

Bundle People and Culture (Open Session) 18 February 2025

Agenda attachments

Item 00 PCC Open Agenda 18022025 v2

0 OPENING ITEMS

1 09:30 – Chair's Welcome, Apologies and Quorum

2 Declarations of Interest

_Updated 20250108-Board Member Register of Interests.xlsx

Item 02 Board Member Register of Interests as at 08 January 2025

3 Minutes of the Previous Meeting: 14 November 2024

Item 03 2024-11-14 Unconfirmed Open People and Culture Minutes

4 Action Log and Matters Arising

Item 04 PCC Action Log 18022025

4.1 Committee Highlight Report from 14 November 2024

Item 04.1 People and Culture Committee Highlight Report 14 November 2024

5 09:35 – Director Update (Combined)

Item 05 People and Culture Director Update – February 2025

6 09:50 – Operations Report Q3 2024/25

Item 06 Operations Quarterly Report for Committee 24-25 Q3

6.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

7 10:00 – Staff Story: Mark Chamber (NEPTS)

Mark will:

- provide an overview of his career at WAST to date and some highlights regarding how previous roles have prepared him (relevant knowledge, skills and experience);*
- some of the challenges Mark has faced in his WAST roles and ideas about what we could do to overcome those.*

8 10:25 – Update on Previous Staff Story: Ela Lewis

Item 08 Ela Lewis's Story Summary Update

9 10:25 – Our WAST Way Update: Transforming Leadership and Culture at WAST

Item 09 Our WAST Way Update-Transforming Leadership and Culture at WAST

Item 09.1 Appendix 1 Sam & Taylor – A Journey Through Our WAST Way

Item 09.2 Appendix 2 Our WAST Way Leadership Behaviours

Item 09.3 Appendix 3 Leadership Development Paths Example

10 10:45 – Cultural Themes and Trends Report

Item 10 Cultural Themes and Trends Report – February 2025

Item 10.1 PCC Cultural Themes Trends Presentation February 2025

11 11:05 – Compassionate Practices Update and Action Plan (Compassionate Practices Deep Dive)

11.2 – Appendix 2 – Copy of Action Plan will be emailed to the Committee.

Item 11 Compassionate Practices Deep Dive Cover Report Feb 2025 Final

Item 11.1 Appendix 1 – Compassionate Practices – February 2025

11.1 11:25 – COMFORT BREAK

12 11:40 – People and Culture Plan Metrics Update and Workforce Scorecard

Item 12.1 Appendix 2 – People and Culture KPIs December 2024 will be emailed to the Committee.

Item 12 People and Culture Plan Metrics Update – February 2025

13 MIQPR

Item 13 MIQPR SBAR PCC Dec24 Jan25hb

Item 13a MIQPR PCC Dec24 Jan25hb

13.1 MIQPR: Review of People and Culture Metrics

This paper is TO FOLLOW.

14 12:10 – Internal Audit Report: Resourcing Policy

Item 14 Resourcing Policy Final Internal Audit Report

15 12:25 – WASPT Highlight Report –November 2024 and January 2025

Item 15 WASPT AAA Report Nov 24 and Jan 25

16 12:35 – Internal Audit Report: Exposure to Fumes

Item 16 Exposure to Fumes Final Internal Audit Report

- 16.1 12:45 – LUNCH BREAK
- 17 13:25 – Annual Effectiveness Review 2024/25
 - Item 17 People and Culture Committee Effectiveness Review
 - Item 17.1 Annex 1 – Committee remits delegated by Board 24–25
 - Item 17.2 Annex 2 – People and Culture Committee Terms of Reference 2024–25
 - Item 17.3a Annex 3 – PCC Cycle of Business 2024–25
 - Item 17.3b Annex 3 – PCC Cycle of Business 2024–25 Cycle Notes
 - Item 17.4 Annex 4 Draft People and Culture Committee Annual Report 2024–25
- 18 14:05 – Risk Management and Board Assurance Framework
 - Item 18 Risk Management Report PCC 180225
- 18.1 Deep Dive on Risk 160 (High Absence Rates): Managing Attendance
 - Item 18.1a Managing Attendance at Work Update Report – February 2025
 - Item 18.1b PCC Deep Dive Absence 2023–2024 February 2025
- 19 14:35 – Audit Tracker Q3 2024/25
 - Item 19 SBAR Audit Tracker to Committees – 2425 Q3 (October–December 2024) Reporting – PCC
 - Item 19.1 PCC Internal Audit Actions Tab 2023–24
 - Item 19.2 PCC Internal Audit Actions Tab 2024–25
 - Item 19.3 PCC External Audit Actions Tab 2023–24
- 20 14:45 – Policies for Approval
 - 20.1 Occupational Health Policy*
 - 20.2 Recruitment and Selection Policy*
 - 20.3 Occupational Immunisation Policy*
 - 20.4 Equality Impact Assessment Policy*
 - 20.5 Bank Worker Policy*
 - Item 20 Policies for Committee Approval – PCC 180225
 - Item 20.1 Occupational Health Policy v0.13 (030225)
 - Item 20.2 Recruitment Selection Policy v19.15 (220125)
 - Item 20.3 Occupational Immunisation Screening Policy v0.12 (030225)
 - Item 20.4 EqIA Policy v0.15 (030225)
 - Item 20.5 Bank Worker Policy v0.14 (030225)
- 20.1 14:55 – CONSENT ITEMS
- 21 Cycle of Business Monitoring Report and Committee Priorities
 - Item 21 Committee Priorities and Cycle of Business Monitoring Report – February 2025
 - Item 21a Annex 1 P&C CoB Monitoring Report – February 2025
 - Item 21b Annex 1 P&C CoB Monitoring Report Cycle Notes – February 2025
- 22 WASPT Minutes – November 2024
 - Item 22 2024_11_15–WASPT Minutes–Confirmed (Approved 27012025)
- 22.1 14:55 – CLOSING ITEMS
- 23 Reflections and Summary of Decisions/Actions
- 24 Any Other Business
- 25 Date and Time of the Next Meeting: 15 May 2025
- 25.1 CLOSE

Length of Meeting:		05:35	Agenda Status:	18 February 2025 - OPEN People & Culture Committee				Deadline for Papers: 07/02/2025		
Time	Mins allotted	Agendum	Title	Item for	Item requested by	Format of Item	Paper prepared by	Item presented by	Colleagues to cc	Scheduled at ELT
OPENING ITEMS										
09:30	00:05	1	Chair’s Welcome, Apols and Quorum	Information	Standing	n/a	n/a	Ceri Jackson	n/a	
		2	Declarations of Interest	To State Conflicts	Standing	n/a	n/a	Ceri Jackson	n/a	
		3	Minutes of the Previous Meeting: 14 November 2024	Approval	Standing	n/a	n/a	Ceri Jackson	n/a	
		4	Action Log & Matters Arising 4.1 Including the Committee Highlight Report from 14 November Meeting	Discussion	Standing	Paper	n/a	Ceri Jackson		
09:35	00:15	5	Director Update (Combined Report)	Information	CoB	Paper	P&C	Angie Lewis,Carl Kneeshaw	Sarah Davies	
09:50	00:10	6	Operations Report Q3 2024/25	Information	CoB	Paper	Operations	Lee Brooks	Toni-Marie Norman	
FOR APPROVAL, ASSURANCE AND DISCUSSION										
10:00	00:25	7	Staff Story: Mark Churchill, NEPTS	Discussion	CoB	Presentation	People and Culture	Angie Lewis, Carl Kneeshaw	Sarah Davies	
10:25	00:00	8	Update on Previous Staff Story (Ela Lewis)	Information	CoB	Paper	People and Culture	Angie Lewis, Carl Kneeshaw	Sarah Davies	
10:25	00:20	9	Our WAST Way Update: Transforming Leadership and Culture at WAST	Assurance	Forward Planner	Presentation	People and Culture	Angie Lewis, Sara Mills	Sarah Davies, Sara Mills	
10:45	00:20	10	Cultural Themes and Trends Report	Assurance	CoB	Paper	People and Culture	Carl Kneeshaw, Liz Rogers Angie Lewis, Catherine Goodwin	Sarah Davies	
11:05	00:20	11	Compassionate Practices Update and Action Plan (Compassionate Practices Deep Dive)	Assurance	Forward Planner	Paper	People and Culture	Carl Kneeshaw, Liz Rogers	Sarah Davies	
11:25	00:15	COMFORT BREAK								
11:40	00:30	12	People and Culture Plan Metrics Update and Workforce Scorecard (To include the People and Culture Plan Metrics Annual Review, IMTP 25-28 Priorities)	Assurance	CoB	Paper	People and Culture	Angie Lewis	Sarah Davies	
		13	Monthly Integrated Quality and Performance Report	Assurance	CoB	Paper	SPP	Alex Crawford	Alex Crawford, Hugh Bennett, Mel O'Connor	
		~~13.1~~	~~MIQPR Review for People and Culture Metrics~~	~~Endorsement~~	~~CoB~~	~~Paper~~	~~SPP~~	~~Alex Crawford~~	~~Alex Crawford, Hugh Bennett, Mel O'Connor~~	
12:10	00:15	14	Internal Audit Report: Resourcing Policy	Assurance	CoB	Paper	Gov	Lee Brooks, Osian Lloyd	Corporate Governance	
12:25	00:10	15	WASPT Highlight Report (January 2025)	Assurance	CoB	Paper	Gov	Christian Fox, or Mark Marsden	Trish Mils, Sara Williams	
12:35	00:10	16	Internal Audit Report: Exposure to Fumes	Assurance	CoB	Paper	Gov	Liam Williams, Osian Lloyd	Corporate Governance	
12:45	00:40	LUNCH								
13:25	00:40	17	Annual Effectiveness Review 2024/25	Approval	CoB	Paper	Gov	Trish Mills	Julie Boalch, Alex Payne	
14:05	00:30	18	Risk Management and Board Assurance Framework Risk 160 - High absence rates; Risk 163 - Maintaining Effective & Strong TU Partnerships; Risk 201 - Reputation; Risk 558 - Deterioration of staff health and wellbeing.	Assurance	CoB	Paper	Gov	Julie Boalch	n/a	
		18.1	Deep Dive on Risk 160 (High Absence Rates): Managing Attendance	Assurance	Planner	Paper	People and Culture	Carl Kneeshaw	Sarah Davies	
14:35	00:10	19	Audit Tracker Q3 2024/25 Reporting	Assurance	CoB	Paper	Gov	Trish Mills	Lisa Trounce	
14:45	00:10	20	Policies for Approval: *Occupational Health Policy *Recruitment and Selection Policy *Occupational Immunisation Policy *Equality Impact Assessment Policy *Bank Worker Policy	Approval	CoB	Paper	Gov	Julie Boalch	Lisa Trounce	
CONSENT ITEMS										
14:55	00:00	21	Cycle of Business Monitoring Report and Committee Priorities	Assurance	CoB	Paper	Gov	Trish Mills	Alex Payne	
		22	WASPT Minutes (November 2024)	Information	CoB	Paper	People and Culture	Christian Fox, or Mark Marsden	Alex Payne	
CLOSING ITEMS										
14:55	00:10	23	Reflections and Summary of Decisions/Actions	Discussion	Standing	n/a	n/a	Ceri Jackson	n/a	
		24	Any Other Business	Discussion	Standing	n/a	n/a	Ceri Jackson	n/a	
		25	Date & Time of the Next Meeting: 15 May 2025	Information	Standing	n/a	n/a	Ceri Jackson	n/a	
15:05	05:35	CLOSE								

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Alex Crawford	Assistant Director of Planning and Transformation
Christian Fox	Trade Union Partner and Co-Chair of WASPT
Ceri Jackson	Non Executive and Chair of Committee
Carl Kneeshaw	Director of People
Angie Lewis	Director of Culture Change
Osian Lloyd	Head of Internal Audit, NWSSP
Mark Marsden	Trade Union Partner and Co-Chair of WASPT
Trish Mills	Director of Corporate Governance/Board Secretary
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	Non-Executive Director * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1995		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	Non-Executive Director * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	Executive Director of Operations	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	Non-Executive Director * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303]	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
		Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021		
DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
		Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
EVANS, Bethan	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncoed Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995		
HITCHON, Estelle	Director of Partnerships and Engagement	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	Non-Executive Director & Vice Chair of the Trust Board * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee – Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company – Stroke Association – Company Director	Directorships	08 October 2020		
KILLENS, Jason	Chief Executive	Honorary Professor – Swansea University	Personal or Departmental Sponsorship	2019		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	Director of People	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
		NI Declaration				
LEWIS, Angela	Director of Culture Change	NI Declaration				
MARSH, Rachel	Executive Director of Strategy, Planning and Performance	NI Declaration				
MILLS, Patricia (Trish)	Director of Corporate Governance/ Board Secretary	NI Declaration				
PARRY, Hugh	Trade Union Partner	NI Declaration				
ROWAN, Hannah	Non-Executive Director * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	Director of Digital Services [appointed 26.09.2023]	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals – Leading Practitioner	Any Other Interest	25 April 2024		
		Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	Executive Director of Finance and Corporate Resources	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	Trade Union Partner	NI Declaration				
WILLIAMS, Liam	Executive Director of Quality and Nursing [from 01 August 2022]	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

**UNCONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE MEETING
(OPEN SESSION) HELD AT CARDIFF MRD AND REMOTELY VIA MICROSOFT
TEAMS ON THURSDAY 14 NOVEMBER 2024**

Chair: Ceri Jackson

Members:

Ceri Jackson	Non-Executive Director and Chair (MRD)
Bethan Evans	Non-Executive Director
Hannah Rowan	Non-Executive Director

Prescribed Attendees:

Lee Brooks	Executive Director of Operations
Alex Crawford	Assistant Director of Planning and Transformation
Christian Fox	Trade Union Partner
Estelle Hitchon	Director of Partnerships and Engagement
Carl Kneeshaw	Director of People (MRD)
Angela Lewis	Director of Culture Change (MRD)
Trish Mills	Director of Corporate Governance/Board Secretary
Lizzie O'Shea	Freedom to Speak up Lead Guardian
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources (MRD)
Damon Turner	Trade Union Partner
Marcus Viggers	Trade Union Partner

Attendees:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Adam Cann	Head of Workplace Wellbeing (MRD)
Kat Copley	Head of Inclusion and Engagement
Sarah Davies	People and Culture Directorate Business Manager
Colin Dennis	Trust Chair
Dr Catherine Goodwin	Assistant Director Inclusion, Culture and Wellbeing (MRD)
Melfyn Hughes	Welsh Language Services Manager
Caroline Jones	Corporate Governance Officer
Alison Kelly	Business and Quality Manager
Ela Lewis	Senior Project Manager
Alex Payne	Corporate Governance Manager (MRD)
Felicity Quance	NWSSP Audit and Assurance

Liz Rogers	Deputy Director of People and Culture Directorate (MRD)
Lisa Trounce	Head of Compliance and Assurance
Nicola White	Head of Health and Safety (Item 101/24 only)
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Jo Kelso	Head of Workforce Education & Development
Mark Marsden	Trade Union Partner

89/24 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the hybrid meeting of the People and Culture and confirmed the meeting met quorum. Apologies were received from Jo Kelso and Mark Marsden.

90/24 DECLARATIONS OF INTEREST

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

RESOLVED: That no new declarations were received.

91/24 MINUTES OF PREVIOUS MEETING, ACTION LOG AND HIGHLIGHT REPORT

The Minutes of the Open meeting held on 30 August 2024 were considered and agreed as a correct record.

38/24 relating to the dedicated investigation that would be reviewing cases, it was requested that cases where there was police involvement to be separated out to provide more accurate timelines of investigations. Angela Lewis confirmed that the action would be picked up going forward and the Committee agreed that the action could be closed.

68/24 - To strengthen the narrative particularly around diversity in the Workforce Plan. This was completed; with the relevant narrative having been strengthened and had been signed off by the Board and therefore the action was closed.

66/24 - To consider whether there was a correlation with sickness absence and the impact of violence and aggression incidents. Details to be included in future report. Angela Lewis confirmed this was being addressed and ongoing with Violence and Aggression colleagues. It was felt that this should be mandated within ESR, however currently managers could only be advised/encouraged to complete ESR. The action was accepted for closure.

69/24 - *To include in the next report (partnerships and engagement), outcomes and impacts using examples in terms of qualitative feedback as an overall partnership piece. Further discussion with the Chair, and Trish Mills to consider which data should be captured.* This action was ongoing an update would be brought to the next meeting. The action remained open.

Members noted the highlight report from the meeting held on 30 August and had no further comments.

RESOLVED: That the

- 1) Minutes of the meeting held on 30 August 2024 were approved; and**
- 2) Actions as set out above were agreed; and**
- 3) The highlight report from the 30 August meeting was noted.**

92/24

DIRECTOR OF PEOPLE AND CULTURE DIRECTORATE UPDATE

Angela Lewis formally welcomed to Carl Kneeshaw to his first meeting of the Committee and confirmed that the next update would be a joint update. She highlighted key areas from her update:

Staff Survey – The response rate, following a more intense engagement approach as of 12 November 2024, was 27.2%. The internal aspiration was to achieve 30% and Angela Lewis encouraged people to use the virtual backgrounds and invite others to complete the survey, in order to shape plans going forward. It was recognised that the Trust were doing well in comparison to other NHS bodies in Wales.

Equality Diversity and Inclusion (EDI) – An inclusive recruitment initiative had been progressed with Digital colleagues, targeting local communities, with more applications being received from minority and ethnic communities. Hannah Rowan commented on the need to build on the positives of the initiative and rollout further or review the lessons learned to improve future campaigns.

Awards/Recognitions – Angela Lewis was delighted to share the Trust's Education and Development Team has been part of the successful WAST nominations at the recent NHS Wales Awards, having won in both categories they were nominated. The awards related to the introduction of Pentrox for our Community First Responders use to manage pain with our patients and our Care of the Newborn and Thermoregulation education and development programme.

Alex Crawford was invited to provide a brief summary of the Chief Executive Roadshow feedback from the occurrences held in October 2024. Key points on this feedback included:

- CPD sessions were run prior to the events;
- Digital engagement was good;
- Fran Jones was the winner of the CPD bursary.

Of the feedback that was sought, 54 individual responses were received; of which 32 were from staff in the Operations Directorate. The majority of staff indicated that they would attend a future Roadshow. It was recognised that the Siren platform was the main route for engagement for marketing the event.

The feedback included comments regarding the venues chosen for the Roadshows and whether more appropriate locations could be chosen. Additionally, it was fed back that there was on over emphasis on content previously covered; with corporate colleagues requesting a wider remit of activity across the organisation and how they contribute to the operational change.

It was indicated that staff valued the opportunity to network and collaborate and commented positively on the leadership visibility. The carousels – on subject specific areas - were also welcomed. Damon Turner asked whether there was data on the less represented areas where staff members come from, in order to focus on those regions in the future.

Colin Dennis expanded on Damon Turner's comment regarding consideration of less represented areas of the Trust and requested consideration that volunteers / the volunteering arm of the Trust could be a focus area for the next round of Roadshows, to ensure they felt as valued as other staff members.

The Committee acknowledged this feedback and recognised the continuous improvement approach to the roadshows. Bethan Evans thanked Angela Lewis and her team for the ongoing excellent work, with regards to the update received.

RESOLVED: That

- 1) The Director Update was noted; and**
- 2) Feedback from the Chief Executive Roadshows would be considered, to shape future events.**

Lee Brooks highlighted the following areas relevant to the Committee:

- The Volunteer Services Organisational Change Process was underway, albeit slightly delayed, from the original timeline. This will provide an enhanced experience for volunteers both in terms of onboarding and support.
- Recruitment and deployment of the new roles within the Emergency Medical Service Centre (EMSC) structure had begun, with call handling supervisors moving from Band 4 to Band 5. This gave parity with 111 call handling coordinators.
- The seven Operations Managers have completed training and will be active from next week, with other roles being progressed.
- This month will see the rollout of the single allocator model and deploying dispatch boundary changes. The team had worked well with both staff and Trade Union partners. Whilst staff were anxious about the change, they expressed a desire to continue making these positive changes.
- Call handling sickness remained a significant issue with nights and weekends being prominent. The team were deploying absence management processes, with some staff leaving the service prior to the process being finalised. A series of listening exercises were held to inform the action plan which had been developed with TU partners. Members discussed that the autonomy of the role could be a factor in staff leaving but was not within the Trust's gift to change it. Additionally, the nature of the role meant that some staff would naturally conclude it was not the right fit for them.
- An increase in layers of management would improve the knowledge and understanding of staff and ensure policies could be applied appropriately. A number of staff had reached out to Angela Lewis prior to applying for these senior roles which indicated their genuine desire to explore and understand the importance of culture in leadership positions. .
- Work was ongoing for the North Emergency Medical Service Control (EMSC) move, anticipating the work would be completed in this financial year, with staff hopefully transitioning in quarter one of 2025/26.
- End of shift overruns still remained a focus with an increase in October, correlating to the increase in handover lost hours. The Operations Management Team remain active around the importance of staff finishing their shift on time, especially going into December.

- The Urgent Care Service (UCS) transition is showing a decrease in resource utilisation, which is understood to be due to changes in how UCS resources are deployed. In response, actions are being taken to ensure continued effective use of these resources. The goal is to promote the P3 backup option for EMS staff, who have previously hesitated to call for urgent care transport due to a lack of available resources.

With new capacity being created, EMS will be encouraged to call for UCS when suitable, as this will improve their ability to meet patient transport needs. Efforts are underway to encourage Healthcare Professionals (HCP) to use the HCP line instead of 999; allowing for better management of their activities. Upcoming changes to the Clinical Safety Plan, along with the deployment of Clinical Navigators in December, will further ensure that UCS-suitable cases are prioritised for dispatch rather than resulting in "can't send" outcomes.

The Committee thanked Lee Brooks for his analysis and updates on EMS call handler absences. Lee acknowledged the challenges, and stated that there was no immediate need for Committee support. He noted ongoing improvements in career opportunities and the working environment, and that excellent work had been undertaken to maximise the 111 Call Handler establishment. Colleagues were reminded of a pause during the deployment of the new triage system, but recovery was expected as December approaches, which was a positive outlook. The abandonment rate currently stands at 5.8%, indicating good performance.

There was focus on promoting the Welsh language, especially among 111 staff who may lack confidence in using it. The team have implemented measures to build this confidence and has adjusted how calls are managed and routed through the telephony system.

Hannah Rowan queried the increase in mental health absence rates. Angela Lewis confirmed work was ongoing to review if there were particular areas of concern within the organisation. Catherine Goodwin also commented on the destigmatisation of talking about mental health, which may have been masked previously with another sickness reasons. This could be contributing to the increase in figures associated with mental ill health.

Members recognised the level of commitment and the work going on across the organisation within the Operations Directorate and thanked Lee Brooks for his report.

RESOLVED: That the Operations progress was noted.

Angela Lewis introduced Ela Lewis who presented her story through the lens of our change community. Ela is a registered nurse by background but has been working as a Senior Project Manager in the Trust since January 2024.

Ela explained how her first exposure to health and social care began in her teens and continued during her university years, where she had the chance to volunteer internationally in Tanzania and Sri Lanka. At 17, while volunteering in Tanzania, she engaged with hospitals, an orphanage, schools, and experienced local life. This experience taught her how environment, culture, and lived experiences influence our perceptions.

The importance of respecting others without judgment was highlighted, along with an acknowledgment of the privilege of accessing free healthcare and pursuing education. As a woman, the ability to help others and advocate for community change was seen as a significant privilege, which served as a major motivator in her life and why she pursued a career in Health and Social Care.

Ela pursued her dream of becoming an intensive care nurse after studying nursing at university, aiming to care for people during their most challenging times. However, her experience was altered by the Covid-19 pandemic. This was her first experience of change at a large scale.

Ela observed how decisions directly affected patient care and how the rapid pace of change impacted healthcare workers. This experience highlighted for her that sustainable change relies on people who need compassion and a sense of value. During the Covid-19 pandemic, systemic challenges became more apparent, and she struggled with feelings of inadequacy in contributing to overcoming these issues.

Ela left her job for a graduate role as part of the Academi Wales Leadership Programme. Ela gained broader exposure to the Welsh public sector, working with various stakeholders from industry and social care providers, including Health Boards. She learned project management tools to facilitate collaborative efforts. Understanding among all parties was crucial, as it involved recognising what was important in each sector and the challenges that hinder change.

Ela was fortunate to accept a position within the Trust where she helped shape care delivery in a remote setting. Utilising both her nursing and project management skills, she focused on individualising care, exploring how to best support patients in a way that suits their needs. She also considered how to leverage technology and create opportunities for community members to support one another.

Ela completed the change management training, which she found enjoyable and beneficial. It equipped her with practical tools for facilitating difficult discussions and shifting perspectives. Recognising that change can be challenging, she and the team have been able to push boundaries and challenge the status quo by applying these tools.

The focus moving forward is on avoiding stagnation and helping others feel at ease with the idea that continuous change is the new normal. Given the significant changes occurring, it's crucial to create a supportive environment where colleagues can openly share their feelings of overwhelm or fear. Acting with compassion will help everyone navigate this journey together.

Members praised Ela for her work to date and the impact she is making at the Trust and celebrated her as an individual. It was noted that she was nominated and shortlisted for an international award for Nurse Leadership in Digital Healthcare, as well as being part of an award-winning team at the Trust's own internal awards.

Ela talked about having the privilege of working closely with care homes, helping them utilise available technology. While new technology can evoke fear, it also inspires motivation. Ela was reassured when entering these spaces where people were eager to participate in the change process. This presents an opportunity to shape the future of care, using technology to ensure individuals receive the care they need in environments that make sense to them, rather than defaulting to emergency departments.

Bethan Evans recognised it can be challenging to onboard all staff, especially given the geographical dispersion and the fast pace of change, which can be frightening for many. It was noted that there are different approaches needed to better support staff during this transition.

Alex Crawford commented that Ela's role as a leading change champion should be a source of pride for the organisation, especially within the nursing community. While the focus often leans toward other disciplines, Ela stands out as a guiding light. Her contributions highlight the importance of change champions and the value of graduates within the organisation, emphasising pride in the graduate scheme.

The Chair thanked Ela for sharing her story and the work that she does within the Trust. She expressed a sense of pride and inspiration from Ela's story. The Chair also emphasised the significance of recognising hidden champions within the organisation and the need to listen and respond to staff feedback.

RESOLVED: Ela Lewis' story was well received and her story celebrated.

Staff Story Diagram - Kayleigh Wheeler Co-chair of Voices Network

The Staff Story Diagram from the previous meeting was noted. The actions in the Diagram were noted. These include continuing to work with the WAST Voices and support the network in its organisational delivery of this activity.

95/24

PEOPLE AND CULTURE PLAN METRICS UPDATE AND WORKFORCE SCORECARD

This was the first report where the metrics and the scorecard had been brought together and Angela Lewis highlighted key points. She noted that the report focused on quantitative data.

The increase in colleagues becoming part of our Networks was highlighted, showing a good level of engagement across the organisation. It was an indicator that people of all levels wanted to have a voice around culture change and improvement.

Whilst recognising there are pockets where there are sickness absence issues, overall, this showed a sustained improvement. Huge efforts are being made by managers, people services and Trade Unions partners which were contributing factors to the improved position; with early intervention from Occupational Health colleagues to support our people.

Mandatory In Service Training (MIST) compliance following the commencement of the programme in April was at 47.8% at the end of September 2024; which showed good progress.

Challenges with Performance Appraisal and Development Reviews (PADR) compliance was acknowledged with more narrative in the report about the measures and actions being taken. Members agreed that it was important that PADR conversations were meaningful and viewing compliance figures alone was therefore not the only quality measure. This was emphasised at a recent Trust Leadership Symposium.

Job evaluation has seen some significant challenges linked to the substantial number of new roles as a result of the new model. Significant investment was put into this, and thanks was given to Christian Fox who had been pivotal in progressing the work.

Due to the focus on sexual safety at work in the Trust, an increase in disciplinary cases have been noted. Active support from Trade Union partners helped ensure these were being addressed efficiently and swiftly, whilst recognising there were gaps in knowledge and understanding in this area. Work was ongoing with the Welsh Trade Union Congress to understand if there was any bespoke training for all those involved.

RESOLVED: That the report regarding the People and Culture Plan Metrics and the Workforce Scorecard was received and the progress to date was discussed. The Committee took assurance from the update given.

MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT (MIQPR)

Alex Crawford presented the MIQPR for September 2024 and noted that much of the report content has been covered within earlier agenda items. However, he highlighted some key points:

- Culture of Quality and Performance – The Trust has a strong culture of integrated quality and performance, with clear visibility into metrics related to people and patients.
- Data Quality Issues – There are ongoing issues particularly with Health and Safety metrics which are being addressed within the digital team.
- Patient Related Metrics – Response rates were not at desired levels, but efforts were ongoing to improve remote clinical care capacity. Handovers exceeded 20,000 hours with the number expected to rise as winter approaches.
- Production Targets – The Trust is exceeding its production targets.
- There was a strong focus on metrics at a directorate level, with the Quality Performance Management Framework and self-assessments being implemented. Improved dashboards were helping focus on key areas like PADRs.

Members noted that significant efforts were being made to improve data quality, patient care, and performance metrics, with a strong emphasis on quality and continuous improvement.

RESOLVED: That the September MIQPR report was considered, and the Committee took assurance from the update given.

Angela Lewis presented the refreshed Health and Wellbeing Plan 2025-29, which aligned to the overarching People & Culture Plan. Notwithstanding this, it was felt this was important to have a standalone document as it was a pivotal part of the organisation's approach to health and wellbeing. The Plan focuses on improving the work environment, employee experience, and management skills related to wellbeing and mental health. Additionally, the Plan follows the Health Inspectorate Wales good practice guide; emphasising meeting basic needs, an evidence based approach, and a relational and systemic focus. Angela noted that the Plan was accompanied by an Equality Impact Assessment which the Committee received, the findings of which were not adverse.

Adam Cann, Head of Workplace Wellbeing, referred to areas the Wellbeing Team were involved in such as providing assessment, signposting and follow up support for staff facing various challenges – which included domestic violence, mental health issues and musculoskeletal injuries. The Team also provided consultations for managers and teams for sensitive situations such as suicide risk and complex mental health problems.

The Wellbeing Team focuses on both preventative and reactive support, including a Trauma Risk Management network and crisis support. Adam stated that the Health and Wellbeing Plan was aligned with the broader People and Culture Strategy. Key objectives of the Plan included assessing changing wellbeing needs, promoting wellbeing and positive health behaviours, and ensuring staff were aware of available services.

Members noted that staff face issues such as sleep difficulty, musculoskeletal problems and higher sickness absences due to stress and anxiety. There was a point raised regarding the levels of Post Traumatic Stress Disorder (PTSD) among staff, with a special focus on suicide risk. Adam emphasised the higher risk of suicide among frontline Emergency Medical Service colleagues and linked it to factors such as returning to work after long period of sickness and poor mental health. He suggested that instead of focusing on assessing resilience, the organisation should provide buffers and support systems to prevent PTSD, depression, burnout, and fatigue.

Angela Lewis reassured that behind the high-level delivery plan, there are detailed local action plans to ensure comprehensive support and implementation of the health and wellbeing initiatives detailed. Members discussed the concept of resilience; with concerns about screening for resilience during recruitment. It was emphasised that support systems and team dynamics play a crucial role in buffering against stress and trauma. The importance of compassionate leadership and team support was highlighted.

It was recognised that the most successful approach was to build resilience within teams, strengthening connections and fostering a collaborative and inclusive environment. Members noted the importance of supporting diverse recruitment, including individuals with past mental health issues, and the role of the organisation in providing a supportive environment for all staff.

Following this discussion, the Committee confirmed its contentment with the Health and Wellbeing Plan 2025-29 as presented and endorsed the Plan for onward submission to the Trust Board, for approval.

RESOLVED: That The People and Culture Committee reviewed and endorsed the Health and Wellbeing Plan 2025-29 (with the supporting Equality Impact Assessment) and recommended its submission to the Trust Board for approval.

97/24

CHANGE MANAGEMENT INTERACTIVE SESSION

Sarah Davies outlined how the initiative began, which was to build a change community to empower colleagues at all levels to lead and support change, aiming for sustainable impact. Since March 2023, considerable progress has been made; including training 76 colleagues in change management and facilitating development sessions for the Executive Leadership Team.

The change community had been established to foster a culture of collaboration, trust, and growth. This community provides a supportive non-judgemental environment for colleagues to practice new skills, build confidence, and share experiences. Angela Lewis's active leadership plays a crucial role in this effort.

The Trust has implemented the Awareness, Desire, Knowledge, Ability, Reinforcement (ADKAR) model of change management. This is a five-stage framework for managing change, focusing on individual changes to achieve organisational results. This model is being embedded in the Clinical Model Transformation Programme, with dedicated change leads supporting each work stream. The model breaks change down into clear stages and is action and outcome focused.

The Trust has developed templates and guidance to support change leads, which will help ensure a consistent approach to change management across the programme. The aim is to engage and empower colleagues to navigate changes effectively. The widespread engagement and interest across all Directorates in the change management initiative was noted.

Members took part in an interactive session and to share what aspects of the discussion excited or sparked interest and how they could be supported. Concerns were also invited. The following comments were made:

- Christian Fox raised a concern about what staff should do if their manager was not supportive of the change initiative. He asked if there were alternative avenues or other people they could approach if they encounter an obstacle. Sarah Davies acknowledged the need to communicate the change community's role to colleagues across the organisation and took an action to do so to support managers and the community.
- Trish Mills commented on the recent experiences the Change Champions played during the Organisational Change Process within her Directorate. The integration of change management principles with leadership, particularly through "Our WAST Way," was seen as vital for future progress.
- Christian's comment and Sarah's similar point highlighted the alignment between change management and quality improvement efforts. These two areas worked closely together. If someone raises an issue locally and doesn't get the desired traction, they could escalate the issue through the Quality Improvement Team, which provides support in quality and continuous improvement across the organisation. across the organisation.
- Bethan Evans noted that the initiative provided an opportunity for people to develop themselves, build confidence and find their voice. It empowered individuals to realise skills they may not have known they had. She was pleased to hear that people of all levels were included.
- Estelle Hitchon reflected that often the best changes are driven by passionate individuals. She suggested harnessing this passion within change champions rather than assigning projects to them. The goal was to encourage individuals with ideas to take on change champions roles either formally or informally.
- Estelle suggested that future leadership roles should require evidence of change management experience to ensure those aspiring to leadership roles had the energy and appetite to drive change.
- Alex Crawford reflected that these connections between quality improvement, change projects and transformation reflected a bottom up approach. He expressed a concern around the pace of change and the ability to support the leads effectively, stressing the importance of providing support to managers who may lack formal training or tools, helping them to gain confidence and improve communication during change conversations.

The current approach to change management in the Trust is under review / subject to continuous improvement, to address its strengths and weaknesses. The Quality Improvement and Change Management Teams are collaborating on this review. A new platform was being developed to better support ideas, innovations, and service improvement opportunities from colleagues.

Moving forward, the Trust's focus will be on aligning change management with ongoing cultural transformation and leadership development. The aim is that change management considerations / techniques will become a natural part of every process across the Trust.

Angela Lewis' commitment to ensuring that change management principles and techniques are embedded in the leadership work within the Trust was reiterated and the Committee agreed this as a formal Committee action. The Chair thanked Sarah Davies for her presentation and confirmed the Committee's support to the Trust with regards to its change management journey.

RESOLVED: That

- a) Assurance was provided on the progress made in establishing a change management foundation within the Trust;**
- b) A strategic direction for embedding these practices was clarified; and**
- c) Committee members committed to support this journey.**

98/24

WASPT HIGHLIGHT REPORT – 25 SEPTEMBER 2024

The Welsh Ambulance Services Partnership Team (WASPT) is the Trust Board's local Partnership Advisory Forum. The highlight report set out the ongoing projects, upcoming challenges, and the steps being taken to address matters in partnership.

The meeting discussed historical challenges during the festive period, such as low Unit Hour Production and staffing issues. Assorted options were considered to manage these challenges and the 15 November 2024 WASPT meeting would look at these issues.

The report highlighted efforts to enhance collaboration and joint problem-solving within the Trust, including observing and reflecting on partnership behaviours and conflict management styles.

It was recognised that good progress was being made in relation to transition in Emergency Medical Technicians (EMT) to Band 5, with partnership notices issued to set out arrangements. This included addressing backpay timing and necessary training over the coming months.

There was a concern about the secondary assignment section within the report, specifically regarding Emergency Medical Technician (EMT), Emergency Care Assistant (ECA) and Ambulance Care Assistant (ACA) roles. This would be discussed at the meeting on 15 November 2024.

Trade Union partners attended social partnership training at Welsh Government, highlighting the organisations strong position compared to others. The Trust's approach to partnership working was noted as being advanced across NHS Wales and wider public sector, with challenges being worked through in a collegiate fashion.

Various health and safety initiatives were taking place with respect to diesel fumes, including the pilot of extractor fans with filtration and plans to employ a fixed-term occupational hygienist to assess air quality. A spotlight communication on diesel fumes had been issued but concerns remain, with discussions to continue at the WASPT meeting on 15 November.

RESOLVED: That the positive progress being made was recognised and the Committee was assured in that regard from the Co-Chairs of the WASPT from the meeting held on the 25 September 2024.

99/24 REVALIDATION AND REGISTRATION REPORT FOR NURSING AND MIDWIFERY COUNCIL (NMC) 2024

Liam Williams presented the 2024 annual statement regarding Nursing and Midwifery Council (NMC) revalidation and registration for nurses and midwives within the Trust. This report confirms the processes for ensuring that all Registered Nurses and Midwives maintain their professional registration obligations with the NMC. It also provided a registration update as of September 2024 for NMC registrants.

The Report indicated that there were 290 people in the organisation with an active NMC registration; two people were highlighted as in a position that requires an NMC registration but are not registered (however this was due to incorrect position numbers); one person was highlighted as having two NMC numbers (however this was a data input error); one person highlighted as having a lapsed registration; however a manual check on the NMC database confirmed an active registration for this individual. The report therefore confirmed that NMC registrations and revalidations within the Trust in 2024 has remained at 100% compliance.

RESOLVED: That the Committee took assurance from the Revalidation and Registration report for Nursing and Midwifery Council for nurses and midwives employed by the Trust for 2024.

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

Julie Boalch presented this report and noted that the cycle of reporting meant that these were the same as those reported to Trust Board in September 2024. All risks had been reviewed and good discussions had taken place in readiness for the next Trust Board meeting and the meeting of the Audit, Risk and Assurance Committee.

Risk 201 (damage to the Trust's reputation following a loss of stakeholder confidence) remains at a score of 20 (4x5). Members noted the risk is inextricably linked to several of the metrics measured and discussed at various Committees.

Risk 163 (maintaining effective and strong Trade Union partnerships remains at a score of 16 (4x4) but is expected to reduce in the next reporting cycle. The risk was also presented to Welsh Ambulance Services Partnership Team (WASPT).

Risk 558 (deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences) remains unchanged at a score of 15 (3x5). It was noted that the Health and Wellbeing Plan that was approved at this meeting will support the mitigations further.

RESOLVED: That the contents of the Risk Management and Board Assurance Framework report were considered and discussed. The updates against Risks 201, 163 and 558 were noted.

HEALTH & SAFETY REPORT – QUARTER 1 AND 2, 2024/25

Liam Williams confirmed that the report set out in detail the analysis behind the RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reporting and other work the team had undertaken over the past six months. Nicola White raised the key points for members which included:

- Compliance reduced to 40% in Q1 with 14 RIDDOR incidents but increased to 72% in Q2 with eleven incidents reported. The drop in compliance was due to additional Health and Safety Executive requirements on RIDDOR submission forms, which now required details from relevant investigations. The team is focused on improving compliance back to 100%.
- Manual handling of patients and slip, trips, and falls continue to be the most consistent themes for RIDDOR submissions. Recent additions to the RIDDOR submissions, that required investigation details by the Health and Safety Executive, have impacted on the Trust's compliance to submission requirements.
- Health, safety, and fire training compliance is below Trust and Welsh Government expectations. Staff are encouraged to improve compliance levels.

- Sustained focus on managing diesel fumes is maintained by the Deputy Head of Health and Safety and it is a matter of regular discussion in WASPT as set out in the AAA report to this meeting.
- Following HSE recommendations, Institute of Occupational Safety and Health (IOSH) Leading Safely training was delivered to Board members to help them take a more strategic view of health and safety.
- The Chief Executive's podcast on the Safety, Health Practitioner (SHP) platform discussed the importance of effective health and safety, which was celebrated by the team.

Liam Williams added that whilst improvements were being made, the organisation was not yet meeting all required legislative standards. This was crucial in case of an event where compliance with HSE requirements needed to be demonstrated. Progress was acknowledged; but there was still significant work to be done.

Liam added that a workshop held two weeks previously focused on the future working of the National Health and Safety Committee. It was a productive session with strong partnership and commitment from Trade Union partners and colleagues across the organisation. The workshop aimed to address complex and challenging areas, building on partnership work over the past year.

Chris Turley observed the position regarding fire safety reporting. He referred to a previous paper received by the Committee on people and culture metrics which noted that fire safety was highlighted as an improving area. However, in the current health and safety report, it was flagged as a red alert which indicated a need for action. Chris agreed to take an action to review the Trust's position into the fire safety reporting and related issues regarding data quality and reliability and will report back to the Committee at a future date. and ensuring clarity.

The Committee noted the emphasis which remained on continuous improvement, and acknowledged the progress demonstrated within the report, and the collaborative efforts to enhance health and safety standards within the Trust. Members thanked Liam Williams and Nicola White for the report update.

RESOLVED: That the contents of the report were noted.

102/24

AUDIT TRACKER & AUDIT REPORTS

The Audit Tracker for Q2 2024/25 was reviewed, and the Committee noted the update with good movement in internal audit actions. There remained several historic actions from the Trade Union Release Time internal audit which were proving to be an issue; however, meetings were being held to discuss progress where required.

Members noted that several actions were on their third and final revised date; however it was anticipated they would be closed in the next quarter. It was noted that there were revised dates for all outstanding Audit Wales actions from the Review of the Workforce Planning audit. Due to this Trish Mills intended to discuss the actions with Carl Kneeshaw to offer support on how they can be progressed.

RESOLVED: That the

- 1) actions within the report for Q2 2024/25 were noted; and**
- 2) revised dates for actions were noted.**

103/24

POLICIES FOR APPROVAL

The following policies were before the Committee for approval:

- (a) Welsh Language Policy: Trish Mills presented the policy, and noted that it was the first of its kind in the Trust, with a focus on cultural change rather than just simply with standards.

The increase in the use of Welsh in meetings and events was noted, and Trish indicated a positive cultural shift. The NHS Wales 111 team, which recently won the Welsh Language Award, exemplifies this progress.

Responsibilities were outlined for the Trust Board and the Welsh Language Champions, with Board Development sessions planned for February to further promote the use of the Welsh Language. Members noted that the Welsh Language Advisory Group will monitor compliance in line with the policy, and escalate any issues to the Equality, Diversity and Inclusion Steering Group.

Thanks were given to Melfyn Hughes's efforts and extensive consultation, the policy had strong support from those consulted during its development.

- (b) Driving at Work Policy: Julie Boalch confirmed that the Driving at Work Policy had undergone a robust review and there would be legislative changes in the next six months.
- (c) The NHS Wales Flexible Pensions Policy and the All Wales Pregnancy Loss Policy, being national All Wales policies, were adopted.
- (d) The Managing Attendance at Work Policy amendments were noted.

RESOLVED: That the

- 1) Welsh Language Policy was approved;**
- 2) Driving at Work Policy was approved;**

- 3) **NHS Wales Flexible Pensions Policy together with the All Wales Pregnancy Loss Policy were formally adopted; and**
- 4) **Immediate amendment to the Managing Attendance at Work Policy was adopted**

104/24 CONSENT ITEM – Not discussed in the meeting

Committee Cycle of Business Monitoring Report & Committee Priorities.

105/24 CONSENT ITEM – Not discussed in the meeting

Welsh Ambulance Services Partnership Team (WASPT) Minutes of the meeting held on the 09 July 2024.

106/24 CONSENT ITEM – Not discussed in the meeting

Assurance to Audit, Risk and Assurance Committee (ARAC) regarding Trust Speaking Up Safely Arrangements.

107/24 CONSENT ITEM – Not discussed in the meeting

Health and Care Professions Council Revised Standards of Conduct – update.

108/24 KEY MESSAGES FOR BOARD

Reflections on the meeting were that the members felt that the discussions were less transactional and more 'future-focused' than has been the case in previous meetings. There was a sense of progress and engagement in various initiatives, such as the change management community and the health and well-being activities.

Members noted the importance of maintaining a holistic view of people and culture activities and ensuring that the narrative and conversations aid the Committee in connecting the dots across various plans and priorities within the Trust's strategic plan.

Additionally, there was consideration of how best to facilitate the meeting in a hybrid manner and the most appropriate use of the chat within the Teams meeting. The Chair will consider any necessary adjustments required for future meetings.

109/24 ANY OTHER BUSINESS

Nothing raised.

110/24 DATE OF NEXT MEETING

The next meeting was scheduled for the 18 February 2025.

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
69/24	30 August 2024	Partnerships and Engagement	To include in the next report, outcomes and impacts using examples in terms of qualitative feedback as an overall partnership piece. Further discussion with the Chair, and Trish Mills to consider which data should be captured.	Estelle Hitchon	14 November 2024	Update for February 2025 Meeting: Ceri Jackson, Estelle Hitchon and Trish Mills met to discuss this on 26 November. Estelle will provide a verbal update to the February meeting, however scoping work has commenced to define more clearly what is encompassed under 'partnerships' and to determine which committee or committees are responsible for this area. It is anticipated that this effort will extend into the first quarter of 2025/26 to prevent overburdening the teams during a busy period. A paper will be presented to Trust Board in May regarding partnerships and engagement at a strategic level, linked also to reputational risk 201. Update at November Meeting: Action to remain open with a report to be received at the next meeting. Update for November Meeting: meeting in process of being arranged to understand the requirement in order that appropriate report can be developed. The action should remain open.	Open
97/24	14 November 2024	Change Management	Angela Lewis agreed to ensure that change management principles and techniques are embedded in the leadership work being done, particularly through the WAST Way. This includes supporting colleagues through change and ensuring that change management is at the heart of leadership development.	Angie Lewis	18 February 2025	Update for February 2025: The initial meeting has been held to explore embedding change management principles into leadership development through the WAST Way. Further sessions are scheduled to finalise the approach. If the Committee is satisfied with the action being taken the action is proposed for CLOSURE.	Complete
101/24	14 November 2024	Health and Safety Report	Chris Turley noted the mixed messaging in fire safety reporting in the People and Culture Metrics report and the Health & Safety report. One being highlighted as improving area and one flagged as red indicating a need for action. He agreed to take the lead with Fire Safety and the need for improvements and potential issue re data quality and ESR figures.	Chris Turley	18 February 2025	Update for February 2025: Update TO FOLLOW.	Open



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PEOPLE AND CULTURE COMMITTEE HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

The papers for this meeting can be found by following this [link](#) to the Committee page on the Trust website.

Trust Board Meeting Date	29 November 2024
Committee Meeting Date	14 November 2024
Chair	Ceri Jackson

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The **Health and Wellbeing Plan 2025-2029** (attached at **Annex 1**) was endorsed and is recommended to the board for approval. The plan emanates from the overarching People and Culture Plan but remains a standalone document due to its pivotal importance. The plan was accompanied by an Equality Impact Assessment which the committee reviewed, and following thorough discussion on the plan affirmed the beneficial effects of the plan on our workforce. The plan shows the high-level outcomes, with local action plans sitting behind them focusing on meeting the basic needs of staff, promoting well-being, providing preventative and reactive support, all while maintaining service quality.

ADVISE

(Detail any areas of on-going monitoring, approvals, or new developments to be communicated)

2. There is a **significant amount of change** taking place across WAST, and that brings pressure for our people, both with respect to change itself, but also the pace of change. This was a primary focus for the meeting.
3. **Ela Lewis**, with a background in nursing (registered nurse) and currently a Senior Project Manager for the Connected Support Cymru project, shared her inspiring journey as a change champion. Her path began with volunteering roles in Tanzania and Sri Lanka, leading to a career as an intensive care nurse - a role driven by her appreciation for healthcare and a passion to assist others. At WAST, Ela has applied her clinical expertise and project management skills to innovate remote care delivery, advocating for personalised care and the integration of technology. Her change management training at WAST equipped her with essential tools for facilitating difficult conversations and effecting meaningful change.



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Ela highlighted the crucial role of creating a supportive environment where colleagues can express their emotions and collaborate effectively on the change journey. Ela's contributions, especially in volunteer coordination and the implementation of remote clinical devices, have been notably impactful, earning her widespread gratitude within WAST.

4. A **change management session** was delivered on the progress made in the Trust in building the change community, following the adoption of the ADKAR approach to change management. ADKAR stands for Awareness, Desire, Knowledge, Ability, Reinforcement, This approach aims to empower colleagues at all levels to lead and support change within the Trust, creating a sustainable impact by providing local support and guidance to help people feel confident and capable of navigating change. Since March 2023, 76 colleagues have completed accredited change management training. Furthermore, a development session was facilitated for the Executive Leadership Team and the Board to establish a common language around change management throughout the organisation. The following progress related to this work was noted:
 - **Change Community:** The Trust has established a change community focused on creating a culture of collaboration, trust, and growth. This community aims to build a supportive, non-judgmental environment where colleagues can practice new skills, test their thinking, build confidence and competence, and share experiences to learn from each other.
 - **Structured Approach:** The Trust has developed and implemented a structured approach to change management centered around the ADKAR model, which focuses on individual change to achieve organisational results. This model breaks change down into clear stages and is action and outcome focused.
 - **Embedding Change Management:** The approach is being embedded within the clinical model transformation programme, with dedicated change leads from the change community supporting program workstreams. The goal is to ensure a consistent approach to change management across the program.

Moving forward, the Trust's focus will be on aligning change management with ongoing cultural transformation and leadership development. The aim is for change management to become a natural part of every process, whilst having oversight of the impact of change on our people. d. Angela Lewis confirmed her commitment to ensuring that change management principles and techniques are embedded in the leadership work within the Trust, particularly through our 'The WAST Way'. This will ensure that change management is at the heart of leadership development.

5. The report from the Director of Cultural Change and the Director of People was received with the following of particular note:
 - **Staff survey** results at a 27.2% response rate was an improvement on last year and it is anticipated the target of 30% will be met, with ongoing communications and engagement to encourage participation.
 - Multiple **awards** and recognitions have been received over the past few months, highlighting the external acknowledgment of the team's work. Recent events such as roadshows, leadership symposiums, and the WAST Awards have been well-attended and appreciated.



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- **Inclusive recruitment** events in collaboration with digital colleagues targeting local communities have shown positive results, with increased applications from minority and ethnic communities.
 - Feedback on the **CEO roadshow** was largely positive, but there is a need to encourage more front line staff and ensure a balance of content for the audience. Members were assured that the format will continue to iterate and improve based on feedback.
6. The **Welsh Language Policy** and the **Driving at Work Policy** were approved. Amendments to the **NHS Wales Managing Attendance at Work Policy** was also approved.
7. The **Q2 Operational Update** highlighted several initiatives including structural change in the volunteer management team aimed at enhancing volunteer experience, a reduction in UCS resource including deployment of P3 backup to EMS staff, reinforcing the use of the healthcare professional line rather than 999 and changes to the Clinical Safety Plan. Updates received on EMSC Coordination, including recruitment, the single allocator model, and estate improvements in Central and North Wales. Concerns expressed regarding mental health absence rates currently above the two year average and 999 call handler sickness and attendance, especially during nights and weekends. An ongoing focus on improving the culture within EMSC continues and has been supported by the recent listening exercise that Angela Lewis undertook which involved engagement sessions with staff from all centres across Wales. The feedback from these sessions has been shared with the senior leadership team in EMSC and has been incorporated into the cultural action plan.. A slight increase was noted in October for shift overruns and the correlation with increased handover lost hours. 111 Call Handler Establishment is recovering heading toward the winter period. Progress in promoting Welsh language use among 111 staff and the positive impact on call handling in 111 and NEPTS.
8. **Carl Kneeshaw** joined his first meeting of the committee as the Director of People and was warmly welcomed.
9. **Reflections** on the meeting were that the members felt that the discussions were less transactional and more 'future-focused' than has been the case in previous meetings. There was a sense of progress and engagement in various initiatives, such as the change management community and the health and well-being activities. Members noted the importance of maintaining a holistic view of people and culture activities and ensuring that the narrative and conversations aid the Committee in connecting the dots across various plans and priorities within the Trust's strategic plan. Additionally, there was consideration of how best to facilitate the meeting in a hybrid manner and the most appropriate use of the chat within the Teams meeting. The Chair will consider any necessary adjustments required for future meetings.

ASSURE

(Detail here any areas of assurance the Committee has received)

10. The Committee received the **People and Culture Plan Metrics** (quantitative this quarter) and the **MIQPR** for September 2024. Given the fact that the Board does not receive all these metrics in the MIQPR, the following areas of assurance will be of interest.



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- The increasing number of disciplinary cases was expected, and a sign that our people feel more comfortable speaking up. The recent Sky News piece on sexual safety highlighted again that there is work still to do across the ambulance sector, and that the work WAST is doing is influencing this more widely. The significant toll these cases take on those investigating, supporting and those accused was recognised. The Audit, Risk and Assurance Committee were recently assured on our speaking up arrangements and the CEO roadshow included a focus on speaking up, with board members pledging their support.
 - A significant increase in colleagues joining various staff networks indicated positive engagement and a willingness to contribute to cultural change within WAST.
 - A sustained improvement in sick absence rates across the organisation was noted, attributing this to the efforts of managers, people services, trade union partners, and early intervention support from occupational health.
 - Challenges with PADR compliance was acknowledged, with ongoing efforts to ensure they are meaningful and valuable to all parties.
 - The significant progress in addressing job evaluation cases was noted, with thanks to the efforts of Trade Union Partners and the People Services Team.
 - A downward trend in turnover was welcomed.
 - There is ongoing work to address data quality issues, particularly in health and safety metrics.
11. The Welsh Ambulance Services Partnership Team (WASPT) is the board's local partnership advisory forum. The **WASPT highlight report** sets out the ongoing projects, upcoming challenges, and the steps being taken to address them in partnership. The following was noted from the WASPT meeting on 25 September 2024:
- Our approach to partnership working was noted as being advanced across NHS Wales and wider public sector with challenges being working through in a collegiate fashion.
 - Progress was noted on transitioning Emergency Medical Technicians to band 5, with partnership notices issued to set out arrangements. This includes addressing backpay timing and necessary training over the coming months.
 - The meeting discussed historical challenges during the festive period, such as low Unit Hour Production and staffing issues. Various options were considered to manage these challenges and the 15 November WASPT meeting will look at these.
 - The report highlights efforts to enhance collaboration and joint problem-solving within the Trust, including observing and reflecting on partnership behaviours and conflict management styles.
 - Various health and safety initiatives are taking place with respect to diesel fumes, including the pilot of extractor fans with filtration and plans to employ a fixed-term occupational hygienist to assess air quality. A spotlight communication on diesel fumes has been issued but concerns remain, with discussions to continue at the WASPT meeting on 15 November.
12. **Health and Safety Report for Q1 and Q2** was presented and the committee noted:
- Although there have been improvements in fire safety training, compliance with statutory health and safety and fire safety training still falls short of both the Trust's and the Welsh Government's required standards. Managers are encouraged to ensure all staff meet the required training levels, with compliance monitoring conducted through business meetings to raise awareness and compliance among staff.



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- RIDDOR reporting compliance improved from 40% in Q1 to 72% in Q2, despite challenges due to additional HSE requirements. Manual handling of patients and slip trips and falls continue to be the main themes.
- There is sustained focus on managing diesel fumes, with a dedicated project manager overseeing this.
- The CEO's podcast on effective health and safety was featured on an international platform, highlighting its importance.

13. The **Nursing and Midwifery Council (NMC) registration and revalidation** report for 2024 provided assurance of 100% compliance during 2024.
14. The **Audit Tracker** was reviewed, and the Committee noted the update and that there had been good progress in closure of internal audit actions for the quarter, which some historic actions still proving challenging, particularly on the Trade Union Release Time audit. There were revised dates for all outstanding external audit actions from the 'Review of the Workforce Planning' audit.
15. In private session the committee reviewed progress against eleven **suspensions over four months** which is an increase from seven reported in the last quarter. However, it was explained that a number of these cases were scheduled for hearings in November. Four cases are with the **Employment Tribunal** (a decrease of one from the previous quarter). Members were assured on actions in place to manage these cases.
16. Members received the Cyle of Business **Monitoring Report, and the Committee priorities update** with no issues to escalate.

RISKS

Risks Discussed: The four risks within the remit of this Committee were reviewed and it was acknowledged that these had been discussed throughout the items within the agenda:

160 – High absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service - whilst there has been a significant reduction in absence levels, the score of 20 (5x4) remains static however, this will remain under review given the significant work undertaken to strengthen the controls, assurances, and mitigating actions. The position in August that showed an uncommon but positive decrease in levels for that period and the data will be assessed over the next four months to establish whether the improvement in levels is sustained. Should this be the case, then it is likely that this risk score will be reduced.

201 – Damage to the Trust's reputation following a loss of stakeholder confidence which remains at a score of 20 (4x5). The risk is inextricably linked to several of the metrics measured and discussed at PCC.

163 – Maintaining effective and strong Trade Union partnerships has reduced in score from 16 (4x4) to 12 (3x4) reflecting the positive engagement and partnership working operating well and ongoing discussions on a range organisational change issues.



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558 - Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences remains unchanged at a score of 15 (3x5).

The Committee acknowledged risks **223 and 224** overseen by the Quality, Safety & Patient Experience Committee; however, considered at each of the Board Committees given they impact every area of the Trust.

New Risks Identified: No new risks identified at this meeting for the register.

COMMITTEE AGENDA FOR MEETING

Director Update	Operations Quarterly Report Q2	Staff Story and Staff Story Update
People and Culture Plan Metrics	Workforce scorecard	MIQPR
Health and Wellbeing Plan	Change Management	WASPT highlight report
Revalidation and Registration (NMC)	Risk Management and BAF	Health and Safety Report
Audit Tracker	Policies for approval	Cycle of business and monitoring (consent item)
WASPT Minutes (consent item)	Assurance to ARAC re speaking up safely (consent item)	HCPC revised standards of conduct (consent item)

COMMITTEE ATTENDANCE

Name	9 MAY 2024	8 AUGUST 2023	16 NOVEMBER 2023	20 FEBRUARY 2024
Ceri Jackson				
Bethan Evans				
Joga Singh				
Hannah Rowan				
Angela Lewis				
Carl Kneeshaw				
Chris Turley		Left at end of item 13		
Lee Brooks	Sonia Thompson			
Liam Williams	Jonathan Turnbull-Ross			
Estelle Hitchon				
Andy Swinburn				
Alex Crawford				
Trish Mills	Julie Boalch			
Damon Turner				
Marcus Viggers				
Christian Fox	Hugh Parry			
Tim Cahalane				

	Attended
	Deputy attended
	Apologies received
	No longer member



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Director Update: *People & Culture*

PEOPLE AND CULTURE
COMMITTEE
18 FEBRUARY 2025



CARL KNEESHAW

DIRECTOR OF
PEOPLE

ANGIE LEWIS

DIRECTOR OF
CULTURE CHANGE

Culture

We're thrilled to share that our EDI Team has been invited to attend a round table discussion in the House of Lords on Tuesday 11th March. The International Womens Day event is being hosted by Dame Tanni Grey-Thompson who will be discussing gender equality matters with specially selected guests, our OD Manager, Hayley, being one of them. Hayley has been invited following her work with the Mastering Diversity Conference. This is a fantastic opportunity to showcase the strides we're making in promoting equality, diversity, and inclusion, and to contribute to important conversations on gender equality at a national level.

Following the implementation of our People and Culture Plan, we're pleased to share updates against key pieces of work under the themes of **Culture**, **Capacity** and **Capability**. As well as delivering on our ambitions, our focus is now on embedding the Plan throughout the organisation, continuing the conversations and assessing impact.

Carl has enjoyed getting out and about to meet the teams and in December, he was able to present several members of our Education and Development Team colleagues with their King's Coronation Commemorative Coins and Medals, during a visit to our Workforce Education and Development Centre (pictured).



Continued investment over the past year into our people networks has resulted in progress across a number of areas. Our Network Chairs have led the initiatives and applications for our Trust to be recognised for the support it provides to our workforce and subsequently, within the past 6 months, WAST has been awarded a Stonewall Bronze Award and climbed over 100 places in the Workforce Employer Index, achieved Disability Confident Employer 'Commitment Status' and Carer Confident Employer Award Status.

Our Culture Champions Network continues to thrive, now with 161 members, and 68% of these coming from operational roles. The "Demystifying Culture" workshop has engaged 54 participants so far, while the Leading by Example induction programme — now on its ninth session — supports champions in their roles, with additional sessions planned to meet growing interest. Culture Champion Open Day events are being held at stations across Wales, enabling conversations about culture, sharing information about the network, and welcoming new members. A huge thank you to all our Culture Champions for helping to drive positive change across our organisation. More exciting developments to come in 2025!

Capacity

Since the introduction of the new All Wales Flexible Working Policy in August, 225 applications have been processed across directorates, with the majority being accepted. Coaching sessions to support managers in confidently handling flexible working requests will shortly begin, reflecting our commitment to fairness, equality, and improving colleague experience. By supporting flexible working, we aim to reduce turnover and enhance retention.



Dr. Catherine Goodwin presenting at the Tackling Workplace Sexual Harassment in the Public Sector conference

We're pleased to announce the launch of our new 'Moving On Conversation' process in January. To support this initiative, awareness sessions will be offered, empowering leavers to complete the questionnaire independently, with their manager or with a People Services colleague. The insights from these conversations will provide a deeper understanding of reasons for movement and departure plus valuable feedback on factors influencing colleague experience. This initiative is integral to our aim of reducing turnover, improving retention and enhancing recruitment by addressing key trends and themes impacting our organisational culture at a local level.

We've seen a positive response to the recent Siren notice encouraging frontline colleagues to take up the pertussis vaccine, helping to protect pregnant mothers and infants within our population; flu vaccine uptake has failed to gain momentum, however. Flu clinics continue to be advertised on Siren, with both OH and peer vaccinators offering the flu vaccine until the campaign concludes at the end of February.

Capability

We continue to implement our plans to promote sexual safety within the workplace with our WAST Voices leading educational campaigns and helping to develop our sexual safety training sessions. The next steps will be to pilot the training within some of our EMS Teams focusing on sexual safety, inappropriate behaviours and professional boundaries. In January, Dr. Catherine Goodwin represented WAST at a conference for Wales' Public Sector Leads (pictured) around "Tackling Workplace Sexual Harassment in the Public Sector", bringing expert experience and skills to enhance our collective approach to preventing and addressing sexual harassment in the workplace.

Catherine also joined Dr Adam Cann providing emotional support to the 230 people attending AACE's latest Uncomfortable Conversations webinar series, this time about Suicide, with experts and those with lived experience talking about suicide within the ambulance sector.

We're currently reviewing the latest round of bursary applications, a key initiative in our ongoing commitment to support and enable continuous professional development across the organisation. These bursaries help provide colleagues with the opportunity to further their education, skills and knowledge, which directly contributes to building a highly skilled workforce that can meet the evolving needs of the service.

To better prepare colleagues progressing to the role of EAP, the Education team have developed a Level 3 Award in Coaching through ILM. As part of this qualification, the EAPs have gained an understanding of the tools and techniques that can be used to facilitate an effective mentoring relationship. They are further supported by the E&D team, who have been providing feedback on their chosen approaches, mentoring plans and sessions held with their mentees.

We're currently recruiting for Essential Skills Tutors, which is a significant step forward in our ambition to enhance colleague experience and support the professionalisation of our services. By bringing these tutors on board, we will be able to offer our people the opportunity to gain Essential Skills qualifications such as literacy, numeracy and digital literacy internally, negating the need for external college enrolment and empowering colleagues to progress within the Trust.

This initiative is directly aligned with our strategic workforce plan, encouraging ongoing development, investing in our people and strengthening our employee offer. It reflects our commitment to creating a supportive environment where colleagues can build the skills they need to thrive and grow, ultimately cultivating a more capable and engaged workforce.



Challenges & Risks



- Winter pressures
- Pace of change and activity across the Trust
- Shift overruns

Coming Up

- CEO Roadshows w/c 7th April 2025
- Staff Survey results (March 2025)



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OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2024-25 Q3 (October – December 2024)

National Operations & Support

General Update

Specialist Operations Response Team (SORT) Enhancement

Following the successful award of funding from Welsh Government earlier this year on the SORT enhancement business case, work is progressing well to roll out the enhancement across Wales. A Senior Paramedic has been recruited who will join the team shortly, making a welcome addition to the HART and SORT clinical capabilities. A SORT Operations Manager has also been recruited and is due to take up post in January. SORT awareness sessions have taken place across North and South Wales and the equipment funded as part of the business case has been procured and is therefore complete. Vehicles however could not be secured in year with the time available since the award was confirmed, and colleagues are actively engaged on rolling capital budget forward.

Volunteering

The Volunteer team has successfully completed an Organisational Change Process (OCP) and is now operating in the new Function Based Model. This will bring efficiency across the team and streamline recruitment and onboarding as the new model of working takes effect. Additionally, our new Volunteer Management System "GO Assemble" has now been configured and is live across the volunteer team, with a phased launch to volunteers scheduled to roll out from January.

In October we held our Volunteer Conference in a new and successful hub and spoke format, with the conference held in Llandudno and streamed to Swansea with over 100 volunteers attending both events.

Grenfell Fire Inquiry Report

The EPRR team have undertaken a review of the two published Grenfell Inquiry reports. The fire at Grenfell Tower in West London in the early hours of 14 June 2017 spread rapidly, tragically causing the death of seventy-two people. Our assessment of the recommendations from the two Inquiry reports have been presented and compared with the recommendations from the Manchester Arena Inquiry (MAI). Our review found no additional actions that the Trust need consider, with the Grenfell recommendations mirroring the recommendations from MAI. This output however has been considered by the Executive Leadership Team and subsequently submitted as supplementary evidence to the MAI submission to commissioners.

Manchester Arena Inquiry (MAI)

Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes.

Resourcing, EMS Coordination and Quality

Challenges

HM Coroners (HMC)

The Operations Quality team continues to receive coroner requests meaning that the backlog of statements remains present. Capacity within Operations Quality (OQ) continues to be realigned where possible to support with the construction of statements and a robust quality assurance process is in place to ensure that accurate statements can be reviewed and signed by the Locality/Service Managers in EMS Coordination for serving to HMC. Any requests from HMC to prioritise or final deadlines are prioritised dynamically. Following the EMS Coordination (EMSC) reconfiguration, more capacity from EMSC Service Managers will now be aligned to coroner statement completion, which it is anticipated will help to manage the ongoing demand from HMCs across Wales.

Red Code Breathing Problem

The Operations Quality team has been examining the increase in incidents related to ineffective breathing (Red) over an extended period. Numerous reports have been prepared for both the Operations Senior Leadership Team and the Executive Leadership Team, reviewing the rise in Red calls since 2019. There has been a sustained increase in Red calls related to breathing problems since 2019, with a further notable escalation occurring in 2024. Previous SBARs identified issues with call coding and recommended measures, such as training EMS Coordination staff and clarifying call processing post-Red Review.

Detailed analysis targets the top five MPDS determinants for breathing problems, especially the 06E01 code, and examines age-related variations, focusing on the 0-4 age group. Several process changes may have contributed to the increase in ineffective breathing Reds, including modifications to Echo determinant codes, the introduction of Red Review, and pandemic protocol adjustments. An extensive MPDS audit revealed a significant proportion of non-compliant calls, identifying instances of over-coding. Concerns also exist regarding under-coding within this chief complaint, which is a challenge reported by other ambulance Trusts as well.

The analysis indicates a decline in the proportion of 06E01 incidents resulting in hospital transport, with a rise in those treated at the scene or using their own transport after ambulance arrival. There has been a notable increase in 06E01 incidents originating from 111 calls, particularly within the 0-4 age group, suggesting possible over-triaging. Immediate actions have been taken for clinical validation before such incidents are transferred from 111 to 999, and efforts are ongoing to understand the issue between the Integrated Care and EMS Coordination teams.

IMTP

E-Timesheet Workshop

In November stakeholders from across the Trust and partner organisations, including Trade Union Partners, met to discuss the implementation of the electronic timesheet within our current rostering system. This project has been on the agenda for some time, but this date marks a significant step forward, moving into the scoping phase of the project with implementation planned for 2025. It was useful to understand the key issues and challenges, but with a clear focus from all present that this is an area that we need to progress for the benefit of all colleagues. The inaugural Project Board will be in January 2025 with the Assistant Director of Operations, Resourcing and EMSC as the Senior Responsible Owner. The project documentation is currently being drafted to ensure that all the requirements, benefits and risks to the project are clearly set out.

General Update

EMS Coordination Restructure and Reconfiguration

The restructure and reconfiguration programme went live on the week of the 25 November 2024. This is probably the most significant change our control rooms have experienced in decades and marks the start of a new era for EMS Coordination with improved ways of working, a much-needed progressive career structure, and capacity to better support our people. Over the last few months, the team have been actively recruiting into the centres and have appointed four new Locality Managers, which includes one for each EMSC centre and the fourth to manage the Clinical Navigators. Alongside this we have also appointed seven Operations Managers to provide 24/7 coverage across the 3 centres and to be the first point of contact for any significant or critical incidents which may occur.

Rapid Clinical Screening

On 4 November 2024, we welcomed nineteen Clinical Navigators into EMS Coordination. These roles are vital as we move into the first phase of our Clinical Services Model. Our new Clinical Navigators commenced their training ready for the Rapid Clinical Screening go live on 18 November. This was the first cohort of Clinical Navigators, and we will welcome a further six colleagues who join us from other NHS organisations in January 2025. This marks the first major step forward into our new model and will be an exciting time for the Trust as we start to shape the future service offer.

Medical Transfer Protocol Suite (MTPS)

MTPS is a suite of three Medical Priority Dispatch System (MPDS) protocols for interfacility (hospital) transfers for use by health care professionals. A review of the success of these protocols is ongoing and analysis of the non-emergency protocols so far has been positive. The emergency protocol (Protocol 45) has shown a high ratio of reds. Whilst these meet the operational performance target for reds, a paper is being refined with the findings and options to address any identified issues.

Emergency Medical Service

Challenges

Powys Major Incident Train Crash

WAST declared a Major Incident on 21 October 2024 for a train crash at Stay Little (Talerddig) Powys. The crash involved two passenger trains with initial reports indicating a high number of casualties. WAST declared a level 5 Major Incident and mobilised over 20 resources to the

scene including EMRTS and HART. As the incident progressed and more information was available from the scene, it became apparent that the patient numbers were not as high as initially thought and some resources were stood down.

WAST treated 15 casualties, the majority of which were minor injury patients with 1 deceased patient on scene. An internal debrief has been held and WAST has hosted the multiagency debrief. Both reports are being collated, but initial lessons identified include the challenges associated with a rural location, access for commanders to the scene and the need to activate the command groups promptly. Unsurprisingly, there are some synergies with some recommendations made to commissioners following our work focussed on the MAI.

December Critical Incident

On Monday 30 December, the Trust experienced high activity following the Christmas break, compounded by significant lost capacity due to handover delays, which severely hampered our ability to respond effectively. As the day progressed, the number of waiting incidents escalated, leading to increased community wait times. In response, the Trust initially escalated to REAP Level 4 (Extreme Pressure), prioritising all available capacity to front line services. However, this proved insufficient to meet the demand levels, necessitating the declaration of a Critical Incident. At the peak, more than 400 calls were awaiting ambulance response, and consistently over 50% of emergency ambulances were unavailable due to handover delays. The situation was further exacerbated by high rates of respiratory illness, resulting in extremely high hospital bed occupancy and reduced patient flow.

Command arrangements were established and remained in place until the incident was stood down in the early hours of 1 January. Activity on 31 December offered some respite, allowing the team to recover the waiting incident numbers. The evening of New Year's Eve, while busy, was fortunately uneventful and this may have been helped by the high profile and proactive media engagement.

IMTP

Advanced Paramedic Organisational Change Process

Operations and Clinical teams are working together to align the APP structure as part of the Trust's transformational work which will see a senior APP role at Band 8a and other APP roles including prescribing at Band 7. An OCP is currently underway for this work. The 24/25 APP recruitment process is well underway with applicants being appointed from both internal and external environments with final advert being released for the March term.

EMT Transition Programme

Further to the Trust's EMT transition programme to enhance the training and education of EMT2 to Emergency Ambulance Practitioners, we are now working closely with the Learning and Development team to ensure that all EMT 2s who are eligible and wish to undertake the EAP training is allotted a place on an available course. Courses are running into 2026.

General Update

Quality & Support Days

The Operations Directorate completed an operational effectiveness Quality and Support Day on Monday 28 October to further work to improve compliance against key performance indicators and to provide feedback to operational staff. While overall results were positive, the feedback did highlight a need for further consolidation of the hospital dual pin handover processes. Heads of Service and Service Managers have secured time on new starter courses and next year's MIST courses to reinforce and refresh all operational effectiveness items such as key performance indicators and dual PIN handover.

End of Shift OVERRUNS EMS

To further support the work to reduce end of shift overruns, another end of shift handover POD is operational in Glangwili Hospital, Carmarthen. Due to the rurality of Hywel Dda it is hoped that this will make a difference to staff wellbeing and prevent lengthy end of shift overruns. This is a milestone for Hywel Dda, and once a brief period of evaluation has taken place, the local team will look to roll out similar infrastructure on Worthybush and Bronglais sites.

Palliative Care

To further consolidate the End of Life Care work in the Swansea Bay Health Board area, Hywel Dda has established a 6 month trial of a Palliative Care Paramedic response car to provide essential advanced knowledge and treatment regimes for the complex needs of End of Life Care patients.

Ambulance Care

Challenges

NEPTS Roster Review

Work has continued to progress a service wide review of NEPTS rosters. This is the first ever national review of the services rosters and should hopefully deliver improved performance and efficiency. ORH have produced roster keys, which have gone through internal validation and the review will now move to the engagement and consultation phase.

Service Performance

Maintaining recent performance levels has become more challenging in the face of increasing pressures in planned care activity and the need to operate within the available resource envelope. Engagement with the commissioners has begun to identify solutions to address these challenges and to ensure the service remains in a robust position to continue to support planned care recovery in the future. The Trust is holding out not to return to our previous overspend position.

Recruitment Following Transition

Following recent EMT recruitment and many of the successful candidates being from ACA2 roles, this has left a reduced workforce in a number of areas. As EMT transition courses continue, this has limited the the availability to source additional training capacity. While there are pre-planned ACA courses, these were planned over 12 months ago to cover normal recruitment and attrition and will not provide adequate capacity to meet the required demand. Where budget is available, the service will utilise alternative resource options to address areas of sub-optimal resourcing.

IMTP

End of Shift OVERRUNS UCS

The Ambulance Care team have been focused on reducing shift end over runs for the Urgent Care Service line. Initial focus was on reducing overruns greater than 2 hours, this was refocused to 90 mins+ in the summer after significant improvements were observed and 2hr+ overruns were almost eradicated. Following further improvements in the 90+ sector, the team will further reduce this target to 60 minutes from January 2025.

Ambulance Care Practice

Work to focus the Urgent Care Service on its core purpose, and ensure that UCS staff work only within their scope of practice, has progressed well and the calls allocated to the service are now much more aligned. Further work will commence in early 2025 to introduce a number of ambulance care practice development roles that will help review and develop Ambulance Care practice across all service lines. This will be a first for this area of the business and will also complement succession planning and service integration across operations.

General Update

Quality Assurance

The NEPTS service has continued to utilise and develop its balanced scorecard approach to performance management. This is gathered via a dashboard which includes activity, performance, staff compliance, patient experience and management compliance measures. The dashboard is informed not only by data from WAST systems, but also from patient feedback gained via online, postal and text patient surveys and annual birthday calls for regular travellers. The outcomes of the dashboard are used to identify areas of development for the service that can improve experience and outcomes.

Integrated Care

Challenges

Establishment

Recruitment for 111 call handlers across Wales has presented ongoing challenges, but we are committed to addressing these obstacles and improving our staffing levels. Despite difficulties, we've successfully recruited 65.4 full time equivalents to join the 111 Call Handling Team resulting in much improved levels of resourcing going into the winter period.

The establishment of clinicians has faced some challenges due to staff transitioning into new roles within the Clinical Navigation team. However, we have maintained a stable UHP despite these changes. To address this, we are actively recruiting and have enhanced our recruitment strategy to ensure we attract the best candidates.

The recruitment plan for band 6 clinicians is progressing well, with the three planned cohorts already advertised. Cohort one will start on 6th January 2025, cohort two on 24th February 2025, and cohort three on 7th April 2025. Additionally, two more inductions are planned for the summer months, with these still to be advertised. We're confident that these efforts will strengthen our team and support continued growth.

The Duty Operations Manager (DOM) team establishment is also challenged, and we are actively recruiting to backfill these positions. There are three vacancies to fill, two have now been recruited into with a start date of 20th January 2025. The third vacancy is actively looking to be backfilled.

Sickness

Sickness absence remains a cause of concern across Integrated Care despite considerable efforts to target the causes of sickness absence. Integrated Care is taking the necessary steps to understand the key drivers and develop meaningful interventions. Integrated Care has commenced a trial with Occupation Health to allow those colleagues who are unwell to get access to immediate occupational health and wellbeing support.

Mental Health Response Vehicle (MHRV)

Following a successful trial, the availability of the MHRV has been expanded across 3 Southeast health boards, 7 days a week between the hours of 1300-0100. A Senior WAST Mental Health Practitioner and Emergency Medical Technician will work together on the vehicle to assess and treat patients in the community for a timelier response, and to reduce avoidable hospital admissions.

The Mental Health Response Vehicle (MHRV) has been active since the 3rd of November 2024. Recent recruitment has increased the number of Mental health practitioners (MHP) from 8 to 10, with the 2 additional remaining in training until 17th January 2025. The MHRV has responded to 144 patients where 40.2% of those patients were treated at scene. and a further 9.38% conveyance rate. The average time on scene for the MHPs has been 41:08 minutes.

Clinical Model Transformation

The Clinical Model Transformation has continued to be a significant focus throughout this quarter. Below are some of the recent works and upcoming implementations:

- **Rapid Clinical Screening** includes high acuity live review, queue safety, remote clinical support, and green call screening, all of which are operational. Screening of Amber 2 calls is scheduled to go live the week commencing 16th December. Screening of Amber 1 calls is set to go live at the end of January, coinciding with the commencement of the remaining appointed clinical navigators.
- **Call Categorisation** is currently with WG for approval and undergoing review. Findings will be communicated once available.
- Remote Integrated Care Service has **Care Planning** now live and the **CPSS winter desk** is now also live. Capacity has been freed up in CSD to conduct remote clinical assessments on 999 screened calls. 111 access to 999 pathways is available and live, providing greater access to urgent primary care appointments.
- Urgent Community Response Service has developed an appointment scheduling SOP, which will be presented to STB with recommendations. APP OCP is underway.

Welsh Improvement Plan 2024

The 111 Service Welsh Improvement Plan 2024 addresses the challenges and measures implemented to enhance the performance of the 111 service in handling Welsh-language calls. Performance at the Start of 2024 answer rate ranged between 50–58% and has increased to 75%. During the summer, a targeted plan was developed to address the issues and improve the Welsh-language call handling this is ongoing, and work will continue to improve access for our Welsh speaking callers. Integrated Care was very honoured to receive a Trust award for the work that has been completed to increase access ongoing.

Quality & Support Days

Integrated Care has successfully introduced monthly Quality and Support Days across Wales, with four highly successful events already completed. During these days, Integrated Care Managers have met with as many staff members as possible, fostering open conversations and increasing their visibility within the workforce. These events have generated valuable insights and data, with key themes covered across the days:

- Day 1: Performance and Understanding Performance
- Day 2: Communication and Workplace Morale
- Day 3: Sexual Safety and Reporting
- Day 4: 'You Said, We Did' – A review of feedback from the previous quarter

The feedback has been overwhelmingly positive, and we are excited to continue this model, aligning it with the excellent results from our recent staff survey. This initiative is helping to strengthen communication, improve staff morale, and ensure that we continue to evolve in line with the needs and suggestions of our teams.

Ela Lewis' Story

Golden Threads in Change Management

Importance of Compassionate Leadership:

- Enabling a supportive and psychologically safe environment where people can communicate their anxieties.
- Change can be difficult, important to actively listen and ensure people feel that their contribution and efforts are valued.

Key Take Aways:

The tools that were shared during the programme have been applied to support navigation of colleagues through the change process and work collaboratively to overcome challenges and achieve a shared vision.

Next steps:

Foster Collaboration and Harness Expertise: To promote a culture of collaboration by engaging individuals from within and outside the organisation to work towards a shared objective. Leverage the diverse expertise and perspectives of team members, stakeholders, and partners to drive innovative solutions and successful change initiatives.

Monitor, Evaluate Progress and Celebrate Successes: Recognise and celebrate milestones and achievements to maintain morale and motivation. Share success stories to highlight the positive impact of change. Encourage a culture of continuous improvement by fostering a mindset that embraces ongoing change through celebrating successes.

Create a Psychologically Safe Environment: Provide opportunities for colleagues to contribute ideas for future improvements. Enable colleagues to share concerns and frustrations to work towards a solution. Remain compassionate whilst recognising the complexity of change.



Volunteer Experience: Volunteered in local and international health and social care settings, which provided exposure to different cultures, perspectives and care modalities.

Frontline Experience: Pursued a career in nursing and worked within an intensive care unit. The COVID-19 pandemic demonstrated the impact of large-scale change and the need for compassion during the change process.

Exposure to Public Sector: Transitioned from frontline nursing to a graduate role in Academi Wales leadership programme, focusing on enabling community-based management of care through collaboration within the Welsh public sector.

WAST: Joined WAST to enable innovation within remote care delivery, leveraging both nursing and project management skills to enable clinicians to individualise care and harness technology to meet the urgent and emergency care needs of the patient.

AGENDA ITEM No	09
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	3

Our WAST Way Update: Transforming Leadership and Culture at WAST

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Angela Lewis, Director of Culture Change
AUTHOR	Sara Mills, Head of Culture and OD
CONTACT	Sara.mills@wales.nhs.uk

EXECUTIVE SUMMARY

- Purpose:** This paper introduces *Our WAST Way*, provides an update on progress and outlines the next steps for implementation.
- Progress:** Leadership behaviours are finalised, interactive resources and Management Essentials are in development and the Pathway Pioneers Group is being established to support implementation, development and testing.
- Next Steps:** *Our WAST Way* will launch in Q1/Q2 2025, including the interactive brochure, Management Essentials and initial learning opportunities. Future phases will introduce tailored learning paths and integrate the framework into key processes, such as PADRs and recruitment.
- People and Culture Committee Role:** Provide constructive feedback during implementation, champion the importance of *Our WAST Way* and support its alignment with WAST's strategic goals.

RECOMMENDATION:

- The PCC is asked to **RECEIVE** and **COMMENT** on the content of this update and **COMMIT TO** the role of PCC in this agenda.

KEY ISSUES/IMPLICATIONS

As above.

REPORT APPROVAL ROUTE

People and Culture Committee 18th February 2025

REPORT APPENDICES

- 1 Sam & Taylor's Story – A vision for Our WAST Way
- 2 Final Leadership Behaviours PDF
- 3 Our WAST Way Learning Path Example

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	Yes
Environmental/Sustainability	NA	Legal Implications	Yes
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	Yes	Risks (Inc. Reputational)	Yes
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	Yes	TU Partner Consultation	Yes

6. Introduction

This paper introduces *Our WAST Way*, a progress update and next steps for its implementation.

At WAST, we know that compassionate, inclusive, and collaborative leadership is more than a set of ideals, it is grounded in research that consistently links this leadership approach to better patient outcomes and high performing teams. [Studies from the NHS and other sectors](#) show that leaders who demonstrate care, build inclusivity and connection enable more engaged, motivated and innovative teams, creating workplaces where people can thrive and deliver the best possible care to our patients.

This vision comes to life through *Our WAST Way*, our new leadership and management framework. It sets out clear leadership behaviours based on three core principles:

- **Care:** Supporting others, understanding their challenges and looking after personal wellbeing to perform at our best.
- **Valuing Everyone:** Building an inclusive, respectful culture where diverse perspectives are sought, heard and acted upon.
- **Connect:** Strengthening collaboration, communicating purpose, leading through change and inspiring others to deliver results.

This vision is illustrated with 'Sam and Taylor's story' – personas we have created to bring the vision for Our WAST Way to life (appendix 1a).

These stories reflect the transformative potential of *Our WAST Way*. By embedding these leadership behaviours across the organisation, we will build a culture where leaders, teams, and patients flourish.

7. Why This Matters

Our WAST Way places emphasis not on the technical skills of a leader's role, but on *how* they lead and interact with others. It complements technical and professional capabilities rather than replacing them.

The framework is designed to:

- Develop behaviours that create a positive and supportive workplace culture.
- Empower leaders at all levels to inspire and engage their teams.
- Enhance staff retention, wellbeing and support service transformation.
- Build an effective and capable leadership pipeline to prepare WAST for the future.

By promoting clear and consistent leadership behaviours, *Our WAST Way* will transform WAST into an organisation where people are inspired to work, grow, and lead.

8. Progress to Date

a) Leadership Behaviours Finalised (appendix 1b)

- Developed around our principles of *Care*, *Valuing Everyone*, and *Connect*, the leadership behaviours are tailored to align with different leadership levels, from leadership for all to first-line managers to executives.
- Engagement with a range of stakeholders, alongside research and consultation, shaped both the positive behaviours we aspire to and the counter behaviours we aim to leave behind.
- The behaviours of *Care*, *Valuing Everyone*, and *Connect* are now established as cultural drivers, complementing technical and professional competencies. These align with our 'OUR Best' organisational behaviours, ensuring continuity and relevance (see appendix 1b). Work is underway to incorporate 'OUR Best' behaviours into these core principles. The leadership behaviours were developed from 'OUR Best' and integrating these principles will better articulate the culture we are moving towards, making it more memorable for staff. This evolution builds on the existing behaviours, rather than replacing them.

b) Engaging, Accessible Resources

- We are creating an interactive digital brochure that presents the leadership behaviours in an engaging format. This will support leaders to reflect on their strengths and identify growth areas.
- The brochure will also guide leaders on how to navigate transitions between operational and strategic roles.

c) Management Essentials

- This foundational programme and resources hub focuses on essential people-management skills, such as managing difficult conversations, onboarding and managing employee development.
- It aligns with *Our WAST Way* behaviours to ensure consistency and relevance.

d) Pathway Pioneers Group (PPG)

- A diverse group of staff from across WAST is being established to provide feedback, test resources and act as advocates for the framework.

e) Stakeholder Engagement

- Input from staff at all levels has informed the framework, with further engagement planned through workshops, leadership events and future development sessions.

9. Next Steps

a) Learning Paths (see appendix 1c for example)

We are developing tailored learning paths for four leadership levels:

1. Leadership for All
2. First Line Leadership
3. Senior Leadership
4. Executive Leadership

The learning paths will provide leaders with tools and opportunities to reflect on their strengths, identify areas for growth, and create personalised development plans. This will include a self-assessment tool, on-demand learning, coaching and mentoring, and access to structured development programmes, as well as suggestions for ways individuals can develop in their role, e.g. through stretch projects and additional temporary responsibilities.

