GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

# Joint Commissioning Committee

## Highlight Report from the Quality, Safety and Outcomes Sub-Committee

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| **Dyddiad y Cyfarfod / Date of Meeting** | 21/07/2026 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public |
| | Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Helen Tyler, Head of Governance and Risk, NWJCC |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC |
| **Noddwr yr Adroddiad / Report Sponsor** | Carole Bell, Director of Nursing and Quality, NWJCC |

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|---|---|
| **Pwrpas yr Adroddiad / Report Purpose** | For Assurance |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
|---|---|---|
| **Committee / Group / Individuals** | **Date** | **Outcome** |
| Health Boards | Various | Noted |

## 1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 29 June 2026.

Key highlights from the meeting are reported in Section 2.

## 2. HIGHLIGHT REPORT

(Links to reports highlighted – June 2026)

| Status | Update |
|---|---|
| **Alert / Escalate** | **Fragile Specialised Services and Workforce Pressures –** Members discussed continued fragility across a number of specialised services, including cardiac surgery, neurosurgery, intestinal failure services, thrombectomy pathways and renal dialysis capacity. Workforce sustainability, capacity constraints and service resilience were highlighted as recurring themes. Members requested that these issues be escalated to the Joint Committee and considered through the emerging Joint Committee Assurance Framework.<br><br>**JACIE Accreditation Risks** – Risks relating to Bone Marrow Transplant and CAR-T services continue to be highlighted. Loss of accreditation would have significant implications for patient pathways and service delivery across Wales. Assurance continues to be sought regarding contingency planning.<br><br>**Caswell Clinic** – Caswell Clinic remains in escalation, although significant progress has been made since escalation commenced. The Committee noted ongoing work towards de-escalation and requested a further lay member visit to review progress. Continued reliance on independent sector placements due to unavailable medium secure beds remains a concern.<br><br>**Cardiac Surgery** – Members were advised that cardiac surgery services in Cardiff had moved to Level 2 escalation following the reporting period. Concerns remain regarding data quality, the absence of sufficient improvement plans and limited visibility of progress.<br><br>See ***Appendix 1*** for the Escalation Trajectories of the services currently in escalation and the actions being undertaken to manage these.<br><br>**All Wales Individual Patient Funding Request (IPFR) Panel** – Members welcomed improved health board attendance and panel resilience. Continued concerns regarding Powys Teaching Health Board attendance were highlighted and will be raised through appropriate forums and reflected in this highlight report. |
| **Advise** | Reports from each of the Directors of Commissioning were received. The following items were discussed.<br>Director of Commissioning for Specialised Services<br>• Services were generally stable during the reporting period with no new escalations reported at time of publication. |

| Status | Update |
|---|---|
| | Members discussed quality and sustainability risks across cardiac surgery, neurosurgery, intestinal failure, thrombectomy, dialysis services and PET-CT demand growth. The Committee requested enhanced future reporting on specific quality impacts.<br><br>Welsh Kidney Network (WKN) Report<br>• Members received assurance that there had been no significant changes to risks during the reporting period. Four Nationally Reportable Incidents are expected to close shortly, with learning and closure reports to be brought to a future meeting. The Committee welcomed continued development of governance reporting arrangements following integration of the WKN into NWJCC.<br><br>Director of Commissioning for Ambulance Services and National Programmes<br>• Members discussed ongoing demand and capacity challenges across Emergency Ambulance Services, NHS 111 Wales and Non-Emergency Patient Transport Services (NEPTS). Ambulance handover delays remain a significant quality and safety concern. Improvements to NHS 111 digital services and roster redesigns are planned. A further update on the NEPTS Improvement Board will be requested.<br><br>Director of Commissioning for MHLDVG Report<br><br>• The Committee received updates regarding St Andrew's Healthcare repatriation arrangements, the Adult Welsh Gender Service review, Cygnet Bury concerns and Caswell Clinic. Members noted continued progress in reducing the number of Welsh patients remaining at St Andrew's Healthcare and were assured that patient safety issues continue to be actively monitored.<br><br>The Incident and Concerns Report highlighted<br>• Members noted 12 new Nationally Reportable Incidents, 6 complaints, 1 Ombudsman referral and 19 closure reports. Particular attention was given to strengthening thematic analysis, organisational learning and assurance regarding how learning from WAST incidents is embedded across services. A Regulation 28 review regarding a Cardiac Incident is underway and the outcome will be reported back to QSOC. |

