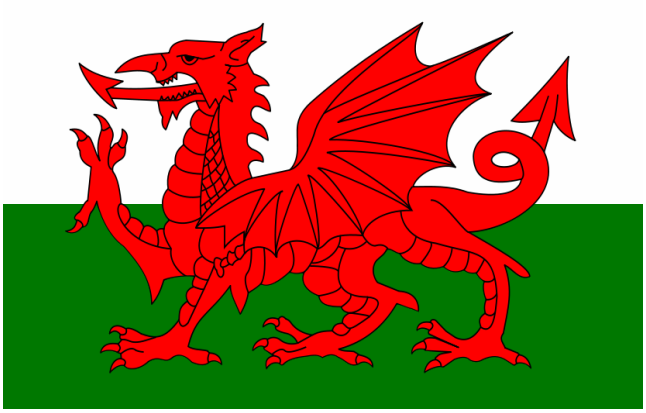
IMPLEMENTATION OF

PATIENT SAFETY ALERTS

IN WALES



30th September 2013

Action against Medical Accidents (AvMA)
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Registered Charity No: 299123

Background

This report has been produced by Action against Medical Accidents (AvMA), the patient safety charity. The object was to establish to what extent patient safety alerts which had already passed the deadline for completion, had been complied with by Health Boards in Wales and what action, if any, is being taken about this by regulators. Patient Safety Alerts (also referred to as "safer practice notices" or "rapid response alerts") were issued by the National Patient Safety Agency (NPSA) about issues which are known to have gone wrong in the NHS on a repeated basis, causing harm or even death. Examples include alerts designed to avoid mistakes with various high risk medicines; use of naso-gastric tubes; giving the right patient the right blood; and ensuring that implements are not left in patients' bodies after surgery. A number of 'required actions' for Health Boards are identified, with a deadline specified by which all of the actions should be completed. Compliance with the alerts is mandatory. The Standards for Health Services in Wales published by the Welsh Assembly Government in 2010[1] includes this standard:

"22. Managing Risk and Health and Safety: organisations and services will have systems in place which comply with legislation and guidance that ……acts upon safety notices, alerts and other such communications".

This report follows two previous reports AvMA published in June 2011 and August, 2012 which highlighted worrying levels of non-compliance with patient safety alerts and made recommendations for the problem to be addressed.

The core data (Appendix A) on which this report is based relates to the latest data available on the National Leadership and Innovation Agency for Healthcare website (**www.patientsafetywales.org.uk**). This is their report on how things stood at the end of the quarter April-June 2013. Welsh Assembly Government refused AvMA's Freedom of Information request for more up-to-date data on the basis the information was due to be published on an unspecified date in the future (see Appendix B). The core data details status of alerts by individual alert and Health Board where the work was due to be completed before July 2013. There are 72 alerts that fall in this category. The alerts themselves can be found on the NPSA website: **www.nrls.npsa.nhs.uk/resources/type/alerts**. For the purposes of this report, any alert where the Health Board has declared work as 'ongoing' is described as "not complied with" or "outstanding". This is because all of the required actions in the alert should have been completed by the stated deadline across the whole Health Board. (It does not mean that no part of the Health Board is complying with the alert).

The status of each alert is presented in the form that it had been reported by each Health Board itself. There has not necessarily been any independent verification that actions on a given alert reported as "complete" actually are complete. Note also that the report relates to the position at the end of June 2013. It is possible that Health Boards will have since become compliant with some of the alerts since that date, but it still means that they were overdue at the time of the data collection.

This year we decided to check what steps the regulator, Health Inspectorate Wales, had taken to ensure that Health Boards complied with safety alerts. Health Inspectorate Wales describe their core role as: *"to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers, that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this."* For the response to our Freedom of Information Request (see Appendix C).

[1] *Doing Well, Doing Better: Standards for Health Services in Wales, 2010*
http://www.nhswalesgovernance.com/Uploads/Resources/pWIHKe4fu.pdf

Key Findings

Details of each patient safety alert and its status within each Health Board can be found in the tables in the appendix. The key findings are:

- Whilst there has been a significant improvement in compliance generally, it remains the case that not a single Health Board in Wales had complied with all patient safety alerts for which the deadline for completion had already passed, in spite of the reports of June 2011 and August 2012.