In time, formal learning programmes with potential accreditation or certification will be introduced to offer recognised qualifications aligned with leadership journeys.

b) Phase 1 Rollout (Q1, Q2 2025)

The initial rollout will include:

- Launch of *Our WAST Way* with the interactive brochure, Management Essentials, and early learning opportunities.
- Workshops (virtual and in-person) to familiarise managers with the framework and prepare them for meaningful development conversations.

c) Continuing Development (Q3, Q4 2025/26)

- Integration of *Our WAST Way* into key processes, including PADRs, recruitment, and onboarding.
- Further development of formal leadership programmes at multiple levels (First Line, Senior, and Executive Leadership).
- Ongoing evaluation and refinement based on feedback and engagement.

d) Long-Term Plans (2026 and beyond)

- Introduction of a 360-feedback tool for senior leaders to support individualised development through insights from teams and stakeholders.

- Embedding succession planning and talent management into the framework to ensure a sustainable pipeline of capable leaders.

10. What We Need from You

- Understand the Vision:** Familiarise yourselves with the principles and behaviours underpinning the framework and how they support WAST's strategic objectives.
- Champion the Framework:** Advocate for *Our WAST Way* as a critical tool to transform our leadership culture, ensuring alignment with organisational priorities.
- Support Implementation:**
 - Help secure the necessary resources and time for effective implementation.
 - Encourage alignment of *Our WAST Way* with existing systems and processes.
- Provide Constructive Feedback:** Actively contribute insights during implementation, particularly regarding:
 - The alignment of the framework with WAST's overall strategy.
 - Areas where further adjustments may enhance its effectiveness.
- Monitor Progress:** Play an oversight role by reviewing updates on engagement, impact and key milestones, ensuring the framework achieves its intended outcomes.

11. Conclusion

Our WAST Way is more than a leadership framework—it's a cultural transformation that places people at the heart of everything we do. By equipping our leaders to lead with Care, Value Everyone, and Connect, we can create a workplace where every team member feels supported to deliver their best.

With your support, we can make this vision a reality, ensuring WAST is an inspiring and inclusive place to work, grow and lead.

12. Appendices

- 1a. Sam & Taylor's Story – A vision for *Our WAST Way*
- 1b. Final Leadership Behaviours PDF
- 1c. *Our WAST Way* Learning Path Example

Sam's Story: Building a Career in Leadership

'Sam' joined WAST as a Control Centre Service Manager, drawn by the organisation's commitment to leadership development and a positive workplace culture. They were thrilled to join an organisation where leadership was about inspiring others and making a difference.

A Positive Start

From the beginning, Sam noticed WAST's focus on aligning leaders with its behaviours. The recruitment process emphasised finding leaders who could build a positive team culture and show Care, build Connections, and Value Everyone. Upon joining, Sam was introduced to Our WAST Way—a clear and practical framework that set out what great leadership looks like at WAST. They also accessed Management Essentials, which offered helpful tools to navigate key responsibilities like onboarding and managing team development. Even with their prior management experience, Sam found these resources invaluable and felt supported as they settled into their role.

Growing Through Leadership Development

Sam's journey into leadership development began with bite-sized, self-service resources available through Our WAST Way. Short online courses allowed them to explore leadership behaviours and how to lead in a way that supported WAST's culture. These courses fit neatly around Sam's busy schedule, and their line manager made it clear that leadership development was a priority—not just something to squeeze in when convenient. For example, when onboarding new team members, Sam didn't just follow processes—they focused on creating a positive and inclusive experience. By making each new colleague feel valued and supported, Sam saw their team members grow more confident and engaged from the start.

Growing Through Feedback

As Sam settled into their role, they approached their first Performance and Development Review (PADR) with curiosity. Using the self-assessment tool from Our WAST Way, Sam reflected on their leadership strengths and areas for growth. This tool helped structure a meaningful conversation with their line manager, who provided specific examples of where Sam had excelled and areas for improvement. Together, they identified development opportunities that matched Sam's goals and workload. Some were quick wins—like short, on-demand courses—while others, like leadership programmes, offered a chance for deeper learning. The focus wasn't just on what Sam achieved but how they achieved it, aligning their actions with WAST's leadership behaviours.

Leading a Strategic Change

A turning point came when Sam was asked to take on a stretch project—a strategic change initiative in their area. With support from their manager and mentor, Sam led a project to improve coordination between the control centre and other departments, addressing long-standing challenges that had impacted service delivery. This project pushed Sam to work beyond their immediate team, collaborating with managers and colleagues from different parts of the organisation. They applied the principles of Connect by building trust in the team and working in partnership with TU partners, ensuring that everyone involved felt heard and valued. Through this experience, Sam developed new skills in strategic thinking, change management, and cross-team collaboration. The project not only delivered tangible improvements in how teams worked together but also highlighted Sam's potential to operate at a more strategic level.

Confidence, Growth, and Impact

The stretch project gave Sam the confidence to take deliberate steps toward a more senior role. Their mentor encouraged them to reflect on how to practice the leadership behaviours required at the next level. At the same time, Sam's leadership style had a ripple effect on their team. By modelling positive behaviours, Sam saw their team members become more proactive, solve problems creatively, and take greater ownership of their work.

Inspiring the Next Generation of Leaders

One of the most rewarding parts of Sam's journey was seeing their team flourish. Sam encouraged team members to reflect on their own leadership potential and gave them opportunities to learn and develop, further embedding the principles of Our WAST Way.

By creating a culture where people felt empowered and valued, Sam ensured the team was equipped to sustain its success even after they moved on to a more senior role. This ripple effect didn't just benefit the team—it helped drive innovation and service improvements across WAST.

Taylor's Story: Excelling as a Manager

'Taylor' didn't see themselves as someone climbing the career ladder but had always taken pride in being a good team member. When the opportunity came to step up into a Team Leader role at WAST, Taylor was both excited and apprehensive. They were drawn to the organisation's focus on developing a positive workplace culture and the role they could play, but knew that leading a team would be a new and challenging experience.

A Challenging Start

From the start, Taylor found the transition to a management role challenging. They were used to being a supportive team member, but now they had to navigate new responsibilities and lead their peers. During recruitment, the questions weren't just about their technical expertise—they focused on how Taylor could lead with care, create an inclusive work environment, and strengthen connections in the team. Once in the role, Taylor was introduced to Our WAST Way, a practical framework for leadership and management that emphasised these same principles. They found Management Essentials particularly useful, as it provided clear guidance on key areas like managing performance, holding meaningful conversations, and supporting team development. Taylor appreciated having a resource they could rely on to navigate the challenges of managing the team.

Leading with Purpose

Taylor used the principles of Care, Valuing Everyone, and Connect to guide their day-to-day management. They focused on creating a supportive, inclusive environment where their team felt valued and trusted. For instance, when a team member struggled to balance work and personal challenges, Taylor used tools from Management Essentials to hold an empathetic and solutions-focused conversation. By addressing the issue with care, they not only supported the team member's wellbeing but also strengthened the team's overall morale. Taylor also made use of the self-assessment tool to reflect on their leadership behaviours and found it helpful to identify small, practical ways to grow and improve.

Building Skills and Confidence

The learning opportunities available through Our WAST Way allowed Taylor to stay up to date with best practices and build confidence in areas like navigating change. One key turning point came when Taylor attended a workshop focused on inclusive leadership. They learned techniques for confidently challenging unprofessional behaviours within the team. By addressing these issues directly and constructively, Taylor created a more respectful and professional work environment, which led to improved team morale and performance. Taylor's line manager recognised their commitment to managing well and encouraged them to connect with a coach. While Taylor wasn't interested in moving into a higher role, they found the coaching valuable for refining their approach and addressing specific challenges they faced.

Developing Leadership Skills in the Team

As Taylor grew in their role as a manager and leader, they also focused on developing leadership skills within their team. They encouraged team members to take on new responsibilities and provided guidance and support to help them succeed. For example, Taylor offered regular feedback and coaching, helping these team members build confidence to step up and take initiative.

Driving Positive Outcomes

As Taylor's team thrived under their steady, people-focused leadership, team members reported feeling more engaged and motivated, which led to improvements in productivity and service delivery. One of the most rewarding moments for Taylor came during a team project to improve a key process. By enabling open communication and encouraging contributions from everyone, Taylor led the team to develop a simple but effective solution that saved time and improved outcomes for patients. Taylor's leadership also had a ripple effect beyond their immediate team. By developing leadership skills within the team, Taylor supported some team members in moving into more senior positions. This not only benefited the individuals but also strengthened the overall leadership capacity within WAST.

The Power of Leadership

Taylor's story highlights another important dimension of Our WAST Way. Not every leader is looking to progress—but every leader can grow, learn, and make a positive impact. Through the framework's tools, resources, and development opportunities, Taylor became the kind of leader who inspires trust, enables collaboration, and helps their team deliver their best.

Our WAST Way Leadership Behaviours

When we lead at **OUR BEST**:

We **CARE**

We **VALUE EVERYONE**

We **CONNECT** people and services.



By putting these principles at the heart of our leadership, we create a culture that enables us all to deliver OUR BEST for our people and the communities we serve. We believe leadership is for everyone—each of us has a role in shaping the future of WAST.



Care	Leadership For All	First Line Leadership	Senior Leadership	Executive Leadership
<i>Do you understand and manage your impact on others?</i>	I pay attention to what I say and do and how this impacts on others, and adjust my behaviour to improve relationships	I reflect on what I say and do and how my behaviour impacts on others, making changes to improve my leadership	I regularly assess how my leadership and behaviour affects relationships and the culture, making changes for greater positive impact	I continually challenge myself and our leadership team to evaluate the impact of our leadership on culture, adapting behaviour to meet the needs of people, the situation and to achieve our long-term goals
<i>Do you really support and understand the challenges of our people?</i>	I listen to the challenges others face and look for ways to support and encourage them	I listen to and understand the strain and challenges of my team and help them find solutions without getting overwhelmed	I take time to listen to and understand the strains and challenges within my service, working with others to find solutions	I prioritise listening to and understanding the complex challenges our people and sector face, using this insight to prioritise, set direction and align resources



Respect Others



Continually improve
our Service

Care	Leadership For All	First Line Leadership	Senior Leadership	Executive Leadership
<i>Do you look after yourself so you can be your best for others?</i>	I take care of my well-being so I can stay focused and supportive for those around me	I look after my wellbeing so I can best manage the day-to-day demands of the role and remain supportive of others	I actively manage my resilience by addressing what impacts my well-being, so I can be calm, responsive and supportive of those I lead	I lead by example in prioritising well-being, understanding what affects my resilience and how to manage it, so I can provide clear and consistent leadership
<i>Do you have the conversations that need to be had?</i>	I have honest and respectful conversations with others to build trust and help work through challenges together	I have essential conversations with team members, even when they are difficult or sensitive, approaching them openly and thoughtfully and ensuring my message is clear	I have the essential conversations, both within and outside my team, to build relationships, understand perspectives and find a way forward	I effectively manage high-stakes conversations using influence and an understanding of others' needs, to negotiate agreements that align with our long-term goals

CARE does not look like:

- Being overly kind or avoiding difficult decisions or conversations, leaving issues unresolved
- Focusing only on tasks or 'getting things done' without considering the impact on others
- Listening to concerns but failing to follow through with meaningful support or action
- Neglecting own well-being, which can make it harder to support or lead others effectively
- Being overly empathetic or getting too involved in other people's issues, blurring professional boundaries



Broaden our
Understanding



Practice
Ethically



Be inclusive
of the whole Team

Value Everyone	Leadership For All	First Line Leadership	Senior Leadership	Executive Leadership
<i>Do you seek out different perspectives and use them to make better decisions?</i>	I seek out and listen to others who have different perspectives to my own, so that I can better understand situations	I seek conversations with others who can provide different perspectives and challenge, to help my team and me make fairer decisions	I actively seek diverse perspectives beyond what is familiar, encourage others to do the same, and use these insights to challenge and improve our services	I am a visible leader who engages with our people, partners and the public to understand the challenges and opportunities we have, ensuring this knowledge shapes our decisions and priorities
<i>Do you give your time to understand and develop others?</i>	I take time to understand the strengths and experiences of others and look for ways to learn with them and from them	I give time and attention to all members of my team, getting to know their individual strengths and goals and helping them to grow and develop	I invest my time and attention in supporting our people, by building on their strengths and encouraging a culture where we learn and improve together	I create a culture where development is prioritised, encouraging shared learning and conversations that generate the insight and innovation needed to shape our services
<i>Do you gather and give quality feedback to develop yourself and others?</i>	I provide respectful feedback to help others grow and improve, while being open to feedback about myself	I give feedback as part of everyday conversations with my team, focusing mostly on what is going well whilst being clear and supportive if improvement is needed; I also seek and act on feedback from others to improve my own behaviour	I give regular feedback on individual and team performance, highlighting positives, whilst being supportive, clear and consistent when improvements are needed; I also gather and act on feedback to improve myself, my team and my service	I share our successes by highlighting the outcomes and efforts of our people, take ownership when we underachieve and encourage open and honest feedback; I actively seek and respond to diverse feedback to make improvements to my leadership



Broaden our
Understanding



Practice
Ethically



Be inclusive
of the whole Team

Value Everyone	Leadership For All	First Line Leadership	Senior Leadership	Executive Leadership
<i>Do you play an active role in creating a fair, respectful and inclusive culture?</i>	I treat everyone fairly and with respect and I speak up when I see behaviours that are not professional or inclusive	I actively promote the fair and respectful treatment of everyone, challenging behaviours that are not professional or inclusive, responding quickly to concerns that are raised and supporting those who speak-up	I play a key role in building a professional service that is consistently fair and respectful - recognising positive practices, challenging behaviours that undermine inclusivity and making the changes that will improve our culture	I take personal responsibility for creating an organisation which our people, partners and the public can rely on to be fair, professional and truly inclusive, and I lead changes to our culture and systems when we fall short

VALUING EVERYONE does not look like:

- Undermining open and honest feedback by ignoring it in decision-making, or sharing what someone has raised in confidence
- Taking credit for successes without acknowledging the contributions of others
- Over-emphasising fairness by treating everyone the same instead of addressing individual strengths and needs
- Spending time and sharing information only with select colleagues, creating favouritism or cliques that divide the team
- Not calling out unprofessional or inappropriate behaviour to 'keep the peace' or to avoid being perceived as unfair



Take **O**wnership



Show **B**elief in other

Connect	Leadership For All	First Line Leadership	Senior Leadership	Executive Leadership
<i>Do you involve and work with others to achieve results?</i>	I work with others to achieve shared goals, exchanging ideas and finding solutions together	I seek opportunities to share knowledge and work with others, understanding how we can deliver improvements together	I bring people and partners together to own shared goals, ensuring accountability for making improvements and delivering change	I unite diverse stakeholders around ambitious long-term goals, building trusted relationships and shared accountability for delivering the change needed
<i>Do you extend trust to others so they can make decisions and take ownership?</i>	I trust others to take ownership of their work, offering support and guidance when needed	I mainly lead by guiding people and helping them find their own solutions, rather than just telling them what to do, only using a more direct approach in urgent or crisis situations	I delegate to the right level, trusting others to make decisions while coaching them through situations where risks are too high, intentionally empowering and supporting them to take ownership	I build shared leadership and ownership across the organisation by trusting others to lead using their strengths and expertise, and so enabling our senior leaders to focus more on strategic issues
<i>Do you communicate our shared purpose and goals, commit to them and take others with you?</i>	I consider how my work contributes to our shared purpose (why we do what we do), and I communicate this positively to others	I communicate our shared purpose (why we do what we do) and our goals, helping team members to understand how their work contributes to achieving these	I promote our shared purpose and goals, emphasising how each of us plays a role in achieving them, and I hold myself and the team accountable not only for what we deliver but also how we do it	I use our shared purpose to guide decisions and priorities, focusing on goals that improve our culture and service, highlight everyone's role, and inspire bold action toward achieving our ambitions



Take Ownership



Show Belief in other

Connect	Leadership For All	First Line Leadership	Senior Leadership	Executive Leadership
<i>Do you consider the impact of change and support others to work in new ways?</i>	I recognise my reactions to change, focus on the benefits, and support others in adapting to new ways of working	I pay attention to how others respond to change, listen to concerns, and support them to work in new ways	I take time to lead and manage people through change, listening to concerns and empowering them to influence and implement new ways of working	I focus on how change impacts our people and the wider system, enabling transformation by sharing a clear vision, removing barriers and building networks of support and influence
CONNECT does not look like: • Missing opportunities to involve others, causing duplication, overlooked issues, or delays • Micromanaging instead of trusting others to make decisions and take ownership • Communicating goals vaguely, leaving people unclear about their role and what they need to do • Avoiding change to keep everyone happy, or pushing change forward without addressing its impact on people • Building support for change only from those who agree with you, rather than seeking diverse views to ensure changes are effective and lasting				

Leadership Development Paths*

Executive Leadership

Leads the organisation

Senior Leadership

Leads an area or function

First Line Leadership

Leads a team

Leadership for All

Leads self and others

Our WAST Way Leadership Behaviours

360 feedback against behaviours and personal development plan

Self-assessment against behaviours and personal development plan

WAST Leadership Development Opportunities e.g. Symposium, Courses, Online Learning & Resources

Management Essentials Programme

Coaching and Mentoring Opportunities

Formal Accredited Leadership Development Programme at Each Level, includes project

External Leadership Development Opportunities e.g. with AACE, HEIW, NHS Leadership Academy, Academi Wales

Our WAST Way Annual 'Festival of Leadership'

**The leadership behaviours help identify strengths and areas for improvement. With their manager's support, individuals choose learning and development activities suited to their level, focusing on what meets their immediate and long-term needs instead of all available options.*



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	10
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

Cultural Themes and Trends Report

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Carl Kneeshaw, Director of People Angie Lewis, Director of Culture Change
AUTHOR	Liz Rogers, Deputy Director of People
CONTACT	Liz.Rogers@wales.nhs.uk

EXECUTIVE SUMMARY

1. The attached presentation deck provides People and Culture Committee (PCC) with the latest information on Employee Relations, Turnover, Moving on Interviews and Speaking up Safely. PCC will be presented with separate reports on Compassionate Practices and Managing Attendance at this meeting, therefore data is not included in this report.

Employee Relations – Disciplinary Cases

2. Between July 2024 and December 2024, 63 new disciplinary cases were opened. This is significantly higher than the same period the previous year but mirrors the experience of July to December 2023 in that there are more cases during these months than in the previous months.
3. The average duration of cases closed between July and December was 33 days (this includes cases open and ongoing into July to December). The average duration of cases submitted and closed during the period was 5 days less at 28 days and compared to 30 days for the same period last year. However, 6 cases with police involvement had an average duration of 122 days. This indicates the impact of external bodies on investigations within WAST. The reduction in days to 33 may also be impacted by the appointment of 3 full time IOs in August 2024 and more cases being fast-tracked (18% increase) and 28% of Initial Assessments were concluded with an informal discussion.
4. Of the cases, 56% of are related to inappropriate behaviour and 35% of the cases relate to sexual safety. Of the cases opened in the period, 44% remain in process.



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Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Staff Turnover

5. Over the past 12 months, turnover has reduced from 9.03% in January 2024 to 7.88% in December. Rates are low in Corporate Teams and EMS with EMSC and Integrated Care showing high levels of turnover. There is a project referenced in the Managing Attendance presentation for EMSC and IC regarding recruitment with the aim of reducing turnover by improving the recruitment process.

Moving On Interviews Data from the Pilot

6. Slides 10 through to 14 provide screen shots of data from the pilot and leavers who have completed the form or had an interview with their line manager.
7. The Trust's existing Pre-Exit Interview Policy has been in place since 2007. An NHS All Wales project was started in 2019 but was halted due to the pandemic and has not been restarted. Therefore, a decision was made to undertake a review for WAST.
8. This Procedure has been piloted within 111, Powys EMS and Hywel Dda EMS since February 2024. This new approach provides much richer information which can be used locally and organisationally to drill down into drivers for leaving and is output via a BI report. The People Services team can provide this information to Directors and their management teams.
9. The process is now accessible to all across the organisation from January 2025. Questions also include experience and witnessing of discrimination and bullying and harassment. Areas such as work life balance and access to learning and development opportunities within the pilot area (111 in particular) have come through the feedback.

Speaking Up Safely

10. Sixty-five concerns have been raised in the last six months via Speaking Up Safely with October being the highest month, likely linked to it being Speaking Up Safely month with promotional activities going on. Thirty-three percent were originally raised anonymously. This was reduced to 21% as a relationship was established with those speaking up.
11. Issues raised focus on incivility (63%) with 27% having elements of bullying and harassment and 36% with an element of inappropriate behaviour / attitude. There were 6 sexual safety cases (9.2%).



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12. In terms of outcomes, 28 cases are closed and 37 remain open with a range of actions underway including formal investigations. Actions are taken to capture learning from cases. This is done collaboratively with colleagues from Culture Team, People Services, Safeguarding and managers.
13. Feedback from those engaging is wide ranging from feeling heard and validated to 'I will never speak up again'. These comments will be driven by a range of reasons including the individual's perception of the outcomes to the issues raised.

RECOMMENDATION

14. The Committee is asked to:

- a) **Accept and note the report and presentation deck**
- b) **Note the rollout of Moving on Conversations across the organisation with future updates to be received through the Cultural Themes and Trends report**
- c) **Note the SUS case volumes identified in the report.**

KEY ISSUES/IMPLICATIONS

15. There has been a significant amount of activity undertaken across the Team since the last report and the volume of cases is challenging to manage for all colleagues involved.
16. It is good to see that most cases are being turned around in a significantly shorter timeframe. When the case duration was measured in line with the compassionate practices work, the baseline for an investigation duration was 207 days – an average of 7 months. This halved in 2023 and now is averaging 28 days. Undoubtedly, recruiting three full-time Investigating Officers has had a direct bearing but we also note the impact of police investigations on the length of time cases take to action with these cases taking 4 times longer to conclude. A number of cases are particularly challenging and emotive, and we are mindful of how that affects colleagues involved in those cases.
17. Our new Moving on Interview process puts WAST significantly ahead of other HBs and Trusts in terms of having a digitised process which can be interrogated. An initial questionnaire identified that no other stakeholders have the level of robustness we are developing, it is reported that there are very low numbers of exit interviews being completed and no analysis is being undertaken.



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18. We are also the first organisation in the NHS in Wales to appoint a full-time Guardian. The impact of the role in terms of the numbers of cases identifies the demand in the system. We expect to see an increase in numbers in the shorter term as colleagues grow in confidence to come forward. It is also helpful to reflect on recent high profile cases such as Nottinghamshire Healthcare NHS Trust where concerns raised went ignored.

REPORT APPROVAL ROUTE

PCC 18.02.2025

REPORT APPENDICES

Appendix 1: PCC Cultural Themes Trends Presentation February 2025

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	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	✓	Risks (Inc. Reputational)	✓
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	✓

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Cultural Themes and Trends



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Cultural Themes and Trends
Version 4.0
Released: February 2025

by People Services

Purpose of this Report

- Provide insight into employee relations activity (reflecting the work on creating an environment where colleagues feel safe to speak up).
- Provide information on the link between disciplinary case and compassionate practices (separate deep dive report at this meeting).
- Share progress on Moving on Interviews noting the rollout to the whole organisation with effect from January 2026 and provide an overview of the rich data we can now analyse from interviews and feedback from leavers to inform culture work.
- Review Managing Attendance Data to complement the separate deep dive item at this meeting.

Culture

'We will be recognised and renowned as being an exceptional place to work, volunteer, develop and grow'

2030 Strategy

We recognise that our journey to establish a new culture is ongoing, and our employee relations data reveals an honest reflection of our present standing. Together, we'll leverage these insights to shape a brighter future, fostering an environment where our shared aspirations align with daily realities

To understand the present employee experience, we will candidly delve into the insights derived from employee turnover, Moving on Conversations and Managing Attendance at Work data. These indicators shed light on our current workforce's engagement, satisfaction, and overall well-being. Together, we will proactively build upon the employee experience, attracting and retaining the finest talents, and nurturing a workforce ready to embrace the challenges of the future.

Capacity

'Our future workforce will be agile, highly skilled and capable'

2030 Strategy

Capability

'Our leaders will be compassionate, collaborative and courageous'

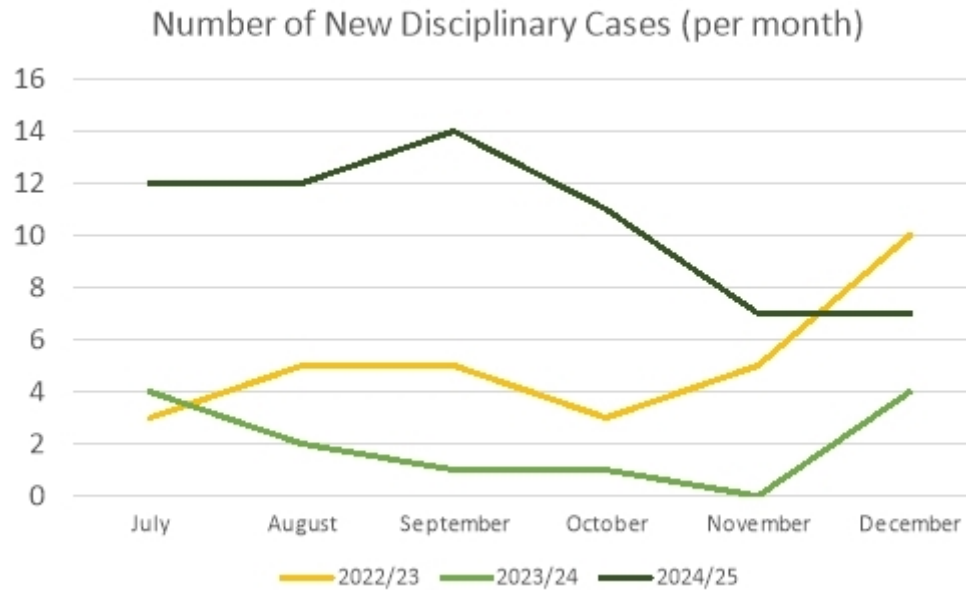
2030 Strategy

Our leaders and managers are a focal point in enhancing capability. We are committed to providing them with the necessary knowledge, skills, and adaptability to navigate complexities and respond effectively to the evolving needs and aspirations of our diverse workforce. We will continue to support our managers to develop their skills to be competent leaders. Together, we shape a successful future.

EMPLOYEE RELATIONS



EMPLOYEE RELATIONS

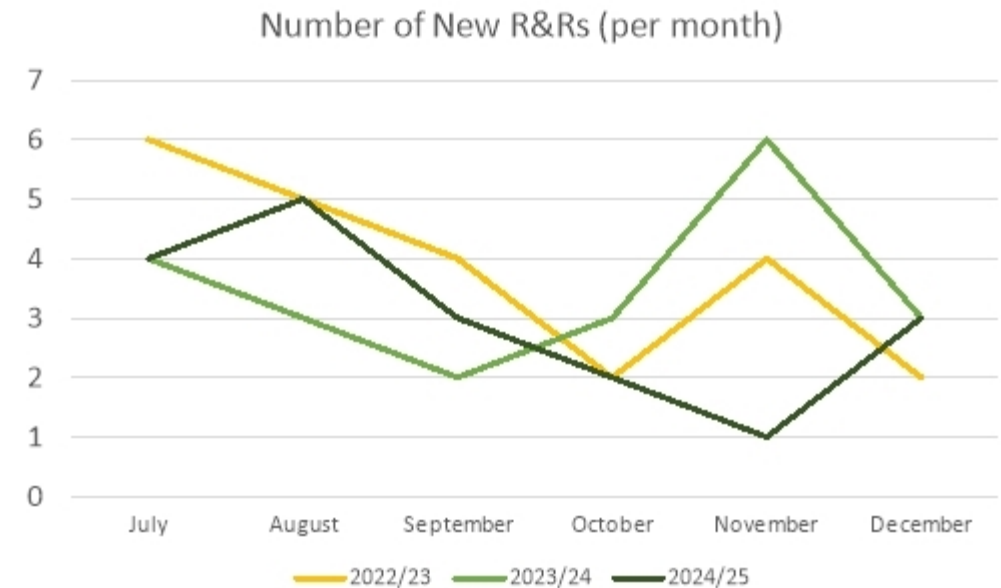


In the period July 2024 to December 2024, the total number of new disciplinary cases was 63.

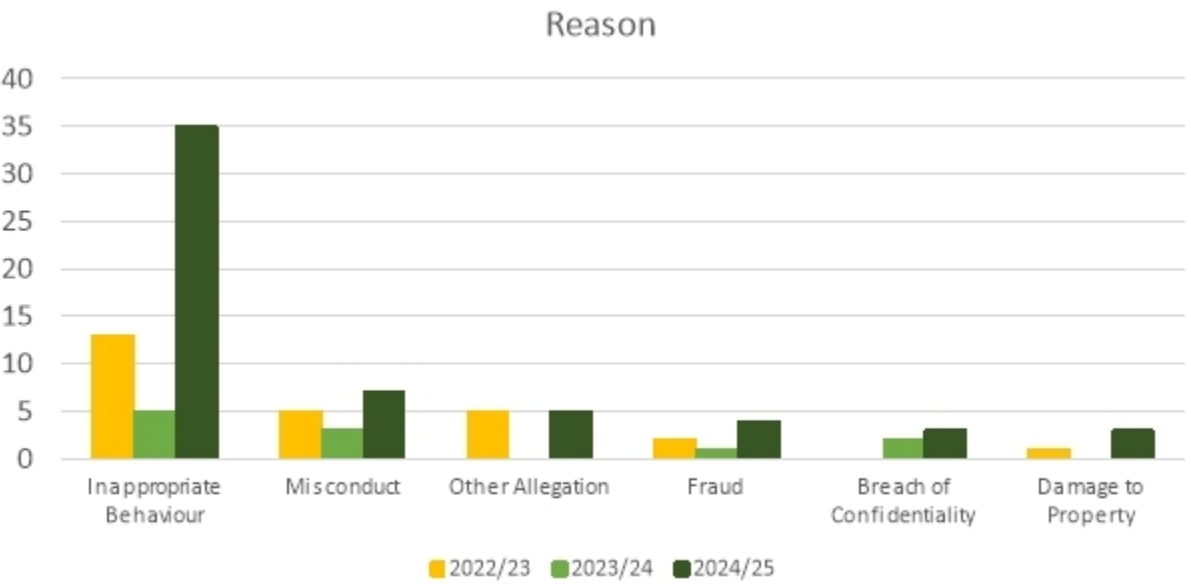
There has been a significant **increase** in new cases in this reporting period compared to the period from July 2023 to December 2023. This trend is consistent with a recurring increase observed during the same months in the 2022/2023 period.

In the period July 2024 to December 2024, the total number of new R&Rs was 18. This is a slight **decrease** with the same period in 2023/2024, with a total of 21 new R&Rs.

Based on this period, the average number of new R&Rs per month is currently 3.



EMPLOYEE RELATIONS: DISCIPLINARY CASES



Inappropriate behaviour persists as the predominant reason for disciplinary measures, accounting for **56%** of cases between July 2024 and December 2024.

35% of the current Disciplinary cases (including Initial Assessments) are reporting a **sexual safety** element.

33 Days

The average duration of cases closed during the period July to December

2024 was 33 days, from start to completion (inclusive of formal investigation). In this period 6 longstanding cases with **Police involvement** were closed with an average duration of 122 days.

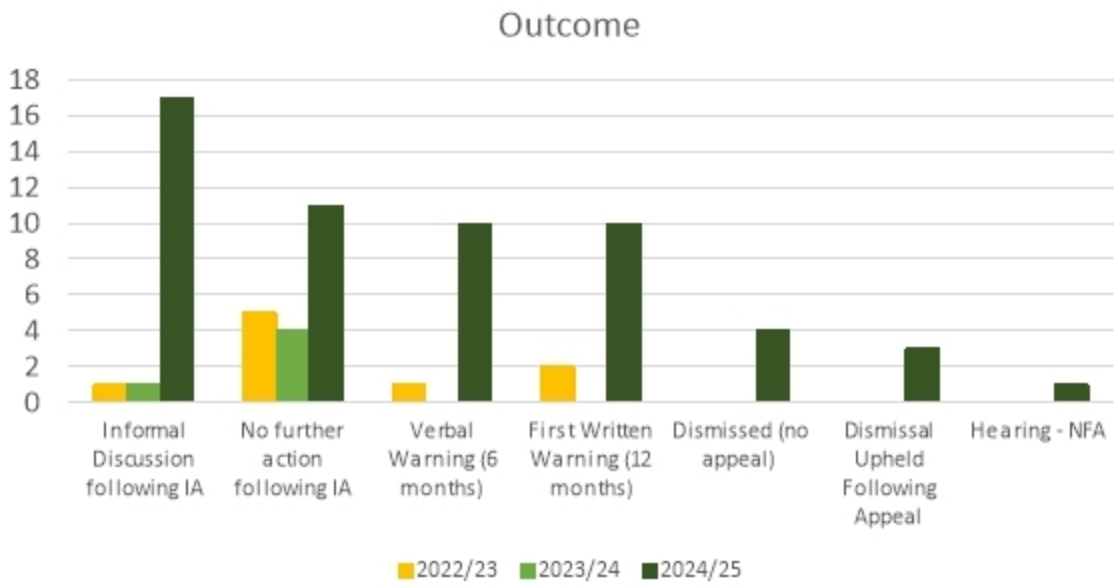
14 Cases were fast tracked between July and December 2024. This is 18% increase compared with the corresponding period in 2023.

14 Fast Track

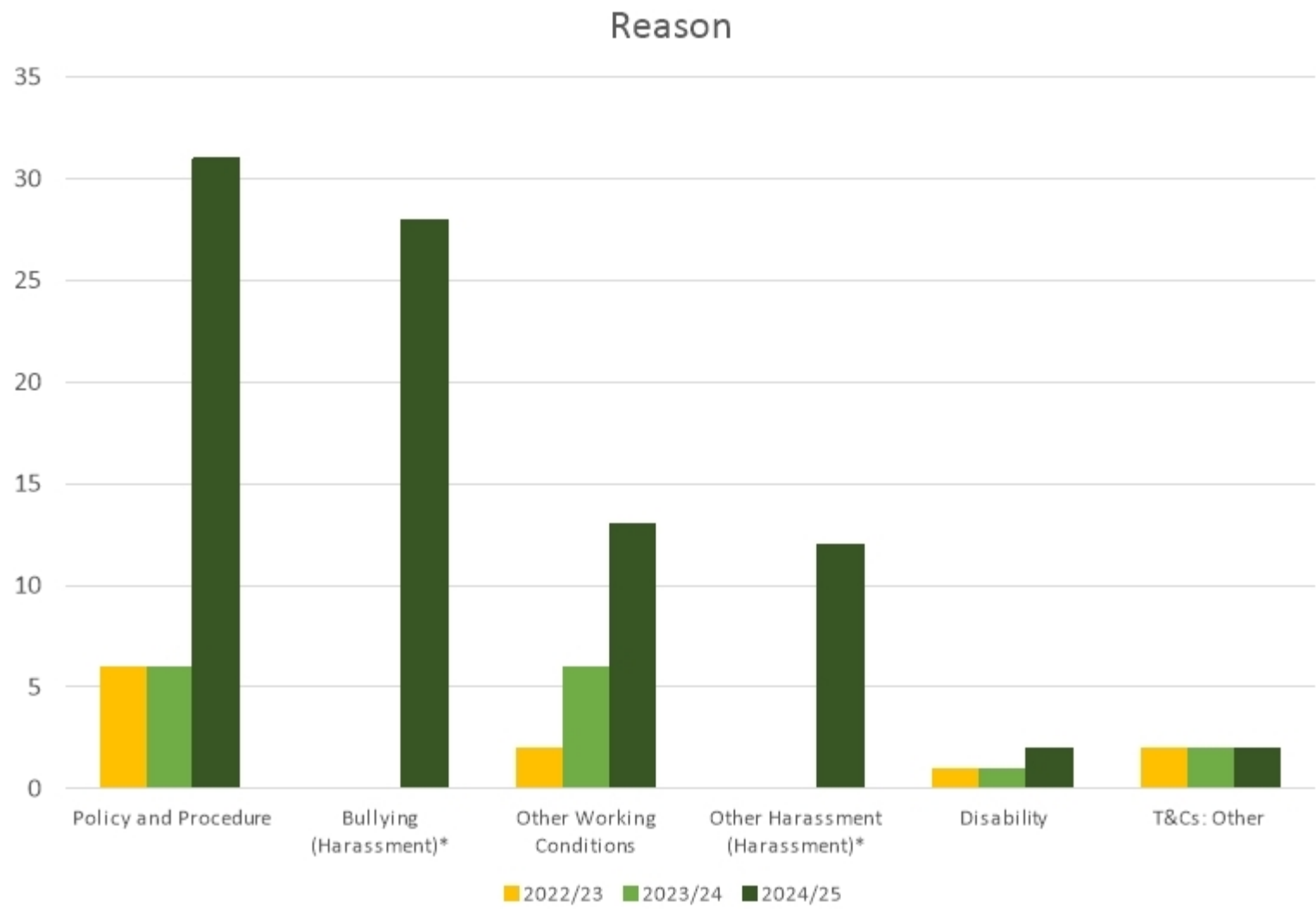
34 cases remain open.

Of the closed cases, **28%** concluded with **informal discussion following an initial assessment**.

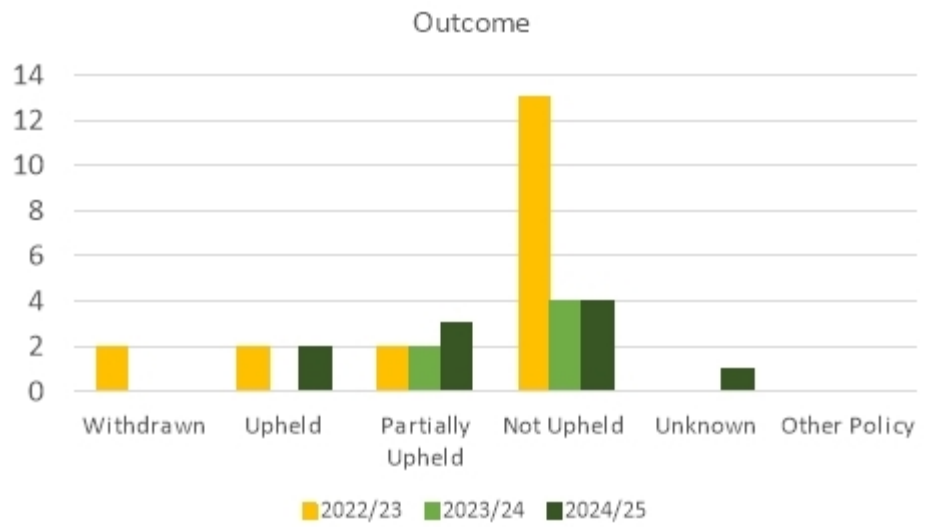
‘Other’ includes cases resolved with welfare support and situations addressed through generic reminders due to anonymity.



EMPLOYEE RELATIONS: REQUEST FOR RESOLUTION



Of the new cases submitted between June and December 2024, 8 **remain open**. This equates to 44% of new cases submitted in this period.



For cases submitted and closed from July to December 2024, the average duration from submission to closure was 28 days, compared to 30 days for the corresponding period in 2023.



*Not an available category in 2022/2023

WORKING TOWARDS IMPACT: Disciplinary and Compassionate Practices



FINDINGS:

- 35% of new cases between July and December 2024 were in relation to a Sexual Safety concern and are categorised under inappropriate behaviour and the number of cases in relation to sexual safety is steadily increasing.
- There is a notable increase in the number of cases resolved through informal action in line with compassionate practices, 28% of cases were resolved informally in this period.
- From June to July 2024, 6 longstanding cases with Police involvement were closed with an average duration of 122 days.
- The average duration for R&R cases submitted and closed from July to June 2024 has decreased to 28 days compared to 30 days in the corresponding period in 2023, despite the number of cases received remaining relatively consistent.
- The development and consultation of the All Wales Disciplinary policy will impact on how we manage processes going forwards.



ACTIONS:

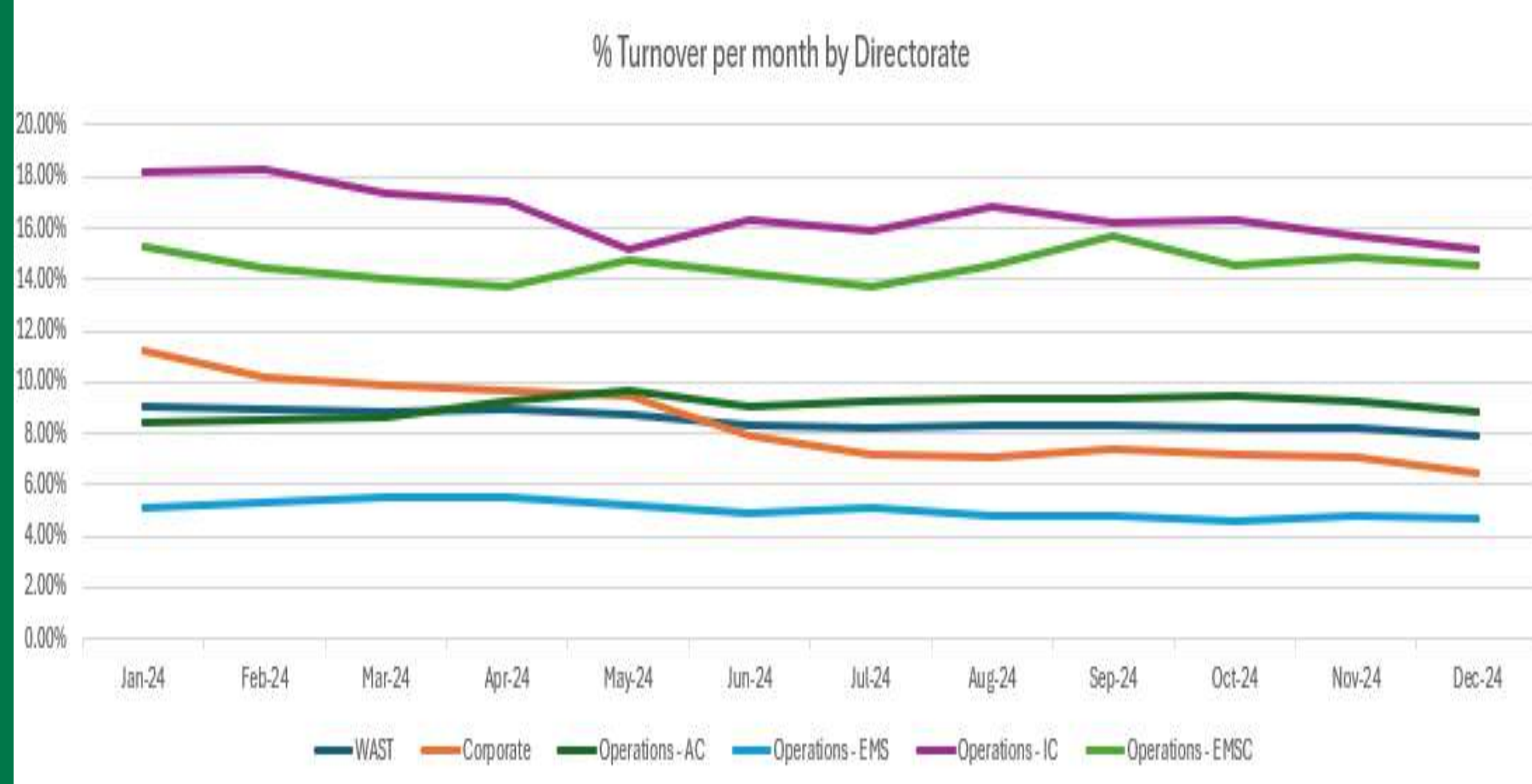
- The Compassionate Practices for All Action Plan has been reviewed in June 2024 to focus on implementation of agreed actions to further enhance our commitment to employee Wellbeing and cultivate a compassionate workplace culture.
- The Compassionate Practices approach is continuing to be embedded in the organisation, awaiting formal evaluation with a view this is part of 'business as usual'.
- The findings from the evaluation will be formally presented to the People & Culture Committee once concluded.
- We continue to work closely with Trade Union Partners to improve our people processes.
- We continue to engage with individuals who are comfortable to share their story and experience, to learn through listening and to respond to what they are saying.



IMPACT:

- We continue to articulate and embed a culture across the organisation which focuses on creating an environment where wellbeing and compassion are at the heart of the employee experience.
- We have made space for the voice of people with different experiences to be heard.
- A formal evaluation of the Compassionate Practices programme is underway and further slides are included outlining more detail on this approach.

STAFF TURNOVER



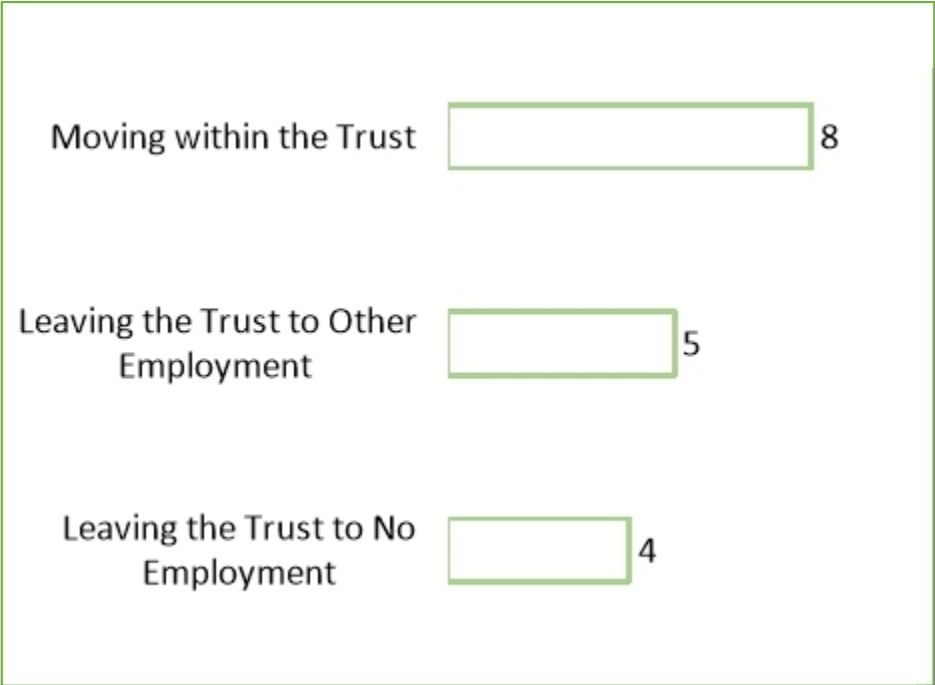
Key Themes...

Turnover rates across the Trust have fallen within the past 12 months, **from 9.03% in January 2024 to 7.88% in December 2024**

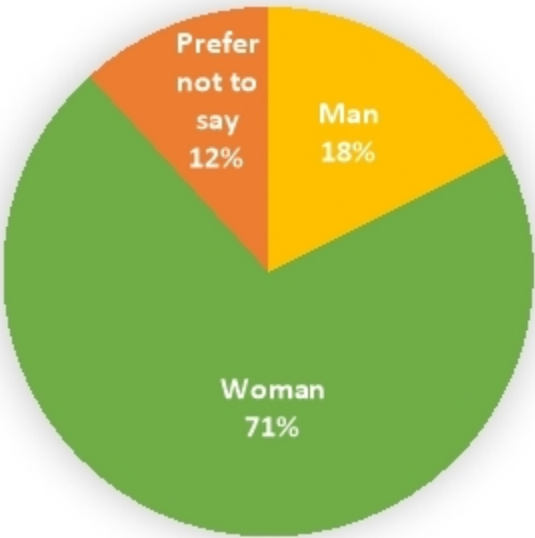
Turnover rates remain low within EMS and Corporate roles, **however EMSC and IC roles still showing high level of turnover**, all be it with a reduction over the past 12 months.
(IC includes 111)

MOVING ON INTERVIEW PILOT DATA

Between 1st August and 31st
December 2024, 17 responses
have been received from 111 pilot



Of Trust leavers recorded
in ESR for the same period
have completed the
questionnaire





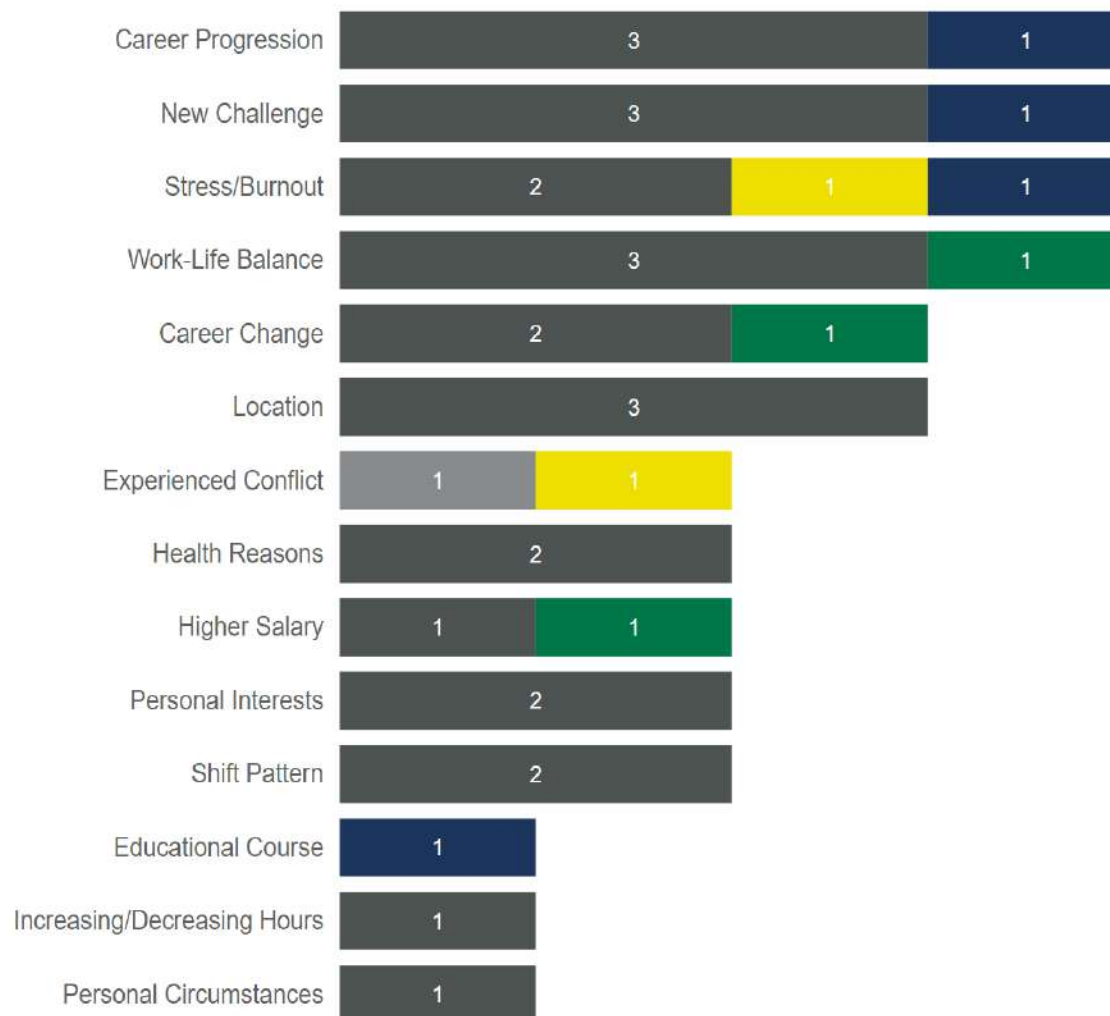
Reasons for Leaving



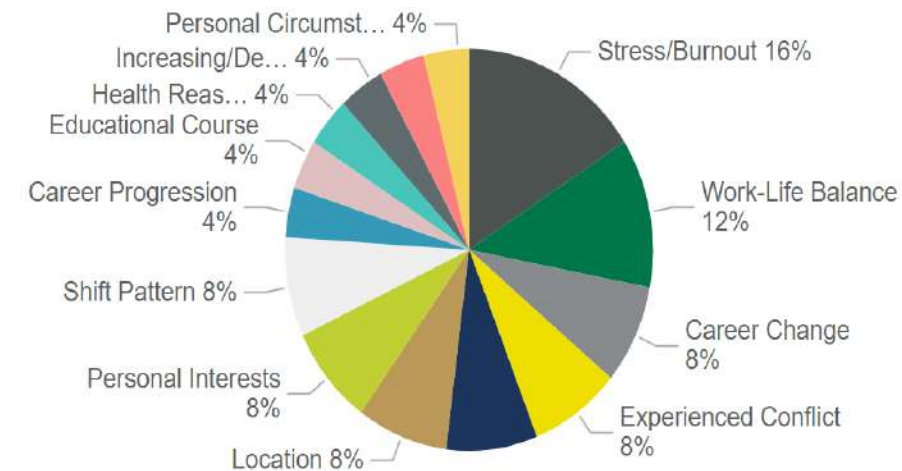
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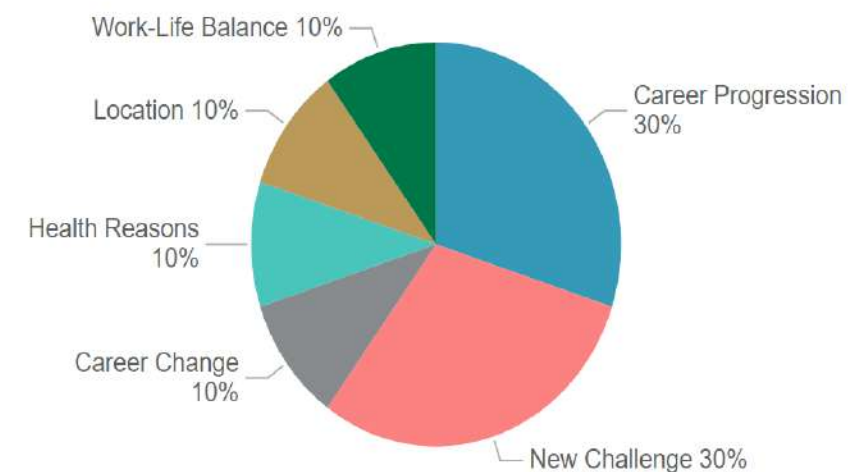
Age Range ● 25 - 34 ● 35 - 44 ● 45 - 54 ● 55 - 64 ● Under 24



Leaving the Trust



Changing Roles





Reasons for Leaving



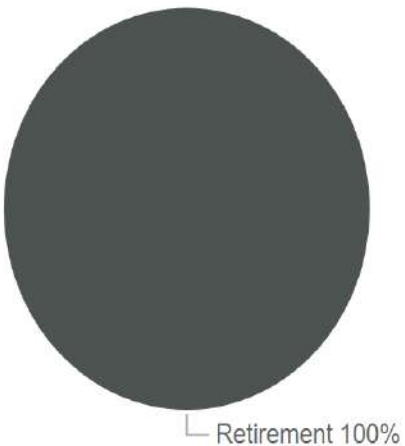
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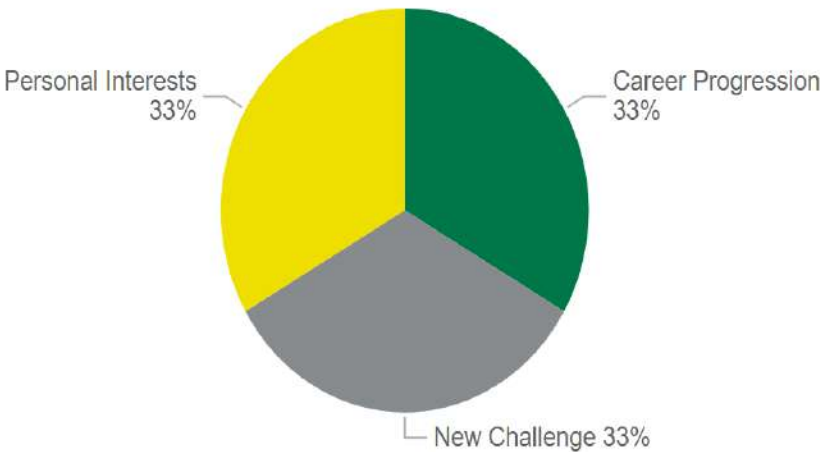
Age Range ● 25 - 34 ● 65+



Leaving the Trust



Changing Roles



Key Themes

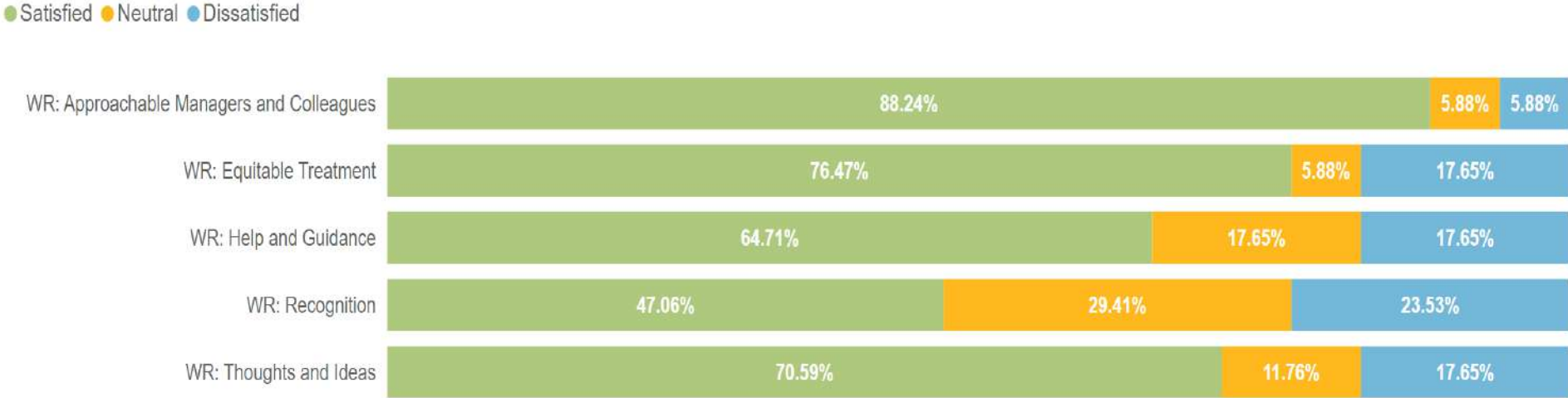
Employees were asked to rate their satisfaction with team behaviours—including approachability, access to help and guidance, recognition, equitable treatment, and communication—as well as their level of agreement with statements about development and progression opportunities available to them.

Women reported more varied experiences with workplace relationships, with overall satisfaction lower than men’s. 83% of women found their managers and colleagues approachable, compared to 100% of men. Similarly, women rated the ability to share thoughts and ideas less favourably, with only 58% satisfied and 25% dissatisfied.

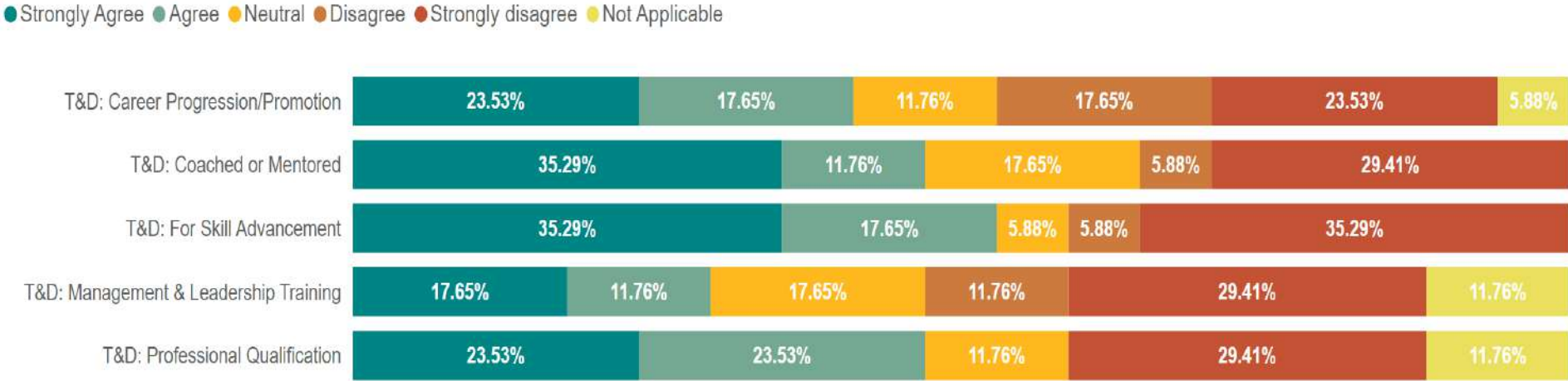
Women expressed stronger dissatisfaction across all training and development areas, with high disagreement rates (up to 41% strongly disagreeing for management & leadership training. Men, on the other hand, were evenly split between agreement, neutrality, and disagreement in most areas.

Click Here to Filter

Workplace Relationships



Learning & Development Opportunities





Health and Wellbeing (All Staff)



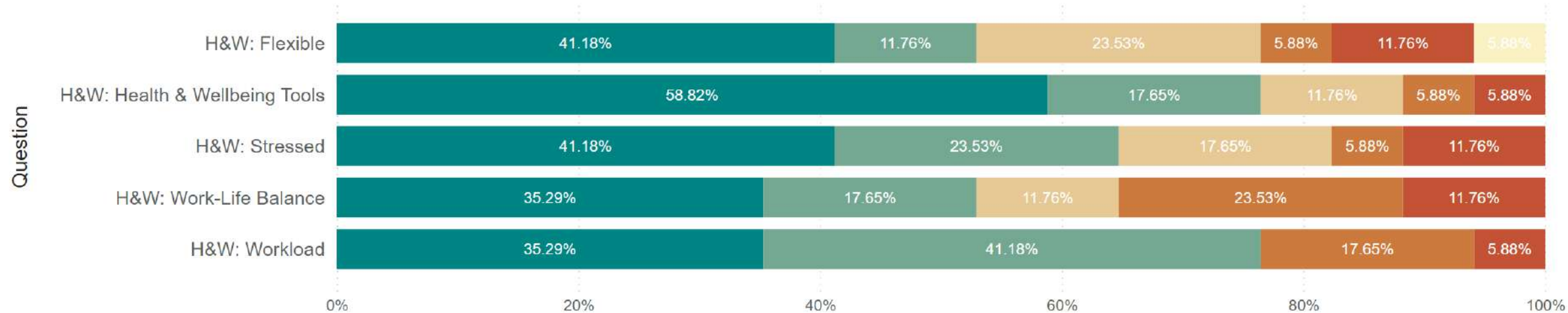
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Health & Wellbeing Practices

Answer Strongly Agree Agree Neutral Disagree Strongly disagree Not Applicable



H&W: Improve Freetext

- *Longer screen breaks
- *Less pressure on staff when taking longer after calls
- *More overtime hours
- *Better shift patterns or hours to improve work life balance

Actions resulting from the culture review.

Being contacted by line manager whilst sick and had sicknote to cover absence put additional pressure on me at a time when I was dealing with my ill health.

Duvet days. More dogs! (and time offline to see them when they are in)

More accessible route to occupational health. i.e not cancelling appointments repeatedly. Wellbeing days, team-building activities, team meetings to talk about overall team progress.

no

none at present

Total Employees
Witnessed or Experienced
Discrimination

1

Total Employees
Witnessed or Experienced
Bullying/Harassment

3



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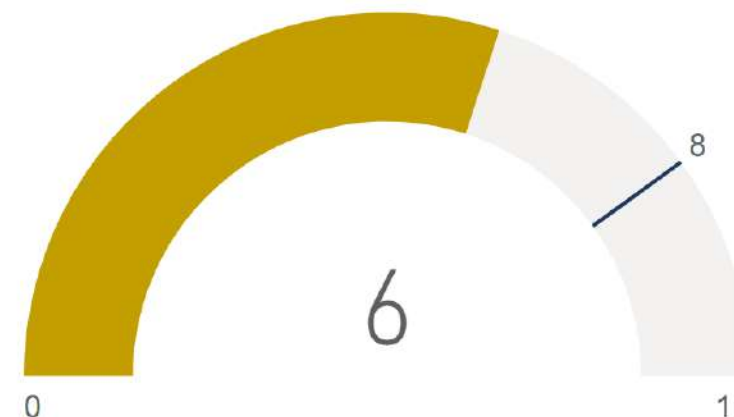
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We asked employees to describe our culture in three words...

[Click Here to Filter](#)



Likelihood to Recommend WAST as a Workplace



Total Responses

17

Completed
Questionnaire
Independently

3

Flexible Working

I am already working on a set rota which has helped with my work life balance, but I need more weekends off work and this is something that cannot be done working in a 24/7 service where weekends are the busiest times.

I was offered retraining after I had already secured a new post.

N/A

No

There are not any adjustments that could be made for me to stay in this current role.

We have discussed this, however with my current position and the changes within the 111 service have led me to find a more suitable role which supports my work/life balance

Yes

yes - line manager support prior to leaving to try and assist and support my work life balance with multiple options available and discussed

yes, starting paramedic university course

ves. very accomadating.



WORKING TOWARDS IMPACT: Staff Turnover and Moving on Conversations



FINDINGS:

- Generational differences drive turnover trends: younger employees (<35) prioritise career progression and challenges, while older employees prioritise work-life balance and stress.
- Development opportunities are a key concern, with 35% lacking access to coaching/mentoring and 41% to leadership training.
- Despite 76% awareness of well-being tools, 64% report workplace stress, and 52% feel work-life balance is not actively supported.
- Employees stress the need for culture review actions and improved OH services, citing long waits and cancellations as barriers.
- Flexible working arrangements are frequently discussed with line managers but are often not accommodated.



ACTIONS:

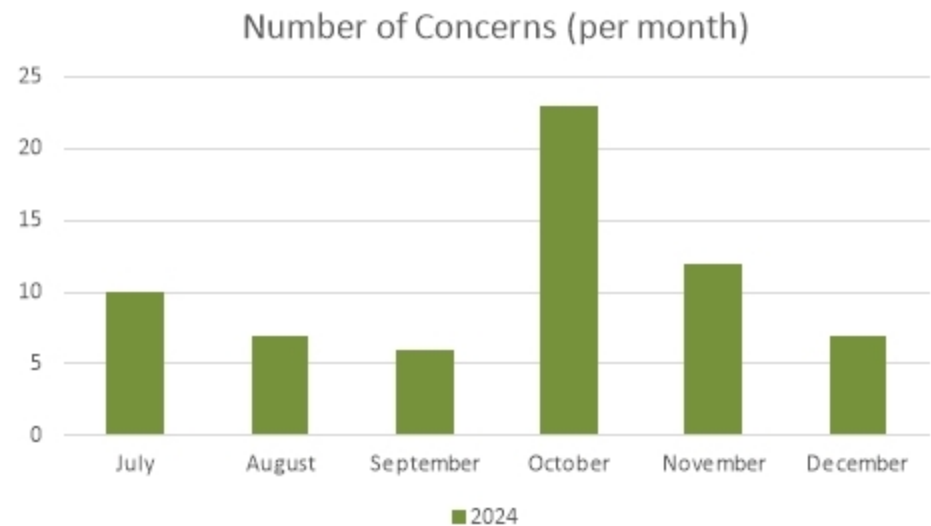
- Pilot areas were transitioned to the full Moving on Conversation process from 6th August 2024 and a Trust-wide roll out commenced 1st January 2025. A communication and training plan is in place to support implementation.
- Collaborating with digital teams to integrate an electronic trigger from the Staff Movements Advice (SMA) Payroll Application. This is planned for launch on 1st February 2025 and will prompt managers completing leaver forms to invite employees to participate in Moving on Conversations.



IMPACT:

- The rollout will facilitate the identification of patterns and trends across the entire Trust, enabling targeted improvements and support strategies to be implemented effectively.
- Digitalisation of data processes provide more immersive insights into employee departures, enhancing the ability to identify and address key issues affecting staff retention.
- The provision of training and integration of a digital trigger will significantly enhance engagement with the process, ensuring more proactive participation in Moving on Conversations.

Speaking Up Safely: *Concerns*



- There were 65 concerns raised via SUS in the last 6 months.
- The average amount of concerns per month is 10.
- In October SUS received the highest number of concerns at 23, likely to be a result of promotion for Speak up Month.



- Around half of SUS concerns are raised confidentially.
- At the point of contact 33% were raised anonymously but this dropped to 21% after a rapport was built with some of the people who spoke up.

Speaking Up Safely: *Themes*



Reason for Concern

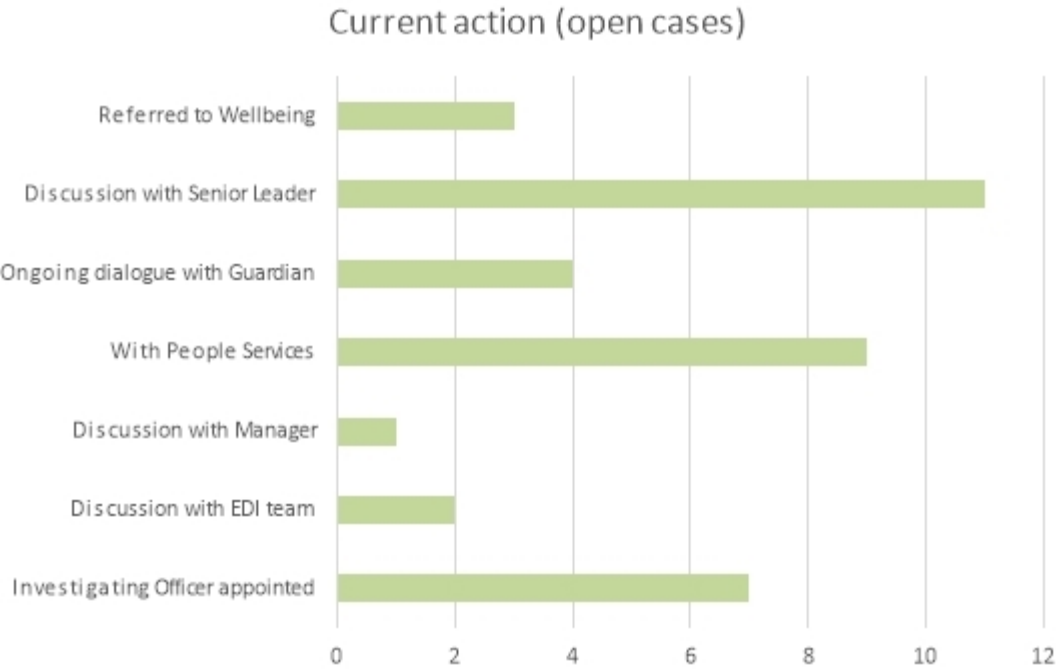
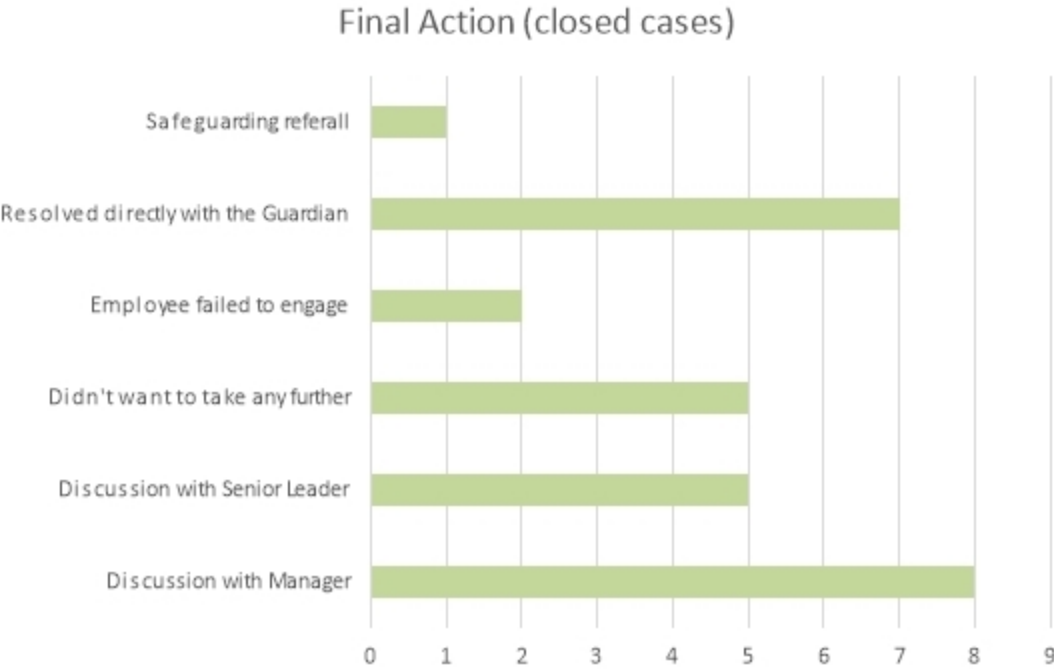


- In the last 6 months, **63% of concerns** had an element of **incivility** between our people, with **27%** having an element of **Bullying & Harassment** and **36%** with an element of **Inappropriate attitudes & behaviours**
- In this period there were **6 cases of sexual safety** raised to SUS

Speaking Up Safely: *Action Taken*



From the cases raised in this period, 28 are closed and 37 remain open



Speaking Up Safely

How do we learn from SUS cases?



- In Jan 2025 we held our first ever **Lessons Learned Case Review**
- In Jan 2025 we launch the **Lessons Learnt Forum**- allowing ideas for improvement to be discussed and actioned
- Use the feedback to inform **best practice**
- Beginning to look at a **support scheme** for those who have suffered **detriment** from speaking up

Speaking Up Safely

Feedback



'I felt safe, respected , heard and validated'.

'Sensitivity of the issues discussed, **objectivity**, a feeling that I am **irritating** my line manager by sharing it'.

'I will never speak up again.'

Speaking Up Safely

*How can **you** help?*



- Complete your **training** on ESR
- **Talk about** Speaking Up Safely
- As you support people, **signpost** them to Speaking Up Safely
- **Offer** to attend a meeting with someone who wants to Speak Up
- Wear the **Speak Up pin badge** to show your allyship
- **Model** Speaking Up
- Be an **active bystander**



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AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

Compassionate Practices Deep Dive

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Carl Kneeshaw, Director of People
AUTHOR	Liz Rogers, Deputy Director of People
CONTACT	Liz.Rogers@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide People and Culture Committee with an update on the work on compassionate practices across WAST and give an update on actions to address audit recommendations to date.
2. The presentation outlines the journey to date and provides an update on progress against the four recommendations from the 2024 audit.
3. Good progress has been made on the action plan developed to deliver compassionate practices into business as usual and the way we approach employee relations issues. Of the 46 actions in the plan, 40 have been completed and embedded. The audit recommendations have been added to the action plan and are being managed through that route.
4. Outstanding actions relate to evaluation, targeted attendance at training, sharing of the FAQ guide and detailed analysis of our baseline data to support evaluation. There are other pieces of work in train which account for the non-completion to date.
5. Also, as a part of the work highlighted in the action plan there have been improvements in governance, compliance and processes led by the IO team based in People Services who have reviewed documentation and developed processes to fill gaps identified.
6. **RECOMMENDATION:** Committee is asked to:

Confirm assurance on the progress against the audit actions

Note the progress against the action plan.



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KEY ISSUES/IMPLICATIONS

7. The compassionate practices work began in November 2022 with a session for around 100 senior managers and TU partners. This was followed up with further training sessions for managers across the organisation.
8. A range of activities including practical changes such as reviewing templates for disciplinary letters and redeveloping initial assessment documentation has been undertaken over the past two years to support managers in looking at investigations through a different lens with a focus on the impact of the process on all those involved.
9. We have seen reductions in the length of time to undertake investigations and a more compassionate approach to managing cases.
10. An internal audit was undertaken in between March and May 2024 with four medium level actions being identified.
 - The compassionate practices action plan should be reviewed to ensure timescales are reasonable and capture both the planned changes and implementation periods.
 - Revised timescales should feature within the updates provided to the People and Culture Committee to ensure awareness of any delays to plan implementation.
 - Post training feedback should be sought in line with the original action, to capture attendees learning from the training and identify any changes in practice.
 - The Trust should review the case management tracker to identify individuals that have previously been involved in undertaking initial assessments as a priority group for attending future compassionate practices training sessions.
11. The first recommendation has been completed and good progress is being made against the other actions. There are external elements which also affect the delivery of the recommendations regarding evaluation and FAQ guide which is captured in the presentation deck.
12. An internal evaluation on the impact of the training has been completed with feedback received from managers who have participated in the training noting the difference it has made in terms of their approach to investigations and allegations. The data evaluation elements are being undertaken independently in part through work with ABHUB and the University for Continuing Education Krems (Danube University Krems).



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This work is underway and is a review of the impact of compassionate practices on our employee relations data. The information has been supplied and the team have met with the scientists on two occasions to date. The outcome of this will be shared with Committee.

REPORT APPROVAL ROUTE

People and Culture Committee – 18 February 2025

REPORT APPENDICES

Appendix 1: Compassionate Practices Presentation Deck
Appendix 2: Compassionate Practices Action Plan

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

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Compassionate Practices Update



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Compassionate Practices Update
Version 1.0
Released: January 2025

by P&C Team
Liz.Rogers@wales.nhs.uk

The Journey So Far

There has been significant work on Compassionate Practices to reduce employee harm in disciplinary processes. We continue to work closely with ABUHB colleagues.

New approach introduced November 2022

Action plan to support embedding the approach developed

224 colleagues have received training in Compassionate Practices

Investigating Officer training sessions delivered to 70 individuals

3 x reducing misogyny and improving sexual safety training sessions delivered (2023)

Internal audit of progress and processes undertaken (March – May 2024)

3 x full time Investigating Officers appointed to the People Services team

People Services team attended AACE Development Programme, focusing on sexual safety (2024)

Disciplinary documentation reviewed, tested and delivered to support approach (2024)

Continue to embed approach and ensure audit actions completed

Update on Audit Recommendations

RECOMMENDATION	ACTION TAKEN
The compassionate practices action plan should be reviewed to ensure timescales are reasonable and capture both the planned changes and implementation periods.	• Action plan reviewed and updated post audit and used as a live and organic document to track actions • Actions grouped into 9 main objectives, with target completion dates
Revised timescales should feature within the updates provided to the People and Culture Committee to ensure awareness of any delays to plan implementation.	• Action plan attached for PCC members Outstanding actions / actions in progress: • Evaluation of training - detailed external evaluation in train • Detailed analysis of our baseline data - high-level analysis has been undertaken – external evaluation in train • FAQ guide – overtaken by All Wales work

Update on Audit Recommendations

RECOMMENDATION	ACTION TAKEN
Post training feedback should be sought in line with the original action, to capture attendees learning from the training and identify any changes in practice.	• High level evaluation is undertaken after each training session • External evaluation in train • Survey completed on changes to personal practice (Nov 2024) • 1 to 1 feedback interviews with TUPs, managers and PS colleagues (for external evaluation)
The Trust should review the case management tracker to identify individuals that have previously been involved in undertaking initial assessments as a priority group for attending future compassionate practices training sessions.	• 2025 training directed at IOs and managers doing initial assessments. • Waiting on HEIW dates for next training sessions



Action Plan Progress

- **The updated action plan contained 46 actions, focusing on:**
 - Training provision
 - Data analysis
 - Initial Assessment development and completion
 - Investigation process and completion
 - Individual wellbeing
 - Team development
 - Collaborative work across the People and Culture team
 - Celebrating successes
- **40 actions are complete** and are BAU. This includes:
 - Review of documentation
 - Production of top tips documents
 - Creating a lessons learned forum with OD, Safeguarding and Operational colleagues
- **Outstanding actions** - evaluation, targeted training attendance, FAQ guide and detailed analysis of our baseline data.

Compassionate Practices 2025

Next Steps for Compassionate Practices in WAST



We continue to articulate and embed a culture across the organisation which focuses on creating an environment where wellbeing and compassion are at the heart of the employee experience



We continue to deliver the action plan and await the formal evaluation, with a view to this approach being 'business as usual'



The findings from the evaluation will be presented to the People & Culture Committee once concluded



We continue to work with HEIW to deliver training to colleagues



We will review the impact of this work internally and coach managers in developing their compassionate practices approach

Thank you for listening, happy to take any questions



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Compassionate Practices Deep Dive

AGENDA ITEM No	12
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	5

PEOPLE AND CULTURE METRICS

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Angela Lewis - Director of Culture Change Carl Kneeshaw – Director of People
AUTHOR	Sarah Davies – Head of Change and People Insights
CONTACT	Sarah.davies31@wales.nhs.uk

EXECUTIVE SUMMARY

This item provides:

- An update against People and Culture Plan qualitative metrics;
- An overview of People and Culture KPIs (December 2024 data);
- A review of existing People and Culture Plan metrics; *and*
- A summary of our proposed People and Culture priorities for the 2025/28 IMTP.

KEY ISSUES/IMPLICATIONS

RECOMMENDATION: The PCC is asked to:

- **RECEIVE** and **COMMENT ON** progress to date shared within **Appendices 1 and 2**
- **SUPPORT** the recommendations made in relation to metrics (**Appendix 3** paragraphs 4, 6, 9 and 11).
- **SUPPORT** the proposed priority focus areas for the 2025-28 IMTP (**Appendix 5** paragraph 5)

REPORT APPROVAL ROUTE

- PCC 18.02.2025
- ELT 29.01.2025

REPORT APPENDICES

Appendix 1: SBAR – People and Culture Metrics
Appendix 2: People and Culture Scorecard December 2024
Appendix 3: SBAR – People and Culture Plan Metrics Review
Appendix 4: Quantitative Metrics List
Appendix 5: SBAR – People and Culture IMTP Priorities

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	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	YES
Health and Safety	YES	TU Partner Consultation	YES

Appendix 1: SBAR: People and Culture Metrics – December 2024

SITUATION

1. The purpose of this report is to:
 - a. provide Committee members with an update against several of the previously agreed qualitative People and Culture Plan metrics, in order to provide a high level indication of the impact of our People and Culture Plan; *and*
 - b. provide an overview of the key People and Culture performance data and trends (December 2024) and associated improvement actions.
2. This paper is intended to be read in conjunction with the **Monthly Integrated Quality and Performance Report**. The MIQPR provides a high level overview of performance in relation to several People and Culture indicators. This report provides a greater level of detail (both data and narrative) in relation to a wider range of workforce performance indicators.

BACKGROUND

3. Following discussion at the August 2023 meeting of the People and Culture Committee, it was agreed that updates will be shared with Executive Leadership Team every 2 months and People and Culture Committee every quarter, to demonstrate progress in terms of implementation and impact of our People and Culture Plan. As agreed, these updates will alternate between a focus on quantitative and qualitative metrics; this item focusses on qualitative metrics.
4. As agreed at the August 2024 PCC meeting, this item will now also incorporate the People and Culture Scorecard, in a bid to more clearly show the associated connections.
5. As a result of our increased and dedicated focus on cultural transformation, we are observing an anticipated uptick in Employee Relations (ER) cases. Whilst this increase reflects heightened awareness and willingness among colleagues to raise concerns, it has also placed additional demands on the team's workload. Furthermore, there is a

notable impact on the Safeguarding Team, as many of these cases intersect with SG responsibilities. To ensure transparency and support effective workload management, metrics relating to the number of new Safeguarding cases opened each month and the total number of open Safeguarding cases will be included in these reports and in future, the number of Safeguarding cases closed each month will also be reported, providing a clearer picture of trends and impact.

ASSESSMENT

People and Culture Plan Metrics

Culture

6. Data demonstrates that disciplinary cases are rising, a trend that aligns with our efforts to encourage speaking up and reinforce a culture of transparency and accountability. Increased reporting suggests that colleagues feel more comfortable raising concerns, which links to our ambition to increase levels of psychological safety across the Trust. This increase should therefore be seen as progress towards establishing a healthy, open organisational culture. The subsequent impact on workload, however, should be noted, both for People and Culture teams and Safeguarding colleagues.
7. December 2024 data reflects 45 open safeguarding allegation cases; a significant number of these include an element of sexual misconduct. It should be noted that this data is only representative of data drawn from the safeguarding team records (not ER case data) and does not include any cases that are known to local management but have not been identified as presenting a safeguarding risk. A significant portion of the Safeguarding Team's time is subsequently currently dedicated to case management, impacting their capacity to focus on other key priorities.
8. Feedback from our people network members is confirming that these communities are offering a safe and supportive place for our staff to come together and share experiences. We're currently working to introduce more structure around Terms of Reference to ensure clarity on purpose and remit, to enable colleagues to contribute fully and meaningfully. Members are finding the education and awareness sessions provided by our networks particularly valuable, both from a personal and professional perspective.
9. Network members are reporting and demonstrating a real appetite and desire to be part of our culture change journey. Colleagues are also keen to share examples of good and poor practise which is helping us understand our people's experience and will shape our plans as we move forward.

Capacity

10. WAST Voices Advocates facilitated a Roadshow in December to engage with colleagues who spend time at hospitals, either outside A&E or in other spaces at hospital sites. The purpose of the activity was to engage with colleagues, seeking their thoughts and views, share information about People Networks and Wellbeing and to show appreciation by being present. The visits were mostly well-received and some valuable insight was gained and will be shared.
11. Not all colleagues were aware of our People Networks and some cited digital literacy as a barrier to engagement and others flagged issues with iPads (Siren accessibility;

devices don't always work). Others shared a desire to come to work and do their job, with no inclination to participate in our networks.

Capability

12. Our focus on embedding change management practices across the organisation is beginning to show positive results. Feedback from colleagues regarding the role of dedicated Change Leads highlights the value of this approach. For example, within the Clinical Model Transformation (CMT) programme, a senior leader implemented engagement activities on the advice of a Change Lead, despite initial scepticism about the value. The outcome was overwhelmingly positive, with the leader recognising the tangible benefits of these activities and praising the contribution of the Change Lead.
13. The success of our Change Community meetings is another indicator of progress. These sessions have become safe spaces where colleagues feel supported to practice their skills, share learning and build confidence in applying learning. Honest feedback gathered during these sessions is providing valuable insights into the practical application of change management learning and will help us shape our plan for the Community.
14. Many colleagues find the tools and skills covered in the Change Management training highly useful, particularly for specific projects. Positive feedback has been received across the board in relation to the subsequent increased ability to balance people-focused approaches with process-driven work.
15. Colleagues have reported that training has helped them better understand the emotional dynamics of change, such as managing resistance, change fatigue and maintaining engagement. Thanks to opportunities provided within our Change Community, members are also reporting improved confidence in addressing change-related challenges, particularly around communication and stakeholder engagement.
16. Feedback from Change Community members indicates that knowledge gained is enabling colleagues to design and implement new processes more effectively. There is a strong appetite for integrating change management tools more deeply into routine practices, which aligns with our ambition to integrate change management skills within Our WAST Way leadership development framework.
17. Feedback highlights some barriers to application of learning, which will help us tailor our plans effectively. Some colleagues noted that they are not using the tools and skills as much as they would like, often due to role constraints and / or limited opportunities. Feedback also indicates that competing demands and the fast pace of work is hindering the ability to fully utilise and embed change management practices.
18. Whilst we are still in the early stages of embedding change management at WAST, these "green shoots" of progress are encouraging. They demonstrate that our efforts are starting to take hold and provide a solid foundation for future growth. Building on this feedback, we will continue to refine our approach, enhance resources, and strengthen the Change Community as a key enabler of our People and Culture strategy. Importantly, these reflections reveal the broader cultural shift taking root, with colleagues beginning to think more strategically about change, focusing on the emotional impact, managing expectations and effective engagement.

