Agenda Item
3.6

Quality Safety and Outcomes Sub-Committee

Incidents and Concerns Report

Dyddiad y Cyfarfod / Date of Meeting	24/08/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
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Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Assurance Choose an item.

Committee / Group / Individuals	Date	Outcome
Senior Leadership Team (SLT)	17/08/2026	Noted

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 June 1st to July 31st 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

For the reporting period, 14 new NRI's were reported to the specialist services commissioning teams and 3 Early warning notifications. 16 new complaints were received, with no new Ombudsman referrals. (**See Appendix 1**). All incidents are under investigation, with assurance processes in place through commissioning oversight and provider governance structures**.**

During the reporting period, NWJCC received seven 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.

During the last QSOC meeting (28/06/2026) the following was included under the incidents section and further detail was requested on the outcome of this.

A patient 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. The incident is now subject to a Regulation 28.

The following actions have been implemented by the Health Board in response to the Regulation 28. Under each heading there are further embedded assurance /actions within the Health Board to endorse these processes.

- Immediate Clinical Review and Strengthened Referral Criteria
- Enhanced Clinical Assessment Standards
- Training and Education for Physiologists
- Strengthened Documentation and Communication Pathways
- Development of a Standard Operating Procedure (SOP). A comprehensive SOP for device the escalation of the unwell patient, covering Audit and Quality Assurance

- Digital Support
- Engagement with Staff and Wider Learning.

To develop the service improvements benchmarking exercises were conducted. The development of the Red Flag questions is a change to practice in Wales. On discussion with our colleagues in neighbouring health boards, it appears the undergraduate Cardiac Physiology teaching on recognition of systemic illness in patients is limited. The questions in device clinics remain focused on cardiology specific conditions, such as heart failure. The Health Board has developed broader Red Flag questions and an associated training package.

3. RECOMMENDATIONS

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

- **Scrutinise** the content of the report
- **Take assurance** from the activity undertaken in response to the reported matters and **provide assurance** to the NWJCC that incidents and concerns are being appropriately managed.

Appendix 1 – Operational Update

1. **New Nationally Reportable Incidents** (NRI's) see table below.
Fourteen NRIs were reported during the period, relating to care delivery issues across Women and Children and Ambulance and 111. 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
01/06/2026	WAST	The patient was found deceased on ambulance arrival. Further investigation is required to confirm if there was a missed opportunity to escalate the priority of the call to Amber 1 following a clinical assessment on the telephone
01/06/2026	WAST	The Trust registered an amber 1 call. Patient had sustained a possible broken leg. The patient had requested to be transferred in her own wheelchair and whilst taking the patient down the steps the crew miscalculated, and the patient received a further injury.
01/06/2026	WAST	An investigation into call categorisation found a second 999 call fluctuated between a Red and Amber 1 priority. The call should have remained allocated to a red category This would have meant the crew would have continued to the patient and could have with an earlier response of 9.5 hours. The patient was transferred to the ambulance, where unfortunately Recognition of Life Extinct policy was implemented following 30 minutes of advanced life support.
02/06/2026	WAST	The Trust registered multiple emergency calls for a patient whose condition was reported to be deteriorating. The final call reported that the patient was not awake or breathing. When the first resource arrived on scene, Recognition of Life Extinct policy was implemented.
03/06/2026	WAST	The Trust registered an initial emergency call for a patient reported as conscious, breathing, drowsy and not responding. A second call was subsequently prioritised as a cardiac arrest.

		The crew arrived with the patient approximately 26 minutes after the first call had been received and approximately 9 minutes after the call had been prioritised.
03/06/2026	WAST	The Trust registered two emergency calls for a patient. The first caller reported that the patient had collapsed and was on the floor. The call was prioritised as urgent. The second call was received later and the patient was reported as not conscious and not breathing. The call was categorised as a cardiac arrest. Recognition of Life Extinct policy was implemented. The call was appropriately coded; however, audit concluded that a breathing verification diagnostic tool should have been used. It is unknown whether the information disclosed during the assessment tool would have led to a change in call priority.
09/06/2026	WAST	The Trust received multiple calls over several hours for a patient whose condition deteriorated while awaiting a response. By the time a crew attended, the patient had sadly died. A review found that one call should have been prioritised at a higher level, which may have resulted in an earlier response.
09/06/2026	WAST	A call was referred as suitable for clinical screening. Following an audit of the first call, it determined this should have been managed differently due to ineffective breathing descriptors. It is likely the call would have been managed as an emergency priority and possibly received a sooner response.
10/06/2026	WAST	The Trust registered multiple emergency calls for a patient with chest pain. The caller was advised of an estimated delay and that a clinician would call back. A subsequent audit identified that an ineffective breathing descriptor had been missed. A later call reported that the patient had reached hospital and the patient subsequently died in hospital.

