Draft Minutes of the JCC
Quality Safety and Outcomes Sub-Committee (QSO)
29 June 2026 at 13:30 hrs
by Microsoft Teams

Members:		
Susan Elsmore	(SE)	Chair and Lay Member, NWJCC
Mandy Rayani	(MR)	Vice Chair and Lay Member, NWJCC
Shameem Nawaz	(SN)	Lay Member, NWJCC
In Attendance:		
Iolo Doull	(ID)	Medical Director, NWJCC (part meeting)
Sue O'Leary	(SO)	Director of Mental Health, Learning Disabilities and Vulnerable Groups, 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 2.1 and 3.1 only)
Adele Roberts	(AR)	Deputy Director of Nursing and Quality, NWJCC
Ross Whitehead	(RW)	Director of Commissioning for Ambulance Services and National Programmes, NWJCC
Melanie Wilkey	(MW)	Director of Commissioning for Specialised Services, NWJCC
Observing:		
Susan Browne	(SB)	Assistant Director of Commissioning for Specialised Services, NWJCC (For items 2.1 and 3.1 only)
Faye Collier	(FC)	Quality and Outcomes Business Partner, NWJCC
Vicki Dawson-John	(VDJ)	Quality and Outcomes Business Partner, NWJCC
Kirsty John	(KJ)	Quality and Outcomes Business Partner, NWJCC
Angharad Lawson	(AL)	Medicines Optimisation Pharmacist, NWJCC (For Item
Adele Roberts	(AR)	Head of Quality and Patient Care, NWJCC
Gareth Mitchell	(GM)	Corporate Governance Manager, NWJCC
Angela Mutlow	(AM)	Strategic Director of Operations and Corporate Services, Llais
Guests:		
Bethan Davies	(BD)	Renal Unit Manager, SBUHB (For item 2.1 only)
Gwen Quirke	(GQ)	Welsh Language Services Assistant, SBUHB (For item 2.1 only)
Huw Rees	(HR)	Patient (for Item 2.1 only)
Ben Screen	(BS)	Welsh Language Translator, CTMUHB (For item 2.1 only)
Apologies:		
Dr Phillip Kloer	(PK)	CEO Member, Hywel Dda University Health Board,
Carole Bell	(CB)	Director of Nursing and Quality, NWJCC
Minutes:		
Helen Tyler	(HT)	Head of Governance and Risk, NWJCC

Item Ref	Agenda Item
QSO26/025	**1.1 Welcome and Introductions** The Chair welcomed everyone to the meeting and introductions were made. The Chair extended a warm welcome to Huw Rees who was attending to share his patient story. The Chair also welcomed colleagues who were attending to support the patient story, namely Gwen Quirke, Welsh Language Assistant and Bethan Davies, Renal Unit Manager both from SBUHB and Ben Screen from CTMUHB as the appointed Welsh translator. The meeting, which was held via Microsoft Teams, was quorate and no objections were raised to the meeting being recorded for administrative purposes.
QSO26/026	**1.2 Apologies for Absence** Apologies for absence were **noted,** as detailed above. The absence of Chief Executive representation was noted, and it was acknowledged that greater resilience for Chief Executive attendance was required at Sub-Committees.

QSO26 /027	**1.3 Declaration of Interests** No additional interests were declared during the meeting. The Chair reminded members and attendees of the importance of recording declarations.
QSO26 /028	**1.4 Minutes of the Meeting held on 27 April 2026 and Matters Arising** The minutes of the meeting held on the 23 April 2026 were **approved** as a true and accurate record.
QSO26 /029	**1.5 Action Log** The Action Log was received. Members **noted** the three open actions. None of the current actions were due for the meeting. It was acknowledged that Actions QSO026/002 and QSO026/003 would be incorporated into the Agenda for the scheduled September 2026 Development Session. Action QSO026/001 would remain on the Forward Plan of Business to be shared in early 2027.
