

Agenda Item

4.3

Quality Safety and Outcomes Sub-Committee**Director of Commissioning for Ambulance Services and National Programmes**

Date of Meeting	30/10/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Harding, Deputy Director of Commissioning for Ambulance Services and National Programmes & Quality Lead.
Cyflwynydd yr Adroddiad / Report Presenter	Claire Harding, Deputy Director of Commissioning for Ambulance Services and National Programmes & Quality Lead
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Claire Harding, Deputy Director of Commissioning for Ambulance Services and National Programmes & Quality Lead

Pwrpas yr Adroddiad / Report Purpose	For Noting For Assurance
--------------------------------------	-----------------------------

Committee / Group / Individuals	Date	Outcome
Senior Leadership Team (SLT)	14/10/2026	Noted

1. SITUATION / BACKGROUND

This paper provides an update to the Quality, Safety and Outcomes Sub-Committee on key developments and risks across the commissioned services within the ambulance and national programmes portfolio, which on this occasion include; Emergency Ambulance Services, Non-Emergency Patient Transport Services (NEPTS), NHS 111 Wales, Neonatal Transport and Sexual Assault Referral Centres (SARCs).

Each area is set out to describe the quality issues, alongside describing impacts, mitigations and areas requiring further JCC consideration or escalation.

Strategically, all areas outlined within this report align to:

- A Healthier Wales
- Six Goals for Urgent and Emergency Care
- Varying strategic frameworks aligned with the varying portfolios the division holds
- Multiple legislative frameworks, guidance, evidence and assurance areas that the JCC contributes to through its activities which often span multiple domains beyond the remit of the NWJCC
- NWJCC Annual Plan priorities

A full overview of Commissioned Activity is set out in **Appendix 1** for background information and to provide context to the updates and sources of assurance detailed in this report.

2. ASSESSMENT

2.1 Quality Oversight

WAST continues to identify sustained system demand, patient flow constraints and hospital handover delays as the principal contributors to avoidable harm across NHS 111, Emergency Medical Services (999) and Non-Emergency Patient Transport Services (NEPTS).

Whilst confirmed serious harm events remain uncommon relative to service activity, wider quality intelligence, including patient feedback, complaints, learning from deaths, coronial reviews and safeguarding activity, continues to demonstrate the impact that delays in access to care can have on patients, families and carers. The NWJCC has strengthened its approach to quality oversight through improved triangulation of safety, experience, performance and outcome measures, recognising that patient harm and distress are not always captured through traditional incident reporting mechanisms.

WAST has strengthened its Quality Management System through enhanced governance arrangements, implementation of a Quality Assurance Dashboard and improved use of quality intelligence. There is increasing evidence that information derived from patient experience, complaints, safeguarding, incidents, coronial learning and learning from deaths is being used to identify themes, monitor outcomes, inform decision-making and drive service improvement.

The NWJCC continues to maintain oversight of recurring patient safety themes identified through quality intelligence and governance processes. During the reporting period, the Quality, Safety and Outcomes Committee considered concerns regarding repeat call-taker incidents, including inappropriate call designations and the potential impact on patient outcomes. Further assurance was requested regarding associated harms and the effectiveness of actions taken. NHS Wales Performance and Improvement has advised that its review remains ongoing, with findings to date indicating no significant change in incident themes, investigation outcomes, learning identified or actions implemented. Further discussions will take place following completion of internal governance processes to determine whether additional assurance is required and to ensure learning continues to inform improvement activity.

Nationally Reportable Incidents continue to provide important intelligence regarding the most serious patient safety risks. Recurring themes have included call handling, remote clinical assessment and response prioritisation during periods of high demand. These themes are analysed alongside wider quality intelligence to support targeted safety improvement and risk reduction.

WAST has also strengthened its culture of continuous improvement through the WAST Improvement Network (WIN), which provides staff with an accessible platform to identify opportunities for innovation and service improvement. Between September 2025 and March 2026, 30 new improvement ideas were submitted, demonstrating increasing staff engagement in shaping service development and patient care.

WAST's quality improvement activity continues to align with the Health and Care Quality Standards, with a focus on delivering safe, timely, effective, efficient, equitable and person-centred services. Ongoing development of workforce assurance, staff wellbeing measures, patient experience intelligence and information management processes continues to support a positive quality and safety culture.