People and Culture KPIs

19. **Appendix 2** provides a summary of People and Culture KPIs up to and including December 2024 data.
20. Mandatory In-Service Training (MIST) compliance rates are currently running at 73% with 3 months remaining of the programme. Regular updates regarding compliance are shared with Senior Operations Team (SOT) with locality specific performance shared with Locality Managers (LMs) on a twice monthly basis.
21. During the reporting period, a correction was applied to ESR relating to a Core Skills Training Framework (CSTF) competency, specifically, Resuscitation at Level 1, resulting in a drop in compliance across the organisation. The main group affected by this correction are those in corporate roles. A short eLearning course has been devised and deployed on Learn365 to swiftly rectify compliance and return current performance of 76.55% back to the normal level of >95%. Fire Safety compliance remains below the 85% threshold as does Information Governance; the latter has had an eLearning course co-produced by colleagues in the IG function of the Digital Directorate and Education & Development, deployed via Learn365 where engagement can be targeted directly and monitored to individual granularity.
22. There have been monthly increases in sickness absence during the last 4 months of 2024 and People Services continue to support managers to ensure there is a focus on wellbeing, compassionate practices and supportive work environments for colleagues. December 2024 showed a Trust-wide increase in sickness absence (8.69% compared to the lowest percentage in September 2024 at 7.46%). Comparing the same period in 2023, the Trust reports an overall reduction in sickness absence (an average of 1.04% reduction across the last 4 months of 2024). The Operations Directorate reported an increase in December 2024 to 9.36% compared with the lowest percentage in June 2024 at 8.03%. Comparing the same period in 2023 Operations have reported an overall decrease in sickness absence (an average of 1.08% reduction across the last 4 months of 2024). Short term absence continues to fluctuate month on month; however, long term absence continues to decrease.
23. Although R&R cases have been fairly consistent over this period, with an average of 3 new case per month, 56% of cases have been opened and closed in this period, with the majority themes relating to Policy & Procedure and Bullying & Harassment. There has been a significant increase in formal ER cases reported (including cases at the Initial Assessment stage and those with 3rd party involvement e.g. Counter Fraud/Police). 56% of cases relate to inappropriate behaviour, with 35% of overall cases having a sexual element, which is a steadily increasing theme. Throughout this period, 6 longstanding Police cases were concluded. There is a notable increase in the number of cases resolved through informal action in line with compassionate practices; 28% of cases were resolved informally in this period.
24. Recruitment colleagues continue to monitor metrics including 'Vacancy creation to conditional offer', 'Time to shortlist' and 'Vacancy creation to ready for start date', which greatly impacts on our time to hire. The pan Wales target for 'Vacancy creation

to conditional offer' is 44 days and we returned an average of 45.5 days within the last 3 months, with December seeing the greatest hike in figures. The pan Wales target for 'Vacancy creation to ready for start date' is 71 days but the Trust returned an average of 75.5 days, with November returning the highest figure; this is due to the recruitment team working with appointing managers to close older records. We are also seeing a higher number of adverts being advertised for extended periods. The target for 'Time to shortlist' is 3 days and WAST's current average is 3.5 days. Recruitment colleagues continue with data cleansing exercises and a continuous drive to educate managers on the impact of delays during recruitment exercises, both of which seek to improve recruitment figures.

25. We've seen a slight increase in PADR compliance from 75.89% to 76.55% in this reporting period but this remains below the Welsh Government target of 85%. We continue to focus on quality improvements, gathering feedback from staff, identifying barriers and exploring best practices outside the organisation to inform our approach. Our goal is to re-engage staff and enhance the PADR process to drive both completion and meaningful conversations.
26. Considerable focus has remained on Job Evaluation and a comprehensive update paper is scheduled to go to ELT which will set out our future plan. Improvements continue to be achieved with the average number of days to complete a job description going through the process down to 17 days; additionally, there are no job descriptions in the system more than 28 days.

RECOMMENDED

27. That PCC:
 - a. **RECEIVE** and **COMMENT ON** progress to date.

Appendix 3: SBAR: People and Culture Plan Metrics Review

SITUATION

1. The purpose of this report is to review the current People and Culture Plan Metrics reporting framework, assess its effectiveness in providing actionable insights and provide recommendations for maintaining the existing reporting structure.

BACKGROUND

2. Following the launch of our People and Culture Plan in May 2023, a set of metrics were developed in order to assess its impact.

ASSESSMENT

3. At present, updates are provided to the People and Culture Committee on a quarterly basis and to ELT on a 2 monthly basis. Noting that significant changes in organisational culture are unlikely to manifest within such short intervals, updates alternate between a focus on quantitative and qualitative metrics. The nature of cultural shifts often requires a more extended timeframe for meaningful change to be observable and substantial differences may not always be apparent in each reporting cycle. This approach, however, allows us to capture the subtleties of both data types over time, facilitating a more accurate depiction of the gradual development of our People and Culture initiatives.
4. It is **recommended** that reports continue to alternate between qualitative and quantitative, enabling provision of both high-level trends and in-depth contextual analysis.
5. Both quantitative and qualitative reports are structured around the 3Cs of our People and Culture Plan (Culture, Capacity and Capability), ensuring alignment with our strategic priorities and providing a clear framework for organising and interpreting data.
6. It is **recommended** that categorisation of metrics under these three pillars continues, to ensure a balanced focus on each area and to provide clarity and consistency for colleagues in understanding how metrics link to strategic goals.
7. The quantitative report monitors engagement with initiatives like the NHS Wales Staff Survey and local pulse surveys; it also tracks engagement with our Staff Networks, providing an indication of our impact in terms of amplifying colleague voice and creating a sense of belonging and inclusion. Additionally, it measures key organisational health indicators such as sickness rates, turnover, PADR completions and compliance with statutory and mandatory training requirements. Employee relations data, including disciplinary cases and requests for resolution, further contribute to understanding workplace dynamics.
8. As a result of our increased and dedicated focus on cultural transformation, we are observing an anticipated uptick in Employee Relations (ER) cases. Whilst this increase

reflects heightened awareness and willingness among colleagues to raise concerns, it has also placed additional demands on the team's workload. Furthermore, there is a notable impact on the Safeguarding Team, as many of these cases intersect with SG responsibilities. To ensure transparency and support effective workload management, metrics relating to the number of new Safeguarding cases opened each month and the total number of open Safeguarding cases will be included in these reports and in future, the number of Safeguarding cases closed each month will also be reported, providing a clearer picture of trends and impact. In addition, it is proposed that the number of live and closed Speaking Up Safely cases be included in reporting going forward.

9. It is **recommended** that the current quantitative metrics are retained and relevant Safeguarding and Speaking Up Safely metrics added (list contained within **Appendix 4**).
10. The qualitative report spotlight adapts to emerging priorities and available data, including survey response highlights and evaluations from events and educational programmes to assess impact and value. Reports have also included feedback from moving-on interviews, shedding light on reasons for leaving and offering insights for retention plans, plus themes emerging from staff network activities and WAST Live questions, providing an understanding of recurring issues, staff concerns and engagement levels. Together, these qualitative metrics provide a richer, more nuanced understanding of organisational culture and colleague experience.
11. It is **recommended** that the current approach to qualitative reporting be retained, allowing flexibility to spotlight available and relevant data.

RECOMMENDED

12. That PCC:
 - a) **SUPPORT** the recommendations made (paragraphs 4, 6, 9 and 11).

Appendix 4: Metrics List

Existing:

- Staff Survey Completion Rate
- Network Membership
- Disciplinary Cases
- Formal Requests for Resolution
- Cultural Reviews Underway
- Turnover
- Sickness (12 Month Rolling)
- Sickness (In Month)
- MIST Compliance
- Statutory and Mandatory Training Compliance
- PADR Compliance

Proposed Additions:

- New Safeguarding Cases
- Total Open Safeguarding Cases
- Number of Live Speaking Up Safely Cases
- Number of Speaking Up Safely Cases Closed

Appendix 5: SBAR: People and Culture IMTP Priorities

SITUATION

1. The purpose of this report is to provide an overview of our 2025-28 IMTP priorities from a People and Culture perspective.

BACKGROUND

2. Throughout 2024-25, we have continued to strengthen our internal capacity to drive culture change, harnessing the passion and energy of our flourishing people networks. 2025-28 will see us further developing change capability and capacity both formally and informally, to support the many projects and transformation activities across the organisation.
3. Our proposed People and Culture priorities for the Integrated Medium-Term Plan (IMTP) build on the foundation of our existing People and Culture Plan. These priorities reflect our commitment to driving forward initiatives that promote belonging and inclusivity, support our people and align with broader organisational ambitions, such as the Clinical Model Transformation Programme and the outcomes of our ongoing cultural transformation efforts.
4. At the time of writing, prioritisation work is still ongoing and we are working with colleagues to understand and shape our role in supporting broader organisational ambitions.

ASSESSMENT

5. The following provides an overview of our proposed focus areas for the 2025-28 IMTP:
 - EDI remains a golden thread running through all our work. Alongside embedding EDI into our everyday practices (through delivery of our Strategic Equality Objectives), we are committed to driving forward the successful delivery of our statutory action plans. Specific initiatives will also include partnering with HEIs to increase student diversity and launching targeted campaigns to attract candidates from a wide variety of backgrounds for the full range of career opportunities within WAST.
 - Delivering on our Strategic Workforce Plan to ensure we have the right people, with the right skills, in the right roles. This includes workforce modelling and aligning recruitment strategies to meet future demands, including those associated with the CMT Programme.
 - Building on our existing recruitment efforts, we aim to refine our onboarding processes to create a seamless and engaging experience for new starters. Additionally, we will prioritise the job evaluation process to ensure roles are accurately and efficiently assessed.
 - Supporting attendance and enhancing health and wellbeing across our workforce are vital to sustaining organisational capacity; this will include targeted initiatives to reduce sickness absence and delivery of our Health and Wellbeing Plan to enhance colleague wellness and experience.

- Investing in the education and development of our people is a key priority. We will also review and implement the Digital Skills Strategy for 2025–2030 and develop a comprehensive People Development Plan for the same period, ensuring alignment with organisational priorities and future workforce needs.
 - Guided by our People and Culture Plan, we will continue to support organisational change efforts, including those driven by the CMT Programme. This involves embedding change management practices that are compassionate and inclusive and leading on associated OCPs.
 - Our approach to employee relations will emphasise fairness and compassion, as we continue to promote practices that prioritise understanding and resolution, contributing towards development of a supportive workplace culture.
 - Collaboration with our Trade Union Partners is critical. We recognise the importance of maintaining and strengthening trust and engagement with our partners; the delivery of a Conference in March 2025 will be a core part of this and we are proudly sharing our story at the forthcoming Ambulance Leadership Forum (ALF). The coming year will bring some challenging issues which we will need to handle in partnership and as such, our continued focus on enhancing our collaborative and co-production approach to partnership working is vitally important.
 - Focusing on psychological safety and addressing fundamental needs (“getting the basic right”), we aim to create an environment where colleagues feel valued, supported and empowered to perform their best, identifying and addressing barriers that currently negatively impact colleague experience. Increasing sexual safety and addressing misogyny are key areas of challenging and emotive work that we are deeply committed to tackling.
 - Leadership development remains a central focus for us and the rollout of *Our WAST Way* will be central to building leadership capability and competency across the organisation.
 - We are also reviewing the Behaviours Framework to build on solid foundations, incorporating feedback and refining it to reflect our evolving cultural landscape. By aligning the framework with *Our WAST Way*, we aim to ensure that our behaviours guide and empower leaders and managers to help us build our desired culture and enhance colleague experience across the board.
 - 2025-26 will see us developing our new People and Culture Plan, to be launched by May 2026. We are committed to building on the strong foundations established under the current plan and by reviewing the impact of our work over the past three years and drawing on rich insights from our people, we will ensure that our future Plan is both forward-thinking and grounded in what matters most to colleagues.
6. These priorities reflect our ongoing commitment to building on the strong foundation of our current People and Culture Plan, whilst simultaneously responding to new and emerging challenges. They aim to ensure we continue to support and develop our people in a way that aligns with Trust ambitions and enhances overall colleague experience.

RECOMMENDED

7. That PCC **SUPPORT** the proposed priority focus areas (paragraph 5).

AGENDA ITEM No	13
OPEN	
No of ANNEXES ATTACHED	1

**MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD –
December 2024/January 2025**

MEETING	People & Culture Committee
DATE	18 th February 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Melanie.O'Connor@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. 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 **December 2024/January 2025**.
2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators.
3. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators, with the result that there are a number of Board approved metrics which are not available at this time.
4. The response times for red 8-minute performance was 48.33 % in January 2025, with performance being maintained compared to December 2024, despite winter pressures. Amber 1 median was 2 hours 32 minutes, much longer than the one and a half hours the Trust has normally been experiencing. The Trust knows these extended times (the ideal is 18 minutes) leads to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (95% in December, achieving the benchmark) and fully rolling out the CHARU service (89% in December and 94% in January, the

highest achieved to date); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 27,212 hours to handover in January 2025, which is the highest January figure yet recorded. This level of lost capacity is difficult to compensate for, despite all the actions being taken by the Trust.
6. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours, in particular, investing in clinical screening and APPs, which form part of the CMT Programme.
7. 111 call handling performance has stabilised post-delivery of the new 111 CAS. The service did not achieve the 5% abandonment rate in January 2025, although performance improved to 8.2% from 14.5% in December 2024.
8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with both oncology and renal journeys being above target in January 2025. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25, a key efficiency.
9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 8.69% in December 2024, above 8% for only the second month since March 2024. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions achieved the 30% benchmark figure in January 2025 at 29.19%.
10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace. Key parts went live in December, in particular, remote clinical screening (RCS), which was a cultural shift in how the Trust manages 999 demand.

RECOMMENDATION

PCC is asked to: -

- i. **Consider** the December 2024/January 2025 Integrated Quality & 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.

REPORT APPROVAL ROUTE

18.02.25 People & Culture Committee (PCC)
19.02.25 Executive Leadership Team (ELT)

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

SITUATION

1. 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 **December 2024/January 2025**.
2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give a general overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators:-

PCC

Slide Title	Slide Number
Safeguarding, Data Governance & Public Engagement Indicators	14
Health & Safety Indicators	15
Patient Experience Surveys	17
Ambulance Abstractions and Production Indicators	18
Sickness Absence Indicators	19
Staff Turnover	20
PADR and Training Rate Indicators	21
Heath & Wellbeing/Shift Overruns	22
Disciplinary Hearings and Applicants Shortlisted	23

BACKGROUND

3. This Integrated Quality & Performance Report contains information on 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
4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. The 2024/25 revised metrics have been agreed.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

5. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
6. **999** call answering times improved in January 2025 with the 95th percentile reducing to 10 seconds, compared to 1 minute 10 seconds in December 2024. The 65th percentile and median performance remain consistently good, however data quality checks are being undertaken.
7. **111 call answering performance has improved over recent weeks**, and the call abandonment performance was at 8.2% in January, but still failing to achieve the 5% target. One of the key issues has been the temporary reduction in call handling staff in post caused by a redirection of available training capacity following the delivery of the new 111CAS system. Recruitment has been undertaken to recover the staff in post to the establishment position which has seen performance improve, but high sickness levels are having an effect. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).
8. 111 demand in January 2025 was 2.7% lower than during January 2024. The Trust has procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.
9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 92%. Response times for lower priority calls declined, recording 62.2% and 60.9% for P2CT and P3CT respectively.
10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for January 2025 was 48.33%, remaining below the 65% target, but improving slightly compared to December 2024. The Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in January was 2 hours 32 minutes and the Amber 1 95th percentile was 11 hours 45 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm.
11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). A recruitment gap has been identified and is currently being addressed through a series of corrective actions, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to implement a

material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which will be implemented before winter. Areas of focus include: -

- Data quality issues have been identified with APPs and these are currently being addressed.
- Further investment into remote clinical capacity (+28.5 FTEs);
- Further investment in APPs (+32 APPs);
- Development of the remote integrated care service (111 clinicians and CSD clinicians);
- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.
- Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

12. The one area of particular focus for recruitment is CHARU: with the Trust looking to recruit up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity. The Trust achieved an 94% CHARU UHP in January 2025, the highest it has achieved and is now seeking to close the remain gap through the recruitment of fully qualified paramedics.

13. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 27,212 hours were lost during January 2025, the highest figure recorded for any January. Cardiff & Vale's handover lost hours continue to remain comparably much lower, due to an organisational focus within the health board. While some small improvements have been seen in other health boards during 2024, Betsi Cadwaladr health board remains significantly high and above its two-year average figure, with 10,735 hours being lost within the health board during January. WG have re-iterated to health boards the critical importance of improvements in this area. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.

14. Ambulance Care (Patient Experience): Oncology performance in January 2025 was 76%, achieving the 70% target. Renal performance improved to 70.6% which was also above target. Advanced discharge & transfer journey performance increased to 81% but still remains below its 95% target. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is also about to re-roster NEPTS transport which will better align available capacity with changing demand patterns (on target).

- 15. National Reportable Incidents (NRIs) / Concerns Response:** the Trust reported three NRI's to the NHS Executive in December 2024, remaining consistent with November 2024; and 10 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In December 2024 complaint response times improved to 73%, an improvement on the 71% recorded in November 2024, remaining just below the 75% target, with cases remaining complex.
- 16. Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 88.7% in December 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate increased to 22.3% in December 2024 compared to 19.1% in November 2024.
- 17.** The Trust can report on call to door times for Stroke and STEMI patients. For December 2024, these highlight call to hospital door times of three hours and 6 minutes for stroke patients and two hours and sixteen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, as a result of the pressures and issues outlined in this report.
- 18.** In January 2025, 7,758 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to the application of the Clinical Safety Plan to approximately 92 callers. Both of these figures are a significant reduction on December 2024 levels. The Trust believes that 50% of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards supports this view, but data linking planned for 2025 is a key enabler to properly evidence this. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

- 19. Hours Produced:** The Trust produced 127,833 Ambulance Response unit hours in January 2025 and delivered an emergency ambulance unit hours production (UHP) of 97%, achieving the 95% target.
- 20. Response Abstractions:** EMS abstraction levels decreased to 29.91% in January 2025, below the 30% benchmark figure. Response sickness abstractions stood at 8.12% (benchmark 5.99%).
- 21. Trust sickness absence:** the Trust's overall sickness percentage was 8.69% in December 2024, a slight increase on the 8.06% recorded in November 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue

to reduce this level supported by the ten-point plan. The 8% is above the 2023/24 IMTP ambition of 6%.

- 22. Staff training and PADRs:** PADR rates did not achieve the 85% target in January 2025, but improved slightly to 77.02%. Compliance for Statutory and Mandatory training increased slightly to 85.64% and continues to achieve the 85% target.
- 23. People & Culture Plan:** the Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook another round of a pan-Wales of CEO Roadshows in October 2024. The next round of CEO Roadshows are planned for April 2025.

Finance & Value

- 24. Financial Balance:** the reported outturn performance at Month 9 is a surplus of £42k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

- 25.** We are not able to report on the consult & close rates as the 111 contribution is not available due to issues with system changes within the 111 CAS system. The IMTP ambition (and Welsh Government target) remains 17% at this point in time. The Trust is currently validating new data in this area.
- 26.** Same Day Emergency Care (SDEC) centres continue to only see a low level of ambulance activity and handover levels remain extreme, which make the work on the updated clinical model, before next winter, a tactical imperative. Data quality checks are underway.

Summary

- 27.** The indicators used at this high-level highlight that 111 has been resilient during the winter months, more so than in previous years. For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme. However, hospital handover lost hours have increased and remain extreme. These levels give further imperative to continuing with the clinical model transformation. NEPTS performance was stable, with the Trust about to re-roster NEPTS transport.

RECOMMENDATIONS

PCC is asked to: -

- i. **Consider** the December 2024/January 2025 Integrated Quality & 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.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

December 2024 / January 2025

Annex 1 – Top Indicator Dashboard



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: February 2025

by Commissioning & Performance Team



Section 1: Monthly
Indicators / Top Indicator
Dashboard



Top Monthly Indicators	Target 2024/25	Nov-24	Dec-24	Jan-25	2 Year Average	RAG	Top Monthly Indicators	Target 2024/25	Nov-24	Dec-24	Jan-25	2 Year Average	RAG
Our Patients							Health & Well-being						
Timeliness Indicators							Sickness Absence (<i>all staff</i>)	6.0%	8.06%	8.69%	N/A	7.86%	R
NHS111 Call Handling Abandonment Rates	< 5%	6.4%	14.8%	8.2%	8.9%	R	Mental Health Absence Rates	Reduction Trend	2.58%	2.93%	N/A	2.26%	R
111 Clinical Triage Call Back Time (P1)	90%	97.7%	93.4%	92.0%	98.1%	G	Staff Turnover Rate	Reduction Trend	8.45%	7.95%	7.95%	8.69%	G
999 Call Answer Times 95th Percentile	00:06	01:00	01:10	00:10	00:17	R	Statutory & Mandatory Training	>85%	84.47%	85.51%	85.64%	75.84%	G
999 Red Response within 8 minutes	65%	47.6%	47.6%	48.3%	49.5%	R	PADR/Medical Appraisal	>85%	76.51%	76.55%	77.02%	72.51%	A
999 Amber 1 Median	00:18	01:56	03:00	02:32	01:27	R	Number of Shift Overruns	Reduction Trend	3,534	4,190	4,156	3,686	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	75.2%	77.6%	76.0%	72.7%	G	Inclusion & Engagement / Culture						
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	76.3%	74.7%	81.0%	80.1%	R	NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.6%	1.7%	1.7%	1.7%	G
Clinical Outcomes / Quality Indicators							Value						
Return of Spontaneous Circulation (ROSC)	Increasing Trend	19.1%	22.3%	N/A	19.1%	G	Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	100.00%	N/A	100%	G
Stroke Patients with Appropriate Care	95%	90.5%	88.7%	N/A	80.2%	A	EMS Utilisation Metric (CHARU)	Increasing Trend	28.1%	31.3%	N/A	27%	G
Stroke Call to Hospital Door Times	Reduction Trend	02:48	03:06	N/A	10.0%	R	Average Jobs per Shift (All Vehicles)	Increasing Trend	2.26	2.29	N/A	2.32	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	70.1%	76.7%	N/A	50.2%	R	NEPTS on the Day Cancellations	Reduction Trend	13.8%	13.3%	N/A	13%	R
National Reportable Incidents reports (NRI)		3	3	N/A	4		Partnerships / System Contribution						
Can't Send & Cancelled by Patient Volumes	Reduction Trend	11,154	11,842	8,242	8,964	A	Inverting the Triangle						
Concerns Response within 30 Days	75%	71.0%	73.0%	N/A	49.6%	A	Successful Consult & Close Outcome	17.0%	N/A	N/A	N/A	13.1%	
Enactment of the Duty of Candour Total		4	1	N/A	4		% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.46%	11.03%	N/A	11.3%	G
Our People							Number of Handover Lost Hours	7,500	20,995	25,195	27,212	22,159	R
Capacity							NHS111						
Hours Produced for Emergency Ambulances	95-100%	95%	95%	97%	90%	G	NHS111 Dental Calls	Increasing Trend	N/A	N/A	N/A	6,986	
							Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	N/A	962	

In-Month RAG Indicates =
Green: Performance is at or has exceeded the target (*Indicates no action is required*)
Amber: Performance is at or within 10% of target (*Indicates some issues/risks to performance (monitoring is required)*)
Red: Performance is less than 10% of target (*Indicates close monitoring or significant action is required*)
TBD: Status cannot be calculated (To Be Determined)

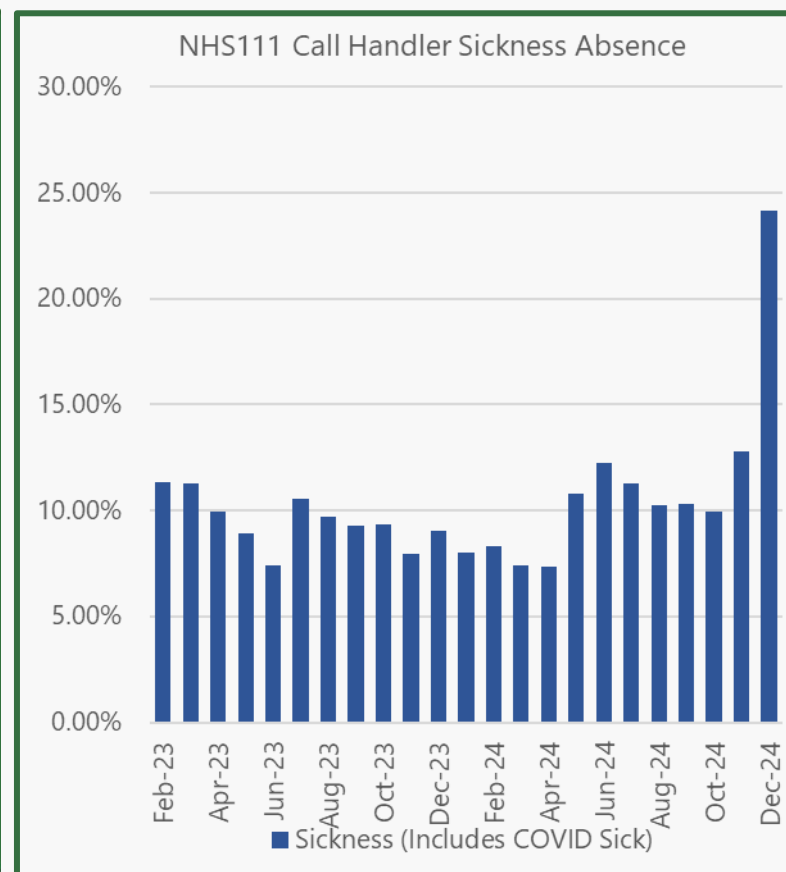
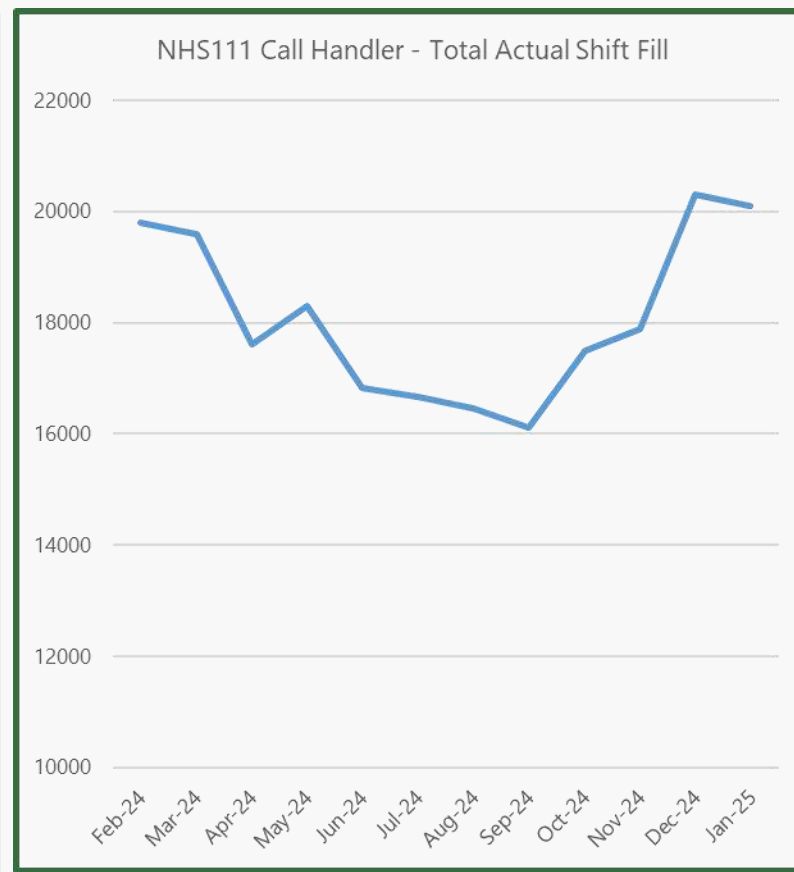
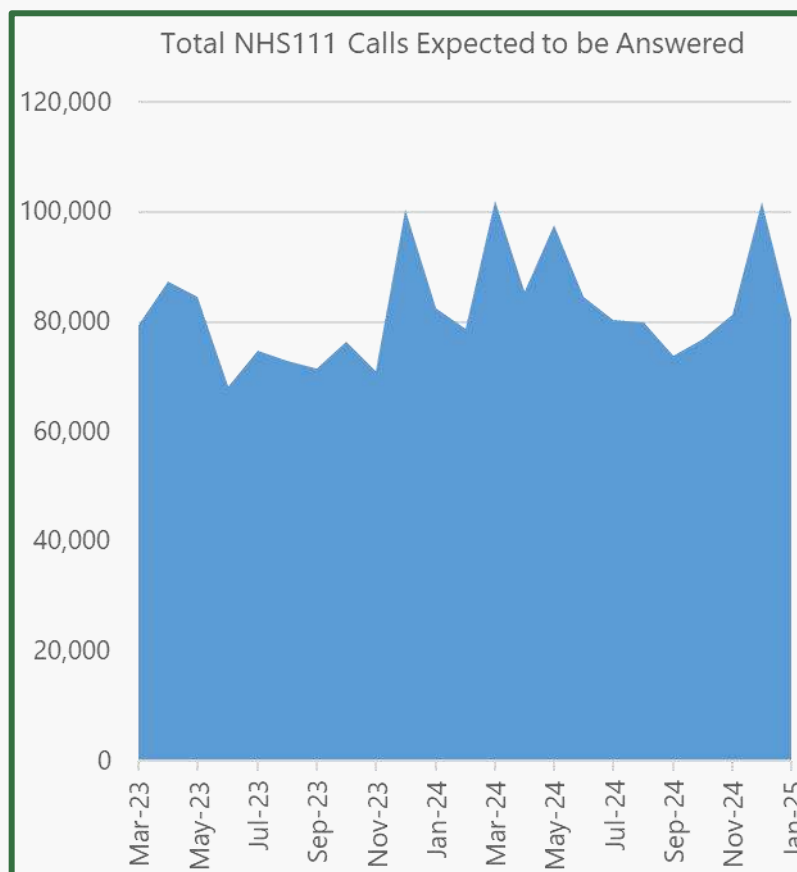
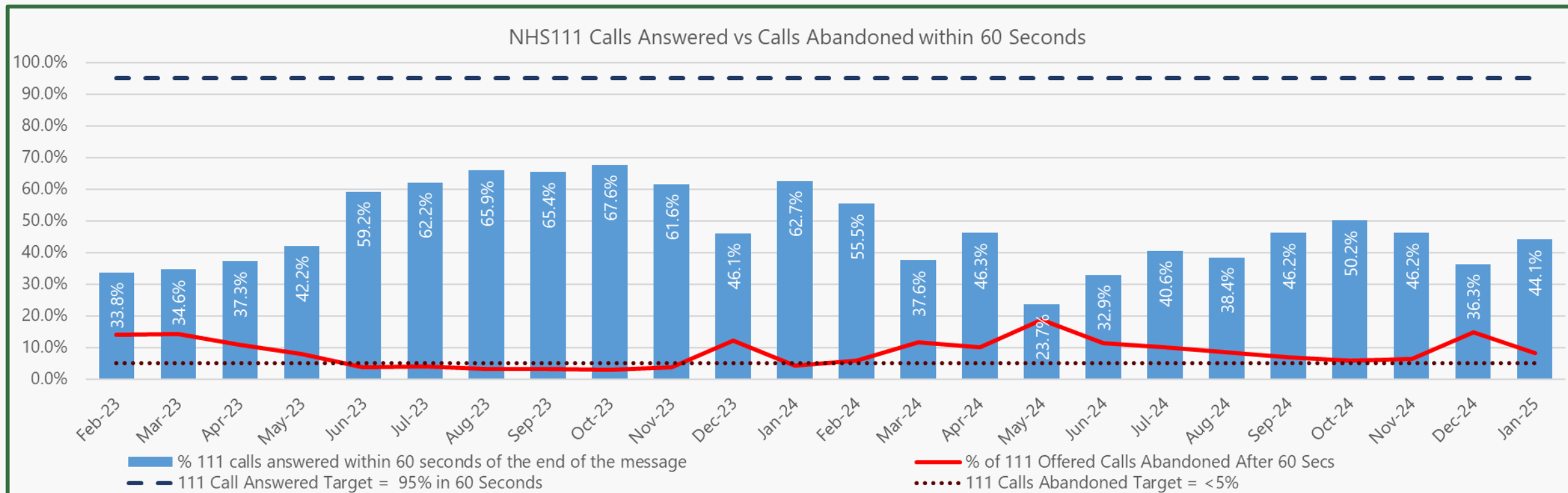
Welsh Ambulance Services University NHS Trust

Our Patients: Quality, Patient Safety & Experience

111 Call Answering/Abandoned Performance Indicators

Influencing Factors – Demand and Call Handling Hours Produced

(Responsible Officer: Lee Brooks)



Analysis

The 111-call abandonment rate decreased to 8.2% in January 2025 from 14.8% in December 2024. The percentage of 111 calls answered within 60 seconds increased, from 36.3% in December 2024 to 44.1 % in January 2025, but continues to remain below the 95% target.

Following a decline in performance during the middle part of 2024, due mainly to the introduction of the new 111CAS system, which went live on 30th April 2024, performance has seen a gradual improvement. However, figures are not yet back to the levels seen during 2023 when call answering averaged 52% and abandonments less than 8%.

Remedial Plans and Actions

Key actions include:

- Actions have been undertaken to try and improve the call handling position across the Winter months with record levels of resourcing seen in December 2024 as well as opportunities for further bolstering including overtime, bank and managers/supervisors also re-aligned to call handling.
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work review that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.

Expected Performance Trajectory

The expectation is that with the recruitment of additional staff, performance will continue to improve; however, there are risks including higher levels of demand and high sickness levels. The 111 service did see a spike in sickness in December.

Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced

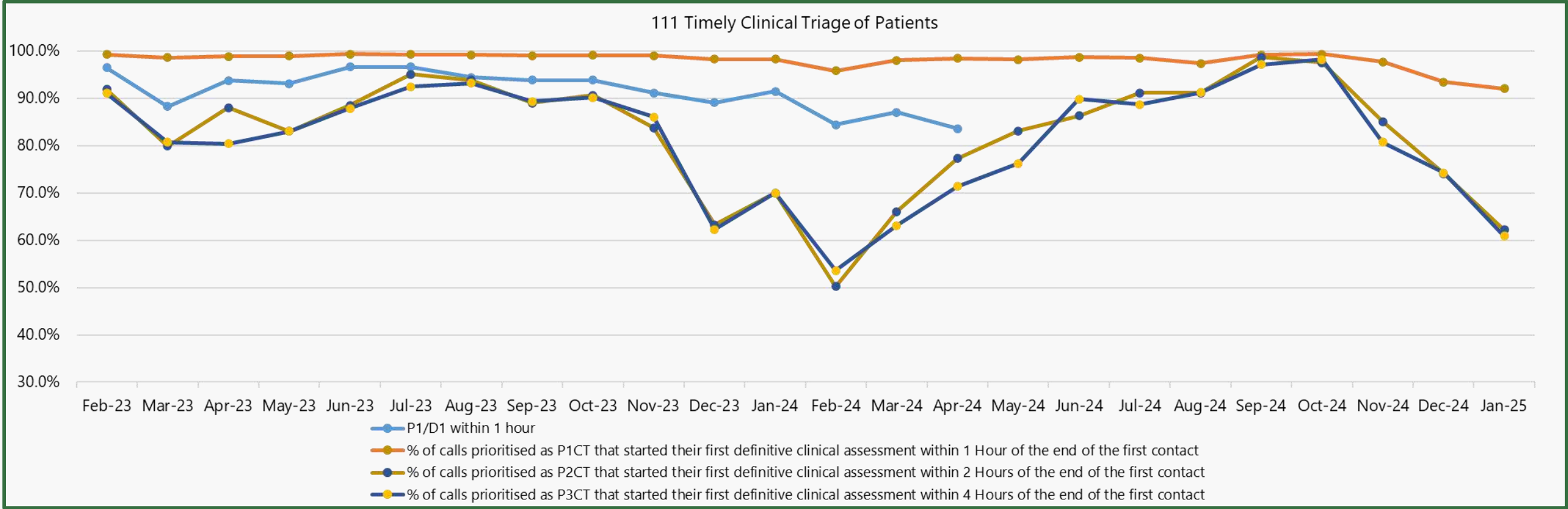
(Responsible Officer: Lee Brooks)

P1CT

G

FPC

NB: Data quality issues have been identified in 111. These are currently being addressed.



Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 92.0% in January 2025.

Ring back times for lower category calls did see an improvement from February 2024, however, they have since followed a similar pattern to last year and declined from October 2024 to January 2025. If continuing to follow a similar pattern it is expected that these times will improve once again from February 2025.

Numbers of clinician hours produced decreased last month, dropping from 12,052 hours in December 2024 to 11,591 hours in January 2025. Clinician sickness absence during December 2024 was 12.66%.

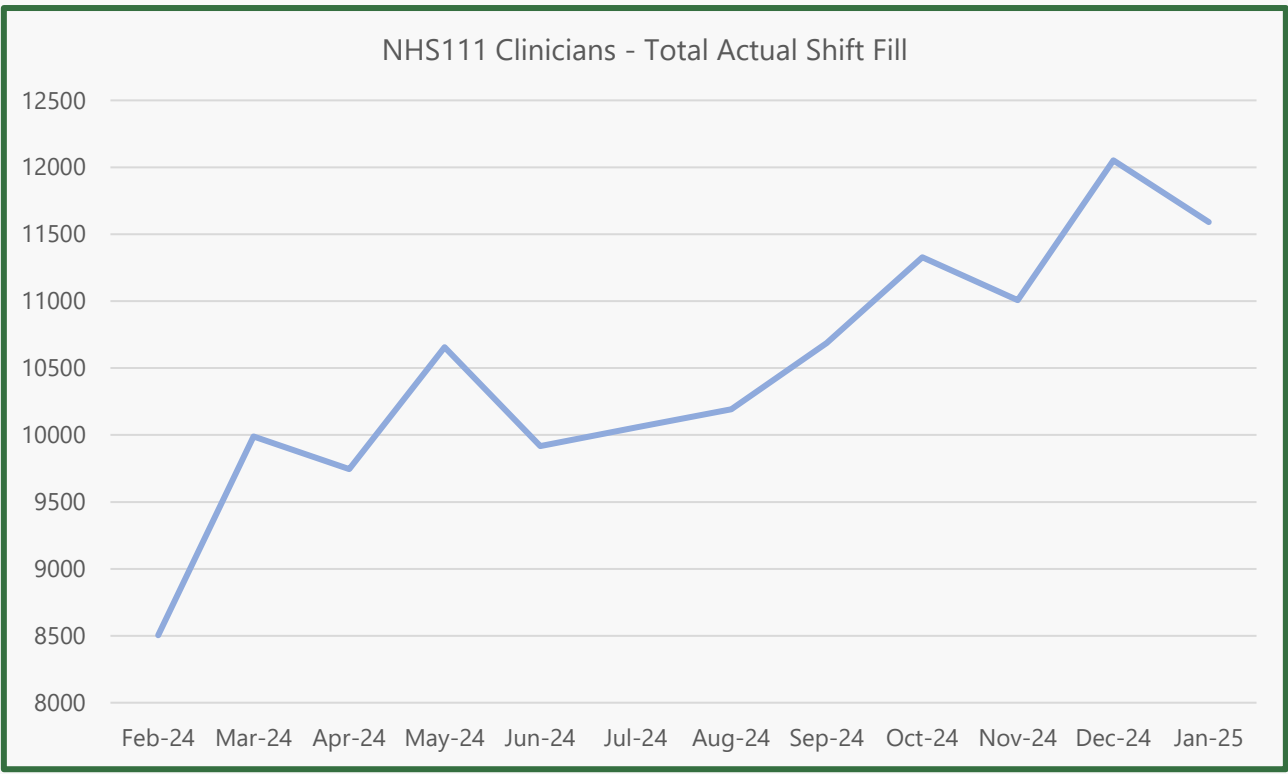
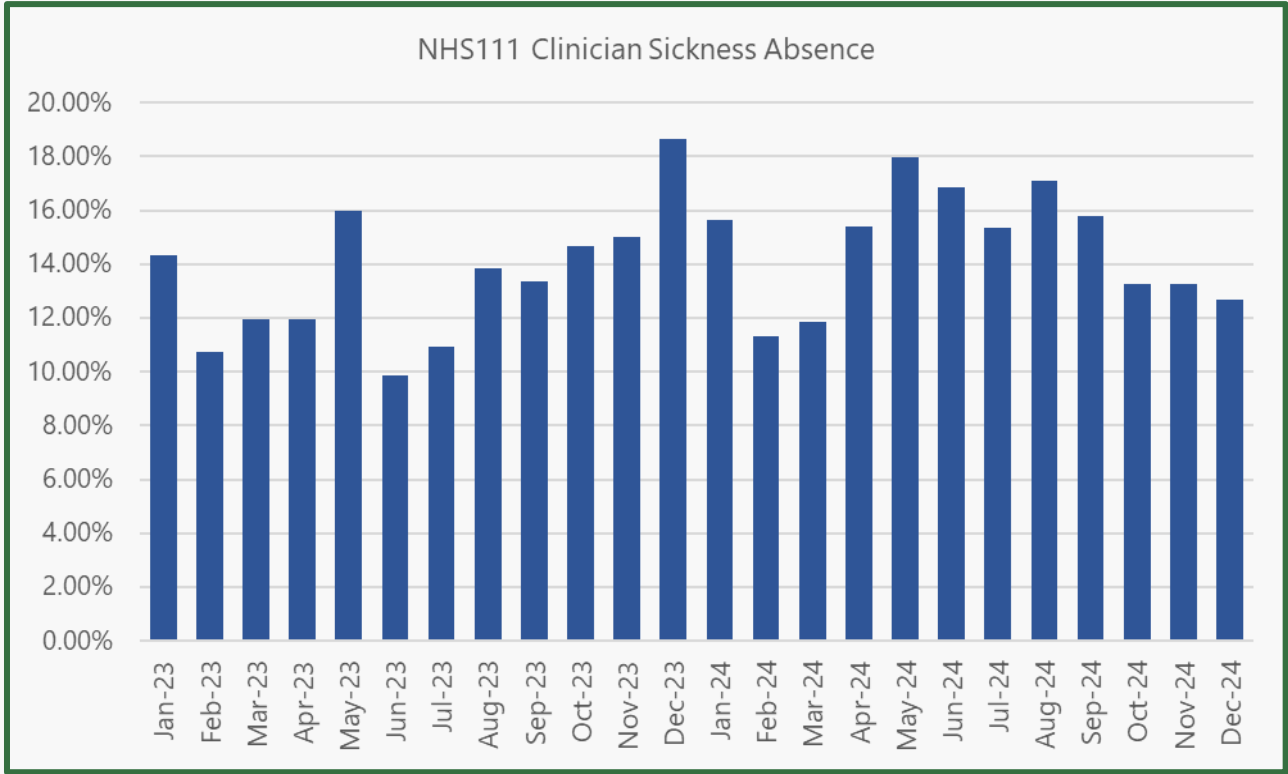
Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians
- A review to determine appropriate levels of capacity to meet increasing demand (this may now be delayed to enable the impact of the work on the digital front end to take effect).

Expected Performance Trajectory

The new 111CAS will bring performance benefits. Initial approach to performance prediction developed, but further work being undertaken to refine the accuracy of the predictor.

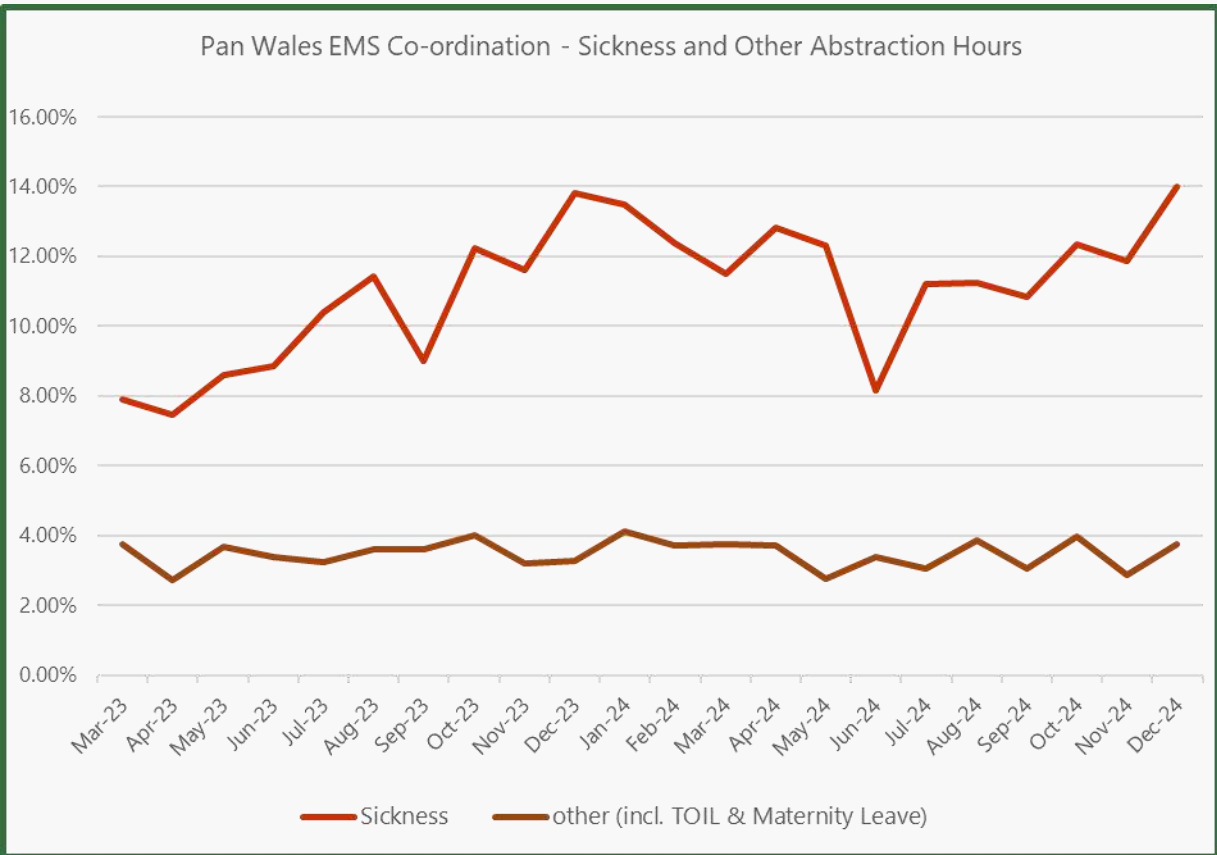
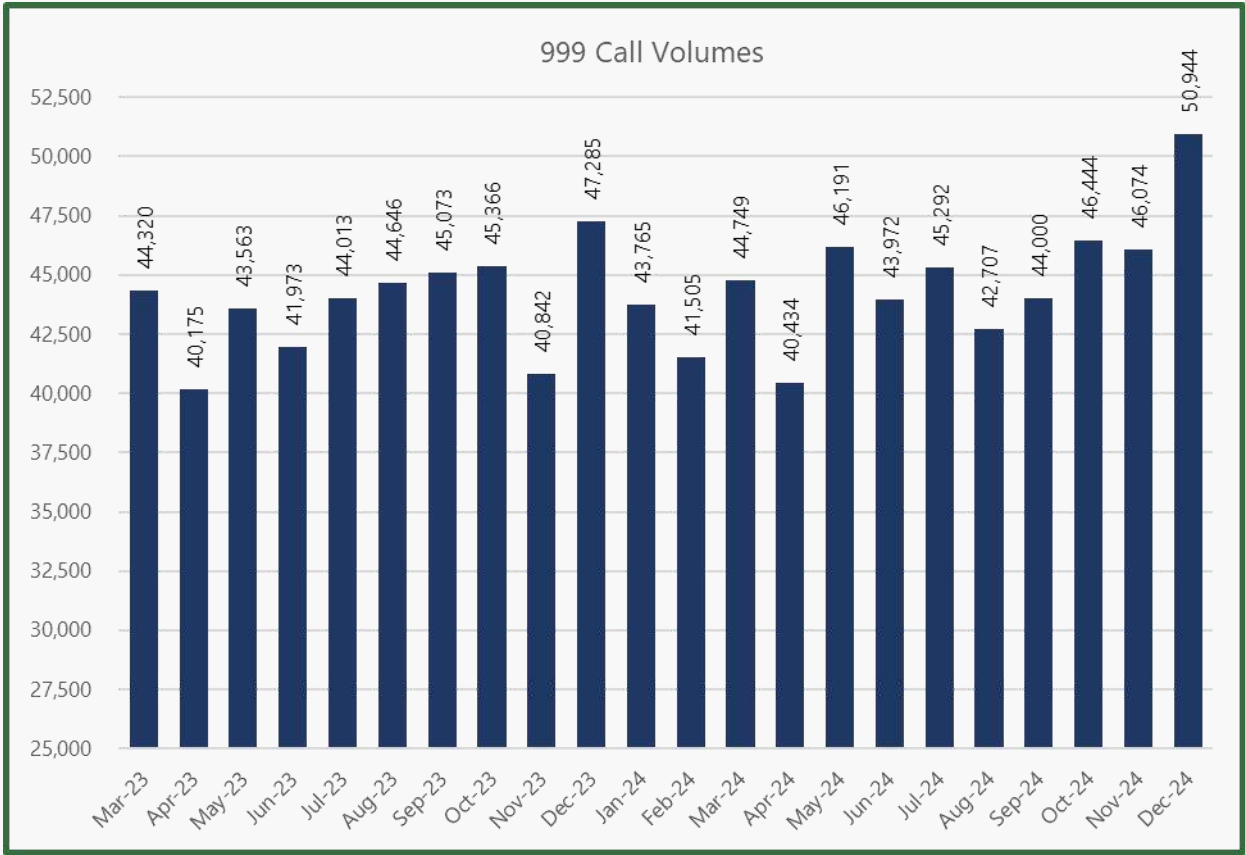
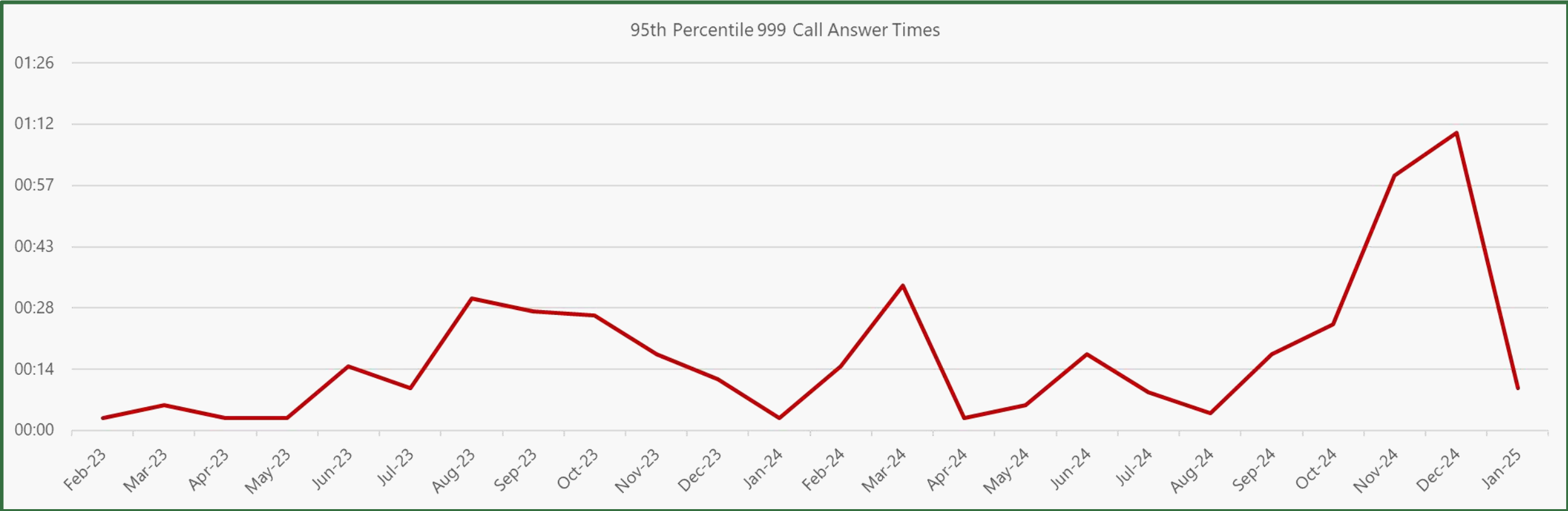
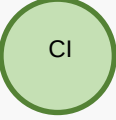


Our Patients: Quality, Safety & Patient Experience

999 Call Performance Indicators

Influencing Factors – Demand and Hours Produced

(Responsible Officer: Lee Brooks)



Analysis

The 95th percentile 999 call answering performance improved to 10 seconds in January 2025 but failed to achieve the 6 second target; however, the median call answer time for the 999-service has been consistently good at 2 seconds (October 2024). However, due to the migration of the 999-telephony service, data quality checks are being undertaken for further 2024 data.

There was an increase in demand in December 2024 to 50,944 calls from 46,074 in November 2024.

Sickness levels saw an increase from 11.86% in November 2024 to 13.99% in December 2024.

Remedial Plans and Actions

- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Further recruitment is underway in North, with 3 cohorts starting by the end of the fiscal year.
- Work is ongoing to identify what is contributing to high sickness via the Managing attendance at work and attrition via the recruitment and selection processes.

- A transformation programme concluded in November:
- **Roster Review.** A dispatch roster review for Allocators and Dispatchers. Complete.
 - **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams. Complete.
 - **Broader Ways of Working.** This project is looked to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and reduction in variation across centres. Complete.

Expected Performance Trajectory

The median and 65th percentile are performing very well and are stable. Paper currently being drafted on future resilience of EMSC i.e. winter demand v capacity (with efficiencies).

Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

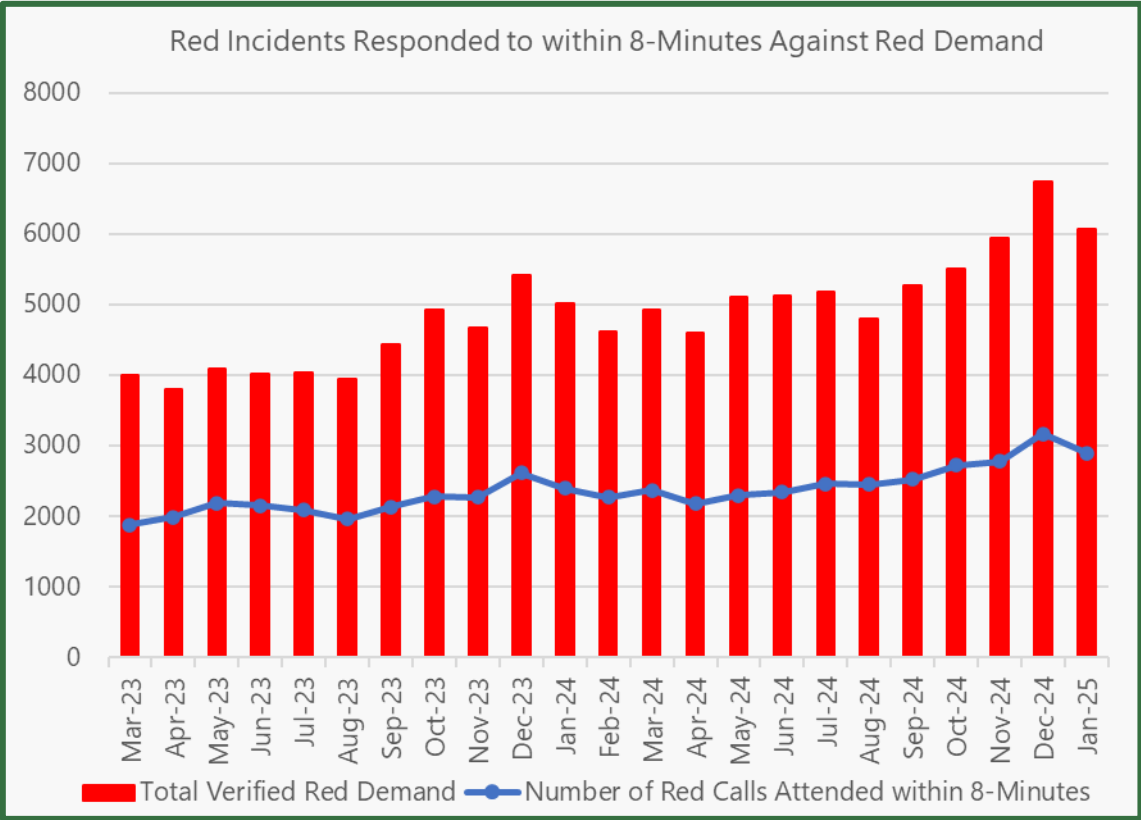
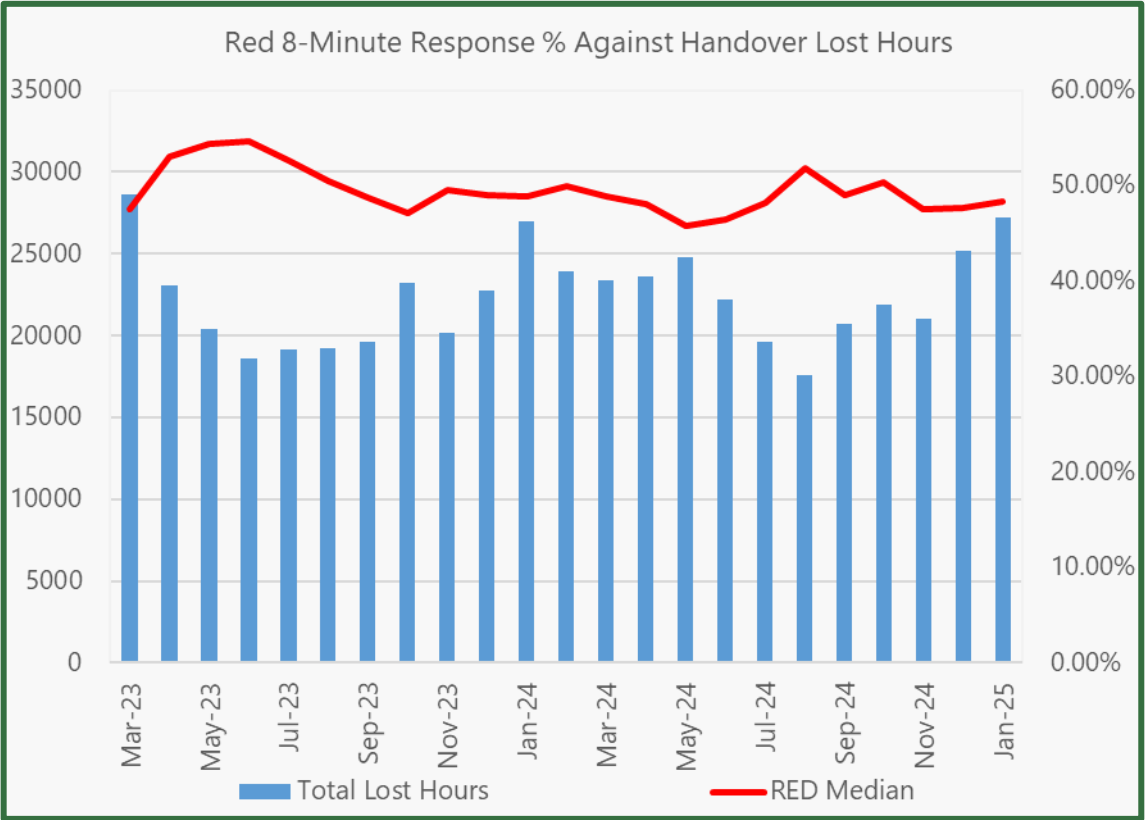
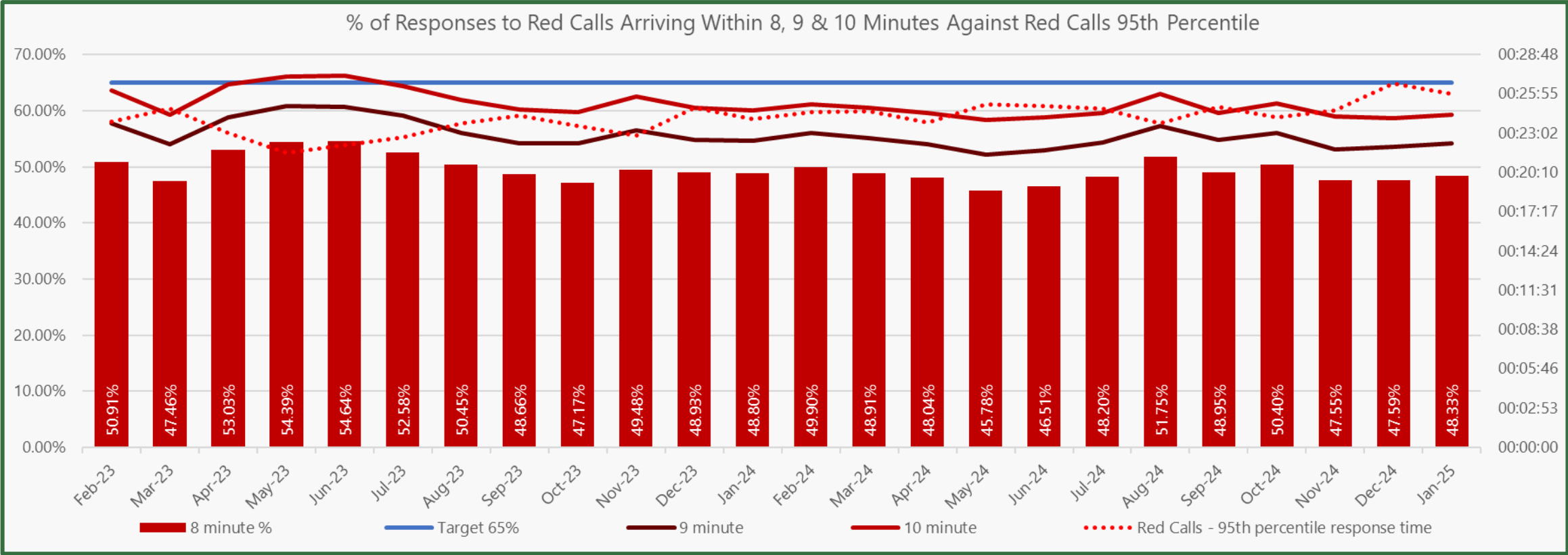
8 Min

R

QUEST

FPC

CI



Analysis

Red 8-minute performance continues to remain below the 65% target increasing marginally in January 2025 to 48.33%.

Red 10-minute performance for January 2025 was 59.3%, which is marginally below the 2-year average (61.1%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in January 2025 being 21.24% higher than that seen in January 2024. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for January 2025 of 2,900, being 20.83% higher than the figure for January 2024, and the second highest figure yet recorded. i.e. the Trust is reaching more red calls in 8 minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**, which shows that as handover rates decrease, so red performance improves. There were 27,212 lost hours in January 2025.

Remedial Plans and Actions

The main improvement actions in the Trust's gift are:

- To maintain commissioned establishment in post levels overall: the Trust achieved its 95% UHP benchmark in January with 100.7% UHP (all resources);
- Full roll out of the Cymru High Acuity Response Unit (CHARU): the Trust achieved its highest ever CHARU UHP in January;
- Continued focus on production and abstractions: abstractions were fractionally above benchmark in December; and
- The rapid deployment, before winter 2024/25 of the first phase of actions towards an updated clinical model e.g. rapid clinical screening, as outlined in our IMTP; the Trust achieved this.

Expected Performance Trajectory

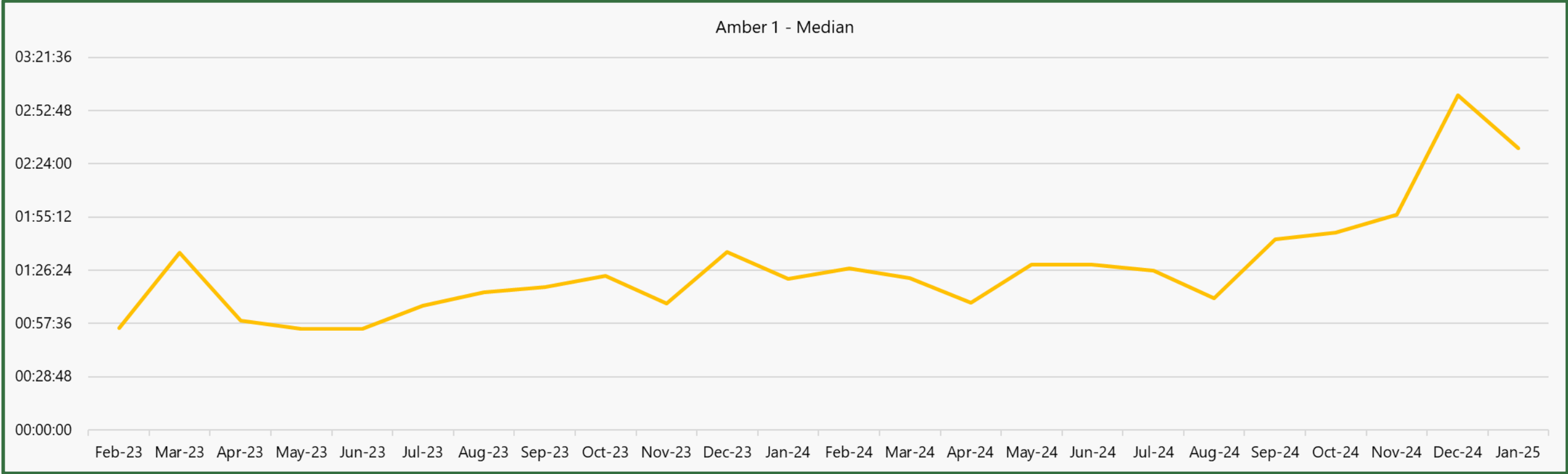
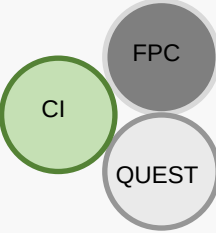
Modelling for winter has now been completed and the results shared with Welsh Government as part of winter planning. The Trust submitted a comprehensive winter plan to Welsh Government.

Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)



Analysis

The Amber 1 median performance time decreased during January 2025 to 2 hours and 32 minutes compared to 3 hours in December 2024. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also decreased during January 2025 to 11 hours 45 minutes, down from 12 hours 11 minutes in December 2024. This time remains far too long and remained above the 2-year average figure of 6 hours 46 minutes.

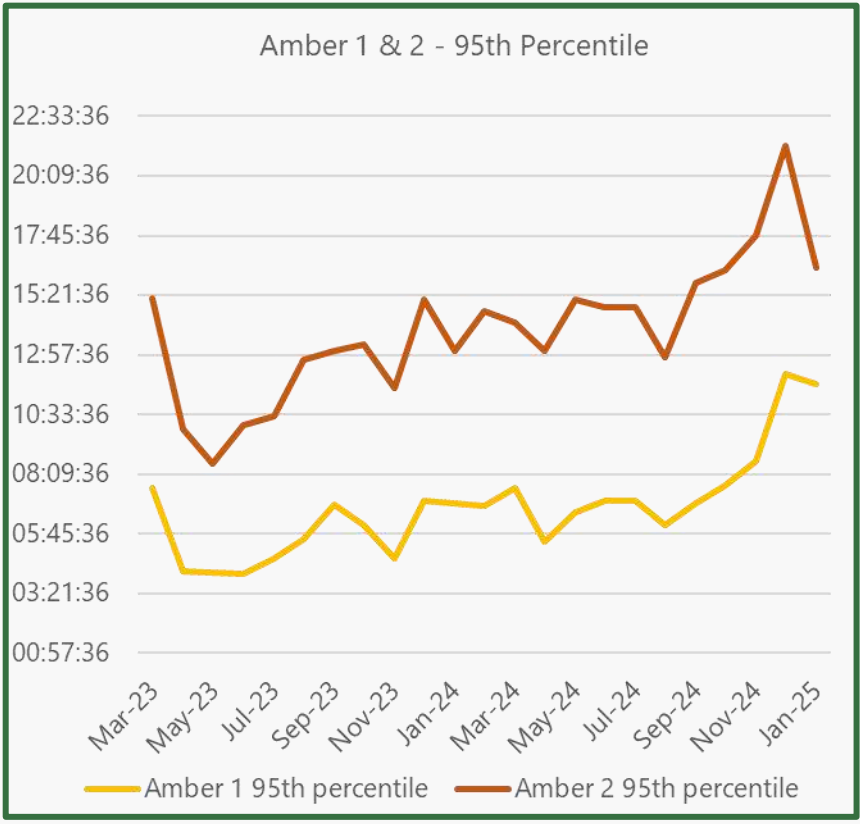
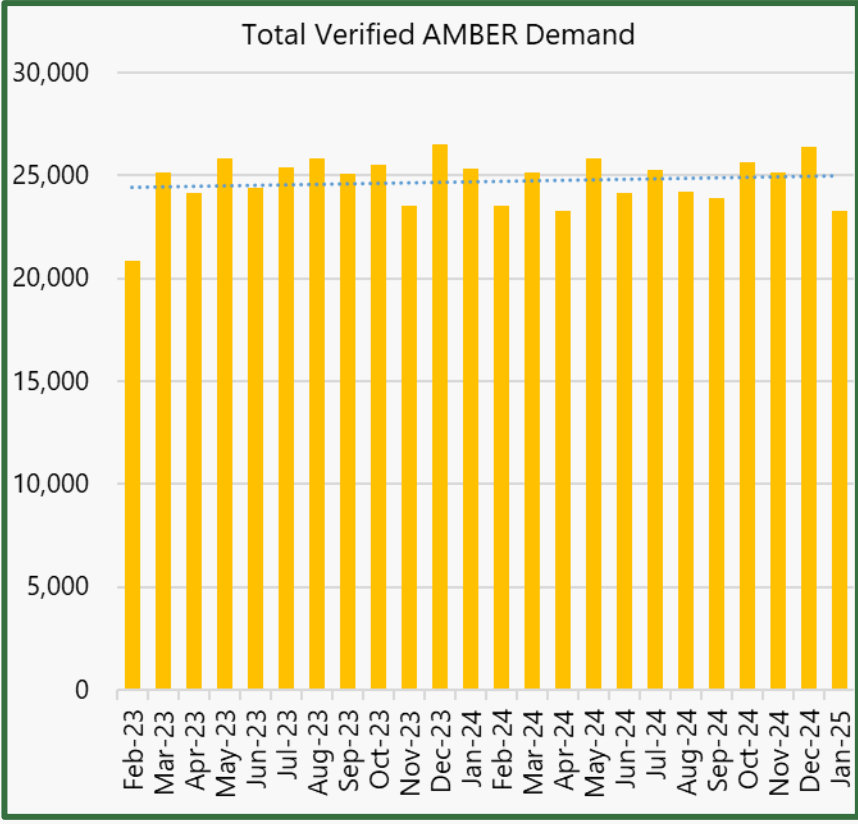
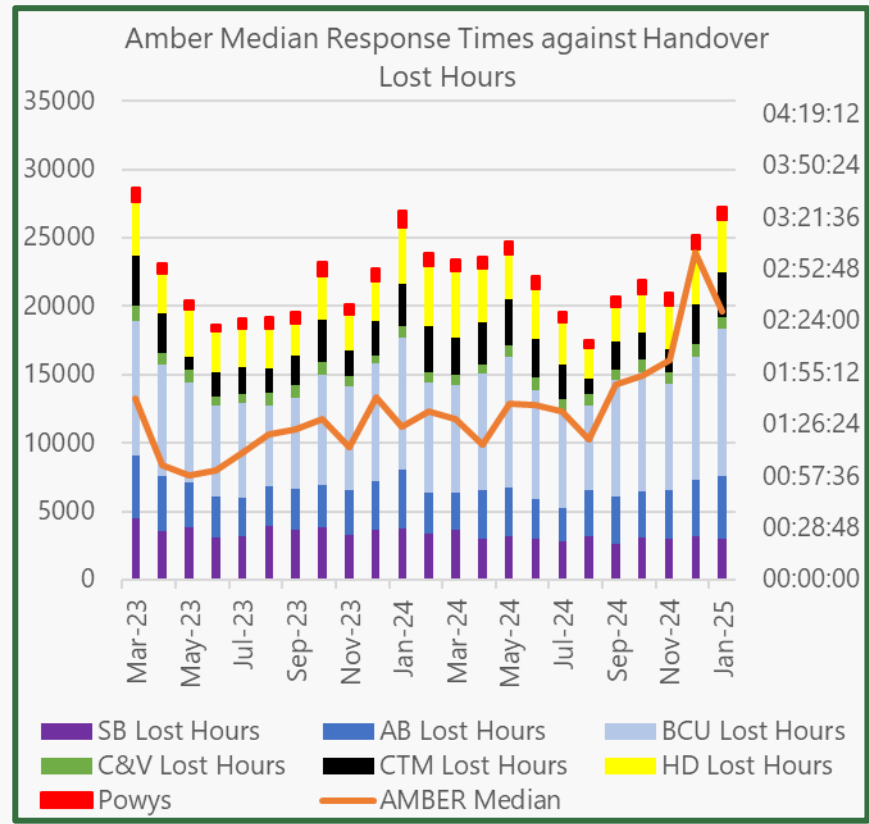
As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. Unless there is a material reduction in handover lost hours and a transformation of the 999 emergency ambulance pathways, the Trust will continue to see long amber waits and avoidable patient harm. Trust expecting to join a WG led meeting on how handover can be reduced to the 6,000 level.



Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

D&T

R

Oncology

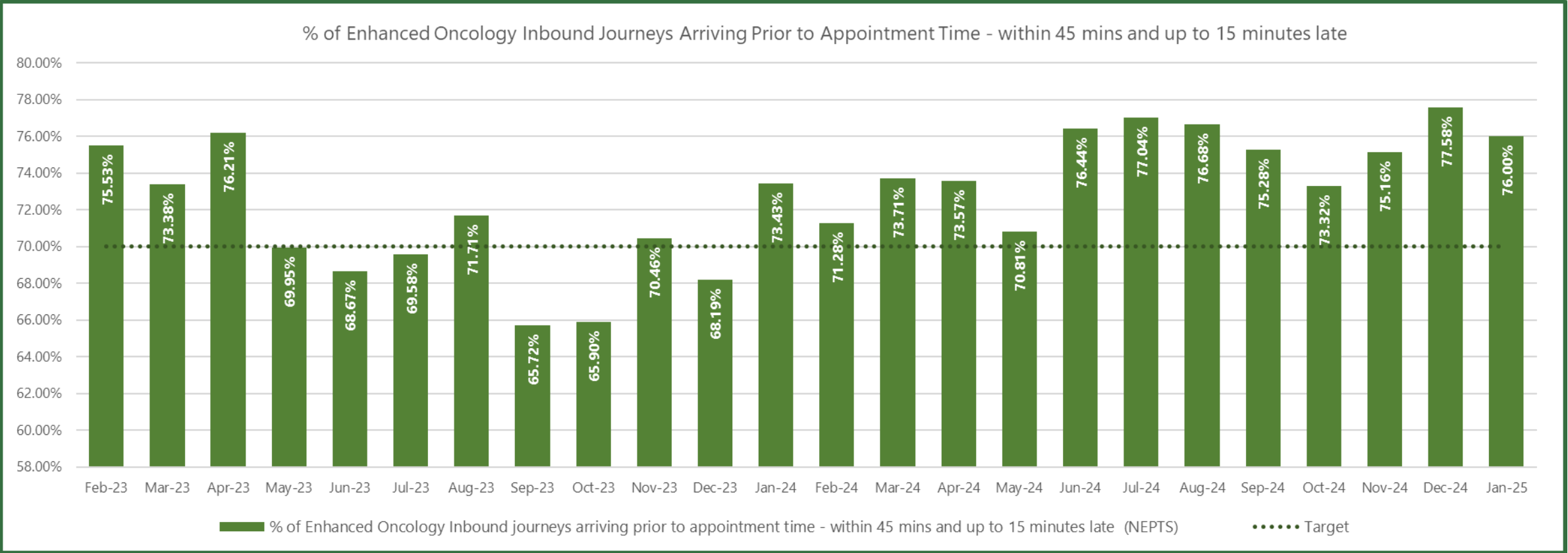
G

Welsh Calls

G

FPC

CI



Analysis

76% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in January 2025, once again achieving the 70% target. Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment improved in January 2025 to 81% but remains below the 95% target. (95%).

Enhanced Renal journeys minimally increased for the second month in a row to 70.6%, which therefore achieved the agreed performance standard of 70% for the first time since September 2024.

Call volumes answered increased to 18,808 calls during January 2025, up from 15,449 in December 2024; however, the average speed of call answering declined from 2 minutes 1 second to 4 minutes 21 seconds.

ACA1 sickness remains above the 5.99% target, attaining 9.23% in January 2025. However, ACA2 sickness has fallen below the target, achieving 4.94% in January 2025.

Remedial Plans and Actions

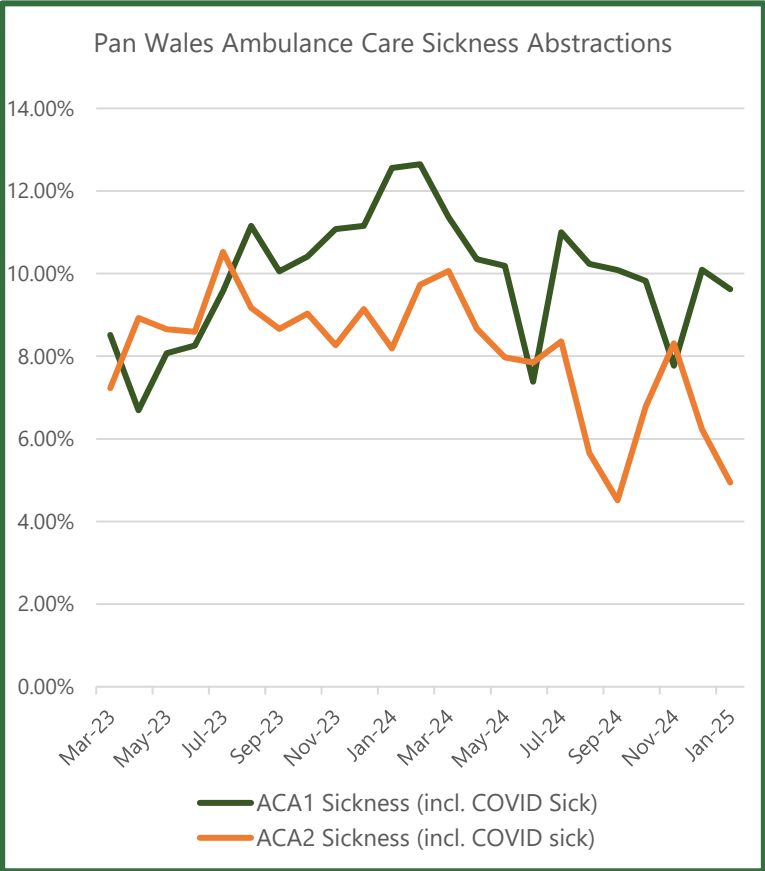
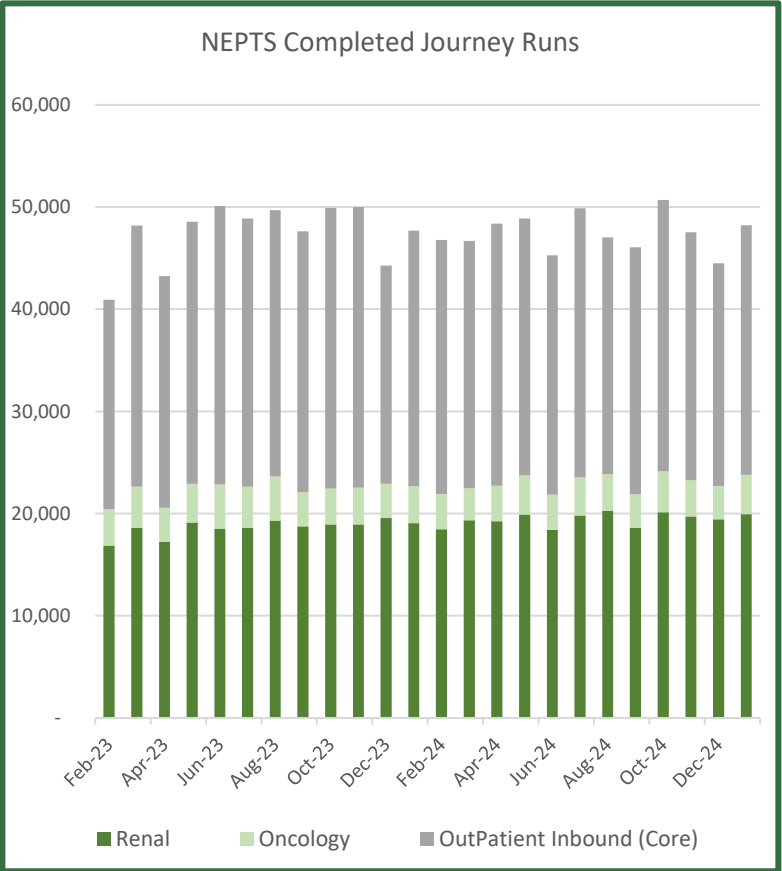
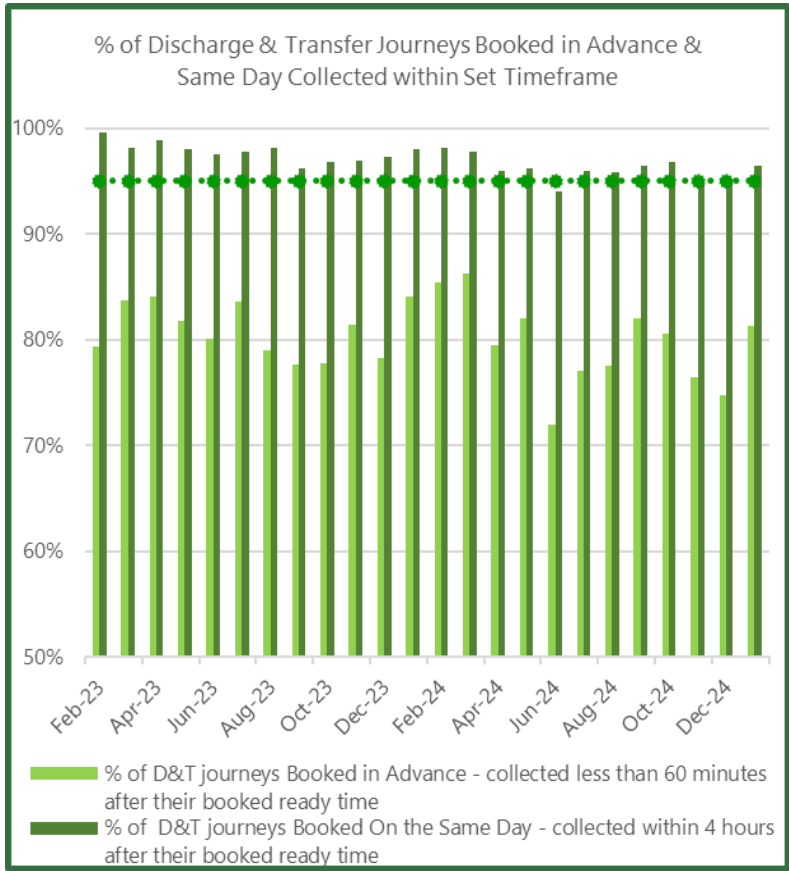
Increased performance on data management and journey recording times is underway, with enhanced focus on weekend performance. Projecting an improvement in performance over next few months, although caution on achieving the 95% figure as this was always an aspirational target that needs engagement and system change from Health Boards which is complex and challenging to achieve.

New rosters have been finalised based on updated demand with the roster review about to commence.

Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

The re-roster, which will take several months to deliver will enable the Trust to reach more patients within the current resource envelope (+400 additional patient journeys per week).



