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

Joint Commissioning Committee

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

Dyddiad y Cyfarfod / Date of Meeting	22/09/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Aaron Fowler, Committee Secretary, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

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
Senior Leadership Team (SLT)	16/09/2026	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee (JC) Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 24 August 2026.

Key highlights from the meeting are reported in **Section 2**.

2. HIGHLIGHT REPORT

(Links to reports highlighted – August 2026)

Status	Update
Alert / Escalate	**Joint Accreditation Committee of the International Society for Cellular Therapy ISCT and the European Group for Blood and Marrow Transplant EBMT (JACIE) Accreditation Risks** – Members noted the continued critical risk relating to JACIE certification for Bone Marrow Transplant and CAR-T services. The Committee noted the action plan submitted by Cardiff and Vale University Health Board and the work underway to understand mitigating actions and future planning implications through the Integrated Medium-Term Plan (IMTP) and clinical review processes.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed. **Director of Commissioning for Specialised Services** • Members discussed quality, safety and outcome risks across the specialised services portfolio, including **JACIE** accreditation risk which is highlighted above. • **Cardiac Surgery** – Cardiac surgical services had been escalated to Level 2, with an initial action plan received and further detail requested to address gaps in data, reporting and assurance. • **Plastic Surgery and Paediatric Endoscopy** – Members noted ongoing waiting list and service sustainability pressures in plastic surgery services in South and North Wales, as well as an emerging risk in paediatric gastroenterology relating mainly to endoscopy waiting lists. Further work was being undertaken to understand the pathways and ensure that patients were prioritised appropriately. • Members noted that **thrombectomy** remained on the organisational risk register and that further consideration would take place through the Joint Committee. **Welsh Kidney Network (WKN) Report** • Members received assurance on four nationally reportable incidents that had closed through the Quality and Patient Safety process. • The Committee noted one risk scored at 16 relating to renal dialysis capacity. Members also noted the forthcoming October Renal Network Conference and that information would be shared with Lay Members should they wish to attend. **WKN: Welsh Language Patient Story - Chronic Renal Disease and Home Dialysis** • The Committee welcomed the open and transparent approach taken by the network, including the sharing of learning across Wales. Members also received a follow-up update on the

Status	Update
	previous Welsh language patient story, noting assurance on patient travel times, transport performance, patient experience at Neath Port Talbot dialysis site and mechanisms for patients to raise concerns. **Director of Commissioning for Ambulance Services and National Programmes** • Members noted improvement in ambulance **handover hours**, while recognising that performance remained above commissioned capacity. • Updates were received on **NHS 111** digital developments. • **Non-Emergency Patient Transport Services (NEPTS) and WAST Call-Taking Processes** – Members requested further assurance on non-emergency patient transport cancellations, quality and equity implications, and WAST call-taking processes, including algorithms, modelling and the framework in place. • Members noted an emerging issue relating to adult critical care transfer service vehicle availability, with work underway with the provider to seek assurance on delivery. • NWJCC and Police colleagues were progressing an 18-month programme to streamline SARC commissioning across Wales, covering the future service model, specification, finance, governance and performance arrangements. • **Major Trauma Network -** The Committee noted that interim overnight coordination arrangements remained in place, supported by EMRTS, while discussions continued with WAST and the network to agree a sustainable 24-hour model. The issue would be kept under review and escalated if the risk increased or a long-term solution was not identified. **Director of Commissioning for MHLDVG** • Members noted the position regarding St Andrew's Healthcare, independent sector performance improvement plans and the positive de-escalation of Caswell Clinic from Level 3 to Level 2. The Committee received assurance that patient safety risks and issues within commissioned services were being managed and monitored. Incident and Concerns Report • Members noted 14 new nationally reportable incidents, three early warning notifications and 16 new complaints, with no new referrals to the Ombudsman. Further work was requested to strengthen the presentation of outcomes, learning and wider sharing of Regulation 28 learning across health boards.
Assure	The Committee received the QSOC Sub-Committee's assigned risks from the **NWJCC Operational Risk Register** as of 31 July 2026. The Committee noted that the risk picture remains stagnant, with a number of long-standing risks that had not moved for a considerable period. AF confirmed that this has been reflected at JC. A **Consolidated Neurosciences Risk Report** was also included for noting.

