

Agenda Item

3.6

Quality Safety and Outcomes Sub-Committee
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Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	29/06/2026
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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 31 March 2026 to June 1st 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, 12 new NRI's were reported to the specialist services commissioning teams. 6 new complaints were received, with 1 new Ombudsman referral. (**See Appendix 1**). There is currently a number of newly reported NRIs relating to WAST due to improved reporting mechanisms between Welsh Ambulance Service Trust and the JCC. Key risks identified to these incidents relate to call taker categorisation error and delayed remote clinical assessment. 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.

2.1.3 During the reporting period, NWJCC received nineteen 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.

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.

Twelve NRIs were reported during the period, relating to care delivery issues across WAST, cardiac and cancer and blood services, including a cardiac patient who passed away whilst awaiting a bed and a delay with a GI endoscopy which led to a cancer progression. Several incidents relate to call taker categorisation error where patients have passed away whilst waiting for ambulances that could have possibly attended the scene sooner.

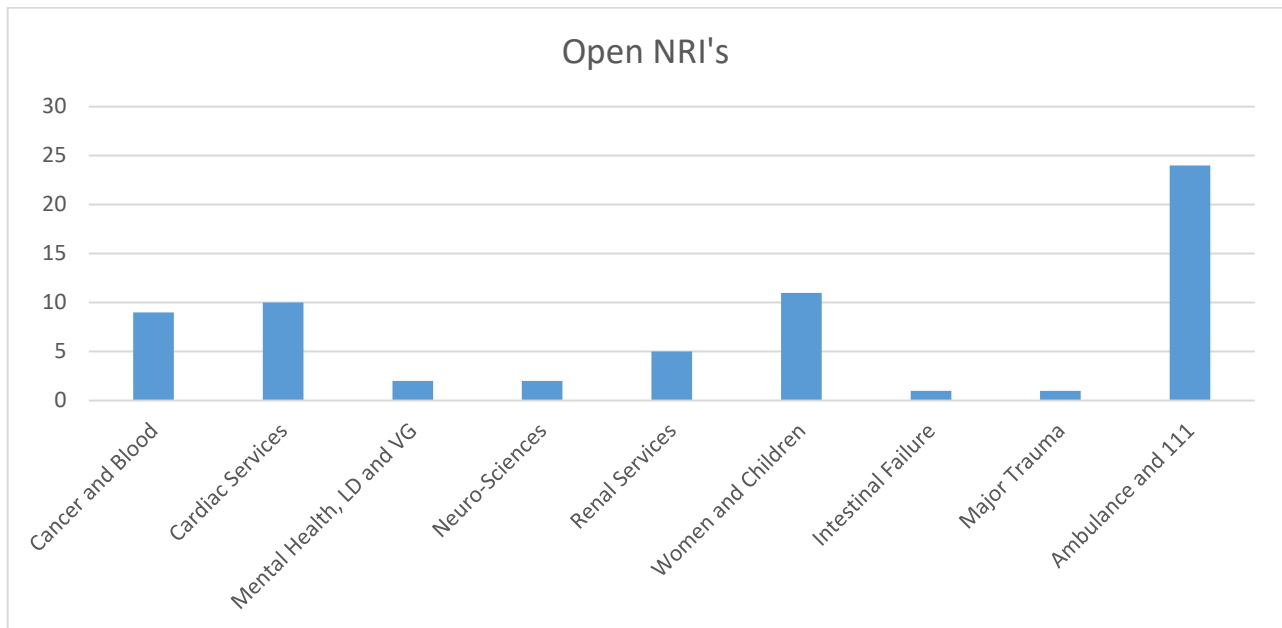
Each incident is subject to provider-led investigation, with oversight by the relevant commissioning team and escalation through established governance routes.

Date reported	Commissioning Team	Brief Description
01/04/2026	Cardiac	A 55-year-old gentleman raised concerns through to cardiac physiology due to swelling over his pacemaker site and was seen in cardiology clinic. A plan was made during clinic to admit the patient later in the week to investigate the pacemaker however the patient had not been able to be admitted due to beds being unavailable, the patient passed away whilst awaiting a bed. Now subject to a Regulation 28.
01/04/2026	Cardiac	Patient with a known case of severe heart failure secondary to ischaemic heart disease was not fitted with an Implantable Cardioverter Defibrillator (ICD) in a timely manner, resulting in patient experiencing a cardiac arrest and needing prompt resuscitation.
02/04/2026	WAST	The Emergency Medical Dispatcher (EMD) selected the incorrect protocol. Patient was deceased upon arrival of emergency services
10/04/2026	WAST	An earlier response could have arrived with this patient approximately 2 hours sooner than it did arrive, had the resource been allocated appropriately. Patient had passed away.
24/04/2026	WAST	On WAST arrival the patient was in Cardiac Arrest, despite efforts by the attending staff, patient passed away. The Serious Case