- There were still 15 instances of patient safety alerts not complied with over five years past the deadline.

- There were 61 instances of an alert not having been complied with, compared with 140 in 2012. This represents an improvement of over 50% on the situation in 2012.

- The best rate of compliance was Powys Teaching Health Board, which had only 2 alerts outstanding compared with 15 in 2012.

- The worst rate of compliance was at Hywel Dda Health Board, which had not complied with 23 of the alerts which had passed the deadline for completion. However, Betsi Cadwaladr University Health Board is also of particular concern with 15 alerts not complied with.

- Just as worrying as the continued non-compliance with patient safety alerts by health boards in Wales, was that Health Inspectorate Wales, which is responsible for monitoring and regulating the NHS in Wales with regard to safety, could find no record of them having taken up this issue with a single health board.

Summary for each Health Board (2013 results in **bold,** 2012 results in brackets)**:**

Health Board	**No. of Alerts outstanding 2013 (**2012)
Abertawe Bro Morgannwg University Health Board	**4** (16)
Aneurin Bevan Health Board	**4** (11)
Betsi Cadwaladr University Health Board	**15** (34)
Cardiff & Vale University Health Board	**5** (12)
Cwm Taf Health Board	**8** (25)
Hywel Dda Health Board	**23** (27)
Powys Teaching Health Board	**2** (15)

(Total number of NPSA alerts past the deadline for completion = 72)

Response to our Recommendations in our 2012 Report

Our recommendations in 2012 were:

1 All Health Boards should prioritise implementation of all the required actions in patient safety alerts which are passed the deadline for completion, and comply with future alerts by the deadline which has been given.

2 All Health Boards should publish their status vis a vis patient safety alerts and their action plans for complying with them on their own websites in a user-friendly way, which is accessible to the public. Progress with complying with patient safety alerts should be considered at public Board meetings, and/or Quality and Safety meetings should be held in public.

3 Representatives of Welsh Assembly Government, Health Inspectorate Wales, and the Health Boards should meet with AvMA and the Board of Community Health Councils in Wales to discuss arrangements for monitoring and regulating compliance with patient safety alerts and information which should be available to the public.

We are pleased to report significant improvement in compliance with alerts, but at least two of the health boards are still not taking this issue seriously enough, or are incapable of making the necessary changes.

A snapshot survey of health boards' websites revealed that only one (Betsi Cadwaladr) had easy to find information about its compliance with patient safety alerts. There was little evidence of the issue being reported or discussed in public by the boards. We were very glad to note that information on each board's compliance with alerts is now published on the Leadership and Innovation Agency for Healthcare website (**www.patientsafetywales.org.uk**). However, the latest information available on the site (as at 23.09.13) related to the period April-June 2013. Welsh Assembly Government refused our Freedom of Information request for more up-to-date data.

We were disappointed that our recommendation for a multi agency meeting, including representatives of patients, to discuss a strategy for reaching full compliance for alerts was not followed. Furthermore, the Health Minister rejected our request for a meeting.

Conclusions

Whilst there has been a significant and welcome improvement in compliance with patient safety alerts across the boards since we started publishing reports on this issue, it is very concerning that Hywel Dda and Betsi Cadwaladr health boards still have so many alerts outstanding, some of which are years past the deadline for completion and that not a single health board is fully compliant. According to Standards for Health Services in Wales there should be 100% compliance. Patients are being left at unnecessary risk. It is possible that some patients may have suffered harm or even died needlessly as a result of alerts not being complied with.

Furthermore, we are deeply disappointed by the lack of priority accorded to this vital element of patient safety. It is disturbing that Health Inspectorate Wales could not provide any evidence of taking action to ensure compliance with patient safety alerts. This is in spite of 15 instances of alerts which had not been complied with which were over five years past the deadline. Health Inspectorate Wales appears to have ignored our previous reports and failed to take any action at all to protect patients' safety by ensuring patient safety alerts are complied with. This is a serious dereliction of duty. There is an urgent need to review and reform the way that patient safety is regulated in Wales.

