

Agenda Item

4.6

Quality Safety and Outcomes Sub-Committee

Incidents and Concerns Report

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| Dyddiad y Cyfarfod / Date of Meeting | 27/04/2026 |
| Statws Cyhoeddi / Publication Status | Open/ Public Not Applicable |
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|---|----------------------------------|
| Pwrpas yr Adroddiad / Report Purpose | For Assurance Choose an item. |
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| Committee / Individuals | Group / | Date | Outcome |
|----------------------------|---------|----------------------------------|-----------------|
| N/A | | Click or tap to enter a date. | Choose an item. |

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 1 February 2026 to 31 March 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, six new NRI's were reported to the specialist services commissioning teams. Five new complaints were received, with no new Ombudsman referrals. (**See Appendix 1**) Key risks identified relate to communication failures, safeguarding concerns, and clinical pathway delays. All incidents are under investigation, with assurance processes in place through commissioning oversight and provider governance structures.

2.1.2 NWJCC continues to work closely with NHS Wales Performance and Improvement and the Welsh Ambulance Services Trust (WAST) to better understand the issues identified and to 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 is ongoing with NHS Performance and Improvement colleagues to refine this approach to ensure consistency in reporting thresholds and assurance arrangements. Further detail is included within **Appendix 1** and an update regarding the Avoidable Harm report is referenced within the Directors report.

2.1.3 Several NRI's remain open. 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 During the reporting period, NWJCC received eleven incident closure forms from providers. These were reviewed by the relevant commissioning teams, who confirmed they were assured that each incident had been appropriately investigated. The outcomes, actions, and learning identified have been noted and will be monitored as part of ongoing commissioning and quality assurance processes.

2.2.1 On April 1st 2026 Welsh Government launched the new NHS Wales Complaints, Incidents and Redress Process 'Listening to People'. This will replace the previous guidance 'Putting things Right' and has been shared with committee. Listening to People strengthens and simplifies the way concerns are handled and introduces clear standards, a single point of access and a consistent commitment to openness, timely communication and compassionate support.

3. RECOMMENDATIONS

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

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

Appendix 1 – Operational Update

1. New Nationally Reportable Incidents (NRI's) see table below.

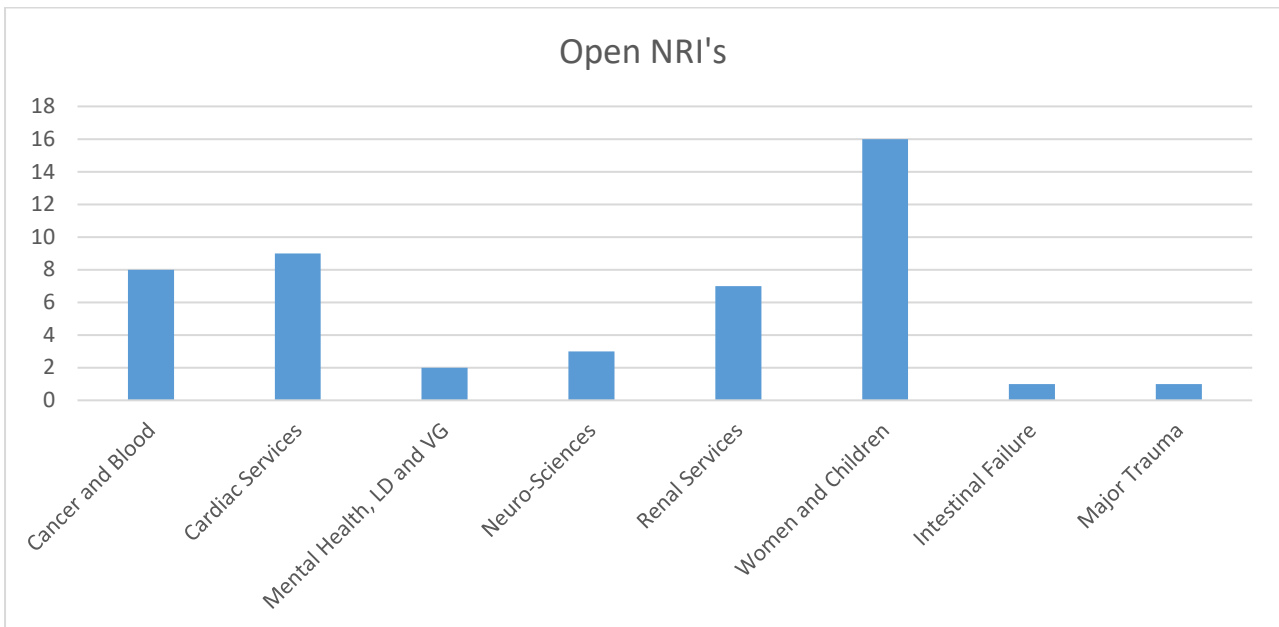
Six NRIs were reported during the period, relating to care delivery issues across oncology, cardiac and surgical services, including a serious paediatric surgical incident and a neonatal death following emergency intervention.