QSO26 /030	**2.1 Welsh Language Patient Story – Chronic Renal Disease and Home Dialysis** The Chair passed to AR who introduced the patient story and explained how HR was in attendance to share his experience of home dialysis and the benefits of receiving treatment in Welsh. Prior to the patient story being heard, RP provided information and explained the focus on equitable access to home therapies across Wales, the benefits of home dialysis, and the challenges in achieving high uptake, noting the importance of early patient engagement and the role of the National UK Kidney Association Patient-Reported Experience Measures (PREM) survey in capturing patient feedback. A pre-recoded video in Welsh with English subtitles was shared. The video described the patient's journey with home dialysis, highlighting the importance of patient involvement, Welsh language accessibility, and the support from clinical teams, with specific mention of consultants and nurses who facilitated self-care and home therapies. BD detailed the development of new custom-built dialysis units in Bridgend and Neath Port Talbot, including a dedicated home therapies area, while the patient, HR raised concerns about extended patient transport times and the impact on patient experience. HR also mentioned the significance of appropriate food options for dialysis patients and mentioned that a number of his fellow patients were unhappy with the current food provision. It was suggested that a review of food options should be undertaken in light of this patient feedback. SB and MW both agreed to investigate travel and food provision issues further. RW also confirmed that transport co-ordination would be reviewed. SB agreed to collect and analyse date on patient travel times and experiences, with the outcomes to be shared at a future meeting. **ACTIONS:** • SB - Collect and evaluate data on patient travel times and experiences following the move to the new Neath Port Talbot Dialysis Unit, including the impact on self-care patients, and report findings to the committee at a future meeting. • SB - Gather and report patient experiences from the new Neath Port Talbot Dialysis Unit promptly, rather than waiting for the annual PREM survey, and provide an update to the committee at a future meeting. • SB and RW - Review and discuss with the Welsh Ambulance Service Trust (WAST) the current transport arrangements for dialysis patients, including travel times and patient experiences. • The above information, once available to be shared with the patient for information. Members resolved to: • **Note** the Patient Story.
QSO26 /031	**3.1 Report from the Welsh Kidney Network** The Committee received the Welsh Kidney Network (WKN) quality and safety update and noted that there were no significant changes to risks during the reporting period. Members were advised that four national reportable incidents were expected to be closed and updates in relation to these would be brought to the next QSOC meeting. The Committee noted that these incidents would provide opportunities for shared learning and reflection across the network. In response to a query regarding how learning was disseminated, the Committee noted that closure reports and learning from incidents were reviewed through the WKN national Quality, Patient Safety, with summaries circulated to relevant colleagues for local

	sharing. Learning was also discussed at the WKN annual conference, including sessions focused on challenging cases and incidents. The Committee was assured that incidents were logged and revisited after an appropriate period to confirm whether agreed actions had been implemented and learning embedded into practice. The Committee noted that the governance arrangements for WKN had recently changed and that the approach to reporting outputs from WKN quality and patient safety discussions into QSOC was still developing. Members agreed that the level and type of information brought forward for assurance would continue to be refined as the revised arrangements bedded in. A meeting invite and agenda for the WKN annual conference, scheduled for 9 October, would be shared with Committee members for information and attendance where possible. The members of the Quality Safety and Outcomes Sub Committee are asked to: • **Receive** the report as **assurance**.
QSO26 /032	**4.1 Report from the Director of Commissioning for Specialised Services** The Committee received the Specialised Services report and noted that services were generally stable during the reporting period, with no new escalations reported at the time of writing. The Committee was advised that cardiac surgery in Cardiff had subsequently moved to level 2 escalation, with further detail to be brought to the next meeting following further engagement. Members noted continued fragility and system pressure across a number of specialised services, including workforce and capacity constraints in intestinal failure, neurosurgery and cardiac surgery; sustained demand growth in renal dialysis and PET-CT; and access challenges across highly specialised pathways, including thrombectomy. The Committee also noted quality and sustainability risks relating to JACIE accreditation for bone marrow transplant and CAR-T services, and ongoing data quality issues in cardiac surgery. It was agreed that reported fragile services would be escalated and highlighted to the JCC within the QSOC Highlight report. In response to questions on workforce pressures, the Committee noted that recruitment and retention challenges reflected wider system constraints and provider pressures. It was acknowledged that these pressures could affect service resilience even where posts had been recruited to. Members were advised that cardiac surgery data quality remained a significant concern, with escalation agreed due to the lack of clear line of sight on improvement and the absence of sufficient action plans to address the position. The Committee discussed the auditory implant service and noted that a planned meeting with Cardiff and Vale University Health Board had not taken place, due to the absence of appropriate executive representation, and was being rescheduled. The service was reported to be performing at the expected level; however, members noted concerns regarding the sustainability of this position, given its reliance on additional hours, extra shifts and waiting list initiatives. Assurance was being sought from Cardiff and Vale University Health Board that the improvement could be sustained. Members sought assurance regarding contingency planning for JACIE accreditation and expressed their expectation that this was being looked into at an early stage. The Committee noted that the Cardiff submission was due on 8 July, with a decision expected within one to two months following this. Work was underway to identify capacity for CAR-T provision should this be required, and options for derogations with Cardiff and Swansea would be explored in the first instance for bone marrow transplant services. The Committee noted that outsourcing bone marrow transplant provision would be challenging due to patient numbers, treatment intensity and travel implications, and that loss of accreditation would result in significant pathway change rather than a short-term arrangement.