Welsh Assembly Government took the maximum time permitted by the Freedom of Information Act to respond to our Freedom of Information request simply to say they would not provide the information requested. The excuse given was that the information would be published at an unspecified date in the future. Welsh Assembly Government's and Health Inspectorate Wales' failure to take this issue seriously enough has let patients in Wales down, has left patients at unnecessary risk and has probably contributed to avoidable harm to patients.. Their failure to engage constructively with us and other patients' groups in Wales over this adds insult to injury.

APPENDIX A

Compliance of Welsh Organisations against Patient Safety Wales Notices
2013 - Q1

ID	Name	Date issued	Action by	Abertawe Bro Morgannwg University	Aneurin Bevan Health Board	Betsi Cadwaladr University Health	Cardiff & Vale University Health	Cwm Taf Health Board	Hywel Dda Health Board	Powys Teaching Health Board	Public Health Wales	Velindre NHS Trust	Wales Ambulance Services	Number of organisations that are not compliant
NPSA/2005/7	Ensuring safer practice with Repevax and Revaxis vaccines	01/05/2004	10/06/2005	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	0
Safer Practice Notice 01	Improving infusion device safety	20/05/2004	31/03/2005	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	0
NPSA/2005/11	Safer patient identification	22/11/2005	01/05/2006	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	0
NPSA/2006/12	High dose morphine and diamorphine injections	25/05/2006	31/10/2006	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	0
NPSA/2006/SPN14	Right patient, right blood: advice for safer blood transfusions	09/11/2006	01/05/2007	Complete	Ongoing	Ongoing	Complete	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	2
NPSA/2007/15	Colour coding hospital cleaning materials and equipment	10/01/2007	31/03/2008	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Complete	0
NPSA/2007/16	Early identification of failure to act on radiological imaging reports	05/02/2007	28/02/2008	Complete	Ongoing	Ongoing	Ongoing	Complete	Complete	Complete	Complete	Complete	ot Applicab	3
NPSA/2007/17	Bedrails Safer Practice Notice	26/02/2007	28/08/2007	Complete	Complete	Ongoing	Complete	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	1
No 24	Standardising wristbands improves patient safety	03/07/2007	18/07/2009	Complete	Complete	Complete	Ongoing	Complete	Complete	Complete	Not Applicable	Complete	ot Applicab	1
NPSA/2009/SPN001	Throat Packs	28/04/2009	14/10/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	ot Applicab	0
NPSA/2009/SPN002	Risk to patient safety of not using the NHS Number as the national identifier for all patients	24/06/2009	18/09/2009	Complete	Complete	Complete	Ongoing	Complete	Complete	Complete	Complete	Complete	ot Applicab	1

