

Agenda Item

4.6

Quality Safety and Outcomes Sub-Committee

Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	30/10/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Assistant Director of Nursing. Interim Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Assistant Director of Nursing Interim Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Interim Director of Nursing

Pwrpas yr Adroddiad / Report Purpose	For Assurance Choose an item.
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Committee / Group / Individuals	Date	Outcome
Senior Leadership Team	19/10/2026	Noted

1. SITUATION / BACKGROUND

This report provides an update on incidents, concerns, and complaints reported to the Joint Commissioning Committee (JCC) across Specialised Services, Mental Health, and Ambulance/111 services for the period August 1st to September 30th 2026.

Within **Appendix 1** the report summarises Nationally Reportable Incidents (NRI's), Serious Incidents (SI's) notified by NHS England, Early Warning Notifications (EWN's), open and closed incidents, complaints, and Ombudsman

referrals. The report outlines governance arrangements for monitoring and learning.

2. ASSESSMENT

2.1.1 For the reporting period, four new NRI's were reported to the specialist services commissioning teams with a further 11 reported from Ambulance and 111. Four Early Warning Notifications were received, and 30 new patient complaints were received with no new Ombudsman referrals. (**See Appendix 1**). There were also 132 enquires/ concerns received from the public and stakeholders to the NWJCC requesting further information and detail about the Welsh Gender Service gender affirming surgery pause and the independent review of surgical waiting lists, these do not fall under the formal complaint process but are being responded to. Further detail and analysis are included in Appendix 1.

2.1.2 The NWJCC continues to work closely with the Welsh Ambulance Services Trust (WAST) to better understand and clarify assurance and process requirements. This includes reviewing call triage and assignment processes, identifying gaps in controls and escalation pathways, and strengthening oversight to mitigate patient harm. As part of this work, initial director-led meetings have taken place to develop a clearer understanding of how NRI's are identified and reported by WAST. Work continues to be ongoing with NHS Performance and Improvement colleagues to refine this approach to ensure consistency in reporting thresholds and assurance arrangements a further update is expected from NHS Performance and Improvement in early November.

2.1.3 Fifty-one NRI's remain open, detail of the commissioning portfolios related to these are within **Appendix 1**. Delays in closure are primarily due to ongoing provider investigations and governance processes. Commissioning teams maintain regular contact with providers and monitor progress through assurance meetings and incident tracking logs. Ongoing monitoring of learning and development continues through Assurance meetings Quality reporting and clinical visits to the teams.

2.1.4 An open action from the previous report was to identify how learning from Regulation 28 incidents were shared across Wales, as opposed to with individual organisations. Committee members are asked to note that this work is undertaken through a national forum known as the All-Wales Inquest network. All regulation 28's are reviewed and learning fed back into the Health Boards across Wales. This includes learning from regulation 28 reports in England. The BEACON dashboard within NHS performance and Improvement also has a section on the Prevention of Future Deaths Reports and the outcomes and learning from this. This data is shared with all Health Boards

3. RECOMMENDATIONS

The members of the Quality, Safety and Outcomes Sub-Committee are asked to:

- **Review** the content of the report
- **Provide assurance** to the NWJCC on the information provided

Appendix 1 – Operational Update

New Nationally Reportable Incidents/ Early Warning Notifications (NRI / EWN)

Fourteen NRIs were reported during the reporting period, relating to care delivery issues across Women and Children's, Renal and Ambulance and 111 commissioned services.

Four Early Warning Notifications were received.

Each incident is subject to provider-led investigation, with oversight by the relevant commissioning team and escalation through established governance routes.

Please see further detail and themes below regarding NRI's and EWN's received.

1.2 Specialised Services and Renal

There were three NRI's shared with JCC relating to specialised services for this reporting period. These have been shared with the appropriate commissioning teams, outcome and learning from these will be further monitored through the clinical and commissioning team. Themes from these centred around delay in diagnosis and inappropriate early termination of treatment.

1.3 Ambulance Service and 111

The 11 NRI reports received in the reporting period in the table above have been themed.

These include:

Theme	Number
Call taker categorisation error	6
Missed opportunity/ clinical care treatment and management	5

Whilst the number of NRI's appear high the number of NRIs reported each month remains low in relation to the number of patient contacts across the Trust's three patient pathways.