| Status | Update |
|---|---|
| | • A development session looking into incidents and NRI reporting has been scheduled to better understand NWJCC processes. |
| **Assure** | The Committee received the QSOC sub-committee's assigned risks from the NWJCC Operational Risk Register as of 31 May 2026. After QSOC scrutiny and review, the JCC will receive the May 2026 risk register at its July 2026 meeting. The following were highlighted;<br><br>Whilst the reported risks were mostly unchanged, Members noted emerging neurosurgery risks and welcomed work to strengthen strategic risk oversight through the Joint Committee Assurance Framework. The positive de-escalation of the hereditary anaemia service risk was also noted.<br><br>Risk Management and Assurance Framework – The Committee endorsed the Risk Management Procedure, Joint Committee Assurance Framework (JAF), Risk Appetite Statement and strategic risk reporting arrangements for onward consideration by the Joint Committee. Members welcomed the strengthened approach to strategic risk management and assurance and were pleased with the progress made to strengthen Risk Management.<br><br>The Escalation Trajectories Report was received and is attached at **Appendix 1.** The Committee received assurance regarding services currently in escalation and noted that updates had been considered through the Director reports.<br><br>The Regulator Report was received. The Committee reviewed Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) activity and received assurance regarding ongoing monitoring and follow-up arrangements. Particular attention was drawn to the forthcoming Caswell Clinic inspection findings. |
| **Inform** | **Patient Story –**<br>QSOC received a Welsh language patient story on chronic renal disease and home dialysis, highlighting the benefits of home therapies, the importance of early patient engagement, Welsh language accessibility and strong clinical support. The patient raised concerns about extended transport times and the suitability of food provision for dialysis patients. QSOC agreed that these issues should be reviewed, with further work to gather and analyse patient travel experiences, review transport coordination with WAST, and consider food provision feedback. |

| Status | Update |
|---|---|
| | The patient story and associated follow-up actions will be escalated to the Joint Commissioning Committee for awareness and assurance.<br><br>**Blueteq Governance Arrangements –** Members approved the new Standard Operating Procedure for Blueteq form, strengthening governance controls around high-cost medicines commissioned by NWJCC.<br><br>**Policy Validation Group** – Members received assurance regarding ongoing work to maintain and review commissioning policies, recognising both the importance of this work and the workforce constraints affecting delivery.<br><br>**Forward Plan of Business** – The Committee reviewed and noted the 2026–27 Forward Plan. |
| **Appendices** | Appendix 1 - Escalation Trajectories. |

## 3. ASSESSMENT

| **Objectives / Strategy** | |
|---|---|
| **Dolen i Amcan (au) Strategol CBC**<br>**Link to JCC Strategic Objectives(s)** | Maximise Value |
| | Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration |
| **Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals**<br>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales) | A Resilient Wales |
| | A Healthier Wales |
| **Dolen i Hwyluswyr Ansawdd** (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /<br>**Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales)) | Leadership |
| | Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective |
| **Dolen i Feysydd Ansawdd** (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /<br>**Link to Domains of Quality** | Effective |
| | Efficient; Equitable; Person-centred; Timely; Safe |

| | |
|---|---|
| (Duty of Quality Statutory Guidance (gov.wales)) | |
| **Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)** | No - Not Applicable |

| **Impact Assessment** | | |
|---|---|---|
| **Ansawdd** *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below: This is a summary of the latest meeting of the JCC |
| **Cydraddoldeb** *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?* | Yes: ☒ | No: ☒ |
| | Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~<br><br>Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ | If no, please include rationale below:<br>This is a summary of the latest meeting of the JCC |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report. | |
| **Effaith Adnoddau** *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)* | Yes (Include further detail below) | |
| | The performance of the services will be used to develop the Plan and identify the areas where resources may be required. | |

## 4. RECOMMENDATIONS

The Joint Commissioning Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report; and
- **Receive** the report as **assurance**.