Our Patients: Quality, Safety & Patient Experience

Clinical Indicators

Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

Stroke

A

ROSC

G

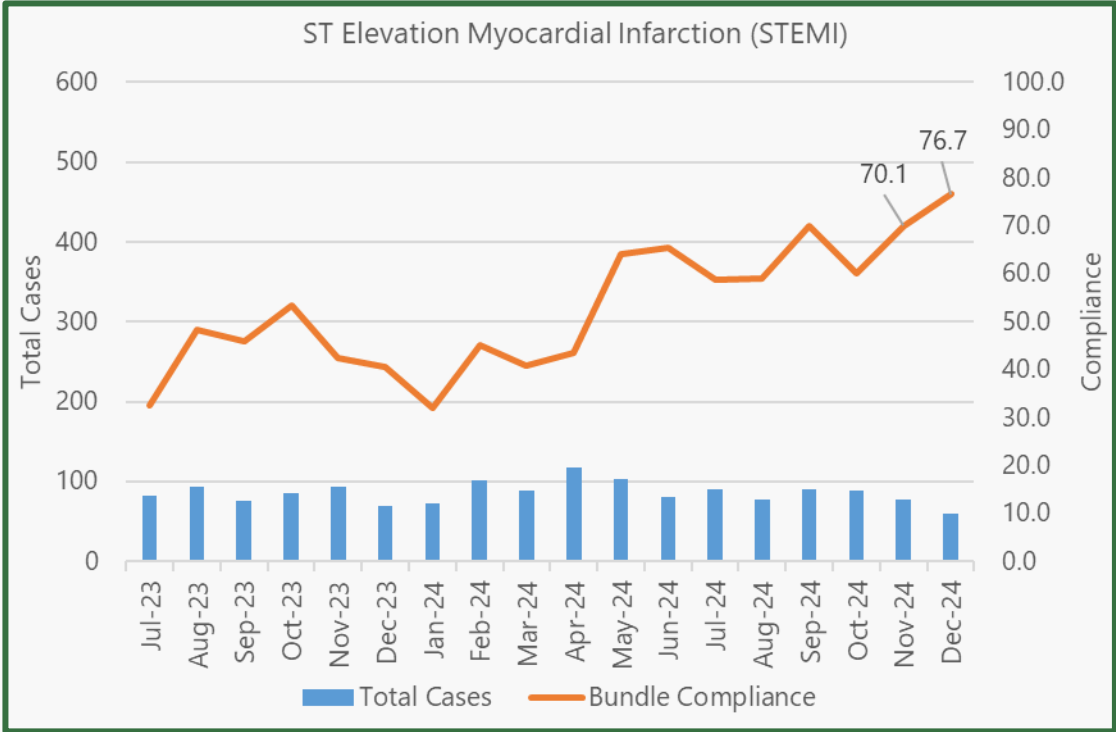
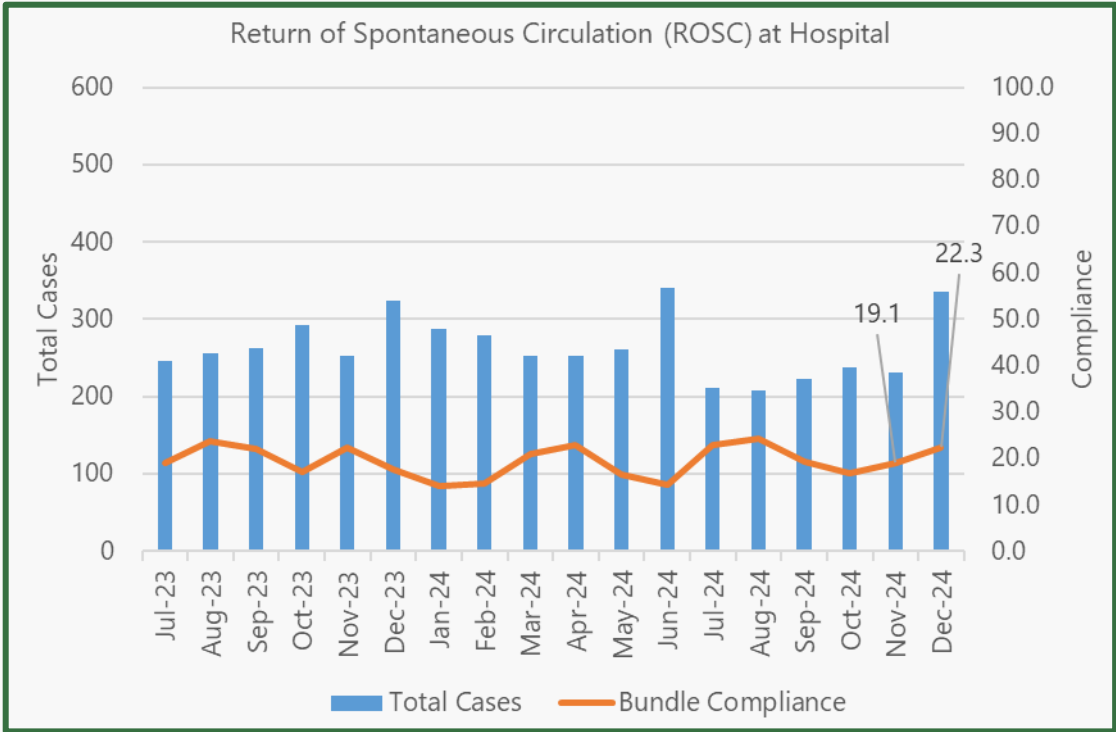
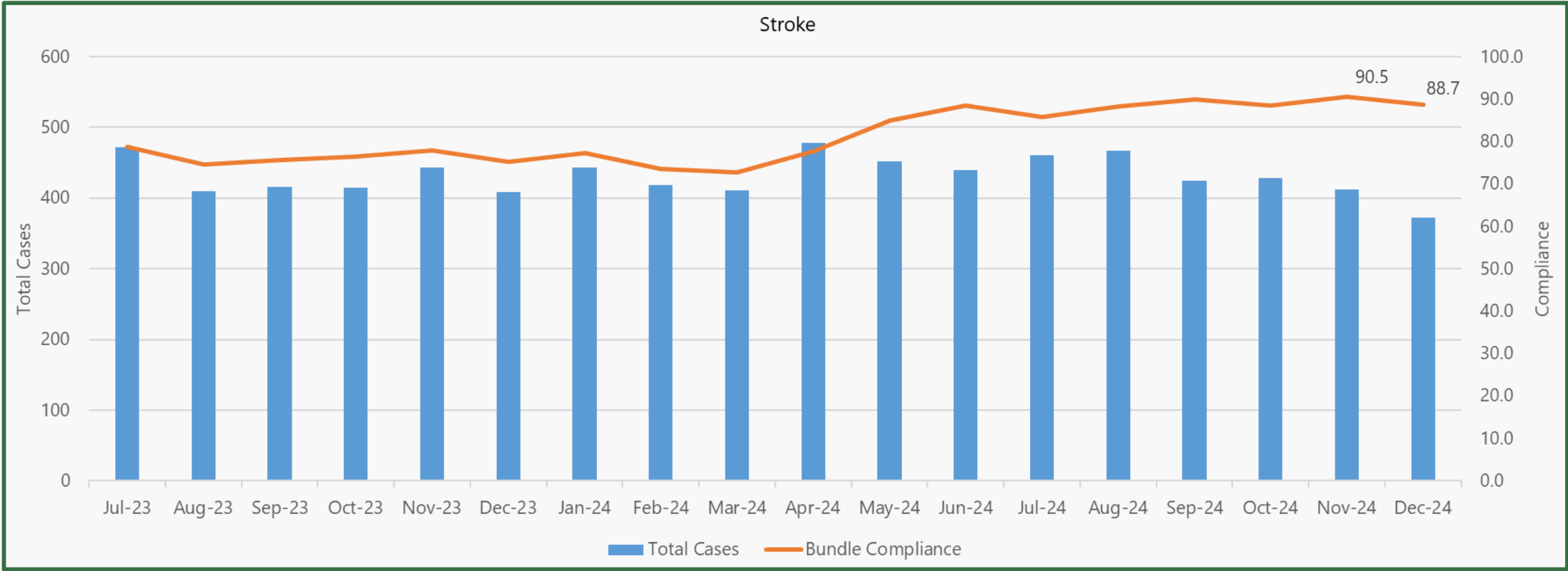
STEMI

R

Self-Assessment:
Strength of Internal
Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)



Analysis

The percentage of patients documented as receiving appropriate care bundles in December 2024 was:

Stroke – 88.7%, a slight decrease from 90.5% in November. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

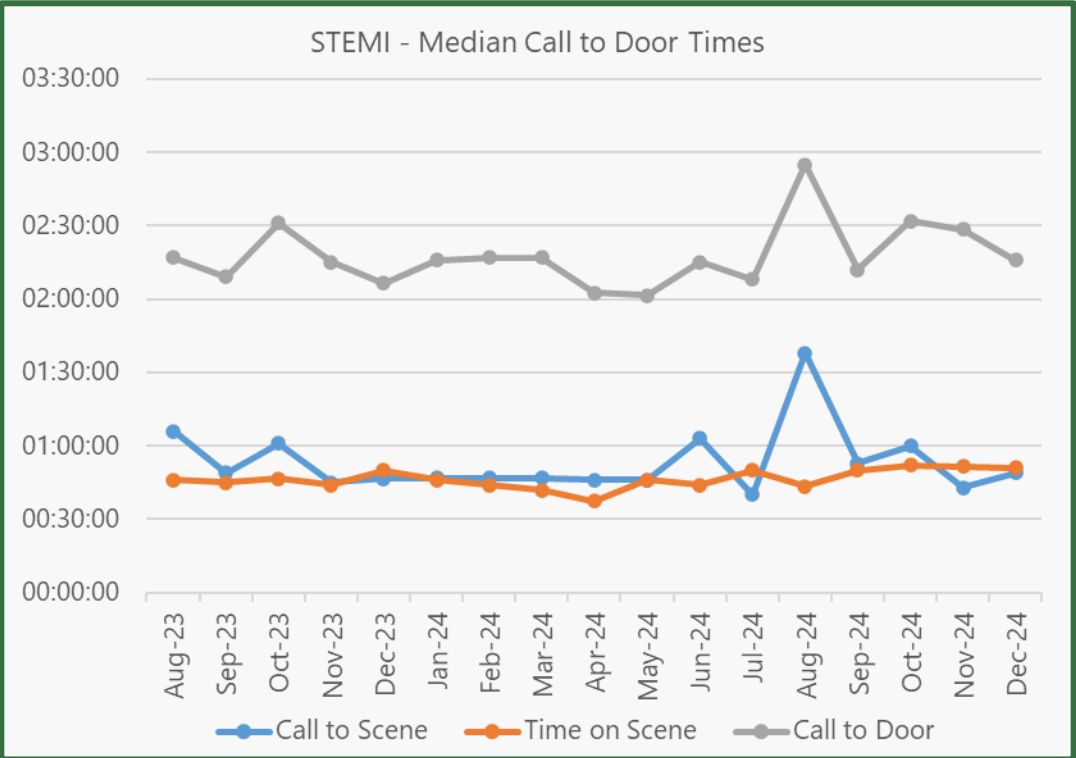
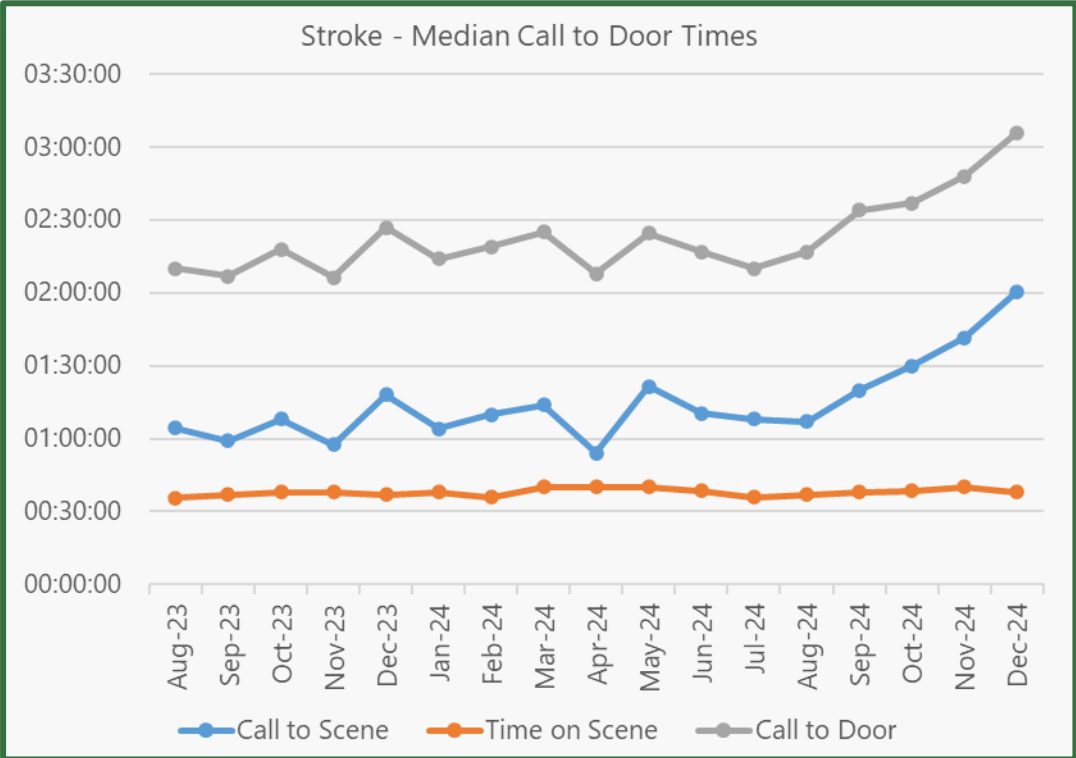
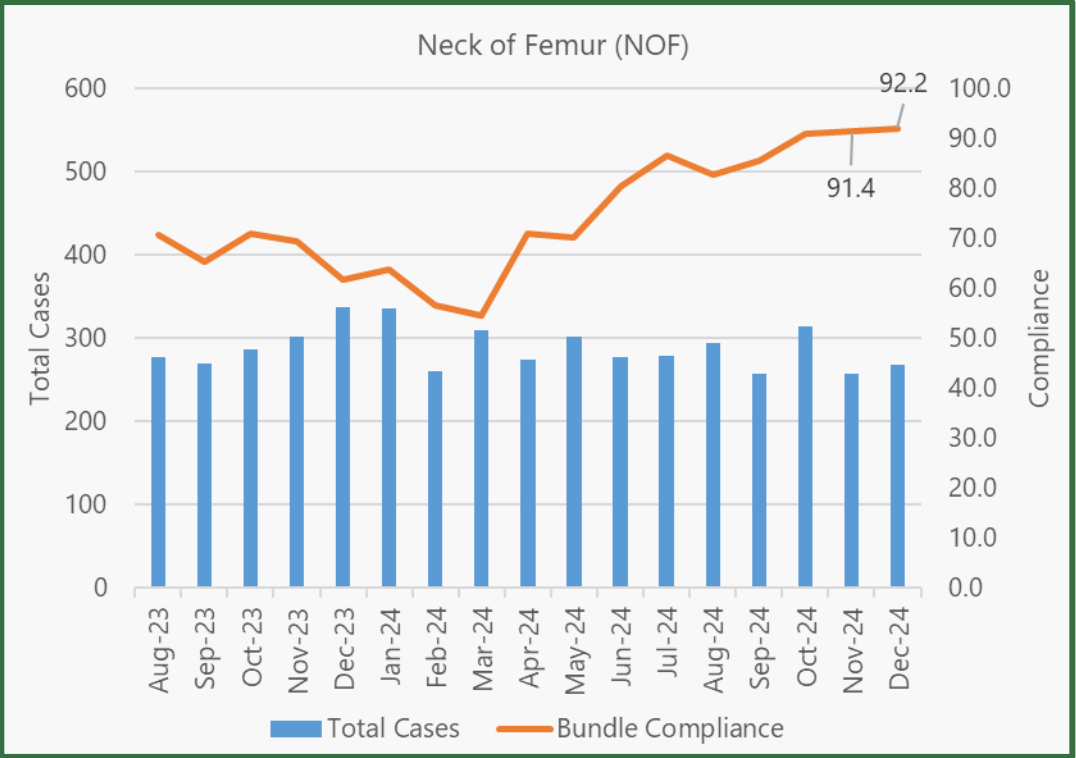
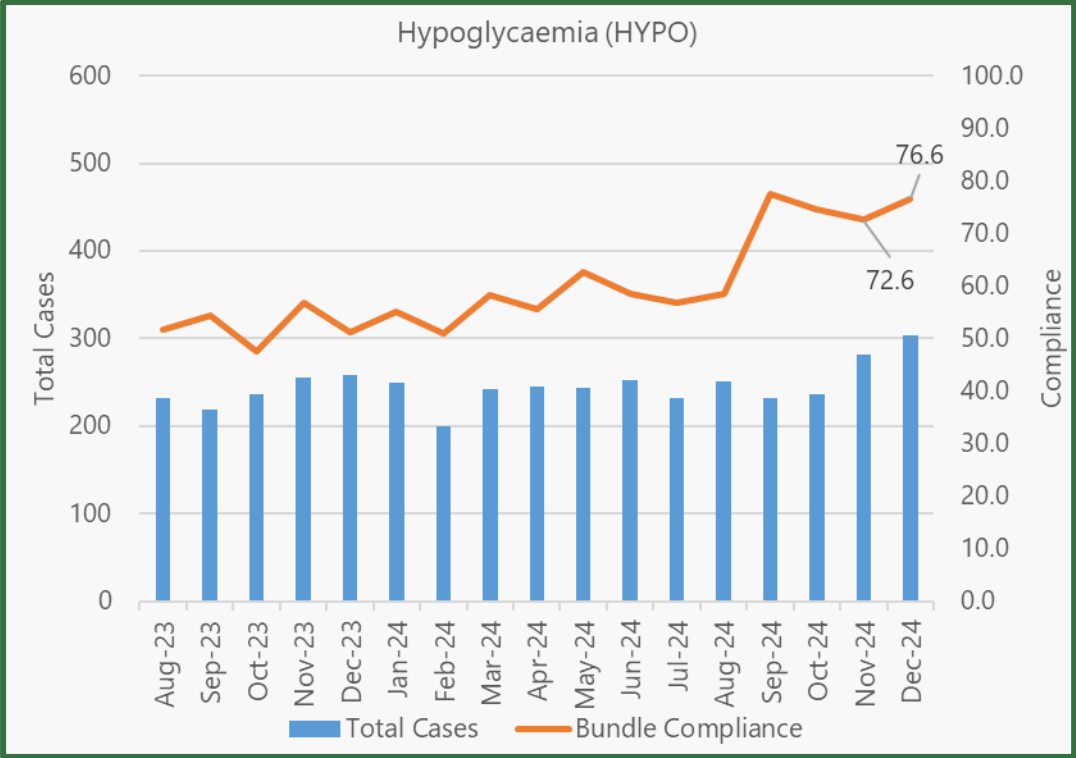
STEMI (heart attack) – 76.7%, an increase from 70.1% in November. There was a marked improvement in documenting all criteria. A ‘nudge’ to improve electronic Patient Clinical Record completion and compliance to Aspirin and GTN was implemented at the end of October, and User Interface changes for justified exceptions with GTN were implemented in November. These have demonstrated a contribution to the improvements for the December care bundle data.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 22.3%, an increase from 19.1% in November. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A ‘nudge’ to improve documentation for specific fields including outcome was implemented in October 2024.

N.B. Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this are multifactorial and as such it is not possible to identify the specific element. Following the switch to the electronic Patient Clinical Record , the way data is collected has changed. Automated Clinical Indicator reports are generated from data directly inputted by clinicians. As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:

- Design of the electronic Patient Clinical Record User Interface
- Clinician interaction with the electronic Patient Clinical Record
- Accuracy of the scripting to extract the data from the data warehouse to create the reports.

Further electronic Patient Clinical Record User Interface changes are planned for the next update scheduled for Spring 2025, the impact will be monitored by the Clinical Intelligence & Assurance Group.



Analysis

The percentage of patients documented as receiving appropriate care bundles in December 2024 was:

Hypoglycaemia (diabetic patients with low blood glucose) – 76.6%, an increase from 72.6% % in November. There has been an increase in all criteria which has positively impacted on the bundle compliance. CI improvement work continues which includes electronic Patient Clinical Record User Interface changes for documenting non-diabetic patients with a low blood glucose level.

Fractured Neck of Femur (hip fracture) – 92.2%, a slight increase from 91.4% in November. The use of a ‘nudge tool’ for analgesia implemented in June provided a prompt when important information is not documented. This, along with an improvement in documenting pain score over the last 3 months has contributed to the improved bundle compliance.

Call to door times for Stroke and STEMI – Extended call to scene times for both stroke and STEMI during October impacted on the call to door times. Some improvement can be seen for STEMI in November and December, however for stroke, there are extended times.

Remedial Plans and Actions

- A recovery plan implemented from April – September 2024:
- Focussed on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Supported a review of scripting used for reports.
- Supported further use of the ‘nudge’ tool with those for Aspirin & GTN with STEMI, and aspects of ROSC implemented at the end of October.

Expected Performance Trajectory

As a result of the work from the CI Recovery Group T&F group and the ongoing improvement interventions, a continued increase in compliance rates is expected and will be monitored by the Clinical Intelligence & Assurance Group.

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

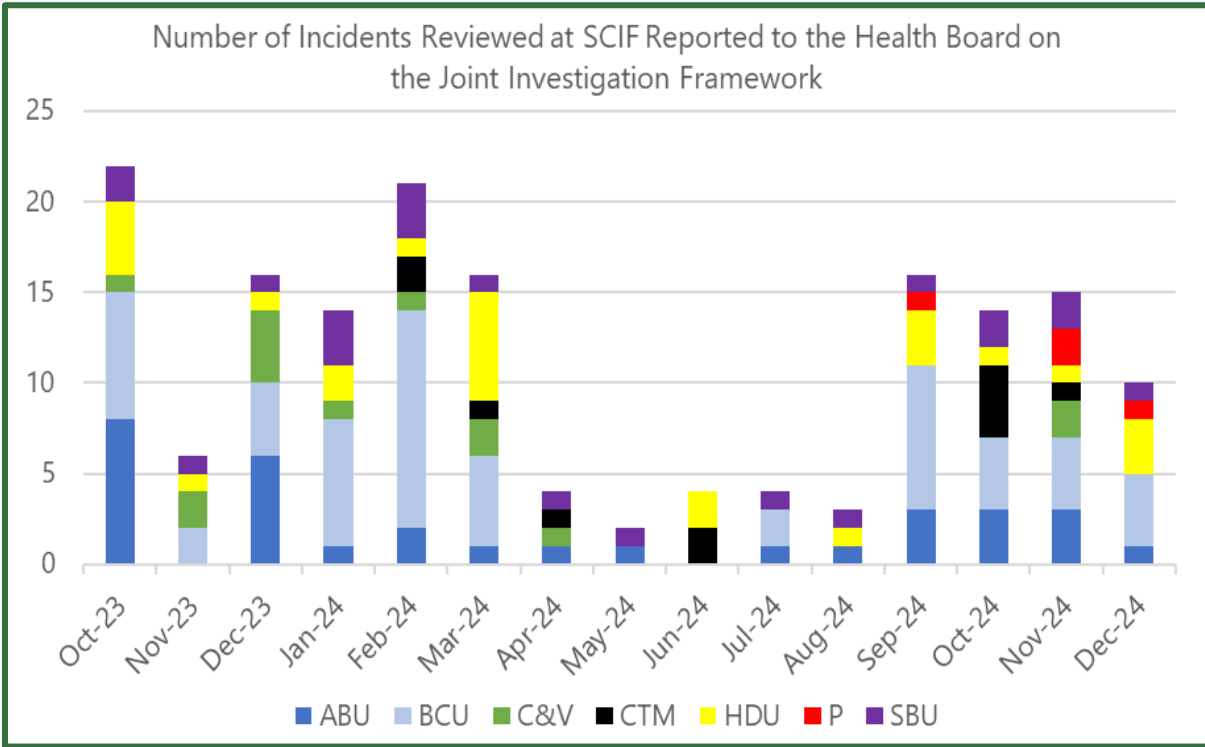
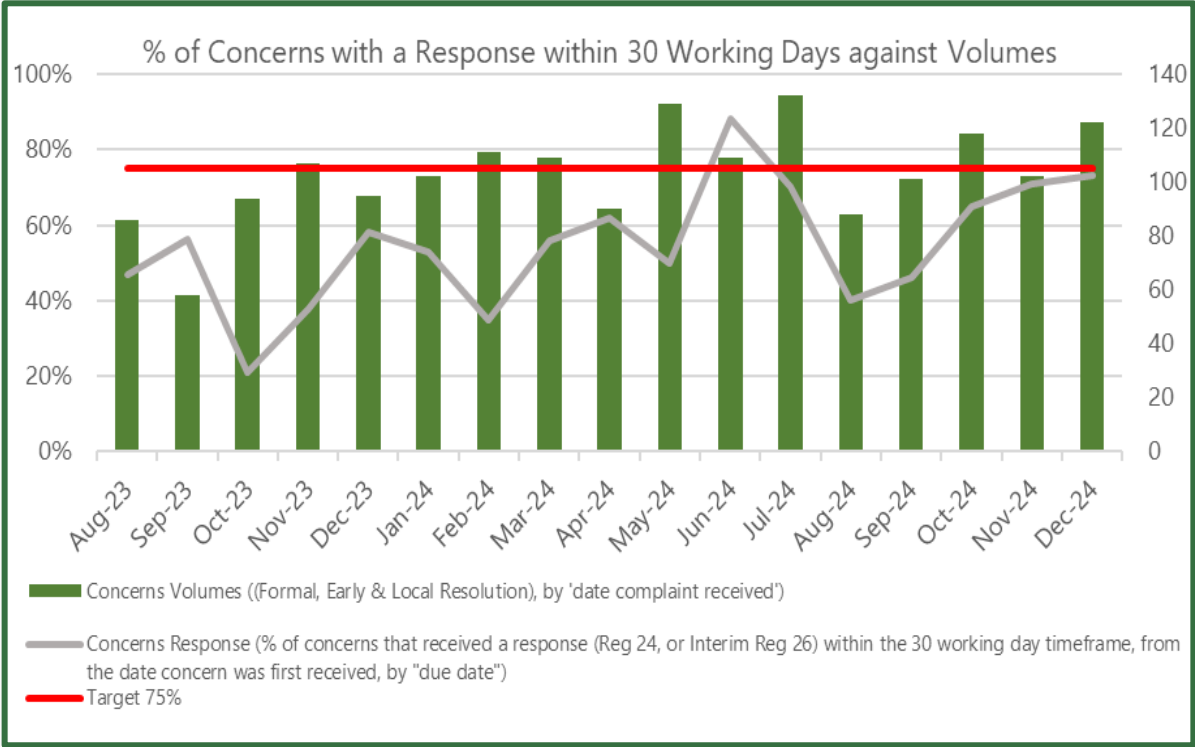
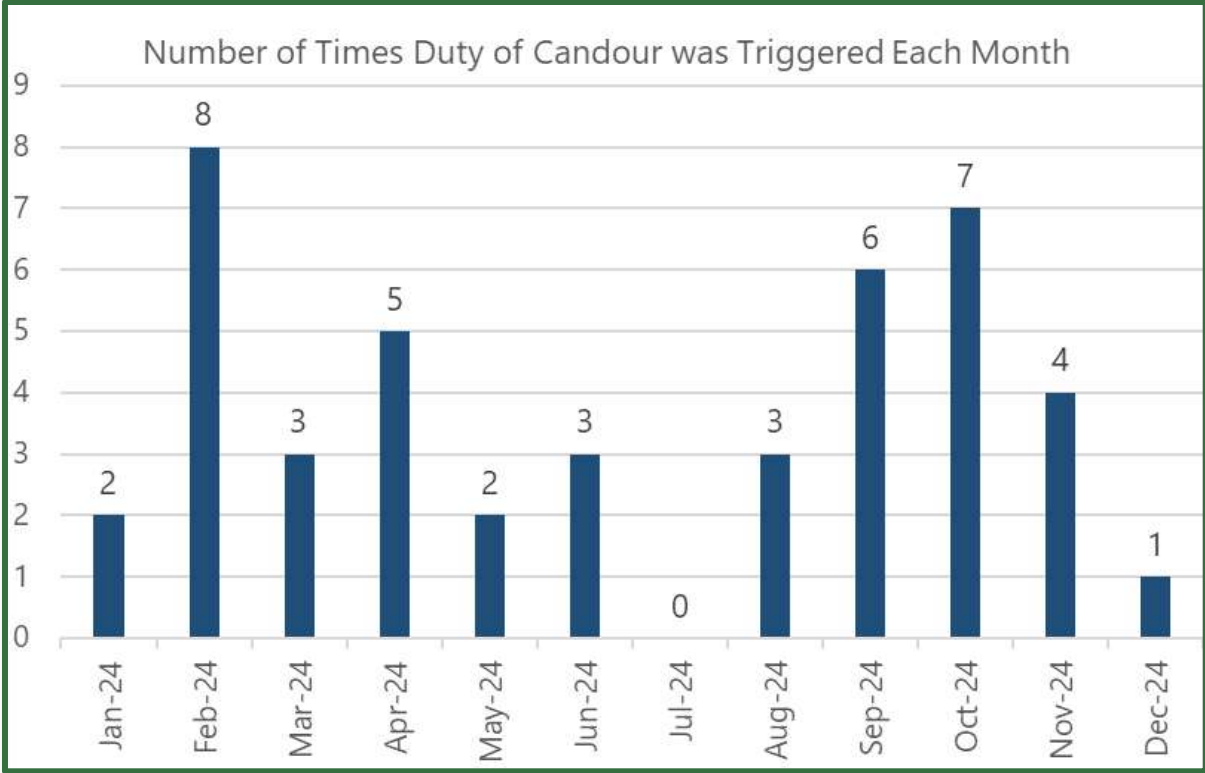
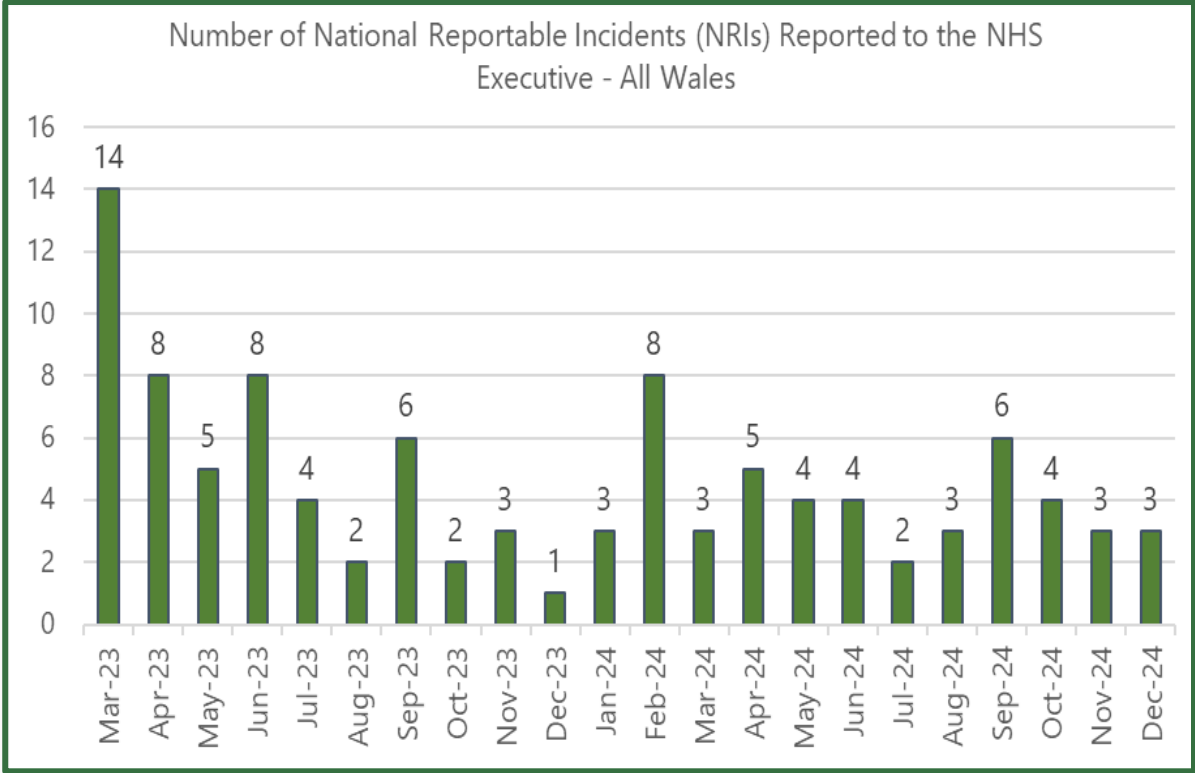
(Responsible Officer: Liam Williams)

Concerns.
A

Self-Assessment:
Strength of Internal Control:
Moderate

QUEST

Health & Care Standard
Health - Safe Care / Timely Care



Analysis

The Trust's performance against the target of 75% responses issued within 30 working days has recovered following an exercise to reduce number of overdue open complaints.

Open complaint volumes are, however, gradually increasing again, reflective of the Trust receiving more complaints than it closes each month. This will be an area of focus, however operational pressures over the winter period present a risk to maintaining progress.

The number of NRIs reported and number of Joint Investigations of Moderate harm or above identified remains at a reasonably consistent level, although it is anticipated that this may increase over the winter months.

Remedial Plans and Actions

- Ongoing monitoring of national incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis.
- All teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales organisations as visible in the national Quality and Safety dashboard, Beacon

Expected Performance Trajectory

Patient and Family Relations and Patient Safety Teams will be focusing on working towards national performance targets as part of a PTR & Legal Services Department 'Recovery Plan'. The teams anticipate an increased workflow over the winter period and therefore will be focused on effective allocation of resources in order to prioritise mandatory and statutory service delivery.

*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change **NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated

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

Our Patients: Quality, Safety & Patient Experience

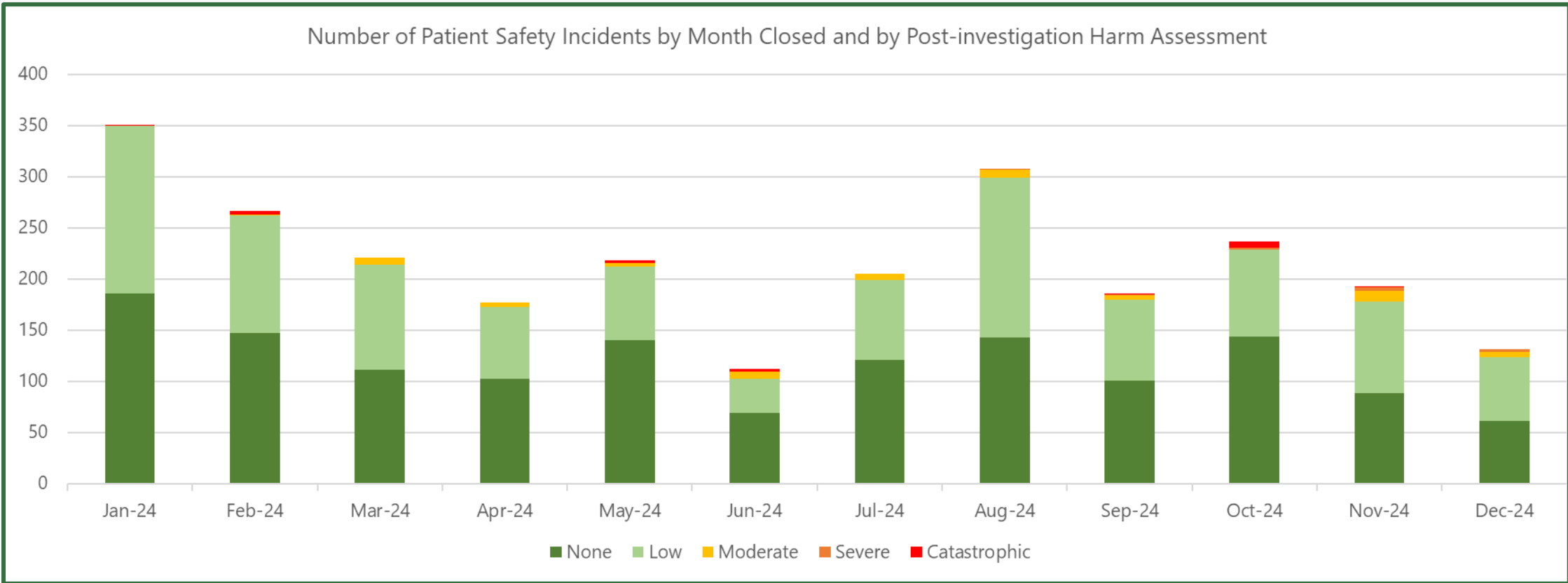
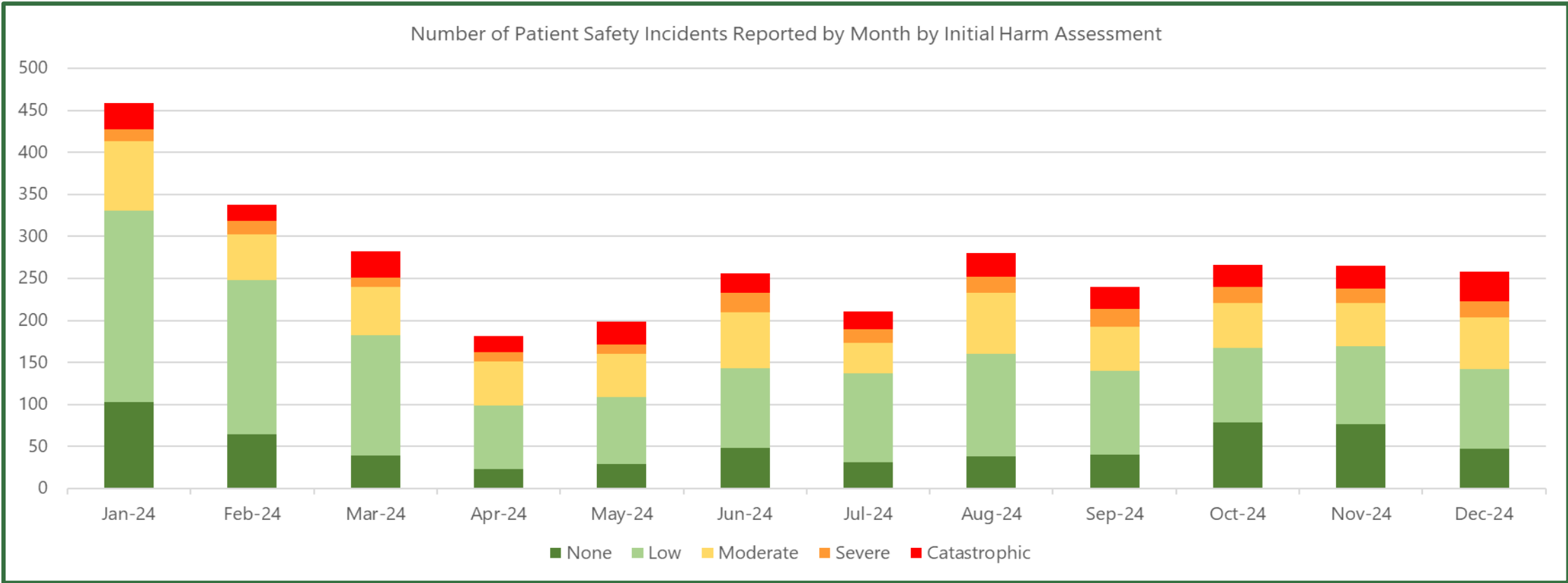
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

Health & Care
Standard
Health – Safe Care



Analysis

There is a gradual increase in incident reporting since the beginning of the financial year across all harm gradings. This is being monitored across the months to assess the impact of seasonal system pressures. The proportional levels of harm being reported remain reasonably consistent.

Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident); however, the introduction of the Rejection SOP by the Quality Team has reduced the risk of duplication. Incident volumes include those reported internally by WAST staff, but also those reported by Health Board colleagues about WAST services or care.

Harm levels for December 2024 were: -

- No harm or hazard - 47
- Low - 95
- Moderate - 62
- Severe harm - 19
- Catastrophic/Death - 35

Remedial Plans and Actions

- Incident management culture and processes are being considered as part of an emerging Datix Recovery and Improvement Plan and monitored carefully to support the Clinical Model Transformation work.
- Temporary staffing resource within the Datix team will enable development of pivotal business intelligence products to facilitate greater awareness and analysis of our patient safety incident data.

Expected Performance Trajectory

Incident volumes are anticipated to increase further over winter and with the introduction of new service models where near-miss reporting is being encouraged. It is also predicted that a higher number of patient contacts across their wait time will result in more incidents occurring but with a gradual downwards trend in the number of Severe/Catastrophic and Death incidents occurring.

Our Patients: Quality, Safety & Patient Experience

Coroners, Mortality and Ombudsmen Indicators

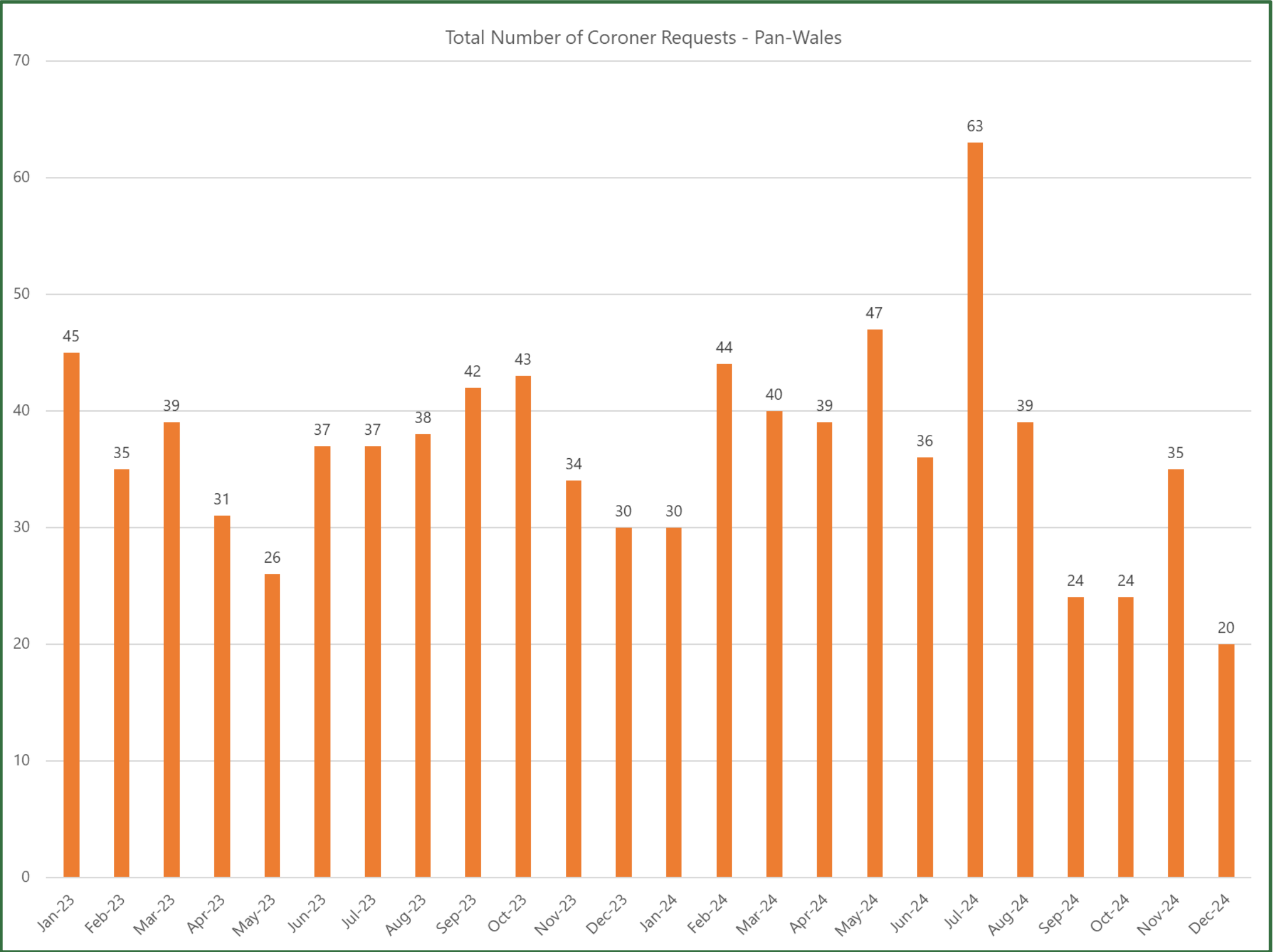
(Responsible Officer: Liam Williams)

Coroners
Self-Assessment:
Strength of
Internal Control:
Moderate

Mortality
Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

Health & Care
Standard
Health – Safe Care



Analysis

The number of coroner approaches remains variable and unpredictable. Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. It is noticeable that many requests are accompanied by short timescales. These factors combined makes this an area of continued pressure across Trust services, and a source of additional burden to staff involved, often revisiting events from several years past. The Trust has responded to 2 Regulation 28 Prevention of Future Death reports this month. Both were responded to within the 56-day stipulated timeframe.

Mortality - The Trust is developing a multi-directorate approach to reviewing Medical Examiner Service Feedback, in line with the revised All Wales Learning from Mortality Reviews Model Framework (Second Edition). This has included a Level 1 triage meeting and a Level 2 Medical Examiner Learning Panel. Level 1 triage is now being undertaken contemporaneously by Patient Safety Team with no concerns about timeliness / performance. There is a backlog of Level 2 cases, but it is anticipated that this will be recouped over the next two quarters as the Panel approach embeds and familiarity enables more efficient reviews.

There is a decreasing number of Medical Examiner referrals since April 2024 which is believed to be due to relational work undertaken with other health bodies to reduce the duplication of cases, whereby the same case was, at times, previously being sent by both the ME service and the associated Health Board. This trend will however be monitored closely to assess whether there are other influencing factors.

Remedial Plans and Actions

- Additional temporary resource in the Legal Services team is supporting the management of inquest coordination and activity across the Trust.
- Operational teams are trialling a collaborative style of statement across services to ensure, as service delivery models become increasingly sophisticated, that our statements accurately represent the patient pathway of care and provide a coherent chronology and explanation of events.

Expected Performance Trajectory

Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate.

Our Patients: Quality, Safety & Patient Experience

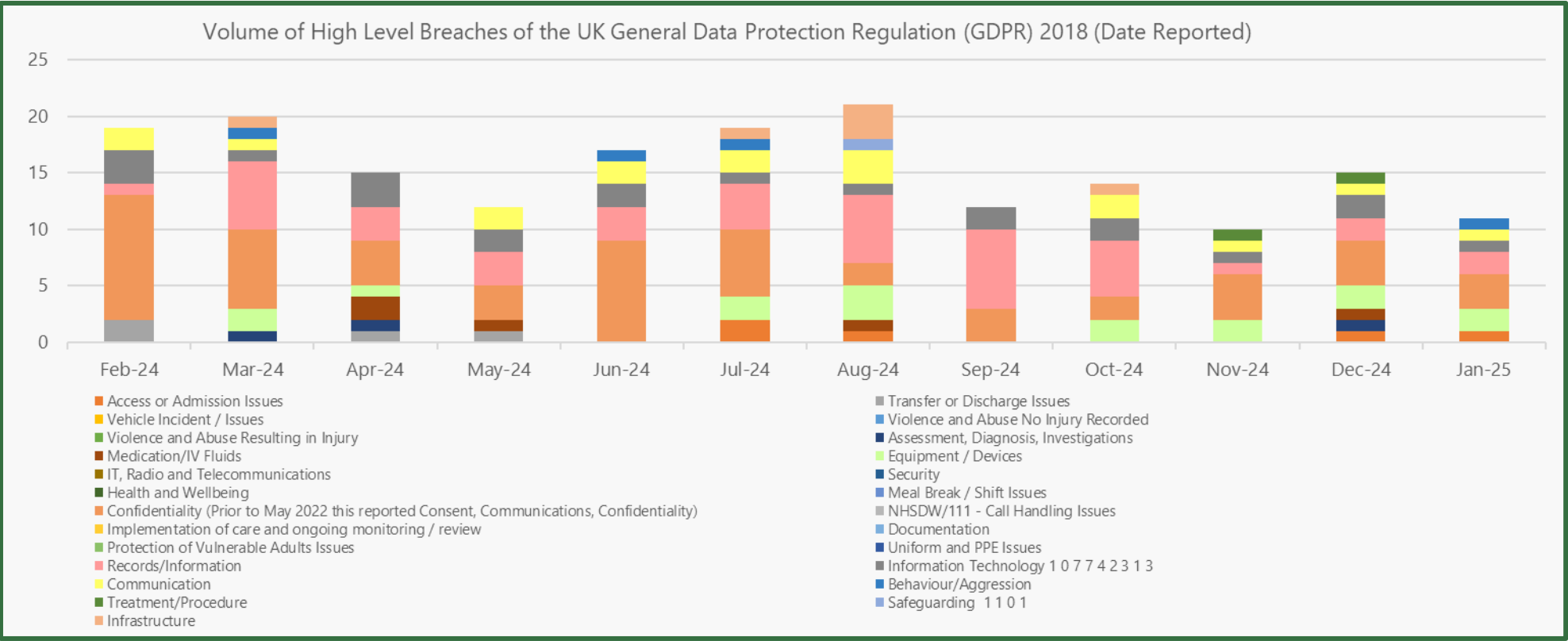
Safeguarding, Data Governance & Public Engagement Indicators

(Responsible Officers: Jonny Sammut & Liam Williams)

Health & Care
Standard
Health – Safe Care

Self-Assessment:
Strength of
Internal Control:
Strong

PCC



Analysis

Safeguarding: In January 2025 WAST colleagues submitted a total of 234 Adult at Risk Reports, 86% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 693 reports were shared with local authorities across Wales during this reporting period. There have been 211 Child Safeguarding Reports submitted in January 2025, 91% of these were processed within 24 hours.

Data Governance: In January 2025, there were 11 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 11 breaches, 2 related to Records/Information, 1 Information Technology, 1 Communication, 2 Equipment/Devices, 2 IG/Confidentiality, 1 Behaviour, and 1 Access / Admission.

Public Engagement: During December, PECl attended 8 community engagement opportunities, engaging with approx. 198 people. This included a Learning Disability Health profile event in Powys, where we were able to continue engagement with the learning disability community including carers and other HCPS and a Dementia Carers group in Caerphilly. Attended further 'Winter Messaging' event at Glangwilli Hospital to discuss and promote the NHS 111 Wales service.

Remedial Plans and Actions

Safeguarding: The Trust manages all safeguarding reports digitally via Doc-works Scribe 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 WAST colleagues with using the Doc-works Scribe system and liaising with local authorities when required. Only minimal paper safeguarding reports are now received, they are used as a back-up and are sent directly to the Safeguarding Team for actioning. The Safeguarding Team monitor any paper reports received and provide direct feedback to colleagues to improve practice.

Data Governance: During the reporting period, of the 11-information governance related incidents reported on Datix, 1 incident was reported to the Information Commissioner's Office (ICO) as it met the risk threshold. Following a review, the ICO closed the incident on the basis of the report and remediation actions taken. The IG Team continues to review and provide advice on reported incidents where applicable.

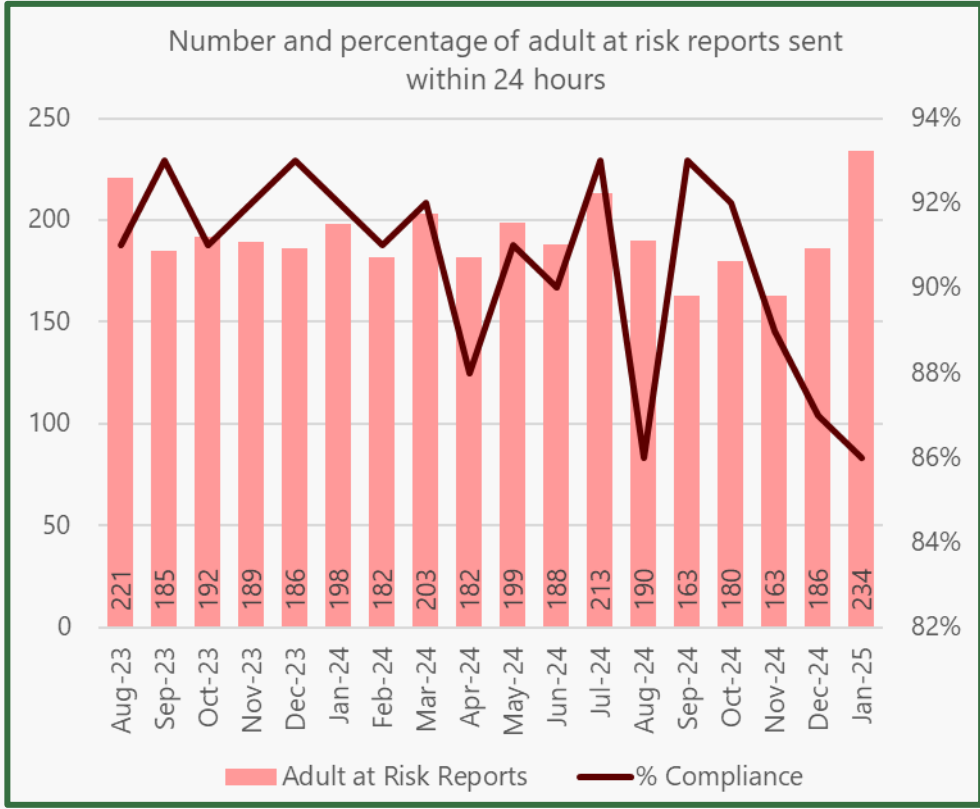
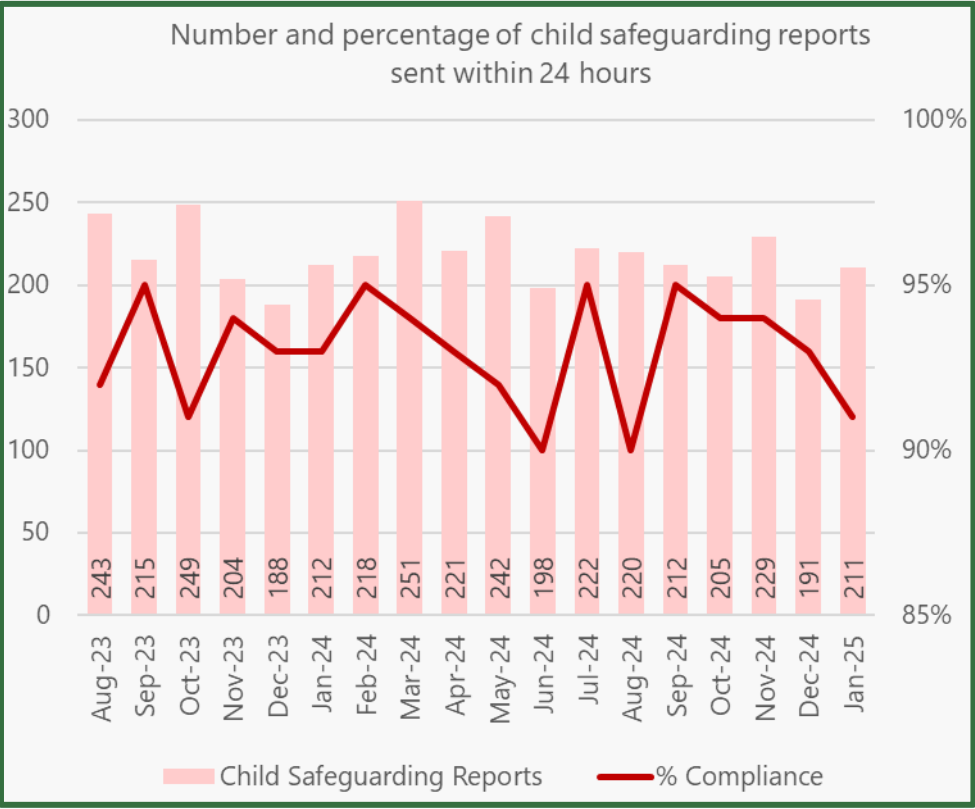
Public Engagement: The work delivered by the PECl Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit Improvement Action Plan continues to be progressed in readiness for the submission deadline in March 2025. The status of the Action Plan is reported to and monitored by IGSG.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.



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

Safeguarding Data source: Doc Works

Our Patients: Quality, Safety & Patient Experience

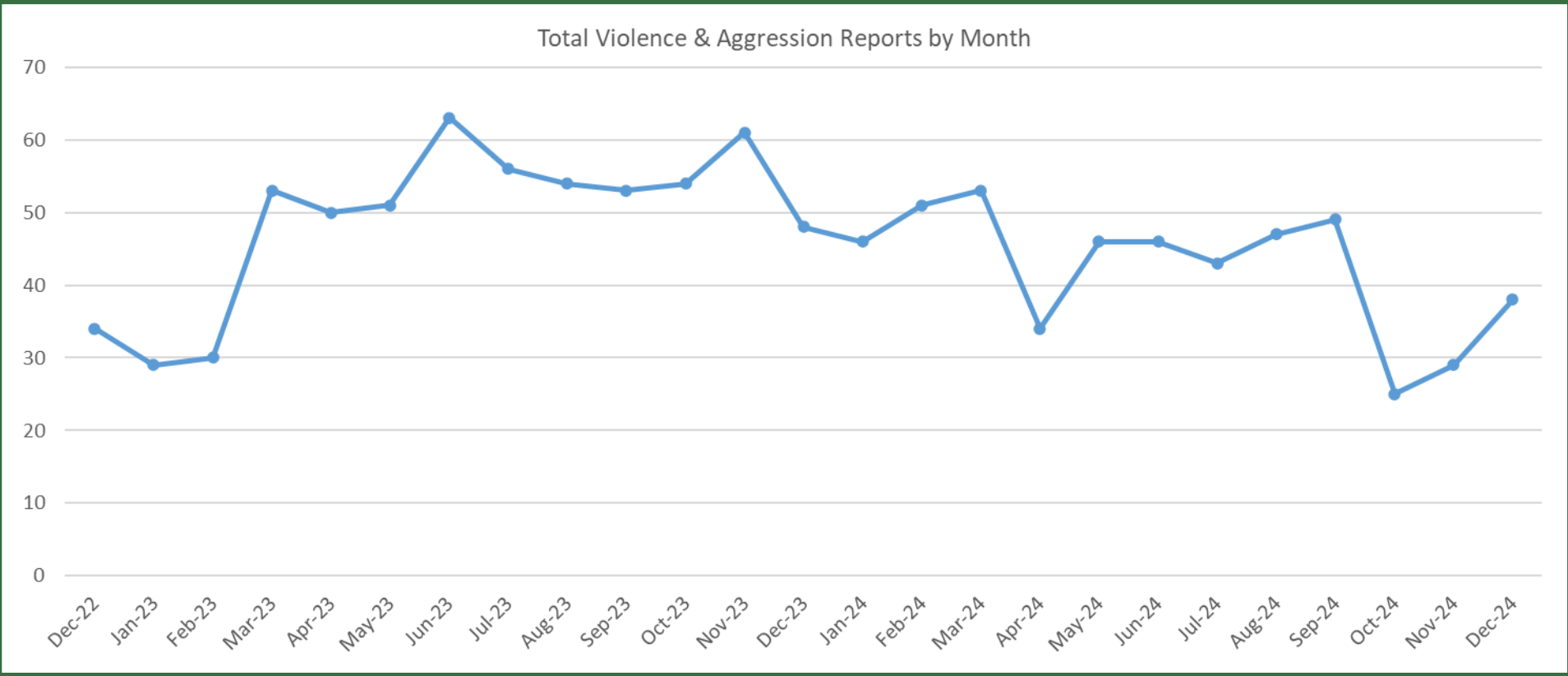
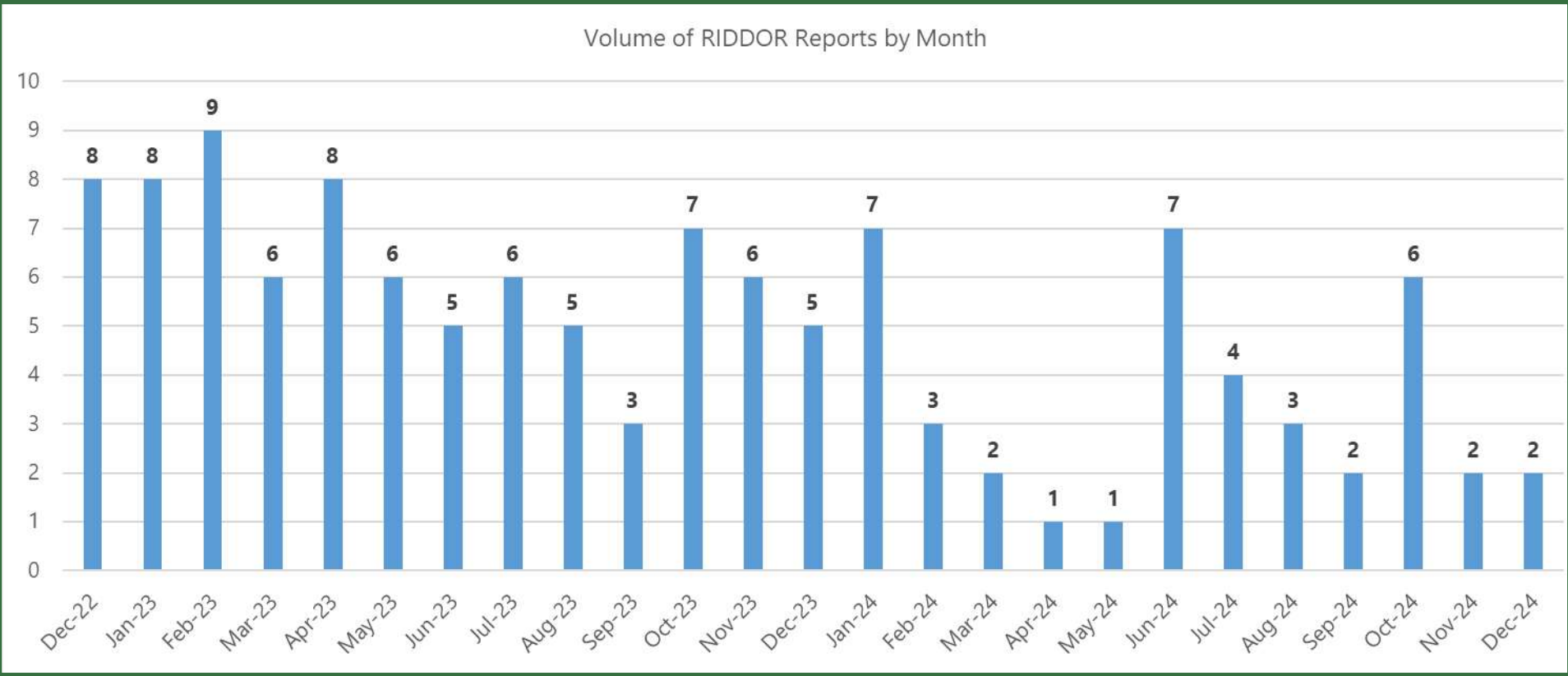
Health & Safety (RIDDORS) Indicators

(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

Health & Care
Standard
Health – Safe Care



Analysis
RIDDOR: There were 15 incidents requiring reporting under RIDDOR during Quarter 3 2024. 12 were Most being unable to perform their normal duties for more than 7 days and 3 were Most specified reporting injuries. 90% of the RIDDOR's were submitted within the HSE reporting timelines due to good working relationships with the H&S and Operational Teams. Manual Handling Patients (8 RIDDORS) and Slips and Trips (4 RIDDORS) continue to be the most consistent theme for RIDDOR submissions.

Violence and Aggression: A total of 91 incidents have been reported of V&A in Quarter 3 2024. 7 Physical Assaults on staff were reported during the quarter with 84 incidents of verbal abuse. 24 incidents were reported as Moderate in harm and 39 noted as low harm with 3 cases being noted as causing severe harm. The number of moderate and low harm incidents have returned to the lower levels previously seen within the Trust. Such variations can have a number of causes which are being investigated by the V&A function.

Remedial Plans and Actions
RIDDOR: Work continues to improve communication between H&S and Operations Department to ensure efficient reporting and suitable corrective actions for RIDDOR incidents. A review of manual handling provisions within the Trust has been undertaken and SBAR prepared noting areas for improvement.

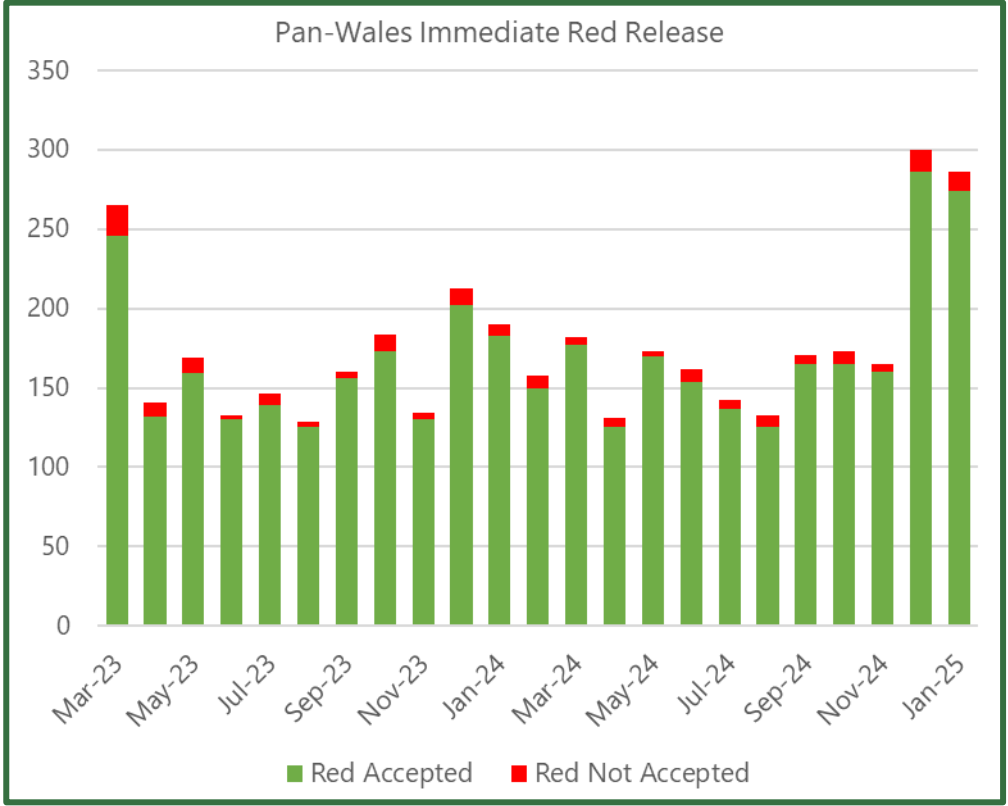
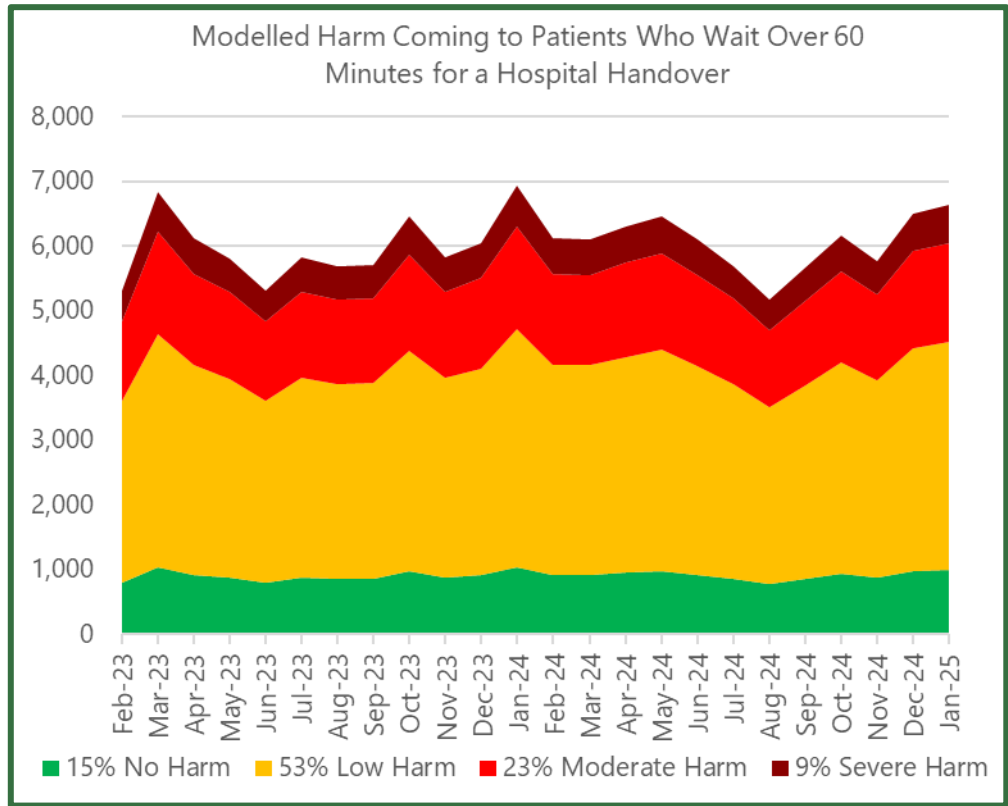
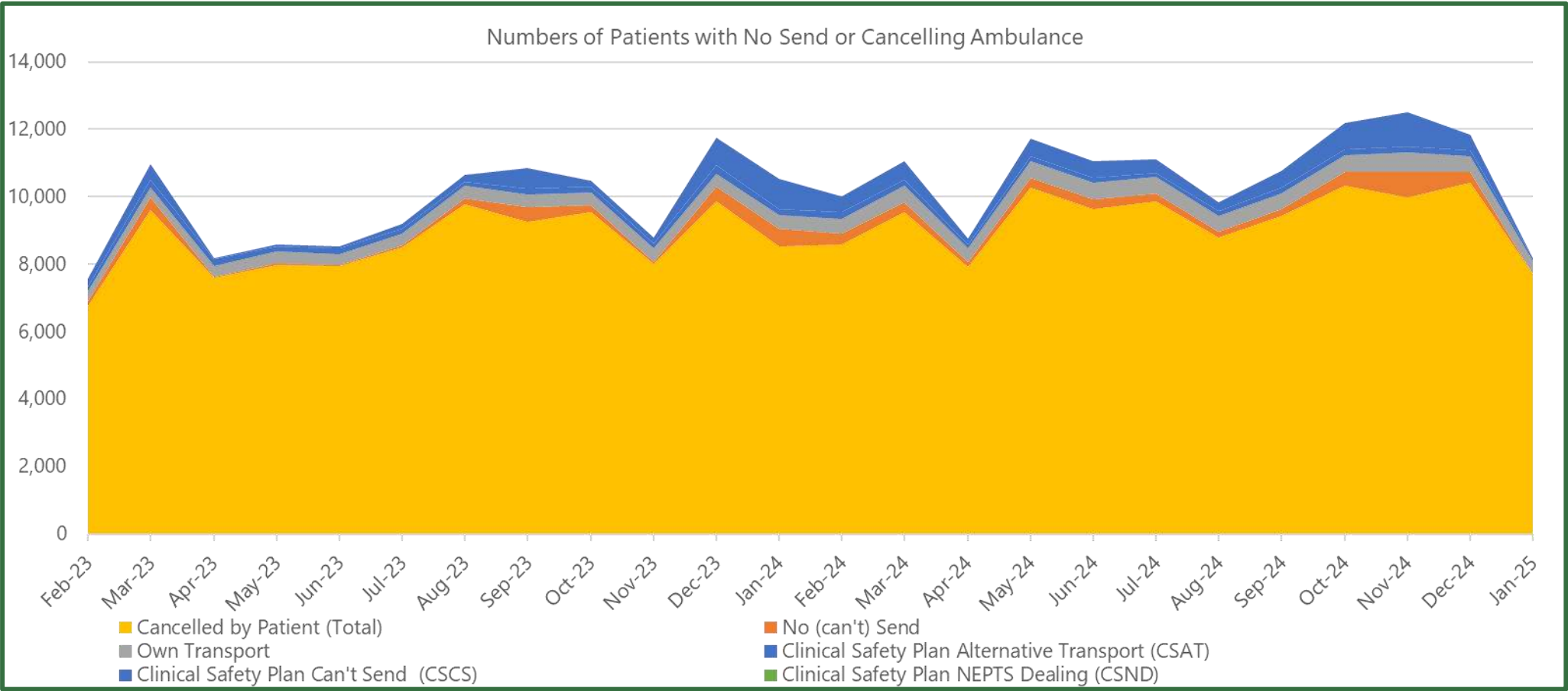
Violence and Aggression: V&A incident causation is being trended to identify the suitability of recording incidents in response to the volume of low harm and no harm incidents to with the aim of undertaking suitable investigations and providing sufficient support for staff members affected. Of note is Most staff on staff reported incidents The team continue working with the Clinical Support Desk to explore mechanisms to better protect staff by use of Community Behavioural Orders via the Patient Care Plans.

Expected Performance Trajectory
RIDDOR: The number of manual handling injuries sustained by staff continues to be main cause of RIDDOR incidents and this is expected to remain the case whilst the improvements in manual handling aides and training are being implements. The other main cause of RIDDOR incidents, slips and trips, varies inline with the prevailing weather conditions as these improve going into the spring it is expected they will reduce.

Violence and Aggression: Whilst there has been a downward trend in V&A incident numbers the current performance remains steady in terms of numbers. The majority of incidents recorded are verbal in nature arising from our call centres. Work is being undertaken to improve the reporting of incidents.

Our Patients: Quality, Safety & Patient Experience

Potential Patient Harm Indicators



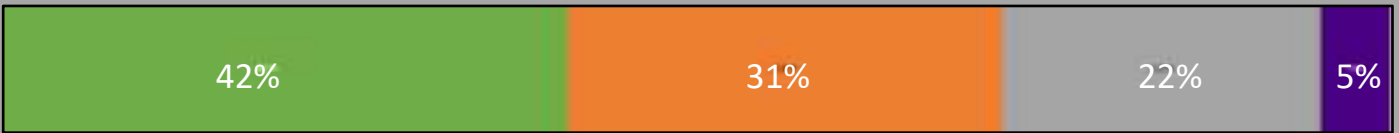
Analysis

In January 2025, 92 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport. In addition, 7,758 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from the 10,418 in December 2024.

There were 1130 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in January 2025. Of these 274 were accepted and released in the Red category, with 12 not being accepted. Further to this, 192 ambulances were released to respond to Amber 1 calls, but 652 were not.

The graph in the bottom left shows that in January 2025 of the 6,629 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (994 patients) would experience no harm, 53% (3,513 patients) would experience low harm, 23% (1,524 patients) would experience moderate harm and 9% (596 patients) would experience severe harm.

In January 2025 CSP levels for the Trust were:



Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements but have now restarted. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,500 hours of handover lost hours.

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 Trust's ability to respond to demand. See also slides on Red performance and Amber performance, in particular, remedial actions.

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

Our Patients: Quality, Safety & Patient Experience

Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

Health & Care
Standard
Health – Safe Care

December 2024		
NEPTS (286 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	84
Were you happy with the transport you received?	85	96
999 (11 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	90
The 999-call taker who answered your call explained what was going to happen next.	85	90
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	91
The length of time I waited for an ambulance to arrive was acceptable.	85	44
111 (21 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	49
Did you follow the advice given to you by NHS 111 Wales?	85	59
Would you consider using NHS 111 Wales again?	85	62
WAST Overall - Friends & Family Test	Ranked from very poor to very good.	
How was your overall experience with the service today?		
Ambulance care	92.59% Good	4.12% Poor
Integrated Care (NHS 111 Wales Telephone line only)	60.00% Good	27.78% Poor
EMS (including CSD)	81.82% Good	18.18% Poor
NHS 111 Wales Online	61.29% Good	16.13% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey, responses provided show that people are satisfied with the overall service they receive. With the question ‘Were you happy with the transport your received’, came out above the 85-benchmark figure (n=96). However, the length of time waited for transport home following an appointment continues to be problematic and did not hit the benchmark in relation to the question ‘How long did you wait for your transport to take you home after your appointment.’ Questions within the 999-section around the call handling process all reached the 85 benchmark, those being ‘The 999-call taker who answered your call was reassuring’ (n=90). ‘You felt confident in the call taker ability to manage your call and provide appropriate advice?’ (n=91), and ‘The 999-call taker who answered your call explained what was going to happen next (n=90). The question ‘The length of time I waited for an ambulance to arrive was acceptable?’ failed to reach its benchmark (n=44). Whilst within 111 no questions reached the 85 benchmark. Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

Remedial Plans and Actions
We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:
999 EMS Response (incorporating CSD)
Ambulance Care (NEPTS)
NHS 111 Wales Telephony
NHS 111 Wales Online

A DPIA to be submitted to the ICO for their consideration about use of SMS text messages to directly distribute survey requests to 999 service users is complete and is with colleagues in Information Governance before submission to the ICO. Plans to place QR codes in the back of EMS vehicles to increase patient feedback are progressing and we have spoken to IPC and Fleet colleagues about what is needed to proceed.

We continue to engage with the Once for Wales Programme Board who have updated the 'All Wales Patient Experience Question Set' and 'People's Experience Framework’.

Expected Performance Trajectory
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

Our People

Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production

G

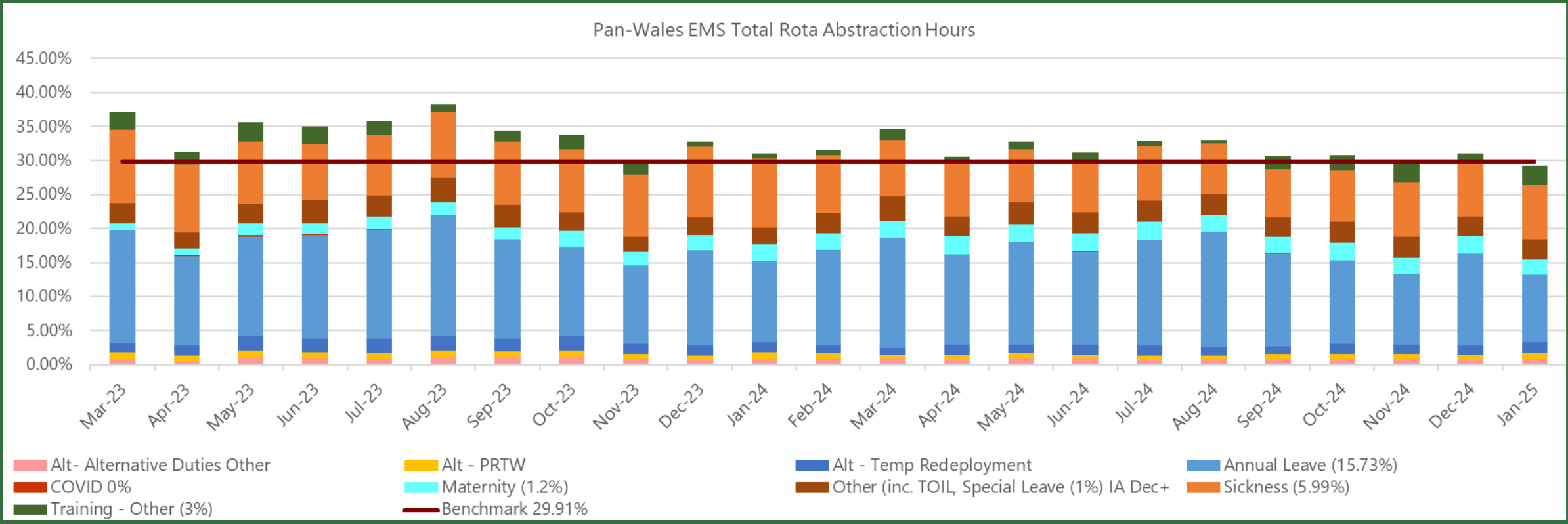
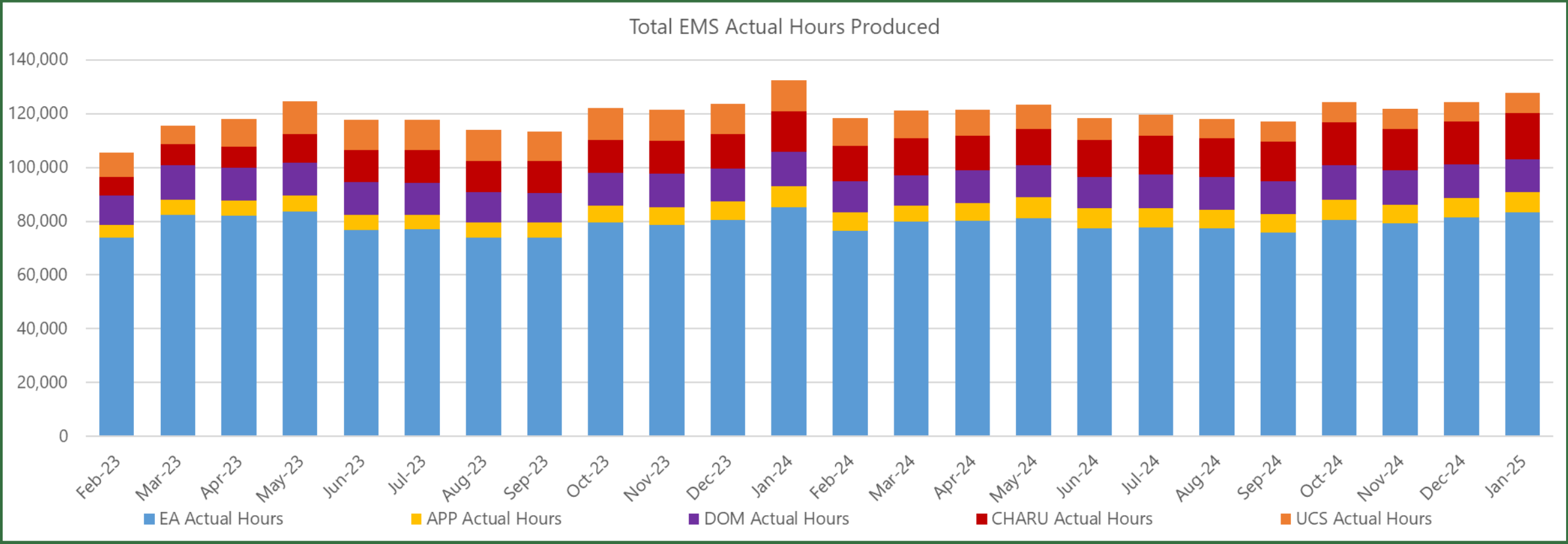
Abstractions

R

CI

PCC

FPC



Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 127,833 hours during January 2025, a decrease compared to the 132,508 hours produced during January 2024. The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. January 2025, saw a total EMS abstractions (excluding Induction Training) of 29.19%. This was a decrease on the 31.05% recorded in December 2024, and achieving the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 9.89% followed by sickness at 8.12%.

Emergency Ambulance Unit Hours Production (UHP) achieved 97% in January 2025 which equated to 83,245 Actual Hours.

In January 2025 CHARU UHP was 94% against the full roll out requirement.

Remedial Plans and Actions

- Continued focus on managing attendance across the Trust and managing abstractions from rosters.
- Full roll out of CHARUs.
- Continued focus on staff in post to establishment, aiming for 95% benchmark.
- Smoothing of staff between urban and rural areas.
- Focus on recruitment to reduce identified vacancy gap, in particular, EMTs and APPs.

Expected Performance Trajectory

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel is good, while the abstractions benchmark has been achieved a number of times this year.

Our People

Capacity - Sickness Absence Indicators

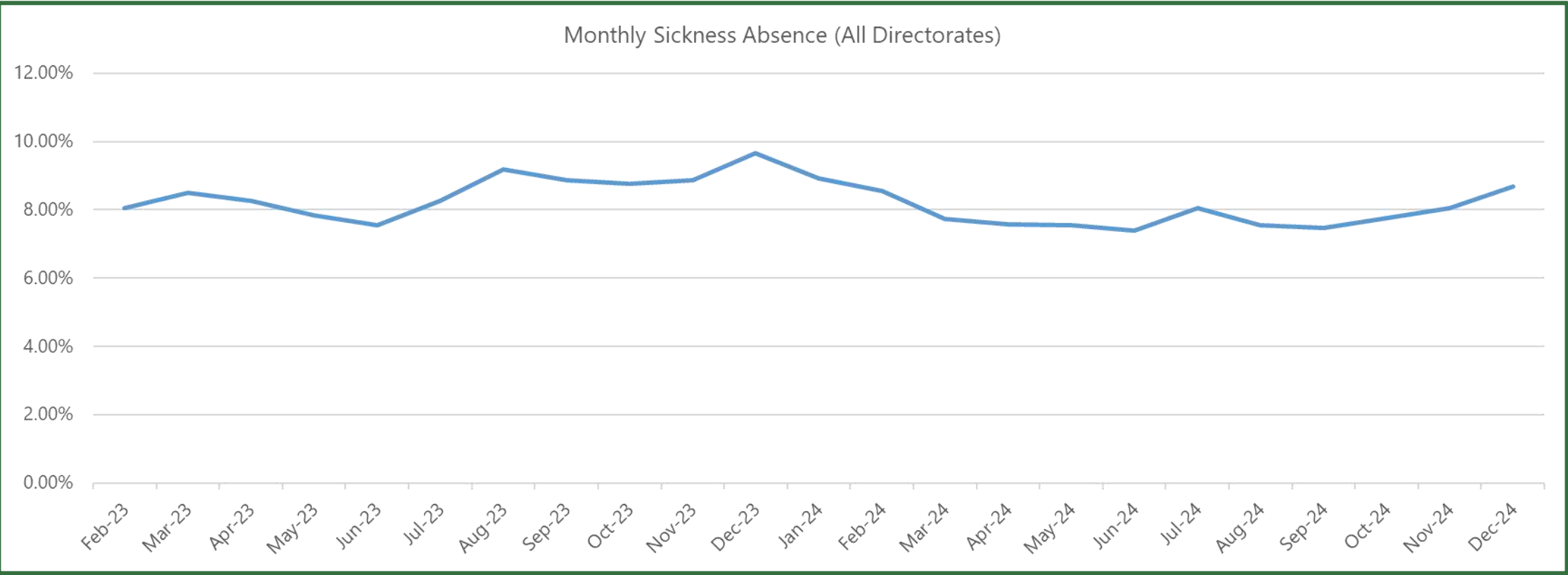
(Responsible Officer: Angela Lewis)

Mental Health

R

PCC

CI

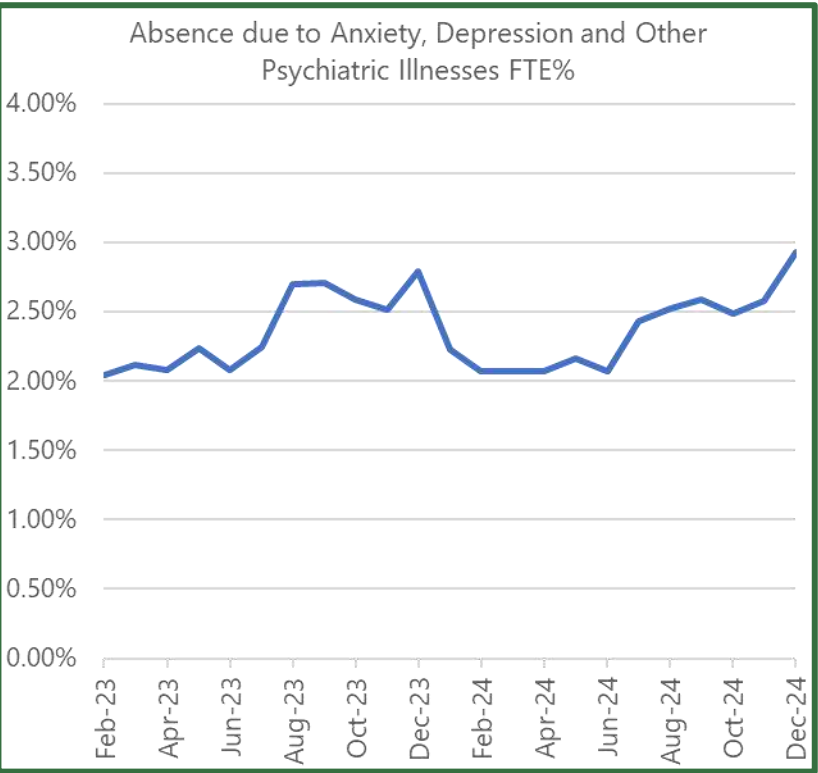


Analysis

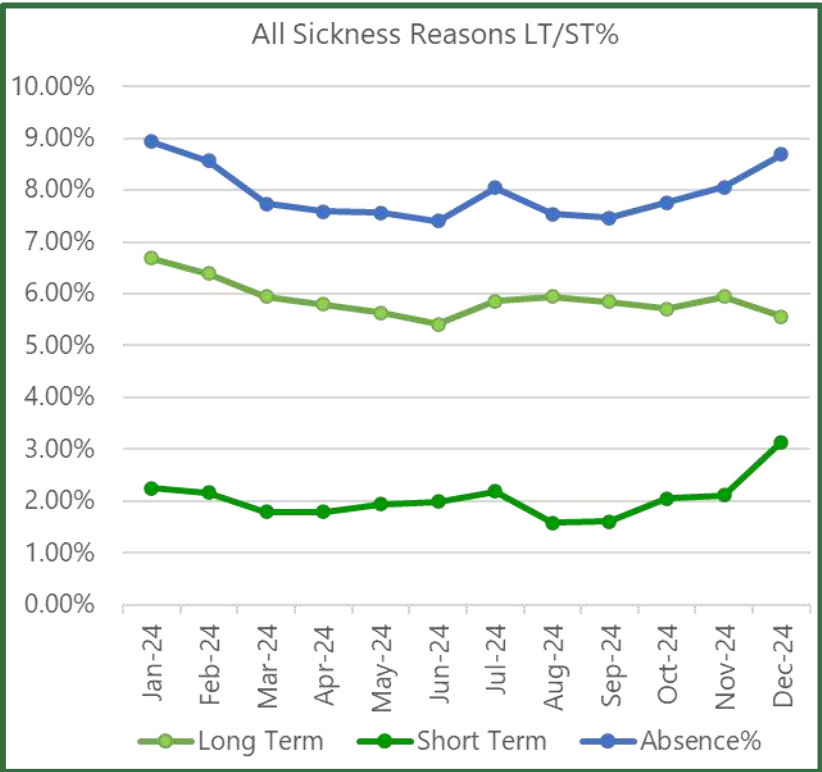
There was a slight increase in overall sickness absence rates between November 2024 and December 2024, rising from 8.06% to 8.69%. Long term absence decreased from 5.95% in November 2024 to 5.56 % in December 2024, while short-term absence increased slightly to 3.14% in December from November 2024 (2.11%).

