Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Welsh Ambulance Services University NHS Trust: Review of progress following HIW reviews

HIW review of the effectiveness and sustainability of improvements arising from reviews published in 2020 and 2021.

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did 5

2. Summary of assessment 6

3. What we found 8

Theme 1: Patient flow, handover, crew release and pathways 9

Theme 2: Escalation processes 12

Theme 3: Patient communication and NEPTS cancellations 14

Theme 4: Leadership, governance, wellbeing and training 16

Theme 5: Data quality and accurate recording 20

4. Conclusion and next steps 22

Areas of noteworthy practice 22

Next steps 23

Appendix A – Recommendations 25

1. What we did

Healthcare Inspectorate Wales (HIW) undertook an assessment to consider how far the Welsh Ambulance Services University NHS Trust (WAST) has addressed the concerns and recommendations arising from two previous HIW reviews.

The first review published in 2020, considered patient management arrangements within Emergency Medical Service Clinical Contact Centres (EMSCCCs). It also included arrangements for patients waiting in the community, workforce capacity, escalation, training, wellbeing, leadership, and incident reporting.

The second review published in 2021 considered patient safety, privacy, dignity, and experience while patients waited in ambulances outside Emergency Departments during delayed handovers.

Together, those reviews described connected risks across the urgent and emergency care pathway. Delays in hospital handover reduce ambulance availability, which in turn affects patients waiting in the community, the operation of EMSCCCs, workforce pressure, escalation, clinical oversight, and patient experience. We acknowledge that this is not an issue the Trust can resolve alone, and that sustained improvement requires continued action from health boards, commissioners and wider system partners.

This assessment focused on the Trust's 2026 response to our requested five theme updates, which included:

- Patient flow and handover processes
- Escalation processes
- Communication with patients and NEPTS cancellations
- Leadership, governance, workforce, and learning culture
- Data quality and accurate recording.

To support our understanding of the progress made under the above themes, we asked the Trust to complete a self-assessment and submit this to us along with supporting evidence by the end of January 2026. The information was provided to us and was considered alongside other intelligence held by HIW.

We assessed the information submitted within the self-assessment and supporting evidence against the above themes, and considered whether it demonstrated implementation, embedding, effectiveness and sustainability.

2. Summary of assessment

Executive Summary

During early 2026, Healthcare Inspectorate Wales (HIW) assessed the extent to which Welsh Ambulance Services University NHS Trust (WAST) has addressed the findings and recommendations arising from HIW reviews published in 2020 and 2021.

Overall, we found that the Trust has made strong progress since our previous reviews and is in a materially stronger position than that described in 2020 and 2021. The Trust has introduced a wide range of governance, operational, workforce, clinical and digital improvements, many of which now appear embedded within routine operational and governance arrangements. We found evidence of strengthened oversight of delayed handovers, improved clinical decision-making arrangements, more developed escalation processes, increased leadership capacity, enhanced workforce support arrangements and strengthened digital and data governance.

We also identified several areas of noteworthy practice. These include the development of advanced clinical decision-making and alternative care pathway models, strengthened clinical support arrangements within EMSCCCs, improved operational oversight of system pressures, enhanced workforce support and speaking-up arrangements, and investment in training, development and digital governance. These developments suggest that the Trust has responded positively and constructively to many of the concerns identified through our previous reviews.

However, whilst implementation and embedding are generally well evidenced, the evidence submitted was less developed in demonstrating impact. Across several themes, the Trust described strengthened governance arrangements, monitoring processes and improvement programmes, but there was more limited evidence demonstrating sustained improvements in patient outcomes, staff experience, operational performance or wider system effectiveness. Further assurance is required regarding programme evaluation, patient harm reduction, organisational learning, workforce competency in practice and measurable improvements in data quality.

Delayed handovers remain the most significant assurance challenge. Although the Trust provided evidence of improvements in handover performance, alternative pathway development and patient flow initiatives, the risk associated with delayed emergency department handovers continues to be assessed by the Trust at its highest level. This limits the level of assurance that can currently be derived from the improvements described. Assurance is also constrained by the limited evidence available regarding the contribution of health boards and wider system partners to improving patient flow across Wales.

Overall, we conclude that the Trust has made positive progress since our previous reviews and is in a materially stronger position than that described in 2020 and 2021.

However, further evidence is required before a higher level of assurance can be provided regarding the effectiveness, sustainability and whole-system impact of improvements. In particular, further assurance is required regarding the sustained impact of major transformation programmes, reductions in patient harm associated with delayed handovers, shared accountability across the urgent and emergency care system, operational compliance, organisational learning and measurable improvements in data quality.

This report makes eight recommendations requiring a formal Trust response. These recommendations focus on evaluation of major improvement programmes, system-wide accountability, demonstration of reduced patient harm, operational compliance, communication with patients, organisational learning, workforce competency and data quality. The recommendations are set out in the improvement plan.