**Executive Director Lead: Melanie Wilkey**

**Commissioning Lead: Krysta Hallewell**

**Commissioning Team: Neuro-Sciences**

**Date of Escalation Meetings: 28/04/2026**

**Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026**

## Service in Escalation:

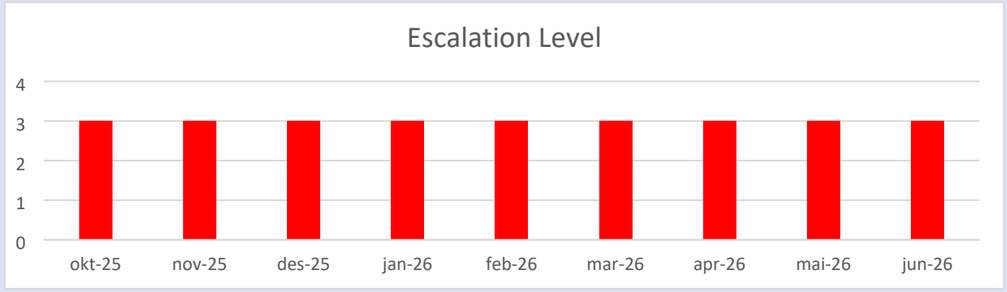
## Specialist Auditory Implant Device Service

**Current Escalation Level 3**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↔ June 26 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

**Escalation Trajectory:**




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **October 2025** | **3** |

**Rationale for Escalation Status:** Due to insufficient progress against agreed improvement actions monitored through the quarterly Service Performance Management meetings since January 2024, and continued underperformance against the RTT position relative to the specific ministerial target for this patient cohort, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends escalation to **Level 3 – Escalated Measures**.

The service now requires significant and sustained improvement, with Executive-level oversight and intervention necessary to address performance risks and secure recovery against agreed standards.

**Background Information:**

**The escalation of the Cardiff and Vale Specialist Auditory Implant Device Service to Level 3 of the NWJCC Escalation Framework was initiated in October 2025 and endorsed by the NWJCC Senior Leadership Team.**

**The NWJCC assurance and confidence rating remains Low. A formal escalation letter was issued to Cardiff and Vale UHB on 6 October 2025. However, delays in confirming a named Executive Lead and Health Board availability resulted in a postponement of the initial escalation meeting.**

**The first formal escalation meeting was subsequently held on 22 January 2026.**

| Action (NWJCC Lead: Director of Commissioning): | Action Due Date | Completion Date |
|---|---|---|
| Escalation endorsed by SLT | Oct 25 | Oct 25 |
| Escalation letter sent to CVUHB | Oct 25 | Oct 25 |
| Escalation meeting to discuss detail and progress against action plan (every 4 weeks) | Ongoing | Ongoing |

**Issues/Risks:**

**February 2026 Update – Commissioning and provider teams to jointly clarify: Historic and current commissioning expectations for CT scans, where clinical interpretation of scans should take place and whether pathway changes created unintended delays.**

**April 2026 update the pre-surgical CT scan pathway remains an open action. Progress has been made on the Long-Term Agreement (LTA), and the service will share the draft in due course. The service has highlighted the impact of additional activity undertaken to reduce backlog pressures, noting a decline in staff morale. There is a recognised risk that ongoing pressures on staff wellbeing may contribute to increased sickness absence. Escalation meeting planned for the 16th April has been moved to the 28th of April at the request of the service.**

**June 2026 – There has been significant progress in addressing the 52 week waits in the service and there are no patients currently at 52 weeks working towards a 36-week target. Work ongoing with the review and rebasing of the LTA. The pre surgical scan pathway is still an open action with an SOP in draft. An operational manager has been moved into the service for support but there are still some concerns around stress wellbeing with the service being stretched due to increased activity to reduce the longest waiters.**