Status	Update
	The **Escalation Trajectories Report** was received and is attached at **Appendix 1.** The Committee received assurance regarding services currently in escalation. Members noted that one services was in escalation level 3 and that detail had been considered through the relevant Director reports. An update on auditory implant services will be included in the next report to provide further assurance on staff morale. The **Regulator Report** (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) was received. The Committee received assurance that the report would be considered as part of the forthcoming QSOC development session to strengthen how regulatory information is presented and used to support assurance. **All Wales Individual Patient Funding (IPFR) Report** The Committee noted that the deep dive was underway and that a review of the IPFR form would be undertaken in due course.
Inform	**Patient Story** – QSOC received a patient story relating to specialist spinal rehabilitation. Members welcomed the strongly positive account of person-centred, coordinated and compassionate care, recognising the role of the multidisciplinary team, specialist expertise, continuity of care and psychological support in achieving positive outcomes. **QSOC Development Day** – Members noted that the development day agenda had been updated and would include an item on EQIA and prioritisation. **Forward Plan of Business** – The Committee reviewed and noted the 2026–27 Forward Plan of Business.
Appendices	Appendix 1 - Escalation Trajectories.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC 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 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd	Leadership

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
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~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: 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 2 of this report; and
- **Receive** the **report** as assurance

Director Lead: Melanie Wilkey
Commissioning Lead: Krysta Hallewell
Commissioning Team: Neuro-Sciences

Date of Escalation Meetings: 05/08/2026
Date Last Reviewed by Quality & Patient Safety Committee: 24/08/2026

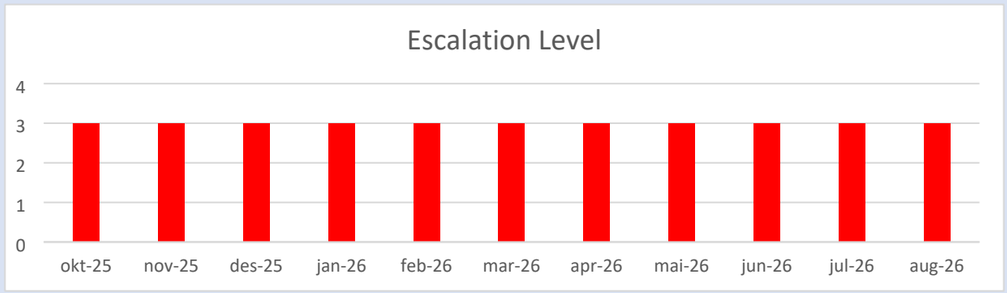
Service in Escalation: Specialist Auditory Implant Device Service

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ August 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 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.
August 2026 – Escalation meeting held 5th August. The service has addressed the longest waiters and by August will be working to a 36-week target. The service are modelling against the BCUHB service and have the data and optimal pathways and are in the process of arranging a visit. The SOP for pre surgical scan pathway has been embedded into Audiology service operating procedure. At present the service do not feel they can meet a 26-week target. Sickness has decreased and the morale of the team has improved. There continues to be ongoing discussions around LTA and sustainability of the service

Director Lead: Sue O'Leary
Commissioning Lead: Sue O'Leary
Commissioning Team: Mental Health

Date of Escalation Meetings: 03/08/2026
Date Last Reviewed by Quality & Patient Safety Committee: 24/08/26

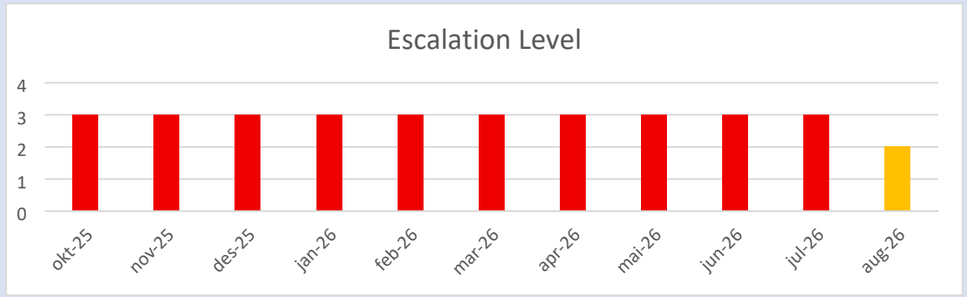
Service in Escalation: Caswell

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ August 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 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.

