



**Draft Minutes of the JCC
Quality Safety and Outcomes Sub-Committee (QSO)
24 August 2026 at 14:00 hrs
by Microsoft Teams**

Members:		
Susan Elsmore	(SE)	Chair and Lay Member, NWJCC
Dr Phillip Kloer	(PK)	CEO Member, Hywel Dda University Health Board (HDdUHB)
Shameem Nawaz	(SN)	Lay Member, NWJCC
Mandy Rayani	(MR)	Vice Chair and Lay Member, NWJCC
In Attendance:		
Helen Ashcroft	(HA)	Deputy Director of Commissioning for Specialised Services, NWJCC
Carole Bell	(CB)	Director of Nursing and Quality, NWJCC
Joanna Dainton	(JD)	Deputy Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups, NWJCC
Iolo Doull	(ID)	Medical Director, NWJCC
Aaron Fowler	(AF)	Committee Secretary and Assistant Director of Governance, NWJCC
Rhodri Pyart	(RP)	Welsh Kidney Network Quality Lead, Cardiff & Vale University Health Board (For items 3.1 and 3.1.1 only)
Ross Whitehead	(RW)	Director of Commissioning for Ambulance Services and National Programmes, NWJCC
Observing:		
Faye Collier	(FC)	Quality and Outcomes Business Partner, NWJCC
Matthew Edwards	(ME)	Assistant Committee Secretary, NWJCC
Kirsty John	(KJ)	Quality and Outcomes Business Partner, NWJCC
Emma Jones	(EJ)	Welsh Kidney Network Lead Nurse, NWJCC
Penny Letchford	(PL)	Deputy Medical Director, NWJCC
AnnMarie Pritchard	(AP)	Head of Commissioning, Welsh Kidney Network (WKN)
Adele Roberts	(AR)	Deputy Director of Nursing and Quality, NWJCC
Guests:		
Kate Sherwood	(KS)	Specialist Rehabilitation Physiotherapist, Cardiff and Vale University Health Board (CVUHB) – for item 2.1 only
Apologies:		
Angela Mutlow	(AM)	Strategic Director of Operations and Corporate Services, Llais
Sue O'Leary	(SO)	Director of Mental Health, Learning Disabilities and Vulnerable Groups, NWJCC
Melanie Wilkey	(MW)	Director of Commissioning for Specialised Services, NWJCC
Minutes:		
Gareth Mitchell	(GM)	Corporate Governance Manager, NWJCC
Item Ref	Agenda Item	
QSO26 /047	1.1 Welcome and Introductions The Chair welcomed attendees to the meeting and apologies were given for the late start of the meeting. The Chair welcomed Kate Sherwood, Specialist Rehabilitation Physiotherapist (Llandough Spinal Unit) attending to support the patient story. The meeting, which was held via Microsoft Teams, was quorate and no objections were raised to the meeting being recorded for administrative purposes.	
QSO26 /048	1.2 Apologies for Absence Apologies for absence were noted , as detailed above.	
QSO26 /049	1.3 Declaration of Interests No additional interests were declared during the meeting.	
QSO26 /050	1.4 Minutes of the Meeting held on 29 June 2026 and Matters Arising The minutes of the meeting held on the 29 June 2026 were approved as a true and accurate record.	
QSO26 /051	1.5 Action Log	