3. What we found

This report sets out our assessment of Welsh Ambulance Services University NHS Trust's progress in addressing the findings and recommendations from HIW's 2020 and 2021 reviews. It considers the Trust's 2026 response and the evidence submitted to support it. The purpose of the report is to provide a balanced view of how far improvements have been implemented, embedded and sustained, while identifying noteworthy practice, remaining assurance gaps, and recommendations for further improvement.

The 2020 review focused on how patients were managed by Emergency Medical Service Clinical Contact Centres (EMSCCCs) from the point at which a 999-emergency call was received until an ambulance arrived. HIW considered patient management, workforce, and governance arrangements supporting quality and patient safety. The review identified that systems and processes were in place to provide safe and effective care, but that staff were working in a demanding and stressful environment affected by workforce capacity, resource constraints, delayed handovers, training gaps, senior leadership visibility concerns, and inconsistent incident reporting.

The 2021 review focused on patients waiting in ambulances outside Emergency Departments (EDs) during delayed handovers. It found that prolonged handover delays were a regular occurrence across Wales and were affecting patient safety, privacy, dignity, patient experience, and ambulance availability. The review also identified variation in handover processes, uncertainty over accountability for patient care, a need for stronger escalation processes, workforce support, and more effective governance and learning arrangements.

We did not review each recommendation separately. Instead, we used the findings and recommendations from the 2020 and 2021 reviews, alongside current HIW intelligence, to identify common themes and areas of continuing assurance interest. This allowed us to assess progress in a more integrated way.

The Trust's 2026 response set out its position across five requested themes: patient flow and handover processes; escalation processes; communication with patients and Non-Emergency Patient Transport Service (NEPTS) cancellations; leadership; governance; workforce and learning culture; and data quality and accurate recording. We assessed the evidence submitted against these themes and considered whether it demonstrated implementation, embedding, effectiveness and sustainability.

Our assessment distinguishes between evidence that arrangements exist and that those arrangements are making a measurable difference. Governance frameworks, policies, dashboards, training programmes, and escalation protocols are important, but they do not, by themselves, demonstrate effectiveness or sustained improvement.

Throughout this report, we therefore consider both the presence of improvement

activity and the strength of evidence demonstrating its impact.

Theme 1: Patient flow, handover, crew release and pathways

Previous HIW findings

The 2020 review identified delayed hospital handovers as a major factor affecting the Trust's ability to respond to patients waiting in the community. Staff consistently described handover delays as the root cause of limited ambulance availability, call waiting queue backlogs and increased waits for emergency ambulance responses. The review reported that almost 9,000 ambulance hours per month were lost during 2019 because of hospital handover delays, with 13,821 hours lost in December 2019 alone.

The 2021 review confirmed that delayed handovers remained a serious system-wide concern. It found that prolonged handovers were affecting patient safety, privacy, dignity and experience, and reducing the Trust's ability to coordinate timely responses for patients waiting in the community. It also identified inconsistent handover processes, variation between sites, and uncertainty among staff regarding responsibility and accountability for patients during delayed handovers.

The significance of these findings is that handover delays create risk at multiple points in the urgent and emergency care pathway. They affect patients already waiting outside EDs, they reduce ambulance availability, and they increase pressure on EMSCCCs and crews managing patients waiting in the community.

What the Trust has implemented

The Trust's response demonstrates that it has implemented a wide range of initiatives intended to address these issues. The Trust describes a deliberate move away from viewing handover delays solely as a hospital handover issue and towards a broader whole-system patient flow approach. This includes Clinical Model Transformation, Welsh Government Ambulance Performance Framework pilot work, test-of-change initiatives with health boards, IMTP actions and responses to Audit Wales recommendations. Oversight of these pressures is supported through Board Assurance Framework Risks 223 and 224. Risk 223 relates to ambulance response capability and access to patients waiting in the community, whilst Risk 224 relates to delayed handovers at EDs.

The Trust also describes strengthened handover guidance and escalation arrangements. These include Immediate Release Protocols, Regional Escalation Protocols, Resource Escalation Action Plan (REAP), Clinical Safety Plans, daily huddles, national escalation calls, shift reports, command oversight, and Electronic Patient Care Record (ePCR) documentation. These arrangements indicate a stronger governance and operational framework than was evident in either the 2020 or 2021 reviews.

Evidence of progress

The Trust's evidence includes reference to the Integrated Quality and Performance Dashboard for December 2025, and states that November 2025 recorded the lowest handover lost hours in four years, alongside improvements in average handover times in many acute hospitals. The Clinical Model Transformation scorecard also showed increased consult-and-close rates and increased remote clinical decision-making. Supporting evidence submitted by the Trust described increased remote clinical assessment activity and more incidents being resolved without an ED outcome. The Trust also reported that the removal of the previous "No Send/ Can't Send" outcome category was intended to provide greater clinical oversight of these decisions and influence a reduction in ED walk-in activity.