Compliance of Welsh Organisations against Patient Safety Wales RRRs

2013 - 01

ID	Name	Date issued	Action by	Abertawe Bro Morgannwg University Health Board	Aneurin Bevan Health Board	Betsi Cadwaladr University Health Board	Cardiff & Vale University Health Board	Cwm Taf Health Board	Hywel Dda Health Board	Powys Teaching Health Board	Public Health Wales	Velindre NHS Trust	Wales Ambulance Services Trust	Number of organisations that are not compliant
Rapid Response Report 1	Risk of confusion between cytarabine and liposomal cytarabine (Depocyte)	18/06/2007	18/07/2007	Complete	Complete	Complete	Complete	Not Applicable	Complete	Complete	Not Applicable	Complete	Not Applicable	0
Rapid Response Report 2	Non-lipid and lipid formulations of injectable amphotericin	03/09/2007	01/10/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
Rapid Response Report 3	Emergency support in surgical units: dealing with haemorrhage	10/09/2007	30/11/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
Rapid Response Report 4	Fire hazard with paraffin-based skin products	26/11/2007	26/02/2008	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
NPSA/2008/RRR001	Oral anti-cancer medicines: risks of incorrect dosing	22/01/2008	22/07/2008	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Complete	Not Applicable	0
NPSA/2008/RRR002	Intravenous Heparin Flush Solutions	24/04/2008	24/07/2008	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Complete	Not Applicable	0
NPSA/2008/RRR003	Chest drains: risks associated with the insertion of chest drains	01/05/2008	17/11/2008	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Not Applicable	Not Applicable	Complete	Not Applicable	2
NPSA/2008/RRR005	Reducing dosing errors with opioid medicines	04/07/2008	30/01/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
NPSA/2008/RRR006	Infusions and sampling from arterial lines Rapid Response Report	28/07/2008	30/01/2009	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2008/RRR004	Vinca alkaloid minibags (adult|adolescent units)	11/08/2008	06/02/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
NPSA/2008/RRR007	Haemodialysis patients: risks associated with water supply (hydrogen peroxide)	30/09/2008	31/10/2008	Complete	Complete	Complete	Complete	Not Applicable	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2008/RRR008	Risk of omitting Hib when administering Infanrix-IPB+Hib	12/10/2008	04/11/2008	Not Applicable	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2008/RRR010	Resuscitation in mental health and learning disability settings	26/11/2008	20/05/2009	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2008/RRR011	Reducing risk of overdose with midazolam injection in adults	09/12/2008	09/06/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
NPSA/2008/RRR009	Avoiding wrong side burr holes-craniotomy	11/12/2008	12/05/2009	Not Applicable	Not Applicable	Not Applicable	Complete	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2009/RRR012	Reducing risk of harm from oral bowel cleansing solutions	19/02/2009	07/09/2009	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete	Complete	Complete	Not Applicable	2
NPSA/2009/RRR001	Mitigating surgical risk in patients undergoing hip arthroplasty for fractures of the proximal femur	11/03/2009	14/09/2009	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2009/RRR02	Female urinary catheters causing trauma to adult males	30/04/2009	01/09/2009	Complete	Complete	Ongoing	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	1
NPSA/2009/RRR003	Preventing harm to children from parents with mental health needs	28/05/2009	27/11/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	0
NPSA/2009/RRR004	Preventing delay to follow-up for patients with glaucoma	11/06/2009	10/12/2009	Complete	Complete	Ongoing	Ongoing	Complete	Ongoing	Complete	Not Applicable	Not Applicable	Not Applicable	3
NPSA/2009/RRR005	Minimising risks of suprapubic catheter insertion (adults only)	29/07/2009	29/04/2010	Complete	Complete	Complete	Complete	Complete	Ongoing	Not Applicable	Not Applicable	Not Applicable	Not Applicable	1
NPSA/2009/RRR006	Oxygen safety in hospitals | Rapid Response Report	29/09/2009	29/03/2010	Ongoing	Ongoing	Ongoing	Complete	Complete	Ongoing	Complete	Not Applicable	Complete	Not Applicable	4
NPSA/2009/RRR007	Reducing the risks of tourniquets left on after finger and toe surgery	09/12/2009	09/06/2010	Complete	Complete	Ongoing	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Not Applicable	1
NPSA/2010/RRR008	Vaccine cold storage	21/01/2010	21/07/2010	Complete	Complete	Complete	Complete	Complete	Ongoing	Complete	Not Applicable	Complete	Not Applicable	1
NPSA/2010/RRR009	Reducing harm from omitted and delayed medicines in hospital	24/02/2010	24/02/2011	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete	Not Applicable	Complete	Not Applicable	2
NPSA/2010/RRR010	Early detection of complications after gastrostomy	31/03/2010	30/09/2010	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Not Applicable	Complete	Not Applicable	0
NPSA/2010/RRR011	Checking pregnancy before surgery	28/04/2010	28/10/2010	Complete	Complete	Complete	Complete	Complete	Ongoing	Complete	Not Applicable	Not Applicable	Not Applicable	1
NPSA/2010/RRR012	Reducing the risk of retained swabs after vaginal birth and perineal suturing	26/05/2010	26/11/2010	Complete	Complete	Complete	Complete	Complete	Ongoing	Complete	Not Applicable	Not Applicable	Not Applicable	1
NPSA/2010/RRR013	Safer administration of insulin	16/06/2010	16/12/2010	Complete	Complete	Complete	Complete	Complete	Ongoing	Complete	Not Applicable	Complete	Not Applicable	1
NPSA/2010/RRR014	Reducing treatment dose errors with low molecular weight heparins	30/07/2010	28/01/2011	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete	Not Applicable	Complete	Not Applicable	2
NPSA/2010/RRR015	Prevention of over infusion of intravenous fluid* and medicines in neonates	26/08/2010	28/02/2011	Complete	Complete	Complete	Complete	Complete	Ongoing	Not Applicable	Not Applicable	Not Applicable	Not Applicable	1
NPSA/2010/RRR016	Laparoscopic surgery: Failure to recognise post-operative deterioration	23/09/2010	24/03/2011	Complete	Ongoing	Complete	Complete	Ongoing	Ongoing	Complete	Not Applicable	Not Applicable	Not Applicable	3
NPSA/2010/RRR017	The transfusion of blood and blood components in an emergency	21/10/2010	26/04/2011	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
NPSA/2010/RRR018	Preventing fatalities from medication loading doses	25/11/2010	25/11/2011	Complete	Ongoing	Ongoing	Complete	Ongoing	Complete	Complete	Not Applicable	Complete	Not Applicable	3
NPSA/2010/RRR019	Safer ambulatory syringe drivers	16/12/2010	16/12/2011	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable	0
NPSA/2011/RRR001	Essential care after an inpatient fall	13/01/2011	14/07/2011	Complete	Complete	Ongoing	Complete	Complete	Complete	Ongoing	Not Applicable	Complete	Not Applicable	2
NPSA/2011/RRR002	Keeping newborn babies with a family history of MCADD safe in the first hours and days of life	26/10/2011	26/04/2012	Complete	Complete	Complete	Complete	Complete	Ongoing	Complete	Not Applicable	Not Applicable	Not Applicable	1
NPSA/2011/RRR003	Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors	28/11/2011	31/03/2012	Complete	Complete	Complete	Complete	Ongoing	Ongoing	Not Applicable	Not Applicable	Ongoing	Not Applicable	3
NPSA/2012/RRR001	Harm from flushing of nasogastric tubes before confirmation of placement	22/03/2012	12/09/2012	Complete	Complete	Complete	Complete	Ongoing	Ongoing	Complete	Not Applicable	Complete	Not Applicable	2