11/06/2026	WAST	Caller reported that a patient had fallen and was on the floor. The call was reviewed for suitability for alternative transport and by the Clinical Support Desk. As direct contact details were unavailable, welfare contact could not be completed. The call was later upgraded and an ambulance resource allocated. Access issues were noted and police assistance was requested. The patient was found deceased. The incident was reported as a Nationally Reportable Incident due to a missed opportunity in process.
18/06/2026	WAST	A call for a patient was marked as a duplicate and closed by a clinical navigator, even though new information had been provided suggesting the patient's condition was getting worse. This information may have indicated the need for a higher priority response, which could have led to the patient being seen sooner.
03/07/2026	WAST	The initial call for the patient was registered and referred to 111. The call was returned from 111 and prioritised for urgent response. A final call was received reporting cardiac arrest. A high-acuity response unit arrived at scene. Initial clinical opinion suggests that the patient's death may have been prevented had a resource arrived sooner. At the time of reporting, staffing levels appeared to have impacted response time.
15/07/2026	Women and Children's	A baby was delivered by elective caesarean section and transferred to a tertiary centre on the same day due to congenital abnormalities. A sudden deterioration was noted and immediate resuscitation commenced but was unsuccessful. Due to the unexpected and currently unexplained nature of the death, the case has been referred to the Coroner. An initial review identified no immediate concerns regarding the care provided. The case meets the MBRRACE-UK criteria for National Reportable Incident reporting.
24/07/2026	WAST	Several emergency calls were made regarding a patient. Following ambulance assessment, the patient was discharged at

		scene. A subsequent review found that the decision to discharge could not be supported. The following day, the patient attended hospital and was diagnosed with a stroke. Due to delay in diagnosis and investigation, the patient was not initially eligible for time-critical stroke treatment. The patient's condition deteriorated and surgical intervention, intensive care and a prolonged period of rehabilitation followed.

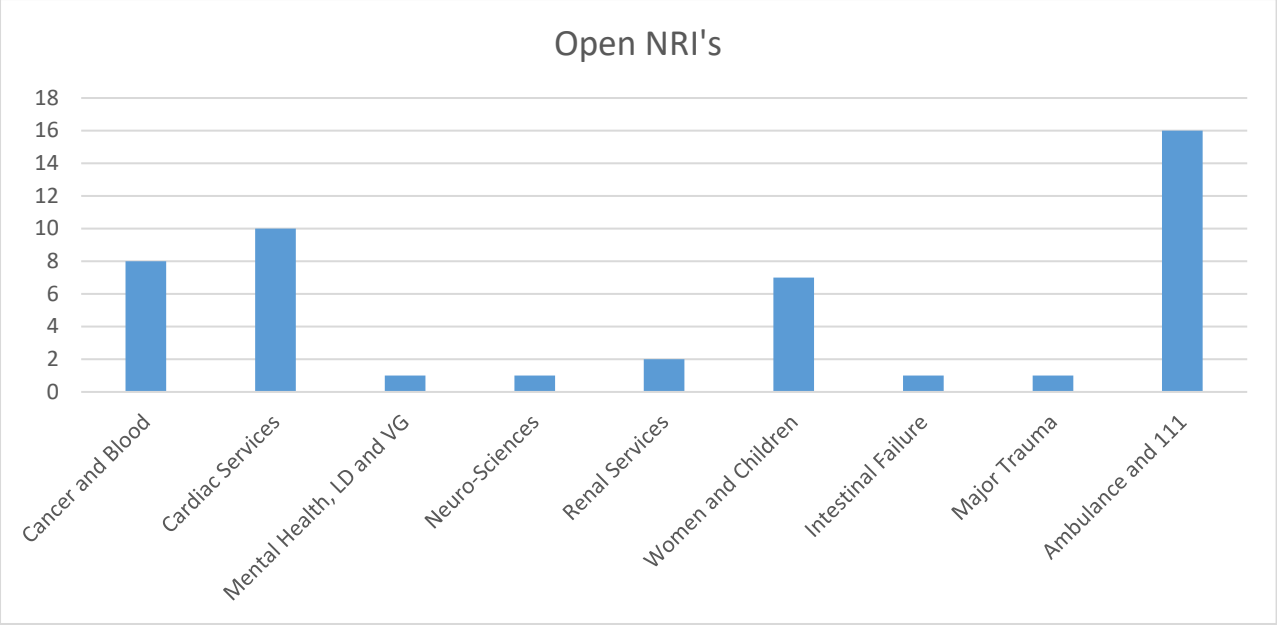
1.1 Early Warning Notifications

The following table summarises the Early Warning Notification received within the reporting period:

