Confirmed Minutes of the JCC
Quality Safety and Outcomes Sub-Committee (QSO)
02 June 2025 at 13:30 hrs
In Person at Charnwood and by Microsoft Teams

Members:

Susan Elsmore (Chair)	(SE)	QSO Chair and Lay Member, NHS Wales JCC (Teams)
Shameen Nawaz	(SN)	Lay Member, NHS Wales JCC
Mandy Rayani	(MR)	QSO Vice Chair and Lay Member, NHS Wales JCC
Paul Worthington	(PW)	Lay Member, NHS Wales JCC (Teams)

In Attendance:

Leanne Amos	(LA)	Business Coordinator, Quality, NHS Wales JCC
Carole Bell	(CB)	Director of Nursing & Quality, NHS Wales JCC
Adrian Clarke	(AC)	Acting Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups, NHS Wales JCC
Kirsty John	(KJ)	Quality Lead, NHS Wales JCC
Phil Kloer	(PK)	Chief Executive, Hywel Dda UHB (Teams)
Jacqui Maunder	(JM)	Committee Secretary and Associate Director of Corporate Services, NHS Wales JCC (Teams)
Sarah McMillan	(SM)	National Lead Nurse, Welsh Kidney Network [WKN] (Teams - up until the conclusion of Item 2.1)
Rhodri Pyart	(RP)	WKN Quality Lead, Consultant Nephrologist Cardiff and Vale UHB, (Teams - up until the conclusion of Item 2.1)
Adele Roberts	(AR)	Head of Quality and Patient Care, NHS Wales JCC
Andy Swinburn	(AS)	Director of Paramedicine, Welsh Ambulance Services University NHS Trust [WAST] (Teams – items 3.1 and 3.2)
Ross Whitehead	(RW)	Director of Commissioning for Ambulance Services and 111, NHS Wales JCC (Teams)
Melanie Wilkey	(MW)	Director of Commissioning for Specialised Services, NHS Wales JCC
Liam Williams	(LW)	Director of Quality and Nursing, WAST (Teams – items 3.1 and 3.2)

Observing:

Penny Letchford	(PL)	Associate Medical Director for Mental Health, NHS Wales JCC
Leanne Hawker	(LH)	Partners In Healthcare Lead, WAST (Teams – item 3.1)

Apologies:

Iolo Doull	(ID)	Medical Director, NHS Wales JCC
Angela Mutlow	(AM)	Strategic Director of Operations and Corporate Services, Llais

Helen Tyler (HT) Head of Corporate Governance, NHS Wales JCC

Minutes:
Karla Williams (KW) Risk & Assurance Officer, NHS Wales JCC

The meeting opened at 13:30 hrs.

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QSO25/038	**1.1 Welcome and Introductions** Susan Elsmore (SE), the QSO Chair welcomed everyone to the meeting and introductions were made. The meeting was held via Microsoft Teams and in person, and it was **noted** that a quorum had been achieved. No objections were raised to the meeting being recorded for administrative purposes.
QSO25/039	**1.2 Apologies for Absence** Apologies were **noted** as above.
QSO25/040	**1.3 Declaration of Interests** No other declarations of interest were received.
QSO25/041	**1.4 Minutes of the Legacy Meeting held on 31 March 2025 and Matters Arising** The minutes of the meeting held on 31 March 2025 had been reviewed and **approved** as a true and accurate record of discussions. There were no matters arising from the minutes for discussion.
QSO25/042	**1.5 Action Log** The action log was received, and members **agreed** to close the completed actions: • **QSO25/009 – Joint Commissioning Committee Risk Register – Risks Assigned to the QSO Sub-Committee** – Risk 53 feedback updated under item 5.4. • **QSO25/010 - Report from the Director of Commissioning for Ambulance Services & 111** - GDPR Data Breaches included within the report under item 5.2. • **QSO25/011 - Report from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups -** rapid tranquilisation issue update included within the report under item 5.3. Members **noted** the progress against the open action QSO25/009 highlighting the risk appetite had been scheduled for the December 2025 strategy workshop.