	The Action Log was received. Members noted the three open actions. It was acknowledged that Actions QSO026/004 would be closed following the meeting when the patient could be updated. QSO026/006 and QSO026/007 would remain open, and on the action log until they could be closed. Members further noted and agreed the closure of the seven since the last meeting.
QSO26 /052	2.1 Patient Story – Specialist Spinal Rehabilitation The Committee received a patient story introduced by KS, Specialist Physiotherapist at the Spinal Cord Injury Unit, University Hospital Llandough. The story described a patient's experience following an unexpected autoimmune event, Neuromyelitis Optica Spectrum Disorder (NMOSD), which affected her spine and eyesight and resulted in paralysis. The patient described the impact of her injury, her transfer to the specialist spinal unit, and the tailored rehabilitation, multidisciplinary care and facilities that supported her recovery. The Committee noted the strongly positive account of person-centred, coordinated and compassionate care, and recognised the significant contribution of the wider multidisciplinary team in supporting patients through long periods of rehabilitation and adjustment. Members welcomed the story as a powerful example of the outcomes that could be achieved by the Level 1 spinal unit in Wales and expressed thanks to the patient and KS and the team for sharing it. In discussion, members highlighted the importance of continuity, kindness, specialist expertise and coordination across services, particularly for patients travelling from across Wales to access specialist rehabilitation. It was noted that patients remained under the care of the specialist centre for life, with consultant-led follow-up, multidisciplinary outreach support and access to advice where required. Members also noted that psychological support was available to patients throughout admission and following discharge, with more informal support arrangements in place for staff. The Committee noted that the physiotherapy team was fully staffed, with some ongoing pressures in other specialties, and that recent consultant support had strengthened inpatient care and lifetime follow-up. Members thanked those involved and welcomed further dialogue on any areas where the JCC could provide additional support. The members of the Quality Safety and Outcomes Sub Committee resolved to: • Note the Patient Story
QSO26 /053	3.1 Report from the Welsh Kidney Network The Committee received the Welsh Kidney Network quality report, which included details of four nationally reportable incidents that had been closed through the Quality and Patient Safety process. It was noted that comprehensive discussions had taken place across the network to identify learning, agree improvement plans and establish monitoring arrangements to ensure that learning was shared and implemented across Wales. Members discussed the importance of standardising alert processes, communication and documentation, particularly where standard operating procedures (SOP) had been referenced in incidents. The Committee was advised that relevant procedures had been developed locally and that the network continued to support the sharing and replication of learning across services. It was further noted that a number of the incidents related to interfaces with other specialties, including radiology and haematology, demonstrating the importance of cross-specialty learning. The Committee welcomed the openness and transparency demonstrated by the network in reviewing incidents and sharing learning. Members also noted the need to balance sufficient detail in future reports to support assurance with the confidentiality requirements associated with incident reporting. The Committee noted the current renal dialysis capacity risk and that planning was underway for the Welsh Kidney Network conference in October. It was agreed that information about the October conference would be shared with members, with lay members invited to attend where possible.



The members of the Quality Safety and Outcomes Sub Committee resolved to:

- **Receive** the report as **assurance**.

3.1.1 Welsh Kidney Network: Welsh Language Patient Story – Chronic Renal Disease and Home Dialysis

The Committee received a follow-up in response to the Welsh Kidney Network patient story considered at the previous meeting. The update focused on three key areas: patient travel times, patient experience at the Neath Port Talbot dialysis site, and transport arrangements with the Welsh Ambulance Services NHS Trust.

The Committee was advised that Swansea Bay University Health Board had undertaken discussions with patients affected by the change in services, supported by patient information and third sector involvement. Assurance was provided that transport performance to the Neath Port Talbot dialysis site was generally positive, with July data showing that 348 of 436 patient journeys were completed within agreed target times. It was further noted that 98% of the 62 patients relocated from Morriston to Neath Port Talbot had benefited from shorter journeys, and that the purpose-built facility, including dedicated parking, had contributed to an improved patient experience.

Members noted the range of mechanisms available for patients to raise concerns, including direct contact with clinical teams, complaint and suggestion boxes, dedicated telephone and email routes, and anonymous reporting options. The Committee was also advised that patient feedback relating to food provision at the unit was being considered with Fresenius Medical Care, with further consultation planned to establish the wider patient view. Any concerns relating to transport were reviewed through existing WAST processes, with examples provided of individual patient journeys being reviewed and improved.

The Committee noted the work undertaken with the UK Kidney Association on Patient-Reported Outcome Measures (PROM) and Patient Reported Experience Measures (PREM), including a joint workshop focused on home therapies and improvement opportunities. Action plans were being developed by local areas and would be monitored through commissioning arrangements with NHS providers. Members welcomed the comprehensive follow-up, recognising that the patient story had been used to identify wider learning and service improvement opportunities across the network.

The members of the Quality Safety and Outcomes Sub Committee resolved to:

- **Note** the report for **Assurance** that recommended actions have been undertaken.

QSO26
/054

3.2 Report from the Director of Commissioning for Specialised Services

The Committee received the Specialised Services report and noted that work was underway to revise the presentation of future reports in response to previous feedback. The report was taken as read, with specific updates provided on a number of quality, safety and outcome risks across the specialised services portfolio.