The highest reasons for absence in December 2024 were Anxiety/ Stress/ Depression, other musculoskeletal problems, cold/cough/flu/influenza, Gastrointestinal problems and injury fracture. Absence due to Mental Health increased from 2.58% in November 2024 to 2.93% in December 2024.

From the start of the flu campaign until end of mid Jan-25, 1,417 flu vaccines have now been administered by our WAST OH / Peer Vaccinators. 1,253 were given to WAST employed staff with 216 WAST staff also confirming they have received the flu vaccine elsewhere i.e. GP / Pharmacy, therefore, 28.4% of the WAST workforce has now been vaccinated. A further 238 WAST staff have completed our Microsoft Form to state they wish to opt-out from having the flu vaccine this year.



Average working days lost per FTE (Annual)	
18.12 days	
Single month Absence %	
8.69%	
Long Term	Short Term
5.56%	3.14%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.93%	(excluding Back) 0.81%



Remedial Plans and Actions

- The team have been working closely with the Clinical Directorate flu project team for the 2024/25 flu campaign, they have been holding flu clinics across the regions. Additional clinics were held throughout November and December.
- Due to limited resource within the team, we have revised the programme plan for the pilot Health Check Programme, Health Diagnostics, (HD), which looks at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. We have been working closely with the provider to arrange relevant training and to launch the programme in February.
- Communications will continue to drive and promote the Flu Campaign to engage with the highest number of staff possible. Many events have been attended by Occupational Health / Peer Vaccinators so far and there are still several key events upcoming where Vaccinators will be available to further promote the flu vaccine.

Expected Performance Trajectory

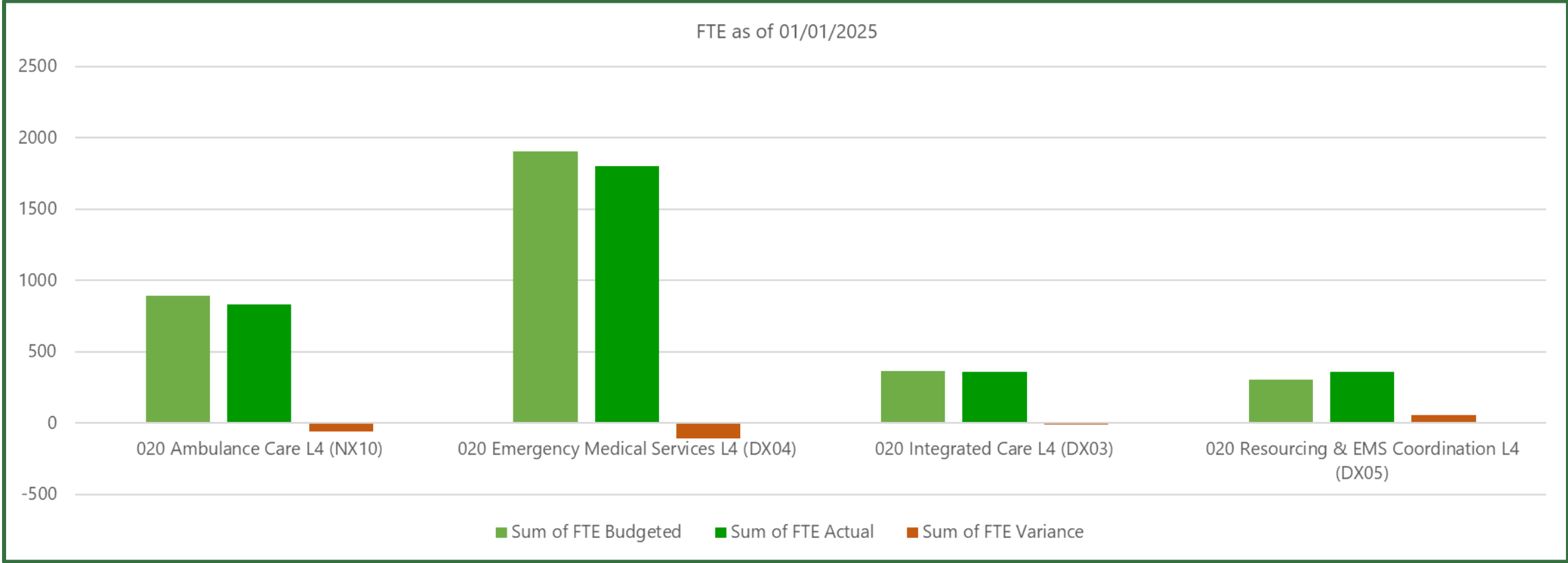
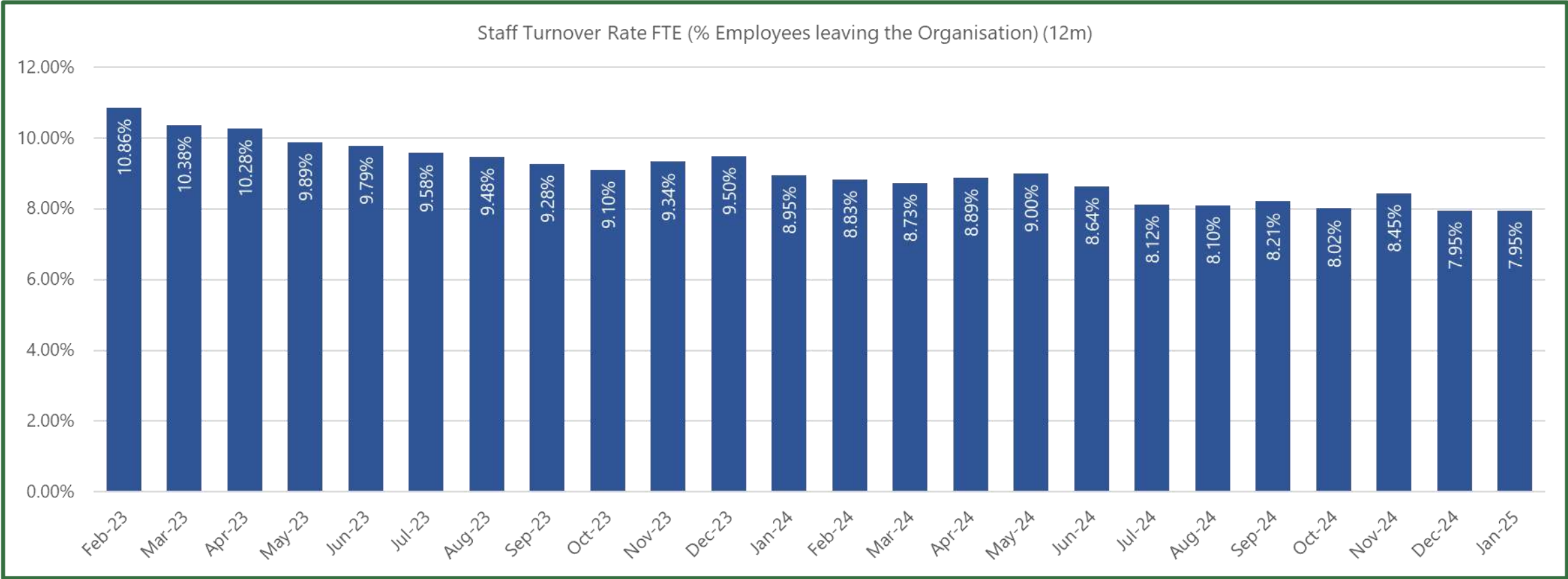
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

*NB: Sickness data will always be reported one month in arrears

Our People

Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)



Analysis

Staff turnover rates in January 2025 were 7.95%, remaining consistent with December 2024. January saw 27 leavers (23.03 FTE). Turnover in months at the end of the quarter are generally higher. This was compensated by 54 joiners (51.29 FTE) in January. Of those leaving, the group with the greatest number were Paramedics (7 people), Call Operators and Staff Nurses (4 people).

Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, i.e., regarding turnaround times for referrals the national KPI states: The 1st offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time.

Our waiting times have fluctuated over the past months, this has been due to staff changes and staff sickness. The current waiting time for a referral (management referral or self-referral is 3 weeks)..

Staff are currently waiting approx. 4.3 days for pre- employment screenings from date of this has been due to submission to first offered appointment.

Remedial Plans and Actions

- The team continue to work closely with Civica to improve the system, including a text reminder service for appointments.
- The Wellbeing team continue to support colleagues and managers by attending regular meetings, providing targeted support and facilitating drop-in sessions for colleagues.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits/ drop-in clinics, presenting to newly recruited staff and through attendance at managers’ meetings.
- The Health and Wellbeing Plan for 2025-29 was approved by the WAST Board in Q3 2024/25. The delivery period will begin in the April 2025. The focus of the plan is to highlight improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges increasingly on a systemic level, in addition to providing support on an individual level.

Expected Performance Trajectory

The team continue to review the Occupational Health and Wellbeing provision, so that we ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement.

Our People

Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR

A

Stat & Mand

G

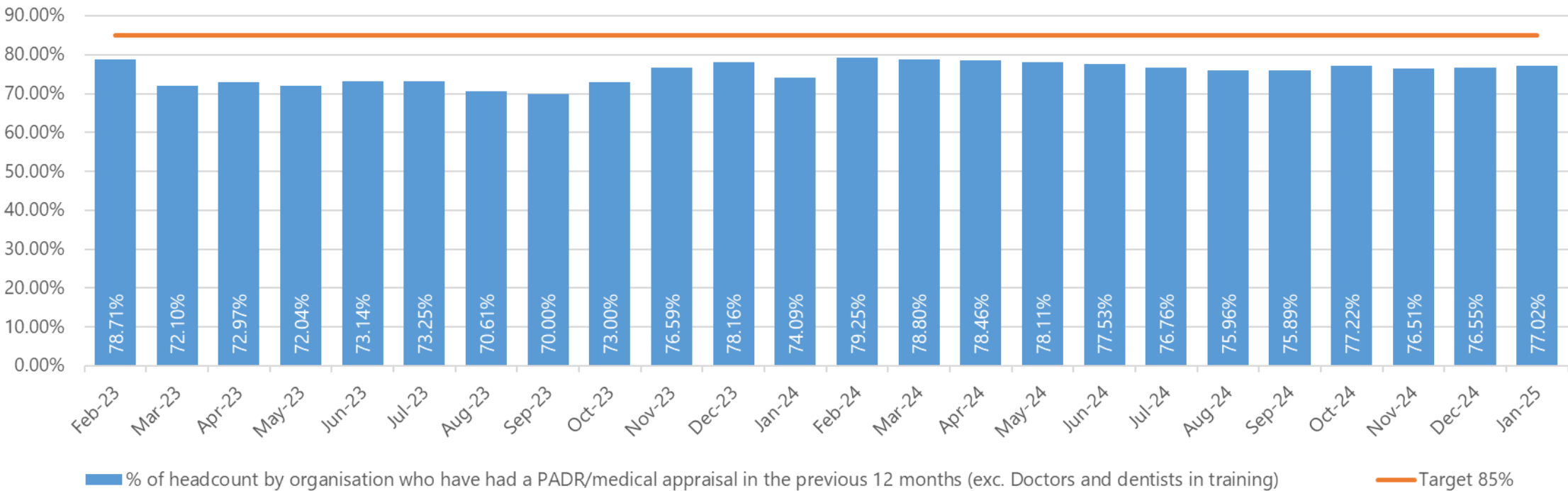
CI

PCC

Health & Care
Standard
Health – Staff &
Resources

Self-Assessment:
Strength of Internal
Control: Strong

% of Organisation who have had a PADR/Medical Appraisal in Previous 12 Months



Analysis

PADR rates minimally increased from 76.55% in December 2024 to 77.02% in January 2025 and remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In January 2025 Statutory & Mandatory Training rates reported a combined compliance of 85.64%; which is a minimal increase but achieves the 85% target for the second consecutive month. However, only Dementia Awareness (97.06%), Moving & Handling (94.30%) and Safeguarding Adults (91.01%), achieved the 85% target. Equality & Diversity (82.73%) Fire Safety (77.01%), Paul Ridd (74.04%), Information Governance (73.71%), Violence Against Women, Domestic Abuse & Sexual Violence (73.30%), Fraud Awareness (72.17%) and Welsh Language Awareness (69%) all remain below this target.

There are currently 18 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

Remedial Plans and Actions

Engagement in the PADR process serves as a Key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee Development, support better Communication between managers and employees and develop a culture of accountability and continual improvement.

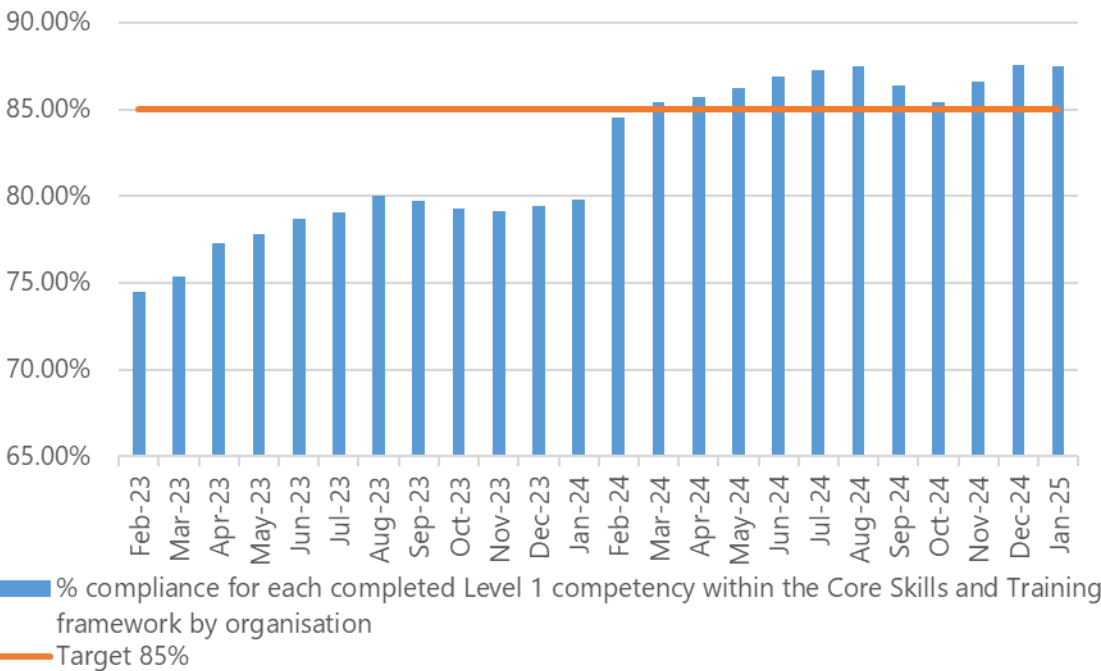
There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly environment enabling easier access to these reportable competencies.

Expected Performance Trajectory

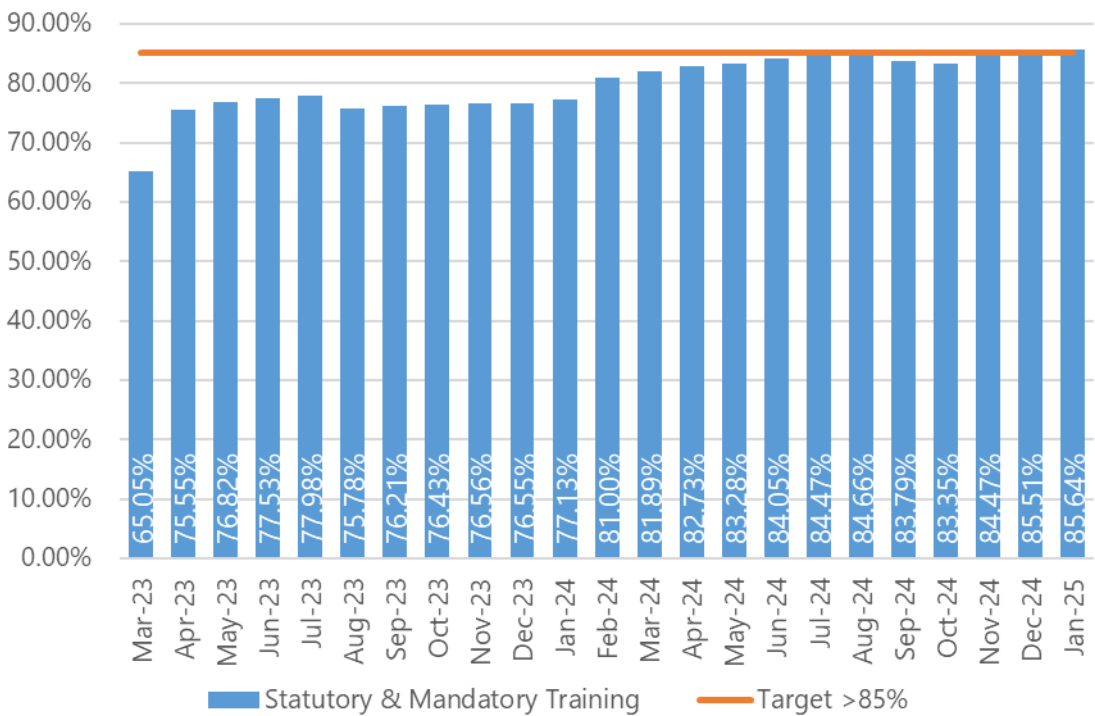
Performance is improving as compliance has risen.

Skills and training Framework	NHS Wales Minimum Renewal Standard
Equality, Diveristy & 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	Yearly
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
Welsh Language Awareness	3 years
Paul Ridd Learning Disability Awareness	No Renewal
Enviroment, Waste and Energy (Admin & Clerical Staff only)	Yearly
Duty of Quality	3 years
Fraud Awareness	3 years
Prevent Awareness	No Renewal

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



% Compliance Statutory and Mandatory Training (10 CSTF Modules)



Our People

Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

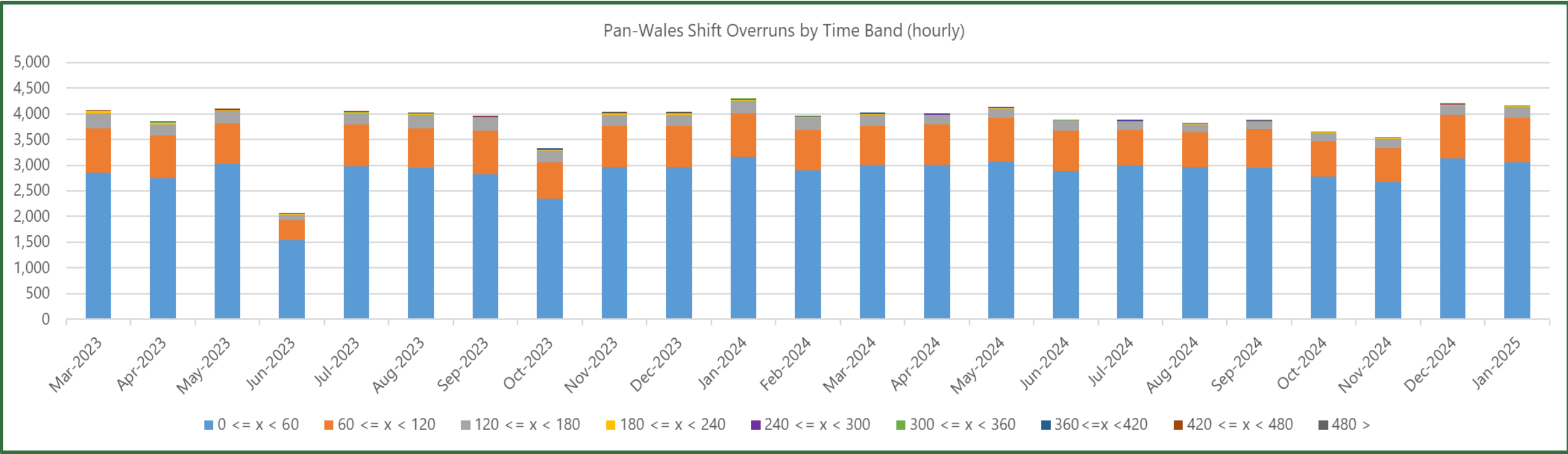
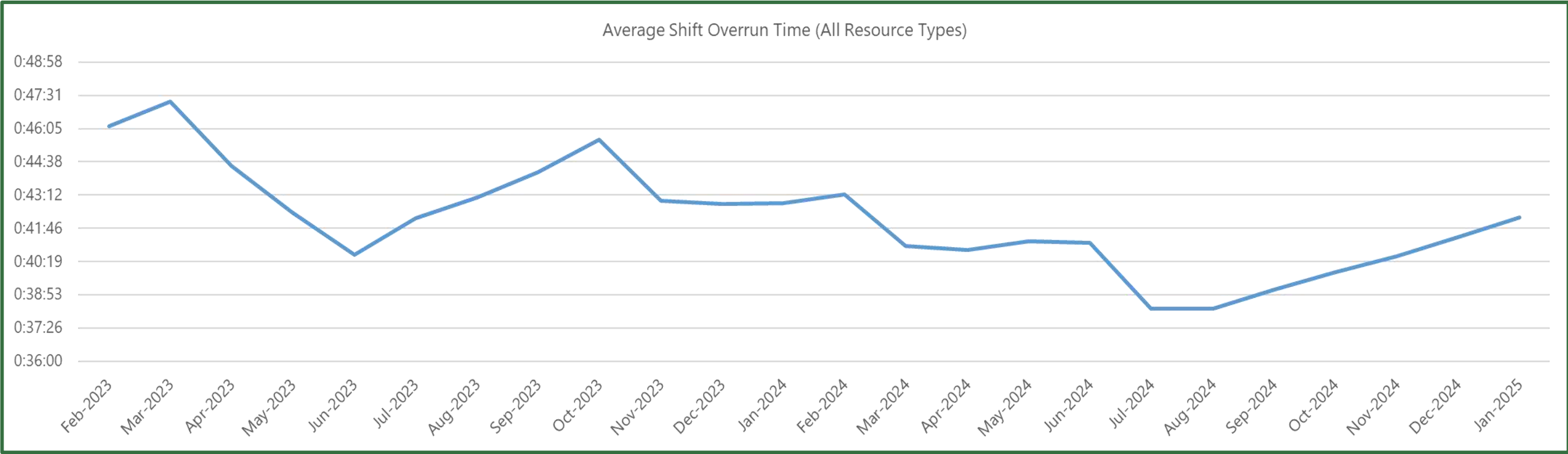
Overruns

R

CI

FPC

PCC



Analysis

There were 4,156 shift overruns during January 2025.

The average overrun figure for January 2025 was 42 minutes and 14 seconds, a minimal increase from December 2024 (00:41:22). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 75.3% of the total. 19.5% fall within the 61 to 120-minute category, 4.7% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

Remedial Plans and Actions

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.

As part of the Trust's winter resilience planning, it introduced "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

Expected Performance Trajectory

Overruns correlate with handover lost hours and may continue to increase.

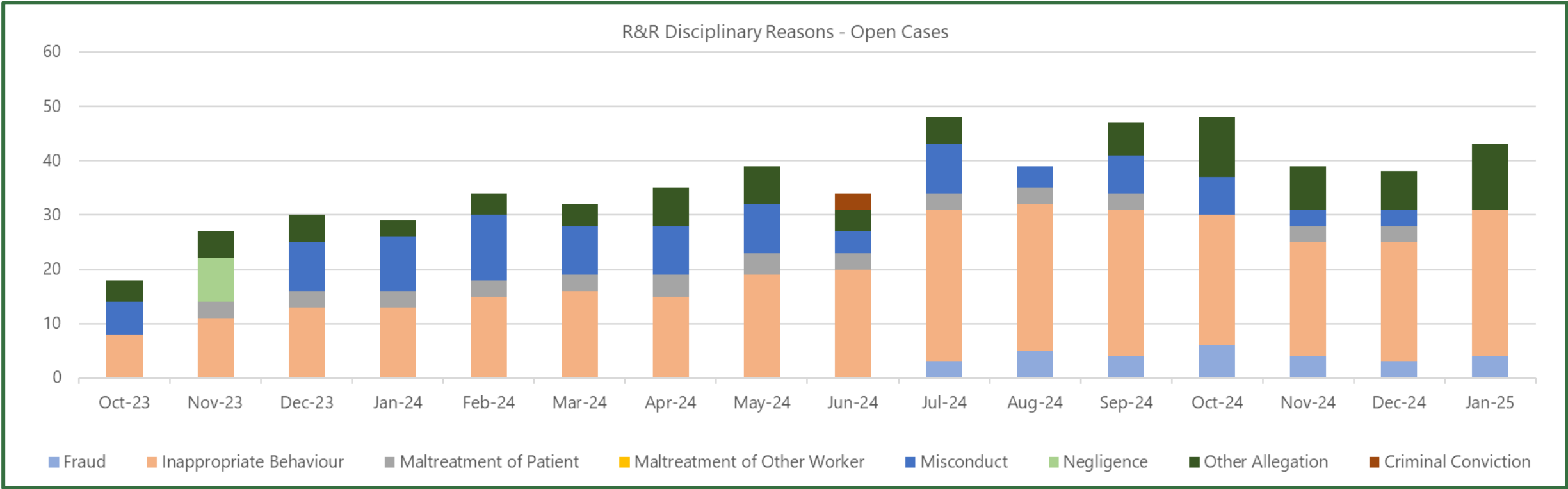
Our People

Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment:
Strength of Internal
Control: Moderate

PCC



Analysis

There were 43 open formal disciplinary cases recorded at the end of January 2025, which is an increase compared to 38 in December 2024. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by fraud.

There were 16 open formal Respect and Resolution cases submitted by employees in January 2025, slightly higher than December 2024 (13). These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in January 2025, 1,248 job applications were processed, and 315 interviews planned.

Of the 1,248 applications, a total of 714 were from under-represented groups with 513 in the category of Ethnicity, 110 within Disability and 91 identifying within Sexual Orientation.

In January 2025, 15.8% (n=113) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 20.3% in December 2024.

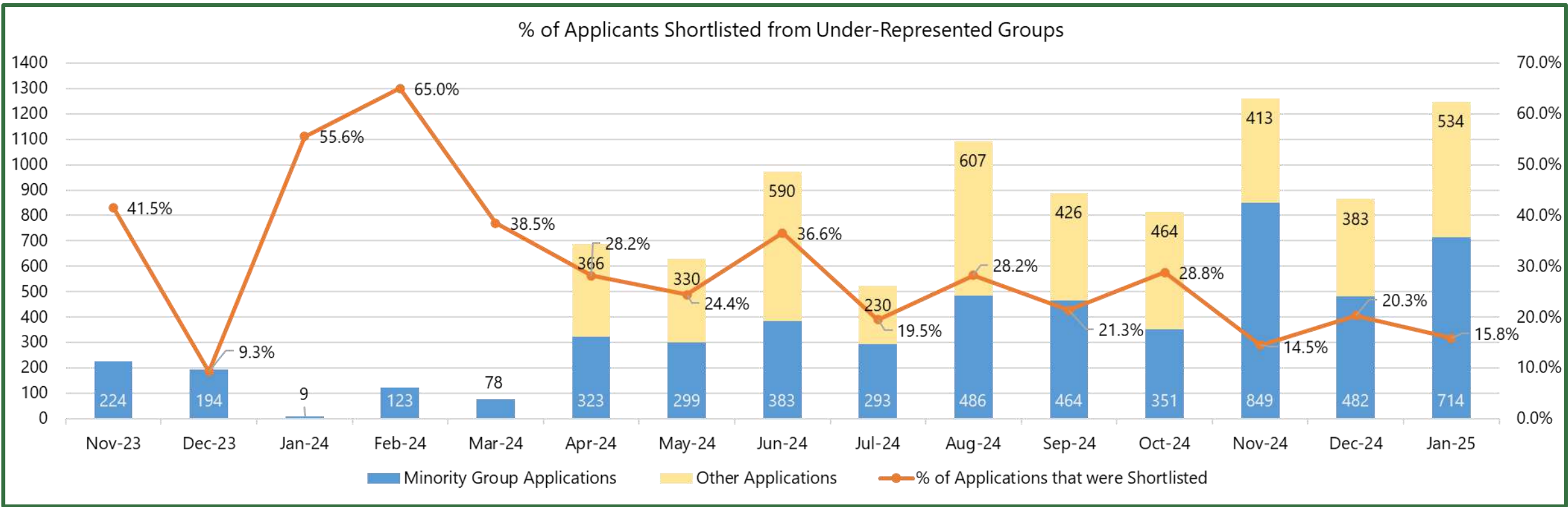
Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events. Two workshops have taken place to recruit for Black, Asian and Ethnically diverse applicants into our digital roles. Unconscious bias training for the managers that will be involved in their recruitment is underway.

Expected Performance Trajectory

Continue to monitor levels, no trajectory for this measure.



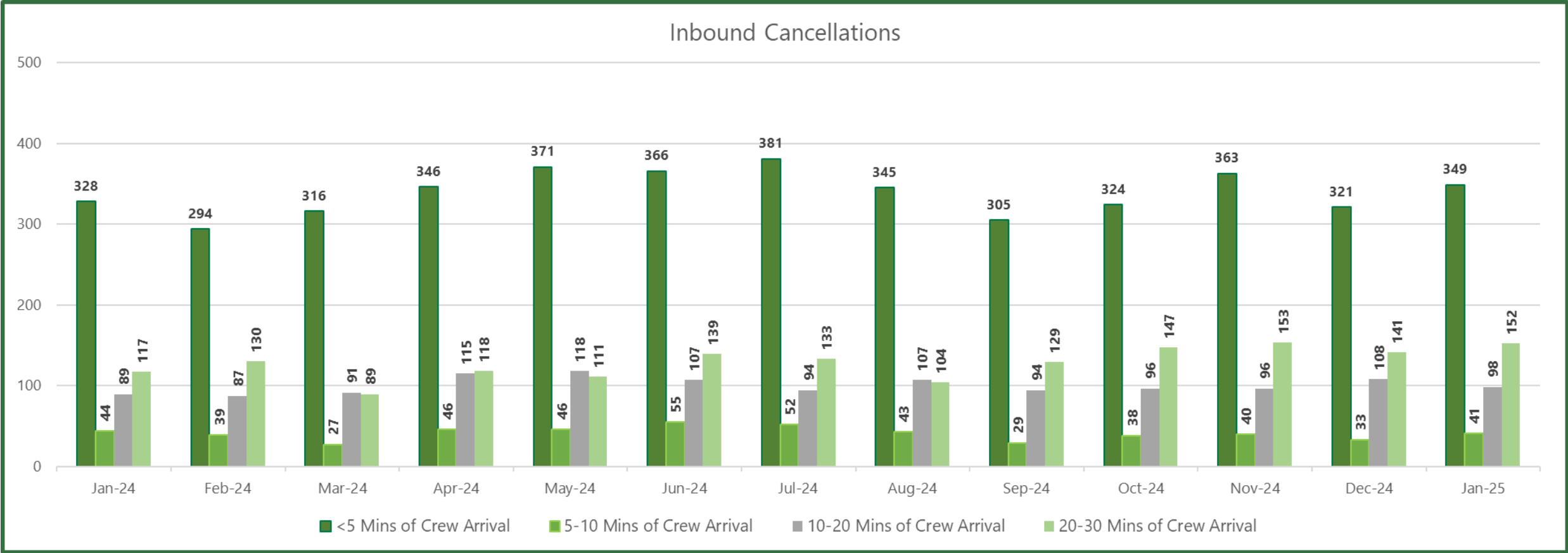
Finance, Resources and Value

Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
R

FPC



Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a slight increase in January 2025 to 349, compared to 321 in December 2024. The total number of cancellations within 30 minutes also increased from 603 in December 2024 to 640 in January 2025.

In January 2025 there were 92 travel bookings cancelled by patients, increasing from 76 in December 2024.

The other top reasons for less than 5-minute cancellations included: 32 patients not located, 22 unwell/too ill to travel and 5 no appointment.

Same day cancellations decreased again in January 2025 to 12%, down from 13.3% in December 2024.

Remedial Plans and Actions

Work with Hywel Dda to develop a direct link between their PAS system and our CAD, has been delayed by a clash of organisational priorities. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment, that requires WAST transport.

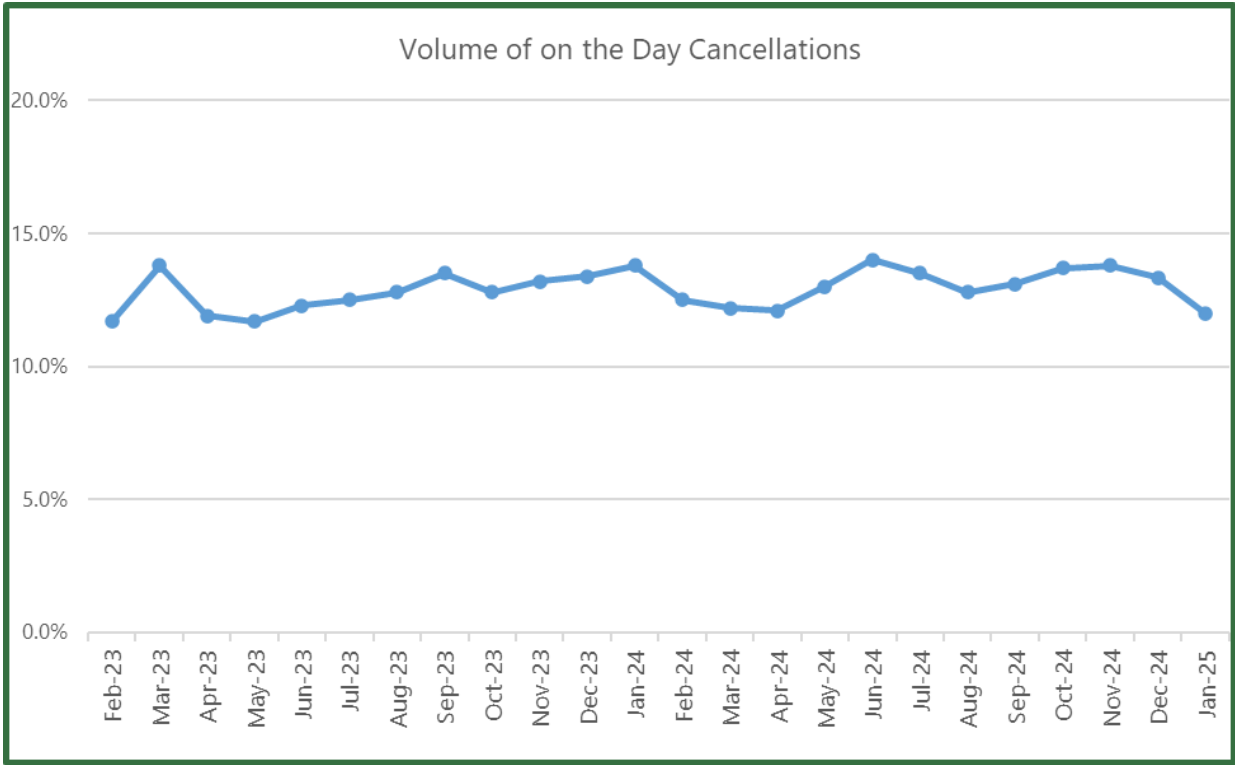
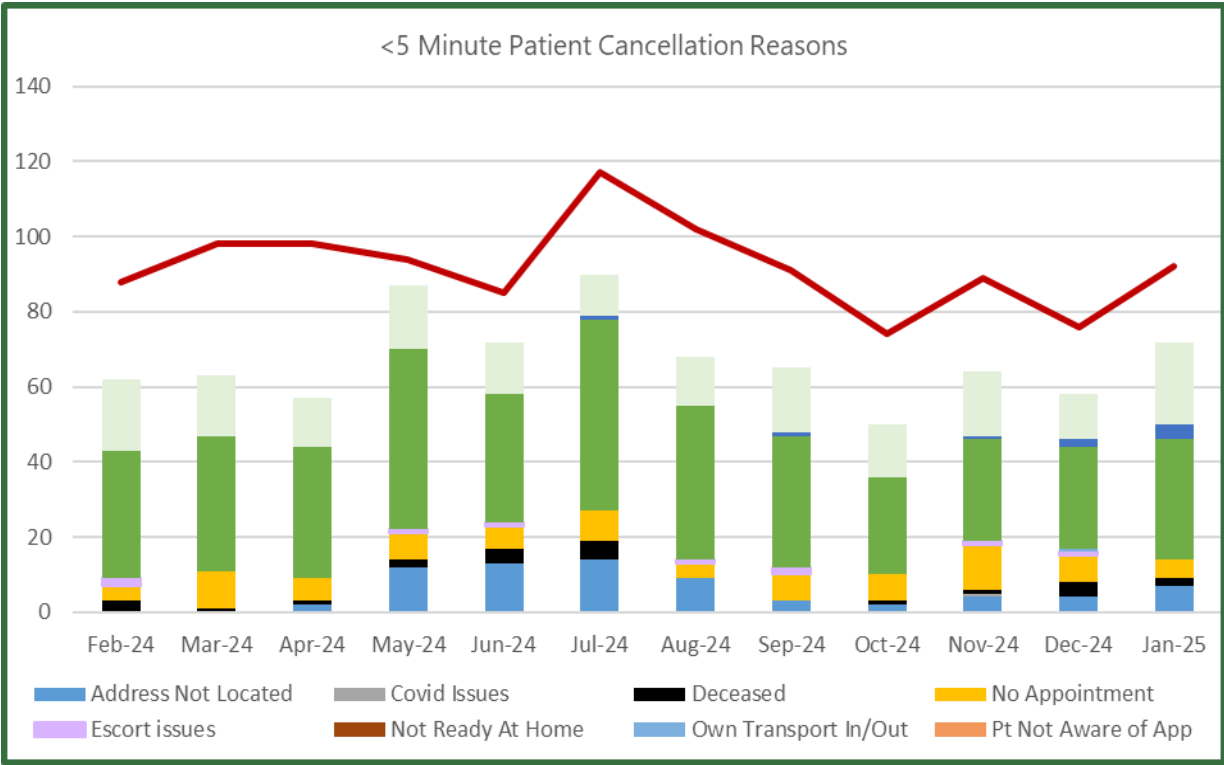
Work is also underway to enhance the service’s text messaging options to improve notification to patients.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory as many of the factors affecting this are outside of our direct control.

Please note that that figures may be lower than overall totals due to some records having no cancellation date.

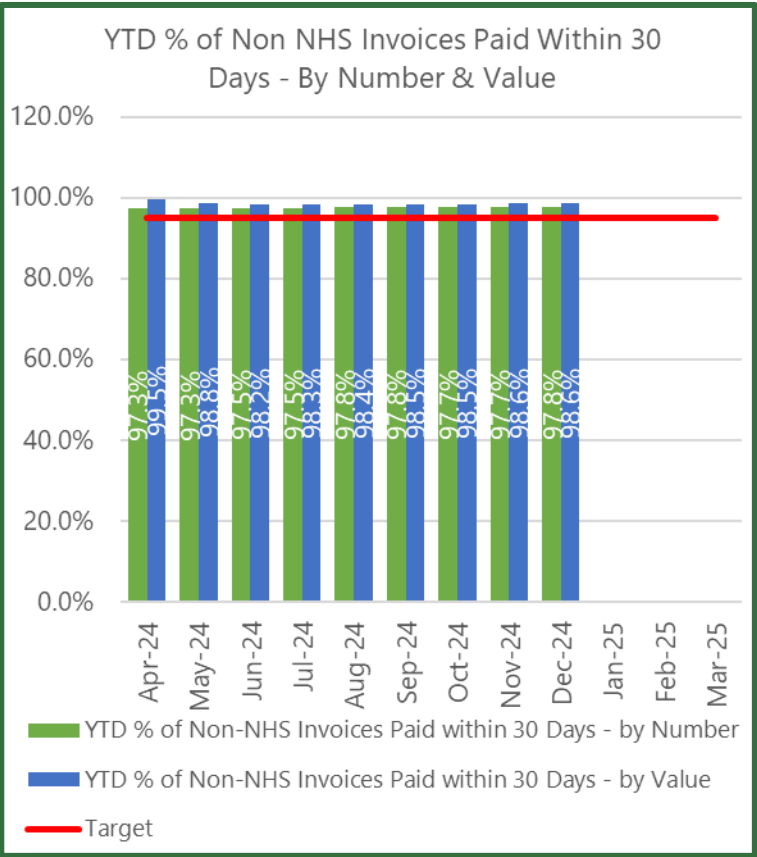
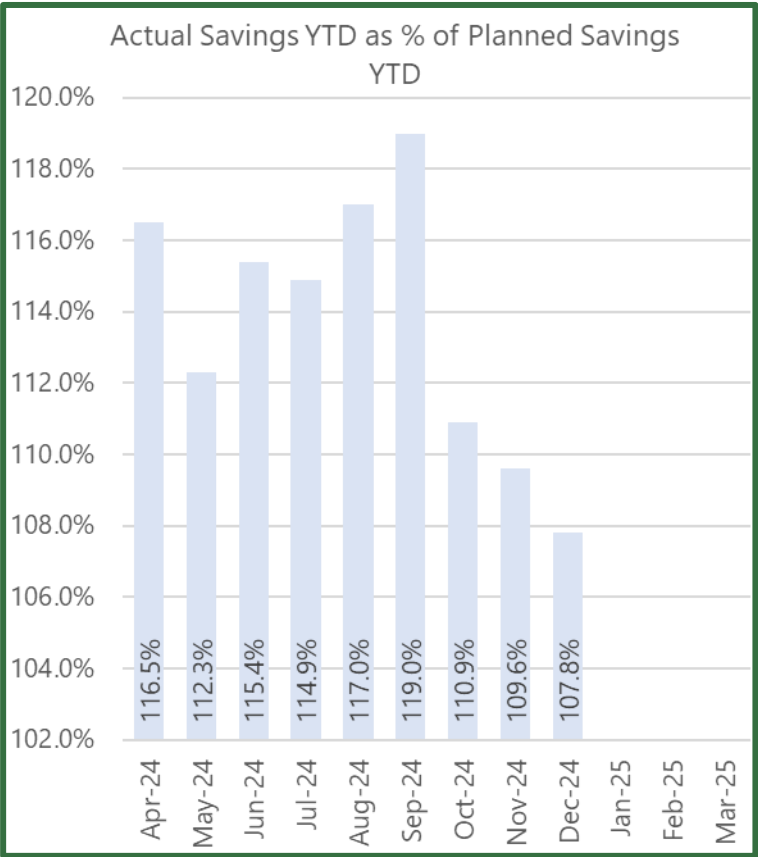
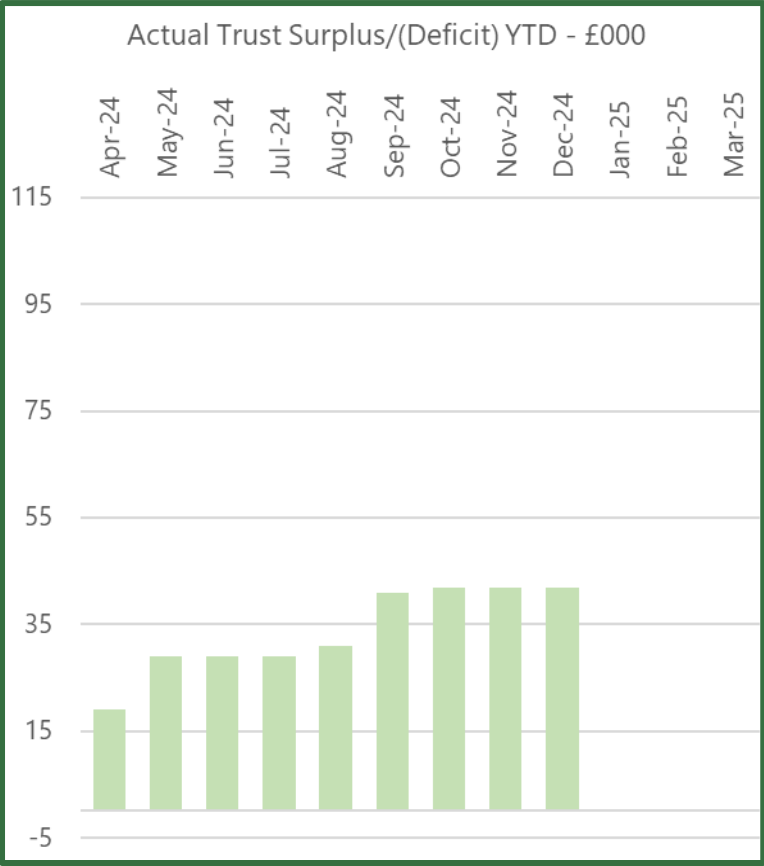
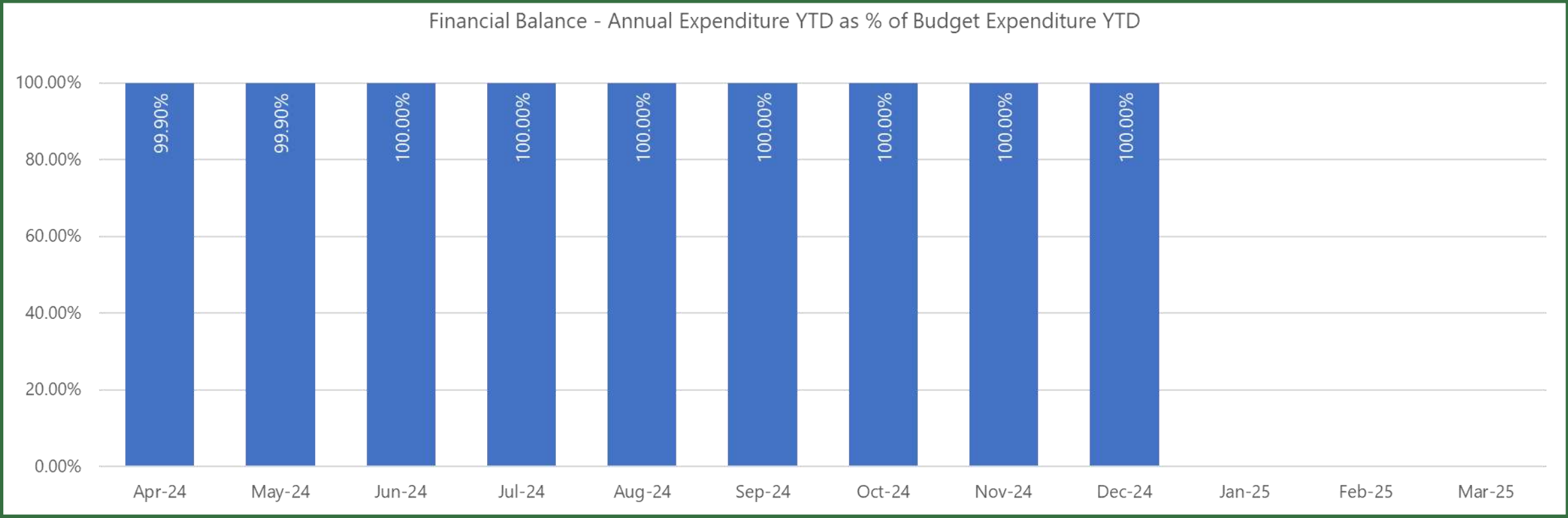
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*



Finance, Resources and Value

Value - Finance Indicators

(Responsible Officer: Chris Turley)



Analysis

The reported outturn performance at Month 9 is a surplus of £42k, with a forecast to the yearend of breakeven

For Month 9 the Trust is reporting planned savings of £5.084m and actual savings of £5.481m (an achievement rate of 107.8%).

The Trust's cumulative performance against PSPP as at Month 9 is 97.7% against a target of 95%.

At Month 9 the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust is forecasting to breakeven; however, key areas of focus include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and
- An improved approach to benefits realisation

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2024/25 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2024/25 financial year of c£6.4m.

Finance, Resources and Value

EMS Utilisation & Average Job/Shift Times

(Responsible Officer: Lee Brooks)

Jobs Per Shift

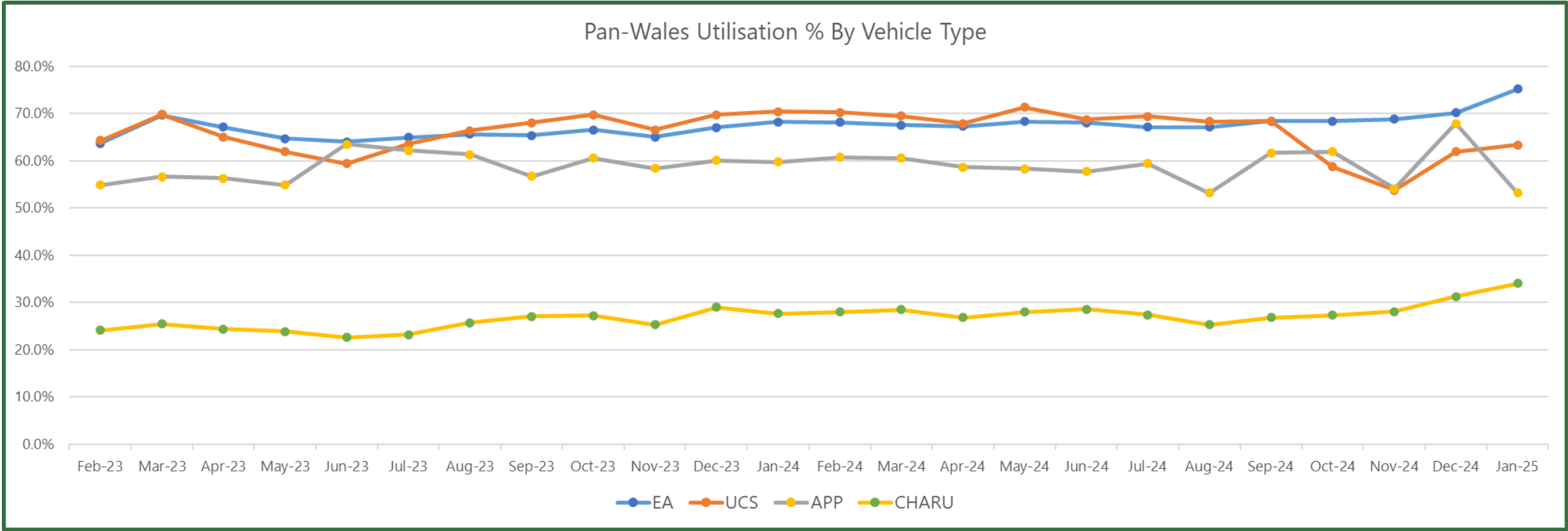
R

CHARU Utilisation

G

FPC

NB: Data quality issues have been identified within APP data. These are currently being addressed.



Analysis
Pan Wales Utilisation metrics in January 2025 were 67% for all vehicles types, an increase from 59.5% in December 2024. EA saw the highest rate during the month at 75.2%, which is the sixth month in a row this metric has increased. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle increased in January 2025 for UCS (3 hours 9 minutes), APPs (1 hour 22 minutes) and EAs (2 hours 28 minutes).

Overall average jobs per shift was 2.46 in January 2025, indicating a slight increase from December 2024 (2.29). EAs averaged 2.49 jobs per shift and UCS crews 1.50. This is lower than what would be ideal and a product of handover delays.

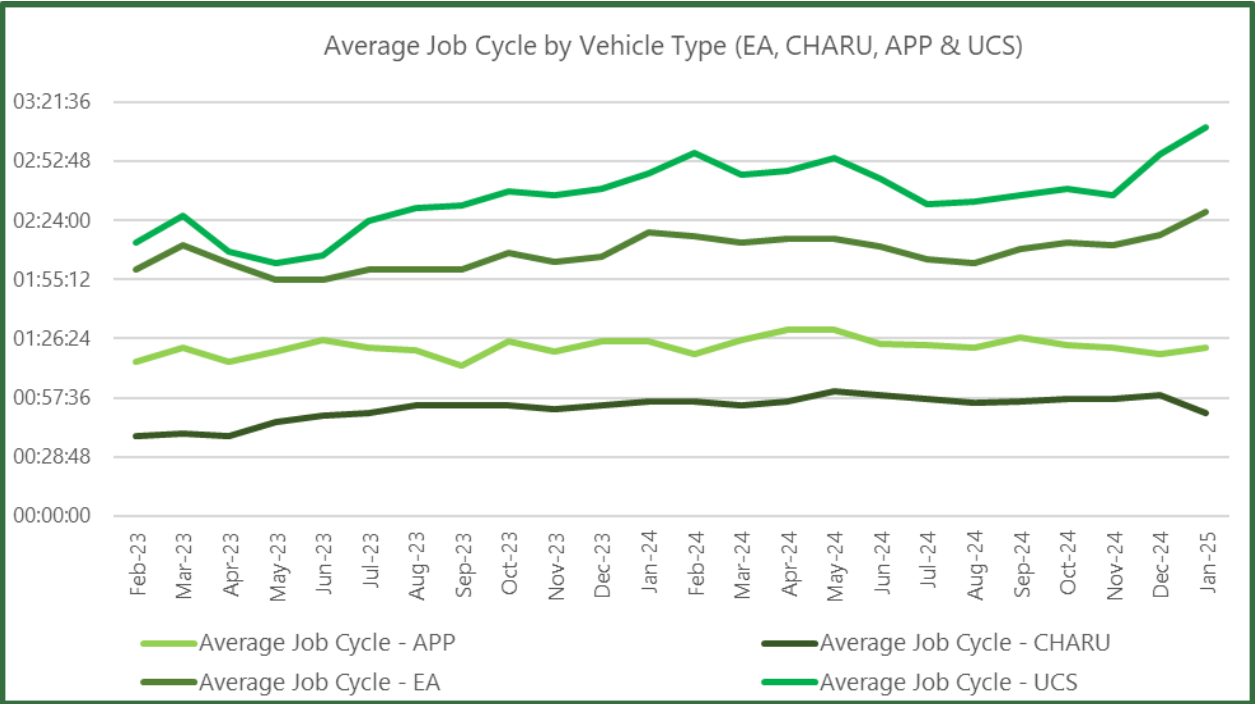
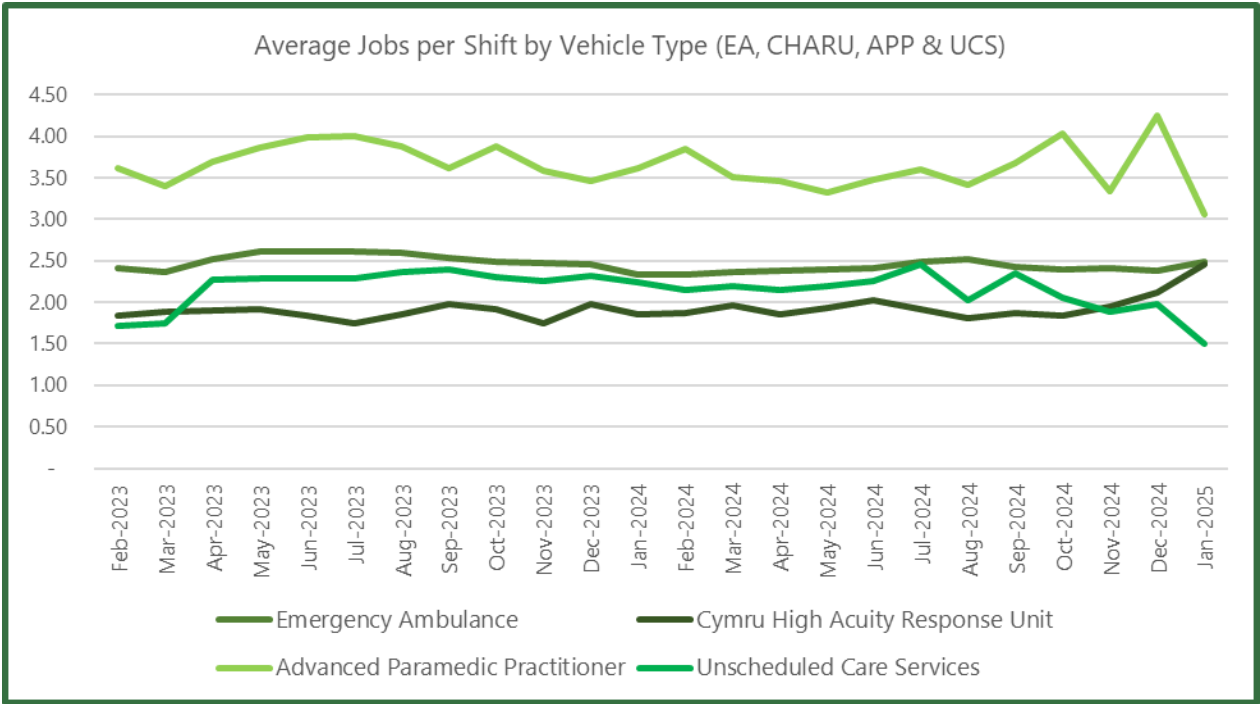
APPs attended on average 3.07 jobs per shift and CHARU's 2.46. Both sets of data are under review.

Remedial Plans and Actions
EA and UCS jobs per shift is fundamentally a product of handover delays.

For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster.

CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs.

Expected Performance Trajectory
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.



Partnerships / System Contribution

NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

NB: Data quality issues have been identified in 111. These are currently being addressed.

Analysis

During January 2025, 59,707 calls were allocated into the 14 categories displayed in the graph opposite, a decrease compared to the 65,673 seen during December 2024. However, data quality issues continue within 111 reporting which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 29.9% of all calls during January 2025, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in January 2025, 6,471 calls were ‘Stopped at Source’, with no onward referral, a slight decrease from 6,496 in December 2024. 14,046 calls were referred to 999/ED in January 2025.

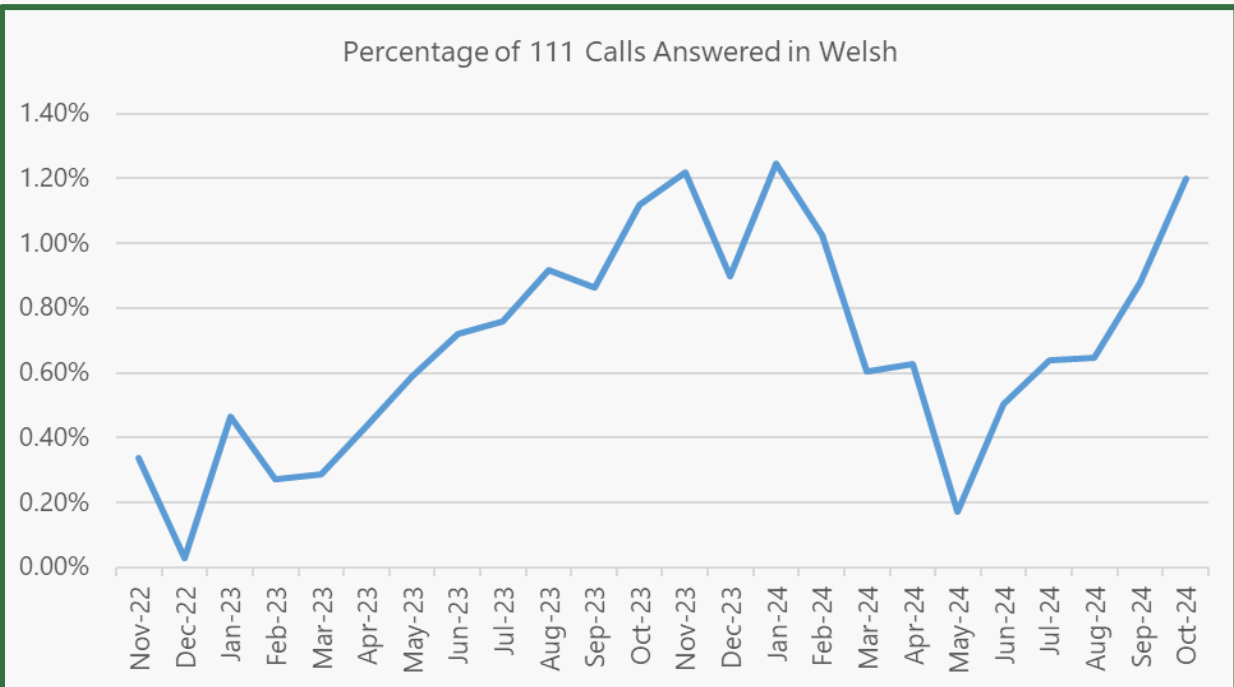
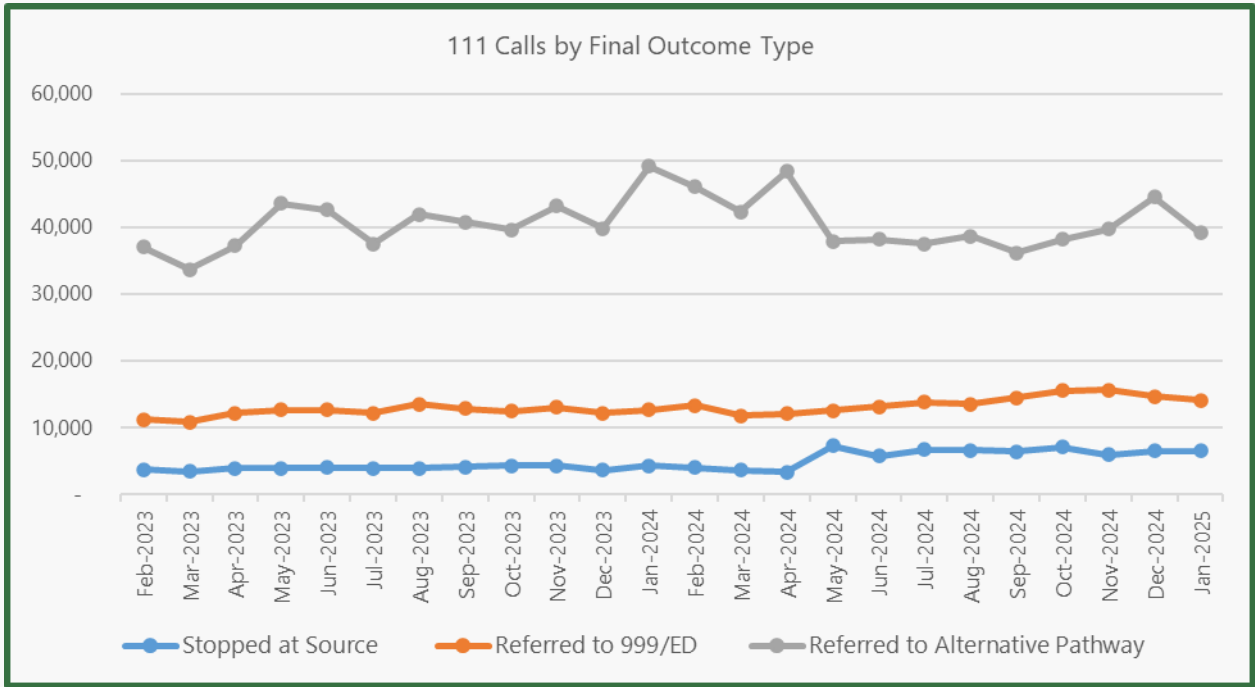
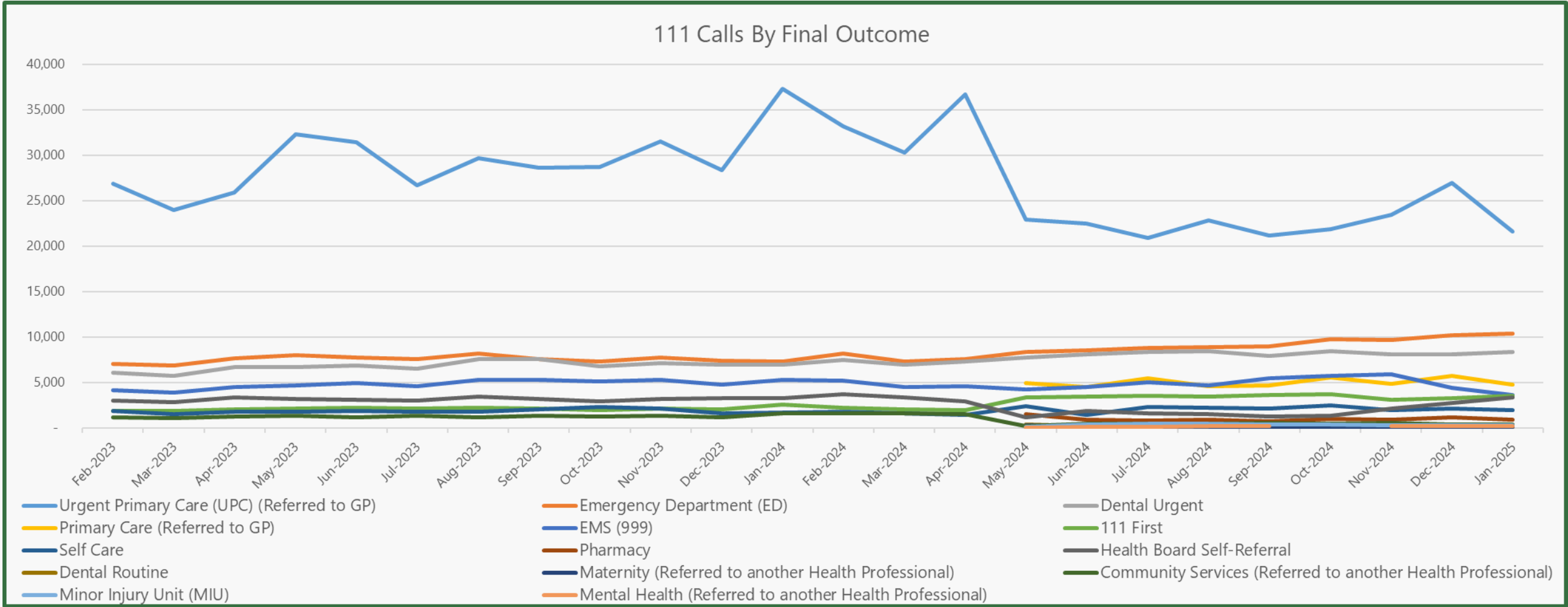
The percentage of 111 calls answered in Welsh increased from 0.88% in September 2024 to 1.20% in October 2024. This equated to 68% of all 111 calls being offered in Welsh being answered. A data quality review is being undertaken meaning this metric is currently unavailable .

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST, Six Goals, commissioners and DHCW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.



Partnerships / System Contribution

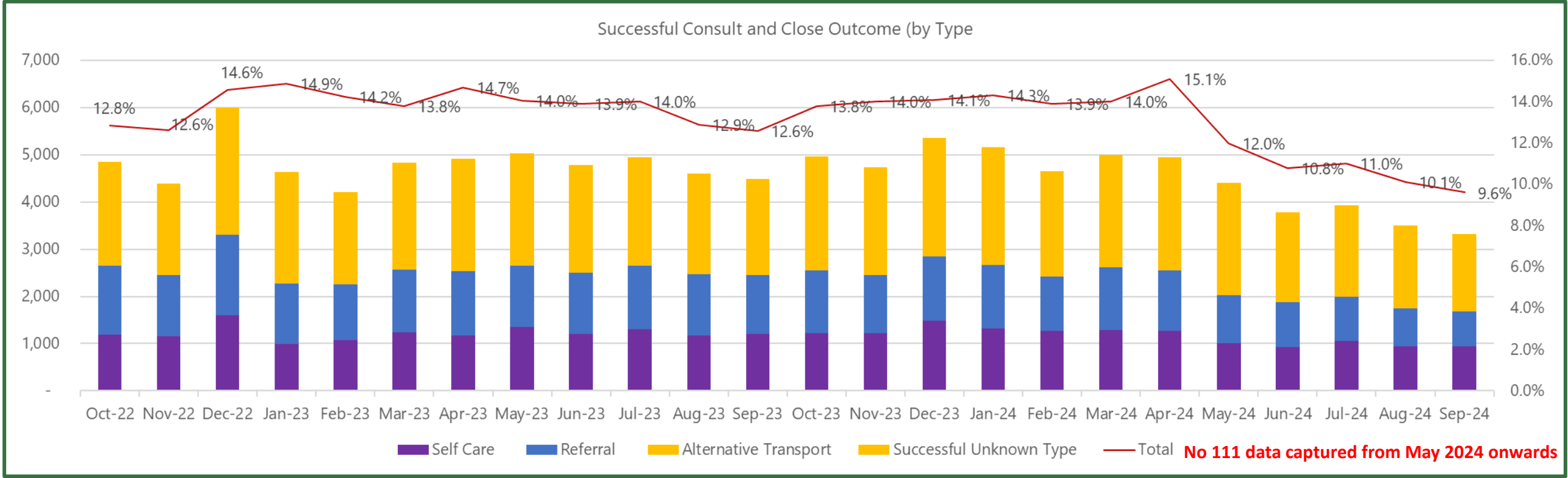
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

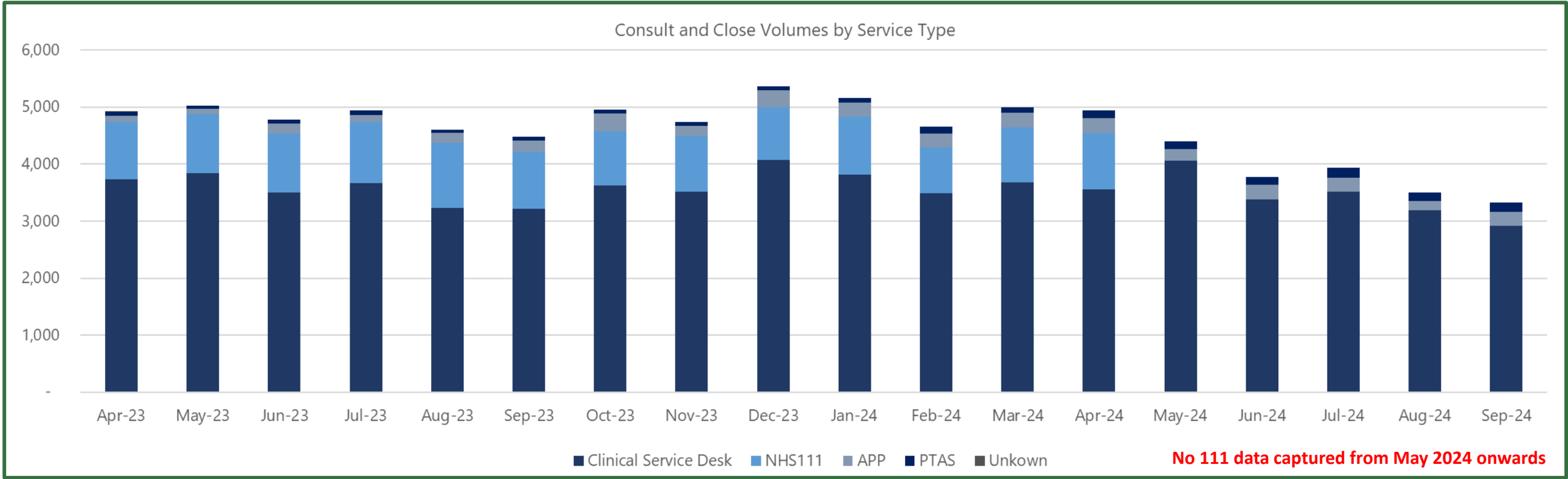
C&C
Outcomes

FPC

NB: Data quality issues have been identified in 111. These are currently being addressed.



No additional analysis possible given no 111 data is currently available on these metrics.



Partnerships / System Contribution

Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

Conveyances

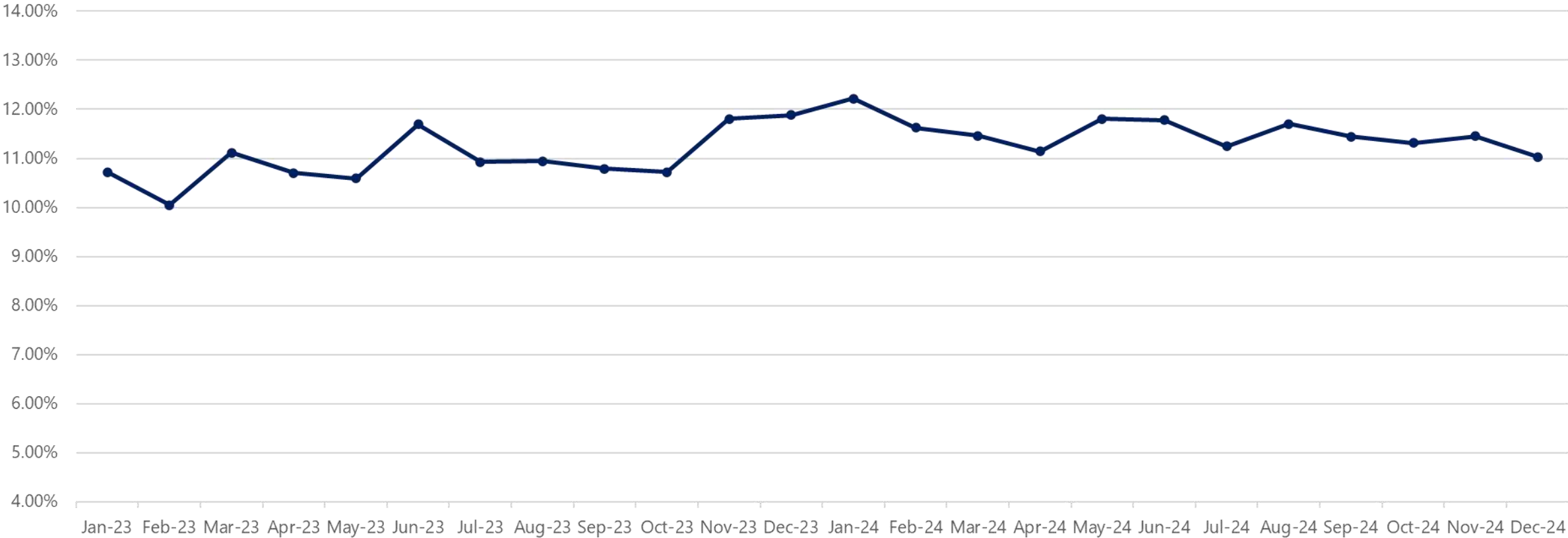
G

FPC

Ministerial Measure

NB: Data quality issues have been identified in APP data. These are currently being addressed.

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



Analysis

In December 2024 11.03% of patients (1,475) were conveyed to a service other than a Type One ED, while 31.06% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased, from 3,884 in November 2024 to 4,036 in December 2024.

The APP conveyance rate was 46.6% in October 2024 and continues to experience a generally increasing trend since March 2023; whilst the DCR table highlights by code the incidents where the preferred response should be an APP (if available). Pilot schemes are in place to clinically dispatch advanced and enhanced clinical resource to safely manage care closer to home, however, data quality is being undertaken and therefore no further data is available.

Patients conveyed to SDEC's in October 2024 remained low at 0.14%. No further data is available.

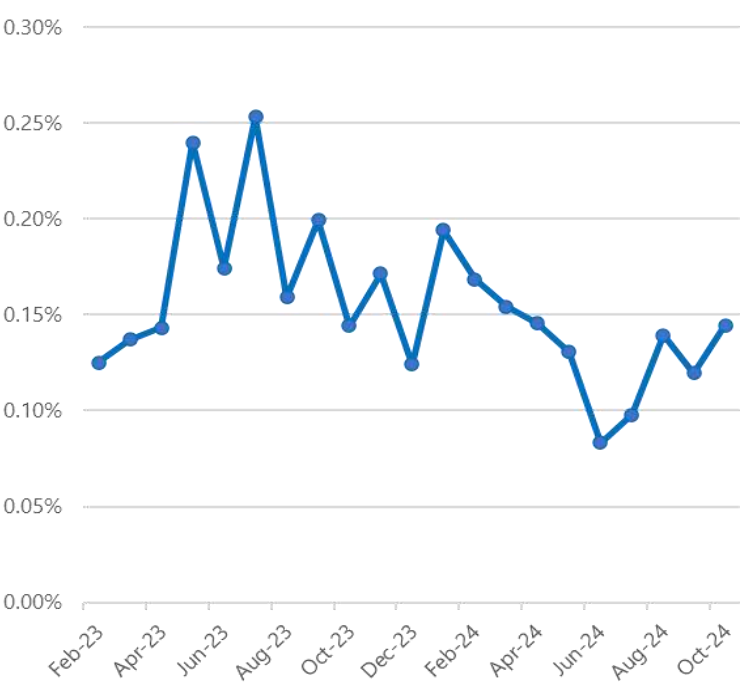
Remedial Plans and Actions

- Continued contribution to the SDEC strategy the 6 goals programme with HB actions around reporting measures from referral and bedding of SDECs in times of escalation. It should be noted that WAST data reflects a direct referral to an SDEC where some HB models require a conveyance to ED initially and then streaming to SDEC on this basis.
- Further investment in the APP workforce in 2024/25 (+32 APPs).
- Formal education support and induction package for APPs agreed trust-wide.
- Embedding the Urgent Care response within the Clinical Model Transformation, tasking optimisation (alongside HB partners if available), scheduling care and APP development and workforce.
- Inclusion of specific Frailty and Falls workstream within Urgent Care Response Service with involvement in the review of the All Wales Falls Response Framework alongside NHS Executive Colleagues.

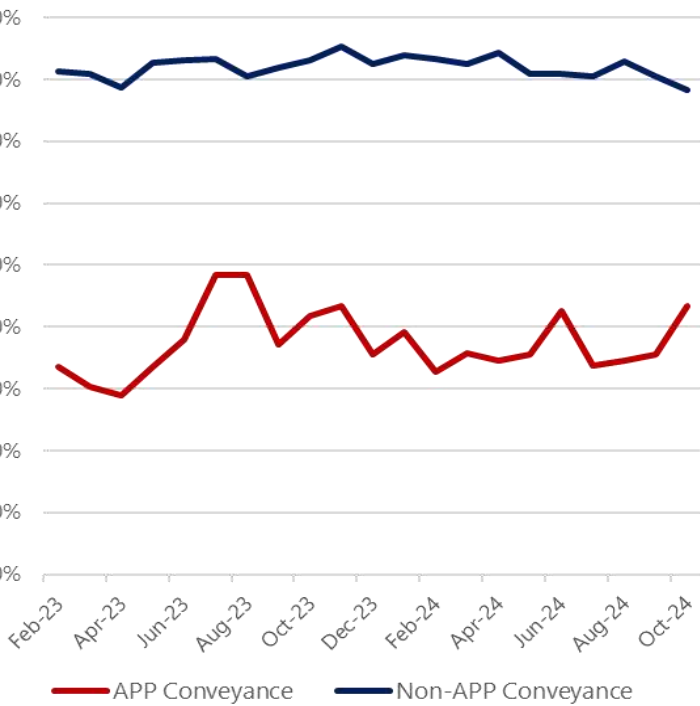
Expected Performance Trajectory

The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Seasonal modelling continues to be undertaken.

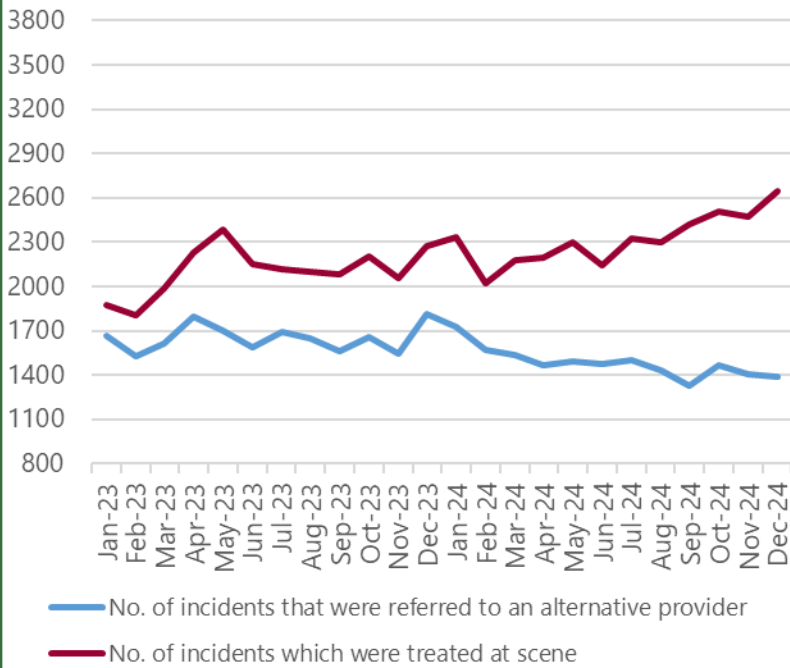
% Patients Conveyed to SDEC Units Pan-Wales



APP vs Non-APP Conveyance Rates



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



Partnerships / System Contribution

Handover Indicators

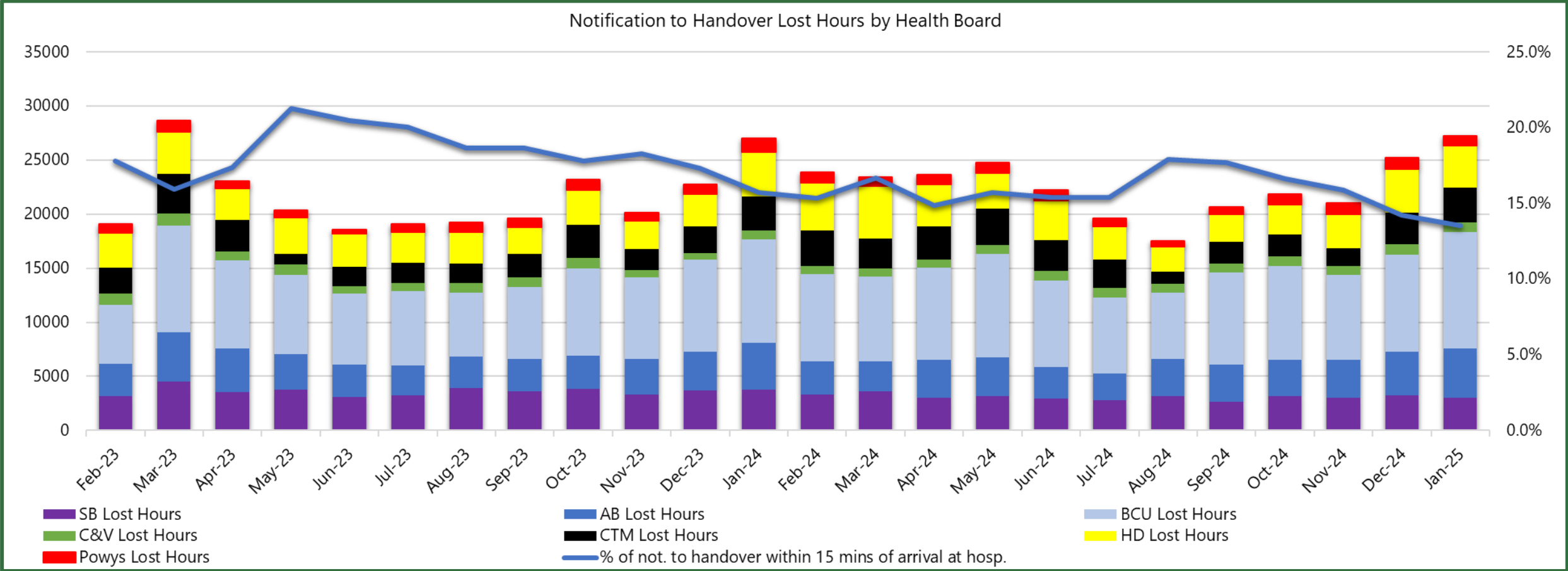
(Responsible Officer: Health Boards)

Lost Hours

R

CI

QUEST



Analysis

271,028 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Feb-24 to Jan-25), compared to 260,830 hours over the same timeframe the previous year. There were 27,212 hours lost in January 2025, which is 0.84% higher than the 26,984 hours lost during January 2024.

The hospitals with the highest levels of handover delays during January 2025 were:

- Grange University Hospital (ABUHB) at 4,400 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 4,067 lost hours
- Glan Clwyd Hospital (BCUHB) at 3,114 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 3,082 lost hours

Notification to handover lost hours averaged 878 hours per day during January 2025 compared to 813 hours per day in December 2024.

