

Bundle People and Culture (Open Session) 5 September 2022

Agenda attachments

ITEM 0 - PCC Agenda 05 Sept 2022.docx

- 1 09:30 - Chair's welcome, apologies, and confirmation of quorum - PH
- 2 09:31 - Declarations of interest - PH
- 3 09:32 - Minutes of last meeting - PH
ITEM 3 OPEN P and C mins 10 May 2022.docx
- 4 09:34 - Action log - PH
ITEM 4 - Public People and Culture Action and Decisions Log.xlsx
- 5 09:35 - Director of Workforce and OD Update - CG
ITEM 5 Director Update - PCC - 05.09.22.pptx
- 6 09:45 - Operations Quarterly Report - LB
ITEM 6 Ops Directorate Quarterly Report for Committees 22-23 Q1 (Jul22) FINAL.pdf
- 7 09:55 - Staff Story – Violence & Aggression - CG
- 8 10:15 - Corporate Risk Register/ Board Assurance Framework - JB
ITEM 8 Executive Summary Risk Management Report PCC 050922.docx
- 9 10:25 - Improving Attendance Project Progress Update - LR
ITEM 9. Improving Attendance Report September 2022.docx
ITEM 9.1 - Appendix 1 - Improving Attendance PC Committee 05.09.22.pdf
ITEM 9.2 Appendix 2 - Managing Attendance Plan July 2022 Summary.docx
- 9.1 10:45 - Comfort Break
- 10 10:55 - Health & Safety Update including Annual Report - LW
ITEM 10 Executive Summary HS Annual Report PCC 2021-2022 V2.docx
- 11 11:07 - Monthly Integrated Quality and Performance Report - HB
ITEM 11 MIQPR SBAR PCC July 2022.docx FINAL.docx
ITEM 11.1 Annex 1 MIQPR July 2022 Updated 15.08.22.pptx FINAL.pdf
ITEM 11.2 Appendix 2 - Staff Wellbeing Deep Dive to PCC_.pptx FINAL.pdf
- 12 11:19 - Workforce Performance Scorecard Report - LR
ITEM 12. Workforce Performance Scorecard.docx
ITEM 12.1 Appendix 1b - Workforce KPIs July 2022.xlsx
ITEM 12.2 Appendix 2 - Personal Appraisal Development Review.pdf
- 13 11:29 - Cycle of Committee Business and Committee priorities - TM
ITEM 13 SBAR for PCC on Cycles of Business - Sept 22.docx
ITEM 13.1 P&C Cycle of Business 2022-23 - V0.4.xlsx
ITEM 13.2 PCC Committee Priorities September 22.docx
- 14 11:41 - Welsh Language Annual Report - TM
ITEM 14 SBAR Welsh Language Standards Annual Report 2021-22.docx
ITEM 14.1 Adroddiad Safonau'r Gymraeg 2021-22.pdf
ITEM 14.2 Welsh Language Standards Annual Report 2021-22.pdf
- 15 11:51 - Amended Pay Progression Policy - LR
ITEM 15 ES Pay Progression Policy- amended June 2022 - 03_08_22.docx
ITEM 15.1 Appendix 1 a NHS Wales Pay Progression Policy Updated 30.05.2022.pdf
ITEM 15.2 Appendix 1b Welsh- NHS Wales Pay Progression Policy Updated 30.05.2022.pdf
- 15.1 11:56 - Comfort Break
- 16 Internal Audit Report -JB
ITEM 16 Executive Summary PCC - Internal Audit Report 050922.docx

- 16.1 12:06 - Internal Audit tracker - JB
- 16.2 12:09 - Recruitment Practices - JB
ITEM 16.2 Recruitment Practices_Final Internal Audit Report.pdf
- 16.3 12:11 - Learning organisation advisory audit - CG
ITEM 16.3 WAST_2122-19_Learning Organisation_Final Internal Audit Report for client issue.pdf
- 16.4 12:16 - Driving Licence Assurance Report - CG
ITEM 16.4 PCC Assurance Report - Driving Licence Audit.docx
ITEM 16.4a - Appendix 2 WAST_1920_Drivers Medicals_Final Internal Audit Report_for client issue.docx
ITEM 16.4b Appendix 3 - WAST_202021-33_Follow Up Review_Final Internal Audit Report_for Trust issue.pdf
- 17 12:21 - Seasonal Influenza Campaign and End of Season Flu Report 2021-22 - AS
ITEM 17 Seasonal Influenza Campaign SBAR Final for PCC 05.09.22.docx
ITEM 17.1 End of Season Flu Report 21-22 Final Draft.pdf
- 18 12:31 - Raising Concerns Framework - TM
ITEM 18 SBAR for PCC on Raising Concerns - Sept 22.docx
- 19 12:41 - WASPT Advisory Group Update - TM
- 20 12:51 - Minutes of Sub-Groups - SESG, Diversity and Inclusion Steering Group
ITEM 20 EDISG Minutes (updated) 06.07.22.docx
- 21 12:56 - Issues to be raised at Board - PH
- 22 12:58 - Any other business - PH
- 23 13:00 - Date of next meeting - 29 November 2022



MEETING OF THE PEOPLE AND CULTURE COMMITTEE

Held on 05 September 2022 from 09.30 to 13.30

Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Paul Hollard	Verbal	5 mins
2.	Declarations of interest	Information	Paul Hollard	Verbal	
3.	Minutes of last meeting	Approval	Paul Hollard	Paper	
4.	Action log	Review	Paul Hollard	Paper	
5.	Director of Workforce and OD Update	Information	Catherine Goodwin	Paper	10 mins
6.	Operations Quarterly Report	Information	Lee Brooks	Paper	10 mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
7.	Staff Story – Violence & Aggression	Discussion	Catherine Goodwin	Verbal	20 mins
8.	Corporate Risk Register/ Board Assurance Framework	Assurance	Julie Boalch	Paper	10 mins
9.	Improving Attendance Project Progress Update	Assurance	Liz Rogers	Paper	20 mins
COMFORT BREAK – 10 MINS					
10.	Health & Safety Update including Annual Report	Assurance	Liam Williams	Paper	12 mins
11.	Monthly Integrated Quality and Performance Report	Assurance	Hugh Bennett	Paper	12 mins
12.	Workforce Performance Scorecard Report	Assurance	Liz Rogers	Paper	10 mins
13.	Cycle of Committee Business and Committee priorities	Approval & Assurance	Trish Mills	Paper	12 mins
14.	Welsh Language Annual Report	Approval	Trish Mills	Paper	10 mins
15.	Amended Pay Progression Policy	Approval	Liz Rogers	Paper	5 mins
COMFORT BREAK – 10 MINS					
16.	Internal Audit Report 16.1. Internal Audit tracker 16.2. Recruitment Practices 16.3. Learning organisation advisory audit 16.4. Driving Licence Assurance Report	Discussion Assurance	Julie Boalch/ Catherine Goodwin	Paper	15 mins



17.	Seasonal Influenza Campaign and End of Season Flu Report 2021-22	Discussion	Andy Swinburn	Paper	10 mins
18.	Raising Concerns Framework	Discussion Assurance	Trish Mills	Paper	10 mins

CONSENT ITEMS

The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.

19.	WASPT Advisory Group Update	Information	Trish Mills	Verbal	10 mins
20.	Minutes of Sub-Groups 20.1. SESG 20.2. Diversity and Inclusion Steering Group	Information	C. Goodwin	Paper	5 mins

CLOSING ITEMS

21.	Issues to be raised at Board	Discussion	Paul Hollard	Verbal	5 mins
22.	Any other business	Discussion	Paul Hollard	Verbal	
23.	Date and time of next meeting 29 November 2022	Information	Paul Hollard	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Alex Crawford	Assistant Director of Planning
Catherine Goodwin	Interim Director of Workforce & OD
Paul Hollard	Committee Chair and Non Executive Director
Liz Rogers	Deputy Director of Workforce & OD
Trish Mills	Board Secretary
Andy Swinburn	Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing

**UNCONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE
 MEETING (OPEN SESSION) HELD REMOTELY VIA MICROSOFT TEAMS ON
 10 May 2022**

Chair: Paul Hollard

PRESENT:

Paul Hollard	Non Executive Director and Chair
Hugh Bennett	Assistant Director, Commissioning & Performance
Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Director of Operations
Craig Brown	Trade Union Partner
Andrew Challenger	Assistant Director, Professional Education & Training
Sarah Davies	Workforce and OD Business Manager
Bethan Evans	Non Executive Director
Dr Catherine Goodwin	Deputy Director of Workforce and OD
Wendy Herbert	Assistant Director of Quality & Nursing
Estelle Hitchon	Director of Partnerships and Engagement
Melfyn Hughes	Welsh Language Officer
Ian James	Trade Union Partner
Paula Jeffery	Regional Clinical Lead
Fflur Jones	External Audit
Jo Kelso	National Ambulance Training College
Trish Mills	Board Secretary
Donna Morgan	Principal Auditor, NWSSP
Lisa O'Sullivan	Senior Paramedic (Staff Story)
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Angela Roberts	Trade Union Partner
Liz Rogers	Organisational Culture & Workplace Wellbeing Lead
Hannah Rowan	Non Executive Director
Paul Seppman	Trade Union Partner
Joga Singh	Non Executive Director
Andy Swinburn	Associate Director of Paramedicine
Chris Turley	Director of Finance and Corporate Resources

APOLOGIES:

Rachel Marsh	Executive Director of Strategy and Planning
Bethan Evans	Non Executive Director
Jeff Prescott	Corporate Governance Officer
Alex Crawford	Assistant Director of Planning

22/22 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed all to the meeting of the People and Culture Committee and advised that the meeting was being audio recorded. Apologies were recorded from Rachel Marsh, Bethan Evans, Jeff Prescott and Alex Crawford.

23/22 DECLARATIONS OF INTEREST

No new declarations were made in addition to the standing declarations which were already noted on the Trust register.

24/21 MINUTES OF PREVIOUS MEETING AND ACTION LOG

The Minutes of the Open meeting held on 22 February 2022 were considered and agreed as a correct record. The Action log was considered, reviewed and updated.

RESOLVED: That the Minutes of the meeting held on 22 February 2022 were AGREED.

25/22 DIRECTOR OF WORKFORCE & OD UPDATE

Dr Catherine Goodwin presented the Workforce and OD update and gave a brief overview on highlights within the Directorate. Dr Goodwin drew Members attention to the ongoing work and progress around the PADR process and also the very welcome investment in people services. Other highlights on the report included the behaviours launch, where the Trust had launched the new behaviours at the CEO Roadshows in March 2022, the Allyship programme, which Since its launch at Board Development Day in December 2020, had seen over 100 colleagues attend an Allyship Programme workshop and Occupational Health and Wellbeing, where the TRiM Lead had visited all A&E departments weekly in South Wales, helping Staff understand the Wellbeing offered within the Trust.

Finally, Members offered their congratulations and sincere thanks to Andrew Challenger, Assistant Director of Professional Education and Training, who would soon be retiring from the Trust after 35 years' service, with Jo Kelso taking over leadership of the Education and Training Team. Members noted and acknowledged the contributions and wealth of experience he had brought to the Education and Training department during his many years of service.

RESOLVED: That the update was NOTED.

26/22 OPERATIONS QUARTERLY REPORT

Lee Brooks introduced the Operations Quarterly Report as read and gave a brief overview and update on some of the main areas covered within the report. These included the welcome reduction from REAP 4, which after a month, had now gone to REAP 3 and while this was an easing of the pressure, it still represented significant strain upon the service.

Members attention was also drawn to the withdrawal of Military support, which the Trust had so far managed well with minimal impact upon resourcing. However, Covid related absences remained high and sickness rates, particularly in the EMS field were very high, with a clear trend toward lower resourcing at weekends do to these absences.

Other areas of note were the Training of CSD staff in the new Emergency Communication Nurse System (ECNS), which had commenced alongside other areas of the project. A go live date was being honed by the Project Board with a view to this happening during May.

Fianlly, the rept noted that Cardiff and Vale core 111 and '111 First' service had gone live on 16th March 2022. This marked the culmination of a six-year programme of roll out, as a result 111 was now live across Wales. This national platform provided the basis for 111 to continue towards the organisational ambition of 111 representing the 'Gateway to Care' in Wales.

Members received the report and queried how the roll out of the 111 service within the Cardiff and Vale Health Board area had gone in terms of teathing issues or technical problems. Lee Brooks confirmed that the roll out had gone well with no areas of concern or technical issues to report.

Members then commented on the high sickness absence rates, particularly in the EMS and CCC settings and observed that a deep dive into these absences may be required in order to better understand the reasons for the high rates compared to other areas of the Trust.

RESOLVED: That the update was NOTED.

27/22 STAFF STORY – SENIOR PARAMEDIC ROLE

Andy Swinburn introduced Lisa O'Sullivan, a Senior Paramedic (SP) based in the Cardiff and Vale locality. Lisa O'Sullivan talked to Members about her career in the Trust, the journey which had led to her becoming an SP and what the role meant to her.

Members heard about the typical working week for an SP and what that would generally entail, including some of the specialist skills that the SP's were able to offer to patients as well as when supporting colleagues. These included essential skills in cases of cardiac arrest, including CPR and intubation with figures showing that cardiac incidents attended by an SP had a Return of Spontaneous Circulation (RoSC) in 40% of cases compared with just 8.5% when an SP was not on scene.

Lisa O'Sullivan then spoke to Members about the challenges of the role and the way in which this impacted her directly, noting that sometimes she would be the only SP within the area, which could result in being asked travel relatively large distances, attend one critical incident after another.

Lisa O'Sullivan also informed Members that it was apparent that some staff within the Clinical Contact Centres did not fully understand the role of an SP, with some tasks being allocated to Duty Operations Managers when it would have been more suitable for it to be attended by an SP.

Members thanked Lisa O'Sullivan for discussing her experiences with the Committee and asked whether the current, lengthy handover delays were effecting her ability as an SP to offer effective clinical support to colleagues. Lisa O'Sullivan confirmed that the delays were a significant issue which meant that colleagues within her team were unable to attend as many calls as they would ideally like to. In turn, this reduced the opportunity for them to be observed and for them to receive clinical advice or feedback when dealing with patients.

RESOLVED: That the staff story was NOTED.

28/22 CORPORATE RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

Julie Boalch presented the Corporate Risk Register and Board Assurance Framework report as read, drawing out highlights for the Committees attention. The purpose of the report was to provide the Committee with an update in respect of the corporate risk activity since the previous meeting in February.

The report showed that there were 3 of 17 Corporate Risks currently assigned to the Committee for overview, namely Risk 160 – High Absence Rates, Risk 163 – Maintaining Strong and Effective Trade Union Partnerships and Risk 201 - Damage to Trust reputation following a loss of stakeholder confidence. Each of these 3 risks had been reviewed as part of the transformation programme of work and had been rearticulated and approved by the Executive Management Team.

Members were informed that two of the risks had increased in score since the last meeting. These were Risk 160 and Risk 163, with the latter being escalated to the Corporate Risk Register and subsequently, reported to the Trust Board.

Members received the report and welcomed the increase in score for Risk 160 as high sickness absence rates remained a key issue for the Trust. Members also noted the importance of maintaining strong and effective Trade Union Partners as this had been positive and beneficial to the Trust and TU partners previously.

RESOLVED: That

- 1. The re-articulation of the 3 Corporate Risks assigned to the Committee for oversight as part of the risk transformation work programme were NOTED.**
- 2. The increase in score of Risk 160 from 16 to 20 were NOTED.**
- 3. The escalation of Risk 163 to the Corporate Risk Register was NOTED.**
- 4. The suspension of the Board Assurance Framework (BAF) for 3 months was NOTED.**

29/22 ABSENCE MANAGEMENT ACTION PLAN

Liz Rogers introduced a reports on the project plan to support the reduction of sickness absence levels within the Trust. The purpose of the report was to provide the Committee with an update on progress, findings and outcomes while also giving assurance and information on any areas of risk.

The report showed that in order to address the high levels of absence, a project plan had been developed with a range of workstreams tackling various challenges, including support to managers, building on the wellbeing offer and interventions for supporting colleagues off on long term sick.

Members were informed that the delivery of the project plan was in the mobilisation phase with some pilots already underway, including a pilot project for employees calling in sick to contact their line manager rather than the Resourcing Team. In addition, Occupational Health and Wellbeing Team activities, including working with the 111 team on the wellbeing offer to employees was well underway, ensuring people knew what support was available and how this could be accessed.

Members heard how there was a strong focus on supporting managers to undertake their role in terms of managing attendance within their team and for them to access the data they needed to make decisions. To facilitate this, the Deputy Director of Workforce and OD was working with the Assistant Director of EMS on operational support for managers across the business with the proposal to utilise two Locality Managers or one Locality Manager and two Duty Operations Managers to support in the reduction of absence across operations teams. Training would be mandated and will be delivered through short sessions, focussing on a particular element of sickness management such as the return to work conversation, getting the best results from Occupational Health and supporting colleagues with an underlying health condition.

Members received the report and commented on the importance of early intervention when reducing the overall length of time a person was off sick, particularly when support and help was available but staff may not necessarily be aware of it. Members agreed that good communication was important in making sure that staff were aware of the available support and that working in partnership with Trade Unions would be beneficial to all parties when spreading the message.

RESOLVED: That the Committee COMMENTED on the report and the contents were NOTED.

30/22 TU PARTNERSHIP ARRANGEMENT UPDATE

Dr Catherine Goodwin and Paul Seppman gave an update and feedback on the Trade Union Partnership arrangements. Members were informed that they were in the process of agreeing the terms of reference and would provisionally look to convene every six weeks with the group consisting of several decision making members.

The TU Partnership would be focussing on strategic initiatives with a more operationally focussed group meeting in between. It was recognised that the Trade Union Cell, which had been important throughout the pandemic was not sustainable and conversely, the arrangements seen previously with the WASPT group would not be suitable for the current needs, aims and ambitions of the TU Partnership.

Members welcomed the update and acknowledged that the organisation was now in a different place to where it was pre-pandemic. Given this, it would not be suitable to go back to the old arrangements and the new TU Partnership arrangements represented a very positive step which would be beneficial to all parties moving forward.

RESOLVED: That the update was NOTED.

31/22 MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT

Hugh Bennett gave an update on the Monthly Integrated Quality and Performance Report (MIQPR). Members were informed that in many areas, the indicators showed a continued poor picture in terms of the quality and safety of the service that the Trust provided to patients. Demand across all areas of the service increased in Mar-22, this coupled with other factors such as the continuation of the Omicron and Deltacron CoVID-19 variants, high levels of sickness (including CoVID-19 related absence) and extreme handover lost hours continued to impact on the Trust.

During this reporting period, the Emergency Ambulance Services Committee, Welsh Government and the 111 Programme Board had been very supportive of the Trust through the pandemic, supporting a range of mitigations. However, whilst the patient safety concerns were set to increase in 2022/23 as system pressure remained high, most short term in year non-recurrent mitigations, such as military support were due to end on 31 March 2022. In addition, recurrent and increased funding for more permanent patient safety initiatives into 2022/23 looked unlikely at this point in time.

Members received the report and expressed concerns over the impact that such high pressure would have upon staff, the public and stakeholders given the declining ability to reach patients within the community. It was noted that many of these problems were being exacerbated by events which were largely beyond the Trust's control such high sickness absence levels, excessive handover delays and a sharp increase in post production lost hours.

After considering the report, Members felt that there was not currently sufficient assurance around performance and that further information was required, possibly following the deep dive into Post Production Lost Hours at the upcoming Finance and Performance Committee. In addition, further remedial actions may become apparent after the next meeting of the Quality and Patient Safety Committee.

RESOLVED: That

- 1. Whether the Mar-22 Integrated Quality and Performance Report and actions being taken provided sufficient assurance;**
- 2. Whether further information, scrutiny or assurance is required, or**
- 3. Whether further remedial actions are to be undertaken through Executives was CONSIDERED.**

32/22

WORKFORCE PERFORMANCE SCORECARD REPORT (INCLUDING PADR PERFORMANCE AND 22/23 APPROACH)

Dr Catherine Goodwin and Liz Rogers updated Members on the Workforce Performance Scorecard. The purpose of the report was to provide an overview of the key workforce performance data and trends as of March 2022 along with the associated improvement actions. The Committee's attention was drawn to two main areas, namely plans to address PADR completion and progress around Employee Relations, with a view to reducing existing disciplinary cases and to ensure any new allegations were dealt with appropriately at the initial assessment stage of the disciplinary process.

Members were informed that over the last three months, People Services have led the way in raising the issue of PADR completion at every meeting they had attended. Requests to increase completion of PADRs within portfolios and teams had been made at each management level from Executive Management Team, ADLT, SOT and throughout the Trust using traditional digital communication channels. However, this had not yet resulted in a significant rise in completion rates.

In terms of employee relations, the report showed that substantial progress has been made over the last 12-month period to reduce existing disciplinary cases and to ensure any new allegations were dealt with appropriately at the initial assessment stage of the disciplinary process. As a result, there has been a decrease from 46 disciplinary cases recorded in April 2021 to 19 cases recorded in March 2022.

However, formal requests for resolution, in accordance with the Respect and Resolution Policy, which was introduced in June 2021, had seen a substantial increase in number with 16 cases recorded in March 2022. Further work was now needed to gain a greater understanding of why concerns are unable to be dealt with and concluded at the informal stage of the Respect and Resolution process.

Members received the report and commented on the progress and actions being undertaken, particularly around PADR's and employee relations. Members welcomed the reduction in disciplinary cases but expressed concern over the rise in formal requests for resolution in accordance with the Respect and Resolution Policy. It was observed that the Roster Review and the changes this would bring to certain areas of the Trust was a likely driver for the increase in these applications.

RESOLVED: That the Committee RECEIVED and COMMENTED on the reported performance and associated actions.

33/22 WORKING SAFELY PROGRAMME INTRODUCTION

Wendy Herbert provided a brief overview of the changes to reporting arrangements for the Health and Safety function from May 2022, with the People and Culture Committee now overseeing the Trust's health and safety provision and performance on behalf of the Trust Board. Previously, this function was undertaken the Quality, Patient Experience and Safety Committee (QuEST).

The report outlined the recent history of the function, providing context for the transformational efforts currently underway. Additionally, the report provided advice to the Committee on key matters for consideration, and priority areas for scrutiny and support, with the Health and Safety Annual Report 2021-22 being provided to the People and Culture Committee at the next available meeting.

Members were informed that over recent years, the Trust had identified a high corporate risk (Ref: 199) in regard to health and safety compliance. Over the pandemic, and into the post pandemic period, the risk had been broadened to include the safety culture of the organisation. The Committee was asked to note the significant improvement work undertaken over 2021, which had enabled the Trust to ascertain the level and significance of the improvement actions required, and to commence action.

The report showed that over the next 12 months, the Trust expected to see further positive change implemented within the health and Safety function and Committee members were requested to positively challenge, seek assurances, and support efforts in driving the transformational agenda forward.

Members received the report and welcomed the transition of health and safety reporting to the People and Culture Committee, particularly in aligning matters with the wider reports received by the Committee such as Occupational Health and Wellbeing and the Committees focus upon staff, patients, partners and contractors.

RESOLVED: That the report was NOTED.

34/22 COMMITTEE PRIORITIES

Trish Mills informed Members that discussions had previously taken place around what the Committee should be prioritising and focussing upon. While these priorities were yet to be confirmed, it was becoming increasingly clear from earlier discussions and agenda items, which areas would likely be priorities moving forward.

Paul Hollard confirmed that during earlier discussions, a number of priorities were identified within the IMTP and that the Committees focus should remain in that area.

Trish Mills informed members that these priorities would be circulated and discussed at the next People and Culture Committee meeting along with the Cycle of Business.

RESOLVED: That the update was NOTED.

35/22 INTERNAL AUDIT FOR COMMITTEE

Julie Boalch provided the Committee with an update in relation to the outstanding recommendations from Internal Audit reviews. In addition, the paper set out the Internal Audit plan activity and included copies of current and relevant Audit Reports that provided a fundamental line of assurance to the Committee.

Members were informed that currently, there were two internal audit reports relevant to the Committee which formed part of the 2021/22 Internal Audit Plan. These were the report on recruitment practices – Equality, Diversity & Inclusion and the report on Organisational Culture – A Learning Organisation.

In addition, there were two internal audit reviews relevant to the Committee on Sickness Absence Management and Trade Union release time. Both of these were included in the 2022/23 Internal Audit Plan. While no high priority recommendations were showing as overdue, there were three lower priority recommendations that were showing as overdue. Therefore, the Governance team continued to seek assurance from Senior Management relating specifically to each report that recommendations had been considered and completed within agreed timeframes and that all was being done to ensure that the follow up of recommendations would not result in further Limited or No Assurance rated reports.

Members received the update and questioned the Recruitment Practices - Equality, Diversity & Inclusion report, querying whether this contained any provision to ensure the recruitment of Welsh Language skills across the organisation. Members commented that the Trust was committed to ensuring, promoting and strengthening the use of Welsh language skills across the organisation and that this commitment was documented at paragraph 2.2 within the report.

RESOLVED: That:

- 1. the contents of the report were CONSIDERED and NOTED.**
- 2. the Internal Audit Plan activity was CONSIDERED.**
- 3. the two current Internal Audit Reports relevant to the Committee were RECEIVED.**
- 4. the Trust's proposals to address each recommendation with the inclusion of revised completion dates were CONSIDERED; and**
- 5. any specific items that the Committee wished to see raised to Senior Management and Audit Committee were AGREED.**

WELSH LANGUAGE ADVISORY GROUP REPORT

Melfyn Hughes gave an update on developments within the Welsh Language advisory group and advised Members that there had been a significant increase in demand and costs for translations to meet compliance with the Standards. A business case for centralising translation services and having the bulk of translations done by an in-house translator had been developed on an invest to save model and it was anticipated that this would be considered by the Executive Management Team in May 2022.

In addition, the Board Secretary had informed members of the Welsh Language Advisory Group that one of her objectives for next year under her PADR was to develop a Welsh language Framework that would pull together all areas of work involving the Welsh language rather than have a single Welsh language strategy.

Members were then informed of the outstanding effort and assurance being provided by the 111 Service on work carried out to improve service delivery for Welsh speaking service users, including focused staff CPD training on how to deal with Welsh calls and weekly Welsh language provision service analysis.

Members received the update and noted the current developments, querying when the Committee would be able to get a first look at the Welsh Language Framework being developed by the Board Secretary. Melfyn Hughes confirmed that this would be available to the Committee at the next scheduled meeting, due to take place in September 2022.

RESOLVED: That the update was NOTED.

LEARNING FROM RECENT DISCIPLINARY CASES

Liz Rogers introduced a report which focused on the learning identified from recent disciplinary cases, bringing into consideration the recommendations from those cases which could be adopted by the Trust. The recommendations were designed to reflect ways in which the Trust could improve how future cases were managed

The report also considered the learning in the framework of 'just culture' principles and how the Trust could explore and take forward these principles in partnership with Trade Union colleagues. Some of the main recommendations included:

- Introducing a stage prior to the investigation of fact to consider if the formal initial assessment of fact (IAF) was appropriate in exceptional cases.
- Ensuring there was a robust IAF for a case prior to an investigation being triggered which should be completed by an independent manager outside of the line management chain
- Taking a pause to reflect on the IAF findings

- Increasing WOD team engagement in the process to improve support to investigating officers and increase the pace
- Prioritising the completion of investigations to avoid unnecessary delays
- Preparing witnesses in advance on what to expect and have clarity on questioning processes.

These recommendations recognised that each case was different and that in each case there were people at the heart of the process. Dealing with allegations which resulted in the triggering of an investigation was challenging for those at the centre of the allegations and as such, these would always need to be handled with sensitivity and care.

Members received the report and agreed that the resolution of disciplinary cases in the most efficient and least disruptive manner was in the best interests of all concerned. However, it was observed that in order for this to happen, some flexibility would be required from both the Trust and Trade Union Partners to achieve this goal.

Members also noted the need for guidance on referrals to professional regulatory bodies such as the Health and Care Professions Council (HCPC) and the Royal College of Nursing (RCN) to be incorporated into the process in order to tie in with the Trust's Professional Regulation Policy.

RESOLVED: That the report was NOTED and the recommendations contained within were APPROVED.

38/22 TUP ANNUAL REPORT

The TUP Annual report was received by the Committee. Members noted the contents and commented that although the report was presented as read, it provided significant assurance to the Committee in regards to the partnership activity being undertaken.

RESOLVED: That the contents of the report were NOTED.

39/22 MINUTES OF SUB-GROUPS

The Minutes of the sub-groups were presented as read and for information purposes only.

40/22 ISSUES TO BE RAISED AT BOARD

The Chair informed Members that discussions with Trish Mills would take place outside of the meeting to determine which items would be taken forward and raised at Board.

41/22 ANY OTHER BUSINESS

There was no other business

42/22 DATE OF NEXT MEETING

The date of the next meeting was scheduled for 05 September 2022.

PUBLIC ACTION LOG
WELSH AMBULANCE SERVICES NHS TRUST - People and Culture Committee

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
29/22a	10 May 2022	Absence Management Plan	Investigate the use of automated data for sickness recording	Liz Rogers	6 September 2022	<u>Update for 6 September 2022</u>	Open
29/22b	10 May 2022	Absence Management Plan	More information requested on the action plan in terms of timelines on RAG rating and outcomes.	Liz Rogers	6 September 2022	<u>Update for 6 September 2022</u>	Open
33/22	10 May 2022	Health and Safety	The health and safety report for the September meeting to feature high up the agenda	Dr Catherine Goodwin	6 September 2022	<u>Update for 6 September 2022</u>	Open
34/22	10 May 2022	Committee priorities	Circulate the committee priorities via email aligned to the IMTP people priorities.	Trish Mills	6 September 2022	These were circulated to member	Complete

Open
Complete
Closed
Not Due



GIG
CYMRU
NHS
WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust



Director Update: Workforce and OD

People and Culture Committee 5th September 2022

Team WOD

We are pleased to share that Angela Lewis has been appointed as the Trust's new Director of Workforce and Organisational Development and will be commencing in role on Monday 12th September 2022. We also welcome Paola Spiteri – OD Manager (EDI), Angie Roberts – People Services Assistant, Billie Hughes – Job Evaluation Facilitator and Morounmubo Farukanmi – People Business Leader to the WOD Team.

Workforce Planning & Transformation

The request for an additional 100FTEs (90EMT and 10 ACA2s) in time for winter pressure has seen the team working tirelessly to ensure success with our recruitment. The current EMT recruitment drive has brought 140 of the 150 required for this year. The team is on target to meet the overall requirement. ACA2 continues to be an issue due to the requirement to have C1 license along with 5 GCSE qualifications at C grade and above. EMT has recently approved an ACA2 C1 fast track scheme for c60 applicants that will see the Trust bearing the cost of the C1 license for those with the right level of qualifications. It is hoped that this will bring in the required numbers by Q4.

EDI

The Welsh Government has released their Anti-Racist Wales Action Plan- [Anti-Racist Wales Action Plan \(gov.wales\)](https://gov.wales/anti-racist-wales-action-plan). There are implications for WAST, with some deadlines for December 2022. Work has begun on raising awareness and developing an action plan of our own. Organisationally, we are looking to improve the accessibility of our documents, particularly those that have an external presence, such as the IMTP and Annual Reports. For the first time EDI metrics and information will be included in the Integrated Quality & Performance Report. Swansea University and Glyndwr University will be sharing their modules information for their Paramedic Science degree to see what if anything can be added from an EDI perspective. Pride Cymru is back for 2022 and the Welsh Ambulance Service, alongside colleagues from across NHS Wales lead the Pride parade. There was a 'Virtual Pride' event held on Wednesday 24th August, allowing people who are unable to travel to Cardiff to get involved in a Pride themed activity.

Recruitment

The recruitment team have been working tirelessly to ensure additional EMS staff are recruited in time for winter pressures. In addition to running large volume recruitment and selection campaigns, they have been engaging with schools and colleges and attending various events, such as the Royal Welsh show, to raise the profile of careers within the Welsh Ambulance Service.



DTUs

2 new Driver Training Units (pictured above) are due to be delivered shortly, further expanding and enhancing our driver education fleet.





GIG CYMRU NHS WALES
 Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru
 Welsh Ambulance Services NHS Trust



Director Update: Workforce and OD

People and Culture Committee 5th September 2022

People Services

A 12 week review of the new People Services Structure has taken place with positive feedback from the team. To support key areas of development a comprehensive training programme has been scheduled for the team including customer service, GDPR, safeguarding and EDI. The team have focused on a number of key areas including sickness absence management, supporting OCPs, roster review & recruitment. The Head of People Services has completed the 'Restorative Just Culture' training provided by Mersey Care. Additional training for key individuals across WAST is being explored with a view to roll out across the organisation.

Workforce Development Centre - Pentwyn

This month sees the long awaited move into our new, state of the art, Workforce Education and Development centre in Cardiff. Based in the Pentwyn MRD, we have built on the resource approach enjoyed in both Ty Elwy and Matrix House with integrated stores and immersive facilities – ensuring all road-based colleagues get to benefit from the same quality experience, regardless of their base. Our thanks go to the Estates Team for delivering another excellent resource!

OH & Wellbeing

Drop-in sessions by Wellbeing have recommenced in North Wales CCC and continue regularly in South Wales. The Chaplaincy recruitment programme has successfully recruited 8 new Chaplains who are currently undergoing employment checks before training commences. REACT training has begun to be delivered across WAST. The Circle of Support group has had its inaugural meeting – this has replaced the Road to Recovery Group and is now inclusive of any staff member living with a long-term health condition. The Women's Health Group has welcomed speakers from our Employment Assistance Programme, the Menopause Team and the Royal Osteoporosis Society. Future speakers include Gynaecology and Women's Aid. Hearing surveillance has commenced for all staff in CCC/111 and NEPTS Control throughout WAST. A new OHA for the Southeast region joined the Team in May 2022 and recruitment for a new administrator has been successful. Mobile clinics continue to all A&E departments offering required vaccinations to all frontline patient facing staff. Health Promotion campaigns supported include Skin Cancer, Mental Health Awareness, Men's Health, World Breastfeeding and Love Your Lungs Weeks.

Education & Training

Preparations are in hand to welcome over 250 new ACA, NQP and Trainee EMT recruits into all three of our Workforce Development Centres as we grow our Ambulance Response and Ambulance Care workforces by 100 during 2022/23. The team have had the dual challenge of weaving changes to both the clinical and driving curriculum as well as ensuring the learning experience remains one that is held in high esteem across all Ambulance Services and with FutureQuals – the AACE recognised provider of accredited qualifications. We welcomed 4 new Learning & Development Managers into the team – Laura Wilson joining us in Pentwyn, Sam Ricketts and Arwel Watkins, both at Matrix House and Dylan Jones who further enhances the team in Ty Elwy. We have sadly said goodbye to one of our outstanding Operational Driving Instructors – Scott James MBE – may he make the impact in his new role that he has done in WAST and did in his former role in the Army. Recent recruitment campaigns for APP, SP and DOM has led to a number of our Operational Clinical Tutors gaining promotions and other development opportunities – the net result of this is that we are searching for Ambulance Care & Response colleagues interested in developing their skills and joining the team as Operational Tutors in both Clinical and Driving disciplines.



OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2022-23 Q1 (Apr-Jun22)

❖ NATIONAL OPERATIONS AND SUPPORT

Mobile Testing Units (MTU) Programme

Following submission of the Trust's proposal for the retention of Mobile Testing Units, Welsh Government has confirmed an extension of the contract until 31st March 2023. This contract provides for three MTU teams (one in the North and two in South) working Monday-Friday with some weekend contingency factored in should this be required.

EPRR and Specialist Operations

Her Majesty the Queen's Platinum Jubilee celebrations took place in June with a four-day weekend where members of the public celebrated across the UK. The EPRR team was part of the multi-agency planning with partners from the Welsh Police forces and our Health Board colleagues, to ensure we worked together across communities. The Trust anticipated an increase in demand and put plans in place which included additional command arrangements, MRT teams, Cycle Response Units and Alcohol Treatment Centres.

In May, our EPRR specialist and non-specialist assets took part in Exercise Celtic Consolidation - a large multi-agency exercise testing our combined response to a Manchester Arena style attack at Cardiff City Stadium. The exercise involved twenty WAST staff (including HART and SORT) working with partners from EMRTS, St John Ambulance Cymru, South Wales Police and South Wales Fire and Rescue. Further multi-agency exercises have taken place to look at our combined response to a Chemical, Biological, Nuclear and Radiological Attack in the South of Wales with a similar exercise being planned to take place in the North of Wales in July 2022. Further exercising opportunities are also planned to look at our response to specific sites, such as the Severn Tunnel.

In June, six members of staff and a DOM travelled to the Isle of Man to support the Manx Ambulance Service during this year's TT race. Our staff worked alongside the Isle of Man ambulance service staff and colleagues from Gibraltar and Guernsey. The staff who deployed reported that the experiences they had were hugely beneficial to them clinically and personally, and we look forward to a continued relationship with colleagues in the Isle of Man.

Work on the Trust's business continuity plans remains ongoing. Exercise Joshua was very successful in testing our internal response to ICT failures. This has allowed the team to produce the Trust's Critical ICT Disruption Plan. This plan was further tested via exercise Joshua 2 which took place at the end of June 2022. An exercise report shall follow.

The WAST Hazardous Area Response Team (HART) celebrates its' 10-year anniversary in 2022 and events have been planned to mark this occasion. HART continues to provide the

Trust's specialist response to incidents involving chemicals, limited access and egress and incidents at height. Work is continuing to update the HART Incident Ground Technology and this work will continue over the coming months.

Prolonged Period in High Escalation (REAP levels)

The aim of the Resource Escalation Action Plan (REAP) is to describe the arrangements to be considered by the Trust in response to a strategic or dynamic assessment of pressures affecting or likely to affect service delivery. The categorisation is considered weekly at the Operations Weekly Demand, Capacity and Performance meeting which is attended by members of the Senior Leadership Team and others.

High levels of REAP were not really intended for prolonged periods of time, mainly because the actions within REAP are intended to help the Trust recover the situation. Throughout the period of the pandemic, and the current high pressures, the actions either within REAP, or other actions taken like cohorting areas, are not resulting in an ability to de-escalate.

An absolute application of the REAP actions for prolonged periods of time is highly likely to have medium to long term impacts on our capacity to transform, on regulatory requirements, and management and clinical supervision activity.

The Executive Management Team have therefore agreed that after a period of REAP 4 extending for two weeks, that the Strategic commander in consultation with the respective Director, balance the application of REAP 4 actions between the immediate needs of the presenting operational and clinical situation, versus the medium to long term impacts on transformation, regulatory requirements and management and clinical functions. At CSP 4a in REAP 4, it has also been agreed that all available clinical staff are expected to support patient facing duties.

Volunteering

In the first week of June, we celebrated our amazing workforce of volunteers during National Volunteer Week. Several coordinated media releases shone a light on the work of our volunteers who continue to provide a dedicated response as Volunteer Car Drivers, or Community First Responders.

❖ EMERGENCY MEDICAL SERVICE (EMS)

EMS Roster Review

The purpose of the EMS Roster Review project is to: deliver EMS Response rosters for Cymru High Acuity Response Unit (CHARU) replacing Rapid Response Vehicles (RRV), Emergency Ambulance (EA) and Urgent Care Service (UCS) aligned to patient demand; improve staff well-being and achieve an efficiency gain (not saving) of 72 FTEs, by December 2024.

Voting on the EMS Roster Review closed on Friday 20th May 2022. The project team have been working over the past few weeks to ratify the results, which is now complete. Whilst

the results of the vote have been shared with all staff an additional validation process is being confirmed with our trade unions. An implementation plan has been agreed at Project Board, which is scheduled to commence with Emergency Ambulance rosters in Hywel Dda from 5th September. A separate implementation plan for UCS and CHARU will be agreed in due course.

The project remains on track to be completed by the end of Q4 2023.

❖ RESOURCING & EMS COORDINATION

On 30th June 2022 the Senior Leadership Team approved the Standard Operating Procedure (SOP) for Remote Supervision. The purpose of the SOP is to allow remote supervision of Emergency Medical Dispatchers. Supervision is provided for EMDs in order to provide support for call handling performance, complex call management and clinical support for call escalation. This will also provide the opportunity for a remote call audit function, which will enhance our ability to carry out live call audit and will support the ongoing improvement in quality of the call handling service we offer communities across Wales. In addition, this facility will also support the ability for Clinicians through the Clinical Support Desk to directly listen in to calls, which will support the provision of timely clinical support when needed.

Following a period of stasis over the winter period, the EMS Coordination Reconfiguration Project Board resumed on 23rd May 2022. Project Board Members, which includes Trade Union Partners agreed to focus on the areas within the Project that can be progressed over the forthcoming months that will improve the delivery of services within the Centre and will focus on a review of the demand and capacity across the Centres, a roster review within the Department, the allocation of work across boundaries, and other opportunities for continuous improvement. This will report through the Operational Transformation Programme Board.

A Global Rostering System (GRS) Steering Group will shortly be set up to review the functionality available through the GRS Rostering System. Due to the onset of Covid many aspects of functionality available through the Rostering System were not implemented and additional functionality is now available to the Trust that would significantly improve the way we manage functions such as Continuous Professional Development, Timesheets and Annual leave. There are several system improvements that could prove incredibly useful to the organisation and staff alike and would help move us to a position where staff members are able to carry out a number of functions themselves. It is hoped that this Steering Group will help shape not only the current use of the GRS system but would also shape further development to the system to realise greater opportunities for working in a more efficient way.

❖ AMBULANCE CARE

Capacity Management Plan

Since the Capacity Management Plan has been deployed to try to control the Trust's spend on taxi usage, we have seen a reduction in expenditure. Further work is required to fully understand the impacts of using the Capacity Management Plan but financially this is aiding cost containment.

NEPTS Cleric Upgrade

Following completion of the new externally hosted environment for the upgraded NEPTS Computer Aided Dispatch (CAD), the new system is on schedule to go live in August 2022.

Transfer of UCS to Ambulance Care

The transfer of the urgent care service (UCS) to the Ambulance Care section took place on the 1st July. Early indications are that the transfer has occurred as expected, focus will now be placed upon integrating the service into the Ambulance Care function and refocusing the service towards delivering its' core purpose.

NEPTS Plurality Model Redesign

The first phase of the redesign of the NEPTS plurality model continues with tenders out for all externally commissioned work, this time using the new 3Q quality approach to measure both quality and value.

The new plurality model should improve value for money whilst also ensuring that we utilise providers of the highest quality. The new contracts will start to go live from the 1st October 2022.

❖ INTEGRATED CARE

111 Press 2

111 Press 2 went live in the Hywel Dda Health Board area on the 20th June. The service, operated by the Health Board in collaboration with WAST connects callers requiring urgent mental health support to a specialist practitioner. Further roll outs of the service are expected through the summer. We are closely monitoring any unanswered demand which returns to 111 core service. The early analysis indicates small numbers during the hours the service is non-operational.

111 Rostering

Following a significant staff engagement exercise the 111 Operations team have been working with Trade Unions, Resourcing and Staff to improve our approach to resourcing.

During July trials of new shift lengths and shift start times will commence pan-Wales. It's expected that these trials will improve our people's working lives and improve the alignment between 111 demand and capacity.

Further trials of fixed rosters are being developed to be in place later this summer.



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Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	8
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	People & Culture Committee
DATE	5 th September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide the People & Culture Committee (PCC) with an update in respect of Corporate Risks that are relevant to the Committee’s remit for review.
2. In addition, it provides a progress update in respect of the Risk Transformation Programme which was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the Integrated Medium Term Plan (IMTP) (2022/25).

RECOMMENDATION:

3. **Members asked to consider the contents of the report and:**
 - a. **Discuss the risks relevant to Committee.**
 - b. **Note that the ‘avoidable harm’ action plan will be incorporated into the BAF to support further mitigation of Risks 223 and 224.**
 - c. **Note the improved Board Assurance Framework.**
 - d. **Note the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.**
 - e. **Note the 2022/23 Risk reporting timetable.**
 - f. **Note the transfer of Risk 199 to the People & Culture Committee.**
 - g. **Note the increase in score of Risk 201 from 15 to 20.**

KEY ISSUES/IMPLICATIONS

4. Concerns were escalated to the Trust Board by the Chairs of Quality, Patient Experience and Safety Committee (QUEST), the People and Culture Committee (PCC), and the Finance and Performance Committee (FPC) in relation to the significant impact on staff and patients as a result of system pressures and particularly as a consequence of delays in handover at emergency departments.
5. The Trust Board received a further paper in July 2022 on actions to mitigate real time avoidable patient harm in the context of extreme and sustained pressure across the

urgent and emergency care system which has negatively impacted patient flow through all hospital sites and led to a substantial growth in emergency ambulance handover lost hours and a growing number of cases of avoidable harm or death to patients.

6. These actions, for the Welsh Ambulance Service and system stakeholders, will further mitigate the Trust's highest scoring risks 223 and 224 and will be reflected in the Board Assurance Framework during the September Board and Committee reports.
7. It is acknowledged that, whilst QuEST has oversight of risks 223 and 224, these remain the Trust highest scoring risks and affect every area of the organisation. Thus, updates will continue to be presented at FPC, QuEST and PCC Committees in relation to these two risks.
8. The Trust Board will be informed of the progress against the actions within the plan and these will be closely scrutinised by Committees.
9. Further, this paper sets out the outcome of the work that has been undertaken to date to strengthen and rearticulate the Trust's Corporate Risks, relevant to Committee, including new titles, summary descriptions and scores which Members are asked to note.
10. A review of each Corporate Risk score has been undertaken by mapping each control to related assurances and by identifying any gaps in these as well as any actions that can be taken to further mitigate the risk.
11. Members are asked to note the risk reporting timetable approved by Audit Committee.
12. The new nationally agreed Risk Matrix is included in this paper for information.
13. The Executive Management Team (EMT) received formal, monthly feedback from the Assistant Director Leadership Team (ADLT) on activity relating to the corporate risks for approval.

REPORT APPROVAL ROUTE

14. The report has been considered by:
 - ADLT – 21st March 2022
 - ADLT – 22nd April 2022
 - EMT – 11th May 2022
 - Audit Committee – 7th June 2022
 - Trust Board – 28th July 2022

REPORT ANNEXES

15. SBAR report.
16. Annex 1 - Summary table describing the Trust's Corporate Risks.
17. Annex 2 - Risk Matrix
18. Annex 3 – Risk Reporting Timetable

19. Annex 4 - Board Assurance Framework

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

- 1 The purpose of this report is to provide an update in relation to the Trust's Corporate Risks, relevant to Committee, with a particular focus on the work that has taken place to rearticulate and strengthen these.
- 2 The controls and assurances have been mapped in order to consider the robustness of a control, any gaps in controls and assurances and any further actions that have been identified to mitigate those gaps and the risks.
- 3 A summary report describing each of the corporate risks as of 12th May 2022 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR). The new timetable means that there is a lag which will resolve itself through the September reporting cycles; however, the risk owners update progress against the risks in accordance with the review schedule in place across the Trust, with the highest scoring risks reviewed on a monthly basis.
- 4 The approved National Risk Matrix is included in Annex 2 for Members information.
- 5 A Risk Reporting Schedule is included in Annex 3 for information.
- 6 The improved Board Assurance Framework (BAF) report is included in the paper in Annex 4.

BACKGROUND

- 7 The Risk Management and Board Assurance Framework Transformation Programme was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the IMTP (2022/25). A full progress report will be presented to the June 2022 Audit Committee as agreed.
- 8 The immediate priority was for a detailed review of the Trust's 5 highest scoring risks with the remaining corporate risks to follow and a programme of work has commenced to strengthen the articulation of the corporate risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.
- 9 The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments on all new risks in addition to reviewing any changes to existing risks and mitigating actions, reporting activity to the Executive Management Team (EMT), Board Committees and Trust Board.

ASSESSMENT

- 10 There are currently 16 Corporate Risks on the register, 4 of which are assigned to PCC for oversight, and these are described in the summary table in Annex

1. The table sets out the rearticulation of each of the Corporate Risks including new titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

Highest Scoring Risks

- 11 The immediate priority of the transformation programme was to undertake a full review of the Trust's highest scoring risks: Risks 223, 224, 199, 316 and 160 which has been completed. New titles were determined, and the risks clearly articulated with new summary descriptions, controls and assurances which have been mapped and actions identified resulting from any gaps.
- 12 The same process has been applied to the remaining Corporate Risks on the CRR and these are described in the table in Annex 1 focussing on titles, summary descriptions and scores only. The full Risk detail, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 4; however, whilst significant progress has been made, this work is not fully complete with a number of risks still a work in progress.
- 13 The EMT has approved the rearticulation of each of the Corporate Risks, which are included in the summary table in Annex 1.
- 14 It is acknowledged that, whilst QuEST has oversight of risks 223 and 224, these remain the Trust highest scoring risks and affect every area of the organisation and, therefore, updates will continue to be presented at FPC, QuEST and PCC Committees in relation to these two risks.
- 15 Members are asked to note that there were a number of actions outlined at the July 2022 Trust Board meeting which will mitigate real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service. These actions will further mitigate the Trust's highest scoring risks 223 and 224 and will be incorporated into the Board Assurance Framework during the July/August review of these risks. Members will see these reflected in the reporting for the September Board and Committee meetings.

Closure and De-Escalation of Risks

- 16 No risks have been closed from the CRR or de-escalated to Directorate Registers since the last meeting in May 2022.

Transfer of Risks

- 17 Risk 199 has transferred to the PCC from QuEST for oversight given that the Health & Safety function and programme of work are now included in the Terms of Reference and cycles of business for this Committee.

Changes to Risk Scores

- 18 There has been one change to the risk scores since the last meeting in May 2022.
- 19 **Risk 201** - *Damage to Trust reputation following a loss of stakeholder confidence.* The previous title was *Trust Reputation*.
- IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations*
- THEN there is a risk of a loss of stakeholder confidence in the Trust*
- RESULTING IN** *damage to reputation and increased external scrutiny.*
- 20 The Risk Owner and ADLT recommended the risk score be increased to 20 (4x5) from 15 (3x5) as the ability to mitigate issues outside of the organisation are not within WAST's control these are contributing to the effects on the Trust's reputation. The increase in score was approved by the EMT and reported to Trust Board on the 26th May 2022 and Audit Committee on the 7th June 2022.

Further Review of Risks

- 21 Work is ongoing to consider and develop potential new Risks for inclusion on the CRR and consideration will be given during the coming weeks to the following:
- *Patient Safety/Putting Things Right Team*
 - *NHS Decarbonisation*
 - *Supply Chain Issues – Digital Equipment*
 - *Securing Stakeholder Support to Deliver the Strategy and IMTP*
 - *Capacity to deliver change (IMTP)*
 - *Ongoing Impact of CoVID and Increasing Demand for Services (IMTP)*
 - *Staff health and wellbeing in the face of continued pressure (IMTP)*

Board Assurance Framework

- 22 One element of the Risk Transformational Programme was to develop a transitional BAF that focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives. Until such time as the more mature and strategic BAF is developed during 2023/24 as part of the transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.
- 23 This BAF was presented to Audit Committee in June 2022 and will be presented to each of the Committees as a standing Agenda item throughout the reporting cycles.

National Approach and Risk Matrices

- 24 Members are asked to note the new, nationally agreed Risk Scoring Matrices (Annex 2). These have been developed in partnership across Health Boards and Trusts to align the approach to Risk Management across the NHS in Wales wherever possible.

Reporting Timetable

- 25 Members are asked to note the agreed risk reporting timetable described in annex 3.
- 26 Each of the red and high scoring risks will be reviewed monthly by the Risk Owners with the support of the Risk Team as part of the agreed review frequency matrices; however, these will be reported to Trust Board on a quarterly basis and any additional actions included where possible.


RECOMMENDED:

- 27 **Members asked to consider the contents of the report and:**
- a. Discuss the risks relevant to Committee.**
 - b. Note that the ‘avoidable harm’ action plan will be incorporated into the BAF to support further mitigation of Risks 223 and 224.**
 - c. Note the improved Board Assurance Framework.**
 - d. Note the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.**
 - e. Note the 2022/23 Risk reporting timetable.**
 - f. Note the transfer of Risk 199 to the People & Culture Committee.**
 - g. Note the increase in score of Risk 201 from 15 to 20.**

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER: Summary				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
199	<p>Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation</p> <p>Previous title: <i>Compliance with Health and Safety legislation</i></p>	<p>IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance</p> <p>THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments</p> <p>RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation</p>	Director of Quality & Nursing	<p>20 (4x5)</p> <p>➔</p>
160	<p>High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service</p> <p>Previous title: <i>High Sickness Absence Rates</i></p>	<p>IF there are high levels of absence rates</p> <p>THEN there is a risk of a reduced resource capacity</p> <p>RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience</p>	Director of Workforce & Organisational Development	<p>20 (5x4)</p> <p>➔</p>
201	<p>Damage to Trust reputation following a loss of stakeholder confidence</p> <p>Previous title: <i>Trust Reputation</i></p>	<p>IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations</p> <p>THEN there is a risk of a loss of stakeholder confidence in the Trust</p> <p>RESULTING IN damage to reputation and increased external scrutiny</p>	Director of Partnerships & Engagement	<p>20 (4x5)</p> <p>⬆</p> <p>Increase from 15 to 20</p>

CORPORATE RISK REGISTER: Summary

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
163	Maintaining Effective & Strong Trade Union Partnerships <i>Previous title: Trade Unions/Partnership Working</i>	<p>IF the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained</p> <p>THEN there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised</p> <p>RESULTING IN a negative impact on colleague experience and/or services to patients.</p>	Director of Workforce & Organisational Development	<p align="center">12 (4x3)</p> <p align="center"></p>

Annex 2 – Proposed National Risk Matrix begins at the top of the next page (10)

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate / Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Risk Reporting Timetable

	ADLT	EMT	Deadline for Papers	Audit Committee	FPC	Trust Board	QuEST	PCC
1	5th May 2022	11th May 2022	31st May 2022	7th June 2022	18th July 2022	28 th July 2022	11th August 2022	6th September 2022
2	8th August 2022	24th August 2022	8th September 2022	15th September 2022	19th September 2022	29 th September 2022	10th November 2022	29th November 2022
3	31st October 2022	9th November 2022	24th November 2022	1st December 2022	16th January 2023	26 th January 2022	9th February 2023	21st February 2023
4	23rd January 2023	8th February 2023	23rd February 2023	2nd March 2023	20th March 2023	30 th March 2022		

Risk Register locked and no further changes will be made apart from any amendments agreed at EMT.

* No risk report to FPC on 14th November 2022 (duplicate of 19th September 2022 report).

* Risk Report for Trust Board on 24th November 2022 will reflect that which will be submitted to Audit Committee on the 1st December 2022

Annex 4 – Board Assurance Framework

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust’s ability to provide a safe and effective service	Date of Review:	11/04/2022	TREND ➡	20 (5x4)		
		Date of Next Review:	30/06/2022				
IF there are high levels of absence e.g. sickness and alternative duties	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score	
				Inherent	4	4	16
				Current	5	4	20
				Target	3	4	12
IMTP Deliverable Numbers: 1,5, 9, 10, 12, 17, 18, 19, 20, 26, 34							
EXECUTIVE OWNER		Director of Workforce & Organisational Development		ASSURANCE COMMITTEE		People and Culture Committee	
CONTROLS			ASSURANCES				
<ul style="list-style-type: none"> a. Managing Attendance at Work Policy/Procedures in place b. Respect and Resolution Policy c. Raising Concerns Policy d. Health and Wellbeing Strategy e. Operational Workforce Recruitment Plans f. Roster Review & Implementation g. Return to Work interviews are undertaken h. Training i. Directors receives monthly email with setting out ESR sickness data j. Operational managers receive daily sickness absence data via GRS k. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme l. WAST Keep Talking (mental health portal) m. Suicide first aiders n. TRiM o. Peer Support network p. Coaching and mentoring framework q. Staff surveys r. Stress risk assessments s. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC t. External agency support e.g. St John Ambulance, Fire and Rescue u. Strategic Equality Objectives v. Volunteers w. Monthly reviews of colleagues on Alternative duties x. Manager guidance on managing Alternative duties y. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee 			<p>Internal Management (1st Line of Assurance) 'a.Policy reviews to ensure policies and procedures are fit for purpose (covering a – c)</p> <ul style="list-style-type: none"> a. Audits by People Services on sickness (covering a) b. Sickness forms part of Workforce Scorecard to People & Culture Committee (covering s) c. Action plans arising from meetings with colleagues implemented through monthly diarised meetings (covering w) d. Minuted meetings and action logs for EMT & People & Culture Committee (covering y) <p>External Management (1st Line of Assurance) e. All Wales review of All Wales Attendance at Work Policy (covering a)</p> <p>Independent Assurance (3rd Line of Assurance) f. Internal Audits scheduled through Shared Services Partnership (covering controls a – x) g. Audit Wales – Taking Care of the Carers report in October 2021 (covering controls a – x)</p>				
GAPS IN CONTROLS			GAPS IN ASSURANCE				
<ul style="list-style-type: none"> • Wellbeing policy currently being produced (covering control d) • There is no steering group for Health and Wellbeing – there are plans to restart the group (covering control d) • Consistency and Application in Managing Attendance at Work Policy (covering control a) • Education and communication with managers about resources available and how to implement it e.g. stress risk assessments (cover controls a – v) • It is not known what is undertaken with respect to the data covered in assurances i and j once it is received 			<p>Internal</p> <ul style="list-style-type: none"> • Reporting on training compliance (covering control h) • Absence data is not updated in a timely manner into ESR by managers (covering controls i, j and s) • There are other factors that impact on sickness which can't be controlled <p>External None identified at the present moment</p>				

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service		Date of Review:	11/04/2022		TREND	20 (5x4)
			Date of Next Review:	30/06/2022		➡	
IF there are high levels of absence e.g. sickness and alternative duties	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score	
			Inherent	4	4	16	
			Current	5	4	20	
			Target	3	4	12	
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Implementation of Improving Attendance project		Deputy Director of Workforce & OD	30.09.23				
2. Implementation of Behaviours Refresh Plan		Assistant Director – Inclusion, Culture and Wellbeing	31.10.22				
3. Long term sickness absence deep dive		Deputy Director of Workforce & OD	31.07.22				
4. Develop guidance for line managers to support addressing challenging conversations and change		Deputy Director of Workforce & OD	31.07.22				
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)		Freedom to Speak Up Arrangements Task & Finish Group	31.07.22				
6. Strengthen Freedom to Speak Up Arrangements policy and advice		Deputy Director of Workforce and OD	31.05.23				
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements		Deputy Director of Workforce and OD	31.05.23				
8. Accountability meetings with senior ops managers		Deputy Director of Workforce & OD	30.09.22				
9. Attendance Management training for managers		Deputy Director of Workforce & OD	31.12.22				
10.PADR review including wellness questions		Assistant Director – Inclusion, Culture and Wellbeing	31.05.22				
11.Restart the Health and Wellbeing Steering Group		Assistant Director – Inclusion, Culture and Wellbeing	31.05.22				
12. Roll out of meta data compliance policy solution		Senior ICT Security Specialist	31.12.22				

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation		Date of Review:	24/05/2022		TREND	20 (4x5)
			Date of Next Review:	30/06/2022		➔	
IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	4	5	20	
			Target	2	5	10	
IMTP Deliverable Numbers: 1, 7, 9, 12, 16, 17, 24, 25, 26, 33, 35, 38							
EXECUTIVE OWNER		Director of Quality and Nursing	ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee People and Culture Committee		
CONTROLS		ASSURANCES					
<ul style="list-style-type: none"> a. Systematic review and assessment of Health and Safety arrangements and Governance (Health & Safety Management system) b. Health & Safety Governance and reporting arrangements e.g. committees and sub-groups c. Provision of dedicated health and safety expertise and advice d. Health & Safety Policy and procedures e. Mandatory Health and Safety training f. Scheduled H&S visits and inspections g. Risk assessments (including local risk assessments -Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities) h. Working Safely Programme Board, Dynamic Delivery Action Group & Programme Manager to provide oversight of Working Safely Action Plan i. IOSH Managing Safely for Managers training in place j. IOSH Leading Safely for Directors and Senior Managers training in place 		Internal Management (1st Line of Assurance) <ul style="list-style-type: none"> a. Assessment criteria set for management system (all Wales system) b. Monthly H&S report to ADLT, quarterly report and annual report to ADLT, H&S committee, EMT, PCC c. Working Safely team in place until end of September 2022 d. H&S Policy approved in 2018 e. Quarterly statistics available from ESR and this forms part of Head of Health and Safety's quarterly report f. Head of Health and Safety's monthly report to ADLT g. Covid 19 assessments are monitored by Business Continuity and Recovery Cell Team (BCRT) on a weekly basis. Other risk assessments and SOPs are held on Sharepoint and have been submitted to SOT for approval h. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored fortnightly through Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved. i. Attendance and competency figures provided in a monthly report to ADLT and quarterly report to committees and above j. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis External Independent Assurance (3rd Line of Assurance) Internal Audit to be undertaken in Q4 22/23(covering a – j)					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
<ul style="list-style-type: none"> • Baseline audit for (a) not to be commenced till Q1 2022 (<i>being addressed in Actions 1 & 7</i>) • The Health and Safety Policy and some procedures are due to be reviewed by the end of Q1 2022 (<i>being addressed in Action 1</i>) • Effective learning from events to be documented (<i>being addressed in Action 1</i>) • Operational pressures on service impacting on Working Safely Programme delivery (covering control h) (<i>being addressed in Action 1</i>) • Staff available to deliver training (covering control i). There is an aim to commence training in May 2022 (<i>being addressed in Action 4</i>) • Staff availability to provision and schedule training (covering control j) (<i>being addressed in Actions 2 & 3</i>) • 2 live vacancies for H&S Business Partners will be advertised week commencing 3.05.22. This will need to be filled (covering control c) (<i>being addressed in Action 4</i>) 		Internal <ul style="list-style-type: none"> • Capacity issues in assessing management system (covering assurance a) • Subgroups of H&S committee currently under review (covering assurance b) • After September 2022, uncertainty over capacity to deliver to the Working Safely programme (covering assurance c) • Review of H&S Policy is due at end of Q1 2022 (covering assurance d) • Workforce Transformational change will influence content within H&S policy (covering assurance d) • Developing schedule for H&S inspections and visits. Once this is undertaken, metrics to be developed (covering assurance f) • Current copies of risk assessments and SOPs are not available at all stations (covering assurance g) • Do not know how many SOPs are required until baseline audit completed (covers assurance g) • H&S team in discussions with best way of monitoring Personal safety commitments (covering assurance j) • Do not have a schedule of training in place but expecting to complete this in Q1 2022 (covering assurance j) 					

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation		Date of Review:	24/05/2022		TREND	20 (4x5)
			Date of Next Review:	30/06/2022		➔	
IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	4	5	20	
			Target	2	5	10	
<ul style="list-style-type: none"> Poor uptake in H&S training due to sustained pressures and under capacity to deliver in H&S (covering control e) <i>(being addressed as part of Actions 2 – 3)</i> Lack of cultural baseline to demonstrate H&S awareness (covering control a) <i>(being addressed in Action 5)</i> A compliance register is under construction that describes the requirements of the various Health & Safety legislation that we need to comply with (covering control a) <i>(being addressed in Action 6)</i> An assessment section will provide assurance on how we are complying with the legislation (covering control d) <i>(being addressed in Action 7)</i> 							
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)		Head of Health & Safety	31.08.22				
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)		Head of Health & Safety	31.12.22				
3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)		Head of Health & Safety	31.12.22				
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)		Head of Health & Safety	31.03.22	Completed H&S Workforce report was presented and discussed at EMT on 6.04.22. Director of Finance and Corporate Resources would be formulating a paper for discussion at the ADLT/EMT meeting on 13.04.22 to discuss the issue of investment in Corporate Services based on the evidence provided in H&S Workforce report.			
5. Culture survey to all members of staff (forms part of WSAP)		Head of Health & Safety	30.06.22				
6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)		Working Safely Programme Manager	30.06.22				
7. An initial assessment will provide assurance on how we are complying with the legislation.		Working Safely Programme Manager	Assurance - 30.06.22 Rolling programme of audits – 31.12.22 (Checkpoint date)				

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence			Date of Review:	19/04/2022	TREND ↑	20 (4x5)
				Date of Next Review:	30/06/2022		
IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	THEN there is a risk of a loss of stakeholder confidence in the Trust	RESULTING IN damage to reputation and increased external scrutiny		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	4	5	20	
			Target	3	5	15	
IMTP Deliverable Numbers: 2,18, 26, 34, 38							
EXECUTIVE OWNER		Director of Partnerships and Engagement	ASSURANCE COMMITTEE		People and Culture Committee		
CONTROLS			ASSURANCES				
<ul style="list-style-type: none"> a. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders b. Challenging of media reports to ensure accuracy c. Media liaison to ensure relationships developed with key media stakeholders d. Board approved Engagement Framework e. Engagement Framework Delivery Plan f. Engagement governance and reporting structures are in place g. Escalation procedure for issues to the Board 			Internal Management (1st Line of Assurance) <ul style="list-style-type: none"> a. Agendas, minutes and documents of engagement events b. Programme of daily media engagement c. Same as b d. Issues of reputation monitored at EMT – minuted meetings and action logs. f. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs g. Minuted meetings, action logs and Board papers External Not applicable				
GAPS IN CONTROLS			GAPS IN ASSURANCE				
<ul style="list-style-type: none"> a. Inability to control external environment b. Dependency on Commissioners' decisions c. Unpredictable external environment affecting the way the Trust operates d. Engagement Framework is due to be submitted to the Board for approval in May 2022 (covering control d) e. Engagement Framework Delivery Plan suspended due to Covid-19 and will be reinstated subject to the Engagement Framework being approved by the Board (covering control e) f. Lack of resilience in the function – team is very small so any absences would have an impact on ability to respond 			Internal <ul style="list-style-type: none"> • Engagement Framework Delivery Plan suspended due to Covid-19 and will be reinstated subject to the Engagement Framework being approved by the Board (covering control e) External Not applicable				
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:		
1. Submit refreshed Board Engagement Framework to Trust Board for approval			Director of Partnerships & Engagement	26.05.22			
2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee			Director of Partnerships & Engagement	30.09.22 – Checkpoint Date			
3. Monitoring internal Quality and Performance of Trust			Executive Management Team Finance and Performance Committee Quality, Safety and Patient Experience Committee People and Culture Committee Audit Committee	31.03.23 – Checkpoint Date			
4. Engaging with internal and external stakeholders to develop confidence			CEO & Director of Partnerships & Engagement	31.03.23- Checkpoint Date			
5. Monitoring external factors that may affect the Trust			CEO & Director of Partnerships & Engagement	31.03.23 – Checkpoint date			

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:	18/05/2022	TREND	12 (4x3)
				Date of Next Review:	31/08/2022	➔	
IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	RESULTING IN a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score	
			Inherent	5	3	15	
			Current	4	3	12	
			Target	4	3	12	
IMTP Deliverable Numbers: 2, 4, 6, 11, 20, 34							
EXECUTIVE OWNER		Director of Workforce and Organisational Development		ASSURANCE COMMITTEE		People & Culture Committee	
CONTROLS				ASSURANCES			
<ul style="list-style-type: none"> a. Agreed (Refreshed) TU Facilities Agreement developed in partnership b. Go Together Go Far (GTGF) statement and CEO/TU Partners statement c. IPA Workshops d. Trade Union representation at Trust Board, Committees e. Monthly Informal Lead TU representatives and Chief Executive meetings f. Staff representative management in Task & Finish Groups g. Fortnightly TUP Cell meetings h. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team i. Quarterly Report on TU activity to People and Culture Committee 				Internal Management (1st Line of Assurance) <ul style="list-style-type: none"> a. Agreed document which states governance arrangements and the criteria for time off for TU activity etc. b. Both parties refer to the documents and are signed up/committed to it c. Meetings completed with participation from TUs and senior managers. Attendance lists are available d. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in e. Diarised meetings f. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference g. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings. h. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings i. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes External Not applicable			
GAPS IN CONTROLS				GAPS IN ASSURANCE			
<ul style="list-style-type: none"> • Need to move back to business-as-usual footing • Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring 				None identified			
Actions to reduce risk score or address gaps in controls and assurances				Action Owner	By When/Milestone	Progress Notes:	
1. Clarify the formal and informal consultation and engagement framework and definitions				Deputy Director of Workforce & Organisational Development	31.05.22		
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing				Deputy Director of Workforce & Organisational Development	31.05.22		
3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree				Deputy Director of Workforce & Organisational Development	30.06.22		
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).				Deputy Director of Workforce & Organisational Development	30.09.22		

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)

22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	IMTP Deliverable
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance



GIG
CYMRU
NHS
WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	9
OPEN or CLOSED	
No of ANNEXES ATTACHED	2

IMPROVING ATTENDANCE

MEETING	People and Culture Committee
DATE	5th September 2022
EXECUTIVE	Dr Catherine Goodwin, Interim Director of Workforce and OD
AUTHOR	Liz Rogers, Deputy Director of Workforce and OD
CONTACT	Liz Rogers, Deputy Director of Workforce and OD

EXECUTIVE SUMMARY

Sickness Absence levels are recognised as a significant concern in WAST. To address the levels, an Improving Attendance Project Plan has been developed and is being delivered into the organisation by a joint team from WOD and Operations.

The purpose of the report is to:

Provide Committee with an update on sickness data and progress since the last meeting.

Provide assurance on progress and report by exception on any areas of risk.

KEY ISSUES/IMPLICATIONS

There is progress being made in terms of reducing sickness absence overall with a reduction in long term sickness absence and the number of cases. Short term sickness is also moving in the right direction but has been subject to a rise in Covid absences in June and July. Data is shared in the attached PowerPoint deck.

The delivery of the project plan is well established and good progress is being made.

Progress is tracked and Project meetings are scheduled fortnightly to monitor actions and progress.

To date activities are on schedule against the plan (attached at Appendix 1)

Assurance is given to the Committee that progress against the actions is in line with what was planned.

Committee are asked to note the impact of a rise of COVID cases in June and July which has impacted on short term sickness absence figures, however this was

significantly reduced at the start of August and we will hopefully see this trend continue.

The Board is asked to:

- **NOTE** the data reported in the attached PowerPoint deck
- **NOTE** the impact of Covid cases on attendance figures
- **NOTE** progress against the project plan

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
EMT	17 th August 2022	For noting
P&C Committee	5 th September 2022	For noting

REPORT APPENDICES

Appendix 1 PowerPoint deck
Appendix 2 Managing Attendance Plan progress update

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

SITUATION

1. WAST had seen a significant increase in sickness absence levels through 2021 and the beginning of 2022, which have been regularly reported to Committee and Board.
2. To respond to the high levels of absence, a project plan was developed with a range of workstreams tackling various challenges, including support to managers, building on the wellbeing offer and interventions for supporting colleagues off on long term sick.

3. The organisation and P&C Committee recognised the need to address the levels of absence in a sensitive way, aligned to policy and being mindful of the general wellbeing of the workforce which is significantly affected by the pressures on the service such as handover delays.

BACKGROUND

4. Over the past few months, the Improving Attendance team have been working hard supporting managers within Operations to improve attendance across their teams. This engagement is having a positive impact.
5. The team have taken on board their workstream activities and are delivering against the plan.
6. The impact of Covid continues to play its part and is reflected in the figures.
7. The plan is an organic document and is continually updated to consider organisational changes, challenges and pressures.
8. There are also external decisions taken on an All Wales basis which impacts on the plan and activities to support people returning to work. Changes to pay for colleagues with Covid came into effect on 1st July, however, Covid absence is not yet counted in absence triggers.

ASSESSMENT

Data Analysis

1. Appendix 1 is a PowerPoint deck outlining the changes in sickness figures over recent months since the last Committee. Committee members will note the month-on-month reduction in long term sickness absence since April from 6.18% to 5.70% in May and 5.18% in June. In addition, more long term sickness cases are being closed than opened every month since March.
2. Short term sickness absence figures have fluctuated. April reported a figure of 4.96%, May was 3.25%, June was 3.94%. However, mental health related absence has reduced month on month. MSK absence increased slightly in May and has reduced again in June bringing it back to the April figure.
3. Covid absence has been an issue in June and July as there has been an increase in figures through those months. This is also reflected in community figures. The end of May showed Covid absences down to around 50 a day across the workforce in Operations. June saw absences rise to 133 at the end of the month then hit a peak of 170 on 10th July. This impacts on short term absence data. At the time of writing, Covid absences are sitting at 81.
4. In terms of Operations May saw a solid reduction in levels. EMS reduced from 12.89% to 9.74%, Ambulance Care from 10.97% to 8.71%. The increase in Covid data is reflected in the June data, seeing a slight rise. Month on month data can be viewed on slide 9 of the deck.

Alternative Duties

5. Work has been ongoing to review colleagues undertaking alternative duties. There are some challenges around the data as information is held in different places and systems and does not always align to local intelligence, as well as the moving picture of colleagues switching between categories e.g. from sickness to alternative duties and to secondment and so on. Descriptors are being reviewed and changed. Most of those on alternative duties have been doing so for less than 4 months (34) and are in alternative roles due to health issues e.g. recovering from surgery, or carrying a temporary injury (39).

Improving Attendance Plan

6. Appendix 2 gives Committee the position on project progress as at the end of July. There are actions now completed or running as BAU. There are currently no actions rated as red.
7. It is useful to put some narrative around the plan, including feedback from the delivery team and the organisation. Observations from the team have been that they have seen some silo working which has created inconsistency. Not all managers would be properly prepared for meetings with the necessary information to hand meaning the right outcome was not reached. There is still a heavy reliance on paper. Some managers are not confident on the process and what they can do, meaning they were unlikely to challenge where it was needed. The discretion in the policy is being used inappropriately and return to works and wellbeing referrals can be a tick box exercise.
8. Over the last quarter there has been a culture shift with managers having a real focus on supporting attendance and a move away from a place where absence is accepted as inevitable and something that cannot be managed effectively. There are EMS working groups promoting peer support to share best practice. There is a review of paperwork for short-term sickness absence, streamlining the forms and reducing complexity. The bitesize training sessions delivered so far have been well received. There is better use of ESR and a business intelligence (BI) reports but there is still much room for improvement here. A rhythm of review meetings with members of the project team is in place where managers are supported for example by coaching and talking through approaches on how to help team members. All long-term sick cases are being appropriately managed with regular conversations with colleagues away from work. Drop-in sessions for managers in Integrated Care have been established and are running every week.
9. Further challenges have been identified alongside more opportunities to improve and do things differently. Challenges include limited digital access and usage of data and different data collection tools i.e. ESR, GRS, local spreadsheets and paper records, in addition to a lack of knowledge, education and awareness of what should be done. Opportunities include building confidence and consistency of approach, the more managers do, the better they will become. The training sessions about Occupational Health have increased the understanding and importance of supporting health and wellbeing and managing attendance so more of this focus is important.

Expanding peer to peer conversations on what works and working through scenarios and cases is positive and has proved helpful for new and less experienced managers.

10. As the project moves on, the team will continue to deliver the workstreams. Creating a national approach and reducing the regional silos where different ways of managing attendance is seen, will be a focus. Sharing with managers the need to get closer to their teams to pick up on trends and engage faster in a proactive way is key to the messaging and setting of expectations as prevention is better than cure. Supporting team members to be in work in a sustained way is at the heart of the project.

RECOMMENDED

1. The Committee is asked to:
2. **NOTE** and **COMMENT** on the Report



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru

Welsh Ambulance Services
NHS Trust

Improving Attendance Update

P&C Committee 5th September 2022





Improving Attendance Programme



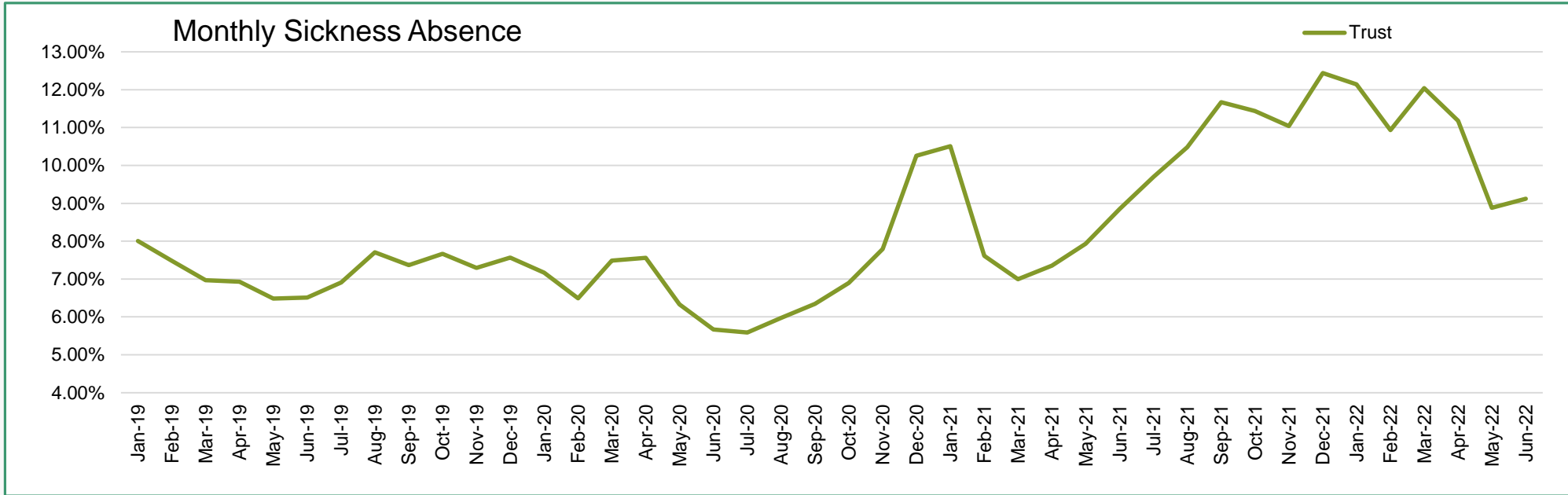
SUMMARY

- June saw a slight increase in sickness absence at 9.12% from 8.88% in May.
- The slight increase in June was mainly due to short term sick as a result of Covid absence
- Although official figures not yet confirmed, July is showing a further increase (indicative figure 10.34%). Again, this seems to be primarily COVID driven as we have seen high figures through most of the month
- Year to date sickness absence is 10.92% (01/07/2021-30/06/2022)
- Figures are not following the estimated trajectory, primarily driven by Covid impacting short term sickness absence, however the end of year target for the organisation is 10%





WAST: Sickness Absence



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	8.01%	7.48%	6.97%	6.93%	6.48%	6.51%	6.91%	7.71%	7.37%	7.67%	7.29%	7.57%
2020	7.17%	6.49%	7.48%	7.56%	6.33%	5.66%	5.59%	5.97%	6.34%	6.89%	7.79%	10.26%
2021	10.51%	7.61%	7.00%	7.35%	7.93%	8.85%	9.70%	10.48%	11.67%	11.44%	11.04%	12.44%
2022	12.14%	10.93%	12.04%	11.18%	8.88%	9.12%						

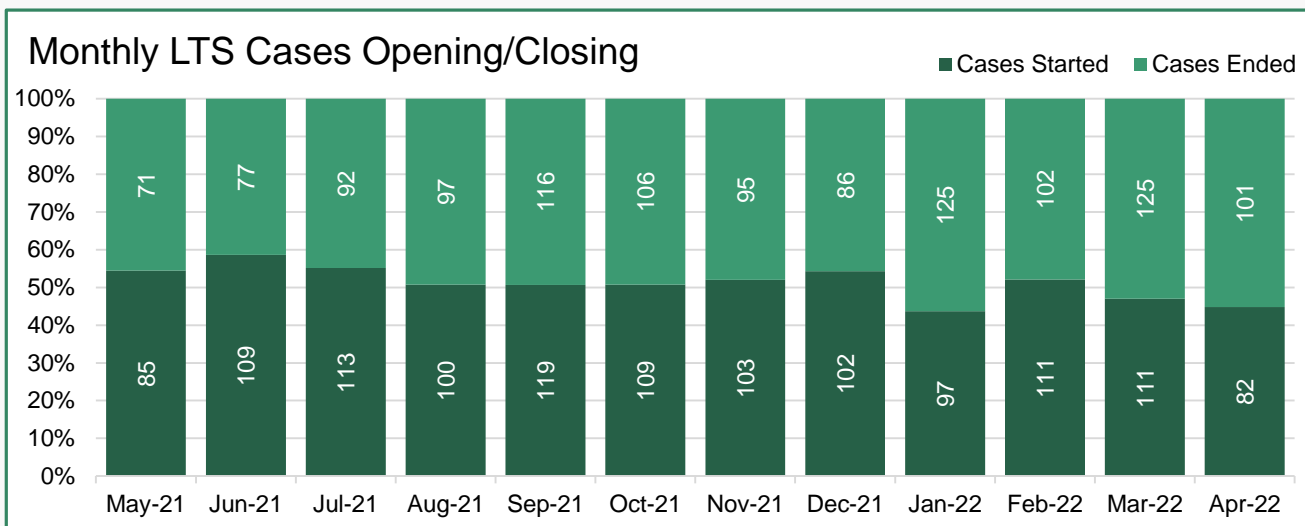




Analysis: Sickness Absence – Overview

April 2022

Average working days lost per FTE (Annual)	
24.68 days	
Single month Absence %	
11.14%	
Long Term	Short Term
6.18%	4.96%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding Back)
2.47%	1.26%



Absence Reason	Headcount	Abs Occurrences	%	Abs FTE %
S10 Anxiety/stress/depression/other psychiatric illnesses	177	179	22.2	2.47%
S15 Chest & respiratory problems	278	283	15.8	1.76%
S27 Infectious diseases	225	227	13.8	1.53%
S12 Other musculoskeletal problems	87	87	11.3	1.26%
S13 Cold, Cough, Flu - Influenza	128	132	7.1	0.79%
S25 Gastrointestinal problems	140	141	5.6	0.62%
S11 Back Problems	43	43	5.4	0.61%
S28 Injury, fracture	34	34	3.2	0.36%
S21 Ear, nose, throat (ENT)	49	51	2.7	0.30%
S99 Unknown causes / Not specified	33	33	2.3	0.25%

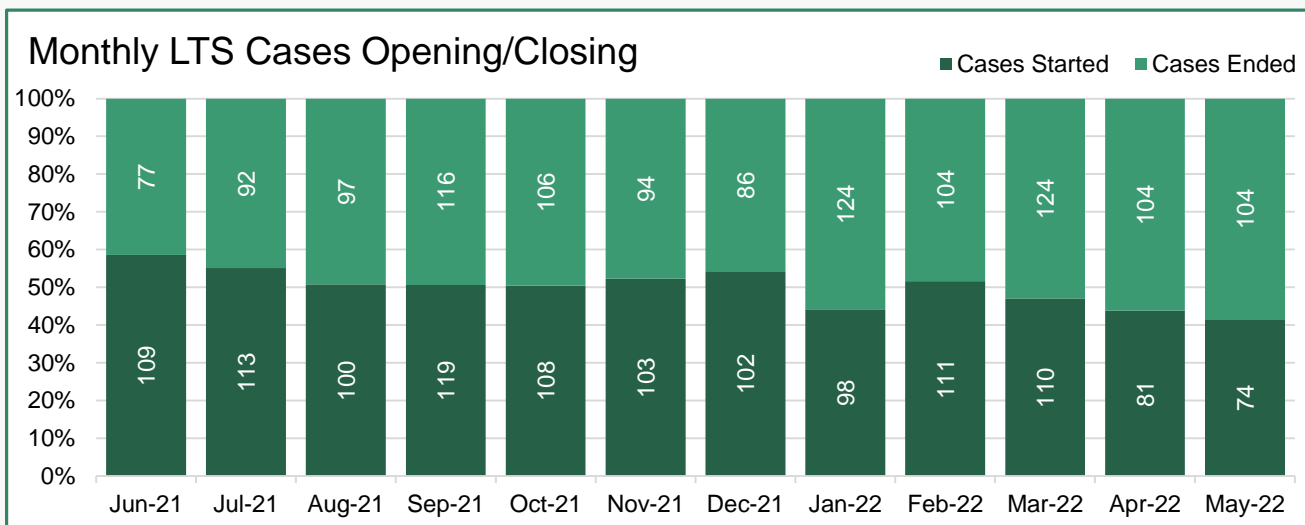




Analysis: Sickness Absence – Overview

May 2022

Average working days lost per FTE (Annual)	
24.89	days
Single month Absence %	
8.95%	
Long Term	Short Term
5.70%	3.25%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding Back)
2.29%	1.35%



Absence Reason	Headcount	Abs Occurrences	%	Abs FTE %
S10 Anxiety/stress/depression/other psychiatric illnesses	168	168	25.5%	2.29%
S12 Other musculoskeletal problems	100	101	15.1%	1.35%
S15 Chest & respiratory problems	128	129	10.6%	0.95%
S27 Infectious diseases	86	86	7.7%	0.69%
S25 Gastrointestinal problems	152	153	6.3%	0.56%
S11 Back Problems	52	53	6.3%	0.56%
S28 Injury, fracture	44	44	6.2%	0.56%
S13 Cold, Cough, Flu - Influenza	60	60	4.6%	0.41%
S21 Ear, nose, throat (ENT)	53	54	3.8%	0.34%
S26 Genitourinary & gynaecological disorders	26	28	2.5%	0.22%



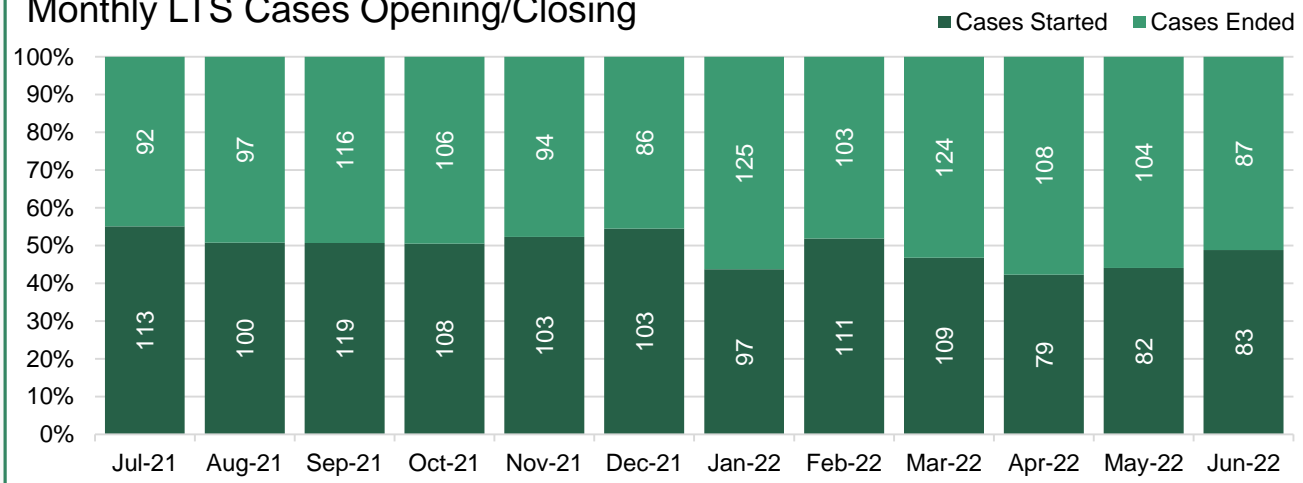


Analysis: Sickness Absence – Overview

June 2022

Average working days lost per FTE (Annual)	
24.89 days	
Single month Absence %	
9.12%	
Long Term	Short Term
5.18%	3.94%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.22%	(excluding Back) 1.27%

Monthly LTS Cases Opening/Closing

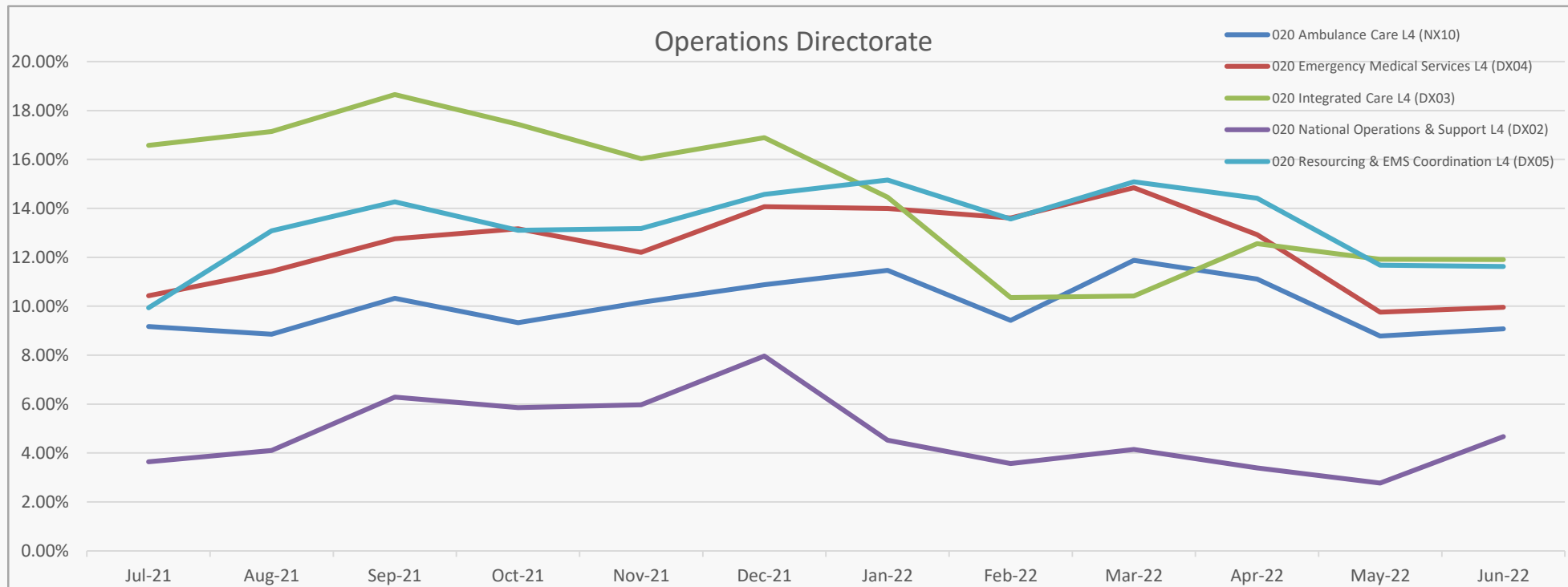


Absence Reason	Headcount	Abs Occurrences	%	Abs FTE %
S10 Anxiety/stress/depression/other psychiatric illnesses	167	171	24.40	2.22%
S12 Other musculoskeletal problems	91	91	13.94	1.27%
S15 Chest & respiratory problems	145	148	10.61	0.97%
S27 Infectious diseases	149	150	10.48	0.96%
S25 Gastrointestinal problems	149	151	6.18	0.56%
S13 Cold, Cough, Flu - Influenza	91	92	5.47	0.50%
S11 Back Problems	46	46	5.28	0.48%
S28 Injury, fracture	42	42	5.08	0.46%
S99 Unknown causes / Not specified	46	48	3.22	0.29%
S21 Ear, nose, throat (ENT)	39	40	2.88	0.26%





WAST Sickness Absence – 9.12% June Trust; 9.90% Operations



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
020 Ambulance Care L4 (NX10)	9.17%	8.86%	10.33%	9.33%	10.16%	10.87%	11.47%	9.42%	11.88%	11.11%	8.78%	9.07%
020 Emergency Medical Services L4 (DX04)	10.43%	11.42%	12.76%	13.16%	12.21%	14.07%	14.00%	13.61%	14.84%	12.93%	9.76%	9.95%
020 Integrated Care L4 (DX03)	16.58%	17.15%	18.65%	17.44%	16.03%	16.89%	14.46%	10.35%	10.42%	12.56%	11.92%	11.91%
020 National Operations & Support L4 (DX02)	3.64%	4.10%	6.29%	5.86%	5.97%	7.96%	4.52%	3.56%	4.14%	3.39%	2.77%	4.67%
020 Resourcing & EMS Coordination L4 (DX05)	9.93%	13.08%	14.26%	13.10%	13.18%	14.57%	15.16%	13.56%	15.08%	14.41%	11.67%	11.62%
Grand Total	10.53%	11.40%	12.78%	12.50%	12.01%	13.48%	13.15%	11.82%	13.13%	12.15%	9.65%	9.90%





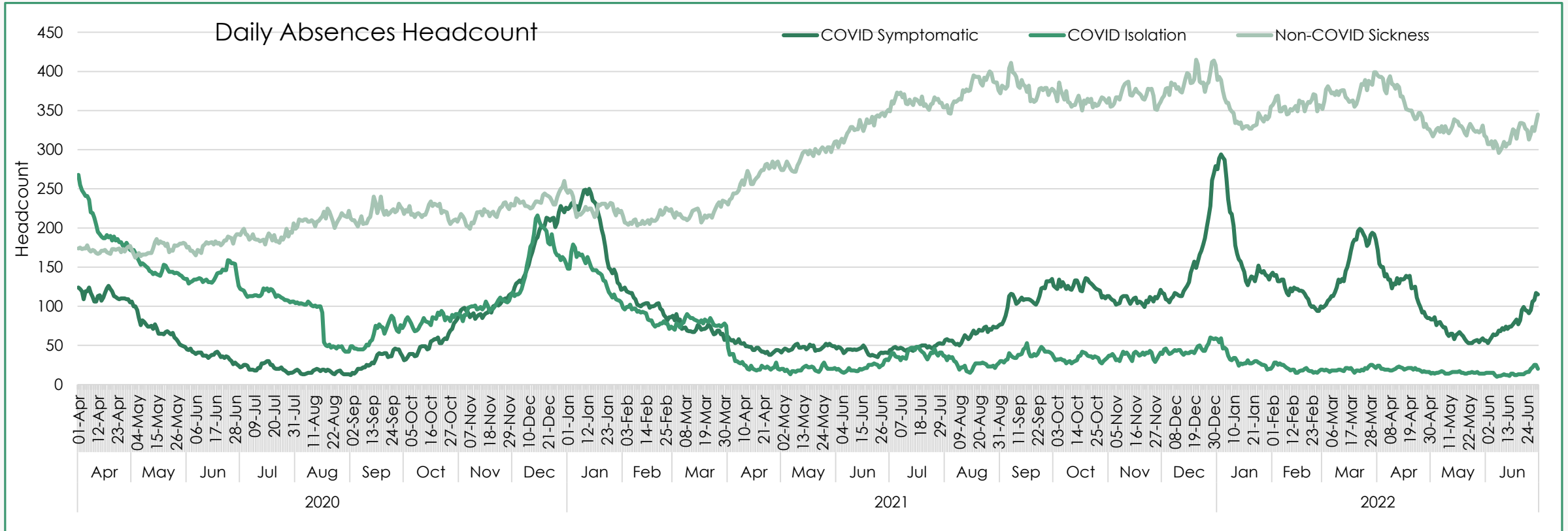
Sickness Absence – Current July Data Position

- Early indications are showing an increase for July to 10.30%
- Predominantly this increase is due to STS relating to Covid
- The main significant rise across the operations directorate can be shown with Ambulance care rising from 9.22% (June) to 10.82% (July) & EMS rising from 9.95% (June) to 11.78% in (July)
- Integrated Care have seen a very small increase from 11.92% (June) to 11.97% (July) & Resourcing & EMS Co-ordination increasing from 11.62% (June) to 11.97% (July)



COVID Absence Analysis: Apr-20 to Jun-22

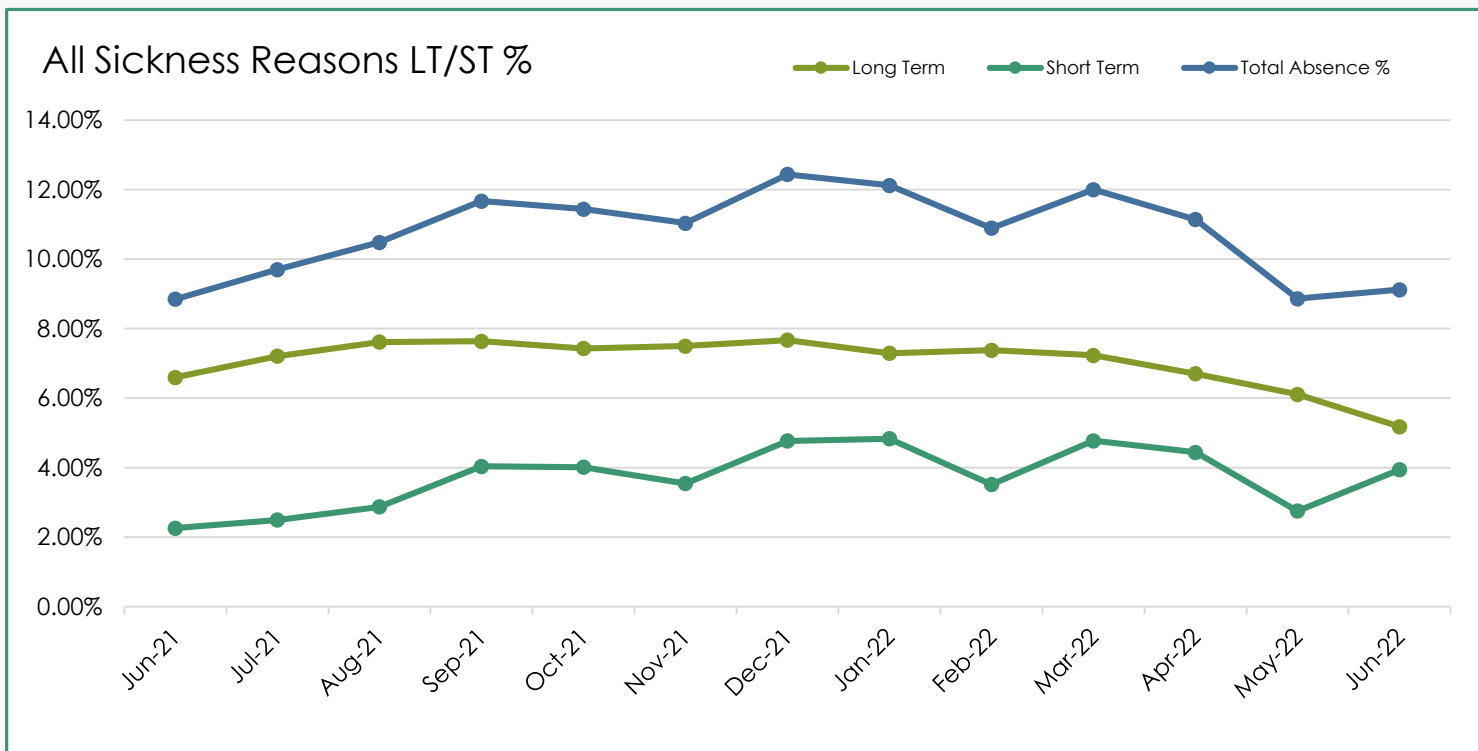
115 Symptomatic and 20 Self Isolation cases @ 30th June 2022





Analysis: Sickness Absence – June 2022

- Reduction in long term sickness absence in June compared to May
- Increase in short term sickness absence in June compared to May
- Stress and anxiety has reduced by 1.1%, MSK has reduced by 1.6%



Month	Long Term	Short Term	Total Absence %
Jun-21	6.59%	2.26%	8.85%
Jul-21	7.21%	2.49%	9.70%
Aug-21	7.61%	2.87%	10.48%
Sep-21	7.64%	4.03%	11.67%
Oct-21	7.43%	4.01%	11.44%
Nov-21	7.50%	3.54%	11.04%
Dec-21	7.67%	4.77%	12.44%
Jan-22	7.29%	4.83%	12.12%
Feb-22	7.38%	3.51%	10.89%
Mar-22	7.23%	4.77%	12.00%
Apr-22	6.70%	4.44%	11.14%
May-22	6.11%	2.75%	8.86%
Jun-22	5.18%	3.94%	9.12%



COVID 19 – Sickness Management

- 17 colleagues currently off on long term sick with Covid
- Covid absence in May was 1.51%
- June saw an increase to 1.90%
- Indicative figures for July is showing an increase to 2.54%





Analysis: Alternative Duties



- Significant challenges in ascertaining accurate information
 - Data not centrally stored
 - GRS does not always align to local intelligence
 - No centrally agreed definition of what constitutes alternative duties
 - Movement between categories

Alternative Duties – Health	39
Alternative Duties – Employee Relations	6
Moved from Alternative Duties to Sickness Absence	0
Permanent Redeployment – either going through process or perm redeployment secured but not started	5
Return to Work	6
Previously on alternative duties but now seconded	0
Tailored Adjustments (recorded as alternative duties)	2



Analysis: Alternative Duties



Reason for Alternative Duties	Number of Colleagues	Average Length of Alternative Duties
Awaiting Surgery	2	5 months
Post Surgery	4	3.5 months
Long COVID	3	7 months
Other (Health)	30	3.5 months

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS1 Wellbeing Support	Ensure our wellbeing strategy is delivered and meets the needs of employees	Workstream is aligned to wellbeing strategy activities	CB	14.03-25.04		11.04 Complete. Workstream mapped against the Wellbeing Strategy
		OH engagement with sickness reviews	CB	28.03-ongoing		Complete and ongoing. OH engagement where appropriate for complex cases.
		Development of wellbeing offer with 111 (inc comms)	CB	21.02 – 04.04		Offer developed and available to colleagues
		Delivery of wellbeing offer with 111 (inc comms)	CB	21.02 – 11.04		Delivery underway to those who need access
		Develop OH offer for induction for 111	CB	21.02 - 11.04		Completed
		Promotion of wellbeing offer to WAST employees e.g. Thrive	CB	21.03 – 02.05		Contract renewal completed. Promo activities ongoing. 02.05 Strat of Thrive contract renewal. Mini launch for HA/Thrive to be discussed.
		Offer mental health conversations training to managers (via React trainers)	CB	02.05 – 12.09		React training available. Live date 18.07.22
		Implementation of health surveillance activities to fill any gaps identified e.g. hearing, night workers, air quality, HAVS	CB	24.04 – ongoing		09.05 - Hearing Surveillance commenced in C&W and North. 18.07 – Hearing Surveillance commenced SE Wales Awaiting information from Working Safely Group regarding next steps for other surveillance
		Implementation of delivery of clinics to stations / ED	CB	18.04-01.08		18.04 started in South West Wales, 09.05 Started North Wales, 24.04 Started in South East Wales, 01.08 starting C&W Wef 01.08 van clinics now throughout Wales
		OH data reporting development	CB			
		Health diagnostics and assessment development	CB	09.05 – ongoing		Funding dependent. 09.05 initial meeting to discuss business case. 20.06 meeting with provider. 27.06 SBAR development underway.
		Wellbeing drop-in sessions & health promo via OHAs and Wellbeing Practitioners	CB	18.04-31.03.23		Continuing the programme in South/C&W-targeted visits dependent on required need. Calendar of events- 2022/23. 02.05 Design of annual events and promotion calendar
		Approach to functional assessments	CB	18.04-ongoing		18.04- initial meeting, 16.05 TU consultation meeting. Amendment to wording – addition of voluntary not mandatory 26.06 – EQIA produced and SBAR amended 11.07 – EQIA being reviewed by ED&I lead
		Delivery of OH training to managers	CB	18.04 – ongoing		May – delivery of initial 4 sessions in May to Ops managers. Good feedback. 27.06 - Further sessions being scheduled.
		On site physio clinics	CB	HOLD		25.04 Meeting FitBack - discussion development of programme. 16.05 Currently not cost effective due to numbers of staff accessing service and geography. Review in October dependent on referral rate.
		Options for creating social exercise groups			On hold	
		Make recommendations based on research for health and fitness interventions		09.05 – ongoing		Expedite letters for staff for assessment / treatment / MRI scans at HB's. Some positive responses received

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS2 Data and Information	To ensure data and information is available to stakeholders and those stakeholders are confident to use that data	Review monthly data and trend analysis. Share information with managers in hot spot areas		28.03 - ongoing		Monthly case conference meetings between People Services and management teams. 25.04 Deep dive CCC 09.05 Data shared with BCU and Carmarthen localities
		Provide monthly sickness data analysis to SOT inc hot spots and trends		04.04 - ongoing		Wef April monthly paper to SOT. Paper updated 16.05 Fortnightly paper to SLT Fortnightly reporting rhythm to EMT request to reduce to monthly 13.07 rejected, maintain fortnightly ufn.
		Refresher training to managers on accessing ESR sickness data through BI and Managers Self Service supported by easy to use guides		18.04 – 30.09		22.07 AJ and JVH discussion on how best can support. Preferred route currently utilise a BI video guide on how to run reports etc.
		Schedule sickness audits reviewing application of policy, RTW and identify missed interventions for staff and provide feedback to managers		09.05 – ongoing		09.05 Initial audits by People Services Assistants using ESR. Informs actions and priorities
		Roll out of 'keep me well and in work' conversations with employees (6+ sickness episodes in a 12 month rolling period) utilising action cards		18.04 – 11.07		22.07 Picked up by All Wales policy / relaunch action card. Completed
		Provide shared drive to collate all sickness absence data for People Services Team		14.02- 07.03.		17.02 Completed
		Roll out e-learning (All Wales) package for sickness absence to managers		Hold		22.07 Awaiting e-learning package from All Wales
		Build interfaces required to maximise flow of absence information between systems		30.05 – 3.10		11.07 Engagement with Resources colleagues. Next steps, seek IT support and budget and scope requirements. Then get clarity on realistic timelines for the work.
		Robotic Process Automation options for managing attendance		Reviewing		Need options review on value for money and benefits. May be other parts of the organisation which will get more benefit from Blue Prism resource

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS3 Management Support		Review current support provided to managers and develop key focus areas for People Services team and roll-out		07.03 – 11.04		Completed 01.05 by People Services Leaders. Based on work volumes team will not attend every MA meeting but will meet with managers to review cases in their areas.
		EMS working group to implement local sickness reporting trial including script to follow for improving attendance at work and effective redeployment/Alt duties and evaluate		07.03 – 03.10		07.03 Trial commenced for BCU. Sickness for trial area reduced in March but increased in April. Further trend was down. Positive feedback from staff and managers with alternative solutions and better staff/ manager relationships.
		Add additional pilot area into sickness reporting		18.04-01.09		09.05 SBAR to EMT with feedback and proposal to extend project. Extension agreed. 30.05 extended across N Wales and Carms. Staff are being supported. 111 have introduced an attendance number for staff to phone when they are unable to attend work, with a focus being on supporting them to remain in the workplace. Feedback is showing that we are able to tailor duties / offer shift swaps etc by the employee speaking to the manager
		Develop EDI and sickness session		11.04 – ongoing		02.05 Content development 27.05 Content complete 06.06 Draft session reviewed and signed off 22.07 Finalising training rollout
		Develop attendance policy session		06.06 – 11.07		Intention to create a T&F group to review the All Wales training session when launched to ensure fit for purpose for WAST. 22.07 Still awaiting launch of training session Mitigation: Will hold until mid August produce a WAST session if not delivered
		Develop managing sickness conversations session, deliver pilot, schedule training for managers and		09.05 – 03.10.		09.05 Paperwork review for STS suggestions to streamline. 17.05 – TU cell for noting 17.05 Work on sessions development 11.07 Three lunch and learns drafted, submitted for content sign off 22.07 One session content sign off. Training rollout plan nearing completion 29.07. All sessions signed off ready for delivery
		Produce recorded training session		22.08 – 05-09		Produce video post pilot feedback
		Develop action cards for Ops team for referral to assist in MA activities		16.05 – 01.08		16.05 Action card development started 11.07 Cards draft complete 18.07 QC and amendments minor tweaks before release 25.07 Cards due to be released
		Maintain regular case review meetings with managers incl. OH input and agree actions.		04.04- ongoing		Completed action and BAU. Central spreadsheet capturing all sickness updates and alt duties, utilised by People Services Team and shared on central Team. Case conference dates: 25.04, 23.05, 13.07(EMS), 15.07(AmbCare) Ensure updates are checked and recorded during each meeting
		People Business Leaders monthly 121s with senior managers focus on sickness, ER and required support		04.04- ongoing		Completed action and now BAU. Monthly meeting established with People Services Leader, People Business Leaders and People Services Partner. Dates 24.05, 25.07

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS4 Workforce Engagement/ Ownership		Develop short workshop and questionnaire to understand workforce views on sickness absence, support offering and sickness ownership	LR	04.07-17.10		22.07 First draft of questions completed. Need review. Looking at best way to share questions and collate information. Need to get questionnaire out at beginning of September. Mindful of timing in terms of REAP 4 and service demand.
		Set up and deliver focus groups x4	LR	04.07 – 17.10		Will be booked in post the questionnaire delivery
		Review and develop interventions based on feedback	LR	17.10 – 31.12		
		Build interventions into project plan	LR	17.10-31.12		
		Develop communications rhythms – sharing high level figures and impact of those, celebrate (caution with presenteeism and message to those with chronic conditions / trauma) reducing absences	LR	30.05 – ongoing		25.06 Meeting with Comms for advice and guidance. First tranche of comms developed. Needs some more work before sharing with Comms. 25.07 Approach developed. Ready to share with Comms for support and feedback

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS5 Long Term Absence Support inc Covid		Roll out guidance from All Wales Guidance for the Managing Long Covid Working Group	AJ	21.02-ongoing		Ongoing and BAU. Latest guidance issued 12.07. All current guidance has been circulated. New guidance circulated in response to changes to pay due to covid absences.
		Engagement with colleagues with long Covid on return to work options (post changes in sick pay wef 1.07.22)	AJ	21.02 - ongoing		04.04 Colleagues advised of change of WG decision and extension of sick pay. 18.04 All colleagues off with long Covid engaged in monthly LTS meetings 30.06 All affected colleagues advised on sick pay change arrangements
		Monthly case reviews on 100 day plus cases with managers	AJ	21.02-ongoing		18.04 – Established in EMS, now BAU. Smaller ad hoc provision outside of EMS based on business need
		Deliver monthly case conferences inc OH, DDWOD and BPs	AJ	21.02-ongoing		BAU - Case conferences ongoing. Attendance includes PSA, OH and Managers
		Develop and implement recovery pathways	CB			Temp parking until September due to workloads on the project
		Covid pay change on 01.07 (changed from 01.04) advise those on Covid LTS	AJ	30.05 - 11.07		Completed
		Amend to Covid pay to 30.06 advise those impacted	AJ	30.05- 11.07		Completed
		Ensure all LTS Covid cases have been referred to OH for up to date review	RM/AJ	07.03 - ongoing		13.04 Completed Into rhythm of referrals based on the needs of the individual

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS6 Pilot Projects		Launch of the new behaviours across the business	CG	By 31.3		Completed – launched at March’s roadshows
		Embed new behaviours across the business	CG	Ongoing		Plan for rollout and delivery with OD team (held separately to MA plan)
		Alternative rostering arrangements – working patterns / self rostering options	LR	12.09-03.23		Kick off post ACAS work with TU Partners to move on Leading Change Together work
		CCC deep dive with management team	JS/AJ	18.04 – ongoing		OH team engaged and working with CCC. 27.06 work with MA team and CCC team underway.
		Decompression time project	LR	12.09-30.03.23		Kick off post ACAS work with TU partners and Ops colleagues (may need to park until fill vacancies in the service)
		Behaviours and culture projects	CG			Wider work on behaviours underway (as above)
		Investigate social event options				Hold for now as other work on MA and other projects are prioritised
		Comms strategy re health promotion and messaging – reach to the workplace	CB	25.04 - ongoing		22.07 All health promotion events covered and completed for 2022. Communications to be sent out prior to the event starting.
		Engagement with paramedic students on role realities	EG	04.04-ongoing		University engagement on what is required underway. 11.07 Students who want a bank contract have been issued with one

WAST MANAGING ATTENDANCE PLAN SUMMARY – 22ND JULY 2022

Area of Focus	What is the objective?	Action	Lead	Start /Finish	RAG	Comments/Corrective Action
WS7 Stress and Anxiety		People Services Team additional training on stress risk assessments	LR	20.06-19.09		22.07 not yet started will arrange rollout for Sept post-holiday season
		Ensure risk assessments are undertaken at the earliest opportunity and review actions	AJ	20.06 – ongoing		22.07 People Services Team supporting managers to complete stress risk assessments for colleagues who would benefit.
		Stress Risk Assessment Process manager training	AJ/LR	22.08-16.10		22.07 Will add in when other training rolled out to managers
		Produce training video and FAQ on the process	AJ/LR	19.09 – 10.10		Meetings with Thrive/Health Assured to produce videos to promote services
		Delivery of pro-active assessments on colleagues at work	CB	18.04 – ongoing		Wellbeing drop-in sessions (CCC/111/NHSD) and health promotion via OHA's and Wellbeing Practitioners at stations/HBs -A&E
		Review referral pathways to wellbeing support	CB	18.04-ongoing		22.07 Review of all contracts/SLAs and other external provision (including funded options) completed. Review of comms re wellbeing for packages recommended
		Develop pathway and support process for violence and aggression cases	DP	20.06-24.10		22.07 Initial discussions underway. LR to work with DP on developing the pathway. Will pull together a task and finish group



AGENDA ITEM No	10
OPEN or CLOSED	Open
No of APPENDICES ATTACHED	0

Health and Safety Performance Annual Report 2021- 2022 (V2)

MEETING	People and Culture Committee
DATE	14th September 2022
EXECUTIVE	Executive Director of Quality and Nursing
AUTHOR	Head of Health and Safety
CONTACT	Nicola White Nicola.white3@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides an update to the People and Culture Committee on key information in relation to health and safety performance, key issues and activities in the period of 1st April 2021 -31st March 22.