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QSO25/043	**2.1 Welsh Kidney Network** Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current quality and patient safety issues within the WKN commissioned services. Sarah McMillian (SM) WKN Lead Nurse highlighted two new National Reportable Incidents (NRIs): a delay in referral for investigation of a suspicious finding on a chest X-ray, which turned out to be a lung carcinoma, and an error in plasma administration which delayed an incompatible plasma exchange, patient receiving compatible rather than incompatible plasma. SM noted WKN currently hold 6 risks on the Commissioning Risk Register. Within this reporting period 1 additional risk has been added to the WKN Risk Register: • WKN 22 - Management of CPE/CPO for kidney patients in Wales. The risk rating was currently at a risk score 9. Of the 6 risks, one is over 15 and therefore sits on the NHS Wales Joint Commissioning Committee (NWJCC) Risk Register Ref 65 - Kidney Dialysis capacity across Wales. This risk has been included within the NWJCC Foundation Plan submission for 2025/2026 covering growth including the Independent Service Providers (ISPs). The controls that were in place were noted, including value in health care funding, which has been secured to increase the number of transplant and home dialysis patients. This is being monitored through regional meetings and the WKN commissioning performance dashboard. SM and Rhodri Pyart (RP) advised the challenges in reaching agreement on the Carbapenemase-producing organisms (CPO) and Carbapenemase Producing Enterobacteriaceae (CPE) work with Healthcare Associated Infection & Antimicrobial Resistance Programme (HARP), Public Health, and standardising guidelines. RP noted there was an upcoming meeting with the hope to set a common standard solution across Wales. RP highlighted the extensive data available to the renal department, with an aim to leverage IT solutions to identify CPO tests and analyse the frequency of positive outcomes. The importance of patient engagement was discussed, acknowledging the challenges associated with isolating patients in dialysis units, and emphasising the necessity of their compliance and active participation in the process. Mandy Rayani (MR) raised a query about the timeliness of incident reporting to the NWJCC. Carole Bell (CB) provided assurance that this was an isolated incident and the provider had been reminded of the

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	Service Level Agreement (SLA) arrangements and timescales for reporting. Philip Kloer (PK) inquired about the value in healthcare funding work and was interested in variation in transplant and home dialysis rates across Wales. RP explained the factors contributing to the variation as rural patients' reluctance to engage in transplant processes due to travel distances and other factors like ethnicity and deprivation. RP highlighted positive progress in transplant work-up, pre-emptive transplantation, and live donor transplantation, noting Wales' leadership in some aspects. It was acknowledged there was further work required. RM emphasised the cost-effectiveness and quality of life benefits of transplants and home therapies, offering to present data on this in the future. PK expressed interest in equity. RP agreed to benchmark across the UK and vary across Wales for transplants and home dialysis, noting the role of health boards and other partners. **ACTION**: RP to present cost-effectiveness and quality of life benefits of transplants and home therapies, including benchmarking across the UK and variances across Wales for transplants and home dialysis, at a future meeting. Members resolved to: • **Note** the report.
QSO25/044	**3.1 Patient Story** Liam Williams (LW), Welsh Ambulance Services University NHS Trust (WAST) Executive Director of Nursing, introduced the patient story and recounted the tragic experience of the Maxwell family. The patient, a woman in need of urgent medical attention, waited six hours for an ambulance. Despite multiple calls and visible deterioration, the ambulance arrived too late. The patient passed away, and her family was left devastated, not only by the loss but also by the traumatic aftermath, including a post-mortem that prevented them from saying goodbye properly. Her son, who performed cardiopulmonary resuscitation (CPR) before the ambulance arrived, expressed deep emotional trauma and a loss of trust in emergency services. He emphasised the threefold impact: on the family, on ambulance staff, on public confidence and the need for systemic change to prevent similar tragedies and restore public confidence. The story deeply moved the committee, especially the Chair, who acknowledged the emotional weight and the importance of learning

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	from such experiences. Members agreed to thank the family for sharing their story and acknowledged the erosion of public trust and the need to rebuild it through transparency, responsiveness, and improved outcomes. It was highlighted there were plans underway to enhance patient feedback mechanisms, including SMS outreach and video submissions. Andy Swinburn (AS), Executive Director of Paramedicine for WAST, noted the delay was attributed to systemic issues, including ambulance handover delays and high demand. Ross Whitehead (RW) highlighted that a significant portion of ambulance resources are used for non-emergency cases which causes strains on the system. It was noted there would be a new performance framework introduced from 1 July 2025 to prioritise life-threatening cases, expansion of rapid clinical screening and care planning desks. This will improve triage and reduce unnecessary dispatches. Further investment in digital tools and remote clinical support will help to better manage demand. WAST has implemented TRiM (Trauma Risk Management) and psychological support for staff exposed to traumatic incidents and efforts were ongoing to reduce sickness absence and improve workforce resilience. Carole Bell (CB) highlighted that the family experience was taken seriously and suggested evaluating the changes that were made and the impact the changes have on families. CB asked how this would be captured. LW replied that the scale of feedback was not currently captured and only received when patients contacted WAST directly, although WAST actively seek feedback through forums and groups. This highlighted there was a need to push for more robust data sharing and pathway-level analysis to inform system-wide improvements. Members agreed the Maxwell family's story would be used as a catalyst for change, with a commitment to follow up and demonstrate tangible improvements. Members resolved to: • **Note** the patient story.
QSO25/045	**3.2 Ambulance Deep Dive** Ross Whitehead (RW) and WAST colleagues provided members with a Quality Assurance Deep Dive presentation. RW provided an overview of WAST internal and external assurance arrangements and reflected that the commissioning approach moving forward included a more