	In relation to neurosurgery, the Committee received assurance that safe interim arrangements were in place following the suspension of a neurosurgeon, including use of existing pathways, nurse-led clinics and referral of urgent cases to Bristol where capacity was restricted. Members noted that no urgent cases requiring referral had been identified following waiting list review. The Committee recognised the wider issue of workforce sustainability in highly specialised services, particularly where small numbers of clinicians support individual subspecialties, and noted that relevant risks had been captured on the risk register and would inform future commissioning intentions. The Committee encouraged future reports to be presented using the new QSOC template, which members had found helpful in supporting scrutiny and assurance. Members also requested that future updates detail the specific quality impacts of the issues highlighted. **ACTION:** AR agreed to work with the specialised services directorate on the next report and incorporate the Lay Member feedback linked to quality into the report. The Committee also noted that emerging themes relating to fragile services and workforce pressures would be considered through the Joint Committee Assurance Framework once implemented, enabling a more strategic view of risk across services. The members of the Quality, Safety and Outcomes Sub Committee are asked 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 /033	**4.3 Report from the Director of Commissioning for Ambulance Services and National Programmes** The Committee received the Ambulance Services report, which covered the Emergency Ambulance Service, NHS 111 Wales and the Non-Emergency Patient Transport Service, alongside updates on neonatal transport and Sexual Assault Referral Centres. Members noted that, across the commissioned ambulance services, there remained a broad mismatch between demand and capacity, with differing drivers across each service area. In relation to emergency ambulance services, the Committee noted that ambulance handover delays remained a key driver of pressure, although performance was reported to be moving in the right direction, albeit not at the pace expected. Members were advised that work was underway to revise the relevant Joint Committee risk to better articulate the role of the Joint Committee in informing and driving change, and that NHS Performance and Improvement was supporting health boards and the WAST to develop joint plans for sites where improvement was not being delivered at the required scale. The Committee noted ongoing peaks in demand for NHS 111 Wales, particularly at specific times during weekdays and weekends. Members were advised that the WAST was undertaking a full roster review, with revised rosters expected to be implemented in the autumn to better align capacity with demand. The Committee also noted the receipt of recurrent funding to improve the digital front end of NHS 111 Wales, including improvements to website information, enhanced symptom checkers and future development of chatbot functionality to support demand management and improve patient flow. In respect of the Non-Emergency Patient Transport Service, members noted that demand continued to exceed available capacity. Roster reviews were expected to release additional capacity, although not sufficient to meet all demand. The Committee noted the dependency on health board outpatient modernisation to reduce transport demand and the introduction of additional steps to apply eligibility criteria more consistently. In response to a query regarding late-notice cancellations, members noted that cancellations close to appointment times created significant operational challenges and that further work was underway to improve system links between health boards and WAST, streamline patient contact routes and reduce avoidable cancellations.