The People and Culture Committee are requested to note the following:

- (1) The National Health and Committee Terms of Reference was subject to review with the new arrangements fully implemented during Q1 2022/23 moving the Committee to provide a more strategic overview (para 6).
- (2) The Working Safely Programme 'Pump Prime' phase began on the 1 October 2021 with the appointment of the Working Safely Programme Manager. In addition, recruitment pressures impacted on the recruitment of all of the team. Additionally, capacity of the Business as Usual (BAU) team has impacted on delivery of the programme, as the Working Safely Team has also been managing BAU activities (paras 14-18).
- (3) Instability within the function has proven challenging in relation to being able to respond in a timely manner to support all organisational requirements. A Health and Safety Workforce Transformation Business Case was presented to the Executive Management Team during Q4 2021/22 for approval (para 22). A position is expected to land during Q1 2022/23.
- (4) A review of the work undertaken as part of the "Pump Prime" phase of the Working Safely Programme and the creation of the business case for the Health and Safety Team in relation to Risk 199 and resulted in a draft proposal to reduce the risk level to 15 (par 50).

KEY ISSUES/IMPLICATIONS

It is recommended that the Executive Management Team gives its attention to the following key issues:

- (5) Statutory training for Fire Safety and Manual Handling is below Trust expectations (para 25). Manual Handling incidents continue to be the Trust's highest trend for RIDDOR reporting (para 58, table 13). This is a concern as there is no current designated Safer Handling Lead within the Trust.
- (6) Reporting of incidents in line with RIDDOR reporting requirements proved to be a challenge throughout Quarters 1 & 2. Significant improvements have been made as capacity increased however, there are some ongoing issues with timely reporting of incidents onto DATIX (paras 33-38 & 40).
- (7) Risk 199 – has been subject to review. Several pieces of work undertaken in Q4 2021/22 to assist with potential reduction on risk rating for consideration in Q1 2022/23 (para 50).
- (8) Welfare incidents have increased by approximately 200% since the last financial year. Consideration to be given to increase in staffing and abstraction rates (para 61).
- (9) Despite the limited resources within the Safety function support has been given in key areas (para 71):
- (10) Investigations into violence and aggression incidents are often insufficient in detail. This is proving challenging to evidence anecdotal evidence from staff with potential deviations from Policies and Procedures when deploying crews;
- (11) Internal investigation into the NEPTS road traffic collision that occurred in North Wales in April 2021 concluded in Q4 2021/22. Report to be presented to Executive Management Team in Q1 2022/23 (para 52):

While this report provides the Health and Safety performance within the last twelve months, the Trust recognises that the pandemic heavily impacted on capacity to progress with improvements to the overall Health and Safety Management System. The outcome of the Business Case will look to provide additional resources and to restructure the function in alignment with organisational arrangements. The Working Safely Programme established in October 2021 will provide a holistic, comprehensive means of ensuring a robust, suitable, and sufficient management system, additionally driving the Trust forward to a mature culture of interdependency.

REPORT APPROVAL ROUTE

National Health & Safety Committee – 3rd May 2022
 Executive Management Team – 1st June 2022
 People and Culture Committee - 14th September 2022

REPORT APPENDICES

ANNEX 1 – SBAR which provides the background for this report.

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed

Confirm that the issues below have been considered and addressed

EQIA (Inc. Welsh language)	N/A	Financial Implications	N
Environmental/Sustainability	N/A	Legal Implications	Y
Estate	Y	Patient Safety/Safeguarding	N/A
Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	Y	TU Partner Consultation	Y

SITUATION

1. This report provides analysis of the level of health and safety (H&S) performance throughout the organisation for 2021-2022.
2. The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.
3. The assessment section of this report is structured in line with the All-NHS Wales Health and Safety Management System (HSMS) Principles (1-11) and subsequently the National Health and Committee Action log and Working Safely Programme Action Plan. The principles are.
 - Principle 1- Leadership, Accountability and Culture;
 - Principle 2- Competent People;
 - Principle 3- Compliance Assurance;
 - Principle 4- Risks and Opportunities;
 - Principle 5- Learning from Events;
 - Principle 6- Occupational Health;
 - Principle 7- Asset Management;
 - Principle 8- Contractor and Supplier Management;
 - Principle 9- Communication;
 - Principle 10- Emergency Preparedness;
 - Principle 11- Measuring Performance.
4. Health and safety items that fall within the scope of Health and Safety Principles not detailed within this report have been considered and contained in the context of the Working Safely Programme and reported via its Strategic Transformation Board. Additionally, some health and safety items can be within the scope of more than one principle e.g. the development of safety alerts - P5 Learning from Events or P9 Communication.

ASSESSMENT

AAA Highlight Report

5. The Alert Advise Assure Highlight Report provides a concise overview of:

ALERT / ESCALATE	RIDDOR Reporting Reporting of incidents in line with RIDDOR reporting requirements proved to be a challenge throughout Quarters 1 & 2. Significant improvements have been made as capacity increased however, there are some ongoing issues with timely reporting of incidents onto DATIX (paras 33-38 & 40).
ADVISE	H&S Legislative Compliance Register The Health and Safety Legislative Compliance Register framework is under development and is to be subject to assessment by Health and Safety Function and business units leads in Q2 2022.

	<p>H&S Hazard Register The Health and Safety Hazard Register framework is under development and is to be subject to assessment by Health and Safety Function and business units leads in Q2 2022.</p>
ASSURE	<p>HSE Interaction No enforcement action from the Health and Safety Executive or Local Authority however, a welfare concern was raised in relation to Monmouth Station (para 31).</p> <p>Organisational Risks Risk 199 has been subject to review with changed to the title to more effectively articulate the risk. The new title is now, "Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation"</p>
INFORM	<p>Non-Patient Welfare Incidents have shown an increase in loud noise reporting within the call centre environment that require further investigation (para 30). Local Authority has contacted the Trust to discuss noise monitoring within Vantage Point House in May 2022 (para 31).</p>

6. The National Health and Safety Committee Terms of Reference (ToR) were reviewed to align to a more strategic arrangement. This was approved in Q3 by the Executive Management Team and is to be implemented fully in Q1 2022/23. The revised ToR require the submission of an Annual Report to the People and Culture Committee, with the intention of outlining the work of the National Health and Safety Committee and to identify how it has fulfilled the duties required of it.
7. The Annual Report specifically comments on key issues considered by the National Health and Safety Committee in terms of health & safety, security and the adequacy of policies and plans in place.
8. During the period of April 2021 - March 2022, the National Health and Safety Committee met in July, October and January (2022).
9. Key challenges to date have included COVID, RIDDOR reporting, estates challenges, operational issues and health & safety resources.

Additional Activities and Delivery 2021-2022

10. In addition to report content, the Health and Safety function has continued to provide support on several key pieces of work namely (list not exhaustive):

- health and safety considerations for facilities at Beacon House; Ty Elwy; Vantage Point House (VPH) reconfiguration;
- a construction audit at the new Make Ready Depot in Pentwyn;
- ongoing support to undertake audits following clusters of COVID or areas of concern;
- supported and contributed to Outbreak Control Team Meetings, development of two safety alerts;
- development of a Health and Safety intranet page;
- investigations into road traffic incidents;
- facilitated the development of several operational generic task related risk assessments for EMS and NEPTS;
- Clinical Control Centre lighting survey at VPH;
- DATIX code mapping;
- evacuation chair selection at VPH;
- Supporting crews in court;
- TV interview for JESG;
- attendance at NARSF and NASEG;
- supported the new cohorting arrangements at Morriston Hospital and the Grange Hospital and which have been implemented;
- the development of several COVID-19 risk assessments to support operational crews;
- significant investment in time supporting local managers in the development of local risk assessments and development of safe systems of work where health and safety expertise and guidance was required;
- provided assistance to legal and claims on specific personal injury claims;
- Duty Operational Managers induction training;
- Health and Safety inductions delivered to Newly Qualified Paramedics.

ASSESSMENT

Principle 1- Leadership, Accountability and Culture

Health and Safety Function Resource

11. In June 2021 the external, Interim Head of Risk, Health and Safety was successfully appointed into the substantive position of Head of Health and Safety. The Risk element of the previous role was removed from the portfolio to sit within Corporate Governance.
12. The Health and Safety function has been subject to a significant amount of flux with many members of staff leaving or joining the team. In October 2020, the three Health and Safety Managers and the Administration Officer were not in work due to a Human Resources related matter. This was resolved in September 2021 however; a continued staffing challenge has endured. This disruption continued to place additional pressures on the rest of the team.
13. During Q1 2022, a Directorate Support Officer commenced their permanent position within the Trust serving both the Health and Safety function and the Infection Prevention and Control team.

Working Safely Programme

14. In Q1 2021 the Trust recognised that the Health and Safety Transformation Plan was more inclusive to other business units and subsequently was further developed to become the Working Safely Programme. This programme became an IMTP deliverable for the Trust. To support this Programme, funding was allocated to resource additional roles during the programme's 'Pump Prime' phase - October 2021- September 2022.
15. One of the 2 fixed term H&S Coordinator posts (previously appointed in Q3 2020 to provide some support to the function), was successfully appointed to the fixed term position of the Working Safely Programme Manager in August 2021. The other left the organisation for a permanent contract in November 2021.
16. With the external market buoyant for health and safety professionals, with demand outstripping supply following increased focus placed on the sector during the pandemic, there were significant challenges in recruiting into all positions that were allocated funding. In November 2021, 1 of the 2 fixed term Health and Safety Coordinator posts was filled and during Q3 & Q4, 3 WAST staff members were seconded into the role of Staff Officer and integrated into the team to support the 'Pump Prime' phase.
17. During Q1 2022, the second fixed term Health and Safety Coordinator commenced with the Trust. Additionally, a Health and Safety Manager has been sourced via a consultancy agency to provide sickness absence cover support in Q4 2021 until the 2 Health and Safety Managers positions are filled (interviews scheduled for May 2022).
18. The appointment of a newly established team has provided a continuous period of challenges in gaining organisational awareness however, despite these challenges, the team is working together very effectively.
19. During the year, most of the business-as-usual duties required of the Health and Safety Team have been fulfilled by staff either recruited or seconded to the Working Safely Programme.

Working Safely Transformation Board

20. The Working Safely Transformation Board was established in Q3 2021 with its action plan developed and approved by the Executive Management Team in Q3 2022. From this comprehensive plan, the top 10 priority deliverables were approved with 6 delivered by Q4 2021. These include an improved risk assessment process incorporating human factors and a complete online DSE training and assessment package that will provide financial benefits as it allows the Trust to turn off its current system provided by an external provider. Both deliverables will be implemented during Q1 2022/23.
21. The governance arrangements for the programme have been established with the setting up of a Dynamic Delivery Group to steer the progress of the products being developed and the establishment of the Strategic Programme Board to ensure the programme delivers on its IMTP requirements.

Health and Safety Transformation Business Case

22. In Q4 2021, the business case entitled 'Health and Safety Workforce Transformation' was developed and subsequently presented to the Executive Management Team. This business case details a proposal for a tiered approach for effective integration of the team into the Trust leadership structures. It is expected a decision will be communicated during Q1 2022 and will influence the delivery of the 5-year Working Safely Programme Plan.

COVID Advisory Support

23. Continuing from the previous financial year, the Quality, Safety and Wellbeing Advisory Cell reduced frequency to bi - weekly. It continued to act as an advisory function on matters related to quality management, infection prevention & control, wellbeing, patient safety and health & safety, to provide advice and guidance to Trust teams, groups and cells. This group fed into the Senior Pandemic Team, more lately the Business Continuity and Recovery Team.
24. Throughout the year there has been the continual need to support areas with the workplace risk assessments required because of the COVID-19 pandemic. The risk assessment template has seen 2 revisions to aid the quality of the assessments and these have made a positive impact on Trust premises. The completion rate for the first revision was 100 percent, whilst the completion rate for the second revision is high the Safety Team is assisting the areas where there are questions outstanding.

Policies

25. The Lone Worker Policy was presented at Policy Group in August 2021/22 and recommended that it progress through the approval process. Subsequently, it was presented to the Executive Management Team with recommendations of the development of supporting procedures for both Corporate and Operational staff. Further discussions are ongoing with further meetings scheduled for Q1 2022 to determine a way forward.

Principle 2 - Competent People

Health and Safety Training Compliance (as of 31 March 2022)

26. Statutory training compliance levels for Manual Handling and Fire Safety are well below the Trust and Welsh Government compliance requirements. With the Trust continuing to experience high levels of manual handling reported incidents Managers are required to encourage staff to bring their training back up in line with required compliance levels.

Training Course	Required	Achieved	Compliance %
Health and Safety Awareness	4057	3736	92.09%
Fire Safety	4057	2142	52.08%
Manual Handling	6546	3335	50.95%
Violence and Aggression	10075	8826	87.60%

Table 1: Illustrates training performance

IOSH Managing Safely Courses

26. Due to function capacity, periods of high operational pressures and availability to attend, only 3 IOSH Managing Safely courses were delivered to 20 Operational Team Leaders online, via Microsoft Teams. All were able to pass the course. As a result, learners were able to clearly understand their Health and Safety accountability as managers. All found the course material applicable to their roles and benefitted from the practical risk assessment undertaken during the course with the help of their tutor. The feedback from all attendees was very positive. Following the course Managers are actively engaging with the Health and Safety function for help and support with Health and Safety issues.
27. A schedule for monthly training sessions has been developed for Quarters 1 & 2 2022 with training recommencing in May 22.

Leading Safely Training

28. IOSH Leading Safely Training has been developed and piloted in Q2 2021/22. This course is aimed at the Executive Directors and Board and senior management within the Trust. A schedule for training is being communicated in Q1 2022/23.
29. A WAST Leading Safely Conversations Audit Training has also been developed and piloted in Q2 2021/22. This is part of the Working Safely behavioural training programme for the Executive Management Team, the Board and all the management team. A schedule of training will be communicated in Q1 2022/23.

Principle 3 - Compliance Assurance

Enforcement Authority Interaction

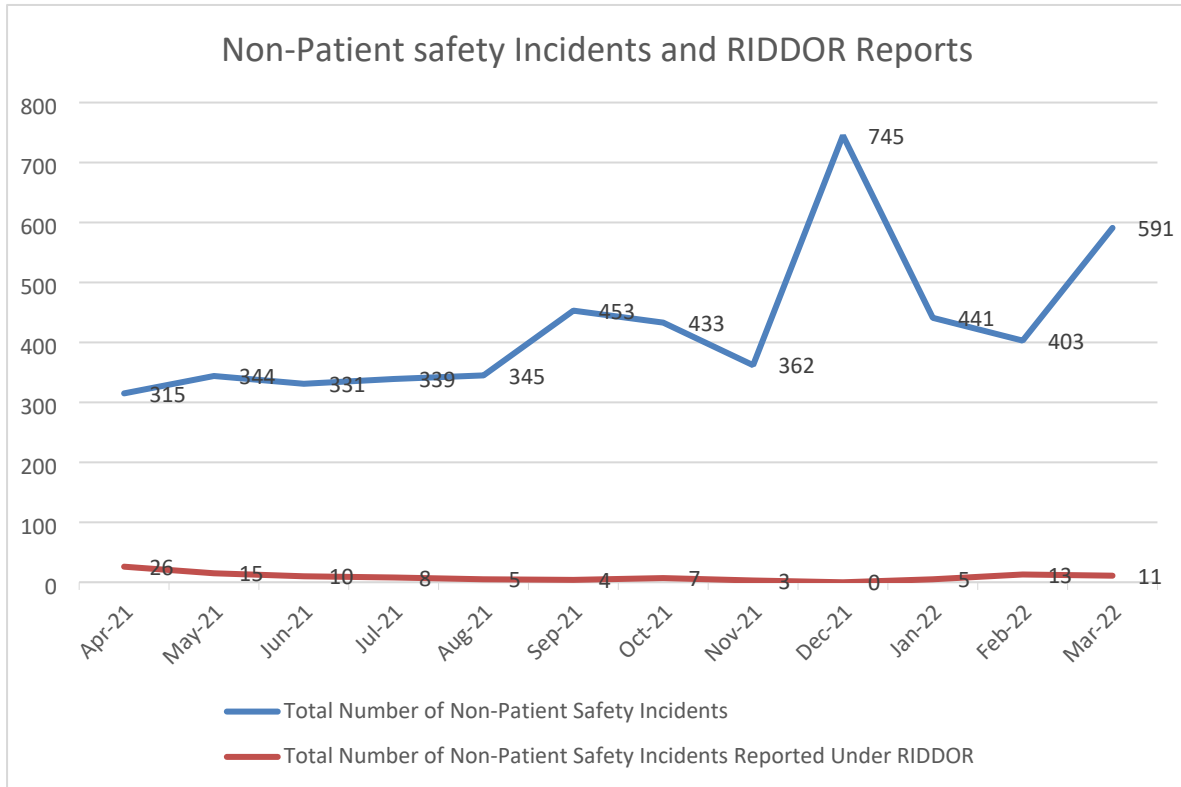
30. During Q4 2021/22 Local Authority has been in contact with the Trust regarding noise levels in Vantage Point House following 2 RIDDORS reported to the Health and Safety Executive (HSE). During 2021/22 there were 137 incidents reported on DATIX for the 111 business unit. Initial scoping work was undertaken with a full noise monitoring survey undertaken on 16/04/2022. A full report will be submitted to the Assistant Directors Leadership Team (ADLT) during Q1 2022/23 and the Executive Management Team for discussion and approval for any potential action if required. A meeting with Local Authority has been scheduled for April 2022.
31. Additionally, in Q4 2021/22, the Trust received a workplace concern from the HSE regarding welfare concerns at Monmouth Station. This did not progress to a visit from the Inspector or any Notifications of Contravention however, a health and safety inspection undertaken in Q2 2021/22, previously in conjunction with Estates, had identified actions that require addressing.
32. Anecdotal evidence suggests there is an expectation that the Trust is likely to be subject to an inspection by the HSE during Q3 2022 for Violence and aggression, Manual Handling and potentially the safe use of sharps.

Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 2013

33. Following an action required by the HSE in a Notification of Contravention in 2020 was the lack of timeliness in submitting RIDDOR reports by the Trust. A new reporting process was communicated throughout and implemented on 26 August 2020. Previously all RIDDORS were reported by relevant Line Managers and did not allow for quality control. The new process was expected to ensure RIDDOR submissions are overseen by the H&S function only. This was to provide consistency and ability to submit in a timely manner.
34. Significant improvements have made within the Q4 2021/22 as capacity within the Health and Safety function increased. However, there are still challenges in meeting RIDDOR reporting times frames. Delays between the reporting are due to several factors the main ones being:
 - A lack of factual information to make a report to the authorities;
 - An injured person is away from work and communication with their line manager has not been able to understand the reason for the absence;
 - The Line Manager/DOM/OTL has not been available to progress the investigation and note if it meets the requirements for reporting under RIDDOR;
 - Some incidents are being identified by handler as reportable when subject to scrutiny, they are deemed not reportable. This places additional pressures on the function to review these incidents (table 6). This was presented at Senior Operational Team meeting in April 2022 to address concerns and assist with improving overall reporting compliance.
35. There is potential for the Trust to receive Notifications of Contravention from the Health and Safety Executive (HSE) for late RIDDOR reports for COVID-19 cases, as a significant period of time is being required to complete local investigations and a backlog of investigations continue to be progressed. The Trust continues to provide a team of staff members to provide additional support to Line Managers and the Health and Safety function.
36. 1,030 staff have been reported onto DATIX as confirmed as tested positive for COVID-19+ for the period of April 2021 - March 2022, with the highest numbers during Q4 2021/22. A breakdown of reporting is located within appendix 1.
37. RIDDOR stakeholder panels continue to be held and subsequently 62 RIDDORS have been submitted to the Health and Safety Executive since the start of the pandemic. To date there has been no further action from the HSE in relation to COVID-19 RIDDORs submitted. Approximately 30% of reported COVID cases have been subject to a full investigation.
38. Performance indicators measuring progress of investigations and RIDDORs submitted to the HSE were presented at Senior Pandemic Team meetings and since Q1 2022/23 to the Business Continuity and Recovery Cell.
39. With the HSE changing their RIDDOR guidance position on 01/04/22 to report on cases where there is evidence to support exposure from a COVID patient only, this will significantly reduce the amount of work pressures required and provide more capacity to clear the outstanding backlog.

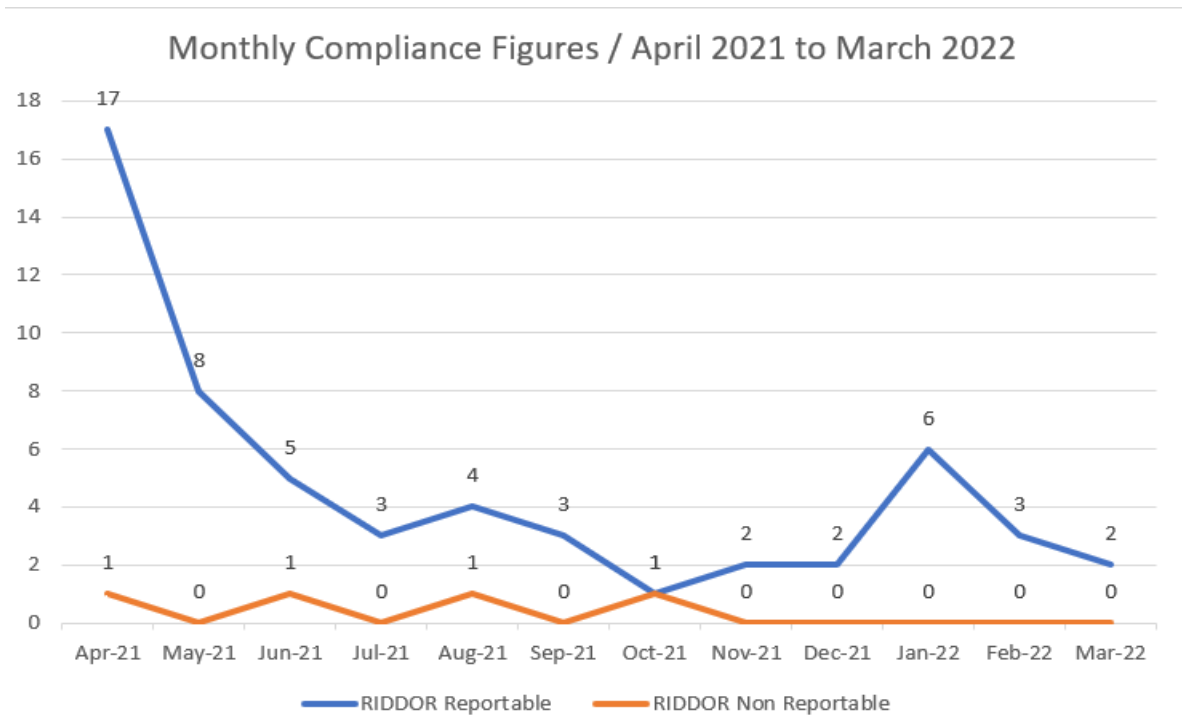
RIDDOR Reporting Rates

40. The tables below highlight the number of non-patient safety incidents identified by handler as RIDDOR reportable. A further breakdown is provided under Principle 11 - Measuring Performance.



Graph 1: Illustrates incidents identified as RIDDOR reportable against number of non-patient safety reported incidents.

Number of RIDDORs submitted and number of incidents (identified as reportable by handler) but are non-reportable incidents.



Graph 2: identifies number of RIDDORs submitted.

Number of RIDDORS submitted outsider of reporting requirements (injury -10 day/ sickness absence - 15 days)

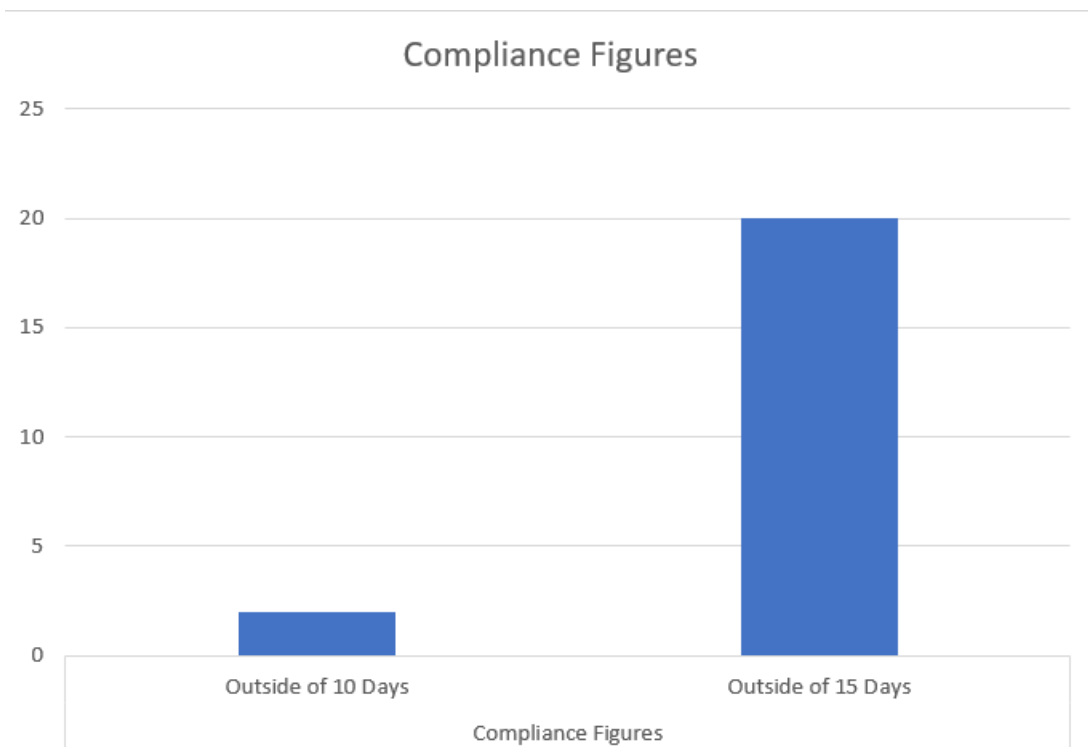
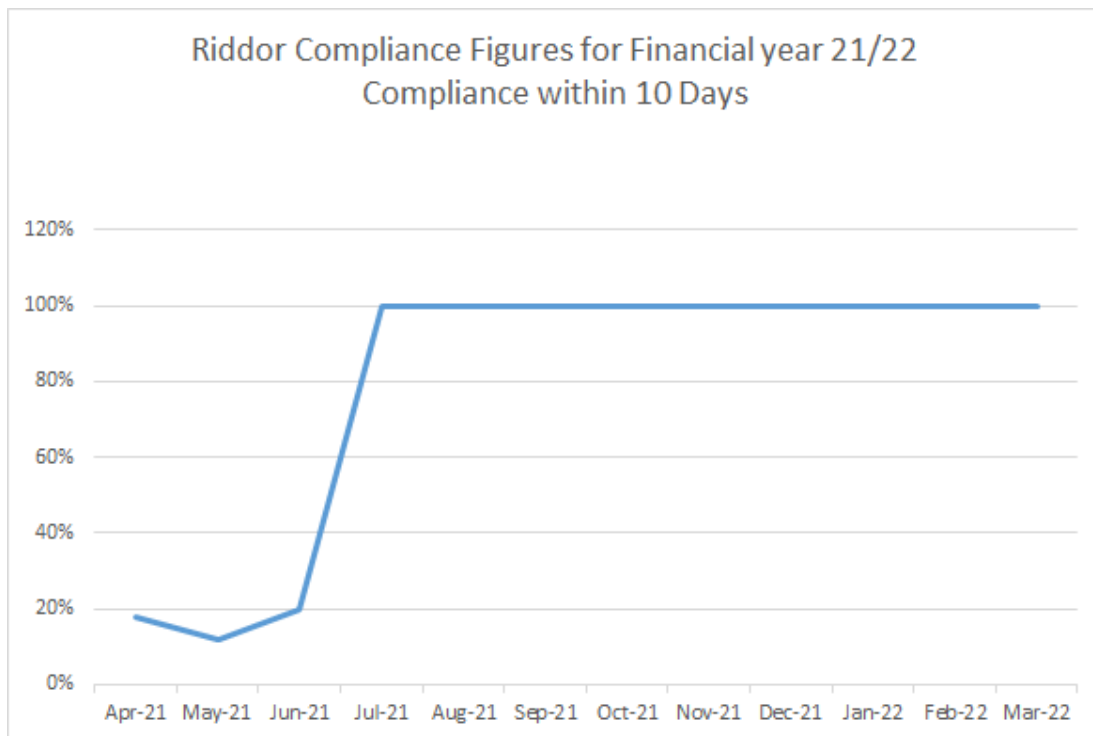
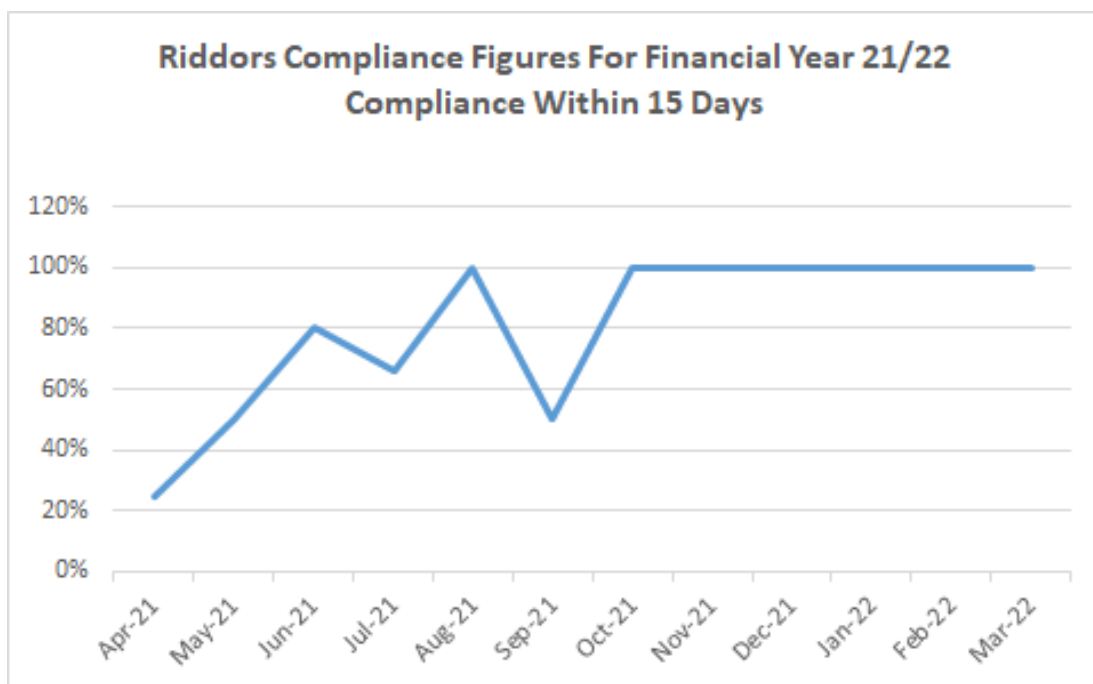


Table 2: Highlights number of RIDDORS submitted outside of reporting requirements for 10 and 15 day categories.

RIDDOR Compliance



Graph 3: Illustrates RIDDOR reporting compliance for Injury category



Graph 4: Highlights RIDDOR reporting compliance for sickness absence category.

Workplace Risk Assessments

41. The Workplace Risk Assessment template was further reviewed to reflect changes to guidance and subsequently the Trust commenced its fourth review of its estate workplace risk assessments. Compliance was monitored frequently at the Senior Pandemic Team meetings. Both Trade Union partners and the

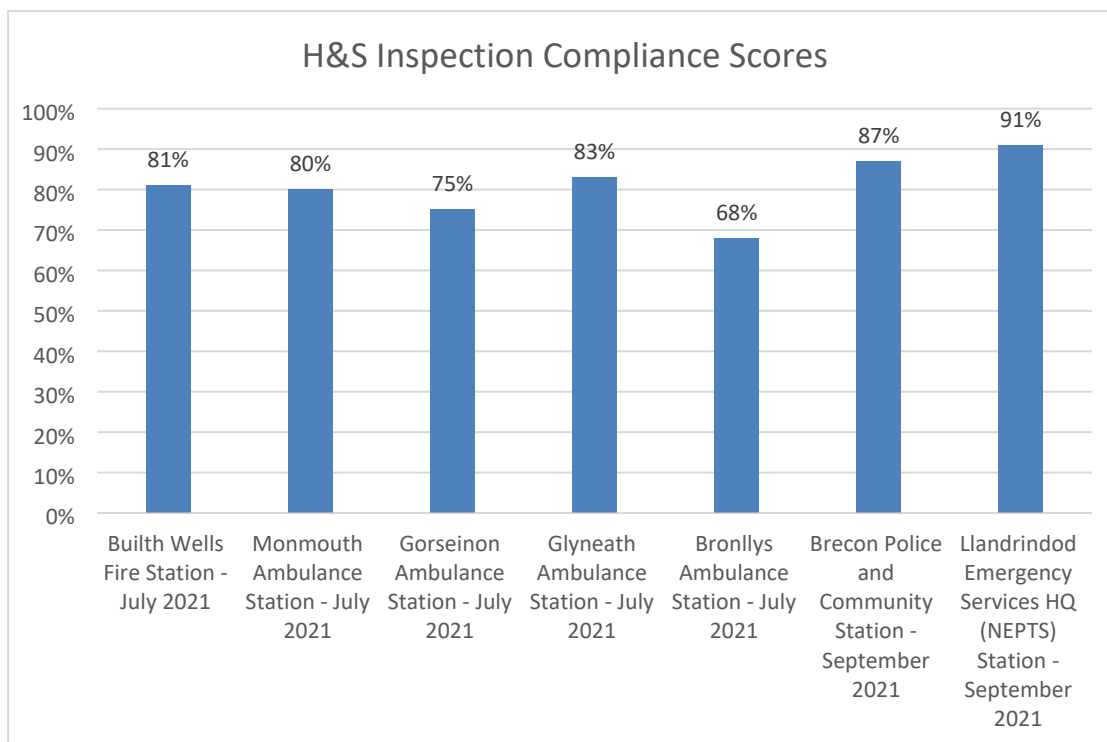
Health and Safety function have supported the process with the completion and review of additional site risk assessments and additionally undertaking health and safety premise inspections where issues have been identified via risk assessment or Trade Union partners / staff concerns.

Introduction of COVID Champions – Dec 2022

42. Following a request from the Operations Directorate in Q3 2021/22 for COVID champions to be present within areas of high footfall, a COVID inspection checklist was developed and implemented in December 2022 and completed by Managers / COVID Champions. Six Champions have been nominated for key areas such as Vantage Point House, Ty-Elwy, Matrix House and the Clinical Contact Centres. All 6 members of staff have commenced 1 of the Working Safely Programme actions of receiving behavioural (positive safety conversations) training. This commenced the start of the Trust's behavioural safety work and will assist greatly within their remit of COVID Champions. Additionally, the checklist was developed further and made available on tablets for easier completion.

Premise Inspections

43. Several Health and Safety inspections have been undertaken on the following premises between the period of April 2021/22, following issues raised to provide support to Estates colleagues:
- Monmouth;
 - Glyn-Neath;
 - Brecon Police and Community Station;
 - Llandrindod Wells NEPTS shared station;
 - Builth Wells Fire Ambulance Station;
 - Amlwch;
 - Gorseinon;
 - Bronllys;
 - Bassaleg;
 - Pontypool.
44. The output of these were contained with the Health and Safety monthly report which is presented at ADLT and quarterly at National Health and Safety Committee.



Graph 5: Illustrate premise inspection compliance scores

45. It is to be recognised that this score is dependent upon a range of factors and that scoring in several cases (Estates, statutory requirements compliance and items not applicable to the premises) have raised the overall compliance rating. The current health and safety inspection has recently been reviewed to incorporate IPC and Environmental criteria with a three-year inspection schedule to be implemented during Q1 2022/23.
46. Further premise inspections have been conducted at several sites, to provide advice in relation to COVID requirements and control of pathogen spread.
47. Common themes arising from Workplace Risk Assessment and site inspections are:
- challenges around social distancing due to foot fall levels;
 - locker provision;
 - parking facilities;
 - obtaining statutory information from landlord;
 - Inconsistencies in relation to cleaning regimes.

Principle 4- Risks and Opportunities

48. In Q4 2021/22 a diesel fume monitoring survey was undertaken by an outside provider at Glan Clwyd Hospital. A paper outlining the findings and recommendations is to be submitted to ADLT for discussion in May 2022.
49. Further surveys are set to be undertaken throughout Q1 2022/23 at the Grange and Morryston hospitals.

Risk Register

50. There is one Health and Safety risk on the Corporate Risk Register Risk 199 – Failure to embed an interdependent and mature health and safety culture which could cause harm and breach in compliance. This risk has most recently been reviewed and is monitored monthly. Several actions have been assigned against the risk in order to reduce the current risk score of 20. At time of writing, several actions are near completion that is expected to enable the risk to be reduced to a risk score of 15.
51. Risk 316 – Potential for high volume of Personal Injury Claims citing work related COVID exposure – previously listed on the Clinical Risk Register (CRR) was closed and archived during Q4 2021/2 due to current intelligence from our Legal team regarding claims to date.

Corporate Risk Register			
Risk Title	Risk ID	Risk Score	Progress against action
Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	199	15	<p>Likelihood subsequently reduced in May 2022 due to the following;</p> <ul style="list-style-type: none"> • Implementation of the Working Safely Programme; • Health and Safety governance and reporting arrangements in place; • Work-force review concluded; • Compliance Register framework completed, assessments to commence in Q2 2022; • Approval for Health and Safety Management System;
Potential for a high volume of Personal Injury claims due to work acquired COVID infections.	316		<p>HSE changes of position on the 1 April 2022 removed the requirement for staff-to-staff contamination. This significantly reduces the potential for industrial injury claims going forward the date of legislation changes. COVID infections prior to the 1 April 2022 will still require investigation to identify the source of infection for reporting to the HSE under the previous legislative requirements. Risk closed on 28 March 2022. Risk archived.</p>
Directorate Risk Register			
Risk Title	Risk ID	Risk Score	Progress against action
Health and Safety Team-Resource capacity.	372	16	Risk to be subject to significant review in Q2 to reflect conclusion of Workforce Transformation business case and subsequent appointments

			made to commence on 3 rd October 2022.
Local H&S Risk Register			
Risk Title	Risk ID	Risk Score	Progress against action
Risk of Violence and aggression towards staff	400	15	Violence and Aggression Manager to commence with the Trust on 22 nd August 2022. Postholder will be required to undertake a strategic review of violence and aggression processes during Q3-Q4 2022. This risk has been reviewed by Directorate management for further consideration.

Principle 5 - Learning from Events

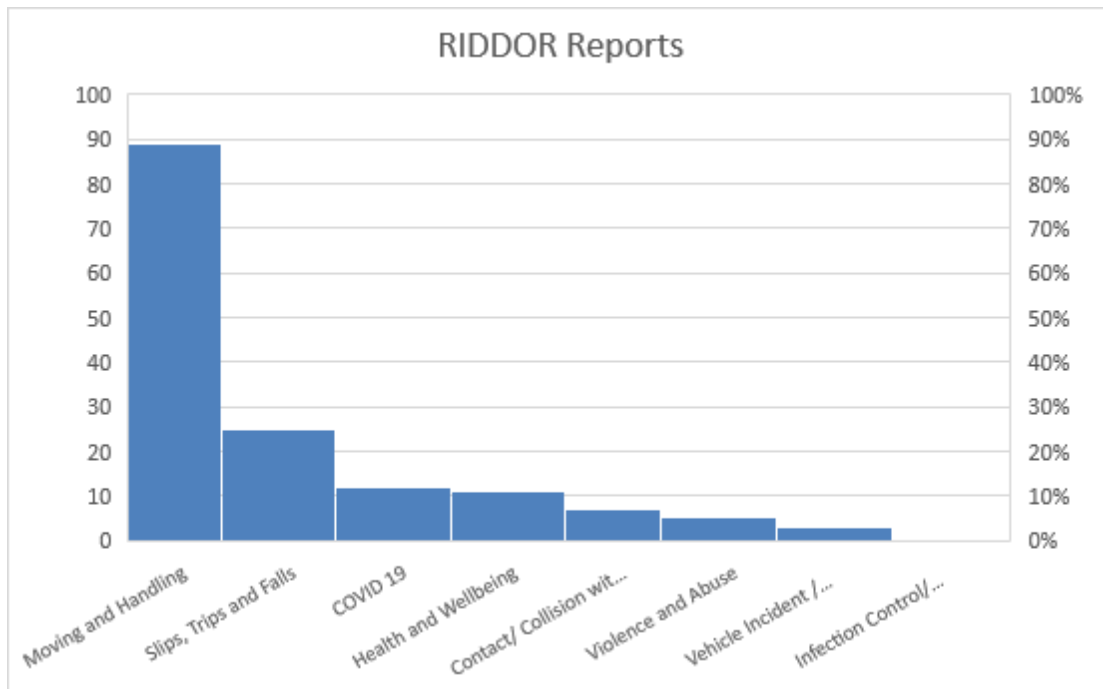
52. Following the Non-Emergency Patient Transport Service (NEPTS) serious road traffic collision near Dolgellau on the 8th April 2021, an investigation panel was established and chaired by the Executive Director for Quality and Nursing. Initial recommendations were made and actioned and a thorough internal investigation was undertaken jointly by the National Manager for NEPTS and the Head of Health and Safety.
53. The internal investigation concluded in February 2021 with a comprehensive investigation report expected to be provided to the Executive Management Team in Q2 2022.
54. As a result of one of the initial recommendations, a Safety Restraint video was developed by the Communications team with the health and safety function and NEPTS staff. This video was launched by the CEO at WAST Live on 25th August 2021 and has been cascaded throughout the Trust.

Principle 11- Measuring Performance

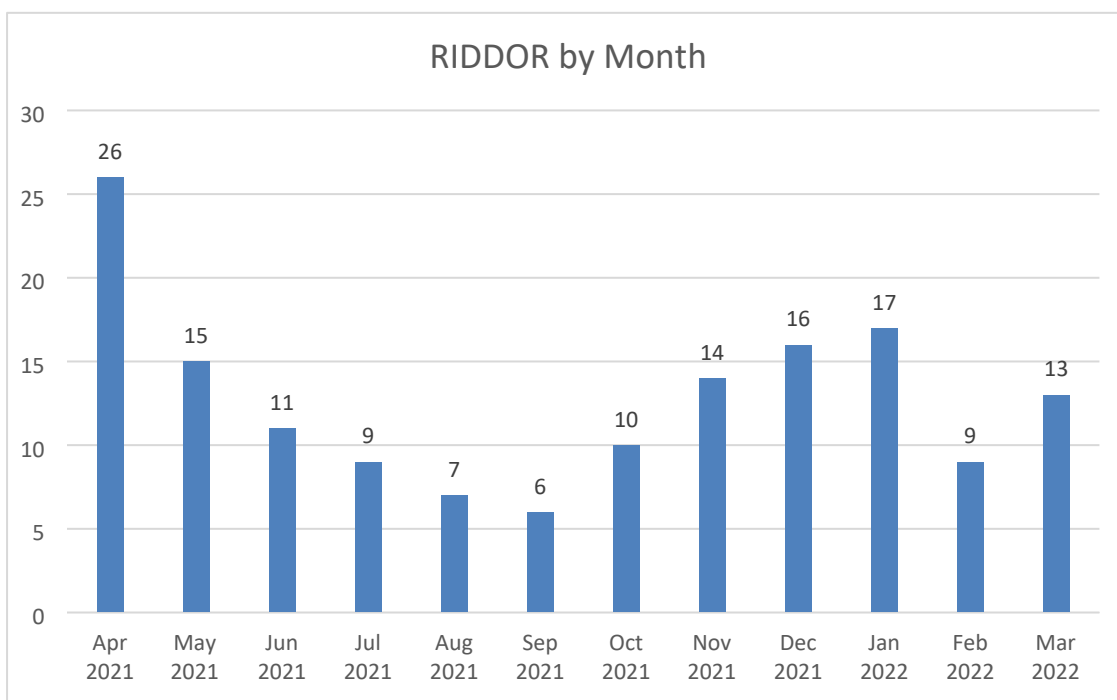
COVID incidents

55. 1,030 staff have been reported onto DATIX as confirmed as tested positive for COVID-19+ for the period of April 2021 - March 2022, with the highest numbers during Q4 2021/22. A breakdown of reporting is located within Appendix 2.

Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 2013.



Graph 6: Illustrates RIDDOR categories (includes incidents wrongly identified as being RIDDOR reportable)

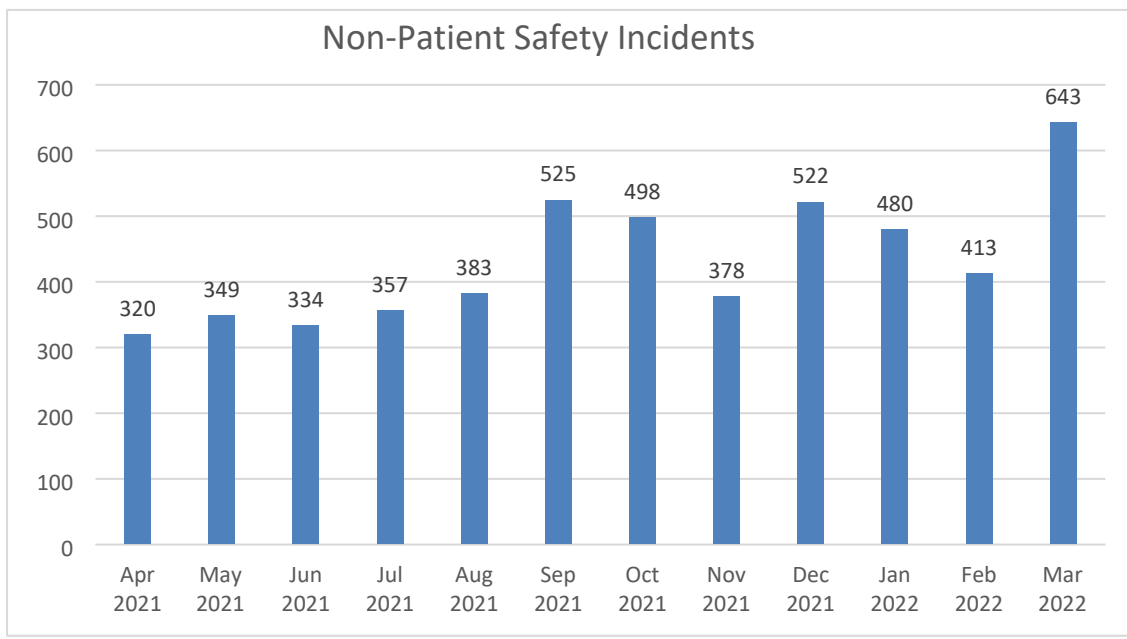


Graph 7: Illustrates number of incidents identified by handler or H&S function as RIDDOR reportable per month

Incident Reporting

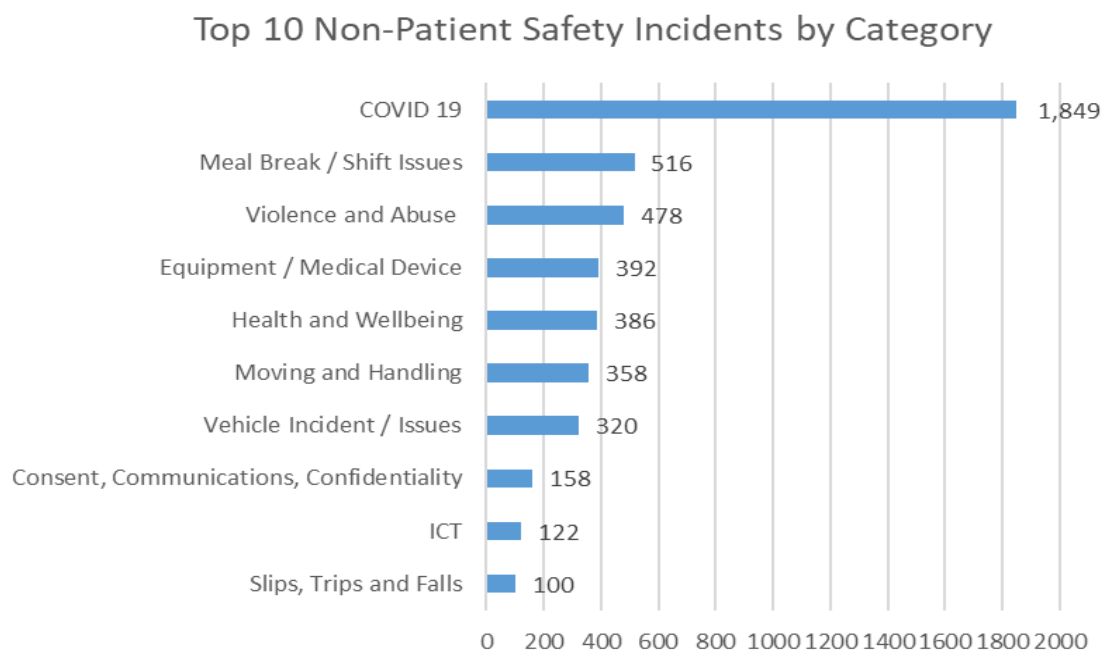
56. There has been a 19% increase from 2020/21 with 5,202 non-patient incidents reported in the current financial year to date, the vast majority related to EMS Operations.

Number of Non-Patient Safety Reported Incidents



Graph 8: illustrates number of Non-patient Safety Incidents by month

Top 10 Non-Patient Incidents Reported by Category

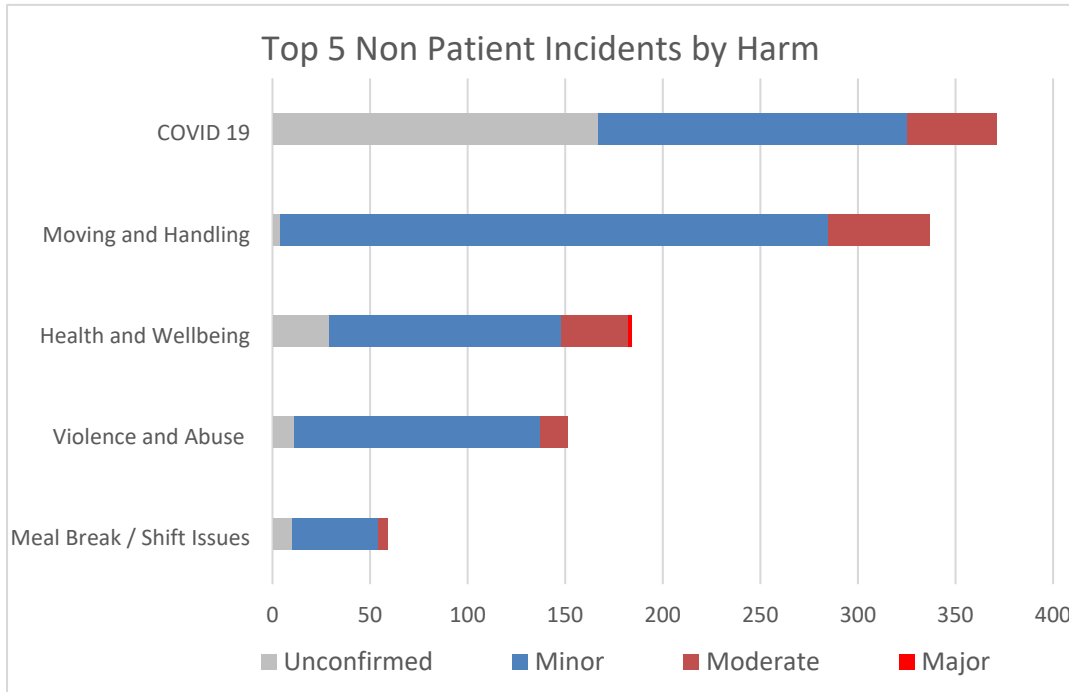


Graph 9: Illustrating top 10 staff reported incident category

57. The high levels of COVID-19 incidents reflect the reporting of staff with COVID-19 or its symptoms. These are also responsible for the surge in incident numbers during the 4 months from December 2021 to March 2022.

58. Manual handling injuries remain the primary cause of harm to staff (excluding COVID-19 related incidents) and of RIDDOR-reportable incidents.

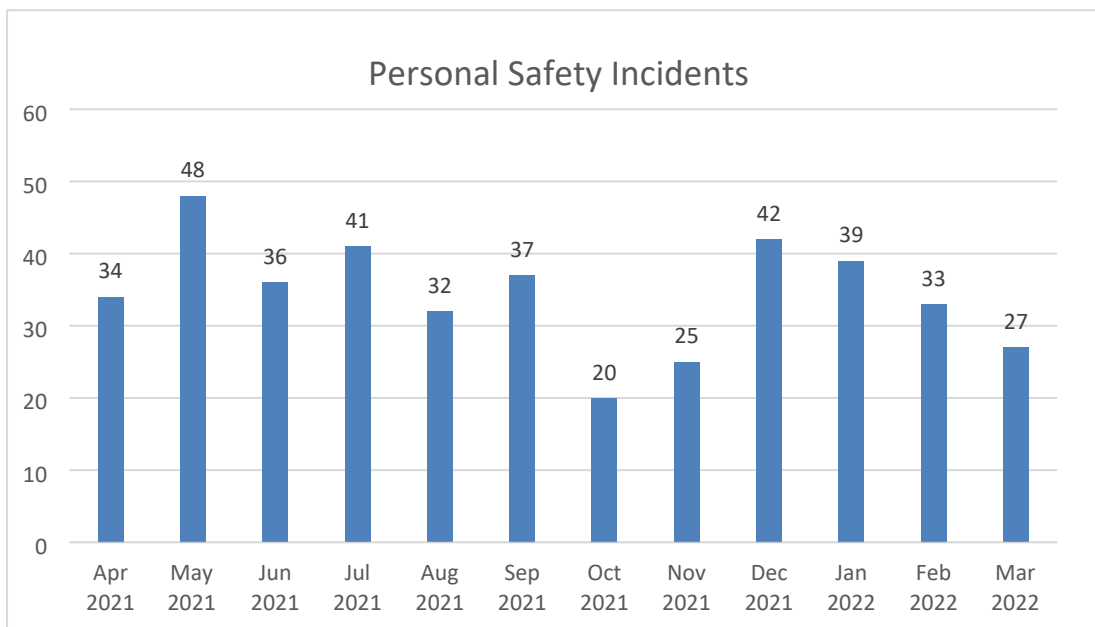
Top 5 Non-Patient Incidents by Harm Rating



Graph 10: Number of non-patients reported incident by harm rating

59. Personal safety incident volumes are slightly elevated compared to the previous year, particularly during May - Aug 2021.

Number of Personal Safety Reported Incidents



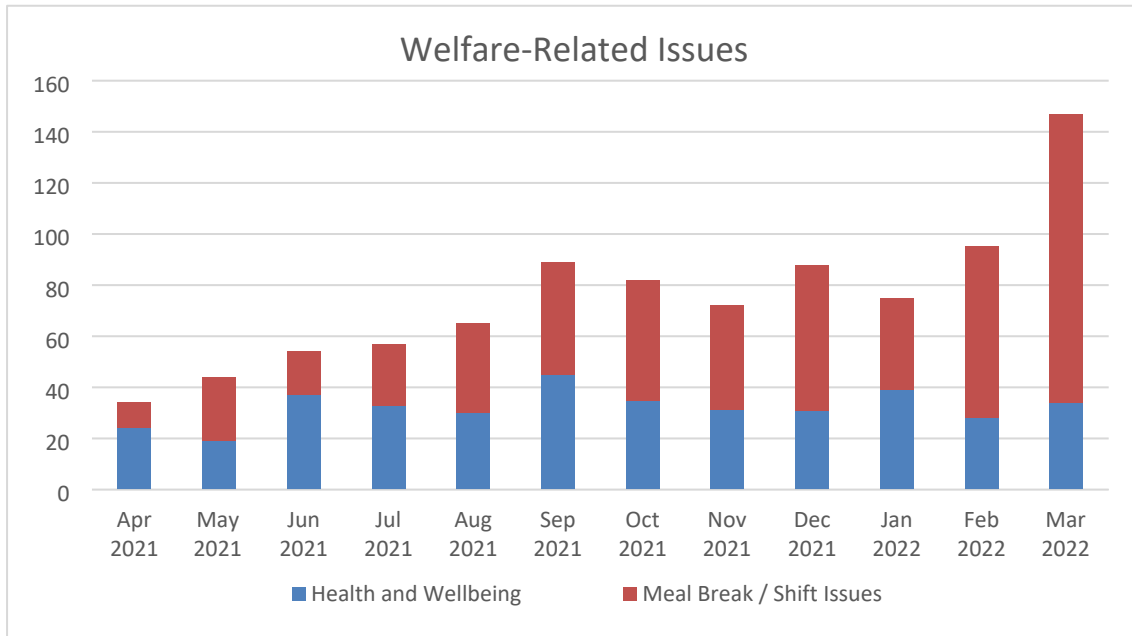
Graph 11: Illustrating number of Personal Safety incidents

60. The high levels of incidents relating to equipment/medical devices reflects a more comprehensive approach to the recording of faulty or lost Digi-pens.

61. Over 900 incidents were reported relating to a combination of health & wellbeing. These included incidents related to missed meal breaks, shift over-runs,

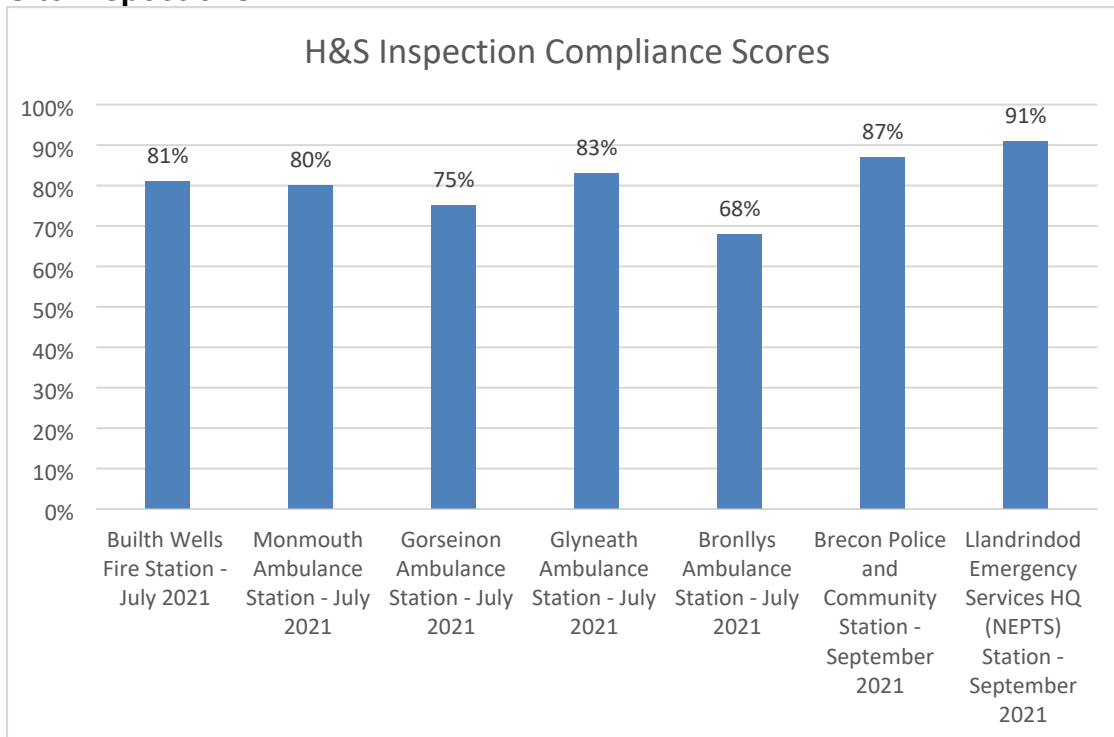
tiredness and fatigue, stress and anxiety. The volume of incidents was seen to increase during the winter period with volumes reaching 147 incidents in March 2022. A long-term solution for these will need to be sort in collaboration with Operational Colleagues, Occupational Health Team and People Services.

Number of Welfare Related Reported Incidents



Graph 12: Illustrating number of welfare related incidents.

Site inspections



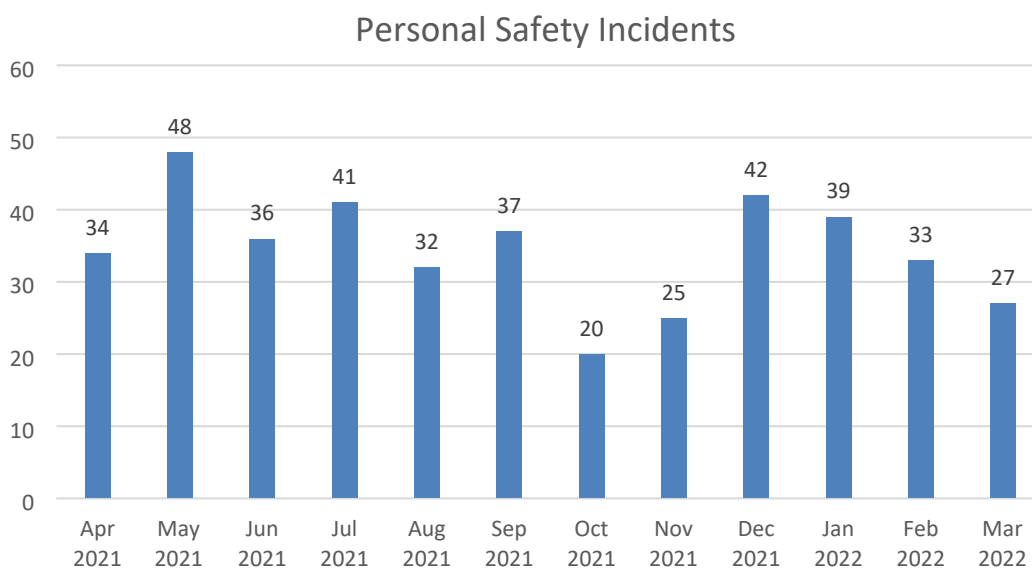
Graph 13: Illustrates H&S compliance per premise.

Violence and Aggression

62. Since the launch of the Obligatory Response to Violence (ORV) document in November 2018, incident rates continue to increase each year. The ORV annual reporting period is January – December.

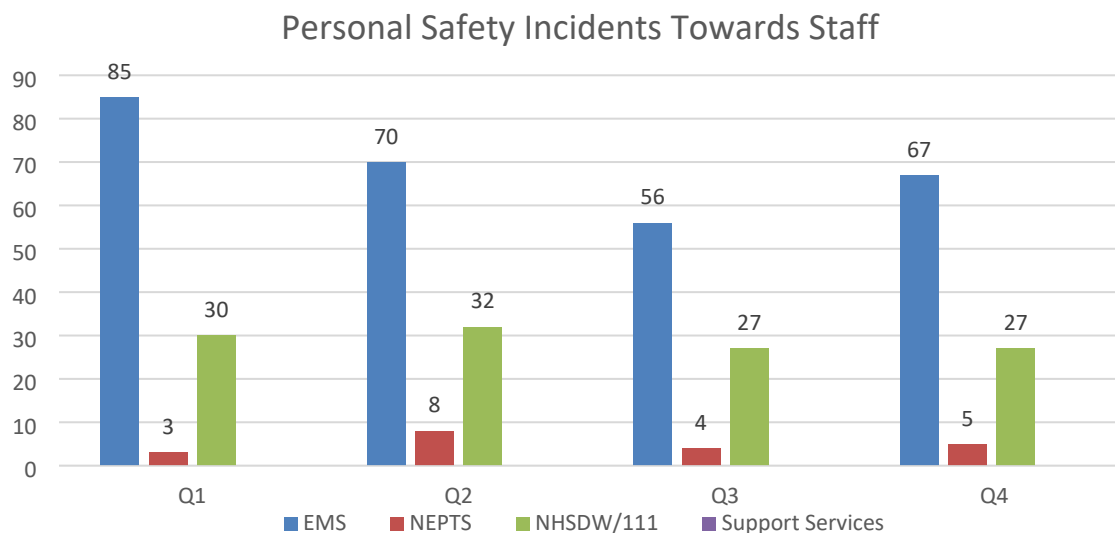
- November 2018 to December 2018 – 28;
- January 2019 to December 2019 – 366;
- January 2020 to December 2020 – 495;
- January 2021 to December 2021 – 500;
- Total - 1,389

Number of reported personal safety incidents rates per month.



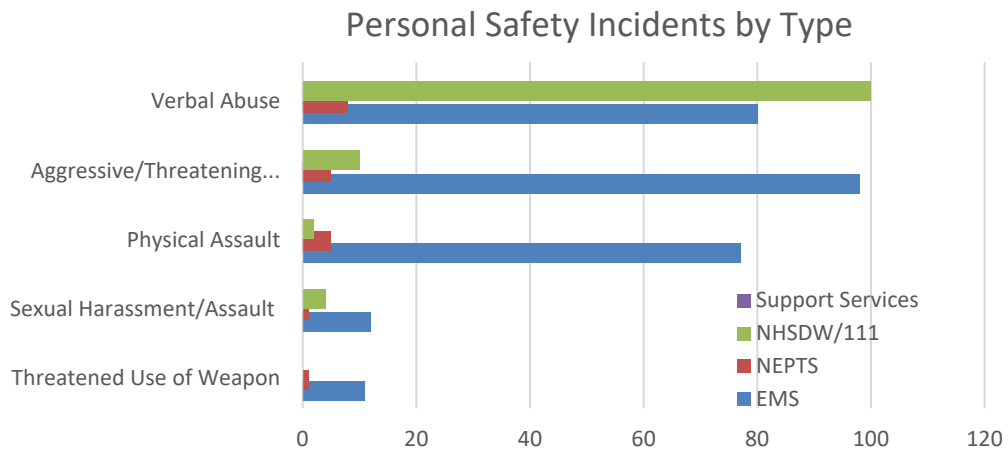
Graph 14: illustrates number of personal safety incidents reported per month.

Number of reported personal safety incidents rates per month against respective business unit.



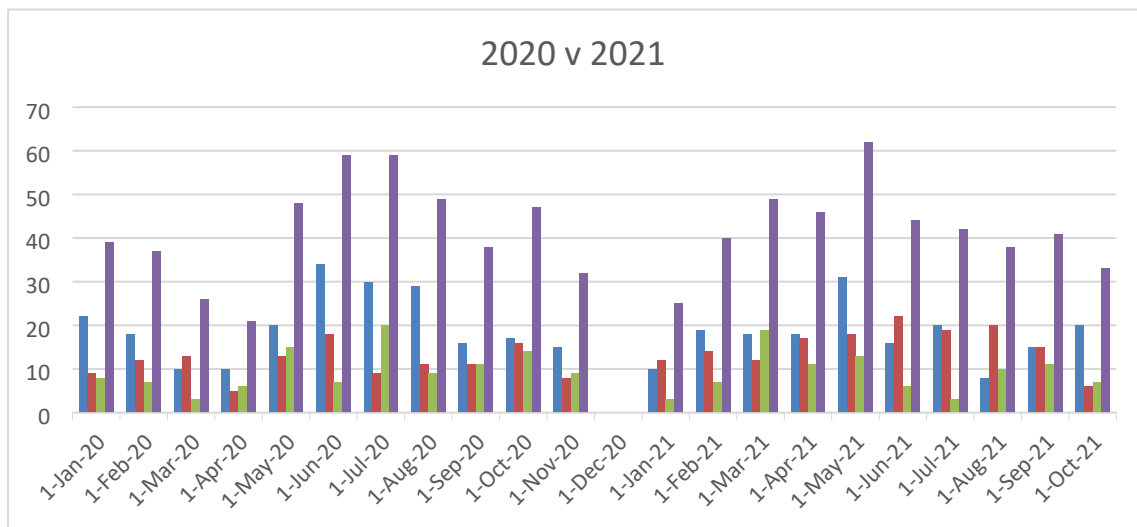
Graph 15: highlights personal safety incidents per business unit.

Number of reported personal safety incidents rates per month by type.



Graph 16: identifies personal incidents by category.

Number of reported personal safety incidents per business unit since November 2018.



Graph 17: Violence and Aggression reported incidents breakdown 2020 – 2021

Court Outcomes

63. Since November 2018, 103 cases have progressed through the courts.
64. Prosecutions have taken place for offences against WAST staff. These include physical assault, threats of violence, racial abuse, sexual assault, homophobic abuse and criminal damage, often reported in the local and national press. Outcomes include (not exhaustive):
 - 26 weeks custodial sentence;
 - 12-month custodial sentence suspended for 18 months custodial sentence;
 - 24-month community order;

- 150 hrs unpaid work;
 - £1000 compensation order in favour of the victim.
65. As of the April 2022, there were currently three scheduled hearings set for Magistrates Court in the next few weeks.

66. The table below details Violence and Aggression incidents outcomes:

Annum	Crown and Magistrate Courts Cases.
2018 (Nov-Dec)	7
2019	25
2020	46
2021 (Jan-Feb)	25
TOTAL	103

Table 3: Breakdown of Violence and Aggression incidents outcomes.

67. Service Impact Statements have been provided by the Chief Executive Officer. This informs the court of the negative impact of these cases have on service delivery.
68. 29 custodial sentences have been handed down by the courts. The financial penalties include fines, CPS costs, victim surcharges and compensation orders. Compensation orders made by the Courts (to staff and / or Trust) and have exceeded £25,000.

69. The table below details sentences passed by courts since November 2018:

	Custodial Sentence	Suspended Sentence	Financial Penalty	Community Order	Out of Court disposals (Restorative Justice)
Nov 2018 to Dec 2018	2	1	6	3	2
Jan 2019 to Dec 2019	10	5	19	7	19
Jan 2020 to Dec 2020	12	14	40	24	19
Jan 2021 to Dec 2021	5	7	18	18	12

Table 4: Breakdown of court sentencing Nov 2018 – December 2021.

70. The number of sentences passed between January and December 2021 were lower than previous years due to a combination of factors associated with the impact of the Covid-19 Pandemic on the judicial system. However, post pandemic now indicates a return to previous reporting figures.

Objectives

71. The following objectives are set for 2022-202:
- Implementation of the Workforce Transformation Workforce review following the landing of the business case and funding;

- Transition of the Working Safely Programme 'Pump, Prime 'phase into Business-as-Usual activities in Q3 2022-23;
- Delivery of the Institute of Safety and Health (IOSH) Leading Safely courses for the Board, Executive Team, Assistant Directors Leadership team and Heads of Service;
- Assessment against the Trust's Legislative Compliance Register;
- Assessment against the Trust's Hazard Register;
- Baseline assessments against the All Wales NHS Health and Safety Management System;
- Implementation of sub-groups of the National Health and Safety Committee;
- Roll out of Trusts Culture Survey;
- Development of a Safety for Leaders training package for Line Managers;
- Approval and implementation of a two-tier 'Learning from Events' investigation process with subsequent development and implementation of in-house e-learning investigation training package to support;
- Commencement of the Trust premise health and safety audit schedule;
- Implementation of the risk assessment training and procedure approval;
- Development and approval for the Control of substances Hazardous to Health (COSHH) Procedure and Training package;
- Developed and approved Dangerous Substances and Explosive Atmospheres (DSEAR) procedure.



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AGENDA ITEM No	11
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – June/July 2022
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MEETING	People and Culture Committee
DATE	06 th September 2022
EXECUTIVE	Rachel Marsh – Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Nicola Quiller – Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Nicola.Quiller@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **July 2022** (with the exception of Sickness where June 2022 is reported).

RECOMMENDATION

Trust Board is asked to:-

- **Consider** the July 2022 Integrated Quality and Performance Report and actions being taken and determine whether:
 - a) the report provides sufficient assurance;
 - b) whether further information, scrutiny or assurance is required, or
 - c) further remedial actions are to be undertaken through Executives.
- **Consider** the deep dive (Appendix 2) on Staff Well-Being measures.

KEY ISSUES/IMPLICATIONS

Overview

This Integrated Quality & Performance Report contains information on 28 key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus:

- Our Patients (Quality, Safety and Patient Experience);
- Our People;
- Finance and Value; and
- Partnerships and System Contribution.

These four areas of focus broadly correlate with the Quadruple aims set out in 'A Healthier Wales'.

As previously agreed, the metrics which form a part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against our plans (IMTP) and strategies. This annual review is complete and was endorsed at the July Finance & Performance Committee and Trust Board meetings; changes will be applied for the August 2022 report.

Our Patients – Quality, Safety and Patient Experience

Call answering (safety): The speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.

999 answering times have been challenged through significant increases in demand. The median and 65th percentile performance remain good, but the call answering tail increased in July 2022 and remains over 50 seconds, which is higher than the Trust would want.

There is no additional funding secured into 2022/23 for 999 call handlers. Forecasting and modelling has been completed on the future call taker requirement through to December 2024, including new roster keys. The modelling has identified an additional staffing requirement. The Trust has decided to proceed with a roster review.

111 call answering performance deteriorated further in July and there are ongoing issues with Adastra adding pressure to the system. Recent negotiations with commissioners suggest that the Trust has broadly the right number of call handlers in post, however, further work is required to reduce capacity lost through sickness absence, align capacity with demand and improve efficiencies. A recent demand & capacity review of 111 by Operational Research in Health (ORH) was formally approved by EMT on 03 August 2022.

111 clinical response: the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls with improvements recorded in the answering of P1CT and P2CT, however P1/D1 (Dental) and P3CT calls saw a decline in performance in July 2022. The Trust knows that the waits for a clinical ring back are too long. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies currently. Urgent discussions are underway to develop a more focused plan to increase clinician numbers.

Ambulance Response (safety / patient experience): Red and Amber response times declined into July 2022 and an increase in patient demand was seen. The Amber 1 tail (95th percentile) remains at unacceptable levels, at six hours 50 minutes. These long response times have a direct impact on outcomes for many patients. This was the focus of the discussion at F&P Committee and QUEST committee who remain extremely concerned at the levels of avoidable harm to patients. Actions within the Trust's control include:

Capacity:

- Recruitment: the Trust has a revised control total of 1,825 FTEs for Ambulance Response which takes into account the uplift in FTEs required for the Cymru High Acuity Response Unit (CHARU), the decision not to reduce any emergency ambulance cover in Hywel Dda and directly commissioned services. The Trust has recently received an additional £3m in 2022/23 which will allow the Trust to recruit 100 FTEs. Due to the length of training, the majority of these additional staff will become operational in Q4. The estimated relief gap with this +100 FTEs is -64 FTEs.
- Summer/winter modelling: the Trust completed its summer modelling and has shared the results. The Trust has gone onto model a March 2023 position which includes the impact of the +100 FTEs and lower hospital handover based on recent Ministerial direction. The Trust has agreed tactical mitigations, which have been included in the Performance Improvement Plan. F&P Committee noted their considerable concerns and it was agreed that the detailed modelling (summer) would be shared with the whole Board (complete).

Efficiency (rosters, abstractions/sickness absence and post production lost hours):

- The Ambulance Response roster review is on target for go live between September 2022 and November 2022. This will have the equivalent performance impact of 72 FTEs.
- A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks. This is planned to reduce sickness absence in line with a trajectory included in the IMTP.
- Further discussion continues constructively with trade union partners on a range of other potential workforce efficiencies and staff-well-being.

Demand Management

- The Trust has prioritised 41 additional clinicians into the Clinical Support Desk, with 36 Paramedic FTEs and five mental health practitioners successfully recruited and now in place. As well as improving the safety of the patients that are waiting, this investment will also mean an increase in consult and close rates, with the Trust now aiming to achieve a 15% rate for the second half of 2022/23, an increase in the previous benchmark of 10.2% which has been delivered. The Clinical Support Desk has made good progress and currently has a 6% vacancy level against the new establishment of 96 FTEs.

One of the key factors in relation to response times is the capacity lost to handover outside emergency departments. There were over 24,000 hours lost in July 2022, which represents 30% of the total number of conveying resource hours produced for the month. The levels are so extreme that all the actions within the Trust's control

cannot mitigate and offset this level of loss. Urgent and high level discussions have taken place between the Trust, Health Board CEOs and the CEO of NHS Wales. A number of mitigating actions have been agreed and a target of no >4 hour waits and a reduction of 25% in minutes per ambulance arrival (from Oct. 21 baseline). Delivery against these commitments will be monitored through this performance report in future months (starting from the August 2022 data).

Ambulance Care (formally NEPTS) (Patient Experience): performance was above target for enhanced renal patient arrivals prior to appointment in July 2022 and has improved for patients requiring discharge; however, overall demand for the service continues to increase, although it has not yet recovered to pre CoVID-19 levels. EASC (10th May 2022) had a “focus on” development session on NEPTS, which included looking at the imbalance of demand and capacity and options for resolving this. The feedback from the “focus on” session with EASC indicated a need to look at NEPTS changing demand and the capacity to support this. In the short term a capacity management plan is in place whilst pre-work is being undertaken on a potential roster review next year. A more efficient management of demand is another line of enquiry.

National Reportable Incidents (NRIs) / Concerns Response: the Trust reported 2 NRIs to the Delivery Unit in July 2022, compared to 3 in June 2022; and 26 serious patient safety incidents were referred to health boards in July 2022 under the “Appendix B” arrangement, compared to 24 in June 2022. In July 2022 complaint response times improved to 22% therefore failing to meet the 75% target. In the main, many of these incidents will be as a result of continued longer response times and the actions outlined below therefore are key.

Our People (workforce resourcing, experience and safety)

Hours Produced: 111,168 Ambulance Response ambulance unit hours were produced in July 2022. The emergency ambulance unit hours production (UHP) was 94% in July 2022 and RRV UHP was 71%. Key to the hours produced is the abstractions which remain high.

Response Abstractions: abstraction levels increased in July 2022 to 40%, but are significantly improved from the high in March 2022 of 49%, however, they remain much higher than the 30% benchmark. COVID-19 has had a significant impact on abstractions with sickness abstractions being 12% in July 2022 (benchmark 5.99%). Workforce fatigue is also an issue.

Trust Sickness absence: The Trust’s overall sickness percentage was 9.12% in July 2022 which represents a decrease compared to June 2022. High sickness levels were seen across all areas of the Trust’s operations including Ambulance Response, EMS Co-ordination, 111 and Ambulance Care, affecting capacity in all areas. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level. In addition, Employee Assistance Provider (EAP) data suggests that most requests for counselling are as a result of work related stress. A specific Managing Attendance programme has been established, led by the Deputy Director of WOD, to identify and implement actions across a range of areas to improve sickness absence and alternative duties.

Staff training and PADRs: Stat / Mand training compliance rates have been improving and hit the target of 85% for the first time in nearly 2 years. PADR levels remain low.

Finance and Value

Financial Balance: The Trust has reported outturn performance for July 2022 with a deficit of £3,000 and has a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

Post-production lost hours: The efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. The EMS Demand & Capacity Review identified that the Trust benchmarked favourably on all elements of PPLH other than return to base meal breaks. The Trust and TU partners continue to work together on options for change.

Partnerships/ System Contribution

Shift left: much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 11.7% in July 2022, compared to the benchmark of 10.2%, which was exceeded during 2021/22.

The Trust has an ambition to shift more patient demand left, where it is clinically safe and appropriate to do so through both consult and close and see & treat, a position consistent with the EMS commissioning framework. To this end the Trust has increased the establishment in the Clinical Support Desk by 41 FTEs, almost doubling the existing establishment, with 36 Paramedic FTEs and a 5 mental health professionals FTEs into the Clinical Support Desk (CSD). The Trust is also implementing new clinical triage software (now live) and working with health boards on how they can support remote demand management. There is a revised ambition of 15% for consult and close into 2022/23 (for the second half of the year).

The Trust **conveyed** 30% of patients to emergency departments in July 2022, but this figure needs to be treated with significant caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In July, over 14,000 patients cancelled their ambulance and we were unable to send an ambulance due to application of CSP levels to just over 1,000 callers. In the longer term, as we know, we are clear that the system needs to transform if it is to become more sustainable. A formal programme to take forward "inverting the triangle" has been established. A bid as been submitted to Welsh Government to start to increase numbers of APPs being trained; however, this was not successful.

Handover lost hours: 24,021 hours were lost in July 2022. These levels are unprecedented and extreme and whilst the Trust can seek to mitigate the impact of handover lost hours through various efficiencies, the Trust cannot offset this scale of lost hours. The Trust continues to raise this issue with EASC, Health Boards and Welsh Government. Fortnightly meetings have been established with each health board by the CASC, which WAST attends, which are designed to focus on action plans and trajectories for improvement. The 2022/23 EASC commissioning intentions

for handover lost hours focuses on setting improvement trajectories per site; however, the pressure on the unscheduled care system as Wales emerges from the pandemic mean that the Trust can expect these extreme levels to continue into 2022. Ministerial direction indicates that the Immediate Release Directions should be accepted and an escalation procedure has been agreed nationally for implementation from the 25th July 2022.

Staff Well-Being Measures

A number “deep dives” have been undertaken by other committees over the last 12 months on a variety of topics e.g. shift left metrics. Invariably the focus is on patient safety in some form.

The People Services Directorate and Strategy, Planning & Performance Directorate determined that it would provide balance to undertake a similar “deep dive” on staff well-being. The deep dive attached at Appendix 2, identifies current metrics available to the Trust (and emerging ones). It identifies that these metrics are less developed than they are for patient safety/performance, but that there is an opportunity to increase the Trust’s focus on this area.

Summary

The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust provides to patients. Demand across the 111 and EMS services increased in June 2022, this coupled with other factors such as the continuation of the CoVID-19 variants, high levels of sickness (including CoVID-19 related absence) and extreme handover lost hours continue to impact on the Trust, in particular, the EMS. EASC, WG and the 111 Programme Board have been very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited as the fiscal position becomes much tighter. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however for EMS the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. The Trust has just received further funding (£3m) for +100 FTEs into Ambulance Response, which is welcome, but it remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation.

The staff well-being deep dive (Appendix 2) identifies that there are metrics available to the Trust in this area, but they are more anecdotal and less developed than they are for patient safety/performance; and that there is an opportunity for improvement in this area.

REPORT APPROVAL ROUTE

Date	Meeting
18 August 2022	Assistant Director of Commissioning & Performance
31 August 2022	Executive Management Team
06 September 2022	People and Culture Committee

REPORT APPENDICES

Appendix 1 – Top Indicator Dashboard

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	x	Financial Implications	x
Environmental/Sustainability	x	Legal Implications	x
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	x	Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	x
Health and Safety	x	TU Partner Consultation	x



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Monthly Integrated Quality & Performance Report

July 2022

Annex 1 – Top Indicator Dashboard





Section 1: Monthly Indicators / Top Indicators Dashboard



Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Jul-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience					
111 Abandoned Calls	< 5%	18.60%	14.6%		R
111 Patients called back within 1 hour (P1)	90%	94.00%	94.5%		G
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:52	00:57		R
999 Red Response within 8 minutes	65%	55.2%	52.0%		R
999 Amber 1 Mean		01:39:58	2:19:23		TBD
Green 2 Mean		02:18:01	02:31:53		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	77%		G
National Reportable Incidents reports (NRI)	Reduction Trend	5	2		A
Datix Incidents Closed (Volumes Received)		365	538		TBD
Coroner Requests	Reduction Trend	35	34		TBD
GDPR High Level Breaches	Reduction Trend	21	17		TBD
RIDDOR Volumes	Reduction Trend	12	12		A

In-Month RAG Indicates =
 Green: Performance is at or has exceeded the target (Indicates no action is required)
 Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Jun-22	Jul-22	2 Year Trend	RAG
Our People						
Capacity						
Hours Produced for Emergency Ambulances	95%	95.0%	94%	94%		A
Health and Wellbeing						
Sickness Absence (all staff)	5.99%	10.48%	9.12%	-		R
Staff Turnover Rate	Reduction Trend	8.71%	11.54%	11.64%		A
Frontline CoVID-19 Vaccination Rates	-	3913	4,283	-		-
PADR/Medical Appraisal	>85%	60%	59.25%	64.66%		R
Value						
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	8,582	7678:44:36	7008:44:36		A
Partnerships / System Contribution						
111 Consult and Close	Improve	7,843	17,208	17,694		G
Combined 999 & 111 Hear & Treat	15.0%	10.4%	11.8%	11.7%		A
Immediate Release Request Volumes (Red/Amber 1)	TBD	682	623	769		TBD
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.90%	12.5%	11.90%		A
Number of Handover Lost Hours	< 150 hrs per day	15,955	23,387	23,978		R

Amber: Performance is at or within 10% of target (Indicates some issues/risks to performance (monitoring is required))
 TBD: Status cannot be calculated (To Be Determined)





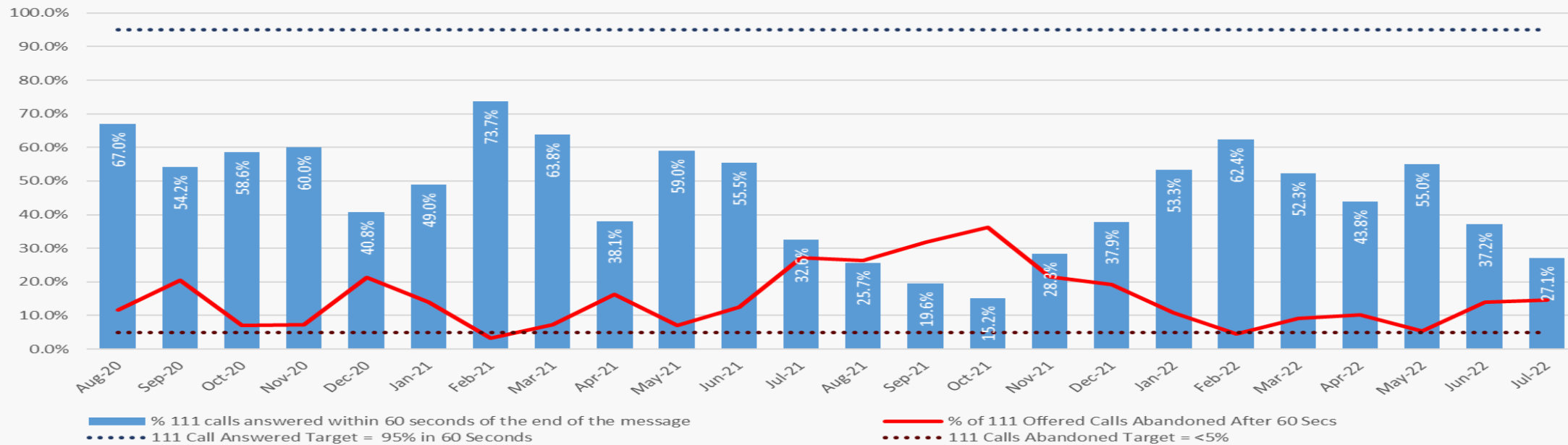
Our Patients: Quality, Patient Safety & Experience

111 Call Answering/Abandoned Performance Indicators



Influencing Factors – Demand and Call Handling Hours Produced

111 Calls Answered vs Calls Abandoned within 60 Seconds



Analysis

111 call abandonment is a key patient safety indicator for the service. July 2022 saw a decline (worsening) in abandonment rates to 14.6%, therefore failing to meet the 5% target.

The percentage of 111 calls answered within 60 seconds of the end of the message improved in July 2022 to 27.1%. Given the continued high volumes of calls per month, this still represents a significant number of people who receive a patient experience which didn't meet the levels achieved in February 2022 (62.4%).

111 call demand increased marginally in July 2022 compared to the previous month.

The graph alongside also shows that capacity (staff hours) has been increasing in line with the roll-outs and as planned; however, despite recruiting significant numbers of additional staff as agreed with commissioners, sickness abstractions for Call Handlers (which includes COVID-19 Sickness) remain high at 14.75% for NHS111 in July 2022. This means that demand is higher than forecast, capacity is lower than planned leading to the longer average call answer times as seen.

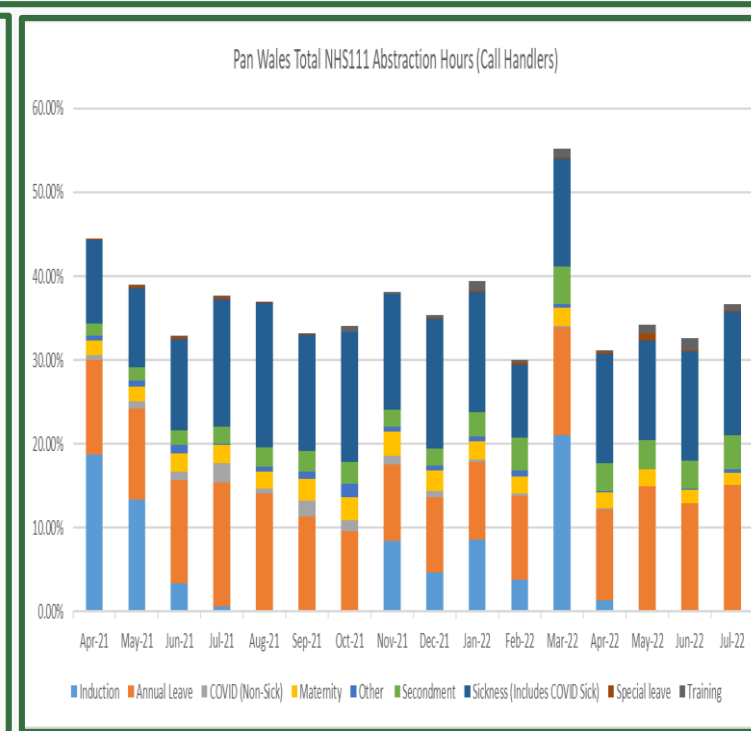
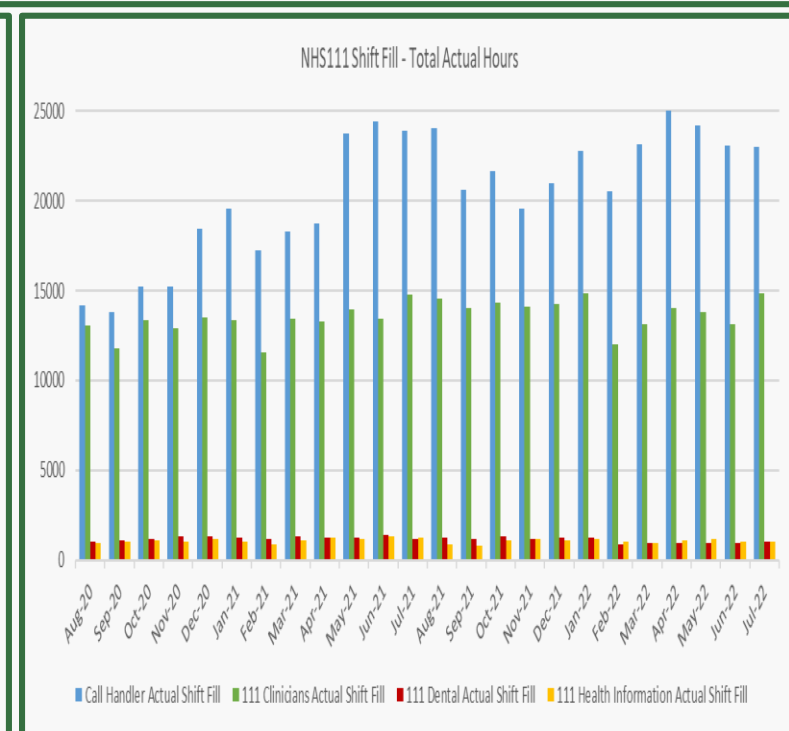
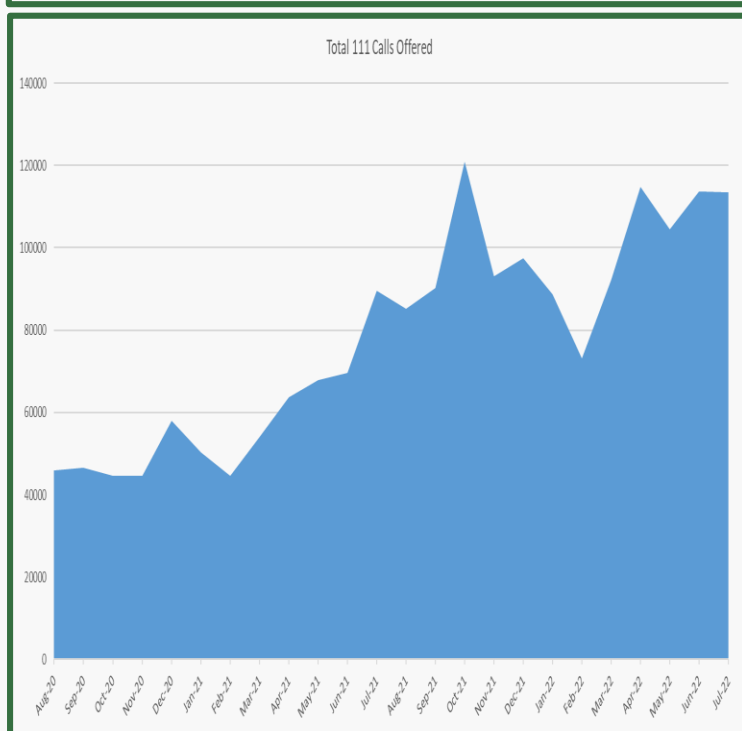
Communication regarding the use of 111 is regularly circulated to the public, which includes utilising online 111 Wales; in July 2022 there were 348,944 visits to the website. In July 2022 the top viewed pages were My Health Online with 20,885 visits, COVID which accounted for 17,192 followed by leg pain symptom checker which accounted for 14,553 hits.