The NWJCC is also strengthening service specifications through the introduction of additional quality, safety, patient experience, workforce, equality and outcome-focused KPIs to support greater transparency, routine commissioner assurance and a more comprehensive assessment of service quality. Continued development of integrated reporting and data triangulation will further support understanding of quality, performance, outcomes and the impact of improvement activity.

Ongoing mitigations include enhanced clinical oversight through Integrated Clinical Contact Centres, expansion of remote and specialist clinical models, implementation of the Ambulance Performance Framework, targeted improvement work across stroke, STEMI, frailty and falls pathways, delivery of the NEPTS Future Vision 2030 programme, and continued system-wide action to improve patient flow and reduce hospital handover delays.

Assurance can be taken that WAST continues to strengthen quality governance, organisational learning and the use of quality intelligence. Positive progress is evident through reductions in ambulance hours lost through hospital handover delays, improvements in NHS 111 access and call abandonment rates, strengthened governance arrangements and greater use of patient experience, complaints, safeguarding, incident and mortality information to support service improvement.

The development of the Quality Assurance Dashboard strengthens reporting arrangements and enhanced benefits realisation processes are improving visibility of emerging risks, recurring themes and improvement opportunities. The introduction of additional quality, safety, patient experience, workforce, equality and outcome-focused KPIs should further strengthen transparency and routine commissioner assurance.

However, significant risks remain associated with system-wide pressures, constrained patient flow, ambulance response delays and residual hospital handover delays, which continue to present the greatest risks to patient safety, experience and outcomes, particularly for clinically vulnerable patients and those requiring time-critical care. Continued assurance should be sought regarding the effectiveness of actions to reduce harm associated with delays, address recurring call-taker incidents, strengthen organisational learning, improve outcomes for vulnerable groups and demonstrate measurable benefits from clinical model transformation and the NEPTS Future Vision 2030 programme.

Overall, WAST demonstrates strengthening quality governance, improvement activity and organisational learning. However, delivery of sustainable improvements remains dependent on wider system progress in patient flow, urgent and emergency care capacity and hospital handover performance, which continue to represent the most significant risks to quality and patient safety across services.

Some specific areas of current focus are outlined here:

2.2 Emergency Ambulance Services

Emergency Medical Services (999) continue to identify prolonged ambulance response waits and hospital handover delays as the most significant risks to patient safety. Handover lost hours for July (9,336), and August (8,608) show some improvement when compared with June, however have increased again in September (11,677).

Patients with time-critical conditions, including stroke, STEMI, sepsis, frailty-related falls and mental health crises, remain at greatest risk of deterioration whilst awaiting assessment, conveyance or definitive care. Although improvements in hospital handover performance have reduced ambulance hours lost and demonstrate positive system-wide collaboration, delays continue to affect ambulance availability, patient flow and timely access to care.

Patient, family and lived-experience feedback consistently highlights the physical and emotional impact of delays whilst recognising the professionalism and compassion of WAST staff. This intelligence continues to provide valuable insight into the human impact of system pressures and informs improvement activity and organisational learning.

Areas of **impact** as a result of this situation include:

- Reduced ambulance availability, particularly impacting response to orange and yellow acuity calls.
- Increased risk to patient outcomes across the urgent and emergency care pathway.
- Ongoing workforce and reputational risk arising from sustained pressure and public scrutiny.

There are a number of **mitigations** that have been considered and are being implemented including:

- A National Handover Improvement Approach introduced with measurable improvement prior to winter escalation
- Winter monitoring arrangements commencing from November 2026

There are some **constraints to these mitigations** which include:

- Acute bed capacity and flow constraints.
- Reliance on Health Board operational change beyond direct NWJCC influence and control.

Our **commissioning assurance** approach seeks assurance through:

- Active monitoring through the newly established commissioning arrangements Provider Performance Assurance Group (PPAG)
- National ambulance handover performance data and trend analysis.
- Risk on the NWJCC Risk Register (78) de-escalated from 25 to 20, reflecting reduced likelihood but ongoing high consequence.
- Risk reviewed regularly.

There will be a number of issues requiring **Sub Committee Consideration**

- Ambulance handover performance risk continues. Progress is being made with the Committee Secretary and team to strengthen how this risk is articulated and managed through a commissioning lens, recognising that the main drivers sit outside direct commissioner control.

- Whilst a high-impact risk, there are limited additional controls available from a commissioning perspective beyond assurance, escalation and system influence. Ongoing mitigation is therefore reliant on Health Board delivery of improved flow and discharge, with the role of the NWJCC focused on oversight, coordination and appropriate risk tolerance.