The Trust's investment in Advanced Paramedic Practitioners (APPs) is particularly noteworthy. Its 2025 data showed that APPs conveyed 35.5% of patients to EDs compared with 67% for standard paramedics. Advanced Paramedic Practitioner Navigation (APPNAV) conveyance was reported as 38.1%. This is among the strongest outcome evidence submitted because it demonstrates a measurable difference in conveyance outcomes and supports the case that APP models may reduce unnecessary ED conveyance.

The introduction of Clinical Navigators and Remote Integrated Care also responds directly to concerns from the 2020 review about access to clinical support within EMSCCCs. The Trust reports that Clinical Navigators have streamed 57% of incidents to remote clinical assessment pathways. This demonstrates that the model is being used and that more clinical decision-making is being brought earlier into the pathway.

These developments demonstrate a more sophisticated operational model than was evident in the previous reviews. The Trust has strengthened clinical decision-making, introduced more structured operational oversight and developed alternatives to traditional ambulance dispatch and ED conveyance.

Assurance limitations

Despite this progress, important assurance gaps remain. The Trust has not provided formal evaluation reports demonstrating which interventions have caused the reported improvements or whether those improvements are sustainable. This matters because Clinical Model Transformation, Clinical Navigators, Remote Integrated Care and APP models are central to the Trust's improvement narrative, but their specific impact on delayed handovers, patient flow, ambulance availability, and patient outcomes has not yet been fully evidenced.

Risk 224 remains scored at 25, indicating that delayed handovers remain a significant unresolved system risk. We found that the continued presence of this risk at the highest possible rating limits the assurance that can be derived from the improvements described. Whilst the Trust has strengthened controls and implemented mitigation

measures, the evidence provided does not yet demonstrate that the underlying risk associated with prolonged handovers has reduced sufficiently to indicate sustained system-wide improvement.

There is also a tension between reported operational improvements and the continued maximum risk score. If handover lost hours and average handover times have improved, but the principal handover risk remains at the highest rating, further explanation is required. We expect the Trust to consider whether the risk score reflects ongoing system fragility, variation between sites, risk of deterioration during escalation, or limited confidence that improvements are sustainable.

Further evidence is also required to demonstrate whether patient harm associated with delayed handovers has reduced. The evidence submitted provides assurance that the Trust has implemented controls and monitoring arrangements, but it does not yet provide sufficient outcome evidence showing reduced harm, sustained patient safety improvement, or measurable whole-system impact.

We also found that assurance on the effectiveness and sustainability of handover improvements is restricted by the limited evidence available from health boards. Many of the improvements described by the Trust depend on wider system action, including patient flow, ED capacity, timely handover, immediate release arrangements, alternative pathway availability, and escalation processes. Delayed handovers therefore cannot be assessed as a Trust only improvement issue.

There is also insufficient evidence demonstrating that frontline staff consistently understand and apply handover guidance and SOPs across all sites. The Trust has described policies and frameworks, but the evidence does not sufficiently demonstrate workforce-wide training, competency assessment, compliance audit, or point-of-care evidence showing consistent application during periods of operational pressure.

HIW assessment

Overall, we found that the Trust has made substantial progress in strengthening its approach to patient flow, delayed handovers, alternative pathways and operational oversight. The evidence demonstrates a more mature and integrated approach than was evident during our previous reviews, including strengthened governance arrangements, improved clinical decision-making, increased use of alternative pathways and enhanced oversight of operational pressures.

We found evidence that several improvement initiatives have been implemented and embedded within routine operational and governance arrangements. Positive examples include the development of APP and APPNAV models, the introduction of Clinical Navigators and Remote Integrated Care, strengthened escalation and handover arrangements, and increased organisational focus on whole-system patient flow. The evidence submitted also demonstrates some measurable improvements, including reduced conveyance rates through advanced clinical pathways and reported

reductions in handover lost hours.

However, whilst implementation is generally well evidenced, the Trust has not yet provided sufficient information demonstrating the effectiveness, sustainability and impact of many of these initiatives. In particular, evidence remains limited regarding the specific contribution that major transformation programmes have made to reducing delayed handovers, improving ambulance availability, reducing patient harm and delivering sustained system-wide improvement.

These limitations mean that, while the Trust has demonstrated extensive mitigation activity and some reported operational improvement, the evidence does not yet provide sufficient assurance that the underlying strategic risk associated with delayed handovers has reduced.

Overall, we conclude that the Trust is in a stronger position than at the time of our previous reviews in relation to patient flow, delayed handovers and alternative pathways. However, further assurance is required before higher levels of assurance can be provided regarding the effectiveness, sustainability and whole-system impact of the improvements described.