Remedial Plans and Actions

- The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency. Discussions are ongoing with commissioners to confirm the commissioned WTE for call handlers, which we think will be around 178 WTE. We are currently broadly at that number with no vacancies.
- Work continues on sickness absence in line with the Trust's managing absence work programme
- Work is underway to look at the rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore the time spent is related to clinician availability. At present there are high levels of vacancies

Expected Performance Trajectory

With call handler numbers broadly at commissioned levels, call answering times will only be improved through improved efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line)

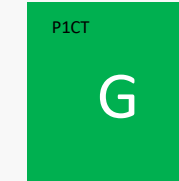




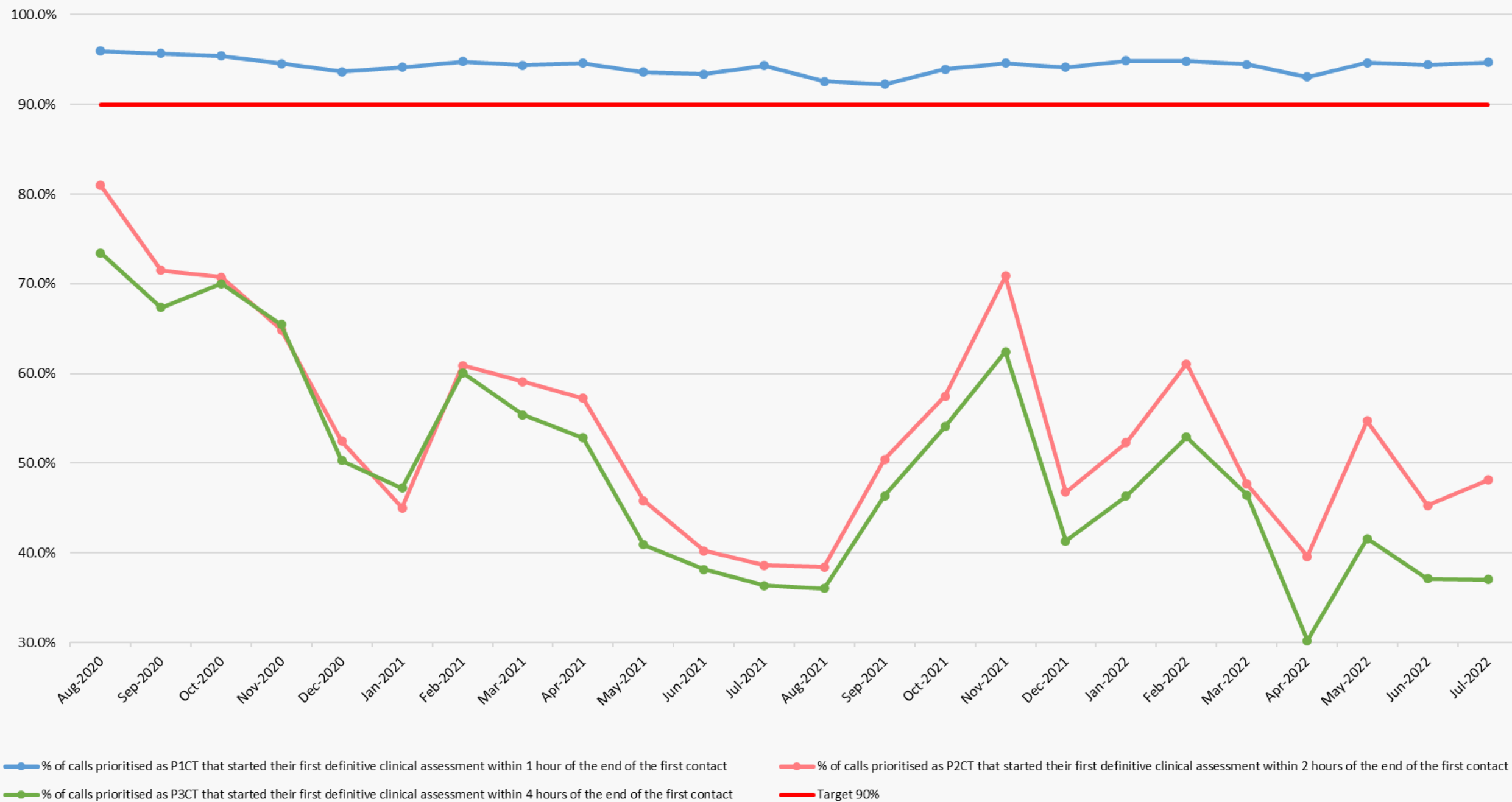
Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Timely Clinical Triage of Patients



Analysis

The performance of 111 calls receiving a timely response to start their definitive clinical assessment remains a challenge, with the continuing exception of the highest priority calls.

The highest priority calls, P1CT, continue to receive a timely response which has continuously achieved the 90% target over the last 2 years.

For lower category calls the Trust is still not meeting the 90% target, and, in July 2022 a decline was seen in P1CT and P2CT, however P1/D1 and P1CT categories saw improvements.

Demand for the service continues to grow (see previous slide) which will affect performance, but in addition, recruitment and retention of clinical staff also remains problematic.

Remedial Plans and Actions

The main driver of improved performance will be the correct number of clinicians in post to manage current and expected demand. At present there are significant numbers of clinical vacancies. Urgent consideration is being given to an updated action plan which may include:

- Utilisation of other clinicians to fill vacancies
- Maximising opportunities through agile working
- Review of existing staff bases
- Review of service model
- Targeted recruitment drive

Expected Performance Trajectory

Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Urgent work is now underway to agree a series of actions that might help to increase recruitment, reduce turnover and reduce demand on clinicians, but performance is likely to be poorer than the Trust would want for some time to come.



(Responsible Officer: Lee Brooks)

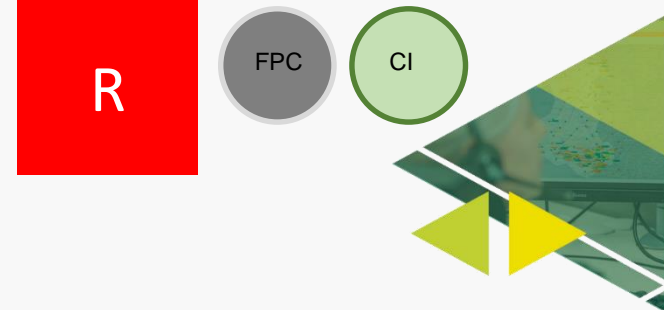
Welsh Ambulance Services NHS Trust



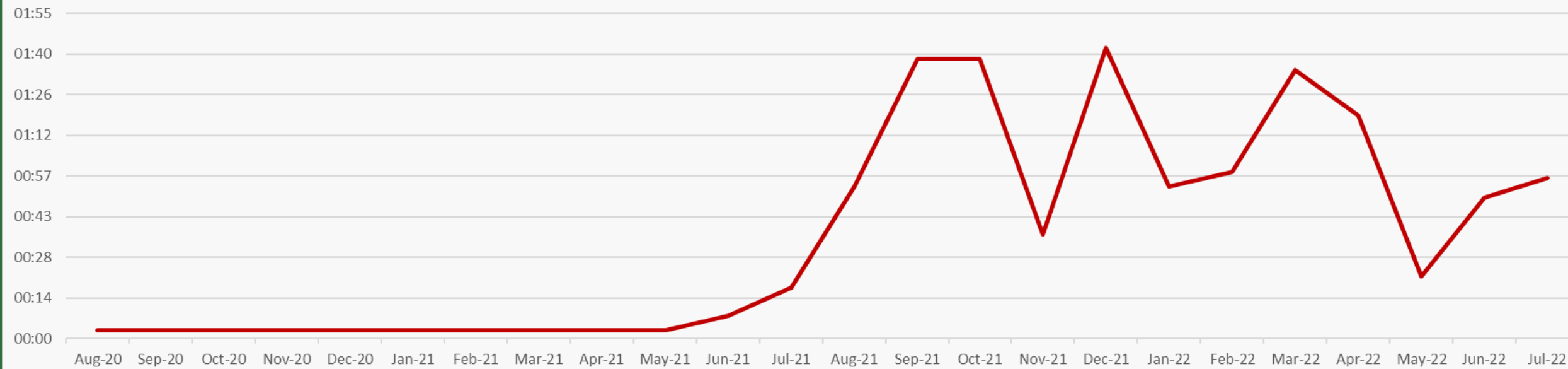
Our Patients: Quality, Safety & Patient Experience

999 Call Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



95th Percentile 999 Call answer times



Analysis

The 95th percentile 999 call answering performance declined again in July 2022 to 57 seconds, compared to 50 seconds June 2022. Therefore, failing to meet the 6 second answer target for the eleventh consecutive month largely as a result of increased call demand, particularly at weekends. Increasing call answering times are a significant concern in relation to patient safety, however 87.4% of calls were answered within 6 seconds in July 2022.

The median call answer times for 999 services remains consistently at 2 seconds. In July 2022 65th percentile continued to average at 3 seconds.

The Trust received 50,039 emergency 999 calls in July 2022, an increase compared to June 2022, lower than July 2021 but higher than July 2020. The continued high call volumes are likely to be a result of public activity returning to normal levels, along with the impact of the continuing pandemic. July 2022 saw an increased level of staff abstraction due to sickness and COVID (13.32%), however this continues to reduce capacity within the call centres.

Remedial Plans and Actions

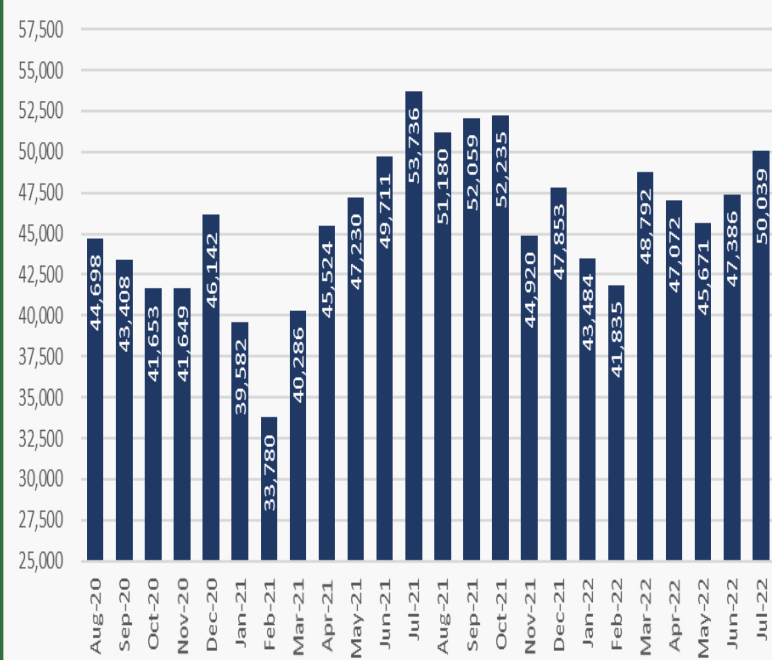
- EMS CCC meet twice weekly to review demand profiles and align staffing levels appropriately. Resources teams are focussing on balancing capacity across the 7-day period, targeting overtime to weekends and Mondays where patterns of demand and reduced UHP are identified.
- Additional funding original approved has been withdrawn this fiscal year and as such EMD establishment will remain at baseline demand levels within the financial envelope for EMS Coordination.
- Increased pressure and sustained levels of 999 demand above baseline is impacting on staff attrition and wellbeing.
- There are currently 73 FTEs (94.81%) Clinical Support Desk staff in post of the overall 77 FTE establishment, 3 of these people are in training. Therefore, there are currently 4 FTE Vacancies.

****NB: FTE Data correct as of 21/07/2022**

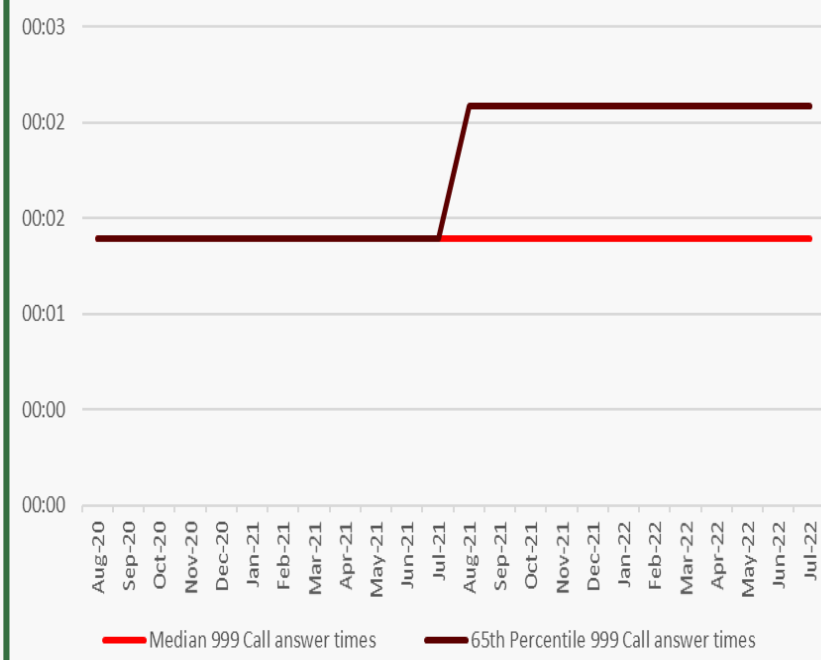
Expected Performance Trajectory

Performance is expected to continue to be difficult with demand forecasted to increase throughout the fiscal year. EMS Coordination continue to focus on proactive recruitment to mitigate the impact of current attrition rates; and a roster review.

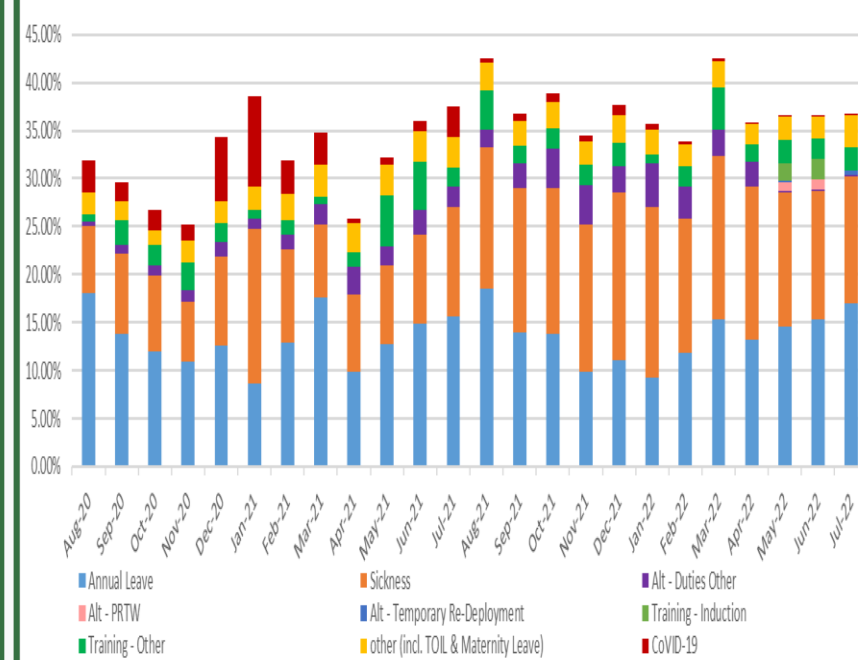
999 Call Volumes



Median & 65th Percentile 999 Call Answer Times



Pan Wales Total CCC Abstraction Hours

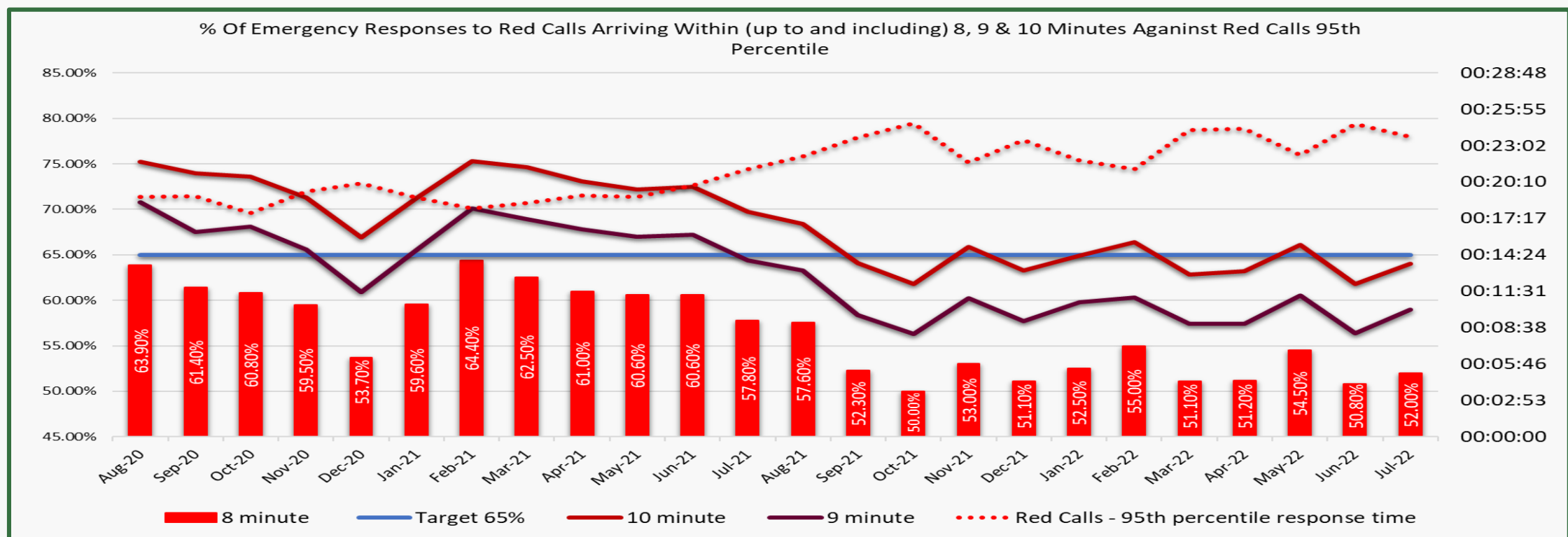
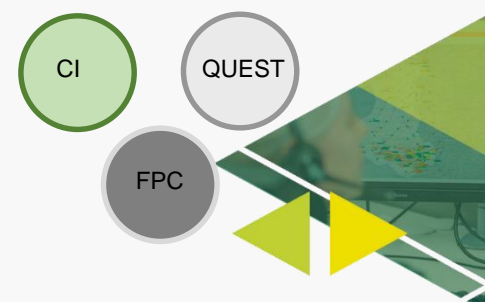




Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Analysis

Red performance improved in July 2022; however, it remains significantly lower than the 65% target; the target has not been achieved since July 2020. There was also significant health board level variation with only one (C&V) of the seven health board areas achieving the 65% target. A continuing level of poor performance was forecast in the spring plan based on predictions of demand, lost hours and hours produced. Red 10-minute performance was 64% in July 2022.

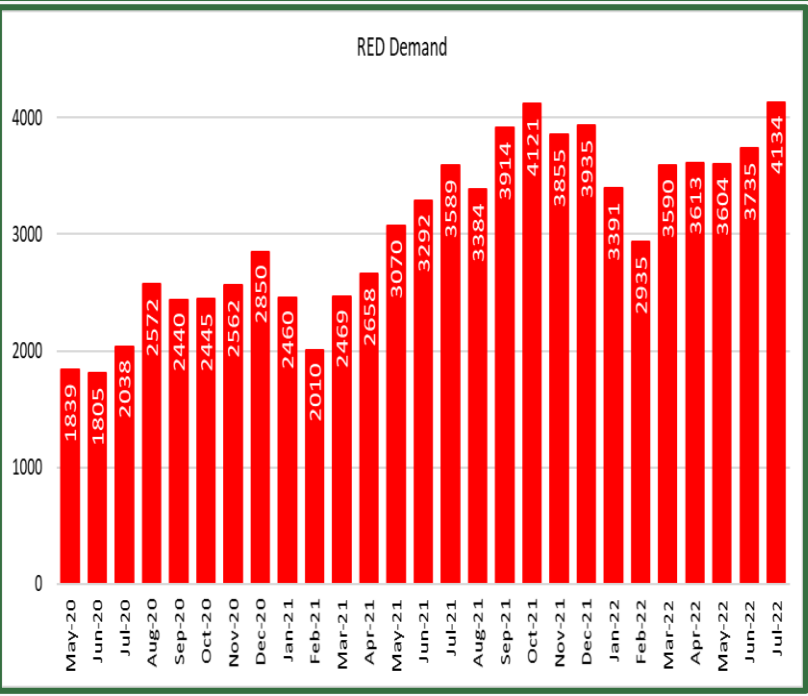
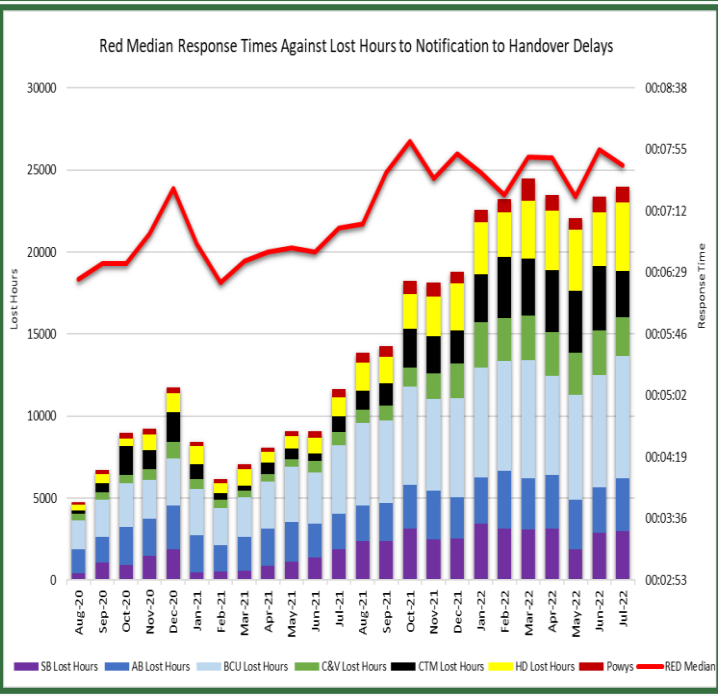
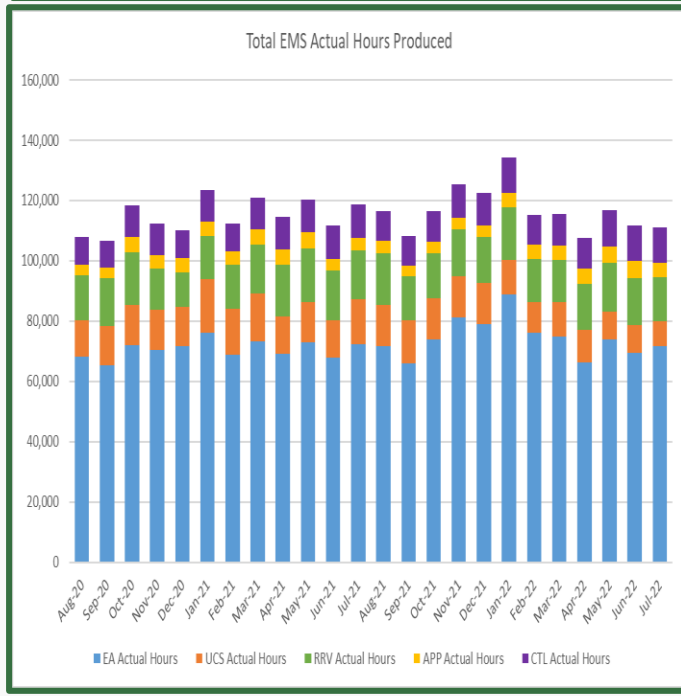
Three of the main determinants of Red performance are Red demand, unit hours produced, and handover lost hours.

Red demand in the last 2 years has seen a particular increase, outside of normal expected variation which is impacting on response times. Demand is not expected to decrease, and the current levels have been built into forecasting and modelling work.

The lower centre graph demonstrates the correlation of performance with hospital handover lost hours, with extreme levels of losses continuing to be seen with 23,978 hours lost in July.

The number of EA actual hours produced increased slightly, however RRV hours decreased in July 2022 compared to June and were lower than planned, with continuing high (though reduced) levels of abstraction due to sickness absence (c13%)

There are many other factors which affect red, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues (this requirement remains in place).



Remedial Plans and Actions

- The main improvement actions are:
- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23.
 - Reduce hours lost through sickness absence through managing attendance programme – trajectory for improvement in place as part of IMTP.
 - Increasing capacity through modernisation of practices and supporting staff well-being. This is under discussion with TU partners currently.
 - Working with partners to reduce hours lost at hospital. Handover reduction plans and trajectories are currently being developed by health boards facilitated by the NCCU. Agreement on immediate release and fit to sit, together with commitment to no >4 hour waits and a reduction in 25% overall.
 - Improving efficiency – new rosters to be implemented September – November. Equivalent of 72 WTE additional staff
 - Implementation of CHARU service as part of new rosters will positively impact on red performance in particular. It is only partially funded however.

Expected Performance Trajectory

Modelling indicates an improved March 2023 position, new rosters and handover reduction, but further reduction is required (and reduced abstractions) to achieve Red 8 minute 65%..



(Responsible Officer: Lee Brooks)

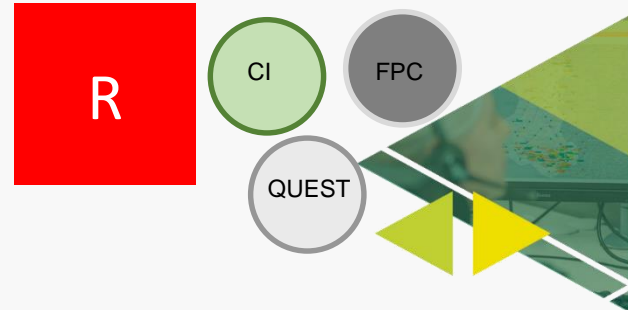
Welsh Ambulance Services NHS Trust



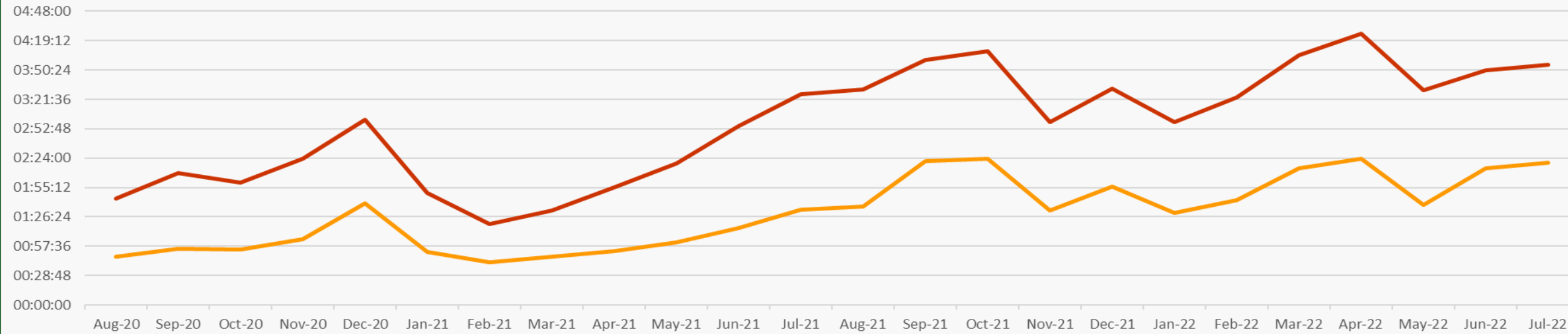
Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Amber 1 & 2 Mean Performance



Analysis

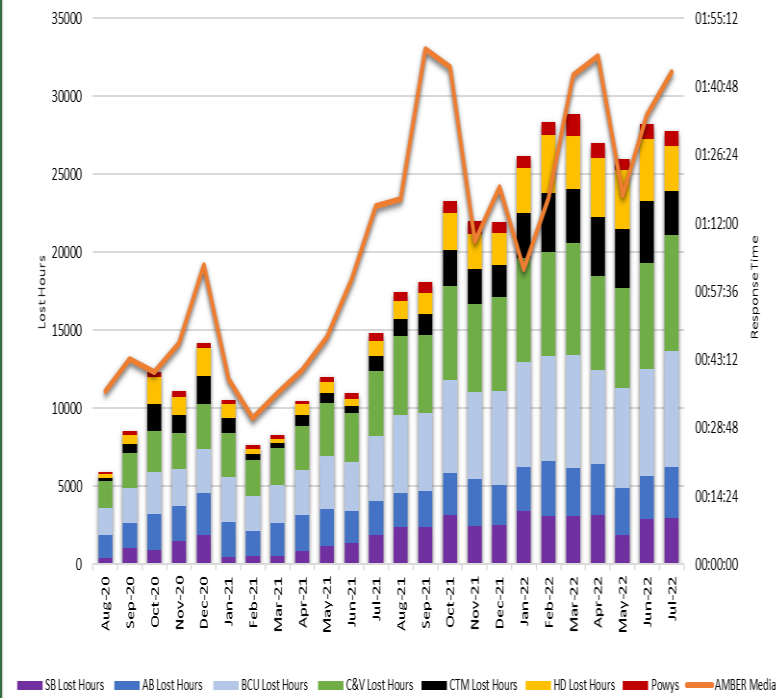
Amber performance saw declines in the percentiles in July 2022, with the exception of Amber 95th Amber 2 95th. In addition, there were still some very long patient waits. The ideal Amber 1 median response time is 18 minutes. Amber 1 and 2 mean performance also saw declining performance as indicated in the top graph.

In July 2022, 778 patients (all categories, not just Amber) waited over 12 hours, an increase when compared to June 2022, continuing to represent a very poor quality and experience of service. 659 of these patients were in the Amber category.

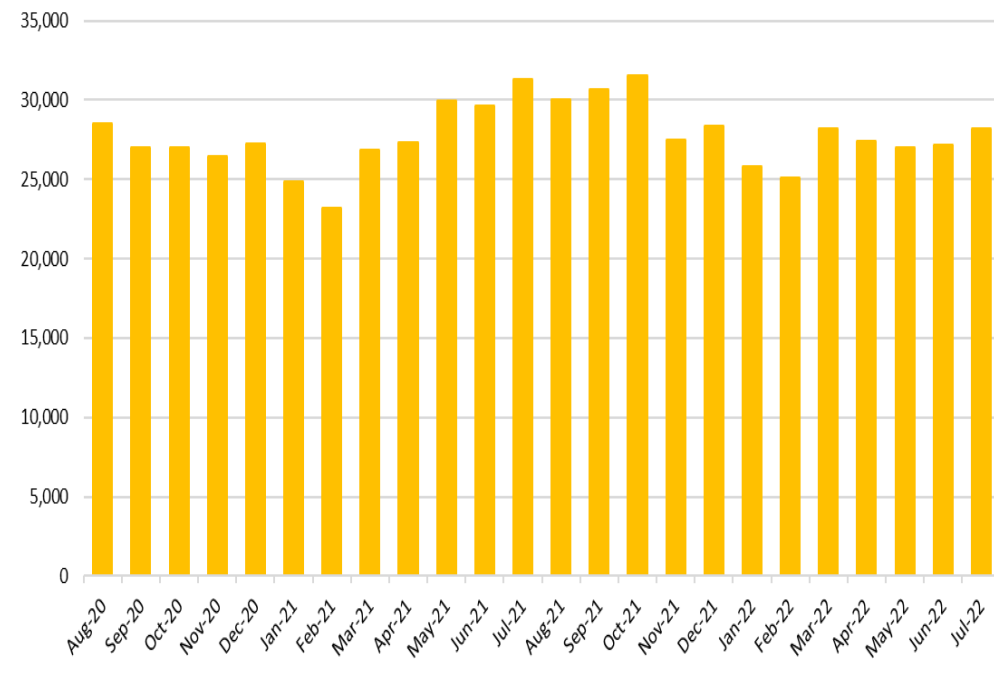
Amber demand increased in July 2022 and activity remains at a high level, additionally continuing high handover continue to affect performance.

There is strong correlation between Amber performance and lost hours due to notification to handover delays, as demonstrated in the graph on the bottom left of this page. The number of hours lost to notification to handover delays in July 2022 increased to 23,978. remaining higher than the worst recorded in December 2019 (13,820).

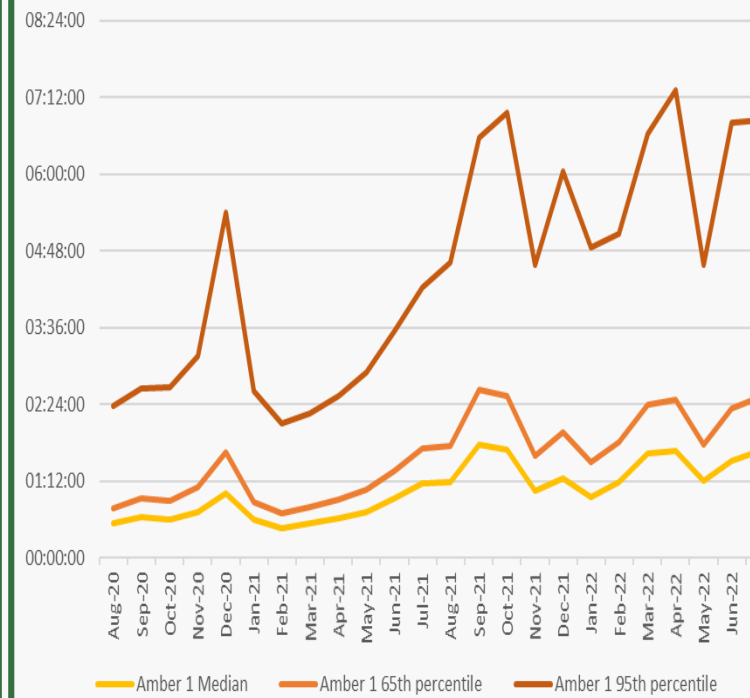
Amber Median Response Times against Lost Hours to Notification to Handover Delays



Total Verified AMBER Demand



Amber 1 Median, 65th and 95th Percentile



Remedial Plans and Actions

The Trust carefully monitors long response times and their impact on patient safety and outcomes. The Trust supplies regular information to the CASC and EASC; and from November 2020 the Trust began producing monthly quality, safety & patient experience (QSPE) reports for each health board. The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments, efficiencies and system efficiencies, not all of which are within the Trust's control, and which are unlikely to show improvement in the coming months.



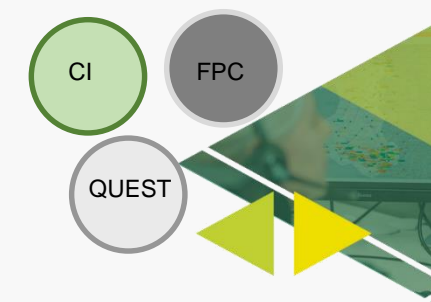
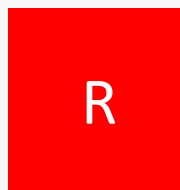
(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust

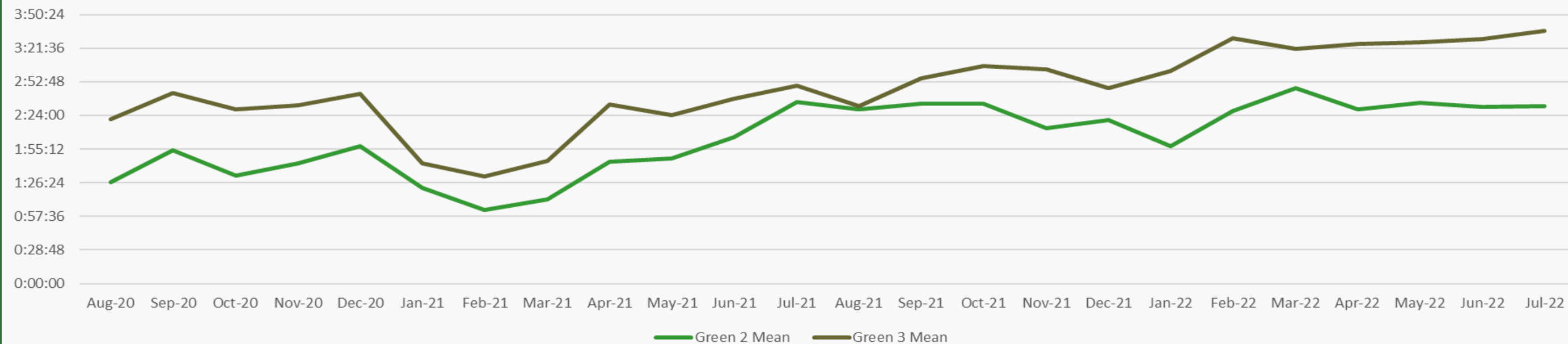


Our Patients: Quality, Safety & Patient Experience Green Performance Indicators

Influencing Factors – Demand, Hours Produced and HCP



Green 2 & 3 Mean Performance



Analysis

Green performance saw declines in the percentiles in July 2022, with the exception of Green 2 65th and Green 3 95th. In addition, there were continuing very long patient waits. The ideal Amber 1 median response time is 18 minutes. Green 2 and 3 mean performance also saw declining performance as indicated in the top graph.

Green demand increased month on month to 7,101 calls in July 2022, however this is a reduction compared to 9,097 in July 2021 and 8,864 in June 2020. Demand in the Green category will have been significantly impacted by CSP levels throughout July 2022.

Requests for patients who need emergency transport to hospital or between hospital sites within 1 to 4 hours from Health Care Professionals declined in July 2022 to 54.3%.

Remedial Plans and Actions

The Trust carefully monitors CSP levels. The Trust supplies regular information to the CASC and EASC; and from November 2020 the Trust began producing monthly quality, safety & patient experience (QSPE) reports for each health board. The actions being taken are largely the same as those related to Red performance on the previous slide.

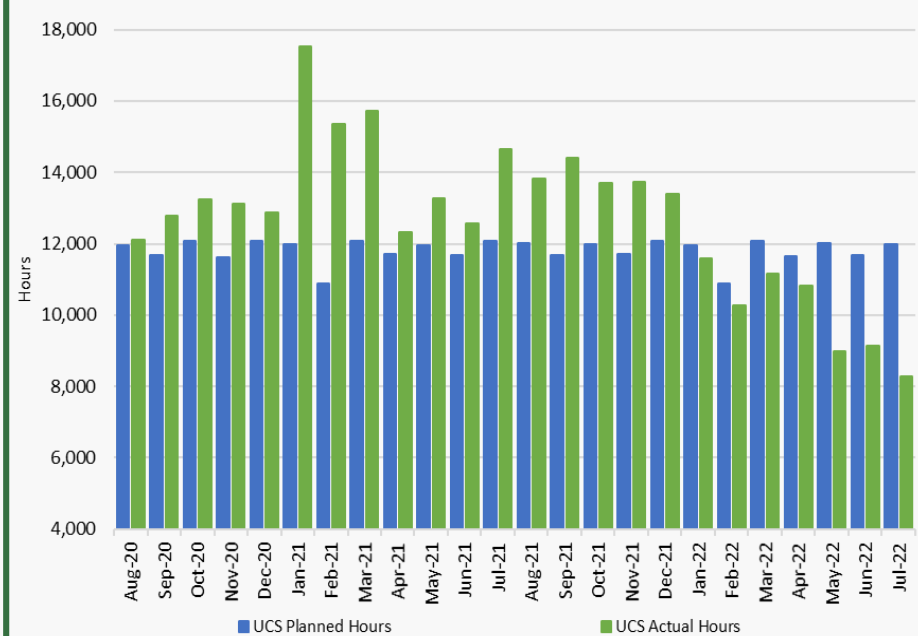
Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Green. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments, efficiencies and system efficiencies, not all of which are within the Trust's control, and which are unlikely to show improvement in the coming months.

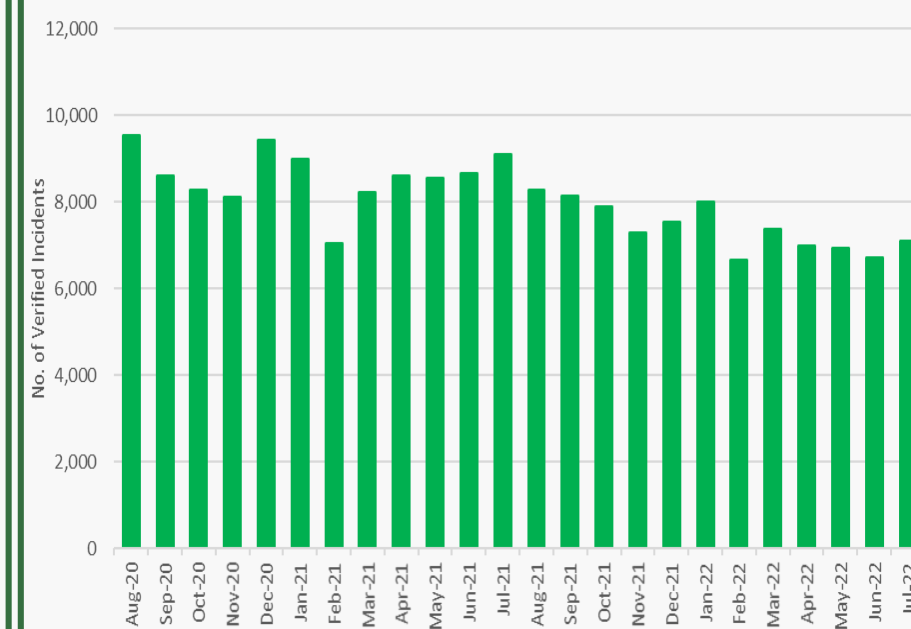
Green HCP 1-4 Hour Performance



UCS Hours Planned vs Actual



Total Verified GREEN Demand



(Responsible Officer: Lee Brooks)

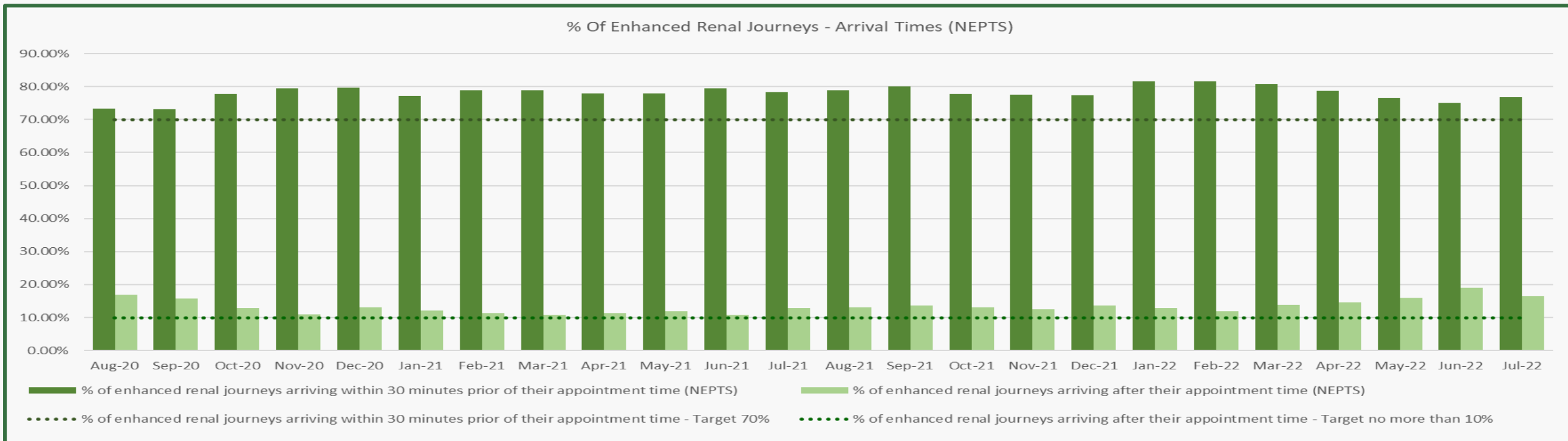
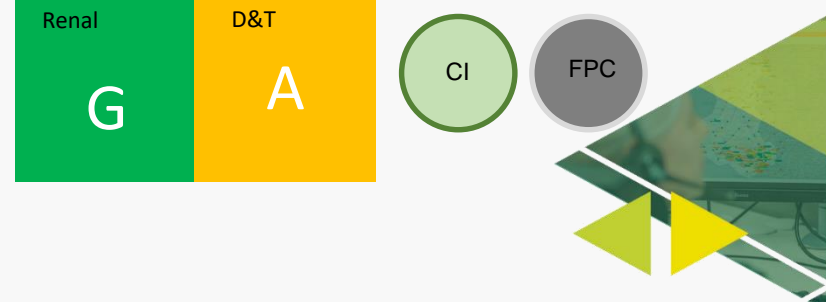
Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

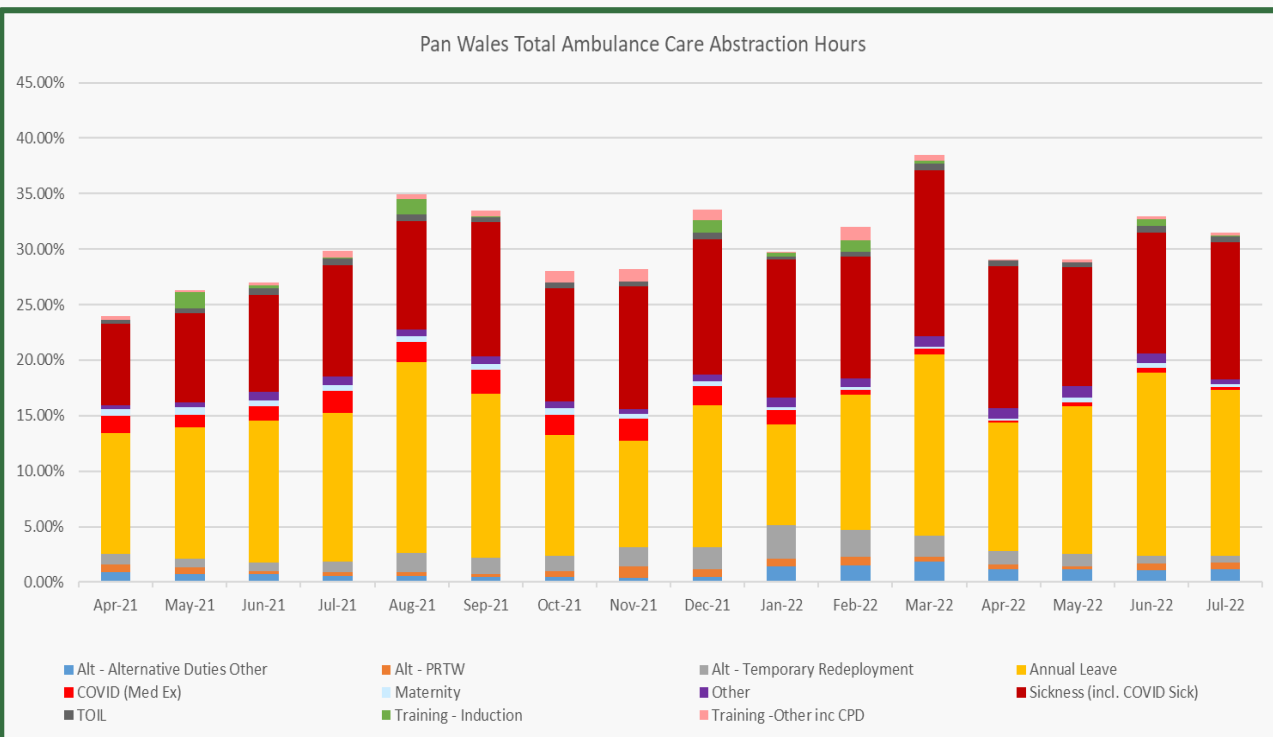
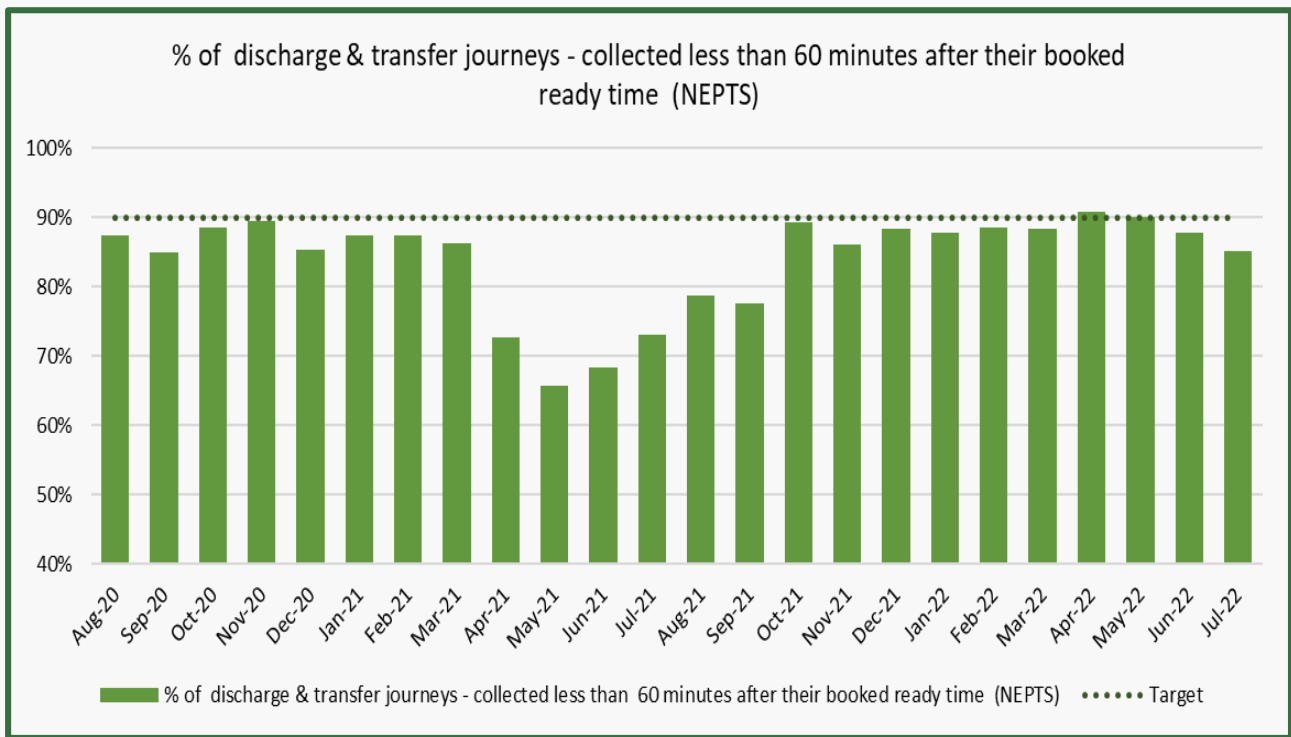
Ambulance Care Indicators

Patient Experience



Analysis
Ambulance Care has seen a stabilisation of areas of service delivery affecting patient experience. In July 2022 85% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, therefore not achieving the 90% target and a decline compared to June 2022 (88%). 76.7% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target and 16.5% arrived after their booked appointment time, falling outside of the 10% target.

- Key factors affecting these indicators are demand and capacity:
- **Social distancing on transports:** this ended in June 2022 so there is no reduction in capacity because of this.
 - **Capacity** continues to be adversely affected by other factors such as sickness absence levels, although these are seeing improvements there was an increase in July to 12.35%.
 - Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but overall it is still not quite at pre-pandemic levels.
 - As the Trust emerges out of pandemic response and the health system is "re-set" it is anticipated that further demand increases could be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.



- Remedial Plans and Actions**
- **Demand:** Continue to work with health boards to understand and model the impact of their recovery plans;
 - **Demand:** In the absence of additional funding, the service has implemented a capacity management plan to assist it in ensuring it remains within budget and prioritises resources for those most in need
 - **Efficiencies:** Work is underway on actions to improve efficiency, including those actions identified through the D&C review, in particular, re-rostering.
 - **Capacity:** discussions with EASC on options for balancing demand and capacity.

Expected Performance Trajectory
 At present, the uncertainty around demand and future impacts of the pandemic and system recovery means that it is difficult to forecast performance; however, it is likely that the service will experience both positive and negative fluctuations of performance until activity normalises across the system.



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

SCIF. **A**

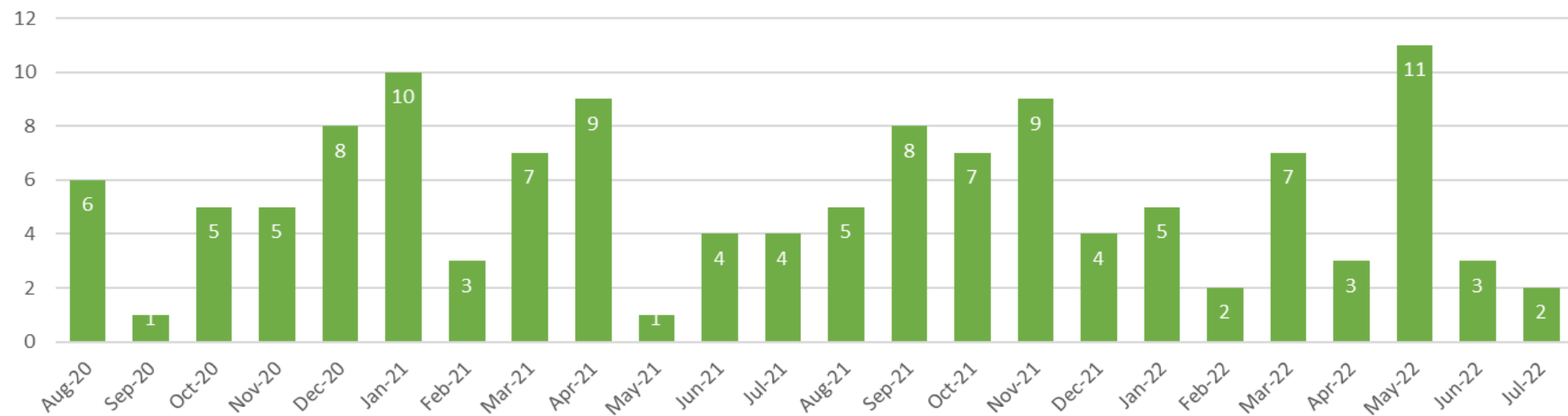
Self Assessment:
Strength of Internal
Control: Moderate

QUEST

Health & Care
Standard
Health - Safe Care /
Timely Care



Number of SCIF cases reported as National Reportable Incidents (NRI) By Date Reported to the Delivery Unit by WAST



Analysis

The percentage of responses to concerns improved in July 2022 to 22%, compared to 13% in in June 2022, however, it still fell below of the 75% target. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of NRI's and the availability of other departments to provide a timely response to requests for information. The number of total concerns increased in July 2022 (123) when compared to June 2022 (100).

There were 5 SCIF forums held in July 2022, during which 34 cases were discussed, 2 of these cases were reported to the Delivery Unit and 26 were passed to Health Boards as National Reportable Incident Framework 'Appendix B' incident referrals.

Year on year the overall volumes of NRIs is on an increasing trend. The sharp increase seen in September – November 2021 and again in March and May 2022 is concerning and has been linked to the significant delays across the system along with the continued levels of NRIs. In May 2022 there were 0 NRIs relating to Red calls, 6 relating to Amber calls and 0 relate to Green calls. There were 5 NRIs as a result of calls prioritised Amber which should have been Red.

At present it is not possible to report on the number of cases within the Complex Case Panel and Redress due to the implementation of the new Once for Wales Datix RL system.

As reported earlier, in July 2022 778 patients waited over 12 hours, an increase month on month, and when compared to 494 in July 2021 and 23 in July 2020.

36 Compliments were received from patients and/or their families in July 2022, a slight decrease compared to the previous month (37).

Remedial Plans and Actions

A range of actions are in place:-

- The general theme in relation to the Trust's concerns portfolio is timeliness to respond.
- There is continued engagement with Health Boards in relation to Joint investigations where the primary causal factor is in relation to delayed handover.
- Concerns have been highlighted following a Delivery Unit report into the Health Boards handling of Appendix B cases, some of which should potentially have been reported as Nationally Reportable Incidents (NRI's) by the HBs.
- Health Board specific QSPE reports are being shared with each respective HB Directors of Nursing.
- The key strategic action is the EMS Operational Transformation Programme.

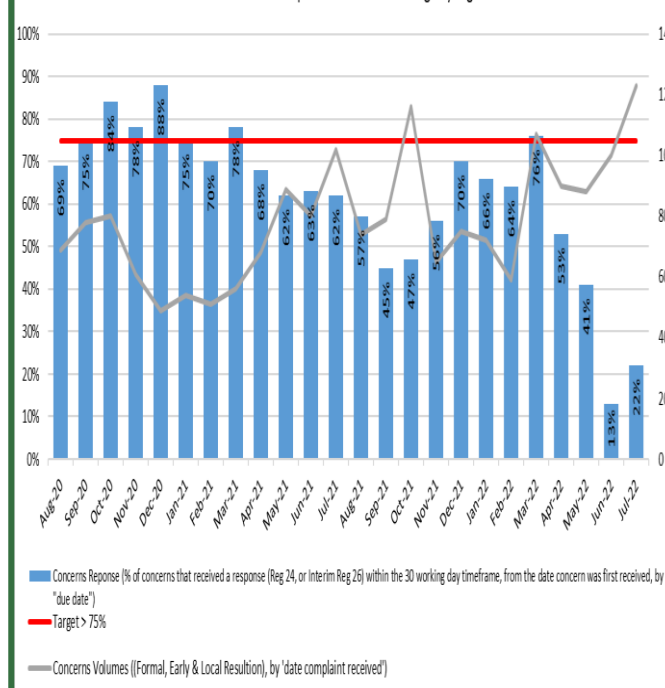
Expected Performance Trajectory

Following the end to Military assistance on 31 March 2022, the Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge for the Trust.

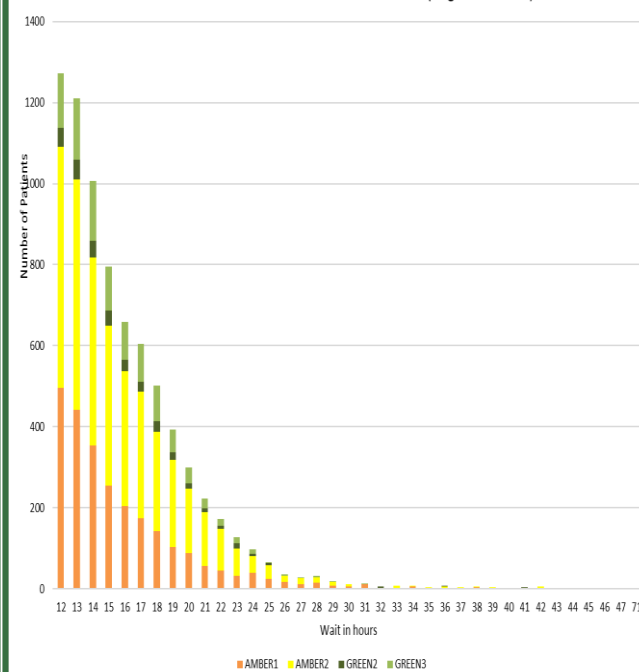
****NB: July 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change. At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.**

****NB: Complex Cases will always report one month in arrears**

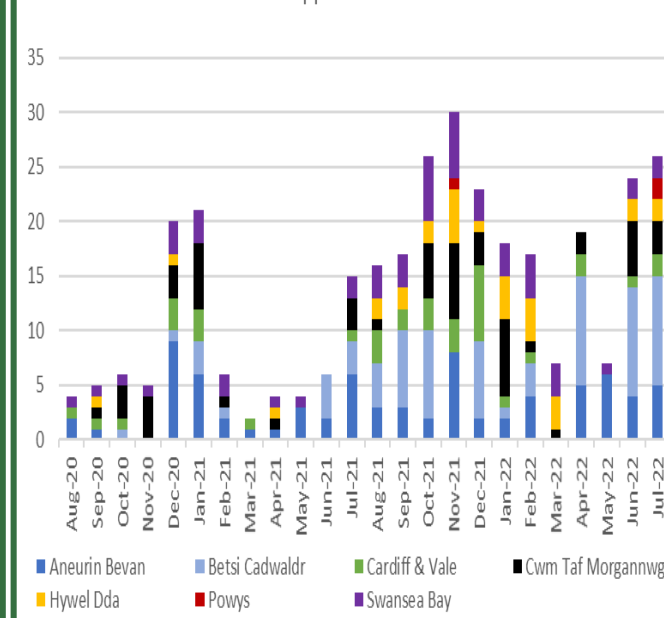
% of concerns with a response within 30 working days against concerns volumes



Number of Patient Waits over 12 hours by Priority Type Cumulative Position over last 12 months (Aug-21 to Jul-22)



Number of National Reportable Incident cases agreed to refer to Health Board reported as Serious Incident Framework 'Appendix B' HB referrals



NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager



(Responsible Officer: Liam Williams)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient Safety Indicators

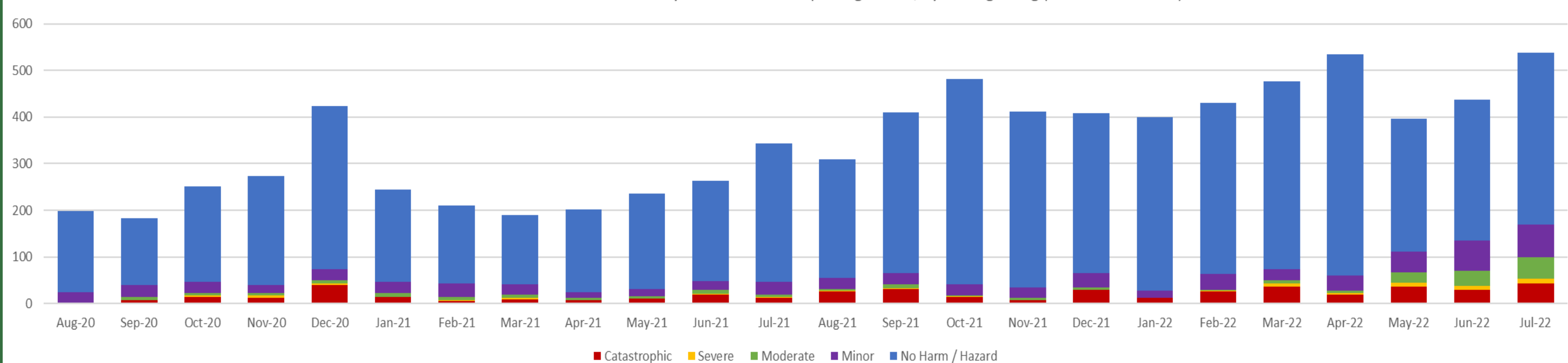
Self Assessment:
Strength of Internal
Control: Moderate

PCC

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Number of Incidents closed on Datix system within the reporting month, by harm grading (Volumes Received)



Analysis

Patient Safety: The number of patient safety adverse incidents submitted within July 2022 increased to 538; 368 of these were in relation to incidents where there was no harm or hazard, 71 were minor, 46 were moderate, 10 were severe and 43 incidents were catastrophic. 2,034 cases were closed in July 2022 in comparison to 146 in June 2022 (*This is largely due to the transition from Datix Web to Datix Cymru*).

Remedial Plans and Actions

Patient Safety: Capacity issues have impacted the ability of some teams in their ability to support investigations due to ongoing operational pressures related to the continued pandemic.

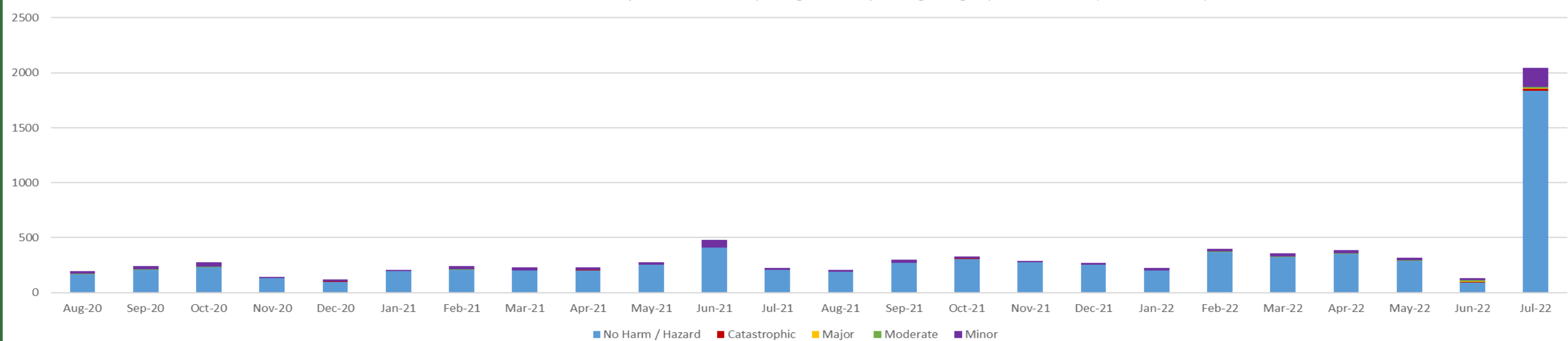
Expected Performance Trajectory

The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

****NB: July 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change.**

At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.

Number of Incidents closed on Datix system within the reporting month, by harm grading at point of closure (Volumes Closed)



Data source: Datix



(Responsible Officer: Liam Williams)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

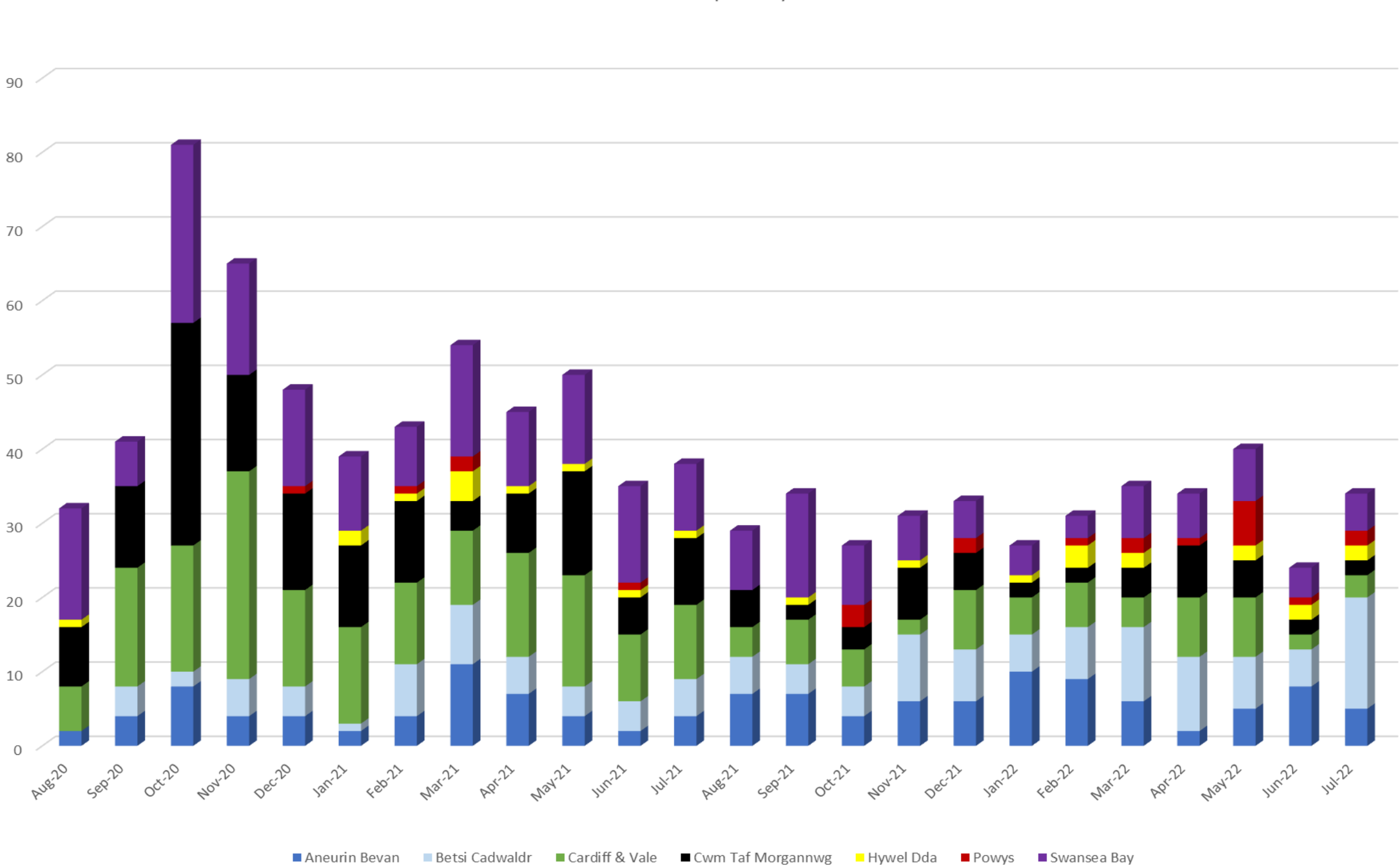
Coroners and Ombudsmen Indicators

Self Assessment:
Strength of Internal
Control: Strong

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Number of Coroner Requests by Health Board



Analysis

Coroners: In July 2022, The number of in month requests continue to be increased from pre-pandemic requests. The timeliness of the Trusts response and unexpected deaths continues to be the main themes. The Trust has noticed that there has been a marked increase in the BCUHB area.

At the end of July 2022 there are 387 claims open; these relate to Personal Injury (70 Claims); Personal Injury - Road Traffic Accidents (44 Claims), Clinical negligence (105 claims); Road Traffic Accident (147 claims) and Damage to Property (21 claims).

Ombudsman: There are currently 14 open Ombudsman cases in July 2022. At present cases are not being investigated, which supports the Trusts actions.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are being arranged for September - December at this time.

Ombudsmen: All cases are recorded and monitored on the Datix System..

Expected Performance Trajectory

Coroners: The Trust continues to focus on the learning from our investigations and report these via the Patient Safety Highlight report, which is presented to the Executive Management Team and Trust Board.

In addition to this, learning from our investigations continues to be presented to the Patient Safety, Learning and Monitoring Group and our Scrutiny Panels.

Individual learning it also a huge focus across the organisation with significant attention on both clinical and CCC areas of business.

We also continue to engage with our Health Board colleagues where we have utilised the Joint Investigation Framework and/or where there is a focus on joint investigations and learning.

Ombudsmen: The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

Data source: Datix



(Responsible Officer: Liam Williams)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Safeguarding, Data Governance & Public Engagement Indicators

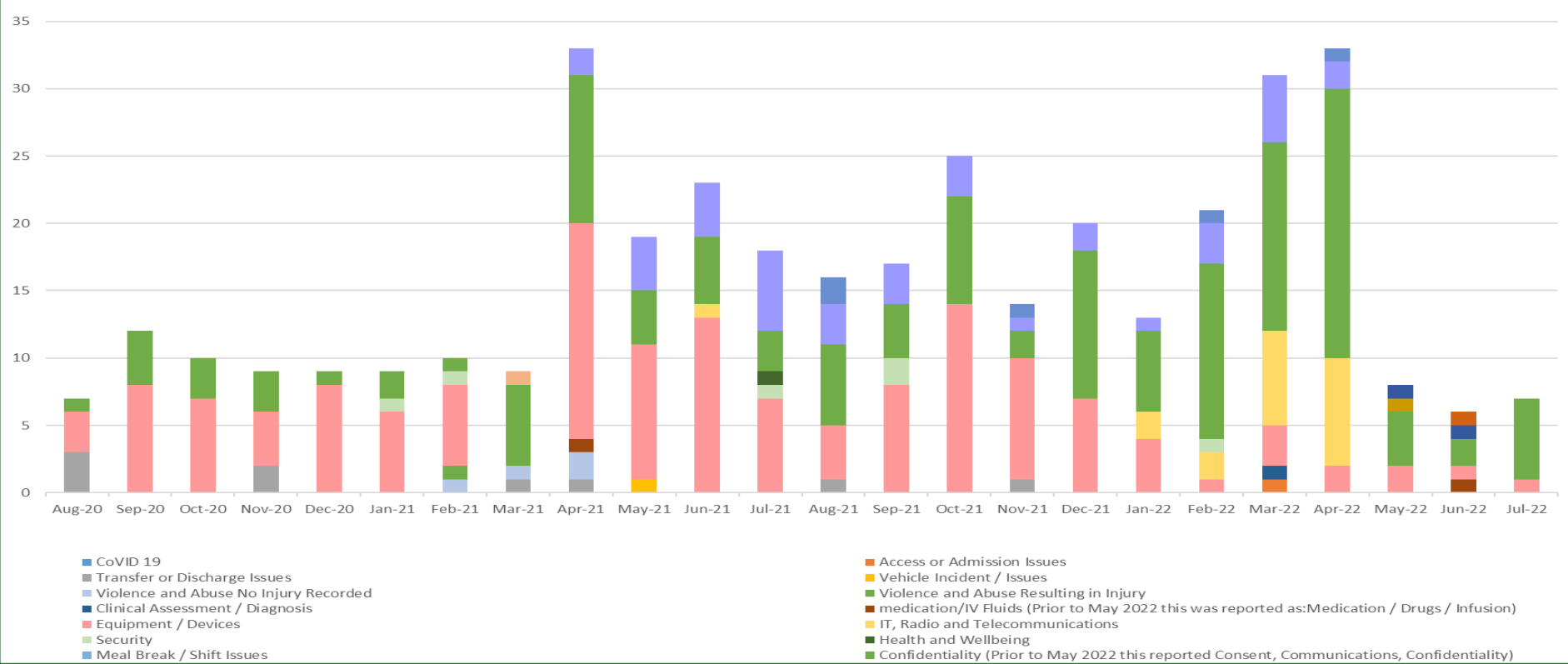
Health & Care Standard
Health – Safe Care

Self Assessment:
Strength of Internal Control: Strong



NB: Next Public Engagement update (Jul-Sep 2022) Due October 2022

Volume of High Level Breaches of the UK General Data Protection Regulation (GDPR) 2018 (Date Reported)



Analysis

Safeguarding: In July 2022 staff completed a total of 110 Adult at Risk Reports, an increase compared to June 2022 when 103 were reported. 99% of these were processed within 24 hours.

There have been 149 Child Safeguarding Reports in July 2022, a decrease from June 2022 when 152 reports were made. In June 2022 93% were sent within 24 hours.

Data Governance: In July 2022 there were 17 information governance (IG) related incidents reported on Datix RL categorised as an Information Governance (IG) breach, a decrease when compared to both May and June 2022. 10 related to records/information, 6 related to Confidentiality, and 1 related to Equipment / Devices

Public Engagement: For the first time since 2019 the PECEI Team have re-started and proactively engage with people and communities in person, by attending community events, open days, school visits and other forums. This face-to-face engagement permits meaningful conversations with people about using the services we provide; helping communities feel listened to and empowered to drive change. There were 66 engagement events held in Quarter 1, allowing engagement with 2,472 people. 71 NHS 111 Wales website surveys were returned, 80 people completed a survey about their experience of calling NHS 111 Wales. We continue working with NEPTS colleagues to promote patient experience surveys for users, surveys are sent direct via post, text and online. 280 NEPTS surveys were completed in this quarter. In this quarter we made a 999-patient experience survey available for the first time, this was completed by 30 people who shared their views on recent experiences of calling 999. More work will be done to further promote these surveys and capture more patient feedback. 117 compliments were also logged and processed; these positive experiences are also celebrated every Thursday on our social media channels using the #ThankYouThursday hashtag.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support staff with the use of the Docworks Scribe App and liaise with local authorities when or where required. Numbers of paper safeguarding reports have significantly reduced with the embedding of Docworks; however, they are used as a back-up and are sent directly to the Safeguarding Team for further action. Continued monitoring supports practice in this area which is seeing a steady improvement.

Data Governance: During the reporting period, of the 17-information governance related incidents reported on Datix all incidents have been reviewed and investigated where necessary by the IG team and remedial actions taken where appropriate. 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office.

Public Engagement: Though we continued to engage with communities across Wales throughout the coronavirus pandemic, this was done in a much more digital way, holding online events and joining online forums and meetings. Whilst this online engagement was crucial and allowed us to maintain connections, it was widely acknowledged that for many, online engagement was a barrier, and some felt excluded from participating in online activities in general. A return to in person community engagement is very welcome and allows to re-start having rich conversations with people about their experiences and expectations. It is acknowledged that coronavirus cases in the community are rising again, the PECEI Team will continue to take measures to ensure staff and communities safety during engagement events.

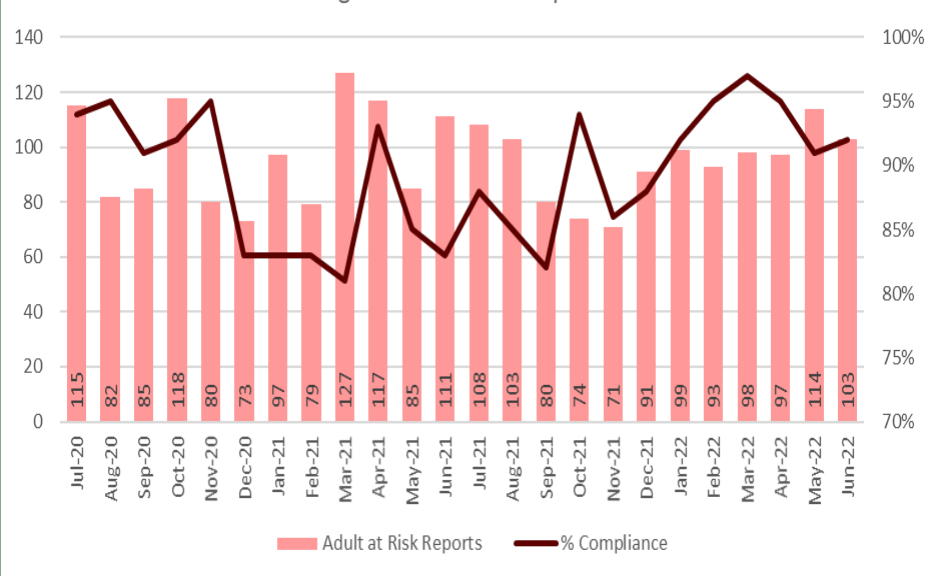
Expected Performance Trajectory

Safeguarding: The Trust continues to aim to achieve 100% of Adult and Children at risk referrals within 24 hours.

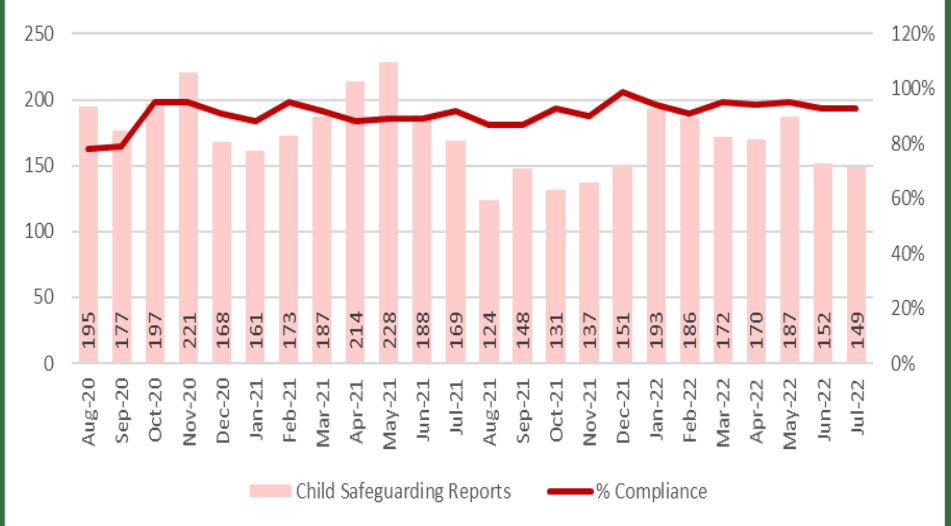
Data Governance: An annual assessment of compliance using the Welsh NHS IG Toolkit; an individual evidence-based assessment consisting of 255 items; will continue to be utilised to measure the Trust against National Information Governance and Security Standards. For its FY2021-22 submission, the Trust has achieved a score of 77% against the standards. This is compared with a score of 78% for FY2020-21. As a result of the impact of COVID-19, focus had remained on maintaining compliance levels. The IG Toolkit requirements will continue to be monitored and actioned by the IG Team.

Public Engagement: Outcomes of our engagement with people and communities across Wales remain consistent to those previously reported. With people continuing to tell us that long waits and delays remain their primary concern; though the transport, care or treatment they ultimately receive is good. This theme is repeated across all services delivered by the Welsh Ambulance Service - 999 emergency care, Non-Emergency Patient Transport and NHS 111 Wales. The PECEI Team will continue engaging with communities, proactively communicating with people and communities, sharing important information regarding Trust services and appropriate use of these during the current period of increased demand. Learning from our engagement will be shared with partners, stakeholders and colleagues and will be used to help influence quality improvement.

Number and Percentage of Adult at Risk Reports sent within 24 Hours



Number and Percentage of Child Safeguarding Reports sent within 24 Hours



Safeguarding Data source: Doc Works

NB: Data Governance Incidents are based on 'Date Reported' rather than 'Incident Date' and the process is currently manual until a dashboard is implemented and is therefore subject to change



(Responsible Officer: Liam Williams)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

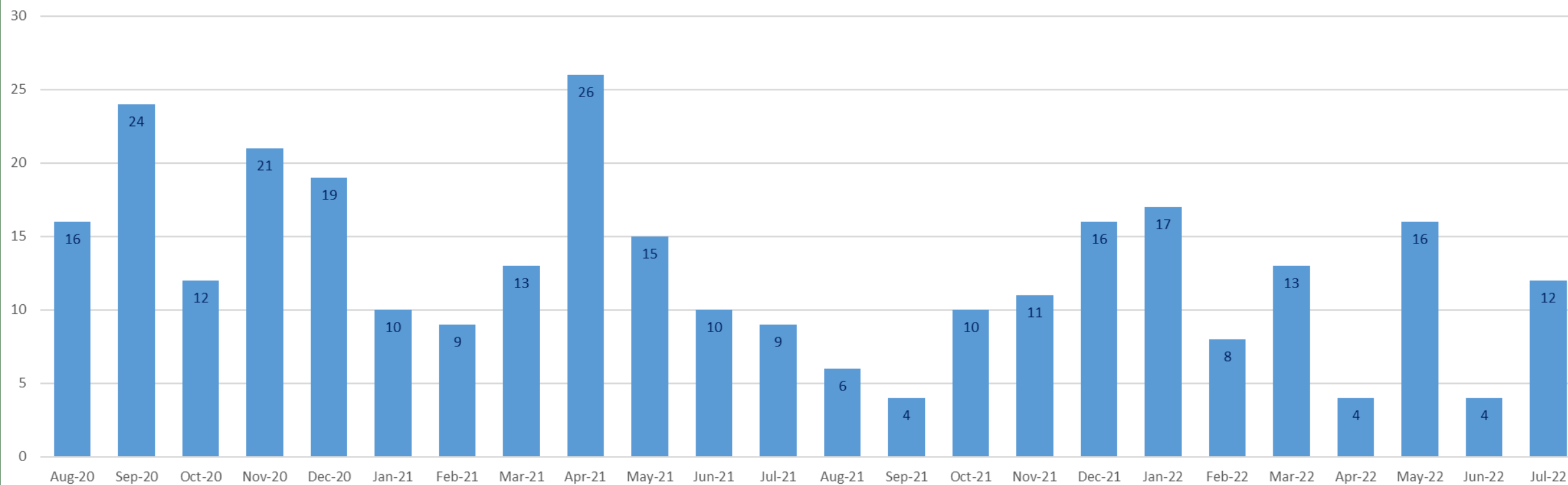
Health & Safety (RIDDORS) Indicators

Self Assessment:
Strength of Internal
Control: Moderate

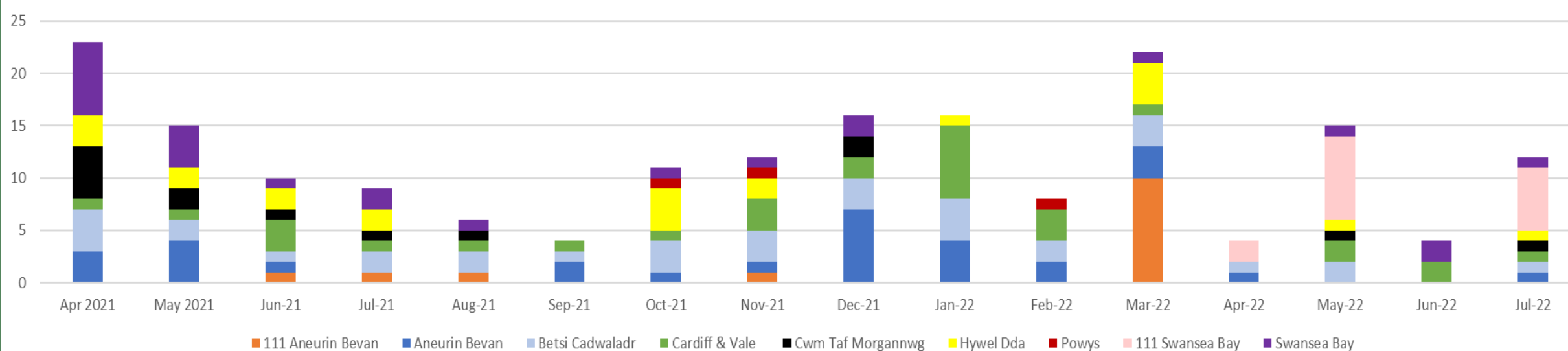
QUEST

Health & Care
Standard
Health – Safe Care

Volume of RIDDOR Reports by Month



Volume of Riddor Reports by Health Board



Analysis

Whilst there is a strong level of internal control with respect to GL1 Metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around obtaining staff details are impacting on timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE).

In July 2022 there were 12 RIDDORS reported. As shown in the bottom graph, ABUHB, BCUHB, C&VUHB, CTMUHB, HDUHB and SBUHB accounted for 1 report each and 111 Swansea Bay accounted for 6 reports.

Remedial Plans and Actions

Some members of the Health & Safety Team have been granted authorisation to access details from the Electronic Staff Record (ESR) which will provide timely access to key details in relation to RIDDOR reporting. However, one key member responsible for reporting of RIDDORS left the organisation in November 2021. Additionally, the Regional H&S Manager also responsible for reporting is on long terms sickness absence.

The Trust's compliance with Health and Safety legislation requires further work to specify and detail areas to improve compliance. A draft transformation plan has been approved by EMT endorsing the commencement of this comprehensive holistic action plan, through a Working Safely Programme.

Expected Performance Trajectory

The Trust continues to work towards improving internal controls and the timeliness of reporting RIDDORS.

The Trust has recently agreed (and funded) a new structure for the Health & Safety Team, which is currently being recruited into, whilst a clear programme of work exists for reviewing and updating policies and procedures.

****NB: July 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change**

Data source: Datix



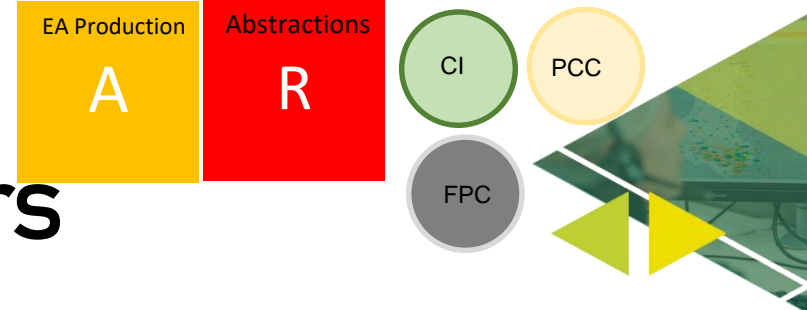
(Responsible Officer: Liam Williams)

Welsh Ambulance Services NHS Trust

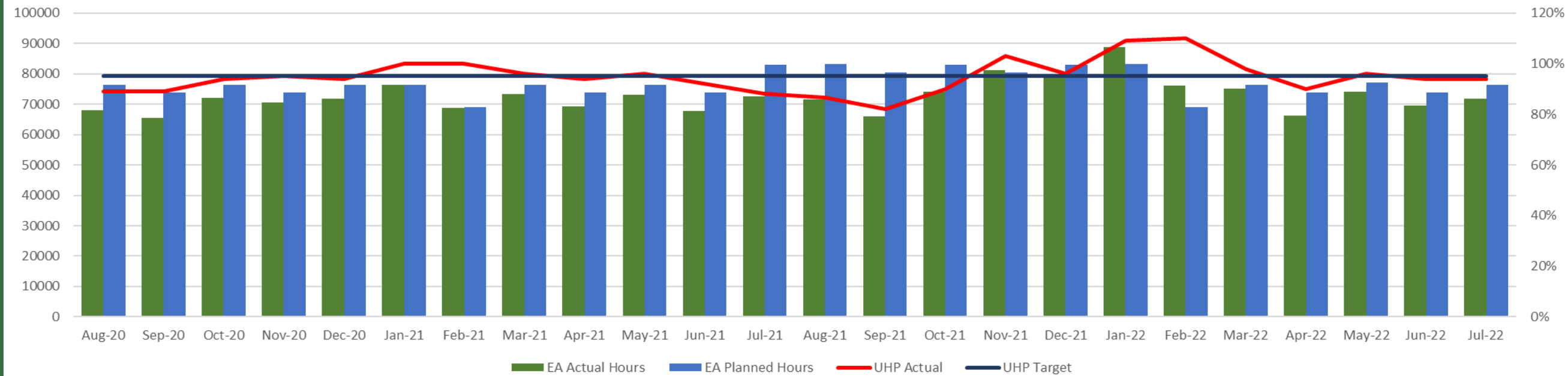


Our People

Capacity - Ambulance Abstractions and Production Indicators



Emergency Ambulance Unit Hours Production



Analysis

As shown in the bottom right graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In July 2022, total abstractions stood at 39.92%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 15.26% and sickness at 11.95%. Sickness abstractions for July 2022 were higher than the previous year (11.11%) however, COVID-19 (non-sickness) related abstractions decreased in July 2022 when compared to June 2021 accounting for 0.30% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 94% in July 2022 (71,682 Actual Hours), falling short of the 95% benchmark. RRV UHP achieved 71% (14,583 Actual Hours) compared to 79% in June 2022. The total hours produced is a key metric for patient safety (included on slide 7 red performance). In July 2022 the Trust produced 111,168 hours, but the graph shows that even despite significant funding for increased substantive numbers of staff, total hours produced has not risen sustainably.

Remedial Plans and Actions

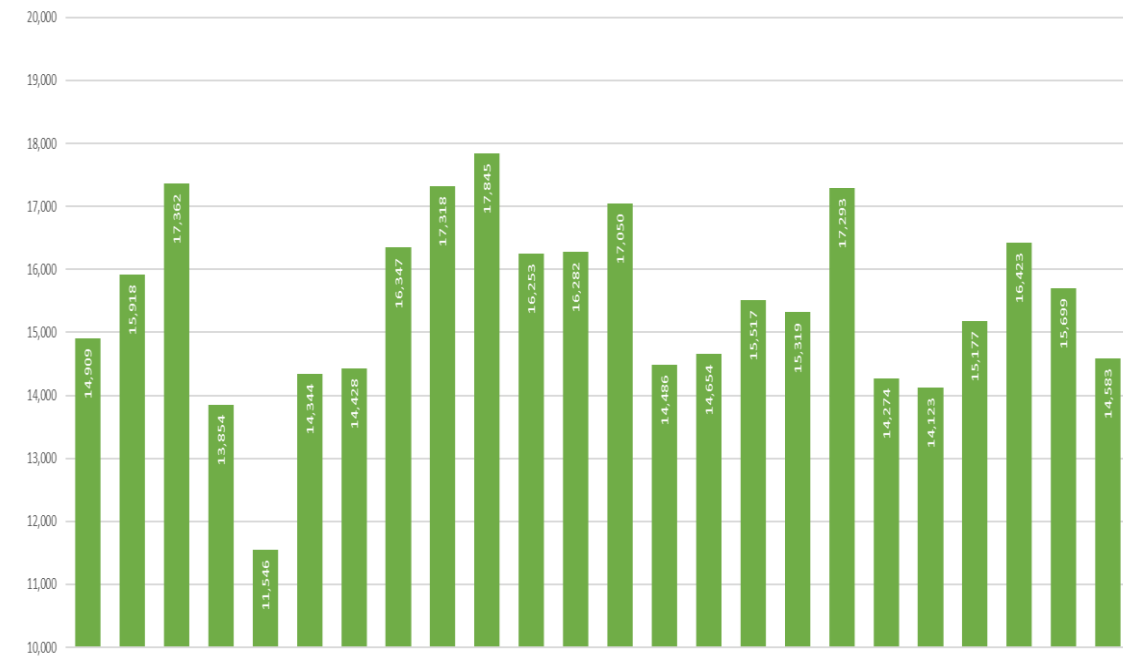
The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A new formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks. In future months, we will include a graph in this pack of performance against the agreed trajectory/

The key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 100 WTE to be recruited this year.

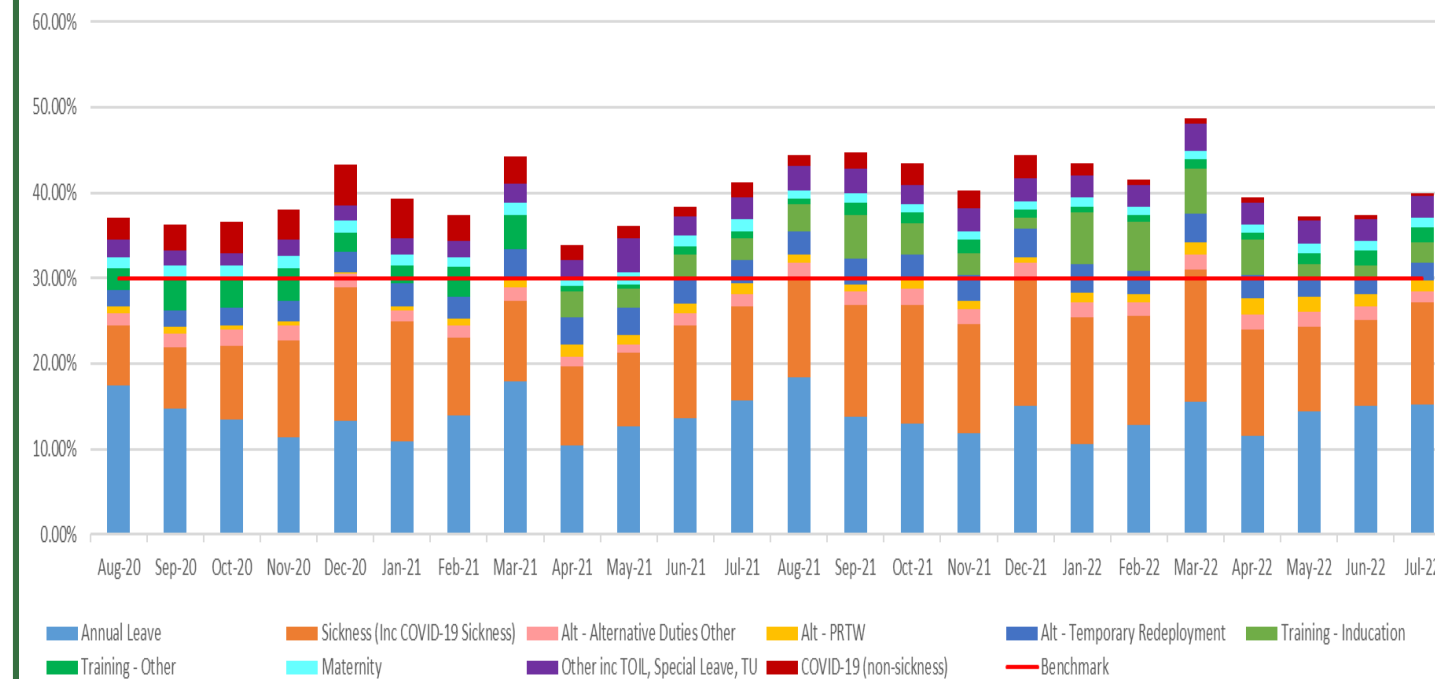
Expected Performance Trajectory

Subject to the longer-term impact of COVID-19 the benchmark is a UHP of 95% across the Trust's three main resource types and an abstraction rate of 30%. The Trust is proposed, as part of the Transition Plan, that a higher level of abstractions (and relief) is used.

RRV Actual Hours



Pan Wales EMS Total Rota Abstraction Hours

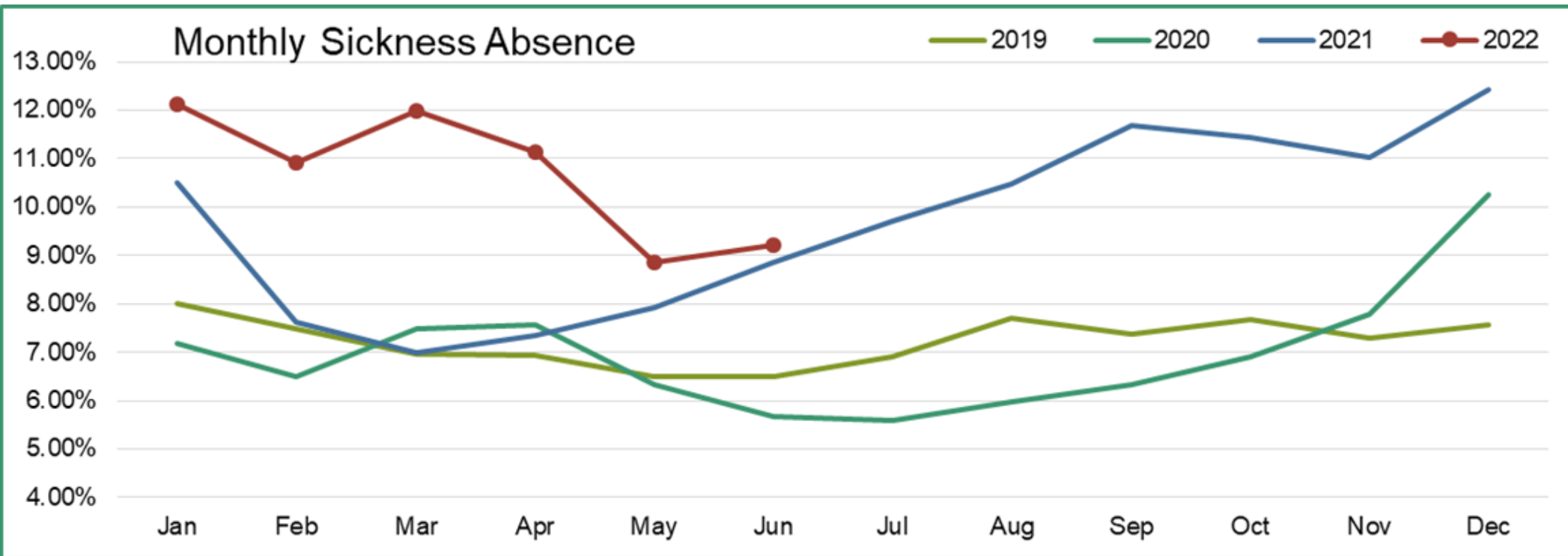




Our People Health & Wellbeing - Sickness Absence Indicators



NB: July 2022 update not available



Analysis

The monthly sickness absence figure for June 2022 was 9.12%, a decrease of 0.26% from last month. There has been a small increase in all overall absence levels which is predominantly due to the sharp increase in short term COVID absence.

Long term sickness levels as been reducing month on month and this trend continues. Continued support is offered through a variety of resources and in June 2022:

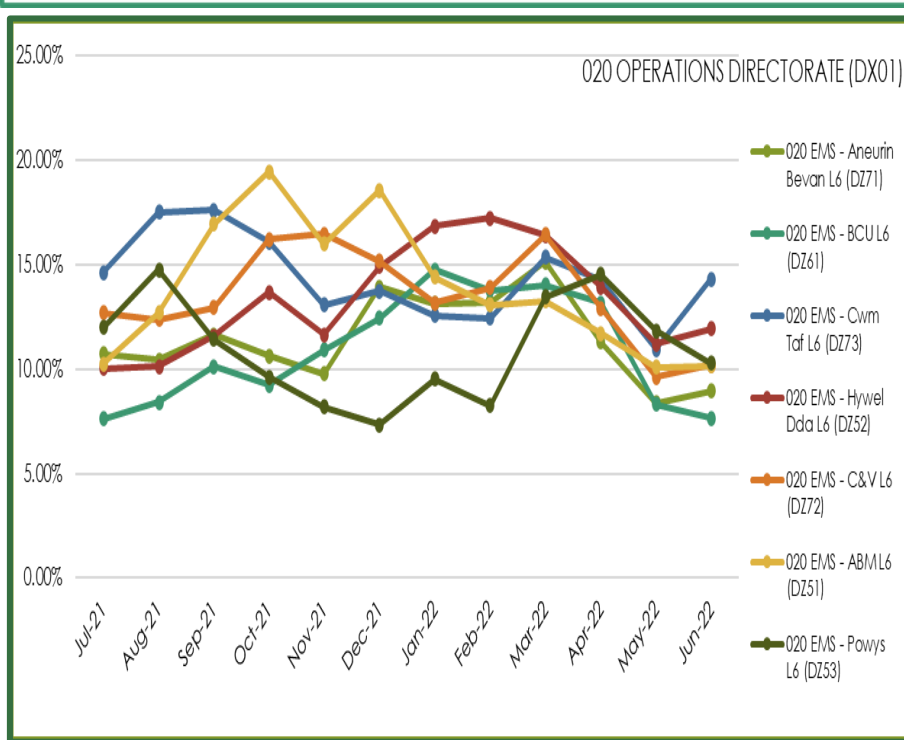
- 42 referrals were received for Physiotherapy and the average length of time from referral to first Contact was 1.9 days
- The average length of time from referral to Televid Clinical Assessment was 3.1 days
- The average age of those referred is 45 years, with back issues being the main reason for referral.
- Health Assured – EAP call summary was 24 calls
- A total of 580 staff signed onto the Thrive App with 52 Active Users in the month

Remedial Plans and Actions

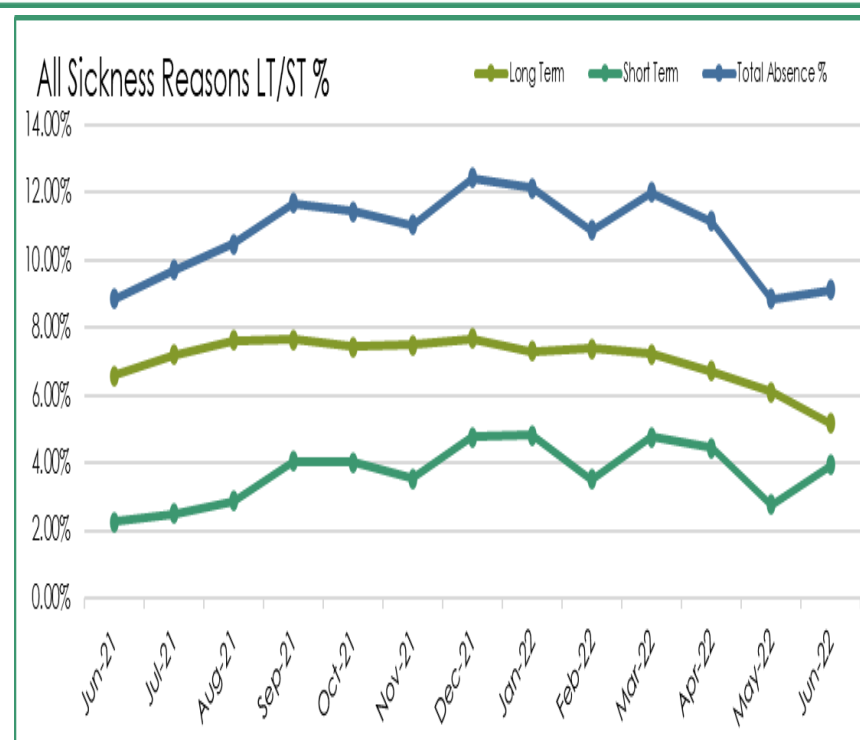
- Comprehensive training and support resources are being rolled out across the Trust.
- The sickness absence management programme is being adopted across CCC as a result of the improvements seen across EMS
- Considerable focus has been directed on colleagues undertaking alternative roles as a direct result of sickness absence (RTW), Health and Wellbeing and COVID
- Proactive engagement with Occupational Health has been strengthened to aim to support colleagues back to work and avoid absence
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences
- Regular meetings are held to discuss complex cases
- Case reviews have been undertaken to agree next steps for colleagues that are on LTS due to COVID so that comprehensive RTW plans are developed
- Local training to embed ESR and Business Intelligence reports to support attendance at work is being rolled out
- A recent Peer Support Network ahs been set up by the Trust, with 65 members as of July 2022. REACT training (a tool to guide members through supportive conversations about mental wellbeing) is being delivered; at present 15 of the 65 colleagues engaged have attended. The network is overseen by the lead for TRiM and the Trusts Assistant Psychologist. There are plan underway to deliver REACT training as part of 111 induction training.