In January 2025, the Trust could have responded to approximately 8,584 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

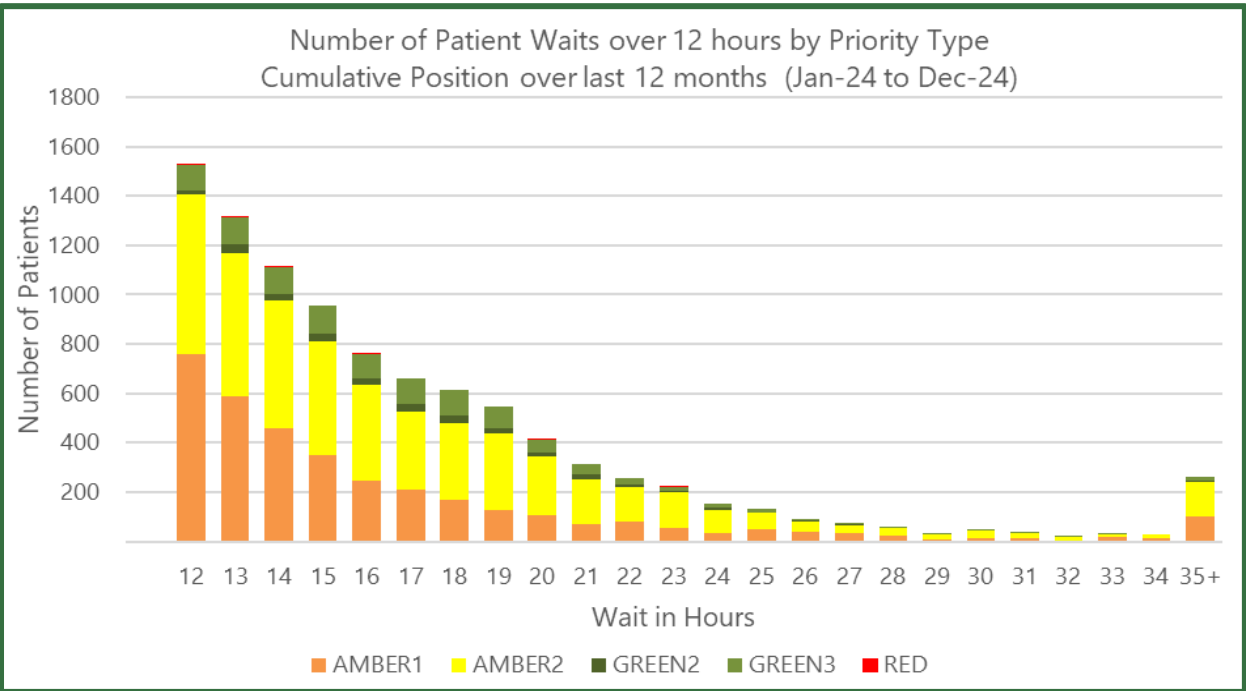
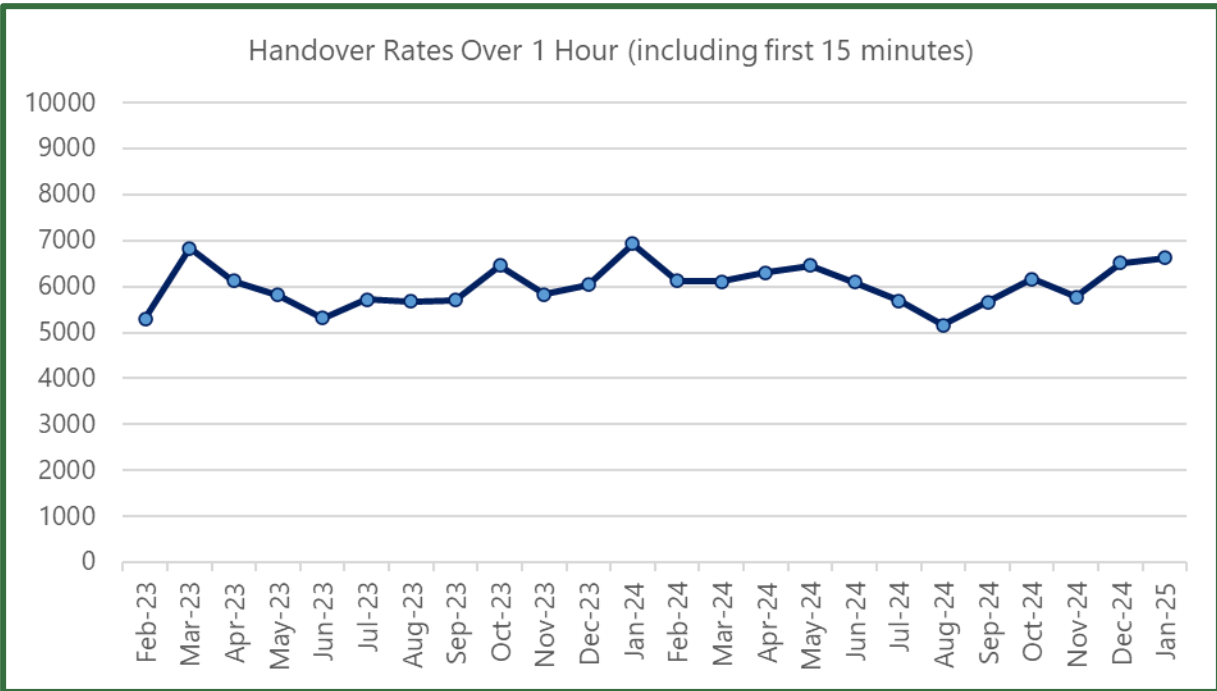
In December 2024, 1,623 patients waited over 12 hours for an ambulance response. In December 2024

Remedial Plans and Actions

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

Expected Performance Trajectory

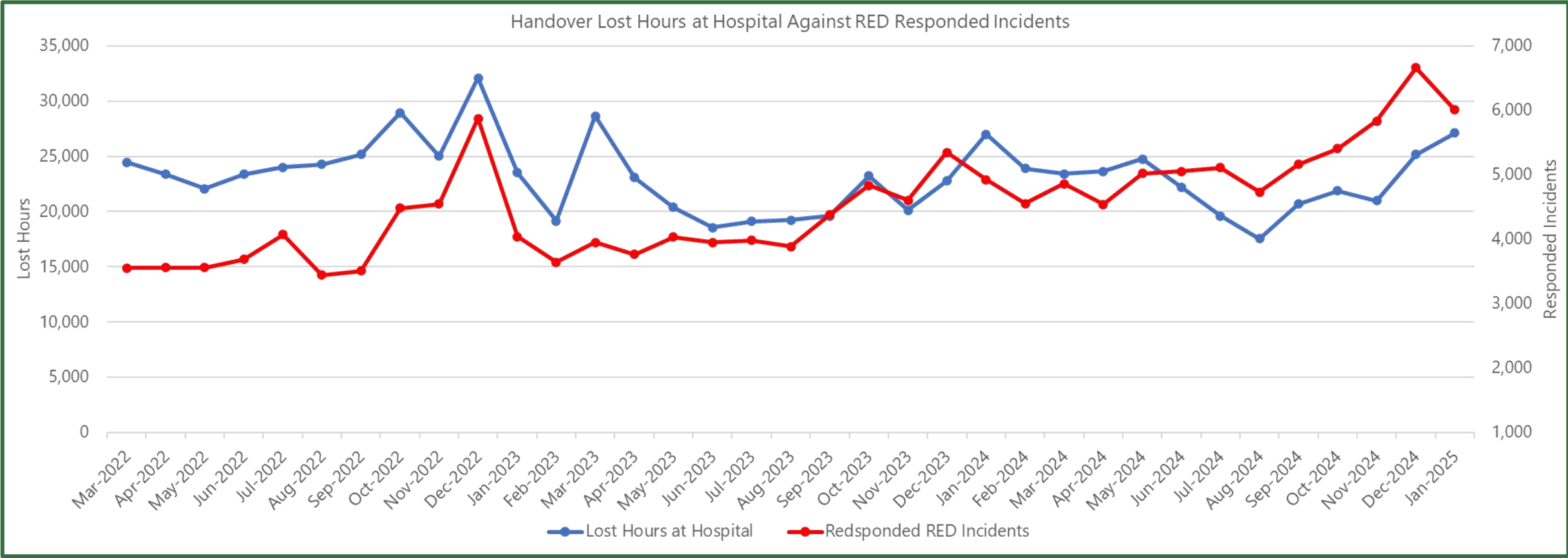
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.



Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)



Analysis

The top graph highlights that as handover lost hours have increased since February 2022, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

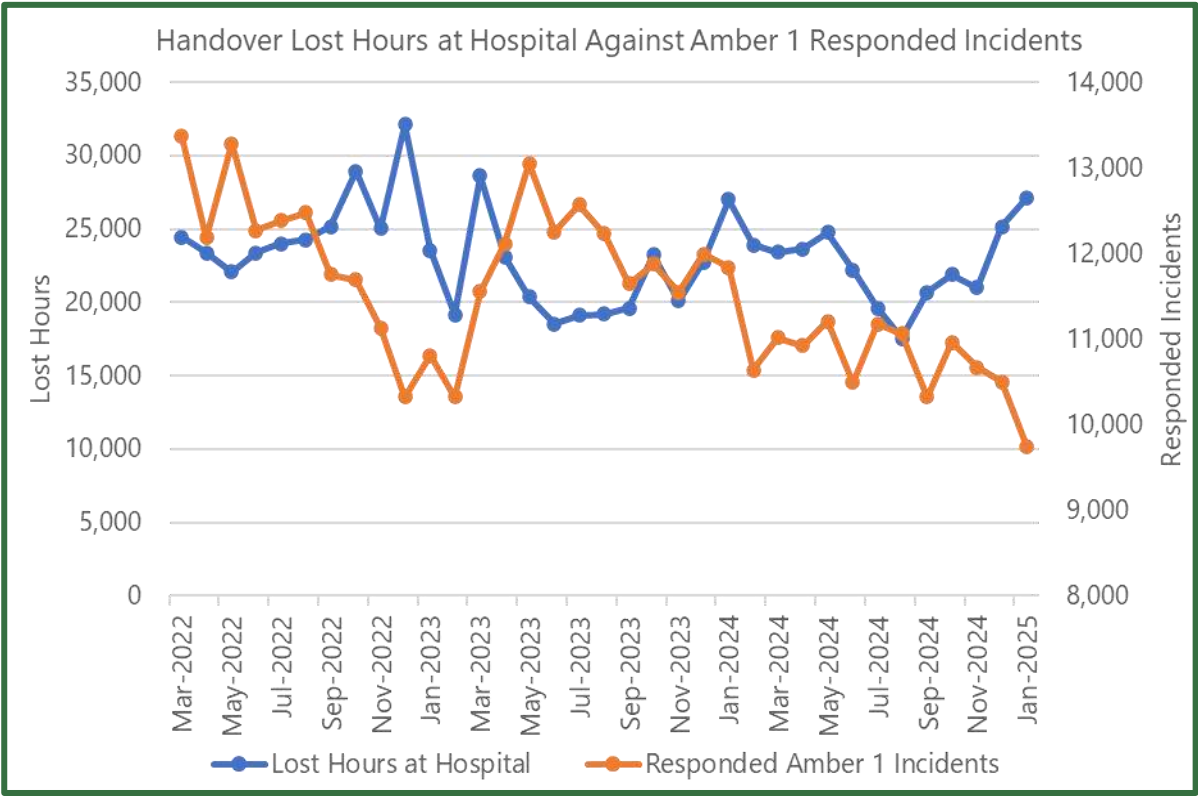
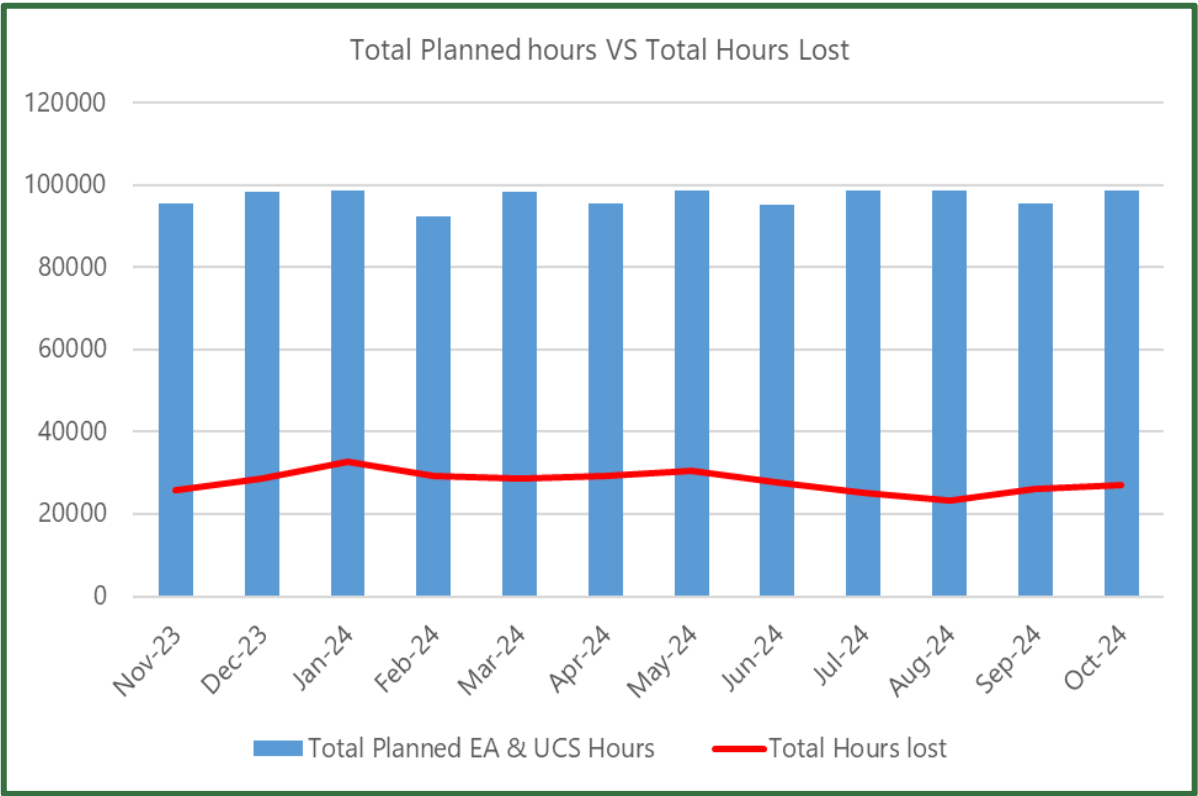
However, as the bottom right graph illustrates, there is a correlation between lost hours increasing and a decrease in the number of Amber 1 incidents being responded to, particularly at times of high demand, such as during December 2022. This is notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Welsh Government target is no patient handovers of more than one hour, which equates to 7,500 lost hours a month. The Welsh Government target was to see a 30% reduction in this metric by December 2024. However, this has not been achieved, with the 27,212 hours lost in January 2025 being higher than the same month in 2024.



*NB: Data correct at time of abstraction

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

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 caret hat 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.	Duty of Candour	A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.
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

Resourcing Policy

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

Contents

Executive Summary.....	3
1. Introduction.....	4
2. Detailed Audit Findings	4
Appendix A: Management Action Plan.....	10
Appendix B: Assurance opinion and action plan risk rating	18

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Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Johanna Butt, Principal Auditor
Executive sign-off:	Lee Brooks, Executive Director of Operations
Distribution:	Judith Bryce, Assistant Director of Operations, National Operations and Support; Jonathan Edwards, Assistant Director of Operations, Resourcing & EMS Coordination; Siobhain Frain, Service Manager, Resourcing; Ian Bellamy, Resource Manager - Central & West 111/CSD; Carl Melville, Resource Manager - North; Danni Green, Resource Manager – South East; James Roberts, Rostering Systems Manager.
Committee:	Audit, Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and 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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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Report Opinion

Trend	
 Limited More significant matters require management attention. Moderate impact on residual risk exposure until resolved.	N/A - no previous audit.

Assurance summary¹

Objectives	Assurance
1 Appropriate Resourcing Policy in place.	Limited
2 Systems in place to capture key requirements of Resourcing Policy.	Reasonable
3 Consistent application and management of processes.	Limited
4 Reporting of exceptions / deviations.	Reasonable

Purpose

To review the Trust's Resourcing Policy, its compliance with national terms and conditions, and to assess its application as an enabler for effective resource production.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- The Resourcing Policy to be reviewed and updated;
- Ongoing significant process mapping exercise to be completed to inform the development of functional Standard Operating Procedures (SOPs). The different approaches being applied between services and local arrangements across Wales result in an inconsistent application of the Resourcing Policy;
- Working Time Directive breaches are not reviewed or reported on;
- The process for Time Off In Lieu (TOIL) requires clarity;
- Whilst Outside Resource Authorisations (ORAs) decisions are recorded on GRS, there is currently no reason code assigned to them; and
- There are timeframes for actions for both the Resource Team and staff included in the Resourcing Policy, however there is currently no Key Performance Indicator (KPI) reporting.

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Resourcing Policy and SOPs	1 Design	High
2	Working Time Directive breaches	2 Design	High
3	Process for agreement of TOIL	2 Operation	Medium
4	Outside Resource Authorisations (ORAs)	2 Operation	Medium
5	KPI Reporting	4 Design	Medium

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

- 1.1 To meet demand placed upon its services, Welsh Ambulance Services University NHS Trust (the 'Trust') is required to make arrangements to manage the deployment of its workforce efficiently and effectively and within Agenda for Change terms and conditions of employment. In doing so, it must continue to deliver care which is of the highest quality to its service users. Effective resourcing is fundamental to ensuring that staff are deployed in the most efficient way to ensure the best use of public money in the delivery of NHS services, and that the needs of the patient are placed firmly at the centre of the management of the workforce.
- 1.2 The risks considered during the course of this review included the application of ineffective resourcing practices and arrangements resulting in breach of terms and conditions, inefficient use of staff and resources, increased financial costs, an adverse impact on staff wellbeing, and patient harm.
- 1.3 Our review has not included an assessment of the adequacy of the rosters in place or the method for uploading these onto the relevant systems, which is outside the scope of this review.
- 1.4 Further, our review has not included testing of the information included on the Global Rostering System (GRS) or ShiftTrack against any expected records that should be maintained by the manager or individual.
- 1.5 Discussions with Locality Managers and staff have not been undertaken during the course of our review. Rather, we have considered the corporate arrangements in place and how the regional Resourcing Teams (North, South-East; and Central and West) manage such arrangements.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	5	1	-	6
Operating Effectiveness	-	3	-	3
Total	5	4	-	9

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in [Appendix A](#).

Objective 1: There is a clear and documented policy in place for the effective deployment of staff, which is compliant with applicable employment terms and conditions.

- 2.3 The Resourcing Policy (the 'Policy') has been in place since March 2014 and has not been updated since its issue date. See **Matter Arising 1**. We understand that the Trust had started to review the Policy in 2019. However, this was paused due to the COVID-19 pandemic and progress since was impacted by industrial action.
- 2.4 The purpose of the policy is *"to ensure that annual leave, time off in lieu of General Public Holiday (GPH) and time off in lieu (TOIL) and other planned absences are managed effectively, fairly and consistently across Wales. This should be in accordance with the entitlements and arrangements defined under NHS Terms & Conditions, the European Working Time Directive and within financial allocations to provide the required levels of resources"*. It states that the principals within the document are applicable to all staff and managers within the organisation.
- 2.5 Review of the Policy confirms that it lacks clarity in certain sections. For example, it makes reference to the *"Green Book"* which does not exist. Additionally, it includes references *"local arrangements/agreements"*, some of which we understand may result from custom and practice but are not defined (for further details refer to *audit objective 3*). See **Matter Arising 1**. We acknowledge, however, that the Policy was produced with reference to the NHS Terms & Conditions Handbook, which is referenced throughout. We also note that the individual contractual hours are reflected in the systems (see para 2.9) in place.
- 2.6 Some Standard Operating Procedure (SOPs) have been produced to support the Policy, including the *'Resource Procedure for 111 / NHS Direct Wales (NHSDW)'*; *'Resource Services: Red Flag Day Procedure (High Priority Rest Day for Relief)'*; *'Resource Services Standard Operating Procedure: Change of Duties'*; and *'Resource Services Standard Operating Procedure: Relief Shift Allocation Prior to a Period of Leave'*.
- 2.7 We acknowledge that the Trust has also decided to produce functional SOPs for each area i.e. the 111 service; Clinical Support Desk (CSD); Emergency Medical Services (EMS) Co-ordination; Ambulance Care and finishing with EMS staff (the largest cohort and most complex in respect of local arrangements). To date, the Trust has produced a draft SOP for the 111 service which, at the time of our review, had not been approved as final. See **Matter Arising 1**.

Conclusion:

- 2.8 The Policy in place has not been updated in 10 years. However, we acknowledge that a review process commenced in 2019 but progress was impacted by both the COVID-19 pandemic and, more latterly, industrial action. We understand that there are a number of local arrangements in place, and were informed that these differ, however such is currently not quantified or formally defined. The Trust has a plan to develop functional Standard Operating Procedures for each area to provide further clarity to support the operation of the Policy. We have therefore assessed this objective as **limited** assurance.

Objective 2: Systems are in place to capture the key requirements of the Resourcing Policy e.g. annual leave, sickness, time in lieu, trade union time etc.

- 2.9 Global Rostering System (GRS) is the main system in place to capture the key requirements of the Resourcing Policy, as it covers the majority of services including Clinical Support Desk (CSD), Emergency Medical Services (EMS) Co-ordination, Ambulance Care and EMS. ShiftTrack is used for resourcing 111 service staff only (circa 200 whole time equivalent (WTE) staff). The relevant regional Resourcing Teams (of which there are three – North; South East; and Central & West) are responsible for the administration of the respective systems.
- 2.10 Requests for all leave types should be requested on GRS / ShiftTrack in advance, in line with defined timescales set out in the Policy. These are subject to review and approval by the Resourcing Team, who refer to the abstraction rate and UHP % as part of their decision-making process before approving or declining the request.

Abstraction Reporting:

- 2.11 The Resourcing Team generates weekly abstraction reports from the systems and issues to localities and directorate service areas. These reports vary in format and content with EMS, EMS Coordination and Ambulance Care containing the most detail, including in relation to abstractions, sickness, overtime hours and annual leave booking compliance.

Unit Hour Production reporting:

- 2.12 Weekly Unit Hour Production (UHP) reports are also produced for each function. These detail the expected staffing levels (i.e. what the core rosters produce to meet the demand profile) against the actual staffing levels (i.e. what they have subject to establishment, vacancies and abstraction levels e.g. annual leave, sickness leave, training). These reports are generated by GRS, which has a live feed; and as such all reports are accessible to the resourcing team and operational managers to support decision making regarding short notice abstraction requests. Examples of such include annual leave and TOIL within the 6-week planning cycle, along with resourcing relief planning and administration of shift changes with the rota.
- 2.13 For reports in relation to the 111 service, manual intervention is required due to the reporting capabilities of the ShiftTrack system. However, we acknowledge that the process is less complex and there are fewer staff on the system, as reflected by the production of a draft SOP for the 111-service (see para 2.7).

Working Time Regulations:

- 2.14 Working Time Regulations set out rules limiting working hours and provide for rest breaks and paid holidays. The GRS system flags when a member of staff is expected to breach based on the shifts / hours worked an allocated to them. However, this can be overridden on the system. See **Matter Arising 2**.
- 2.15 A Working Time breach analysis report can be generated from GRS, but we were informed that this is not routinely produced and reviewed currently. We requested

the report and this highlighted a significant number of breaches. The ShiftTrack system doesn't currently have this capability and no checks are undertaken. See **Matter Arising 2**.

Time off in Lieu (TOIL):

- 2.16 As stated in the Resourcing Policy: *'The NHS Terms & Conditions Handbook asserts that "Staff may request to take time off in lieu as an alternative to overtime payments. However, staff who, for operational reasons, are unable to take time off in lieu within three months must be paid at the overtime rate.'*
- 2.17 As per Appendix 3 of the Policy, where a TOIL day is required and 8+ days' notice has been provided *"applications will not normally be refused - each application will be considered on its own merits"*. There is currently no cap or accepted level of abstraction in relation to TOIL. As such, when TOIL requests are made, this presents a challenge for Resource Co-ordinators as it is reasonable for staff to expect that, provided the required notice has been provided, TOIL will never be declined irrespective of the demand and capacity for that day. See **Matter Arising 3**. We note that this has been raised recently during discussions with Trade Union partners.

Sickness leave:

- 2.18 Sickness leave is captured on both GRS and Electronic Staff Record (ESR); however we understand that there is currently no reconciliation to ensure that the information is consistent and complete on both systems. Audit Wales recommended in their 'Review of Workforce Planning Arrangements' report (issued in November 2023) that *"the Trust Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible"*. The Trust responded that *"use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data."* This action was due for completion in September 2024 but we understand that there have been some delays in the work required with the GRS provider in the first instance. We have therefore not raised a recommendation within this report.

Facility time:

- 2.19 The arrangements in place to capture and record facility time were reviewed as part of our Trade Union Release Time review (issued July 2023, limited assurance). We concluded that whilst the Facilities Agreement recommends processes to follow, such were not mandated, and several methods of recording facility time were in place. The lack of integrated systems for capturing this data at an organisational level, further reduces visibility and compliance. At the date of reporting, the recommendations raised at this report remain open on the Trust's audit tracker.

Conclusion:

- 2.20 The systems in place capture the key requirements of the Resourcing Policy in respect of annual leave, sickness, time in lieu, trade union time. There is weekly reporting from both the GRS and ShiftTrack systems including the UHP and

Abstraction reports. However, there is a lack of review and reporting on Working Time breaches and the process for TOIL requires further clarity. There is no reconciliation of sick leave between GRS and ESR, although we note the limitation with interconnectivity between the systems and the development being undertaken by the Trust to address this. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 3: There is consistent application and management of the processes across Wales.

- 2.21 The Trust has recognised that the application and the management of the process across Wales differs; and we acknowledge that the Resourcing Policy (see para 2.5) allows for such inconsistencies as it highlights and allows for local arrangements. At the date of our audit fieldwork, the Resourcing Team were at the early stages of process of mapping the different resourcing processes across the regions and services, and we recognise that this is a significant piece of work to be undertaken. See **Matter Arising 1**.
- 2.22 We acknowledge that there are some documented notes for use by the Resource Managers/Coordinators reflecting local arrangements within their regions, such as details of some stations which have rostered leave, some with self-roster leave and others with 'lettered leave'; but also recognise that not every nuance used is documented. Some of the local arrangements may work well across all localities, but without a point of consolidation such cannot be effectively considered/implemented.
- 2.23 Outside Resource Authorisations (ORAs) are captured for any annual leave, TOIL, or change of shift requests that have been authorised by line managers but would not have been so if processed via the Resourcing team in accordance with the Policy. For the period 01 April 2024 to 30 September 2024, a total of 1,969 ORAs were recorded. Our understanding is that these local authorisations typically override decisions already taken by the Resourcing Team. We acknowledge that there may be valid reasons for the line manager's decision and the approval of the request appropriate, noting the application of local arrangements throughout the Trust. However, there is no reason code within GRS, therefore there is currently no management information regarding the underlying reason for the ORA. See **Matter Arising 4**.

Conclusion:

- 2.24 The Trust has recognised that there are inconsistent processes, both across the services and throughout Wales at both a regional and local level; and at the date of reporting was in the early stages of process mapping these. We acknowledge that the Resourcing Policy currently allows for local arrangements and these processes might work well at individual stations, but there is a need for such to be consolidated to ensure a fair, consistent and effective process. We also note the need to enhance the ORA reporting. Noting this, we have assessed this objective as **limited** assurance.

Objective 4: Appropriate reporting mechanisms are in place for any exceptions or deviations from the requirements of the Resourcing Policy.

- 2.25 It is recognised that monthly abstractions from the rosters are key to managing the number of hours the produces, along with the number of staff in post. As per paras 2.11 and 2.12, weekly UHP and Abstraction reports are produced and distributed which include compliance against elements of the resource policy e.g. the percentage of annual leave booked. Such are considered through the performance meetings for each of the individual functions, which can range from daily, weekly and twice weekly. In addition, Service Managers and Locality Managers have system access to view live data.
- 2.26 There is regular reporting of Ambulance Abstractions and Production Indicators as part of the Monthly Integrated Quality and Performance Report (MIQPR) reporting. This includes analysis and commentary on the performance against the accepted abstraction rate as detailed in the policy, being approximately 30%, and unit hours production, along with remedial plans and actions. The most recent report, presented to the September 2024 Finance and Performance Committee highlighted that the abstractions benchmark has been achieved a number of times this year, with the highest proportion of abstractions being due to annual leave 17% followed by sickness absence at 7.5%.
- 2.27 Additionally, Regional Resource Managers send more detailed reports to Locality Managers relating to the requirement of the Resourcing Policy, these have included, but not limited to:
- a. annual leave summaries;
 - b. TOIL credits which are older than 3 months and due for payment; and
 - c. contractual hours balances, by individual, detailing that where staff have excessive balances for both credits or debits these will be managed through relief planning; and
 - d. Sickness absence report detailing which sickness certificates are overdue.
- 2.28 However, as detailed within *audit objective 2*, there is currently no review or reporting of Working Time Regulation breaches. **See Matter Arising 2.**
- 2.29 The Resourcing Policy includes key timeframes for making and authorising requests, however, there is currently no reporting on these. **See Matter Arising 5.**

Conclusion:

- 2.30 There is regular reporting and analysis on UHP and abstractions throughout the Trust, including within the MIQPR reported at Board and Committee level. Locality, Operational and Line managers are also provided with more detailed reporting and have system access to view live data. The Policy includes timeframes for submitting and authorising requests yet there is no reporting of performance against these. Noting this, we have assessed this objective as **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Resource Policy and SOPs (Design)		Impact
The Resourcing Policy (the 'Policy'), which is applicable to all staff and managers within the organisation, has been in place since 2014 and has not been updated since its issue date of March 2014. Review of the Resourcing Policy confirms that it lacks clarity in certain sections. For example, it makes reference to the "Green Book" which does not exist. Additionally, it includes references "local arrangements/agreements", some of which we understand may result from custom and practice but are not defined. We acknowledge that the Trust has decided to produce functional Standard Operating Procedure (SOPs) for each area i.e. 111; Clinical Contact Desk (CCD), Emergency Medical Services (EMS) Co-ordination, Ambulance Care and finishing with EMS staff (the largest cohort and most complex in respect of local arrangements). To date, the Trust has produced a draft SOP for 111 which at the time of our review had not been approved as final. We recognise that the Policy allows for local arrangements and the Trust has recognised the variation of the process across Wales but that such isn't quantified. At the date of our audit fieldwork, the Resourcing Team were already at the early stages of process of mapping the different resourcing processes across the regions – we recognise that this will take a significant amount of time to complete as details of local arrangements are consolidated.		Potential risk of: Inconsistent application of the Policy.
Recommendations		Priority
1.1	The mapping exercise should be completed to ensure that all local arrangements or differences in application of the Policy are appropriately recorded.	High
1.2	The functional SOPs for each area should be completed, approved and communicated to all staff.	
1.3	The Resourcing Policy should be reviewed and revised (or re-drafted), approved at an appropriate forum and communicated to all staff.	

Agreed Management Action		Target Date	Responsible Officer
1.1	Resourcing Policy allows for local arrangements, which results in variation of process across the Trust which currently is not quantified. Resourcing will complete the process mapping and documentation of all local arrangements and differences in the application of the Policy across operational HBs by function. This will be submitted via the Resourcing monthly management team meetings.	November 2024	Siobhain Frain, Service Manager Resourcing
1.2	Resourcing will construct departmental Standard Operating Procedures to support consistent application relevant to individual functions. SOT will review and agree each of the SOPS will be published and communicated to staff and resourcing teams.	March 2025	Siobhain Frain, Service Manager Resourcing
1.3	The Trust accepts this recommendation, and the Resourcing Policy will be reviewed and revised. A Resourcing Policy Group, in partnership with Trade Unions, will convene to review the existing policy. Governance arrangements including SOT, SLT and ELT will ensure changes are agreed and recorded.	October 2025	Jonathan Edwards, Assistant Director of Operations Resourcing & EMS Coordination

Matter Arising 2: Working Time breaches (Design)				Impact																																		
Working Time Regulations requires that staff have a minimum of 11 hours off between shifts - daily rest; and an average weekly rest of 1 day off in 7 (averaged over 2 weeks). The Trust has taken the decision, through the Resourcing Policy to combine this with the minimum 11hrs daily rest, therefore 35hrs minimum per week, however, the combined 2-week average has been set as 70hrs. The GRS system flags where a shift is not compliant with the 11-hour daily rest period or where a member of staff has exceeded 12 working days without a rest period. However, this can be overridden. There is no similar flag on ShiftTrack, where Resourcing staff would have to manually review the roster to identify any such incidents. There is a report available on GRS, namely, 'WT breach analysis' report. We were informed that this report is not currently used or reviewed. We requested the report and this highlighted instances of minimum length between shifts of less than 11 hours, and continuous days working over 12 days: <table border="1"> <thead> <tr> <th rowspan="2">Region</th><th colspan="2">01/04/2023 – 31/03/2024</th><th colspan="2">01/04/2024 – 30/09/24</th></tr> <tr> <th>11-hour breach</th><th>12-day breach</th><th>11-hour breach</th><th>12-day breach</th></tr> </thead> <tbody> <tr> <td>Central and West</td><td>83</td><td>-</td><td>40</td><td>-</td></tr> <tr> <td>North</td><td>95</td><td>5</td><td>14</td><td>2</td></tr> <tr> <td>South East</td><td>203</td><td>-</td><td>53</td><td>-</td></tr> <tr> <td>Integrated Care</td><td>38</td><td>-</td><td>22</td><td>-</td></tr> <tr> <td>Grand Total</td><td>419</td><td>5</td><td>129</td><td>2</td></tr> </tbody> </table> Resource Managers reviewed the reports and we were informed that some included breaches where shifts are defined as "RLF 0" or certain display names that have predefined hours underneath but may not necessarily be an actual breach. As such, the true number of breaches may be lower than the report, but without going through the report on a line-by-line basis the true WT Breach figure is not known.				Region	01/04/2023 – 31/03/2024		01/04/2024 – 30/09/24		11-hour breach	12-day breach	11-hour breach	12-day breach	Central and West	83	-	40	-	North	95	5	14	2	South East	203	-	53	-	Integrated Care	38	-	22	-	Grand Total	419	5	129	2	Potential risk of: Breach in legislation.
Region	01/04/2023 – 31/03/2024		01/04/2024 – 30/09/24																																			
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Integrated Care	38	-	22	-																																		
Grand Total	419	5	129	2																																		

Recommendations		Priority	
2.1	Resource Managers should undertake regular review of the WT breach analysis reports, within GRS and ShiftTrack, to identify whether it is a “true” breach and these should be reported.	High	
2.2	Resource Managers should consider whether there is a training need for Resource Co-ordinators or for wherever the WT breach originated e.g. if it was as a result of local arrangements or shift changes.		
Agreed Management Action		Target Date	Responsible Officer
2.1	The requirement for review the Working Time (WT) breach analysis reports has been included as part of the Quality Control and Audit Management processes. Resource Managers will undertake a monthly review of the Working Time (WT) breach analysis reports, to identify whether it is a “true” breach and if these should be reported. Any true breaches are passed through to Heads of Service for action.	November 2024	Siobhain Frain, Service Manager Resourcing
2.2	Resource managers, following the monthly audit of the WT breach analysis report, will identify any individual or system trends and issues and any remedial actions addressed through line management structures.	November 2024	Siobhain Frain, Service Manager Resourcing

Matter Arising 3: Process for agreement of TOIL (Operation)		Impact	
As per Appendix 3 of the Resourcing Policy, where a TOIL day is required and 8+ days' notice has been provided "applications will not normally be refused - each application will be considered on its own merits". There is currently no cap or accepted level of abstraction in relation to TOIL. As such, when requests are made, this presents a challenge for Resource Co-ordinators as it is reasonable for staff to expect that, provided the required notice has been provided, TOIL will never be declined – irrespective of the demand and capacity for that day.		Potential risk of: - Negative impact on workforce due to lack of clarity; and - Negative impact on delivery of service.	
Recommendations		Priority	
3.1	The process for TOIL should be reviewed, revised, agreed and communicated to provide clarity for both the Resource co-ordinators and staff.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3.1	The process for agreeing TOIL will be reviewed, revised, agreed and communicated as part of the Resourcing Policy review (see Management Action response 1.3). This will provide clarity for both the Resource co-ordinators and staff.	October 2025	Jonathan Edwards, Assistant Director of Operations Resourcing & EMS Coordination

Matter Arising 4: Outside Resource Authorisations (ORAs) (Operation)			Impact
Outside Resource Authorisations (ORAs) are captured for any annual leave, TOIL or change of shift requests that are authorised by line managers but would not have been so, if processed via the Resourcing Team under the resourcing policy. Not all ORAs are decisions that have had the opportunity to be passed via the Resourcing Team in the first instance e.g. a line manager might approve the request before advising the Resourcing Team. We acknowledge that there may be valid reasons for the line manager decision, and the approval of the request may be appropriate. For the period 1 April 2024 – 30 September 2024, a total of 1,969 ORAs were recorded. From discussion with Management it was confirmed that ORA is included as a drop-down choice under GRS abstraction report group 'Other'. At the time of our audit there wasn't a reason code included to capture the rationale for the decision, which might provide the Trust with useful management information to understand the different reasons for the ORAs.			Potential risk of: Lack of management information that could provide clarity on the reasons for ORAs.
Recommendations			Priority
4.1	The Trust should consider revising the GRS structure to include ORA as an abstraction report group with a drop-down list detailing the reason for the ORA.		Medium
4.2	The reasons for ORAs, if captured, should be reported and monitored.		
Agreed Management Action		Target Date	Responsible Officer
4.1	The Trust will revise the GRS structure to include ORA Absence Group and SOT will agree associated ORA Absence types for implementation to the rostering system. This will be agreed through SOT.	December 2024	Siobhain Frain, Service Manager Resourcing
4.2	Once ORA Absence Types are agreed by SOT and implemented into the rostering systems, a self-service reporting guide will be provided to operational teams to permit local monitoring. Formal quarterly reporting by Resourcing dept will be provided to SOT to monitor.	January 2025	Siobhain Frain, Service Manager Resourcing

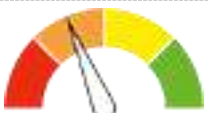
Matter Arising 5: KPI Reporting (Design)		Impact	
The Resourcing Policy includes key timeframes for making requests and authorising requests, including, but not limited to: a. <i>Employees will be notified of the outcome of their request within four calendar days. This will potentially be reduced to 3 calendar days on the first review of this procedure;</i> b. <i>Staff wishing to request a cancellation of their previously submitted leave must inform their Line Manager or relevant Resource Centre as soon as practicable. As a guide, four weeks' notice of this request would be good practice;</i> c. <i>All vacant shifts will be visible on GRS web or Workforce Manager (i.e. ShiftTrack) and available to the workplace level 28 days prior to the shift needing to be covered;</i> d. <i>Where there are no local agreements: Overtime will be offered with up to 10 days' notice given;</i> e. <i>Notification of acceptance of overtime shift will be confirmed by the Resource Centre five days in advance of the overtime shift being worked unless this is to cover short notice absence.</i> However, there is currently no reporting on these.		Potential risk of: • Lack of performance monitoring.	
Recommendations		Priority	
5.1	The Trust should ensure that performance against all expected timeframes within the Resourcing Policy are reported and monitored.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	The Trust accepts this recommendation. The KPIs listed within the report are based on the existing resourcing policy. A reporting framework will be developed as part of the Resourcing Policy Review (see Management Action response 1.3). There are however two areas that have been completed or superseded as per below:	October 2025	Siobhain Frain, Service Manager Resourcing

	- Action 5.1c – visibility of vacant shift. This functionality exists and is evident within the GRS system options. This is complete. - Action 5.1 d & e. Availability and acceptance of overtime - These KPIs are no longer applicable due to the implementation of the overtime allocation SOP and Financial Savings Plans.		

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:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	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.

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.



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WELSH AMBULANCE SERVICE PARTNERSHIP TEAM (WASPT) HIGHLIGHT REPORT

This highlight report provides the reader with details of the key areas discussed at the last WASPT meeting. The report is intended to be used to communicate the work of this Board advisory group to the People and Culture Committee and the wider organisation. Areas that require the attention of the People and Culture Committee are set out in the Alert section.

WASPT Meeting Date All WASPT meetings are held in person	15 November 2024 27 January 2025
People and Culture Committee Meeting Date	18 February 2025
Chair	Christian Fox (November) Rachel Marsh (January)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the People and Culture Committee to areas of attention)

1. The November WASPT meeting was held the day after the last People and Culture Committee meeting, therefore this highlight report covers both meetings.
2. WAST have been invited to deliver a session at the **Annual Ambulance Leadership Forum Conference** (ALF), which is to be held in Leeds on 11 and 12 March this year. Initially this was going to be a breakout session but has been promoted to the main conference stage. The session will be introduced by the Director of Culture Change and delivered by two Trade Union partners, the Deputy Director and Head of Culture and Organisational Development to talk about WAST's experience, learning and activities of building respectful and cohesive relationships.
3. The People and Culture Committee will recall that In 2022, WAST invited ACAS in to support the development of working relationships between the leadership team and TU partners. A report was received at the end of 2022 which made recommendations on how to rebuild relationships and move forward. An update on the actions agreed is received at each WASPT meeting. A key event to come out of this is a **Social Partnership Conference** that will be held on 31st March 2025. The conference will be opened with a keynote address by the Minister for Skills, Culture and Social Partnership, Jack Sargent. Members agreed this will be a key demonstration of WAST's good partnership working.

ADVISE

(Detail any areas of on-going monitoring, approvals, or new developments to be communicated)



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4. Sara Mills, Head of Culture and Organisational Development, attended the November meeting to provide feedback on **observations of the engagement and reflective session**. This was as part of the ACAS action plan to explore how the team can continue strengthening our partnership practices, reinforce collaboration and joint problem-solving within the Trust and reflect on how partnership behaviours and conflict management styles are used during the meetings. Accepting it has been a challenging journey; members recognised the positive and collective progress so far acknowledging there is still work to do to continually improve together.
5. In both November and January members were updated on progress of the **Emergency Medical Technicians 2/3 business case**, noting that this had been formally considered by at the Joint Commissioning Committee (JCC) meeting. Commissioners had not been able to commit fund the £10m recurrent growth required for the EMT pay deal in the context of other financial commitments and pressures yet to be considered. It was agreed that the in-year costs would be absorbed by the Trust to cover the back pay from November 2023 and the part year effect from November 2024 to March 2025. This does remove any flexibility to undertaken other discretionary schemes before financial year end. The more significant issue is the Integrated Medium Term Plan (IMTP) process and that the Trust would put forward costed options to consider how the additional recurrent cost may be managed. Members agreed that a collective Task & Finish group process would be convened to consider all the options and how these can be brought to effect linking into the IMTP process and the planning required should the agreement to fund centrally not be reached.
6. In November and January members discussed the disparity between the number of **111 and CSD CPD** hours allocated. Meetings will take place this quarter to collaboratively address the issue, form unified perspective and navigate the way forward.
7. The November meeting was updated that the **Christmas Planning Group** met to discuss the significant operational challenges and members discussed options to manage the challenges of the Christmas period, safeguarding both patient safety and staff wellbeing and the need to for collective action to ensure the service is as safe as possible on key dates. Third party providers will be explored to test the market given the significant effect on the gaps in rosters will have on Unit Hours Produced (UHP) and forecasted abstractions of 24%. An update was provided in the January meeting with good feedback relayed.
8. The January meeting provided an update on the development of the **2025-2028 IMTP**. This included the Well-being of Future Generations Act **wellbeing objectives** which were developed in partnership and include:
 - A sustainable employer
 - An environmentally sustainable organisation
 - A collaborative partner
 - A proactive an innovative care provider



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9. In November it was agreed that the **spotlight item in Siren** will be focused on development of the social partnership and to share the reflections infographic demonstrating the successful and positive improvements in partnership working. In January, that item was agreed to be discussion of overruns and TOIL (see below).
10. Reflections in November on the **national Sky coverage** highlighted that the article was alluding to the issue being one of the Trust's rather than specifically that of the UK Ambulance Service and prevalent in England in the way it was framed by Association of Ambulance Chief Executives (AACE).
11. A **WASPT workshop** was due to be held in November to consider the potential introduction of a 36 hour working week; however, this will be deferred to future meeting with a workshop Health & Safety featuring as the workshop topic in January 2025. This included the Society and Health Practitioner podcast with Jason Killens on integrating our health and safety culture
12. Members **reflected** that Christian Fox had done a great job Chairing his first meeting in November which was considered a good and constructive meeting with valid points raised and addressed by all. Despite challenging discussions on TOIL and overruns it was agreed that the meeting was positive and professional.
13. In November the Chair welcomed **Carl Kneeshaw, Director of People**, to his first meeting and expressed thanks to **Sara Williams, Workforce Policy & Governance Lead**, for providing secretariat support to the group. This function has now transferred to the Corporate Governance Team under the responsibilities of the Trust's Standing Orders.

ASSURE

(Detail here any areas of assurance)

14. At both meetings members discussed **Diesel Fumes** noting concerns in November that the Dyson fans had not yet been procured and the urgency around this. Work had commenced on the Standard Operating Procedure which will operationalise deployment of the fans at a local level and will need to be shared with emergency department teams to ensure arrangements are being prepared. The electronic installation at emergency department sites was noted as a potential risk. In January the update included that fans had been deployed and that lockers were also being supplied for their safe keeping. There is additional ongoing work at some emergency department sites to secure shore lines, however all sites have committed to this initiative.
15. In November members received assurance on the progress of the **review of culture within the Clinical Support Desk (CSD)** which was commissioned by the Executive Director of Operations and conducted by Honne. The mediator acknowledged the significant progress already made with an action plan being developed from the learning.



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16. Updates were received at both meetings on the actions within the **Welsh Health Circular: Implementation of the Non-pay Elements of the 2022-4 Collective Agreement** noting that positive progress has been made on flexible working elements, Industrial Injury TFG and the Occupational Health service.
17. The **ACAS Action Plan** verbal update was received at both meetings with no escalations highlighting the induction programme underway. Following the success of partnership development sessions during 2023 and 2024, further sessions will be held in May for wider management engagement.
18. In November the **National Health & Safety Committee AAA** was received for assurance with no escalations raised noting that the reset day had been productive with collaboration and commitment to CPD dates next year.

Local Partnership Forums

19. The Senior Leadership Team/Trade Union Partnership (SLT/TUP) AAA from July 2024 was noted having previously been circulated. The group had not met in October 2024 and no escalations were raised.
20. The December SLT/TUP discussed in detail TOIL, and the AAA noted that the group agreed to explore a trial framework where TOIL requests would be approved if they are submitted at least 28 days in advance and taken within six months of the request date. A small team will assist the Resource Department with the administrative aspects of TOIL management. In parallel, it was agreed that the Resource Policy would be reviewed and updated to align with the trial findings and Agenda for Change guidance.
21. The issue of overruns and TOIL was discussed in more detail at the January meeting. Trade Union Partner raised concerns regarding staff wellbeing due to overruns and consequent delays in approval of TOIL. Some Trade Unions are surveying their members on the issues and raising it to their full time officers. There was frustration expressed that despite overruns featuring in the IMTP, there was not the desired reduction in overruns.
22. The frustration was shared by management, and discussion ensued on the initiatives in place within WAST's control such as shift protection and pods, however all agreed that much was outside of WAST's control, with long handover delays the primary cause. Noting that the data on overruns needs closer review, it was agreed that there was merit in further collective thinking on what else could be done to reduce overruns. A task and finish group approach will be taken to this, with the issues related to TOIL being dealt with as set out above in STL/TUP.



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23. The Corporate Partnership Forum met on 4 November 2024 with positive discussions and no specific escalations raised in the meeting. Members discussed the membership of the CPF noting the significant number of apologies being received. This will be considered at the next CPF along with the frequency of meetings. No meeting was held ahead of the January WASPT meeting.

RISKS

24. No formal risk register risks discussed, or new risks identified.

COMMITTEE AGENDA FOR MEETING – NOVEMBER 2024

Feedback from Sara Mills on engagement and reflective session	Progress on EMT 2/3 business case	Christmas planning update
Update on non-pay elements of the 22-24 collective agreement	ACAS actions update	111 and CSD CPD hours
H&S AAA report	SLT/TUP AAA report	Corporate Forum AAA report
Spotlight item for Siren Communications	Diesel fumes options update	
WASPT WORKSHOP		
Deferred		

COMMITTEE AGENDA FOR MEETING – JANUARY 2025

TU Items: TOIL; overruns and impact on staff wellbeing	Partnership Conference task and finish group	Progress on EMT 2/3 business case
IMTP 2025-2028; including Wellbeing objectives	Diesel fumes update	Update on WHC implementation of non-pay elements of the 2022-24 collective agreement
ACAS actions update	SLT/TUP AAA report	Spotlight item for Siren Communications
	Diesel fumes options update	
WASPT WORKSHOP		
Health and Safety		

COMMITTEE ATTENDANCE

Name	02 May 2024	09 July 2024	25 September 2024	15 November 2024	27 January 2025	28 March 2025
Joint Chairs						
Jason Killens	Chair		Chair			
Mark Marsden (Unison)		Chair		Christian Fox Chair		
Management Representatives						
Angela Lewis						
Carl Kneeshaw						
Lee Brooks						
Rachel Marsh					Chair	
Chris Turley						



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COMMITTEE ATTENDANCE						
Name	02 May 2024	09 July 2024	25 September 2024	15 November 2024	27 January 2025	28 March 2025
Andy Swinburn						
Estelle Hitchon						
Trish Mills	Julie Boalch			Julie Boalch		
Chair Corporate LPF	Catherine Goodwin	Julie Stokes	Julie Stokes	Liz Rogers	Liz Rogers	
Trade Union Representatives						
Unite representative		Alison Williams	Alison Williams	Alison Williams	Alison Williams	
Unite representative	Hugh Parry	Hugh Parry	Hugh Parry	Hugh Parry	Hugh Parry	
Unite representative	Christian Fox	Christian Fox	Christian Fox	As above	Christian Fox	
GMB representative			Richie Bullen		John Phillips	
GMB representative	Maldwyn Jones	Maldwyn Jones	Maldwyn Jones	Maldwyn Jones	Maldwyn Jones	
GMB representative	Marcus Viggers	Marcus Viggers	Marcus Viggers	Marcus Viggers	Marcus Viggers	
Unison representative	Henry Garrard	Henry Garrard	Henry Garrard		Henry Garrard	
Unison representative	Bethan Williams					
Unison representative	Damon Turner	Damon Turner	Damon Turner	Damon Turner		
RCN representative			Aimee Williams	Aimee Williams		
RCN representative						
RCN representative						

	Attended
	Deputy attended
	Apologies received
	No longer member/Not member

Exposure to Fumes

Final Internal Audit Report

December 2024

Welsh Ambulance Services University NHS Trust



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Contents

Executive Summary.....	3
1. Introduction.....	4
2. Detailed Audit Findings	5
Appendix A: Management Action Plan.....	12
Appendix B: Assurance opinion and action plan risk rating	19

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Debrief meeting:	3 October 2024
Draft report issued:	24 October 2024
Management response received:	11 December 2024 & 16 December 2024
Final report issued:	18 December 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Ross Hughes, Principal Auditor
Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
Distribution:	Penny Durrant, Interim Deputy Director of Nursing, Quality & Governance; Nicola White, Head of Health & Safety; Graham Stockford, Deputy Head of Health & Safety; Hugh Parry, Trade Union Partner; Jo Kelso, Head of Workforce Education & Development; Sonia Thompson, Assistant Director of Operations (EMS); Aled Williams, Assistant Director of Digital
Committee:	Audit & Risk Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and 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

Purpose

To evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Guidance needs to be updated to inform employees that the shoreline can be re-started once it cuts off.
- There is no work programme in place for the cyclical completion of Risk Assessments at Emergency Departments, which are expected to be undertaken in partnership with Trade Unions.
- Unannounced spot checks identified that staff are not complying with guidance set to prevent their exposure to fumes
- Work is ongoing to enhance data collation in respect of fume exposure, via Data Vault.
- Health & Safety Committee meetings have been cancelled due to timeliness of papers being issued.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 Guidance documents	Reasonable
2 Monitoring and managing compliance with the Workplace Exposure Limits.	Reasonable
3 Reporting of emissions and their impact	Reasonable

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Update guidance on the use of shorelines	2 Operation	Medium
2	Risk assessment work programme	2 Operation	Medium
3	Non-compliance with guidance	2 Operation	Medium
4	Enhancing data collation via Data Vault	2 Design	Medium
5	Timeliness of Health & Safety Committee papers	3 Operation	Medium

1. Introduction

- 1.1 Under Section 7 of the Health and Safety at Work Act 1974, employees have a duty to take reasonable care for the health and safety of themselves and others who may be affected by their acts or omissions whilst at work. This extends to co-operating to enable the employer to fulfil its legal duty to protect workers from exposure to hazardous substances, and to comply with the Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- 1.2 Short term exposure to diesel exhaust fumes can cause coughing, and irritation of the eyes, nose, throat and respiratory tract. Long term exposure may lead to serious health effects, including increasing the risk for lung cancer. Workplace Exposure Limits (EH40/2005), as defined by the Health & Safety Executive indicates the following limits for fumes along with the British occupational exposure limits for combustion gases (which is the reference used by the Trust):

Substance	Long term exposure limit (8-hour reference period)	Short term exposure limit (15-minute reference period)
Carbon Monoxide	23 mg.m ³	117 mg.m ³
Carbon Dioxide	9,150 mg.m ³	27,400 mg.m ³
Nitrogen Dioxide	0.96 mg.m ³	1.91 mg.m ³
Nitrogen Monoxide	2.5 mg.m ³	-

- 1.3 As a result of long delays being incurred in the transfer of care of patients between the Trust and Health Boards, and staff running the engines of ambulances outside Emergency Departments, there is increased reporting of incidents relating to diesel fumes exposure within the Trust. During quarter 3 (2023/24) such had increased by 7% with 47 incidents recorded. There has been a decrease those reported for 2024/25 with 29 incidents being reported between April and October.
- 1.4 The Trust's Health & Safety department has been working with Occupational Health team, Operational Managers, Trade Unions, the Fleet department and health boards to identify short and long-term solutions to the exposure being sustained, which are compounded by handover delays due to wider system pressures, including a requirement to complete fume risk assessments.
- 1.5 The potential risks considered in the review were as follows:
- Non-compliance with Health & Safety Executive, and other legislative requirements;
 - Reputational risk by failing to address concerns / safety issues raised by Trust staff, health board staff and patients, which could lead to them coming to harm due to exposure to fumes; and
 - The Board may not be aware of serious concerns relating to impact of exposure to fumes across hospital sites.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	-	2
Operating Effectiveness	-	5	-	5
Total	-	7	-	7

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in [Appendix A](#).

Objective 1: There is clear and documented guidance in place for limiting staff exposure to fumes.

2.3 As we would expect, there is no standalone policy outlining the Trust and staff’s roles and responsibilities towards limiting exposure to diesel fumes, as this should not occur given the target time to handover a patient from the an ambulance to hospital is fifteen minutes. However, the Trust’s Health and Safety Policy does make reference to substances covered within the scope of the Control of Substances Hazardous to Health (COSHH) 2002 (as per para 1.1).

2.4 The Quality, Safety and Patient Experience (QSPE) Directorate have recently issued two Safety Notices (via email and also accessible on SharePoint) which are associated with diesel fumes:

- Diesel Fumes: Staff control measures whilst outside Emergency Departments (EDs): issued January 2024. The notice outlines the work that has been undertaken by the Trust to establish the risk presented by diesel fumes and the means of mitigating the risk associated with it; as well as setting out the personal responsibilities and actions required of staff, including how to use a shoreline connection.
- Air Purifiers Onboard Vehicles: issued May 2024. The notice outlines that the Trust has installed two air purifying units (AirBubble38i) on all its Emergency Medical Service (EMS) ambulance fleet (see para 2.23).

2.5 The Health and Safety Siren page also has a specific section in relation to diesel fumes, which sets out the precautions to take to limit exposure. It also provides details of the risk assessments (see para 2.8) undertaken at EDs across NHS Wales for 2022/23 and 2023/24. However, there are opportunities to strengthen the Siren page to capture the mitigating actions the Trust has put in place and the mechanisms to manage and monitor compliance (see **objective 2**).

Conclusion:

- 2.6 The Health and Safety policy includes references to substances covered within the scope of COSHH with a link to further guidance. There is reference, on Siren, to the precautions to limit exposure to diesel fumes; and recent guidance has been issued to further support employees to limit their exposure whilst awaiting patient offload outside EDs. However, there are opportunities to strengthen the Siren page. Noting this, **reasonable** assurance has been determined.

Objective 2: Mechanisms are in place to monitor and manage compliance with the Workplace Exposure Limits, with appropriate mitigating actions identified where applicable.

- 2.7 A number of activities have been taken to review the concentration of fumes outside EDs, to lower the risk of exposure for Trust and Health Board employees as well as the general public, including:
- Risk Assessments.
 - Environmental testing.
 - Installation of shorelines.
 - Installation of air purifiers; and
 - Spot checks and Quality & Support Days.

Risk Assessments

- 2.8 Since 2022/23, the Trust's Health & Safety team have been undertaking risk assessments to assess the significant hazard presented by exposure to diesel engine exhaust emissions (DEEE) (as indicated by visible soot build up and odour). Each site will be allocated a risk score, scored on a five x five matrix against severity and likelihood (max risk score 25). (See Table 1 below)

Table 1: Emergency Department Risk Ratings per most recent Risk Assessments

Hospital Emergency Department	Current Risk Level to Trust Employees	Expected Risk Level to Trust Employees with Additional Controls
2024/25		
Bronglais	4	2
The Grange	4	2
Princess of Wales	4	4
Prince Charles	4	4
Glan Clwyd	4	2
Glangwili	4	2
Prince Phillip	4	2
Royal Glamorgan	4	4
Withybush	4	2
Wrexham Maelor	4	2
Ysbyty Gwynedd	4	2
2022/23		
Morriston	9	6

Hospital Emergency Department	Current Risk Level to Trust Employees	Expected Risk Level to Trust Employees with Additional Controls
Royal Gwent	3	No further controls noted on risk assessment
University Hospital Wales	9	6
University Hospital Llandough	3	3
Singleton	Not evidenced	

- 2.9 A remedial action plan is included within the risk assessment, tailored to the specific site, to help lower the DEEE within the area reviewed (see para 2.34).
- 2.10 We did not evidence a schedule in place to ensure that all EDs are risk assessed on a regular basis. Based on the risk assessments undertaken it was noted that the following five EDs have not been assessed since the original assessment in 2022 – Singleton, Royal Gwent, University Hospital Llandough, Morriston and University Hospital Wales; for which the latter two had a risk score of 9. **(See Matter Arising 2)**
- 2.11 On review of the 2022/23 risk assessments, it was noted only two of the 15 were undertaken in partnership with the Trade Unions. None of the risk assessment forms for 2023/24 or 2024/25 captured that a Trade Union partner was present. **(See Matter Arising 2)**

Environmental Testing

- 2.12 In addition to the risk assessments, in March 2024 the Trust procured the services of SOCOTEC UK Ltd, to conduct environmental testing outside EDs to monitor the 'Respirable Elemental Carbon and Combustion Gases (CO₂, CO, NO₂ and NO)' over a 24hr period within the ambulance bays. Seven sites are to be monitored as part of this contract and, at audit fieldwork completion, only one had yet to be completed (Glangwili Hospital Emergency Department).
- 2.13 During the course of audit fieldwork, we observed a monitoring visit undertaken at Morriston (10 September 2024). Through discussion, and review of the SOCOTEC report, we understand that there is currently no workplace exposure limits for elemental carbon in the UK. However, the Association for German Studies has set an occupation exposure limit of 0.05 mg.m⁻³ for the respirable fraction. It is this level that is being used as a guide for testing, but note that it isn't a legally binding limit in the UK.
- 2.14 The monitoring consists of both static monitoring on the ambulance bay central pillars and personal monitoring on Trust personnel (usually paramedic and health and safety officer assisting in the testing), to measure the carbon levels in the area over the 24-hour period (noting personnel monitors are for as long as they are stationed in the bay awaiting off-loading, or for an 8-hour period). A report is then produced to capture the results along with any recommendations identified, and these are presented to the Health & Safety Committee (for further details on reporting, see **objective 3**)
- 2.15 So far, the testing by SOCOTEC has concluded that all 'Respirable Elemental Carbon and Combustion Gases' are below the monitoring thresholds at the sites

visited, with the exception of three personal monitors showing a result exceeding the 0.05mg, with clearly stated explanations for the possible increased levels recorded.

Shoreline Cables and Use

- 2.16 In consultation with the health boards, the Trust began installing shoreline cables outside Emergency Departments in 2022. The cable allows emergency vehicles to be connected to the mains power outlet, reducing the need for the ignition to be on and therefore lowering diesel fumes being emitted from the vehicle.
- 2.17 Whilst guidance has been issued on the use of shorelines (see para 2.4) we have been advised that concerns have been raised as the shoreline switches off after a short period of time (15 minutes), therefore not maintaining the use of the onboard heater (the dual heaters provide air conditioning during warmer conditions). This has led to engines being left running to keep the heater on. We were advised by the Health and Safety Team that there is a way to override this, however we note that no formal communication of such has been issued to Trust employees (**Matter Arising 1**).

Data Vault

- 2.18 In recognition of the data that has been collated in recent years regarding diesel fumes, the Trust are in the process of creating a central repository (data vault) for such. Information to be collated will include, time spent by staff outside ED awaiting offload, how many vehicles are there during the wait, time spent by staff on breaks, time spent by staff in depot. (**See Matter Arising 4**)

Quality & Support Days / Spot Checks

- 2.19 From December 2023 the Trust introduced Quality & Support days. These consist of the EMS & Ambulance Care Management Teams locating themselves across hospitals, ambulance stations, renal units and other Trust locations to complete reviews of observed practice covering vehicle and equipment condition, PPE and uniform requirements, the safe use of equipment. As the coverage has evolved, included in the review is also whether shorelines are being utilised when awaiting handover:

Table 2: Shoreline usage by vehicles when available

Month	Yes	No	N/A (No shoreline available due to the number of vehicles already in waiting in the ambulance bay)
February 2024	105	6	45
March 2024	169	10	96
April 2024	158	18	144
June 2024	30	3	26
July 2024	128	11	122
August 2024	86	8	95
September 2024	64	7	102

2.20 In addition, the Health & Safety Team undertake unannounced inspections, to ensure staff are compliant with the shoreline guidance and individual guidance.

2.21 From April 2024 to June 2024, 23 inspections were undertaken with the following issues reported:

- 74% of available shorelines were not being utilised;
- Additionally, staff were frequently observed congregating behind vehicles – the position of which is directly related to the vehicle engine exhaust;
- Over 20% of the audits highlighted that crews were not complying with any control measures;

It was noted that shoreline compliance reported during un-announced visits was significantly lower than during pre-announced Quality & Support days.

2.22 To address these issues, with effect from June 2024, Education & Development included diesel fume management around shoreline and vehicle heater within all new driver induction programmes. These require sign off by inductees and Education & Development staff. **(See Matter Arising 3)**

Equipment Trials

2.23 The Trust has installed air purifying units (AirBubble38i) into all its EMS ambulance fleet. The units have HEPA (high-efficiency particulate absorbing) and VOC (volatile organic compounds) filters and are designed to remove 99%+ of particles from the air. Whilst there is primarily a clinical need for these units (i.e. IPC control measures), there are other benefits to staff and patients as other airborne particles, including some diesel fumes, are also filtered which aid in mitigating against other issues.

2.24 The Trust is also trialling the use of other equipment to reduce diesel fume exposure:

- Electric (Dyson) Heaters: to lower the emissions of fumes from the onboard heaters, the Trust is looking to trial these heaters in EMS vehicles for a one-week period (in October 2024) at the Grange University Hospital ED.
- Local Exhaust Ventilation (LEV) System: designed to reduce employee's exposure to airborne contaminants, such as fumes in the workplace, by capturing the emission at source and transporting it to a safe emission point or to a filter/scrubber.

2.25 On conclusion of the heater trial, the Trust is looking to undertake a trial for a LEV system, from both vehicle exhaust and heater exhaust vents, for a two-week period, again at the Grange University Hospital ED.

2.26 The Trust will compare the results of these trials to determine which option will be best suited to the Trust, noting that the introduction of the heaters will be more cost effective than the LEV system.

Conclusion:

2.27 The Trust has put in place a number of mechanisms and controls to help lower its employee's exposure to diesel fumes; including environmental testing and are continuing to seek new initiatives to limit employee exposure to fumes. Unannounced spot checks are undertaken to confirm adherence to such, but this has highlighted staff non-compliance. There is no formal risk assessment schedule in place with some high-risk scoring EDs not having been reviewed since 2022. Further, work needs to progress with the establishment of a data vault to enable a central repository for all fume related information. Noting this, we have determined **reasonable** assurance for this objective.

Objective 3: Reporting of emissions, and their impact, is undertaken with issues escalated as appropriate.

2.28 There is a defined reporting framework in place for the reporting of emissions:

Fume Mitigation Task & Finish Group

2.29 The pan-Wales Fume Mitigation Task & Finish Group was established in September 2024, which we understand replaces the previous working groups that were in place for each health board. At the date of reporting, two meetings had been held (September & October 2024). A highlight report has been produced from the October meeting and is to be issued to the next Executive Leadership Team, prior to being presented at the next Health & Safety committee.

Health & Safety Committee (H&SC)

2.30 The main reporting group for diesel fume exposure is the national Health & Safety Committee. Whilst we have been provided with either agendas, papers, minutes and / or action logs from five meetings held between February 2023 to May 2024, eight meetings should have been held during this period. Summary reports (including results from the static testing) were presented and remedial action plan updates and review of the minutes for each meeting noted in-depth discussions around the issues associated with DEEE.

2.31 During discussions with the Trade Union Representative, it was noted that some H&SC meetings were cancelled due to a timeliness issue in getting the Committee papers out to attendees in sufficient enough time for them to read, review and discuss the papers with colleagues prior to the meeting. **(See Matter Arising 5)**

Welsh Ambulance Service Partnership Team (WASPT)

2.32 WASPT is a forum which is attended by both Trust senior management, including the Chief Executive, Board Secretary and Trust directors, and representatives from the Trade Union Partners, GMB, UNITE, UNISON and the RCN, to discuss any issues or concerns within the Trust. From review of the papers for the eight meetings held during the period April 2023 – September 2024, diesel fume exposure has been a key topic of discussion.

2.33 Further, to facilitate transparency between the Trust and the Trade Unions, in December 2023, a report was issued to WASPT consolidating the results of the

third-party static testing undertaken at all ED locations between April 2022 – March 2023. Results were also noted for the two occasions where Elemental Carbon exceed the EU limit during personal testing, with explanations provided by the third party highlighting that these were due to guidance not being followed.

- 2.34 A report was also issued to the December meeting detailing the remedial actions raised during the Trust Risk Assessments. This highlighted the status of all 87 actions; of which, at the date of audit fieldwork, 68 were closed and 19 were in progress.
- 2.35 An AAA (Alert, Advise, Assure) report is prepared for each WASPT meeting and included in the papers for the People and Culture Committee.

Executive Leadership Team (ELT)

- 2.36 The Executive Team are updated on the issues related to Diesel Fumes and the work being undertaken within the Trust to lower the risk associated with the issue. Two reports have been presented to ELT since the start of the financial year (July and September), which detail the work being undertaken to lower DEEE, results from static monitoring and unannounced spot checks, updates on the actions within the remedial action plans, and potential new initiatives including the costings.

People & Culture Committee (PCC)

- 2.37 A review of the PCC papers between May 2023 – August 2024 (six meetings) identified that there has been coverage of diesel fume exposure at all meetings – through both the WASPT and Health & Safety Committee updates.
- 2.38 A review of the minutes for May 2024 identified that an in-depth discussion around the issue with DEEE was held, focusing on the concerns raised by staff around diesel fumes and the work being undertaken to limit the risk being presented to staff. The minutes state that the Chair has *'confidence that the Trust were sighted of the issues with diesel fumes and that the Committee will continue to monitor the position via the Health & Safety updates and H&SC AAA reports'*.
- 2.39 We note that information on diesel fumes is reported to Trust Board via highlight reports from WASPT and PCC. The Health and Safety annual report issued to July Board meeting noted the ongoing work undertaken by the Trust to lower potential exposure to diesel fumes.

Conclusion:

- 2.40 The Trust has a clear reporting framework to be regularly sighted on the issues related to diesel fumes. In addition, the Health & Safety Team have recently set up a pan-Wales Fume Mitigation Task & Finish Group. It was noted that the papers for the Health & Safety Committee are not routinely issued in a timely manner and has resulted in some meetings being cancelled by the Trade Unions. Accordingly, we assign **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Update guidance on the use of shorelines (Operation)		Impact	
During the course of fieldwork, we were informed that some of the shorelines trip the on-board heaters after a 15-minute period. This has led to engines being left running to keep the heaters on. We were advised by the Health and Safety Team that there is a way to override this issue (turn on the ignition and press the climate button in the Genisys system). However, there is no evidence of this being shared and communicated with the relevant users.		Potential risk of: Trust employees increasing the risk of exposure to fumes	
Recommendations		Priority	
1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	The Trust has undertaken previous communications to inform staff of this issue. Further action will be taken to seek systematic improvement and will ensure that clear guidance on restarting diesel heaters after shoreline trips is communicated cross all relevant staff to promote operational safety and efficiency. A review of former safety notices will be undertaken, and a further formal safety notice will be issued to relevant staff groups. Training has been reviewed: information on shoreline use is now included in induction training and Trust driving courses for new entrants and staff moving into EMS from Ambulance Care too.	December 2024 Completed	Nicola White, Head of Health & Safety Jo Kelso, Head of Workforce Education & Development

	Information will be provided in the 5-yearly High Speed Driving Assessment from FY 2025/26.	Completed	Jo Kelso, Head of Workforce Education & Development
	Information will also be produced through the Workforce Education & Development Learn365 platform on the use of shorelines to ensure the topic is incorporated in training and education sessions.	March 2025	Nicola White, Head of Health & Safety

Matter Arising 2: Risk assessment work programme (Operation)		Impact	
There is currently no schedule in place to ensure that all EDs are risk assessed on a regular basis. Based on the risk assessments undertaken, it was noted that the following five EDs have not been re-assessed since 2022 – Singleton, Morriston, Royal Gwent, University Hospital Wales and University Hospital Llandough. It was also noted that Risk Assessments had been reported as being undertaken in partnership with the Trade Unions. On review of the risk assessments that have been undertaken between 2022 – 2024, only two of the assessments highlight that a Trade Union Partner was present.		Potential risk of: The Trust not seen to be demonstrating transparency.	
Recommendations		Priority	
2.1	The Trust should have a risk assessment work programme in place to ensure that all EDs are risk assessed on a regular basis.	Medium	
2.2	For transparency, and good practice, the Trust should invite Trade Union Partners to attend when undertaking the onsite ED Risk Assessments.		
Agreed Management Action		Target Date	Responsible Officer
2.1	The Trust is committed to reviewing sites as per the frequency deemed appropriate following risk assessment undertaken by a Health & Safety professional. Following introduction of additional control measures for Winter 2024, the Trust will develop a work programme for risk assessment review for all EDs ensuring assessments are conducted annually.	January 2024	Nicola White, Head of Health & Safety

2.2	Scheduled dates for the assessments (as per 2.1) will be made available for Trade Union Partners to attend ED risk assessments ensuring transparent and collaborative practices.	January 2025	Nicola White, Head of Health & Safety

Matter Arising 3: Non-compliance with guidance (Operation)			Impact
From April 2024 to June 2024, 23 unannounced inspections were undertaken at EDs to assess whether staff were complying with Trust guidance. The following issues were reported: 74% of available shorelines were not being utilised; - Over 20% of the audits highlighted that crews were not complying with any control measures; and - Staff were frequently observed congregating behind vehicles – the position of which is directly related to the vehicle engine exhaust. It was noted that shoreline compliance reported during unannounced visits was significantly lower than during pre-announced Quality & Support days.			Potential risk of: Trust employees increasing the risk of exposure to fumes
Recommendations			Priority
3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.		Medium
Agreed Management Action		Target Date	Responsible Officer
3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood. The action will be presented at SOT (Senior Operations Team) and a feedback mechanism will be discussed and created to monitor the situation.	January 2025	Nicola White, Head of Health & Safety Sonia Thompson, Assistant Director of Operations (EMS)

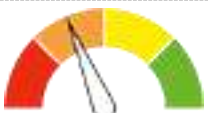
Matter Arising 4: Enhancing data collation via Data Vault (Design)		Impact	
In recognition of the data that has been collated in recent years regarding diesel fumes, the Trust are in the process of creating a central repository (data vault) for such. The intention is to track Trust where paramedics are positioned during their shifts to capture the time they spend within EDs where fume build up is at its highest. Information to be collated will include time spent by staff outside ED awaiting offload, how many vehicles are there during the wait, time spent by staff on breaks, time spent by staff in depot etc.		Potential risk of: Lack of transparency in data maintained for fume exposure.	
Recommendations		Priority	
4.1	The development of the data vault should be completed to ensure the relevant data is recorded from the earliest possible stage.	Medium	
4.2	To ensure completeness of such, the Trust should ensure that the systems currently used are designed to routinely capture the information required.		
Agreed Management Action		Target Date	Responsible Officer
4.1	The Trust has completed the data vault to capture accurate and comprehensive data on potential incidents where fume exposure could have occurred, ensuring transparency and informed decision making. Now the digital architecture is complete, further development is required to capture broader data sources (e.g. risk assessments). The Trust will finalise the development of the data vault system to centralise and track staff exposure data effectively.	March 2025	Aled Williams, Assistant Director Digital
4.2	Where possible, any relevant data source will be automated for transfer into the Data Vault.	As above	Nicola White, Head of Health & Safety

Matter Arising 5: Timeliness of Health & Safety Committee papers (Operation)		Impact	
The main reporting group for diesel fume exposure is the national Health & Safety Committee. Whilst we have been provided with either agendas, papers, minutes and / or action logs from five meetings held between February 2023 to May 2024, eight meetings should have been held during this period. Through discussion with the Trade Union Partner Representative, it was noted that the papers for the National Health & Safety Committee were not issued to them in a timely manner. Such has meant the Trade Union members did not have sufficient time to read, review and discuss the papers prior to the meeting. This has also resulted in meetings being cancelled.		Potential risk of: Issues with fume exposure not being identified or escalated to Trust Board.	
Recommendations		Priority	
5.1	The designated deadline to issue Health & Safety Committee papers, prior to the meeting date, should be adhered to. This will allow the Trade Unions to have sufficient time to review and discuss key matters within the papers and avoid meetings being cancelled.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	The Trust has reviewed the Committee terms of reference and undertaken an organisational development workshop with Committee members. Going forward, there will be enforced adherence to deadlines for issuing Health & Safety Committee papers to ensure timely review by Trade Union members preventing meeting cancellations.	January 2025	Nicola White, Head of Health & Safety

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:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	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.

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.



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AGENDA ITEM No	17
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

2024/25 COMMITTEE EFFECTIVENESS REVIEW

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's Standing Orders and committee terms of reference require that board committees evaluate their effectiveness annually and prepare an annual report to the Trust Board.
2. The approach for the 2024/25 effectiveness review for this committee sees a move away from the lengthy questionnaires of the past, and a focus on its delegated remit and the assurance reporting in particular that it receives on a regular basis.
3. The board has established this committee to support it in discharging its responsibilities effectively. The operating arrangements of this committee should allow it to spend time to delve deeper into issues within its remit, identify assurance gaps, and set the necessary context for informed decision-making. It is vital therefore that that time is spent effectively and that the delegated remit is both appropriate and manageable. Essential to this is a clear work programme and robust reporting.
4. A presentation will accompany this paper in committee; however, members are requested to review the committee's remit (summarised below and in full in the current attached terms of reference) and its cycle of business ahead of the meeting.

RECOMMENDATION

5. Members are invited to assess whether the committee's remit, as outlined below and in its terms of reference, remains appropriate for 2025/26. Consideration should be given to any desired amendments, additions, or removals, as well as any areas that might be better addressed by another committee.
6. Members are invited to evaluate the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members are asked to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee, including any individual reports.
7. Additionally, members are asked to take part in a short Mentimeter quiz¹ during the meeting to answer the following questions:
 - (a) What would help you as report writers/reviewers/receivers of assurance
 - (b) What works well in this committee
 - (c) What improvements could we make in this committee
8. The Committee is requested to review the draft Annual Report and provide any comments ahead of it being finalised and circulated for email approval by Chair's Action.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Terms of reference and final annual report to be approved by way of Chair's Action following this meeting and presented to ARAC and the board thereafter.

REPORT APPENDICES

Annex 1 – Committee remits for 2024/25
Annex 2 – Committee terms of reference
Annex 3 – Committee cycle of business
Annex 4 – Draft committee annual report

¹ This can be accessed during the meeting via the QR code and accessing it on mobile phone browser or via Menti.com on your desktop. The code to access the survey will not be made available until the day, however it could be helpful to have Menti.com open on your laptop should you prefer using this over a mobile.

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

2024/25 COMMITTEE EFFECTIVENESS REVIEW

SITUATION

1. Annual effectiveness reviews are designed to evaluate the efficacy of the committee, review operating arrangements, and propose changes to improve its support, challenge, scrutiny and oversight responsibilities.
2. Whilst our commitment to the duty means we adopt a continuous improvement methodology throughout the year, this annual effectiveness review is an opportunity to formally review this committee's remit and membership, consider the reports it receives, and look back at the work of the Committee in 2024/25.

BACKGROUND

Role of the Board and its Committees

3. The Trust Board is accountable for governance, risk management and internal controls at WAST. It focuses on the following key areas:
 - Developing the **strategy, vision, and purpose** of the Trust. Identifying priorities, establishing goals and objectives, applying resources, understanding risks to the achievement of objectives, and allocating funds to support the decisions that need to be made around strategic planning.
 - Shaping the **culture** of the Trust in several ways, including the way in which it engages with our people, our patients and stakeholders, the way it manages its agenda, by the nature of the discussions at the Board and the relative emphasis given to different performance criteria, by the visibility of its members in the organisation, and by where it chooses to invest time and resources. Board and committee members must live up to the highest ethical standards of integrity and probity and abide by the Nolan Principles.
 - Setting organisation wide expectations and accountability for high performance and compliance with the **duty of quality** and the **duty of candour** as set out in the Health and Care (Quality and Engagement) (Wales) Act 2020. Ensuring that all staff understand their role in the effective and high-quality provision of care in a governance framework that ensures a balance between trust, constructive debate, and effective challenge in a culture of openness and learning.

- Ensuring there is a robust system of **risk management and internal controls** in place, and that the board are sighted on the mitigations in place for the principal risks to the delivery of the strategy.
 - **Holding to account**, and being held to account, for the delivery of the strategy in accordance with the strategic and performance frameworks developed by the Board.
4. The board has established several committees to support it in discharging its responsibilities effectively. These committees are designed to undertake the detailed work required to provide robust assurance, explore risks and performance issues, and examine key matters within their specific remits. By doing this 'heavy lifting,' they have the capacity to delve deeper into issues, identify assurance gaps, and set the necessary context for informed decision-making. Attached at **Annex 1** is a snapshot of the remits of all six committees of the Trust Board, and the Corporate Trustee framework.
 5. Committees meet for extended periods, allowing them to afford the time and attention to critical matters that the full board cannot. This structure ensures that items are thoroughly examined and discussed, enabling a more expert understanding of their implications. Following each meeting, committees report back to the board and corporate trustee on the assurance they have received and escalate any significant issues or concerns for further consideration. This approach ensures that the board is well-informed and able to focus on strategic oversight.

Effectiveness

6. The Trust's Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which this committee forms an integral part. Each committee is required to submit an annual report to the board setting out its activities during the year and a review of its performance.
7. In 2022/23 and in 2023/24 these reviews consisted of a lengthy questionnaire completed by members, and a pre-review of the terms of reference and questionnaire responses by the committee Chair, Executive Lead and Corporate Governance Team. These were then presented to the committee with proposed changes to both the remit and operating arrangements. The survey and the presentation of results in the committee meeting garnered waning engagement as reviews progressed through the seven committees. This was in part because of the time of year these were undertaken (which was during the busy winter period

for the Trust), and because there is duplicative membership across several committees.

8. In April 2024 the Audit, Risk and Assurance Committee (ARAC) agreed a different approach to these reviews for the 2024/25 year to garner further engagement of members.
9. The new approach for committees other than ARAC² centres on discussion in the meeting on the delegated remit of the committee and assurance reporting. The pre-submitted questionnaire will be replaced by a few simple questions for the interactive committee session on best practice and improvements that could be made.

ASSESSMENT

10. This committee's terms of reference are attached at **Annex 2**.

The Remit of this Committee

11. The terms of reference set out its purpose, membership, operating arrangements, members' commitment to the duty of quality, and its delegated duties and remit. The duties of this committee can be summarised as follows:

11.1 To scrutinise and review the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviours, on behalf of the Board.

11.2 To provide assurance to the Board of the Trust's leadership arrangements regarding Trust behaviours and cultures, health, safety and welfare, people and culture related partnership and engagements, and arrangements to ensure compliance with the Welsh Language Standards.

The Work Programme of this Committee

12. The terms of reference are accompanied by a cycle of business (otherwise known as a work programme) for each committee. This committee's cycle is attached at **Annex 3**. The text in red is a direct lift from the terms of reference narrative and what follows then is the reporting that has been agreed will provide the necessary assurance and/or opportunities for scrutiny and challenge on the duties delegated to this committee by the board. This cycle of business and its accompanying notes were approved by the committee in May 2024.

² ARAC follows the National Audit Office questionnaires as best practice

13. Cycles of business play a pivotal role in the effectiveness and efficiency of the committee. They are the basis upon which agenda are drafted to inform a fulsome commissioning of papers. The notes section contains context added from a number of sources including audit reports, directions from the committee, agreed approaches or policy positions.
14. The cycle of business should aim to cover 90% of the items expected to come before the committee. This framework enables directors and their teams to plan the internal governance pathways that each report should follow before reaching the committee.
15. The cycle of business is accompanied by a detailed schedule of submission deadlines, ensuring papers are lodged with the Corporate Governance Team in a timely manner for each committee meeting and published in line with the Trust's Standing Orders.

Internal Governance and Flows of Assurance

16. With the exception of the People and Culture Committee and the Charity Committee, the board has not established sub-committees reporting to its committees. Instead, the Trust has implemented internal governance structures that serve as integral components of the broader governance framework. These structures link operational management activities with the strategic oversight provided by the board and its committees. Importantly, these forums (outlined below) do not report directly to any board committee:
 - **Organisational Governance**
Includes governance forums reporting to the Executive Leadership Team (ELT), along with their sub-committees and task-and-finish groups.
 - **Strategy Development and Delivery**
Encompasses the Strategic Transformation Board, its sub-committees, and working groups.
 - **Directorate Governance**
Refers to governance structures established by individual directors within their directorates.
17. These forums enable directors to:
 - Address specific portfolio areas effectively;
 - Foster a collaborative approach across the Trust;
 - Establish robust monitoring and assurance processes;
 - Escalate issues for resolution as needed;
 - Formulate assurance reports to meet their accountability responsibilities to the board and relevant committees.

A well-defined cycle of business for the committee is essential to support directors in creating appropriate forums, providing clarity to report writers, and ensuring the smooth flow of reporting.

18. The cycle of business will guide the type of reporting needed; however, all assurance reporting must meet high standards to support effective decision-making. The hallmarks of a good board or committee paper include:

- Clarity and accessibility, ensuring the paper is:
 - free from jargon and accessible to all board and committee members, regardless of technical expertise;
 - presented with a clear, logical structure and relevant headings;
 - focused on key issues within the committee's remit, avoiding unnecessary detail;
 - complimented by an executive summary highlighting key points for quick reference; and
 - not duplicative.
- Strategically aligned and clearly identifies key risks, their potential impact, and how these risks are managed or mitigated.
- Evidence-based and balanced, ensuring it:
 - Is drawn from robust, reliable data and evidence;
 - provides a balanced view by presenting both positive and negative findings; and
 - includes trends and comparisons (e.g., performance over time or against benchmarks).
- Offers actionable recommendations for addressing issues or enhancing performance, clearly defining next steps and responsibility for implementation.
- Uses visual aids (e.g., charts, graphs, dashboards) to present data clearly.
- Highlights the implications of findings for patients and other key stakeholders.
- Demonstrates learning from incidents, audits, and external inspections, showing how findings contribute to a culture of improvement and excellence.

By adhering to these principles, the Trust can ensure that assurance reports effectively supports the board and its committees in making informed and strategic decisions.

19. While it is essential to define the bulk of the work to be received by a board committee through the cycle of business, it is equally important to recognise that not all items received by the committee serve as assurance. Some reports provide valuable context for complex issues or deliver information that, while not strictly assurance, supports a broader understanding of the Trust's operations and strategic priorities.
20. Assurance itself extends beyond formal reporting. It includes qualitative inputs such as patient and staff stories, which bring a human perspective to the committee's work. Additionally, the triangulation that occurs during board visits - when members engage directly with our people and patients - provides invaluable insights that complement formal assurance processes. Together, these elements enrich the committee's ability to make informed and well-rounded decisions.
21. Bearing the above in mind, members are invited to consider the reporting that the committee receives on a regular basis in particular and reflect on and suggest improvements that may be made to strengthen and/or streamline assurance to the committee.

Annual Report

22. The committee's annual report has been prepared in draft and is attached at **Annex 4**. The report provides assurance to the board on the discharge of the committee's responsibilities through the year, progress against priorities, and membership/quorum.
23. Following this committee meeting, any amendments to the terms of reference and feedback from members on its effectiveness will be incorporated into a revised draft, which will be circulated to members for review.

Next Steps

24. ARAC, at its early May 2025 meeting, will review the committee's annual report and its effectiveness evaluation, as well as any proposed changes to its terms of reference and operating arrangements. ARAC will be asked to assure the board at its May 2025 meeting that the arrangements the board has in place for its committee structure and spread of delegations is appropriate and manageable into 2025/26.
25. The next meeting of this committee falls after the early May 2025 ARAC meeting, therefore any changes to the terms of reference and the annual report will be circulated to the committee for email approval by Chair's Action following this meeting. The Committee Chair will also propose priorities for 2025/26 as result of the discussions from today's meeting.

RECOMMENDATION

26. Members are invited to assess whether the committee's remit, as outlined below, remains appropriate for 2025/26. Consideration should be given to any necessary amendments, additions, or removals, as well as any areas that might be better addressed by another committee.
27. Members are invited to evaluate the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members are asked to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee.
28. Members are asked to take part in a short Mentimeter quiz in the meeting answering the following questions:
 - (d) What would help you as report writers/reviewers/receivers of assurance
 - (e) What works well in this committee
 - (f) What improvements could we make in this committee
29. The Committee is requested to review the draft Annual Report and provide any comments ahead of it being finalised and circulated for email approval by Chair's Action.

WAST BOARD COMMITTEE REMITS – 2024/25

Quality, Patient Experience and Safety Committee

- Duty of Quality and Duty of Candour
- KPIs in remit
- Clinical & quality plans
- Health and Care Quality Standards
- Quality Impact Assessment
- Mental health
- Infection prevention and control
- Safeguarding
- Continual quality improvements
- Learning
- Mortality reviews
- Putting Things Right
- Clinical negligence & personal injury
- Clinical effectiveness
- Clinical audit
- Citizens voice & patient experience
- Clinical and quality governance
- Risks, audits, policies in remit

People and Culture Committee

- People & Culture plan and metrics
- KPIs in remit
- Trust Behaviours
- Health and wellbeing
- Staff & volunteer experience
- Speaking up safely
- Equality, diversity, and inclusion
- Recruitment and retention
- Trade Union relationships
- Leadership & development
- Succession plans
- Welsh language
- Health and safety
- Health and Care Standards in remit
- Registration and revalidation
- Partnerships and engagement
- Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee with onward reporting to Board via the AAA

Finance and Performance Committee

- Long term strategic direction
- Long term financial direction
- Capital and revenue monitoring
- Financial sustainability
- Business cases and PIRs
- Compliance with statutory duties
- IMTP endorsement and delivery
- Value based healthcare
- Performance against targets set by Commissioners and Welsh Gov.
- Quality & Performance Management Framework (QPMF) outcomes
- Trust wide KPIs (MIQPR)
- Recovery plans for performance
- Demand and capacity
- Estates
- Fleet
- Environment and sustainability
- Digital systems
- Digital plan direction
- Information governance
- Information security
- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security
- Risks, audits, policies in remit

Audit, Risk and Assurance Committee

- Governance and assurance
- Effective systems of good governance, risk management and internal control
- Board Assurance Framework
- Annual Report
- Audited financial accounts
- Standing Orders and SFIs
- Accounting policies
- Assurance processes
- Policies for reg. compliance
- Schedule of losses & special payments
- Single tender actions
- Internal audit (inc annual plan; reports; HOIA Opinion)
- Audit Wales (inc annual plan; ISA260; structured assessment; reports;
- QPMF implementation
- Audit management responses
- Local Counter Fraud Service
- Standards of business conduct
- Whistleblowing processes
- Patient's property
- Policies in remit

Remuneration Committee

- Contractual arrangements for staff
- Appointment, termination, remuneration, terms of service and appraisal for Chief Executive; Executive Directors (including interim); Very Senior Managers
- Redundancy, VERs, Settlement settlements

Academic Partnerships Committee

- Strategic collaboration with education providers and commercial partners
- Collaboration with partners in health, social care, local authority and third sector
- Partnership arrangements
- University Trust Status
- Plans to build capacity of whole workforce
- Research governance framework
- Risks, audits, policies in remit

Charity Committee (Corporate Trustees)

- Charity strategic direction
- Charitable funds monitoring including systems and processes
- Review by Audit Wales of accounts
- Fundraising
- Bursary Panel
- Promote the charity
- Annual Report and Financial Accounts
- Approve expenditure over £5,000
- Bids Panel
- Risks, audits, policies in remit

OVERSEE

SUPPORT

CHALLENGE

ESCALATE

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2024/25

1. INTRODUCTION

- 1.1. The Trust's Standing Orders provide that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees"*.
- 1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **People and Culture Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.
- 1.3. The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:
- providing advice on strategic development and performance within the terms of reference;
 - undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
 - carrying out specific responsibilities on the Board's behalf; and
 - providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

- 2.1 The purpose of the People and Culture Committee ('the Committee') is to enable scrutiny and review of the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviour to a level of depth and detail not possible in Board

meetings. The Committee will provide assurance to the Board of the Trust's leadership arrangements; behaviours and culture; training, education and development; equality, diversity and inclusion; health, safety and welfare; people and culture related partnerships and engagement; the Welsh Ambulance Services Partnership Team (advisory group); and Welsh Language, in accordance with its stated objectives and the requirements and standards determined by the Welsh Government, the NHS in Wales and other regulatory bodies.