**Executive Director Lead: Sue O'Leary**

**Commissioning Lead: Sue O'Leary**

**Commissioning Team: Mental Health**

**Date of Escalation Meetings: 30/04/2026**

**Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026**

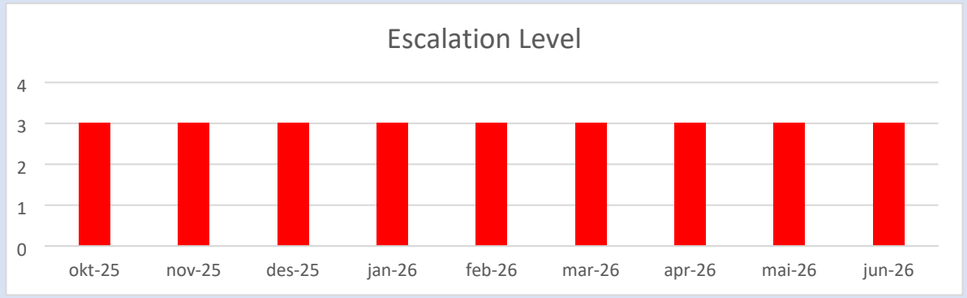
## Service in Escalation: Caswell

**Current Escalation Level 3**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↔ June 2026 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

**Escalation Trajectory:**




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **January 25** | **3** |

**Rationale for Escalation Status:** The service has been placed under formal escalation due to sustained concerns relating to safety and quality within the facility. A site visit by NWJCC representatives in July 2025 identified significant safety and quality concerns. These were reported to the JC in September 2025, which commissioned a full-service review.

The review, undertaken between 15 September and 3 October 2025, assessed compliance with recognised Medium Secure Unit standards and included patient-level review. It identified serious safety and quality issues requiring urgent action.

Similar concerns had been raised in a 2022 NCCU review and were echoed in a June 2025 independent report on Swansea Bay University Health Board's Mental Health and Learning Disability services, which highlighted compromised care standards and weaknesses in leadership and oversight.

The findings indicate systemic governance and safety risks requiring immediate improvement action and strengthened executive oversight.

**Background Information:**

**The escalation of the Caswell Clinic Service to Level 3 of the NWJCC Escalation Framework was initiated and endorsed by the NWJCC Senior Leadership Team in October 2025, following significant safety and governance concerns.**

**Following engagement with the Swansea Bay Executive Team, the service was placed in Level 3 escalation, with weekly improvement meetings established with Caswell senior leaders and monthly oversight meetings with the Health Board Executive. A detailed improvement plan**

| Action (NWJCC Lead- Director of Mental Health AC) | Action Due Date | Completion Date |
|---|---|---|
| In Committee update to JCC members | October 2025 | October 2025 |
| Letter to SBUHB Executive team | October 2025 | October 2025 |

**aligned to recognised standards was developed, with a number of urgent actions identified. Admissions were paused pending assurance that immediate safety risks had been addressed.**

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**February 2026 Update**

**Admissions were suspended in September 2025 due to significant staff and patient safety concerns. Immediate risk mitigation actions were implemented over a three-month period. Assurance was received in January 2026, and admissions recommenced on 9 January 2026.**

**Robust oversight remains in place, including:**

- **Weekly meetings between MHLDVG and Caswell senior leadership to monitor delivery of the action plan, with independent verification of completed actions.**
- **Fortnightly meetings between the MHLDVG Director and Swansea Bay Executive Team to seek further assurance and address delivery risks.**

**The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.**

| | | |
|---|---|---|
| JCC to meet with Caswell SLT on a weekly basis | Complete | Complete |
| Suspension for new admissions to the clinic | Complete | Complete |
| JCC to meet with Caswell SLT on a fortnightly basis | Complete | Complete |
| Clinic reopen to admissions | January 2026 | January 2026 |
| JCC to meet with Caswell Team and Executive Lead monthly | April 2026 | ongoing |

**Issues/Risks:**

**The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.**

**Caswell Clinic remain in Level 3 escalation. Discussions have been held within JCC to establish what needs to be done in order to reduce the level of escalation in the future. Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan. This will give the JCC a description of what the service has done in order to resolve or mitigate the issues raised at the time of the initial review. Once that has been received by the MHLDVG division, each action will be reviewed against the evidence supplied with a view to understanding what level of progress has been made and what the ongoing escalation level will be. The current series of meetings between the MHLDVG and SBUHB have been suspended and will be rearranged following receipt of the updated action plan from the service in order to ensure that the ongoing meetings are relevant, with the appropriate personnel, and discuss relevant points of the action plan".**