Theme 2: Escalation processes

Previous HIW findings

The 2020 review identified concerns about the consistency of REAP and Demand Management Plan escalation arrangements. Staff reported that escalation and de-escalation levels were not always applied consistently and that the rationale for escalation decisions was not always clear. The review also found that senior managers did not routinely attend EMSCCCs as directed within escalation processes, particularly out of hours.

These findings were important because escalation processes are central to managing demand, clinical risk, and operational pressure. Inconsistent escalation can affect the timeliness of decision-making, clarity of responsibilities and the ability of staff to respond effectively during periods of high demand.

What the Trust has implemented

The Trust's response indicates that escalation arrangements have been strengthened significantly. The Trust reports that escalation processes are now set out in SOPs and operational policies, with defined escalation triggers, roles and responsibilities, and clinical and operational decision-making routes. Oversight has also been strengthened through a revised EMS Coordination Management model. In addition, the Trust has introduced an Operations Manager role providing national performance and escalation monitoring.

The Trust has also provided escalation documentation, including the EMS Clinical

Incident Response SOP, EMS Coordination Business Continuity Plan, Quality Meeting Highlight Reports, and the Trust's Incident Response Plan. These documents show that escalation arrangements are described and monitored through governance processes.

Evidence of progress

We found positive evidence in relation to Clinical Navigators. The Clinical Navigator Quality Assurance Framework provides structured training, induction, and ongoing audit, including checks on escalation-related decision-making. It includes monthly audits, deviation scoring, and feedback processes. This is a stronger quality assurance model than was evident at the time of the 2020 review and provides a positive example of how the Trust checks whether escalation decisions are being made appropriately within a defined staff group.

The Clinical Navigator model therefore provides a clearer line of sight between training, audit, feedback, and practice for one important staff group. This is positive because it moves beyond policy description and provides some evidence of quality assurance in practice.

Assurance limitations

The evidence is stronger for Clinical Navigators than for other EMSCCC staff groups. We found limited evidence of formal training completion records, competency sign-off or workforce-wide assessment of escalation understanding for call handlers, dispatch staff, and supervisors. The quality assurance reports, complaint investigations, incident reviews and audit activity submitted by the Trust continue to identify issues relating to call prioritisation, coding accuracy, protocol compliance and the consistent application of operational processes. These findings indicate that variation in understanding and application remains and support the need for continued assurance and improvement activity.

The quality assurance model is also weighted towards retrospective review. The Trust describes call reviews, case audits, incident investigations, and Datix reporting, but there is limited evidence of proactive escalation-specific audits that assess whether escalation processes are followed consistently in day-to-day operations. While the Trust has implemented arrangements to address the wider operational incident backlog, the scale of unresolved incidents may limit the timeliness of assurance, investigation and organisational learning.

HIW assessment

Overall, we found that the Trust has made positive progress in strengthening escalation arrangements since our 2020 review. The evidence demonstrates that escalation processes are now supported by clearer governance arrangements, defined operational frameworks, documented procedures and strengthened management oversight. The revised EMS coordination management structure and introduction of enhanced escalation monitoring arrangements provide a more robust framework than

was evident at the time of our previous review.

We also found positive evidence that aspects of the escalation process are subject to quality assurance and oversight, particularly through the Clinical Navigator Quality Assurance Framework.

However, the evidence submitted was stronger for Clinical Navigators than for the wider EMSCCC workforce. Further assurance is required to demonstrate consistent understanding and application of escalation processes across call handlers, dispatch staff and supervisors, and to show that proactive assurance arrangements are routinely testing practice during day-to-day operations.

Overall, we conclude that escalation arrangements have improved significantly and are supported by stronger governance and assurance structures than were evident in 2020. However, further assurance is required to demonstrate consistent workforce-wide understanding, competency in practice, and that learning from escalation issues is effectively shared and embedded.

Theme 3: Patient communication and NEPTS cancellations

Communication with patients during delays

Communication with patients during delays is a key patient experience and dignity issue. Our 2020 review highlighted concerns regarding welfare check calls, including the difficulty staff experienced in maintaining timely welfare checks during periods of high demand and the frustration caused when staff were unable to provide clear expected arrival times. Our 2021 review also found that delayed handovers affected patient experience, including access to basic needs, dignity and communication during prolonged waits.

The Trust's response describes a framework for communicating with patients during delays. This includes expected time of arrival scripts, policy standards, clinical and operational guidance, media statements, operational oversight arrangements and the use of patient experience feedback, complaints, incidents, Duty of Candour processes and staff feedback to inform learning and improvement. This demonstrates that the Trust recognises communication as an important component of quality, safety, dignity and patient experience.

Assurance limitations

At the time of our assessment, we found that the evidence available provided greater assurance regarding the existence of communication processes, governance arrangements and oversight mechanisms than their effectiveness in practice. Whilst the Trust described the arrangements in place, we found limited evidence demonstrating whether communication was consistently improving patient experience during periods of delay and operational pressure.