	The Committee noted the update on neonatal transport, including that the national oversight group for the implementation of the maternity and neonatal assessment had been established. Members were advised that programme and project arrangements were being developed with the service and wider stakeholders to identify options for neonatal transport, aligned to the broader Joint Committee review of neonatal services. It was also noted that WAST had established a Non-Emergency Patient Transport Service Improvement Board and that relevant discussions would be fed into that work. **ACTION:** A specific update in relation to the work of the NEPTS Improvement Board to be included in the next report. Members resolved to: **Emergency Ambulance Handover** • **Endorse** the approach being taken to revise the current JCC risks • **Take assurance** that the actions within the remit of the JCC are being undertaken to mitigate risk. **111 Performance** • **Take assurance** that the actions within the remit of the JCC are being undertaken to mitigate risk **Non-Emergency Patient Transport Service (NEPTS)** • **Take assurance** that the actions within the remit of the JCC are being undertaken to mitigate risk **Neonatal Transport** • **Note** and **take assurance** that the arrangements that are in place to progress this work **Sexual Assault Referral Centres** • **Note** and **take assurance** that the arrangements in place to continue to commission in partnership with policing and police and crime commissioner colleagues.
QSO26 /034	**4.4 Report from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MHLDVG)** The Committee received the MHLDVG report, the report was taken as read and specific updates on the hospital framework, the review of the Adult Welsh Gender Service and the Caswell Clinic escalation position were provided. In relation to the hospital framework, the Committee noted continued coordination with NHS England regarding the transfer of Welsh patients from St Andrew's. Members were advised that, from an initial cohort of 22 patients, four Welsh patients remained on site, with alternative placements being progressed. The delay in completing all transfers by the end of June was noted to be due to the complexity and individual needs of the remaining patients. The Committee noted that an investigation was ongoing following the death of a Welsh patient at Heatherwood Court, involving the provider and Cardiff and Vale University Health Board, with a further update expected at the next meeting. Members also discussed concerns raised by patients at Cygnet Bury. It was noted that one concern was historic and related to a patient no longer at the hospital, while a more recent concern related to a current patient. The JCC had brought forward its routine audit inspection of the hospital in response to the concerns, and members received assurance that the relevant health board, CAMHS out-of-area placement arrangements, the provider and JCC case management were actively involved in oversight and follow-up. The Committee noted that a review of the Adult Welsh Gender Service was progressing. Members were reminded that the JCC commissions assessment, referral and ongoing care through the Welsh Gender Service, while surgical provision is commissioned through NHS England and providers in England. The review would take account of relevant recommendations arising from the NHS England Levy Review and would include independent expertise to support consideration of the current service model and delivery arrangements.

	The Committee received an update on Caswell Clinic, which remained in escalation within the MHLDVG Directorate. Members noted that the JCC was working closely with Swansea Bay University Health Board and the provider team to progress a de-escalation plan, with a view to moving from level 3 to level 2 in the coming months, subject to evidence of improvement against outstanding actions. The Committee noted that considerable improvement had been made since escalation commenced, and that actions arising from the Healthcare Inspectorate Wales review had been aligned with the JCC action plan where appropriate. Members discussed the contractual and patient placement impact of the continued unavailability of medium secure beds at Caswell Clinic, including the resulting use of independent sector placements. The Committee received assurance that the JCC was engaging with Swansea Bay University Health Board regarding the contractual implications and that these matters would continue to be considered through LTA discussions. **ACTION**: It was also agreed that a further lay member visit to Caswell Clinic would be arranged to enable members to see progress and better understand the impact of the improvements made. Members resolved to: • **Take Assurance** that patient safety risks or issues within commissioned services are being managed and monitored as set out above.
QSO26 /035	**4.5 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 had been highlighted by the relevant Director reports. Members resolved to: • **Note** the content of the report; and • Receive the report as **assurance.**
QSO26 /036	**4.6 Incident and Concerns Report** A report outlining a summary of concerns and incidents reported to the NWJCC from provider and commissioned services was received within the 31st of March to the 1st of June reporting window. Members **noted**: • 12 new NRIs (National Reportable Incident) had been reported. • 6 new complaints had been received. • 1 Ombudsman referral received and closed. • 19 incident closure forms. It was noted that the majority of reported incidents related to the WAST. Members recognised that the increase in reported incidents reflected improved reporting arrangements, strengthened relationships with WAST quality and safety colleagues, and a clearer shared understanding of the information required by the JCC to support commissioner assurance. The Committee discussed the need to move beyond the volume of reported incidents to a clearer understanding of themes, analysis, learning and the mechanisms through which learning is shared and embedded. Members were advised that work was underway with WAST to better understand incident reporting processes, including NRI forms, call categorisation themes, clinical escalation routes and the forums through which learning is disseminated. The Committee noted that further work was required to ensure that outcome forms more clearly reflected the learning and actions taken. Members sought assurance regarding the support, supervision and training available to call handlers where incidents involved call categorisation or decision-making issues. The Committee noted the importance of understanding the impact on staff as well as patients, and of ensuring that learning was not focused solely on individuals but also considered wider system pressures, demand, rostering and support mechanisms. It was noted that further work was being undertaken to obtain clearer assurance on training arrangements and operational support within WAST.