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	collaborative commissioning approach. RW highlighted the 15 care standards across the 5-step patient pathway which has 6 core requirements underpinning service delivery across all steps. The presentation slides included the following; 1. **Governance** – Effective systems to assure high-quality, evidence-based, patient-focused care 2. **Patient Experience & Satisfaction** – Mechanisms for feedback, complaints, and learning from incidents 3. **Equity** – Equal access to services regardless of location. 4. **Clinical Care** – Evidence-based, measurable, and safely delivered care by qualified staff 5. **Staffing** – Adequate, well-supported, and appropriately skilled workforce 6. **Safety** – Services must protect patients and the public from avoidable harm. Members noted that WAST's quality assurance was governed through an integrated governance approach. The Clinical Quality and Governance Group (CQGG) triangulates incident themes, patient experience, safeguarding, and regulatory compliance. CQGG is informed by sub-groups and reports to the Executive Leadership Team and Trust Board. The structure ensures early identification of quality risks, tracking of actions, and embedding of strategic learning. Key risks identified by WAST were noted as below: • Transfers of Care Delays at Emergency Departments • Workforce Constraints – Utilisation, absence, and abstraction • Digital Infrastructure Challenges – Affecting operational efficiency • Strategic Quality Plan and Quality Management System – Ensuring continuous improvement. Several forward-looking initiatives WAST would be pursuing were highlighted: • Clinical Advisory Group (CAG) – Supports alignment with national policy, quality, ethics, and population health • Value-Based Healthcare – Informing investment decisions and improving outcomes • Digital Innovation – Leveraging AI and smartphone technology for remote and prehospital care • System-Wide Enablement – Using 111 Wales and clinical infrastructure to support broader NHS Wales goals. PK found the presentation informative and expressed an interest in further exploring innovation, recognising that maintaining current practices will not resolve existing issues.

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	RW noted that at the last Joint Committee (JC) meeting, WAST's overall productivity and its contribution to the system was discussed. Joint work with Hywel Dda University Health Board and Swansea Bay University Health Board is being arranged as regional support and agreement will help and accelerate the conversation across Wales. RW noted that the Ministerial Advisory Group report and NHS Executive changes, along with the Six Goals Programme, were helping to clarify roles and responsibilities. This was creating opportunities to direct patients to appropriate care and convert emergency or urgent care into planned care. Shameem Nawaz (SN) asked if the patient engagement work was for 999 and 111. LW agreed to share with colleagues their community involvement annual report as this provides a sense of the work completed to date. **ACTION:** LW to share the WAST Community Involvement Annual Report. Members resolved to: • **Discuss** and **note** the deep dive into the Ambulance Service.
QSO25/046	**4.1 Joint Commissioning Committee Risk Register – Risks Assigned to the QSO Sub-Committee** Members received the risk register as at 30 April 2025 and Jacqui Maunder (JM) highlighted there were 13 high risks in total, 7 of those were assigned to the Quality Safety and Outcomes Sub-Committee for monitoring and scrutiny purposes. Key risk updates included: • **78 Ambulance Capacity** - Deep dive conducted; remains the highest scoring risk at 25 • **79 Type A aortic dissection** - Continued collaboration with Cardiff and Vale University Health Board and Swansea Bay University Health Boards • **65 Renal Dialysis** - Submitted into IMTP 2025/26; awaiting outcome • **55 Neonatal Workforce** - Reviewed by Women & Children's commissioning team; Level 3 escalation meeting held in May 2025 • **56 Neonatal Infection Control** - Reviewed by Women & Children's commissioning team; further update expected • **82 Neurorehabilitation at SBUHB** – Risk increased from 12 to 16 continued collaboration with Cardiff and Vale University Health Board and Swansea Bay University Health Boards • **83 Paediatric Orthopaedic Surgical Service** – New risk added, service under internal discussion.