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
JCC to meet with Caswell SLT on a weekly basis	Complete	Complete

August 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.**

Whilst the service has been de-escalated to Level 2 (see below) the JCC continues to meet with Caswell on a fortnightly basis to continue ongoing assurance processes.

Suspension for new admissions to the clinic	Complete	Complete
JCC to meet with Caswell SLT on a fortnightly basis	Ongoing	Complete
Clinic reopen to admissions	January 2026	January 2026
JCC to meet with Caswell on a fortnightly basis to continue ongoing assurance processes	August 2026	Ongoing
Letter to SBUHB exec team informing of de-escalation to Level 2	August 2026	Complete

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.

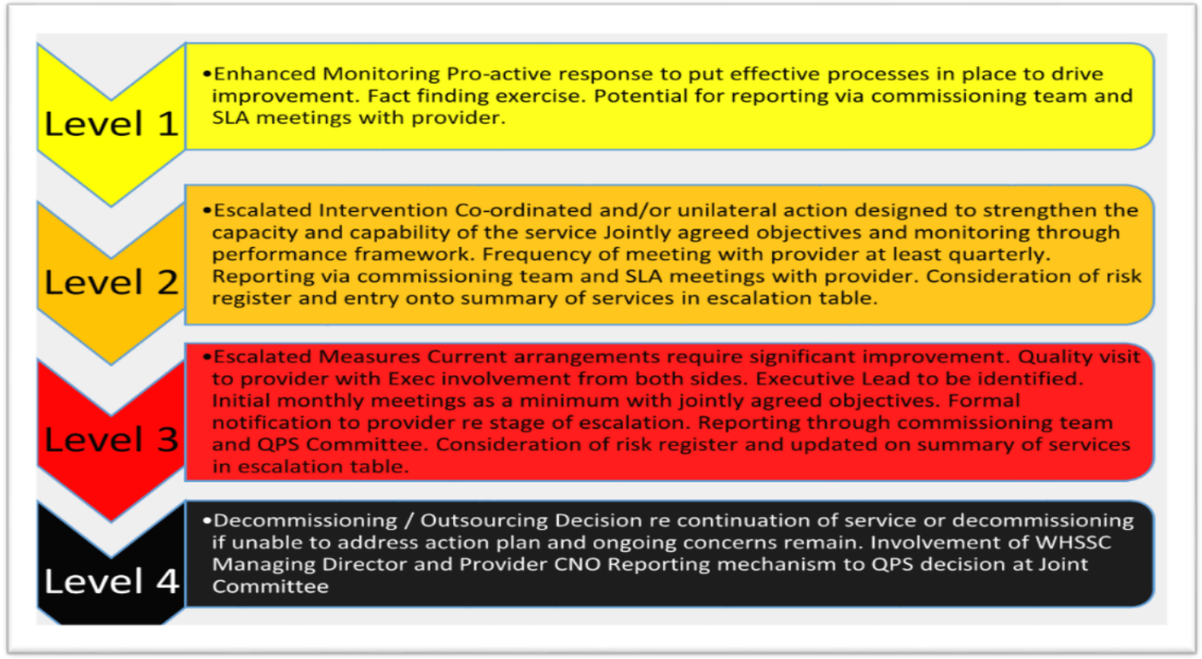
Caswell Clinic remain in Level 3 escalation. Discussions have been held within JCC to establish what needs to be done in order to reduce the level of escalation in the future. Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan. This will give the JCC a description 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.

August 2026 – Following an escalation meeting with the service the JCC recognised the considerable progress that has been made by staff across Caswell Clinic and SBUHB in addressing the issues identified within the Improvement plan since late 2025. It also acknowledges the work undertaken across the service to strengthen quality, safety and operational arrangements. A review undertaken in July by colleagues from the NWJCC Quality & Safety, Medical and Mental Health teams, working in collaboration with SBUHB and Caswell Clinic teams, confirmed that all immediate concerns have now been mitigated and that most actions within the de-escalation plan have been achieved. Continued focus will be required to ensure that these improvements are sustained and fully embedded across the service. Several areas will remain subject to ongoing monitoring in line with level 2 escalation and assurance to support the maintenance of progress achieved to date and to ensure that improvements continue to be embedded. The JCC will continue to work with the service to support and assure further improvement in care planning, clinical risk assessments and the wider governance programme.

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: • 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. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required 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 • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans 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: • 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. • 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. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. 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.

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. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. 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. 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