Since completion of our assessment, the Trust has provided additional evidence through its Improvement Plan, including patient experience survey findings, quality audit activity, governance reporting, compliments analysis and patient feedback. This evidence provides positive indicators relating to dignity, involvement in care and the provision of information to patients and demonstrates that communication arrangements are subject to routine monitoring and review.

Whilst this additional evidence provides further assurance, continued monitoring and evaluation will remain important to demonstrate the consistency and effectiveness of communication arrangements during periods of prolonged delay and significant operational pressure. Given the findings of previous HIW reviews regarding the impact of delays on patient experience, dignity and wellbeing, any future assurance should continue to focus on demonstrating sustained improvements in patient experience and communication outcomes.

Non-Emergency Patient Transport Service cancellations

The evidence relating to NEPTS is stronger. The Trust reported that during 2025, the service completed 552,602 journeys and recorded 169,895 cancellations. The Trust advised that most of these cancellations occurred before the service planning process commenced, most commonly because appointments had changed, been cancelled, or transport was no longer required. Of the 63,368 journeys cancelled within four hours of the planned appointment time, the majority were cancelled by hospitals or patients. A further 29,434 journeys were cancelled under the Trust's Capacity Management Plan where demand exceeded available capacity. The Trust also noted that journey numbers do not directly equate to individual patients as most patients have both inbound and outbound journey bookings. The Trust described daily, weekly, directorate and Board-level monitoring of cancellation performance.

We found that the Trust demonstrated a clear understanding of the capacity challenges affecting NEPTS. The evidence submitted identified pressures associated not only with increasing activity levels but also increasing service complexity. These include longer journeys, higher acuity patients, reduced volunteer driver availability, increased reliance on specialist ambulance provision for renal services and increased mileage associated with oncology and outpatient services.

The Trust also provided evidence of improvements in several timeliness measures, including inward outpatient, oncology and renal performance. In addition, the Trust described several mitigation measures, including text confirmation systems, improved booking and cancellation processes, enhanced patient communications, system integration, roster review, volunteer driver recruitment and journey planning improvements.

However, despite these actions, cancellation levels remain significant and capacity remains insufficient to meet current levels of demand. We found that many of the factors contributing to cancellations extend beyond the direct control of the Trust and

are likely to require commissioner, stakeholder and health board decisions regarding service capacity, eligibility criteria, service standards and investment.

HIW assessment

Overall, we found mixed levels of assurance across this theme. In relation to communication with patients during delays, the Trust has developed governance arrangements, guidance, communication processes and oversight mechanisms. At the time of the review, there was limited evidence demonstrating the effectiveness of these arrangements in practice. However, the additional evidence subsequently provided through the Trust's Improvement Plan, including patient experience survey findings, quality audit activity, governance reporting and patient feedback, provides further assurance regarding patient experience, including positive indicators relating to dignity, involvement and explanation. While this evidence is encouraging, continued monitoring will be important to demonstrate the consistency and effectiveness of communication arrangements during periods of delay and operational pressure.

In relation to NEPTS, the evidence is stronger. The Trust demonstrated a clear understanding of the challenges affecting service delivery and provided evidence of monitoring arrangements, mitigation measures and some measurable improvements in performance. We found that the Trust has taken a proactive approach to managing increasing demand and service complexity, although cancellation levels remain significant and capacity continues to represent an ongoing challenge.

Overall, we found that the Trust has demonstrated progress in its approach to patient communication and management of NEPTS pressures. The additional evidence provided through the Improvement Plan strengthens assurance regarding communication with patients, particularly in relation to patient experience monitoring and governance oversight. However, the Trust continues to face significant capacity challenges within NEPTS and further assurance will be required to demonstrate sustained improvements in patient experience, reductions in avoidable cancellations and the long-term effectiveness of improvement measures.

Theme 4: Leadership, governance, wellbeing and training

Leadership and governance

The 2020 review identified concerns about senior leadership visibility, communication, and engagement with operational staff. It found that 70% of EMSCCC survey respondents felt communication between senior management and operational staff was ineffective, and that staff felt concerns were not always heard, acknowledged, or addressed.

The Trust’s response demonstrates significant structural improvement. The Trust introduced a revised EMS Coordination career structure in November 2024, including

additional management posts. This includes the Band 7 Operations Manager role described earlier, together with Band 8a Locality Managers for each of the three coordination centres, providing strengthened operational leadership, escalation oversight and a clearer line of sight from Band 3 Call Handlers to Head of Service. The introduction of Clinical Navigators also provides improved 24/7 clinical leadership and supervision

These developments are noteworthy because they respond directly to previous HIW concerns regarding leadership presence and governance. The revised structure provides a stronger foundation for operational oversight, staff support and escalation. It also suggests the Trust has recognised that leadership presence must be built into routine operational arrangements rather than being dependent on ad hoc senior intervention.