- 2.2 The Committee will provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to all matters relating to staff and staffing of the Trust.
- 2.3 The Committee will approve on behalf of the Board, relevant Directorate policies, procedures, and other written control documents in accordance with the Trust's scheme of delegation.
- 2.4 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.
- 2.5 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

The Committee will, in respect of its role in providing advice and assurance to the Board: -

- 3.1 Oversee and contribute to the development of the Trust's People and Culture Plan aligned to the 2030 Delivering Excellence Long Term Plan.
- 3.2 Noting that the Finance and Performance Committee oversees delivery of the Integrated Medium Term Plan (IMTP), this Committee will conduct any required deep dives into aspects of the people and culture elements of the IMTP and monitor delivery of other strategic people and culture priorities which may not be included in the IMTP.
- 3.3 Receive and consider projects of major strategic organisational change where there is a significant impact on our people's health and wellbeing, and cultural change.
- 3.4 Monitor progress and seek assurance of arrangements in place to embed the Trust's behaviours, ensuring a continued journey of positive culture change.
- 3.5 Receive assurance that there is a robust plan in place for the health and wellbeing of our people and monitor the effectiveness of arrangements in place to support and protect the mental, physical, and financial wellbeing of staff.
- 3.6 Consider the experience of our people, including volunteers, and seek assurance of the effectiveness of mechanisms used for measuring, and for hearing and acting upon their experiences.
- 3.7 Receive assurance that arrangements are in place to allow staff to raise concerns in confidence, and that those processes allow any such concerns to be investigated proportionately and independently and that the learning from such concerns is considered and applied.
- 3.8 Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan and be assured its implementation is monitored; champion and support the plan and the work of the equality, diversity, and inclusion networks.
- 3.9 Receive assurance on the development and implementation of the Trust's recruitment and retention plans.

- 3.10 Receive assurance that Trust management and Trade Union Partners continue to develop and build a shared understanding and common purpose through formal and informal consultative partnership working to ensure the efficiency and success of the Trust for the benefit of all.
- 3.11 Receive assurance that the Trust has in place appropriate policies and procedures for its people; approve people and culture policies.
- 3.12 Monitor the effectiveness of the Trust's leadership and management development and succession planning arrangements.
- 3.13 Monitor performance against key people and culture indicators including but not limited to sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinarys and suspensions, turnover and recruitment; enabling deep dives to take place into specific areas of concern.
- 3.14 Monitor progress and seek assurance that arrangements are in place to meet the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted within the Trust.
- 3.15 Ensure the Trust is discharging its statutory responsibilities, including but not limited to health and safety; equality, diversity, and inclusion; relevant Health and Care Quality Standards requirements; and that professional standards of registration and revalidation are maintained.
- 3.16 All matters relating to partnerships and engagement relevant to our people and cultural change.
- 3.17 any other matter in relation to the Committee's overall purpose and responsibilities

Corporate Risks and Audit Recommendation Tracker

- 3.18 The Committee will monitor the principal risks relevant to its remit and consider the controls and mitigations of related risks and provide assurance to the Board that such risks are being effectively controlled and managed.
- 3.19 The Committee will receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

Authority

- 3.20 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.
- 3.21 The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.
- 3.22 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

- 3.23 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.
- 3.24 In these circumstances, the Chair and the Lead Executive (Director of People and Culture), supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).
- 3.25 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

- 3.26 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

- 3.27 The Welsh Ambulance Services Partnership Team (WASPT) is an advisory group of the Board and was re-constituted in November 2022 following the pandemic. The Board has agreed that WASPT is a sub-committee of this Committee and as such reports regularly by way of a AAA highlight report. Similarly, issues raised are reported, and where necessary escalated, to the Board by way of this Committee's AAA highlight report.

4. MEMBERSHIP

Members

- 4.1 The membership of the Committee will comprise:

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board.

Attendees

- 4.2 The membership will be supported routinely by the following core attendees:

- Director of People and Culture
- Executive Director of Finance and Corporate Resources
- Executive Director of Operations
- Director of Partnerships and Engagement
- Executive Director of Paramedicine
- Assistant Director of Quality and Nursing (TBC)
- Assistant Director of Planning and Transformation
- Freedom to Speak Up Guardian
- Trade Union Partners (x4)
- Chairs of Sub-Committees (or their nominee)
- Board Secretary

- 4.3 The Trust Chair and Chief Executive will have a permanent standing invite to attend the Committee. Where the Executive Director of Operations nominates a Deputy/Assistant Director to attend meetings, that individual will be approved by the Chair and must be a regular and consistent attendee.

- 4.4 The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its

discussions on any particular matter.

- 4.5 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

Member Appointments

- 4.6 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.
- 4.7 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.
- 4.8 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

- 4.9 The Board Secretary, on behalf of the Committee Chair, shall:
- (a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
 - (b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least two of the four members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

- 5.2 Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

- 5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

- 6.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

- (a) joint planning and co-ordination of Board and Committee business; and
- (b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

- 6.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.
- 6.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- (a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;
- (b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
- (c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum (as set out in section 5)

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at

least annually but more frequently if required.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
3.1 Oversee and contribute to the development of the Trust's People and Culture Plan aligned to the 2030 Delivering Excellence Long Term Plan									
3.2 Noting that the Finance and Performance Committee oversees delivery of the Integrated Medium Term Plan (IMTP), this Committee will conduct any required deep dives into aspects of the people and culture elements of the IMTP and monitor delivery of other strategic people and culture priorities which may not be included in the IMTP									
3.3 Receive and consider projects of major strategic organisational change where there is a significant impact on our people's health and wellbeing, and cultural change									
3.12 Monitor the effectiveness of the Trust's leadership and management development and succession planning arrangements									
People and Culture C'ee elements of IMTP	STB	Annually					DPC	Endorsement	Proposed people and culture elements of IMTP to PCC for review ahead of full IMTP review by F&P and Board (inc L&M - 3.12)
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	F&P monitor delivery of strategy via IMTP. Exception reports to PCC by Director or by F&P request where required
Strategic Workforce Plan	TBC	Bi-annually					DPC	Endorsement	Receipt by the Committee for endorsement before it goes to Trust Board, and then follow up for review 6 months later.
Cultural themes and trends report	TBC	Bi-annually					DPC	Assurance	First reported in 23/24; Regular reporting on the Compassionate Practices Action Plan to be included.
Learning and development reporting	TBC	TBC					DPC	Assurance	Reporting to be developed in 2024/25 to assure the Committee on training, education, development & succession
3.13 Monitor performance against key people and culture indicators including but not limited to sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinarys and suspensions, turnover and recruitment; enabling deep dives to take place into specific areas of concern									
3.4 Monitor progress and seek assurance of arrangements in place to embed the Trust's behaviours, ensuring a continued journey of positive culture change									
People and culture metrics annual review	TBC	Annually					DPC	Approval	To review and agree the Committee level metrics for the coming year (i.e. those over and above MIQPR metrics)
MIQPR review for people and culture metrics	FPC	Annually					EDSPP	Endorsement	People and culture, H&S, and Welsh Language KPIs for inclusion in MIQPR
People and culture metrics report	TBC	Quarterly					DPC	Assurance	First reported in August 2023
Workforce Scorecard	TBC	Quarterly					DPC	Assurance	
MIQPR	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics. See cycle note 12 on PADRs
Suspensions over 4 months report	TBC	Quarterly					DPC	Assurance	Closed session
3.5 Receive assurance that there is a robust plan in place for the health and wellbeing of our people and monitor the effectiveness of arrangements in place to support and protect the mental, physical and financial wellbeing of staff. See Note 1									
End of Season Flu Campaign Report	COGG	Annually					DP	Assurance	To include flu and general vaccination status in accordance with statutory and regulatory requirements - see Note 2
3.15 Ensure the Trust is discharging its statutory responsibilities, including but not limited to health and safety, equality, diversity and inclusion; relevant Health and Care Quality Standards requirements; and that professional standards of registration and revalidation are maintained									
Health and Safety Report	NH&S C'ee	Quarterly					EDQN	Assurance	Bi-annual report on the working safely programme but MIQPR to include KPIs. See note 3
Annual Health & Safety Report	NH&S C'ee	Annually					EDQN	Assurance	Requested for inclusion from 2024/25 onwards; to be received in the August 2024 meeting.
Revalidation and registration report	N/A	Annually					EDQN & EDP	Assurance	Report from EDQN and DP confirming revalidation of registered staff - see Note 4
Gender pay gap report	TBC	Annually					DPC	Assurance	Report presented for 22/23 in Feb (Q4) 24. TBC timing of this going forward
Annual Equality Report	TBC	Annually					DPC	Assurance	See Note 11
Health and care standards	TBC	TBC					DPC	Assurance	Assurance on compliance with people related HCS (as amended with new Act)
3.6 Consider the experience of our people, including volunteers, and seek assurance of the effectiveness of mechanisms used for measuring, and for hearing and acting upon their experiences									
Staff Story	N/A	Quarterly					DPC	Discussion	Staff stories to be topical to the main issues where possible
Staff Story updates	None	Quarterly					DPC	Assurance	Closing of the loop from themes/issues raised in staff stories. Letter to staff. See Note 5
NHS Staff survey and action plan	ELT	Annually					DPC	Assurance	TBC if September - See Note 6
WAST pulse surveys and action plans	ELT	Ad Hoc					DPC	Assurance	
3.7 Receive assurance that arrangements are in place to allow staff to raise concerns in confidence, and that those processes allow any such concerns to be investigated proportionately and independently and that the learning from such concerns is considered and applied									
Speaking Up Safely Report	TBC	TBC					DPC	Assurance	Speaking Up Safely reporting being developed in 23/24 - see Note 7
3.8 Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan and be assured its implementation is monitored; champion and support the plan and the work of the EDI networks - See Note 10									
Report on Anti-racist Wales Action Plan	TBC	TBC					DPC	Assurance	Reporting to Committee to be confirmed - see Note 8
3.14 Monitor progress and seek assurance that arrangements are in place to meet the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted within the Trust									
Reporting on Welsh Language Standards	WLAG	Bi-annually					BS	Assurance	Note the WL framework is in IMTP 2024-27 and revised Welsh Language Standards reporting in development
Welsh language annual report	WLAG/ELT	Annually					BS	Endorsement	Must be on website in September. Goes to Board thereafter in September.
3.10 Receive assurance that Trust management and Trade Union Partners continue to develop and build a shared understanding and common purpose through formal and informal consultative partnership working to ensure the efficiency and success of the Trust for the benefit of all									
WASPT AAA report	WASPT	Quarterly					DPC	Assure/Escalate	As well as minutes (effective 24/25).
Partnership Agreements	WASPT	Ad Hoc					DPC	Endorsement	Trade union partnership agreements - See also Note 9
3.16 All matters relating to partnerships and engagement relevant to our people and culture change									
Partnerships & Engagement Report	TBC	Bi-annually					DPE	Assurance	Reporting on engagement framework for people and culture to be developed - linked to major organisational change in TOR 3.3
Partnership Agreements	ELT	Ad Hoc					DPE	Review	Review partnership agreements (e.g. armed services covenant; disability partnerships) - See also Note 9
3.9 Receive assurance on the development and implementation of the Trust's recruitment and retention plans.									
NHS Workforce Model	Workforce Planning Grp	TBC					DPC	Endorse	
Workforce Plan aligned to IMTP	Workforce Planning Grp	Annually					DPC	Endorse	Committee reviews tactical workforce plan, capacity & demand reviews; review strategic workforce plans when developed .
3.11 Receive assurance that the Trust has in place appropriate policies and procedures for its people; approve people and culture policies									
Report from policy group	Policy Group	Annually					BS	Assurance	Annual report to illustrate the policies within the remit of the committee are in date and there is full policy coverage assurance
Policies for review and approval	Policy Group/ELT	Ad Hoc					Various	Approval	Board to approve Raising Concerns and H&S policy (SoRD para 17)
3.18 The Committee will monitor the principal risks relevant to its remit and consider the controls and mitigations of related risks and provide assurance to the Board that such risks are being effectively controlled and managed.									
Board Assurance Framework	Board	Quarterly					BS	Assurance	
Corporate Risk Register - People and culture	Board	Quarterly					BS	Assurance	
Audit Recommendation Tracker	ADLT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc					Relevant Director	Assurance	
3.17 Any other matter in relation to the Committee's overall purpose and responsibilities									
Operational Update	N/A	Quarterly					EDO	Information	
Director of P&C Update	N/A	Quarterly					DPC	Information	Including spotlight on TUP successes and challenges from 1 April 2025
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	Review against cycle progress at each meeting
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS									
Relevant External Reports	N/A	Ad Hoc					Various	Assurance	

DPP = Director of People & Culture
 EDO = Executive Director of Operations
 EDQN = Executive Director of Quality and Nursing
 DPE = Director of Partnerships and Engagement
 EDP = Director of Paramedicine
 BS = Board Secretary

 Cycled for each meeting
 Ad hoc item - prompt for agenda setting
 Reporting developing

Health and wellbeing	TOR 3.5 - health and wellbeing offer will be included in the People and Culture Plan and reported via the IMTP
Flu Vaccine	Not mandatory; WG have a target for patient facing staff
	Delivery on the Working Safely Programme is via IMTP however bi-annual updates on working safely programme to maintain visibility over 23/24
Health and Safety	Health and Safety Internal Audit Report July 2023 - <i>There is good oversight over the Programme with regular reporting to the Programme Board and to the People and Culture Committee (PCC) but could be enhanced by noting progress against the programme's deliverables</i>
Revalidation	RNC every 3 years; HCPC every 2 years; GMC every 3 years
Staff story updates	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 agenda for the following meeting.
Staff survey	Staff survey goes out [Sept?] and reports end [March].
Speaking Up Safely	DPC will develop reporting on Speaking Up Safely through 24/25 as FTSU Guardians embed; in the meantime the cultural themes and trends captures some of this reporting. (AP): For 25/6 the timing of the PCC assurance to ARC on the FTSU arrangements (whistleblowing) needs to be considered - take to ARAC after PCC. Review for 25/26 CoB.
Anti-racist Wales Action plan	Wider public, third sector and Government funded private sector In relation to the leadership responsibility we hold for public, third and those private sector organisations we fund. 5 core actions identified WG will expect and will hold them to account, via our Accountability Group: 1. A strong commitment to lead from the front and demonstrate it in terms of anti-racist values, behaviours, representation at all levels of your organisations and accountability measures. 2. Participation in all decision making and senior leadership groups in a way that enables lived experiences of ethnic minority people to be heard and acted upon. 3. Achieve, at the very least, minimum requirements of the Equality Act 2010 and publish your results in an open and accessible forum/platform. 4. Ensure minimum standards and provision of culturally sensitive and appropriate services, including provision of translation and interpretation. 5. Ensure robust complaints policies and processes for racial harassment that are validated to the satisfaction of ethnic minority groups.
Working in Partnership	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, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership'.
EDI Networks	Promote the networks and Committee involvement including NED champion roles
Annual Equality Report (5)	SEP 2024-2028 approved March 24. 22/23 report presented in February (Q4) 24. TBC timing of this going forward. WRES reporting (national WRES report being coordinated by HEIW. WRES data will help provide baseline for future actions on ARWAP. <i>This should be a group of reports to be received in August: the SEP Annual Report, the Annual Workforce Equality Monitoring Report and the Workforce Race Standards report.</i>
PADR	Audit Wales Quality Governance Review 2022 made recommendations related to mortality reviews. The 2024 Quality Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: R5 - The Trust has low Personal Appraisal and Development Reviews (PADR) compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this. <i>The report found whilst PADR completion rates have improved since our original review, they continue to be below the Trust's target rate.</i>
General	These cycles are developed with reference to the specific lines of the TOR for this Committee. This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board



PEOPLE AND CULTURE COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.
2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.
3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.
4. The committee met on 18 February 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The committee is established to enable scrutiny and review of the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviour to a level of depth and detail not possible in Board meetings. The committee will provide assurance to the Board of the Trust's leadership arrangements; behaviours and culture; training, education and development; equality, diversity and inclusion; health, safety and welfare; people and culture related partnerships and engagement; the Welsh Ambulance Services Partnership Team (advisory group); and Welsh Language, in accordance with its stated objectives and the requirements and standards determined by the Welsh Government, the NHS in Wales and other regulatory bodies.

MEMBERSHIP AND ATTENDANCE

6. The committee met four times as scheduled in 2024/25 and was quorate on each occasion.
7. The committee is supported by the Chair and three Non-Executive Directors (NED) as members, and several core attendees with good attendance. The membership of the committee changed in year following changes to the NED composition. Joga Singh left the Trust Board on the 31 August 2024 and following her appointment as a NED in Autumn 2024, Hayley Hutchings is now a member of the committee. The meeting of the committee in February 2025 was her meeting.
8. During the year the leadership structure within the People and Culture Directorate changed and the role of the Director of People and Culture was separated to provide for a Director of People and a Director of Culture Change. Angela Lewis begun in the role of Director of Culture Change in Autumn 2024. Carl Kneeshaw was appointed to role of Director of People, with November being his first meeting of the committee.
9. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2024/25. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE				
Name	9 MAY 2024	8 AUGUST 2023	16 NOVEMBER 2023	20 FEBRUARY 2024
Ceri Jackson				
Bethan Evans				
Joga Singh				
Hannah Rowan				
Angela Lewis				
Carl Kneeshaw				
Chris Turley		Left at end of item 13		
Lee Brooks	Sonia Thompson			
Liam Williams	Jonathan Turnbull-Ross			
Estelle Hitchon				
Andy Swinburn				
Alex Crawford				
Trish Mills	Julie Boalch			
Damon Turner				
Marcus Viggers				
Christian Fox	Hugh Parry			
Tim Cahalane				

	Attended
	Deputy attended
	Apologies received
	No longer member

10. The Chair of the Committee until 31 March 2024 Paul Hollard, completed his eight year tenure on the Board at the end of the 2023/24 financial year. Ceri Jackson became the Chair from 1 April 2024. Due to the aforementioned changes to the committee composition in year there are no changes to membership proposed at this time.

COMMITTEE'S VIEWS ON EFFECTIVENESS

11. The committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 18 February 2025, which included a review of its terms of reference and cycle of business.

[insert here following the 18 February meeting the views of the members on the effectiveness of the committee]

12. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The committee's business in 2024/25 included:

12.1. **The lived experiences of our people** were shared at the meetings:

- In May the Committee heard from a member of staff on the front line – **Matthew T Jones, a Locality Manager** in Pembrokeshire who attended the committee to share his learning on the work he has undertaken on the attendance and sickness within his locality. Matt's reflections included: having a safe space to learn from mistakes in the beginning of the project, linking into the People & Culture Plan, an excellent example of how a whole team in the Emergency Medical Service has been involved in supporting staff back into work following a period of absence, the work that has been done to support staff in complex cases and the innovation and creative thinking within his team.
- In August, **Kayleigh Wheeler, Operations Manager Ambulance Care**, shared her journey to her current leadership role at WAST. Despite facing homophobia, misogyny, and bullying, Kayleigh received support from colleagues and became active in the WAST Voices network. She aims to amplify quieter voices and address bullying and harassment through various campaigns and sessions. Her presentation highlighted her resilience and commitment to positive change at WAST. While challenges remain, Kayleigh believes the organisation is progressing with improved accessibility and transparency of senior leaders.

- In November, **Ela Lewis**, with a background in nursing (registered nurse) and currently a Senior Project Manager for the Connected Support Cymru project, shared her inspiring journey as a change champion. Ela highlighted the crucial role of creating a supportive environment where colleagues can express their emotions and collaborate effectively on the change journey. Ela's contributions, especially in volunteer coordination and the implementation of remote clinical devices, have been notably impactful, earning her widespread gratitude within WAST.
 - In February the committee heard from XXXX.
- 12.2. The **2024-2030 Strategic Workforce Plan** was received in August. This was reviewed and endorsed by the committee before approval by the Trust Board. This Plan directly aligned to the focus of the IMTP and the Trust's long-term vision.
- 12.3. At the August meeting the committee received a suite of **annual reports in respect of 2023/24** for consideration which required approval by the Trust Board. These were the **Strategic Equality Plan Annual Report 2023/24**, the **Workforce Equality Monitoring Report 2023/24**, the **Gender Pay Gap Report 2023/24**, the **Welsh Language Annual Report 2023/24**. The latter report was presented bi-lingually, and the breadth and depth of the report was appreciated by members.
- 12.4. The committee began receiving a **Cultural Themes and Trends** report at every other meeting. In August data relating to employee relations cases, sickness and training and the impact on the culture at WAST, was received. It was noted that there had been an increase in employee relations cases, but as of August 2024 over 200 individuals had received training in compassionate practices, and 70 had attended investigating officer training. In February the committee received an introduction to the 'WAST Way' ... XXXX.
- 12.5. Related to this at its meeting in February 2025 an update was received on the work around **compassionate practices** and the related actions in the compassionate practices action plan.

12.6. The committee noted the significant amount of change taking place across WAST which brings pressure on our people, both with respect to change itself, but also the pace of change. This was the primary focus for the meeting of the committee in November, at which a session was delivered on **change management**. The aim is for change management to become a natural part of every process, whilst having oversight of the impact of change on our people. d. Angela Lewis confirmed her commitment to ensuring that change management principles and techniques are embedded in the leadership work within the Trust, particularly through our 'The WAST Way'. This will ensure that change management is at the heart of leadership development. This following progress related to this work was noted:

12.6.1 **Change Community:** The Trust has established a change community focused on creating a culture of collaboration, trust, and growth. This community aims to build a supportive, non-judgmental environment where colleagues can practice new skills, test their thinking, build confidence and competence, and share experiences to learn from each other.

12.6.2 **Structured Approach:** The Trust has developed and implemented a structured approach to change management centred around the ADKAR model, which focuses on individual change to achieve organisational results. This model breaks change down into clear stages and is action and outcome focused.

12.6.3 **Embedding Change Management:** The approach is being embedded within the clinical model transformation programme, with dedicated change leads from the change community supporting program workstreams. The goal is to ensure a consistent approach to change management across the programme.

12.7. The committee received an update on the Trust's **Speaking Up Safely** arrangements at its meeting in February 2025, and it was noted at the November meeting that the Audit, Risk and Assurance Committee were assured on our speaking up arrangements. Additionally, the CEO roadshows in Autumn 2024 included a focus on speaking up, with board members pledging their support.

- 12.8. The **Partnerships and Engagement report** was received in August. This focused on regional Partnership Boards and the Wellbeing of Future Generations Act. The report signifies a move towards more strategic engagement and partnership working, aligning with broader organizational and national priorities.
- 12.9. The committee received insights from the **NHS Staff Survey** which focused on stress and burnout in the workplace and the links between addressing these issues with our overarching People and Culture ambitions and Health and Wellbeing Plan.
- 12.10. The **Staff Development Outline Plan** was received in May. It was noted that this is a deliverable in the People and Culture Plan, which aims to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities.
- 12.11. Related to this activity, the committee acknowledged the significant volume of **learning and development** taking place at all levels of the Trust. The committee was introduced to the '**WAST Way**' in year, a behavioural approach which intends to enable a culture of compassionate, inclusive and collaborative leadership includes leadership behaviours which are drafted and engagement on these is underway.
- 12.12. **Health and Safety updates** were received with a focus on RIDDOR compliance, risk assessment compliance, manual handling, the effects of diesel fumes on our people (which was also the subject of the advisory group WASPT discussions), and violence and aggression. These updates included several positive aspects such as high compliance rates for RIDDOR reporting which demonstrates a grip of control and flows of work in the Trust. Additionally in August, the committee received the **2023/24 Health and Safety Annual Report** which was approved. Members noted the maturing culture of health and safety in WAST and the focused attention the team had throughout the year.

- 12.13. The **Health and Well-being Plan 2025-2029** was received in February 2024 for comment and subsequently received in November 2024. The committee endorsed the Plan for submission to the Trust Board for approval. The plan showed the high-level outcomes, with local action plans sitting behind them focusing on meeting the basic needs of staff, promoting well-being, providing preventative and reactive support, all while maintaining service quality.
- 12.14. A follow up report on the **Seasonal Influenza Campaign 2023/24** report was received. The Trust's final uptake of staff vaccinated for the **Seasonal Influenza Campaign 2023/24** was 36.5%, which is a decrease of 8% from last year's campaign. Lessons learnt from this campaign have informed an extensive list of areas that require continued development for future flu campaigns.
- 12.15. The Committee received assurance on the processes in place for 2024 **registration and revalidation** with respect to the Nursing and Midwifery Council and noted 100% compliance.
- 12.16. **Updates are received from the Director of People and Culture** at each Committee, and these were changed in year to reflect a new look and a balanced view on both successes and challenges. Following the change to the structure of the People and Culture Directorate in year and the separation of the people and culture elements of the Director's remit, the committee began receiving updates from the Director of People and the Director of Culture Change as of November 2024.
- 12.17. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.
- 12.18. The **MIQPR** and **People and Culture Plan metrics** were received at each meeting, with a particular focus on sickness absence levels, recruitment, PADRs, statutory and mandatory training, moving on interviews, and shift overruns. At the May meeting a deep dive was received on the **disciplinary processes and compassionate practices** approach in the Trust.
- 12.19. In private session in August, the committee received the **2023/24 Workforce Race Equality Standards Report** for 2024. The report and proposed action plan were endorsed and subsequently submitted to the Trust Board for approval.

12.20. The committee approved the following **policies** in year:

- Homeworking Policy
- Professional Regulation Policy
- NHS Wales Respect and Resolution Policy
- Welsh Language Policy
- Driving At Work Policy
- Occupational Health Policy
- Recruitment and Selection Policy
- Occupational Immunisation Policy
- Equality Impact Assessment Policy
- Bank Worker Policy

12.21. In private session the Committee looks at **suspensions** over four months and **Employment Tribunal** cases.

12.22. **Reflections** are taken at the end of meetings and included:

- In May, it was noted that the first hybrid meeting post-Pandemic worked well, but that there are procedural considerations which must be considered given this approach. Additionally, it is important to ensure there are sufficient breaks included.
- In August it was noted that the meeting was well Chaired and there were many positive items being discussed, including the staff story and the progress shown within the Health and Safety Annual Report.
- In November, the committee felt that the discussions were less transactional and future focused, The importance of taking a holistic view of people and culture activities was noted.

12.23. The Committee **cycle of business** was approved in May 2024.

12.24. **Risks** relevant to this Committee are reviewed at each meeting and the agenda is driven by these risks. The highest rated risks, sickness absence (160), reputation (201) and latterly Trade Union relationships (163) were the focus and drive agenda setting. Risk 163 was presented in detail to the WASPT for the first time in May 2024, in recognition that this risk is dynamic.

12.25. The **annual effectiveness review** was conducted in the February 2025 meeting. As detailed earlier in this Return the approach to the 2024/25 review was different to previous years.

- 12.26. The **Audit tracker** and actions assigned to the committee were reviewed at each meeting. Good progress is being made to close management recommendations.
- 12.27. The reasonable assurance **Retention of Staff** Internal audit report was received, Key matters arising from included finalisation and ratification of the 'moving on interview' process. The purpose of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention.
- 12.28. The **Seatbelt Action Plan** Internal Audit was received, which gave a reasonable assurance opinion. The purpose of this audit was to review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance,
- 12.29. The reasonable assurance Internal Audit on **Disciplinary Case Management** was received. The purpose of this audit was to assess the adequacy of the arrangements in place for the management of the disciplinary process, and to focus on the demonstration of compassionate leadership principles, in addition to compliance with the Trust's defined disciplinary processes.
- 12.30. The reasonable assurance Internal Audit report on **Volunteers Governance** was received. The purpose of the audit was to review the adequacy and effectiveness of the Trust's governance and operational management of volunteer activities.
- 12.31. The **Exposure to Fumes** internal audit report was received, with a reasonable assurance opinion. The purpose of this audit was to evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.
- 12.32. The **Resourcing Policy** internal audit was received, with a limited assurance opinion. The purpose of this audit was to review the Trust's Resourcing Policy, its compliance with national terms and conditions, and to assess its application as an enabler for effective resource production.

13. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. In November that report was provided verbally due to the proximity of the meeting and the Board meeting.
14. The **Committee's priorities for 2024/25** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.
15. The Committee is serviced by one Sub-Committees, which is the Welsh Ambulance Service Partnership Team (WASPT). WASPT held its first meeting in April 2023 and the AAA Highlight Reports provided to each meeting set out the work of this advisory forum in the year.
16. The operational and corporate sub-structures that feed into WASPT, including local partnership forums were formed in 2023. These forums provide opportunities for resolution and escalation at a more local level, focusing WASPT on strategic issues.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

17. The proposed changes to terms of reference for this committee for 2024/25 are marked up in [Annex 1] and include XXX.

[to be completed following the 04 February meeting]

18. In addition, there will be some changes to operating arrangements which include:
[to be completed following the 04 February meeting]

COMMITTEE PRIORITIES

19. The Committee received an update on progress against its priorities at each meeting. The 2024/25 priorities were:

Priority	Progress
Impact of wellbeing initiatives on our people.	- The upcoming Cultural Themes and Trends Report (to be received at the February 2025 meeting) will include consideration of the employment relations cases, sickness absence and compassionate practices. There will also be a focus session (as part of the Cultural Themes and Trends item) on sickness absence received at the February 2025. - The Health and Wellbeing Plan which was received by the Committee in November 2024 - includes commentary on the Trust's approach to understanding the impact of wellbeing initiatives on our people. This Plan was subsequently approved by the Trust Board at its meeting in November 2024. - Objective 1 of the Health and Wellbeing Plan is proposed to be to "Assess and Understand the health and wellbeing of our workforce". In relation to this objective, the Trust will implement a robust assessment framework to identify and address specific stressors. The data-driven approach will provide actionable insights, enabling targeted interventions and creating a foundation for sustainable wellbeing improvements. Charity funding will be sought to support and expand these assessment tools. - Additionally, Objective 2 of the Health and Wellbeing Plan is proposed to be "Proactively promote protective health and wellbeing offers at all levels within WAST for our people and their families and ensure they are available to all". The Health and Wellbeing

Priority	Progress
	Plan is being received by the Committee at its meeting in November 2024 for endorsement. - The Committee regularly receives the People and Culture Plan Metrics, the Workforce Scorecard, and the MIQPR, through which it will understand the impact of various wellbeing initiatives on our people. Additionally, the Committee receives the output of 'Pulse Surveys' and annual NHS Staff Survey, with the associated actions plans – both of which are programmed in the Committee's Cycle of Business.
Culture of conversations with a focus on communication and conversations with managers and their people.	- The Trust's focus on a 'Culture of Conversation' continues. A significant aspect of our improvement strategy is moving beyond simply focusing on the completion rates of PADRs. We are working towards making every PADR conversation meaningful, ensuring that these discussions reflect our values of compassion, inclusivity, and collaboration. - This shift aligns with the development of <i>Our WAST Way</i>, a new behaviours and development framework for leaders and managers that outlines their responsibilities in creating a positive and supportive work environment. The Committee will receive updates regarding the development of <i>Our WAST Way</i> at its meeting in February 2025. The '<i>Our WAST Way</i>' intends to incorporate the importance of change management skills for our people. It is noted that the Committee received an update on development on change management initiatives in the Trust at its meeting in November 2024.

Priority	Progress
	- Additionally, the Committee continues to have a focus on the organisational culture, with 'Cultural Themes and Trends' reports being brought forward regularly. The Committee received this report at its meeting in August 2024. The next 'Cultural Theme and Trends Report' will be received by the Committee in February 2025, in line with the Cycle of Business.
A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives.	- The Committee has an ongoing focus on equality, diversity and inclusion – with the relevant business having been incorporated into its annual Cycle of Business. The Director of Culture will provide updates to the Committee regarding the work of the Equality, Diversity and Inclusion Steering Group (EDISG), as required. The EDISG will be supporting the implementation of the Strategic Equality Objectives from which the Director of Culture will provide assurance to the Committee. - The Trust is committed to ensuring that equality, diversity and inclusion are integral to all we do within People and Culture. Rather than viewing EDI as a separate initiative, we strive to make it a continuous golden thread that connects every workstream. By doing so, we help colleagues see and embrace EDI as foundational to our work, creating a space where decisions are influenced by our commitment to inclusion and equity. - Alongside embedding EDI into our everyday practices (through delivery of our Strategic Equality Objectives), we are committed to driving forward the successful delivery of our Statutory Action Plans. Specific initiatives will

Priority	Progress
	also include partnering with Higher Education Institutions to increase student diversity and launching targeted campaigns to attract candidates from a wide variety of backgrounds for the full range of career opportunities within WAST. - At the August 2024 meeting the Committee received the Strategic Equality Plan Annual Report for 2023/24, the Annual Workforce Equality Monitoring Report for 2023/24, the Annual Gender Pay Gap Report for 2023/24, and the Workforce Race Equality Standards Report for 2023/24, and the Welsh Language Annual Report for 2023/24. These are the key matters of annual reporting regarding equality, diversity and inclusion.
The Trust's approach to development of our people.	- At its meeting in May 2024 the Committee received the 'Staff Development Outline Plan' which is a deliverable of the People & Culture Plan. The aim of this is to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities. - At the May meeting the Committee were assured that mapping was underway on professions and roles, which will define skills and competencies. An update will be given to the Committee at a future date. It is noted that the 'Learning and Development' reporting is still in development.

Priority	Progress
	- The People and Culture Plan metrics – which the Committee receives at every meeting – includes metrics regarding the statutory and mandatory training (giving organisational compliance figures) in addition to the MIST compliance. - The People and Culture Plan metrics provided to the Committee also include qualitative feedback regarding the Trust’s learning and development initiatives, which enables us to take a continuous improvement approach to the development of our people. -

20. It is good practice for committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the committee has agreed the following priorities for 2025/26:

[to be completed following the 04 February meeting]

21. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

22. The next steps are as follows:

- 22.1. Ensure changes to operating arrangements agreed at paragraph XX are cycled into work programme for review in 2025/26
- 22.2. Update the cycle of business with revised terms of reference.

RECOMMENDATION

23. The Trust Board is requested to:

- 23.1. Receive and note the contents of the Committee Annual Report for 2024/25 and analysis of its effectiveness; and
- 23.2. Approve the changes to the Terms of Reference.

AGENDA ITEM No	18
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the 4 risks that are relevant to Committee's remit and additionally the Trust's 2 highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight.
2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.
3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each of these principal risks and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2.
4. Each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.
5. All principal risks were presented to the Trust Board on 29 November 2024 and have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.
6. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

7. The Trust's two highest scoring risks **223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) remain static at the highest score of 25. These scores reflect individual cases of avoidable harm, highlighting ongoing challenges in the unscheduled care system due to the levels of handover delays.
8. The number of lost hours due to handover delays remained significant in September 2024 at 20,693 which is higher than the same period in 2023.
9. Handover delays continue to present patient safety risks and extended waits in the community with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. Delays are also presenting as a theme in the Medical Examiner Service referrals for the first two quarters of 2024/25.
10. The Trust Board continues to focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) to address these risks.
11. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Two key ones being the number of calls being closed safely and efficiently by clinicians through the Consult and Close initiative in the contact centres as well as a significant improvement in sickness and attendance levels.
12. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.
13. To support the continued, detailed review and mitigation of these risks, a workshop took place on 06 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. A follow up workshop is planned for late January 2025 to complete the work to brigade controls into six internal and external themes.
14. Risk 160 *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, is rated 20. Sickness absence remains a key challenge for the organisation and whilst there has been a significant reduction in absence levels, the score remains static as these are higher than

desired. The position in August that showed an uncommon but positive decrease in levels for that time of year. The data will be assessed over the next four months to establish whether the improvement in levels is sustained. Should this be the case, then it is likely that this risk score will be reduced.

15. Risk 163 *Maintaining Effective & Strong Trade Union Partnerships* was rated 20. The score has reduced from 16 (4x4) to 12 (3x4) in this review period which reflects good relationships with Trade Union partners and that engagement and partnership working is operating well. Workshop sessions for TU partners and managers have been delivered across the organisation to those both in senior and local roles. The programme of engagement and relationship building will continue throughout 2024/25, and work is underway to deliver the action plan in partnership. Trade Union partners have noted the excellent partnership working at WAST and recognised that the structures are embedding well.
16. In relation to Risk 201 *Reputation*, whilst it is acknowledged that the rating for this risk remains high and has been static for some time it is inextricably linked to several of the metrics measured and discussed at the People & Culture Committee.
17. Risk 558 *Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures* currently remains unchanged.

RECOMMENDATION:

18. **Members are asked to consider and discuss the contents of the report.**

KEY ISSUES/IMPLICATIONS

19. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE

20. The BAF was considered by:
 - Assistant Directors Leadership Team (14 October 2024)
 - Executive Leadership Team (23 October 2024)
 - Audit, Risk and Assurance Committee (21 November 2024)
 - Trust Board (29 November 2024)

REPORT ANNEXES

- Annex 1 - Summary table describing the Trust's Corporate Risks.
- Annex 2 – Scoring Matrix
- Annex 3 – Frequency of Risk review
- 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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	IF significant internal and external system pressures continue THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community RESULTING IN patient harm and death	Executive Director of Operations	25 (5x5) ➡
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	IF patients are significantly delayed in ambulances outside A&E departments THEN there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised RESULTING IN patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	25 (5x5) ➡
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	IF there are high levels of absence THEN there is a risk that there is a reduced resource capacity RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	20 (5x4) ➡
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation	IF there is an inability of the Trust to deliver its core services because of system or organisational pressures THEN there will be a loss of stakeholder confidence in the Trust RESULTING IN a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver	Director of Partnerships & Engagement	20 (4x5) ➡

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		its strategic ambition, damage to reputation and increased external scrutiny		
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	IF significant internal and external system pressures continue THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	15 (3x5) ➔
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	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 THEN there is a risk that Trade Union 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.	Director of People & Culture	12 (3x4) ↓ 16 (4x4)

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	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	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 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death			Date of Review:		01/10/2024		TREND	25 (5x5)
				Date of Next Review:		01/11/2024		➡	
IF significant internal and external system pressures continue		THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score		
				Inherent	4	5	20		
				Current	5	5	25		
				Target	2	5	10		
IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27									
EXECUTIVE OWNER		Director of Operations		ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee			
Risk Commentary Q1 2024/2025									
The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. Handover lost hours in June were 22,230, July were 19,599 and August were 17,540.									
The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.									
Improvement actions led by Welsh Government and system partners include: -									
a) Audit Wales’s investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)									
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)									
c) NHS Wales reduces emergency department handover lost hours by 25% (E)									
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)									
e) Alternative capacity equivalent to 1000 beds (E)									
f) Implement nationwide approach to emergency department ‘Fit 2 Sit’ (E)									
g) Implementation of Same Day Emergency Care services in each Health Board (E)									
h) National Six Goals programme for Urgent and Emergency Car (E)									
CONTROLS				ASSURANCES					
				Internal Management (1 st Line of Assurance)					
1. Regional Escalation Protocol				1. Daily conference calls to agree RE levels in conjunction with Health Boards					
2. Immediate release protocol				2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs). V1.3 has been reviewed, updated and released (August 2024).					
3. Resource Escalation Action Plan (REAP)				3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.					
4. 24/7 Operational Delivery Unit (ODU)				4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.					
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans				5. Same as 4 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings.					
6. Limited Alternative Care Pathways in place				6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.					
7. Consult and Close (previously Hear and Treat)				7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in the action plan.					
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation				8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However,					

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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score		
			Inherent	4	5	20		
			Current	5	5	25		
			Target	2	5	10		
		it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. This is part of the IMTP Deliverables 2024-2027.						
9. Clinical Safety Plan		9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.						
10. Recruitment and deployment of CFRs		10. 11 new onboarding courses for June to December with projection of 110 new CFRs by 3 rd December 2024. Currently 400 volunteers supporting 6500 hours every month. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR’s, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1’s and volunteer highlight report (IMTP).						
11. ETA scripting		11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.						
12. Clinical Contact Centre (CCC) emergency rule		12. Emergency Rule is incorporated into CSP 999 levels.						
13. National Risk Huddle		13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.						
14. Summer/Winter initiatives		14. Monitoring through SLT and STB. Senior Planning Team (SPT) was stood up for the duration of Winter 2023/24. Christmas Planning Meetings established from April 2024 for winter period 2024/2025.						
15. CHARU implementation		15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.						
16. Clinical Model and clinical review of code sets		16. Reported through CPAS and DCR Review reporting through CQGG						
17. Remote clinical support enabling discharge at scene		17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%						
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)		18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.						
19. Information sharing		19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.						
20. Completed EMS Roster Review		20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.						
21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls		21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.						
22. Transfer of Care		22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief						
23. Virtual Ward – Connect Support Cymru		23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place. • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of May 2024.						
24. ARA – - YGC, Swansea Bay and GUH		24. ARA in GUH finished 31 st March 2024. Holding area in Swansea and YGC remains ongoing.						

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			Current	5	5	25		
			Target	2	5	10		
25. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.		25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.						
26. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.		26. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the ‘Six Goals for Urgent and Emergency Care’ work.						
27. Undertake the next 5-year strategic EMS Demand and Capacity review (the 2019 version will run out this year – 2024)		27. Review has been undertaken and has been reported to close F&P committee July 2024 and Trust Board July 2024. This review details the level of resourcing required in different handover lost hour scenarios with different ways to respond to it e.g. traditional model or evolved CRN.						
GAPS IN CONTROLS		GAPS IN ASSURANCE						
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system		1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.						
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow								
3. Local delivery units mirroring WAST ODU								
4. Handover delays link to risk 224								
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.		5. The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.						
6. Handover Improvement Plans agreed between WAST and Health Boards		6. Performance targets for Handover with Health Boards have been introduced by the commissioner.						
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals		7. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.						
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.								
9. Volunteer Alternative Responder Scheme (VARs)		9. Live from June 2024 with further scheme due to rollout across Wales.						
10. There is currently no JCC implementation plan associated with the 2023 Demand and Capacity Review		10. The requirements for a funded implementation plan for the review i.e. resource envelope change from the JCC. The review is being reported to JCC board development session in August 2024 and is expected to go to JCC committee later this year. The expectation is that the 2025/26 commission intentions will respond to the review.						
Please note that the gaps listed are not WAST’s and are therefore outside of the control of WAST								
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:				

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			Inherent	4	5	20		
			Current	5	5	25		
			Target	2	5	10		
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.		Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)				
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)		ADLT Sub-Group	30.09.22 - Superseded					
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]		Director of Paramedicine / Director of People & Culture	Superseded	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.				
4. APP recruitment		Assistant Director of Operations	March 2025	Aug24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval.				
5. IMTP Deliverables 2027-2027 – implementation of new clinical model.		Assistant Director of Integrated Care (with SRO through CMT Board)	March 2025	Phase 1 for winter May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.				
6. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]		Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.				
7. New 2023 EMS Demand and Capacity (roster) review		Assistant Director of Planning & Performance	Completed	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March. May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.				
8. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.		Assistant Director of Quality Governance	Superseded with the implementation of the new model (ref: Action 5)	Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered in partnership with St John Ambulance Cymru to deliver the CWR element. Initial phase due to conclude in March 2024, further extended to May 2024 due to SJAC funding accommodating extension arrangement. • NHS Charities Together (grant) funding obtained through external application, to develop internal volunteer capacity/volunteer workforce as CWRs. Piloting of the CWR model commenced in Spring 2024, with				

12

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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score		
			Inherent	4	5	20		
			Current	5	5	25		
			Target	2	5	10		
					an expansion of the model in mid-October. Recruitment, onboarding and training continues with aspiration to recruit CWRs across Wales. • The SBRI innovation challenge has supported a phase 2 delivery of the digital ward model: enabling remote clinicians to care for patients in a ‘virtual ward’ capacity. It is envisioned this will enable patients to reach to right care at the right time, whilst being monitored remotely. The pilot has commenced for care homes in Wales, and a dedicated remote clinician is supporting the initiative generating organisational learning to expand remote care planning role the Trust can provide for the NHS Wales. The pilot initiative will conclude in March 2025. • The nature of this project of work aligns to the RICs workstream of the Clinical Model Transformation programme; the work will form part of the RICs workstream from September 2024.			
9. Maximise the opportunity from Consult and Close: - Successful resolution without ambulance (double EMS) - Successful resolution without conveying to ED			March 2025	Trust ambition is to improve Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.				
10. Palliative Care Paramedic Unit		Assistant Director of Operations	Extended to May 2024 - new date TBC	Reducing demand via APPs – 15 th January Start. 15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals. 21/06/2024 - Unit still ongoing.				
11. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		CEO	Q1 2024-2025	• 01/10/2024 - The review of the unscheduled care report part 2 (accessing urgent and emergency care) is underway and will come to the committee in November 2024. • Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.				
12. Royal Glamorgan Early Diagnostic		Executive Director of Operations	August 2024	• Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities. • May 24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.				

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				Date of Next Review:		06/10/2024		➡	
IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments		THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score		
				Inherent	5	5	25		
				Current	5	5	25		
				Target	3	2	6		
IMTP Deliverable Numbers: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31									
EXECUTIVE OWNER		Director of Quality & Nursing		ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee			
Risk Commentary Q2 2024/25									
The risk score remains constant at 25 for quarter 2 2024/25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. JCC EASC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023. Eradication of handover waits of > 4 hours: there were 3,404 over four-hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024.The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, coronial enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.									
Improvement actions led by Welsh Government and system partners include:									
a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 ‘Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) by the end of April 2025 b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024). d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) revised to March 2023/24. e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000. f) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales) g) Implement nationwide approach to emergency department ‘Fit 2 Sit’ (Welsh Government: Chief Medical Officer and Chief Nursing Officer) – paused. Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.									
CONTROLS				ASSURANCES					
				Internal Management (1 st Line of Assurance)					
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.				1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.					
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.				2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023, it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop					

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				Inherent	5	5	25	
				Current	5	5	25	
				Target	3	2	6	
			more consistency which would include aligning the outputs / outcomes with the ‘Six Goals for Urgent and Emergency Care’ work. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.					
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016))			3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.					
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).			4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.					
5. Workstreams put in place to meet requirements of <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i> . Goal 4 incorporates the reduction of handover of care delays through collective system partnership.			5. Monthly Integrated Quality and Performance Report and WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. The Trust also has a presence on all the individual goal boards.					
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).			6.					
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.			7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.					
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient’s Fundamentals of Care as best they can in the circumstances.			8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST					
9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.			9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.					
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.			10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. On Call cover is reviewed weekly at SLT Performance Meetings.					
11. Escalation forums to discuss reducing and mitigating system pressures.			11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.					
12. WAST Education and training programmes include deteriorating patient (NEWS), tissue viability and pressure damage prevention, dementia awareness, mental health.			12. Monthly Integrated Quality and Performance Report (April 2024 overall 82% - Safeguarding is 78% and dementia awareness remains over 91%).					
13. Clinical audit programme in place.			13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.					
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.			14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.					
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government.			15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including ‘Actions to Mitigate Avoidable Patient Harm Report’ (last presented to Trust Board May 2024) and Board sub-committee oversight and escalation through ‘Alert, Advise and Assure’ reports.					

15

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				Target	3	2	6		
Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating “The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service’s statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets.”									
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.			16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of May 2024 is ‘Implementing and operationalising’. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical & Quality Governance Group.						
17. Clinical Support Desk First in place			17.						
18. Summer/Winter initiatives			18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2024/25.						
			External Sources of Assurance Management (1 st Line of Assurance)						
			1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).						
			2. Healthcare Inspectorate Wales (HIW) ‘Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover’ Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC						
			3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.						
			4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided ‘Reasonable Assurance’ with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.						
GAPS IN CONTROLS			GAPS IN ASSURANCE						
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing with full establishment expected by July 2024.									
2.			1. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 56 overdue nationally reportable incident (NRI) investigations, with 63 NRIs open in total. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.						
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.			2. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.						
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients’ NEWS.			3. Strengthening of patient safety reports and audit processes as e PCR system embeds.						
5. Variation pan Wales / England as position not implemented across all emergency departments.			4. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.						

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						Current	5	5	25
						Target	3	2	6
6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.				5. HIW approve and sign off WAST elements of recommendations.					
				External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators					
Actions to reduce risk score or address gaps in controls and assurances				Action Owner	By When/Milestone	Progress Notes:			
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project				WAST QI Team (QSPE)	TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).			
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.				Assistant Director of Quality & Nursing	Q3 2024/25	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available and access for the Patient safety Team is being explored. Work on-going with Health Informatics regarding patient safety and health board dashboards capacity in Health Informatics impacting and dates revised. • Local dashboards have been developed but requiring manual data extraction			
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.				Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.			
4. Recruit and train more Advanced Paramedic Practitioners.				Director of Paramedicine	Q4 2024/25	• The Trust uplifted its APP establishment by a further 15.7 FTEs in 2023/24 (funded through internal movements). For 2024/25 the Trust is funding a further uplift of 32 APPs (additional funding, not internal movements). • The above uplifts will increase the APP establishment to 120.7 FTEs.			
5. Overnight falls service extension and future modelling				Executive Director of Quality & Nursing	31.09.2024	•Overnight falls service extension and future modelling • Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) • Utilisation rates continue to be monitored: • Nighttime utilisation: - Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% • Daytime utilisation: - Q2 57% Q3 56% Q4 to date 58% April 2024 – 54% • Combined day and night Q2-Q3 58% Combined day and night Q4 to date 59% Combined day and night April 2024- 55% There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1 62% for April 2024 The 2023 EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners and health boards. There is an immediate focus on the contract beyond September 2024. The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 2024.			

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						Inherent	5	5	25
						Current	5	5	25
						Target	3	2	6
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).		Executive Director of Quality & Nursing	Q4 2024/25	- Monthly updates to progress against actions following the baseline assessment and readiness returns continued. - RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. - Key policies updated and approved further updates following release of revised Putting Things Right Regulations which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended. - Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.					
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.		Executive Director of Quality & Nursing	Q2 2024/25	- Currently awaiting WG feedback on the submitted business case. - Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case.					
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.		Executive Director of Quality & Nursing	Q2 2024/25	- OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. - Final posts due to be recruited to and in place by July 2024.					
9. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		CEO	Q2 2024/25	- Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support). - WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. - The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales. - Audit Wales have confirmed this has been reprofiled into 2024/25.					
10. Patient handover actions.		Executive Team	Under review	Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team.					
11. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.		Executive Director of Quality & Nursing	Q3 2024/25	Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.					
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)		Executive Director of Strategy, Planning &		Trust to produce its own six goals plan (Goal 4 links to handover of care)					

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:		26/09/2024	TREND	20 (5x4)
				Date of Next Review:		26/10/2024	➡	
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: 13, 14, 15, 22, 24, 25, 26								
EXECUTIVE OWNER			Director of People & Culture	ASSURANCE COMMITTEE	People and Culture Committee			
Risk Commentary								
Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. Whilst the sick absence rates went up in July it was positive to note the decrease in August. Traditionally, the school holiday period had often seen an increase in absence rates; therefore we intend to assess the data for the next four months to establish whether the improvement is sustained. If there is a sustained improvement, then it is likely that this risk score will be reduced.								
CONTROLS				ASSURANCES				
				Internal Management (1 st Line of Assurance)				
1. Managing Attendance at Work Policy/Procedures in place and followed				1. (a) Audits undertaken by People Services Team (b) Outputs reviewed				
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence				2. R&Rs addressed in timely way to reduce risks of sickness absence. Compassionate Practices approach engaged. Referral of colleagues to appropriate levels of support				
3. Updated Freedom to Speak Up Policy replacing the Raising Concerns Policy- recognising issues at work may contribute to sick absence				3. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23 Freedom to speak Up Safely process introduced from the start of October 2023 including three Trust guardians.				
4. Health and Wellbeing Strategy – key document that outlines commitment to wellbeing and supportive culture				4. Regular reference to strategy to ensure themes are addressed and linked to wider people and culture plan 28/11/2023 Health and Wellbeing Strategy coming to an end in 2024 to be replaced with a new plan with a focus on employee experience in line with the All-Wales Framework and the People and Culture Plan 2023-2026				
5. Operational Workforce Recruitment Plans - provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure								
6. Roster Review & Implementation- to support demand and capacity which can have an impact on absence levels				6. Roster Review for EMS completed. Review in 111 underway				
7. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required				7. Process regularly reviewed and managers provided with relevant training and coaching on process and importance of carrying out return to work interviews promptly				
8. Training on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained				8. Regular bitesize training provided for managers, adapted to reflect feedback and to ensure all aspects of managing attendance is understood				
9. Directors receive monthly email with setting out ESR sickness data - ensures ownership and awareness.				9. Monthly reporting provided with opportunity for discussion with relevant people services lead and Director				
10. Operational managers receive daily sickness absence data via GRS- ensures ownership and awareness				10. Provided daily, with opportunity for discussion with relevant people services lead and operational managers				
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support				11. Monthly reporting on services provided, volume of referrals and timeframes for accessing support.				
12. WAST Keep Talking (mental health portal) additional measures to offer support				12. Quarterly reporting on numbers accessing and regular promotion of service. Reported in MIQPR				
13. Suicide first aiders- additional layer of support				13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have access. Mental Health Team deliver this				
14. TRiM- additional layer of support				14. Quarterly reporting on access to TRiM and promotion of service Included in MIQPR				
15. Peer Support network- additional level of support				15. Promotion of network and support provided				
16. Coaching and mentoring framework- additional level of support				16. Promotion of network and support provided 28/11/2023 on pause to focus on Leadership Framework with a focus on culture and its impact on the experience of work and workplace wellbeing				
17. Staff surveys- assess levels of engagement and wellbeing				17. New HIVE survey tool will provide data on overall engagement and wellbeing 28/11/2023 the NHS Wales Staff Survey has also just closed and will provide information in the new year to inform us further.				
18. Stress risk assessments- identify measures that can be taken to address issues				18. Reference to the assessments during attendance management line manager training and to the TUS 28/11/2023 OH to lead on a refresh of stress risk assessments use				

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:		26/09/2024	TREND	20 (5x4)
			Date of Next Review:		26/10/2024	➡	
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	
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC		19. Sickness forms part of Workforce Scorecard to People & Culture Committee and is also supported by PCC deep dives into sickness. Reporting is also shared with CASC and the JCC. Discussions on sickness are reported in minutes and AAA to Board					
20. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure		20.					
21. Monthly reviews of colleagues on Alternative duties		21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings					
22. Manager guidance on managing Alternative duties		22. Evidence of managers guidance in place and referenced in attendance management training					
23. Monthly report on absence to ELT and report to every meeting of People & Culture Committee via the Workforce Report and provision of deep dives when requested.		23.					
24. Sickness audits for localities- provides additional level of detail		24. Audits carried out and actions taken forward					
25. Additional support for areas with higher-than-average absence – emphasis is on understanding reasons and developing action plans		25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues					
26. Review of top 100 cases -carried out monthly		26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.					
27. Deep dives on specific issues and reasons for absence		27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management e.g. – mental health and causes 28/11/23 Recognition of the impact of employee experience and workplace conditions and link to absence. Reported to ELT for information					
28. Implementation of the Managing Attendance Project 2022-23 completed and ongoing activities maintained		28. BAU evaluating for delivery					
29. Implementation of Behaviours Refresh Plan completed		29. BAU evaluated for delivery					
30. 2023 10-point action plans shared with EMT for assurance and RAG rated to track progress quarter		30. Offers assurance to ELMT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports					
31. Work in Confidence system implemented and Freedom to Speak Up Month in October 2023 focused attention on this		31. External Management (2nd Line of Assurance)					
32. Actions from Audit of Nov 22 completed		32. Audit actions completed					
33. Strengthen Freedom to Speak Up Arrangements policy and advice and roll out of platform for raising concerns (in relation to Freedom to Speak Up Arrangements) (Having additional mechanisms in place for individuals to speak up potentially reducing work related stress and anxiety which is a key reason for absence)		33. Monitor FTSU concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.					
34. Health and Wellbeing Steering Group in place		34. Monitored through numbers of FTSU concerns raised and continual promotion via Comms and Roadshow Events.					
35. Actions identified from the Managing Attendance Audit implemented		35. Agendas, minutes etc.					
36. PADR review undertaken and now including wellness questions		36. Underway and now BAU – we need to say what this means by way of assurance					
37. Scrutinising on a monthly basis all long-term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.		37. PADRs undertaken and questions asked; Discussion on levels of long-term sick absence is undertaken in a variety of forums including EASC, ELT and PCC.					
38. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.		38. Meetings taking place and active discussions on operational areas experiencing high levels of absence					
39. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.		39. Meetings taking place and active discussions on operational areas experiencing high levels of absence					
40. Specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified		40. It is on each agenda and outcomes are available for discussion at H&SC.					
41. Review of top 100 cases by the wider People & Culture Team - monthly (Wellbeing, OCC Health, People Services). This takes place to consider whether any of those cases required additional interventions.		41. Director of People & Culture receives assurance from the team following each of the monthly meetings.					
		Independent Assurance (3 rd Line of Assurance)					

20

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:		26/09/2024	TREND	20
				Date of Next Review:		26/10/2024	➡	(5x4)
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
			1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)					
			2. Audit Wales – Taking Care of the Carers report in October 2021					
GAPS IN CONTROLS			GAPS IN ASSURANCE					
(a) Consistency and Application in Managing Attendance at Work Policy			There are other factors that impact on sickness which can't be controlled					
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received			9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers					
1 – 22 Education and communication with managers about resources available and how to implement it e.g., stress risk assessments			1.					
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:			
1. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.			Head of Culture	31/01/25	Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases. Piloting bite size chunks in Autumn with results in January 2025.			
2. Case studies developed on examples of areas of business where attendance management has improved significantly to share learning across WAST			Deputy Director of People & Culture	31/10/24	Case studies will be published, shared and discussed at leadership meetings and evidence of good practice adopted			
3. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST			Deputy Director, People and Culture	31/01/25	Discuss at P&C Business Meeting and share at ELT/PCC with recommendations.			
4. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change.			Director of People & Culture	Ongoing	Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.			
5. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.			AD for Culture, Inclusion & Wellbeing	Ongoing	Evaluation of pilot after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted.			
6. Development of the 2024/25 Managing Attendance Plan (see below for individual actions.			Deputy Director, People and Culture	To commence 30/05/24	Key plan actions noted below			
7. Delivery of actions to support managers handling attendance issues with skills, capability and confidence			Deputy Director, People and Culture	31.03.2025				
8. Coaching for managers on cases on one and locality basis.			Deputy Director, People and Culture	31.03.2025				
9. Increase manager support on data interpretation and analysis			Deputy Director, People and Culture	31.03.2025				
10. Increase manager understanding of options for colleagues who are not able to sustain their attendance e.g. flexible hours, reduced hours etc			Deputy Director, People and Culture	31.03.2025				
11. Culture work on creating the sense of team and peer responsibility / ownership			AD for f Culture Inclusion and Wellbeing	31.03.2025				
12. Analyse link between hot spots and the culture in these areas to address cultural issues			AD for Culture, Inclusion & Wellbeing	31.03.2025				
13. Improve preventative measures and pro-active work			Deputy Director of People and Culture	31.03.2025				
14. Identify opportunities to improve roles – flexibility, control, confidence			Deputy Director of People and Culture / ADs, Operations	31.03.2025				
15. Opportunities to adapt the work environment – overruns, shift patterns, rest and recuperation			Deputy Director of People and Culture / ADs, Operations	31.03.2025				

21

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:		26/09/2024	TREND	20 (5x4)
				Date of Next Review:		26/10/2024	➡	
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		
16. Review workloads		Deputy Director of People and Culture / ADs, Operations	31.03.2025					
17. Review patterns of absence		Deputy Director of People and Culture	31.03.2025					
18. Development of a mental health referral pathway		AD for Culture, Inclusion and Wellbeing	31.03.2025					
19. Develop the team around the person model / individual support network		Deputy Director of People and Culture	31.03.2025					
20. Increase lifestyle advice and guidance		AD for Culture, Inclusion and Wellbeing	31.03.2025					
21. Undertake proactive testing to identify undiagnosed conditions		AD for Culture, Inclusion and Wellbeing	31.03.2025					
22. Review reporting on OH		AD for Culture, Inclusion and Wellbeing	31.03.2025					
23. Review opportunities on men’s mental health e.g. support groups		AD for Culture, Inclusion and Wellbeing	31.03.2025					

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation			Date of Review:	26/09/2024		TREND	20 (4x5)
				Date of Next Review:	26/10/2024		➡	
IF there is an inability of the Trust to deliver its core services because of system or organisational pressures	THEN there will be a loss of stakeholder confidence in the Trust	RESULTING IN a lack of stakeholder support for the Trust’s long term strategic vision, a failure to deliver its strategic ambition, 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: 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 16, 25, 27								
EXECUTIVE OWNER		Director of Partnerships and Engagement		ASSURANCE COMMITTEE		People and Culture Committee		
Risk Commentary Q3 2024/25								
The risk score remains constant at 20 (highly likely and catastrophic). The organisation's reputational risk is one which is long-standing and entrenched. At the time of writing, conversations with key, mission critical stakeholders remain live in respect of the Trust's proposed clinical service model/transformation programme. The outcome of these discussions will inform the next steps in relation to proposed transformation and, as such, are critical in terms of the Trust's reputation. Similarly, with winter approaching, and the attendant pressures and risks that come with it, the risk to Trust reputation remains significant.								
CONTROLS			ASSURANCES					
			Internal Management (1 st Line of Assurance)					
1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition			1. Feedback reported via ELT, TSAG etc/					
2. Revision of engagement framework delivery plan (approved by Board Jan 2023) to reflect feedback from stakeholders and revised timelines for strategy engagement			2. Will report via strategy programme architecture plus discussion at Board development/PCC etc. Included in 2024/25 IMTP					
3. Challenging of media reports to ensure accuracy			3. Programme of daily media engagement documented on digital system					
4. Media liaison to ensure relationships developed with key media stakeholders			4. Programme of daily media engagement documented on digital system					
5. Routine stakeholder and staff engagement, including the recent round of Executive roadshows and WAST Live.			5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update)					
6. Engagement governance and reporting structures are in place			6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs.					
7. Annual deep dives on reputation in place			7. Reported to Committees, documented in minutes, action logs and papers					
8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT			8. Minuted meetings, action logs and Board papers					
9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders			9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording)					
10. Monitoring external factors that may affect the Trust			10. ELT verbally updated on a regular basis with written notes if appropriate					
11. Board oversight, scrutiny and challenge of performance, concerns, quality			11. What is the assurance that this control is effective					
12. Internal Quality and Performance monitoring in the Trust and raising system issues			12. What is the assurance that this control is effective - reports at ELT, Finance and Performance Committee, Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee					
GAPS IN CONTROLS			GAPS IN ASSURANCE					
1. The delivery plan is currently under review and is subject to further agreement			1.					
2. Managing the narrative of the media			2.					
3. Strategic collaboration – further work needed to formalise opportunities			3.					
Actions to reduce risk score or address gaps in controls and assurances			Action Owner		By When/Milestone		Progress Notes:	
1. Reputation audit year two planned			Director of Partnerships & Engagement		Complete		Audit launched on 09 April 2024 and ran until 01 May 2024. High-level results presented at People and Culture Committee on 09 May and at Board Development on 27 June to assist the Trust to understand the impact of the reputation audit and to support our approach to stakeholder engagement.	
2. Agree Stakeholder Influencing Plan			Director of Partnerships & Engagement		Q2 24/25		Currently in development and will be considered by the CMT Programme Board in September 2024. This will be a live document and evolve with the programme.	
3. Roll out of Stakeholder Influencing Plan			Director of Partnerships & Engagement		Q2-3 24/25 onwards		Roll out underway.	
4. Reputation Audit deep dive on findings to be presented at Board Development			Director of Partnerships & Engagement		Complete		Findings were also presented at the 09 May People and Culture Committee meeting and will inform the approach to stakeholder engagement plan.	

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences			Date of Review:	02/10/2024		TREND	15 (3x5)
				Date of Next Review:	02/11/2024		➡	
IF significant internal and external system pressures continue		THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST	RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		Likelihood	Consequence	Score	
				Inherent	4	5	20	
				Current	3	5	15	
				Target	2	5	10	
IMTP Deliverable Numbers: 13, 14, 21, 26								
EXECUTIVE OWNER		Director of People & Culture		ASSURANCE COMMITTEE		People & Culture Committee		
Risk Commentary								
This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. However, the ongoing system pressures including long handover delays, overruns, missed breaks and the perpetuating impact of increased sickness levels continues to mean this risk remains static. WAST continues to work in partnership with the system to pilot viable options for addressing the external factors. Although there has been some success in some areas, we are yet to see these being scaled to an extent that the employee experience has been impacted. Since 2020 we have not seen the previous pattern of easing over the summer months and with the current public health risk of measles and continuing risks of covid this risk remains static. The People and Culture Plan 2023-2026 is a good summary of the controls and actions addressing this risk. The old Health and Wellbeing Strategy and its replacement build on this. Nationally the Health and Wellbeing Framework due for publication in Summer 2024 also addresses the system wide employee experience challenges. The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.								
CONTROLS			ASSURANCES					
			Internal Management (1 st Line of Assurance)					
1. Health and wellbeing strategy 2020-2024 in place and shared across the Trust. The new Health and Wellbeing Plan 2025-2028 has now been drafted and is out for consultation. The aim of the new plan is to expand on consideration of employee experience to recognise that individual wellbeing interventions are not sufficient in mitigating system wide pressures.			1. New Health and Wellbeing Plan 2025-2028 aligned closely to People and Culture Plan and delivery monitored via the Health and Wellbeing Steering Group, reporting into the People and Culture Business Meetings. New All Wales Framework also in development with an emphasis on workplace experience due for publication in June 2024.					
2. Occupational Health & Wellbeing team with range of support options for individual mental health interventions, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians.			2. Current waiting times now within SLA of 6 days, self-referrals and self-appointment booking. External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR.					
3. Wellbeing support and training for line managers a peer support network and TRiM intervention for trauma information.			3. Rolling programme of workshops, attendance at team events when requested, evaluation and numbers trained reported at OHW operational meetings. Diarised meetings, webinars and workshops in place through a rolling programme. Have these happened and what was the benefit? How do we measure it.					
4.			4. Tools are available on WAST intranet.					
5. TRiM			5. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place.					
6. Acting on results of staff surveys relating to staff experience, data triangulated with pulse surveys and other cultural metrics as detailed in the People and Culture Plan.			6. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/204 with directorate specific data released in April 2024.					
7. HSE stress risk assessments			7. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams.					
8. KPIs are reported fortnightly to regarding Occupational Health and Wellbeing activity			8. Received at OHW operational team meeting and reported in MIQPR.					
9. Wellbeing drop-in sessions for CCC and 111 staff			9. These sessions are now part of business as usual across services and a user experience form is being designed to collate more formal quantitative feedback for OHW operational team meetings. Data to date has been qualitative and the quantitative has been measured by engagement with the service.					
10. Fast track physiotherapy to address MSK issues.			10. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR					
11. Occupational Health team inclusion in sickness and absence meetings			11. Have the meetings been of benefit and how do we measure it					
12. Stress risk assessments			12. These are part of the IOSH Managing Safely Training.					
			External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete					
GAPS IN CONTROLS			GAPS IN ASSURANCE					
			4. Reporting on wellbeing training take up this is now being reported into OHW Operational Team Meetings.					
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with			Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages.					

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences			Date of Review:		02/10/2024		TREND	15 (3x5)
				Date of Next Review:		02/11/2024		➡	
IF significant internal and external system pressures continue		THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST		RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm			Likelihood	Consequence	Score
						Inherent	4	5	20
						Current	3	5	15
						Target	2	5	10
Health and Safety. With the arrival of the new OH Manager these discussions have restarted, and colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2.									
				Effects of elevated reop status affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing. Attendance at all events by operational staff consistently low due to service pressures.					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner		By When/Milestone	Progress Notes:				
1. People and Culture Plan 2023-2026 relevant Actions		Assistant Director for Inclusion, culture and wellbeing		Annual Plan	First year due to be reviewed at next People and Culture Committee May 2024 23/7/24 Final year review included in consultation process for new plan				
2. Health and Wellbeing Plan 2025-2029		Assistant Director for Inclusion, culture and wellbeing		To be agreed at board autumn 2024.	New plan out for consultation until June 2024 16/4/2024 Ongoing 23/7/24 Extended consultation period until end of August 2024 2/10/24 Consultation drawing to a close and final plan due to ELT on 23/10/24				

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:		26/09/2024		TREND	12 (4x3)
				Date of Next Review:		26/12/2024			
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: 1, 13, 14, 19, 22, 30, 32									
EXECUTIVE OWNER		Director of People & Culture		ASSURANCE COMMITTEE		People & Culture Committee			
Risk Commentary									
A tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Also, specific workforce issues related to potential respect and resolution processes have been addressed.									
Work is well underway to seek to improve partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of P&C and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally good. At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is operating well and as a result the score has been reduced to 12 (3x4) during the quarter. However, there is a recognition that the nature of partnership working and the issues that arise mean that the level of risk fluctuates more regularly than others and will be kept under review. The Executive Owner will change from November 2024 to Director of People – same for Risk 160.									
CONTROLS				ASSURANCES					
				Internal Management (1 st Line of Assurance)					
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership				1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.					
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement				2. Both parties refer to the documents and are signed up/committed to it					
3. IPA Workshops				3. Meetings completed with participation from TUs and senior managers. Attendance lists are available					
4. Trade Union representation at Trust Board, Committees				4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned because of TU partner buy in					
5. Monthly Informal Lead TU representatives and Chief Executive meetings				5. Diarised meetings					
6. Staff representative management in Task & Finish Groups				6. Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference					
7. WASPT re-established post stand down of cell structure post pandemic.				7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.					
8. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team in place and operating				8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings					
9. Quarterly Report on TU activity to People and Culture Committee				9. 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					
10. Structures below WASPT in place from June 2023				10. Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.					
11. Project plan in place to support the improvement in relationships based on the ACAS report from 2022.				11.Development of mentoring and training opportunities for TUPs to support their roles.					
12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).				12.Training for local managers and TUPs in development and diarised delivery for February / March 2024.					
13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT				13. Change in senior TU personnel on a temporary basis meaning new senior TU representative needs to be brought up to speed with work on improving partnership working.					
14. 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.				14. Action plan developed and shared with TUs. Implementation underway. A series of partnership working sessions (5) have been delivered to around 120 colleagues – managers and TU partners. Feedback from the sessions was captured and next steps were reviewed. There is an ACAS action plan which is a live doc and is reported to WASPT to update progress.					
15. Rhythm of meetings to curate and focus on relationships				16. AAA, minutes, monthly sessions with CEO, DoPC and DoO. Informal sessions with CEO, DoPC and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoPC on other partnership forum arrangements.					
GAPS IN CONTROLS				GAPS IN ASSURANCE					

26

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:		26/09/2024		TREND	12 (4x3)
				Date of Next Review:		26/12/2024			
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		
1. Need to move back to business-as-usual footing			None identified						
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring									
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:				
1. Refresh of engagement programme post Industrial Action and establish work			Deputy Director of People & Culture	30/08/23 Underway and work ongoing. Plan delivery to be completed in 2024. However, this will be subject to the national picture.	Plan agreed and being monitored via WASPT. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated.				
2. Continue the rollout of partnership training across WAST			Deputy Director of People & Culture	Ongoing					
3. Develop the next round of initiatives based on the output from recent sessions			Deputy Director of People & Culture	31/03/25	Observation of partnership forums and further development work is ongoing regarding initiatives to support embedding partnership training across the organisation				
4. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring			Deputy Director of People & Culture	31/03/25					
5. Develop consultation guidance for managers			Deputy Director of People & Culture	31/03/25					
6. Consider how we celebrate success and capture the positive learning			Deputy Director of People & Culture	31/01/25					

Key - List of Strategic and IMTP objectives

Strategic Objective 1: Providing the right care or advice, in the right place, every time		BAF risks
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163, 424
2.	Rapid (111) call answering, initial triage and onward referral	223, 424
3.	Timely, high quality clinical assessment, advice and referral	223, 224, 424
4.	Seamless transfer of 111 callers to wide range of available pathways	223, 424
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223, 424
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223, 424
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100, 424
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224, 424
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139, 424
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223, 424
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201, 424
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139, 424
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: - Enhance and strengthen internal capacity for delivering culture change - Develop amplify employee voice to increase employee engagement - Continue the implementation of our compassionate practices approach	160, 558, 623, 201, 163, 424
14.	Capacity: - Implement our Strategic Workforce Plan - Continue to embed a culture of positive attendance management - Continue our focus on 'getting the basics right.'	100, 160, 163, 223, 224, 424, 558, 594, 623
15.	Capability: - Grow and develop our leadership and management capability - Reinforce and promote career pathways and professional development. - Create an environment centred around effective, ongoing conversations ('Check Ins')	100, 139, 160, 223, 224, 260, 594, 424
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201, 424
Strategic Objective 3: Being at the forefront of innovation and technology		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542, 424
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623, 424
19.	Develop & agree Digital Plan - Everyday essentials - Security, Safety & Cyber - Digital Pioneers - Transformation - Data, Information & Insight	163, 260, 623, 424
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223, 424
21.	Meet the requirements of the Wellbeing of Future Generations Act	558, 424
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224, 424
Strategic Objective 5: Being quality driven and clinically led		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224, 424
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594, 424
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224, 424
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558, 424
27.	Meaningful engagement and co-production with communities	223, 224, 424
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
Strategic Objective 6: Delivering exceptional value		
30.	Sustainable savings & efficiencies	139, 163, 224, 424
31.	Generate income alongside our core commissioned functions	139, 224, 424,
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163, 424
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542, 424

AGENDA ITEM No	18.1
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

Managing Attendance at Work Update

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Carl Kneeshaw, Director of People
AUTHOR	Liz Rogers, Deputy Director of People
CONTACT	Liz.Rogers@wales.nhs.uk

EXECUTIVE SUMMARY

The focus on reducing sickness absence across the organisation remains with significant attention being paid to supporting managers to reduce absence within their teams.

The patterns of absence through 2024 mirror previous years patterns but at a lower rate for the majority of services.

The attached slide deck provides a comparison of absence trends over the last three months of 2024 as well as a deep dive into increased absences in Integrated Care and EMSC.

The report includes a case study from Swansea and Neath localities which demonstrates a positive impact on mental health absence.

In addition, the report contains comparison data between WAST performance benchmarked against the most recent public data of other UK Ambulance services.

The purpose of the report is to:

- Provide Committee with an update on sickness data and ongoing progress to continue to reduce absence levels.
- Undertake an analysis on Integrated Care and EMSC absence levels and actions to reduce absence in these areas.
- Share a case study and the impact on mental health sickness absence.
- Provide a review of WAST's position compared to others in the sector.

KEY ISSUES/IMPLICATIONS

Committee are asked to note the continued work on sickness absence with support to operational managers by the People Services team.

The Committee is asked to:

- **NOTE** the report

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
ELT	12 th February 2025	For noting
P&C Committee	18 th February 2025	For noting

REPORT APPENDICES

Appendix 1 PowerPoint deck

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 were regularly reported to Committee and Board. Data has continued to be provided to ELT, Committee, Board and CASC on a regular basis since.

BACKGROUND

2. At the beginning of 2022/23 in response 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.
4. In subsequent years further activities have been undertaken such as the delivery of a ten point plan through 2023/24, following up on the project plan delivery.

ASSESSMENT

5. The deck identifies the trends across directorates over the last three months of 2024. Absence trends for the year mirror 2023 at a lower level, with the exception of February 2024 which was 0.5% higher compared to the same period in 2023. The lowest percentage absence for both years was in June, running at 7.55% in 2023 and 7.40% in 2024.

Trust Data

6. There was an increase in absence across the Trust in December 2024, following the trend from the previous year. However, overall absence for the Trust is showing as 8.69% which is 0.90% lower in December 2024 than in December 2023.
7. Anxiety, stress and depression remains the highest reason for absence across the last 2yrs.

8. Long term absence has steadily reduced over the last year to 6.39% in December 2024 from 6.22% in December 2023.
9. Short term absence has fluctuated over the last year with a decrease in December 2024 to 2.48% from 2.69% in December 2023. The top reasons for short term absence in this quarter are gastrointestinal and cold, cough & flu. There has also been an increase in reported absence due chest & respiratory problems. This reflects the situation in the general population as a result of the 'quademic'.

Corporate Directorates

10. In terms of Corporate Directorates absence fluctuated in 2023 & 2024. The Corporate Governance, Strategy, Planning & Performance and Partnerships & Engagement Directorates show small to zero absence in the last 5 months of 2024. The Digital Directorate absence increased in October 2024 to 4.81% from 1.5% in September 2024. There was a further increase to 5.47% in November 2024 and a further increase to 7.14% for December. January notes an indicative decrease to 5.31%. The Quality, Safety & Patient Experience Directorate absence has been above the target trajectory of 6% for the last 4 months. January 2025 has an indicative figure of 10.09%.
11. In terms of Operations, absence trends for 2024 mirror that of 2023, although higher in January & February 2024 compared to the same period in 2023. There is a reduction from 10.43% in December 2023 to 9.36% in December 2024 for the whole Directorate. The lowest percentage absence for both years was in June. It is important to note that the overall trends compared to previous years is positive. As a benchmark, in January 2022 absence in EMS was 14.00%, 11.47% in Ambulance Care, 15.16% in EMS co-ordination and 14.48% in Integrated Care.

EMS

12. Absence trends for EMS follow the same lines as the Directorate. EMS absence has reduced by an average of 2% from 2023 to 2024 with the lowest figure being 6.74% in June 2024. Long term absence has consistently decreased however November and December saw an increase relative to the rest of the year and is at 5.75% for December 2024. Short term absence has fluctuated over the last year and is at 2.29% for December 2024.

Ambulance Care

13. Absence trends in Ambulance Care again follow the same pattern but at lower levels. There is a 0.99% reduction in December 2024 compared to 2023. The majority of absence in the service is due to long term sickness with efforts focused on concluding cases exceeding nine months. Mental health conditions are the main reason for absence and managers are proactively offering occupational health and wellbeing to support employees, in addition to offering a therapeutic return to work with the aim to shortening the length of absences.

National Operations and Support

14. For National Operations and Support trends for the last three months of the last two years have followed the same pattern, however, there has been an increase by an average of 2% this year compared to 2023. December 2024 saw an increase to 7.14% which is the highest level since February. Both short and long term absences have increased in ODU and HART teams.

Integrated Care

15. Integrated Care 2024 figures for the period are also trending below last year's figures but show an increase between October and December with December finishing at 12.38%.

EMSC

16. EMSC has recently been subject to a sickness audit by People Services and results show good compliance with policy and processes to manage attendance. However, absence has increased in 2024 compared to last year for this period. Whilst long term sickness has decreased, short term absence has increased with the top reasons being mental health and gastrointestinal problems.
17. There has been significant reconfiguration within EMSC changing the models and ways of working. This inevitably causes an increase in absence. Within this area there has been concentrated effort on culture improvement work. TU partner feedback indicates issues in the area. Absence has significantly increased amongst new starters and these absences have been prolonged as those absent look for other work and then resign. There has also been significant change across Integrated Care and a culture review has been commissioned.

18. A range of actions have been put in place to support these services alongside the culture review. This includes wellbeing and preventative measures, deep dives, coaching and mentoring managers, ensuring the right applicants are attracted and appointed to the role and in the north, weekly one to ones are being delivered to pre-empt issues.

Swansea / Neath Localities

19. Late 2023 saw the implementation of welfare pods to support the end of shift finish. This was quickly increased to supporting meal break cover. Since the pods have been introduced, there has been no single claim for a missed meal break (average saving of £7K pa).
20. There has been a consistent reduction in absence across these localities, excluding an increase in Oct & Nov 2024 compared with the same period in 2023. The increase related to the unexpected death of a colleague. Employees were supported appropriately and returned to work within 6-8 weeks.
21. The Head of Service has surveyed the team on the perceived benefit of the pod. There were approximately 60 responses, all stating there had been a positive impact on their mental health & stress levels since the introduction. Interestingly, there has been a reduction in anxiety, stress & depression as the top reason for absence (now second highest reason), with musculoskeletal as the top reason for absence. However, anxiety, stress & depression are the highest reason for absence in both localities for December 2024 which again may be impacted by the loss of a colleague and reflections of the Christmas period.

Benchmarking in the Sector

22. We have gathered Board Report data of other ambulance services to review our position with sector comparators as opposed to other health organisations in NHS Wales. Data from July 2024 shows that East Midlands Ambulance Service had higher absence than WAST. East of England and North West had similar levels of absence to WAST. The lowest was SWAST at 5.50%, West Midlands was lower but they calculate their data differently to others.

Additional considerations

23. The introduction of the pod in Swansea/Neath and the feedback from local crews reflects that wellbeing factors such as the ability to take breaks in an appropriate space has a significant impact on mental health and attendance. There are the 'big ticket' issues faced by WAST i.e. overruns, handover delays, the ability to take TOIL which, if possible to address, will have a significant impact on attendance. A number of projects have been run to trial ways to reduce overruns. A task and finish group will be established with TU partners on opportunities to reduce overruns and address TOIL issues further.

RECOMMENDED

24. The Committee is asked to:

- **NOTE** the Report.

Welsh Ambulance Services University NHS Trust

Managing Attendance Deep Dive Report



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Presentation Title Managing Attendance Deep Dive
Report
Version 1.0
Released: Jan 2025

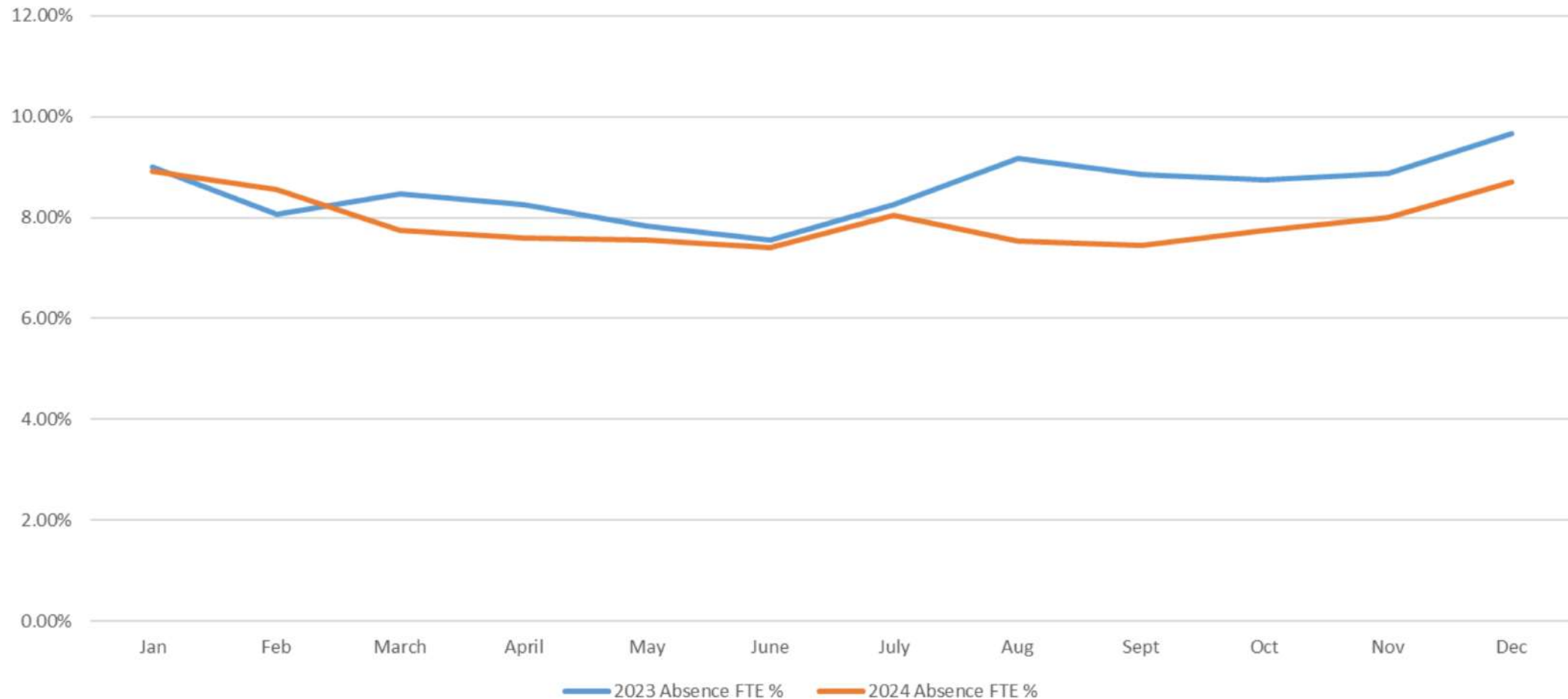
by People Services
Liz.rogers@wales.nhs.uk

Managing Attendance at Work Deep Dive

SUMMARY OF CONTENT

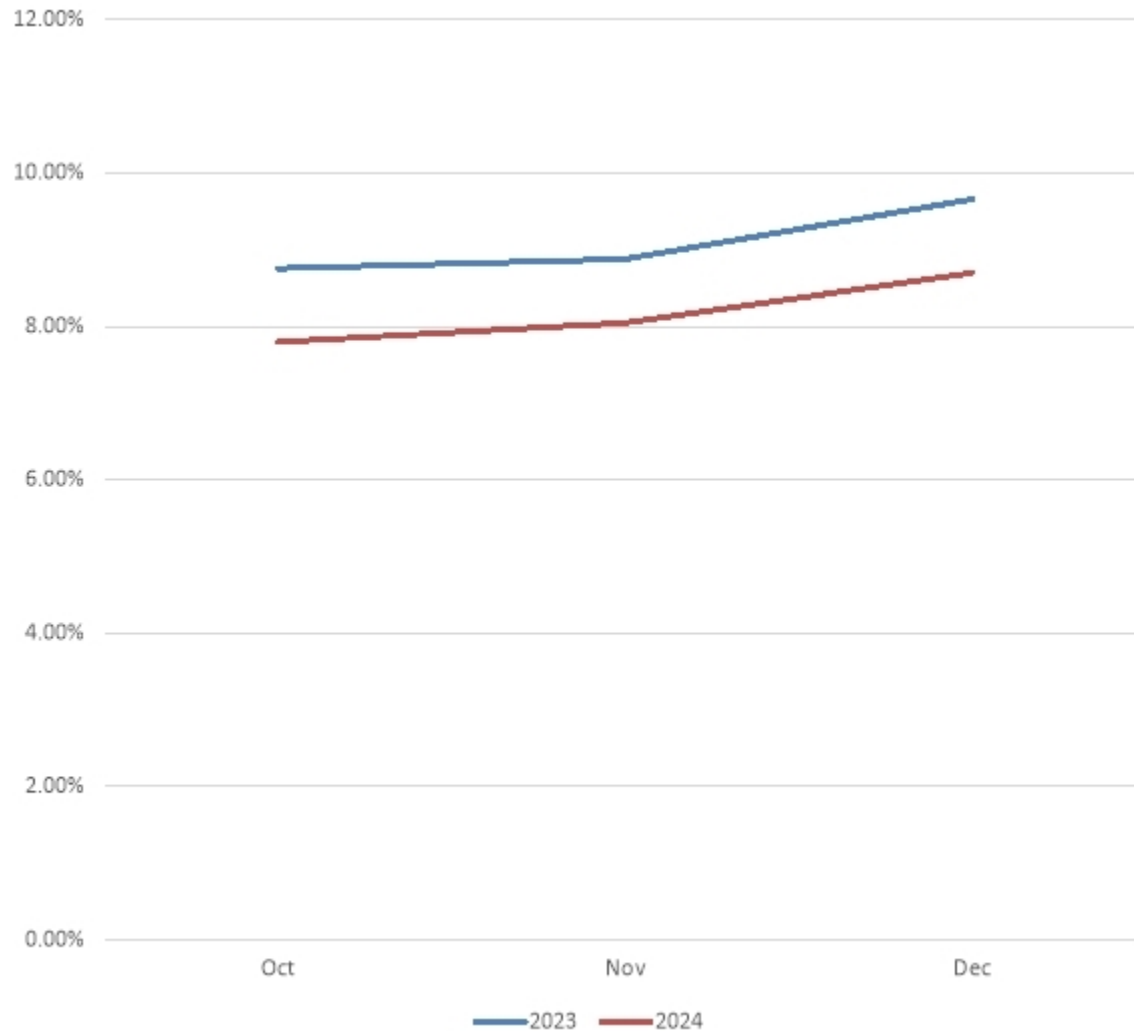
- Comparison of Trust, Corporate Directorate and Operations Directorate absence trends for 2023 and 2024
- A focused comparison of Trust absence trends for last quarter of 2023 and 2024
- A comparison of Operational Directorate areas absences from last quarter of 2023 and 2024
- Potential drivers for increase in absences in Integrated Care & EMSC and action plans to manage MAAW
- Absence benchmarking against UK Ambulance Services

Comparison of Trust absence trends for 2023 and 2024



Absence trends for 2024 mirror that of 2023, although 0.5% higher in February 2024 compared to same period in 2023. The lowest percentage absence for both years was in June, at 7.55% in 2023 and 7.40% in 2024.