	The Committee discussed a serious cardiac incident involving a patient who had required admission but was not admitted due to bed availability and subsequently died. Members expressed concern that this may not be an isolated issue, given wider concerns regarding cardiac services and service pressures. The Committee was advised that the incident was subject to ongoing investigation through Putting Things Right and was being monitored through the cardiac commissioning team. A Regulation 28 Notice had been issued following this incident. Members received a brief explanation of the Regulation 28 process, noting that Regulation 28 Notices are issued by a coroner where concerns are identified and require a formal response and action. The Committee noted that the implications of a Regulation 28 Notice may extend beyond the individual service or health board and could have wider NHS Wales implications. **ACTION**: It was agreed that the outcome of the Regulation 28 process would be brought back to the Committee to support oversight and completion of the learning cycle. Members noted the continued need for strengthened thematic analysis, evidence of learning and clear follow-up on significant incidents. Members resolved to: • **Scrutinise** the content of the report • **Provide assurance** to the NWJCC on the updates shared.
QSO26 /037	**4.7 Regulator Report (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC)** The Committee received the regulator report, covering the reporting period up to 1 June. Members noted that two Care Quality Commission reports had been received during the period: one relating to an eating disorder placement at Ellen Mead, which retained an overall rating of good, and one relating to Potters Bar Clinic CAMHS, which was also rated good. The Committee noted three Healthcare Inspectorate Wales inspection reports. The final report for the perinatal mental health unit within Swansea Bay University Health Board was awaited. In relation to Heatherwood Court and Tŷ Llidiard CAMHS unit, members noted that there were no immediate actions identified, although action plans remained in place and were being progressed. Members were advised that the Caswell Clinic report had been received in the interim and that further detail would be brought back to the next meeting, aligned with the discussion under the Mental Health report. Members resolved to: • **Note** the report; and • **Receive** the report for **assurance** as part of the commissioning cycle.
QSO26 /038	**4.8 Report from the All-Wales Individual Patient Funding Request (IPFR) Panel** The Committee received the All-Wales Individual Patient Funding Request (IPFR) Panel report and noted the improved engagement from health boards, which had supported attendance and ensured that no panel meetings had been cancelled during the reporting period. Members acknowledged the significant time commitment required to support the panel. The Committee welcomed the appointment of two lay members to the panel and noted that this strengthened the panel's membership alongside the lay chair and health board representation. Members discussed the ongoing challenges in securing consistent Powys Teaching Health Board attendance, recognising that Powys had a smaller pool of representatives to draw upon. The Committee noted the importance of health board participation in providing assurance that funding decisions were being considered appropriately, while also recognising that meetings had remained quorate. Members agreed that continued engagement with Powys would be important to support increased attendance. It was agreed that the issue of Powys engagement would be flagged through the QSOC highlight report to the Joint Committee and raised through relevant peer group forums, in addition to previous correspondence issued to the Powys Chief Executive regarding the need for improvement.

	Members were advised that the IPFR process had recently been considered by the Welsh Affairs Committee from a cross-border perspective. The Committee noted that the IPFR application form continued to be a source of concern for clinicians and that review and revision of the form would be beneficial. Members also noted the positive position in relation to successful applications. Members resolved to: • **Note** the report. • **Receive** the report as assurance regarding the efficacy of the IPFR Panel.