The Committee noted the position in relation to CAR-T and blood and marrow transplant (BMT) services, including the critical risk regarding Joint Accreditation Committee of ISCT and EBMT (JACIE) certification. Members noted the action plan submitted by Cardiff and Vale University Health Board and the work being taken forward to understand potential mitigating actions and implications for future planning through the Integrated Medium-Term Plan (IMTP) and clinical review processes. Members also noted waiting list and service sustainability pressures in plastic surgery services in both South and North Wales, with work ongoing in relation to elective recovery funding in South Wales and the finalisation of additional activity through Connah's Quay to support North Wales.

Updates were provided on paediatric neurology, where recruitment and outreach arrangements with health boards were progressing, and on an emerging risk in paediatric gastroenterology relating mainly to endoscopy waiting lists. The Committee noted that further work was underway to understand the pathway and ensure that patients were being prioritised appropriately, with the risk to be added to the risk register. Cardiac surgical services had been



escalated to level 2, with an initial action plan received from Cardiff and Vale University Health Board and further detail requested to address gaps in data, reporting and assurance.

Members discussed an issue relating to the echocardiography pathway between Betsi Cadwaladr University Health Board and Liverpool Heart and Chest Hospital, noting that this was under investigation and would be reported back once further information was available.

ACTION: MW to feedback to the committee once investigations have been concluded.

The Committee also considered the potential impact of held posts on service coordination within the Artificial Limb and Appliance Service (ALAS) services and was advised that the relevant appointment had now been approved, which was expected to mitigate the identified risk.

In relation to thrombectomy, the Committee noted that the service was included on the organisational risk register and was subject to an ongoing deep dive. It was confirmed that an in-committee discussion was planned for September Joint Committee, with formal recommendations expected to be made in public in November following consideration through the appropriate forums. Members emphasised the need to ensure that deep dives did not delay assurance reporting to QSOC and that the Committee continued to receive the most up-to-date quality information available.

The members of the Quality Safety and Outcomes Sub Committee resolved to:

- **Note** the specialised commissioning updates summarised in this report,
- **Note** the summary of specialised risks described and escalate as necessary and;
- Receive the report as **assurance**.

QSO26
/055

3.3 Report from the Director of Commissioning for Ambulance Services and National Programmes

The Committee received the Ambulance Services and National Programmes report. Members noted a mixed position across the portfolio, with improvement in ambulance handover hours, which had reduced from around 18,000 hours at the start of the year to just over 9,000 hours, while remaining above commissioned capacity.

Members welcomed the developing assurance described in relation to the maturing relationship between the JCC quality team and WAST, including increased scrutiny and oversight. The Committee also noted an emerging issue relating to adult critical care transfer service vehicle availability, with work underway with the provider to seek assurance on delivery.

In relation to NHS 111, members discussed the digital support offer and emphasised the need for future service design to take account of wider accessibility requirements, including disability, language and neurodiversity. The Committee was advised that scrutiny would continue in relation to WAST's assessment of accessibility and that an updated business case was awaited to support release of funding for the digital element. Members noted that the virtual agent was currently undertaking around 5,000 interactions per month, with further functionality expected during the autumn, including updated symptom checkers and potential future options to support onward referral or escalation.

Members raised the need to understand the impact and user experience of the digital front door, including whether the current product represented the most effective long-term approach or whether alternative options should be considered. It was agreed that further discussion should take place with Digital Health and Care Wales (DHCW), WAST and commissioners to consider the broader digital front-end offer, including opportunities to reduce call abandonment and improve navigation into urgent care services.

In relation to non-emergency patient transport services (NEPTS), members noted concerns regarding cancellations and the potential for inequity of access, particularly for rural communities. Assurance was provided that WAST had established a NEPTS Improvement Board and that the JCC was working with the provider to ensure intelligence from health



boards informed improvement activity. **ACTION:** It was agreed that a more detailed report would be brought to a future meeting, with a quality and equity lens, including further information on patient experience, cancellations and the work of the NEPTS Improvement Board.

Members discussed call taker incidents and whether these related only to training and categorisation errors or also reflected wider issues with the underlying algorithms. The Committee was advised that concerns regarding inappropriate call designations and potential adverse patient outcomes had been raised through the weekly quality brief and that retrospective work was underway. **ACTION:** It was agreed that the JCC quality team would follow up with NHS Wales Performance and Improvement (PNI) and WAST to understand progress in concluding this work and ensure learning was informing the approach.

The Committee considered the strategic role of clinical response models, including the future role of Cymru High Acuity response Unit (CHARU) services, emergency ambulance services and clinical assessment services across WAST and health boards. It was noted that these questions would be considered through the strategic review and development of service specifications, with a focus on the resources required to meet community demand and support population needs.