However, we found that the evidence remains largely descriptive. The Trust has shown that leadership structures have changed but have not provided sufficient evidence demonstrating that these changes have improved staff experience, psychological safety, communication, operational decision-making, or governance risk. Future assurance should therefore assess the impact of these changes, not only their implementation.

Learning and staff feedback

The 2020 review identified that staff wanted more effective mechanisms to submit views and suggestions and receive feedback on the outcome. It also found concerns about incident reporting, including uncertainty about what should be reported, limited time to complete reports, and lack of feedback following Datix submissions.

The Trust now describes multiple mechanisms for staff feedback and organisational learning, including NHS Wales staff survey participation, pulse surveys, local engagement forums, social partnership arrangements, Quality Impact Assessments, and the Clinical Model Transformation programme. These mechanisms are supported by 'SimplyDo', Datix, Duty of Candour, and the Trust's Improvement Network and Quality Management Group oversight.

There are positive examples where the Trust reports that staff survey participation increased to 43.2% in 2025, compared with 35.2% in 2024 and 23.2% in 2023. It also describes how a 2025 cultural survey influenced the Clinical Model Transformation programme by leading to revisions in programme pace, role clarity, change management support and leadership expectations.

However, increased survey participation does not, by itself, demonstrate improved staff experience or psychological safety. It is encouraging because it may indicate greater engagement, but further evidence is required to show whether staff feedback has led to measurable change, whether staff confidence has improved, and whether concerns raised through feedback mechanisms are consistently acted on and closed.

We found that the evidence does not yet demonstrate that feedback loops are consistently closed. The Trust gathers feedback, but evidence is limited in showing what decisions were made as a result, what changed in practice, whether improvements were measured and whether they were sustained. This limits assurance that staff feedback is embedded into decision-making in a demonstrable and systematic way.

Duty of Candour, reporting and speaking up

The Trust has also described how Duty of Candour, Datix and 'Always On' reporting contribute to its wider learning arrangements. However, the evidence provided does not yet show clearly how learning from these routes is brought together, acted on and tracked through to improvement.

The Trust has strengthened speaking-up arrangements since the 2020 review. Staff can now raise concerns through line management, formal incident reporting, the Speaking Up Safely framework, Work in Confidence and other feedback routes. A full-time Lead Guardian was appointed in June 2024, and the Trust reported that 113 concerns were raised between July 2024 and June 2025. We found that this demonstrates staff are aware of, and are making use of, the available reporting mechanisms. The Trust also reported that an NHS Wales Shared Services Partnership audit confirmed strong governance, clear processes and the safe handling of concerns.

However, the number of concerns raised does not, by itself, provide assurance regarding the effectiveness of the speaking-up arrangements. The evidence submitted does not sufficiently demonstrate the nature of concerns raised, actions taken in response, lessons learned, or whether concerns resulted in measurable improvements. Further evidence is therefore required to demonstrate that speaking-up arrangements are contributing to a culture of openness, learning and psychological safety, and that concerns raised by staff lead to tangible and sustained improvement.

Workforce wellbeing

Workforce wellbeing is one of the stronger areas of evidence. The 2020 review identified sickness absence, stress, morale, and workforce capacity as key issues. At that time, EMSCCC sickness levels were around 10%, and staff described significant pressure arising from demand, handover delays, and staffing constraints.

The Trust's response describes a broader well-being framework. This includes occupational health support, resilience programmes, flexible working, psychological safety measures, trauma risk management, suicide risk training and employee assistance programme access. It also includes well-being drop-ins, stress and sleep workshops, People Networks and People and Culture Committee oversight.

The Trust also provided organisational workforce data demonstrating that sickness absence reduced from a peak of 12.5% in December 2021 to 9.26% in December 2025, with a low of 6.81% recorded in May 2025. Whilst these figures relate to the wider Trust

workforce rather than EMSCCC specifically and are therefore not directly comparable with the sickness absence levels reported in the 2020 EMSCCC review, they provide some evidence of improvement in organisational sickness absence over time.

However, the evidence does not clearly demonstrate which specific interventions contributed to the reduction in sickness absence, whether the improvements are sustained across all services and staff groups, or whether staff experience has improved alongside the reduction in absence.

Training and development

The Trust's response demonstrates considerable progress. It describes Board oversight of training, the 'Our Way' leadership framework, International Academies of Emergency Dispatch qualified instruction, Emergency Medical Dispatcher certification, structured induction, and mentorship and call signoffs. It also describes remote integrated care induction, Datix and complaints training, mandatory in-service training, ESR tracking, continuing professional development and regulated qualifications. The Trust also noted that mandatory in-service training achieved reasonable assurance in audit.