2.3 NHS 111 Performance

NHS 111 Wales continues to report a relatively low overall risk profile, with confirmed serious harm remaining rare. However, delays in call answering, access to clinical assessment and completion of call-backs remain recognised risks, particularly for patients whose condition may deteriorate whilst awaiting advice or onward care. Patient experience feedback continues to identify access, communication and waiting times as key themes.

Most recent data suggests that the profile of demand for the service has changed since it was first designed with evidence suggesting a profile of in-hours demand that is far higher than anticipated.

Improvement activity remains focused on enhancing timely access to care, improving patient experience and strengthening service resilience. This includes progression of the NHS 111 re-rostering programme, continued focus on workforce wellbeing and attendance, and delivery of digital improvements including the NHS 111 virtual agent (Albot), WhatsApp integration, multilingual functionality and text-based access. These developments support a more accessible and person-centred approach whilst contributing to wider NHS Wales ambitions for digitally enabled services.

Areas of **impact** as a result of this situation include:

- Persistent queues and delays
- Increased call abandonment
- Higher repeat calling
- Loss of flow through the system
- Existing staff under pressure
- Complexity of calls can lead to longer handling times.

There are a number of **mitigations** that have been considered and are being implemented including:

- Review of data with WAST colleagues – specifically seeking to understand the in-hours demand
- Identification of actions that will aid stabilisation, improve flow and transform the service
- Focus on digitalisation of the front end of the service
- Introduction of new symptom checkers

There are some **constraints to these mitigations** which include:

- Out of hours colleagues engagement with the digital improvements

Our **commissioning assurance** approach seeks assurance through:

- Newly established Provider Performance Assurance Group
- Review of demand profile with WAST, and identification of mitigating actions
- Commence discussions on the role of 111 within the broader emergency and unscheduled care system

There will be a number of issues requiring **Sub Committee Consideration**

- As part of the strategic review being undertaken by the JCC, a new service specification will be developed for 111. This will offer opportunity to make any required changes to the service.

2.4 Non-Emergency Patient Transport Service (NEPTS)

NEPTS service delivery remains stable, with generally positive patient experience measures. However, short-notice cancellations, return journey delays and reliance on wider system processes continue to affect service reliability and patient experience. A significant proportion of cancellations arise from factors outside the direct control of the service, including appointment changes by Health Boards and patient-initiated cancellations. Whilst external to NEPTS, these factors materially affect operational efficiency, capacity utilisation and patient experience. For some vulnerable patients, delays or cancellations may contribute to missed appointments, delayed treatment and reduced continuity of care.

WAST continues to deliver improvement activity through its NEPTS Improvement Board against the NEPTS Future Vision 2030, supporting longer-term improvements in quality, resilience, accessibility, operational efficiency and patient experience.

The **impact** from a **Quality, Safety and Outcomes perspective** include:

- Impact on patient experience due to late notice cancellations or non-provision of planned outpatient transport.
- Increased risk of delayed discharge and transfer activity, contributing to wider system congestion and indirect pressure on urgent and emergency care.

The resulting **Mitigations and controls** have been put in place:

- Demand management and efficiency options developed by WAST and shared with commissioners through commissioning assurance groups
- The establishment of a NEPTS improvement board within WAST and NWJCC taking a system leadership role to identify and resolve drivers outside of the direct control of the provider

- Establishment of NEPTS National Working Group with health boards, WAST and system partners to develop and deliver actions aligned to the NEPTS Future Vision (2030)

There are a number of **constraints to the mitigations:**

- Many of the underlying drivers and opportunities for efficiency sit outside direct provider or commissioner control (e.g. booking behaviours, late cancellations)
- Sustainable improvement is dependent on system wide engagement and agreement

The following are received by the JCC as supporting **Evidence and Assurance:**

- NEPTS performance and demand reports considered through the new Provider Performance Assurance Group
- Commissioner oversight of options for improvement

More detailed information regarding the NEPTs improvement work will be provided at the QSOSC Committee.

2.5 Adult Critical Care Transfer Service

The Adult Critical Care Transfer Service (ACCTs) continues to provide specialist transfers for critically ill patients across Wales; however, the service faces ongoing operational risks relating to fleet resilience and vehicle availability. The current model relies on two frontline transfer vehicles supported by a single reserve ambulance shared between Bangor and Cardiff, creating challenges when vehicles are unavailable due to maintenance or breakdown. Limited availability of suitable specialist replacement vehicles and the absence of approved capital funding for additional fleet capacity present risks to service continuity and may contribute to delays in time-critical patient transfers. The service have loaned vehicles from WAST to avoid impact and are working to bring others back on line as soon as is possible.