QSO26 /039	**5.1 NWJCC Organisational Risk Register (ORR) – Risks Assigned to the Quality, Safety and Outcomes Sub-Committee** The Committee received the Organisational Risk Register report and noted that there were 15 risks on the register, of which seven were assigned to the QSOC Sub-Committee. These comprised risks relating to Cancer and Blood Services, Neuroscience, the Welsh Kidney Network, and Women and Children's services. Members noted that, while the register remained relatively static during the reporting period, work was underway to strengthen the dynamic management of risks, mitigations and actions. The Committee noted that six emerging neurosurgery risks had been identified for potential inclusion on the Organisational Risk Register. These had been considered by the Senior Leadership Team, with commissioning leads and the risk team asked to review the scoring and descriptions to ensure risks were appropriately articulated and to identify any themes that could be consolidated across services. Members noted that this work would support escalation of strategic risks through the Joint Committee Assurance Framework where appropriate. The Committee also noted the positive de-escalation of the hereditary anaemia service risk following the allocation of funding through the annual plan. Members welcomed the direction of travel and recognised the improvements being made to the risk management approach. In relation to risk 89, concerning paediatric neurology service provision, members sought assurance on the start date for the recruited Alder Hey post and emphasised the need to maintain pace to support timely patient access. **ACTION:** It was agreed that an update on the Alder Hey position would be shared in the next register update. The Committee discussed the wider risk environment facing NHS Wales, including increasing demand, constrained investment, workforce pressures and the potential for further risks to emerge across commissioned services. Members were assured that the proposed consolidation of risks was intended to improve strategic visibility and avoid duplication, rather than suppress reporting. It was noted that thematic risks, such as workforce and service fragility, would be described at the appropriate organisational level while retaining links to the underlying service-specific risks. Members noted the importance of considering risk appetite as the register matures, particularly in determining whether risks were being tolerated within agreed appetite or require further treatment, escalation or decision-making. The Committee emphasised the need to remain focused on the impact of risks on patient safety, service quality and delivery. Members 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 /040	**5.2 Risk Management and Assurance** The Committee received the Risk Management and Assurance report and noted the significant work undertaken to develop the JCC's risk management approach, following engagement with lay members, the Senior Leadership Team, the Chair and the new Chief Commissioner.

	Members were advised that the documents had been subject to detailed review and that feedback had been incorporated into the version presented to the Committee. The Committee noted that, while the JCC is required to follow the risk management procedures of Cwm Taf Morgannwg University Health Board as host body, the proposed documents had been tailored to reflect the JCC's role as a commissioning organisation. This included revised terminology, risk domains and reporting templates intended to support clearer ownership and management of risk from a commissioning perspective. Members considered the proposed Risk Management Procedure, Joint Committee Assurance Framework, Risk Appetite Statement and Matrix, together with associated reporting templates and proposed strategic risks. In response to a query regarding engagement with Chief Executives, the Committee noted that, subject to consideration by QSOC and the Planning, Performance and Finance Committee, the documents would be shared with Chief Executives for comment. Any appropriate feedback would be incorporated before the documents were presented to the Joint Committee on 21 July. Members welcomed the clarity and structure of the proposed approach and recognised the significant work undertaken by the team. The Committee noted that the revised framework, policy and templates provided clearer strategic alignment and strengthened assurance compared with previous arrangements. The Committee supported the continued development of the risk management and assurance arrangements and agreed that the documents should proceed through the planned engagement route, with any further comments incorporated ahead of final approval by the Joint Committee. Members resolved to: • **Endorse** the Procedure • **Endorse** the JAF and JAF report • **Endorse** the proposed Risk Appetite Statement and Matrix; and • **Endorse** the draft Strategic Risks for inclusion within the JAF report.