**June 2026 – Following receipt of a consolidated report in late April 2026 evidencing significant progress against the original review findings, commissioning, quality safety and medical teams have undertaken a detailed assessment to identify the remaining actions required for de-escalation to level 2 monitoring. More integrated oversight arrangements are in place, via monthly escalation meetings from April 2026, with ongoing engagement with the service to support delivery. A clear set of outstanding actions are in place with the health board, with a commitment to review and sign off evidence on a rolling basis.**

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| **Level 1 ENHANCED MONITORING** | Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes:<br>• No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further.<br>• Continued intervention is required at level 1 and a review date agreed.<br>• Escalation to Level 2 if further intervention is required<br>There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider |
| **Level 2 ESCALATED INTERVENTION** | Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include<br>• Provider performance meetings<br>• Triangulation of data with other quality indicators<br>• Advice from external advisors<br>• Monitoring of any action plans<br>A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes:<br>• Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring.<br>• If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures |
| **Level 3 ESCALATED MEASURES** | Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives.<br>Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum:<br>• Chair (JCC Executive Lead)<br>• Associate Medical Director - Commissioning Team<br>• Senior Planning Lead – Commissioning Team<br>• JCC Head of Quality<br>• Executive Lead from provider Health Board/Trust<br>• Clinical representative from provider Health Board/Trust<br>• Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary.<br>At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2. |

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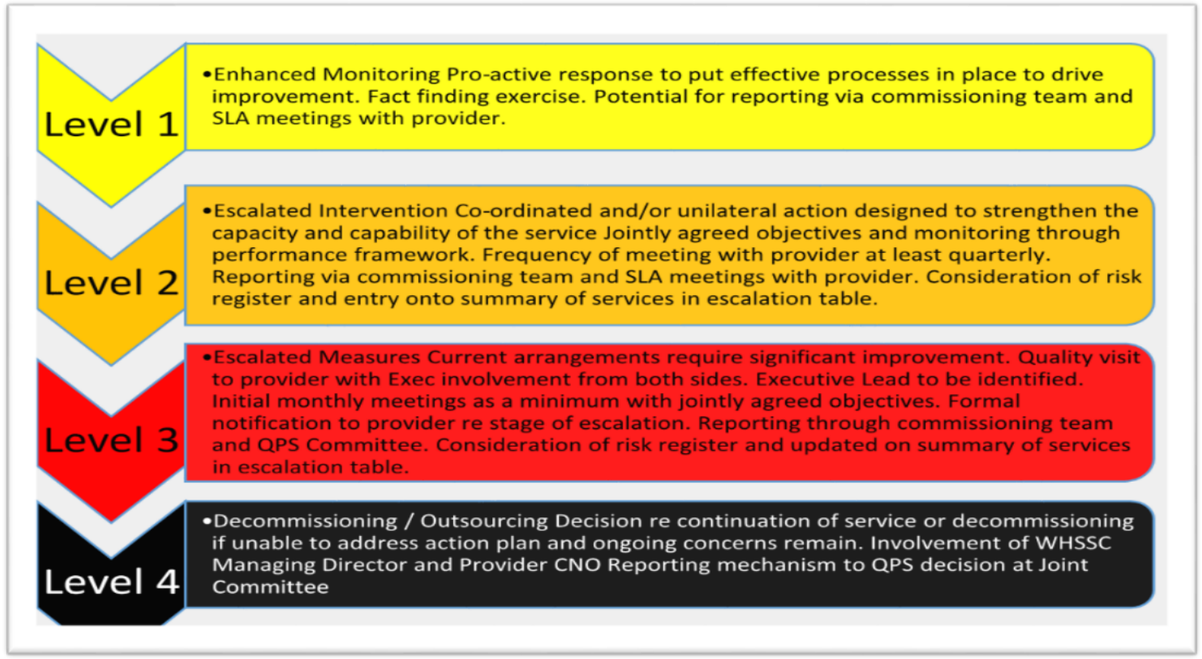
| **Level 4 DECOMISSIONING/OUTSOURCING** | Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation.<br>The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue:<br>1. De-commissioning of the service<br>2. Outsourcing from an alternative provider. This may be permanent or temporary<br>3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider.<br>Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level.<br>At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales. |




**SERVICES IN ESCALATION**

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position