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	JM noted there was always a timing issue with reporting risks and this was not unusual within the NHS Wales JCC and would feedback to the executives for more clear and consistent wording within the reports. **ACTION**: Improve timing of risk reporting to align with directorate updates. **ACTION**: Review and refresh risk register entries to ensure completed actions are reclassified as controls. Ensure actions are clearly linked to risk reduction and the wording is consistent and meaningful. Members resolved to: • **Note** the report, • **Consider** and **scrutinise** the risks assigned on behalf of the NWJCC; and • Provide **assurance** to the JCC on the effective management of the risks.
QSO25/047	**5.1 Report from the Director of Commissioning for Specialised Services** A report for the Commissioning of Specialised Services was received. Melanie Wilkey (MW) reported on various specialist services, highlighting: • Neonatal escalation ongoing; paediatrics de-escalated • PET-CT supply issue resolved • DBS service review underway • Cardiff and Vale University Health Board to extend thrombectomy hours from 1 July • Concerns raised about auditory implant service recruitment delays. Members resolved to: • **Note** the specialised commissioning updates summarised in this report; and • **Note** summary of specialised risks described and escalate as necessary.
QSO25/048	**5.2 Report from the Director of Commissioning for Ambulance Services & 111** A report for the Commissioning of Ambulance Services and 111 was received. RW presented the report and the quality and safety dashboard, which includes high-level reports on quality domains was highlighted. Members resolved to: • **Note** the content; and • **Receive** the report as assurance.

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QSO25/049	**5.3 Report from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups** A report for the Commissioning of Mental Health, Learning Disabilities and Vulnerable Groups was received. The report provided an update on the Quality Safety and Outcomes Sub-Committee (QSO) issues related to the Mental Health, Learning Disabilities & Vulnerable Groups (MHLDVG) Commissioning Team portfolio as of March 31, 2025. Adrian Clarke (AC) presented the report and highlighted: • Gender services update in preparation for next QSO • Perinatal review shared • Concerns about St Andrews' provider; quality assurance ongoing • Caswell Clinic occupancy and commissioning arrangements discussed. PK requested clarification on commissioner versus health board responsibilities. AC and CB confirmed there were mental health measures, therefore, the HBs were the named coordinators of those named placements. They should have an oversight on the function of care coordinator has been delegated by commissioners. AC would be happy to share slides on the framework and will share in a future meeting. **ACTION**: Add item on Mental Health Framework to a future agenda and AC to present. Members resolved to: • **Note** the report; and • **Receive** the report as assurance.
QSO25/050	**5.4 Incident and Concerns Report** A report outlining a summary of concerns and incidents reported to the JC from provider and commissioned services, covering April to May 2025 (with the exception of the Ambulance Service and 111 which covers the period February /March in line with the WAST reporting period). The Emergency Medical Retrieval and Transfer Service report is also taken through to the SBUHB Quality and Safety group. Ongoing work has been discussed previously but CB highlighted: • There was a new section in the report which included a summary of the NHS Executive weekly patient brief • 5 incidents were closed within this reporting period. Learning has been shared across providers and similar services • Ombudsman complaint not upheld • Safeguarding concern resolved. Members resolved to:

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	• **Note** the report; and • **Receive** the report for assurance.
QSO25/051	**5.5 Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC)** An update on regulatory activity was provided. Members noted the updates from Health Inspectorate Wales (HIW) and Care Quality Commission (CQC) on various services and noted the ongoing collaboration with Health Inspectorate Wales (HIW) to improve reporting and assurance processes. Members resolved to: • **Note** the report; and • **Receive** the report for assurance.
QSO25/052	**6.1 Forward Plan of Business 2025-2026** Members noted the forward plan of business.
QSO25/053	**7.1 Any Other Business** There was no other business to discuss.
QSO25/054	**7.2 Items to be deferred/escalated to the Joint Commissioning Committee / other Sub-Committees and review of any actions to future meetings** Members considered that the followings issues should be highlighted in the highlight report up to the JC: • Comments made of the time delay of the risk register • Listening and learning from the ambulance patient story and deep dive, proposing to take this separately to JC.
QSO25/055	**7.3 Date of Next Meeting** The meeting closed at 16:07. The next meeting is scheduled for 04 August 2025.