The service has been asked to provide a daily sitrep with regards vehicle availability, and has recently undertaken a risk assessment. They have provided assurance that there is no patient harm. Colleagues within the JCC are currently considering the most appropriate means of support and escalation for the service.

In support of strengthened commissioning oversight, NWJCC commissioning colleagues, including Finance and Quality Business Partners, undertook an assurance visit to the EMRTS and ACCTs bases at Cardiff Heliport. The visit provided valuable operational insight, enabled commissioners to contextualise quality, performance and workforce information, and strengthened relationships with service leaders and frontline teams.

The resulting **Mitigations and controls** have been put in place:

- Expectation of daily SITREP reporting from the team
- Risk assessment

There are a number of **constraints to the mitigations**:

- Sustained availability of vehicles to loan from WAST
- Non availability of capital monies for new fleet

Commissioning **assurance** is gained through :

- Seek regular commissioner assurance through newly established PPAGs
- Commissioning team discussion on support and escalation

2.6 Major Trauma Overnight Desk

The overnight Major Trauma Desk arrangements remain under review following notification from EMRTS that it can no longer sustainably provide the current unfunded out-of-hours service. A multi-agency risk assessment has identified significant patient safety and operational risks associated with the loss of specialist overnight trauma coordination; however, the NHS Wales Joint Commissioning Committee has confirmed that overnight provision is not currently a commissioned service and that no additional commissioner funding has been identified. Providers have therefore been asked to work collaboratively to develop a sustainable, cost-neutral operating model for overnight trauma coordination whilst managing the associated clinical and operational risk.

The **impact** is:

- Potential risk for patients being taken to the wrong place for their care

Mitigations have been put in place as follows:

- Development of a risk assessment by providers
- Development of an options appraisal by providers
- Correspondence requesting a cost neutral solution is found
- Reminder that the extant position of the original business case was to have no overnight desk with the Trauma Lead at the Major Trauma Centre being the default cover provider by night

There are some constraints to these mitigations

- EMRTs have stated they will cease to provide cover from December 2026
– there is not as yet an identified solution

For purposes of **assurance**, these issues are discussed at the Major Trauma Network Delivery Assurance Group (DAG) and through the JCC Exec to Exec meeting.

2.7 Neonatal Transport

The publication of the All-Wales Maternity and Neonatal Assurance Assessment Report, "The Path to Safer Beginnings in Wales" highlighted inequities in care due to the interim model remaining in place and the variation in service specifications between the in-hours and out-of-hours provision. This work will be considered by the JCC as part of its wider response to the assessment.

The resulting **mitigations and controls** have been put in place:

- Agreement to establish project arrangements to manage the change from a temporary arrangement to a more permanent arrangement

There are **constraints** to the mitigation outlined above, including:

JCC capacity to deliver – however posts being filled and should be in place by end of Q3

- Health Boards engagement with the work given the long history that precedes this
- Resource considerations of the model
- Alignment with the broader neonatal review being undertaken within the JCC

Required **Evidence and assurance** is received and considered through the Neonatal Transport Delivery Assurance group.

2.8 Health Inspectorate Wales Report

Health Inspectorate Wales published a report early in October, that assessed the progress made by the Welsh Ambulance Services NHS Trust since reviews published in 2020 and 2021. In summary, the report (<https://www.hiw.org.uk/system/files/2026-10/WAST%20Review%20EN>).

concluded that WAST is significantly stronger than in previous reviews, with improvements in governance, leadership, workforce support and clinical models, but the key challenge is demonstrating measurable impact, while delayed handovers remain the most significant risk.

3. RECOMMENDATIONS

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

- **Note** the report; and
- **Receive** the report as assurance.

Appendix 1 – Operational Update

3.1 Strategic Review

The strategic review of ambulance services continues to progress. Progress to date has included:

- Reviewing of the existing commissioning frameworks
- Review of historical baseline, investment and expenditure
- Review of productivity and performance
- IMTP delivery including commissioning intentions

Current areas of focus include the development of a 'Commissioning for Value' framework supported by 3 new service specifications for Emergency Ambulance Services, Non Emergency Patient Transport and 111.