This represents a significant maturation of training infrastructure since the 2020 review. However, we found that the evidence demonstrates training availability, attendance, and governance more clearly than competency in practice. Further assurance should show whether staff consistently apply training during prolonged handover care, escalation, risk documentation, and incident reporting.

HIW assessment

Overall, we found substantial evidence of progress across leadership, governance, organisational learning, workforce wellbeing, speaking-up arrangements and training. The Trust has invested in leadership capacity, while also expanding mechanisms for staff engagement, feedback, and speaking up. In addition, the Trust has broadened wellbeing support and developed a more comprehensive training and development infrastructure to support staff across the organisation. Taken together, these developments represent a more mature governance and workforce support framework than was described in our 2020 review.

However, the evidence submitted remains stronger in demonstrating that arrangements exist than in demonstrating their effectiveness and impact. Across several areas, including leadership visibility, organisational learning, speaking-up arrangements, psychological safety and workforce development, the Trust has not yet provided sufficient evidence demonstrating how these initiatives have improved staff experience, organisational culture, competency in practice or learning outcomes.

Overall, we found that the Trust has made significant progress in addressing many of the workforce and governance concerns identified in previous HIW reviews. Future assurance should focus on measurable impact, closed-loop learning, improved staff experience and evidence that workforce development and wellbeing initiatives are

translating into sustained changes in practice and organisational culture.

Theme 5: Data quality and accurate recording

Previous HIW findings and Trust response

Accurate data is essential for assurance ratings, performance monitoring, service planning, patient safety, and Welsh Government reporting. The 2021 review identified concerns regarding accurate recording of handover times through dual-PIN processes. The Trust's response demonstrates a strengthened approach to digital governance and data quality.

The Trust describes a refreshed Digital Plan for 2024–2029 and expansion of the Data Quality Assurance Team from 0.6 to 2.6 whole time equivalent. It also describes a bespoke e-learning module, data quality metrics, and reporting through the Information Governance Steering Group and the Information Asset Management Group. In addition, the Trust describes ePCR and continued use of the dual-PIN process.

These developments provide a stronger foundation for future assurance than was evident in the earlier reviews.

Assurance limitations

We found limited evidence demonstrating measurable improvement. The Trust did not provide sufficient ePCR audit results, trend data, dual-PIN compliance reporting, site-level variation analysis or examples of data quality issues being identified, corrected, and prevented from recurring.

This is important because the quality of data underpins assurance on handover performance, ambulance availability, patient safety, Welsh Government reporting and operational decision-making. The Trust has described the governance arrangements intended to improve data quality, and several assurance mechanisms are already in place. However, the evidence does not clearly demonstrate that these arrangements are consistently producing accurate, complete, and timely data in practice.

HIW assessment

Overall, we found that the Trust has made positive progress in strengthening its approach to data quality and digital governance. The refreshed Digital Plan, expansion of dedicated data quality capacity and oversight through established committee structures demonstrate increased organisational focus on data quality as both a governance and patient safety issue. This represents a more mature approach than was evident during our previous review and provides a stronger foundation for assurance, performance monitoring, service planning and reporting.

However, whilst the Trust has demonstrated that governance arrangements, oversight mechanisms and improvement initiatives are in place, the evidence submitted was less

effective in demonstrating measurable improvements in data quality outcomes. In particular, we found limited evidence relating to ePCR audit findings, trends in data quality performance, dual-PIN compliance, site-level variation and examples showing how data quality issues are identified, addressed and prevented from recurring.

Accurate and reliable data is fundamental to assurance regarding handover performance, ambulance availability, patient safety and wider service performance. Future assurance should therefore focus on demonstrating measurable improvements in data integrity and providing evidence that data quality improvements are supporting operational decision-making, service planning and organisational learning.

4. Conclusion and next steps

Having considered the evidence submitted by the Trust and supporting documentation, we found that it has made substantial progress in responding to the findings and recommendations arising from our 2020 and 2021 reviews. It is therefore in a materially stronger position than that described in those reviews.

The evidence demonstrates that the Trust has introduced a wide range of governance, operational, workforce, clinical and digital improvements. Many of these improvements appear to be embedded within routine organisational structures, governance processes and operational practice. We found evidence that clinical decision-making arrangements had improved, supported by stronger escalation processes and increased operational oversight. Leadership arrangements had also been strengthened, together with broader workforce wellbeing support and enhanced speaking-up arrangements. Improvements were also evident in training and development infrastructure, digital governance, and data quality management.

A particular strength of the Trust's response is that many improvements are not presented as isolated or short-term actions. They appear to form part of wider organisational arrangements for governance, operational oversight and assurance. This suggests that the Trust has responded positively and constructively to many of the concerns raised in HIW's previous reviews.