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

| Date reported | Commissioning Team | Brief Description |
|-------------------|--------------------|--|
| 06/02/2026 NRI | Cardiac | Medical Examiner identified a potential missed opportunity in a patient with heart block who died of cardiogenic shock. |
| 17/02/2026 NRI | Neurosciences | A patient presented in as an emergency stroke experienced delay in diagnosis and referral, which resulted in a missed opportunity for thrombectomy. |
| 26/02/2026 NRI | Cancer & Blood | A patient presented with a thoracic mass and was transferred for specialist intervention but discharged without definitive diagnosis or treatment. There were delays in confirming histology and initiating oncology care. Patient later re-presented acutely unwell with respiratory compromise, deteriorated rapidly despite treatment, and died from hypoxic brain injury. |
| 17/03/2026 NRI | Cardiac | A patient was admitted with a Myocardial Infarction and accepted for Coronary Artery Bypass Graft. Pre-operative lung function tests were undertaken but not available to the surgical team, despite known Chronic Obstructive Pulmonary Disease. Post-operatively, the patient developed severe respiratory failure, leading to multi-organ failure and death. |
| 26/03/2026 | Renal | A patient was cared for on a tertiary ward with limited isolation capacity, during a period |

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| NRI | | where other patients were identified with Oxa-48 E. coli. He was subsequently readmitted and died shortly afterwards. |
| 27/03/2026 NRI | Women and Children | A patient was diagnosed in infancy with Persistent Müllerian Duct Syndrome (PMDS), leading to multiple surgical interventions during childhood. A later specialist review found this diagnosis to be incorrect, with histology confirming the tissue removed was an undescended testis. The misdiagnosis was confirmed and communicated in 2025. The patient now has reduced fertility markers and has been referred for specialist assessment. |

Current Open NRI's.



2. Ambulance Service and 111

The NWJCC have received 19 NRI reports and outcome forms during the reporting period. These are historical and are related to cases from January 2025 – up until May 2025. Work is ongoing between WAST and NHS P & I to fully understand the categorisation and future reporting arrangements.

Themes include:

| Theme | Number |
|------------------------------------|--------|
| Call categorisation | 6 |
| Delayed remote clinical assessment | 6 |
| Remote Clinical Error | 1 |
| Delayed Vehicle response | 1 |
| Incorrect protocol followed | 1 |
| Face to face Clinical Assessment | 3 |
| Safeguarding | 1 |

The new WAST Avoidable Harm report has also been shared with NWJCC which sets out revised process around managing and monitoring harm.

Whilst the number of NRI's may seem high it must be recognised the number of NRIs reported each month remains low in relation to the number of patient contacts across the Trust's three patient pathways.

The Ambulance Commissioning team will continue to monitor WAST performance on PTR reporting which remains poor despite significant additional resources. A further recovery plan and trajectory for improvement has been requested by the Ambulance Board.

3. Complaints

The table below summarises current open complaints, complaints closed during the reporting period, and new complaints received.

| Date Received | Status | Brief Description |
|----------------------------------|-----------------------------|---|
| 19/08/2025 re-opened 28/10/25 | Closed 31/03/26 | Patient refused treatment in WFI, case reviewed in light of recent legal advice |
| 20/01/2026 | Open | Welsh Gender Service complaint of an alleged incorrect procedure following a referral to Nuffield |
| 10/2/2026 | Open | EATS service and its ongoing failure to provide an AAC device (Provider responding) |
| 19/02/2026 | Closed 20/03/2026 | Questions regarding funding of adaptations to a wheelchair |
| 02/03/2026 | Open | MP Concern regarding an IPFR decision relating to breast surgery (Provider responding) |
| 27/03/2026 | Open | AM Concern relating to funding of adaptations to a wheelchair |

| | | |
|------------|-------------|---|
| 27/03/2026 | Open | Concern relating to lack of provision for Breast surgery (DIEP Procedure-Provider responding) |
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Strategic and Regulatory Assessment

| Objectives / Strategy | |
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| Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s) | Not Applicable |
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| 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)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales)) | 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)) / Link to Domains of Quality</i> (Duty of Quality Statutory Guidance (gov.wales)) | 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: <input type="checkbox"/> | No: <input checked="" type="checkbox"/> |
| | 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: <input type="checkbox"/> | No: <input checked="" type="checkbox"/> |
| | 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i> | There is no direct impact on resources as a result of the activity outlined in this report. | |
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Acronyms

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| BEACON | Dashboard developed on an All Wales basis |
| BCUHB | Betsi Cadwaladr University Health Board |
| CVUHB | Cardiff and Vale University Health Board |
| DIEP | Deep Inferior Epigastric Perforator |
| EMRTS | Emergency Medical Retrieval and Transfer Service |
| EWN | Early Warning Notification |
| JCC | Joint Commissioning Committee |
| LTP | Listening to People |
| MIQPD | Monthly Integrated Performance Report |
| NEPTS | Non Emergency Patient Transport Service |
| NRI | Nationally Reportable Incident |
| NWJCC | NHS Wales Joint Commissioning Committee |
| PMDS | Persistent Müllerian Duct Syndrome |
| PTR | Putting things right |
| QuEST | Quality Patient Experience and Safety Committee |
| SBUHB | Swansea Bay University Health Board |
| SI | Serious Incident |
| WAST | Welsh Ambulance Service NHS Trust |
| WFI | Welsh Fertility Institute |