3.2 Manchester Arena Inquiry Assessment

The formal position of the Joint Commissioning Committee was presented to the JCC at its formal meeting on the 21st July 2026. Work continues to assess implementation of the recommendations within a resource neutral position.

3.3 Emergency Ambulance Services

The JCC has implemented strengthened governance arrangements with WAST to enable regular oversight of performance of services. Performance for the highest acuity Purple Arrest category remained within the 6–8-minute target in September. The median response time was 7 minutes 31 seconds, compared with 7 minutes 24 seconds in August and 7 minutes 39 seconds in July. The 90th percentile response was 17 minutes 56 seconds, within the ambition of less than 20 minutes.

Return of Spontaneous Circulation (ROSC) was 25.7% in September, an improvement compared with 19.7% in August and 23.4% in July. September performance was therefore within the WAST stated ambition of 25–30%. The reported two-year average is 21.7%.

Performance for Red Emergency incidents remained outside target. The median response time increased from 9 minutes 1 second in August to 9 minutes 32 seconds in September, against an ambition of 6–8 minutes. The 90th percentile response time increased from 22 minutes 8 seconds to 22 minutes 46 seconds, against an ambition of less than 20 minutes.

Performance for Orange Now incidents also deteriorated in September. The median response time increased from 1 hour in August to 1 hour 23 minutes in September, compared with an ambition of less than 60 minutes.

The September position represents a deterioration from the summer position and will require continued monitoring to establish whether the change

represents a sustained change in performance as the system enters the winter period. Weekly monitoring during the winter is being established to support.

3.4 Ambulance Patient Handover

The JCC continue to produce a weekly dashboard outlining the position of handover at all hospitals in Wales.

Emergency Medical Services (999) continue to identify prolonged ambulance response waits and hospital handover delays as the most significant risks to patient safety. Handover lost hours for July (9,336), and August (8,608) show some improvement when compared with June, however have increased again in September (11,677).

3.5 Non-Emergency Patient Transport Service (NEPTS)

The NEPTS service across Wales continues to be under significant challenge due to a number of key drivers including increased travel times due to service reconfigurations, increased complexity, journey lengths and increased private provider costs commissioned by WAST on behalf of Wales, impacting on capacity to deliver. The prioritisation of resource has resulted in cancellations in outpatient transport and discharge transport.

To address and deliver strategic actions aligned to productivity and efficiency improvements within the NEPTS service and to deliver the objectives of the NEPTS Future Vision (2030), the Ambulance Services and 111 Commissioning Team will establish a NEPTS National Working Group, consisting of health boards, WAST, Welsh Government and other system partners (i.e., NHS P&I and DCHW)

At the request of the JCC, WAST have reviewed undertaken modelling against a number of options for improving NEPTS capacity within existing resources.

In addition to the above, WAST have worked through a complex review of NEPTS rosters with the potential to deliver an increase in the amount of transport capacity within available resources through improved efficiencies. These are anticipated to be implemented in Q3.

3.6 NHS 111 Wales

Following receipt of non-recurrent Welsh Government funding, the Ambulance Services and 111 Commissioning Team has been working closely with WAST to improve the digital experience for patient accessing the NHS 111 Wales website:

- The NHS 111 Wales virtual agent (Albot) has been developed and functional since August 2025 with approaching 6000 contacts per month (approx. 7% of 111 call volumes) with a 'soft launch' and no advertising or promotion.

- WhatsApp integration is being developed to replicate NHS 111 Wales functionality through the WhatsApp broadening accessibility and engagement across a widely used messaging platform.
- Enhancing digital inclusion by introducing multilingual support and a text-only channel that allows users to connect with 111 call handlers without relying on voice calls.

There remains an ongoing challenge with the functionality of the 111 website and its development to support the aim of 'digital first' services. Additional funding has been provided for the ongoing improvement of the digital front end of 111. The Ambulance Services and 111 Commissioning Team are working closely with WAST regarding the benefits that can be realised and targeting of investment to make the most significant contribution to patients.

111 call abandonment will remain a key measure of system pressure and experience which will continue to be monitored alongside further development of call abandonment rates by wait time band.

WAST are actively working on improving the productivity of the 111 service within the existing resource available. A full re-rostering exercise is underway within the 111 service which will result in shift patterns being implemented that are more closely aligned with expected demand in addition to providing a better experience for staff. The re-roster is on target for implementation within Quarter 3 2026/27.