Date issued	Action by	Abertawe Bro Morgannwg University Health Board	Aneurin Bevan Health Board	Betsi Cadwaladr University Health Board	Cardiff & Vale University Health Board	Cwm Taf Health Board
23/07/2002	31/10/2002	Complete	Complete	Complete	Complete	Complete
24/02/2004	01/03/2005	Complete	Complete	Complete	Complete	Complete
18/09/2005	01/01/2006	Complete	Complete	Complete	Complete	Complete
01/06/2006	31/01/2007	Complete	Complete	Complete	Complete	Complete
28/03/2007	13/03/2008	Ongoing	Complete	Ongoing	Complete	Ongoing
28/03/2007	30/09/2007	Complete	Complete	Complete	Complete	Complete
28/03/2007	31/03/2008	Ongoing	Complete	Ongoing	Ongoing	Ongoing
28/03/2007	31/12/2007	Complete	Complete	Complete	Complete	Complete
28/03/2007	30/09/2007	Complete	Complete	Complete	Complete	Complete
02/09/2008	31/03/2009	Complete	Complete	Complete	Complete	Complete
26/01/2009	01/02/2010	Complete	Complete	Complete	Complete	Complete
19/11/2009	23/11/2010	Complete	Complete	Ongoing	Ongoing	Complete
01/12/2009	31/12/2010	Complete	Complete	Complete	Complete	Complete
09/02/2010	09/02/2011	Complete	Complete	Complete	Complete	Complete