		Incident Forum determined that industrial action was a potential contributory factor. An investigation has commenced to determine the root cause/causes.
27/04/2026	WAST	A 999 call was registered from the police reporting a 51-year-old female who was conscious, breathing and making remarks to kill herself. A clinical consultation commenced which documents 3 failed contacts with no answer from the patient's telephone number. An emergency response arrived at the scene approximately 3 hours and 9 minutes after the 999 call had been received and recognition of life extinct was implemented.
13/05/2026	WAST	Call Sign Activity report revealed that, had a call been categorised as 'Orange Now' could have responded sooner and could have resulted in the incident being attended approximately two hours and twenty minutes earlier. The recognition of life extinct policy was implemented at scene.
15/05/2026	WAST	Access to services delayed - case was presented to Serious Case Incident Forum and the panel agreed that a resource could have arrived approximately 40 minutes sooner if the first call remained for allocation rather than being transferred to 111 and therefore met the criteria as Nationally Reportable Incident.
15/05/2026	WAST	The patient passed away at the scene. The case was presented to Serious Case Incident Forum, the panel agreed that the first call should have been of a higher category. The EMD selected the incorrect protocol. The call should have been an ARREST protocol. Therefore, if the correct protocol had been selected a resource could have arrived at the patient sooner.
22/05/2026	WAST	The case was presented to Serious Case Incident Forum which identified that resources were not allocated as per clinical response model. There were calls allocated a response registered several hours after this

		call, in the same zone without rationale. This includes an emergency ambulance (EA) and falls resource. This means this patient would not have been allocated a response for the first 10 hours and 22 minutes but there was a missed opportunity to attend approximately 3 hours sooner. Patient sadly died
27/05/2026	Cancer and Blood	A patient was referred for endoscopic treatment, an upper GI endoscopy identified early cancer, partially resected but with residual dysplasia requiring repeat endoscopic resection within 3 months. Due to prolonged lack of theatre access despite repeated escalations, definitive treatment was delayed. Histology has confirmed progression to cancer which was potentially preventable with timely access.
29/05/2026	WAST	A 999 call should have been prioritised Amber 1 rather than Amber 2. If this had occurred, it is possible that an earlier response could have been achieved by approximately seven hours and 45 minutes.

Current Open NRI's.



2. Ambulance Service and 111

The NWJCC have reported on the 9 NRI reports received in the reporting period in the table above.

Themes include:

Theme	Number
Delayed remote clinical assessment	1
Delayed vehicle response	1
Incorrect protocol	2
Call taker categorisation error	5

3.1.1 Complaints

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

Date Received	Status	Brief Description
20/01/2026	Open	Welsh Gender Service complaint of an alleged incorrect procedure following a referral to Nuffield
02/03/2026	Open	MP Concern regarding an IPFR decision relating to breast surgery (Provider responding)
27/03/2026	Closed 14/05/2026	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)
14/04/2026	Open	Parent concern EAT service delay in assessment (Joint response with provider)
15/04/2026	Open	Concern regarding Medical Director at a Regional Health Board presence and behaviour at Saturday's One Year Later gathering in Cardiff City Centre.
16/04/2026	Closed 14/05/2026	Lack of service provision for neonates
22/4/2026	Open	EATS service and its ongoing failure to provide an AAC device (Provider responding)
05/05/2026	Open	Concern about commissioning documentation and governance arrangements relating to facial feminisation surgery
07/05/2026	Open	AM concern regarding waiting time for patient who has tested positive for BCRA gene and has previously had breast cancer
18/05/2026	Open	Patient concern relating to waiting time for manual wheelchair
18/05/2026	Open	Patient concern relating to delivery time of wheelchair

3.1.2 Referral to the Ombudsman

Concern was raised with the Ombudsman from an email trail received into the

JCC (listed above within the complaints table 05/05/26) re facial feminisation policy. This is not commissioned by the JCC despite several email responses to the complainant and a response from the Ombudsman stating they were not proceeding with the complaint, the complainant has continued to question the JCC about the process and policies unrelated to facial feminisation surgery. This remains with the governance/legal team.

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)) / 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
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	If more than one applies please list below:
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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.	

Acronyms

AAC	Augmentative and Alternative Communication
BCRA	Gene mutation
DIEP	Deep Inferior Epigastric Perforator
EA	Emergency Ambulance
EATS	Electronic Assistive Technology Service
EWN	Early Warning Notification
GI	Gastrointestinal
ICD	Implantable Cardioverter Defibrillator
JCC	Joint Commissioning Committee
NRI	Nationally Reportable Incident
NWJCC	NHS Wales Joint Commissioning Committee
SI	Serious Incident
WAST	Welsh Ambulance Service NHS Trust