Expected Performance Trajectory

The Trust is aware that some staff may need more time to recover due to Long-CoVID and may require a longer phased return to work alongside putting in place other supporting mechanisms. Work is also ongoing to consider the mental health aspects of COVID-19 and working from home and the Trust is actively seeking ways to consider the possibility of hidden health and wellbeing issues. It is therefore difficult to forecast or predict performance against this indicator, but the expectation is that the target is unlikely to be achieved in this financial year.



Average working days lost per FTE (Annual)	
24.89 days	
Single month Absence %	
9.12%	
Long Term	Short Term
5.18%	3.94%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.22%	(excluding Back) 1.27%



(Responsible Officer: Catherine Goodwin)

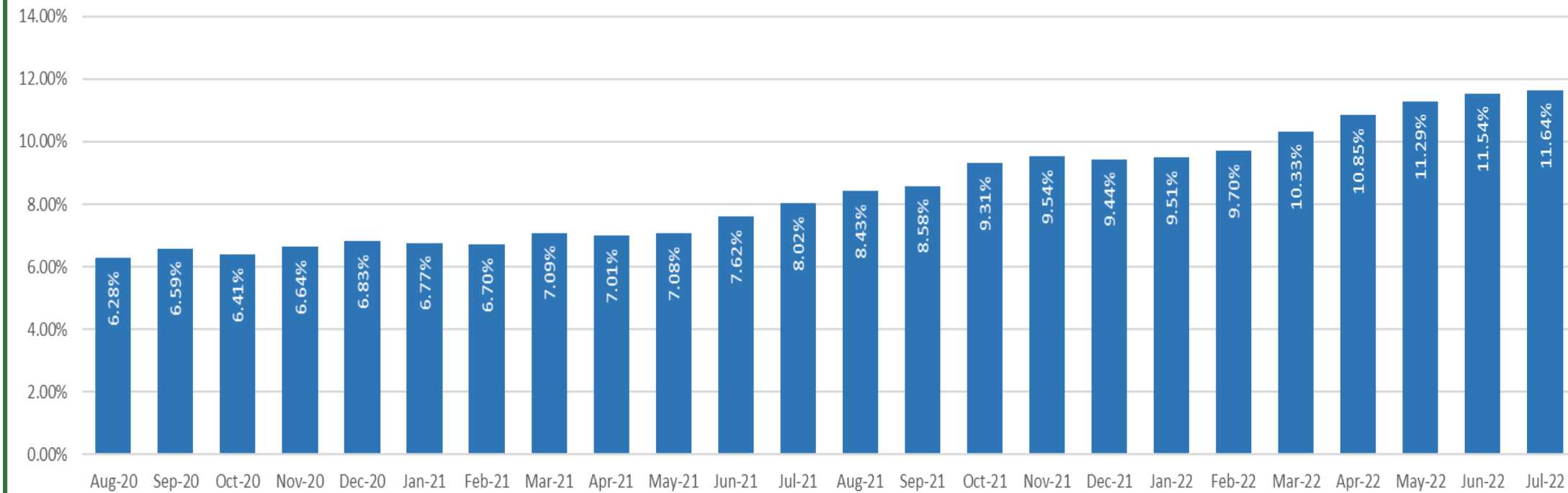
Welsh Ambulance Services NHS Trust



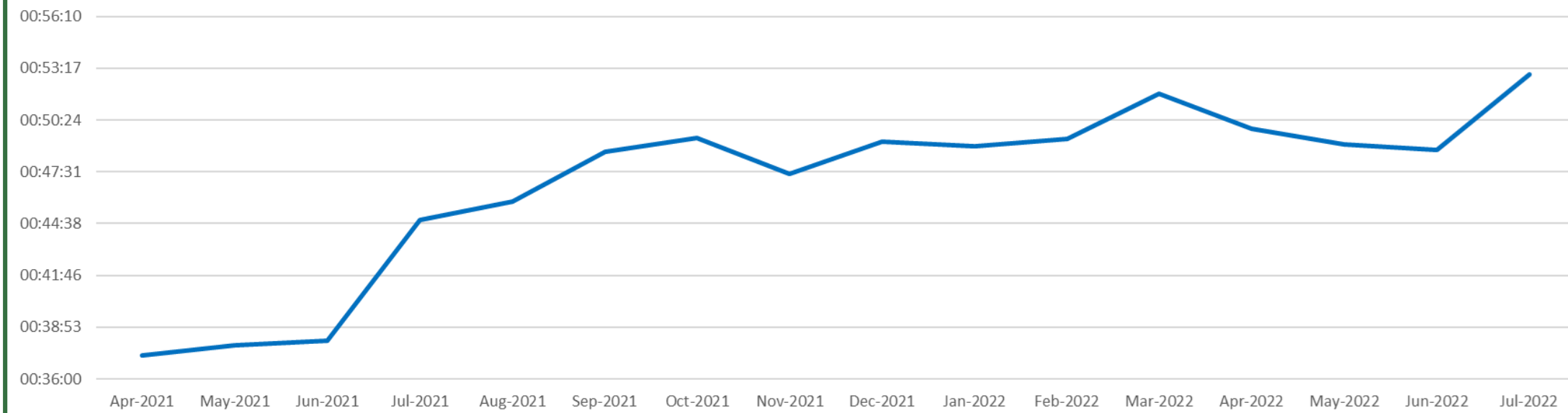
Our People Workforce Planning



Staff Turnover Rate FTE (12m)



Total Shift Overtime Time (All Resource Types)



Analysis

Staff turnover rates in July 2022 were 11.64% and have been on an increasing trajectory since May 2021 (with the exception of December 2021 when a small decrease was seen month on month). In comparison Staff turnover rates were 8.02% in July 2021.

Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

The Trust has a budgeted establishment of 1,654 FTEs for 2022-23; this will allow an increased response capacity of 100 FTEs to maximise UHP to 100% where possible.

The Demand and Capacity Roster review for EMS has concluded and new rosters will be rolled out across the Trust, commencing in September 2022.

Remedial Plans and Actions

A managing attendance programme has been implemented throughout the Trust, consisting of:

- Comprehensive training and support resource are being rolled out across WAST
- The sickness absence management programme is being adopted across CCC as a result of the improvements seen across EMS
- Considerable focus has been directed on colleagues undertaking alternative roles as a direct result of sickness absence (RTW), Health and Wellbeing and COVID
- Proactive engagement with Occupational Health has been strengthened to aim to support colleagues back to work and avoid absence
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences
- Regular meetings are held to discuss complex cases
- Case reviews have been undertaken to agree next steps for colleagues that are on LTS due to COVID so that comprehensive RTW plans are developed
- Local training to embed ESR and Business Intelligence reports to support attendance at work is being rolled out

The results of a staff survey undertaken in partnership with Swansea University into staff Wellbeing at the Trust are due to be received in September 2022.

A deep dive of staff and wellbeing has been undertaken and presented to People and Culture Committee in August 2022.

Expected Performance Trajectory

The Trust will continue to increase response capacity through partnership working with volunteers and other co-responders and through improved productivity.



(Responsible Officer: Catherine Goodwin)

Welsh Ambulance Services NHS Trust



Our People Staff Vaccination Indicators

NB: April 2022 COVID-19 Vaccine Data not Available

Self Assessment:
Strength of Internal
Control: Moderate

Flu

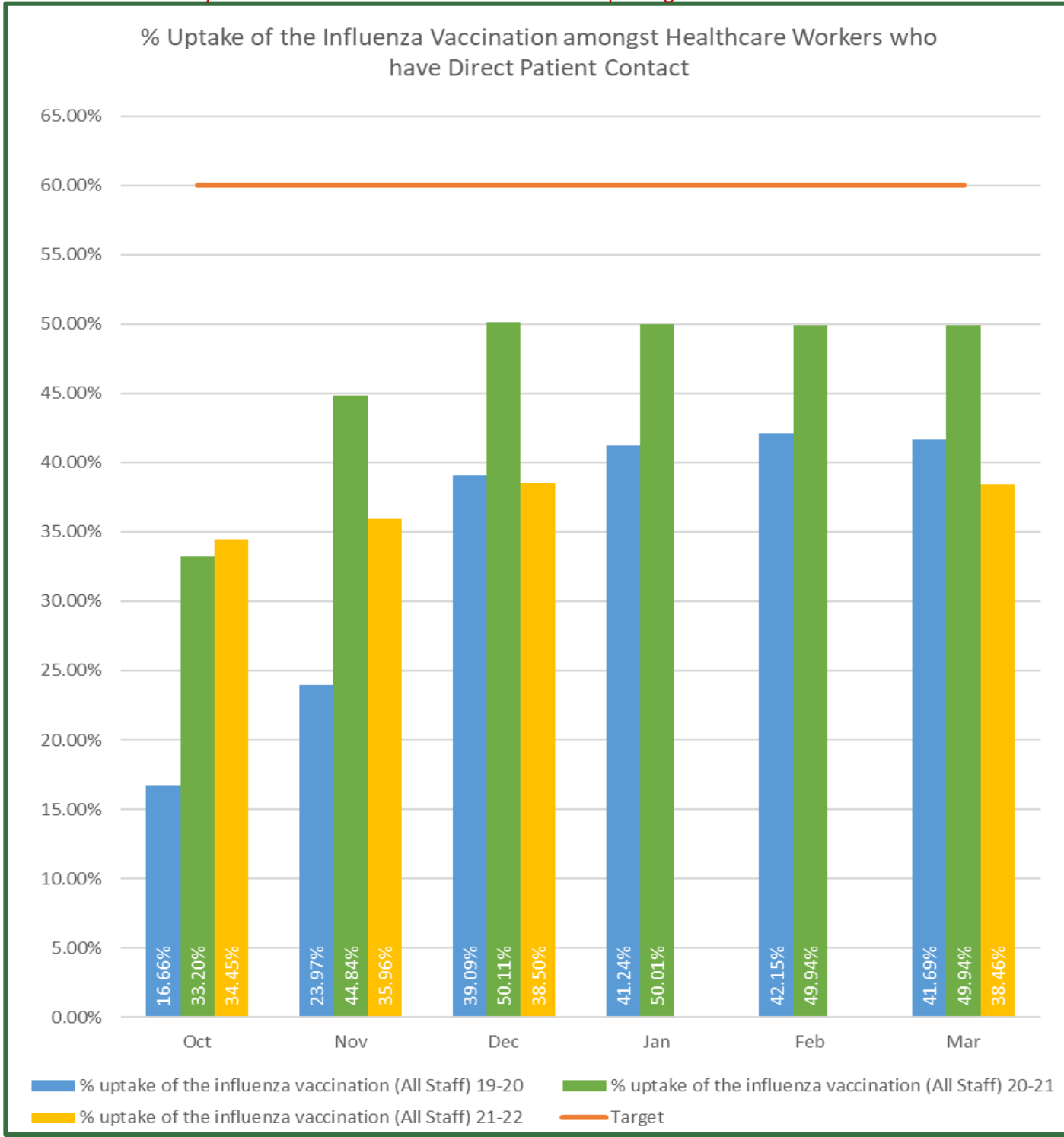
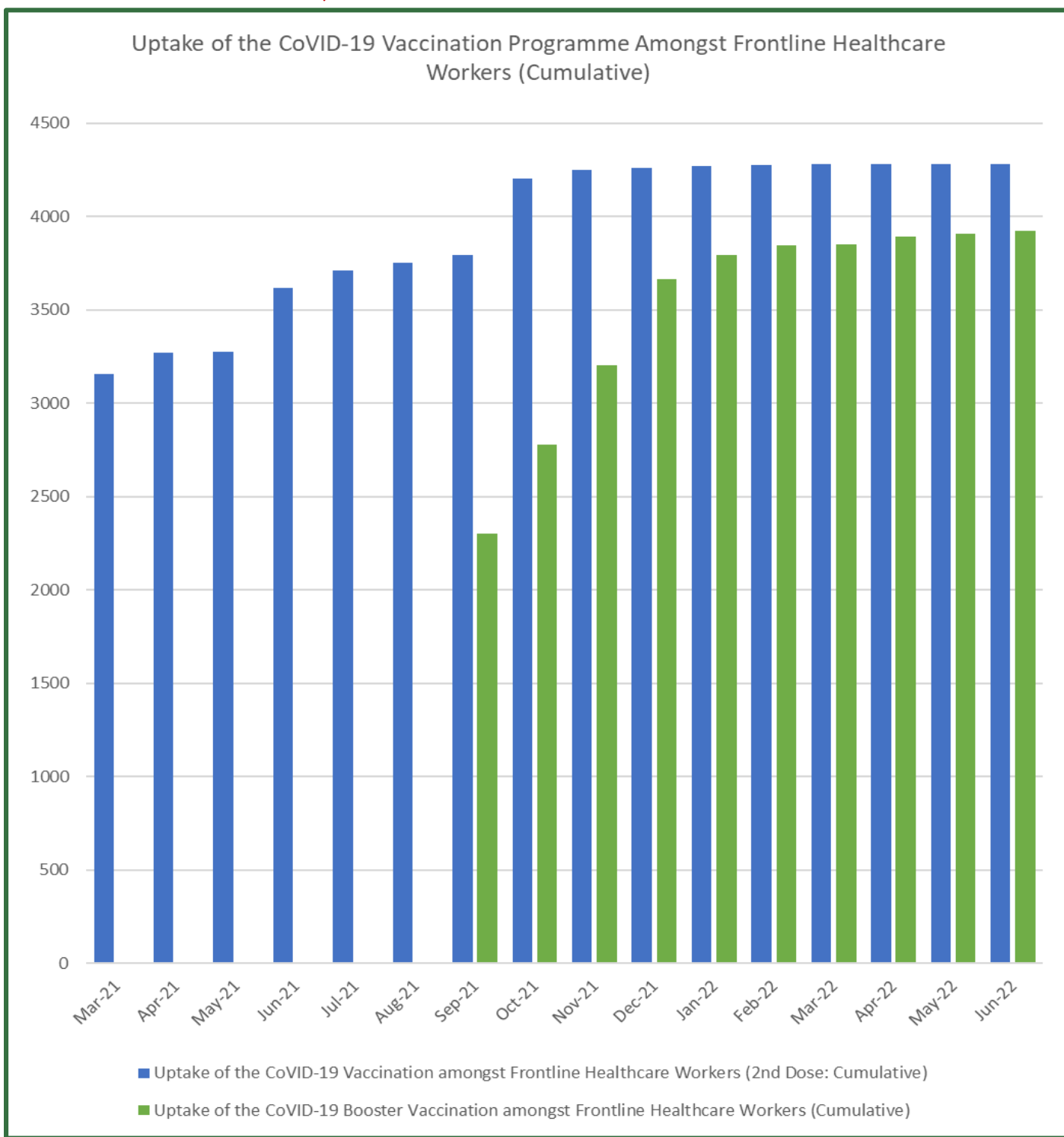
R

CI

PCC

NB: Next Reporting Flu Campaign October 2022

Health & Care
Standard
- Health (PPI)



Analysis
 The 2021-22 flu campaign got underway in Oct-21 and has now concluded; as indicated in the graph to the left 38.46% of EMS (response) and NEPTS staff received a vaccination, therefore not achieving the 60% target.

Due to a technical error in the downloading of data for the Trust are unable to report monthly data for January & February 2022.

Of the 4,532 staff currently employed (All staff) front line (Patient Facing and Non-Patient Facing staff), 95% of staff have received a first dose COVID-19 vaccination, 95% (4,283) have received a second dose and 87% (3,925 Staff) have received a booster vaccination. In addition 94% of volunteers have received a first dose vaccination, 93% have received a 2nd dose and 88.5% have received a booster vaccination.

Remedial Plans and Actions
 Staff data has been refreshed to accurately staff numbers employed by WAST.

Expected Performance Trajectory
 An evaluation of the 2021-22 flu campaign is currently being completed. Early indications from the southern hemisphere are that there has been more flu in their winter. The Trust is currently developing forecasts for the winter period that build in CoVID-19 and flu..

Date source: Cohort Electronic System / Welsh Immunisation System (WIS)



Our People

PADR and Training Rates Indicators

R

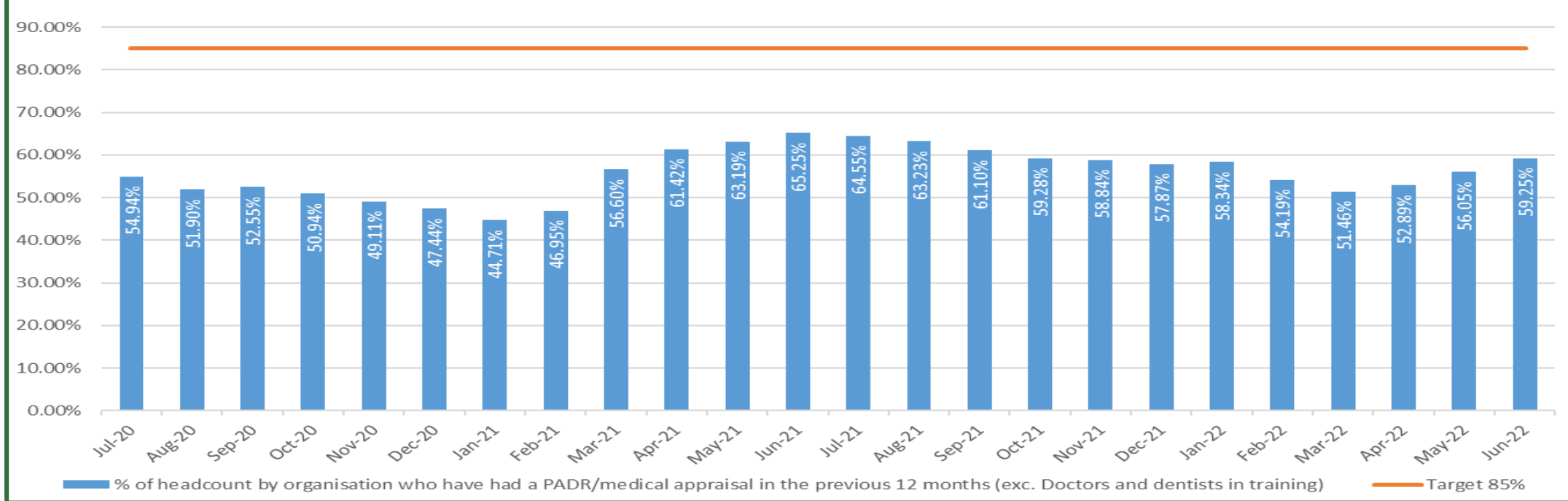
Self Assessment:
Strength of Internal
Control: Strong

CI

PCC

Health & Care
Standard
Health – Staff &
Resources

% of headcount by organisation who have had a PADR/medical appraisal in previous 12 months



Analysis

PADR rates for July 2022 improved for the fifth consecutive month to 64.66% however they continue to remain well below the 85% target.

July 2022 Statutory & Mandatory Training rates increased by 0.04% from the July 2022 figure, once again achieving the 85% target for the second time in 24 months. Fire Safety (67.72%) and Moving & Handling (85.43%) both failed to achieve the 85% target; however, Information Governance (85.84%) and Safeguarding Adults (88.30%) achieved the target in July 2022.

There are currently 2 (13 for Admin & Clerical Staff) Statutory and Mandatory courses that all NHS employees must complete in their employment. These are listed in the table to the right.

Skills and Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection Prevention & Control - Level 1	3 years
Information Governance (Wales)	2 years
Moving and Handling - Level 1	2 years
Resuscitation - Level 1	3 years
Safeguarding Adults - Level 1	3 years
Safeguarding Children - Level 1	3 years
Violence & Aggression (Wales) - Module A	No renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No renewal
Environment, Waste and Energy (Admin & Clerical staff Only)	Yearly

Remedial Plans and Actions

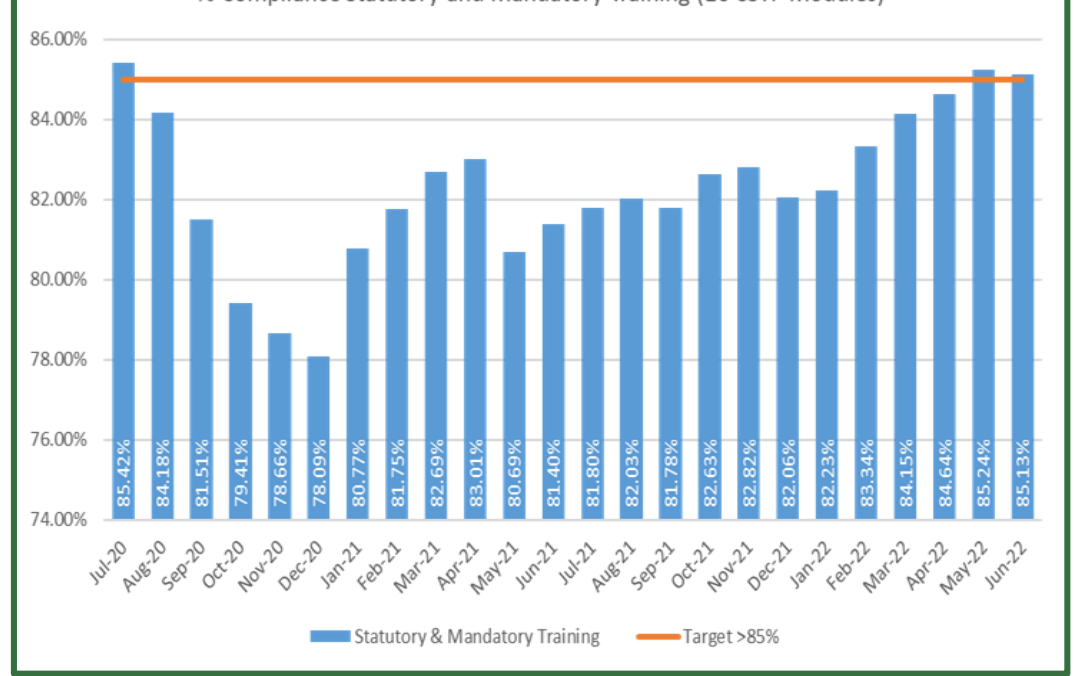
Since the onset of CoVID the Learning and Development team have moved the Trust towards a more blended model of education. All staff are actively encouraged to take ownership of their e-learning through self-identification of topics they are required to update. This is done through logging into ESR and reviewing individual compliance. Where e-learning is appropriate staff log in and complete this in a timely manner. This then negates the need for colleagues to attend classroom based CPD days where it is not necessary. CPD is supported by the ESR Team and user guides, and other supportive information is available through the WAST intranet and via Yammer.

A campaign is underway to 'mop up' last years non-compliance and is due for completion shortly. A presentation to SOT and SESG in July 2022 will outline proposals for 22-23 CPD topics and structure. In addition, meetings are ongoing with the Ambulance Response Team to highlight compliance rates for Frontline staff and continue to monitor.

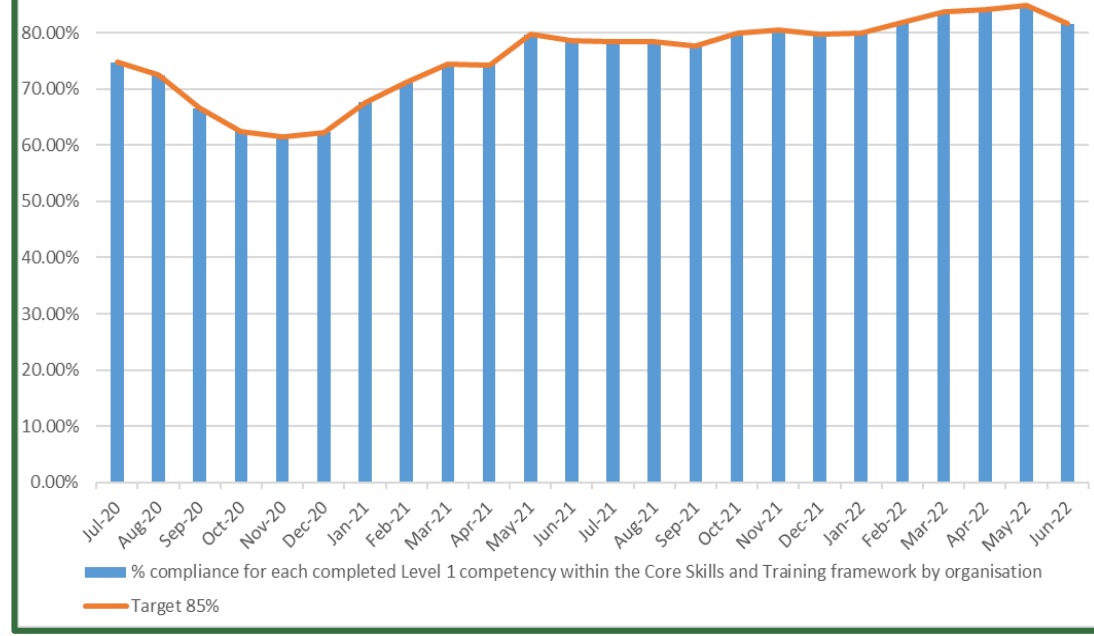
Expected Performance Trajectory

Uptake in the e-learning based topics continues to be very positive and staff of all grades have embraced the concept and are engaged with this new concept. Staff seem to have bought into the "new normal" and the Trust expects to continue to see improving compliance figures across the Trust.

% Compliance Statutory and Mandatory Training (10 CSTF Modules)



% compliance for each completed Level 1 competency within Core Skills & Training framework



Data source: ESR



Our People Inclusion and Engagement



NB: Slide under Development - will include ethnicity and age category data in future iterations

Analysis
As of July 2022, 79.73%, of staff have completed mandatory Equality and Diversity Training.

In July 2022 21.5% of staff have recorded that they have Welsh language listening and/or speaking skills at level 2 or above (NB: this is as a % of staff who have a level recorded, not against headcount).

In 2021/22 the number of vacancies advertised where Welsh language skills were deemed as essential accounted for 8 adverts in comparison to 441 adverts where Welsh language was desirable and 6 where it was not necessary.

In July 2022 gender pay as a percentage of the workforce indicates that for those employed within bands 2 - 5 employment is more equally distributed, with 31.60% of females and 30.82% of males fulfilling those roles; however, employment within the higher paid bands is frequently undertaken by males. 14.59% of females are employed in Band 6 and 7 roles compared to 18.61% of males and of those employed within Band 8 roles 1.69% are females and 2.19% are males. The Trust has a diverse senior leadership team and of the 11 members, 5 of these are women (NB: 2 are interim at the time of reporting).

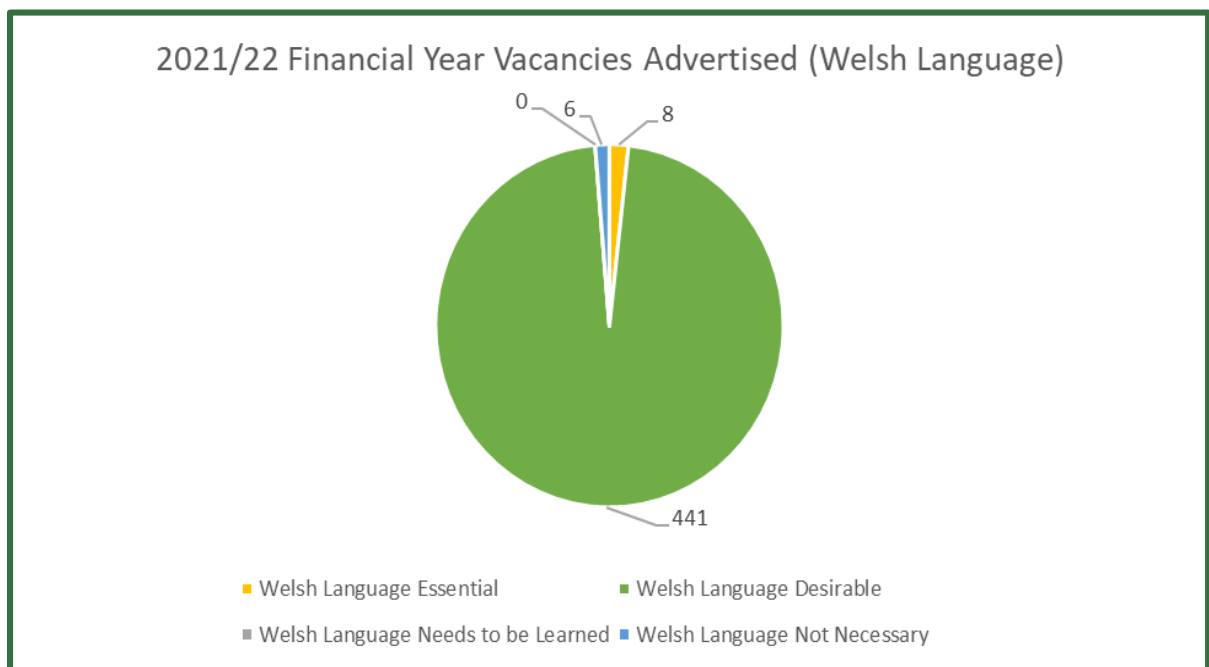
100 colleagues have begun Allyship journeys, including Board members, and the programme continues to be well received; work is underway to ensure the programme is updated and bespoke wherever possible to ensure greater engagement.

Remedial Plans and Actions
 The Trust has seen a sharp increase in the demand for services conducted in the Welsh language, staff are encouraged and given opportunities to undertake Welsh language training and each department has a 'Welsh Language Champion'.

The roll out of the Allyship programme has been positive and it is now being reviewed to ensure it is fit for purpose and valuable to staff.

Expected Performance Trajectory
 Having listened to feedback from communities, stakeholders and colleagues the Trust has developed seven new behaviours to ensure we can always be our best and is more committed than ever to improving the future and embracing new ways of working.

The Trust continues to follow guidance issued for Welsh Language standards (2015) to ensure compliance when advertising vacancies, which are advertised in both the English and Welsh language for any posts where Welsh language skills are essential or desirable.



	Female %	Male %
Band 2	1.56	1.73
Band 3	16.45	14.87
Band 4	7.90	9.91
Band 5	5.69	4.31
Band 6	11.73	13.51
Band 7	2.86	5.11
Band 8 - Range A	0.89	1.21
Band 8 - Range B	0.50	0.41
Band 8 - Range C	0.22	0.45
Band 8 - Range D	0.09	0.11
Other	0.24	0.26



(Responsible Officer: Catherine Goodwin)

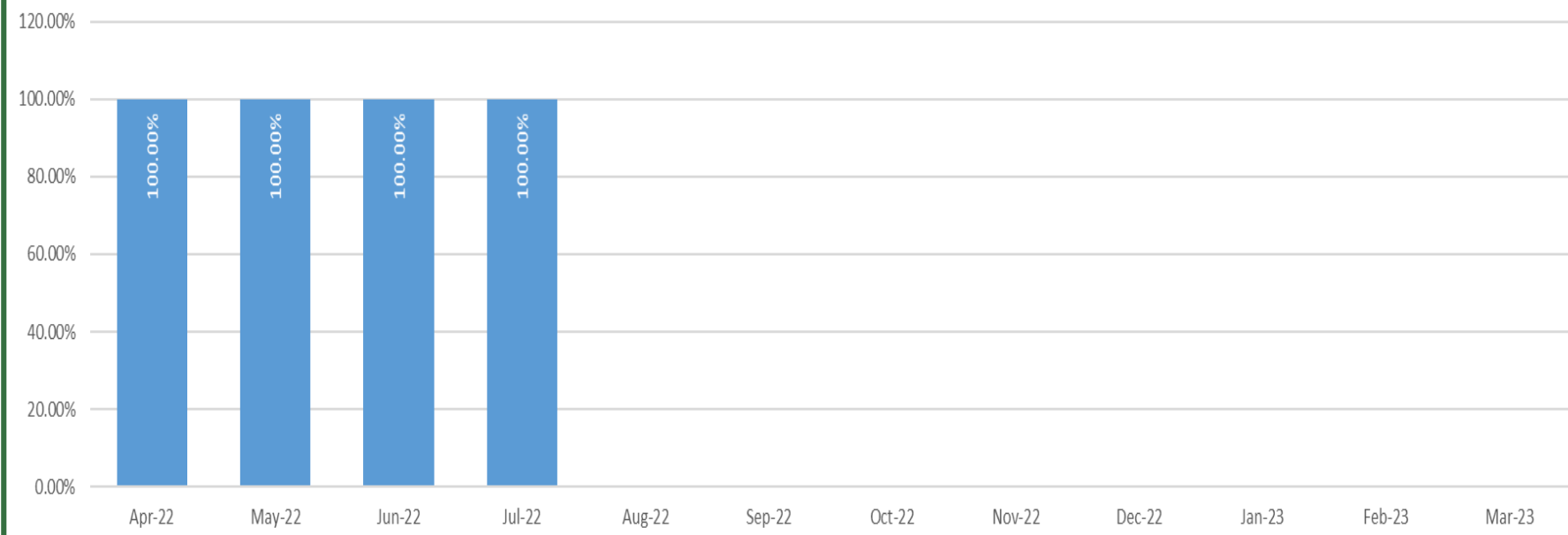
Welsh Ambulance Services NHS Trust



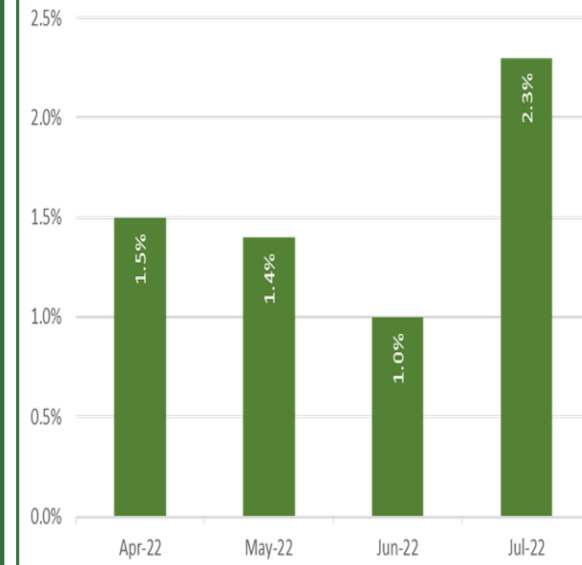
Finance and Value Finance Indicators



Financial balance - annual expenditure YTD as % of budget expenditure YTD



Agency/Locum (premium) spend as a percentage of the total bill (£'000)



Analysis

The reported outturn performance at month 4 is a deficit of £3,000, with a forecast to the yearend of breakeven.

For month 4 the Trust is reporting planned savings of £1.430m and actual savings of £1.475m, an achievement rate of 103.1%.

Cumulative performance against the Public Sector Purchase Programme (PSP) as of July 2022 was 96.7% against a target of 95%.

As of June 2022, the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

The Trust's financial plan for 2022-25 will build on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2022-25 financial plan was submitted to WG following Board sign off on 31st March 2022.

No financial plan is risk free. Financial risk management forms a key element of the project plans which underpin both the Trust's ambitions and savings targets. The Trust continues to seek to strengthen where it can its financial capacity and corporate focus on finance, and as an organisation have structures in place to drive through the delivery of our financial plan.

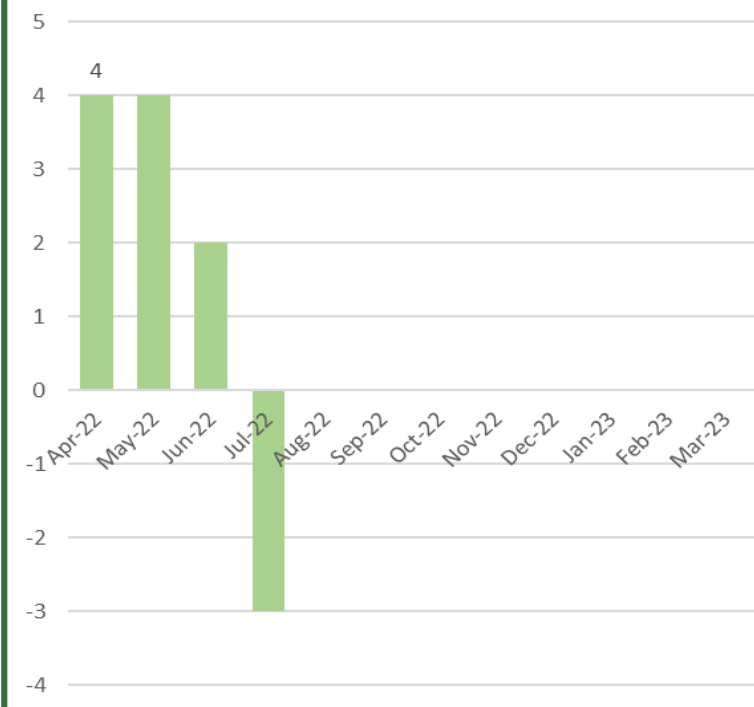
Key specific risks to the delivery of the 2022/23 financial plan include:

- Continuing financial support from Welsh Government in relation to Covid costs;
- Availability of capital funding to support the infrastructure investment required to implement service change, and the ability of the Trust to deliver the revenue consequences of capital schemes within stated resource envelope;
- Financial impact of EASC Commissioning Intentions, and confirmation of the EMS financial resource envelope as assumed within our financial plan;
- Ensuring additional avoidable costs that impact on the Trust as a result of service changes elsewhere in the NHS Wales system are fully recognised and funded;
- Ensuring any further developments are only implemented once additional funding to support these is confirmed;
- Delivery of cash releasing savings and efficiencies;

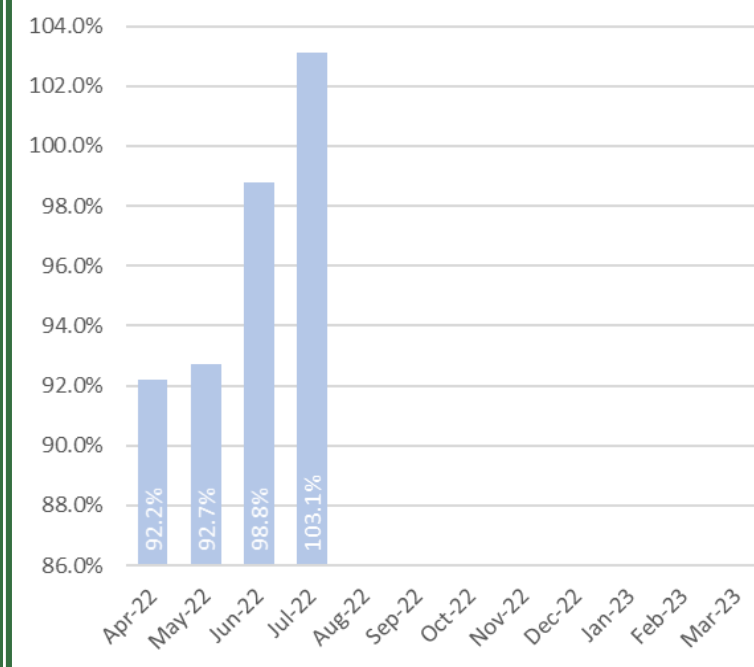
Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to continue to deliver further planned savings into 2022/23.

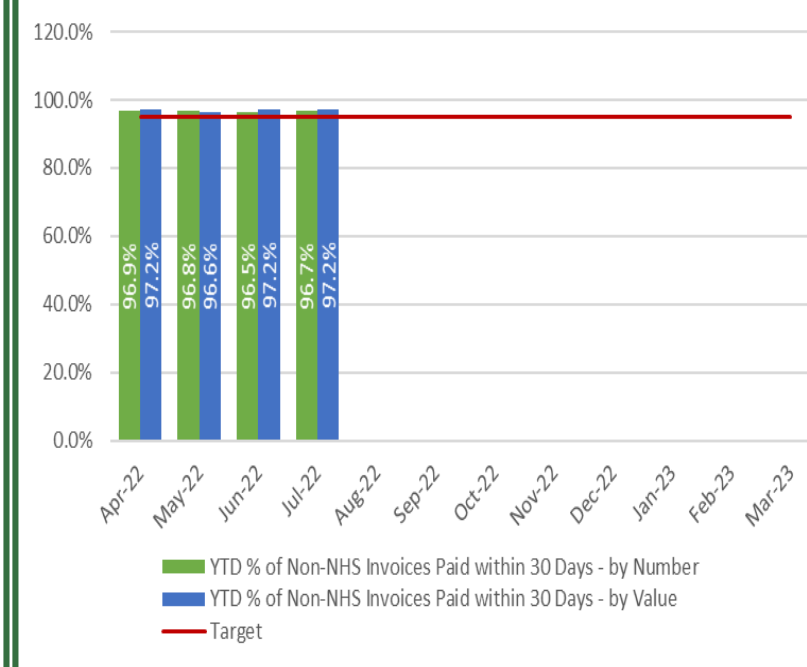
Actual Trust Surplus/(Deficit) YTD - £000



Actual Savings YTD as % of Planned Savings YTD



YTD % of Non NHS Invoices Paid Within 30 Days - By Number & Value





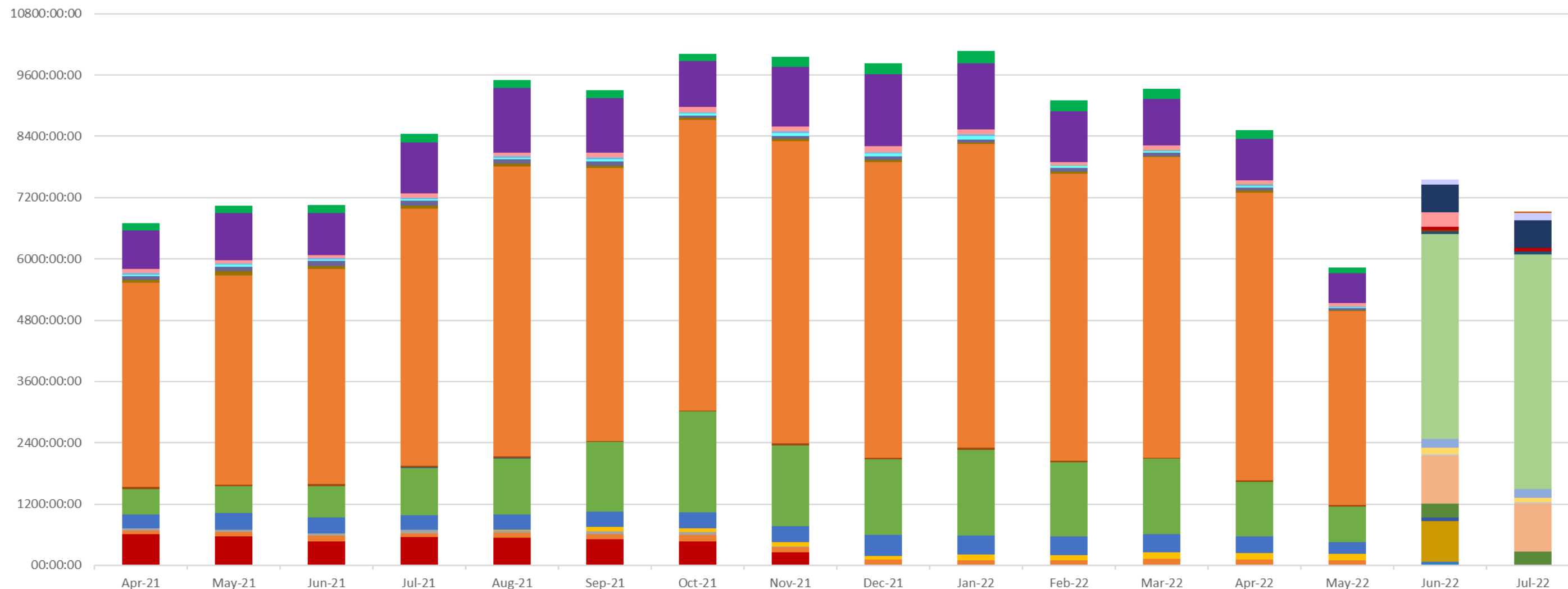
Value / Partnerships & System Contribution

EMS Utilisation & Postproduction Lost Hours Indicators



NB: Revised data reported based on amendments in QlikSense and refinements applied to improve accuracy in reporting

Post Production Lost Hours - By Unavailability Reason (EA, RRV & UCS)



Analysis

There were 6,932 post production lost hours (PPLH) across EA, RRV & UCS vehicles in July 2022; a decrease when compared to June 2022 (7,559).

In July 2022 hours lost through PPLH can be down to numerous factors, including, but not limited to Return to Base, Meal Breaks (4,597 Hours), HALO duties (948 hours) and Vehicle Cleaning (537 Hours). It can also be as a result of different processes at hospital sites causing variation in process in flow throughout the system that contribute towards post- production lost hours.

Remedial Plans and Actions

This is currently an area of focus via a series of workshops with TU Partners.

Expected Performance Trajectory

The current data needs to be treated with a degree of caution, for example, there are good reasons for some post production lost hours, plus there are issues of data entry. The Trust has recently undertaken more benchmarking on PPLHs which suggests that it compares favorably with two other ambulance services, but less so with a third. Contact is being sought with this third service. A deep dive on was presented to May-22 F&P Committee.

****NB: PPLH Data correct at time of extract**

- CLEANING – CoVID19
- HALO DUTIES
- SOILED UNIFORM - NOT AVAILABLE
- TRAUMATIC STAND DOWN - NOT AVAILABLE
- U/A DOM Duties
- U/A Meeting
- U/A Traumatic Incident Stand Down
- COMMUNICATIONS - NOT AVAILABLE
- L3 PPE Cool Down
- STAFF ILLNESS - NOT AVAILABLE
- VEHICLE CLEANING - NOT AVAILABLE
- U/A Equipment
- U/A Patient Documentation
- U/A Undisturbable Rest Break
- CoVID 19 RTB/ Awaiting Decontamination Cleaning
- POLICE INTERVIEW - NOT AVAILABLE -
- STAFF INJURY - NOT AVAILABLE
- U/A Event Resource
- U/A RTB Stand Down Mealbreak
- U/A Vehicle Cleaning
- Crew Documentation
- RTB S/D MEALBREAK - NOT AVAILABLE
- Tactical Approach to Production Crew Concern
- End Shift
- U/A HALO Duties
- U/A Soiled Uniform
- U/A Staff Illness/ Injury
- EQUIPMENT - NOT AVAILABLE
- SAFEGUARDING/POVA - NOT AVAILABLE
- TRAINING ON BASE - NOT AVAILABLE
- U/A Crew Off Duty
- U/A Leave- Not Available
- U/A Staff Illness/ Injury



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



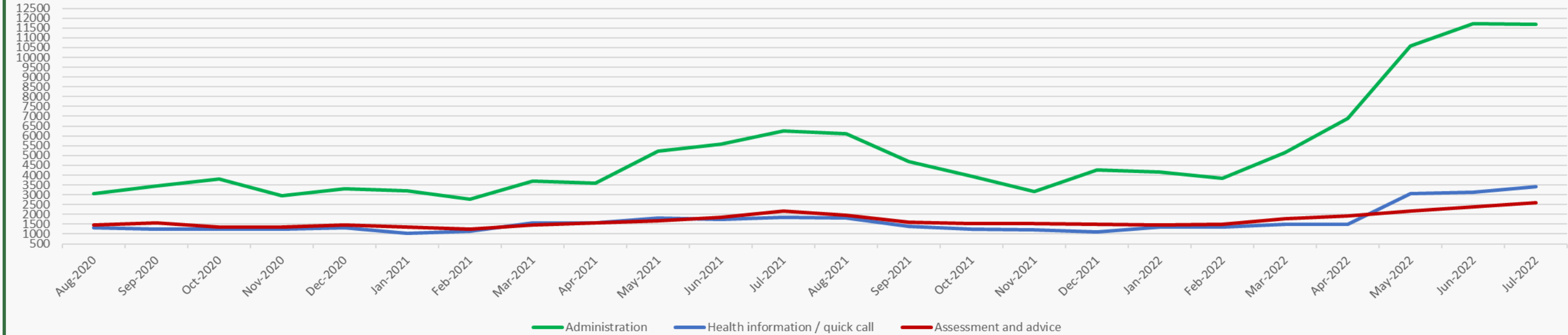
Our Patients: Quality, Safety & Patient Experience

111 Hand Off Metrics and 111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Consult and Close



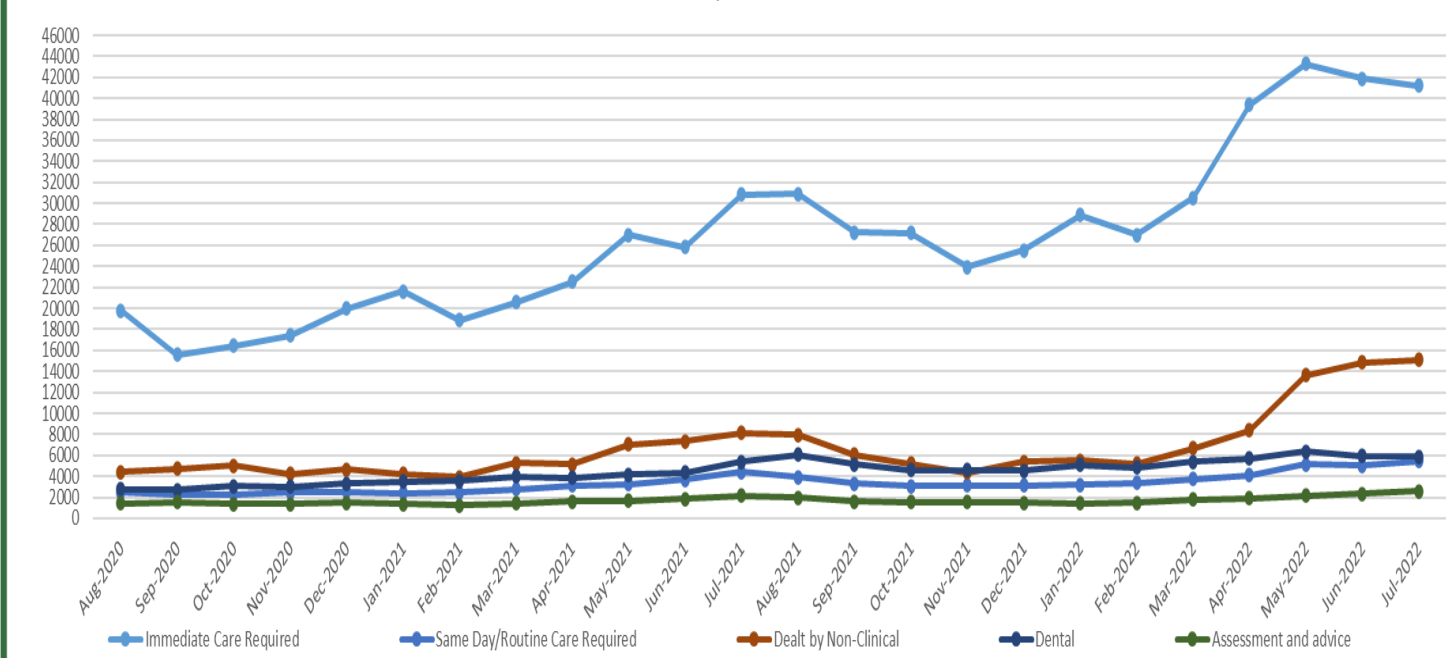
Analysis

In July 2022 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 41% of calls.

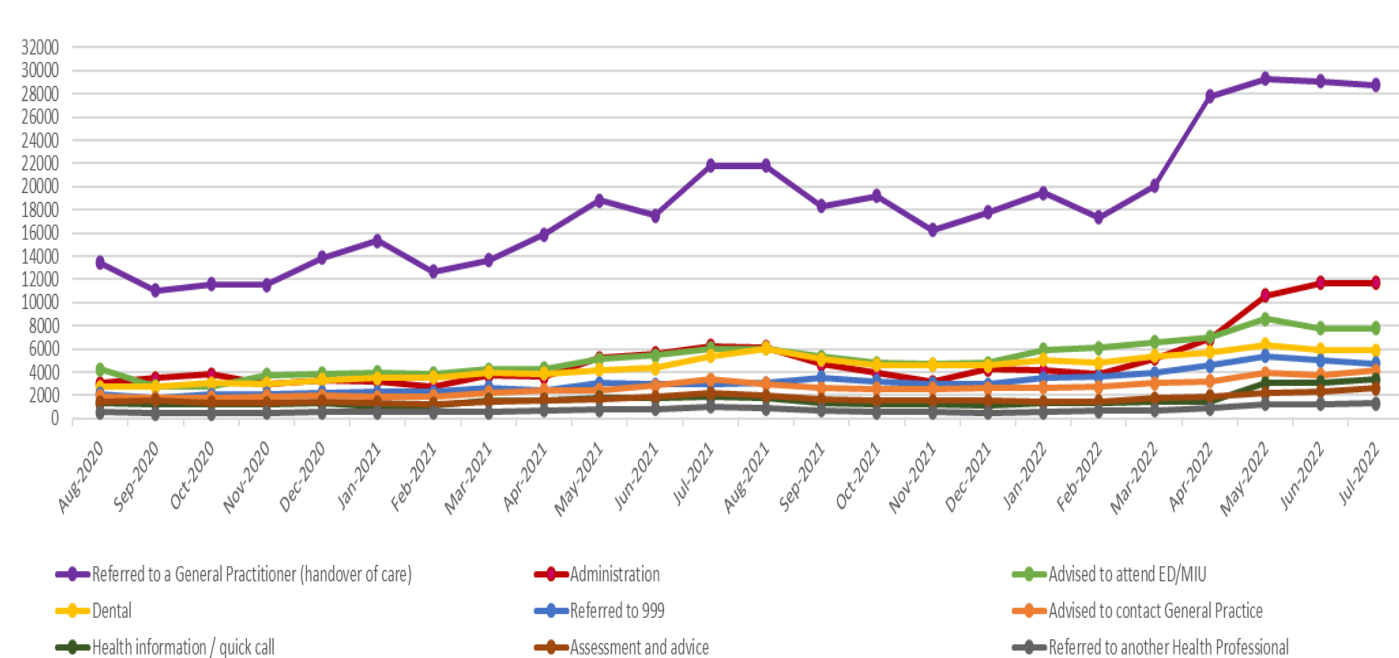
Calls falling in the Immediate Care Required category saw the highest volume; this includes calls referred to General Practitioner (28,752), and advised to attend ED/MIU (7,759) and calls referred to 999 (4,726).

In July 2022 70,265 calls were received in the 9 categories displayed in the bottom right graph, an increase when compared to 70,039 in June 2022; 26,511 in July 2020 and 50,955 in July 2021.

111 Calls by Final Outcome



111 Calls By Final outcome



Remedial Plans and Actions

Work is underway to develop live informatics which provide real time information on clinician availability to allow improved understanding and management; this will enable the Trust to report more meaningful metrics and accurately monitor patient outcomes.

Expected Performance Trajectory

A Contract Analyst is currently undertaking work to improve 111 data metrics available; this will allow us to report more meaningful and relevant data in relation to whether patients are directed to the most appropriate and best outcomes.

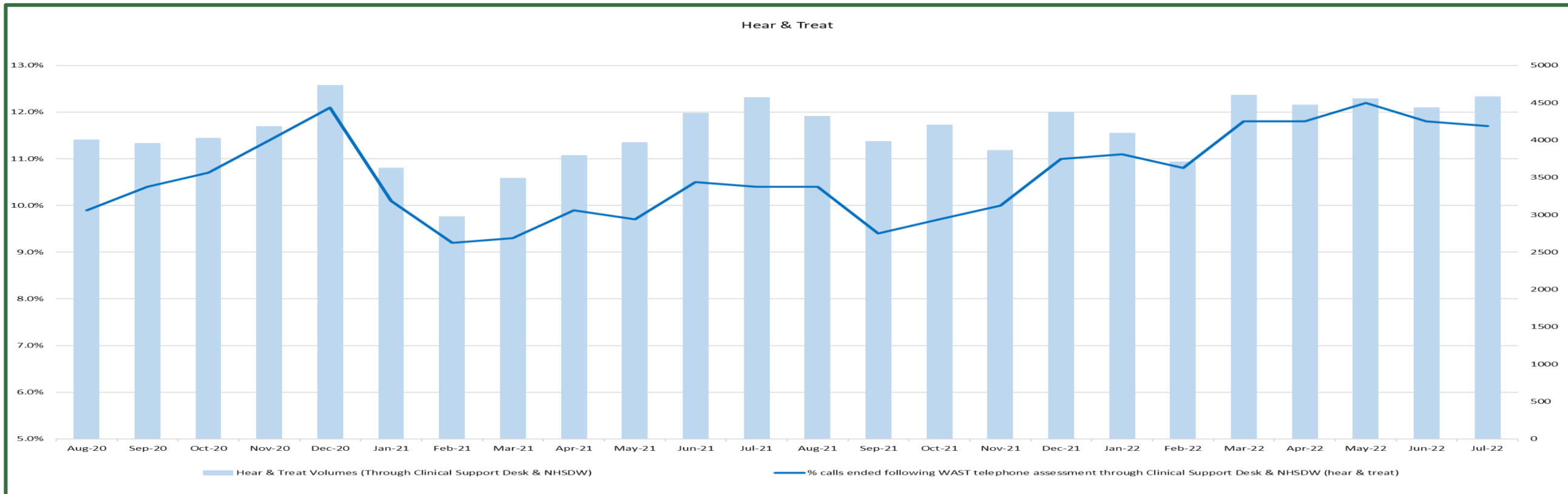


(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Partnerships / System Contribution Consult & Close Indicators



Analysis

The **Clinical Service Desk (CSD)** and **NHSDW (Hear & Treat)** achieved 11.7% performance in July 2022, therefore continuing to achieve the historical 10.2% target for the eighth consecutive month but failing to achieve the new target of 15%.

8.3% of hear & treat volumes were achieved by the CSD in July 2022. In comparison, 3.4% of hear & treat was by NHS111.

The percentage of re-contacts within 24 hours of telephone hear and treat has fluctuated over the last two years, peaking in Jun-20 to 15.7%.

Re-contact rates in July 2022 were 7.2% a decrease compared to 8.2% in June 2022, however, this is an increase compared to 6.9% in July 2021.

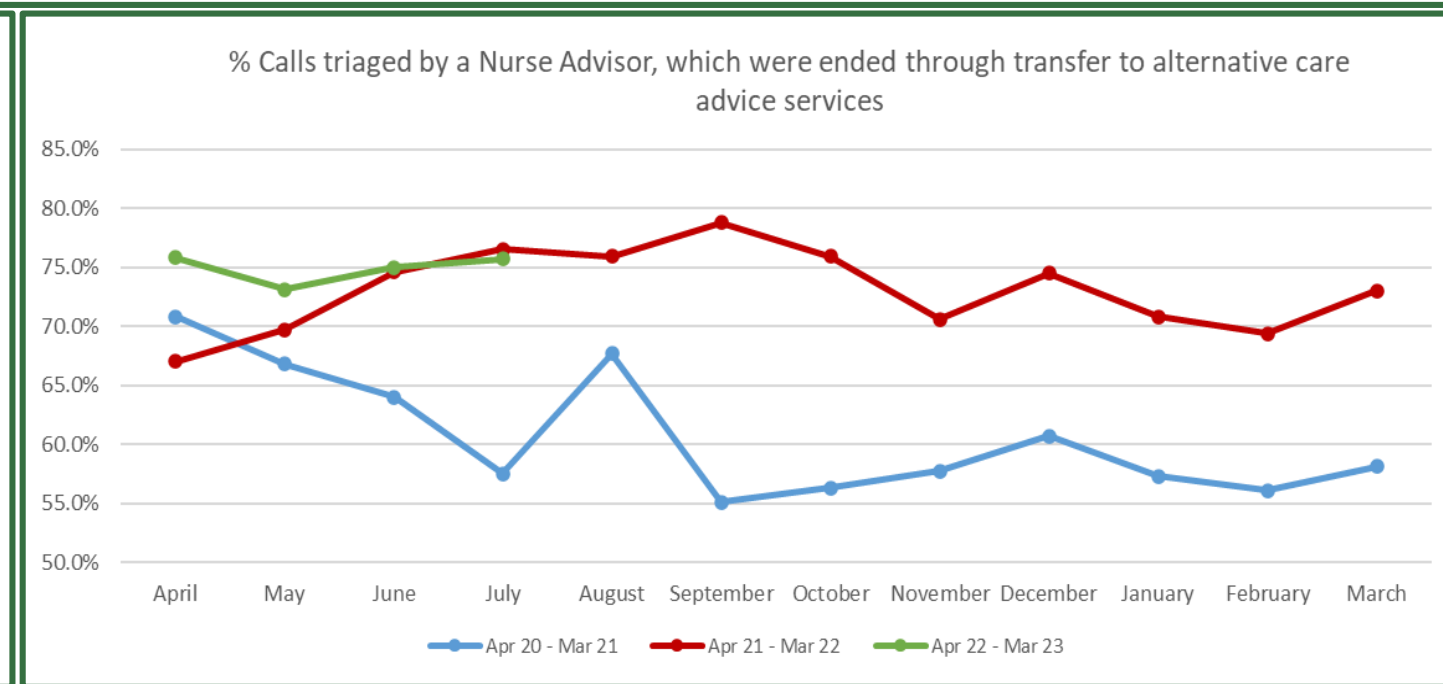
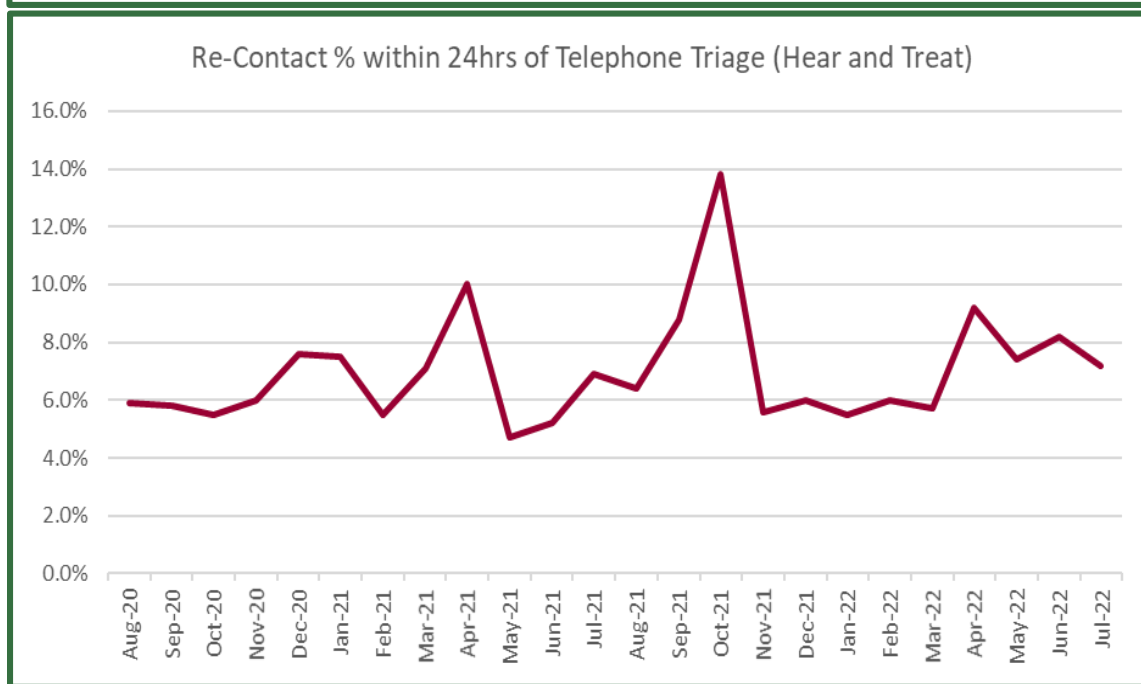
The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services increased month on month to 75.7% in July 2022; by comparison, this figure was 76.5% in July 2021.

Remedial Plans and Actions

- Funding has been agreed to double the size of the CSD, including introduction of 5 mental health practitioners. In the first few months of the year, the staff have been onboarded and have been training on the new ECNS system. It is likely therefore that we will start to see the full effect into Q2 / Q3
- The team are also undertaking detailed process maps of the work that they do in order to identify where improvements can be made
- The revised establishment is 96 FTEs with current in post 90 FTEs.

Expected Performance Trajectory

The current target for this year is 15% hear and treat rate for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling. We would hope to be achieving this in the second half of the year



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust

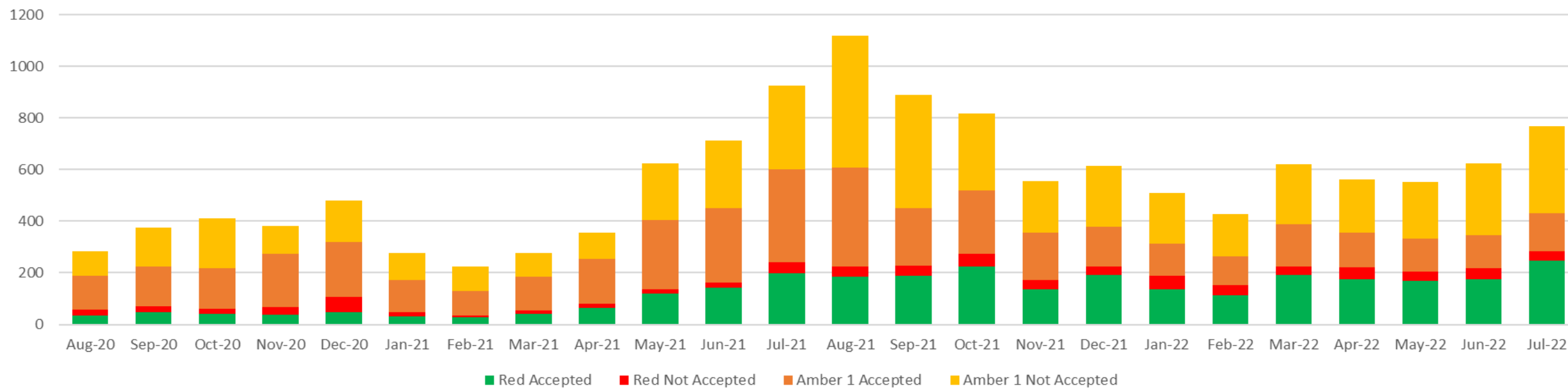


Partnerships / System Contribution Conveyance to ED Indicators

TBD



Pan-Wales Red & Amber 1 Immediate Release Requests



Analysis

There were 761 request made to Health Board EDs for immediate release of Red or Amber 1 calls. Of this 249 were accepted and released in the red category, 35 were not accepted. In conjunction to this, 147 ambulances were released to respond to Amber 1 calls, but 338 were not accepted.

During July 2022, the Trust has not seen any days at CSP level 1, Business as Usual (BAU); 12 days were spent at Clinical Safety Plan (CSP) level 4a, resulting in clinical screening of Amber 1 calls and the Trust being unable to respond to calls in the Amber 2 and Green categories advising these patients to contact their GP, 111 Online or make their own way to a Minor Injury Unit (MIU), those callers within the HCP category are advised to make their own way to hospital. 12 days were spent at CSP level 3b, therefore seeing the Trust only being able to respond to Red and in some exceptions, Amber 1 calls, with Amber 2 calls being clinically screened and the Trust unable to respond to Green and HCP calls. 6 Days were spent at CSP level 3a and again resulting in the Trust only responding to Red calls and in some exceptions Amber 1 and 2 calls. 1 day was spent at CSP 2c seeing the Trust respond to Red calls and only those calls with exception in the remaining categories.

In July 2022 683 ambulances were stopped due to CSP alternative transport and 370 were as a result of CSP Can't send options. In addition, 12,512 ambulances were cancelled by patients (including patients refusing treatment at scene) and 405 patients made their way to hospital using their own transport.

Remedial Plans and Actions

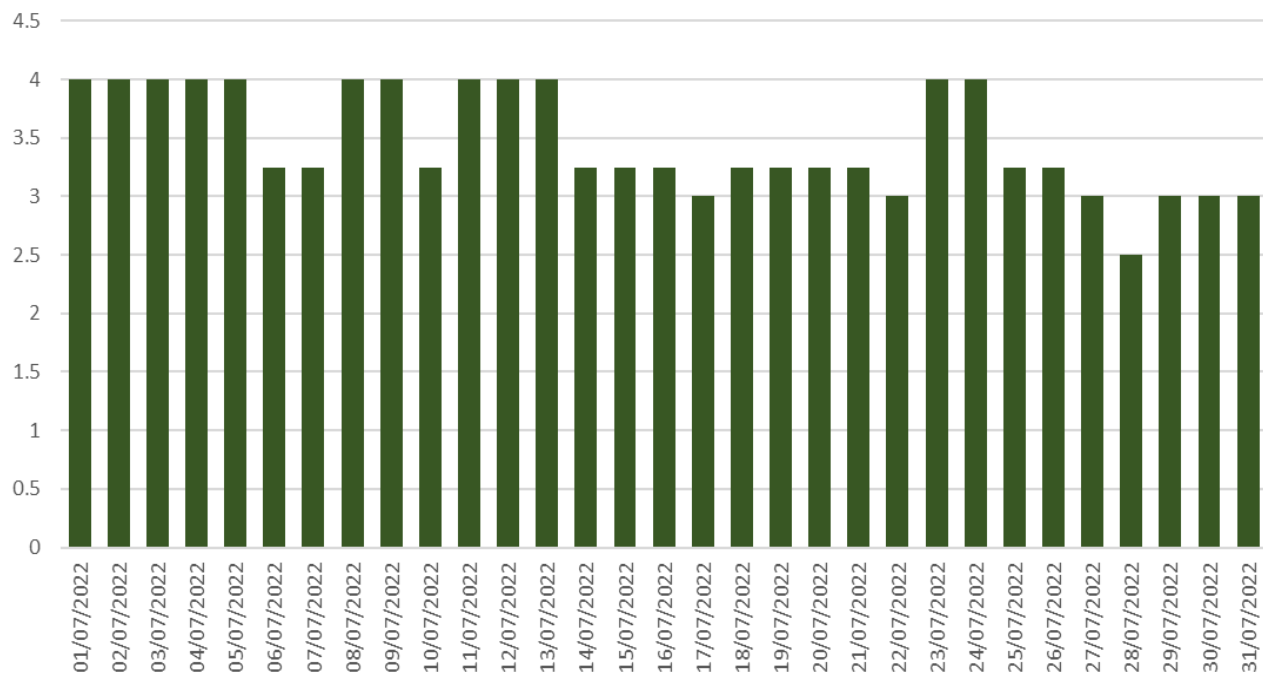
DMP escalation is not taken lightly and the CCC can make the decision to go to levels 1-3. Above these levels the ODU and strategic command will be involved with the CCC manager (in hours) and CCC tactical (out of hours) will be available to offer advice.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand.

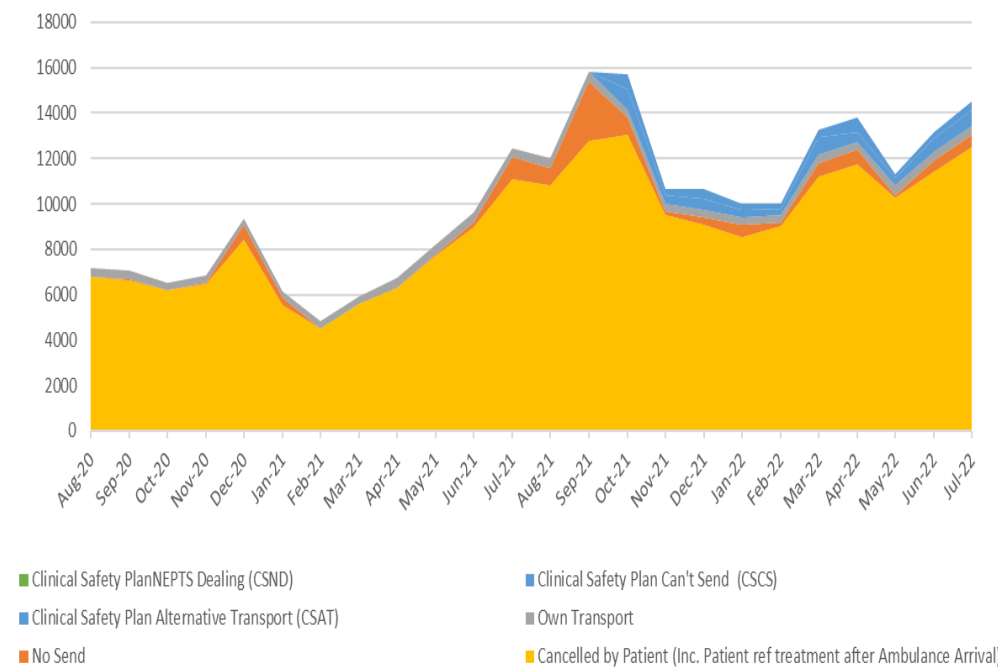
Winter pressures will impact the Trust and seasonal planning is being used to prepare for this.

Maximum Daily CSP Level



Key	
CSP 1	1
CSP 2a	2
CSP 2b	2.25
CSP 2c	2.5
CSP 3a	3
CSP 3b	3.25
CSP 4a	4
CSP 4b	4.25

Numbers of Patients with No Send or Cancelling Ambulance



(Responsible Officer: Andy Swinburn)

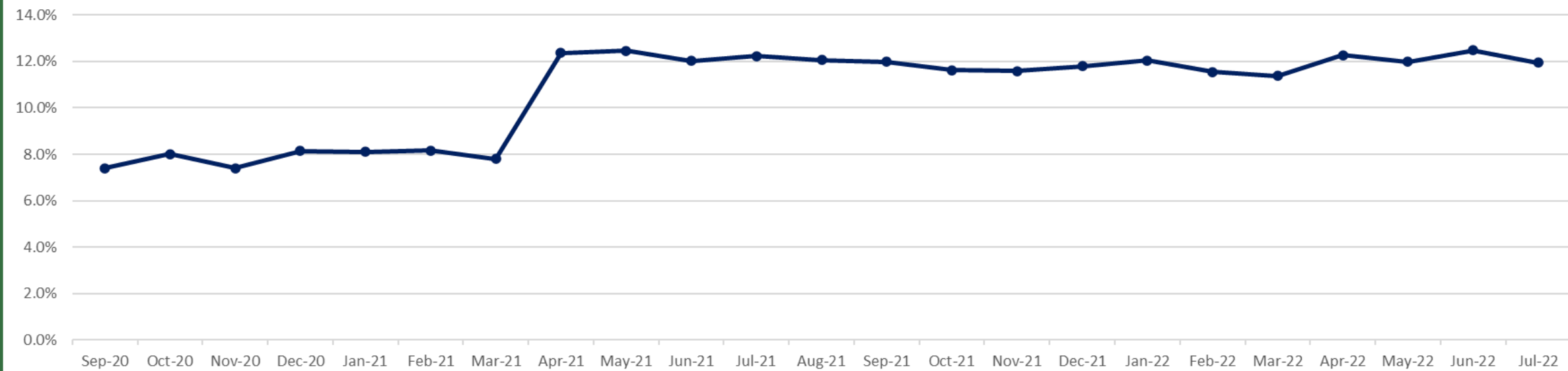
Welsh Ambulance Services NHS Trust



Partnerships / System Contribution Escalation and Patient Experience



% of Total Conveyances taken to a service other than a Type One Emergency Department



Analysis

Although not shown here, the percentage of patients conveyed to EDs decreased (i.e. improved) compared to the same period last year. In July 2022 conveyance to EDs as a proportion of total verified incidents was 29.76% (compared to 35.41% in July 2021). In addition, 11.9% of patients (1,594) in July 2022 were conveyed to a service other than a Type One ED.

The combined number of incidents treated at scene and referred to alternate providers decreased in July 2022 when compared to June 2022. 1,684 incidents were referred to alternative providers in July 2022 and 2,176 incidents were treated at scene; however, a review of other outcomes (see graph) shows that there are a number of incidents where there was a no send due to escalation of the Clinical Safety Plan (CSP).

Remedial Plans and Actions

This indicator captures the impact of all “shift left” activity, for example hear & treat, see & treat (APPs, Band 6 Paramedics), pathways and conveyance to other hospital locations e.g. minor injury units (MIUs), direct admissions etc. Years 3-5 of the EMS Operational Transformation Programme offer the potential to take a more transformative look at options for further reducing conveyance, where it is clinically safe and appropriate to do so. The initial results of this modelling are expected w/c 24 January 2022 (received).

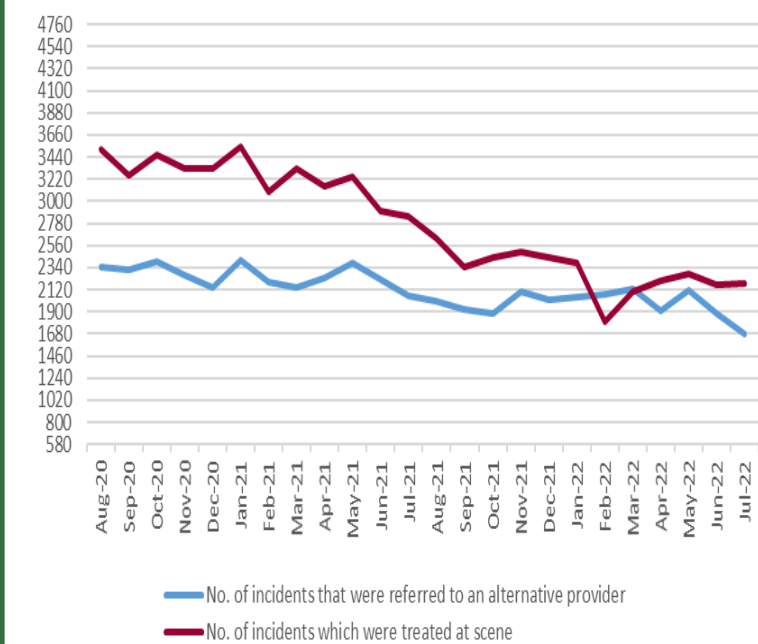
As part of the IMTP and working with partners across the health system. WAST has been asked to lead on the development of a National Respiratory work stream. A four phased proposal has been designed to deliver sustainable service level improvement for respiratory patients across Wales aligned to the national strategic direction and delivered in collaboration with Health Boards & key stakeholders: delivery will be dependent on cooperation with health boards who will need to provide a service to refer into; however, this has the opportunity to increase referrals to alternative providers.

One of the Trust’s commissioning intentions is to develop an optimising conveyance strategy, which will bring forward clearer proposals linked to further work on the EMS Demand & Capacity Review.

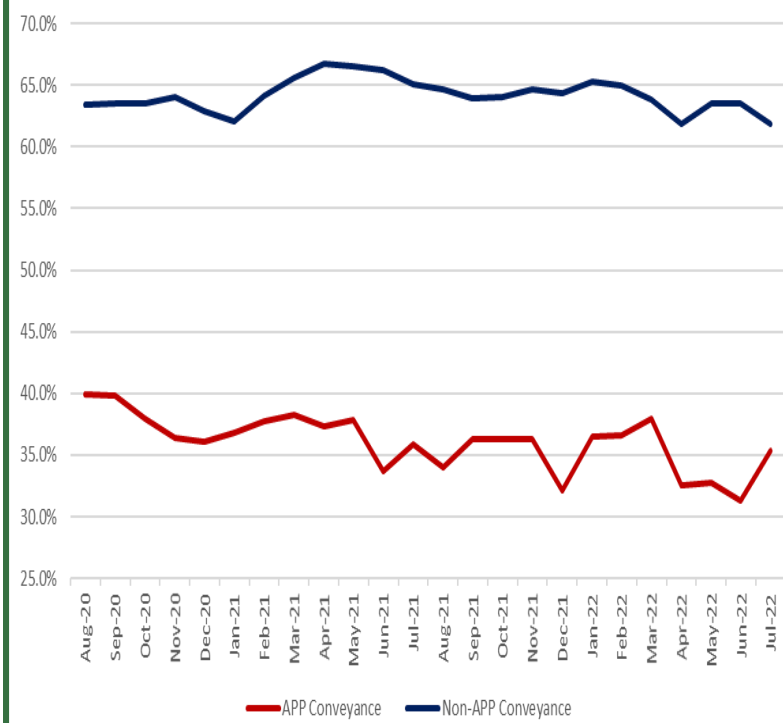
Expected Performance Trajectory

The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well.

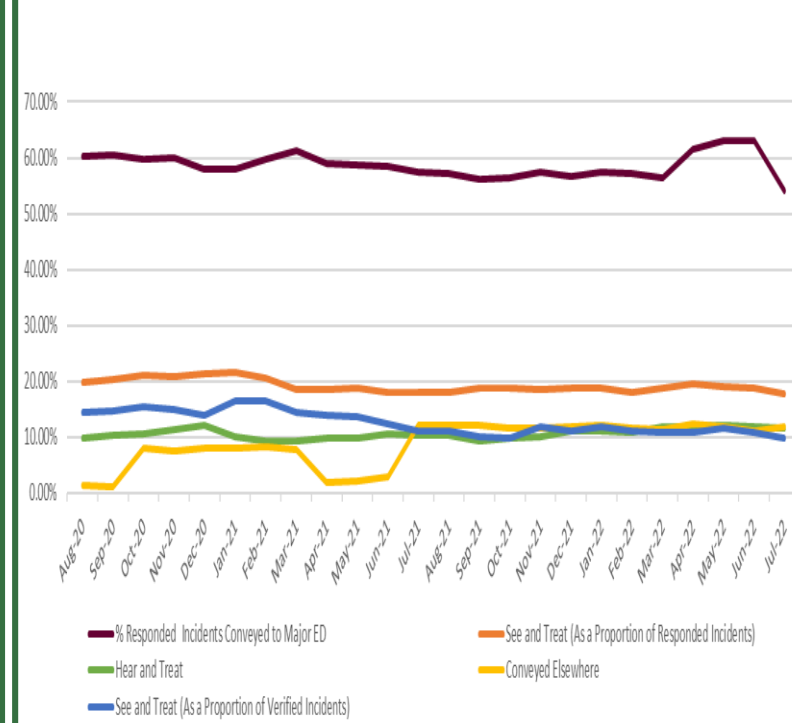
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



APP vs Non-APP Conveyance Rates

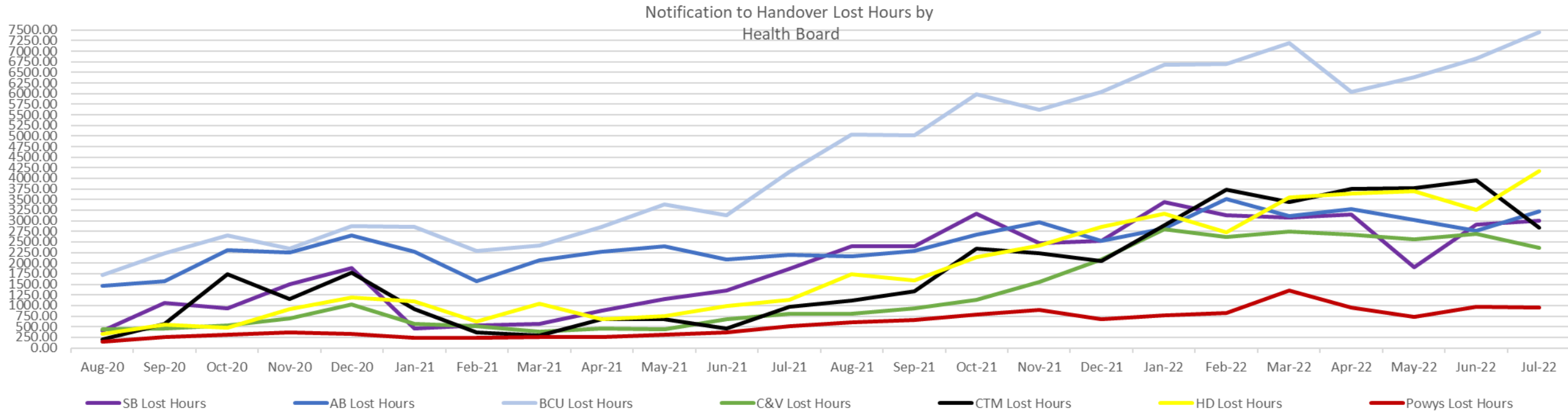
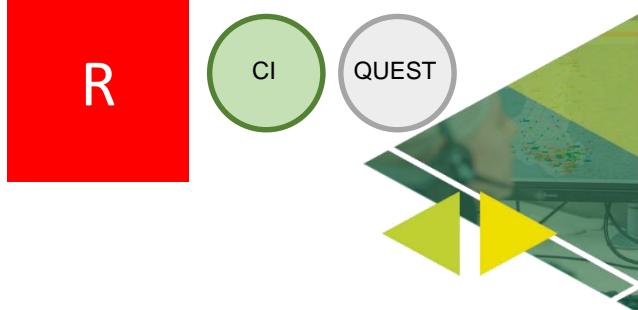


% of Patients Conveyed to Major ED, Triaged through Hear or See and Treat or Conveyed Elsewhere





Partnerships / System Contribution Handover Indicators



Analysis

246,352 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 100,981 in same period a year ago (August 2020 to July 2021). 24,021 hours were lost in July 2022, a 51% increase compared to 11,685 lost hours in July 2021 and an increase when compared to 13,820 recorded in December 2019, the previously worst recorded month, prior to August 2021. The hospitals with highest levels of handover delays during July 2022 were Glan Clwyd Hospital Bodelwyddan (BCUHB) at 2,895 lost hours, the Grange University Hospital (ABUHB) at 2,788 lost hours, Morriston Hospital (SBUHB) at 2,779 lost hours and the University Hospital of Wales (CVUHB) at 2,233 lost hours.

Notification to handover lost hours averaged 773 hours a day in July 2022, 515% higher than the commissioning intention of no more than 150 hours per day.

In July 2022 the Trust could have responded to 7,564 more patients if handovers were reduced.

Remedial Plans and Actions

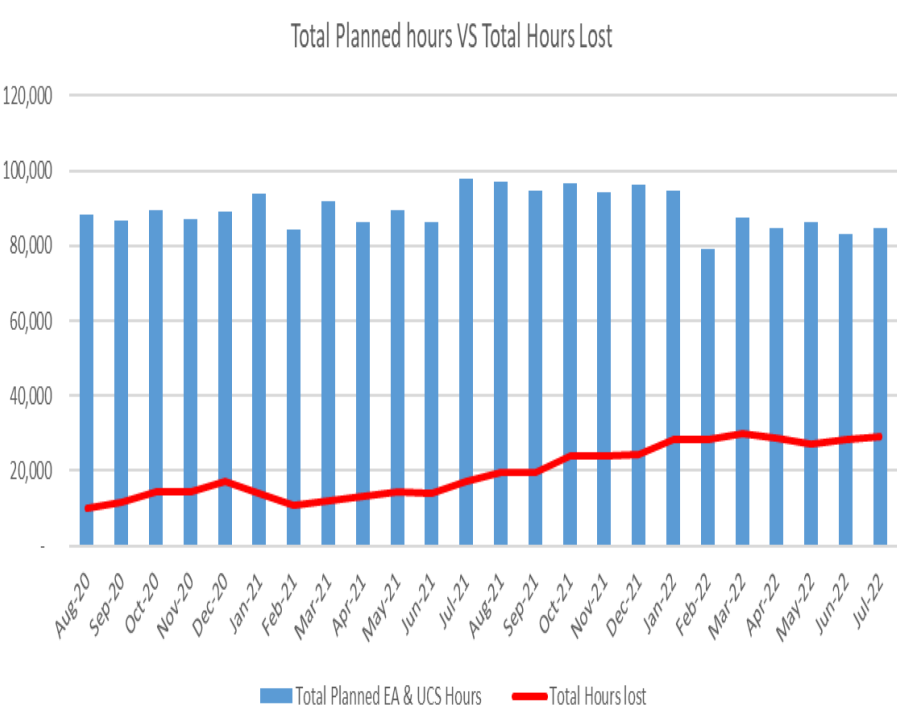
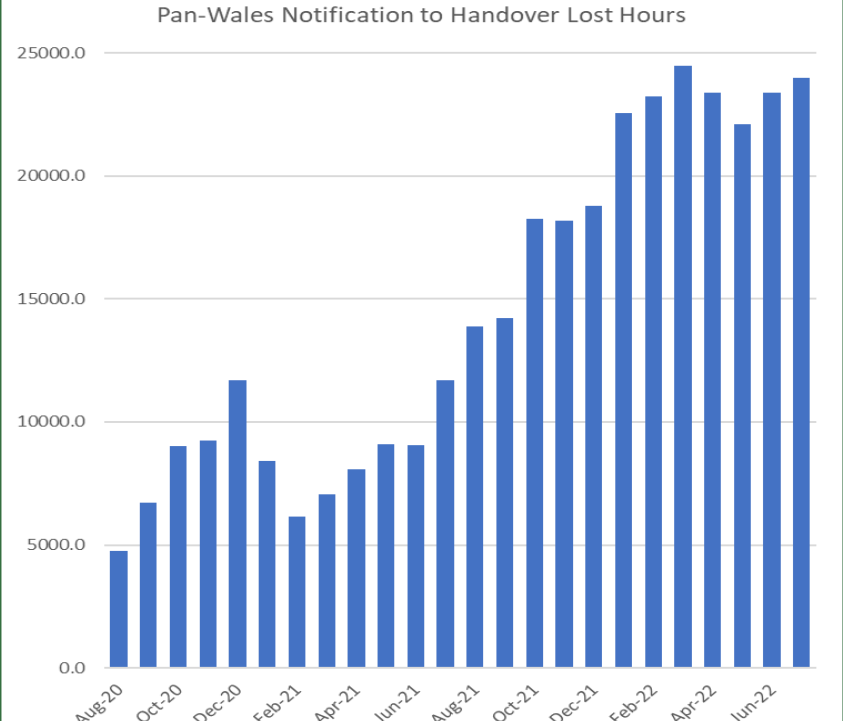
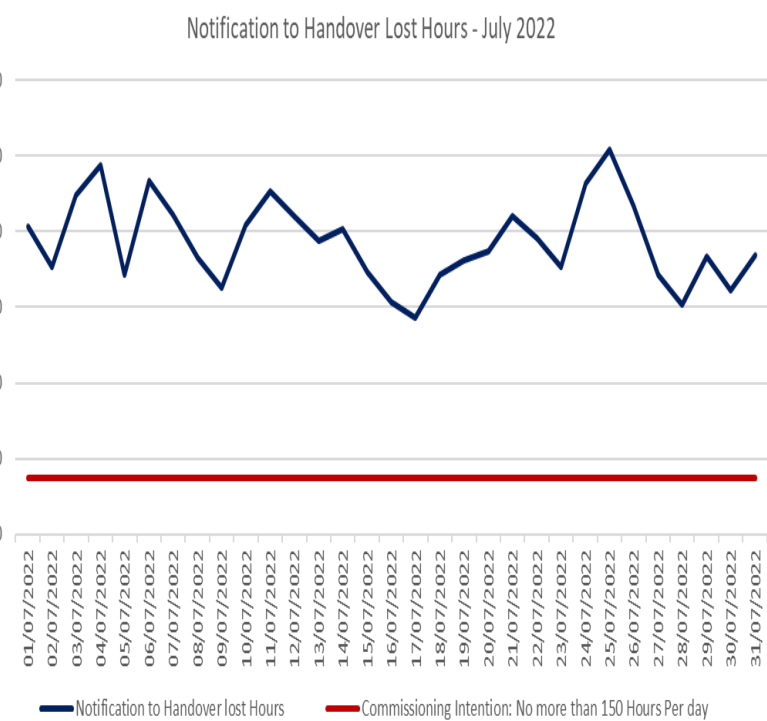
Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government / Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve.

Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.

The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR). 22 ideas have been received through the WIIN platform from staff in June 2022.

Expected Performance Trajectory

The direction is that handover lost hours should return to 25% of their Oct-21 levels, just under 14,000 hours, that there should be no waits over 4 hours and non-release for Immediate Release Requests should become a Never Event.



(Responsible Officer: Health Boards)

Welsh Ambulance Services NHS Trust

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up they are counted as “abandoned” as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	Hours Produced for Emergency Ambulances	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	Sickness Absence (all staff)	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	Frontline COVID-19 Vaccination Rates	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	Statutory and Mandatory Training	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	PADR/Medical Appraisal	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	Ambulance Response FTEs in Post	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	Financial Balance – Annual Expenditure YTD as % of budget Expenditure	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	Post Production Lost Hours	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	111 Consult and Close	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust’s Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	999 / 111 Hear and Treat	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	% Incidents Conveyed to Major EDs	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	Number of Handover Lost hours	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	Immediate Release requests	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls



Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	D&T	Discharge & Transfer	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	DU	Delivery Unit	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	EASC	Emergency Ambulance Service Committee	HR	Human resources	NRI	Nationally Reportable Incident	SPT	Senior Pandemic Team
CASC	Chief Ambulance Services Commissioner	EAP	Employee Assistance Provider	HSE	Heath and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CC	Consultant Connect	ED	Emergency Department	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	EMD		IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	UCA	Unscheduled Care Assistant
CCP	Complex Case Panel	EMS	Emergency Medical services	IPR	Integrated Performance Report	OH	Occupational Health	UCS	Unscheduled Care System
CEO	Chief Executive Officer	EMT	Executive Management Team	KPI	Key Performance Indicator	P / PHB	Powys / Powys Health Board	UFH	Uniformed First Responder
CFR	Community First Responder	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	PCR / PCRs	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	EPT	Executive Pandemic Team	MACA	Military Aid to the Civil Authority	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	FTE	Full Time Equivalent	MIU	Minor Injury Unit	PECI	Patient Engagement & community Involvement	WAST	Welsh Ambulance Services NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	POD	Patient Offload department	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PPLH	Post Production Lost Hours	WIIN	WAST Improvement & Innovation Network
CSD	Clinical Service Desk	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	PSPP	Public Sector Purchase Programme		
CSP	Clinical Safety Plan	HCP	Health Care Professional	NEWS	National Early Warning Score	QPSE	Quality, Patient Safety & Experience		





GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru

Welsh Ambulance Services
NHS Trust

Appendix 2

Pan-Wales Staff & Wellbeing Deep Dive

August 2022





Executive Overview – Staff and Wellbeing



The deep dive seeks to consider the following issues:

- The available data and anecdotal information on wellbeing to help present how staff are doing in terms of wellbeing
- What this means to the organisation – where we are and where we would like to be
- What are the strengths, weaknesses, opportunities and risks
- What else would be valuable to have in terms of information for evaluation and decision making
- What are the actions to take forward





Section 1 – Direct Survey Feedback from Colleagues



- The last NHS staff survey was undertaken in November 2020.
- The historical nature of these results are noted
- Key messages from the survey are:

**Overall
engagement
score
72%**

People are happy to go the extra mile at work (84.1%)
They feel that people they work with treat them with respect (73%)

Colleagues were enthusiastic about their jobs (76.1%) and are proud to tell people they work for WAST (77.1%)

63.6% of colleagues felt that their manager took a positive interest in their health and wellbeing

Key Improvement Suggestions:

- Improved Training & Development
- Managers to listen more
- More focus on staff wellbeing
- Putting an end to bullying & harassment
- Increased professionalism and positive behaviours





Section 1 – Direct Survey Feedback from Colleagues

WAST Pulse Survey November 2021 – 310 responses



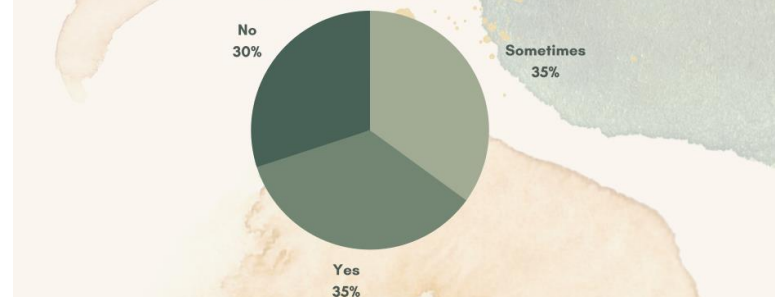
Reoccurring responses from 224 colleagues...

Exhausted Emotional Anxious
 Fed up Drained Tired Worried
 Worn out Overwhelmed
 Deflated Burnt out Sad Stressed
 Low
 Wondering if I made the right decision joining WAST

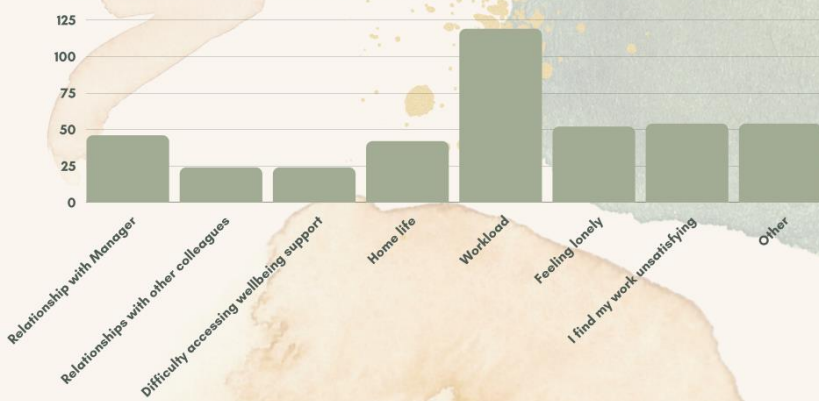
86 out of 310 colleagues responded more positively...

Enjoying the challenge Good
 Grateful Well
 Energised Ok Great
 Happy Supported Balanced Calm
 Love my job

Do you feel as though your wellbeing is supported at work?



Reasons for answering 'No' or 'Sometimes'...



Other reasons for answering 'No' or 'Sometimes'...

Unsafe working practices
 Hospital delays
 No time to consider wellbeing
 Nobody cares
 Sickness absence not managed
 Lack of confidence in Management

What would you like to see more of?





Section 1 – Feedback from Colleagues – Trade Union



- 'Soft' intelligence comes from various sources, but a key source is through Trade Union colleagues' feedback.
- Many colleagues now have low levels of resilience and are exhausted through the systems pressures faced and the residual effects of Covid. There has been no respite through the summer months in terms of handover delays and service demand.
- There are higher than normal levels of R&Rs. Issues raised through R&Rs vary. This is reflected across the whole system in Wales, not just in WAST (and is felt to be a process issue with the 'cuppa conversations' being by-passed).
- How line managers support and engage with their team are of the utmost importance and increasingly so. Pockets of bullying are noted by TUP and investigated where raised.
- We will continue to seek feedback from TUPs on their perceptions and that of their members.





Section 1 – Where do we think we are now?