Appendix B

13 SEP 2013

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Peter Walsh
Chief Executive
Action against Medical Accidents
44 High street
Croydon
Surrey
CRO 1YB

Direct Line: 029 2092 8905
Fax: 029 2092 8877
E-mail:jeremy.white@wales.gsi.gov.uk

Eich cyf / Your ref:
Ein cyf / Our ref: ATISN: 7586

11 September 2013

Dear Mr Walsh,

Request for Information – ATISN 7586

I wrote to you on 13 August 2013 following your request for information. In your request you asked for:

> Details of any action that Healthcare Inspectorate Wales has taken with Health Boards in Wales between June 2011 and the date of receipt of this request, regarding non-implementation or late implementation of patient safety alerts (including Rapid Response Alerts and Safer Practice notices) including:
>
> - Copies of correspondence with Health boards and/or Welsh assembly Government on this subject during this period
> - Copies of meeting notes with Health Boards and /or Welsh Assembly Government on this subject during this period
> - Any internal report on this subject produced during this period

I have not found any information that fits this description. HIW does receive copies of patient safety alerts from the Patient Safety and Experience team in Welsh Government. They are logged on our information system for each Local Health Board. We then take any alerts into account alongside a range of other intelligence when preparing for any relevant inspection and review activity which we undertake. HIW is not responsible for taking any direct action in response to these alerts.

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Appendix C

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Department for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref ATISN 7585

Peter Walsh
chiefexec@avma.org.uk

10th September 2013

Dear Mr Walsh

Request for Information – reference ATISN 7585

I wrote to you on 15 August following your request for information. In your request you asked for:

The latest information Welsh Government holds on the following:

1. Information, in relation to each of the Health Boards in Wales, on the status of Patient Safety Alerts, (including Rapid Response Reports and Safer Practice Notices) issued by the National Patient Safety Agency, which have passed the given deadline for completion of the required actions at the time of collecting the information. (For each Health Board provide the declared status of each alert. For example: "Completed" "Ongoing" "Not applicable" etc.).

2. Copies of any action plans made available to the Welsh Assembly Government from any of the Health Boards in relation to them completing the required actions in relation to those alerts for which the actions have not yet been completed

I have decided that the information in relation to point 1 is exempt from disclosure under section 21 of the Freedom of Information Act 2000 because the Information is accessible to applicant by other means). Section 21(1) states:

Information which is reasonably accessible to the applicant otherwise than under section 1 is exempt information.

This information is published quarterly and is routinely available from www.patientsafetywales.org.uk/home.aspx?SitePageID=633.

Section 21(1) is an absolute exemption and is not subject to the public interest test.

In relation to point 2, the Welsh Government does not hold this information. However, I believe that it is available on request from the Local Health Boards.

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Any information released under the Freedom of Information Act 2000 or Environmental Information Regulations 2004 will be listed in the Assembly Government's Disclosure Log.

If you believe that I have not followed the relevant laws, or you are unhappy with this response, you may request an internal review by writing to:

Joanna Jordan
Director Corporate Services & Partnerships
Department for Health, Social Services and Children
Cathays Park
Cardiff
CF10 3NQ

When dealing with any concerns, we will follow the principles set out in the Welsh Government's Code of Practice on Complaints which is available on the Internet at www.wales.gov.uk or by post.

You also have the right to complain to the Information Commissioner. Normally, however, you should pursue the matter through our internal procedure before you complain to the Information Commissioner. The Information Commissioner can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 01625 545 745
Fax: 01625 524 510
Email: casework@ico.gsi.gov.uk

Also, if you think that there has been maladministration in dealing with your request then you may make a complaint to the Public Services Ombudsman for Wales who can be contacted at:

Public Services Ombudsman for Wales
Ffordd yr Hen Gae
Pencoed
Bridgend
CF35 5LJ

Yours Sincerely

Mrs Ann-Marie Carpanini-Lock
Improving Patient Safety & Experience Team