In relation to Sexual Assault Referral Centre (SARC) services, members sought assurance that work would not result in a further review without delivery. The Committee was advised that the intention was to move forward through an established programme, supported by interim contractual arrangements for a further eighteen months to two years. Members noted that a population needs assessment was being undertaken, alongside work to clarify what the NWJCC and police were each commissioning. The Committee further noted potential future implications arising from proposed changes to police services and the planned abolition of Police and Crime Commissioners in 2028 and was assured that these factors were being considered within ongoing discussions with police colleagues.

Members noted the current variation in SARC delivery models across Wales and the intention to develop a more consistent commissioning approach in partnership with police colleagues. The Committee was advised that, despite recent changes in police personnel, the programme was being established, and interim arrangements were being secured to maintain services while longer-term commissioning arrangements were developed.

In relation to major trauma, members discussed the overnight major trauma desk and the current mitigation arrangements. The Committee was advised that the overnight desk had not been commissioned as part of the original Major Trauma Network arrangements, but that EMRTS had provided additional overnight cover to support WAST staff. Members noted that EMRTS had found this increasingly difficult to sustain and that discussions were underway with the network, EMRTS and WAST to agree a long-term solution for the effective 24-hour coordination of major trauma care in South Wales.

The Committee noted that the status quo remained in place, with EMRTS continuing to provide overnight support and fallback arrangements available through the major trauma consultant where required. It was further noted that WAST had been asked to consider whether broader clinical investment in control rooms could support future arrangements. Members agreed that, should the risk continue to escalate, or a way forward not be identified, the matter would be brought back to the Committee and considered in relation to the risk register. The Committee noted the report and the assurance provided, subject to the follow-up actions identified.

The members of the Quality Safety and Outcomes Sub Committee resolved to:

- Consider and **note** the issues raised within the report, receiving **assurance** that the mitigating actions and controls are being managed or indeed escalated as appropriate.

QSO26
/056

3.4 Report from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MHLDVG)



	The committee received the report. It was noted that St Andrew's remained suspended from the framework. Of the original 22 patients, four remained; planned transfers were in place for two patients, and the outcome of a referral was waited for two further patients. The Committee noted that, from September, Northampton NHS Trust would take over management of the remaining patients. This was not considered to be a long-term solution, and gaps in service availability for specific patient groups would be addressed through the strategic review, which was due to report to the Joint Commissioning Committee in September. In relation to independent sector performance, the Committee noted that two providers had performance improvement plans in place: Heatherwood Low Secure and Cygnet Kewstoke, covering both female locked rehabilitation and female acute services. Progress against these plans would continue to be monitored. The Committee received a positive update that Caswell Clinic had been de-escalated from escalation level 3 to escalation level 2 and Lay members will be returning for a follow-up visit and will report back to the committee following this return-visit. Members noted that the service had made significant progress in addressing the areas of concern and that continued monitoring would take place through monthly meetings with the quality team and heads of commissioning. The members of the Quality Safety and Outcomes Sub Committee resolved to: • Take Assurance that patient safety risks or issues within commissioned services are being managed and monitored as set out above
QSO26 /057	3.5 Escalation Trajectories The Escalation Trajectories Report was received and noted, the Committee acknowledging that the detail of services in escalation had been discussed during previous updates. There were currently two services in Escalation, and these were highlighted by the relevant Director reports. Members noted that the appendices for this report would inform the Chair's Report at September's JC Meeting. Members discussed auditory implant services and queried how assurance was being obtained that staff morale had improved. ACTION: It was agreed that a further update would be included in the next report to provide additional detail on this point. The members of the Quality Safety and Outcomes Sub Committee resolved to: • Note the content of the report; and • Receive the report as assurance
QSO26 /058	3.6 Incident and Concerns Report The Committee received the Incidents and Concerns report, which provided an overview of new incidents, early warning notifications and complaints reported into the JCC. Members noted that 14 new nationally reportable incidents, three early warning notifications and 16 new complaints had been received, with no new referrals to the Ombudsman. The Committee also noted that further detail had been included in response to the previous request regarding Regulation 28 actions. The Committee was advised that a number of the reported incidents related to ambulance services and that the JCC quality team continued to work closely with WAST to better understand incident reporting processes and future reporting arrangements. It was noted that, while the number of ambulance-related incidents appeared high, this should be considered in the context of the overall volume of WAST patient contacts. Members noted that themes and trends from closed complaints were reviewed by commissioning teams and shared with providers and networks as appropriate. Members discussed the importance of presenting incident information in context, particularly where reported outcomes related to ambulance response times. It was noted that the conclusion of investigations would provide important balance, including where incidents were