- Wellbeing levels remain low for a range of reasons such as wider systems challenges, Covid, population issues – cost of living crisis deepening.
- Continuing to support – more comms re wellbeing opportunities, groups such as women's health and events such as Mind over Mountains established, sessions on understanding stress, trauma and burnout. Leadership wellbeing conversations.
- Managing Attendance Project supporting and training managers to better work with their teams
- A survey by Swansea University including questions on wellbeing has been done in Q3/4 2021/22. Results are expected in September.
- There is currently limited opportunity to survey colleagues regularly and in a timely way.
- The Directorate Plan includes an action to review opportunities to implement pulse surveys across the business, or in specific areas. This is underway





Section 2 – HR Data: Leavers

Leaver Reason	Death in Service	Dismissal	Employee Transfer	End of Fixed Term Contract	Flexi Retirement	Mutually Agreed Resignation	Redundancy - Voluntary	Retirement	Voluntary Early Retirement	Voluntary Resignation	Bank Staff not fulfilled minimum work requirement	Total
01.08.21-31.07.22	3	27	6	26	19	12	2	85	13	315	0	508
01.08.20-31.07.21	8	22	18	6	19	11	3	60	12	183	0	342
01.08.19-31.07.20	4	23	4	2	16	9	1	50	8	117	2	236

- The number of leavers has increased over the last 3 years to around 10% in the last 12 months
- Leaver numbers are low through the period leading up to and during the pandemic
- Resignation category includes leavers for promotions, relocations, health etc
- 28 leavers in 21-22 were for work-life balance and 27 for health, 21 for relocation, 188 reason is unknown
- Many organisations across all sectors have experienced higher turnover post pandemic where people are evaluating options
- Alongside this is the pressure of working in the NHS through the pandemic

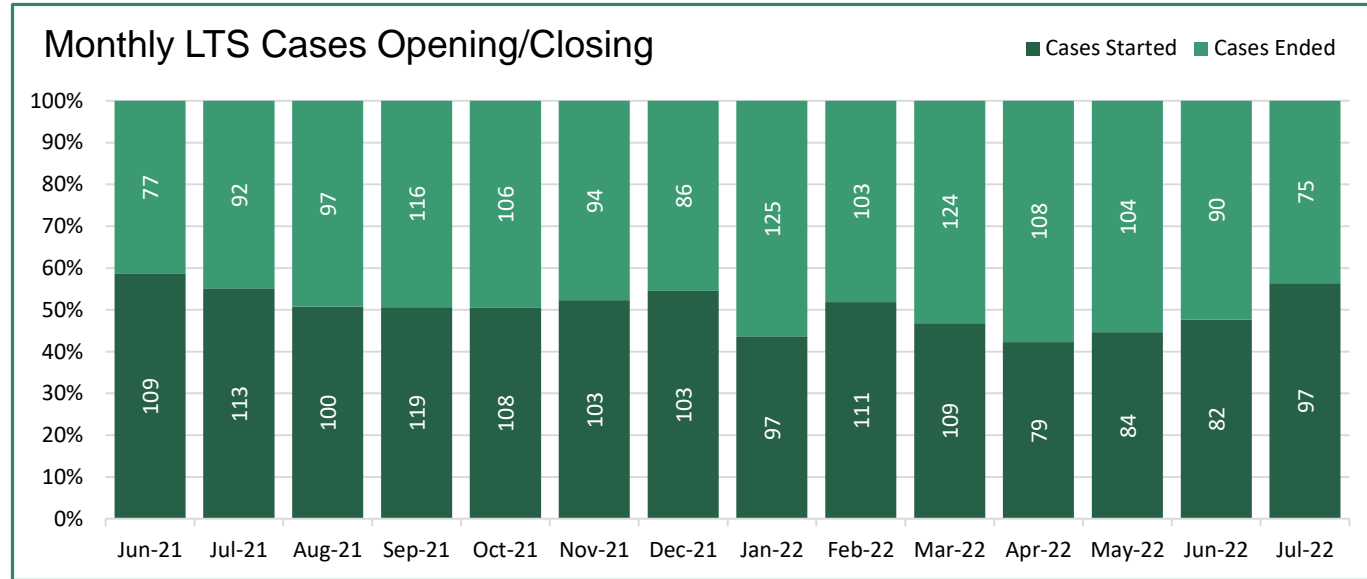




Section 2 – HR Data: Sickness Absence

July 2022

Average working days lost per FTE (Annual)	
25.00 days	
Single month Absence %	
10.32%	
Long Term	Short Term
5.65%	4.67%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.36%	(excluding Back) 1.04%

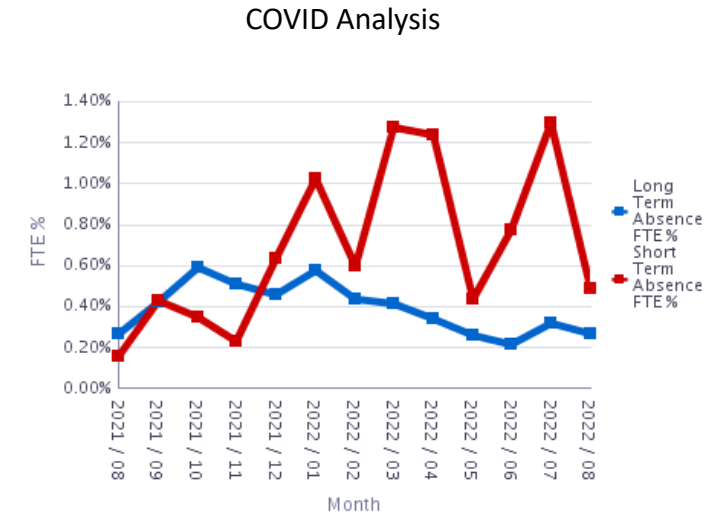
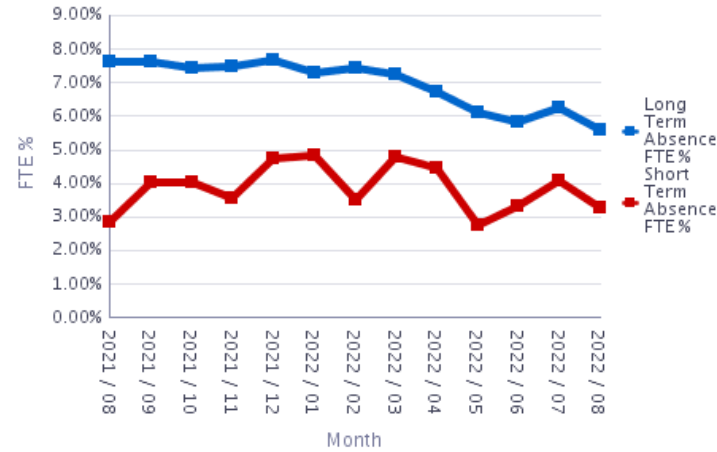
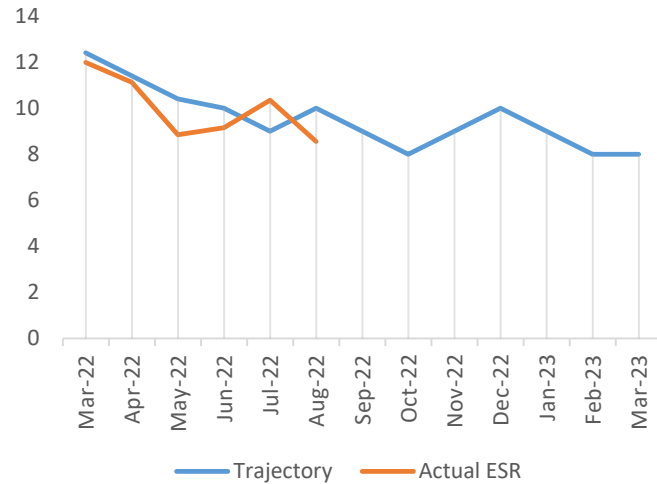


Absence Reason	Headcount	Abs Occurrences	%	Abs FTE%
S10 Anxiety/stress/depression/other psychiatric illnesses	159	162	22.9%	2.36%
S27 Infectious diseases	260	261	15.7%	1.62%
S15 Chest & respiratory problems	175	177	11.8%	1.22%
S12 Other musculoskeletal problems	79	79	10.1%	1.04%
S11 Back Problems	55	56	6.2%	0.64%
S25 Gastrointestinal problems	123	123	5.5%	0.57%
S13 Cold, Cough, Flu - Influenza	104	105	5.1%	0.52%
S28 Injury, fracture	38	39	4.3%	0.45%
S98 Other known causes - not elsewhere classified	25	26	3.0%	0.31%
S99 Unknown causes / Not specified	30	30	2.7%	0.28%





Section 2 HR Data: Sickness Trust Wide MAAW Analysis – August figures indicative



- June and July showed a slight increase in sickness absence mainly driven by Covid. However, indicative figures for August show a decrease in sickness absence
- The decrease is in both short term and long term absence
- As seen in third graph, indications are that COVID absences have decreased again in August





Section 2 –HR Data Suspensions/Disciplinary

This type of information is available and used to be reported in the “IPR”, but is no longer:-

- Data re: average length of suspensions 262 days
- Nos of suspensions over 4 months – 6 cases
- Data re: Average length of disciplinary processes – 281 days (based on current cases)
- Number of R&Rs - 27





Section 3 – Occupational Health and Wellbeing

The Occupational Health and Wellbeing Department refer staff to outside agencies for Wellbeing support as well as having an in-house Wellbeing service. The in-house service is available to staff Monday – Friday from 8am – 4pm. Referrals for January – July 2022 are detailed below:

Provider	Number Referrals Jan – July 2022
Physiotherapy (Fitback)	204
Trauma Counselling (NOSS)	14
EAP (Health Assured)	401
Wellbeing Referrals (In-House Service)	1471
TRiM referrals	506
Referrals to Occupational Health due to Wellbeing and Work Concerns	608
Referrals to Occupational Health due to Traumatic Incident concerns	120





Section 3 – Occupational Health and Wellbeing

As well as provided services both in – house and external, staff are able to access the following for Wellbeing Support:

Immediate/ Urgent

TASC

C.A.L.L.

Samaritans

DAN 24/7 (Drug and Alcohol Helpline)

Mind Blue light programme – also drop in sessions with Haverfordwest Mind

Counselling/ Psychotherapy

Canopi

Online Support, Resources and Guided Self-Help

Thrive App

Silvercloud online CBT

Clic/Mental Health UK





Section 3 – Occupational Health and Wellbeing

(Cont...)

For Veterans

Woodies Lodge

Veterans NHS Wales

Offered by Wellbeing Team

Living Life to the Full and REACT training
Peer Support Network
Wellbeing dog visits for CCC / 111
Drop in sessions at CCC / 111

Financial Support Services
Chaplaincy Service
Zen Rooms in CCC

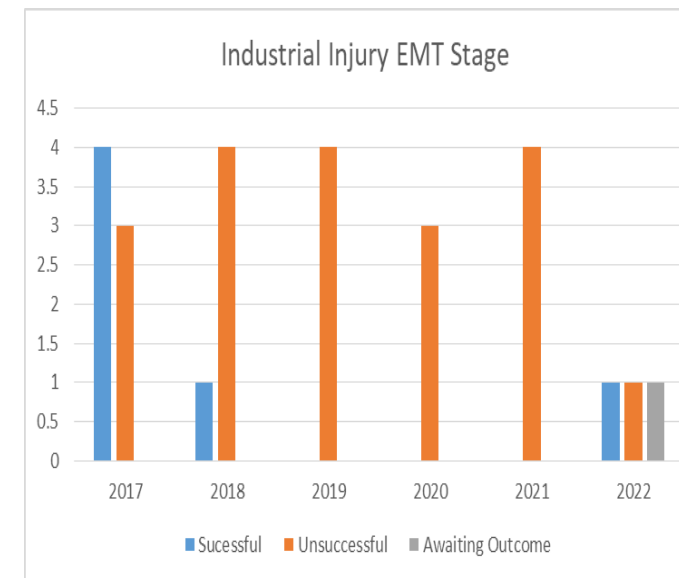
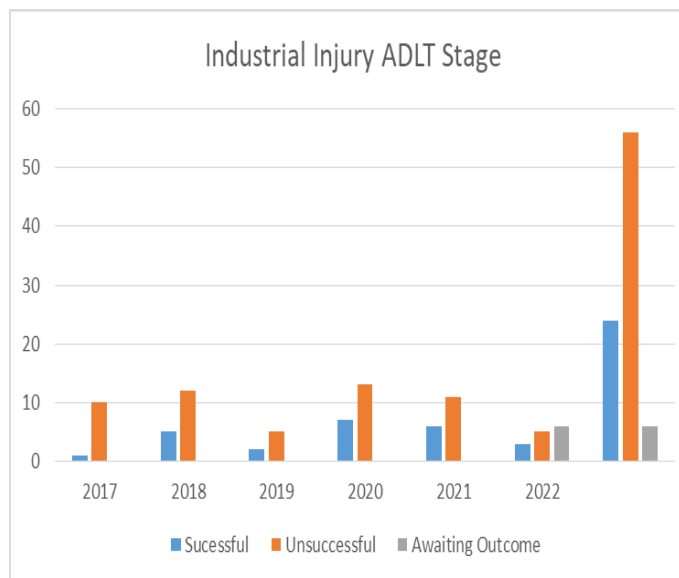
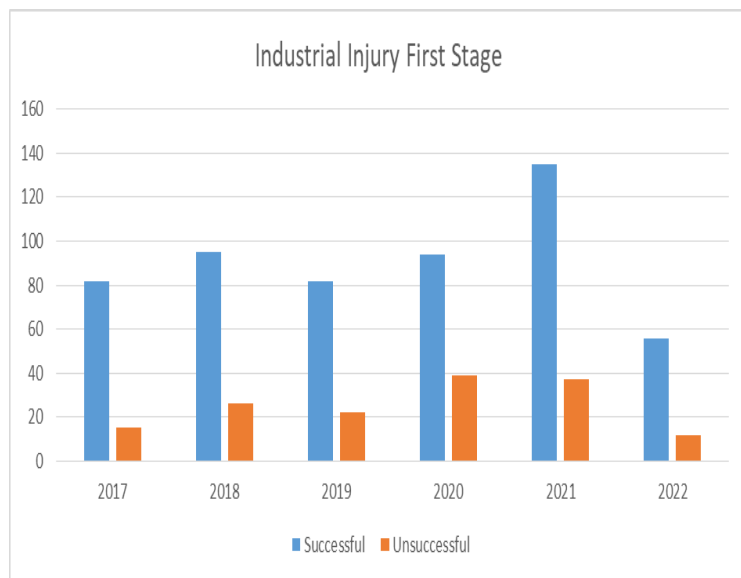
Support Groups

Women's Health Group (formally The Menopause Café) meet fortnightly virtually
Circle of Support Group (for staff with long term medical conditions) meet monthly virtually





Section 3 – Industrial Injury



78% successful at first stage. 28% successful at second stage. 23% successful at third stage. First stage is positive, would expect lower levels at stages 2 and 3. What is not measured is the end to end times between submission and decision. There is a acknowledgement that these times can be too long at stages 2 and 3. Task & Finish Group on-going around Industrial Injury. There has been internal training for ADLT and EMT from lawyers.





Section 3 – Violence & Aggression



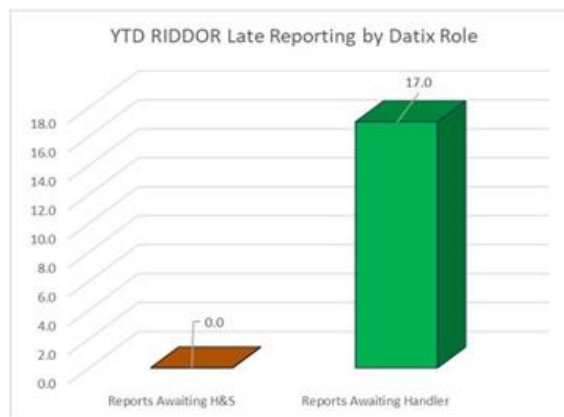
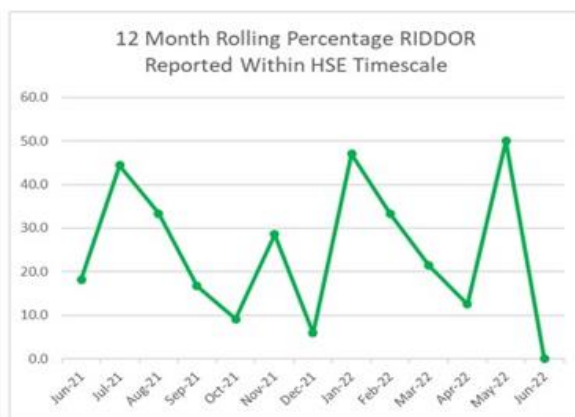
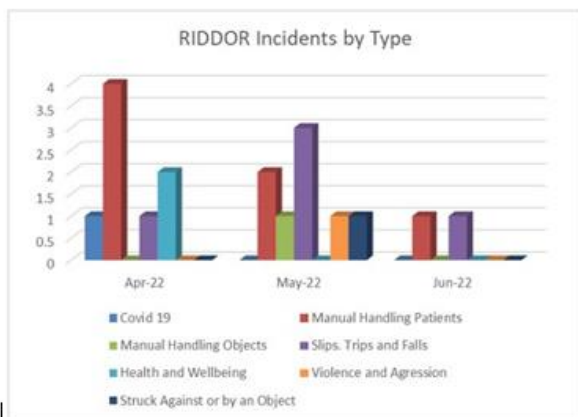
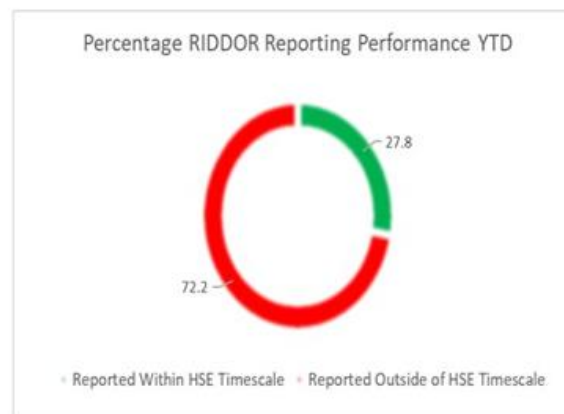
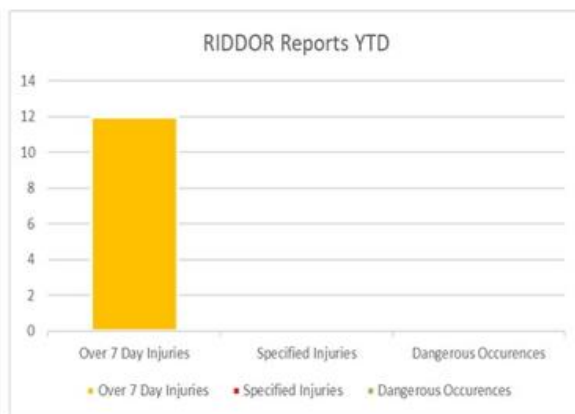
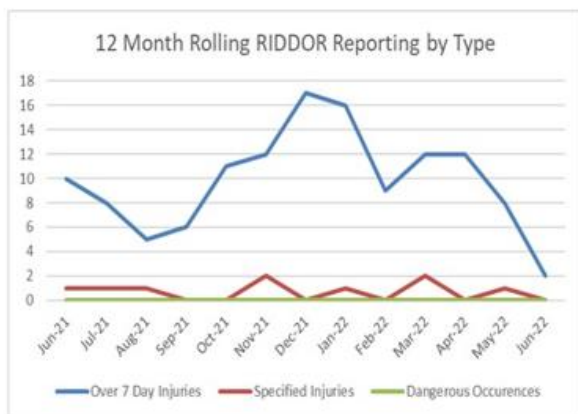
- The Trust is required to meet the requirements of the Welsh Health Circular 12/2021- the Obligatory Response to Violence in Healthcare document and the Emergency Services Act 2018.
- The Emergency Services Act 2018 has introduced offences and increased sentencing for assaults on emergency workers in the course of their duty.
- WAST's Dedicated Case Manager provides support and guidance to victims through the criminal justice system and additionally by referring them to Occupational Health Services.
- A Violence and Aggression Manager commenced their role within the Trust in August 2022. This new post will undertake a strategic review of V&A processes internally and with external partners. A further aim of this role is to increase visibility and access to V&A support Pan Wales.
- V&A metrics presented at National Health and Safety Committee, Executive Management Team and People and Culture Committee.



Section 3 – Health & Safety

Principle 3 - Compliance Assurance

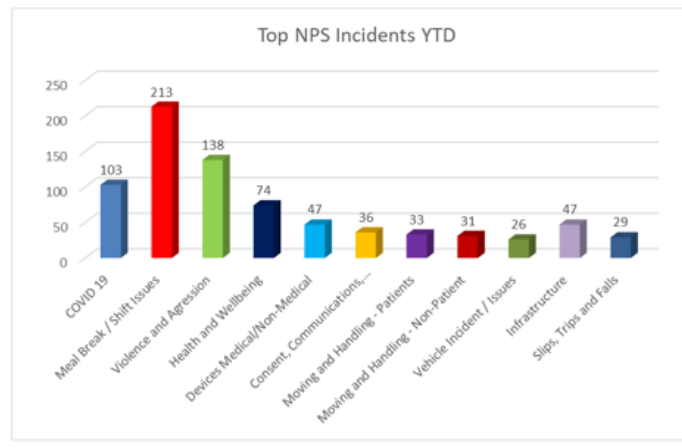
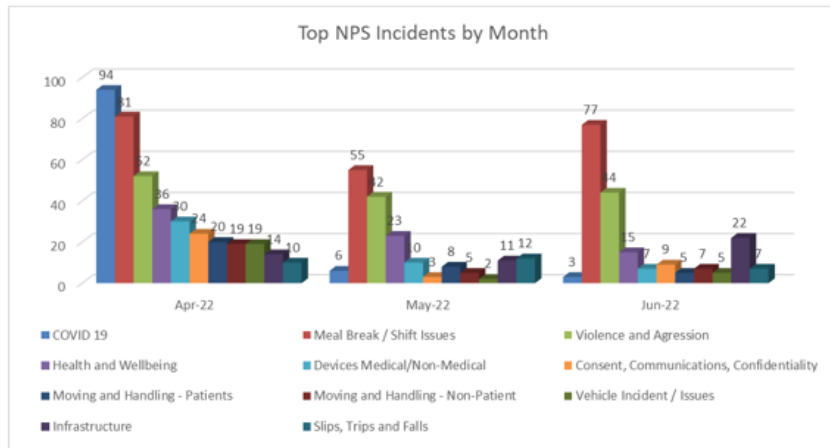
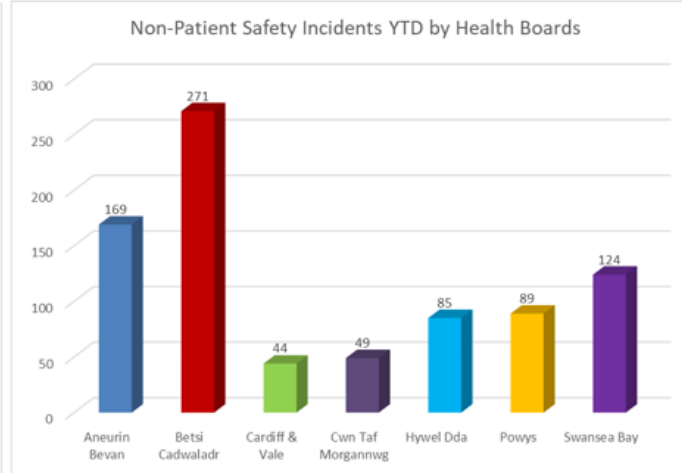
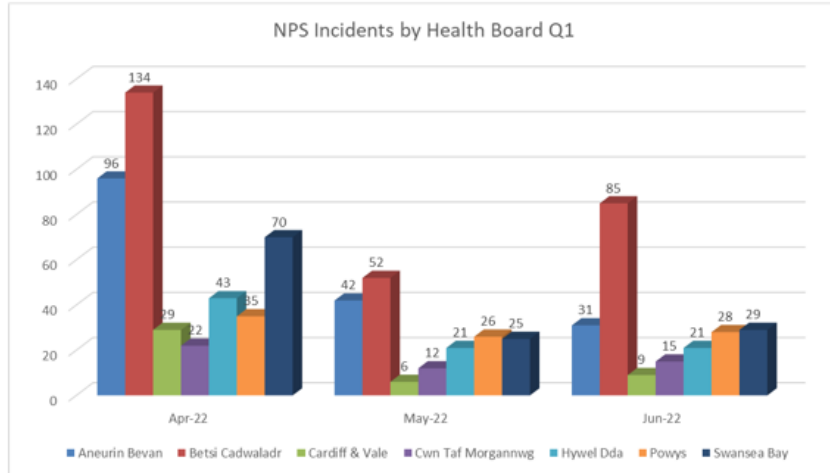
RIDDOR Performance





Section 3 – Health & Safety

Principle 11- Measuring Performance Incident Reporting





Section 4 – Peer Support



A Pan Wales Peer Support Network has been recently established. Currently there are 65 members, with plans to increase this.

REACT training (a tool to help individuals to have supportive conversations with colleagues about their mental wellbeing) is being delivered. 15 have attended to date.

The Network is overseen and supervised by the TRiM Lead and the Trust Assistant Psychologist. Information is communicated on Wellbeing Services available through a Teams Channel.

The 111 service will also receive REACT Training.

Workshops are being delivered on stress and burnout to staff.

The OH&W Team attend all Inductions for 111, CSD and EMT staff.

CHARU Paramedics have had a Wellbeing session as part of their clinical training courses, with more inputs planned.





Section 5 – Equality, Diversity & Inclusion (EDI)

Allyship Programme

The Allyship Programme was launched on the 19th of November 2021. 82 colleagues have attended, between November and March. The programme is based on 3 core principles, whole learning, reflective practice, and self-led learning.

The Allyship programme was developed to help create a more inclusive, compassionate, and culturally responsible workforce in line with Strategic Equality Objectives and our culture and behaviour reset. The foundations of this programme are directly linked to three of the “Five Rs” outlined in the AACE Anti-Racism Promise – Raise Awareness, Responsibility and Respect.

The pilot launch of this programme was successful with many positive comments when feedback was requested, a lesson learned log was recorded to help the development of this program in preparation for the next launch.

Things we need to consider in planning:

- Ensure psychological safety is covered either ahead of the session or at the start.
- Prepare preliminary resource to inform expectations of what will take place within Allyship sessions.
- Implementing a robust method to collect feedback from colleagues who have attended the course to use for future change analysis.
- Consider a quantifiable measuring tool, that is used to track and assess, the status of the Allyship reflective practice workbook.





Section 5 – Reasonable Adjustments – Supporting Colleagues



- As a Disability Confident Employer, we start the process of reasonable adjustments upon application.
- Information is requested via the Trac system, for the OH Team through the recruitment process.
- A preplacement clearance certificate is issued and shared with the new starter and their line manager who is responsible for implementing any adjustments.
- We access grants from Government Access to Work scheme, which provide practical and financial support for people who have a disability or long-term physical or mental health condition.
- Managers or employees can contact OH for support and advice as needed.
- Not all managers may be knowledgeable of the requirement to implement reasonable adjustments. Therefore, OH and WOD advice is recommended.
- A failure to make reasonable adjustments refers to a breach of the employer's Public Sector Equality Duty, which came into force in April 2011 (s.149 of the Equality Act 2010).



Section 5 – Equality, Diversity & Inclusion (EDI)

The Monthly Quality & Performance Report will include (from September's F&P Committee) a new slides on EDI. Potential metrics include:-

- % of staff who have recorded their Welsh Language skills on ESR who have Welsh language listening/speaking skills level 2 (foundation level) and above
- Equality Indicator: Allyship Programme
- Workforce Race Equality Strategy & Action Plan: Gender Pay and Gender employment Numbers
- Workforce Race Equality Strategy & Action Plan: Ethnicity
- Workforce Race Equality Strategy & Action Plan: Mandatory Equality and Human Rights Training Rates
- Welsh Language: Jobs advertised
- 111 Calls processed in Welsh





Summary – Staff and Wellbeing



The situation regarding wellbeing remains challenging

Many of the issues and frustrations are very difficult to influence and change

Management Development with a focus on people skills and support

Continue with robust wellbeing offer and ensure colleagues know where they can get support

Collating financial advice and support opportunities for those in need

Reviewing opportunities for pulse survey tool

Work at a local level through team and champions

P&C Strategy will continue wellbeing focus





AGENDA ITEM No	12
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	3

WORKFORCE PERFORMANCE REPORT

MEETING	People and Culture Committee
DATE	5 th September 2022
EXECUTIVE	Catherine Goodwin - Interim Director of Workforce and OD
AUTHOR	Sarah Davies – Workforce & OD Directorate Business Manager
CONTACT	Sarah.davies31@wales.nhs.uk

EXECUTIVE SUMMARY
The purpose of this report is to provide an overview of the key workforce performance data and trends (July 2022) and associated improvement actions.

KEY ISSUES/IMPLICATIONS
The Committee’s attention is drawn to the following areas: <ul style="list-style-type: none"> Ongoing work on reducing sickness absence across WAST; Improvement in PADR completion rates (65.18% as at 31st July 2022) <p>The Committee is asked to RECEIVE and COMMENT ON reported performance and associated actions.</p>

REPORT APPROVAL ROUTE
<ul style="list-style-type: none"> Noted at Executive Management Team (24.08.22) Noted at WOD Business Meeting (23.08.22)

REPORT APPENDICES
<p>Appendix 1a: SBAR – Workforce Performance Report for July 2022</p> <p>Appendix 1b: Workforce KPI Summary</p>

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	N/A	Financial Implications	YES
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES

Ethical Matters	N/A	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/A

Appendix 1a: SBAR: Workforce Performance Report for July 2022

SITUATION

1. This report provides an overview of the July 2022 key trends and improvement actions as identified in the Workforce and OD (WOD) KPI Summary enclosed at **Appendix 1b**.

BACKGROUND

2. The WOD KPI Summary provides detail of the key performance indicators for WAST's workforce, aligned to the key themes of the Trust's People & Culture Strategy - Planning and Resourcing, Education and Training, Leading and Engaging.
3. This paper is intended to be read in conjunction with **Agenda Item 11 – Monthly Integrated Quality and Performance Report**. The MIQPR provides a high level overview of performance in relation to the following People and Culture indicators:
 - PADR completion rate;
 - Statutory and Mandatory training compliance;
 - Sickness absence rate.

This report provides a further level of detail (both data and narrative) in relation to a wider range of workforce performance indicators.

ASSESSMENT

4. The Committee is asked to note the following headlines and key trends by theme:

Planning and Resourcing

5. **Time to Hire:** WAST's recruitment timelines have continued to exceed the All Wales national target of 71 calendar days since last Summer. The last report for PCC indicated the recruitment process was taking an average of 123 days in March. This reduced to 113 days in April and 111 days in May but has subsequently increased to 131 days as of July 2022. This timeline refers to the date an advert request is submitted on the recruitment system, Trac, to the date an unconditional offer letter is sent to successful candidates. The breach continues to be high due to high volume recruitment campaigns for EMS roles which are skewing the figures and candidates being started in post with outstanding pre-employment checks in some service areas due to pressures within the system.
6. **Job Evaluation:** Number of JDs currently in process remains at a manageable level and has done so during the last quarter. Panels have continued to run, albeit due to organisational pressures from a management perspective along with TU

availability, the arranging of panels has proved challenging on occasions. A change to the lead for JE has now been introduced following implementation of the new People Services structure along with a new JE Facilitator post. Both post holders have attended / will be attending relevant JE training courses, in order that the Trust continues to be provided with a robust JE service in moving forward.

7. **Sickness Absence:** Activities to reduce levels of sickness across WAST through the project plan continue and are on track. June and July saw an increase in Covid absence, reflecting the wider population and which impacted on short term sickness (3.25% May, 3.94% in June and 4.67% in July). This has reduced significantly in August. Current indicative figures suggest August sickness will be around 9% from 10.32% in July (9.12% in June). Over recent months there has been a sustained reduction in long term absence with a slight increase in July. From 5.18% in June to 5.65% in July. Mental health absence is up slightly in July at 2.36% (2.22% in June) whilst MSK absence is down again at 1.04% (1.27% June).
8. **Vaccination Rates:** Vaccination rates for Covid19 vaccination as of 21st July 2022, are that 95% of all staff had received their first and second vaccinations, and 87% had received their booster vaccination. The Autumn Booster programme is currently being organised by the Health Boards who will again deliver this for WAST frontline staff and other staff members indicated, as set out in the JCVI update of 15th July 2022. The Flu campaign for Autumn 2022 within WAST is being finalised and vaccinations are due to be delivered w/c 19th September 2022 with roll out commencing that week.

Education and Training

9. **Statutory and Mandatory Training Compliance:** Whole Trust compliance stands as 83.45% as of 31.07.2022. Leaders and managers across the Trust are provided with compliance data to enable local engagement to improve rates. With particular focus on the face-to-face elements of Statutory & Mandatory training for Operations colleagues, work continues to improve rates.

To mitigate against low CPD attendance rates for road-based staff Statutory & Mandatory training for Financial Year 2021/22, the Workforce Development team provided additional face-to-face sessions, pan-Wales, to support colleagues achieve compliance. These ceased on 15th July 2022 resulting in a final performance position of 84.32% (i.e. 84.32% of all operational colleagues completed the required WAST CPD programme).

The 2022/23 CPD program has been ratified by the Director of WOD in the absence of the scheduled SESSG meeting; this did not occur as scheduled on 25.07.2022, due to REAP 4. The Workforce Development team has redesigned the approach including a rebranding of this specific learning. This approach is two-pronged with a focus on interprofessional learning approaches and a new name to move away from 'CPD Programme' which is perceived as adding little value to the more engaging Mandatory In-Service Training (MIST). MIST will continue to be provided using the combination of one day eLearning and one day face-to-face.

Leading and Engaging

10. **PADRs:** Completion rates across the organisation have increased to 65.18% - this is a 13% increase on the figure reported at the last meeting of the People and Culture Committee. Phase 1 of the PADR Refresh process is now complete, following a series of deep dives across the organisation; the output of this is a new form, contained within **Appendix 2**. Phase 2 will involve development and launch of a manager toolkit to support colleagues and managers through the PADR process and subsequently improve completion rates across the organisation. Phase 3 of the process will involve transfer of this form to ESR, enabling PADR data and information to be fully reportable, to inform organisational training and intervention plans. It is envisaged that the ESR version of the form will be live by November 2022.
11. **Employee Relations:** Employee relations cases have increased in the last quarter to 40 cases in total July 2022. There has been a decrease in Disciplinary cases (15 cases) but an increase in formal Respect & Resolution cases (25 cases). The People Services team are working with employees and managers in respect of the Respect & Resolution requests received and advising how the importance of early and appropriate intervention can prevent situations escalating and be more beneficial to all parties. Of the 25 cases recorded in July, 4 employees and managers have agreed to meet informally. This is the same experience of other Health Boards and Trusts with the belief that the first part of the R&R process is being missed hence the push back to managers and employees on whether there have been any informal discussions as per the policy.

The first meeting to progress how we support staff subject to any disciplinary action, up to and including suspension was held on 4th August 2022, with a further meeting scheduled for late September. We currently have six employees who have been suspended for over four months.

A new process for managers to advise of new ER cases is currently being trialled for 2 months from 25th July 2022. Managers are required to send a notification of an ER case to the Helpdesk. The Helpdesk then pass the call to a People Services Advisor to triage, discuss with the manager and allocate a named People Services colleague to the case.

The senior team are working with ABUHB OD team looking at a piece of work they have been undertaking with Cardiff University based on Just Culture principles. We will be rolling out training to the People Services Team and Managers through Q3 and Q4 with the aim of reducing employee harm through the process.

RECOMMENDED: That the Committee **RECEIVE** and **COMMENT ON** reported performance and associated actions.



Workforce KPIs July 2022

Plan

Job Evaluation

JDs currently in process: 21 ↓
JDs completed in month: 3 ↓
Ave. days to complete: 10 ↓

Recruitment

Vacancy creation to unconditional offer: 131 ↑

Educate

Stat Mand training compliance: 83.45% ↓

Apprenticeships

Apprenticeships in progress: 204 ↓
Apprenticeships completed: 0 ↔

Resource

Sickness

Rolling 12 month: 10.98% ↑
In month: 10.33% ↑
Ave. length of closed LTS: 107.09 ↑

Wellbeing

OH referral to first offer of appointment: 5.5 ↑
Sickness absence attributable to MH: 22.90% ↑

Engage

PADR Compliance: 65.18% ↑

Open ER cases: 15 ↓

Formal requests for resolution: 23 ↑

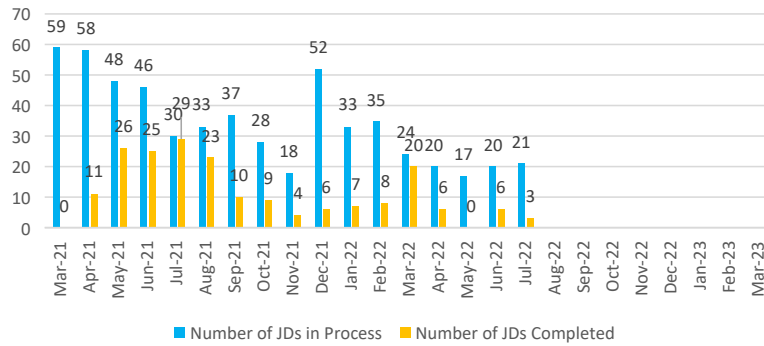
Workplace Safety

V&A Incidents Recorded via Datix: 51 ↑

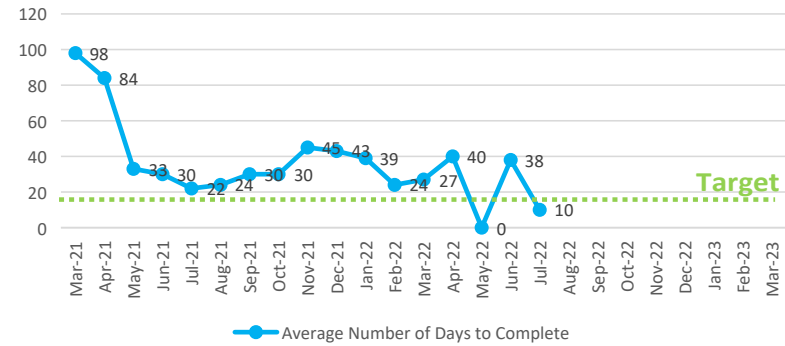


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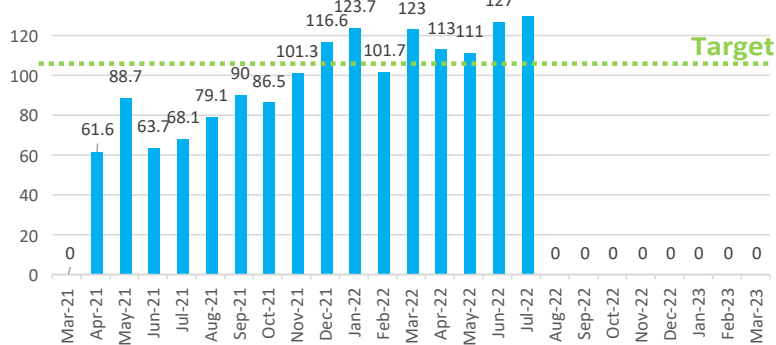
JE: JDs in Process / Completed



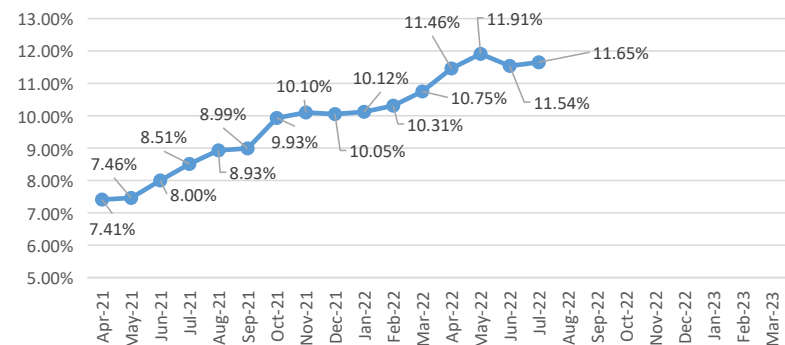
JE: Ave. Days to Complete



Ave. Days Vacancy Creation to Conditional Offer



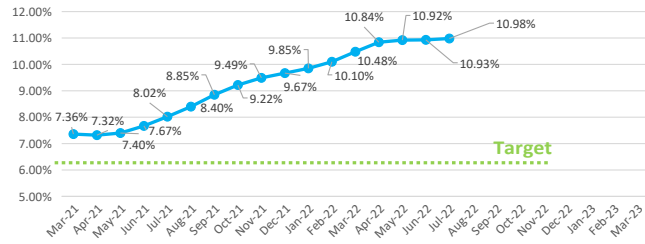
WAST Turnover



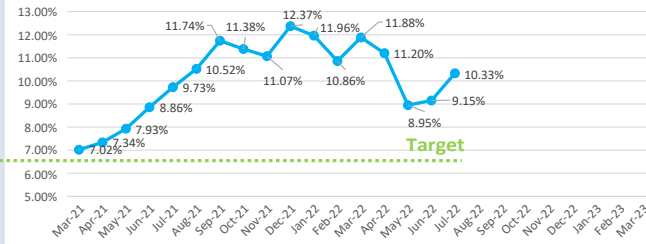


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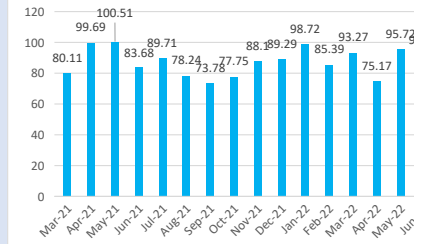
Overall Sickness - Rolling 12 Month



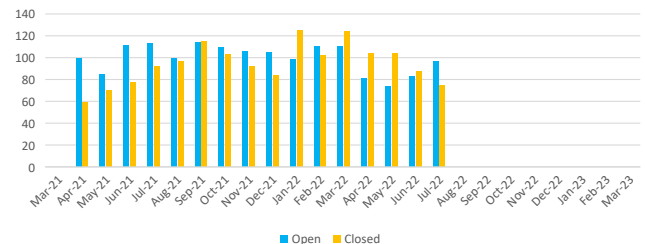
Overall Sickness - In Month



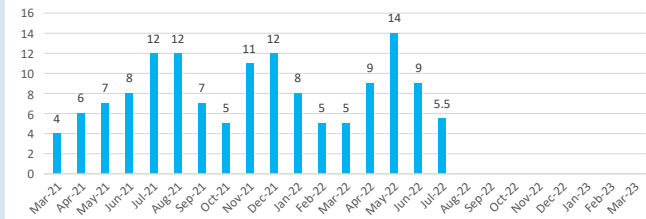
Ave. Length of Closed LTS



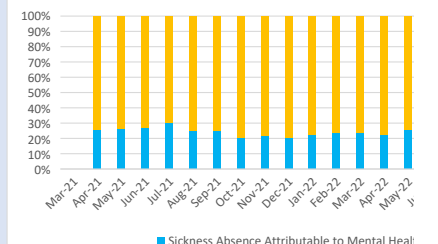
New LTS Opened vs. Closed LTS Cases



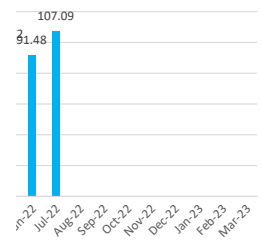
Ave. Days from Receipt of OH Referral to First Offer of Appointment



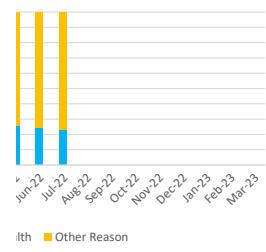
% of Sickness Absence by Reason



5 (Days)



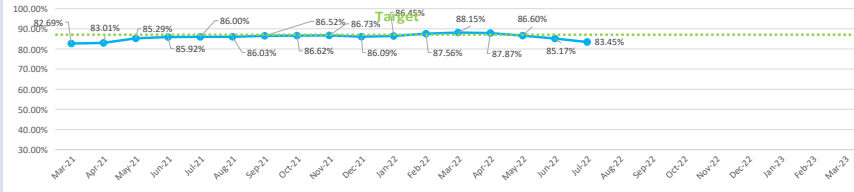
on (In Month)



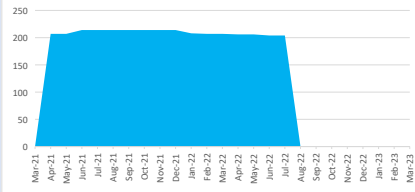


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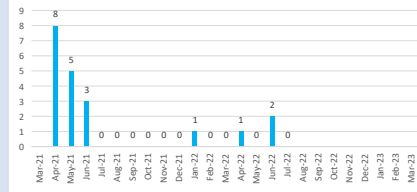
Statutory and Mandatory Training Compliance



Apprenticeships in Progress



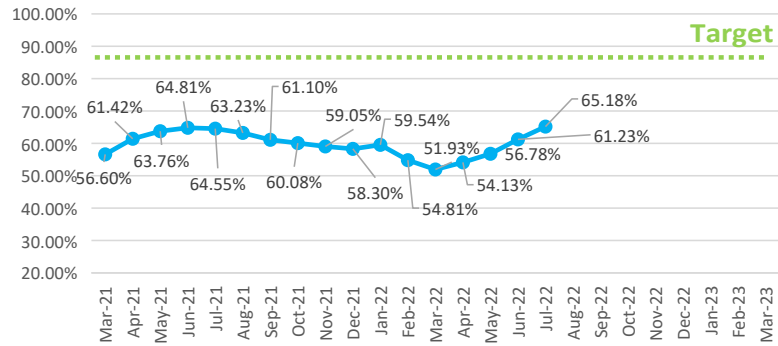
Apprenticeships Completed In Month



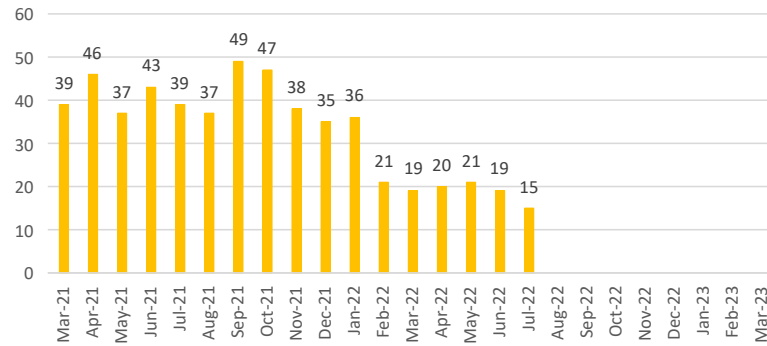


[Return to Summary](#)

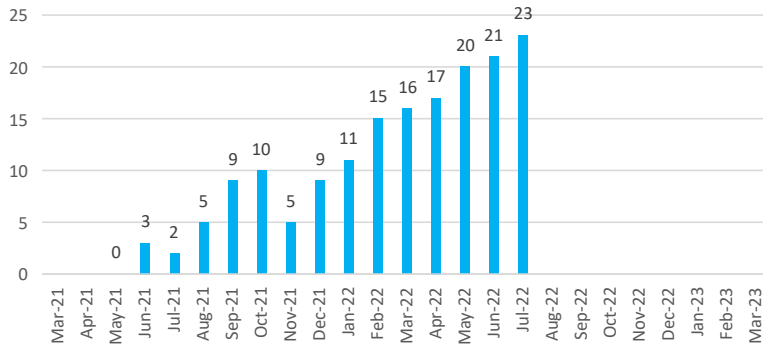
PADR Compliance



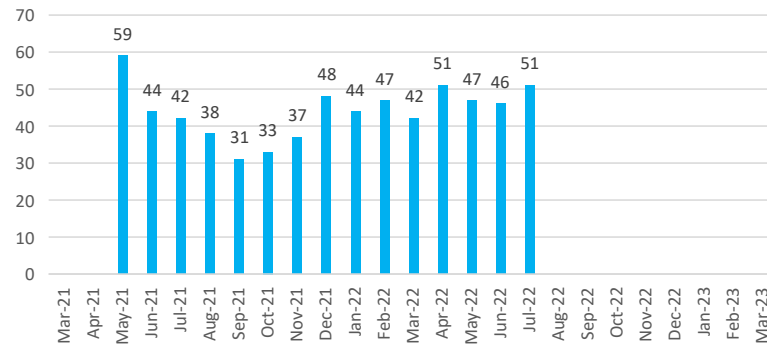
Open ER Cases



Formal Requests for Resolution



V&A Incidents Reported Via Datix



PLAN

	Number of Number of JDs Compl		Average Number of Da		
Mar-21	59	0	Mar-21	98	Mar-21
Apr-21	58	11	Apr-21	84	Apr-21
May-21	48	26	May-21	33	May-21
Jun-21	46	25	Jun-21	30	Jun-21
Jul-21	30	29	Jul-21	22	Jul-21
Aug-21	33	23	Aug-21	24	Aug-21
Sep-21	37	10	Sep-21	30	Sep-21
Oct-21	28	9	Oct-21	30	Oct-21
Nov-21	18	4	Nov-21	45	Nov-21
Dec-21	52	6	Dec-21	43	Dec-21
Jan-22	33	7	Jan-22	39	Jan-22
Feb-22	35	8	Feb-22	24	Feb-22
Mar-22	24	20	Mar-22	27	Mar-22
Apr-22	20	6	Apr-22	40	Apr-22
May-22	17	0	May-22	0	May-22
Jun-22	20	6	Jun-22	38	Jun-22
Jul-22	21	3	Jul-22	10	Jul-22
Aug-22			Aug-22		Aug-22
Sep-22			Sep-22		Sep-22
Oct-22			Oct-22		Oct-22
Nov-22			Nov-22		Nov-22
Dec-22			Dec-22		Dec-22
Jan-23			Jan-23		Jan-23
Feb-23			Feb-23		Feb-23
Mar-23			Mar-23		Mar-23

RESOURCE

Overall Sickness - Rolling 12 Month		Overall Sickness - In Mo	
Mar-21	7.36%	Mar-21	7.02%
Apr-21	7.32%	Apr-21	7.34%
May-21	7.40%	May-21	7.93%
Jun-21	7.67%	Jun-21	8.86%
Jul-21	8.02%	Jul-21	9.73%
Aug-21	8.40%	Aug-21	10.52%
Sep-21	8.85%	Sep-21	11.74%
Oct-21	9.22%	Oct-21	11.38%
Nov-21	9.49%	Nov-21	11.07%
Dec-21	9.67%	Dec-21	12.37%
Jan-22	9.85%	Jan-22	11.96%
Feb-22	10.10%	Feb-22	10.86%
Mar-22	10.48%	Mar-22	11.88%
Apr-22	10.84%	Apr-22	11.20%
May-22	10.92%	May-22	8.95%

Jun-22 10.93%
 Jul-22 10.98%
 Aug-22
 Sep-22
 Oct-22
 Nov-22
 Dec-22
 Jan-23
 Feb-23
 Mar-23

Jun-22 9.15%
 Jul-22 10.33%
 Aug-22
 Sep-22
 Oct-22
 Nov-22
 Dec-22
 Jan-23
 Feb-23
 Mar-23

Ave. Length of Closed LTS (Days)		Open	Closed
Mar-21	80.11	Mar-21	
Apr-21	99.69	Apr-21	59
May-21	100.51	May-21	70
Jun-21	83.68	Jun-21	77
Jul-21	89.71	Jul-21	92
Aug-21	78.24	Aug-21	97
Sep-21	73.78	Sep-21	115
Oct-21	77.75	Oct-21	103
Nov-21	88.1	Nov-21	92
Dec-21	89.29	Dec-21	84
Jan-22	98.72	Jan-22	125
Feb-22	85.39	Feb-22	102
Mar-22	93.27	Mar-22	124
Apr-22	75.17	Apr-22	104
May-22	95.72	May-22	104
Jun-22	91.48	Jun-22	87
Jul-22	107.09	Jul-22	75
Aug-22		Aug-22	
Sep-22		Sep-22	
Oct-22		Oct-22	
Nov-22		Nov-22	
Dec-22		Dec-22	
Jan-23		Jan-23	
Feb-23		Feb-23	
Mar-23		Mar-23	

Ave. Number of Days from Receipt of OH Referral to Fir:Sickness AbOther Reaso

Month	Average Days	Month	Sickness %	Other Reason %
Mar-21	4	Mar-21		
Apr-21	6	Apr-21	26%	74%
May-21	7	May-21	26.30%	73.40%
Jun-21	8	Jun-21	26.90%	73.10%
Jul-21	12	Jul-21	30.30%	69.70%
Aug-21	12	Aug-21	24.90%	75.10%
Sep-21	7	Sep-21	24.80%	75.20%
Oct-21	5	Oct-21	20.60%	79.40%
Nov-21	11	Nov-21	21.80%	78.20%
Dec-21	12	Dec-21	20.80%	79.20%
Jan-22	8	Jan-22	22.70%	77.30%
Feb-22	5	Feb-22	24.00%	76.00%
Mar-22	5	Mar-22	23.60%	76.40%
Apr-22	9	Apr-22	22.20%	77.80%
May-22	14	May-22	25.50%	74.50%
Jun-22	9	Jun-22	24.40%	75.60%
Jul-22	5.5	Jul-22	22.90%	77.10%
Aug-22		Aug-22		
Sep-22		Sep-22		
Oct-22		Oct-22		
Nov-22		Nov-22		
Dec-22		Dec-22		
Jan-23		Jan-23		
Feb-23		Feb-23		
Mar-23		Mar-23		

Statutory and Mandatory Training Compliance

Mar-21	82.69%
Apr-21	83.01%
May-21	85.29%
Jun-21	85.92%
Jul-21	86.00%
Aug-21	86.03%
Sep-21	86.52%
Oct-21	86.62%
Nov-21	86.73%
Dec-21	86.09%
Jan-22	86.45%
Feb-22	87.56%
Mar-22	88.15%

Compliant

Mar-21	90.13%
Apr-21	90.07%
May-21	88.56%
Jun-21	88.56%
Jul-21	88.36%
Aug-21	87.94%
Sep-21	86.64%
Oct-21	91.20%
Nov-21	97.00%
Dec-21	99.00%
Jan-22	100.00%
Feb-22	100.00%
Mar-22	100.00%

EDUCATE	Apr-22	87.87%
	May-22	86.60%
	Jun-22	85.17%
	Jul-22	83.45%
	Aug-22	
	Sep-22	
	Oct-22	
	Nov-22	
	Dec-22	
	Jan-23	
	Feb-23	
	Mar-23	

ENGAGE	PADR Compliance	
Mar-21	56.60%	
Apr-21	61.42%	
May-21	63.76%	
Jun-21	64.81%	
Jul-21	64.55%	
Aug-21	63.23%	
Sep-21	61.10%	
Oct-21	60.08%	
Nov-21	59.05%	
Dec-21	58.30%	
Jan-22	59.54%	
Feb-22	54.81%	
Mar-22	51.93%	
Apr-22	54.13%	
May-22	56.78%	
Jun-22	61.23%	
Jul-22	65.18%	
Aug-22		
Sep-22		
Oct-22		
Nov-22		
Dec-22		
Jan-23		
Feb-23		
Mar-23		

		Open ER Cases	
Mar-21	39		
Apr-21	46		
May-21	37		
Jun-21	43		
Jul-21	39		
Aug-21	37		
Sep-21	49		
Oct-21	47		
Nov-21	38		
Dec-21	35		
Jan-22	36		
Feb-22	21		
Mar-22	19		
Apr-22	20		
May-22	21		
Jun-22	19		
Jul-22	15		
Aug-22			
Sep-22			
Oct-22			
Nov-22			
Dec-22			
Jan-23			
Feb-23			
Mar-23			

Ave. Days from Vacancy Creation to	Budget	Target	SIP Mar	v. Budget	v. Target	
61.6	UCS	220.8	239.98	214.76	-2.74%	-10.51%
88.7	EMT	482.47	566.29	497.2	3.05%	-12.20%
63.7	Para	874.58	899	890.28	1.80%	-0.97%
68.1				Vacancy Rate (%)		
79.1		Budget	Target	SIP April	v. Budget	v. Target
90	UCS	220.8	239.98	215.84	-2.25%	-10.06%
86.5	EMT	482.47	566.29	491.58	1.89%	-13.19%
101.3	Para	874.58	899	885.91	1.30%	-1.46%
116.6		Budget	Target	SIP May	v. Budget	v. Target
123.7	UCS	220.8	239.98	233.34	5.68%	-2.77%
101.7	EMT	482.47	566.29	474.58	-1.64%	-16.19%
123	Para	874.58	899	887.3	1.45%	-1.30%
113		Budget	Target	SIP June	v. Budget	v. Target
111	UCS	220.8	239.98	235.34	6.59%	-1.93%
127	EMT	482.47	566.29	469.58	-2.67%	-17.08%
131	Para	874.58	899	880.13	0.63%	-2.10%
		Budget	Target	SIP Jul	v. Budget	v. Target
	UCS	220.8	239.98	197.14	-10.72%	-17.85%
	EMT	482.47	566.29	520.59	7.90%	-8.07%
	Para	874.58	899	869.66	-0.56%	-3.26%
		Budget	Target	SIP Aug	v. Budget	v. Target
	UCS	220.8	239.98	197.79	-10.42%	-17.58%
	EMT	482.47	566.29	522.2	8.23%	-7.79%
	Para	874.58	899	852.74	-2.50%	-5.15%
		Budget	Target	SIP Sept	v. Budget	v. Target
	UCS	220.8	239.98	196.29	-11.10%	-18.21%
	EMT	482.47	566.29	514.12	6.56%	-9.21%
	Para	874.58	899	906.25	3.62%	0.81%
		Budget	Target	SIP Oct	v. Budget	v. Target
	UCS	220.8	239.98	196.29	-11.10%	-18.21%
	EMT	482.47	566.29	514.12	6.56%	-9.21%
	Para	874.58	899	932.25	6.59%	3.70%
		Budget	Target	SIP Nov	v. Budget	v. Target
	UCS	220.8	239.98	196.29	-11.10%	-18.21%
	EMT	482.47	566.29	528.12	9.46%	-6.74%
	Para	874.58	899	900.02	2.91%	0.11%
		Budget	Target	SIP Dec	v. Budget	v. Target
	UCS	220.8	239.98	212.14	-3.92%	-11.60%
	EMT	482.47	566.29	523.9	8.59%	-7.49%
	Para	874.58	899	901.42	3.07%	0.27%
		Budget	Target	SIP Jan	v. Budget	v. Target
	UCS	220.8	239.98		-100.00%	-100.00%
	EMT	482.47	566.29		-100.00%	-100.00%
	Para	874.58	899		-100.00%	-100.00%

nth

	Budget	Target	SIP Feb	v. Budget	v. Target
UCS	220.8	239.98		-100.00%	-100.00%
EMT	482.47	566.29		-100.00%	-100.00%
Para	874.58	899		-100.00%	-100.00%
	Budget	Target	SIP Mar	v. Budget	v. Target
UCS	220.8	239.98		-100.00%	-100.00%
EMT	482.47	566.29		-100.00%	-100.00%
Para	874.58	899		-100.00%	-100.00%

Formal Requests for Resolution

Mar-21	
Apr-21	
May-21	0
Jun-21	3
Jul-21	2
Aug-21	5
Sep-21	9
Oct-21	10
Nov-21	5
Dec-21	9
Jan-22	11
Feb-22	15
Mar-22	16
Apr-22	17
May-22	20
Jun-22	21
Jul-22	23
Aug-22	
Sep-22	
Oct-22	
Nov-22	
Dec-22	
Jan-23	
Feb-23	
Mar-23	

V&A Incidents Reporte

Mar-21	
Apr-21	
May-21	59
Jun-21	44
Jul-21	42
Aug-21	38
Sep-21	31
Oct-21	33
Nov-21	37
Dec-21	48
Jan-22	44
Feb-22	47
Mar-22	42
Apr-22	51
May-22	47
Jun-22	46
Jul-22	51
Aug-22	
Sep-22	
Oct-22	
Nov-22	
Dec-22	
Jan-23	
Feb-23	
Mar-23	

n

	Compliant	Non-Compliant		Compliant	Non-Compl
Mar-21	85.61%	14.39%	Mar-21		
Apr-21	84.99%	15.01%	Apr-21		
May-21	83.22%	16.78%	May-21		
Jun-21	83.22%	16.78%	Jun-21	8%	92%
Jul-21	82.87%	17.13%	Jul-21	13.68%	86.32%
Aug-21	82.03%	17.97%	Aug-21	20.43%	79.57%
Sep-21	79.71%	21.29%	Sep-21	23.09%	76.91%
Oct-21	87.20%	12.80%	Oct-21	32.70%	97.30%
Nov-21	96.00%	4%	Nov-21	51.00%	49%
Dec-21	99.40%	0.60%	Dec-21	61.20%	38.80%
Jan-22	100.00%	0.00%	Jan-22	69.00%	31.00%
Feb-22	100.00%	0.00%	Feb-22	78.00%	22.00%
Mar-22	100.00%	0.00%	Mar-22	97.18%	2.82%

Non-Compliant

- 9.87%
- 9.93%
- 11.44%
- 11.44%
- 11.64%
- 12.06%
- 13.37%
- 8.80%
- 3%
- 1%
- 0.00%
- 0.00%
- 0.00%

Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22

|

	Turnover							
Mar	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
	7.41%	7.46%	8.00%	8.51%	8.93%	8.99%	9.93%	10.10%

	WAST WTE							
Mar	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
WTE	3858.2	3897.7	3880.69	3868.69	3878.21	3898	3919.60	4002.53
Headcount	4131	4170	4177	4162	4160	4181	4197	4280

ed Via Datix

liant

Apprenticeships in Progress

Apprenticeships Compl

Mar-21

Apr-21 207

May-21 207

Jun-21 214

Jul-21 214

Aug-21 214

Sep-21 214

Oct-21 214

Nov-21 214

Dec-21 214

Jan-22 208

Feb-22 207

Mar-22 207

Apr-22 206

May-22 206

Jun-22 204

Jul-22 204

Aug-22

Sep-22

Oct-22

Nov-22

Dec-22

Jan-23

Feb-23

Mar-23

Mar-21

Apr-21 8

May-21 5

Jun-21 3

Jul-21 0

Aug-21 0

Sep-21 0

Oct-21 0

Nov-21 0

Dec-21 0

Jan-22 1

Feb-22 0

Mar-22 0

Apr-22 1

May-22 0

Jun-22 2

Jul-22 0

Aug-22

Sep-22

Oct-22

Nov-22

Dec-22

Jan-23

Feb-23

Mar-23

Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
10.05%	10.12%	10.31%	10.75%	11.46%	11.91%	11.54%	11.65%		

Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
3977.6	4050.74	4106.02	4091.66	4026.20	4021.80	3983.60	3949.90		
4251	4325	4386	4369	4299	4302	4266	4235		

leted In Month

Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23

Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23



Personal Appraisal Development Review

NAME:	
JOB ROLE:	
DIRECTORATE:	
MANAGERS NAME:	
DATE:	



Personal Appraisal Development Review

The 'Personal Appraisal Development Review' (PADR) process is summarised in the steps below.

Step One:

About You

Step Two:

Review performance and demonstration of values in previous 12-months

Step Three:

Set personal objectives for next 12 months & goal setting

Step Four:

Devise Personal Development Plan

Step Five:

Confirmation of PADR appraisal

This PADR has been designed to reflect on successes that an individual has achieved over the last year and to plan forward to what we hope to achieve in the next year. These must happen at least once a year, however it is highly recommended that conversations are held as frequently as possible (ideally once a month). The ownership of having these frequently conversations is not only with the manager - Colleagues are encouraged to initiate these conversations as they deem necessary. It is important to remember that these conversations (especially those questions in step one) may not take place in a formal setting but may take place in the corridor, back of an ambulance or in the canteen (if other colleagues are not around).

Managers who are undertaking the PADR will be able to find a toolkit for managers on how to effectively conduct these.



Personal Appraisal Development Review

STEP ONE – About you

STEP 1A About You

How am I?

STEP 1B About You

What are you most proud of? My learning, personal and work achievements?

STEP 1C About You

What do you do in order to support your wellbeing?



Personal Appraisal Development Review

STEP ONE – About you

STEP 1D Your observations

Since the last conversation, please share your experience in relation to others what you have observed in relation to WAST behaviours? E.g. Have you seen positive or negative behaviours? Have you called these out? *See Appendix 1 for more information*

STEP 1E Frequency

In the last 12 months, how often have you been able to have a check-in with your manager?

- Frequently Occasionally Rarely First conversation since last PADR

STEP 1F Initiator

Who has initiated these conversations?

- Appraisee Appraiser Both



Personal Appraisal Development Review

STEP TWO

STEP 2A Discuss Performance

Discuss overall performance in last 12 month/since start date. E.g. what has gone well? What has been most challenging? Provide a brief summary below.



Personal Appraisal Development Review

STEP 2B

Review Previous Objectives

Review PADR appraisal documents from last year. Have personal objectives been achieved on time, and in full? What has appraisee learned from undertaking these objectives?

STEP 2C

Progress against agreed objectives

Indicate below the extent to which appraisee performed against objectives set for previous year, focusing on their contribution, their achievements and development.

1. Outstanding

- Performance consistently exceeded in all areas of responsibility.
- The quality of work overall was outstanding and inspires others to achieve same high standards

2. Excellent

- Performance consistently met expectations in all areas and exceeded expectations in some.
- The quality of work overall was excellent.

3. Good

- Performance consistently met expectations in all areas of responsibility.
- The quality of work overall was good.

4. Satisfactory

- Performance met expectations in most areas of responsibility, but some areas need development.
- The quality of work overall was satisfactory.

5. Needs Improvement

- Performance was below expectations in most areas of responsibility.
- The quality of work overall needs improvement.

Agreed Score

← Drop Down Box 1-5

Why did you agree this score?



Personal Appraisal Development Review

STEP 2D Demonstrating WAST Behaviours

Discuss how the appraisee demonstrates the following Trust Values and Behaviours. See Appendix 1 for more information about each behaviour.

1. Outstanding

- Behaviour consistently exceeded expectations in all areas of our values.
- The demonstration of values overall was outstanding and inspires others to achieve same high standards.

2. Excellent

- Behaviour consistently met expectations in all areas of our values, and exceeded expectations in some.
- The demonstration of values overall was excellent.

3. Good

- Behaviour consistently met expectations in all areas of our values.
- The demonstration of values overall was good.

4. Satisfactory

- Behaviour met expectations in most areas of our values, but some areas need development.
- The demonstration of values overall was satisfactory.

5. Needs Improvement

- Behaviour was below expectations in most areas of our values.
- The demonstration of values overall needs improvement.



Take ownership

Agreed Score



Broaden our understanding

Agreed Score



Respect others

Agreed Score



Show belief in each other

Agreed Score



Practice ethically

Agreed Score



Continually improve our services

Agreed Score



Be inclusive of the whole team

Agreed Score

Please use the drop down box to select a score between (1-5) for each behaviour

Why did you agree this score?



Personal Appraisal Development Review

STEP THREE - Set personal objectives and goals for the next 12 months

In this section, include personal and work objective for the next year. Ensure these objectives are specific, measurable and time bound.

Personal Objective	Scheduled Completion Date



Personal Appraisal Development Review

STEP FOUR - Set personal objectives for next 12 months

STEP 4A

Personal Development Plan

Review the learning opportunities the appraise will require in the next 12 months.

Check the following:

- Does the appraisee demonstrate all skills/competencies required for the role?
- Do the objectives in STEP 3 require new/additional skills or knowledge?

On the basis of this, identify below what learning has been agreed, with timescales for completion:

Learning Need and Activity	Scheduled Completion Date	Comments

STEP 4B

Support for the Appraisee

Discuss how the appraisee's line manager can better support them to:

- Maximize their potential
- Deliver their objectives
- Support for wellbeing



Personal Appraisal Development Review

STEP 4C

Statutory & Mandatory Training

Is the appraisee's mandatory training on ESR up to date?

Yes

No

If 'no' what steps are in place to ensure this happens, ensuring the safe delivery of services and best patient experience?

STEP 4D

ESR personal information

Has the appraisee ensured that ESR emergency information, home address, contact numbers and equality & diversity details are up to date?

Yes

No

If 'no' please agree a date when these will be updated by:



Personal Appraisal Development Review

STEP FIVE - Confirmation of PADR

Final Comments from Appraisee

Use this space to provide an overall summary including anything you have not been able to share during your appraisal.

Final Comments from Appraiser

Provide a summary of your overall assessment of the individual's performance during the review period, including any areas requiring improvement.



Personal Appraisal Development Review

STEP FIVE - Confirmation of PADR

Signature of Appraisee:	
Signature of Appraiser:	
Date of Next Review:	

* It is the responsibility of the line manager to upload this review onto ESR. Please click the link and follow guidance on how to do this.

FOR GUIDANCE ON HOW TO UPLOAD THE PADR ONTO ESR - PLEASE CLICK [HERE](#).

Appendix 1

Take Ownership



Show Courage and Take the Lead

Take Accountability for My Decisions

Reflect and Grow From Our Experiences

Broaden Our Understanding

Ask Questions to Deeply Understand

Challenge my Assumptions

Welcome Feedback and Suggestions



Respect Others



Show Owed Respect to Everyone

Communicate with Empathy

Show that I care by Actively Supporting Others

Show Belief in Each Other

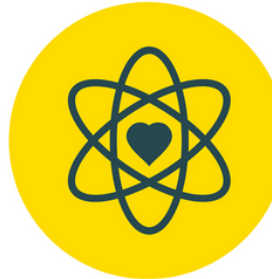
Celebrate our Success together

Talk Positively about the Service and its Future

Build our Reputation



Practice Ethically



Stand up for What is Right

Have Zero Tolerance for Inappropriate Behaviour

Give Clear and Constructive Feedback

Continually Improve Our Service

Notice Opportunities to be Better

Support and Encourage Others and their Wellbeing

Look After my own Wellbeing



Be Inclusive of the Whole Team



Show Curiosity About Difference

Help Everyone to feel like they Belong and are Involved

Clearly Share the Reasoning Behind Decisions



GIG
CYMRU
NHS
WALES | Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	13
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

COMMITTEE CYCLES OF BUSINESS

MEETING	People and Culture Committee
DATE	5 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Development of the cycle of business for this committee is the final step in the 2021/22 effectiveness reviews that were conducted in Q4.
2. The cycle has been developed with direct correlation to the duties in the terms of reference. This will allow members to review the appropriateness of the proposed reports and their frequency.
3. The cycle for the Committee is a maturing document which will grow organically over the next 12 months.

RECOMMENDATION:

4. The Committee is asked to:
 - (a) review the cycles of business, propose any amendments, and approve it as a first version.
 - (b) Confirm that the Committee is not supported at this stage by a sub-committee structure.

KEY ISSUES/IMPLICATIONS

5. There are some areas of the cycle which remain to be developed including health and wellbeing; embedding Trust behaviours and culture change; workforce model and plans; health and care standards; leadership and talent management model; equality, diversity and inclusion; and raising concerns and speaking up. Work will continue with the relevant directors on these areas over the coming months.

6. The committee is required to review the strategic direction of matters within its remit and to monitor their implementation. The cycle includes an annual review of the IMTP elements relevant to its remit ahead of them being approved by the Board, however the monitoring of the IMTP is within the purview of the Finance and Performance Committee. It is therefore proposed that, outside of that, reporting on the IMTP will be at the discretion of the relevant Director or at the request of the Finance and Performance Committee i.e. possibly to do a deep dive on an area that may be off track or to celebrate areas of success.
7. It is recommended that the Committee no longer supports sub-committees reporting into it directly for the time being. The terms of reference provide that the Committee can form sub-committees or task and finish groups should a need arise in the future.

REPORT APPROVAL ROUTE
N/A

REPORT APPENDICIES
Annex 1 – Cycle of business 2022/23

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

CYCLES OF BUSINESS

SITUATION

8. The purpose of this paper is to provide the Committee with a draft cycle of business as the final step in the 2021/22 effectiveness review process.

BACKGROUND

9. The Board carried out its effectiveness review in Quarters 4 2021/22. This included a review of its terms of reference, amendments to which were approved by the Trust Board in May 2022.
10. The final step in the effectiveness review process is the development a cycle of business for the Committee and a review of its sub-committee structure.

ASSESSMENT

Cycle of Business

11. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework, should drive agenda setting. It also:
 - 11.1. allows papers to be planned in advance, giving Directors and report writers the opportunity to plan necessary pre-committee forums and align cycles of business;
 - 11.2. schedules compliance related reports according to legislative or regulatory timeframes;
 - 11.3. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;
 - 11.4. generates commitment to review matters that may sometimes be vulnerable to postponement;
 - 11.5. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;
 - 11.6. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and
 - 11.7. removes the ad hoc elements of agenda setting.
12. Whilst it is inevitable that other items will arise from time to time, the cycle allows them to be prioritised - perhaps coming later on the agenda.
13. The cycle of business at **Annex 1** has been designed to do all the above. It includes further detail on the pre-committee forums, lead presenters, purpose of reports and any relevant and/or helpful commentary. It also includes each of

the duties for the Committee in the terms of reference (in red text) so members can see and demonstrate that the reporting expected for each area will in fact provide appropriate assurance, generate discussion, and allow for the right balance of challenge and support.

14. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. The areas which remain to be developed include:
 - 14.1. Health and wellbeing elements: The Health and Wellbeing Steering Group will recommence in Q3 and will review these terms of reference and advise on assurance reporting for the Committee.
 - 14.2. Further work is required to determine what the reporting will look like for compliance with the relevant Health and Care Standards; embedding the Trust behaviours and positive culture change; workforce model and plan; and the leadership and talent management model. All of these will feature in future iterations of the cycle.
 - 14.3. Raising concerns: The Raising Concerns Task and Finish Group was established in May 2022 to develop the raising concerns framework. A report is on the agenda for the September 2022 Committee that sets out the work of the group in more detail. Reporting on raising concerns is one of the elements of the framework.
 - 14.4. Equality, diversity and inclusion: The EDI Steering Group is currently developing a proposal for assurance reporting.

Sub-Committees

15. During the effectiveness reviews a number of sub-committees/groups were mapped against this Committee. There was a mixture of reporting and minutes being presented from these group which were:
 - Health and Wellbeing Steering Group
 - Equality, Diversity and Inclusion Steering Group
 - Strategic Education Steering Group
 - Partnership Forum
 - Welsh Language Advisory Forum
16. It is recommended that the Committee no longer supports sub-committees reporting into it directly for the time being. The sub-committees above are best placed reporting into organisational/operational structures or directly to Directors, who then report on their portfolio accordingly.
17. The terms of reference provide that the Committee can form sub-committees or task and finish groups should a need arise in the future.
18. The Local Partnership Forum is being reconstituted. This is an advisory forum under the Standing Orders and provides for reporting to the Board through the relevant Director. Options of reporting to the Board could include through this

Committee, or a dual reporting. Further detail will be shared with the Committee as discussions advance and terms of reference are settled.

RECOMMENDATION

19. The Committee is asked to:

- (c) review the cycles of business, propose any amendments, and approve it as a first version.
- (d) Confirm that the Committee is not supported at this stage by a sub-committee structure.

PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2022/23

TERMS OF REFERENCE NOTED IN RED TEXT

3.1 Oversee and contribute to the development of the Trust's people and culture**3.2 Monitor delivery of the Trust's strategy workforce priorities set out in the IMT****3.12 Receive and consider projects of major strategic organisational change where**

Plans underpinning P&C framework	TBC
People and Culture C'ee elements of IMTP	STP
IMTP exception reporting	STB

3.11 Monitor performance against key workforce indicators such as sickness absence specific areas of concern

MIQPR review of metrics	EMT
Committee KPIs review of metrics	TBC
MIQPR	EMT
Committee KPIS	TBC
Suspensions over 4 months report	TBC
Themes and trends from ER cases	TBC

3.4 Champion the health and wellbeing of the workforce, monitor the effectiveness

TBC	H&W Group/Board
Annual Flu report	Board

3.14 Ensure the Trust is discharging its statutory responsibilities, including but not

Health and Safety Report	NH&S C'ee
Revalidation and registration report	N/A
Gender pay gap report	TBC
Health and care standards	TBC

3.5 Consider the experience of staff and volunteers and seek assurance of the effectiveness

Staff Story	N/A
Staff Story updates	None
Staff survey and action plan	Board
Exit interviews	EMT

3.6 Ensure arrangements are in place to allow staff to raise concerns in confidence

TBC	Board
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3.7 Oversee and contribute to the development of the Trust's equality, diversity and

TBC	EDI Group
-----	-----------

3.13 Monitor progress and seek assurance that arrangements are in place to meet

Compliance with Standards Report	WLAG
Welsh language annual report	WLAG/EMT

3.3 Monitor progress and seek assurance of arrangements in place to embed the

Behaviours reset delivery plan	TBC
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3.15 All matters of partnerships and engagement relevant to the remit of the Cor

Partnership Advisory Forum Report	WASPT
Engagement framework updates	TBC
Partnership Agreements	TBC

3.8 Oversight of the development and implementation of the Trust's workforce p

Workforce Model	Workforce Planning Grp
Workforce Plan	Workforce Planning Grp

3.10 Monitor the effectiveness of the Trust's leadership and management develop

Leadership and Talent Management Plan	TBC
3.9 Ensure the Trust has in place appropriate policies and procedures for its work	
Report from policy group	Policy Group
Policies for review and approval	Policy Group/EMT
3.17 Corporate Risks are identified and appropriately managed; CRR and BAF risks	
Board Assurance Framework	Board
Corporate Risk Register - People and culture	Board
Audit Recommendation Tracker	ADLT
Audits within purview of Committee	Audit Committee
3.16 Any other matter in relation to the Committee's overall purpose and respon	
Operational Update	N/A
GOVERNANCE	
Committee effectiveness review annual report	Audit/Board
Review of Terms of Reference	Audit/Board
Committee Cycle of Business annual refresh	N/A
Committee Cycle of Business monthly review	N/A
Committee Review of Annual Priorities	N/A
SUB-GROUPS	
Where applicable	N/A
PROMPTS	
Relevant External Reports	N/A

FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE

strategy and associated strategies and plans, and monitor their implementation

TP

re there is a significant impact on the workforce

TBC					Relevant Director	Approval
Annually					DWOD	Approval
Quarterly					Relevant Director	Assurance

ence, performance appraisal reviews, statutory and mandatory training, incidents of violence and agg

Annually					EDSPP	Approval
Annually					DWOD	Approval
Quarterly					EDSPP	Assurance
Quarterly					DWOD	Assurance
Quarterly					DWOD	Assurance
Bi-annually					DWOD	Assurance

ess of arrangements in place to support and protect the mental, physical and financial wellbeing of st

TBC					DWOD	TBC
Annually					DWOD	Assurance

nt limited to health and safety; equality, diversity and inclusion; relevant Health and Care Standards r

Quarterly					EDQN	Assurance
Annually					EDQN & DP	Assurance
Anually					DWOD	Assurance
TBC					TBC	TBC

effectiveness of mechanisms used for measuring and for hearing and acting upon their experience

Quarterly					DWOD	Discussion
Quarterly					DWOD	Assurance
Annually					DWOD	Assurance
Bi-annually					DWOD	Assurance

ce, and that those processes allow any such concerns to be investigated proportionately and independ

TBC					TBC	Assurance
-----	--	--	--	--	-----	-----------

and inclusion strategic plan and monitor its implementation; champion and support the plan and the

TBC					DWOD	Assurance
-----	--	--	--	--	------	-----------

st the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted v

Bi-annually					BS	Assurance
Annually					BS	Endorsement

Trust's behaviours, ensuring a continued journey of positive culture change

TBC					DWOD	Assurance
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mmittee, including but not limited to trade unions, external organisations and staff communications

Quarterly					DWOD	Information
Bi-annually					DPE	Assurance
Ad Hoc					DPE	Review

Plans and recruitment strategies

TBC					DWOD	Endorse
TBC					DWOD	Endorse

ppment and succession planning arrangements

Annually					DWOD	Endorse
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force; approve workforce policies and monitor compliance

Annually					BS	Assurance
Ad Hoc					Various	Approval

for their remit are presented and Committee is assured on progress and ratings; Audit Recommendations

Quarterly					BS	Assurance
Quarterly					BS	Assurance
Quarterly					BS	Assurance
Ad Hoc					BS/DWOD	Assurance

ibilities

Quarterly					EDO	Information
Annually					BS	Approval
Annually					BS	Approval
Annually					BS	Approval
Quarterly					BS	Review
Quarterly					BS	Review
Ad Hoc					N/A	N/A
Ad Hoc					Various	Assurance

COMMENT

Cycled for each meeting Ad hoc; not regularly cycled; prompt for agenda setting

To include plans on people, culture, health and safety, volunteers, leadership and training, EDI etc
Proposed people and culture elements of IMTP to PCC for review ahead of full IMTP review by F&P and
F&P monitor delivery of strategy via IMTP. Exception reports to PCC by Director or by F&P request where
gression, disciplinarys and suspensions, turnover and recruitment; enabling deep dives to take place into

To review and agree the Board level metrics for the coming year
To review and agree the Committee level metrics for the coming year
Includes balanced scorecard of all Board level metrics
TBC in what format(s) and report(s) this will be presented
Closed session

Staff

Health and Wellbeing Group will recommence in Q3. They will review these elements and propose assurance r

requirements; and that professional standards of registration and revalidation are maintained

See attached cycle notes
Report from EDQN and DP confirming revalidation of registered staff

Staff stories to be topical to the main issues where possible
Closing of the loop from themes/issues raised in staff stories. Letter to staff.

Bi-annual report of themes on exit interviews.

ently and that the learning from such concerns is considered and applied

Raising Concerns Task and Finish Group developing framework and will propose assurance reporting

work of the EDI networks

EDI Steering Group will review the elements of PCC TORs and propose assurance reporting

within the Trust

Note the WL framework will be in IMTP from 23/24
Must be on website in September. Goes to Board thereafter in September.

WASPT is established as an advisory forum. It is proposed that it provides a report to PCC.

Review partnership agreements with unions; other partnering agreements (armed services covenant;

Committee reviews tactical workforce plan, capacity & demand reviews; review strategic workforce plans

Integrated into IMTP for monitoring. Appropriate KPIs for PCC to monitor to be proposed in MIQPR or

Annual report to illustrate the policies within the remit of the committee are in date and there is full policy Board to approve Raising Concerns and H&S policy (SoRD para 17)

ation Trackers monitored

TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in May and Board June

TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in May and Board June

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Review against cycle progress at each meeting

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No sub-committees for PCC, however may set up task and finish groups from time to time

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reporting to PCC

Health and Safety

Learning and improvement

Revalidation

Gender paygap report

Staff story updates

Leadership and management develop.

Staff survey

Culture and behaviours

Working in Partnership

See paper from PCC on 10 May 22 meeting which provides intro.

Working Safely Programme framework aligns the Trust to a Health and Safety Management System, 11 core health and safety principles developed by Heads of H&S within the NHS Wales in 2015. The programme is reflective of ISO45001. Enforcement agencies will use a wider range of evidence beyond ISO45001 but the HSE is of the view the framework enables the Trust to attain the minimum requirements prescribed in law.

Assurance that the health and safety management systems are effective in attaining legal compliance as well as principally improving health, safety and wellbeing through:

- Provision of activity-based risk assessment against high risk activities (identified through a new hazard register)
- Legislative compliance (through a new legislative register)
- Legal compliance against RIDDOR (including learning from incidents and time to submission - legal requirement)
- Training compliance
- Scrutiny of themes and trends in accidents and injury, particularly where a recurring theme is identified (V&A, slips, trips and falls, etc)
- Assurance that the health and safety management structure is reaching the desired objectives i.e. legislative

See paper from 10 May 22 meeting on 'learning from cases' related to a review into investigations and how to do things differently for alignment to a just culture.

Demonstrates that learning comes from such reviews.

How cyclical are these

RNC every 3 years; HCPC every 2 years; GMC every 3 years

Review legislative requirements; expanding this with Keithley to include equal pay

Advisory Internal Audit on learning organisation - 3.1 'We recommend that staff stories are evaluated to identify and deliver actions to address the issues they raise. Agreed to be completed by person curating story. To be on Advisory Internal Audit proposed a refresh of the strategy

Staff survey goes out [Sept?] and reports end [March]. Sent action plan to P&C in [insert] and Board in [insert].

February 22 paper on roll-out of refreshed behaviours and culture reset action plan

Standing Orders 6.0.4 says 'the Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partners responsibilities. It must ensure timely action to change,



AGENDA ITEM No	13.2
OPEN or CLOSED	Open
No of APPENDIX ATTACHED	0

Committee Priorities 2022/23

MEETING	People and Culture Committee
DATE	5 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2022/23.
2. Progress is steady across priorities 1 and 2, however the Committee may wish to discuss whether focused assurance against priority 3 – ‘supporting the implementation and championing the strategic equality objectives, including Welsh language, to promote an inclusive organisation’ is required for the next meeting.

RECOMMENDATION

3. The Committee is asked to note the update and discuss whether further focus is required for priority 3.

KEY ISSUES/IMPLICATIONS

Set out above

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

None

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Yes	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

COMMITTEE PRIORITIES FOR 2022/23

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2022/23.

BACKGROUND

5. During the course of the 2021/22 effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year.
6. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2022 and will be tracked quarterly.

ASSESSMENT

7. The Committee priorities, and progress against them is as follows:

Priority	Progress
1. Monitor and support the actions to reduce absences due to sickness, gaining an understanding of the reasons for long standing high sickness rates to inform future learning.	<ul style="list-style-type: none">• The May and September 2022 meetings received and scrutinised the absence management action plan.• Risk 160 'high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service' is reviewed at each meeting. The September meeting included further detail on the new form BAF.
2. Focus on the health and safety remit which is newly acquired by the Committee.	<ul style="list-style-type: none">• The May 2022 meeting included a detailed paper on the health and safety assurance reporting that will be received by the Committee.• Health and safety assurance reporting included in the cycles of business.• The Board received IOSH training in July 2022.
3. Supporting the implementation and championing the strategic equality objectives, including Welsh language, to promote an inclusive organisation.	<ul style="list-style-type: none">• The Welsh Language Advisory Group report was received in May 2022 indicating standards compliance.• The Welsh Language Annual Report was reviewed in September 2022.• The Equality, Diversity and Inclusion Steering Group are developing a proposal for assurance reporting to the Committee for inclusion in the cycles of business.• EDI metrics and information being developed for the MIQPR.

RECOMMENDATION

8. The Committee is asked to note the update and discuss whether further focus is required for priority 3.



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AGENDA ITEM No	14
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

WELSH LANGUAGE STANDARDS ANNUAL REPORT 2021-22

MEETING	People and Culture Committee
DATE	5 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Melfyn Hughes, Welsh Language Services Manager
CONTACT	Melfyn Hughes Melfyn.Hughes@wales.nhs.uk

EXECUTIVE SUMMARY

1. On 30 May 2019 the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing new Welsh Language Standards under the Welsh Language Measure (Wales) 2011.
2. The Trust needs to demonstrate how it fulfils its obligations under the Welsh Language Measure (Wales) 2011 through implementing the Welsh Language Standards via its Statutory Compliance Notice. (click [here](#) to view notice). The annual report must be published on the Trust's website during September 2022.
3. The annual report is an opportunity for the organisation's to publish its own evaluation of how it has promoted and facilitated opportunities to use the Welsh language and ensure that the Welsh language is not treated less favourably than the English language.

RECOMMENDATION

4. That the Committee note and endorse the annual report.

KEY ISSUES/IMPLICATIONS

5. The 111 service has seen a sharp increase in Welsh language demand due mainly to the last two Health Boards integrating into 111 Wales. Despite answering more calls in Welsh as a result of this, the percentage of calls dropped by 24.3% compared to 2020/21.
6. There has been a steady drop over the past 3 years in the compliance on the number of staff recording their Welsh Language Skills on ESR.
7. In order to meet the increasing demand and cost for translation and to provide a well-rounded and more strategic outlook a centralised translation service is being developed.

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Welsh Language Advisory Group	8 July 2022	For comments and feedback
Assistant Directors Leadership Team	8 August 2022	For comments and feedback
Executive Management Team	17 August 2022	Approval for People and Culture Committee meeting 5 th September 2022
People and Culture Committee	5 September 2022	Note and endorse

REPORT APPENDICES

Annex 1: Welsh Language Standards Annual Report 2021 - 2022

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Yes	Financial Implications	Not applicable
Environmental/Sustainability	Not applicable	Legal Implications	Yes
Estate	Not applicable	Patient Safety/Safeguarding	Yes

Ethical Matters	Not applicable	Risks (Inc. Reputational)	Yes
Health Improvement	Not applicable	Socio Economic Duty	Not applicable
Health and Safety	Not applicable	TU Partner Consultation	Not applicable

SITUATION

1. On 30 May 2019 the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing new Welsh Language Standards under the Welsh Language Measure (Wales) 2011. As a result, the Trust has started to implement actions for compliance with its [Statutory Compliance Notice](#) from the Welsh Language Commissioner.
2. The Trust needs to demonstrate how it fulfils its obligations under the Welsh Language Measure (Wales) 2011 through implementing the Welsh Language Standards. This is the Trust's first Annual Monitoring Report that focuses on our delivery in relation to the Welsh Language Standards.
3. The annual report is an opportunity for the organisation's to publish its own evaluation of how it has promoted and facilitated opportunities to use the Welsh language and ensure that the Welsh language is not treated less favourably than the English language.

BACKGROUND

4. The Compliance Notice indicates specific timescales for compliance against each standard. The Welsh Language (Wales) Measure 2011 creates a system for setting duties on organisations in the form of Welsh Language Standards. These duties apply to delivering services in Welsh, considering the impact of policy decisions on the Welsh language and promotion of the Welsh language.
5. The combined effect of the Compliance Notice and standards is that greater compliance will be required by all Trust services and unless addressed it will leave the Trust at considerable risk of incurring civil penalties which may be up to £5,000 per breach.

ASSESSMENT

6. Delivering care through the language of choice is a matter of clinical need for some and a matter of good practice for all who wish to receive services through the medium of Welsh.
7. The standards are categorised as follows:
 - A **service delivery standard** will be a type of duty imposed to promote or facilitate the use of the Welsh language or to ensure that the Welsh language is treated no less favourably than English when persons that are subject to the standard deliver services to others, or when they deal with others in connection with the delivery of those services.
 - A **policy making standard** will be a type of duty which will require persons to consider the effect of their policy decisions upon opportunities for other

persons to use the Welsh language, or upon treating the Welsh language no less favourably than English.

- An **operational standard** will be a type of duty imposed to promote and facilitate the use of the Welsh language in relation to the carrying out by a person of their functions, business or other undertaking.
- A **record keeping standard** will be a duty imposed in respect of keeping and maintaining details regarding compliance with the other four standards as well as any other complaints concerning the language.
- **Supplementary Standards** deal with various matters including the production of an annual report, monitoring arrangements and the provision of information to the Commissioner

8. 111 Service

The 111 service has seen a sharp increase in Welsh language demand. This is mainly due to the last two Health Boards integrating into 111 Wales.

NHS Wales 111 Service Welsh Language Calls 2021- 2022

Welsh Language Demand	Total Answered Calls for 111	Welsh Calls Offered	Total calls answered in Welsh	% of Calls answered
01/04/21 – 31/04/22	680 161	15341	6949	45%
01/04/20 – 31/04/21	580 457	5436	3788	69.7%

111 answered 3161 more calls in Welsh during the 2021/22 financial year than the previous year (2020/21). This equated to answering 82% more calls in Welsh than the previous year. However, there is a drop in the actual percentage rate of 24.3% in Welsh calls answered compared to calls answered from the previous year.

9. The improvements targeted to improving this in 2022/23 are set out in the Annual Report.

10. Recording staff Welsh Language Skills on ESR

Steady drop over the past 3 years in the compliance on the number of staff recording their Welsh Language Skills on ESR:

2019/20: 96.27%
 2020/21: 91.32%
2021/22: 87.23%

WOD believe that an issue may lie with the links between trac and ESR with trac not being able to record anyone with '0 – No skills' in ESR. WOD have raised issue with Shared Services.

In order to carry out a reliable mapping exercise of the Trust's Welsh language skills capacity this needs to be 100%.

The Workforce Systems Assistant has created a link to a form to capture any missing competence information. A monthly report will be run to check which members of staff are missing any of the competencies. An email will then be sent them with the link to the form, asking them to fill it in with a deadline of a month's time.

11. Centralisation of translation service

In order to meet the increasing demand and cost for translation and to provide a well-rounded and more strategic outlook, a case has been prepared for the Trust to have a centralise translation service that would provide value for money, quality and speed of service to the Trust.

12. RECOMMENDATION:

That the Committee note and endorse the annual report.



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GWASANAETHAU AMBIWLANS CYMRU**

**ADRODDIAD BLYNYDDOL
SAFONAU'R GYMRAEG
2021-2022**

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Rhagair

Croeso!

Fel Cadeirydd a Phrif Weithredwr Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru, mae'n bleser gennym gyflwyno ein trydydd adroddiad ar weithredu Safonau'r Gymraeg.

"Mae Mesur y Gymraeg (Cymru) 2011 yn nodi fframwaith cyfreithiol sy'n gosod dyletswydd ar Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru, ymhlith sefydliadau cyhoeddus eraill, i gydymffurfio â'r Safonau sy'n ymwneud â'r Gymraeg. Mae'r Ymddiriedolaeth wedi ymateb yn gadarnhaol i Safonau'r Gymraeg gan ei bod yn rhoi cyfle i atgyfnerthu'r gofynion ac i wella ansawdd ac argaeledd ein gwasanaethau drwy gyfrwng y Gymraeg.

Mae ymrwymiad clir gan y Bwrdd i weithredu'r Safonau yn 2021/22. Rydym wedi parhau i godi ymwybyddiaeth o ofynion y Safonau drwy gynnwys gofynion y Gymraeg mewn sesiynau sefydlu staff ynghyd â hyrwyddo'r modiwl ar-lein 'Croeso Cymraeg Gwaith' sydd wedi bod yn allweddol i gefnogi staff sydd ar ddechrau eu taith i ddysgu Cymraeg. Yn ogystal, mae cyfrifon cyfryngau cymdeithasol Cymraeg ar gyfer Facebook a Twitter wedi'u sefydlu i wella ein cyfathrebu â'r cyhoedd sy'n siarad Cymraeg.

Yn ogystal â'r ffurflen asesu recriwtio iaith Gymraeg newydd a gyflwynwyd i'r holl reolwyr i'w chwblhau cyn i swyddi gael eu hysbysebu, rydym wedi cyflwyno siart llif canllawiau/proses i gynorthwyo rheolwyr i baratoi hysbysebion cyn i unrhyw swydd gael ei hysbysebu. Mae'r broses yn rhoi manylion am wasanaethau cyfieithu yn ogystal â rhywfaint o eiriad hysbysebu safonol a disgrifiadau swyddi i gynorthwyo rheolwyr.

Mae'r adroddiad hwn yn nodi ein cydymffurfiaeth â'r Safonau'r Gymraeg ar gyfer y cyfnod adrodd rhwng 1 Ebrill 2021 a 31 Mawrth 2022. Rydym yn cydnabod ein bod wedi gwneud cynnydd ond bod angen gwelliannau o hyd er mwyn gwella'r ddarpariaeth o'n gwasanaethau Cymraeg. Er mwyn cyflawni'r gwelliannau hyn, mae'r Ymddiriedolaeth wedi bod yn gweithio'n agos gyda'r Comisiynydd Iaith i sefydlu atebion sy'n diwallu ein hangen gweithredol yn ogystal â sicrhau hawliau siaradwyr Cymraeg.



Martin Woodford
Cadeirydd



Jason Killens
Prif Weithredwr

1. Cyflwyniad

Dyma drydydd adroddiad blynyddol gwaith Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru sy'n arddangos sut mae Safonau'r Iaith wedi cael eu gweithredu.

Ar 30 Mai 2019, symudodd yr Ymddiriedolaeth o weithredu ei Chynllun Iaith Gymraeg o dan Ddeddf yr Iaith Gymraeg 1993 i weithredu Safonau'r Gymraeg fel rhan o Fesur y Gymraeg (Cymru) 2011.

Mae'r Ymddiriedolaeth wedi ymateb yn gadarnhaol i Safonau'r Gymraeg gan ei bod yn rhoi cyfle i atgyfnerthu a gwella ansawdd ac argaeledd ei gwasanaethau drwy gyfrwng y Gymraeg. Datblygwyd canllawiau ychwanegol ar sut i gydymffurfio â'r Safonau ac maent ar gael i staff ar dudalen fewnrwyd newydd Safonau'r Gymraeg.

2. Amdanom ni

Rydym yn dîm o dros 4,000 o bobl sy'n gwasanaethu 3.1 miliwn o bobl yng Nghymru, ynghyd â chefnogaeth amhrisiadwy Ymatebwyr Cyntaf yn y Gymuned, a Gyrwyr Ceir Gwirfoddol sy'n cludo cleifion o'u cartrefi i apwyntiadau ysbyty ac yn ôl.

Rydym yn rhoi cyngor, cymorth a chyfeirio ein defnyddwyr gwasanaeth i'r gwasanaethau cywir i filoedd o gleifion bob blwyddyn drwy ein gwasanaethau ymgynghori. Mae hyn yn cynnwys Gwasanaeth 111 sy'n gyfuniad o Galw Iechyd Cymru (gwasanaeth cyngor a gwybodaeth iechyd 24 awr i'r cyhoedd), ac elfennau trin galwadau rheng flaen, elfennau brysbennu clinigol y gwasanaethau meddygon teulu y tu allan i oriau a'n Desg Glinigol. Rydym yn cludo cannoedd o filoedd o gleifion i fannau gofal, neu i'w cartref bob blwyddyn drwy ein Gwasanaeth Cludo Cleifion Di-frys (NEPTS).

Mae ein derbynwyr galwadau a staff y ganolfan gyswllt clinigol yn delio â mwy na hanner miliwn o alwadau bob blwyddyn, 24/7 a 365 diwrnod y flwyddyn. Rydym ar y rheng flaen o ran darparu gwasanaethau, gan sicrhau bod cleifion yn cael y cyngor a'r cymorth cywir.

3. Cefndir y Safonau Iaith

O dan Fesur y Gymraeg (Cymru) 2011, mae'n ofynnol i bob sefydliad gwasanaeth cyhoeddus yng Nghymru gydymffurfio â dyletswyddau iaith, sy'n sicrhau nad yw'r Gymraeg yn cael ei thrin yn llai ffafriol na'r Saesneg. Mae'r dyletswyddau'n annog hyrwyddo'r Gymraeg, defnyddio'r Gymraeg o fewn gweinyddiaeth fewnol ac yn ei gwneud yn ofynnol i ddarpariaeth gael ei gwneud ar gyfer hygyrchedd y Gymraeg i'r cyhoedd.

Mae adran 44 o Fesur 2011 yn caniatáu i Gomisiynydd y Gymraeg gyhoeddi hysbysiad Cydymffurfio, sy'n ei gwneud yn ofynnol i gorff gydymffurfio ag un neu ragor o safonau sy'n benodol gymwys iddo. Yna cyflwynwyd Rheoliadau Safonau'r Gymraeg (Rhif 7) 2018 i sefydliadu iechyd yng Nghymru.

Yn unol ag adran 44 o fesur 2011, diben Safonau'r Gymraeg yw darparu:

- Eglurder i sefydliadau ar y Gymraeg
- Eglurder i siaradwyr Cymraeg ynghylch pa wasanaethau y gallant ddisgwyl eu derbyn yn Gymraeg.
- Mwy o gysondeb mewn gwasanaethau Cymraeg a gwella ansawdd i ddefnyddwyr

4. Atebolrwydd a Chefnogaeth

Arweinwyr a Hyrwyddwyr y Gymraeg

Ochr yn ochr â Rheolwr Gwasanaethau'r Gymraeg yr Ymddiriedolaeth, mae Ysgrifennydd Bwrdd yr Ymddiriedolaeth sy'n arweinydd gweithredol dros y Gymraeg. Mae gan Fwrdd yr Ymddiriedolaeth Gyfarwyddwr Anweithredol sy'n Hyrwyddwr yr Iaith Gymraeg.

Grŵp Cynghori'r Gymraeg

Mae Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru wedi sefydlu Grŵp Cynghori ar y Gymraeg. Mae'r Grŵp hwn yn darparu mecanwaith ar gyfer adolygu pob agwedd ar Safonau'r Gymraeg ac i sicrhau bod gwasanaeth boddhaol yn cael ei gynnal ar gyfer pob claf ac aelod o'r cyhoedd sy'n defnyddio gwasanaethau'r Ymddiriedolaeth.

Tîm Arweinyddiaeth Cyfarwyddwyr Cynorthwyol

Mae'r Tîm Arweinyddiaeth Cyfarwyddwyr Cynorthwyol yr Ymddiriedolaeth yn gyfrifol am gefnogi'r Tîm Rheoli Gweithredol yr Ymddiriedolaeth ar ddatblygu a chyflawni cynlluniau ac amcanion strategol, targedau ariannol a chydymffurfio â gofynion safonau ac arferion deddfwriaeth. Datblygwyd Traciwr Cydymffurfio â'r Safonau'r Gymraeg ac fe'i hadolygir bob chwarter.

Y Pwyllgor Pobl a Diwylliant

Mae'r Pwyllgor Pobl a Diwylliant yr Ymddiriedolaeth yn rhoi sicrwydd i'r Bwrdd o'i drefniadau arwain ac yn monitro gallur Ymddiriedolaeth i gyflawni ei chyfrifoldebau statudol mewn perthynas â Safonau'r Gymraeg, Iechyd, Diogelwch a Lles, Cydraddoldeb ac amrywiaeth, a gofynion perthnasol y Safonau Gofal Iechyd.

Bwrdd yr Ymddiriedolaeth

Rhan olaf llwybr llywodraethu Adroddiad Blynyddol Safonau'r Gymraeg yr Ymddiriedolaeth yn dilyn y llwybr cymeradwyo'r adroddiad drwy'r Grŵp Cynghori'r Gymraeg, Tîm Arweinyddiaeth Cyfarwyddwyr Cynorthwyol, Tîm Rheoli Gweithredol a'r drwy'r Pwyllgor Pobl a Diwylliant fydd i Bwrdd yr

Ymddiriedolaeth i'w adolygu a thrafod y cynnydd a wnaed o ran cydymffurfio â'r Safonau.

Gweithdrefn Gwyno

Mae'r pryderon a dderbyniwyd ynglŷn â chydymffurfio â Safonau Iaith yr Ymddiriedolaeth, yn cael sylw o dan y Rheoliadau Gweithio i Wella.

Os oes gan y cyhoedd bryder ynglŷn â phrofiad diweddar o ddefnyddio gwasanaethau'r Ymddiriedolaeth, gallant dderbyn a chofrestru eu pryder drwy: e-bostio'r Tîm Pryderon: Amb_PuttingThingsRight@wales.nhs.uk neu drwy lenwi ffurflen ar-lein: [Ffurflen Gyflwyno Pryderon Ar-lein](#)

5. Cydymffurfio â'r Safonau Cyflenwi Gwasanaethau (Safonau 1 – 77)

Mae'r set hon o Safonau yn nodi sut y mae'n ofynnol i'r Ymddiriedolaeth ddefnyddio'r Gymraeg mewn gwahanol sefyllfaoedd er mwyn i siaradwyr Cymraeg gael mynediad di-rwystr i wasanaethau Cymraeg; er enghraifft, wrth anfon gohebiaeth, delio â galwadau ffôn, darparu gwasanaethau ar-lein neu wyneb yn wyneb.

Gohebiaeth (Safonau 1 – 7)

Mae'r Ymddiriedolaeth wedi defnyddio dull cyson o ran defnyddio llofnodion e-byst a phapur pennawd ac mae'n ofynnol i'r holl staff ddefnyddio papur pennawd dwyieithog yr Ymddiriedolaeth. Rydym hefyd wedi mynd ati i annog yr holl staff i gynnwys neges ar lofnodion e-bost gan nodi bod yr unigolyn yn 'croesawu gohebiaeth yn Gymraeg neu Saesneg'.

Galwadau Ffôn (Safonau 8 – 20)

Nid yw Safonau'r Gymraeg fel y gosodwyd ar yr Ymddiriedolaeth yn gosod unrhyw ofyniad cyfreithiol i ateb galwadau 999 yn Gymraeg.

Ar gyfer galwadau eraill bydd staff yn rhoi cyfarchiad dwyieithog wrth ateb y ffôn a phan fydd yr Ymddiriedolaeth yn sefydlu cyswllt dros y ffôn â defnyddiwr gwasanaeth am y tro cyntaf, gofynnir i'r defnyddiwr gwasanaeth a fyddai'n well ganddynt dderbyn galwadau gan yr Ymddiriedolaeth yn Gymraeg neu yn Saesneg yn y dyfodol. Caiff y dewis iaith hwnnw ei nodi a'i barchu. Mae galwadau i Gwasanaeth 111 a NEPTS yn cynnig dewis iaith i alwyr.

Adolygiad o Wasanaeth 111

Yn ystod y flwyddyn ddiwethaf mae Gwasanaeth 111 wedi gweld heriau sylweddol o ran cynnydd yn y galw yn y gwasanaeth yn ogystal â chynnydd yn nifer absenoldeb

staff o ganlyniad y pandemig. Mae hyn wedi cael effaith ar berfformiad y gwasanaeth i ateb galwadau Cymraeg a Saesneg.

Yn ogystal â hynny, mae'r gwasanaeth wedi gweld cynnydd mawr yn y galw am y Gymraeg. Mae hyn yn bennaf o ganlyniad i'r ddau Fwrdd Iechyd olaf integreiddio i 111 Cymru.

Mae'r table isod yn dangos data Galwadau Cymraeg Gwasanaeth 111 GIG Cymru 2021- 2022:

Cyfnod Amser	Cyfanswm o alwadau a atebwyd ar gyfer gwasanaeth 111	Galwadau Cymraeg a gynigwyd	Cyfanswm y galwadau a atebwyd yn Gymraeg	% y galwadau a atebwyd
01/04/21 – 31/04/22	680,161	15,341	6,949	45%
01/04/20 – 31/04/21	580,457	5,436	3,788	69.7%

Ym Mis Mehefin 2021 unodd Bwrdd Iechyd Prifysgol Betsi Cadwaladr gyda Gwasanaeth 111 ac ym mis Mawrth 2022 unodd Fwrdd Iechyd Prifysgol Caerdydd a'r Fro. Dyma ddau o fyrddau iechyd mwyaf Cymru sydd â'r canran uchaf o siaradwyr Cymraeg ymlith poblogaeth Cymru. Bu cynnydd o 9,905 am alwadau Cymraeg a'r flwyddyn flaenorol 2020/21. Mae hyn yn cyfateb i gynnydd o 182% yng ngalwadau Cymraeg i Wasanaeth 111.

Atebodd Gwasanaeth 111 3,161 mwy o alwadau yn y Gymraeg yn ystod blwyddyn ariannol 2021/22 na'r flwyddyn flaenorol (2020/21). Roedd hyn yn gyfystyr ag ateb 82% fwy o alwadau yn Gymraeg na'r flwyddyn flaenorol (2020/21). Er hynny mae cwmpwng yng nghyfradd y canran o 24.3% yn nifer y galwadau Cymraeg gafodd eu hateb o'i gymharu â galwadau gafodd eu hateb o'r flwyddyn flaenorol (2020/21).