QSO26 /041	**5.3 Policy Validation Group Quarterly Report** The Committee received the Policy Validation Group quarterly report and noted the significant volume of commissioning policies requiring review and maintenance. Members recognised the importance, from a patient and public perspective, of ensuring that policies were current and accessible, particularly where policies inform access criteria for specialised services. The Committee discussed the scale of the policy review programme and noted that some policies had not been reviewed for a considerable period. Members were advised that the JCC's workforce capacity presented challenges, as teams were required to balance policy review alongside performance management, commissioning new services and wider operational responsibilities. The Committee acknowledged the need to be open and transparent about the limits of what could be achieved within current resources. Members explored whether opportunities existed to reduce the number of policies through consolidation or by reviewing whether all policies remained necessary. It was noted that, while some limited consolidation may be possible, many policies relate to highly specialised, complex and low-volume services where clear access criteria are required to support equity, appropriate use of resources, compliance with NICE guidance and delivery of good patient outcomes. The Committee noted that the breadth of services commissioned by the JCC, including more than 150 services across over 50 providers, limited the scope for significant consolidation. The Committee noted that the policy review programme would require prioritisation, including judgement about when a full policy was required and when alternative routes, such as IPFR, may be more proportionate for very rare conditions or treatments where there were no known Welsh patients. Members acknowledged the work being undertaken by the Policy Validation

	Group and noted the report for assurance, recognising both the importance of maintaining current policies and the operational constraints affecting the pace of review. Members resolved to: • **Note** the report
QSO26 /042	**5.4 Standard Operating Procedure: Process for Blueteq Form Development** The Committee received the Blueteq Standard Operating Procedure (SOP) and noted that Blueteq had been used by the NWJCC since April 2021 as a mechanism for clinical and financial governance in relation to high-cost medicines commissioned by the organisation. Members were advised that, although Blueteq forms had been in use for some time, there had not previously been a formal SOP setting out how forms should be developed, maintained and the governance arrangements for this. The Committee noted that, as the Medicines Optimisation Team had grown, it was important to formalise internal processes to ensure consistency, clear roles and responsibilities, version control and appropriate clinical input from key stakeholders who use the forms. The Committee noted that the SOP was intended to ensure Blueteq forms accurately reflected relevant evidence-based guidance and supported providers to apply commissioned access criteria consistently. Members were advised that the SOP formalised existing practice and would support strengthened governance, stakeholder involvement and accountability across the form development process. The Committee noted the recent high-cost drugs audit, which had provided a reasonable assurance outcome, and that the further maturation of SOPs and completion of governance processes would support continued improvement. Members welcomed the standardised, evidence-based approach and noted that the SOP provided assurance in relation to the governance of high-cost medicines. Members resolved to: • **Approve** this Standard Operating Procedure at Appendix 1 for implementation.
QSO26 /043	**5.5 Forward Plan of Business 2026-2027** Members resolved to: • **Note** the Forward Plan of Business for 2026-2027.
QSO26 /044	**6.1 Any Other Business** **6.1.1 Welsh Health Circular: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2026/27** This was included for information. Members noted the item which would inform the work of commissioning teams moving forward.
QSO26 /045	**6.2 Items to be deferred/escalated to the Joint Commissioning Committee / other Sub-Committees and review of any actions to future meetings** It was noted that the patient story would be escalated to the Joint Commissioning Committee, with the Renal Network and Swansea Bay University Health Board to follow up the concerns raised and provide feedback and to the patient directly. Feedback on the renal Nationally Reportable Incidents would be provided at the next meeting. Themes arising from the Specialised Services report, including fragile services, workforce pressures and quality issues, would be taken forward and escalated. For the ambulance report, further detail would be brought back on the NEPTS Improvement Board, including how patient experience was being reflected and addressed. The Committee noted that a further visit to Caswell Clinic would be arranged and that the Healthcare Inspectorate Wales report and associated recommendations would be brought back to a future meeting. Updates would also be provided on the ongoing concerns relating to Cygnet Bury. In relation to incidents and concerns, the Committee noted that the outcome of the Regulation 28 process would be brought back to support completion of the learning cycle. Further work would also be undertaken to strengthen the reporting of themes and trends, and to provide clearer assurance on how learning from WAST incidents was shared and embedded across the organisation. The Committee noted that work would continue to review the IPFR application form and to encourage collaborative engagement from Powys Teaching Health Board in the IPFR process.

	It was also noted that the risk management and assurance documents would proceed through the agreed route to the Joint Commissioning Committee, and that policy review work would continue through the Policy Validation Group.
QSO26 /046	**6.3 Date of Next Meeting** The next confirmed meeting was scheduled to take place on the 24th August 2026. The meeting ended at 16.05.