However, the central limitation in the evidence remains the distinction between implementation and impact. Across several themes, the Trust has provided stronger evidence that arrangements, policies, monitoring processes and improvement programmes are in place, than evidence that these arrangements are consistently improving outcomes for patients, staff and the wider urgent and emergency care system. In particular, further assurance is required regarding the effectiveness and sustainability of major transformation programmes, reductions in patient harm associated with delayed handovers, communication with patients during delays, organisational learning, workforce competency in practice, and measurable improvements in data quality.

Overall, we conclude that the Trust has made significant progress and is in a materially stronger position than at the time of our previous reviews. Whilst we found evidence that many improvements have been implemented and embedded, further assurance is required regarding their effectiveness, sustainability and impact. In particular, delayed handovers remain a significant system challenge and continue to limit the level of assurance that can currently be provided.

Areas of noteworthy practice

During this assessment we identified several areas of noteworthy practice which demonstrate meaningful organisational progress since our previous reviews.

Advanced Paramedic Practitioner and APPNAV models

Evidence submitted by the Trust demonstrated substantially lower rates of ED conveyance for patients managed through APP and APPNAV pathways when compared with standard paramedic practice. This was among the strongest outcome evidence submitted during the assessment and demonstrates the potential value of advanced clinical decision-making and alternative care pathways.

Clinical Navigators

The Clinical Navigator model responds directly to concerns identified during our 2020 review regarding access to clinical support within EMSCCCs. The model supports earlier clinical assessment, improved decision-making and increased use of alternative pathways.

Operational Delivery Unit

The Operational Delivery Unit provides structured operational oversight of delayed handovers, ambulance availability, escalation arrangements and wider system pressures. It is a significant component of the Trust's operational management framework.

Leadership and operational oversight

The revised EMS coordination leadership structure provides improved operational leadership, local accountability and management support, and addresses concerns identified during our previous reviews regarding leadership visibility and engagement.

Workforce wellbeing and speaking-up arrangements

The Trust has expanded wellbeing services and strengthened its speaking-up arrangements through the introduction of a full-time Lead Guardian and multiple reporting mechanisms. These developments demonstrate a clear organisational commitment towards staff wellbeing, openness and psychological safety.

Training and development infrastructure

The Trust has significantly strengthened its training and development framework through structured induction arrangements, leadership development programmes, improved governance oversight and monitored compliance arrangements.

Digital governance and data quality arrangements

Investment in digital governance and expansion of dedicated data quality capacity provides a stronger foundation for future assurance activity and service planning.

Next steps

The recommendations arising from this assessment focus on the next phase of improvement. These are highlighted in appendix A. They are intended to move the Trust beyond demonstrating that arrangements have been implemented, towards

demonstrating measurable impact, sustained improvement and stronger evidence of outcomes.

The Trust is required to provide a formal response to the recommendations set out in the improvement plan. The response should identify the actions to be taken, intended outcomes, responsible leads, implementation timescales, and how completion and impact will be measured and evidenced.

HIW will consider the Trust's response and supporting evidence as part of its ongoing assurance activity and future engagement with the Trust. The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Recommendations

Recommendations:
Recommendation 1: Evaluate major improvement programmes The Trust should formally evaluate major improvement programmes, including Clinical Model Transformation, Clinical Navigators, Remote Integrated Care, APP and APPNAV models, and alternative pathway initiatives.
Recommendation 2: Strengthen whole-system accountability for delayed handovers The Trust should work with health boards, system partners and commissioners to demonstrate shared accountability for delayed handovers, patient flow, and ambulance release across Wales.
Recommendation 3: Demonstrate reduction in patient harm associated with delayed handovers The Trust should provide clearer evidence that mitigation activity is reducing patient harm associated with delayed handovers and prolonged ambulance waits.
Recommendation 4: Assure consistent operational compliance with handover and escalation procedures The Trust should strengthen assurance that handover guidance, local SOPs, immediate Release arrangements, escalation processes and related operational procedures are consistently understood and applied across all relevant staff groups and sites.
Recommendation 5: Improve assurance on communication with patients during delays The Trust should provide stronger assurance that patients receive timely, clear, and consistent communication during delays, including during periods of operational pressure.
Recommendation 6: Strengthen organisational learning and closed feedback loops The Trust should demonstrate how learning from incidents, Duty of Candour cases, speaking-up concerns, staff feedback and ‘Always On’ reporting leads to action, measurable improvement, and sustained change.

Recommendation 7: Demonstrate staff competency and behavioural change from training The Trust should strengthen evidence that training and development programmes are resulting in consistent competencies and behavioural change in practice, particularly in prolonged handover care, escalation, incident reporting, and EMSCCC risk documentation.
Recommendation 8: Demonstrate measurable improvement in data quality The Trust should provide measurable evidence of improvement in data quality, including ePCR completeness, timeliness and accuracy, dual-PIN compliance, site-level variation, and data quality corrective action.