Mae'n deg dweud bod y gwasanaeth wedi gweld pwysau sylweddol a pharhaus yn ystod y cyfnod hwn gyda chynnydd sylweddol yn y galw am alwadau / absenoldeb staff oherwydd y pandemig a ddylanwadodd ar y gyfradd ateb gyffredinol ar gyfer pob galwad i 111. Yn ystod y flwyddyn ddiwethaf yn dilyn integreiddio'r gwasanaeth i ddau Fwrdd Iechyd newydd mewn cyfnod byr iawn, bu ymgyrchoedd recriwtio ar gyfer cefnogi'r galw ychwanegol.

Gwelliannau i Wasanaeth 111 sy'n ymwneud â'r Gymraeg 2021-2022 (mae'r rhain yn ychwanegol at y broses sefydledig)

1. Ym mis Tachwedd 2021 cyflwynodd y Gwasanaeth 111 gyfleuster Recordydd Llais Rhyngweithiol newydd. Y Recordydd Llais Rhyngweithiol yw'r negeseuon a'r opsiynau y bydd galwyr yn gwrando arnynt ac yna'n eu dewis wrth ffonio 111 Cymru. Mae'r Recordydd Llais Rhyngweithiol newydd hwn yn cael ei gynnig yn Gymraeg a Saesneg.
2. Mae'r Recordydd Llais Rhyngweithiol Cymraeg newydd wedi'i wella ymhellach gyda sgrïptiau sydd wedi'u dilysu gan gyfieithydd Cymraeg.

3. Mae gwaith pellach yn mynd rhagddo o fewn y Recordydd Llais Rhyngweithiol i gynnig opsiwn cyfleuster testun dwyieithog a fydd yn cyfeirio galwyr at wefan 111.
4. Datblygiad arwyddocaol sydd wedi helpu staff i adnabod galwadau Cymraeg yn y system yw'r cyfleuster rhagrybudd. Bydd y sawl sy'n trin yr alwad yn derbyn neges yn eu clustffonau ychydig eiliadau cyn i'r alwad chael ei chyflwyno, yn cyhoeddi i'r derbynnydd galwadau pa opsiwn mae'r galwr wedi'i ddewis o fewn y Recordydd Llais Rhyngweithiol. E.e., "Deintyddol Cymraeg" neu "Galwad sydd eisoes yn bodoli", ac ati. Mae hyn wedi gwella ein perfformiad ar gyfer ateb galwadau Cymraeg.
5. Datblygwyd hyfforddiant i staff drwy fidio rhyngweithiol ar sut i ddelio a galwadau Cymraeg.
6. Gyda chefnogaeth gan y Tîm Ymgysylltu â Chleifion o fewn yr Ymddiriedolaeth mae Gwasanaeth 111 yn datblygu menter sy'n cynnwys aelodau o'r cyhoedd a fydd yn gwirfoddoli i wirio safon y galwadau i Wasanaeth 111 ac i archwilio profiad defnyddwyr o ddefnyddio'r gwasanaeth. Fe fydd mynediad defnyddwyr at wasanaeth Cymraeg yn faes adolygu allweddol o fewn y fenter hon. Bydd yr adolygiad yn cael ei lansio yn ystod Hydref 2022.

Cyfarfodydd (Safonau 21 – 30)

Pan fydd yr Ymddiriedolaeth yn trefnu cyfarfod gydag aelod neu aelodau o'r cyhoedd, gofynnir i'r rhai sy'n bresennol a ydynt yn dymuno defnyddio'r Gymraeg yn y cyfarfod. Pan fydd unigolion yn mynegi awydd i ddefnyddio'r Gymraeg mewn cyfarfod, bydd yr Ymddiriedolaeth yn parchu'r dewis hwnnw. Mae gan gyfarfodydd bwrdd gyfarwyddwr anweithredol a swyddog llywodraethu sy'n siarad Cymraeg. Mae holl gyfarfodydd y Bwrdd yn fyw dros Zoom gydag opsiwn is-deitlau Cymraeg (ac ieithoedd eraill).

Digwyddiadau Cyhoeddus (Safonau 31 – 32)

O ran y gwasanaethau wyneb yn wyneb a gynigir yn y digwyddiad, bydd gwahoddiad neu hysbyseb y digwyddiad yn gofyn i bersonau roi gwybod i ni os ydynt am ddefnyddio'r Gymraeg. Does dim gofyniad i ddarparu gwasanaeth cyfieithu os nad oes neb wedi rhoi gwybod i'r trefnydd eu bod am ddefnyddio'r Gymraeg yn y digwyddiad.

Dogfennau a Ffurflenni (Safonau 36 - 38)

Mae unrhyw ffurflen sydd i'w llenwi gan aelodau o'r cyhoedd ar gael yn Gymraeg. Mae dogfennau a gynhyrchir gan yr Ymddiriedolaeth ar gyfer y cyhoedd ar gael yn Gymraeg os yw pwnc y ddogfen yn awgrymu y dylid ei chynhyrchu yn Gymraeg, neu os yw'r gynulleidfa ddisgwyliedig, a'u disgwyliadau, yn awgrymu y dylid cynhyrchu'r ddogfen yn Gymraeg. Os oes angen fersiynau Cymraeg ar wahân, bydd y fersiwn Saesneg yn nodi bod y ddogfen neu'r ffurflen hefyd ar gael yn Gymraeg.

Deunydd Hysbysebu a Chyhoeddusrwydd (Safonau 33 – 34)

Mae'r Gwasanaeth Cludiant Cleifion Di-frys yn cludo cleifion sy'n gymwys yn feddygol o bob rhan o Gymru i'w apwyntiadau meddygol mewn clinigau ac ysbytai. Er mwyn i gleifion wirio a ydynt yn bodloni maeni prawf ar sail eu hangen meddygol cynhyrchwyd y poster a'r daflen wybodaeth ganlynol sydd wedi eu dosbarthu ledled Cymru mewn meddygfeydd, ysbytai a chyfleusterau meddygol.

Gwasanaeth Cludiant Cleifion Di-frys

Gallech fod yn gymwys i gael cludiant i apwyntiadau ysbyty

Mae'r Gwasanaeth Cludo Cleifion mewn achosion nad ydynt yn hysbys yn cludo cleifion o bob cwr o Gymru nad ydynt yn gallu am resymau meddygol, i wneud eu ffordd eu hunain i mewn ac allan o'u hapwyntiadau ysbyty. Os nad ydych chi'n gymwys, gallwch roi gwybodi i chi am ddiwlau trafnidiaeth amgen sy'n fwy addas i'ch anghenion.

I gael rhagor o wybodaeth a gweld a ydych chi'n gymwys, ewch i www.ambulance.wales.nhs.uk neu ffonwch **0300 123 2303**

Gallech fod yn gymwys i gael cludiant i apwyntiadau ysbyty

Mae'r Gwasanaeth Cludiant Cleifion Di-frys yn mynd â chleifion sy'n gymwys yn feddygol o bob rhan o Gymru i ac o'u hapwyntiadau meddygol mewn clinigau ac ysbytai. Mae hyn yn cynnwys:

- Apwyntiadau cleifion allanol;
- Triniaeth dialysis ac oncleg;
- Canolfannau ddydd a chlinigau psycho-geriatric;
- Derbyniadau a gynllunir i'w rhyddhau, gan gymwys trosglwyddo rhwng ysbytai.

Dim ond i gleifion sy'n bodloni meiri prawf cymhwysedd ar sail eu hangenion meddygol y mae'r gwasanaeth hwn ar gael.

Os nad ydych chi'n bodloni'r meiri prawf cymhwysedd, gallwch roi gwybodi i chi am ddiwlau teithio amgen, sy'n fwyaf addas i'ch anghenion er mwyn eich galluogi i wneud eich ffordd eich hun ar gyfer eich apwyntiad.

Gallech fod yn gymwys i gael cludiant i apwyntiadau ysbyty

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Ydych chi neu rywun rydych yn ei adnabod yn cael trafferth teithio i apwyntiadau ysbyty?

Os ydych chi neu nhw fod yn gymwys i gael help gyda cludiant.

Mae'r Gwasanaeth Cludiant Cleifion Di-frys yn mynd â chleifion sy'n gymwys yn feddygol o bob rhan o Gymru i ac o'u hapwyntiadau meddygol mewn clinigau ac ysbytai. Mae hyn yn cynnwys:

- Apwyntiadau cleifion allanol;
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- Derbyniadau a gynllunir i'w rhyddhau, gan gymwys trosglwyddo rhwng ysbytai.

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Os nad ydych chi'n bodloni'r meiri prawf cymhwysedd, gallwch roi gwybodi i chi am ddiwlau teithio amgen, sy'n fwyaf addas i'ch anghenion er mwyn eich galluogi i wneud eich ffordd eich hun ar gyfer eich apwyntiad.

Gallech fod yn gymwys i gael cludiant i'r ysbyty os:

- eich bod yn cael dialysis neu driniaeth canser yn rheolaidd;
- angen strelsar ar gyfer y daith;
- Mae angen osgion amoch ar gyfer y daith;
- Mae angen i chi deithio yn eich cadar olwyn eich hun;
- Nad ydych chi'n gallu cerdded heb gymorth parhaus;
- Yn methu â defnyddio trafnidiaeth gyhoeddus oherwydd bod gennych gyflwr meddygol a fyddai'n perylgu eich urddas;
- Mae gennych anawsterau cyfarrebu difrifol neu;
- Byddwch yn profi sgliffethiau o ganlyniad i'r driniaeth neu eich cyflwr.

Os erodech y gallech fod yn gymwys, ffonwch ein llinell archebu ar 81 i chi dderbyn eich llythyr apwyntiad ysbyty ar **0300 123 2303**

Canslo Trafnidiaeth

Mae hyd at 100,000 o swmresau Cludo Cleifion Di-frys bob blwyddyn lle nad yw'r claf yn teithio neu ddim ar gael pan gyrraeddodd em oriau i'w casglu. Mae canslo cludiant os nad oes ei angen bellach yn bwysg iawn ac yn canatáu i ni gymryd y gwasanaeth i giat arall. Os oes angen i chi ganslo archeb ffonwch ni ar **0300 123 2303** i roi gwybodi i ni neu ewch i'r gwefan.

I gael gwybod mwy am sut mae'r gwasanaeth yn gweithio, ac os ydych chi'n gymwys am ein cludiant neu am ba gymorth arall y gallech fod â hawli iddo ewch i

www.ambulance.wales.nhs.uk

Gwefannau a Gwasanaethau ar-lein

Mae'r Ymddiriedolaeth yn gweithredu dwy wefan, sef gwefan [Corfforaethol](http://www.corfforaethol.nhs.uk) sydd wedi ailddatblygu gyda chyfleuster i newid rhwng y ddwy iaith a gwefan Galw lechyd Cymru a ailfrandiwyd ym mis Mai 2020 i GIG 111 Cymru www.111.wales.nhs.uk.

GIG 111 Cymru **37 (32)** gwirwyr symptomau dwyieithog ar-lein sy'n rhoi cymorth a chyngor i'r cyhoedd ar sut y gallant reoli eu symptomau.

NHS 111 Wales Yn ystod y cyfnod adrodd fe dderbyniodd y wefan 4,187,031 (4,300,241) o ymweliadau gyda **33,664 (0.80%) (26,979 (0.62%))** yn ymweliadau i'r wefan Gymraeg.

Mae adrannau beichiogrwydd, teithio a COVID-19 wedi'u diweddarau ac maent ar gael yn ddwyieithog.

O lansiad gwefan newydd GIG 111 Cymru, mae GIG 111 Cymru wedi bod yn gweithredu ei gyfrifon Twitter cyfryngau cymdeithasol Cymraeg a Saesneg ei hun @GIG111Cymru gyda **81 (56)** o ddilynwyr a @NHS111Wales gyda **7,022 (6,702)** o ddilynwyr.

Cyhoeddi Apiau (Safon 44)

Ap Hwb Golau Glas



Wrth i'r pandemig barhau ac yn atal i ni ymgysylltu mewn ysgolion ac mewn lleoliadau cymunedol, roeddem am sicrhau bod gwybodaeth bwysig yn dal i gael ei rhannu gyda'n cenhedlaeth nesaf o alwyr. Ym mis Gorffennaf fe lansiodd ap gemau dwyieithog newydd, 'Hwb Golau Glas', sy'n ceisio helpu plant a phobl ifanc i ddeall beth i'w wneud mewn argyfwng mewn ffordd hwyliog a diddorol.

Wedi'i anelu at bobl ifanc 7-12 oed, mae ap Hwb Golau Glas yr Ymddiriedolaeth yn cynnwys pedair gêm sy'n dysgu defnyddwyr am yr hyn sy'n digwydd pan fyddant yn galw 999 a'r defnydd priodol o wasanaethau brys.

Cyfyngau Cymdeithasol

Mae datblygiadau wedi cynnwys sefydlu cyfrifon cyfyngau cymdeithasol Cymraeg ar gyfer Facebook a Twitter. **Gweler Atodiad 1** ar gyfer data cyfyngau cymdeithasol.

Arwyddion a Hysbysiadau (Safonau 47 - 49)

Mae arwyddion newydd ac y rhai sydd wedi'i hadnewyddu cael eu cynhyrchu'n ddwyieithog gyda'r Gymraeg yn debygol o gael ei darllen yn gyntaf. Yn ystod cyfnod adrodd cafodd arwyddion allanol a mewnol eu cynhyrchu ar gyfer gorsaf ambiwlans newydd Caerdydd.



Gwasanaethau Derbynfeydd (Safonau 50 - 53)

Mae'r modiwl ar-lein 'Croeso Cymraeg Gwaith' ar gael i staff sy'n gweithio mewn derbynfeydd er mwyn datblygu eu sgiliau Cymraeg a gallu cyfarch ymwelwyr yn ddwyieithog.

Dyfarnu Contractau (Standards 57 - 59)

Bydd gwahoddiadau i dendro yn cael eu cyhoeddi'n ddwyieithog os yw pwnc y gwahoddiad i dendro yn awgrymu y dylid ei gynhyrchu yn Gymraeg, neu os yw'r gynulleidfa ddisgwyliedig, a'u disgwyliadau, yn awgrymu y dylid cynhyrchu'r testun yn Gymraeg. Gellir cyflwyno tendrau yn Gymraeg, ac ni chaiff tendr a gyflwynir yn Gymraeg ei drin yn llai ffafriol na thendr a gyflwynir yn Saesneg.

Nid oes unrhyw geisiadau am dendrau na chontractau wedi'u cyhoeddi yn Gymraeg ac ni dderbyniwyd unrhyw geisiadau yn Gymraeg yn ystod y cyfnod adrodd hwn.

Cyrsiau Addysg (Safon 63)

Byddem yn gwahodd y gynulleidfa i roi gwybod i ni am eu dewis iaith ar gyfer cymryd rhan mewn cwrs. Mae Shoctober yn ymgyrch addysg flynyddol sy'n rhedeg bob mis Hydref ac sydd wedi'i gynllunio i ymgysylltu a phlant cynradd i'w haddysgu a hysbysu am ddefnydd priodol o wasanaethau 999 yn ogystal ag addysgu sgiliau achub bywyd hanfodol. Gofynnir i ysgolion am ddewis iaith yn gynulleidfa er mwyn cyflwyno'r sesiwn yn naill ai yn Gymraeg neu Saesneg.

6. Cydymffurfio â'r Safonau Llunio Polisi (Safonau 69 – 77)

Mae pob polisi a weithredir gan yr Ymddiriedolaeth yn destun asesiad o'r effaith ar Gydraddoldeb. Fel rhan o'r asesiad hwn, gofynnir i staff sy'n llunio polisiau neu ddiwygio polisiau ystyried yr effeithiau cadarnhaol a/neu negyddol a allai ddeillio o'r polisi hwnnw ar gyfer y Gymraeg. Mae cymorth ar gael gan Swyddog y Gymraeg yr Ymddiriedolaeth i unrhyw gydweithiwr sy'n cwblhau asesiad cydraddoldeb ac sy'n weithdrefn safonol ar gyfer polisiau newydd a diwygiedig.

Ers mis Ebrill 2017, sefydlodd yr Ymddiriedolaeth broses bolisi diwygiedig ar draws yr Ymddiriedolaeth sy'n sicrhau bod strwythur cadarn ar waith i adolygu polisiau presennol neu ddatblygu polisiau newydd.

Yn ystod y cyfnod adrodd cymeradwyodd Bwrdd yr Ymddiriedolaeth a'i bwyllgorau cysylltiedig 5 polisi (gan gynnwys polisiau newydd a diwygiedig). Aeth 100% drwy'r broses ar gyfer Aseidiadau o'r Effaith ar Gydraddoldeb a'r Gymraeg. Nid oedd angen diwygio unrhyw bolisi mewn perthynas â'r Gymraeg yn dilyn asesiad.

7. Cydymffurfio â'r Safonau Gweithredol (Safonau 79 – 114)

Mae'r set o Safonau Gweithredol yn delio â'r ffordd y mae'r Ymddiriedolaeth yn defnyddio'r Gymraeg yn fewnol ac yn rhoi'r hawl i weithwyr dderbyn gwasanaethau Adnoddau Dynol yn eu hiaith ddewisol.

Polisi ar Ddefnydd Mewnol o'r Gymraeg

Datblygwyd polisi i hyrwyddo'r defnydd o'r Gymraeg o fewn yr Ymddiriedolaeth drwy ddefnydd ffurfiol a chymdeithasol o'r Gymraeg ymhlith ein gweithlu drwy ddysgu rheolaidd a chyfranogiad mewn amrywiaeth o rwydweithiau a digwyddiadau iaith ffurfiol ac anffurfiol. Rhan o'r gwaith hwn oedd cyflwyno'r Gwobr Iaith Gymraeg fel un o'r categorïau ar gyfer Gwobrau Staff blynyddol yr Ymddiriedolaeth. Mae'r wobwr yn cydnabod staff sydd wedi hyrwyddo'r Gymraeg a gwella darpariaeth ddwyieithog mewn gofal iechyd. Yn ystod y cyfnod adrodd, derbyniodd Dylan Vining, Derbynydd Galwadau Galw Iechyd Cymru/111 y wobwr am ei fedrusrwydd a'i hyfedredd fel Derbynydd Galwadau Cymraeg.

Enwebiad Dylan: *Mae Dylan yn fy rhyfeddu pryd bynnag rwy'n gweithio gydag ef pan mae'n cymryd galwad Cymraeg. Wrth siarad â'r cleifion mae'n darllen yr algorithmau yn Saesneg ac yn eu cyfieithu mor gyflym i'r Gymraeg. Mae o wedyn yn gofyn am gyngor oddi wrth y Llinell Gyngor Clinigol 111 sy'n Saesneg, wedyn mae o'n mynd yn ôl at y claf yn Gymraeg heb oedi.*

Dogfennau sy'n Gysylltiedig â Chyflogaeth (Safonau 80 – 81)

Nid oes aelod o staff wedi gofyn i ni am unrhyw ddogfennau sy'n ymwneud â chyflogaeth yn Gymraeg. Fodd bynnag, rydym wedi sicrhau bod yr holl ddogfennau perthnasol (e.e. llythyrau newid oriau, estyniadau secondiad, contract cyflogaeth) wedi'u cyfieithu a'u bod yn barod i'w defnyddio pe bai unrhyw aelod o staff yn dymuno eu derbyn drwy gyfrwng y Gymraeg. Lle mae'r Partneriaeth Cydwasanaethau GIG Cymru (NWSSP) yn cyhoeddi contractau cyflogaeth (drwy'r broses recriwtio o fewn TRAC), anfonir y rhain yn Gymraeg ac yn Saesneg.

Recriwtio ac Apwyntio (Safonau 106 – 109)

Rydym wedi cyflwyno siart llif canllawiau/proses i gynorthwyo rheolwyr cyn i unrhyw swydd gael ei hysbysebu. Mae'r broses yn rhoi manylion am wasanaethau cyfieithu yn ogystal â chynnwys rhestr o eiriad safonol ar gyfer hysbysebion a disgrifiad swyddi i gynorthwyo rheolwyr.

Sefydlwyd Cytundeb Lefel Gwasanaeth cyfieithu gyda Bwrdd Iechyd Prifysgol Betsi Cadwaladr a chaiff ei ddefnyddio i gefnogi anghenion cyfieithu'r Ymddiriedolaeth. Mae'r ffurflen asesu a gyflwynwyd gennym ar gyfer pob rheolwr ei chwblhau er mwyn asesu gofynion y Gymraeg am swyddi, yn parhau i gael ei defnyddio. Mae hyn yn un rhan o nifer o bwyntiau gwirio eraill, cyn i swydd gael ei rhyddhau ar gyfer ei hysbysebu.

Asesu a Chofnodi Sgiliau Cymraeg ar draws y Gweithlu (Safonau 96 a 116)

O gyfanswm o **4,283** aelod o staff mae **3,736 (87.23%)** **3,705 (91.32%)** o weithlu'r Ymddiriedolaeth wedi hunanasesu ac wedi cofnodi eu sgiliau Cymraeg ar ESR. Mae nifer y staff sy'n cofnodi eu sgiliau wedi cynyddu, ond fe wnaeth y ganran ostwng o ganlyniad i gynydd yn y nifer o staff yn y cyfnod adrodd.

Er mwyn cynyddu'r nifer y staff sy'n cofnodi eu sgiliau Cymraeg ar Cofnod Electronig y Staff (ESR). Mae adran y Gweithlu wedi creu dolen at ffurflen i gasglu gwybodaeth colledig. Bydd adroddiad misol yn cael ei redeg i wirio pa aelodau o staff sydd heb gofnodi'r data angenrheidiol. Yna bydd e-bost yn cael ei anfon at yr aelodau staff gyda dolen i'r ffurflen yn gofyn iddynt ei lenwi o fewn mis o dderbyn yr e-bost.

Dadansoddiad o sgiliau gwrando/siarad Cymraeg staff sydd wedi'i cofnodi ar Cofnod Electronig y Staff (ESR) fesul cyfarwyddiaeth:

CYFARWYDDIAETH	Nifer	Angen	Cyrhaeddiad	Cydymffurfiaeth %
Ysgrifennydd y Bwrdd	5	5	5	100%
Cyfarwyddiaeth y Prif Weithredwr	18	18	17	94.44%
Cyfarwyddiaeth Digidol	56	56	47	83.93%
Cyfarwyddiaeth Cyllid ac Adnoddau Corfforaethol	86	86	86	100%
Cyfarwyddiaeth Feddygol a Chlinigol	52	52	49	94.23%
Cyfarwyddiaeth Gweithrediadau	3831	3831	3306	86.30%
Cyfarwyddiaeth Partneriaethau ac Ymgysylltu	17	17	16	94.12%
Cyfarwyddiaeth Ansawdd, Diogelwch a Phrofiad Cleifion	120	120	116	96.67%
Cyfarwyddiaeth Strategaeth, Cynllunio a Perfformiad	11	11	10	90.91%
Cyfarwyddiaeth y Gweithlu a Datblygiad Sefydliadol	87	87	84	96.55%

Swyddi Newydd a Gwag (Safon 117)

Mae'r tabl isod yn cadarnhau swyddi a hysbysebwyd rhwng 1 Ebrill 2021 a 31 Mawrth 2022:

Cyfanswm nifer y swyddi a hysbysebwyd: **456 (270)**

Categori	Nifer y swyddi ymhob categori	Canran y swyddi a hysbysebwyd
Hanfodol	8 (10)	1.7% (3.71%)
Dymunol	441 (255)	97% (94.44%)
Angen dysgu	0 (0)	0% (0%)
Ddim yn angenrheidiol	6 (5)	1.3% (1.85%)

Swyddi Cymraeg hanfodol a hysbysebwyd:

- Derbynnnydd Galwadau, Gwasanaeth Meddygol Brys
- Derbynnnydd Galwadau, Gwasanaeth Cludiant Cleifion Di-frys (NEPTS)
- Addysgwr Ymarfer Proffesiynol, Gwasanaeth 111
- Cynghorydd Gwybodaeth Iechyd, Gwasanaeth 111
- Cynorthwydd Gweinyddol, Gwasanaeth 111

Hyfforddiant (Safon 97)

Rydym yn ymwybodol o'n rhwymedigaeth i gynnig yr hyfforddiant canlynol drwy gyfrwng y Gymraeg:

- Recriwtio a chyfweld
- Rheoli perfformiad
- Gweithdrefnau cwyno a disgyblu
- Ymsefydlu
- Delio â'r cyhoedd
- Iechyd a diogelwch

Nid ydym wedi darparu hyfforddiant ar gyfer Rheoli Perfformiad, Gweithdrefnau Cwynion a Disgyblu ac Ymdrin â'r Cyhoedd yn ystod y cyfnod adrodd. Yn gyffredinol, caiff hyfforddiant ar gyfer y rhain ei gynnal pan gytunir ar newid allweddol mewn polisi a/neu weithdrefn a lle mae angen i ni sicrhau bod rheolwyr yn ymwybodol o'r newidiadau a'i oblygiadau ar eu rheolaeth o staff drwy un o'r prosesau hyn.

Nid ydym wedi cael yr angen i ymchwilio i hyfforddiant yn y meysydd hyn yn ystod y cyfnod adrodd hwn. Fodd bynnag, gallwn gadarnhau, pe bai angen hyfforddiant yn y meysydd hyn, gofynnir i ymgeiswyr a hoffent dderbyn yr hyfforddiant yn Gymraeg, naill ai byddai sesiwn ar wahân drwy gyfrwng y Gymraeg neu drwy gynnig cyfieithydd ar y pryd.

Hyfforddiant a wnaed yn ystod y cyfnod adrodd

Math o Hyfforddiant	Nifer a fynychodd y fersiwn Gymraeg	Nifer a fynychodd y fersiwn Saesneg	Canran a fynychodd y fersiwn Gymraeg
Recriwtio a chyfweld	Ni chynhaliwyd hyfforddiant	Ni chynhaliwyd hyfforddiant	
Rheoli Perfformiad	Ni chynhaliwyd hyfforddiant	Ni chynhaliwyd hyfforddiant	
Cwynion a gweithdrefnau disgyblu	Ni chynhaliwyd hyfforddiant	Ni chynhaliwyd hyfforddiant	
Sefydlu	Ni ofynnodd aelod o staff am unrhyw un o'r cyrsiau ymsefydlu yn Gymraeg, ond cynigir y llyfr gwaith ymsefydlu yn Gymraeg fel mater o drefn i bawb sy'n bresennol.	Cyfanswm: 340 (383)	0% (0%)
Delio gyda'r cyhoedd	Ni chynhaliwyd hyfforddiant	Ni chynhaliwyd hyfforddiant	
Iechyd a Diogelwch	Mae hwn yn gwrs hyfforddi rhyngwladol sydd wedi'i achredu gan IOSH ac nid yw ar gael yn Gymraeg.	Cyfanswm: 30 (10)	0% (0%)

Hyfforddiant i Wella Sgiliau yn y Gymraeg (Safonau 99 - 101)

Mae'r modiwl ar-lein 'Croeso Cymraeg Gwaith' wedi bod yn allweddol i ni fel Ymddiriedolaeth i gefnogi staff sydd ar ddechrau eu taith i ddysgu Cymraeg ac mae **294 (284)** o aelodau staff wedi cofrestru ar y modiwl e-ddysgu i dechreuwyr Cymraeg a hwylusir gan y Ganolfan Dysgu Cymraeg Genedlaethol gyda **97** wedi cwblhau'r cwrs.

Hyfforddiant Ymwybyddiaeth o'r Gymraeg (Safonau 102 – 103)

Mae 'Diwrnodau Croeso' i'r Ymddiriedolaeth yn cynnwys ymwybyddiaeth o'r Gymraeg a mynychodd **340 (383)** o staff yr hyfforddiant hwn yn ystod y cyfnod adrodd.

Hybu'r Gymraeg

Roedd 7 Rhagfyr 2021 yn nodi Diwrnod Hawliau'r Iaith Gymraeg sef y dyddiad pan gafodd Mesur y Gymraeg (Cymru), y ddeddfwriaeth a wnaeth yr hawliau yn bosibl, ei basio gan y Senedd. Fe gefnogodd yr Ymddiriedolaeth Ddiwrnod Hawliau'r Gymraeg ar ei llwyfannau cyfryngau cymdeithasol wrth hyrwyddo i'n defnyddwyr gwasanaeth yr hyn y mae ganddynt hawl ei wneud trwy gyfrwng y Gymraeg. Yn fewnol, hyrwyddwyd cyngor a chanllawiau i'n staff ar sut y gallant gydymffurfio â safonau'r Gymraeg.

8. Cwynion (Safon 115)

Cwynion a dderbyniwyd yn 2021/22

Isod, ceir rhestr o'r cwynion a dderbyniwyd yn ystod 2021/22 ynghyd â chrynodeb o'r camau a gymerwyd. Derbyniwyd tri chwyn:

	Cwyn	Ymateb a gweithredu
	Safon Cyflenwi Gwasanaethau	
1	Derbyniwyd cwyn drwy PTR_Concern@wast.uk gan aelod o'r cyhoedd yn glŷn â methiant Gwasanaeth 111 Cymru i ddelio â'u galwad ffôn yn Gymraeg.	<p>Cysylltwyd â'r unigolyn dros y ffôn gan egluro bod y gwasanaeth wedi profi problemau technegol o ran llwybro galwadau Cymraeg.</p> <p>Materion technegol wedi'u datrys.</p>
2	Cwyn a dderbyniwyd drwy PTR_Concern@wast.uk gan aelod o'r cyhoedd ynghylch methiant Gwasanaeth 111 Cymru i ymdrin â galwad ffôn yn Gymraeg.	<p>Yn dilyn ymchwiliad eglurwyd i'r achwynydd fod pob ymgais yn cael ei wneud i gyfeirio galwadau Cymraeg i'r derbynnydd galwadau Cymraeg priodol o fewn y gwasanaeth. Gan nad yw'r holl staff sy'n delio â galwadau yng Ngallw lechyd Cymru yn siaradwyr Cymraeg, mae'n adegau pan gyfeirir galwadau Cymraeg at dderbynnydd galwadau Di-Gymraeg o ganlyniad i ddiogelwch cleifion ac er mwyn atal oedi posibl mewn gofal brys.</p>
3	Cwyn a dderbyniwyd gan aelod o'r cyhoedd trwy Lywodraeth Cymru yn glŷn â safon iaith y negeseuon Cymraeg i alwyr ar Wasanaeth 111.	<p>Yn dilyn adolygiad trylwyr o negeseuon 111 sylwyd nad oedd rhai geiriau yn cael eu hynganu'n gywir fel y manylir yn yr adborth. Yn ystod y pandemig bu'n rhaid i Wasanaeth 111 addasu mewn modd cymharol gyflym newidiadau sylweddol i sgrïptiau llais.</p> <p>Mae Gwasanaeth 111 bellach wedi'i uwchraddio i system ffôn Cisco newydd sy'n cynnwys negeseuon newydd i alwyr.</p> <p>Datblygwyd proses monitro ansawdd newydd a fydd yn sicrhau bod negeseuon Cymraeg a Saesneg yn glir ac yn gywir.</p>

Blaenoriaethau 2022-2023

Er mwyn cyrraedd canlyniad hirdymor o ddarparu'r "Cynnig Gweithredol" fel rhan annatod o ddarparu gwasanaethau, bydd yr Ymddiriedolaeth yn symud ymlaen â'i gwaith o wella ei gwasanaethau i'w chleifion Cymraeg eu hiaith yn eu dewis iaith.

Canolbwyntir ar waith datblygu yn y meysydd canlynol:

- **Datblygu Fframwaith Iaith Gymraeg**
Er mwyn sicrhau fod yna strwythur, trylwyrdd, llywodraethant a chysondeb ar waith yn natblygiad y Gymraeg drwy'r Ymddiriedolaeth.
- **Cynllun Mwy na geiriau 2022-2027**
Gweithredu'r cynllun 5 mlynedd newydd ar gyfer *Mwy na geiriau* i fynd i'r afael â'r materion allweddol a ddaeth i'r amlwg fel rhan o werthusiad annibynnol y fframwaith *Mwy na geiriau*.
- **Ymgynghoriad ar god drafft Rheoliadau Safonau'r Gymraeg (Rhif 7) 2018**
Ymateb i Ymgynghoriad Comisiynydd y Gymraeg ar ganllawiau ymarferol drafft ar ofynion safonau'r Gymraeg lle mae'n ofynnol i'r Ymddiriedolaeth gydymffurfio â nhw.
- **Canoli gwasanaeth cyfieithu**
Er mwyn bodloni'r galw a'r gost gynyddol am gyfieithu ac i ddarparu rhagolwg mwy strategol, mae achos wedi ei baratoi i'r Ymddiriedolaeth i ganoli gwasanaeth cyfieithu a fyddai'n rhoi gwerth am arian ac ansawdd i'r Ymddiriedolaeth.

Atodiad 1

Cyfrifon Cyfryngau Cymdeithasol dwyieithog: Ystadegau o 1 Ebrill 2021 – 31 Mawrth 2022

Twitter

	@Ambiwlans_Cymru	@WelshAmbulance
Dilynwyr newydd	65 (134)	1,906 (3,059)
Cyfanswm Trydar	430 (572)	572 (753)
Cyfanswm Argraffiadau	191,100 (249,011)	4,806,500 (7,106,000)
Ymweliadau proffil	14,318 (4,041)	239,200 (117,993)
Ail-drydar	309 (499)	6,210 (10,800)
Hoffi	366 (691)	16,188 (30,300)

- Mae cyfres o negeseuon Cymraeg a Saesneg wedi'i baratoi o flaen llaw o ganlyniad i'r angen am gyhoeddi negeseuon y tu allan i oriau drwy swyddog cyfathrebu Di-Gymraeg ar alwad. (Gweler tudalennau 19 - 21)

*Noder: mae cyfanswm y Trydar yn wahanol rhwng y ddau gyfrif am y rhesymau canlynol:

- Mae 'Trydar' yn cynnwys Trydar a ddyfynnir a gyhoeddir yn amlach ar ein cyfrif Saesneg oherwydd nad yw asiantaethau eraill fel gwasanaethau ambiwlans eraill y DU yn rhoi cynnwys yn Gymraeg.
- Mae'r 'Trydar' hefyd yn cynnwys ymateb i sylwadau (e.e. cwynion, diolchiadau, sgorsiau cyffredinol) nad ydynt yn cael eu derbyn yn aml ar y cyfrif Cymraeg. Dros gyfnod prysur y gaeaf, rydym yn aml yn ymateb i gwynion a gyfeiriwyd atom ar ein cyfrif Twitter Saesneg.
- Mae 'Trydar' yn ymwneud ac argyfwng yn cael eu postio ar unwaith yn Saesneg. Os bydd trydar argyfwng yn mynd allan yn ystod oriau gwaith, byddwn bob amser yn ceisio eu hanfon i'w gyfieithu. Fodd bynnag, gofynnir i nifer o'n negeseuon argyfwng cael eu cyhoeddi y tu allan i oriau drwy swyddog cyfathrebu Di-Gymraeg ar alwad.

Facebook

	Ymddiriedolaeth GIG Gwasanaethau Ambiwllans Cymru	Welsh Ambulance Services NHS Trust
Dilynwyr newydd	59 65	4,647 7,546
Hoffi tudalennau newydd	28 59	2,237 6,815
Cyfanswm ymgysylltu â'r post	1,564	433,529
Cyfanswm ymweliadau â'r dudalen	744	67,856
Cyfanswm cyrhaeddiad	136,237 12,612	9,792,474 2,135,600

	English Post	English Caption	Welsh Post	Welsh Caption
1	We are currently extremely busy For those who are less seriously ill or injured, there are other options available	Think carefully before dialling 999. If it is not an emergency, then use the:  @NHS111Wales symptom checkers  Your local pharmacy  Minor Injuries Unit  111 for urgent medical concerns only	Rydym yn hynod brysur ar hyn o bryd l'r rheiny sydd ddim mor ddifrifol wael neu wedi eu hanafu y mae opsiynau eraill ar gael	Meddyliwch yn ofalus cyn deialu 999. Os nad ydyw yn argyfwng yna defnyddiwch:  gwiriwr symptomau @NHS111Wales  Eich fferyllfa leol  Uned Mân Anafiadau  111 am faterion meddygol brys yn unig
2	Our emergency call handlers are very busy and doing everything they can to arrange help for those who need us	Please help us by only dialling 999 if it is a serious or life-threatening emergency. For urgent advice please use @NHS111Wales, your local pharmacy or Minor Injuries Unit	Mae ein gweithredwyr galwadau brys yn brysur iawn ac yn gwneud popeth o fewn eu gallu i drefnu cymorth i'r rheiny sydd ein hangen	Os gwelwch yn dda helpwch ni drwy ddeialu 999 os ydyw yn fater difrifol neu'n argyfwng sy'n peryglu bywyd yn unig. Am gyngor brys, os gwelwch yn dda defnyddiwch @GIG111Cymru, eich fferyllfa leol neu'r Uned Mân Anafiadau
3	The service is experiencing a very high demand	If it's urgent but it's not a serious or life-threatening emergency, please consider other options. In times of extremely high demand, some patients may wait longer for our help. If you need medical help fast but it's not an emergency, try our @NHS111Wales symptom checkers for advice and next steps  https://bit.ly/3hQf6XK	Mae galw mawr iawn am y gwasanaeth	Os ydyw yn fater brys, ond nad yw'n argyfwng difrifol neu'n peryglu bywyd, ystyriwch opsiynau eraill os gwelwch yn dda. Ar adegau pan fo galw mawr iawn, fe all rhai cleifion aros yn hirach am ein cymorth. Os ydych angen cymorth meddygol yn gyflym ond nad yw'n argyfwng, cysylltwch â'n gwirwyr symptomau @NHS111Wales am gyngor a'r camau nesaf  https://bit.ly/3hQf6XK
4	Our NHS 111 Wales service is experiencing a very high volume of calls	Demand on our 111 service means that some people may have problems getting through to us. If you do need us urgently, please keep trying or use our	Mae'r gwasanaeth GIG 111 Cymru yn profi nifer uchel iawn o alwadau	Mae pwysau ar ein gwasanaeth 111 yn golygu y gall rhai pobl gael problemau yn dod drwodd atom. Os ydych ein hangen ar frys, daliwch i alw os gwelwch yn dda neu defnyddiwch ein

		website for information, advice and other services available to help you 📄 https://bit.ly/3K0FB8P		gwefan am wybodaeth, cyngor a gwasanaethau eraill ar gael i'ch helpu chi 📄 https://bit.ly/3K0FB8P
5	All our services remain extremely busy	In times of extremely high demand, some patients may wait longer for our help. Our staff over the phone and on the road are doing everything they can to help you. Please work #WithUsNotAgainstUs and respect ambulance workers	Mae ein holl wasanaethau yn parhau yn hynod brysur	Ar adegau pan fo galw mawr iawn, fe all rhai cleifion aros yn hirach am ein cymorth. Mae ein staff sy'n gweithio dros y ffôn ac ar y ffordd yn gwneud popeth o fewn eu cyrraedd i'ch helpu chi. Os gwelwch yn dda byddwch #GydaNiNidYnEinHerbyn a pharchwch y staff
6	Our 999 and 111 services are experiencing extremely high demand today	#HelpUsHelpYou by 📞 Only calling 999 for a serious or life-threatening emergency 🕒 Not calling 999 for an ETA 📞 Only calling back if the patient's condition worsens or they no longer need our help 📱 Using the @NHS111Wales symptom checkers 🏥 Taking yourself to the Emergency Department or Minor Injuries Unit	Mae ein gwasanaethau 999 ac 111 yn profi galw mawr iawn heddiw	📞 Alw 999 yn unig ar gyfer argyfwng difrifol neu'n peryglu bywyd 🕒 Peidio galw 999 am amcan amser cyrraedd 📞 Galw yn ôl dim ond os ydyw cyflwr y claf yn gwaethygu neu nad ydynt mwyach angen ein cymorth 📱 Defnyddio gwirwyr symptomau @NHS111Wales 🏥 Mynd i'r Adran Achosion Brys neu'r Uned Mân Anafiadau
7	Please only call 999 for the most serious life threatening injuries or illness and help keep our emergency vehicles free for those who desperately need us	We are experiencing very high levels of demand this evening across [INSERT AREA]. Please only call 999 for life threatening injuries or illness and make alternative arrangements to get to hospital to keep our emergency vehicles free for those who desperately need us	Ffoniwch 999 am yr anafiadau neu'r salwch mwyaf difrifol sy'n bygwth bywyd a helpwch i gadw ein cerbydau argyfwng yn rhad ac am ddim i'r rhai sydd ein hangen yn ddirfawr	Yr ydym yn profi lefelau uchel iawn o alw heno ar draws y [INSERT AREA]. Ffoniwch 999 am anafiadau neu salwch sy'n bygwth bywyd a gwnewch drefniadau amgen i gyrraedd yr ysbyty i gadw ein cerbydau brys yn rhad ac am ddim i'r rhai sydd eu hangen yn ddirfawr
		English Hashtags	Welsh Hashtags	

		#HelpUsHelpYou	#HelpwchNiHelpuChi	
		#BeWiseSaveLives	#ByddwchDdoethdAch ubwchFywydau	
		#StaySafe	#Arhoswch yn ddiogel	
		#WithUsNotAgainstUs	#GydaNiNidYnEinHerb yn	
		English Area Names	Welsh Area Names	
		South East	Y De-ddwyrain	
		South West	Y De-orllewin	
		South Wales	De Cymru	
		North East	Gogledd Ddwyrain	
		North West	Gogledd Orllewin	
		North Wales	Gogledd	
		Mid Wales	Y Canolbarth	
		East Wales	Dwyrain Cymru	
		West Wales	Gorllewin Cymru	

Gwybodaeth Bellach

Am fwy o wybodaeth ar Safonau'r Gymraeg cysylltwch â:

Melfyn Hughes
Rheolwr Gwasanaethau'r Gymraeg

Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru
Tŷ Elwy
Ffordd Richard Davies
Llanelwy
Sir Ddinbych
LL17 0LJ
E-bost: Melfyn.hughes@wales.nhs.uk



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

**WELSH AMBULANCE SERVICES
NHS TRUST**

**WELSH LANGUAGE
STANDARDS
ANNUAL REPORT
2021-2022**

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

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Foreword

Croeso! Welcome!

As Chair and Chief Executive of the Welsh Ambulance Services NHS Trust, we are delighted to present our third report on implementing the Welsh Language Standards.

The Welsh Language (Wales) Measure 2011 sets out a legal framework which imposes a duty on the Welsh Ambulance Services NHS Trust, along with other public institutions, to comply with the Standards relating to the Welsh language and provides an opportunity to reinforce the requirements and to improve the quality and availability of services through the medium of Welsh.

There is a clear commitment from the Board in implementing the Standards and during 2021/22 we have continued to raise awareness of the requirements of the Standards by including Welsh language requirements in staff induction sessions together with promoting the online module 'Croeso Cymraeg Gwaith' which has been key to supporting staff who are at the beginning of their journey to learn Welsh. In addition, Welsh language social media accounts for Facebook and Twitter have been set up to improve our communication with the Welsh speaking public.

In addition to the new Welsh language recruitment assessment form that was introduced to all managers to complete prior to posts being released for advert, we have introduced a guidance/process flow chart to assist managers in preparing adverts prior to any post being advertised. The process provides details of translation services as well as some standard advert and job description wording to assist managers.

This Annual Report sets out our compliance with the Standards and is supported by data for the reporting period 1 April 2021 to 31 March 2022. We recognise that we have made progress, but further improvements are planned to improve the provision of our Welsh language services. To achieve these improvements, we have been working closely with the Welsh Language Commissioner to establish solutions that meets our operational needs and ensures the rights of Welsh language speakers.



Martin Woodford
Chair



Jason Killens
Chief Executive

1. Introduction

This is the third Annual Report of the Welsh Ambulance Services NHS Trust's work showcasing how the Welsh Language Standards have been implemented.

On 30 May 2019, the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing Welsh Language Standards as part of the Welsh Language (Wales) Measure 2011.

The Trust has continued to respond positively to the Welsh Language Standards as it provides an opportunity to reinforce and to improve the quality and availability of its services through the medium of Welsh. Additional guidance on how to comply with the Standards have been developed and made available to staff on a new Welsh Language Standards Intranet page.

2. About us

We are a team of over 4,000 people serving the 3.1 million people of Wales, along with the invaluable support of Community First Responders (CFRs), and volunteer car drivers who transport patients from their homes to hospital appointments and back again.

We provide thousands of patients a year with advice, support and signposting to the right services through our Consult and Close services. This includes the NHS 111 Wales Service, which is an amalgamation of NHS Direct Wales (a 24-hour health advice and information service for the public) and the front-end call handling and clinical triage elements of the GP out-of-hours services and our Clinical Desk. We take hundreds of thousands of patients to a place of care, or home, every year through our Non-Emergency Patient Transport Service (NEPTS).

Our Call Handlers and Clinical Contact Centre staff deal with more than half a million calls every year, 24/7 and 365 days a year and we are at the frontline of service delivery, making sure that patients get the right advice and help.

3. Background to the Welsh Language Standards

Under the Welsh Language (Wales) Measure 2011, all public service organisations in Wales are required to comply with language duties, which ensure that the Welsh language is not treated less favourably than the English language. The duties encourage promotion of the Welsh language, the use of Welsh within internal administration and require that provision is made for the accessibility of Welsh to the public.

Section 44 of the 2011 measure permits the Welsh Language Commissioner to issue a compliance notice, requiring a body to comply with one or more standards specifically applicable to it. The Welsh Language Standards (No.7) Regulations 2018 were then introduced to the health sector organisations in Wales.

In accordance with section 44 of the 2011 measure, the purpose of the Welsh Language Standards is to provide:

- Clarity for organisations on the Welsh language
- Clarity for Welsh speakers on what services they can expect to receive in Welsh
- Greater consistency in Welsh language services and improvement of quality for users

4. Accountability and Support

Welsh Language Leads and Champions

Alongside the Trust's Welsh Language Services Manager, the Trust's Board Secretary is the executive lead for the Welsh language. In addition, the Trust Board has a Non-Executive Director who is the Board's Welsh Language Champion.

Welsh Language Advisory Group

The Welsh Ambulance Services NHS Trust has established a Welsh Language Advisory Group. This Group provides a mechanism for reviewing all aspects of the Welsh Language Standards and to ensure that a satisfactory service is maintained for all patients and members of the public who use the services of the Trust.

Assistant Directors Leadership Team

The Trust's Assistant Directors Leadership Team (ADLT) are responsible for supporting the Trust's Executive Management Team on developing and delivering strategic plans and objectives, financial targets and compliance with legislation requirements, standards, and practices. A Welsh Language Standards Compliance Tracker has been developed which provides a RAG rating for compliance against each standard and is reviewed quarterly.

People and Culture Committee

The Trust's People and Culture Committee provides assurance to the Board of its leadership arrangements and monitors progress and seeks assurance that the Trust is discharging its statutory responsibilities in relation to the Welsh Language Standards.

Trust Board

The final part of the of the governance route of the Trust's Welsh Language Standards Annual Report following its approval route via the Trust's

Welsh Language Advisory Group, ADLT, Executive Management Team and the People and Culture Committee will be for the Trust Board to review and discuss the progress made in complying with the Standards.

Complaints Procedure

Concerns received in relation to compliance with the Trust's Welsh Language Standards, are addressed under the Putting Things Right Regulations.

If a member of the public has a concern regarding a recent experience of using Trust services, they can register their concern in a number of ways which is best suited to them: email the concerns team: Amb_PuttingThingsRight@wales.nhs.uk or complete an online form: [Online Concerns Submission Form](#)

5. Compliance with the Service Delivery Standards (Standards 1 – 77)

This set of standards identifies how the Trust is required to use the Welsh language in different situations so that Welsh speakers can have unhindered access to Welsh language services; for example, when sending correspondence, dealing with telephone calls, providing on-line or face-to-face services.

Correspondence (Standards 1 – 7)

The Trust has applied a consistent approach in relation to use of headed paper and email signatures and requires all staff to use the bilingual headed paper of the Trust. We have also actively encouraged all staff to include a message on email signatures noting that the individual 'welcomes correspondence in Welsh or English'.

Telephone Calls (Standards 8 – 20)

The Welsh Language Standards as imposed upon the Trust places no legal requirement to answer 999 calls in Welsh.

For other calls, staff will give a bilingual greeting when answering the telephone and when the Trust establishes telephone contact with a service user for the first time, the service user will be asked if they would prefer to receive future calls from the Trust in Welsh or English. That language preference will be noted and respected. Calls to 111 and NEPTS offer a language option for callers.

111 Service Review

During 2021/22 the 111 Service had seen significant challenges in relation to increased demand as well as an increase in staff absenteeism due to the pandemic. This had an impact on the performance of both English and Welsh language calls that were presented to the service.

In addition, the service saw a sharp increase in Welsh language demand. This was mainly due to the last two Health Boards that were integrated into 111 Wales.

The table below shows the 2021/2022 Welsh Language call demand and answer rate:

NHS Wales 111 Service Welsh Language Calls 2021- 2022

Welsh Language Demand	Total Answered Calls for 111	Welsh Calls Offered	Total calls answered in Welsh	% of Calls answered
01/04/21 – 31/04/22	680,161	15,341	6,949	45%
01/04/20 – 31/04/21	580,457	5,436	3,788	69.7%

In June 2021 Betsi Cadwaladr University Health Board merged with 111 Wales followed in March 2022 by Cardiff & Vale University Health Board. These are two of the largest Health Boards in Wales that contain the highest percentage of the country's Welsh speaking population. The demand during 2021/22 for Welsh language calls increased by 9,905 from that of the previous year 2020/21. This equated to a 182% increase in Welsh demand to the 111 service.

111 answered 3,161 more calls in Welsh during the 2021/22 financial year than the previous year (2020/21). This equated to answering 82% more calls in Welsh than the previous year (2020/21). However, there was a drop in the actual percentage rate of 24.3% in Welsh calls answered compared to calls answered from the previous year (2020/21).

It is fair to say the service has seen substantial and sustained demand pressure during this time with a significant increase in call demand / staff absenteeism due to the pandemic which influenced the overall answer rate for all calls to 111. During the last year following the integration of the service to two new Health Boards in a very short time frame, recruitment campaigns were carried out to support the additional demand.

111 Service Improvements related to the Welsh Language 2021-2022 (these are in addition to established process)

1. In November 2021 the 111 service introduced a new Interactive Voice Recorder (IVR) facility. The IVR is the messaging and options that callers will listen to and then select when calling 111 Wales. This new IVR is offered in both English and Welsh.
2. The new Welsh IVR has been further improved with scripts validated by a commissioned Welsh language translator.
3. Further work is ongoing within the IVR with a soon to be offered bilingual text facility option that will refer callers to the 111 website in English or Welsh dependant on the language selection made by the caller.
4. A significant innovation that has helped with the identification and pick up of Welsh language calls was the introduction of the preannouncement facility. The call handler will be given a voice message in their headphones a few seconds before

the call is presented announcing which selection the caller has chosen within the IVR. E.g., “Welsh Dental” or “Welsh existing call” etc. This has improved pick up rates for Welsh calls.

5. Training has been developed with the use of interactive videos for staff detailing skills and tips on managing Welsh language requested calls.
6. Currently with support from the Patient Engagement Team within the Trust the 111 Service is developing a quality initiative involving public volunteers to conduct targeted calls to 111 and to audit user experience and quality. Accessing the Welsh language service will be a key review area within this initiative. The initial review will be focused on the IVR and access into the service and will be launched in early Autumn 2022.

Meetings (Standards 21 – 30)

When the Trust arranges a meeting with a member or members of the public, attendees will be asked if they wish to use the Welsh language at the meeting. Where individuals express a desire to use Welsh at a meeting, the Trust will respect and accommodate that preference. Board meetings have a non-executive director and governance officer who speak Welsh and all meetings of the Board are livestreamed via Zoom which has the functionality for Welsh (and other language) subtitles.

Public Events (Standards 31 – 32)

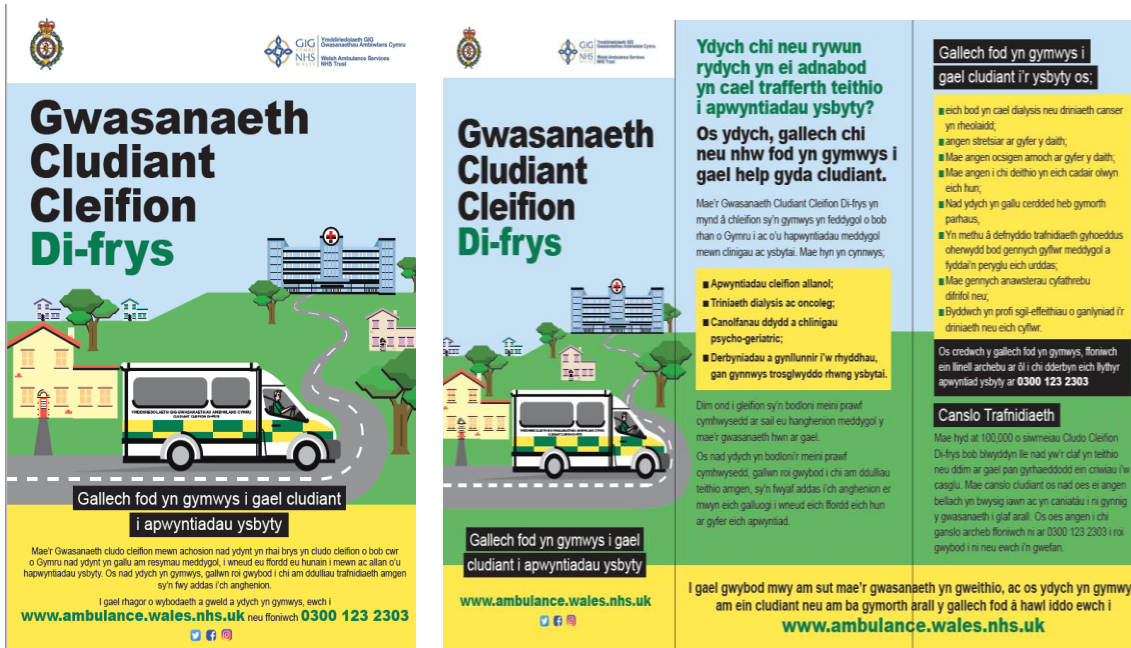
In relation to face to face services offered at the event, the event’s invitation or advertisement will ask persons to inform us if they wish to use the Welsh language. There is no requirement to provide a translation service if no-one has informed the organiser that they wish to use Welsh at the event.

Documents and Forms (Standards 36 - 38)

Any form that is to be completed by members of the public are available in Welsh. Documents produced by the Trust for the public are made available in Welsh if the subject matter of the document suggests that it should be produced in Welsh, or if the anticipated audience, and their expectations, suggests that the document should be produced in Welsh. If separate Welsh language versions are required, the English language version will state that the document or form is also available in Welsh.

Publicity and Advertising Material (Standards 33 – 34)

The Non-Emergency Patient Transport Service takes medically eligible patients from across Wales to and from their medical appointments at clinics and hospitals. In order for patients to see if they meet an eligibility criterion based on their medical need the following poster and information leaflet were produced then distributed across Wales to GP’s, hospitals and medical facilities.



Websites and Online Services (Standards 39 – 43)

The Trust operates two websites: a [Corporate website](#) that has been redeveloped with a facility to switch between the two languages, and the NHS Direct Wales website which was rebranded in May 2020 to GIG 111 Cymru www.111.wales.nhs.uk.

GIG 111 Cymru

37 (32¹) bilingual online symptom checkers which provide help and advice to the public on how they can manage their symptoms.

NHS 111 Wales

During the reporting period the website received **4,187,031 (4,300,241)** visits of which **33,664 (0.80%) (26,979 (0.62%)** visits were to the Welsh language website.

Pregnancy, travel, and COVID-19 sections were updated and available bilingually.

From the launch of the newly branded NHS 111 Wales website, the website has been operating its own Welsh and English social media Twitter accounts @GIG111Cymru with **81 (56)** followers and @NHS111Wales with **7,022 (6,702)** followers.

¹ Orange figures/percentages represent the 2020/21 reporting period

Publishing Apps (Standard 44)

Blue Light Hub app



As the pandemic continued to prevent engagement at schools and in community settings, we wanted to ensure that important information was still being shared with our next generation of callers. In July we launched a new bilingual gaming app, the 'Blue Light Hub', which aims to help children and young people understand what to do in an emergency in a fun and engaging way.

Aimed predominately at 7–12-year-olds, the Trust's Blue Light Hub app boasts four games and teaches users about what happens when they call 999 and the appropriate use of emergency 999 services,

Social Media (Standards 45 – 46)

Developments have included the setting up of Welsh language social media accounts for Facebook and Twitter. **See Appendix 1** for social media data.

Signs and Notices (Standards 47 - 49)

All new or replacement signage is produced bilingually with the Welsh positioned so that it is likely to be read first. During the reporting period new external and internal signage was produced for the Trust's new state-of-the-art ambulance station in Cardiff.



Reception Services (Standards 50 - 53)

The online module 'Croeso Cymraeg Gwaith' is available to staff working in reception areas in order to develop their Welsh language skills and be able to greet visitors bilingually.

Awarding Contracts (Standards 57 - 59)

Invitations to tender will be published bilingually if the subject matter of the invitation to tender suggests that it should be produced in Welsh, or if the anticipated audience, and their expectations, suggests that the text should be produced in Welsh. Tenders may be submitted in Welsh, and a tender submitted in Welsh will be treated no less favourably than a tender submitted in English.

No requests for tenders or contracts were issued in Welsh and none were received in Welsh during this reporting period.

Education Courses (Standard 63)

Any education course that we offer to the public we invite the audience to let us know their language preference of either Welsh or English for participating in the course. 'Shoctober' is an annual, month-long awareness campaign that runs every October and is designed to engage, educate, and inform primary school age learners about appropriate use of 999 services and vital lifesaving skills. Schools are asked for their audience language preference in order to deliver the sessions in either Welsh or English.

6. Compliance with the Policy Making Standards (Standards 69 – 77)

All new policies implemented by the Trust are subject to an Equality Impact Assessment (EqIA). As part of this assessment, staff formulating new or revised policies are asked to consider the positive and/or negative impacts that could result from that policy for the Welsh language. Support from the Welsh Language Services Manager is available to any colleague completing an EqIA and is a standard procedure for all new and revised policies.

From April 2017, the Trust established a revised Trust wide policy process which ensures there is a robust structure in place within which to review existing or develop new policies.

During the reporting period, the Trust Board and its associated committees approved **5** policies (inclusive of new and revised policies). 100% went through the process of EqIA of which Welsh language is a standard equality strand. No policy required amending in relation to the Welsh language following the EqIA.

7. Compliance with the Operational Standards (Standards 79 – 114)

The set of Operational Standards deals with the way the Trust uses the Welsh language internally and gives employees the right to receive Human Resources services in their chosen language.

Policy on the Internal Use of Welsh (Standard 79)

A policy to promote the use of the Welsh language within the Trust has been developed for the formal and social use of Welsh amongst our workforce through regular learning and greater participation in a variety of formal and informal language networks and events. Part of this work was the introduction of a Welsh Language Award as one of the categories for the Trust's annual Staff Awards. The award is to recognise staff who have helped to promote the Welsh Language and improve bilingual provision in healthcare. During the reporting period, Dylan Vining, NHSDW/111 Call Handler received the award for his skill and proficiency as a Welsh speaking call handler.

Dylan's nomination said: *Dylan amazes me whenever I work with him and when he takes a Welsh call, he reads the algorithms in English and translates them so quickly to Welsh when speaking to the patients. He's then seeking advice from the 111 Clinical Advice Line in English then back to the patient in Welsh again super quickly and without hesitation.*

Employment Documents (Standards 80 – 81)

We have not been asked by any member of staff for any employment related documents to be supplied in Welsh i.e., documents that outline training needs or requirements; documents that outline performance objectives; documents that outline or record a career plan; forms that record and authorise annual leave; forms that record and authorise absences from work and forms that record and authorise flexible working hours.

We have ensured that the following documents: change of hours letters, secondment extensions and contract of employment have been translated should any member of staff wish to receive them through the medium of Welsh. Where NHS Wales Shared Services Partnership (NWSSP) issues contracts of employment (via the recruitment process within TRAC), these are sent in both Welsh and English.

Recruiting and Appointing (Standards 106 – 109)

Guidance/process flow charts are used to assist managers prior to any post being advertised. The process provides details of translation services as well as some standard advert and job description wording to assist managers. A translation Service Level Agreement with Betsi Cadwaladr University Health Board has been established to support the Trust's translation needs.

The assessment form we introduced for all managers to complete to help assess Welsh language requirement for posts continues to be utilised. This forms part of a number of other check points, prior to a post being released for advert.

Assessing and Recording Welsh Language Skills across the Workforce (Standards 96 and 116)

From a total of **4,283** members of staff **3,736 (87.23%) 3,705 (91.32%)** of the Trust's workforce have self-assessed and recorded their Welsh language skills on ESR.

The numbers of staff recording their Welsh language skills has increased, however, the percentage has reduced due to an expanded workforce during the reporting period. In order to increase the number of staff recording their Welsh language skills on ESR, Workforce have created a link to a form to capture any missing competencies. A monthly report will then be run to check which members of staff are missing any of the competencies. An email will then be sent to staff members with a link to the form, asking them to fill it in with a deadline of a month's time.

Welsh language listening/speaking skills recoded on ESR per directorate:

DIRECTORATE	Assignment Count	Required	Achieved	Compliance %
Board Secretary	5	5	5	100%
Chief Executive Directorate	18	18	17	94.44%
Digital Directorate	56	56	47	83.93%
Finance & Corporate Resources Directorate	86	86	86	100%
Medical & Clinical Directorate	52	52	49	94.23%
Operations Directorate	3831	3831	3306	86.30%
Partnerships & Engagement Directorate	17	17	16	94.12%
Quality, Safety & Patient Experience Directorate	120	120	116	96.67%
Strategy, Planning & Performance Directorate	11	11	10	90.91%
Workforce & OD Directorate	87	87	84	96.55%

New and Vacant Posts (Standard 117)

The table below confirms posts advertised between 1 April 2021 and 31 March 2022:

Total number of posts advertised: **456 (270)**

Category	Number of posts categorised	Percentage of posts advertised
Essential	8 (10)	1.7% (3.71%)
Desirable	441 (255)	97% (94.44%)
Needs to be learned	0 (0)	0% (0%)
Not necessary	6 (5)	1.3% (1.85%)

Welsh essential posts advertised include:

- Emergency Medical Service (EMS) Call Taker
- Non Emergency Patient Transport Service (NEPTS) Call Taker
- Professional Practice Educator, 111 Service
- Health Information Adviser, 111 Service
- Control Administrative Assistant, 111 Service

Training (Standard 97)

We are aware of our obligation to offer the following training through the medium of Welsh:

- recruitment and interviewing
- performance management
- complaints and disciplinary procedures
- induction
- dealing with the public
- health and safety

We have not undertaken training for Performance Management or Complaints and Disciplinary Procedures during the period that this report covers. Generally, training for these areas is conducted when a key change in policy and/or procedure is agreed, and where we would have to ensure that managers are aware of the change and its implication on their management of staff through one of these processes.

We can however confirm that should training in these areas be necessary, candidates will be asked if they would like the training in Welsh. A session through the medium of Welsh (number dependent) would be arranged or via the use of a simultaneous translation service.

Training carried out during the reporting period

Type of Training	Number who attended the Welsh version	Number who attended the English version	Percentage that attended the Welsh version
Recruitment and Interviewing	None delivered	None delivered	
Performance Management	None delivered	None delivered	
Complaints and Disciplinary Procedures	None delivered	None delivered	
Induction	No one requested for our induction to take place in Welsh, however, the induction workbook is routinely offered to all attendees in Welsh.	Total: 340 (383)	0% (0%)
Dealing with the Public	None delivered	None delivered	
Health and Safety	This is an internationally delivered IOSH accredited training course, and not available in Welsh.	Total: 30 (10)	0% (0%)

Training to Improve Welsh Language Skills (Standards 99 - 101)

The online module 'Croeso Cymraeg Gwaith' has been key to the Trust in supporting staff who are at the beginning of their journey to learn Welsh and **294 (284)** members of staff have registered onto the Welsh language beginners e-learning module facilitated by the National Centre for Learning Welsh with **97** having completed the course.

Welsh Language Awareness Training (Standards 102 – 103)

The Trust's 'Welcome days' includes Welsh language awareness and a total of **340 (383)** staff undertook this training during the reporting period.

Promoting the Welsh Language

The 7th of December 2021 marked Welsh Language Rights Day which is the date on which the Welsh Language (Wales) Measure, the legislation that made the rights possible, was passed by the Senedd. The Trust supported Welsh Language Rights' Day on its social media platforms in promoting to our service users what they are entitled to through the medium of Welsh. In addition, advice, and guidance to Trust staff on how they can comply with the Welsh language standards was also promoted.

8. Complaints (Standard 115)

Complaints received in 2021/22

Below, is a list of complaints received during 2021/22 along with a summary of the actions taken. Three complaints were received:

	Complaint	Response and action
	Service Delivery Standard	
1	Complaint received via PTR_Concern@wast.uk from member of the public regarding failure by the NHS Wales 111 Service to deal with their telephone call in Welsh. Caller had requested for a Welsh language service but as there was no Welsh speaking person to answer their call, the system did not route the call to a non-Welsh speaking call handler.	Individual was contacted by telephone explaining that the service had experienced technical issues with regards to the routing of Welsh language calls. Technical issue was resolved.
2	Complaint received via PTR_Concern@wast.uk from member of the public regarding failure by the NHS Wales 111 Service to deal with their telephone call in Welsh.	Complaint resolved through explanation to complainant via telephone call. It was explained to the complainant that all attempts are made to route Welsh calls to the appropriate Welsh speaking call handlers and that not all the call handlers are Welsh speakers, and there are times that Welsh calls are routed to a non-Welsh speaking call handler due to patient safety and to prevent a potential delay in urgent care.
3	Complaint received from member of the public via Welsh Government regarding the quality of the Welsh language recorded messaging to callers on the 111 Service.	Following a thorough review of the 111 Service messaging it was identified that a few words on the recorded scripts were not pronounced correctly as detailed in the feedback. During the pandemic the 111 Service had to modify in a relatively quick manner considerable changes to the voice scripts recordings. The 111 service has now been upgraded to a newer and robust Cisco telephone platform with new messaging for callers at the front end of the service. A new quality monitoring process has been developed that will ensure that both Welsh and English language front end messaging are clear, accurate and of a high professional standard.

Priorities for 2022-2023

In order to reach the long-term outcome of the delivery of an “Active Offer” that takes the responsibility off the service user to ask for a service through the medium of Welsh, the Trust will continue to progress with its work in improving its services for its Welsh speaking patients in their language of choice as an integral part of service delivery.

Focus will be on developing work in the following areas:

- **Development of a Welsh Language Framework**
To ensure there is structure, rigour, governance, and consistency in the implementation of a framework for the development of the Welsh language throughout the Trust.
- **More than just words 2022-2027 plan**
Implement the new 5 year plan for *More than just words* to address the key issues that emerged as part of the independent evaluation of the *More than just words* framework.
- **Consultation on the draft code of practice for the Welsh Language Standards (No.7) Regulations 2018**
The Trust to respond to the Welsh Language Commissioner on the draft practical guidance on the requirements of the Welsh language standards in which the Trust are required to comply with.
- **Centralisation of translation service**
In order to meet the increasing demand and cost for translation and to provide a well-rounded and more strategic outlook, a case has been prepared for the Trust to have a centralised translation service that would provide value for money, quality and speed of service to the Trust.

Appendix 1

Bilingual Social Media Accounts: Statistics from 1 April 2021 – 31 March 2022

Twitter

	@Ambiwylans_Cymru	@WelshAmbulance
New followers	65 (134)	1,906 (3,059)
Total amount of Tweets	430 (572)	572 (753)
Total impressions	191,100 (249,011)	4,806,500 (7,106,000)
Profile visits	14,318 (4,041)	239,200 (117,993)
Retweets	309 (499)	6,210 (10,800)
Likes	366 (691)	16,188 (30,300)

- Series of ‘Emergency’ demand posts created in Welsh and English as a result of messages being requested out of hours via a non-Welsh speaking on-call Communications Officer. **(See pages 19 – 21)**

*Note: the total amount of Tweets differs between both accounts for the following reasons:

- ‘Tweets’ include quoted Tweets which are published more frequently on our English account due to other agencies such as other UK ambulance services not putting out content in Welsh.
- ‘Tweets’ also include replies to comments (e.g. complaints, thank you notes, general conversations) which are rarely received on the Welsh accounts. Over the busy winter period, we are frequently replying to complaints/feedback directed at us on our English Twitter account.

Facebook

	Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru	Welsh Ambulance Services NHS Trust
New followers	59 65	4,647 7,546
New page likes	28 59	2,237 6,815
Total post engagement	1,564	433,529
Total page views	744	67,856
Total reach	136,237 12,612	9,792,474 2,135,600

	English Post	English Caption	Welsh Post	Welsh Caption
1	We are currently extremely busy For those who are less seriously ill or injured, there are other options available	Think carefully before dialling 999. If it is not an emergency, then use the:  @NHS111Wales symptom checkers  Your local pharmacy  Minor Injuries Unit  111 for urgent medical concerns only	Rydym yn hynod brysur ar hyn o bryd I'r rheiny sydd ddim mor ddifrifol wael neu wedi eu hanafu y mae opsiynau eraill ar gael	Meddyliwch yn ofalus cyn deialu 999. Os nad ydyw yn argyfwng yna defnyddiwch:  gwiriwr syptomau @NHS111Wales  Eich fferyllfa leol  Uned Mân Anafiadau  111 am faterion meddygol brys yn unig
2	Our emergency call handlers are very busy and doing everything they can to arrange help for those who need us	Please help us by only dialling 999 if it is a serious or life-threatening emergency. For urgent advice please use @NHS111Wales, your local pharmacy or Minor Injuries Unit	Mae ein gweithredwyr galwadau brys yn brysur iawn ac yn gwneud popeth o fewn eu gallu i drefnu cymorth i'r rheiny sydd ein hangen	Os gwelwch yn dda helpwch ni drwy ddeialu 999 os ydyw yn fater difrifol neu'n argyfwng sy'n peryglu bywyd yn unig. Am gyngor brys, os gwelwch yn dda defnyddiwch @GIG111Cymru, eich fferyllfa leol neu'r Uned Mân Anafiadau
3	The service is experiencing a very high demand	If it's urgent but it's not a serious or life-threatening emergency, please consider other options. In times of extremely high demand, some patients may wait longer for our help. If you need medical help fast but it's not an emergency, try our @NHS111Wales symptom checkers for advice and next steps  https://bit.ly/3hQf6XK	Mae galw mawr iawn am y gwasanaeth	Os ydyw yn fater brys, ond nad yw'n argyfwng difrifol neu'n peryglu bywyd, ystyriwch opsiynau eraill os gwelwch yn dda. Ar adegau pan fo galw mawr iawn, fe all rhai cleifion aros yn hirach am ein cymorth. Os ydych angen cymorth meddygol yn gyflym ond nad yw'n argyfwng, cysylltwch â'n gwirwyr syptomau @NHS111Wales am gyngor a'r camau nesaf  https://bit.ly/3hQf6XK
4	Our NHS 111 Wales service is experiencing a very high volume of calls	Demand on our 111 service means that some people may have problems getting through to us. If you do need us urgently, please keep trying or use our	Mae'r gwasanaeth GIG 111 Cymru yn profi nifer uchel iawn o alwadau	Mae pwysau ar ein gwasanaeth 111 yn golygu y gall rhai pobl gael problemau yn dod drwodd atom. Os ydych ein hangen ar frys, daliwch i alw os gwelwch yn dda neu defnyddiwch ein

		website for information, advice, and other services available to help you 📄 https://bit.ly/3K0FB8P		gwefan am wybodaeth, cyngor a gwasanaethau eraill ar gael i'ch helpu chi 📄 https://bit.ly/3K0FB8P
5	All our services remain extremely busy	In times of extremely high demand, some patients may wait longer for our help. Our staff over the phone and on the road are doing everything they can to help you. Please work #WithUsNotAgainstUs and respect ambulance workers	Mae ein holl wasanaethau yn parhau yn hynod brysur	Ar adegau pan fo galw mawr iawn, fe all rhai cleifion aros yn hirach am ein cymorth. Mae ein staff sy'n gweithio dros y ffôn ac ar y ffordd yn gwneud popeth o fewn eu cyrraedd i'ch helpu chi. Os gwelwch yn dda byddwch #GydaNiNidYnEinHerbyn a pharchwch y staff
6	Our 999 and 111 services are experiencing extremely high demand today	#HelpUsHelpYou by 📞 Only calling 999 for a serious or life-threatening emergency 🕒 Not calling 999 for an ETA 📞 Only calling back if the patient's condition worsens or they no longer need our help 📱 Using the @NHS111Wales symptom checkers 🏥 Taking yourself to the Emergency Department or Minor Injuries Unit	Mae ein gwasanaethau 999 ac 111 yn profi galw mawr iawn heddiw	📞 Alw 999 yn unig ar gyfer argyfwng difrifol neu'n peryglu bywyd 🕒 Peidio galw 999 am amcan amser cyrraedd 📞 Galw yn ôl dim ond os ydyw cyflwr y claf yn gwaethygu neu nad ydynt mwyach angen ein cymorth 📱 Defnyddio gwirwyr symptomau @NHS111Wales 🏥 Mynd i'r Adran Achosion Brys neu'r Uned Mân Anafiadau
7	Please only call 999 for the most serious life threatening injuries or illness and help keep our emergency vehicles free for those who desperately need us	We are experiencing very high levels of demand this evening across [INSERT AREA]. Please only call 999 for life threatening injuries or illness and make alternative arrangements to get to hospital to keep our emergency vehicles free for those who desperately need us	Ffoniwch 999 am yr anafiadau neu'r salwch mwyaf difrifol sy'n bygwth bywyd a helpwch i gadw ein cerbydau argyfwng yn rhad ac am ddim i'r rhai sydd ein hangen yn ddirfawr	Yr ydym yn profi lefelau uchel iawn o alw heno ar draws y [INSERT AREA]. Ffoniwch 999 am anafiadau neu salwch sy'n bygwth bywyd a gwnewch drefniadau amgen i gyrraedd yr ysbyty i gadw ein cerbydau brys yn rhad ac am ddim i'r rhai sydd eu hangen yn ddirfawr
		English Hashtags	Welsh Hashtags	

		#HelpUsHelpYou	#HelpwchNiHelpuChi	
		#BeWiseSaveLives	#ByddwchDdoethdAch ubwchFywydau	
		#StaySafe	#Arhoswch yn ddiogel	
		#WithUsNotAgainstUs	#GydaNiNidYnEinHerb yn	
		English Area Names	Welsh Area Names	
		South East	Y De-ddwyrain	
		South West	Y De-orllewin	
		South Wales	De Cymru	
		North East	Gogledd Ddwyrain	
		North West	Gogledd Orllewin	
		North Wales	Gogledd	
		Mid Wales	Y Canolbarth	
		East Wales	Dwyrain Cymru	
		West Wales	Gorllewin Cymru	

Further Information

For further information on the Welsh Language Standards please contact:

Melfyn Hughes
Welsh Language Services Manager

Welsh Ambulance Services NHS Trust
Tŷ Elwy
Ffordd Richard Davies
St Asaph
Denbighshire
LL17 0LJ

E-mail: Melfyn.hughes@wales.nhs.uk



AGENDA ITEM No	15
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

Revised Pay Progression Policy for NHS Wales

MEETING	People & Culture Committee
DATE	5 September 2022
EXECUTIVE	Dr Catherine Goodwin, Interim Director of Workforce and OD
AUTHOR	Sara Williams Workforce Policy & Governance Lead
CONTACT	Email: Sara.Williams5@wales.nhs.uk

EXECUTIVE SUMMARY
<p>The purpose of the report is to note the revised Pay Progression Policy for NHS Wales, to be adopted by the Trust.</p> <p>The revised Policy was issued by NHS Wales Employers in June 2022 and is attached as an Appendix to this paper.</p>

KEY ISSUES/IMPLICATIONS
<p>Key issues which are to be brought to the attention of the Committee/Board are as follows:</p> <ol style="list-style-type: none"> The All Wales Pay Progression Policy has been slightly updated and this version now includes reference to the Respect and Resolution policy, in place of the Grievance Policy and ensures consistency between section 5.7 and the flowchart <p>The Committee is asked to note and formally adopt the revised Policy for NHS Wales.</p>

REPORT APPROVAL ROUTE		
WHERE	WHEN	WHY
WOD Business Meeting	18 July 2022	To note the amended Policy
Trade Union Partners Cell	19 July 2022	To note the Policy for approval
EMT	17 August 2022	To note the Policy for approval
People & Culture Committee	5 September 2022	Approval and adoption

REPORT APPENDICES
Appendix 1a – NHS Wales Pay Progression Policy (English) Appendix 1b – NHS Wales Pay Progression Policy (Cymraeg)

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Y	Financial Implications	Y
Environmental/Sustainability	Y	Legal Implications	Y
Estate	Y	Patient Safety/Safeguarding	Y
Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	Y	Socio Economic Duty	Y
Health and Safety	Y	TU Partner Consultation	Y

A light green map of Wales is centered on a teal background. The map is divided into several irregular regions by white outlines, representing health regions. The text 'Pay Progression Policy' is overlaid in white on the western part of the map.

Pay Progression Policy



GIG
CYMRU
NHS
WALES

Sections

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**Pay Progression
Policy**

02

**The Pay Progression
Process**

03

**Appendix 1:
Legal issues**

04

**Appendix 2:
Principles and
Best Practice to
be integrated in
to Local Appraisal**

05

**Appendix 3:
EQUALITY
IMPACT
ASSESSMENT**

01

Pay Progression Policy

Approved by: Welsh Partnership Forum

Issue Date: January 2020

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01 NHS Wales Pay Progression Policy

1. The Core Principles of NHS Wales:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimisation of any patient, service user or member of employees.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support employees working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.



These principles have been developed to help address some of the pressures felt by employees in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

2. Policy Aims, Summary and The Appraisal Process

Policy Aims

- **2.1** This policy applies to all members of staff on NHS Terms and Conditions of Service and has been developed in line with Annex 23 of the NHS Terms and Conditions Handbook and must be used in conjunction with local PADR and KSF policies and with the PADR/ Appraisal principles.
- **2.2** This policy sets out the reasons for pay progression and the procedure to be followed to deal with the pay step process. It clarifies the performance ratings to be used and includes a description of each rating.

The policy also covers issues arising relating to pay step progression and deferment and the process for handling any disagreement and it aims to ensure consistency of approach and application.

- **2.3** The aim of the pay progression approach is to improve performance and productivity as well as support the implementation of change by helping staff to understand more clearly what is expected of them in terms of behaviours and new ways of working. The aim is to provide a framework that seeks to get value for money by linking pay progression with performance rather than time served in a role.
- **2.4** The Pay Progression Policy needs to work closely with the Appraisal Process and therefore sets out some best practice principles for appraisal that all organisations should embed in their local processes.

These principles are:

- We will agree and understand what's expected of us in terms of what we should be doing and how we should be doing it
- We will all receive constructive and timely feedback on how we have done
- We will all ensure that we actively seek to develop and improve what we are doing for the benefit of patients
- **2.5** The Pay Progression Policy together with local Appraisal Policies will encourage and reward all staff to give their best contribution whatever their job is and to ensure that when pay steps are awarded they are a reward for performance not because of time in employment.
- **2.6** The Chief Executive of NHS Wales will ensure that the policy is implemented fairly.



- **2.7** This policy will be subject to a full review in April 2021 when a full year of data on pay progression will be available. This review will include an impact assessment of the number of first and final written disciplinary warnings against the protected characteristics outlined in the Equality Act.

3. Pay Progression summary

- **3.1** To help us give the best possible care and services, whatever our role, it is important that we understand what is expected of us, how our contribution helps the organisation achieve its aims and that we are rewarded for doing the right things well and not because of another year in post. Therefore, pay steps will only be given after we've achieved what's expected of us in 3 areas:

Doing the right things, Doing them the right way, Doing things better.

- **3.2** The reason for introducing pay progression linked to performance is to help improve your performance and productivity and that of the organisation. It will better support the implementation of change by helping you and your manager agree what is expected of you in terms of your behaviours and new ways of working. It is important to understand that this has been introduced to increase value for money and to promote fairness by linking pay progression with performance rather than basing incremental progression simply on time served in the role.
- **3.3** Alongside this rationale, Annex 23 of the NHS Terms and Conditions of Service sets out five specific pay progression standards which set out requirements which need to be demonstrated before you are able to progress to your next pay step point

on your pay step date.

These standards are:

- i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards.
 - ii. There is no formal capability process in place.
 - iii. There is no formal disciplinary sanction live on your record (this policy expands on the specific application of this provision in paragraph 5.4.4).
 - iv. Statutory and/or mandatory training has been completed.
 - v. For line managers only – appraisals have been completed for all your staff as required.
- **3.4** Your pay step submissions will only take place after two, three or five years depending on your pay band. Your appraisals will continue to take place annually.
 - **3.5** All pay bands will have either one or two step points with specified minimum periods before you become eligible to progress. Your pay step point is set in relation to your start date in that pay band. It is expected that if you meet the required standards at your pay step date you will progress to your next pay step point.
 - **3.6** Each year, you and your manager will review how well you have met your objectives, whether you have met the pay progression standards and agree whether your performance is satisfactory or unsatisfactory. In the year when a pay step is due your performance will need to be satisfactory for you to progress to the next pay step point.



If it is unsatisfactory then you will not receive your pay step and you will work with your manager to agree a plan to help you meet the requirements in order that you receive your pay step once the relevant requirements are shown to have been met.

you are at the top of the scale.

Importantly, there will be checks in place to make sure that if you have not been able to meet what was expected of you, through no fault of your own, then you should receive the next pay step.

- **3.7** Pay progression works in parallel with appraisal however they remain as two separate processes. The flow diagram overleaf shows how the two work together.

4. The Appraisal Process

- **4.1** This Pay Progression Policy does not replace or change Appraisal policies but does set out three principles that will be embedded into local appraisal processes. They are:
 - *We will agree and understand what's expected of us in terms of what we should be doing and how we should be doing it*
 - *We will all receive constructive and timely feedback on how we have done*
 - *We will all ensure that we actively seek to develop and improve what we are doing for the benefit of patients*
- **4.2** The details of best practice appraisal techniques which will support performance linked pay progression are included in appendix 2 and should be embedded in your local appraisal processes.
- **4.3** Your appraisals should continue to take place on an annual basis at the very least, regardless of whether it is a year which includes a pay step date, or

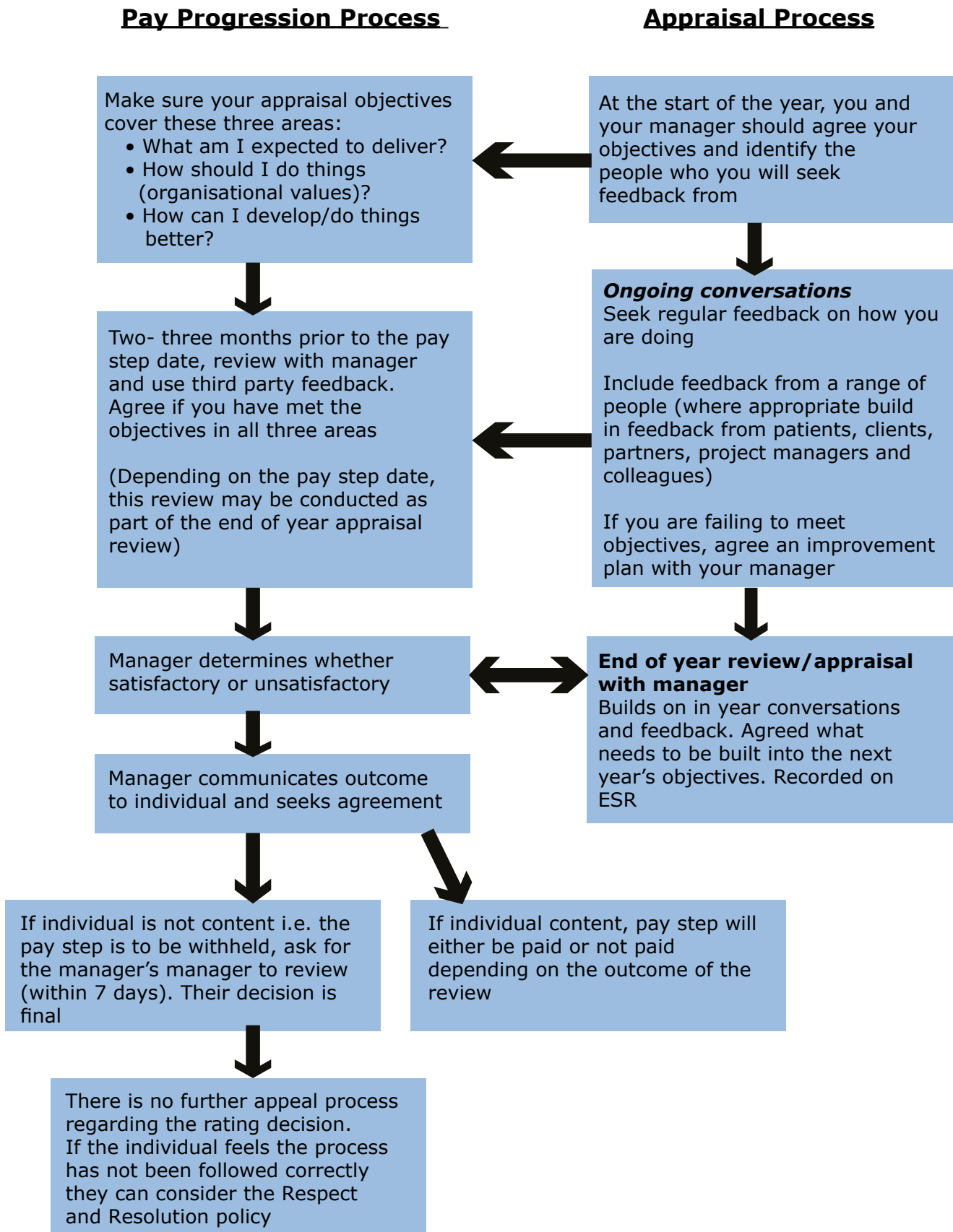


02

The Pay Progression Process

2

The Pay Progression Process



5. Who does what and when?

5.1 Agreeing Objectives

As part of the annual appraisal process, you and your manager will agree a set of objectives which cover:

- what you need to do i.e. the things you need to deliver;
- how you need to do things, i.e. your behaviours, and the way you demonstrate the values;
- ways in which you can seek to develop and improve what you are doing.

You should play an active role in setting the objectives and checking that you understand what your manager expects of you as the extent to which you meet these objectives will determine whether or not you receive your pay step when it is due.

5.2 Feedback

Both you and your manager should actively seek feedback and information from different people (e.g. patients, colleagues, partners), any relevant results/data, project/improvement work you have been involved in. This feedback will help you and your manager prepare for your pay progression review and support the rating you are given.

5.3 Pay Step Review

You should have a review 8-12 weeks before your pay step is due which will be arranged by your manager. Both you and your manager should prepare in advance. At the meeting you should discuss examples of how you have met your objectives, where appropriate using feedback from other people. Depending on your pay step date, this meeting may also be your end of year appraisal/PADR review. It is good practice to have regular conversations and feedback through out the year so there should be no surprises.

If you have been struggling to meet your objectives, this should have been discussed earlier in the year and an improvement plan agreed.

5.4 Agreeing the rating

- **5.4.1** At the end of your pay step review, your manager will tell you your rating i.e. whether you are satisfactory or unsatisfactory and their reasons for the decision. If you both agree the rating, your manager will inform the W&OD department and payroll and undertake the necessary steps in relation to ESR. If the rating is satisfactory your pay step uplift will be paid, if the rating is unsatisfactory you will not receive the pay step.

Satisfactory

Has successfully met core objectives and demonstrated satisfactory progress in achieving other objectives and met the national pay progression principles set out overleaf

Unsatisfactory

Has been unsuccessful in meeting core objectives and/or has not demonstrated satisfactory progress in achieving other objectives and/or has not met the national pay progression principles set out overleaf

Individual organisations will need to determine what will constitute a satisfactory or unsatisfactory performance on a departmental, team or individual basis. It will depend on the type and nature of the role but should be based on clear, reasonable, agreed objectives.



Managers should agree a core set of achievable objectives on which pay progression is assessed but also include furthermore ambitious objectives as part of a wider performance review process. It must, however, be made clear what level of performance would amount to satisfactory and therefore what would be an unsatisfactory level of performance.

- **5.4.2** In addition to achieving objectives the following national pay progression standards will also need to be demonstrated:
 - i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards.
 - ii. There is no formal capability process in place.
 - iii. There is no formal disciplinary sanction live on the staff member's record (the specific application of this provision is set out in paragraph 5.4.4).
 - iv. Statutory and/or mandatory training has been completed.
 - v. For line managers only – appraisals have been completed for all their staff as required.
- **5.4.3** It is expected that you will achieve the required standards at the point of your pay step date. It is also expected that you and your line manager should have had regular discussions about any problems in reaching the required standards before the pay step date. This will allow time for issues to be raised and possible solutions found to enable the pay step point to be opened on time.
- **5.4.4** Your manager must use the pay step review meeting to discuss the standards. If any of the standards have not been met, there should be a review of the previous discussions about these to consider any mitigating factors and to record the decision.

With regard to live disciplinary sanctions, if you are in receipt of a first written warning, your progression won't be delayed because of the warning. Your manager will however, consider the reasons and circumstances giving rise to the sanction, as well as your performance and behaviour since the sanction was applied. This will form part of the information which your manager will use in determining a pay progression rating. If following due consideration your manager determines that you should receive a satisfactory rating, then you will progress to the next pay step. If you receive an unsatisfactory rating your pay step will be delayed. The decision will be clearly recorded, noting the rationale for withholding the pay step. A final warning will always result in a pay step delay.

- **5.4.5** Importantly, if you have not been able to meet what was expected of you, through no fault of your own, then you should receive the pay step.
- **5.4.6** Pay step points will be closed on the payroll system. Once the pay step review has been successfully completed your manager must take the necessary action to open the pay step point.
- **5.4.7** Managers must ensure that the pay step submission process is completed in a timely fashion to ensure that pay step points can be implemented in time for the staff member's pay step date. This must take account of local payroll timescales and ESR requirements.
- **5.4.8** Although you must have successfully completed your last appraisal to move to your next pay step point, the date the appraisal takes place does not have to be linked to your pay step date. If your last appraisal outcome was not satisfactory but remedial actions have been successfully completed by the time of the pay step date you will be able to progress without delay if you meet the other standards.



5.5 Decisions to delay a pay step

- **5.5.1** In situations where standards have not been met and there are no mitigating factors sufficient to justify this, your pay step will be delayed. Your line manager will discuss and agree a plan with you for any remedial action needed to ensure that the required standards for pay progression are met, including a timescale, and how any training and support needs will be met. In such circumstances you must take all necessary steps to meet the requirements as soon as possible and your line manager must provide you with the necessary support.
- **5.5.2** A further pay step review meeting should be arranged at an agreed date to review progress and, where satisfactory, initiate the opening of the pay step. The effective date for progressing to the next pay step should be the earliest date that the relevant requirements are shown to have been met. The pay step date for future years will remain unchanged.
- **5.5.3** Where a pay step is delayed due to a live disciplinary sanction, or a formal capability process, your line manager should initiate a pay step review meeting before the expiry of the sanction or capability plan. This should be used to confirm that all other requirements have been met and to ensure that you progress to the next pay step, effective the day after the sanction expires. Any future pay step dates will remain unchanged.

5.6 Integrating outcomes into next year's appraisal

- **5.6.1** The pay step review should be part of your ongoing performance management discussions with your manager and will provide a useful source of feedback to take into account in the end of year appraisal review and future objective setting.

If you are rated satisfactory then you and your manager can discuss whether you require further development opportunities etc. If you are rated unsatisfactory you and your manager should agree a plan to help you improve and get your performance back on track. These objectives should be included and reviewed in your next appraisal.

- **5.6.2** If your manager identifies that you have been unable to meet your objectives through no fault of your own, then you and your manager will need to work together to reset your objectives or remove the barriers to their achievement

5.7 Dealing with disagreement

Very occasionally, you and your manager may disagree on how well you have met your objectives and therefore on the rating you are given. Wherever possible, you should try to resolve issues with your manager. If your manager rates you unsatisfactory and you feel that you have demonstrated satisfactory progress in achieving your objectives and you have met the national pay progression principles, and you can't resolve the reason for an unsatisfactory rating directly with your manager, then you can ask your manager's manager to review the decision.

This process will take place within the provisions of the Respect and Resolution Policy and should be undertaken within 14 calendar days of notification to your manager that you wish to.

The notification requirements for requesting a formal resolution within the Respect and Resolution policy should be used, setting out the grounds upon which you consider the rating should be reviewed. Your manager's manager will want to understand both you and your manager's points of view. She/he will then make a decision on the rating and will communicate their reasons to both you and your manager.

If you are unhappy with the process, have other concerns not linked directly to the result of your appraisal, or believe that you have been discriminated against in any way, then please raise a formal request for resolution in line with the Respect and Resolution policy. Your manager will then inform the W&OD department and payroll, and update ESR. If it is agreed that you should receive your pay step it will be backdated to the original pay step date.

5.8 Band 8c/d and 9 Roles

We recognise that rewarding good performance with pay steps is a significant and positive change. We also recognise that senior leaders are in the main already expected to be setting and reviewing objectives in this way. They are also more likely to be used to asking for and receiving feedback from a number of people. Additionally, we know it's important for leaders to model the behaviours we want from others.

Therefore, for Band 8c, 8d and 9 roles, there are the following differences:

In the year after you have reached the top of bands 8c, 8d or 9, 5 per cent or 10 per cent of basic salary will become re-earnable. Where a satisfactory performance is agreed, your salary will be retained at the top of the band.

If your performance is deemed to be unsatisfactory, your salary may be reduced by 5 per cent or 10 per cent * from the pay step date. You will be able to restore your salary to the top of the band at the end of the following year by meeting the required standards. You have the right to contest a decision to reduce your pay using the Dealing with Disagreement process outlined above.

*the NHS Staff Council Executive has advised that there are plans to develop some criteria in relation to the application of the re-earnable 5% and 10% of salary and this section of the policy will include the appropriate details once these have been determined.



03

Appendix 1: Legal issues

Absence from Work When a Pay Step Is Due

If you are absent from work for reasons such as sickness or parental leave when a pay step is due, the principle of equal and fair treatment should be followed so that no detriment is suffered as a result.

In the case of planned long-term paid absence such as maternity, adoption and shared parental leave your pay step review can be conducted early if this is reasonable and practical, allowing the pay step to be applied on your pay step date in your absence.

If you are on long-term paid absence such as maternity, adoption and shared parental leave and a pay step review cannot be conducted prior to the pay step date, the pay step point should be automatically applied in your absence provided that there are no disciplinary sanctions or formal capability processes in place.

If there is a live disciplinary sanction in place at the point you go on leave, the pay step point should be applied in your absence if appropriate, effective from the day after the sanction expires.

If there was an active formal capability process underway at the point you go on leave, the pay step point can be delayed. The improvement process should be resumed immediately upon your return. On satisfactory completion, the period of absence should be set aside, and the pay step point backdated to an agreed date as if you had completed the improvement process without being absent.

Suspension from work on full pay is a neutral act. In order to ensure this is the case, your employer should ensure that your pay step point is applied from your pay step review date where you are suspended on that date, provided your performance was deemed satisfactory and you have met the national pay progression standards.

These standards are:

- i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards.
- ii. There is no formal capability process in place.
- iii. There is no formal disciplinary sanction live on your record (this policy expands on the specific application of this provision in paragraph 5.4.4.
- iv. Statutory and/or mandatory training has been completed.
- v. For line managers only – appraisals have been completed for all your staff as required.

If it is unsatisfactory then you will not receive your pay step and you will work with your manager to agree a plan to help you meet the requirements in order that you receive your pay step once the relevant requirements are shown to have been met.

Importantly, there will be checks in place to make sure that if you have not been able to meet what was expected of you, through no fault of your own, then you should receive the next pay step.

Sabbaticals/career breaks are by definition your choice, therefore if you choose to take a sabbatical/career break at any stage during your career your pay progression will be 'frozen' at the incremental point you have achieved at your last working day.

You, therefore, will return to work at the same incremental point you left on.

An assessment will need to be undertaken within a few weeks of returning to identify your training and development needs.

Equality Monitoring

will monitor the application of the policy against the protected characteristics in line with the Equality Act 2010. This may be done a sample basis. A report will then be provided to the Board or appropriate sub committee on an annual basis.

Other Extenuating Circumstances

recognises that there may be other extenuating circumstances that have not already been covered in this section. In cases where it is believed there are extenuating circumstances for not achieving the progression criteria, advice should be sought from your line manager and a relevant member of the W&OD department.



04

Appendix 2: Principles and Best Practice to be integrated in to Local Appraisal processes

4

Appendix 2: Principles and Best Practice to be integrated in to Local Appraisal processes

To help us give the best possible care and services, whatever our role, it is important that we understand what is expected of us and how our personal contribution helps our teams and the organisation achieve its aims.

Appraisal discussions should be ongoing and:

- Provide feedback on how we have done - feedback should be honest, constructive and timely and where possible we should seek feedback from a range of people we work with (e.g. colleagues, stakeholders, patients, project managers)
- Ensure each of us agree and understand what's expected of us and how we should be doing things i.e. what we need to deliver and the behaviours and ways of working that are expected of us
- Ensure that we develop ourselves to do things better and/or move to another role and have a plan of what learning we are going to do

Managers involved in reviewing, assessing, agreeing objectives and supporting personal development plans, must ensure that they are competent and confident to do this role. Learning and development teams can help support managers where this is needed.

Agreeing Objectives

It is vital that we know what is expected of us. Importantly, we should agree our specific objectives so that we own them. Objective setting should always be a two-way conversation.

For objectives to be meaningful, they must be SMART: specific, measurable, realistic, time-based and achievable; they must particularly be "within our circle of control". You should not agree objectives on things you can do nothing about. Good objectives are ones where the outcomes are as a result of what we do and how we behave, i.e. they are things we can control.

Agreeing Development Needs

As part of the review or setting of objectives, it is likely that you will have identified things and/or ways you can do better. These are likely to need us to spend time developing ourselves and you should agree the best way to do this with your manager. Often a formal training course may not be the only or the best solution and you should think about the time you need to spend on your development, not just the budget you may need.

Keeping Records

Keeping accurate records is important and any records that you and your manager keep should be within the General Data Protection Regulations 2018 requirements. Managers must ensure that all details of appraisal meetings are recorded on ESR.



05

Appendix 3: EQUALITY IMPACT ASSESSMENT

1. General

Title of document	Pay Progression Policy (non-medical staff)
Purpose of document	To set out the procedure to be followed for linking pay progression to performance, to describe the process for handling annual incremental reviews, addressing issues arising relating to incremental progression and deferment and to ensure consistency of approach and application. The document shows how pay progression and appraisal processes align and reiterated the need for all staff to have a clear understanding of their expected role and function and have the opportunity to receive feedback about their performance in order that they may develop to their maximum potential.
Intended scope	All non-medical and dental staff employed by NHS Wales.

2. Consultation

Which groups/associations/bodies or individuals were consulted in the formulation of this document?	NHS Wales Partnership Forum (including all unions recognised by NHS Wales); Strategic Pay Taskforce Implementation Group; NHS organisations; Line Managers.
What was the impact of any feedback on the document?	Amendments were made and a commitment given to a full review in April 2021 when a full year of data will be available. See paragraph 2.7.
Who was involved in the approval of the final document?	NHS Wales Partnership Forum & Strategic Pay Taskforce Implementation Group.
Any other comments to record?	

3. Equality Impact Assessment

Does the document unfairly affect certain staff or groups of staff? If so, please state how this is justified.	No.
What measures are proposed to address any inequity?	None
Can the document be made available in alternative format or in translation?	Yes, on request to Workforce & OD Directors.

4. Compliance Assessment

Does the document comply with relevant employment legislation? Please specify.	Yes.

5. Document assessed by:

Name	Pay Progression Partnership Review Group
Post Title/Position	
Date	June 2019





A map of Wales, divided into several health regions. The map is rendered in a light teal color with white outlines for the regional boundaries. The regions are roughly: North Wales, Central Wales, South Wales, and a small region in the southwest. The map is set against a dark teal background with a curved orange border at the top and bottom.

Polisi ar Ddatblygiad Cyflog

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Ddatblygiad
Cyflog**

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**Crynodeb o
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03

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ac Arferion Gorau
i'w hintegreiddio
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05

**Atodiad 3:
ASESIAD O'R
EFFAITH AR
GYDRADDOLDEB**

01

Polisi ar Ddatblygiad Cyflog

Cymeradwywyd gan: Fforwm Partneriaeth Cymru

Dyddiad Cyhoeddi: Ionawr 2020



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01 Polisi ar Ddatblygiad Cyflog

1. Egwyddorion Craidd GIG Cymru yw:

- **Rydym yn rhoi cleifion a defnyddwyr ein gwasanaethau yn gyntaf:** Rydym yn gweithio gyda'r cyhoedd a chleifion/defnyddwyr gwasanaethau drwy gyd-gynhyrchu, gan wneud yr hyn sydd ei angen yn unig, dim mwy, dim llai a pheidio â gwneud dim niwed. Rydym yn onest, yn agored, yn llawn empathi ac yn dosturiol. Rydym yn sicrhau ansawdd a diogelwch yn fwy na dim arall drwy ddarparu'r gofal gorau posibl ar bob achlysur.
- **Rydym yn ymdrechu i wella ein gofal:** Rydym yn gofalu am y rhai sydd â'r angen iechyd mwyaf yn gyntaf, gan wneud y defnydd mwyaf effeithiol posibl o'r holl sgiliau ac adnoddau a gan wneud ymdrech barhaus i sicrhau bod y gofal a'r gwasanaethau yr ydym yn eu darparu'n addas ar gyfer anghenion y defnyddwyr. Rydym yn integreiddio gwelliant yn ein gwaith bob dydd, trwy fod yn agored i newid yn ein holl waith, sydd hefyd yn lleihau niwed a gwastraff.
- **Rydym yn canolbwyntio ar lesiant ac atal:** Rydym yn ceisio gwella iechyd a chael gwared ag anghydraddoldebau drwy gydweithio gyda phobl Cymru i sicrhau eu llesiant heddiw ac ar gyfer y blynyddoedd a'r cenedlaethau i ddod.
- **Rydym yn myfyrio ar ein profiadau ac yn dysgu:** Rydym yn buddsoddi mewn dysgu a datblygu. Rydym yn gwneud penderfyniadau sy'n fanteisiol i gleifion a defnyddwyr ein gwasanaethau drwy ddefnyddio

adnoddau, systemau ac amgylcheddau sy'n caniatáu i ni weithio'n fedrus, yn ddiogel ac yn effeithiol. Rydym yn ddyfeisgar, yn addasu ac yn lleihau amrywiadau amhriodol gan ystyried y sylfaen briodol o dystiolaeth i'n harwain.