	subsequently downgraded or adjusted following review. The Committee requested that future reporting consider how investigation outcomes and learning could be brought back to provide a more complete picture of the position. Members sought assurance on the early warning notification relating to the Welsh Fertility Institute. The Committee was advised that no adverse outcomes had been identified, although the matter remained open pending completion of actions by Swansea Bay University Health Board. Members also discussed the notification relating to patients colonised with an extremely drug-resistant strain of <i>Acinetobacter baumannii</i>. Assurance was provided that the JCC quality team was working closely with Cardiff and Vale University Health Board, attending weekly outbreak meetings and ensuring that environmental actions were in place. It was noted that no further affected patients had been reported to date. Members also highlighted the need to ensure that learning from Regulation 28 matters was shared more widely across health boards where relevant, rather than only with the directly involved organisations. It was agreed that this would be followed up outside the meeting and that an update on wider learning would be provided as appropriate. ACTION: CB to provide an update and wider learning summary across health boards following regulation 28 actions. The members of the Quality Safety and Outcomes Sub Committee resolved to: • Scrutinise the content of the report • Provide assurance to the NWJCC on the information provided
QSO26 /059	3.7 Regulator Report (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) The report was received. Members noted the summary position. CB confirmed there were no additional matters requiring escalation beyond those already discussed during the meeting. The Committee noted that the report would also be considered as part of the forthcoming QSOC development session with a view to strengthening the way regulatory information was presented and used to provide assurance to members. The members of the Quality Safety and Outcomes Sub Committee resolved to: • Note the content of the report; and • Receive the report for assurance as part of the commissioning cycle.
QSO26 /060	3.8 Report from the All-Wales Individual Patient Funding Request (IPFR) Panel The report was received. The Committee noted that the deep-dive was underway and that a review of the IPFR form will be undertaken, in the future. The members of the Quality Safety and Outcomes Sub Committee resolved to: • Note the information presented within the report
QSO26 /061	4.1 NWJCC Organisational Risk Register (ORR) – Risks Assigned to the Quality, Safety and Outcomes Sub-Committee The risk report highlighted that a number of longstanding risks remained largely static and had not moved for some time. However, the Committee was advised that work was ongoing both to progress individual risks and to strengthen the overall approach to risk management. This included work with local teams to identify, and group related lower-level risks where common themes could collectively meet the threshold for inclusion on the organisational risk register (ORR). The Committee noted that this developing approach would support clearer links between operational risks, strategic risks and the Joint Committee Assurance Framework (JAF). The members of the Quality Safety and Outcomes Sub Committee resolved to: • Note the report, • Review and scrutinise the risks assigned to the sub-committee on behalf of the NWJCC; and



	• Endorse the ORR for onwards assurance to the JC on the effective management of the risks.
QSO26 /062	4.2 Forward Plan of Business 2026-2027 The members of the Quality Safety and Outcomes Sub Committee resolved to: • Note the Forward Plan of Business for 2026-2027.
QSO26 /063	5.1 Any Other Business A draft QSOC Development Day agenda was included for noting. The Committee acknowledged that this had since been updated and an updated agenda (which will now include an item on EQIA and prioritisation) would be shared with attendees before the session takes place.
QSO26 /064	5.2 Items to be deferred/escalated to the Joint Commissioning Committee / other Sub-Committees and review of any actions to future meetings The Committee agreed that the Chair's report to the Joint Commissioning Committee should highlight the positive feedback from the patient story and the open and transparent approach demonstrated by the Welsh Kidney Network to the sharing of learning across Wales. The Committee noted the need to highlight the ongoing JACIE accreditation risk and link this to the IMTP, undertake further review of increased waiting times in plastics and paediatric endoscopy, and seek additional assurance on emerging issues relating to the adult critical care transfer service. Members requested that the escalation of Cardiac Surgery to level 2 be highlighted. Members also requested a more detailed update on NEPTS, particularly in relation to patient quality and experience, and further assurance on WAST call-taking processes, including the algorithms, modelling and framework in place.
QSO26 /065	6.3 Date of Next Meeting The next confirmed meeting was scheduled to take place on the 26 th October 2026. The meeting ended at 16:25.