Recent NRI submissions do demonstrate improved reporting of contributory factors, actions and organisational learning, providing greater transparency and assurance to commissioners. Quality oversight is being strengthened through the introduction of Provider Performance Assurance Group meetings, increased commissioner engagement in WAST quality governance forums and improved access to patient experience intelligence.

Further work is underway to understand and address call handler categorisation errors, including opportunities for national benchmarking.

Further evidence is required to demonstrate the consistent implementation of organisational learning and its impact on patient safety and outcomes and continued commissioner oversight will focus on embedding these arrangements and evaluating their effectiveness.

1.4 Early Warning Notifications

Four EWN's were received in this period.

These were 3 for Specialised Services, Women and Children commissioning team and one for Mental Health.

These have been shared with the appropriate teams and actions to monitor and review put in place.

2.0 Current open incidents

- Ambulance and 111 – 32
- Specialised Services including renal – 17
- MH VG LD – 2.

3.0 Updated position on WGS and concerns

This following section provides an update on concerns raised in relation to the temporary pause to referrals from the Welsh Gender Service (WGS) for gender affirming surgery, commissioned by the NWJCC. This includes an overview of patient and carer/stakeholder concerns that have been raised since the decision to pause surgery was announced.

The decision to pause all gender affirming surgery was announced by the NWJCC on 26/08/2026. The decision to pause this surgery was made by the NWJCC due to concerns relating to the quality and safety of the service and the assurances needed to address these areas.

To obtain these assurances, the NWJCC has commissioned an independent review of the surgical referral pathway. The review is being undertaken by expert Clinicians who have clinical experience in gender services.

The review will consider three broad groups of patients:

1. Patients who were either due surgery at the time of the temporary pause on 26.08.26 or are due surgery between then and 31.12.26. These are the immediate priority group for assessment
2. Patients who have had a surgical assessment and are awaiting surgery with a date for surgery sometime after 31.12.26

3. Patients who have been referred for surgery but are waiting for a surgical assessment

The collation of data, patient identification communication and invitation to the assessment process to the patients is ongoing. The recruitment of the clinicians undertaking the reviews is in its final stages, with one clinician already in situ and the review of clinical records underway.

During the reporting period the MHL DVG commissioning team have received:

- 4 patient complaints in August with a further 22 in September relating to the pause in the surgical pathway to gender affirming services, these are currently open. These have all been acknowledged and individualised formal responses are being developed.
- There have been 4 MS concerns received in September these have been responded to and have been closed.
- 120 Stakeholder concerns and general enquiries about the pause have also been all acknowledged and responded to.
- A further 12 enquires are in process of being responded to.
- 46 Freedom of Information Requests

3.1 Key themes from both Patients families and wider stakeholder groups include:

Correspondence received following the pause in surgical referrals demonstrates significant concern regarding the impact on patients and future service arrangements. While delayed access to surgery is the immediate issue, the principal drivers of dissatisfaction are uncertainty, lack of information, concerns regarding transparency, and anxiety about future care.

Key themes include:

- **Psychological impact and distress** arising from prolonged waits, uncertainty and concerns regarding future access to care.
- **Impact on patients awaiting surgery**, including cancelled procedures, financial implications, employment and family arrangements, and concerns regarding referral validity and waiting list status.
- **Uncertainty regarding the scope and duration of the pause**, with frequent requests for clarification on what services are affected, review timescales, and future arrangements.
- **Questions regarding accountability and decision-making**, including the evidence underpinning the decision and perceived proportionality of the response.
- **Requests for greater transparency**, including publication of the review rationale, evidence base, Terms of Reference and stakeholder involvement.
- **Concerns regarding communication**, with many individuals reporting reliance on media and social media rather than direct updates.

- **Concerns regarding ongoing access to wider care and treatment**, including hormone therapy, fertility services, and existing surgical approvals.

The correspondence indicates that the greatest risk to patient confidence arises not solely from the pause itself but from uncertainty regarding the rationale, duration, review process, and future treatment pathway. Continued, timely and transparent communication will be critical in reducing distress, maintaining trust and providing assurance regarding ongoing care arrangements and decision-making processes.

3.2 Llais Engagement

Appendix 2 presents a report submitted to the NWJCC from Llais, '*What we are hearing: the pause to gender-affirming surgery*'. It reflects evidence gathered between late August and early October 2026 from 27 survey respondents, five interviewees and seven representative organisations. Llais notes that this is not a survey of everyone affected and does not claim to represent all 451 people on the surgical pathway.