- **Rydym yn gweithio mewn partneriaeth ac fel tîm:** Rydym yn gweithio gydag unigolion gan gynnwys cleifion, cydweithwyr a sefydliadau eraill; gan ymfalchïo yn ein gwaith, gwerthfawrogi a pharchu ein gilydd, bod yn onest ac yn agored a gwrando ar gyfraniad eraill. Rydym yn ceisio datrys anghytundeb yn effeithiol ac yn gyflym, ac nid ydym yn goddef bwlio neu erledigaeth o unrhyw glaf, defnyddiwr gwasanaeth neu aelod o staff.
- **Rydym yn gwerthfawrogi pawb sy'n gweithio i'r GIG:** Rydym yn cefnogi'n holl gydweithwyr wrth iddynt wneud y swyddi y maent wedi cytuno i'w gwneud. Byddwn yn gofyn yn rheolaidd beth sydd ei angen arnynt i wneud eu gwaith yn well, ac yn ceisio darparu'r cyfleusterau angenrheidiol i ragori yn y gofal y maent yn ei roi. Byddwn yn gwrando ar ein cydweithwyr ac yn gweithredu ar eu hadborth a'u pryderon.

Maent wedi cael eu datblygu er mwyn helpu a chefnogi staff sy'n gweithio yn y GIG yng Nghymru.

Yr hyn sydd wrth wraidd GIG Cymru yw pobl, gweithio gyda phobl, i ofalu am bobl. Mae'r Egwyddorion Craidd hyn yn disgrifio sut gallwn weithio gyda'n gilydd i sicrhau bod yr hyn rydym yn ei wneud a sut rydym yn ei wneud yn cael ei ategu gan ymdeimlad cyffredin o bwrpas y mae pob un ohonom yn ei rannu a'i ddeall.



Mae'r GIG dan bwysau parhaol i gyflenwi mwy o wasanaethau, gyda chanlyniadau gwell a chynnal a gwella ansawdd mewn cyfnod o heriau ariannol sylweddol, disgwyliadau uchel gan y cyhoedd a gyda phoblogaeth sy'n heneiddio ac yn profi lefelau uwch o gyflyrau cronig.

Datblygwyd yr egwyddorion hyn i helpu i fynd i'r afael â'r pwysau y mae'r galwadau hyn yn ei achosi i staff. Byddant yn rhoi cydbwysedd i'r ffordd rydym yn

cydweithio er mwyn i ni ddibynnu llai ar y broses ac yn cael ein cynorthwyo i wneud y peth iawn trwy gael ein llywio gan yr egwyddorion hyn wrth roi polisiau a gweithdrefnau ar waith yn y gweithlu.

Fel pobl sy'n gweithio yn y gwasanaeth iechyd, byddwn yn eu defnyddio i'n helpu i wneud ein gwaith gydag ymrwymiad ymroddedig parhaus i'r rhai sy'n defnyddio ein gwasanaethau, mewn cyfnodau o newid cyson.

Mae'r Egwyddorion yn rhan o ymrwymiad parhaus i gryfhau gwerthoedd cenedlaethol a lleol a fframweithiau ymddygiad sydd eisoes wedi'u sefydlu ledled Byrddau Iechyd ac Ymddiriedolaethau.

Datblygwyd yr Egwyddorion mewn partneriaeth â chynrychiolwyr o blith y cyflogwyr a'r staff.

Defnyddir yr Egwyddorion i greu dull mwy syml a chyson o ran rheoli materion yn ymwneud â chyflogaeth yn y gweithle.

2. Nodau'r Polisi, Crynodeb a'r Broses Werthuso

Nodau'r Polisi

- **2.1** Mae'r polisi hwn gan GIG Cymru yn berthnasol i'r holl aelodau staff sy'n gweithio o dan Delerau ac Amodau Gwasanaeth y GIG, ac fe'i datblygwyd yn unol ag Atodiad 23 Llawlyfr Telerau

ac Amodau'r GIG. Rhaid i'r polisi gael ei ddefnyddio ar y cyd â pholisiau lleol ar yr Adolygiad Gwerthuso a Datblygu Perfformiad (PADR) a'r Fframwaith Gwybodaeth a Sgiliau (KSF), ac egwyddorion PADR/Gwerthuso.

- **2.2** Mae'r polisi hwn yn nodi'r rhesymau dros ddatblygiad cyflog a'r weithdrefn i'w dilyn i ddelio â'r broses godiad cyflog. Mae'n egluro'r graddau perfformiad a ddefnyddir ac mae'n cynnwys disgrifiad o bob gradd. Mae'r polisi hefyd yn ymdrin â materion sy'n codi sy'n gysylltiedig â datblygiad codiad cyflog a'r broses o'i ohirio, a'r broses ar gyfer ymdrin ag unrhyw anghytundeb, a'i nod yw sicrhau cysondeb o ran dulliau a chymhwyso.
- **2.3** Nod y dull datblygiad cyflog yw gwella perfformiad a chynhyrchedd, yn ogystal â helpu i roi'r newid hwn ar waith trwy helpu staff i deall yn gliriach yr hyn y disgwylir ohonynt o ran ymddygiadau a ffyrdd newydd o weithio. Y nod yw darparu fframwaith sy'n ceisio sicrhau gwerth am arian trwy gysylltu datblygiad cyflog â pherfformiad yn hytrach na'r amser a dreulir mewn rôl.
- **2.4** Mae angen i'r Polisi ar Ddatblygiad Cyflog weithio'n agos â'r Broses Werthuso ac, felly, mae'n amlinellu rhai egwyddorion ar gyfer arferion gorau wrth werthuso a dylai pob Bwrdd Iechyd ac Ymddiriedolaeth wreiddio'r rhain yn eu prosesau lleol.

Dyma'r egwyddorion hyn:

- Byddwn yn cytuno ar yr hyn y disgwylir ohonom ni o safbwynt yr hyn y dylem fod yn ei wneud a sut y dylem ei wneud, a byddwn yn deall hynny
- Bydd pob un ohonom yn cael adborth adeiladol ac amserol ar sut rydym ni wedi gwneud
- Bydd pob un ohonom yn sicrhau ein bod ni'n mynd ati i geisio datblygu a gwella'r hyn rydym ni'n ei wneud er budd cleifion

- **2.5** Bydd y Polisi ar Ddatblygiad Cyflog, ynghyd â Pholisiau Gwerthuso lleol, yn annog ac yn gwobrwyo staff i gyfrannu o'u gorau beth bynnag yw eu swydd, ac i sicrhau y rhoddir codiad cyflog yn wobwr am berfformiad, nid oherwydd cyfnod mewn cyflogaeth.
- **2.6** Bydd Prif Weithredwr GIG Cymru yn sicrhau bod y polisi'n cael ei roi ar waith yn deg
- **2.7** Bydd y polisi hwn yn ddarostyngedig i adolygiad llawn ym mis Ebrill 2021 pan fydd blwyddyn lawn o ddata ar ddatblygiad cyflog ar gael. Bydd yr adolygiad hwn yn cynnwys asesiad effaith o nifer y rhybuddion disgyblu ysgrifenedig cyntaf a therfynol yn erbyn y nodweddion gwarchodedig a amlinellir yn y Ddeddf Cydraddoldeb.

3. Crynodeb o Ddatblygiad Cyflog

- **3.1** I'n helpu ni i roi'r gofal a'r gwasanaethau gorau posibl, beth bynnag yw ein rôl, mae'n bwysig ein bod yn deall yr hyn y disgwylir ohonom, sut mae ein cyfraniad yn helpu'r sefydliad i gyflawni ei nodau a'n bod ni'n cael ein gwobrwyo am wneud y pethau cywir yn dda, nid oherwydd y treuliyd blwyddyn arall yn y swydd. Felly, ni fydd codiad cyflog ond yn cael ei roi ar ôl i ni gyflawni'r hyn y disgwylir ohonom mewn 3 maes:

Gwneud y pethau cywir, Eu gwneud nhw yn y ffordd gywir, Gwneud pethau mewn ffordd well.

- **3.2** Y rheswm dros gyflwyno datblygiad cyflog yn gysylltiedig â pherfformiad yw helpu i wella eich perfformiad a'ch cynhyrchedd chi, a pherfformiad a chynhyrchedd y sefydliad. Bydd yn helpu'n well i roi newid ar waith trwy eich helpu chi a'ch rheolwr i gytuno ar yr hyn y disgwylir ohonoch o ran eich ymddygiadau a ffyrdd newydd o weithio. Mae'n bwysig

deall bod hyn wedi cael ei gyflwyno i gynyddu gwerth am arian ac annog tegwch trwy gysylltu datblygiad cyflog â pherfformiad yn hytrach na seilio datblygiad cynyddrannol ar gyfnod yn y rôl yn unig.

- **3.3** Ochr yn ochr â'r rhesymeg hon, mae Atodiad 23 o Delerau ac Amodau Gwasanaeth y GIG yn nodi pum safon datblygiad cyflog benodol sy'n nodi gofynion y mae'n rhaid eu dangos cyn y gallwch symud ymlaen i'ch codiad cyflog nesaf ar ddyddiad eich codiad cyflog.

Dyma'r safonau hyn:

- i. Cwblhawyd y broses werthuso o fewn y 12 mis diwethaf ac mae'r canlyniadau'n unol â safonau'r sefydliad.
 - ii. Nid oes proses allu ffurfiol ar waith.
 - iii. Nid oes unrhyw gosb ddisgyblu ffurfiol yn bresennol ar eich cofnod (mae'r polisi hwn yn ehangu ar gymhwyso'r ddarpariaeth hon yn benodol ym mharagraff 5.4.4).
 - iv. Mae hyfforddiant statudol a/neu orfodol wedi'i gwblhau.
 - v. Ar gyfer rheolwyr llinell yn unig - cwblhawyd gwerthusiadau ar gyfer eich holl staff yn ôl yr angen.
- **3.4** Dim ond ar ôl dwy, tair neu bum mlynedd y bydd eich cyflwyniadau codiad cyflog yn digwydd yn dibynnu ar eich band cyflog. Bydd eich arfarniadau yn parhau i gael eu cynnal yn flynyddol.
 - **3.5** Bydd gan bob band cyflog naill ai un neu ddau o bwyntiau codiad cyflog gydag isafswm cyfnodau penodol cyn i chi ddod yn gymwys i symud ymlaen. Mae eich codiad cyflog wedi'i bennu mewn perthynas â'ch dyddiad cychwyn



yn y band tâl hwnnw. Os byddwch yn cwrdd â'r safonau gofynnol ar ddyddiad eich codiad cyflog, disgwylir y byddwch yn symud ymlaen i'ch pwynt codiad cyflog nesaf.

- **3.6** Bob blwyddyn, byddwch chi a'ch rheolwr yn adolygu pa mor dda rydych chi wedi bodloni'ch amcanion codiad cyflog ac yn cytuno p'un a yw eich perfformiad yn foddhaol neu'n anfoddhaol. Yn y flwyddyn pan fydd codiad cyflog yn ddyledus, bydd angen i'ch perfformiad fod yn foddhaol i chi symud ymlaen i'r pwynt codiad cyflog nesaf. Os yw'n anfoddhaol, yna ni fyddwch yn derbyn eich codiad cyflog a byddwch yn gweithio gyda'ch rheolwr i gytuno ar gynllun i'ch helpu i fodloni'r gofynion er mwyn i chi dderbyn eich codiad cyflog unwaith y dangosir bod y gofynion perthnasol wedi'u bodloni.

Yn bwysig, os na fu'n bosibl i chi fodloni'r hyn y disgwylid ohonoch, ac nad oedd unrhyw fai arnoch chi am hynny, bydd gwiriadau ar waith i sicrhau y dylech dderbyn y codiad cyflog nesaf.

- **2.7** Mae datblygiad cyflog yn gweithio ochr yn ochr â gwerthuso, ond maent yn parhau'n ddwy broses ar wahân. Mae'r diagram llif isod yn dangos sut mae'r ddwy'n gweithio gyda'i gilydd.

4. Y Broses Werthuso

- **4.1** Nid yw'r Polisi hwn ar Ddatblygiad Cyflog yn disodli nac yn newid Polisiâu Gwerthuso, ond mae'n amlinellu tair egwyddor a fydd yn cael eu gwreiddio mewn prosesau gwerthuso lleol. Dyma'r egwyddorion:

- *Byddwn yn cytuno ar yr hyn y disgwylir ohonom ni o safbwynt yr hyn y dylem fod yn ei wneud a sut y dylem ei wneud, a byddwn yn deall hynny*
- *Bydd pob un ohonom yn cael adborth adeiladol ac amserol ar sut rydym ni wedi gwneud*

- *Bydd pob un ohonom yn sicrhau ein bod ni'n mynd ati i geisio datblygu a gwella'r hyn rydym ni'n ei wneud er budd cleifion*

- **4.2** Mae manylion technegau arferion gorau wrth werthuso, a fydd yn cefnogi datblygiad cyflog yn gysylltiedig â pherfformiad, wedi'u cynnwys yn atodiad A a dylent gael eu gwreiddio yn eich prosesau gwerthuso lleol.
- **4.3** Dylai eich arfarniadau barhau i gael eu cynnal yn flynyddol o leiaf, ni waeth a yw'n flwyddyn sy'n cynnwys dyddiad codiad cyflog, neu a ydych chi ar frig y raddfa.

02

Crynodeb o Ddatblygiad Cyflog



Proses Datblygiad Cyflog

Gwnewch yn siŵr bod amcanion eich gwerthusiad yn cwmpasu'r tri maes hyn

- Beth mae disgwyl i mi ei gyflawni
- Sut dylwn i wneud pethau (gwerthoedd sefydliadol)
- Sut gallaf i ddatblygu/gwneud pethau mewn ffordd well?

Dau neu dri mis cyn y dyddiad codiad cyflog, adolygwch hyn gyda'ch rheolwr a defnyddiwch adborth trydydd parti. Cytuno p'un a ydych chi wedi bodloni'r amcanion ym mhob un o'r tri maes

(Yn dibynnu ar ddyddiad y codiad cyflog, gellid cynnal yr adolygiad hwn fel rhan o'r adolygiad gwerthuso diwedd blwyddyn)

Bydd y rheolwr yn penderfynu a fu perfformiad yn foddhaol neu'n anfoddhaol

Bydd y rheolwr yn cyfleu'r canlyniad i'r unigolyn ac yn ceisio'i gytundeb iddo

Os nad yw'r unigolyn yn fodlon, h.y. bwriedir atal y codiad cyflog, dylid gofyn i reolwr y rheolwr adolygu'r penderfyniad (o fewn 7 diwrnod). Mae ei benderfyniad yn derfynol

Nid oes proses apelio bellach ynghylch y penderfyniad ar y dosbarthiad. Os bydd yr unigolyn o'r farn na ddilynwyd y broses yn gywir, gall ystyried y Polisi Parch A Datris

Proses Werthuso

Ar ddechrau'r flwyddyn, dylech chi a'ch rheolwr gytuno ar eich amcanion a nodi pa bobl y byddwch chi'n gofyn iddynt am adborth

Sgyrsiau parhaus
Gofynnwch am adborth rheolaidd ar sut rydych chi'n ei wneud. Cynhwyswch adborth gan amrywiaeth o bobl (lle y bo'n briodol, cynhwyswch adborth gan gleifion, cleientiaid, partneriaid, rheolwyr prosiectau a chydweithwyr)

Os ydych chi'n methu bodloni amcanion, cytunwch ar gynllun gwella gyda'ch rheolwr.

Adolygiad/gwerthusiad diwedd blwyddyn gyda rheolwr
Bydd hwn yn adeiladu ar sgyrsiau ac adborth yn ystod y flwyddyn. Byddwch yn cytuno ar yr hyn y mae angen ei gynnwys yn amcanion y flwyddyn nesaf. Fe'i cofnodir ar ESR

Os bydd yr unigolyn yn fodlon, telir y codiad cyflog neu beidio, yn dibynnu ar ganlyniad yr adolygiad.

5. Pwy sy'n gwneud beth a phryd?

5.1 Cytuno ar Amcanion

Fel rhan o'r broses werthuso flynyddol, byddwch chi a'ch rheolwr yn cytuno ar set o amcanion sy'n cwmpasu:

- yr hyn y mae angen i chi ei wneud h.y. y pethau y mae angen i chi eu cyflawni;
- sut y mae angen i chi wneud pethau, h.y. eich ymddygiadau, a'r ffordd rydych chi'n arddangos y gwerthoedd;
- ffyrdd y gallwch chi geisio datblygu a gwella yr hyn rydych chi'n ei wneud.

Dylech chwarae rhan weithgar wrth osod yr amcanion a gwirio'ch bod yn deall yr hyn mae'ch rheolwr yn ei ddisgwyl ohonoch, oherwydd bydd y graddau rydych chi'n bodloni'r amcanion hyn yn penderfynu p'un ai a fyddwch chi'n cael eich codiad cyflog pan mae'n ddyledus ai peidio.

5.2 Adborth

Dylech chi a'ch rheolwr fynd ati'n weithgar i geisio adborth a gwybodaeth gan bobl wahanol (e.e. cleifion, cydweithwyr, partneriaid), unrhyw ganlyniadau/data perthnasol, gwaith prosiect/gwella rydych chi wedi cymryd rhan ynddo. Bydd yr adborth hwn yn eich helpu chi a'ch rheolwr i baratoi ar gyfer eich adolygiad o ddatblygiad cyflog a chefnogi'r dosbarthiad sy'n cael ei roi i chi.

5.3 Adolygiad Codiad Cyflog

Dylech gael adolygiad 8 i 12 wythnos cyn dyddiad eich codiad cyflog a dylai eich rheolwr drefnu hwn. Dylech chi a'ch rheolwr baratoi ymlaen llaw. Yn y cyfarfod, dylech drafod enghreifftiau o sut rydych chi wedi bodloni eich amcanion, gan ddefnyddio adborth gan bobl eraill lle y bo'n briodol.

Yn dibynnu ar ddyddiad eich codiad cyflog, gall y cyfarfod hwn fod yn werthusiad diwedd blwyddyn/adolygiad PADR ar eich cyfer hefyd.

Mae cynnal sgyrsiau ac adborth trwy gydol y flwyddyn yn arfer da, fel nad oes pethau annisgwyl yn codi. Os ydych chi wedi bod yn cael trafferth bodloni'ch amcanion, dylai hyn fod wedi cael ei drafod yn gynt yn ystod y flwyddyn, gan gytuno ar gynllun gwella.

5.4 Cytuno ar y canlyniad

- 5.4.1** Ar ddiwedd adolygiad eich codiad cyflog, bydd eich rheolwr yn rhoi eich canlyniad i chi, h.y. p'un ai a ydych chi'n foddhaol neu'n anfoddhaol, a'i resymau dros y penderfyniad. Os yw'r ddau ohonoch yn cytuno ar y canlyniad, bydd eich rheolwr yn hysbysu Adran y Gweithlu a Datblygu Sefydliadol a'r gyflogres ac yn cymryd y camau angenrheidiol mewn perthynas ag ESR. Os bydd y canlyniad yn foddhaol, caiff eich codiad cyflog ei dalu; os bydd y canlyniad yn anfoddhaol, ni chewch godiad cyflog.

Boddhaol

Mae wedi bodloni'r amcanion craidd yn llwyddiannus ac wedi dangos cynnydd boddhaol wrth gyflawni amcanion eraill ac wedi bodloni'r egwyddorion datblygiad cyflog cenedlaethol a nodir isod

Anfoddhaol

Bu'n aflwyddiannus wrth fodloni'r amcanion craidd a/neu nid yw wedi dangos cynnydd boddhaol wrth gyflawni amcanion eraill a/neu heb fodloni'r egwyddorion datblygiad cyflog cenedlaethol a nodir isod

Bydd angen i sefydliadau unigol benderfynu beth sy'n cael ei ystyried yn berfformiad boddhaol neu anfoddhaol ar sail adran, tîm neu unigolyn. Bydd yn dibynnu ar y math o rôl a natur y rôl, ond dylai gael ei seilio ar amcanion clir, rhesymol a chytunedig.



Dylai rheolwyr gytuno ar set graidd o amcanion cyraeddadwy i asesu datblygiad cyflog ond dylent hefyd gynnwys amcanion mwy uchelgeisiol fel rhan o broses adolygu perfformiad ehangach. Rhaid bod yn glir, fodd bynnag, ynghylch pa lefel o berfformiad fyddai'n cael ei hystyried yn foddhaol ac, felly, beth fyddai'n berfformiad ar lefel anfoddhaol.

- **5.4.2** Yn ogystal â chyflawni'r amcanion, bydd angen dangos y safonau datblygiad cyflog cenedlaethol canlynol hefyd:
 - i. Cwblhawyd y broses werthuso o fewn y 12 mis diwethaf ac mae'r canlyniadau'n unol â safonau'r sefydliad.
 - ii. Nid oes proses allu ffurfiol ar waith.
 - iii. Nid oes unrhyw gosb ddisgyblu ffurfiol yn bresennol ar gofnod yr aelod staff (nodir cymhwysiad penodol y ddarpariaeth hon ym mharagraff 5.4.4).
 - iv. Mae hyfforddiant statudol a/neu orfodol wedi'i gwblhau.
 - v. Ar gyfer rheolwyr llinell yn unig - cwblhawyd gwerthusiadau ar gyfer eu holl staff yn ôl yr angen.
- **5.4.3** Disgwylir y byddwch yn cyflawni'r safonau gofynnol ar ddyddiad eich codiad cyflog. Disgwylir hefyd y dylech chi a'ch rheolwr llinell fod wedi cael trafodaethau rheolaidd am unrhyw broblemau wrth gyrraedd y safonau gofynnol cyn dyddiad y codiad cyflog. Bydd hyn yn caniatáu amser i faterion gael eu codi a dod o hyd i ddatrysiadau posibl i allu gwneud trefniadau ar gyfer rhoi'r codiad cyflog mewn da bryd.
- **5.4.4** Rhaid i'ch rheolwr ddefnyddio'r cyfarfod adolygu codiad cyflog i drafod y safonau. Os na chyrhaeddwyd unrhyw un o'r safonau, dylid cynnal adolygiad o'r trafodaethau blaenorol am y rhain i ystyried unrhyw ffactorau lliniarol ac i gofnodi'r penderfyniad.

O ran sancsiynau disgyblu byw, os ydych yn derbyn eich rhybudd ysgrifenedig cyntaf, ni fydd eich datblygiad yn cael ei oedi oherwydd y rhybudd. Fodd bynnag, bydd eich rheolwr yn ystyried y rhesymau a'r amgylchiadau a arweiniodd at y sancsiwn, yn ogystal â'ch perfformiad a'ch ymddygiad ers i'r sancsiwn gael ei gymhwyso. Bydd hyn yn rhan o'r wybodaeth y bydd eich rheolwr yn ei defnyddio wrth benderfynu ar ganlyniad datblygiad cyflog. Os bydd eich rheolwr, yn dilyn ystyriaeth ddyledus, yn penderfynu y dylech dderbyn canlyniad boddhaol, yna byddwch yn symud ymlaen i'r codiad cyflog nesaf. Os byddwch yn derbyn canlyniad anfoddhaol, bydd eich codiad cyflog yn cael ei oedi. Bydd y penderfyniad yn cael ei gofnodi'n glir, gan nodi'r rhesymeg dros atal y codiad cyflog. Bydd rhybudd terfynol bob amser yn arwain at oedi codiad cyflog.

- **5.4.5** Yn bwysig, os na fu'n bosibl i chi fodloni'r hyn y disgwyli'd ohonoch, ac nad oedd unrhyw fai arnoch chi am hynny, yna dylech dderbyn y codiad cyflog.
- **5.4.6** Bydd codiad cyflog ar gau ar y system gyflogres. Ar ôl i'r adolygiad codiad cyflog gael ei gwblhau'n llwyddiannus, rhaid i'ch rheolwr gymryd y camau angenrheidiol i agor y codiad cyflog.
- **5.4.7** Rhaid i reolwyr sicrhau bod y broses cyflwyno cais am godiad cyflog yn cael ei chwblhau mewn modd amserol er mwyn sicrhau y gellir gweithredu codiad cyflog mewn da bryd erbyn dyddiad codiad cyflog yr aelod staff. Rhaid i hyn ystyried amserlenni'r gyflogres leol a gofynion ESR.
- **5.4.8** Er bod yn rhaid eich bod wedi cwblhau eich gwerthusiad diwethaf yn llwyddiannus er mwyn symud i'ch codiad cyflog nesaf, nid oes rhaid i'r dyddiad pan gynhaliwyd yr arfarniad fod yn gysylltiedig â'ch dyddiad codiad cyflog.

Os nad oedd eich canlyniad gwerthuso diwethaf yn foddhaol ond bod camau adfer wedi'u cwblhau'n llwyddiannus erbyn dyddiad y codiad cyflog, byddwch yn gallu symud ymlaen heb unrhyw oedi os ydych chi'n bodloni'r safonau eraill.

5.5 Penderfyniadau i ohirio dyfarnu codiad cyflog

- **5.5.1** Mewn sefyllfaoedd lle na chyrhaeddwyd safonau ac nad oes unrhyw ffactorau lliniarol sy'n ddigonol i gyfiawnhau hyn, bydd eich codiad cyflog yn cael ei oedi. Bydd eich rheolwr llinell yn trafod ac yn cytuno ar gynllun gyda chi ar gyfer unrhyw gamau adfer sydd eu hangen i sicrhau bod y safonau gofynnol ar gyfer datblygiad cyflog yn cael eu bodloni, gan gynnwys amserlen, a sut y bydd unrhyw anghenion hyfforddi a chymorth yn cael eu diwallu. Mewn amgylchiadau o'r fath mae'n rhaid i chi gymryd pob cam angenrheidiol i fodloni'r gofynion cyn gynted â phosibl a rhaid i'ch rheolwr llinell roi'r gefnogaeth angenrheidiol i chi.
- **5.5.2** Dylid trefnu cyfarfod adolygu codiad cyflog pellach ar ddyddiad y cytunwyd arno i adolygu cynnydd a, lle bo hynny'n foddhaol, cychwyn agor y gynyddran. Dylai'r dyddiad dod i rym ar gyfer symud ymlaen i'r codiad cyflog nesaf fod y dyddiad cynharaf y dangosir bod y gofynion perthnasol wedi'u bodloni. Bydd dyddiad codiad cyflog y blynyddoedd i ddod yn aros yr un peth.
- **5.5.3** Pan fydd codiad cyflog yn cael ei ohirio oherwydd cosb ddisgyblu fyw, neu broses allu ffurfiol, dylai eich rheolwr llinell gychwyn cyfarfod adolygu codiad cyflog cyn i'r gosb neu'r cynllun ddod i ben. Dylid defnyddio hwn i gadarnhau bod yr holl ofynion eraill wedi'u bodloni ac i sicrhau eich bod yn symud ymlaen i'r codiad cyflog nesaf, gan ddod i rym y diwrnod ar ôl i'r sancsiwn ddod i ben.

Bydd unrhyw ddyddiadau codiad cyflog yn y dyfodol yn aros yr un peth.

5.6 Integreiddio canlyniadau i werthusiad y flwyddyn nesaf

- **5.6.1** Dylai adolygiad y codiad cyflog fod yn rhan o'ch trafodaethau parhaus ar reoli perfformiad gyda'ch rheolwr a bydd yn ffynhonnell adborth ddefnyddiol i'w hystyried yn yr adolygiad gwerthuso diwedd blwyddyn ac wrth osod amcanion at y dyfodol. Os cewch eich dosbarthu'n 'foddhaol', yna gallwch chi a'ch rheolwr drafod p'un a oes arnoch angen cyfleoedd datblygu pellach ac ati. Os cewch eich dosbarthu'n 'anfoddhaol', dylech chi a'ch rheolwr gytuno ar gynllun i'ch helpu i wella a chael eich perfformiad ar y trywydd cywir unwaith eto. Dylid cynnwys ac adolygu'r amcanion hyn yn eich gwerthusiad nesaf.
- **5.6.2** Os bydd eich rheolwr yn nodi na fu'n bosibl i chi fodloni'ch amcanion ac nad oedd unrhyw fai arnoch chi am hynny, bydd angen i chi a'ch rheolwr weithio gyda'ch gilydd i ailosod eich amcanion neu ddileu'r rhwystrau rhag eu cyflawni.

5.7 Datrys anghydfod

Yn achlysurol iawn, gallech chi a'ch rheolwr anghytuno ar ba mor dda rydych chi wedi bodloni'ch amcanion ac, felly, a nghytuno ar y dosbarthiad a roddir i chi. Lle bynnag y bo'n bosibl, dylech geisio datrys problemau gyda'ch rheolwr. Os yw'ch rheolwr yn eich ystyried yn anfoddhaol a'ch bod yn teimlo eich bod wedi dangos cynnydd boddhaol wrth gyflawni eich amcanion a'ch bod wedi bodloni'r egwyddorion datblygiad cyflog cenedlaethol, ac na allwch ddatrys y rheswm dros ganlyniad anfoddhaol yn uniongyrchol â'ch rheolwr, yna gallwch ofyn i reolwr eich rheolwr adolygu'r penderfyniad.



Bydd y broses hon yn digwydd o fewn darpariaethau'r Polisi Parch a Datrys a dylid ei chyflawni o fewn 14 diwrnod calendr i roi gwybod i'ch rheolwr eich bod am fwrw ymlaen â'r mate.

Dylid defnyddio'r gofynion hysbysu yn y polisi Parchu a Phenderfynu ar gyfer gwneud cais am benderfyniad ffurfiol, gan nodi ar ba sail yr ydych yn ystyried y dylid adolygu'r gyfradd. Bydd rheolwr eich rheolwr eisiau deall eich safbwynt chi a safbwynt eich rheolwr. Yna bydd ef/hi yn gwneud penderfyniad ar y gyfradd ac yn cyfleu eu rhesymau i chi a'ch rheolwr.

Os ydych chi'n anhapus â'r broses, os oes gennych chi bryderon eraill nad ydyn nhw'n uniongyrchol gysylltiedig â chanlyniad eich gwerthusiad, neu os ydych chi'n credu y gwahaniaethwyd yn eich erbyn mewn unrhyw ffordd, yna gwnewch gais ffurfiol am ddatrysiad yn unol â'r polisi Parch a Datrys. Yna bydd eich rheolwr yn rhoi gwybod i Adran y Gweithlu a Datblygu Sefydliadol ac i'r gyflogres, ac yn diweddarau ESR. Os cytunir y dylech dderbyn eich codiad cyflog, bydd yn cael ei ôl-ddyddio i'r dyddiad codiad cyflog gwreiddiol.

5.8 Rolau Band 8c/d a 9

Rydym yn cydnabod bod gwobrwyo perfformiad da gyda chodiad cyflog yn newid arwyddocaol a chadarnhaol. Hefyd, rydym yn cydnabod bod disgwyl yn gyffredinol i uwch arweinwyr fod yn gosod ac yn adolygu amcanion yn y ffordd hon eisoes. Maent yn fwy tebygol hefyd o fod wedi arfer â gofyn am adborth a chael adborth gan nifer o bobl. Yn ogystal, gwyddom ei bod hi'n bwysig i arweinwyr ddangos esiampl o'r ymddygiadau yr ydym eu heisiau gan erail.

Felly, mae'r gwahaniaethau canlynol yn berthnasol i rolau Band 8c a d/9:

Yn y flwyddyn ar ôl i chi gyrraedd brig bandiau 8c, 8d neu 9, bydd 5 y cant neu 10 y cant o'r cyflog sylfaenol yn cael ei ad-ennill. Pan gytunir ar berfformiad boddhaol, cedwir eich cyflog ar frig y band.

Os bernir bod eich perfformiad yn anffoddhaol, gellir gostwng eich cyflog 5 y cant neu 10 y cant * o ddyddiad y codiad cyflog. Byddwch yn gallu adfer eich cyflog i frig y band ar ddiwedd y flwyddyn ganlynol trwy gyrraedd y safonau gofynnol. Mae gennych hawl i herio penderfyniad i ostwng eich cyflog gan ddefnyddio'r broses Datrys Anghydfod a amlinellir uchod.

*mae Gweithrediaeth Cyngor Staff y GIG wedi cynghori bod cynlluniau i ddatblygu rhai meini prawf mewn perthynas â chymhwyso'r cyflog 5% a 10% y gellir ei ail-ennill a bydd yr adran hon o'r polisi yn cynnwys y manylion priodol ar ôl i'r rhain gael eu penderfynu.

03

Atodiad 1: Materion cyfreithiol



3 Atodiad 1: Materion cyfreithiol

Absenoldeb o'r Gwaith Pan Fydd Codiad Cyflog yn Ddyledus

Os ydych chi'n absennol o'r gwaith am resymau fel salwch neu absenoldeb rhiant pan fydd codiad cyflog yn ddyledus, dylid dilyn egwyddor triniaeth gyfartal a theg fel na ddioddefir unrhyw anfantais o ganlyniad i hyn.

Yn achos absenoldeb â thâl tymor hir wedi'i gynllunio ymlaen llaw fel mamolaeth, mabwysiadu ac absenoldeb rhiant a rennir, gellir cynnal eich adolygiad codiad cyflog yn gynnar os yw hyn yn rhesymol ac yn ymarferol, gan ganiatáu i'r codiad cyflog gael ei gymhwyso ar ddyddiad eich codiad cyflog yn eich absenoldeb.

Os ydych ar absenoldeb â thâl yn y tymor hir, megis absenoldeb mamolaeth, mabwysiadu neu riant a rennir ac ni ellir cynnal adolygiad codiad cyflog cyn dyddiad y codiad cyflog, dylid gweithredu'r codiad cyflog yn awtomatig yn absenoldeb yr unigolyn ar yr amod nad oes sancsiynau disgyblu neu brosesau gallu ffurfiol ar waith. Os oes cosb ddisgyblu fyw ar waith ar yr adeg eich absenoldeb, dylid gweithredu'r codiad cyflog yn eich absenoldeb os yw'n briodol, gan ddod i rym o'r diwrnod ar ôl i'r sancsiwn ddod i ben.

Pe bai proses gallu ffurfiol weithredol ar y gweill ar yr adeg y byddwch yn absennol, gellir gohirio'r codiad cyflog. Dylid ailddechrau ar y broses wella yn syth ar ôl ichi ddychwelyd. Ar ôl ei gwblhau'n foddhaol, dylid neilltuo'r cyfnod absenoldeb, ac ôl-ddyddio'r codiad cyflog i ddyddiad y cytunwyd arno fel petaech wedi cwblhau'r broses wella heb fod wedi bod yn absennol.

Mae gwahardd cyflogai o'r gwaith â chyflog llawn yn weithred niwtral. Er mwyn sicrhau bod hyn yn wir, dylai eich cyflogwr sicrhau bod eich codiad cyflog yn cael ei weithredu o ddyddiad adolygu eich codiad cyflog lle cewch eich atal dros dro ar y dyddiad hwnnw, ar yr amod yr ystyrir eich perfformiad yn foddhaol a'ch bod wedi cwrdd â'r safonau datblygiad cyflog cenedlaethol.

Dyma'r safonau hyn:

- i. Cwblhawyd y broses werthuso o fewn y 12 mis diwethaf ac mae'r canlyniadau'n unol â safonau'r sefydliad.
- ii. Nid oes proses allu ffurfiol ar waith.
- iii. Nid oes unrhyw gosb ddisgyblu ffurfiol yn fyw ar eich cofnod.
- iv. Mae hyfforddiant statudol a/neu orfodol wedi'i gwblhau.
- v. Ar gyfer rheolwyr llinell yn unig - mae gwerthusiadau wedi'u cyflawni ar gyfer eich holl staff yn ôl yr angen.

Os yw'n anfoddhaol yna ni fyddwch yn derbyn eich codiad cyflog a byddwch yn gweithio gyda'ch rheolwr i gytuno ar gynllun i'ch helpu i fodloni'r gofynion er mwyn i chi dderbyn eich codiad cyflog unwaith y dangosir bod y gofynion perthnasol wedi'u bodloni. Mae'n bwysig nodi, os na fu'n bosibl i chi fodloni'r hyn y disgwyliad ohonoch, ac nad oedd unrhyw fai arnoch chi am hynny, dylech dderbyn y codiad cyflog nesaf.

Yn ôl eu diffiniad, eich dewis chi yw cyfnodau sabothol/seibiannau gyrfa, felly os byddwch yn dewis cymryd cyfnod sabothol/seibiant gyrfa ar unrhyw adeg yn ystod eich gyrfa, bydd eich datblygiad cyflog yn cael ei 'rewi' ar bwynt y gynyddran a gyflawnwyd gennych ar eich diwrnod gwaith olaf. Felly, pan ddychwelwch i'r gwaith, byddwch yn gweithio ar yr un gynyddran ag yr oeddech

pan ymadawoch chi. Bydd angen cynnal asesiad o fewn ychydig wythnosau wedi i chi ddychwelyd i nodi eich anghenion hyfforddi a datblygu.

Monitro Cydraddoldeb

yn monitro sut mae'r polisi hwn yn cael ei gymhwyso o ran y nodweddion gwarchoddedig, yn unol â Deddf Cydraddoldeb 2010. Gellid gwneud hyn ar sail sampl. Yna, bydd adroddiad yn cael ei ddarparu'n flynyddol i'r Bwrdd neu i is-bwyllgor priodol.

Amgylchiadau Esgusodol Eraill

yn cydnabod y gall fod amgylchiadau esgusodol eraill sydd heb gael eu trafod eisoes yn yr adran hon. Mewn achosion lle y tybir bod amgylchiadau esgusodol yn gysylltiedig â pheidio â chyflawni'r meini prawf datblygu, dylid ceisio cyngor gan eich rheolwr llinell ac aelod perthnasol o Adran y Gweithlu a Datblygu Sefydliadol.



04

Atodiad 2: Egwyddorion ac Arferion Gorau i'w hintegreiddio i Brosesau Gwerthuso Lleol

4 Atodiad 2: Egwyddorion ac Arferion Gorau i'w hintegreiddio i Brosesau Gwerthuso Lleol

I'n helpu ni i roi'r gofal a'r gwasanaethau gorau posibl, beth bynnag yw ein rôl, mae'n bwysig ein bod ni'n deall yr hyn y disgwylir ohonom a sut mae ein cyfraniad personol yn helpu ein timau a'r sefydliad i gyflawni eu nodau.

Dylai trafodaethau gwerthuso fod yn rhai parhaus a:

- Rhoi adborth ar sut rydym ni wedi'i wneud - dylai'r adborth fod yn onest, yn adeiladol ac yn amserol, a dylem fod yn ceisio adborth gan amrywiaeth o bobl rydym ni'n gweithio gyda nhw (e.e. cydweithwyr, rhanddeiliaid, cleifion, rheolwyr prosiect) lle bynnag y bo'n bosibl
- Sicrhau bod pob un ohonom yn cytuno ar yr hyn y disgwylir ohonom ni a sut y dylem fod yn gwneud pethau, a'n bod yn deall hynny, h.y. yr hyn y mae angen i ni ei gyflawni a'r ymddygiadau a'r ffyrdd o weithio y disgwylir ohonom ni
- Sicrhau ein bod yn datblygu ein hunain i wneud pethau yn well a/neu symud ymlaen i rôl arall a chael cynllun o ba ddysgu byddwn ni'n ei wneud

Rhaid i reolwyr sy'n ymwneud ag adolygu, asesu, cytuno ar amcanion a chefnogi cynlluniau datblygu personol, sicrhau eu bod yn gymwys ac yn hyderus i gyflawni'r rôl hon. Gall timau dysgu a datblygu helpu i gynorthwyo rheolwyr lle y bo angen hyn.

Cytuno ar Amcanion

Mae'n hanfodol ein bod ni'n gwybod beth y disgwylir ohonom ni. Yn bwysig, dylem cytuno ar ein hamcanion penodol fel ein bod yn berchen arnynt. Dylai gosod amcanion fod yn sgwrs ddwyffordd bob amser.

Er mwyn i amcanion fod yn ystyrllon, rhaid iddynt fod yn rhai CAMPUS: cyraeddadwy, amserol, mesuradwy, penodol, uchelgeisiol a synhwylol; yn benodol, rhaid iddynt "fod o fewn ein cylch rheoli ni". Ni ddylech gytuno ar amcanion sy'n ymwneud â phethau na allwch wneud unrhyw beth yn eu cylch. Mae amcanion da yn rhai lle y mae'r canlyniadau yn deillio o'r hyn a wnawn a sut rydym ni'n ymddwyn, h.y. maent yn bethau y gallwn ni eu rheoli.

Cytuno ar Anghenion Datblygu

Fel rhan o waith adolygu neu osod amcanion, mae'n debygol y byddwch wedi nodi pethau a/neu ffyrdd y gallwch eu gwneud yn well. Mae'r rhain yn debygol o fynnu ein bod ni'n treulio amser yn datblygu ein hunain a dylech cytuno ar y ffordd orau o wneud hyn gyda'ch rheolwr. Yn aml, nid cwrs hyfforddi ffurfiol yw'r unig ateb neu'r ateb gorau, a dylech feddwl am yr amser y bydd arnoch angen ei dreulio ar eich datblygiad, nid dim ond pa gyllideb y gall fod arnoch ei hangen.

Cadw Cofnodion

Mae cadw cofnodion cywir yn bwysig a dylid cadw unrhyw gofnodion a gedwir gennych chi a'ch rheolwr yn unol â gofynion Diogelu Data 2018. Rhaid i reolwyr sicrhau bod holl fanylion cyfarfodydd gwerthuso'n cael eu cofnodi ar ESR.



05

Atodiad 3: ASESIAD O'R EFFAITH AR GYDRADDOLDEB

1. Cyffredinol

Teitl y ddogfen	Polisi ar Ddatblygiad Cyflog (staff anfeddygol)
Pwrpas y ddogfen	Amlinellu'r weithdrefn i'w dilyn wrth gysylltu datblygiad cyflog â pherfformiad, disgrifio'r broses ar gyfer ymdrin ag adolygiadau blynyddol o godiadau cyflog, mynd i'r afael â phroblemau'n codi yn gysylltiedig â datblygiad cynyddrannol a gohirio cynyddran a sicrhau cysondeb o ran dulliau a chymhwyso. Mae'r ddogfen yn dangos sut mae prosesau gwerthuso a datblygiad cyflog yn cyd-fynd ac mae'n pwysleisio'r angen bod pob aelod staff yn deall eu rôl a'u swyddogaeth ddisgwyliedig yn glir a bod ganddynt y cyfle i gael adborth ar eu perfformiad, er mwyn iddynt allu datblygu i'w potensial mwyaf.
Cwmpas bwriadedig	Yr holl staff anfeddygol a deintyddol a gyflogir gan GIG Cymru.

2. Ymgynghori

Ymgynghorwyd â pha grwpiau/cymdeithasau/cyrff neu unigolion wrth lunio'r ddogfen hon?	Fforwm Partneriaeth GIG Cymru (gan gynnwys pob undeb sy'n cael ei chydabod gan GIG Cymru); Grŵp Gweithredu'r Tasglu Strategol ar Dâl; Sefydliadau'r GIG; Rheolwyr Llinell
Beth oedd effaith unrhyw adborth ar y ddogfen?	Gwnaed newidiadau a rhoddwyd ymrwymiad i adolygiad llawn ym mis Ebrill 2021 pan fydd blwyddyn lawn o ddata ar gael. Gweler paragraff 2.7.
Pwy oedd yn rhan o gymeradwyo'r ddogfen derfynol?	Fforwm Partneriaeth GIG Cymru a Grŵp Gweithredu'r Tasglu Strategol ar Dâl.
Unrhyw sylwadau eraill i'w cofnodi?	

3. Asesiad o'r Effaith ar Gydraddoldeb

A yw'r ddogfen yn effeithio'n annheg ar staff penodol neu grwpiau penodol o staff? Os ydyw, dywedwch sut mae hyn yn cael ei gyfiawnhau.	Nac ydyw.
Pa fesurau sy'n cael eu cynnig i fynd i'r afael ag unrhyw annhegwch?	Dim.
A all y ddogfen gael ei darparu mewn fformat arall neu ar ffurf cyfieithiad?	Gall, o wneud cais i Gyfarwyddwyr y Gweithlu a Datblygu Sefydliadol.



4. Asesiad o Gydymffurfiaeth

A yw'r ddogfen yn cydymffurfio â deddfwriaeth cyflogaeth berthnasol? Rhowch fanylion.	Ydyw.

5. Aseswyd y ddogfen gan:

Enw	Grŵp Adolygu'r Bartneriaeth Datblygiad Cyflog
Swydd/Teitl y Swydd	
Dyddiad	Mehefin 2019





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AGENDA ITEM No	16
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	3

AUDIT REPORT

MEETING	People & Culture Committee
DATE	10 th May 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide the People & Culture Committee (PCC) with an update in relation to the outstanding recommendations from Internal Audit reviews.
2. In addition, the paper sets out the Internal Audit plan activity and includes copies of current and relevant Audit Reports that provide a fundamental line of assurance to the PCC.

RECOMMENDATION:

3. **The People & Culture Committee is asked to:**
 - a. **Note and consider the contents of the report.**
 - b. **Consider the Internal Audit Plan activity.**
 - c. **Receive two current Internal Audit Reports relevant to the Committee.**
 - d. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates.**
 - e. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**

KEY ISSUES/IMPLICATIONS

4. Each of the 89 internal audit recommendations have been reviewed by the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) since the last Audit Committee to ensure that any new completion dates are assigned with realistic timescales and a strong narrative and rationale to support any extension.

REPORT APPROVAL ROUTE

5. The report has been submitted to:
- ADLT – 22nd April 2022

REPORT APPENDICIES

6. The Audit Tracker has been circulated as a separate appendix.
7. Recruitment Practices Internal Audit Report.
8. Organisational Culture – A Learning Organisation Draft Internal Audit Report.

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

**WELSH AMBULANCE SERVICES NHS TRUST
PEOPLE & CULTURE COMMITTEE
INTERNAL AUDIT REPORT**

SITUATION

1. The purpose of this paper is to provide the People & Culture Committee (PCC) with an update in respect of recommendations resulting from internal audit reviews that are presented to the Committee for oversight.
2. In addition, the paper sets out the Internal Audit plan activity and includes copies of current and relevant Audit Reports that provide a fundamental line of assurance to the PCC.

BACKGROUND

3. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned and in a timely manner.
4. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.
5. The Internal Audit plans have been developed in partnership with the Executive Management Team to identify current and emerging areas of risk, as well as specific assurance needs within the Trust.

ASSESSMENT

Internal Audit Plan 2021/22

6. There are two current internal audit reports relevant to the PCC which form part of the 2021/22 Internal Audit Plan. The reports are attached as Appendix 1 and 2 respectively in relation to the following reviews:

Internal Audit Report	Assurance Rating	Date received or due to be received at Audit Committee
Recruitment Practices	Reasonable	March 2022
Organisational Culture – A Learning Organisation <i>Draft report not including management responses</i>	Advisory	June 2022

Internal Audit Plan 2022/23

7. There are two internal audit reviews relevant to the PCC which are included in the 2022/23 Internal Audit Plan as follows:

Internal Audit Report	Estimated Date of Audit	Date due at Audit Committee
Sickness Absence Management	Q1	September 2022
Trade Union Release Time	Q2	December 2022

Internal Audit Highlights

8. The Trust continued to face significant operational pressures resulting from the pandemic and REAP level 4 and as such expects to be carrying a slightly higher number of overdue recommendations during this period.
9. At the time of issuing the paper, there were a total of 89 current internal audit recommendations on the tracker. 21 recommendations were marked as complete at the March 2022 Audit Committee and removed from the tracker.
10. 27 recommendations were added to the tracker resulting from 5 Internal Audit Reports which were presented to the Audit Committee in March 2022. None of these recommendations were assigned to PCC for oversight.
11. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	Those directly relevant to PCC	High Priority PCC	Medium Priority PCC	Low Priority PCC
Overdue	59	3	0	3	0
Not yet due*	26	4	0	4	0
Complete	4	3	0	3	0
Total	89	10	0	10	0

* accepting extensions have been applied in line with the agreed pandemic arrangements.

12. There are no high priority recommendations showing as overdue for PCC to review.
13. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total Number of Recommendations on the tracker	Those directly relevant to PCC	Complete PCC	Overdue PCC	Not Yet Due PCC
2019/20	4	0	0	0	0
2020/21	29	0	0	0	0
2021/22	56	10	3	3	4
Total	89	10	3	3	4

14. Of the 3 recommendations that are showing as overdue, these relate to the following reports:
- 21/22 Collaboration Reasonable Assurance review
 - 21/22 Recruitment Practices – Equality, Diversity and Inclusion
15. The number of recommendations by assurance rating and level of priority are detailed below.

Assurance Ratings	Total No. of Recommendations on the tracker	Those directly relevant to PCC	High Priority PCC	Medium Priority PCC	Low Priority PCC
Limited	6	0	0	0	0
Reasonable	72	10	0	10	0
Substantial	1	0	0	0	0
Not Rated	10	0	0	0	0
Total	89	10	0	10	0

16. The Governance team continue to seek assurance from Senior Management relating specifically to each report that:
- Recommendations have been considered and completed within agreed timeframes and;
 - All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

RECOMMENDED:

17. **The People & Culture Committee is asked to:**
- Note and consider the contents of the report.**
 - Consider the Internal Audit Plan activity.**
 - Receive the current Internal Audit Reports relevant to the Committee.**
 - Consider the Trust’s proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to PCC, and**
 - Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**

Recruitment Practices – Equality, Diversity and Inclusion

Final Internal Audit Report

February 2022

Welsh Ambulance Services NHS Trust



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Gwasanaethau Ambiwylans Cymru
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NHS Trust



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Review reference:	WAST-2122-20
Report status:	Final
Fieldwork commencement:	17 th December 2021
Fieldwork completion:	8 th February 2022
Draft report issued:	14 th February 2022
Debrief meeting:	15 th February 2022
Management response received:	24 th February 2022
Final report issued:	24 th February 2022
Auditors:	Simon Cookson, Director of Audit and Assurance Osian Lloyd, Deputy Head of Internal Audit Rhian-Lynne Lewis, Principal Auditor
Executive sign-off:	Claire Vaughan (Director of Workforce and OD)
Distribution:	Dr Catherine Goodwin (Assistant Director of Workforce and OD) Keithley Wilkinson (Head of Equality and Engagement) Jessica Hooper (OD Project Manager) Gareth Thomas (PECI Manager)
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of Welsh Ambulance Services NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose


To provide the Trust with assurance that there are adequate arrangements in place to ensure that applicants from a diverse range of backgrounds are encouraged, supported and able to apply and be successful.

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- Improved links required between work undertaken by the PECI team and the Strategic Equality Objectives
- Limited analysis of the effectiveness of initiatives to attract new staff
- There is no regular analysis of candidate progress to establish and assess barriers to applicants from minority backgrounds
- EDI Steering Group was not quorate, and the Terms of Reference requires updating

Report Classification

		Trend
	Reasonable	N/A
	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved	

Assurance summary¹

Assurance objectives	Assurance
1 Strategy in place	Reasonable
2 Initiatives to attract	Reasonable
3 Analysis	Limited
4 Initiatives to retain	Substantial
5 Reporting	Reasonable

Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 Link PECI work to the Strategic Equality Plan	1	Operation	Medium
2 Analysis of initiatives to attract and recruit	2	Design	Medium
3 Analysis of candidate progress	3	Design	Medium
4 EDI Steering Group ToR and attendance	5	Operation	Medium

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

- 1.1 The Welsh Ambulance Service Trust ('the Trust') has a Strategic Equality Plan in place: *Treating People Fairly 2020-2024*. The strategy sets out a number of Strategic Equality objectives, including for the Trust to take positive action to increase representation and create a positive experience of work for individuals from diverse backgrounds, cultures and identities to ensure the Trust is seen as a great place to work, volunteer, develop and grow for all. This, in turn, should assist the service to understand and be responsive to the needs of the communities it serves.
- 1.2 The key risk considered in this review is the inability to attract, recruit, retain and develop a diverse workforce with a culture that accepts, recognises and respects diversity and that can effectively represent the communities the Trust serves.

2. Detailed Audit Findings

Audit objective 1: there is a strategy in place that focuses on initiatives to attract and retain a skilled workforce from diverse backgrounds, cultures, and identities across the organisation.

- 2.1 The Trust's Strategic Equality Plan 2020-2024 outlines four objectives that aim to ensure it maintains and contributes to a fair and equitable society, and creates a diverse and inclusive culture, both inward and outward facing.
- 2.2 Alongside each of the objectives are several actions that the Trust intends to complete. These include:
 - *Promote a culture of inclusivity and develop leaders who understand and value the benefits of a diverse and inclusive culture.*
 - *Work in partnership to strengthen the voice of all citizens and improve access to information and services in a variety of different formats and languages, including meeting our Welsh language commitments.*
 - *Improve the quality, understanding, accessibility and reporting of our equalities monitoring data, information and stories to show how we are doing in progressing towards delivery of our strategic equality objectives, and inform future action planning.*
 - *Review our recruitment strategy and approach to ensure that applicants from a diverse range of backgrounds are encouraged, supported and able to apply and be successful.*
- 2.3 Our review has shown that there are several mechanisms in place that contribute towards the achievement of these objectives, but that due to the impact of Covid-19, monitoring progress against the actions has been challenging and development work is ongoing to demonstrate outcomes.

-
- 2.4 Examples of the mechanisms in place is the Allyship programme, alignment of Trust events with the NHS Employers calendar and the refresh of the Trust's behaviours and cultures (refer to objective 4 below for further detail).
- 2.5 In addition, the Patient Experience and Community Involvement (PECI) team prepare quarterly reports for the Quality, Safety & Patient Experience Committee. These summarise the work that has been undertaken by the team to engage with communities across Wales. However, there is an opportunity to strengthen the link between the PECI work and how it feeds in and contributes to the objectives set out within the Strategic Equality Plan. **See matter arising 1 in Appendix A**

Conclusion:

- 2.6 The Trust's Strategic Equality Plan establishes four objectives that lay the groundwork for ensuring the Trust is able to attract and retain a skilled workforce from diverse backgrounds. Further work is needed to link the Trust's activities back to the plan. As such, a **Reasonable** assurance rating is determined for this objective.

Audit objective 2: effective initiatives are in place to promote the service to potential employees from diverse backgrounds, cultures, and identities.

- 2.7 The Trust is currently developing a 'Recruitment Outreach Programme' which seeks to ensure recruitment processes reach all societal groups. In particular, this includes working with third sector organisations to ensure that recruitment processes are inclusive and that the net for all recruitment drives is cast as widely as possible. We note that this project is in its infancy and awaiting the appointment of a recruitment advisor to support this work.
- 2.8 Training workshops are available to all recruitment managers to ensure that the recruitment process is inclusive and consistently applied across directorates. This includes a session on unconscious bias with tips and guidance to overcome this in recruitment. In addition, information on recruiting for diversity is included within the recruitment learning launchpad channel within Microsoft Teams. We note that applications are anonymised to help prevent short listers from being able to identify protected characteristics when shortlisting.
- 2.9 The Trust regularly uses social media platforms to promote and advertise roles and there is an intention to increase candidate reach going forward by advertising roles across more diverse networks and job platforms. A specific careers discovery event for individuals from the Black, Asian and Minority Ethnic backgrounds was held in July 2021.
- 2.10 As a result of Covid-19, the Trust has only been able to hold a limited number of career events. However, moving these to online events has provided the opportunity to make them accessible to a more diverse range of candidates and there are plans to undertake more of these. We note that there is currently limited analysis undertaken to establish the effectiveness of these online initiatives. **See Finding 2 in Appendix A**

Conclusion:

2.11 Work is ongoing to develop initiatives to ensure recruitment reach is as wide as possible. A **Reasonable** assurance rating has been determined for this objective.

Audit objective 3: the Trust undertakes analysis of its applicants and how far they progress into the recruitment process, in order to understand and address any inherent barriers.

2.12 There is currently no analysis being undertaken to enable the Trust to identify the number of applicants by background, culture, identity and how far candidates progress through the recruitment process. We understand from discussion with the recruitment team that the trac.jobs recruitment system, which covers all health sector jobs, has the capability to generate reports to provide this analysis. This could help the Trust identify any inherent barriers in the process that need to be addressed. **See matter arising 3 in Appendix A**

2.13 We note that NHS Wales Shared Services Partnership (NWSSP) Recruitment Team issue surveys to all applicants and that the results of these surveys are shared with the Trust. However, themes raised tend to be experience driven and do not therefore provide the relevant level of intelligence required.

Conclusion:

2.14 Limited analysis is currently undertaken of applicants and how far candidates progress through the recruitment process, although the trac.jobs system has the capability to provide this. A **Limited** assurance rating is given for this objective.

Audit objective 4: the Trust have initiatives in place to support and retain its staff.

2.15 The Warm WAST Welcome is an induction programme available to all new starters and existing employees moving into new roles. It provides a broad induction into the organisation's culture, behaviours and values while raising awareness of the importance of equality, diversity and inclusion. 12 weeks after completing the induction, staff are invited to 'check-in' with the team, providing an opportunity for staff to raise any issues or concerns.

2.16 The aim of the Allyship programme, referred to in objective 1 above, is to create a more inclusive and mindful workforce based on continued education and learning around equality, diversity and inclusion, with a clear focus on protected characteristics. We note that this programme is currently in its infancy but that several introductory sessions have been arranged throughout February 2022 to drive the programme forward.

2.17 As part of wellbeing week in November 2021, the Trust issued a pulse survey to staff to gauge how they were feeling. This survey has allowed the Trust to take stock after an unprecedented and challenging period and to assess people's

wellbeing. While the above is not directly an initiative to retain staff, it serves as a mechanism to capture staff satisfaction.

- 2.18 The Trust is a member of several national ambulance forums. These include the National Ambulance Diversity and Inclusion Forum (NADIF), National Ambulance LGBT+ Network, National Ambulance BME Forum (NABMEF), National Ambulance Disability Network (NADN) and the Equality Leadership Group. Representatives from the Trust attend the forums and feed back to the Equality, Diversity and Inclusion (EDI) Steering Group. This helps ensure that that the Trust stays up to date with developments within minority communities and any impact had on Ambulance Trusts across the UK.
- 2.19 The Trust has also established support for two internal staff networks, Inclusion and LGBT+, which also feed into the EDI Steering Group. These offer a safe space for colleagues to come together and share experiences.
- 2.20 One of the initiatives the Trust has in place is to align the events calendar with that of the NHS employers' national campaigns which includes Pride and National Inclusion Week. Awareness for such events is raised via the Siren Trust wide announcements and posters are also issued to Directorates to provide information and promote and encourage staff to get involved. The most recent National Inclusion Week saw a take up from a wide range of staff across the Trust.

Conclusion:

- 2.21 The Trust has several mechanisms in place to support staff. A **substantial** assurance rating is determined for this objective.

Audit objective 5: adequate reporting mechanisms are in place to monitor the diversity of the workforce through the Trust, both locally and at Board level.

- 2.22 The EDI Steering Group is responsible for ensuring that the Trust '*embeds equality, diversity and human rights considerations, while carrying out its respective functions and responsibilities as a service provider and employer.*' The Group meets quarterly and is also committed to meeting the objectives the Trust has set out in the Strategic Equality Plan 2020-2024.
- 2.23 The Group feeds through to the People and Culture Committee (PCC) via the Workforce and Organisational Development (WOD) update and subsequently through to the Board within the PCC update, ensuring that the Board is aware of any issues effecting equality, diversity and recruitment. The minutes for the previous EDI meetings are included within the papers for the Committee and a recent paper taken to the PCC outlined the progress made in relation to the organisational behaviours and cultures reset. In addition, a recruitment update paper was presented to the Committee in May 2021, outlining the recruitment challenges facing the Trust.
- 2.24 A review of the EDI Group Terms of Reference and minutes has shown that of the three meetings reviewed, only one was quorate. Our review also notes that the

terms of reference state that the Group reports to the WOD Business meeting, but this was confirmed as being incorrect. **See matter arising 4 in Appendix A**

Conclusion:

- 2.25 There are mechanisms in place to monitor the diversity of the workforce however the Terms of Reference for the EDI Steering Group require updating and some meetings have not been quorate. As such a **Reasonable** assurance rating is determined for this objective.

Appendix A: Management Action Plan

Matter arising 1: Link PEGI work to the Strategic Equality Plan (Operation)		Impact	
<p>The PEGI team prepare quarterly reports for the Quality, Safety & Patient Experience Committee. These summarise the work that has been undertaken by the team to engage with communities across Wales. However, it has been acknowledged by the team that there is an opportunity to strengthen the link between the PEGI work and how it feeds in and contributes to the objectives set out within the Strategic Equality Plan (SEP).</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Activity undertaken by the Trust is not aligned to the SEP 	
Recommendations		Priority	
1.1	Work is undertaken to link the PEGI work directly to the Strategic Equality Plan	Medium	
Management response	Target Date	Responsible Officers	
1.1	<p>WAST accepts this finding and will increase links between PEGI and the EDI team.</p> <ul style="list-style-type: none"> Set up monthly meetings between EDI team and PEGI team: <ul style="list-style-type: none"> To review progress against SEO objectives To plan joint events To share data/ reports 	April 2022	<p>Keithley Wilkinson, Head of Equality and Engagement Gareth Thomas, PEGI Manager</p>

Matter arising 2: Analysis of initiatives to attract and recruit (Design)	Impact
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The Trust has a number of initiatives in place that help promote the service as an attractive place to work, including membership to a number of National Ambulance Networks, targeted career events and training for staff that helps ensure the recruitment process is inclusive. However, there is currently limited analysis undertaken to establish the effectiveness of these initiatives.

Potential risk of:

- Initiatives are not effective or as successful as intended

Recommendations	Priority
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2.1 Establish mechanisms to allow the Trust to analyse and capture the effectiveness of initiatives	Medium
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Management response	Target Date	Responsible Officer
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2.1 WAST accepts this finding and will explore and establish mechanisms to capture effectiveness.		Keithley Wilkinson, Head of Equality and Engagement
a) Survey new starters about where they heard about working for WAST.	April 2022	
b) Routinely conduct pulse surveys following a careers event.	May 2022	
c) Ask the inclusion network to participate in a focus group to provide qualitative feedback on the effectiveness of initiatives.	June 2022	

Matter arising 3: Analysis of candidate progress (Design)	Impact	
<p>The trac.jobs system provides a data report that breaks down groups of applicants against their progress through the recruitment process. However, this report is not run as a matter of course and as such there is currently no regular analysis undertaken.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Potential inherent barriers are not identified or addressed 	
Recommendations	Priority	
<p>3.1 a. The Trust should consider undertaking regular analysis of reports from Tracjobs and address any inherent barriers potentially impacting candidate progression.</p>	<p>Medium</p>	
Management response	Target Date	Responsible Officer
<p>3.1 a. The trust accepts this finding.</p> <ul style="list-style-type: none"> • Meet with Tracjobs and set up a reporting system for monthly updates 	<p>April 2022</p>	<p>Keithley Wilkinson, Head of Equality and Engagement</p>

Matter arising 4: EDI Steering Group Terms of Reference and attendance (Design)	Impact
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The Equality, Diversity and Inclusion Steering group terms of reference state that the group feeds through to the WOD Business Meeting. However, while establishing the reporting structure we were advised the EDI Steering Group reports to People and Culture Committee.

Our review of the meeting minutes for the last three meetings (noting that there was no April 2021 meeting due to the Covid-19 response) identified that only one was quorate. We note that there were no significant decisions made during either of these meetings.

Potential risk of:

- EDI Group is not compliant with its Terms of Reference

Recommendations	Priority
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- 4.1 a. The Terms of Reference for the EDI Steering Group should be updated to reflect the correct reporting structure.
- b. The Terms of Reference should be reviewed in order to ensure that the membership is appropriate.

Medium

Management response	Target Date	Responsible Officer
---------------------	-------------	---------------------

- 4.1 a. The Trust accepts this finding and will update the Terms of Reference with support from the Deputy Corporate Board Secretary.
- b. The Trust accepts this finding and will review the memberships of the EDI Steering Group.

June 2022

May 2022

Keithley Wilkinson, Head of Equality and Engagement

Keithley Wilkinson, Head of Equality and Engagement

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.</p>
	<p>Assurance not applicable</p>	<p>Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.</p>

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Organisational culture – a learning organisation

Final Advisory Review Report

May 2022

Welsh Ambulance Services NHS Trust



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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust



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Final report issued:	27 th May 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Catherine Goodwin, Interim Director of Workforce and Organisational Development Wendy Herbert, Interim Director of Quality & Nursing
Distribution:	Andy Swinburn, Director of Paramedicine Faz Tahir, Organisational Development Manager Hugh Bennett, Assistant Director of Commissioning Jo Kelso, Head of Education Transformation
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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Executive Summary

A learning organisation is skilled at creating, acquiring, and transferring knowledge, and at modifying its behaviour to reflect new knowledge and insights.

Learning organisation models vary, but typically point to developing strength in five main activities: systematic problem solving, experimentation with new approaches, learning from their own experience and past history, learning from the experiences and best practices of others, and transferring knowledge quickly and efficiently throughout the organisation.

The Trust is engaged in a programme of development which will advance its learning and subsequent change of practices, and that will improve the quality of patient care. The Trust strives for continuous quality improvement through learning, and implementing the lessons taken from that learning, but, whilst accredited against an array of quality and practice standards, the Trust is not at present pursuing formal 'accreditation' as a 'Learning Organisation'. Rather, their main thrust and focus is on delivering an effective ambulance response where that is essential to saving harm or life, and this is their overriding organisational objective.

Notwithstanding, the goal of continuous quality improvement through learning directs much of the development work the Trust does. It is visible widely across the organisation and this review sought to establish the level of attainment of that against these five learning related objectives:

- a culture of continuous improvement and learning is promoted within the Trust;
- working practices are designed to enable collaboration, engagement and sharing of learning and best practice, with appropriate technology to facilitate;
- systems are in place to capture and communicate individual, team and organisational learning;
- learning is designed into working practices, with access provided to opportunities for ongoing education and growth; and
- the Trust receives sufficient reporting and assurance of continuous improvement and learning, to inform development of strategy and vision.

The review is intended to be helpful and informative, rather than judgemental, and as it is advisory we have not provided an assurance rating. We have, however, recorded where we consider enhancements could lead to further improvement and provided recommendations to strengthen and improve Organisational Learning in the following areas:

- to progress the behaviours reset delivery action plan;
- feature lessons learned within project and development initiative protocols;
- capturing actions arising from analysis and evaluation of staff stories; and
- re-issuing the expired Transforming Education and Training strategy.

1. Introduction

- 1.1 The Welsh Ambulance Services NHS Trust ('the Trust' or 'WAST') in 2021 published its Quality Strategy 2021-24. The development of the Strategy, aligned to the Trust's Delivering Excellence 2030 vision and complementing the organisation's wider strategic plans and priorities, has been informed through staff and patient experiences, and recognition of the challenges that they face. In addition to internal influences, the Strategy has been driven by new legislative requirements for health and care organisations in Wales, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This places legal duties upon the Trust including, the duty of quality, the duty of candour and new engagement requirements with the Wales' Citizen Voice Body. The Strategy provides a high-level intent on how the requirements will be ascertained.
- 1.2 The Trust has quality management systems in place and integrated governance to accelerate learning and ensure improvement across the Trust. The Quality, Patient Experience and Safety (QuEST) Committee is responsible for oversight of quality in the Trust's services, and receives a range of regular updates from functional groups across the organisation tasked with quality and safety objectives to fulfil this responsibility.
- 1.3 The Trust also has a Transforming Education and Training Strategy which forms an integral part of the three-year People and Culture Committee Strategy and is aimed at supporting the entire workforce to maximise the benefits of lifelong learning. Workforce and Organisational Development provide a broad range of learning and education resources for staff across the Trust and the dedicated WAST Learning Zone platform provides staff with a variety of interactive online training modules and digital resources.
- 1.4 The advisory review's scope was limited to learning available to the Trust from the monitoring activities in the areas outlined above and sought to establish the effectiveness of the Trust's responses to the issues these highlight.
- 1.5 The key risks considered in this review included:
 - i) opportunities to improve practices from learning are not acted on which may have an impact on service quality and lead to a recurrence of incidents resulting in patient harm; and
 - ii) the Trust may fail to achieve its strategic objectives.

Advisory review

- 1.6 The overarching objective of the review was to provide a view on whether the Trust is maximising opportunities for quality improvement, and to what extent it is supporting a learning environment through leadership reinforced learning.
- 1.7 The review involved assessing WAST development activities in the context of five learning related objectives.

- 1.8 This is an advisory review therefore we have not provided an assurance rating. We have identified learning and provided recommendations to strengthen and improve processes. Our recommendations are set out in Appendix A.

2. Detailed Review Findings

Objective 1: A culture of continuous improvement and learning is promoted within the Trust.

- 2.1 We sought to establish to what extent the culture of the Trust promotes and supports continuous learning by its staff.
- 2.2 The Trust has a stated vision to 'deliver excellence' and continuous improvement and learning is recognised as key in achieving this.
- 2.3 We noted the Trust is currently engaged in an exercise to 're-set' its culture and organisational behaviours, focussed on four primary outputs:
- *diverse leaders upskilled in listening to the organisation;*
 - *a clear picture of Trust culture, sub-cultures and what drives them;*
 - *a refreshed set of organisational behaviours; and*
 - *a plan for how to embed behaviours for sustained change.*
- 2.4 The review, conducted by an external provider, completed in November 2021, recommending that WAST address the following tasks:
- *further address the systemic and symptomatic wellbeing issues;*
 - *conduct a systematic harassment and bullying review;*
 - *build psychological safety through inclusive leadership;*
 - *make everyone feel like a valuable part of the future;*
 - *celebrate the strength of TeamWAST during the pandemic;*
 - *enhance career development dialogue; and*
 - *build upon the whole TeamWAST identity.*
- 2.5 The findings of the review are to be delivered through a 'Behaviours reset' initiative to be rolled out during 2022 and the Trust launched their new behaviours at the CEO roadshows in March 2022. We were advised these have been welcomed across the organisation and that work continues to roll out associated promotional material and guidance. Going forward the intention is to continue to embed these behaviours within WAST teams over the coming months, but we noted many actions set out in the reset delivery plan are overdue and there are a large number with a red RAG status (**Matters Arising 1**).
- 2.6 The inclusion of a duty of quality in the Health and Social Care (Quality and Engagement) (Wales) Act creates an imperative within the Trust to deliver quality and to demonstrate this. This has prompted the inclusion of learning 'ambitions' in the Trust's corporate planning documentation and subsequently, the development of learning strategies, the latter to be delivered by the organisation through Trust wide programmes of training and education.

- 2.7 Following on from this, we sought to identify learning strategies in the Trust's People & Culture, Transforming Education and Training and Quality strategy documents and to ascertain how these are linked to quality improvement.
- 2.8 We noted the following in our review of these strategy documents:
- the People & Culture strategy includes an education objective *'transforming our approach to education and training, providing quality assured, person centred development opportunities, nurturing a supportive Trust-wide culture of lifelong learning'*;
 - the Quality strategy links quality and learning through its recognition of the *'Duties of Quality and of Candour'* set out in the Health and Social Care (Quality and Engagement) (Wales) Act'; and
 - the Transforming Education and Training strategy recognises the quality objectives that drive the services that WAST deliver and lists *'Quality'* as the first of its five strategy themes.
- 2.9 We sought to establish how Trust staff are encouraged to learn and contribute to continuous improvement and innovation and what initiatives are in place to empower staff.
- 2.10 We noted the Transforming Education and Training strategy themes address these elements and the delivery plan expands further, listing actions for delivery, including the following:
- *develop our Education and Training team to enable transition from a 'teaching' to 'facilitation' style;*
 - *recognise dual professionalism of colleagues involved in education and provide meaningful CPD opportunities;*
 - *encourage personal ownership of education and development by supporting and developing reflective practice, moving away from directed learning;*
 - *support nominated education leads to identify and develop relevant learning opportunities for specific areas;*
 - *conduct education and training survey(s) to better understand training needs;*
 - *develop a Training policy that includes Statutory and Mandatory requirements;*
 - *develop the Education and Training delivery team to ensure they have the appropriate qualifications and skills to provide and support education of the highest standard;*
 - *establish a rotational model for education staff, which incorporates operational exposure;*
 - *establish and implement development pathways for Clinical and Driving Instructor roles, enabling effective succession planning to take place; and*
 - *design and deliver appropriate CPD programmes for Practice Educators.*

Conclusion:

- 2.11 We noted the activity to implement changes to organisational behaviours to increase opportunities for learning and development is being reinforced within the

Trust, at various committees and sub-groups (see further in objective 3), and that learning ambitions articulated in Trust level and functional strategies are targeted to improve service quality.

Objective 2: Working practices are designed to enable collaboration, engagement and sharing of learning and best practice, with appropriate technology to facilitate.

2.12 We sought to establish how effective the Trust is at collaborating, engaging with partner organisations and sharing and learning best practice, by examining some recent examples of development initiatives.

2.13 **Older Persons Improvement Programme**

The Older Persons Improvement Programme has been developed to ensure that WAST considers the needs and opinions of Older People in all their services, planning, quality and improvement processes. This development programme is underpinned by the Older Persons Framework, produced in August 2021.

Collaboration

The older persons framework has been developed with healthcare partners, including care homes and domiciliary care providers, volunteer response including community first responders, community-based response services and fire and rescue falls responders, to provide opportunities for improvement across all aspects of health and social care including primary, acute, local authority and the third sector.

Engagement and sharing of learning and best practice

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 actively encourages the involvement of citizens, in this instance older people, in the design, development and delivery of services throughout the organisation. Through co-production and co-design, older people are able to contribute positively to influence the future vision and strategy of the service by ensuring organisation learning occurs through fully understanding the citizens' perspective. This will include developing opportunities for the utilisation of digital technology for patients to provide feedback and actively develop services.

2.14 **Falls and Frailty Framework**

The Falls and Frailty Response Service model has been developed to provide a timely and appropriate response to older and frail persons who contact the Trust for assistance.

Collaboration

The framework aims to support collaboration between organisations, through developing shared awareness, increased confidence and opportunities to improve services. Frailty and Falls Response Services are delivered through a range of collaborative partners including care homes and domiciliary care providers, volunteer response including community first responders, other community-based

response services and fire and rescue falls responders, as well as being supported by Welsh Government and the Emergency Ambulance Service Committee (EASC).

Engagement and sharing of learning and best practice

The Older Persons Education Action Group (OPEAG) has been established to provide a mechanism by which the Trust can develop an action focused, improvement driven, cross directorate approach to the delivery of change in regard to education and older person care for WAST staff across Wales.

The OPEAG has a broad range of objectives in its remit, and this includes to work collaboratively, both within WAST and with external organisations, to identify opportunities for improvement and through the use of quality improvement methodology, lead and advise on the implementation of change. This is achieved through representation from across the Trust by individuals with an interest in education, and who are in a position to action change, challenge and implement quality improvement.

2.15 **Research Innovation & Improvement Hub**

The WAST Research Innovation & Improvement Hub (RIIH) delivers research, innovation and improvement initiatives to support the key service change development themes in the IMTP (e.g. to develop services to influence a 'shift left' of patient demand towards scheduled care as far as possible).

Collaboration

The work is carried out in collaboration with Welsh Government and co-ordinated across Wales, with similar units in each of the Regional Partnership Board areas. Initiatives in progress include:

- advancing the crisis prevention and 'investing to save' agenda, with a cross-sectoral collaboration that connects communities through social prescribing;
- progressing a Welsh NHS Trust innovation partnership model (with PHW and Velindre NHS Trust) for large programmes of collaborative work; and
- a pan-Wales 'missed opportunities' project, comprising Emergency Departments and WAST, to identify barriers and enablers to hospital admission avoidance, which will set the scene for subsequent work streams.

Engagement and sharing of learning and best practice

Work programmes are shared with counterparts in the other RIIH's and several of the initiatives being developed are pan-Wales with involvement from all of the hubs.

2.16 We noted also the Trust has the WAST Improvement & Innovation Network (WIIN) to support the development of innovative ideas put forward by staff (see more under objective 3).

2.17 Safeguarding

A variety of Safeguarding related issues that emerge through routine activities are now being addressed through the development of the '7 minute briefing' communications.

Collaboration

Improvement opportunities are identified through the work of Safeguarding teams in collaboration with colleagues across the Trust.

Engagement and sharing of learning and best practice

The patient engagement team of the Safeguarding function prepare and distribute the 7 minute briefings to WAST staff through a variety of digital channels. The briefings have improved patient services in the areas they have addressed. In particular, WAST have seen improvements in the uptake in referrals to the 'Live Fear Free' all Wales specialist domestic abuse helpline, and to the Fire Service Home Safety Team following the running of 7 minute briefings on these topics.

- 2.18 We noted a further example of engagement and sharing of learning and best practice in the new revised paramedic model structure. This involved the creation of a new band 6 Senior Paramedic (SP) role, to operate in a supervisory capacity and to aid the development of practices through review and analysis of paramedic team responses. Learning gained through this is shared with the clinical leadership team and members of the operations management team, via a dedicated Senior Paramedics Teams channel. We were advised that data gathered from the SPs analysis of paramedic activity is used to help progress priorities, increase compliance and improve quality.

Conclusion:

- 2.19 Examples of working practices involving collaboration, engagement and sharing of learning are widespread in the Trust.

Objective 3: Systems are in place to capture and communicate individual, team and organisational learning, for use in policy design, strategy development and decision making.

- 2.20 We sought to establish what systems are in place within the Trust to capture and communicate learning and how this is then used to inform Trust plans and decision making.

2.21 Individual Learning

The Electronic Staff Record (ESR) system captures and records individual staff learning in their personal records. These accounts record an individual's learning objectives in the Personal Appraisal Development Review (PADR) documentation and clinical supervision helps identify individual clinical staff training needs. ESR dashboards provide summary level information of staff training status across mandatory courses linked to their role.

2.22 Learning through the capture of innovative ideas

Across the Trust, staff are encouraged to identify and share ideas for innovation through WIIN. WIIN offers an on-line portal for the submission of new ideas, encourages innovative thinking across the workforce and offers organisational learning where these ideas are developed into new or enhanced practices. All ideas submitted to the group are carefully considered, assessed, shared, and where selected, developed and rolled-out as practice amendments.

2.23 Ideas are accepted for all areas of activity but there is rigorous assessment and testing of these, including for 'fit' to the Trust's IMTP priorities. Assessment of opportunities is carried out by the WIIN Business Meeting, a cross-directorate group of Trust colleagues who hold expertise and insight in improvement and innovation. The remit of the group includes, but is not limited to, providing expert advice, guidance, recommendations and reporting on WIIN improvements and innovations. Challenging cases that require further scrutiny before approval are escalated to the Assistant Directors Leadership Team (ADLT) for analysis and decision.

2.24 We noted the work of the WIIN group had been interrupted by the pandemic and had only recently been relaunched as a result. The group was unable to identify any recent examples of ideas that had led to practice changes, but we noted developments in the areas of PADR compliance and hospital handover delays had taken place previously as a result of WIIN submissions.

2.25 Learning taken from projects and development initiatives

Lessons learned from projects are typically identified through and captured in project highlight, Situation-Background-Assessment-Recommendation (SBAR) and closure reports shared with relevant committees, committee sub-groups, and the Trust Board. The WAST operational plan progress report to STB includes lessons learned through the work delivered as does the IMTP deliverable assurance report.

Development initiatives similarly report their progress in highlight reports and their outcomes to their oversight committees and these may include sections on lessons learned. We examined several examples where this had been done (although we did not conduct a formal audit sample test of the Trust project lessons learned process).

Regarding what is prescribed in respect of lessons learned reporting, we were advised this area is covered in a WAST Project methodology but because of resource issues, this has not been fully trained or rolled-out across the project management community as yet (see **Matters Arising 2**).

2.26 Learning from adverse incidents and events

Key learning in the Trust is taken from the capture and analysis of adverse incidents and concerns. A framework is in place to record, assess and report incidents and events that take place and, in respect of concerns, to capture patient and community group feedback. Typically, learning is captured within the

functional groups responsible and then shared with the wider organisation via reporting streams to appropriate committees and the Trust Board.

- 2.27 The framework is made up of several key elements described in the paragraphs below.
- 2.28 Incidents and events are captured in the DATIX incident reporting system. All members of staff have access to this central database and are encouraged to record any adverse incident that they have experienced or witnessed. System content is routinely analysed, assessed and reported to oversight groups, and key issues that arise are communicated through the governance framework. Any cases that are considered as potentially causing significant harm are identified and a briefing report is prepared and taken to the Trust Serious Case Incident Forum for discussion. If necessary, they are reported as Nationally Reportable Incidents (NRIs) to the NHS Wales Delivery Unit and investigated accordingly.
- 2.29 Learning from these investigations is presented to the Trust's Patient Safety, Learning and Monitoring Group and these cases are included in a regular Patient Safety report to the WAST CEO (covering patient safety incidents, concerns, ombudsman cases, coroners cases, NRIs (previously serious adverse incidents) and claims). Patient Safety Highlight reports are also presented regularly to QuEST, through which they feed back to the wider Trust where they include a section on key achievements and learning.
- 2.30 Examples of WAST team learning in recent reports include:
- issue of clinical notices - these are issued to the clinician community for implementation;
 - record of clinical reviews held by each of the health boards (which were prompted by incidents that took place) - these record the learning opportunities identified from the reviews e.g., timely deployment of support resources; and
 - the issue of coaching bulletins for Call Handlers and Dispatchers.
- 2.31 Complaints from patients are received and handled by the 'Putting Things Right' team. Cases are examined through a formal process, underpinned by a statutory framework that denotes such things as written response protocols and time limits. Following examination, complainants are offered explanations and where applicable, apologies and / or assurances. In serious cases, complainants can pursue compensation, dealt with under the Trust's losses and special payments framework (see below). Cases are analysed and reported to the QuEST Committee and we noted examples are given of actions that have been taken to address root causes.
- 2.32 The Trust also processes and reports on compensation claims through the losses and special payments process. Quarterly, the Audit Committee receive a paper in relation to the financial payments that have been made by the Trust. This includes the payments made in relation to claims and more recently, themes and trends, and where appropriate, lessons learned. Wider learning for the Trust is achieved by individual line managers sharing information with their staff, and various
-

reporting including on the learning from closed personal injury claims biannually, an annual report on themes, trends and lessons learned from road traffic collisions and the Welsh Risk Pool Services 'Learning from Events' reports.

2.33 Learning from patients and community

The Patient Experience & Community Involvement (PECI) team liaise with community and patient groups to capture a range of feedback and patient experience material. This is then compiled and incorporated into a quarterly PECI highlight report, which provides information on the different ways the Trust collects service user feedback and experience, what it means, and how the Trust is using it to improve the services they provide. Included within this report, presented to the QuEST Committee, is evidence of community engagement work, social media activity and the Trust's involvement in public health.

2.34 Patient and staff stories are another means of capturing events and incidents that lead to organisational learning and changes in practice. These stories are shared via the QuEST Committee (patient stories) and Trust Board (patient / staff stories). Patient stories are analysed using a 'driver diagram', providing a structured means of generating an action plan to address the patient story issue. We note there is no such process for the issues raised in the staff stories (see **Matters Arising 3**).

2.35 The Trust also has an established 'Have your Say' facility live on its website, which enables people to leave feedback about a particular service, including emergency 999 response. Information captured through this channel is shared with relevant managers and reported within patient feedback information to the QuEST Committee.

2.36 In response to the patient voice initiative associated with the recently introduced 'duty to listen' mechanism, the Trust has introduced the People and Community network. A key component of the Trust's Quality Strategy, the network will enable people and communities to become more involved in the work of the Welsh Ambulance Service, amplifying the citizen's voice, ensuring it is heard across the organisation. This is a new initiative to engage with the community and, through the recruitment of network members, improve communications with patients. This network seeks to engage with people the Trust may not have engaged with before and enlist as broad a spectrum of people as possible to facilitate the delivery of more person-centred care. We noted quarterly PECI highlight reports record the communication initiatives that network members have been involved in.

Conclusion:

2.37 Effective learning cascades through the organisational frameworks and gives rise to positive changes to plans and / or processes. We saw this in action in a variety of areas and noted a number where process enhancements might increase learning further.

Objective 4: Learning is designed into working practices, with access provided to opportunities for ongoing education and growth.

- 2.38 We sought to establish the extent to which the Trust is providing staff with opportunities for education and growth, through access to learning opportunities. We also reviewed processes in place for directorates to identify staff development opportunities and needs, and to design and deliver development activities to address these.
- 2.39 The Transforming Education and Training Strategy sets out how education and training needs are to be met and a deliverables appendix records how actions to do so will be rolled out. This is supported by the Strategic Education Steering Group, which has a role to oversee and provide strategic direction in relation to the transformation of education and training within WAST. We noted that the period of the strategy ended at the end of 2021/22 and that a number of the training and education deliverables were overdue and will be carried over into the new strategy period. The new strategy is being developed, but at the time of the audit it's launch was overdue (see **Matters Arising 4**)
- 2.40 We noted staff development needs emerge from a variety of sources which are recorded below:
- mandatory training programmes which are prescribed for all of the UK ambulance services;
 - regular quality review work (auditing, spot checks, clinical audits) conducted in functional activities which identify weaknesses in ways of working that need to be addressed;
 - through capture and evaluation of concerns and SAIs;
 - from objectives set at staff PADR meetings with their line managers;
 - digital expansion, innovation and automation in the workplace;
 - changes in legislation, national competency frameworks, professional standards;
 - changes in service demands and demographics; and
 - learning ambitions recorded in WAST strategies.
- 2.41 Training opportunities for WAST staff are broad and varied and extend to a range of apprenticeships, the paramedic degree level programme provided by Swansea University, and research opportunities with partner organisations e.g., other health bodies, research institutions and universities.
- 2.42 Continuing professional development (CPD) is encouraged and staff are freed from rosters to undertake courses relevant to their roles. Annual provision for CPD in the Trust varies according to role but all Advanced Paramedic Practitioners, Paramedics, Emergency Medicine Technicians and Urgent Care Service officers are allocated 52 CPD hours per year.
- 2.43 We note that to drive developments in this area, the Academic Partnership Committee is responsible for strategic collaboration and partnership working with higher and further education and wider education providers across and beyond

Wales. With the support of this committee, WAST is in the process of applying for University Trust status.

Conclusion:

2.44 Education is pre-eminent in the Trust and staff are offered a broad range of opportunities to increase their learning. Activity in this area is strategy driven but we did note that some of the deliverables of the outgoing strategy document had not been achieved to planned timescale, and that the revised strategy document for the new period had not yet been finalised and issued.

Objective 5: The Trust receive sufficient reporting and assurance of continuous improvement and learning, to inform development of strategy and vision.

2.45 We sought to establish the mechanisms through which functions report their progress in respect of learning objectives to oversight steering groups or committees.

2.46 We noted that corporate level learning objectives are not stated in corporate level planning and strategy documents, but rather, they tend to be articulated as ambitions in functional strategies (examples of these are cited in para 2.8 above), where they serve as enablers to the achievement of the related organisational priorities. We found that progress against the learning ambitions in these documents is typically shared in highlight reports to oversight sub-groups or committees, who then in turn update the Board through the Trust's governance structure.

2.47 We sought to establish how each strand of organisational learning are brought together to demonstrate assurance to the Board and we were provided with materials evidencing an ongoing committee effectiveness review.

2.48 The review indicated changes were needed to improve the range and impact of the committees' work, which would be achieved through the following actions:

- review and revision of the terms of reference of all Trust committees to include learning objectives;
- identifying and scheduling the assurance pieces that the committees would receive to address their objectives, and drafting forward plans setting out their cycles of business;
- ensuring that committee forward plans and related cycles of business cover the terms of reference objectives; and
- implementing new sub-committee highlight reporting to each Trust Board meeting, to replace the sharing of sub-committee meeting minutes.

We noted that that revised terms of reference have been approved by the individual committees and will be presented to Board for approval in May 2022.

2.49 We noted the Board Assurance Framework (BAF) has been paused pending the development of a new model, although we were assured that the Board continues to review the Corporate Risk Register (CRR) in the normal manner.

2.50 We were advised that development work is underway to rearticulate the current corporate risks into a more meaningful format (*'If: Then: Resulting in'*), against which assurance sources will be mapped with greater clarity in the revised BAF model.

Conclusion:

2.51 Oversight committees receive reports of working groups and projects tasked with learning objectives who in turn update the Board through the Trust's governance structure. A committee effectiveness review is in progress that will lead to greater effectiveness and clarity, and improvements to the Corporate Risk Register and Board Assurance Framework.

Appendix A: Management Action Plan

Matter arising 1: Behaviours reset delivery action plan (Operation)	Impact	
<p>We noted the Trust had embarked on a Behaviours study in mid-2021 to identify areas for change. The study, conducted by an external consultant, looked at how the Trust could address difficult issues and emotive subjects, particularly in the wake of a very testing period which had seen enormous pressure placed upon staff and the service as a whole. The aim of this was to make the Trust as inclusive as possible, allowing for free and frank discussions and exchanges of views between managers and staff, with the aim of building a more collaborative workplace where staff were engaged in the process.</p> <p>The study concluded with a 'Behaviours reset' delivery plan, which set out a series of actions to address the themes that had emerged and implement changes to improve ways of working. Whilst we were advised that the Behaviours reset initiative was shared with the workforce at the CEO Roadshows in March 2022, and a progress highlight report was included in papers to the People & Culture Committee in February 2022, we noted a substantial number of actions were overdue at the time of the advisory review. There were a large number of red rated RAG status actions and consequently, we were unable to establish the current status of the delivery plan.</p>	<p>Lack of clarity over the status of the organisational level Behaviours reset plan actions and consequently of the volume and complexity of the work ahead to address the organisational changes it contains.</p>	
Recommendations	Priority	
<p>1.1 We recommend that the behaviours reset delivery plan is brought up to date as a matter of priority in order to clarify current status of this initiative.</p>	<p>Medium</p>	
Management response	Target Date	Responsible Officer
<p>1.1 Management accepts this recommendation, and it has been completed with regular review meetings now in place.</p>	<p>Completed</p>	<p>Faz Tahir Organisational Development Manager</p>

Matter arising 2: Sharing project and development initiative lessons learned (Design)**Impact**

We noted examples of the sharing of learning arising from projects or developments through lessons learned reporting, but were not able to gain assurance that this practice is universal and operates across all projects and development initiatives. Whilst we noted that project PIDs may record a lessons learned section and signal how and when in the project lifecycle this will be delivered, and saw several examples of learning recorded in project closure reports and lessons learned logs, we were unable to gain assurance that all such projects and developments routinely capture and share lessons learned.

Potential risk that errors or oversights that were identified in a project or development are repeated in subsequent projects or developments.

Recommendation**Priority**

2.1 We recommend that project and service development models clearly feature a step to record and share lessons learned to ensure this is firmly embedded in the respective workflows.

Medium

Management response**Target Date****Responsible Officer**

2.1 Management accepts this recommendation and a step will be added to PIDs to record and share lessons learned in an appropriate named forum with a target date and responsible officer.

June 2022

Hugh Bennett
Assistant Director of
Commissioning

Matter arising 3: Analysis of and actions arising from staff stories (Design)**Impact**

The Trust captures and learns from adverse incidents through a variety of channels, one of these being patient and staff stories of their experiences. We noted that patient stories are captured in a 'Driver diagram' template which are used to derive the action that needs to be taken to address the issues raised. However, we saw that this is not the case for staff stories and as a result there is less clarity around how issues identified through these pieces are being addressed.

Potential risk that learning from the experiences reported in staff stories do not translate into actions to address the issues they describe and that as a result, these persist.

Recommendation**Priority**

3.1 We recommend that staff stories are evaluated to identify and deliver actions to address the issues they raise.

Medium

Management response**Target Date****Responsible Officer**

3.1 Management accepts this recommendation and staff stories will now automatically include an evaluation sheet to be completed by the person curating the story.

June 2022

Catherine Goodwin Interim
Director of WOD

Matter arising 4: Transforming Education and Training Strategy re-issue (Operation)		Impact
<p>We noted the Transforming Education and Training Strategy 2019 – 2022 expired in March 2022 and, at the time of the review, had not been revised and re-issued for the new strategy period. We noted that the strategy is transformational and therefore key in supporting delivery of the Trust’s long-term strategic ambitions. We understand that a number of areas of the outgoing strategy are yet to be delivered and as a result will need to be rolled over into the new document.</p>		<p>Potential risk that the Transforming Education and Training agenda is interrupted or delayed in the absence of a current strategy document.</p>
Recommendation		Priority
<p>4.1 We recommend that the expired Transforming Education and Training Strategy is refreshed and re-issued as a matter of priority.</p>		<p>Medium</p>
Management response	Target Date	Responsible Officer
<p>4.1 Management accepts this recommendation, the Education and Training Strategy will be refreshed and re issued as planned as a framework following the delayed refresh of the people and culture strategy. The People and Culture Strategy refresh has been delayed due to system pressures.</p>	<p>December 2022</p>	<p>Jo Kelso Head of Education Transformation</p>

Appendix B: Action plan risk rating

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



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Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	16.3
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	3

COMMITTEE ASSURANCE REPORT – DRIVING LICENCE AUDIT

MEETING	People and Culture Committee
DATE	5 th September 2022
EXECUTIVE	Catherine Goodwin - Interim Director of Workforce and OD
AUTHOR	Andrew Morgan – Senior Education and Development Lead, Driving
CONTACT	Andrew.morgan3@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide the Committee with assurance regarding the improvements made to driving licence check processes, in response to recommendations made in the 2019/20 WAST Drivers' Medicals Internal Audit Report.

KEY ISSUES/IMPLICATIONS

Compliance rate as at 31st March 2022 (reporting period 1st April 2021 – 31st March 2022) = 92%.

Series of improvement actions planned for implementation during August 2022.

REPORT APPROVAL ROUTE

- **Noted** at Executive Management Team (17.08.22)
- **Noted** at WOD Business Meeting (23.08.22)

REPORT APPENDICES

Appendix 1: SBAR – Committee Assurance Report
Appendix 2: WAST Drivers' Medical Internal Audit Report (2019/20)
Appendix 3: Follow Up Review of 2019/20 Limited Assurance Reports

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	N/A	Financial Implications	YES
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	N/A	Risks (Inc. Reputational)	YES

Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/A

Appendix 1: SBAR: Committee Assurance Report

SITUATION

1. The purpose of this report is to provide the Committee with assurance regarding the improvements made to driving licence check processes, in response to recommendations made in the 2019/20 WAST Drivers' Medicals Internal Audit Report (**Appendix 2**).

BACKGROUND

2. An Internal Audit was undertaken in 2019 in relation to WAST drivers and attainment of Group 2 medical standards; as part of this, the review sought to provide assurance that driving licence checks are undertaken annually.
3. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Drivers' Medicals was **Limited** assurance; limited assurance was also given to the specific objective regarding licence checks.
4. In 2021, a Follow Up Review of 2019/20 Limited Assurance Reports (**Appendix 3**) was undertaken, part of which included review of the record keeping and oversight arrangements regarding driving licence checks.
5. The Follow Up Review documented marked improvement in relation to driving licence checks and records arrangements, with further steps planned to provide further assurance including review of the Driving at Work Policy and submission of an annual assurance report to People and Culture Committee regarding driving licence check compliance.

ASSESSMENT

6. The 2021 Follow Up Review noted a driving licence check compliance rate of 85% for 6 of the 7 Trust Health Board areas.
7. As at 31st March 2022, Trust compliance levels for driving licence checks stood at 92%.
8. Operations colleagues overseeing the checking processes and recording arrangements have identified several issues currently affecting compliance rates and reporting abilities; as a result, the following actions are being implemented in order to further improve compliance and reporting ability and to provide a greater level of assurance around this issue:
 - Review of recording and reporting template to more effectively flag licences due for checking;

- Respective Service Managers tasked with improving compliance across individual areas;
- Reinforcing the requirements of the Driving at Work Policy with Operational Managers and supporting better understanding regarding the risks associated with non-compliance;
- Routine reporting of compliance to Senior Operations Team and Operations Senior Leadership Team.

RECOMMENDED: That the Committee **RECEIVE** and **TAKE ASSURANCE FROM** reported performance and associated actions.



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Welsh Ambulance Services
NHS Trust

Drivers' Medicals

Internal Audit Report

2019/20

Welsh Ambulance Services NHS Trust

NHS Wales Shared Services Partnership

Audit and Assurance Services



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Review reference:	WAST-1920-26
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Fieldwork completion:	07 April 2020
Draft report issued:	14 April 2020
Management response received:	11 June 2020
Final report issued:	12 June 2020
Auditors	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Nicola Jones, Audit Manager
Executive sign off	Claire Vaughan, Director of Workforce & Organisational Development (WOD); Lee Brooks, Director of Operations;
Distribution	Helen Watkins, Deputy Director of WOD; Louise Platt, Assistant Director of Operations; Andrew Challenger, Assistant Director, Professional Education & Training;

Andrew Morgan, Senior Education & Development Lead;
Gethin Harries, Occupational Health & Wellbeing Manager
Ceri Bryant – Occupational Health and Wellbeing Manager
Catherine Goodwin – Organisational Culture and Workforce Wellbeing Lead
Charlie Boshier – HR Advisor
Gemma Robinson – e-learning / OLM lead

Committee

Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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1. Introduction and Background

The review of Drivers' Medicals sought to provide the Welsh Ambulance Services NHS Trust (the 'Trust') with assurance that adequate processes are in place to manage the fitness and entitlement of personnel who drive Trust vehicles or volunteer drivers engaged in Trust duties. The Trust has a *Driving at Work* policy, which was approved in September 2018. The audit has considered how the policy is being embedded and assessed the systems and procedures in place for ensuring that Trust personnel and volunteers (either driving under emergency conditions or carrying patients) meet the requirements.

The very nature of an Ambulance Trust leads the public to associate ambulance personnel with a high standard of driving skill and road behaviour. It is therefore of paramount importance that the Trust operates adequate periodic driver checks to ensure compliance with legal obligations for driving at work.

UK driver licensing and licence groups

The UK medical standards for driver licensing list separate medical standards for Group 1 and Group 2 licence holders:

- Group 1 (holders of ordinary driving licence); and
- Group 2 (heavy goods vehicle (HSV) and public service vehicle (PSV) licence holders).

In most cases, the medical standards for Group 2 drivers are substantially higher than for Group 1 drivers. This is because of the size and weight of the vehicle and the length of time an occupational driver typically spends at the wheel.

Fitness to Drive

In addition to the legal minimum standard, the Trust adopts the higher Group 2 medical standards for all employees and volunteers either driving under emergency conditions or carrying patients. However, it should be noted that it is the driver's responsibility to ensure they are fit to drive.

The failure to declare any medical reason that prevents the driver from operating a vehicle would invalidate the Trust's insurance (Welsh Risk Pool) and render the vehicle uninsured whilst being driven by that person.

Health assessments based on the Group 2 medical standards are undertaken pre-placement via the Trust's Occupational Health Service. All ongoing health surveillance in relation to fitness to drive is completed in accordance with Driver & Vehicle Licensing Agency (DVLA) recommendations. There is also a requirement that all drivers aged 45 and over who obtained their C1 licence by acquisition are required to undertake a medical fitness to drive examination with their GP every 5 years or sooner

if determined by the DVLA.

2. Scope and Objectives

The overall objective of the review was to ensure that Trust personnel and volunteers (either driving under emergency conditions or carrying patients) attain the higher Group 2 medical standards as follows:

The areas the review sought to provide assurance on are:

- there are policies and procedures in place that align with the most up-to-date DVLA 'Assessing Fitness to Drive' guidance and define the roles and responsibilities of Trust personnel and volunteer drivers;
- pre-placement medicals and periodic review of drivers fitness to drive is undertaken prior to providing clearance to drive;
- driving licence validity checks are undertaken annually (or shorter intervals if requested);
- appropriate training is provided to drivers to ensure awareness of the legal requirements in respect of fitness to drive; and
- adequate record keeping is maintained for all drivers and any non-compliance with legal driving requirements is reported (along with any actions taken to address the same) and escalated as appropriate.

Limitations of scope

Testing has been limited due to Trust resources focusing on Covid-19. Further detail is included in section 7.

3. Associated Risks

The overarching risks associated with this review were as follows:


- policies and procedures have not been developed or do not align with current DVLA guidance;
- inadequate health / fitness / licence surveillance checks, along with a lack of staff training or awareness of legal requirements, results in patients, staff or civilians coming to harm if an accident occurred, resulting in possible legal action, financial penalties and reputational damage to the Trust;
- lack of capacity within the occupational health team to undertake required assessments; and
- record keeping and reporting in respect of the legal minimum driving requirements is inadequate.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.





The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Drivers' Medicals is **Limited** assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the tables below:

					
1	Policies and Procedures			✓	
2	Surveillance Checks		✓		
3	Driving Licence Checks		✓		
4	Training			✓	

5	Record Keeping & Oversight		✓		

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review highlighted three issues that are classified as weaknesses in the system control/design for Drivers' Medicals.

Operation of System/Controls

The findings from the review highlighted one issue that is classified as weaknesses in the operation of the designed system/control for Drivers' Medicals.

6. Summary of Audit Findings

The Trusts Driving at Work Policy sets out the requirements and responsibilities of staff for driving.

We identified that there is a lack of oversight and collation of records, and a disjointed approach between departments.

There are a number of areas where the policy requires updating and clarification. Whilst our review identified that majority of new starters had occupational health clearance prior to their start date and occupational health requests are processed in a timely manner, there is a risk a number of employees in the trust are undertaking roles without appropriate clearance prior to starting.

We have been unable to provide assurance that:

- all staff members are fit to drive;
- all employees have a valid driving licence; and
- all new starters had completed the appropriate assessments and training before commencing their roles.

Further details are included in section 7 below.

7. Detailed Audit Findings

Objective 1: policies and procedures have not been developed or do not align with current DVLA guidance

The Trust has a 'Driving at Work Policy' that was approved by the Quality and Patient Safety Committee in September 2018, and is due for review in September 2021. The policy is available to staff via the intranet and sets out requirements and responsibilities in relation to driving.

In addition, the Driver and Vehicle Licensing Agency (DVLA) has issued 'Assessing Fitness to Drive' guidance that sets out national medical guidelines on fitness to drive. Whilst this guidance is for medical professionals, it does set out the requirements in relation to Group 2 standards. These are reflected in the Trust's Driving at Work Policy, specifically placing the onus on staff to notify the DVLA / Trust of changes that affect their fitness to drive.

The Policy includes a 'Fitness to Drive' form that is required to be completed every three years, however this is only included as an Appendix and there is no reference to the form within the policy. There is also limited information on the form relating to where the form is required to be sent and actions required if issues are identified.

The responsibilities section within the policy (section 10) sets out the expectations of staff within the Trust; however, this does not reflect all the responsibilities referred to throughout the Policy which could lead to confusion. For example, the main body of the Policy refers to line managers being responsible for undertaking driving licence checks; however, this is not included under the list within the responsibilities section.

The policy includes reference to ongoing monitoring of the policy, using the 'approved audit system', however, there is no central monitoring, neither within Workforce and Organisational Development nor the Operations Directorates, that provides oversight, including whether the appropriate driving licence checks and fitness to drive forms have been completed. (See objective 5 for further information)

See Finding 1 in Appendix A

Objective 2: pre-placement medicals and periodic review of drivers fitness to drive is undertaken prior to providing clearance to drive

As detailed in section 1 above, in addition to the legal minimum standard, the Trust adopts the higher Group 2 medical standards for all employees and volunteers either driving under emergency conditions or carrying patients. However, it should be noted that it is the driver's responsibility to ensure they are fit to drive. There is also requirement that all drivers aged 45 and over who obtained their C1 licence by acquisition are required to undertake a medical assessment by a registered medical practitioner every 5 years or sooner if determined by the DVLA.