18/06/2026	Welsh Fertility Institute	It was identified that the warming media used to thaw frozen embryos between 12-19 May 2026 was out of expiry date of October 2025. The warming media was stored in a clinical area and was opened and recorded for use within the laboratory setting. The media was used for a small number of frozen embryo replacement cycles during the affected period.
08/07/2026	Neurosciences	A Health Board received a media enquiry concerning a patient's reported experience of delays in wheelchair repairs. The patient reported difficulties in obtaining repairs and stated this had significantly restricted their ability to leave home.
31/07/2026	Neurosciences	Patients were identified as colonised with an extremely drug-resistant organism, conferring resistance to almost all available antibiotics. Clinical infection with this organism would present significant treatment challenges.

1.2 Current Open NRI's.

The following table summaries the open NRI's broken down as per Commissiong Team. These are being investigated by the provider and updates provided to the Nursing Quality Team. Any immediate remedial action will have been taken and summarised at the initial report.



Whilst the number of NRI's for Ambulance/111 services 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 JCC Quality Lead is engaged in working closely with WAST to fully understand the serious review of incidents process. This will be aligned to the work being undertaken by NHS Wales Performance & Improvement which has been previously reported.

2. 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
27/03/2026	**Open**	Concern relating to lack of provision for Breast surgery (DIEP Procedure-Provider responding
14/04/2026	**Closed (10/07/2026)**	Parent concern EAT service delay in assessment (Joint response with provider)
15/04/2026	**Closed (29/07/2026)**	Concern regarding inappropriate health professional presence and behaviour at Saturday's One Year Later gathering in Cardiff City Centre.

22/4/2026	**Closed (02/06/2026)**	EATS service and its ongoing failure to provide an AAC device (Provider responding)
05/05/2025	**Closed (29/07/2026)**	Concern about commissioning documentation and governance arrangements etc relating to facial feminisation surgery
07/05/2026	**Closed**	Concern regarding waiting time for specialist assessment and treatment following cancer-related genetic risk
18/05/2026	**Open**	Patient concern relating to wheelchair delivery
03/06/2026	**Closed (29/07/2026)**	Patient concern relating to declined PET scan through IPFR
08/06/2026	**Open**	Patient concern regarding EAT assessment times
17/06/2026	**Closed (30/07/2026)**	NEPTS Changes and Capacity Concerns
18/06/2026	**Open**	AM concern regarding Wheelchair delivery times
22/06/2026	**Open**	MS concern regarding EAT assessment times
06/07/2026	**Closed (30/07/2026)**	AM concern relating to Bariatric surgery
06/07/2026	**Open**	Patient concern regarding staff (Renal)
06/07/2026	**Open**	Patient concern regarding EAT assessment times
06/07/2026	**Open**	Patient concern regarding EAT assessment times
06/07/2026	**Open**	Patient concern regarding EAT assessment times
13/07/2026	**Open**	Patient concern regarding EAT assessment times
16/07/2026	**Open**	Patient concern regarding EAT assessment times
16/07/2026	**Open**	Patient concern regarding EAT assessment times
20/07/2026	**Open**	Patient concern regarding EAT assessment times
22/07/2026	**Closed (30/07/2026)**	AM concern Regarding Tier 4 CAMHS placement
29/07/2026	**Open**	AM concern regarding EAT assessment times

There have been a number of complaints relating to the EAT services. A summary of the action being taken in conjunction wit the provider can be found in the Director of Specialised Services Report.

Themes and trends from closed complaints are considered by the relevant commissioning team and shared where relevant with providers and networks alike.

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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(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 *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken a Quality Impact Assessment Screening?		Reporting on quality matters from last JCC meeting.
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:	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 *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Acronyms

AAC	Alternative and Augmentative Communication
AM	Assembly Member
CAMHS	Children and Adolescent mental health service
CHARU	Cymru High Acuity Response Unit
CSD	Clinical Support Desk
DIEP	Deep Inferior Epigastric Perforator
EAT	Electronic Assisted Technology
EMRTS	Emergency Medical Retrieval and Transfer Service
EWN	Early Warning Notification
JCC	Joint Commissioning Committee
IPFR	Individual Patient Funding Request
ITU	Intensive Treatment Unit
MBRRACE	Mothers and Babies Reducing Risk through Audits and Confidential Enquiry
NEPTS	Non Emergency Patient Transport Service
NRI	Nationally Reportable Incident
NWJCC	NHS Wales Joint Commissioning Committee
PET	Positron Emission tomography

QSOC	Quality Safety Outcomes Committee
RCS	Rapid Integrated Clinical Service
SI	Serious Incident
WAST	Welsh Ambulance Service NHS Trust