Most recently, the data of the 111 service appears to be suggesting a changing profile of demand compared from when it was designed, particularly the use of 111 in hours – JCC and WAST colleagues are currently interrogating this data.

3.7 Emergency Medical Retrieval and Transfer Service

EMRTS has highlighted issues regarding the service's continued ability to provide night-time cover for the Major Trauma Desk. In response, a series of discussions have taken place involving EMRTS, the Major Trauma Network, the Major Trauma Centre, WAST, and the NWJCC to assess the potential impact on service resilience and patient care.

The Ambulance Services and 111 Commissioning team have requested the South Wales Major Trauma Network ODN to work with respective organisations to review the risks of a number of scenarios to jointly exploring feasible options to mitigate identified risks and to ensure safe and sustainable coverage going forward within existing resources.

To date, no resolution has been found, and EMRTs have signalled notice from December 2026

3.8 Adult Critical Care Transfer Service (ACCTS)

The Ambulance Services and 111 Commissioning team are progressing with reviewing the current hosting arrangements for the ACCTS service which is currently hosted by Swansea Bay University Health Board and is aligned with the Emergency Medical Retrieval and Transportation Service (EMRTS).

The review has been completed and has been shared with Swansea Bay University Health Board as the host organisation.

Specific areas of focus have been outlined within the main body of the report

3.9 Cymru Inter-Hospital Acute Neonatal Transport Service (CHANTS)

The Neonatal Transport Service Clinical Leads are currently hosted by NHS Performance and Improvement (P&I). Following changes to the remit of NHS P&I this is no longer sustainable and the requirement for a different arrangement for the clinical lead roles has been identified.

To progress with resolving this, the Director of Commissioning for Ambulance Services and 111 has written to the three provider Health Boards currently delivering the CHANTS service to request a position statement from each organisation in order to identify a temporary operational hosting solution to support ongoing safety, compliance and operational reliability.

The Ambulance Services and 111 commissioning team will continue to work with NHS P&I to develop a transition plan.

Neonatal transfer services are core component of the provision of high quality and responsive neonatal provision. Whilst broader work is currently being undertaken on the provision of neonatal services across Wales, there is a need to consider and review the delivery of the transfer services in South Wales. The interim overnight model has been in place significantly past the original anticipated timeframe and is not a sustainable solution moving forward. The publication of the All-Wales Maternity and Neonatal Assurance Assessment Report, "The Path to Safer Beginnings in Wales" highlighted inequities in care due to the interim model remaining in place and the variation in service specifications between the in-hours and out-of-hours provision. This work will be considered by the JCC as part of its wider response to the assessment.

3.10 Sexual Assault Referral Centres

The Joint Commissioning Committee took responsibility for the commissioning of SARCs from November 2025. The model is commissioned through a partnership between the NHS, policing and the Offices of the Police and Crime Commissioner. The service model comprises services for survivors of sexual assault and includes:

- Forensic examination
- Crisis worker support

- Independent sexual violence advisors (for those navigating a criminal justice pathway)
- Counselling

Services are provided from 3 central hubs and a range of community based premises across South East, South West Wales and Powys (there are alternate arrangements in place for North Wales).

Strategic and Regulatory Assessment

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Not Applicable
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales If more than one applies please list below: A more equal Wales
Dolen i Hwyluswyr Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd</i> (<i>Ilyw.cymru</i>)) / 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 (<i>Canllawiau Statudol Dyletswydd Ansawdd</i> (<i>Ilyw.cymru</i>)) / 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) /	No - Not Applicable If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	
---	--

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Reporting on quality matters from last JCC meeting.
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☐	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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Acronyms

Acronyms / Glossary of Terms	
ACCTS	Acute Critical Care Transfer Service
ARAC	Audit Risk and Assurance Committee
CAD	Computer aided dispatch
EMRTS	Emergency Medical Retrieval and Transfer Service
EMSC	Emergency Medical Services Coordination
IG	Information Governance
JC	Joint Commissioning Committee

NEPTS	Non-Emergency Patient Transport Services
NICU	Neonatal Intensive Care Unit
NWJCC	NHS Wales Joint Commissioning Committee
NRI	National Reportable Incident
OPCCs	Offices of the Police and Crime Commissioners
PADR	Performance Appraisal and Development Review
QuEst	Quality, Patient Experience and Safety Committee, WAST
SARCs	Sexual Assault Referral Centres
SCIF	Serious Case Incident Forum, WAST
WAST	Welsh Ambulance Services University NHS Trust