On appointment to the Trust, drivers are required to complete an OH questionnaire at the recruitment stage. This is reviewed by OH and drivers are required to undertake a medical assessment before OH provide clearance. Following this initial appointment, as noted above it is the responsibility of employees to notify the Trust of any changes that affects their fitness to drive. Staff are also required to complete the 'Fitness to Drive' declaration, included as an appendix in the Driving at Work Policy, every three years, although this was only included in the policy from 2018.

We are advised that in the event staff make a declaration that their acute or chronic medical condition may impact on their ability to drive, there is a clear process that is followed. This involves referral to OH and in some cases, temporary redeployment until further medical intervention and clearance has been received, although due to limited testing we have not seen evidence to confirm this.

There are no formal monitoring mechanisms in place to ensure the 'fitness to drive' declarations are being submitted. These are not currently completed within NEPTS, and whilst we were advised that this requirement has been rolled out in two health board areas within EMS and is planned for further roll out, we are unable to provide assurance that staff members employed by the Trust for at least a three-year period are fit to drive. The Workforce performance scorecard report presented to the March 2020 People and Culture Committee showed there are 1532 staff in post in EMS/ambulance response and 440 staff in post in NEPTS as at the end of January 2020. This suggests, when excluding new starter figures below, our finding relates to the majority of staff within these staff groups.

Occupational Health Clearance data is captured on both the Electronic Staff Record (ESR) and COHORT systems. The COHORT system is used to capture and manage employees' medical information, appointments health surveillance and OH data. However, our audit identified there is no direct interface between these systems and no manual reconciliation is performed between them to confirm accuracy of records.

We obtained a report generated from Electronic Staff Record (ESR) system detailing new starters within Non-Emergency Patient Transport Services (NEPTS) and Emergency Medical Service (EMS) between January 2019 and February 2020. The report captures the assignment start date and the date of OH Clearance and showed that 77% of starters had their occupational health status recorded. The majority of these received occupational health clearance in a timely manner with only 12% receiving clearance following their assignment start date. Furthermore, review of a report generated from the COHORT system showing occupational health clearances processed between 1 March and 10 June 2020 identified that 95% of occupational health requests were cleared within a month, although due to limited staff

availability because of Covid-19 pressures we were unable to confirm whether these were completed prior to the start of employment.

In addition, we selected a sample of 13 drivers who did not have medical clearance recorded on ESR to review on the COHORT system. This check identified seven instances where an occupational health clearance had in fact been completed. Records for remaining six individuals were not present on the system as they had been employed by the Trust for over 20 years. This suggests that the information recorded in ESR relating to OH clearance cannot be relied upon.

Our analysis demonstrates that whilst the majority of starters had OH clearance prior to their start date and occupational health requests are processed in a timely manner, there is a risk a number of employees in the trust are undertaking roles without appropriate clearance prior to starting their starting. Discussion with the OH Manager and an OH Practitioner highlighted that there has not always been clear communication between OH and WOD when staff are being recruited, although mechanisms are being put in place to improve this going forward. This has impacted on the ability to manage the resource effectively in order to ensure checks are undertaken promptly.

See Findings 2 & 3 in Appendix A

Objective 3: driving licence validity checks are undertaken annually (or shorter intervals if requested)

Following checks undertaken during initial assessment and training (refer to objective 4 below where we have noted a lack of central records), the Driving at Work Policy requires driving licence checks to be undertaken on an annual basis. These are the responsibility of line managers and the policy states '*...employees must agree to comply with any mandate, as required by the Trust, which provides the authority for the Trust to check individual licence validity with the DVLA*'.

The Senior Education Lead for the Trust confirmed the driving licence check should be against DVLA records to confirm the driver holds a valid licence, including the correct entitlements / categories and any endorsements. This involves the employee requesting the information online via the DVLA website and sharing it with the line manager. The policy states that managers will keep a record of the checks made, however it does not state the specific information that should be checked i.e. licence validity, category, endorsements, and how this should be captured (i.e. whether copies of DVLA records should be retained) and reported, although it does capture action that should be taken when penalty points are incurred.

We are advised that staff who are on alternative duties in Operations are often tasked to assist in undertaking these checks, so it is important that the requirements are clearly set out. We are advised that records of these checks are maintained locally, separately by the EMS and NEPTS teams respectively. However, we have been unable to confirm this due to resource pressures because of Covid-19.

There is no formal monitoring mechanism in place to ensure these checks are being undertaken and actioned accordingly. Local records are not collated, therefore we are unable to provide assurance that all employees have a valid driving licence. We understand electronic solutions, such as ESR, are being explored in order to capture this information centrally and enable oversight. (See objective 5 below).

In regards to volunteers, the processes around employment checks, including drivers' licences and medical examinations, and training and ongoing supervision were considered in our recent 'Volunteer Car Drivers' Governance Arrangements' reviews in 2018/19 and 2019/20. In response to our findings, the Trust has committed to launching a Volunteer Strategy and to develop a supporting Volunteer Action Plan. The Action Plan includes implementing the infrastructure associated with a Volunteer Department and harmonising processes and Policy for all Volunteers across the Trust.

See Finding 1 in Appendix A

Objective 4: appropriate training is provided to drivers to ensure awareness of the legal requirements in respect of fitness to drive

On appointment to the Trust, drivers are required to undertake a driving course and assessment. The length of the course will depend on the role they will be undertaking, i.e. EMS drivers require more training than NEPTS drivers. Ongoing training is not deemed necessary unless issues are identified (i.e. through accidents or concerns raised in fitness to drive declarations) and staff should be reminded of the requirements and their responsibilities through the annual drivers licence check (refer to objective 3 above).

We were unable to confirm that all new starters had completed the appropriate assessments and training before commencing their roles, due to an absence of a central record capturing this information being maintained by the training department. The Policy states it is the Education and Training team responsibility to retain training records within ESR (see Objective 5 below). We were advised that records are retained within individual hard copy files. However, we were not able to obtain these records for review due to Covid-19 pressures.

As part of the course and assessment, we are advised that driving licences are also checked to confirm that the driver has the appropriate entitlements and to confirm if there are any endorsements. However, we have been unable to confirm this due to the absence of the central record noted above.

Whilst confirmation that appropriate OH clearance is not sought prior to driving assessments being undertaken, we were advised that individuals are asked about medical conditions and OH will be contacted if concerns are raised.

See Finding 4 in Appendix A

Objective 5: adequate record keeping is maintained for all drivers and any non-compliance with legal driving requirements is reported (along with any actions taken to address the same) and escalated as appropriate

As noted under objectives 2, 3 and 4 above we were unable to establish whether complete and accurate records are being maintained regarding OH clearance and ongoing fitness to drive declarations, driving assessments and driving licence validity checks. There appears to be a disjointed approach between the education and training, OH and HR teams with records are not being reconciled. The Policy states it is the Education and Training team's responsibility to retain training records within ESR and to ensure monitoring of the driving at work policy, using the approved audit system. We understand electronic solutions are being explored.

We were informed that ongoing checks should be being undertaken by local operations management, in line with the policy which states Ambulance Operations Manager / Heads of Departments are responsible for monitoring current practice on an annual basis. We were also informed that within EMS, weekly compliance figures are emailed to Locality Managers and Clinical Team Leaders. Although we have not been able to confirm these are in operation due to limited testing, one locality who did respond explained that they had only recently been made aware of the need to complete these and they are currently creating a spreadsheet to capture this information. NEPTS also advise that checks are undertaken by line managers or administrators within each region and are either captured on spreadsheets or the Cleric system.

Volunteer Car Drivers' licence checks are recorded via the Cleric system; this was reviewed as part of the 2018/19 Volunteer Car Drivers' Governance Arrangements review and the follow-up review in 2019/20. Regardless this information is not then collated and therefore we have not seen evidence to demonstrate that mechanisms are in place to ensure compliance is monitored centrally. We have not seen evidence of them being monitored within the Directorates nor at Board / Committee level.

See Finding 4 in Appendix A

8. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined in the table below.

Priority	H	M	L	Total
Number of recommendations	1	3	-	4

Finding 1 Driving at Work Policy (Design)	Risk
<p>The Driving at Work Policy includes the requirements for staff within the Trust, however there are a number of areas that are not clear / require further information:</p> <ul style="list-style-type: none"> a) The Fitness to Drive form is included in the Driving at Work Policy as an Appendix (Appendix 4), which states it is required to be completed by staff every three years. The form is not included in the main body of the policy within the Fitness to Drive section (6.6). The form does not include details on where the form should be submitted, where this information should be captured and actions to be taken if issues are raised. It does also not include an area for staff details. b) The responsibilities section within the policy (10) sets out the expectations of staff within the Trust; however, this does not reflect all the responsibilities referred to throughout the Policy, which could lead to confusion. For example, the main body of the policy refers to line managers being responsible for undertaking driving licence checks on an annual basis; however, this is not included under the list within the responsibilities section. c) The driving licence check section (6.4) states that '<i>...employees must agree to comply with any mandate, as required by the Trust, which provides the authority for the Trust to check individual licence validity with the DVLA</i>'. The Senior Education Lead for the Trust confirmed the driving licence check should be a check against DVLA records to confirm the driver holds a valid licence, including the correct entitlements / categories and any endorsements. This involves the employee requesting the information online via the DVLA website and sharing it with the line manager. The policy states that managers will keep a record of the checks made, however it does not state the specific information that should be checked i.e. licence validity, category, endorsements, and how this should be captured (i.e. copies of DVLA records retained) and reported. The Policy also states it is the Education and Training team responsibility to retain training records within ESR, ensure monitoring 	<p>Staff are not clear on the requirements of the policy and their responsibilities, leading to inadequate health / fitness / licence surveillance checks. This could result in patients, staff or civilians coming to harm if an accident occurred, resulting in possible legal action, financial penalties and reputational damage to the Trust.</p>

Action Plan

<p>of the driving at work policy, using the approved audit system, but this is not currently being achieved (see finding 4).</p>	
<p>Recommendation 1</p>	<p>Priority level</p>
<p>The Driving at Work Policy should be updated with the following:</p> <ul style="list-style-type: none"> a) the requirements to complete the fitness at work form at Appendix 4 should be reflected in the main body of the policy. The form should also be updated to include space for staff details and confirmation of action required following completion of the form (by staff and line managers), including where there are issues identified that may affect fitness to drive. Occupational Health should be consulted to ensure the form is fit for purpose and captures all areas required. b) the Responsibilities section should reflect the responsibilities stated throughout the policy to ensure that staff are aware of these. c) the detailed requirements of the driving licence checking process, i.e. validity, entitlements and endorsements. The policy should also include how this information should be captured and reported / monitored. 	<p>Medium</p>

Management Response 1	Responsible Officer / Deadline
<p>We accept the overall finding, and note that due to COVID 19 restrictions, some evidence was not reviewed.</p> <p>The Driving at Work Policy will be reviewed as suggested to include:</p> <p>a) Amendment to the Fitness to Drive form to include staff details and align to licence checks. The Policy will be updated to ensure reference to the form will be included within the relevant sections of the Policy. Additional information will be offered giving clear guidance on how to check a driving licence check and process a Fitness to Drive forms.</p> <p>b) Amendment to the Responsibility section to reflect the responsibilities, e.g. for all Line Managers, to include driving licence checks / Fitness to Drive forms. A Communication will be shared with all staff informing them of changes and responsibilities via Siren, email, Facebook etc.</p> <p>c) Amend the Driving at Work Policy to include appendices explaining how to check a driving licence for validity, entitlements and endorsements, including monitoring, recording and reporting processes.</p>	<p><i>Executive Lead: Claire Vaughan, Director of WOD</i></p> <p>Andrew Challenger, Assistant Director, Professional Education & Training</p> <p>Andrew Morgan, Senior Education & Development Lead</p> <p>Ceri Bryant, Occupational Health and Wellbeing Manager</p> <p>December 2020</p>

Finding 2 Occupational Health Clearance (Design)		Risk															
<p>Occupational Health Clearance data is captured on both the Electronic Staff Record (ESR) and COHORT systems. The COHORT system is used to capture and manage employees' medical information, appointments health surveillance and OH data. However, our audit identified there is no direct interface between these systems and no manual reconciliation is performed between them to confirm accuracy of records.</p> <p>We obtained a report generated from Electronic Staff Record (ESR) system detailing new starters within Non-Emergency Patient Transport Services (NEPTS) and Emergency Medical Service (EMS) between January 2019 and February 2020. The report captures the assignment start date and the date of OH Clearance and showed a total of 522 new starters, analysed in the table below:</p> <table border="1"> <thead> <tr> <th>Year</th> <th>Number of starters</th> <th>OH clearance confirmed on ESR</th> <th>Fit to work with restrictions</th> <th>No OH clearance information on ESR</th> </tr> </thead> <tbody> <tr> <td>2019</td> <td>366</td> <td>266 (73%)</td> <td>1 (0%)</td> <td>99 (27%)</td> </tr> <tr> <td>2020</td> <td>156</td> <td>133 (85%)</td> <td>4 (3%)</td> <td>19 (12%)</td> </tr> </tbody> </table> <p>Out of the 399 who had occupational health clearance recorded on ESR, 49 (12%) had clearance after their assignment start date. The timescales for clearance varied between 1 and 307 days. Further review of records held on the COHORT system relating to a sample of the drivers with the longest delays demonstrated that the vast majority of occupational health clearances had been completed within a week of the form being signed by the employee (35 days was the longest). In addition, we were subsequently provided with a report generated from the COHORT system showing occupational health clearances processed between 1 March and 10 June 2020. Analysis of this report identified that 95% of the 281 occupational health requests were cleared within a month, although due to</p>		Year	Number of starters	OH clearance confirmed on ESR	Fit to work with restrictions	No OH clearance information on ESR	2019	366	266 (73%)	1 (0%)	99 (27%)	2020	156	133 (85%)	4 (3%)	19 (12%)	<p>Staff may not have appropriate medical clearance to undertake their roles.</p>
Year	Number of starters	OH clearance confirmed on ESR	Fit to work with restrictions	No OH clearance information on ESR													
2019	366	266 (73%)	1 (0%)	99 (27%)													
2020	156	133 (85%)	4 (3%)	19 (12%)													

Action Plan

limited staff availability because of Covid-19 pressures we were unable to confirm whether these were completed prior to the start of employment. In addition, of the 118 drivers who did not have OH clearance stated on ESR, we selected a sample of 13 and provided these to OH to review on the COHORT system. This check identified seven instances where an occupational health clearance had in fact been completed. Records for remaining six individuals were not present on the system as they had been employed by the Trust for over 20 years (refer to finding 3 below regarding ongoing checks). Our analysis suggests that the information recorded in ESR relating to OH clearance cannot be relied upon.

The analysis above demonstrates that whilst the majority of starters (at least 350 out of 522 staff (67%)) had OH clearance prior to their start date and occupational health requests are processed in a timely manner, there is a risk a number of employees in the trust are undertaking roles without appropriate clearance prior to starting their starting. Discussion with the OH Manager and an OH Practitioner highlighted that there has not always been clear communication between OH and WOD on when staff are being recruited, although mechanisms are being put in place to improve this going forward. This has impacted on their ability to manage the resource effectively in order to ensure checks are completed prior to the start of employment.

Recommendation 2	Priority level
<p>a) Those staff identified on ESR as having no OH clearance should be checked on the COHORT system to confirm whether they have had the appropriate clearance. Where they have not had the clearance, they should be contacted for this to be arranged.</p> <p>b) OH clearance should be checked prior to drivers undertaking driver training and assessment.</p> <p>c) COHORT reports on delays in OH clearance should be reviewed, with action taken to address the causes of these.</p>	<p>Medium</p>
Management Response 2	Responsible Officer/ Deadline
<p>We accept the overall finding and note since the audit WAST has employed a new OH Manager; additionally, a new version of COHORT has been introduced (COHORT 10). We note there have been some improvements since the new OH Manager has taken up the role. In relation to the recommendations:</p> <p>a) The OH Manager will ensure that staff who are identified as not having received OH clearance will be checked on the COHORT 10 system for assurance that checks were made; if it is found that staff have not had clearance, they will be contacted for this to be retrospectively arranged.</p> <p>b) Improvements will be introduced by the facilitation of a standardisation meeting prior to the commencement of any new staff/training programmes; attendees from Education & Training, HR, and OH teams will confirm all is in place from a governance and audit perspective. If any anomalies are identified, it will be fast tracked, prior to the staff member joining the training programme.</p> <p>c) Action included above in b)</p>	<p><i>Executive Lead: Claire Vaughan, Director of WOD</i></p> <p>Catherine Goodwin, Organisational Culture and Workforce Wellbeing Lead</p> <p>Ceri Bryant, Occupational Health and Wellbeing Manager</p> <p>Andrew Morgan, Senior Education & Development Lead</p> <p>Charlie Boshier, HR Advisor</p> <p>December 2020</p>

<p>Finding 3 Ongoing Checks – Fitness to Drive & Driving Licence (Operation)</p>	<p>Risk</p>
<p>Fitness to Drive</p> <p>Following occupational health clearance and completion of driving assessments during initial appointment, it is the responsibility of employees to notify the Trust of any changes that affects their ability and fitness to drive. Staff are required to complete the 'Fitness to Drive' declaration every three years, The form, which was included as an appendix in the Driving at Work Policy in 2018, is not referred to in the main body of the Policy and staff that had been employed by the Trust for more than three years when the Policy was issued were not required to submit declarations.</p> <p>Review of the form highlights that it does not specify where the form should be submitted to, where this information is then captured and the actions that should be taken to resolve any issues raised.</p> <p>There are no formal monitoring mechanisms in place to ensure the 'fitness to drive' declarations are being submitted. Furthermore, we were advised that these are not currently completed within NEPTS, and whilst we were advised that this requirement has been rolled out in two health board areas within EMS and is planned for further roll out, we are unable to provide assurance that staff members employed by the Trust for at least a three-year period are fit to drive. The Workforce performance scorecard report presented to the March 2020 People and Culture Committee showed there are 1532 staff in post in EMS / ambulance response and 440 staff in post in NEPTS as at the end of January 2020. This suggests, when excluding new starter figures noted in finding 2 above, this finding relates to the majority of staff within these staff groups.</p>	<p>Staff may not be fit to undertake their roles.</p> <p>The failure to declare any medical reason that prevents the driver from operating a vehicle would invalidate the Trust's insurance (Welsh Risk Pool) and render the vehicle uninsured whilst being driven by that person</p> <p>There is a risk that there may only be a physical check of the driver licence, and not a full check with the DVLA, which may pick up invalid licences or required action not being taken by line managers.</p>

Driving assessments and licence checks

When drivers undertake the initial driving course and assessment, we are advised that driving licences are checked to confirm that the driver has the appropriate entitlements and to confirm if there are any endorsements. However, we were unable to confirm that all new starters had completed the appropriate assessments and training before commencing their roles, due to an absence of a central record capturing this information. The Policy states it is the Education and Training team responsibility to retain training records within ESR. We were advised that records are retained within individual hard copy files. However, we were not able to obtain these records for review due to Covid-19 pressures.

Following checks undertaken during initial assessment and training, the Driving at Work Policy requires driving licence checks to be undertaken on an annual basis. The Senior Education Lead for the Trust confirmed the driving licence check should be against DVLA records in order to confirm the driver holds a valid licence, including the correct entitlements, categories and any endorsements. This involves the employee requesting the information online via the DVLA website and sharing it with the line manager. The policy states that managers will keep a record of the checks made, however it does not state the specific information that should be checked i.e. licence validity, category, endorsements, and how this should be captured (i.e. whether copies of DVLA records should be retained) and reported, although it does capture action that should be taken when penalty points are incurred.

We are advised that staff who are on alternative duties in Operations are often tasked to assist in undertaking these checks, so it is important that the requirements are clearly set out. The Trust has raised a request to allow managers to enter driver licence information onto ESR via Manager Self Service and is awaiting confirmation whether this will be agreed (this is an ESR decision rather than a Trust decision). This would enable reports to be generated from the system and a mechanism to monitor that checks have been completed

Action Plan

<p>and to address exceptions identified. A possible alternative option could include line managers providing their driving licence checks records to WOD to input on ESR.</p> <p>In the absence of an electronic solution, local records must be maintained resulting in a manual and resource intensive process. Separate records are held by the EMS and NEPTS teams respectively. Although we have not been able to confirm these are in operation due to limited testing due to resource pressures because of Covid-19, one EMS locality who did respond explained that they had only recently been made aware of the need to complete these and they are currently creating a spreadsheet to capture this information. NEPTS also advise that checks are undertaken by line managers or administrators within each region and are captured either on spreadsheets or on Cleric.</p>	
<p>Recommendation 3</p>	<p>Priority level</p>
<p>a) There should be more joined up working between HR, OH and Training departments to improve coordination of OH clearances when staff are going through the recruitment process.</p> <p>Following a review of the Fitness to Drive form (see recommendation 1 above), management should:</p> <ul style="list-style-type: none"> a) Identify staff who are required to complete the form (i.e. those who have not had occupational health clearance within the last three years, in particular those over the age of 45 in line with DVLA guidance) and ensure these are completed. b) Review how the information is captured for ongoing reporting and monitoring i.e. through the Occupational Health COHORT system or local records (that would need to be collated centrally) c) Ensure there is oversight of the number of staff who have completed forms to ensure staff are fit to drive. Consider central recording via workforce team. 	<p>Medium</p>

Action Plan

<p>For driver licence checks:</p> <ul style="list-style-type: none"> a) Records of driver assessments and checks undertaken at the training stage (i.e. post the recruitment stage) should be maintained centrally to demonstrate all drivers have had the appropriate checks and completed the correct course before starting their role. b) The Trust should confirm the status of the request to allow driving licence information to be included in the Manager Self Service section on ESR. If it is determined that this is not feasible, consideration should be given for line managers to provide the records to WOD to input centrally for ongoing monitoring and reporting. 	
<p>Management Response 3</p>	<p>Responsible Officer/ Deadline</p>
<p>We accept the overall finding. Relationships between OH, HR and Education & Training (E&T) will be further strengthened by the introduction of a standardisation meeting as in management response to finding 2.</p> <p>The Driving at Work Policy will be reviewed to include the self-declaration form:</p> <ul style="list-style-type: none"> a) The alignment of an annual self-declaration form with the annual driving licence check. b) A review will be undertaken to establish if ESR or COHORT is the most appropriate recording system. c) As per b) above. <p>Driving licence checks:</p> <ul style="list-style-type: none"> a) Licence checks are completed on commencement of training programmes. These records are held on the individual student electronic training file, as per point b above, ESR will be explored for suitability to record, report and monitor. E&T team will introduce this information being uploaded to ESR if system will allow. 	<p><i>Executive Lead: Claire Vaughan, Director of WOD</i></p> <p>Andrew Challenger, Assistant Director, Professional Education & Training</p> <p>Andrew Morgan, Senior Education & Development Lead</p> <p>Gemma Robinson, e-learning / OLM lead</p>

Action Plan

b) A piece of work has commenced to explore the use of ESR to enable manager self-service.

Ceri Bryant, Occupational Health and Wellbeing Manager
December 2020

Finding 4 Record Keeping and Oversight Arrangements (Design)	Risk
<p>As noted under findings 2 and 3 above, we were unable to establish whether complete and accurate records are being maintained regarding OH clearance and ongoing fitness to drive declarations, driving assessments and driving licence validity checks.</p> <p>The Driving at Work policy states the following under 'Audit and Monitoring':</p> <p><i>'The effective monitoring of this policy will be a review of working practises in all Trust areas (1), annual audit safety documentation from all departments (2), monitoring of incidents throughout the Trust (3) and review of the policy at the stated time (4). A structured approach will be adopted for the monitoring of the policy. This will be achieved by reviewing all Datix incidents (Trust incident / accident reporting system (5)). The policy will be reviewed every 3 years unless legislation requires otherwise.</i></p> <p>Whilst it does not state who is responsible for these arrangements within the section, the following is stated within the responsibilities section (10): <i>'The Head of Education and Training has delegated responsibility for driver education within the Trust and will ensure the implementation of the Driving at Work Policy, with the inclusion of adequate training and monitoring.'</i></p> <p>There appears to be a disjointed approach between the education and training, OH and HR teams with records are not being reconciled. The Policy states it is the Education and Training team's responsibility to retain training records within ESR and to ensure monitoring of the driving at work policy, using the approved audit system. We also understand electronic solutions are being explored.</p> <p>We were informed that ongoing checks should be being undertaken by local operations management, in line with the policy which states Ambulance Operations Manager / Heads of Departments are responsible for monitoring current practice on an annual basis. We</p>	<p>The Trust does not have oversight of whether staff are complying with the requirements of the Driving at Work Policy</p>

Action Plan

<p>were also advised that weekly compliance figures are emailed to Locality Managers and Clinical Team Leaders. Although we have not been able to confirm these are in operation due to limited testing, one locality who did respond explained that they had only recently been made aware of the need to complete these and they are currently creating a spreadsheet to capture this information (refer to finding 3).</p> <p>Regardless this information is not then collated and therefore we have not seen evidence to demonstrate that mechanisms are in place to ensure compliance is monitored centrally. We have not seen evidence of them being monitored within the Directorates nor at Board / Committee level.</p>	
<p>Recommendation 4</p>	<p>Priority level</p>
<ul style="list-style-type: none"> a) The mechanisms and lines of responsibility for compliance monitoring, including the escalation route through to Board, should be confirmed. b) Appropriate action should be undertaken to address and resolve non-compliance c) The audit monitoring process for reviewing compliance with elements of the policy, for example spot checks on OH clearance, driving licences etc., should be determined and implemented. 	<p style="text-align: center;">High</p>
<p>Management Response 4</p>	<p>Responsible Officer/ Deadline</p>
<p>We accept the overall finding and note that improvements will be enabled through the introduction of the COHORT 10 system and the use of ESR manager self-service. This will enable:</p> <ul style="list-style-type: none"> a) Improvements in the lines of responsibility, for compliance monitoring through to Board level. b) Non-compliance will be identified and resolved utilising ESR reporting mechanisms. 	<p><i>Executive Lead: Claire Vaughan, Director of WOD</i></p> <p>Andrew Challenger, Assistant Director, Professional Education & Training</p>

Action Plan

c) Snap shot audits will be facilitated to monitor compliance utilising ESR systems on a monthly basis.

Andrew Morgan, Senior Education & Development Lead

Gemma Robinson, e-learning / OLM lead

Ceri Bryant, Occupational Health and Wellbeing Manager

December 2020

Audit Assurance Ratings



Substantial Assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.



Reasonable Assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.



Limited Assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.



No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with WAST. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Office details:

MAMHILAD Office
Audit and Assurance
Cwmbran House (First Floor)
Mamhilad Park Estate
Pontypool, Gwent
NP4 0XS



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

Contact details

Helen Higgs (Head of Internal Audit) – 01495 300846
Osian Lloyd (Deputy Head of Internal Audit) – 01495 300843
Nicola Jones (Audit Manager) – 01792 860592



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Ymddiriedolaeth GIG
Gwasanaethau Ambiwians Cymru
Welsh Ambulance Services
NHS Trust

Follow Up Review of 2019/20 'Limited' Assurance Reports

Internal Audit Report

2020/21

Welsh Ambulance Services NHS Trust

NHS Wales Shared Services Partnership

Audit and Assurance Services



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Appendix A	Assurance Opinion and Action Plan Risk Rating
Appendix B	Responsibility Statement

Review reference:	WAST-2021-33
Report status:	Final
Fieldwork commencement:	6 April 2021
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Final report issued:	27 May 2021
Auditors	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit

Executive sign off Keith Cox, Board Secretary

Distribution Julie Boalch, Corporate Governance
Manager;
Lee Brooks, Director of Operations;
Brendan Lloyd, Medical Director;
Claire Vaughan, Director of
Workforce and Organisational
Development;
Mark Harris, Assistant Director of
Operations - NEPTS
Jonathan Wilson, Clinical Equipment
and Procurement Manager
Andrew Morgan, Senior Education
and Development Lead
Executive Management Team

Committee

Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of Welsh Ambulance Services Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The purpose of the follow-up review of 2019/20 'Limited' Assurance Reports was to assess and report whether the Welsh Ambulance Services NHS Trust (the 'Trust') has implemented the Internal Audit recommendations raised. Four limited assurance reports were issued during 2019/20:

- Vehicle Hire - to provide an assurance that taxi and other vehicle hire within the Trust has been procured, and is being used, in the most cost effective way and that patients are transported safely;
- Appropriately Equipped Paramedics - to provide assurance that clinical equipment is safe and effective at the point of use. We reviewed the process of maintenance and monitoring of equipment with a focus on the orange bag and how lessons learned will influence future purchase of clinical equipment;
- Cleaning Standards - to provide assurance that vehicles and stations are being cleaned to the expected standards. An assessment of the impact of 'make ready depots' (MRD's) was included; and
- Drivers' Medicals - to provide assurance that adequate processes are in place to manage the fitness and entitlement of personnel who drive Trust vehicles or volunteer drivers engaged in Trust duties.

2. Scope and Objectives

We tested a sample of recommendations, focusing on those rated high and medium priority and recorded as being implemented, to provide assurance on progress with implementation. Reliance is placed on the Trust's monitoring mechanisms, principally the Audit Recommendations Tracker, to scrutinise implementation of the remaining recommendations raised within these reviews, in particular any that are overdue.

The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original audits. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plans only.


3. Associated Risks

The overall risk considered in the follow up review is failure to implement agreed audit recommendations and therefore continued exposure to the risks identified in the original audits.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

This report does not provide assurance against the full review scope and objective of the original audits. The 'follow-up review opinion' provides the assurance level against the implementation of the agreed action plan only. Considering the progress made against the action plan the follow-up review opinion is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		All recommendations implemented and operating as expected.

5. Summary of Audit Findings

The Trust has effective arrangements to track progress in relation to audit and review findings. The Audit Committee reviews the internal and external audit recommendation tracker at each meeting and the format of the tracker enables committee members to view updates on progress in relation to the implementation of each recommendation and allows an opportunity to scrutinise. The Trust has also recently begun to refer relevant extracts of the audit tracker to each Board Committee to support oversight and scrutiny for recommendations relating to their remit.

The audit tracker is maintained by the Corporate Governance Manager within Corporate Governance Team. The Team receives all audit reports (both internal and external) for inclusion in committee papers which ensures that the recommendations tracker captures all recommendations raised. The tracker is reviewed by the Assistant Directors Leadership Team on a monthly basis and the Executive Management Team prior to Audit Committee to ensure realistic timescales have been proposed and a rationale is included to support revisions to completion dates.

The organisation is currently carrying a higher number of recommendations in this period than normal due to key staff being redeployed in line with the Trust's response to the CoVID-19 pandemic. There was limited activity in respect of the audit recommendation tracker between March and June 2020, following the decision taken by the Executive Management Team to apply a blanket six month extension to implementation dates. We are aware that one NHS Wales health body has applied a re-prioritised approach for the implementation of outstanding audit recommendations, by determining

whether the delivery of strategic priorities or actions within the Winter Protection Plan are dependent on the implementation of a recommendation. Actions which were deemed as having a high risk to patient or staff safety and wellbeing and where prioritised compliance with legal requirements and statutory duties had been identified were also prioritised. Although we were informed that the number of recommendations have now returned to pre-pandemic levels, the Trust may wish to consider adopting a similar approach should it carry a higher number of recommendations in the future. In June 2020, Audit Committee members requested that recommendations and completion dates be reviewed for its September 2020 meeting to ensure recommendations remain relevant and that timescales for completion are realistic.

We tested a sample of six recommendations, focusing on those rated high and medium priority and recorded as being implemented, to provide assurance on progress with implementation. We referred to the most recent version of the audit recommendations tracker, which was presented at the March 2021 Audit Committee meeting, to select our testing sample as follows:

- Vehicle Hire: both recommendations raised in our report were recorded as implemented (one high priority and one medium priority);
- Appropriately Equipped Paramedics: one high priority recommendation (the remaining high priority recommendation is not yet due) and one of the four medium priority recommendations recorded as implemented (the fifth and remaining medium priority recommendation is overdue); and
- Drivers' Medicals: the one high priority recommendation and the only medium priority recommendation implemented (the remaining two medium priority recommendations are overdue).

All four recommendations raised in the Cleaning Standards review (three high priority and one medium priority) were recorded as overdue.

Our testing confirmed that all were appropriately classified as completed on the tracker. However, it is recognised that further action is ongoing to fully mitigate the risks identified.

6. Detailed Audit Findings

This section captures a summary of our previous findings from our testing sample, along with the progress made to implement the associated recommendations.

- **Vehicle Hire**

Previous Finding 1 - Contract Governance and Quality Assurance (High Priority)

The Trust's Non-Emergency Patient Transport Services (NEPTS) uses taxi and other vehicle hire (private ambulances, voluntary and local authority transport services and 4x4s during winter pressures), otherwise known as alternative providers, to support service delivery when there is no availability from the Trust's own vehicles or Voluntary Car Drivers. Our original audit identified a lack of contract governance and quality assurance over the alternative providers used by NEPTS, leading to an increased risk of excessive and avoidable costs and compromising patient safety and experience. The related financial and patient safety risks to the Trust are further increased with the transfer of the non-WAST NEPTS work from the health boards. As a result of our finding around alternative providers in the 2018/19 'volunteer car drivers - governance arrangements' audit, the Trust had already started to take action to resolve this situation, with the appointment of a Quality Assurance Manager and development of a quality assurance framework. Additionally, the Trust had recently approved the procurement of a third party management solution (365 Response) for the dynamic procurement of alternative providers, pending approval from Welsh Government. This system would allow suitable, pre-approved alternative providers to view and bid for work, removing the need for local procurement arrangements and providing ongoing quality assurance. Whilst these represented positive steps forward and the work had progressed at pace, the Trust was in the early stages of implementation and there was still a long way to go to complete these actions to ensure appropriate contract governance and quality assurance mechanisms are in place.

Our current audit noted the development of a quality assurance (QA) process, detailing the split of responsibilities between 365 Response and the NEPTS Quality Assurance Manager. A NEPTS Quality Data Dashboard has also been developed, which is reported to the NEPTS Senior Management Team and the Senior Operations Team for scrutiny and oversight. The Dashboard includes the number external providers registered (c60 as at March 2021) and the percentage of active providers fully quality assured (60%). The Dashboard also includes a measure on the number of advisories per provider. Advisories are where a company hasn't met all of the requirements or where their evidence provided has lapsed. We were informed that the Dashboard will be presented to the Finance and Performance Committee going forward.

We were informed that all providers that are able to bid for work have been quality assured, the majority of which were QA'd before the transfer of work to 365 Response happened. We were advised that the Trust is currently

working with 28 active non-taxi providers, of which 21 have been fully QA'd. The remaining seven include one longstanding community transport firm which is just waiting for the physical inspection, all of which have been delayed due to the pandemic. The remainder are active on the system but unable to bid for work until all required checks are complete. The remaining providers are taxis, some of which have been approved by NHS Wales Shared Services Partnership (NWSSP) with the remainder are going through the process. The Trust has prioritised completing QA checks over all other alternative providers before taxi companies.

There remains one Welsh Health Board area to transfer into NEPTS. We were advised that the majority of the providers are known and have already been QA'd through other areas of work. There will be exceptions in repatriations where a local health organisation in England requires the Trust to use their provider and fund this. We were advised that those organisations will operate their local contracts and the local Clinical Commissioning Group will recharge the Trust for this work.

We were also informed that a monthly report is generated from the 365 system and shared with managers, budget holders and finance to monitor provider usage and expenditure. Reporting capabilities were further enhanced following the development of a new Qlik dashboard, which allows the service to monitor the performance of external providers, including the timeliness of patient journeys. This dashboard only recently went live in April 2021 and we were advised that it will be used routinely going forward to assist in contract management. The team have also had weekly meetings with 365 Response. This is used to manage and monitor progress through the implementation phase to ensure the system is operating correctly and any updates/requests for improvements are being managed in a timely way.

Whilst further work is ongoing to fully mitigate the risk, this finding is considered **fully implemented** and is therefore closed.

Previous Finding 2 - Invoice Audit and Approval (Medium Priority)

The Trust has an invoice auditing process in place for alternative provider invoices. However, our work in the previous audit identified some inefficiencies in the process and that it was being undertaken differently across the Trust. We also identified that spend with one supplier had not been coded into the NEPTS expenditure code.

Our current audit noted the development of an invoicing process. Whilst we were unable to test the process due to the pandemic, an audit of the application of the 365 Response framework and its impact in improving contract governance and quality monitoring is included in our 2021/22 internal audit programme. We were advised that processing has now been

centralised for the vast majority of invoicing, with the exception of taxi companies, via the 365 Response system. We were informed that there are a small number of providers that still email their invoices but these will not be processed until they have been uploaded to the 365 system. Taxi invoices are checked on a consistent sample basis across Wales.

Journeys and shifts are all reviewed and checked individually against the data in the system and cross checked against internal systems that record missed shifts. Where discrepancies are identified, which we understand are more common with shifts, these are investigated and followed up with the providers to clarify and resolve. Once the invoice has been validated, a requisition is raised on Oracle. Following review and approval by the authorising manager a purchase order is generated and shared with the Finance Department, along with the invoice, for payment.

We were also advised that the implementation of the new centralised process has addressed the segregation of duties issue identified in the previous audit. Although, during times of staff shortages there may be some overlap between decision maker and invoice checker, but this will only be on bids under £1k and will be minimal and avoided where possible. We were informed that there is complete separation to the taxi process. The finance reports referred to under previous finding 1 above are also important in terms of allowing the team to review correct coding of invoices. This is undertaken by local managers and regional/national managers as part of the budget monitoring process.

This finding is considered **fully implemented** and is therefore closed.

- **Appropriately Equipped Paramedics**

Previous Finding 2 – Safe and Secure Storage of Equipment (High Priority)

Four ambulance stations (Barry, Blackweir, Bryncethin and Cwmbwrla) and the central storage facility at Hensol were visited during the original audit to assess the storage arrangement for clinical equipment. Whilst we were satisfied with the arrangements in place at the Barry, Bryncethin and Cwmbwrla stations, we identified a number of issues, including some significant health and safety concerns at the Hensol store and Blackweir station relating to the condition of the building and storage of equipment and consumables. We understand that the Trust was currently exploring the option of relocating these sites, however these findings were disappointing given the recent reviews over the Trust's health and safety arrangements.

Due to the pandemic we did not visit a sample of stations during the follow up audit in order to review the arrangements to ensure equipment and

consumables are safely and securely stored. The Trust's Clinical Equipment and Procurement Manager has not had an opportunity to visit many operational stations, due to the clinical logistics requirements over the past year. We were however advised that the arrangements at Barry, Bryncethin and Cwmbwrla are typical of the Trust's operational stations.

Immediate action was taken to rectify the health and safety issues identified at the Blackweir station and the Trust has now expanded the footprint of the stores area and invested in racking to organise stock. In addition, the clinical logistics function at Hensol has now relocated to a large industrial unit in Trecenydd that is more fit for purpose for a logistics hub. The site has a distribution point for each area, and segregated areas for high value items, decommissioned equipment and quarantined equipment. The facility also allows logistics vehicles to be loaded and unloaded in the main warehouse.

This finding is considered **fully implemented** and is therefore **closed**.

Previous Finding 7 - Disposal of Equipment (Medium Priority)

Our original audit identified that a record of equipment disposals is not maintained. Reliance is placed on operational teams to notify the Clinical Equipment & Procurement Manager of equipment requiring disposal. There is a risk that surplus equipment may be stolen, or obsolete equipment is not disposed of in accordance with policy.

The Trust is progressing with the implementation of the radio frequency identification (RFID) stock inventory solution that will track high value clinical equipment. In the interim, the Trust has developed electronic records, including a list of high value equipment stored at the clinical logistics hub, a register of equipment disposals, an issue sheet for devices and a running stock check of COVID-19 PPE and associated items. These records are stored on Microsoft Teams and on a shared drive.

Reliance is still placed on operational teams to notify the Clinical Equipment & Procurement Manager of equipment requiring disposal. Guidance setting out equipment disposal routes has been issued to staff, with support from the Trust's Environmental Specialist. The equipment should be decontaminated locally and sent to Trecenydd, along with a decontamination certificate. The Clinical Equipment Assistant makes arrangements for the disposal via a licenced waste disposal company, typically Hilditch Auctioneers. We selected a sample of equipment from the disposals register to confirm disposal forms were completed. We also agreed each item to a sales advice note received from Hilditch Auctioneers. We understand that these are provided to Finance to process the monetary receipts from auction or waste disposal costs. No issues noted.

Whilst further work is ongoing to fully mitigate the risk, mainly the implementation of the RFID stock inventory solution, this finding is considered **fully implemented** and is therefore closed.

- **Drivers' Medicals**

Previous Finding 2 – Occupational Health Clearance (Medium Priority)

Our analysis of Occupational Health (OH) Clearance data in the original audit demonstrated that whilst the majority of starters had OH clearance prior to their start date and occupational health requests are processed in a timely manner, there is a risk a number of employees in the Trust are undertaking roles without appropriate clearance prior to starting. Discussion with the OH Manager and an OH Practitioner highlighted that there has not always been clear communication between OH and WOD when staff are being recruited, although mechanisms are being put in place to improve this going forward. This impacted the ability to manage the resource effectively in order to ensure checks are undertaken promptly.

We were advised that communication between the OH and Education and Development functions has improved since the previous audit. A tracker schedule has been developed which details all proposed recruits and includes an OH clearance column for the OH team to check against their records. We were informed that the tracker is maintained and updated on a weekly basis to ensure the Education and Development team is aware of the OH clearance status of all proposed students. We were also advised that the Team contact the recruiting manager four weeks before the start of a course to communicate the prospective students without OH clearance or that haven't attended a medical.

We were informed that meetings are held between the Education and Development team, HR and OH teams prior to the start of each course to resolve any issues. If clearance is delayed due to further medical information being required, the recruiting manager and the Education and Development team are made aware and the student is not allowed to drive Trust vehicles. In addition, we were advised that the Trust receives monthly reports from NWSSP detailing outstanding OH clearances according to their records. The Trust checks this against its own records to ensure no prospective member of staff or staff who change roles commence without appropriate clearance. NWSSP will then chase individuals to submit the OH questionnaire.

This finding is considered **fully implemented** and is therefore closed.

Previous Finding 4 – Record Keeping and Oversight Arrangements (High Priority)

We were unable to establish during the original audit whether complete and accurate records are being maintained regarding OH clearance and ongoing fitness to drive declarations, driving assessments and driving licence validity checks. There appeared to be a disjointed approach between the education and training, OH and HR teams with records are not being reconciled. We were informed that ongoing checks should be being undertaken by local operations management. However, this information was not then collated and therefore we did not see evidence to demonstrate that mechanisms were in place to ensure compliance is monitored centrally. We did not see evidence of them being monitored within the Directorates nor at Board / Committee level.













The current audit reiterated that it is the Line Manager's responsibility to check driving licences and maintain a record to demonstrate these are being undertaken. Guidance has been issued detailing how these check should be completed. Compliance is reported quarterly within the Operations Directorate, with all but one Health Board area (Cardiff and Vale) over 85% compliant currently. In addition, we were informed that spot checks against the DVLA database are completed by the Education and Development team during return to work and remedial driver training programmes, and that driving licence checks are also undertaken by assessors during driver training interactions.

The Driving at Work Policy is currently under review in partnership with Trade Union colleagues. Lines of responsibility will be clarified as part of this process and articulated within the policy. It is proposed that an assurance report be provided to the People and Culture Committee on an annual basis, confirming that all relevant driving licences have been checked and providing details of actions in place to address issues identified. We were also advised that the Policy review will address the need for quarterly spot checks on compliance of driving licence and medical checks.

This finding is considered **fully implemented** and is therefore closed.

7. Summary of Recommendations

The following table summarises the extent to which the original recommendations have been implemented and provides classification of current risks:

Area		Priority 2019/20 audit	Direction of travel	Priority 2020/21 audit
Vehicle Hire				
1	Contract Governance and Quality Assurance		 Recommendation implemented.	Closed
2	Invoice Audit and Approval		 Recommendation implemented.	Closed
Appropriately Equipped Paramedics				
3	Safe and Secure Storage of Equipment		 Recommendation implemented.	Closed
4	Disposal of Equipment		 Recommendation implemented.	Closed
Drivers' Medicals				
5	Occupational Health Clearance		 Recommendation implemented.	Closed
6	Record Keeping and Oversight Arrangements		 Recommendation implemented.	Closed

Audit Assurance Ratings



Substantial assurance: Follow up - All recommendations implemented and operating as expected.



Reasonable assurance: Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.



Limited assurance: Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.



No Assurance: Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment

Confidentiality

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Trust. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Office details:

MAMHILAD Office
Audit and Assurance
Cwmbran House (First Floor)
Mamhilad Park Estate
Pontypool, Gwent
NP4 0XS



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Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services

Contact details

Helen Higgs (Head of Internal Audit) – helen.higgs@wales.nhs.uk
Osian Lloyd (Deputy Head of Internal Audit) – osian.lloyd@wales.nhs.uk



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AGENDA ITEM No	17
OPEN or CLOSED	
No of ANNEXES ATTACHED	1

SEASONAL INFLUENZA CAMPAIGN 2021/22 FINAL REPORT

MEETING	People and Culture Committee
DATE	5 September 2022
EXECUTIVE	Andy Swinburn Director of Paramedicine
AUTHOR	Sarah Champion Business Administration Manager
CONTACT	sarah.champion@wales.nhs.uk

EXECUTIVE SUMMARY

The report has been designed to provide information surrounding the Seasonal Influenza Campaign 2021-22 and detail the uptake of the Flu Vaccine for this year.

The Trust's final uptake of staff vaccinated was 38.46% which is a decrease of 11.4% from last year's campaign. The number of patient-facing staff that are recorded as receiving the vaccine for the 2021-22 campaign has also notably decreased by 11.1%. It is suggested that for the second year, the Covid-19 pandemic has continued to influence the success of the campaign. This, compounded with a variety of other influencing factors, has impacted the delivery and uptake of the vaccination.

The paper presents the constraints experienced throughout the campaign which includes difficulties experienced with vaccine delivery, operational pressures, reporting mechanisms and communication with staff.

Following the review of this year's campaign, recommendations have been devised that are based upon some of the key areas of learning and improvement. They aim to streamline current processes, remove duplication of effort and improve engagement with the workforce. Full details can be found in the end of season report (Appendix 1)

KEY ISSUES/IMPLICATIONS

Reduced uptake of vaccine amongst Trust due to:

- Impact of the Covid-19 pandemic on the flu vaccination programme for the second year
- Supply chain challenges
- Peer vaccinator opportunities minimised
- Disruption of internal communications due to abstraction and ongoing pandemic complications

REPORT APPROVAL ROUTE

Clinical Directorate Business Meeting – 29 June 2022 – For Information

Clinical Quality Governance Group – 30 June 2022 – For Information

Executive Management Team – 13 July 2022 – For Information

People and Culture Committee – 5 September 2022 – For information

REPORT APPENDICES

End of Season Report 2021-22



End of Season Flu
Report 21-22 Final Dr

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)		Financial Implications	x
Environmental/Sustainability		Legal Implications	
Estate		Patient Safety/Safeguarding	
Ethical Matters		Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	
Health and Safety	x	TU Partner Consultation	



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AGENDA ITEM No	
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

Seasonal Influenza Campaign 2021-22 Final Report

MEETING	People and Culture Committee
DATE	5 September 2022
EXECUTIVE	Andy Swinburn Director of Paramedicine
AUTHOR	Sarah Campion Business Administration Manager
CONTACT DETAILS	sarah.campion@wales.nhs.uk

CORPORATE OBJECTIVE	IMTP priority objective 1 & 8
CORPORATE RISK (Ref if appropriate)	N/A
QUALITY THEME	1 – Staying Healthy 7 – Staff and Resources
HEALTH & CARE STANDARD	1.1 – Health promotion, protection and improvement 7.1 - Workforce

REPORT PURPOSE	For information
CLOSED MATTER REASON	

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Clinical Directorate Business Meeting	29 June 2022	For information
Clinical Quality Governance Group	30 June 2022	For information
Executive Management Group	13 July 2022	For information

People and Culture Committee	5 September 2022	For information
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SITUATION

- 1 The Welsh Ambulance Services NHS Trust (WAST) are required together with the rest of NHS Wales to offer all members of staff the opportunity to receive the seasonal influenza vaccine. Although the vaccine isn't mandatory, Welsh Government (WG) have a target of 60% of patient facing staff to receive the vaccine.
- 2 This is the second year that the coordination of the flu vaccine roll out to staff has been undertaken by the Clinical Directorate.
- 3 The continued circulation and new variants of Covid-19 in the lead up to and throughout the flu campaign period has presented specific challenges and identified a situation in which a successful flu campaign would be especially important. Covid-19 is addressed specifically in the end of season report (Appendix 1)

BACKGROUND

- 4 The previous year's (2020-2021) Flu Vaccination Campaign ended with an increase in uptake for WAST Staff.
- 5 A Microsoft Teams page was created as a digital venue to hold the planning information from each area and to provide an online meeting space for the Flu Lead, the nominated area Flu Leads and the Director of Paramedicine.
- 6 The digital flu form was designed and created by the Flu Lead with support from Health Informatics and approved for use by Data Governance. The form was uploaded to the new intranet and links shared on social media platforms for ease of access.
- 7 Incentives for vaccination uptake were offered for the second consecutive year following a successful bid to the Charitable Funds Committee, with the opportunity to enter the prize draw extended until the 6 March 2022.
- 8 Regular communications were sent to staff across the Trust's platforms advising them to check the Intranet for details of where they could get the vaccine. If cancellations of clinics were experienced, staff were advised of the situation and the opportunities to re-arrange.
- 9 During the campaign, the Project Lead returned to their substantive post within the organisation during a period of significant operational pressures. This left the campaign without any project management for a brief period and recruitment delays prevented a replacement from coming into post before the end of the campaign.

ASSESSMENT

- 10 Covid-19 has again severely impacted the flu campaign, and this is addressed in more detail in the attached end of season report.
- 11 There has been a notable decline in the uptake of the flu vaccine with a decline of 11.4% from last year's campaign. It appears that all areas of the Trust have staff that have declined the vaccination.
- 12 There were a number of issues considered that may have impacted on the success of the flu campaign:

Reporting Mechanisms

- 13 WAST do not have the permissions and ability to access the Welsh Immunisation System (WIS) where data is held for those staff who received their vaccination through the mass vaccination centres.
- 14 There is currently no interface that links ESR with our COHORT system where our staff health information is recorded. Manually uploading the data to ESR is a time-consuming process for the workforce systems team.
- 15 Significant issues were experienced with data retrieval from the Microsoft Forms which impacted on the project team's ability to regularly report on the flu vaccine uptake to Public Health Wales and various WAST reporting structures.

Vaccination Supply and Delivery

- 16 Vaccines were purchased by approaching suppliers directly as this was the lowest cost option, however, supply issues compounded by the Covid-19 pandemic left the project team short of vaccines to start the campaign, with staggered smaller deliveries of vaccine over the first 10 weeks. This prevented the team from being able to successfully deliver the anticipated large campaign at the beginning of the flu season. For next year's campaign, the NHS Consortium will be utilised for the ordering of vaccines.
- 17 Due to the significant operational pressures on the service, peer vaccinators did not have the same availability or opportunities as last year. This, combined with Occupational Health staff sickness, impacted the ability and availability to deliver vaccinations to WAST staff.

Communication and Engagement

- 18 There was an engagement rate of 40.73% of WAST staff and of these 1781 staff, 94% decided to receive the flu vaccination.
- 19 The Communications Team were very short staffed during the initial weeks of the flu campaign, including the planning and rollout this year, which resulted in the absence of a comprehensive communications plan.
- 20 Staff engagement is once again an issue. Only around half of staff in post are engaging with the campaign by way of completing the flu consent/opt out form.

There is a need to address communications surrounding those who wish to decline the vaccination and that they will not be discriminated against when this confidential information is registered on the system.

RECOMMENDED: That

1. The findings from the seasonal influenza campaign 2021-22 are noted
2. The suggested recommendations in the report are explored further, particularly in relation to reporting mechanisms and engagement with staff.



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Welsh Ambulance Services NHS Trust

Clinical Directorate

End of Season Report

Seasonal Influenza Campaign 2021-22



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Executive Summary

This report has been designed to provide information surrounding the Seasonal Influenza Campaign 2021-22 and detail the uptake of the Flu Vaccine this year.

The Trust's final uptake of staff vaccinated was 38.46% which is a decrease of 11.4% from last year's campaign. The number of patient facing staff that are recorded as receiving the vaccine for the 2021-22 campaign has also notably decreased by 11.1%. It is suggested that for the second year, the Covid-19 pandemic had continued to impact the delivery and uptake of the vaccination.

Other constraints experienced throughout the campaign were also explored, this included difficulties in vaccine delivery, **operational pressures**, reporting mechanisms and communication with staff.

Following the review of this year's campaign, recommendations have been devised that are based upon some of the key areas of learning and improvement. They aim to streamline current processes, remove duplication of effort and improve our engagement with the workforce.

1. Influencing Factors

1.1 The Impact of Covid-19

The Flu Campaign has again been severely impacted by the COVID-19 pandemic, specifically in relation to the implementation and the delivery of the vaccine.

COVID-19 has resulted in high abstraction rates through self-isolation and household symptoms which impacted on the ability to administer vaccinations to staff and to coordinate clinics. Additional factors had to be considered for the clinics such as the redeployment of staff, flexible working locations, as well as maintaining social distancing and standards of Personal Protective Equipment (PPE) at vaccination settings. In order to prevent increased footfall at stations and other operational sites, Occupational Health were tasked with setting up dedicated clinics for staff via an appointment booking system that enabled COVID-safe practices to be met. This removed the opportunity for staff to quickly arrange for a vaccine in the workplace, via a 'drop-in session', a peer vaccinator offering the vaccine, or just by booking an appointment in their workplace, due to the number of employees working from home. This has significantly impacted in particular on the number of corporate staff receiving the vaccine.

The continuation of COVID-19 vaccinations may have deterred staff from receiving their flu vaccination in addition to their booster jabs. Information regarding the timing and safety of having both the COVID-19 booster vaccination and flu vaccination was unclear at the beginning of the campaign, with advice continually changing and updating. Initial advice recommended that seven days should be seen in between receipt of a COVID-19 vaccine or booster and the flu vaccine. However, it wasn't until the late winter months when it was announced to the public that both vaccines could be given at the same time, with no time gap needed in between. This delay in information to the public including Trust staff would likely have impacted on the decisions of many to have the two vaccines at the same time,

and possibly having the flu vaccine altogether, if there was any concern over receiving both vaccines.

Not only is it expected that COVID-19 was a factor in the limited uptake of the flu vaccine, but it also appears to have impacted the process of reporting uptake details in this campaign. It is expected that several staff received their flu vaccine alongside a COVID vaccination/booster, in settings such as mass vaccination centres and GP surgeries. This has resulted in WAST not being in receipt of what is thought to be large amounts of data, as the project team relied on employees recording this information themselves via the Microsoft Forms facility. If colleagues did not complete the form to advise they had received their vaccine in an alternative setting, then the data has not been recorded as part of WAST's uptake.

1.2 Delivery Restraints

The delivery of the campaign ran into several constraints:

- Vaccines were purchased by approaching suppliers directly as this was the lowest costed option, however, supply issues compounded by the Covid-19 pandemic which left the project team short of vaccines to start the campaign, with staggered smaller deliveries of vaccine over the first 10 weeks. This prevented the team from being able to successfully deliver the anticipated large campaign at the beginning of the flu season. It also resulted in certain groups of staff e.g., frontline staff being initially prioritised for their vaccine.
- Due to the significant operational pressures on the service, peer vaccinators did not have the same availability or opportunities as last year. This, combined with Occupational Health staff sickness, impacted the ability and availability to deliver vaccinations to WAST staff.
- The campaign was also affected by the return of the Project Lead to their substantive post within the organisation during a period of significant operational pressures. This left the campaign without any project management for a brief period and recruitment delays prevented a replacement from coming into post before the end of the campaign. Two corporate staff members were able to support the project on restricted capacity following a minimal handover from the beginning of 2022 to the end of the year's campaign.

2. Previous Campaign 2020-21

The 2020-21 Flu Vaccination Campaign ended with an increase in uptake for WAST Staff on the previous year. The number of total staff that received the vaccination saw a 7.7% increase, following on from a 6% increase in the year previous to that (2019-20). There was also a large increase in the total patient facing uptake which saw a 10.9% increase last year.

Flu Data as of 31st March 2021			
Staff Group	Staff In Post	Received Vaccine	% Of Group
Total WAST	4089	2042	49.9%
Total Patient Facing	2516	1314	52.2%
NEPTS Patient Facing	624	312	50%
EMS Patient Facing	1892	1002	52.2%

Table 1. Last year's final flu data at the end of campaign 2020-21

There was an engagement rate of 55% in the 2020-21 campaign and of those 55% of staff who did engage last year, 91% engaged to say they received the flu vaccine either through WAST or in a different setting.

3. End of Campaign 2021-22

The closure of the 2021-22 campaign has seen a decline of 11.4% of those who have received the flu vaccine. The data to support the figures in this report has been taken from the digital documents completed by staff on Microsoft Forms. These are uploaded via ESR to align with WAST employee records and the Occupational Health COHORT system. However, the final figures do not include the data captured surrounding students or volunteer services.

It is important to remember that the data used in the Flu Campaign consists of two subjects of figures 'Vaccinated' – all those who have received a vaccine either through WAST or another healthcare setting, and 'Engaged' - those vaccinated either through WAST or another healthcare setting and including those who have recorded their decision to decline the vaccination.

Flu Data as of 28th February 2022				
Staff Group	Staff In Post	Received Vaccine	% Of Group	+/- On Last Year
Total WAST	4373	1682	38.5%	- 11.4%
Total Patient Facing	2635	1083	41.1%	- 11.1%
NEPTS Patient Facing	672	247	36.8%	- 13.2%
EMS Patient Facing	1963	836	42.6%	- 10.4%

Table 2. Final flu data for the current campaign 2021-22

This is the second year that data has been captured digitally through Microsoft Forms which has allowed for continual oversight of the vaccine uptake throughout the campaign.

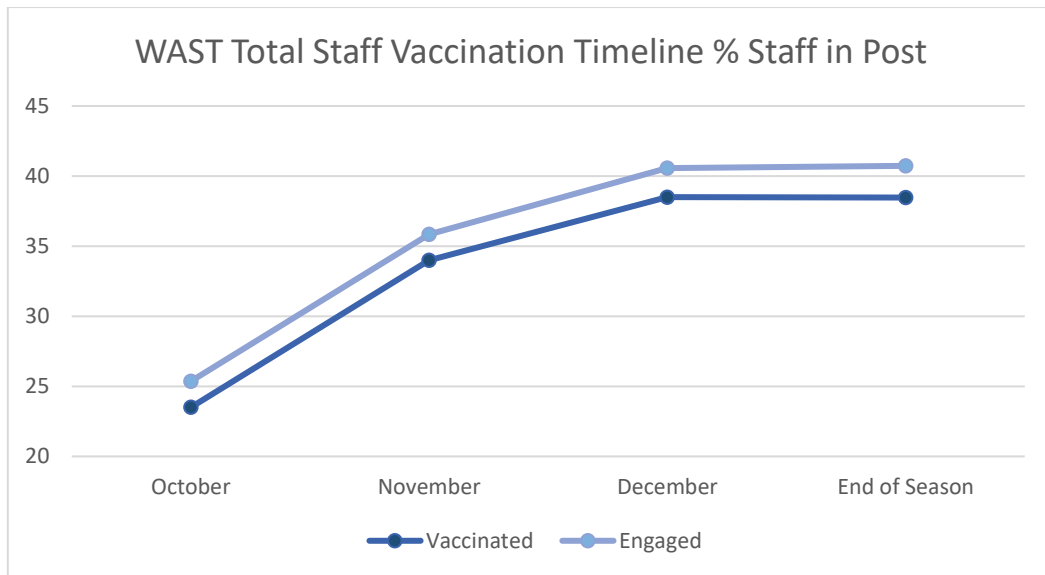


Figure 1. Total % of vaccinations during months of campaign 2021-22

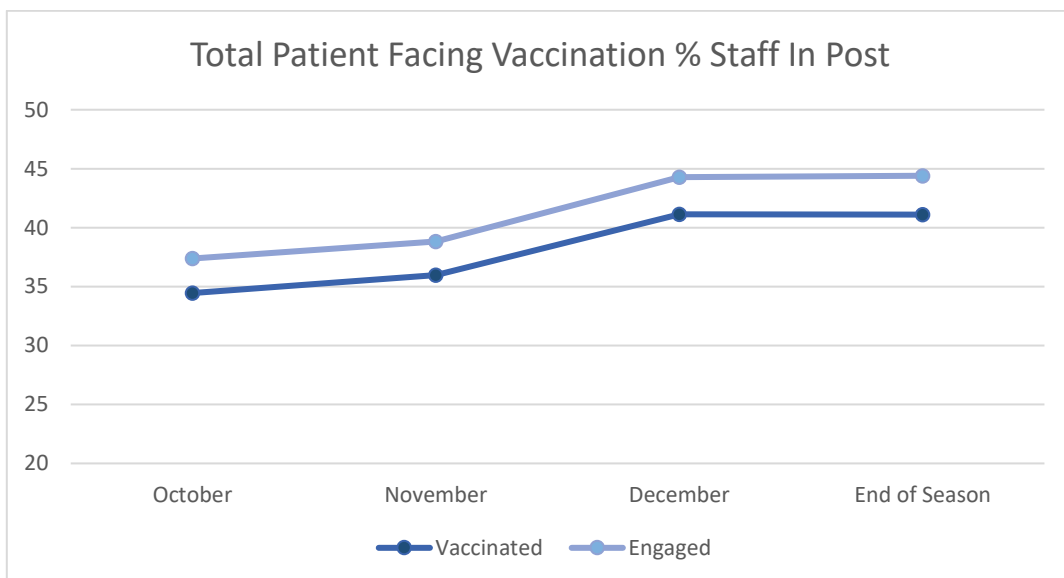


Figure 2. Vaccination % of those in patient facing role during campaign 2021-22

Figure 1 and 2 presents the engagement and vaccination status through this seasons campaign, to include both total staff and total patient facing staff. The graphs demonstrate that the biggest increase in vaccine uptake and engagement came during November for WAST staff as a whole, whereas for patient facing staff most vaccines were delivered before the end of October. This reflects the decision to prioritise patient facing staff with the first batch of vaccinations.

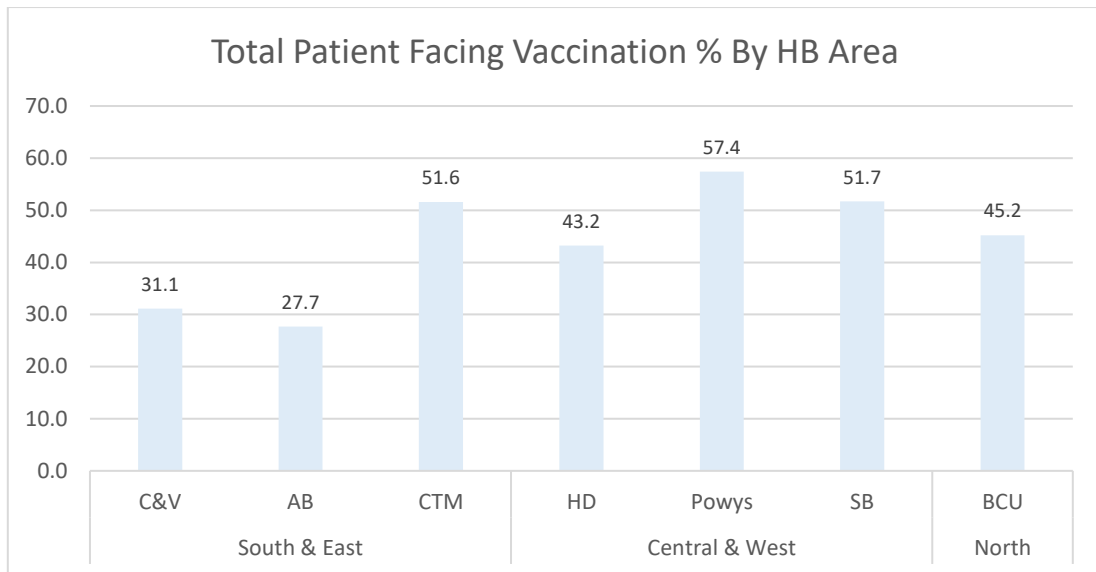


Figure 3. Uptake % of patient facing roles split by 7 Health Boards

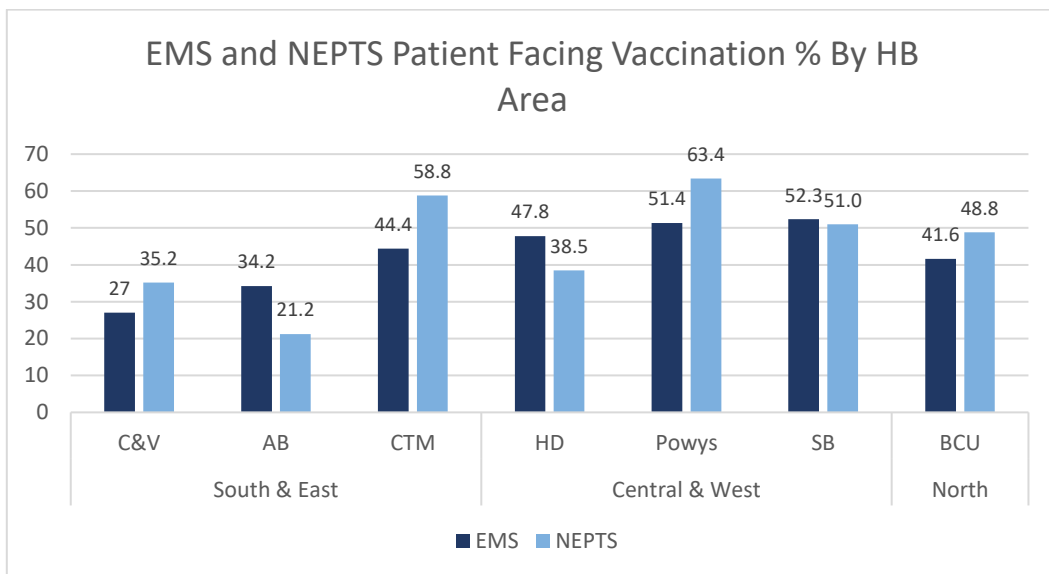


Figure 4. Health Board % uptake split by EMS and NEPTS patient facing staff

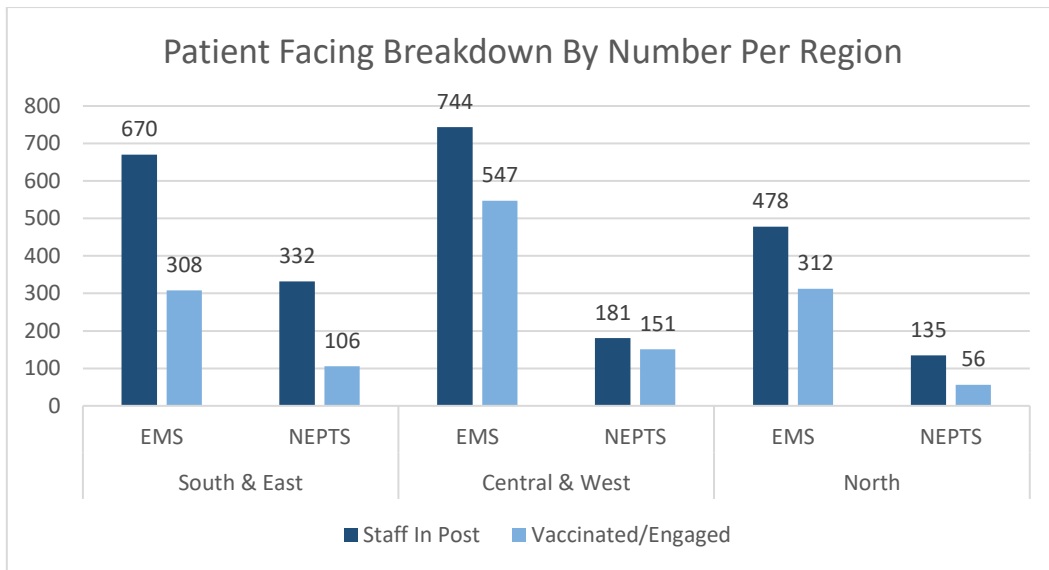


Figure 5. Number of patient facing staff vaccinated in each region

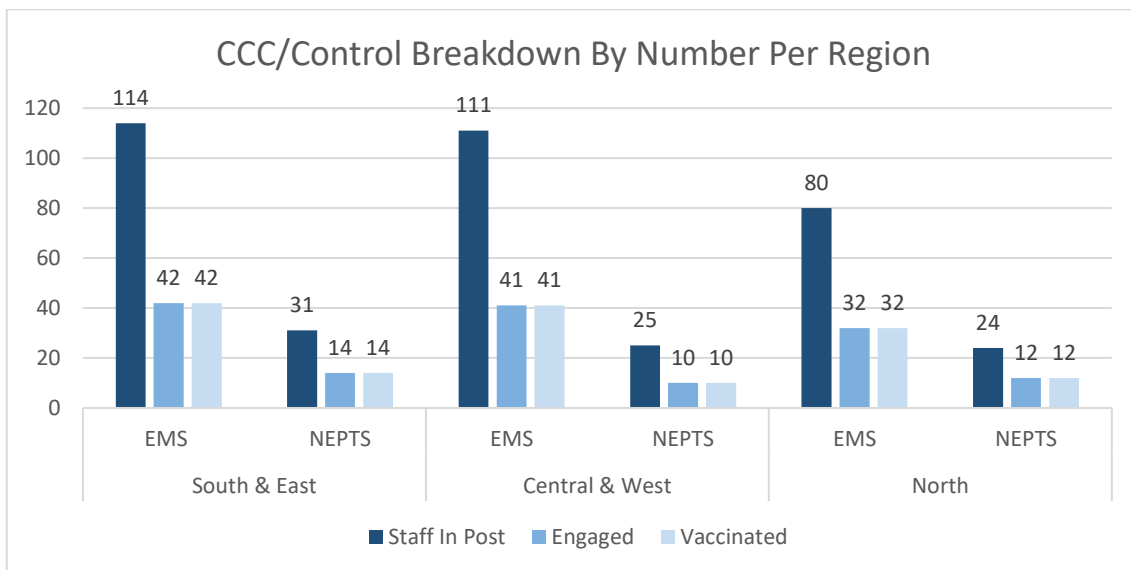


Figure 6. EMS and NEPTS staff in control split by engagement/vaccination

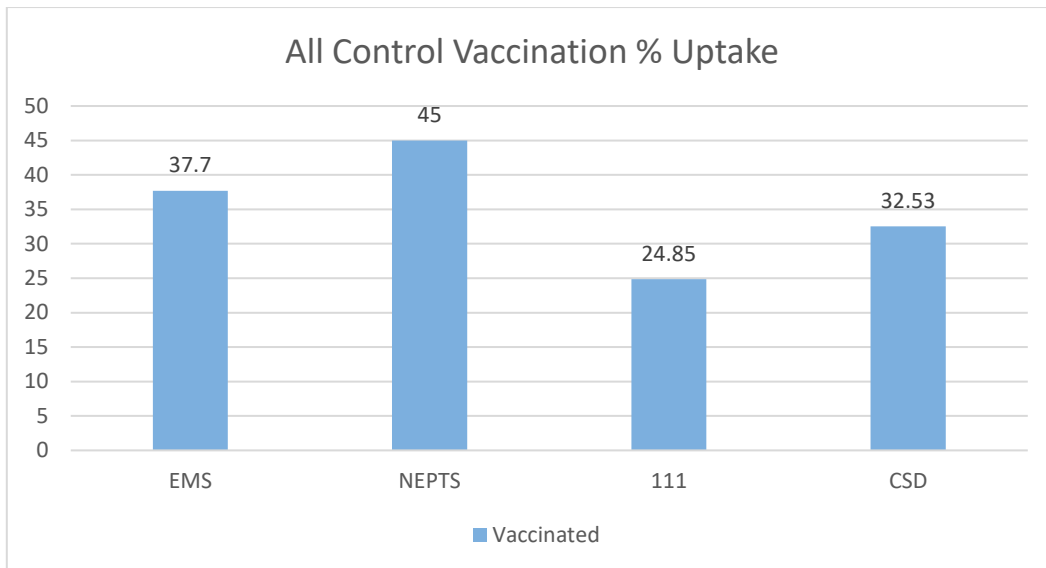


Figure 7. % uptake in all areas of control in WAST

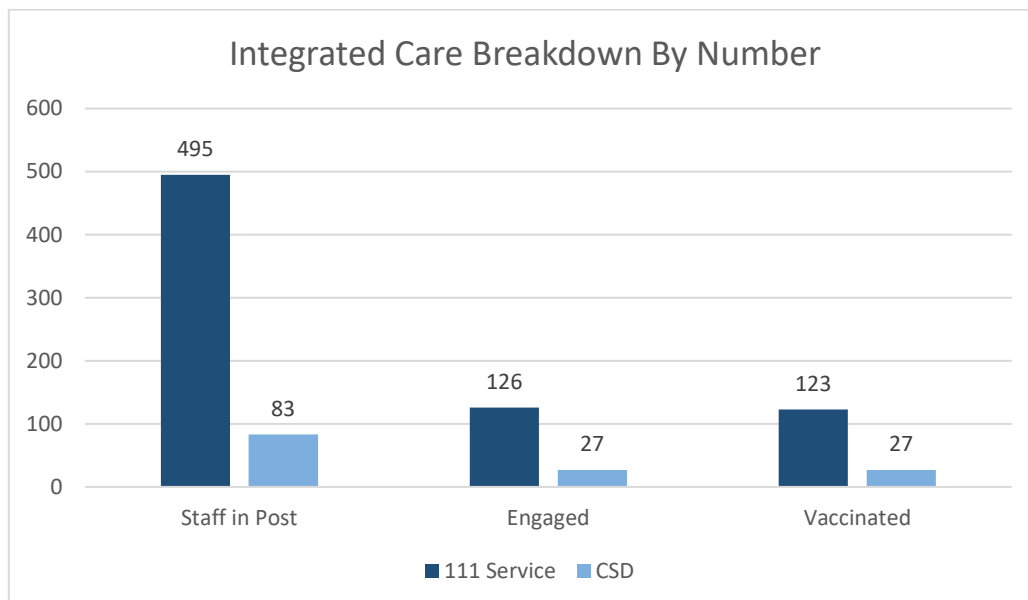


Figure 8. Number of staff in CSD and 111 who received vaccination or engaged

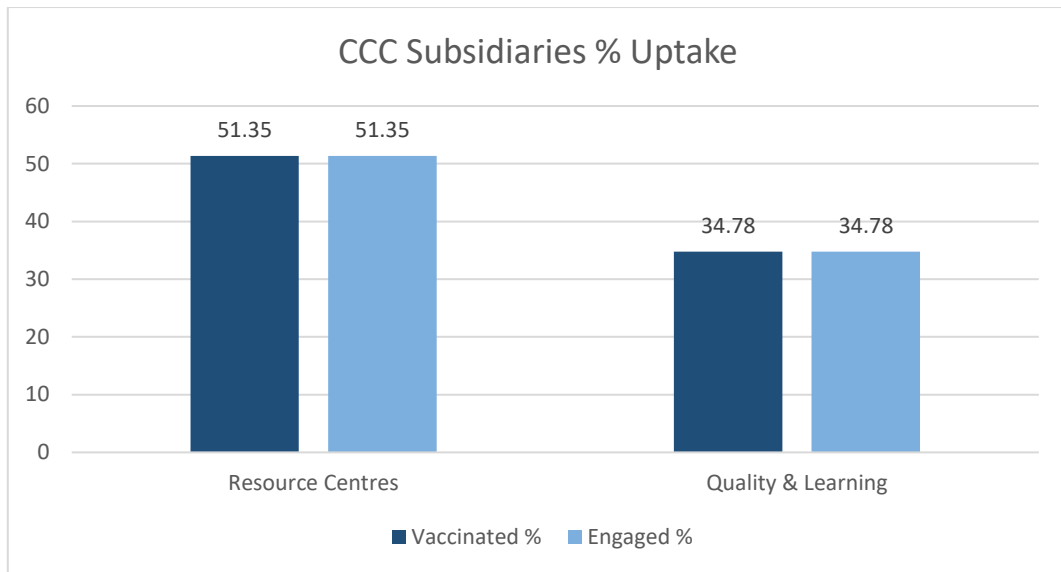


Figure 9. % uptake in subsidiaries of the CCC

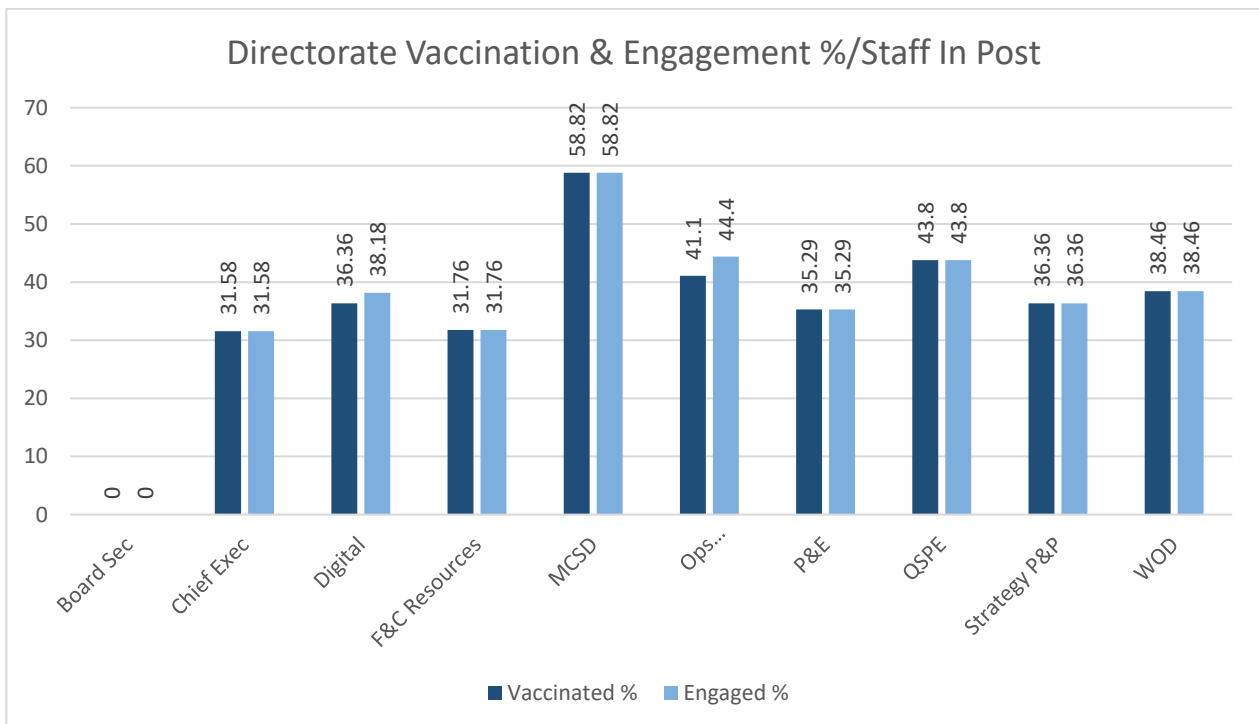


Figure 10. Uptake % in the Directorates, split into vaccination and engagement

In Figure 10, it can be seen that the majority of departments experience the same rate of vaccination as engagement. This shows the small amount of declined vaccinations, with only the Digital and Operations (patient facing) directorates noting a different figure.

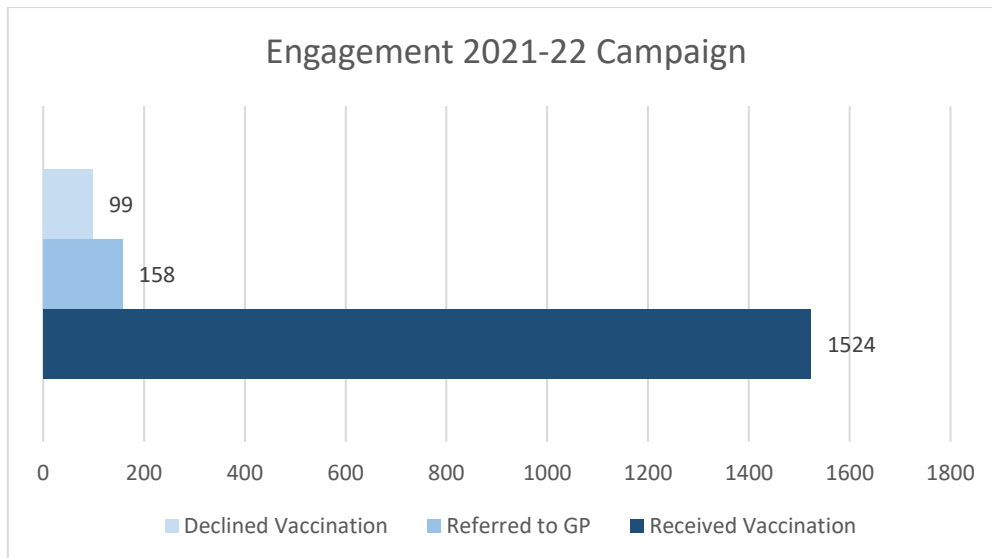


Figure 11. The split of engagement in 2021-22 campaign

The 2021-22 flu vaccination campaign saw 40.73% of WAST staff engaged with the campaign. As seen above in Figure 11, of these 1781 staff, 85.5% (1524) received the vaccination through WAST. Followed with 8.5% recording they went to another healthcare setting to receive the vaccine and 6% advising they were declining the vaccine.

The number of staff who chose to decline the vaccination is lower than seen in the two previous campaigns, compared to 212 last year and 407 the year before. This could have potentially influenced the decrease in staff engagement, as a reduced number of staff registering their declination could be a reason for lower engagement. It is important that staff are reminded that receiving the vaccination is completely their choice and that they will not be discriminated against when this information is registered on the system. It is highlighted to staff that all information remains confidential.

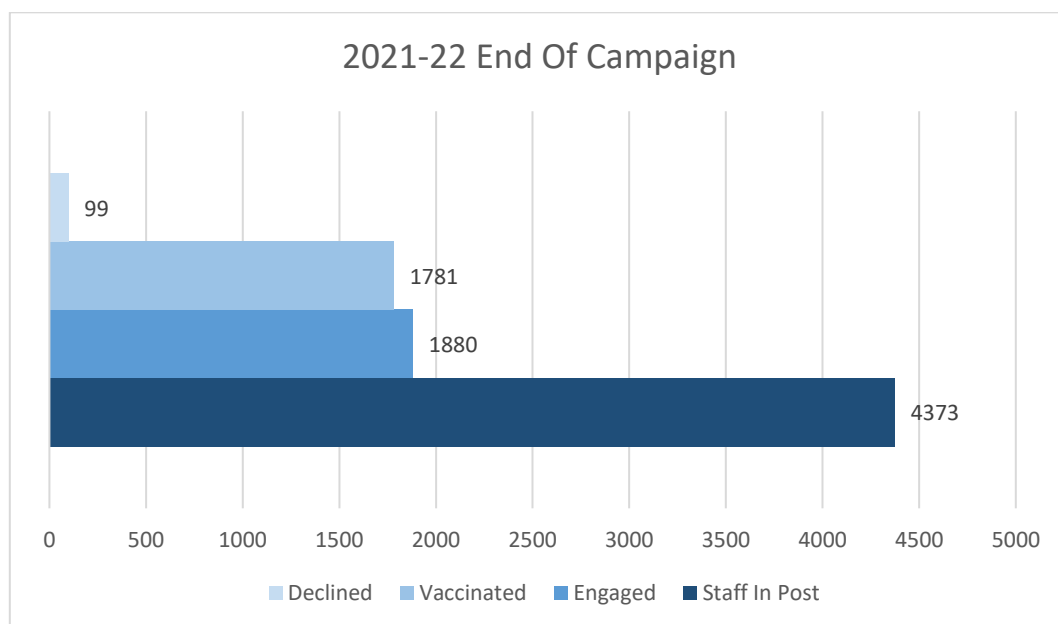


Figure 12. Breakdown of 'End of Campaign 2021-22'

3.1 Flu Vaccine Uptake Comparison

Flu Vaccine Uptake Comparison % Staff in Post			
AREA	2020-21	2021-22	
Total WAST	50	39	-11%
Total Patient Facing	52	41	-11%
NEPTS Patient Facing	50	37	-13%
EMS Patient Facing	53	43	-10%
EMS CCC	48	38	-10%
NEPTS CCC	41	45	+4%
CSD/111	40	26	-14%
Board Secretary	17	0	-17%
Chief Executive	28	32	+4%
Digital	53	36	-17%
Finance & Corp.	39	32	-7%
Medical & Clinical	68	59	-9%
Operations Excl. Response	46	41	-5%
Partnerships & Engagement	88	35	-53%
QSPE	55	44	-11%
Strategy Planning Performance	82	36	-46%
WOD	43	38	-5%

Table 3. Comparison of Directorate % uptake in 2020-21 and 2021-22

As shown in Table 3 above, the uptake in the flu vaccine is lower in the majority of areas compared to that seen in last year's campaign. The biggest difference noted is in the Partnerships and Engagement and Strategy Planning and Performance directorates (though these are quite small Directorates in comparison). There were two areas in WAST that saw an improvement in their uptake, NEPTS CCC and Chief Executive's Office.

Flu Vaccine Uptake Comparison % Staff in Post			
AREA	2019-20	2021-22	
Total WAST	42	39	-3%
Total Patient Facing	41	41	0%
NEPTS Patient Facing	37	37	0%
EMS Patient Facing	43	43	0%
EMS CCC	53	38	-15%
NEPTS CCC	31	45	+14%
CSD/111	34	26	-8%
Board Secretary	14	0	-14%
Chief Executive	30	32	+2%
Digital	N/A	36	
Finance & Corp.	22	32	+10%
Medical & Clinical	74	59	-15%
Operations Excl. Response	44	41	-3%
Partnerships & Engagement	47	35	-12%
QSPE	51	44	-7%

Strategy Planning Performance	44	36	-8%
WOD	36	38	+2%

Table 4. Comparison of Directorate % uptake to campaign 2 years ago (2019-20)

Comparison of figures to the flu vaccination campaign in 2019-20 return figures of a similar nature seen in 2021-22.

4. Data Summary

Efforts were seen to maintain the uptake of the vaccination received in the last campaign and improve on the progress made in previous years. However, the target set by Welsh Government to achieve an uptake of 60% in flu vaccinations by staff, was sadly not met in this year's campaign.

There was an engagement rate of 40.73% of WAST staff and of these 1781 staff, 94% decided to receive the flu vaccination.

In the data received during the campaign it is seen that only 6% of those who engaged through the digital Microsoft Forms collection declined the vaccination.

Unfortunately, when comparing data to the previous campaign, it appears that almost all areas of the Trust have individuals that decline the flu vaccination. When dividing the organisation into 15 different Directorate areas, only two have seen a notable increase in their uptake from last year; NEPTS CCC and Chief Executive.

Comparing numbers closer, the majority of decreases seen in the campaign reflect the uptake seen in the 2019-20 campaign, eliminating the positive progress seen in last year's campaign.

5. Reporting

WAST do not have the permissions and ability to access the Welsh Immunisation System (WIS) where the data is held for those staff who received their vaccination through the mass vaccination centres.

There is currently no interface that links ESR with our COHORT system where our staff health information is recorded. Having to manually upload the data to ESR is a time-consuming process for the workforce systems team as well as having to manually correct errors in data recording.

During this campaign, significant issues were experienced with the downloading of data from the Microsoft Forms function during the months of January and February. This resulted in the team having to manually enter numerous records into the database to allow for it to be recorded on ESR (but which opens the reporting up to human error). This impacted on the project team's ability to regularly report on the flu vaccine uptake to Public Health Wales and various WAST reporting structures.

6. Campaign Summary

The digital flu form was designed and created by the Flu Lead with support from Health Informatics and approved for use by Data Governance. The form was uploaded to the new intranet and links shared on social media platforms for ease of access.

Incentives for vaccination uptake were offered for the second consecutive year following a successful bid to the Charitable Funds Committee with the opportunity to enter the prize draw extended until the 6 March 2022. It is difficult to measure and confirm whether the flu incentive scheme has had a positive impact on the uptake of the vaccination.

The Communications Team were very short staffed during the initial weeks of the flu campaign, including the planning and rollout this year which resulted in the absence of a comprehensive communications plan. Under normal circumstances a plan would be developed similar to the 20-21 campaign. It was also noted that there was under representation on some of the flu vaccination monthly meetings.

Regular communications were sent to staff across the Trust's platforms advising them to check the Intranet for details of where they could get the vaccine. If cancellations of clinics were experienced, staff were advised of the situation and the opportunities to re-arrange. It was found that there could have been better utilisation of internal communication mechanisms to cover absences.

WAST continued to form part of the National Influenza Action Group (NIAG) who met fortnightly during the flu season. Here, regular updates on the surveillance of flu were shared along with each Health Board's progress with their campaigns. A lessons learnt exercise was also completed by NIAG.

7. Learning & Proposals

	Learning	Proposals
1	All staff are not engaging with the Flu Campaign. Current MS Form is time consuming.	The potential to have two different MS Forms for flu engagement is explored; one by which staff could record if they received the vaccine elsewhere/declined and one by which the vaccinator is able to complete should they receive the vaccine. This could also be improved by implementing learning point 2.
2	Having all data stored via MS Forms can create an easy platform to access.	A streamlined approach should be put in place to aid the process of uploading information and figures to ESR and COHORT. This could be through the introduction of a booking system that has the ability to link with the COHORT system.
3	More creative ways of communicating with staff are required	Include the return of a formal communications plan, Podcasts and Clinical Notices to encourage better

		engagement from staff. Explore potential options with the iPad on via personal computers.
4	There is a need to identify an improved method of ordering vaccinations to avoid issues early in the campaign.	The NHS consortium will be used to order bulk vaccines and projected figures have already been submitted for next year's campaign.

Table 5. Learning experienced with proposals for future campaigns

8. Recommendations

The proposals being recommended to WAST for next year's campaign include:

- The adoption of a forced message booking system that would allow for staff to book and record their vaccination. Two potential systems for this have already been explored however it would also be beneficial to consider the possibility of developing something similar in-house to further reduce costs.
- The implementation of a strong and creative communication strategy that commences earlier in the year. There is a need to fully maximise existing methods of staff communication as well as exploring new methods of communication. This will allow for all staff groups to engage with the campaign. Within this, there is a need to address the concerns surrounding having both the flu vaccine and Covid-19 booster at the same time.
- Increase the number of peer vaccinators to allow for more contingency whilst the Trust are experiencing ongoing operational pressures and high abstraction rates.
- Utilise the NHS consortium to order vaccines which should be more suited to the size of the organisation and enable WAST to receive the number of doses required.

9. Conclusion

There has been a noticeable decrease in the number of Trust staff receiving the seasonal influenza vaccine during the 2021-22 season.

Similarly, to last year's campaign, COVID-19 has had a severe impact on the flu campaign this year, whether that be on the figures of those receiving the vaccine or the figures of those who have interacted to record their decision.

As highlighted in previous campaigns, it is apparent that staff engagement is once again an issue. Only around half of staff in post are engaging with the campaign by way of completing the flu consent/opt out form and recording the decision. Moving forward into next year's campaign, there is a need to encourage and support staff to complete the form if they have the vaccine elsewhere or declined.



GIG | Ymddiriedolaeth GIG
CYMRU | Gwasanaethau Ambiwylans Cymru
NHS | Welsh Ambulance Services
WALES | NHS Trust

AGENDA ITEM No	18
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	N/A

RAISING CONCERNS AND SPEAKING UP

MEETING	People and Culture Committee
DATE	5 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY	
<ol style="list-style-type: none"> 1. The purpose of this paper is to provide the Committee with an overview of the work underway to develop a framework for raising concerns and speaking up. 2. The Freedom to Speak Up Task and Finish Group has been formed to develop the framework and the role and remit of the Group is set out in this report. The Group reports into the Assistant Directors Leadership Team and aim to complete their work by March 2023, including the roll-out of the Work In Confidence platform. 3. Staff can continue to raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix whilst the framework is in development. <p>RECOMMENDATION:</p> <ol style="list-style-type: none"> 4. The Committee is asked to note the update. 	

KEY ISSUES/IMPLICATIONS	
<ol style="list-style-type: none"> 5. No issues to raise at this point. 	

REPORT ROUTE	
Assistant Directors Leadership Team (ADLT) – by email circulation. ADLT receives AAA reports following each meeting of the Group.	

REPORT APPENDICIES
None

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

RAISING CONCERNS AND SPEAKING UP

SITUATION

1. The purpose of this paper is to provide the Committee with an overview of the work underway to develop a framework for raising concerns and speaking.

BACKGROUND

2. This Committee approved the All Wales Procedure for Raising Concerns in November 2021.
3. Staff have the ability to raise concerns through a number of avenues currently, including through their line management mechanism, through a dedicated email address, and through a newly introduced 'sensitive issues' function in the Datix Incidents module. The procedure also provides for escalation where raising concerns where line management is inappropriate or not a route the staff member wishes to follow.
4. The Trust will continue to grow a healthy, inclusive and compassionate culture that enables ongoing development and fulfilling careers, healthy working relationships, where everyone feels they have a voice, control and influence. In 2021/22 the Trust procured a confidential third party platform 'Work In Confidence' to support that ambition. The Work in Confidence platform is a web/mobile anonymous dialogue platform to enhance speaking up and engagement.

ASSESSMENT

5. There is recognition that a robust framework must be in place to provide the confidence that staff have a means by which to 'speak up', but they also have confidence that the Trust will appropriately 'listen up' and 'follow up'.
6. In July 2022, the Freedom to Speak Up Task and Finish Group was formed to develop the framework. The Group meets monthly and reports into the Assistant Directors Leadership Team. It is intended that the Group will complete their work by March 2023. The remit of the Group is:
 - Consider and understand the current framework for staff to raise concerns and how the Board is receiving information on themes and learning from the sources across the Trust.
 - Identify and establish a comprehensive framework and supporting infrastructure for raising concerns that incorporates the new online platform.
 - Consider and agree the full extent to which the platform will be used for, i.e., whether it is solely for raising concerns or whether it will also serve as a discussion board for improvement ideas.
 - Consider and develop, with the providers, the consolidated case management element of the platform including reporting, dashboards, and outputs for learning and improvement.

- Consider, design and embed the Survey module that will be used to understand the culture of the organisation and take forward learning.
 - Administer a soft launch of the platform that will include testing, feedback and promotion.
 - Facilitate and monitor the onboarding process of the system within the Trust.
 - Design an outline communications plan prior to and during launch.
7. The Group has used the first few meetings to establish the current baseline and understand the various modes by which staff 'speak up' and consequently how we 'listen up' and 'follow up'. This will assist us in ensuring we configure the Work In Confidence platform to categorise concerns appropriately, recognising where established processes are in place when concerns are triaged i.e. Employment Relations or Putting Things Right processes, and those that may fall into a category that requires a more focused triage arrangement.
8. A draft work plan has been agreed and work will now commence in earnest on the framework which will help to protect patient safety and quality of care, improve the experience of staff, and promote learning and improvement. This will include identifying and developing the necessary policies, procedures, systems, training, education, communication, roles, and responsibilities, learning and reporting.

RECOMMENDATION

9. The Committee is asked to note the update.

Equality, Diversity & Inclusion Steering Group
Wednesday 6th July 2022

Present:

Keithley Wilkinson	Head of Inclusion & Engagement	KW
Trish Mills	Board Secretary	TM
Gareth Thomas	Patient Experience Interim Head of Service	GT
Fatehullah Tahir	OD Manager - Leadership	FT
Charlie Boshier	Recruitment Manager	CB
Jo Kelso	Head of Education	JK
Melfyn Hughes	Welsh Language Officer	MH
Catherine Lloyd	OD Project Support Officer	CL

Apologies:

Catherine Goodwin	Interim Director of Workforce & Organisational Development	CG
Ceri Bryant	OH & WB Manager	CB
Angela Roberts	UNISON Branch Secretary	AR
Kim Tovey	Head of Leadership & Organisational Development	KT
Bronwen Biddle	OD Manager – Engagement & Wellbeing	BB
Beth Eales	Communication Officer	BE
Jennifer Wilson	National Volunteer Manager	JW
Rachel Watling	Head of Communications	RW

REF		ACTION
1.	WELCOME AND APOLOGIES	
	<ul style="list-style-type: none"> The group were welcomed & thanked for their attendance 	

Page Break

2.	MINUTES OF PREVIOUS MEETING / ACTION LOG	
	<ul style="list-style-type: none"> No amendments required to minutes Some actions from action log to be carried over Group wanted to express thanks to Kim Tovey for her contribution to this steering group and to wish her well for her future. 	

	<p>ACTION</p> <ul style="list-style-type: none"> Carry forward incomplete actions from previous action log 	CL
3.	<p>Staff Networks Update</p> <p>Inclusion network</p> <ul style="list-style-type: none"> KW wasn't sure if the network had met since the last meeting and the group confirmed no and that there wasn't an established set of meetings. FT provided some background on the network with a suggestion that due to the time passed it may be worth reaching out to the original members with an invitation for others to join <p>LGBT+ network</p> <ul style="list-style-type: none"> GT advised the LGBT+ network had not met in some time but are looking to re-establish the network on the 15th August in Sheffield. GT hoped that WAST would support the co-chair of the LGBT+ network attending as our representative. GT confirmed Pride Cymru 2022 will take place on the 27th August. WAST with other NHS colleagues will be holding a virtual pride event on Wednesday 24th August to allow those who don't live close to Cardiff to participate. A decision on participating in the 'marketplace' the engagement area at Pride is yet to be made. It's expected the 'marketplace' would cost between £400-£500 for the weekend and thought would need to be put into making the most out of the pitch/stall. For example, recruitment opportunities, volunteering and who would be the appropriate staff to deliver this information. GT & KW invited the group to comment. FT agreed that WAST should have a marketplace pitch with a suggestion of CFRs in attendance CB confirmed a representative from recruitment can be made available to attend in conjunction with a volunteer representative. CB queried the possibility of a vehicle at the marketplace & GT confirmed this wouldn't be a possibility, but one would participate in the parade. JK would like it noted for other events where the attendance of a vehicle is possible a driver education vehicle could be provided. Dependant on demand, a representative from the education team may also be able to attend. 	
	<p>ACTION</p> <ul style="list-style-type: none"> GT to share details of the LGBT+ meeting on the 15th August in Sheffield 	GT

	<ul style="list-style-type: none"> • KW, GT, JK & CB to meet separately to discuss in more detail the attendance of the marketplace at Pride • KW to share Pride merchandise information via email • Dates for future Inclusion Network meetings to be arranged 	<p>KW</p> <p>KW</p> <p>KW</p>
4.	<p>AACE NETWORK UPDATE</p> <ul style="list-style-type: none"> • KW confirmed there is no update to share as he was unable to attend the last meeting. KW will attend the next network meeting and update this group separately in writing. • FT wanted to update the group that he hasn't been able to attend the national BME group however the National BME Forum Conference in London will be held on the 5th October 2022. 	
	<p>ACTION</p> <ul style="list-style-type: none"> • KW to share with the group in writing an update from the next AACE network meeting. • Group to save the date for the National BME Forum Conference on the 5th October 2022 	<p>KW</p> <p>Group</p>
5.	<p>PARTNERSHIP WORKING UPDATE</p>	
	<p>Strategic equality objectives</p> <p>Swansea University & Glyndwr University</p> <p>Engagement – Minority Ethnic Community Health Fair</p> <p>Royal Welsh Show</p>	
	<p>ACTION</p> <ul style="list-style-type: none"> • As there was no time to discuss item 5, KW will summarise an update to share with the group. 	<p>KW</p>
6.	<p>PEOPLE & CULTURE COMMITTEE</p>	
	<p>Terms of Reference</p> <ul style="list-style-type: none"> • TM introduced herself to the group as Board Secretary for WAST and thanked the group for the opportunity to join this meeting. • TM provided some background by sharing that the People and Culture Committee, chaired by Paul Hollard is one of the 7 committees attended by Board. As a practice of good governance, an effectiveness review of all seven committees is being undertaken and TM is using this opportunity to review the 	

	<p>terms of reference. Work is being undertaken to discharging responsibilities and this will bring forward equality, diversity, and inclusion. Part 2 of the effectiveness review will be looking at the subgroups that feed into the 7 committees. It is TM preference that issues come through the executive rather than having a group that sits separately and reports into a committee. However, care must be taken to ensure the message of equality, diversity and inclusion is not diluted.</p> <ul style="list-style-type: none"> • TM wanted to explore ways on how this group could be supported with the reporting lines. • TM shared the People & Culture Committee ToR extracts and discussed delegated powers points 3.7 & 3.14. TM recommended a corporate calendar detailing events to these could be discussed & planned. Hannah Rowan who is a champion for EDI would be keen to become involved. Point 3.14 referred to our compliance with the regulatory and statutory duties and how can these be brought forward. • Group were invited for thoughts & comments. JK welcomed more structure and previous reporting has been to fulfil a compliance requirement and supported the a move forward to allow colleagues to feel included as part of WAST • KW advised a calendar of events is in draft and will be shared. • TM suggested it might be an idea for CG to include part of the calendar in the WOD report to grab attention. • A discussion took place as to whether it was appropriate to have a non-Executive as a member of the group. Further reflection is required as not all members were present today. 	
	<p>ACTION</p> <ul style="list-style-type: none"> • Set up an action with a group of volunteers to answer the questions shared by TM. TM has a deadline of 30th August, therefore a meeting preferably w/c 8th August <ul style="list-style-type: none"> - What are the statutory responsibilities for the Trust related to EDI? - Where are we monitoring compliance with these? - How is that monitoring reported to PCC i.e. through regular existing reports, annual reports, exception reports etc? - Will the EDI strategic plan and objectives be refreshed, and if so on what frequency? - How are the EDI objectives being delivered – entirely through the IMTP, or a mix of IMTP and local directorate plans? If the latter, how can PCC monitor delivery of the strategy? - How can we position PCC and the Board more generally to champion and support the plan and the work of the EDI networks? 	KW

	<ul style="list-style-type: none"> • TM to arrange an introductory meeting with Hannah Rowan and KW 	TM
7.	<p>AOB</p> <p>Accessible Venues</p> <ul style="list-style-type: none"> • A reminder from KW that any meeting hosted in venues, should have their accessibility reviewed. <p>Groups AOB</p> <ul style="list-style-type: none"> • JK added that none gendered spaces to be revisited & included in future meetings. • GT would like to discuss the requirement/need to provide BSL translation for board meetings. • FT would like as part of the action log, future events are raised within the meeting and work closer with communication colleagues. • FT would also like to discuss facilities and prayer rooms. • KW asked if an hour was enough time moving forward for future meetings. JK felt more time is needed or meetings more frequently. FT agrees with JK points especially that frequency should be increased & that the membership of the group needs reviewing as its is workforce heavy and look at Operational colleagues being involved. GT agreed with the comments made by JK & FT and that the current meeting time was a legacy from when service pressures were higher. CB advised that prior to Covid-19 these meeting were 2hours. KW acknowledged all comments made and the next meeting will be at least 90 minutes long. 	
	<p>ACTION</p> <ul style="list-style-type: none"> • Evaluate frequency, time & membership of the group. • Amend the next meeting of 28th September 2022 to 2 hours. • Accessibility to be added to future agenda • None gendered spaces, toilets/showers etc to be added to future agenda • Prayer rooms on WAST premises added to future agenda • BSL translation to be added to future meeting agenda 	KW CL CL CL CL CL
8.	DATE OF NEXT FULL MEETING – 28/09/2022	