The report describes significant distress and uncertainty among people affected by the pause. Key themes include:

- **Psychological impact and disruption to people's lives**, particularly where surgery was cancelled at short notice or after long waits.
- **Communication concerns**, including some people learning of the pause through social media and uncertainty about which organisation was responsible for updates.
- **Requests for clarity and transparency** about the rationale, evidence, scope and proportionality of the pause, the purpose of the clinical reviews and likely timescales.
- **Requests for involvement and support**, including a meaningful say in decisions about care and access to emotional and psychological support while people wait.
- **Financial and practical impacts** arising from cancelled treatment, travel, accommodation, leave and prolonged uncertainty.
- **Positive experiences of care**, with many respondents describing Welsh Gender Service staff as professional, compassionate and supportive.

The NWJCC recognises the distress and uncertainty described by Llais and welcomes the feedback. The pause remains a precautionary, temporary clinical assurance measure relating to the surgical referral pathway; it does not represent a change to, or withdrawal of, the Welsh Gender Service. Hormone therapy, psychological support, speech and language therapy and aftercare continue.

Since the pause was introduced, the NWJCC and Cardiff and Vale University Health Board have taken steps to strengthen assurance, communication and support. These include:

- placing the Welsh Gender Service at Level 3 escalation to provide enhanced oversight;
- commencing independent clinical reviews, initially prioritising approximately 60 people who were due surgery before the end of December 2026, with cases considered in date order;
- Working with Cardiff and Vale University Health Board to publish and update FAQs on the WGS website

- publishing the clinical review Terms of Reference, and sharing In-Committee papers considered in August;
- progressing a separate, wider review of the Welsh Gender Service, with initial findings expected by the end of 2026;
- completing and publishing Equality, Welsh Language and Quality Impact Assessments;
- Working with Cardiff and Vale University Health Board to direct patients to arrangements for the reimbursement reasonable costs incurred because of cancelled treatment; and
- providing support and contact routes, including access to psychological support.

The NWJCC has acknowledged and apologised for the uncertainty and anxiety caused by the initial communication of the pause. It will continue to work with Llais, Cardiff and Vale University Health Board and other stakeholders to provide timely information and support, maintain a clear governance and clinical decision-making record, keep quality and equality impacts under review, and ensure lived experience informs the wider Gender service review.

3.3 Ongoing Complaints within provider Services

Within the current open log of provider services; there are currently 12 ongoing within Specialised services which the service is responding to.

From an Ambulance Commissioning team perspective, the NWJCC will continue to monitor the Concerns Management Improvement Programme. This has transitioned from an initial recovery phase into a more structured improvement programme with strengthened governance revised workstreams and enhanced oversight arrangements. Key risks relate to organisational capacity and workforce sickness rates impacting on delivery. SOP and development of early resolutions in line with LTP are underway. A further recovery plan and trajectory for improvement have been requested by the Ambulance Executive Board.

Strategic and Regulatory Assessment

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Not Applicable
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)	A Healthier Wales
	If more than one applies please list below: A more equal Wales

Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Data to Knowledge
	If more than one applies please list below: Whole systems perspective Leadership Learning, improvement and research
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Effective
	If more than one applies please list below: Efficient Equitable Patient centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Reporting on quality matters from last JCC meeting.
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Reporting on performance matters and the impact on the wider health system. Quality and safety matters also considered.

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	Yes (Include further detail below) Ambulance performance of significant concern to the public and impacts on health boards reputation
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.

Acronyms

ALAS	Artificial Limb and Appliance Service
BEACON	Dashboard developed on an All Wales basis
CAMHS	Children and Adolescence Mental Health Service
EMRTS	Emergency Medical Retrieval and Transfer Service
EMSCCC	Emergency Medical Services Clinical Contact Centre
EWN	Early Warning Notification
JCC	Joint Commissioning Committee
LTP	Listening to People
MS	Member of the Senedd
MHLDVG	Mental Health Learning Disabilities Vulnerable Groups
NRI	Nationally Reportable Incident
NWJCC	NHS Wales Joint Commissioning Committee
PTR	Putting things right
SI	Serious Incident
SOP	Standard Operating Process.
WAST	Welsh Ambulance Service NHS Trust
WGS	Welsh Gender Service
WFI	Welsh Fertility Institute