A focused comparison of Trust absence trends for October, November & December 2023 and 2024



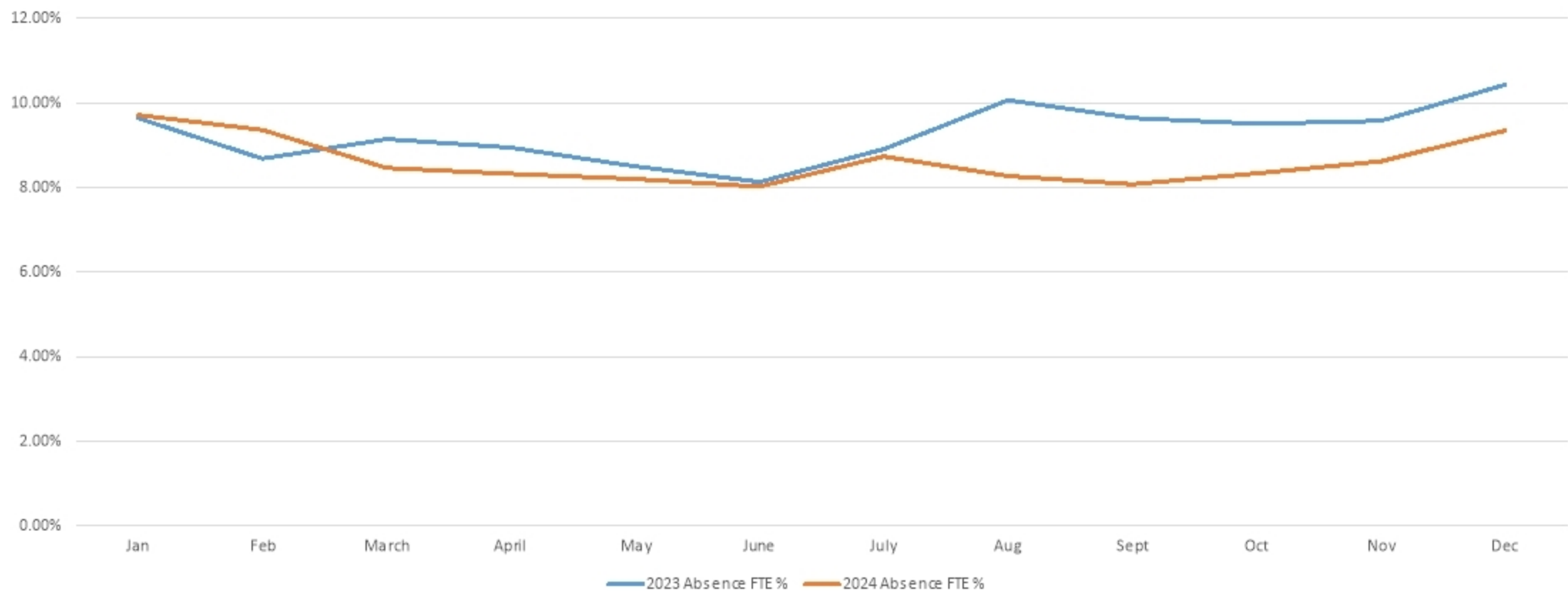
- Increase in absence across the Trust in December 2024, following the trend from the previous year.
- Overall absence is showing 0.90% lower in December 2024 than in December 2023.
- Anxiety, stress and depression remains the primary absence reason
- Long term absence has steadily reduced over the last year (6.39% in Dec 2023 and 6.22% Dec 2024)
- Short term absence has fluctuated over the last year with a decrease in December 2024 to 2.48% from 2.69% in December 2023.
- The top reasons for short term absence in October, November & December 2024 are gastrointestinal and cold, cough & flu. There has been an increase in reported absence due to chest & respiratory problems, This reflects the situation in the general population as a result of the 'quademic'.

Comparison of Corporate Directorate Absence Trends 2023 & 2024

- Absence trends across all Corporate Directorate areas fluctuated in 2023 & 2024.
- The Corporate Governance, Strategy, Planning & Performance and Partnerships & Engagement Directorates show small to zero absence in the last 5 months of 2024.
- The Digital Directorate absence increased in October 2024 to 4.81% from 1.5% in September 2024. There was an increase to 5.47% in November 2024 and a further increase to 7.14% for December 2024. January 2025 indicative absence shows a decrease to 5.31%.
- The Quality, Safety & Patient Experience Directorate absence has been above the target trajectory of 6% for the last 4 months. January 2025 indicative absence shows an increase to 10.09%.

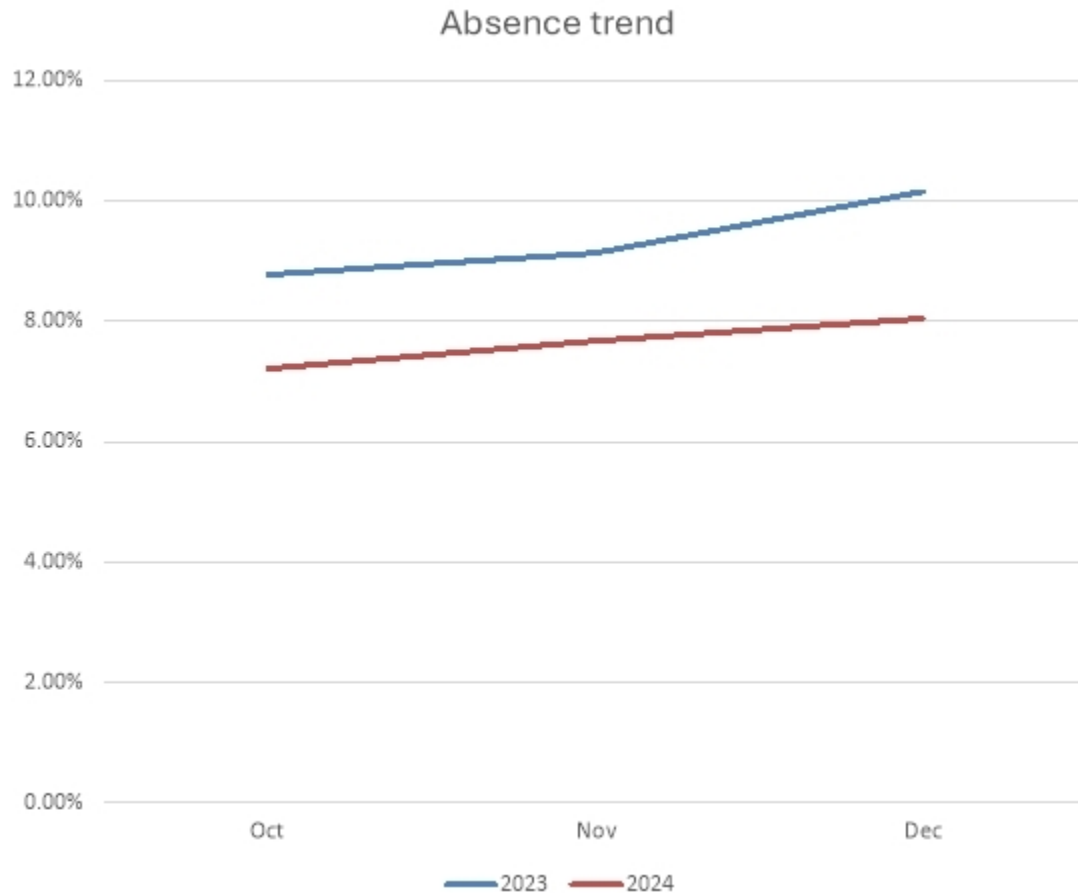
Directorate	Highest absence % in 2023	Highest absence % in 2024	ESR actual absence % Dec 2024
Finance & Corporate Resources	4.41% (March)	3.42 (January)	3.20%
Medical & Clinical	2.31% (June)	2.38% (March)	.90%
People & Culture	6.53% (May)	4.31% (January)	3.65%
Digital	4.44% (April)	5.54% (December)	7.14%

Comparison of Ops Directorate absence trends for 2023 and 2024



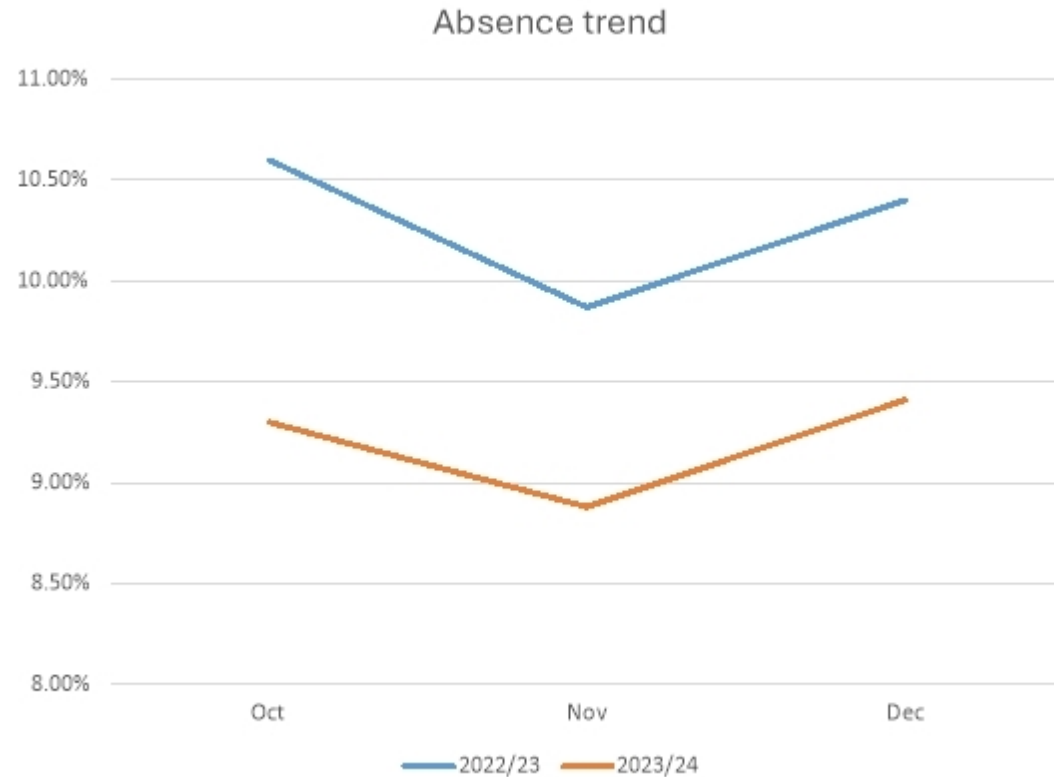
Absence trends for 2024 mirror that of 2023, although higher in January & February 2024 compared to the same period in 2023. The lowest percentage absence for both years was in June, at 8.13% in 2023 and 8.03% in 2024.

EMS focused comparison - Oct to Dec 2023 & 2024



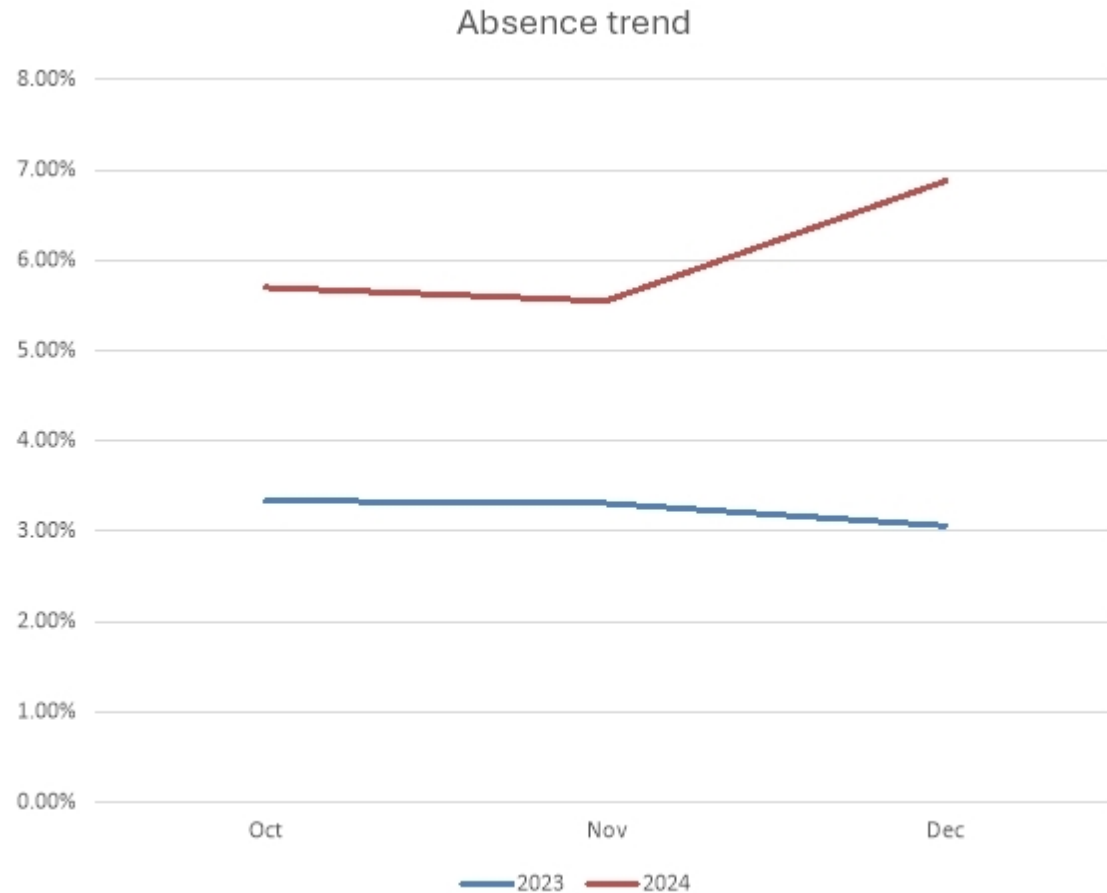
- Reduction by 2.11% in Dec 2024 absence compared with Dec 2023
- EMS absence has consistently reduced by an average of 1.64% (to date) from 2023 to 2024, and the lowest figure was 6.74% in June 2024
- Absence reduced in October 2024 to 7.21%, increased in November 2024 to 7.67% and shows a further increase to 8.04% in December 2024
- Long term absence has steadily decreased across 2024, however, there was an increase in Nov 2024 to 5.74% and a further increase in Dec 2024 to 5.75%
- Short term absence has fluctuated over the last year and is showing an increase to 2.29% for December 2024

Ambulance Care focused comparison - Oct to Dec 2023 & 2024



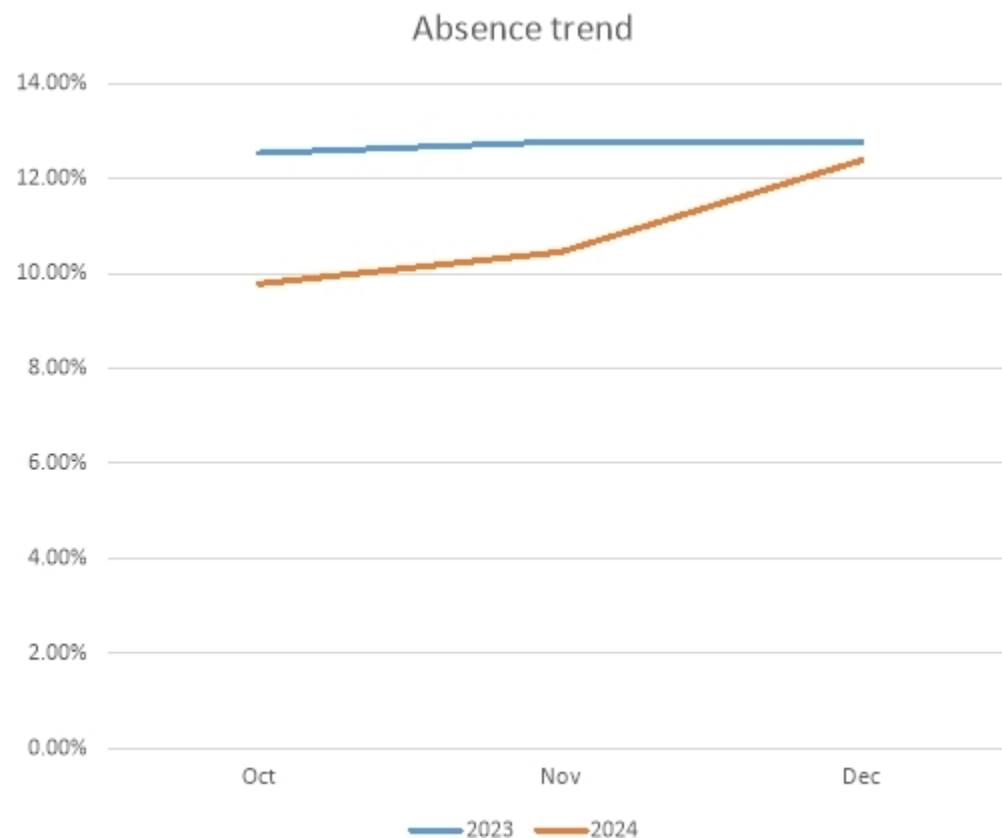
- Reduction of 0.99% in December 2024 absence compared with December 2023
- The majority of absence in Ambulance Care is long term
- There is a focus on bringing long term absence cases exceeding nine months to a conclusion
- Anxiety/stress are the main reasons for absence - managers are proactively offering OH & wellbeing support and therapeutic return to work with the aim to shorten absence

National Ops & Support focused comparison - Oct to Dec 2023 & 2024



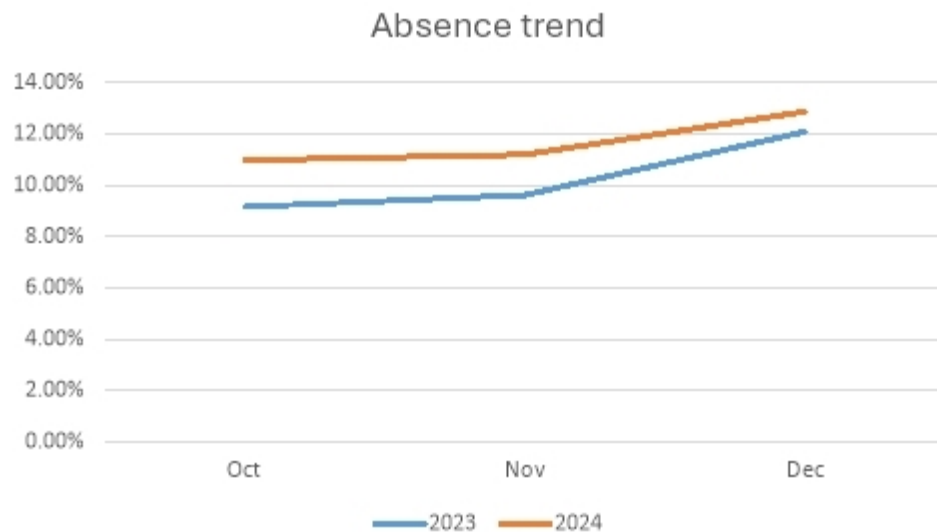
- Absence follows the same trends in October & November for past 2 years but there has been an increase in absence by an average of 2% in 2024 compared to 2023.
- Absence figures for December 2024 shows an increase in absence to 7.14%, which is the highest point since February 2024
- Both long and short term absences have increased in ODU and HART.
- All cases are being supported by People Services Advisors and managed in line with policy

Integrated Care focused comparison – Oct to Dec 2023 & 2024



- Absence trends follow similar lines in October & November in 2023 & 2024, but December 2024 shows an increase
- Absence rates are comparative in December 2023 at 12.76% and a slight decrease in December 2024 at 12.38%
- Stress, anxiety and depression remains the top reason for absence, followed by cough, cold, flu

EMSC focused comparison – Oct to Dec 2023 & 2024



- Absence trends follow same lines, however, absence has increased in 2024 compared to the same period in 2023.
- Long term absence increased in December 2024 to 9.14% from 8.49% in December 2023.
- Short term absence increased to 3.73% in December 2024, with the top reasons for absence anxiety, stress & depression and gastrointestinal problems
- Sickness audit results demonstrate good compliance with the MAAW policy

Potential drivers for Integrated Care & EMSC absence

- EMSC Reconfiguration
 - Restructure
 - Single Allocator Model
 - Desk Boundary Changes
 - Movement of sites (EMSC)
- Llangunnor and Bryn Tirion changes to sites of work
- Continued culture improvement work
- Significant increase in call numbers – critical incident declared in December
- Introduction of new roles and ways of working – Rapid Clinical Screening and preparing for Remote Integrated Care Service
- In recent months, EMSC absence has increased significantly amongst new starters (whilst undertaking training) and a high number resigned during the training or shortly after.
- Some examples of prolonged absences whereby staff actively seeking alternative employment and don't submit notice until they start with a new organisation extending their sickness absence by 6-8 weeks
- Considerable change across Integrated Care including a commissioned culture review

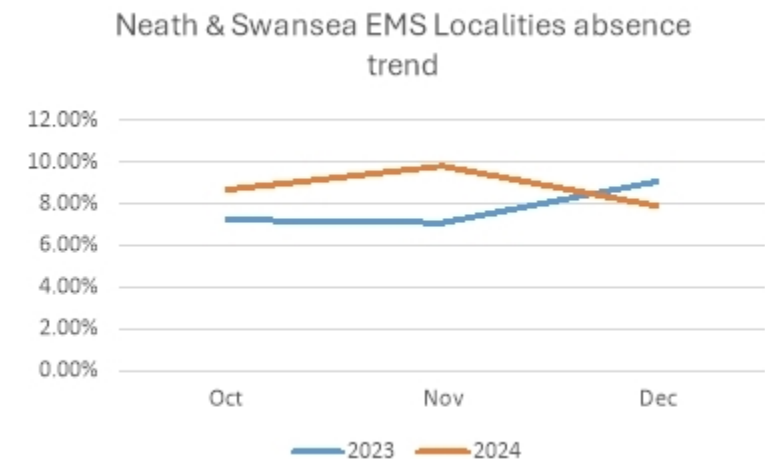
Action Plans for Integrated Care & EMSC Absence

- Action plan in place in EMSC to target a reduction in absence, focus on staff wellbeing and preventative support from managers
- New initiatives being piloted in Integrated Care to provide more timely support to OH
- Regular case conferences with managers, People Services and OH, to support timely interventions for colleagues
- Deep dives planned to review all 12-hour shift absence in EMSC & Integrated Care
- Due to the number of new managers, dedicated coaching and mentoring being provided by People Services team to support
- An in-depth review is being commissioned by the HoS in partnership with TUPs to be undertaken by the EMSC Service Managers into Recruitment, Selection & Training processes to provide more detailed information to candidates of the call taker role. (Many new recruits are in their late teens and early 20s and the expectations on the levels of stress is not understood, basing information on programmes such as the BBC Paramedic programme. They struggle with the exposure to highly contentious situations, 12-hour shifts and working weekends)
- Integrated Care (North) have introduced weekly 1:1s with all colleagues to check in to identify any concerns which potentially impact and develop into a sickness absence for early signposting and wellbeing support

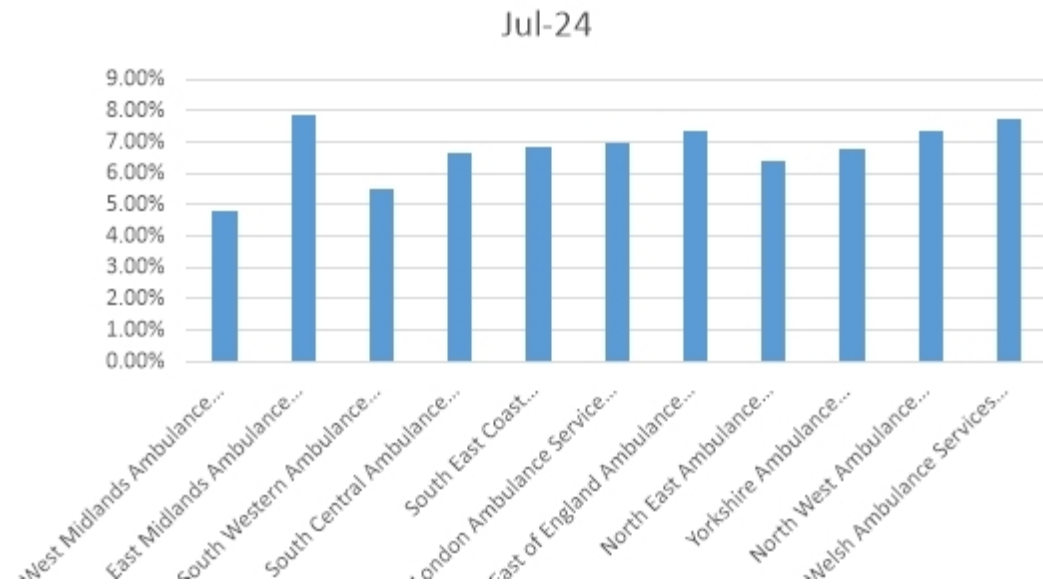
Case Study Area showing a reduction in absence

Swansea/ Neath Localities

- Consistent reduction in absence across these localities, but with an increase in absences in Oct & Nov 2024 compared with the same period in 2023. The increase related to the unexpected death of a colleague. Employees were supported appropriately and returned to work within a 6-8wk period.
- There was a decrease in absence in December 2024 to 7.90%
- Welfare pods were introduced late November 2023 initially to support end of shift finish and quickly increased to supporting meal break cover.
- Since the pods have been introduced, there has been no single claim for a missed meal break (average saving of £7K pa).
- The Head of Service completed a qualitative survey asking 2 questions relating to the perceived benefit of the pod. There were approximately 60 responses, all stating there had been a positive impact on their mental health & stress levels since the introduction.
- There has been a reduction in anxiety, stress & depression as the top reason for absence (now second highest reason), with musculoskeletal as the top reason for absence.
- However, anxiety, stress & depression are the highest reason for absence in both localities for December 2024
- There was also a rise in cold, cough & flu and chest & respiratory problems for short term absences in November & December 2024 (which mirrors the Trust overall)

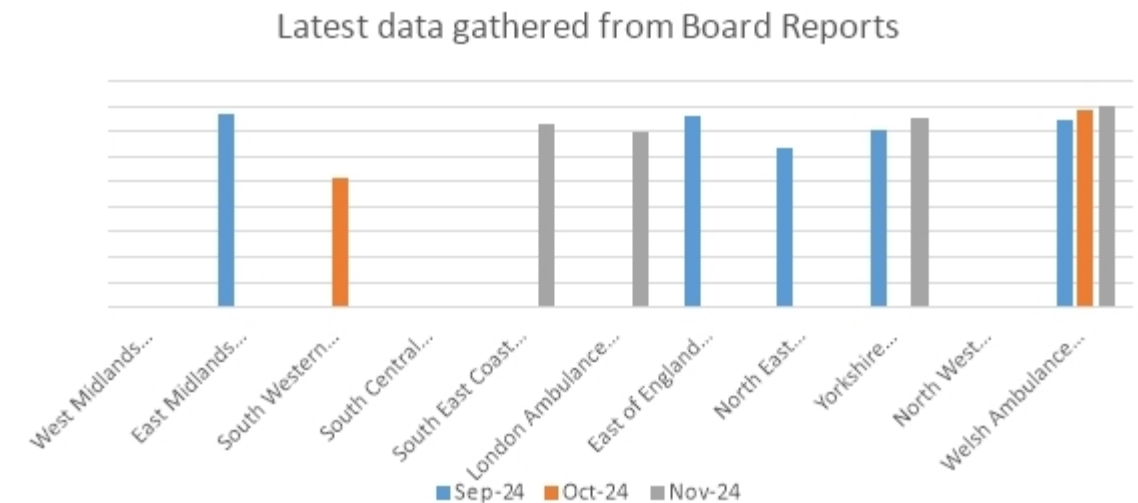


Absence benchmarking against UK Ambulance Services



- From the latest published absence figures in July 2024, absence figures in WAST are mirrored across all UK Ambulance Services.
- The lowest absence percentage is the West Midlands Ambulance Service at 4.80% (different recording to WAST), with South Western Ambulance Service at 5.50%.
- The highest absence percentage is at East Midlands Ambulance Service at 7.86%. WAST absence figure for July 2024 was at 7.38%

- Utilising Board Report data (between Sept, Oct & Nov 2024), there has been an increase in absence figures for 4 UK Ambulance Services, including WAST.
- Two services have shown a decrease in absence figures over the same three months - North East Ambulance Service showed a decrease of 0.08% from July to Sept 2024 and South Western Ambulance Service showed a decrease of 0.40% from July to Oct 2024.



Indicative absence figures January 2025

The CEO, Corporate Governance, Partnership & Engagement and Strategy, Planning & Performance Directorates show an indicative 0% absence for January 2025

Directorate	Absence %	Indicative increase/ decrease from December 2024
WAST	8.60%	Decrease
Digital	5.17%	Decrease
Finance	2.40%	Decrease
Medical & Clinical	1.12%	Increase
People & Culture	6.76%	Increase
QSPE	9.40%	Increase
Operations	9.15%	Decrease

Operations Directorate Area	Absence %	Increase/ decrease from December 2024
EMS	7.97%	Decrease
Ambulance Care	9.31%	Decrease
Integrated Care	13.60%	Increase
Resource & EMSC	12.24%	Decrease
National Support & Operations	6.89%	Decrease

Thank you for listening

For any questions and/or support, please contact the Communications Team.

WAS.Communications@wales.nhs.uk



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Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Presentation Title

AGENDA ITEM No	19
OPEN or CLOSED	OPEN
No of ANNEXES	1

AUDIT TRACKER 2.0 – DECEMBER 2024 (Q3)

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Lisa Trounce, Head of Compliance and Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the People and Culture Committee (PCC).
2. Of the fifty three internal audit actions relevant to this Committee, nine have been closed in quarter (17%). A further three (5.6%) have been identified as 'closure proposed – pending evidence' - if satisfactory is forthcoming, all three of these internal audit actions will have been completed on time / in line with the due date agreed in the audit report.
3. There are a total of twenty-two open internal audit actions for which a change in date has been proposed (marked in blue) – this equates to 41.5% of the total open actions). There is one open action on its third revised date; action 614 (Senior Paramedic Role internal audit). The quarter three update supplied provides assurance that the work required has been completed and the action is on track to be closed in quarter four (in line with its third revised date of March 2025).
4. An update has been provided on the two remaining actions from the 2022/23 Trade Union Release Time Internal Audit which have been proposed for closure in quarter. Committee is asked to consider this and confirm the position of closure.
5. Of those external audit actions relevant to this Committee, three have been closed in quarter of a total of seven. All four of the external audit actions which remain open have revised dates (marked in blue). These all relate to the 'Review of Workforce Planning Arrangements' audit completed by Audit Wales in 2023/24.

6. Of these four open external audit actions: one is reported to be partially complete, two are due for closure during 2024/25 quarter four, and the last remaining action has a revised due date of September 2025 (quarter three).

RECOMMENDATION

7. The Committee is requested to:

- (a) Receive and review any new Internal Audits and Audit Wales reviews within their remit where relevant. There are twenty in total:
 - i) Nine actions relating to the 2024/25 Resourcing Policy Internal Audit, and
 - ii) Eleven actions related to the 2024/25 Exposure to Fumes Internal Audit.
- (b) Monitor management actions to address recommendations in the Audit Tracker, noting any revised dates for actions (which are marked in blue).
- (c) Receive and consider the update provided in respect of the two audit actions relating to Trade Union Release Time (Audit Actions 612 and 613) and to confirm the position of closure.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

2024/25 Q3 Audit Tracker presented to ADLT on the 20 January 2025.

REPORT APPENDICIES

Annex 1 – Tracker 2.0 24-25 Q3 (October-December 2024) Reporting - PCC

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

SITUATION

8. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the People and Culture Committee (PCC).

BACKGROUND

9. In September 2023, the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.
10. The Handbook includes roles and responsibilities for the various stakeholders including:
 - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.
 - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.
 - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.
11. The Tracker has been updated in Quarter three 2024/25. A copy of the Tracker is reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight. There three populated tabs; one for the internal audit actions 2023-24, another for internal audit actions 2024-25, and one for the Audit Wales and Health Inspectorate Wales actions.
12. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in the Digital Directorate. It is intended that this solution will be ready to implement / use during 2025/26 quarter one, with further work being undertaken during 2024/25 quarter four to enable transition from Tracker 2.0 to Tracker 3.0.

ASSESSMENT

13. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:

- Receive audits in their remit;
- Monitor management actions to address recommendations; and
- Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

Internal Audit

14. There are currently a total of fifty three internal audit actions relevant to this Committee listed on the quarter three Audit Tracker:

- Two relate to the 2022/23 **Trade Union Release Time** Internal Audit: both closed in quarter, neither met the original due date in the report (please refer to points 17-21 overleaf and associated recommendation under point 29(c);
- Four relate to the 2022/23 **Senior Paramedic Role** Internal Audit: three of which have been closed in quarter, with the one remaining action due for closure in quarter four;
- Three relate to the 2023/24 **Retention of Staff** Internal Audit: two of which have been closed in quarter;
- Twenty relate to the **Volunteers Governance** Internal Audit: all remain open, nine due dates have not been met, and eleven are not yet due;
- Four relate to the 2023/24 **Disciplinary Case Management** Internal Audit: two have been closed in quarter, with initial due dates not met; and the other two are on their second revised date, both due for closure in 2024/25 quarter four;
- Nine relate to the 2024/25 **Resourcing Policy** Internal Audit: four are on first revised due dates, and five are not yet due;
- Eleven relate to the 2024/25 **Exposure to Fumes** Internal Audit: three are identified for closure pending receipt of evidence, with original due dates met; eight are not yet due; and all eleven are due for closure during 2024/25 quarter four.

15. Of these fifty three internal audit actions relevant to this Committee, a total of nine have been closed in quarter (17%). A further three (5.6%) have been identified as 'closure proposed – pending evidence' - if satisfactory evidence is forthcoming, all three of these internal audit actions will have been completed on time / in line with the due date agreed in the audit report.
16. There are a total of twenty two open internal audit actions for which a change in date has been proposed (marked in blue) – this equates to 41.5% of the total number of open actions.
17. There is one open action on its third revised date; action 614 (Senior Paramedic Role internal audit). The quarter three update supplied provides assurance that the work required has been completed and the action is on track to be closed in quarter four (in line with its third revised date of March 2025).

2022/23 Trade Union Release Time Internal Audit – Actions: 612 and 613 (both proposed for closure in quarter)

18. During the audit, the relationship with Trade Union (TU) partners was noted to be challenging. The Director and Deputy Director of People and Culture engaged with the audit team to discuss the recommendations, emphasising the need to balance risk with maintaining positive relationships with TU partners. It was acknowledged that previous negotiations on the Facilities Agreement had taken 18 months and were met with significant resistance, culminating in a signed agreement in February 2022.
19. The audit focused on two key recommendations related to requesting and recording TU time. These practices are already in place: TU time off is currently signed off by line managers on timesheets and recorded in GRS or Shift Track, which are then used for payroll. The only exception is one colleague in a corporate role, where checks with their manager have confirmed no issues.
20. The spreadsheet included in the Facilities Agreement is not a practical solution due to its limitations (e.g. it cannot be used on iPads and is time-consuming to complete). Recording through timesheets is more efficient and already fulfils the requirements. During the audit, Internal Audit colleagues requested evidence from TUPs on meeting attendance, the provided information was in varying formats demonstrating inconsistency.
21. In assessing risk, the key consideration is whether TU partners are accurately recording time. If discrepancies arise, they will be managed through our standard

processes. This approach balances the need for trust in our TU partners with the risk of introducing overly stringent requirements, which could undermine trust and create further challenges.

22. Our commitment to social partnership encourages trust in the ability of both employees and representatives to meet their obligations responsibly. Our practices align with good practice as recognised by Welsh Government and relevant legislation, and differ from those in other health organisations.

External Audit

23. Of those external audit actions relevant to this Committee, three have been closed in quarter of a total of seven.
24. All four of the external audit actions which remain open have revised dates (marked in blue). These all relate to the 'Review of Workforce Planning Arrangements' audit completed by Audit Wales in 2023/24.
25. Of these four open external audit actions: one is reported to be partially complete, two are due for closure during 2024/25 quarter four, and the last remaining action has a revised due date of September 2025 (quarter three).

Management and Development of the Tracker

26. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Quarter two with a view to closing down or revising as many as possible.
27. With respect to the Committee's responsibility to scrutinise the impact of actions, in 2023 the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.
28. The current version of the audit tracker is now open for Directorate review for actions due during 2024/25 quarter 4 (January to March 2025). These updates will then be reported to the Committee at its next meeting in May 2025.
29. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team will work closely with the points of contact as the SharePoint Tracker 3.0 develops.

RECOMMENDATION

30. The Committee is requested to:

- (a) Receive and review any new Internal Audits and Audit Wales reviews within their remit where relevant. There are twenty in total:
 - i) Nine actions relating to the 2024/25 Resourcing Policy Internal Audit, and
 - ii) Eleven actions related to the 2024/25 Exposure to Fumes Internal Audit.
- (b) Monitor management actions to address recommendations in the Audit Tracker, noting any revised dates for actions (which are marked in blue).
- (c) Receive and consider the update provided in respect of the two audit actions relating to Trade Union Release Time (Audit Actions 612 and 613) and to confirm the position of closure.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Response No in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Proposed rationale for the revised date
612	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (c)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure Action: Engagement with the senior TU partners will be undertaken with the aim of reaching agreement on implementing a standardised simplified approach (in the context of IA within WAST).	Sep-24	Not Met	Dec-24			Closed in Quarter	200125: (LT) ADLT noted closure. 161224: (LR) DOMs sign off requests for TU time at a local level for TU Partners to be abstracted to attend to TU activities. Senior Representatives are spending much time on whole organisational issues but still complete a timesheet and are abstracted with sign off from the line manager. Proposed for closure 071024: (AP) Revised date of December 2024 applied in Q2 24/25, in line with update. 200924: Request that the date is moved to December 2024 as suggested in March in line with the action 613, as the two actions are related. LR will provide further updates on her return to the Trust in Autumn 2024.
613	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (a)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. Action: We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time.	Nov-23	Not Met	Mar-24	Dec-24		Closed in Quarter	200125: (LT) ADLT noted closure, pending form of words to be supplied by LR for PCC Audit Report. ✓received 161224: (LR) A meeting was held with TU Partners with AL and LR in Summer 2023 on recording the time spent on TU activities. At the meeting TU Partners noted a range of significant reasons why the example spreadsheet in the facilities agreement was not usable. A key issue was that it could not be accessed on iPads. Time off is recorded in GRS for all TU reps in Operations except for those in 111 which is recorded in Shift Track. These colleagues are likely to move to GRS recording in the work being undertaken on RICS in 2025. All the TU Partners involved in the audit were able to provide evidence of their detailed TU work when requested by audit albeit in different formats. The Director of People and Culture agreed that this was acceptable in the meeting with TU Partners. DOMs sign off TU Partners time at a local level. ELT have recently received a report on options regarding FT TU Partners. There is some further work to be done on this as directed by ELT. The cost of facility time is calculated by Finance on an annual basis but can be generated more frequently if required. Proposed for Closure ~~160624: LR request to extend deadline to December 2024 as previously agreed. This is being managed by Operations.~~
612	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Medium	3.2	A training plan, and expected timeline for the required clinical skill enhancements should be established.	3.2	An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit for information. These skills will initially be for the SP group only until an assessment and audit is completed for further consideration on safety and efficacy.	Dec-23	Not Met	May-24	Aug-24	Dec-24	Closed in Quarter	~~160624: LR request to extend deadline to December 2024 as previously agreed. This is being managed by Operations.~~ 200125: (LT) ADLT noted closure. 201224: Extended skills workshop has taken place and training programme has started. Training plans included timelines provided to AP on 12.11.2024. Recommended for closure. 081024: (AP) To seek additional evidence of the training plan and timelines before closure (as it wasn't clear from the PPT evidence provided). This note was received in Q2 therefore revised date of December 2024 applied in Q2 24/25. Closure will be accepted when the training plan and associated timelines have been received. 011024: Recommend for closure. Exetnded skills information included in the powerpoint presentation now going through SP Steering Group. First presentation including extended skills plan provided for evidence to close.
613	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Low	4.1	The terms of reference should be reviewed to: •Include a defined pathway for escalation of issues; •Update membership to ensure representation from each locality; andNov •Define quoracy.	4.1	The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team.	Nov-23	Not Met	Feb-24	May-24	Aug-24	Closed in Quarter	200125: (LT) ADLT noted closure. 201224: Quoracy and AAA into SOT included in the ToR and approved by the group on 04.11.2024 as confirmed in email to AP. Recommended for closure. 021024: (AP) CGT not accepted closure position as the ToR revisions don't include everything that is required by the management action. Quorum not included and escalation process not explicit (although says that will provide AAA to SOT). Marked date of August 2024 as red, to indicate not completed. AP engaged with Clinical Directorate to provide advice and request revision of ToR; Greg Lloyd is aware of position. Last updated 01102024; Recommend for closure. SOT approved ToR on 10/09/24. AAA and ToR received as evidence for closure.
614	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.1	The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.	5.1	A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development.	Feb-24	Not Met	May-24	Aug-24	Mar-25	Open	201224: Lessons learned paper has been written and will report in to the next Steering Group. On track for completion within timeframe. 071024: (AP) Clarified with Clinical Directorate that this action is yet to be completed. Requested revised date of March 2025 to allow this to be completed. Revised date for this action of March 2025 added in Q2 24/25.
616	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.3	Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate.	5.3	Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting.	Jan-24	Not Met	May-24	Aug-24	Dec-24	Closed in Quarter	200125: (LT) ADLT noted closure. 20122024: Evidence of standing item on agenda sent via email to AP on 12.11.2024. No forward plan for meetings as this is not typical practice for meeting on this level but this will be a standing item on all of the meetings going forward. Recommended for closure.
655	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.1(b)	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	1.1(b)	The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete.	Jun-24	Not Met	Sep-24	Dec-24		Closed in Quarter	200125: (LT) ADLT noted closure 161224: (LR)- Propose for closure - The process is done and will officially be live on 01.01.2025 and the report has been to ELT on 12.12.2024.
657	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.3	The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process.	1.3	Guidance for managers on using the process developed and signed off	Jun-24	Not Met	Sep-24	Mar-25		Closed in Quarter	200125: (LT) ADLT noted closure 161224 (LR) - Propose for closure - The guidance has been produced and drop in sessions are scheduled for January 2025 when the process is live.

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658	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers / Peter Brown	Angela Lewis	Medium	2.1	The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff.	2.1	An evaluation report will be developed in association with the 111 senior team. It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures.	Sep-24	Not Met	Mar-25			Open	161224: (LR) - Work is progressing as expected and is not due for completion yet. 231024: (AP) Revised date to March 2025 applied in Q2, in line with update. 231024: (AP) Update from PCC: Propose for extension – Unfortunately due to the need to move re-prioritise team resource into manage employee relations and operational HR work, it has not been possible to complete the project as originally
707	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	1.1	The Trust should consider options to address volunteers development. This may not be as formal as a PADR process but should demonstrate the consideration of volunteers improvement needs.	1.1	The Trust accepts this recommendation and will consider options to address volunteer development. This will be assessed during the forthcoming financial year.	Mar-25	Not Yet Due				Open	281024: OCP, after this will then develop volunteer structure - after which development opps will be considered. So at this point in time can't say what evidence will close this off, as need to work through. But the date will not be met.
708	23/24	PCC	Volunteers Governance	Reasonable	Jonathan Chippendale	Lee Brooks	Medium	1.2	The Trust should undertake a review of outcomes and measures now available through the roll out of ePCR to consider indicators which would complement the current performance activity captured.	1.2	Trust Volunteer leads and clinical leads will review and recommend clinical outcome measures for CFRs as well as recommending where these data items will be reported. This action can be held at the Clinical Intelligence and Assurance Group.	Nov-24	Not Yet Due	Mar-25			Open	200125: (LT) ADLT noted 2st revised date (Mar25) 201224: Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. Regarding this action, proposed indicators were discussed at CIAG feeding into APSG however upon consideration were not fit for purpose. JC has suggested better metrics might focus around chain of survival data with CMT advancement so will discuss this in meeting handing action over to Digital.
709	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	2.1	Management should establish a link between the VSG and the Trust Policy review group to allow sight of any relevant policies and allow for volunteer input to be provided, where applicable.	2.1	The Trust agrees that VSG is an appropriate mechanism for the volunteer voice when developing appropriate and relevant policies; We will seek to design a mechanism to support input from VSG for relevant policies.	Nov-24	Not Yet Due	Mar-25			Open	200125: (LT) ADLT approved 1st revised due date (Mar25). NB: Meeting between Head of Compliance & Assurance, Operations Business Managers, and Volunteer Steering Group scheduled to take place 1st week of Feb25 in advance of VSG Meeting on 12/02/25. Therefore due date extended to Mar25 (instead of Jan25 as requested by directorate). Jan24: (LT) HoCA invited to attend VSG meeting on 12/02/25 to discuss and agree process to ensure relevant policies are shared with VSG members for comment. In advance of this meeting. Operations Business Managers and Volunteer Management Team have been asked to considered potential options suggested by HoCA. As meeting not scheduled to take place until February 2025, and process will take a couple of weeks, proposed extension until 31st March 2025, by which time the process will have been agreed, implemented and communicated to Policy Leads.
711	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	3.1	The Trust should consider addressing the highlighted enhancements to Operations Manuals outlined above. * Each manual includes an outline of volunteer team structure but not an outline of where volunteer responsibility sits within the Trust. The inclusion of detail relating to executive and volunteer team responsibilities would enhance the robustness of the manuals. * Individual volunteer agreements have been developed for each volunteer role. It includes volunteers should 'be aware of, and respectful of applicable WAST policies and procedures.' As a signed agreement there is opportunity to strengthen the wording to include an expectation to comply with Trust policies. * The CFR Operations Manual includes a skills matrix for clinical roles. A copy of the dispatch codes which generate CFR deployment are included as an appendix within the CFR Operations Manual, however these are not the latest version in use. It could offer greater clarity to volunteers to include a copy of the skills matrix in place of the deployment codes. *There are triggers for non-compliance with the mandatory elements of the role, but this is not included within either manual. Inclusion of this may assist in volunteer awareness of their responsibilities and processes in place. *The Volunteer Problem Solving process for the	3.1	The Operations Manuals were recently published in February 2024. The Trust will review the Operations Manuals and will incorporate any amendments into this review process.	Feb-25	Not Yet Due			Open	281024: Evidence to close this off is evidence of the review of the manual against the elements of the action. Date is reasonable (as at 281024).	
712	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.1	The Trust should ensure the distribution of received guidance in relation to fundraising to the full CFR population.	4.1	On receipt of any guidance on fundraising, the National Volunteer Manager will within one month, convene a Task and Finish Group, under the governance of the Operations Directorate. The T&FG will be tasked with cascade of any guidance to volunteers	Mar-25	Not Yet Due				Open	20.11.24 - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
713	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.2	The development of a fundraising standard operating procedure should include consideration of the need for periodic returns on fundraising activity and use of funds.	4.2	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Yet Due				Open	20.11.24 - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
714	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.3	The Trust should consider the development of good practice documents to support donation fund management, which could be incorporated into CFR team constitutions and processes.	4.3	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Yet Due				Open	20.11.24 - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
715	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.4	The Trust should prioritise the completion of a Volunteer fundraising risk, including clarifying the ownership of the risk within the Trust.	4.4	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Yet Due				Open	20.11.24 - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
717	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	5.2	Trust management should ensure that gaps in compliance with safeguarding training are addressed for both CFR and VCS roles.	5.2	The Trust will ensure that gaps in safeguarding compliance are addressed for VCS and CFRs.	Sep-24	Not Met	Nov-24	Feb-25		Open	200125: (LT) ADLT noted 2nd revised date (Feb25) Dec24: Extension requested until Feb 25 Nov24: Volunteer Team are delivering drop in sessions for safeguarding training to record internally. Toni awaiting evidence of the training records and monitoring.

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718	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	6.1	The Trust should consider mechanisms to monitor the uptake of the mentoring arrangements outlined within the CFR Operational Manual.	6.1	The Trust will consider mechanisms to monitor the uptake of the mentoring arrangements.	Nov-24	Not Met	Jan-25			Open	200125: (LT) ADLT noted 1st revised date (Jan25) Dec24: Extension requested until Jan25
719	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.1	The Trust should introduce a process which includes responsibility for allocation of calls or timeframes for addressing these [CFR Welfare and Activity Returns].	7.1	The Trust will introduce a process which includes the responsibility to a named individual for allocation of calls and timeframes for addressing these concerns.	Oct-24	Not Met	Feb-25			Open	200125: (LT) ADLT noted 1st revised date (Feb25) Dec24: Extension requested until Feb25. Once OCP in place, the process will be articulated. The process doc will be used as evidence to close it, but the date is not achievable. OCP will be in place late November. Suggest revised date of Feb 2025.
720	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.2	Where a submission has resulted in discussion of any welfare or performance concerns an entry should be maintained within the CFRs individual record.	7.2	This process will also include the documentation of any follow up action on the CFR individual record.	Mar-25	Not Yet Due				Open	Dec24: Directorate confirmed agreed completion date in report remains reasonable and achievable. The new volunteer management system which will go live after the OCP has gone live will allow the Trust to do this. The date for this is achievable. Evidence for this one can be screen shots of the new sysetm and samples of follow up.
721	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.3	The Trust should consider approaches to encourage the full completion of welfare returns to include a response of thriving, surviving, or struggling.	7.3	The Trust will consider approaches to encourage the full completion of welfare returns.	Oct-24	Not Met	Feb-25			Open	200125: (LT) ADLT noted 1st revised date (Feb25) 171224: (TMN) Sent to LT a copy of standing agenda documenting the monthly review of completion of welfare returns, including a work programme to show the pre planned agenda item for future volunteer management meetings. Awaiting confirmationf this evidence is sufficient to close action. Extension requested until Feb25.
722	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	8.1	Management should ensure key dates and stages are completed within the VCS Recruitment spreadsheet. The spreadsheet should be modified to include forecast dates aligned to the six-week recruitment check completion target.	8.1	The Trust will ensure that key dates and stages are completed on the VCS recruitment spreadsheet, including the modification to support forecast dates aligned to the six-week target.	Oct-24	Not Met	Jan-25			Open	200125: (LT) ADLT noted 1st revised date (Jan25) Dec24: Directorate requested extension until Jan25. Staff within the new OCP will be responsible for ensuring the recruitment dates are updated. Redact the screen shots so that there aren't personal details. Sophie to link in with admin team to get understanding of the recruitment spreadsheet. Meeting following this to determine how to evidence. Need to establish if there is a mechanism where the team go through this spreadsheet, is it part of an agenda.
723	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	8.2	Monitoring arrangements should include the retention of key recruitment dates for a period following recruitment to allow the review of process for any steps which cause delays or blockages.	8.2	The Trust will ensure that monitoring arrangements will include the retention of recruitment dates for a determined period to support the review process.	Oct-24	Not Met	Jan-25			Open	200125: (LT) ADLT noted 1st revised date (Jan25) Dec24: Directorate requested extension until Jan25. Staff within the new OCP will be responsible for ensuring the recruitment dates are updated. Redact the screen shots so that there aren't personal details. Sophie to link in with admin team to get understanding of the recruitment spreadsheet. Meeting following this to determine how to evidence. Need to establish if there is a mechanism where the team go through this spreadsheet, is it part of an agenda.
724	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	9.1	As part of the migration of VCS records onto Assemble the Trust should undertake a records stocktake, and address any subsequent gaps identified.	9.1	Following the introduction of Assemble, the Trust will undertake a records stock take and address any gaps identified.	Mar-25	Not Yet Due				Open	Dec24: Directorate confirmed the agreed due date within the report is reaonable and remains achievable. Assemble is the new volunteer management software. Date is achievable.
725	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	9.2	Noting the gap in vehicle check records, there should be inclusion of a completion of vehicle check forms as part of MIST course arrangements.	9.2	The Trust will introduce a system to include the completion of vehicle check lists for VCS volunteers.	Mar-25	Not Yet Due				Open	Dec24: Directorate confirmed that the agreed due date within the report is reasonable and remains achievable. OCP is the mitigating action for this; once in place our own staff will be doing the checks. Date is achievable.
726	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.1	The Trust should confirm a consistent selection criterion for the selection of claims to be validated which includes risk assessment and adequate coverage of outliers.	10.1	The Trust will agree a consistent selection criterion for validation of checks, to include risk assessment and coverage of outliers.	Oct-24	Not Met	Mar-25			Open	200125: (LT) ADLT noted 1st revised date (Mar25) Dec24: Directorate requested extension until March 2025. Mileage claims - this will be done but once OCP in place. Revised date of March 2025, which will allow sufficient time for the new process to be developed and evidenced. A paper that geos through SOT will close this off. Revised date of March 2025.
727	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.2a	Noting the unavailability of summary and validation documents for the Central and West region management should obtain and review documents to confirm the undertaking of checks.	10.2a	The Trust will satisfy itself that Central and West records are subject to appropriate checks and validation.	Jul-24	Not Met	Nov-24	Jan-25		Open	200125: (LT) ADLT noted 2nd revised date (Jan25) 041024: (AP) Revised date of November 2024 added in Q2 24/25, in line with update given. 270924 Recommending new deadline of Nov24 - spreadsheets are now in place to ensure appropriate checks and validation. Further evidence of this will be discussed in upcoming meetings for the moniroing of these checks. Agenda and summary notes will be provided before recommending closure of action.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date
728	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.2b	There should also be periodic checks to ensure documents are saved in a shared accessible location.	10.2b	The Trust will ensure that periodic checks are undertaken to ensure documents are saved in a shared accessible location.	Oct-24	Not Met	Jan-25			Open	200125: (LT) ADLT noted 1st revised date (Jan25) Dec24: Directorate requested extension until Jan25. Jenny/Soph to confirm: Is there a shared channel? Who has access? Teams channel with spreadsheet and schedule of when these are reviewed. Are they scheduled a week prior to review? Is this discussed in any local meetings? Where is this reported? Escalation? Who to and how?
732	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	2.2a	Post training feedback should be sought in line with the original action, to capture attendees learning from the training and identify any changes in practice.	2.2a	Contact will be made with HEIW as the training provider to confirm evaluation process.	Sep-24	Not Met	Dec-24	Jan-25		Open	200125: (LT) ADLT noted 2nd revised date (Jan25) 221024 - Propose for closure - The evaluation is underway with HEIW, therefore believe the action has been met. 211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear.
736	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	4.1	Management should consider approaches to ensure timescales are met as set out within the All-Wales policy, such as provisional appeal dates being agreed at the disciplinary hearing.	4.1	The Trust will continue to monitor compliance against All Wales Policy and ensure any delays are kept to a minimum by proactively securing dates for hearings/appeals etc at the earliest opportunity and note any reason for delays. People Business Leaders will monitor compliance relevant to their Directorates.	Aug-24	Not Met	Dec-24	Jan-25		Open	200125: (LT) ADLT noted 2nd revised date (Jan25) to allow time for submission of evidence required to support closure 221024 - Propose for closure - This action forms part of our roles as the Senior Team within People Services and is therefore very much business as usual. The People Leader job description is sent as evidence that shows it is part of the role and the document that is discussed in these meetings mentioned below is the ER Case Tracker. 211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear.
737	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	4.2	The Trust should include key timescales for each process to be periodically included within reporting provided to the People and Culture Committee for assurance that cases are being progressed in line with agreed All-Wales timescales.	4.2	ER tracker will include times scale compliance against each case. Any non-compliance will be supported with rationale. This will be monitored by the Deputy Head of People Services and People Business Leaders on a monthly basis.	Aug-24	Not Met	Dec-24			Closed in Quarter	200125: (LT) ADLT noted closure 221024 - Propose for closure - The tracker now has the relevant information added, this is on Slide 5 of the evidence (Employee Relations - Disciplinary Cases). This is monitored on a monthly basis and updates will be provided to PCC (added to the existing standing item Cultural Themes and Trends). 211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear regarding the evidence. Clarifications on the evidence provided not resolved in the reporting period. October Update from P&C: Propose for closure - The relevant KPIs have been added to the tracker, which has been sent across as evidence. The relevant members of the team will continue to monitor on a monthly basis and updates are being provided to the People & Culture Committee via the Cultural Themes and Trends standing item, with the document from
742	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	6.1	The People Services team should ensure that ESR records accurately reflect the outcome of disciplinary processes, and should review the case management tracker to identify any historic records which require amendment.	6.1	On completion of all disciplinary hearings, People Services representative to ensure that ESR accurately reflects the outcome of dismissal. Contact with NWSSP payroll may be required to make the changes to past cases ensuring accurate information is recorded.	Aug-24	Not Met	Dec-24			Closed in Quarter	200125: (LT) ADLT noted closure 22.10.2024 - Propose for closure - Guidelines and reminders are sent to the team, including appropriate documents. This is built in to internal audit checks and two have been completed to date so far (23rd August and 21st October). The reports are sent as evidence / information.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIGN PAGE

Visit No.	Year Audit was	Compliance request (%)	Report Title	Resource Rating	Responsible Officer	Director	Priority level	Risk to health	Recommendations	Resolving Time Action	Management Response	Agreed by Director's Report	Open - 1st or 2nd review date	1st review date	2nd review date	3rd review date	Current Status	Where a management action has not met the agreed or revised date, Director must include how: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and
14-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	High	1.1	The mapping exercise should be completed to ensure that all local arrangements or differences in application of the Policy are appropriately recorded.	1.1	Resourcing Policy allows for local arrangements, which results in variation of process across the trust which currently is not quantified. Resourcing will complete the process mapping and documentation of all local arrangements and differences in the application of the Policy across operational HbIs by function. This will be submitted via the Resourcing monthly management team meetings.	Nov-24	Not Met	Jan-25			Open	202125: (1/1) Operations Directorate requested extension until Jan25 202125: (1/1) ADST provisionally noted 1st revised due date (to be advised by Operations Directorate) 271224: (1/1) - Due date extended until Mar25 181224: (1/1) confirmed that this has been passed until February 2025 due to management absence and action pressures
15-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	High	1.2	The functional SOPs for each area should be completed, approved and communicated to all staff.	1.2	Resourcing will construct departmental Standard Operating Procedures to support consistent application relevant to individual functions. SOT will review and agree each of the SOPs will be published and communicated to staff and resourcing teams.	Mar-25	Not Yet Due	Sep-25			Open	202125: (1/1) Operations Directorate requested extension until Sep25 202125: (1/1) ADST provisionally noted 1st revised due date (to be advised by Operations Directorate)
16-24/25	2024/25	PCC	Resourcing Policy	Limited	Jonathan Edwards	Lee Brooks	High	1.3	The Resourcing Policy should be reviewed and revised (or re-drafted), approved at an appropriate forum and communicated to all staff.	1.3	The Trust accepts this recommendation, and the Resourcing Policy will be reviewed and revised. A Resourcing Policy Group, in partnership with Trade Union, will convene to review the existing policy. Governance arrangements including SOT, SLT and ECL will ensure changes are agreed and recorded.	Oct-25	Not Yet Due				Open	
17-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	High	2.1	Resource Managers should undertake regular review of the WT branch analysis reports, within GRS and ShiftTrack, to identify whether it is a "true" breach and these should be reported.	2.1	The requirement for review the Working Time (WT) branch analysis reports has been included as part of the Quality Control and Audit Management processes. Resource Managers will undertake a monthly review of the Working Time (WT) branch analysis reports, to identify whether it is a "true" breach and if these should be reported. Any true breaches are passed through to Heads of Service for action.	Nov-24	Not Met	Mar-25			Open	202125: (1/1) ADST noted 1st revised due date (Mar25) 271224: (1/1) Due date extended until Mar25 to allow time for report to be presented to SOT in Jan25 and SLT Feb25 181224: Resource managers should undertake regular review of WTR branches - due to the management absence a plan has been put in place to review Q2 data (Q2s-Q2s) in monthly vulnerability. Report due to go to SOT end of January 2025.
18-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	High	2.2	Resource Managers should consider whether there is a training need for Resource Co-ordinators or for whenever the WT branch originated e.g. if it was as a result of local arrangements or shift changes.	2.2	Resource managers, following the monthly audit of the WT branch analysis report, will identify any individual or system trends and issues and any remedial actions addressed through line management discussions.	Nov-24	Not Met	Mar-25			Open	202125: (1/1) ADST noted 1st revised due date (Mar25) 271224: (1/1) - Directorate requested due date be extended until Feb25 to allow time for action to be approved by SOT in Jan25 181224: OHA, directorate lead and progress of any issues, underlining requirement to be
19-24/25	2024/25	PCC	Resourcing Policy	Limited	Jonathan Edwards	Lee Brooks	Medium	3.1	The process for TOLs should be reviewed, revised, agreed and communicated to provide clarity for both the Resource Co-ordinators and staff.	3.1	The process for agreeing TOLs will be reviewed, revised, agreed and communicated as part of the Resourcing Policy review (see Management Action response 3.1). This will provide clarity for both the Resource Co-ordinators and staff.	Oct-25	Not Yet Due				Open	
20-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	Medium	4.1	The Trust should consider revising the GRS structure to include OHA as an abstraction report group with a dropdown list detailing the reasons for the OHA.	4.1	The Trust will revise the GRS structure to include OHA Absence Group and SOT will agree associated OHA Absence types for implementation to the resourcing system. This will be agreed through SOT.	Dec-24	Not Met	Mar-25			Open	202125: (1/1) ADST noted 1st revised due date (Mar25) based on action being completed, paper going to SOT in Feb25 and to allow time for any subsequent changes that may be required post discussion. 271224: (1/1) Proposed due date be extended until Feb25 as workstream has been
21-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	Medium	4.2	The reasons for OHA, if captured, should be reported and monitored.	4.2	Once OHA Absence Types are agreed by SOT and implemented into the resourcing system, a self-service reporting guide will be provided to operational teams to permit local monitoring. Formal quarterly reporting by Resourcing dept will be provided to SOT to monitor.	Jan-25	Not Yet Due	Mar-25			Open	202125: (1/1) ADST noted 1st revised due date (Mar25) based on action being completed, paper going to SOT in Feb25 and to allow time for any subsequent changes that may be required post discussion. 271224: (1/1) Proposed due date be extended until Feb25 as workstream has been passed during winter pressures.
22-24/25	2024/25	PCC	Resourcing Policy	Limited	Softhian Fran	Lee Brooks	Medium	5.1	The Trust should ensure that performance against all expected timesframes within the Resourcing Policy are reported and monitored.	5.1	The Trust accepts this recommendation. The KPIs listed within the report are based on the existing resourcing policy. A reporting framework will be developed as part of the Resourcing Policy Review (see Management Action response 2.2). There are however two areas that have been completed or superseded as per below: Action 5.1c - viability of searant shift. This functionality exists and is evident within the GRS system options. This is complete. Action 5.1d & e. Availability and acceptance of overtime. These KPIs are no longer applicable due to the implementation of the overtime allocation SOP and Financial Savings Plan.	Oct-25	Not Yet Due				Open	
32-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	The Trust has undertaken previous communications to inform staff of this issue. Further action will be taken to seek operational improvement and will ensure that clear guidance on restarting diesel heaters after shoreline trips is communicated across all relevant staff to promote operational safety and efficiency. A review of former safety notice will be undertaken, and a further formal safety notice will be issued to relevant staff groups.	Dec-24	Not Met	Jan-25			Closure Proposed (pending evidence)	202125: (1/1) ADST noted 1st revised due date (Jan25) to allow time for progress to be reported / evidence to be supplied.
33-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Jo Kehu	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	Training has been reviewed - information on shoreline use is now included in induction training and Trust-driving courses for new entrants and staff moving into EME from Ambulance Care too.	Already Complete	Met	Jan-25			Closure Proposed (pending evidence)	202125: (1/1) Action reported as already completed. ADST noted 1st revised due date (Jan25) to allow time for evidence to be supplied.
34-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Jo Kehu	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	Information will also be produced through the Workforce Education & Development Learn365 platform on the use of shorelines to ensure the topic is incorporated in training and education sessions.	Already Complete	Met	Jan-25			Closure Proposed (pending evidence)	202125: (1/1) Action reported as already completed. ADST noted 1st revised due date (Jan25) to allow time for evidence to be supplied.
35-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	The Trust is committed to reviewing also as per the frequency deemed appropriate following risk assessment undertaken by a Health & Safety professional.	Mar-25	Not Yet Due				Open	
36-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	2.1	The Trust should have a risk assessment work programme in place to ensure that all EDs are risk assessed on a regular basis.	2.1	Following introduction of additional control measures for Winter 2024, the Trust will develop a work programme for risk assessment review for all EDs ensuring assessments are conducted annually.	Jan-25	Not Yet Due				Open	
37-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	2.2	For transparency, and good practice, the Trust should invite Trade Union Partners to attend when undertaking the onsite ED Risk Assessments.	2.2	Scheduled dates for the assessments (as per 2.1) will be made available for Trade Union Partners to attend ED risk assessments ensuring transparent and collaborative practices.	Jan-25	Not Yet Due				Open	
38-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.	3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood.	Jan-25	Not Yet Due				Open	
39-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Sonia Thompson	Liam Williams	Medium	3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.	3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood. The action will be presented at SOT (Senior Operations Team) and a feedback mechanism will be discussed and created to monitor the situation.	Jan-25	Not Yet Due				Open	

40-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Aed Williams	Liam Williams	Medium	4.1	The development of the data vault should be completed to ensure the relevant data is recorded from the earliest possible stage.	4.1	The Trust has completed the data vault to capture accurate and comprehensive data on potential incidents where fume exposure could have occurred, ensuring transparency and informed decision making. Now the digital architecture is complete, further development is required to capture broader data sources (e.g. risk assessments). The Trust will finalise the development of the data vault system to centralise and lock staff exposure data effectively.	Mar-25	Not Yet Due					Open
41-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	4.2	To ensure completeness of such, the Trust should ensure that the systems currently used are designed to routinely capture the information required.	4.2	Where possible, any relevant data source will be automated for transfer into the Data Vault.	Mar-25	Not Yet Due					Open
42-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	5.1	The designated deadline to issue Health & Safety Committee papers, prior to the meeting date, should be adhered to. This will allow the Trade Unions to have sufficient time to review and discuss key matters within the papers and avoid meetings being cancelled.	5.1	The Trust has reviewed the Committee terms of reference and undertaken an organisational development workshop with Committee members. Going forward, there will be enforced adherence to deadline for issuing Health & Safety Committee papers to ensure timely review by Trade Union members preventing meeting cancellations.	Jan-25	Not Yet Due					Open

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When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

Item Ref No	Audit Wales or Health Report	Year	Commission Assigned to	Report Title	Responsible Officer	Director	Priority Level	Ref. No. of Audit	Recommendation	Progress to 1st, 2nd or 3rd Audit	Management Response	Agreed Deadline in Report	Notes	1st revised date	2nd revised date	3rd revised date	Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first	Current Status
123	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Linda Phillips	Angela Lewis	Medium	2.1	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority):	2.1	Use of Power BI reporting feeding into the integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data.	Sep-24	Not Met	Dec-24			Complete	200125: (LT) ADLT noted closure pending receipt of evidence 16.12.2024 - LR - Propose for closure - Highlight reports are being produced to inform ITPG, they include all the core workforce data to identify trends and decision making. This currently takes a lot of manual intervention as data feed are not connected. The technology may not be available in the short term to get the report automatic as a whole. However, the audit recommendation has been met.	Closure Proposed (pending evidence)
124	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(a)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible.	2.1(a)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. Excel version	Mar-24	Not Met	Oct-24	Dec-24	Mar-25	Partially complete	200125: (LT) ADLT noted 3rd revised due date (Mar25) 271224: (LT) Propose date to be extended to Mar25 to enable report to be presented to ELT in Jan25 and Trust's position to be clarified. 16.12.2024 - LR/HB - Nexus has partially been progressed (the replacement for 'megashet') but this is not an organisational priority and the Trust has subsequently embarked on a very large transformation programme, consequently, we have paused Nexus development to accommodate this. However, we have done a series of fleet calculations (using 'megashet' as a baseline) to estimate fleet requirements for the next two years, on potential areas of workforce growth e.g. APs etc. The ITPG continues to meet weekly (informal) and monthly (formal) and fleet and estate are standing items on the monthly agenda. Also, a report is due at ELT in January, with workforce planning assumptions for next year, which will include fleet and estate considerations. A very high bar is set with Nexus and would be an ideal, but not delivering does not preclude us from planning around fleet and estate.	Open
125	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(b)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Explore ways to resource the management of a system to ensure an up-to-date establishment model.	2.1(b)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. Potential PowerBI version	Sep-24	Not Met	Dec-24			Complete	200126: (LT) ADLT noted closure pending evidence 16.12.2024 - LR - Propose for closure - Workforce highlight reports are being produced to inform ITPG which include all the core workforce data to identify trends and decision making. This currently takes a lot of manual intervention as data feed are not connected. The technology may not be available in the short term to get the report automatic as a whole. However, the audit recommendation has been met. ITPG meeting successfully brings together the team across the disciplines needed to deliver effective planning. Organisationally there is no capacity to undertake more work in this space currently due to other business priorities.	Closure Proposed (pending evidence)
126	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udese-Chibuzor / Liz Rogers	Angela Lewis	Medium	3.1	Evaluating workforce planning training We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme (medium priority).	3.1	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	Jun-24	Not Met	Aug-24	Dec-24	Mar-25		200125: (LT) ADLT noted 3rd revised due date (Mar25) 16.12.2024 - LR - The team have developed and delivered the workforce planning training, take up of this has been limited across the organisation. The evaluation is to be completed in January, therefore an request to extend until March 2025. 211024: (API) Revised date of December 2024 applied in Q3 24/25 as position not clear. 22.08.24 - JK - The Workforce Planning training has been moved onto Learn 365 and development is ongoing to include an evaluation and feedback	Open
127	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udese-Chibuzor / Liz Rogers	Angela Lewis	Medium	4.1	Recruitment support We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation (medium priority).	4.1	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorate as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May-24	Not Met	Sep-24	Dec-24	Sep-25		200125: (LT) ADLT approved 3rd revised due date (Sep25) 16.12.2024 - LR - The centralisation of recruitment has also been highlighted in the Service Review. A business case will be produced to centralise recruitment for ELT to consider. Support is ongoing for EMS and advice provided where capacity allows for other parts of the organisation. This will need to be an OCP as it will impact on roles across the organisation and is also impacted by the budget settlement. Therefore request to extend to September 2025. 211024: (API) Revised date of December 2024 applied in Q3 24/25 as position not clear.	Open
128	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udese-Chibuzor / Liz Rogers	Angela Lewis	Medium	5.1	Metrics for People and Culture plan monitoring The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan (medium priority).	5.1	Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures	May-24	Not Met	Sep-24	Dec-24		Complete	200125: (LT) ADLT approved closure 16.12.2024 - LR - Propose for closure - Recommendation relates to The Strategic Workforce Plan (and the People & Culture Plan) - this was highlighted with auditor. The Strategic Workforce Plan has been approved by Board and is included in the IMTP for People and Culture. The highlight report on Workforce Planning can be shared with PCC covering key workforce data. There is a project plan developed for the next 2 years to deliver the SWPP. 211024: (API) Revised date of December 2024 applied in Q3 24/25 as position not clear.	Closure Proposed (pending evidence)
129	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Liz Rogers / Hugh Bennett	Angela Lewis	Medium	6.1	Benchmarking The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice (medium priority)	6.1	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	Jun-24	Not Met	Sep-24	Dec-24	Mar-25		05.07.24 - AP - Revised date of next of F13 added in F11 24/25 and to discuss closure evidence reviewed with Directorate 200125: (LT) ADLT noted 3rd revised due date (Mar25) 16.12.2024 - LR - Comparison data is difficult to gather as there are no single sources of data and the data also tends to be relatively historic. Currently looking at what options are available to gather data quickly and effectively as connections are made. Therefore an ask for this to be extended to March 2025. 211024: (API) Revised date of December 2024 applied in Q3 24/25 as position not clear.	Open

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	People and Culture Committee	Date of Meeting	18 th February 2025

Presenting Officer	Trish Mills, Director of Corporate Governance / Board Secretary

Policy Name	Directorate	EqIA Completed	Date of Policy Group	Date of ADLT*	Points of Note
Recruitment and Selection Policy	People Services	Completed No Issues	27/11/2024	12/12/2024 (ELT)	FOR APPROVAL
Equality Impact Assessment Policy	People Services	Completed No Issues	18/12/2024	20/01/2025	FOR APPROVAL
Bank Worker Policy	People Services	Completed No Issues	31/01/2025	03/02/2025	FOR APPROVAL
Occupational Health Policy	People Services	Completed No Issues	31/01/2025	03/02/2025	FOR APPROVAL
Occupational Immunisation and Screening Policy	People Services	Completed No Issues	31/01/2025	03/02/2025	FOR APPROVAL

** Effective from mid-December 2024, the Trust's Policy Group transitioned to a sub-group of the Assistant Directors Leadership Group (ADLT), replacing its previous position under the Executive Leadership Team (ELT).*



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Welsh Ambulance Services
University NHS Trust

Occupational Health Policy

Policy Number:	115	Version No:	0.13 Draft	Supersedes:	New Policy
Date of Approval:	TBA	Review Date:	3 years from date of approval	Impact Assessments Completed:	24/06/2024
Classification of Document:	Employment	Type of Document:	Policy	Approved by:	People and Culture Committee
Brief Summary of Document:	This policy is intended to provide information to the organisation on the operational standards of the Occupational Health Service.				
Scope:	The Occupational Health Policy applies to all individuals associated with the Welsh Ambulance Services NHS Trust (WAST), including staff directly employed by WAST (permanent and temporary), Non-Executive Directors, bank staff, volunteers, and contractors delivering services on behalf of the Trust. This policy ensures inclusivity while promoting the physical, psychological, and social wellbeing of all covered individuals through a confidential and impartial occupational health service. References to "staff" or similar terms within this policy encompass all individuals under this scope unless explicitly stated otherwise.				
To be read in conjunction with:	• Health and safety policy • Infection Prevention & Control Policy Elimination of Healthcare Associated Infections • Infection Prevention and Control: Sharps Policy safe use and disposal • Safer Moving and Handling Policy • Control of Substance Hazardous to Health Policy and Procedure • Display Screen Equipment Procedure • New and Expectant Mothers Risk Assessment Procedure • Health and Wellbeing Plan				
Owning Committee	People and Culture Committee				
Policy Lead: Trade Union Lead:	Kim Crichton Maldwyn Jones	Job Title:	Occupational Health Manager Trade Union Partner		
Executive Director:	Carl Kneeshaw	Job Title:	Director of People		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	20/06/2024	Kim Crichton	First draft shared with T&F group via email.
0.2	24/06/2024	Kim Crichton	Updated draft submitted to Policy Group, added references to relevant sections of the WAST Health and Safety Policy
0.3	05/07/2024	Lisa Trounce	Front page updated & blank sections populated Formatting throughout policy document Minor grammatical changes Comments added to indicate action required by Policy Lead
0.4	28/07/2024	Kim Crichton	Required amendments effected and additional information supplied where indicated. Completion of EQIA date Links to referral routes within OH system
0.5	07/08/2024	Lisa Trounce	Review of updated draft policy supplied 28/07/24, including: Formatting on front cover (header removed) Version control updated on front cover Comments indicating to Policy Lead sections which need to be populated / to confirm where required actions have been completed Approval route updated to reflect rescheduled presentation to Policy Group on 20/08/24 Minor formatting throughout
0.6	13/08/2024	Kim Crichton	Added to section 9.8 regarding responsibilities for occupational health.
0.7	13/08/2024	Lisa Trounce	Minor formatting Approval process updated Version number on front sheet amended Version Control Sheet updated
0.8	16/12/2024	Kim Crichton	Comments from Policy Group actioned: 5.1 Operational Overview - timeline for responses added. 5.5 Health Assessment - reworded as agreed 5.6 Health and Wellbeing plan title updated

Version	Date	Author	Summary of Changes
			7.1 EQIA wording updated 7.3 Welsh Language I.A. section updated 8. Roles and Responsibilities amended to reflect changes agreed by Policy Group
0.9	16/12/2024	Lisa Trounce	Final review and edit prior to draft policy going out for Trust-wide consultation, including: • Minor formatting throughout • Renumbering of some sections/paragraphs • Policy Approval Route Updated
0.10	24/01/2025	Kim Crichton	Post consultation changes effected: • Scope of policy - wording updated • Paragraph 5 terminology wording amended to ensure clarity • 5.3 Updated to include definition and reference to HSE guidance • 5.4 Added sub paragraphs plus additional context to section • 5.10 Removed • 7.5.1 Wording amended • 7.5.2 Wording amended • 7.5.4 Wording amended • 7.5.5 Wording amended • 8.2 Amended to Directors • 9.3 More context added re audit reporting • 5.5 Updated information regarding consent • 4.3 Added to section • 5.8 Further specialist information added
0.11	24/01/2025	Lisa Trounce	Updated policy reflecting relevant post consultation comments formatted in readiness for Policy Group on 31/01/2025. Version Control Sheet amended to reflect Policy Group now reports to ADLT not ELT.
0.12	01/02/2025	Lisa Trounce	Post consultation tracked changes accepted, front cover updated, and approval route updated, in readiness for onwards travel to ADLT to recommend approval by Committee.
0.13	03/02/2025	Lisa Trounce	Following ADLT approval, policy prepared for onwards travel to Committee for approval and adoption

Version	Date	Author	Summary of Changes
Keywords	Occupational, health, pre-placement, surveillance, wellbeing		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	N/A	
EqlA / Welsh Language	24/06/2024	Kim Crichton
Environment	N/A	
Quality	N/A	

Task and Finish Group Members

Name	Job Title
Kim Crichton	Occupational Health Manager
Kim Ellis	Assistant Psychologist, Wellbeing Service
Janice Shawcross	Office Manager, Occupational Health
Maldwyn Jones	Dom / Tu Partner
Marcus Viggers	Paramedic / TU Partner
Nicola White	Head Of Health and Safety
Phillip Lloyd	Violence And Aggression Manager
Louise Colson	Head Of Infection Prevention and Control
Jo Kelso	Head Of Workforce Education and Development
Michelle Morse	People Services Partner
Gareth Parry	Operations Manager Volunteer Car Service
Eleanor Blackmore	Clinical Contact Centre Manager

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	20/08/2024	Review new policy prior to Trust-wide consultation. Policy approved for consultation pending agreed amendments
28-day Consultation Period	16/12/2024 – 13/01/2025	Trust-wide consultation/comments
Policy Group	31/01/2025	Review post consultation - Approved for onwards travel to ADLT to recommend approval by Committee.
Assistant Directors Leadership Team (ADLT)	03/02/2025	Approved - Recommended for approval and adoption by Committee
People and Culture Committee	18/02/2025	For Approval and adoption

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

Contents

1. Introduction	7
2. Policy Statement	7
3. Scope	7
4. Aims & Objectives	7
5. Scope of Service	8
5.1 Operational Overview	8
5.2 Preplacement Medical Screening	9
5.3 Health Surveillance	9
5.4 Infection Prevention	10
5.5 Health Assessment During Employment / Attendance Management	11
5.6 Wellbeing.....	11
5.7 Seasonal Activity	11
5.8 Links with General Practitioners and Specialists	12
5.9 Representation on Relevant Groups and Committees.....	12
6. Training and implementation	12
7. Impact Assessments	13
7.1 Equality Impact Assessment	13
7.2 Ethics, Equality, and Diversity	13
7.3 Welsh Language Impact Assessment	13
7.4 Counter Fraud	14
7.5 Records Management	14
7.6 Information Governance	15
8. Roles and Responsibilities	15
8.1 Chief Executive	15
8.2 Directors	15
8.3 Service Managers / Clinical Leads / Locality Managers	16
8.4 Line Managers.....	16
8.5 All Staff	16
8.6 Occupational Health Team.....	17
9. Audit, Monitoring and Compliance.....	17
10. References	18
11. Appendices.....	18

1. INTRODUCTION

Welsh Ambulance Services University NHS Trust (WAST / 'the Trust') employs in excess of 4000 employees and volunteers. This policy is intended to provide information to the organisation on the operational standards of the Occupational Health Service.

2. POLICY STATEMENT

- 2.1 The Trust values the health and welfare of its employees. It aims to provide a confidential occupational health service which is available for all employees and volunteers. It is essential; that the service operates in a confidential and impartial way, acting as adviser to the board, managers, and employees in promoting the physical, psychological, and social wellbeing of the Trusts' workforce.
- 2.2 The Trust is committed to the principles of equality and diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and equal opportunities for users of services, carers, the wider community, and our staff.

3. SCOPE

The Occupational Health Policy applies to all individuals associated with the Welsh Ambulance Services NHS Trust (WAST), including staff directly employed by WAST (permanent and temporary), Non-Executive Directors, bank staff, volunteers, and contractors delivering services on behalf of the Trust. This policy ensures inclusivity while promoting the physical, psychological, and social wellbeing of all covered individuals through a confidential and impartial occupational health service. References to "staff" or similar terms within this policy encompass all individuals under this scope unless explicitly stated otherwise.

4. AIMS & OBJECTIVES

- 4.1 The Occupational Health Policy is designed to provide a comprehensive framework for promoting and maintaining the highest standards of health and well-being among our workforce.
- 4.2 The primary aim is to ensure a safe, healthy, and supportive work environment that enhances the overall health of employees. Our objectives include highlighting the scope of our service provision, to ensure all stakeholders understand the breadth and depth of the occupational health services offered; Outlining overarching standard operating procedures to ensure consistent and high-quality service delivery in alignment with governance requirements.
- 4.3 The policy aims to enhance awareness of the comprehensive responsibilities and services provided by the Occupational Health Team, such as:

- actively supporting the public health agenda through robust disease prevention initiatives and the promotion of healthy lifestyles.
- Aim to reduce the incidence of work-related ill health and mitigate the impact of occupational hazards, thereby fostering a healthier workforce.
- facilitating the rehabilitation and return to work of employees affected by illness or injury, regardless of whether it is work-related.
- Emphasising the importance of physical activity and educates employees on the risks associated with physical inactivity, promoting positive health behaviours.
- Signposting or referring employees for further support in healthy behaviour change.
- Minimising health inequalities within the workforce, ensuring equitable access to Occupational Health services and support.

This policy underscores the commitment to proactively supporting the workforce's health and wellbeing, contributing to a productive, resilient, and inclusive work environment.

- 4.4 The Occupational Health Policy aspires to set a benchmark for excellence in the provision of occupational health and well-being services, consistently striving to exceed statutory requirements for both the organisation and external clients. By adhering to these objectives, the policy aims to cultivate a culture of health and well-being that supports individual employees, and aligns with the broader organisational goals.

5. SCOPE OF SERVICE

The function of the Occupational Health and Wellbeing service operates in an advisory capacity for all those covered under this policy. The primary role of the service is to support the Trust to perform its core functions, namely, to provide a high-quality, effective, and efficient service to patients.

Occupational health is concerned with the prevention of workplace ill health and the promotion and maintenance of the physical, mental, and social wellbeing of those covered under this policy. Its role is to advise on the health needs of individuals at work and on their fitness to undertake their role. This involves assessing both the effect of the working environment on health and the influence of an individual's health on their ability to fulfil their role. The service has no disciplinary role.

5.1 Operational Overview

- 5.1.1 The Occupational Health service will provide core services for staff employed within the Trust across Wales, for approximately 4000 staff and approximately 1000 volunteers, which operates across 90 ambulance stations, three contact centres, four regional offices and four vehicle workshops.

5.1.2 In addition, it will have agreements in place for bespoke provision for other external contracts / services as agreed with the Trust.

5.1.3 It will be operational from 08:00 to 16:00 hours, weekdays excluding bank holidays and weekends.

5.1.4 Methods of contacting the service:

a) Telephone contact with voicemail service for out of hours calls: 0300 123 9850

b) Email: amb_genmbx_occupationalhealth@wales.nhs.uk

NB: Calls and emails aim to be responded to within the next working day.

c) Management Referrals and Self-Referrals can also be completed at any time via the on the Occupational Health All Wales procured electronic management system.

i) For Self-referral: <https://wast.opasg2.com/selfreferral>

ii) Management referral: <https://wast.opasg2.com/login/> (to be completed by Line-Managers which hold a manager's login account as set up by Occupational Health)

5.2 Preplacement Medical Screening

Pre-employment/pre-placement medical screening for all individuals covered by this policy, including prospective employees and volunteers, is carried out in accordance with relevant legislation to ensure that they are fit to undertake their roles without risk to themselves, their colleagues, patients, or the general public..

5.3 Health Surveillance

5.3.1 Also see <https://www.hse.gov.uk/health-surveillance>. Health surveillance is a systematic process to detect early signs of work-related ill health among employees exposed to certain health risks. It involves collecting and using health data to protect and improve workforce wellbeing and ensure compliance with health and safety legislation. Health surveillance helps to identify potential health issues at an early stage, enabling timely interventions to prevent further harm.

Occupational Health aims to ensure that, as far as reasonably practicable, appropriate, and timely; health surveillance is undertaken to avoid occupationally related ill-health.

5.3.2 The successful implementation of health surveillance is only possible when managers take effective steps to risk assess and control health risks at work.

5.3.3 It is the responsibility of managers to identify those staff requiring health surveillance.

5.3.4 Health and safety law requires health surveillance when workers remain exposed to health risks even after controls are put in place. This is because control measures may not always be reliable, despite appropriate checking, training and maintenance. Health surveillance of workers exposed to specific hazards is carried out. Providing appropriate health surveillance in accordance with identified risk assessments and service contracts. This includes, but is not limited to:

- Night time workers
- Respiratory sensitisation
- Noise
- Hand arm Vibration
- Skin sensitisation
- Vision

This list is not exhaustive, and health surveillance will be carried out as required, either by the Trust or outsourced, depending on the skill set and resources available within the service.

5.4 Infection Prevention

Occupational Health plays a critical role in supporting infection prevention and control within the workplace, ensuring the health and safety of all those covered by this policy. This is achieved through a comprehensive approach to managing risks associated with infectious diseases and providing expert advice and support to staff. Key measures include:

5.4.1 Immunisation Programs: Providing appropriate immunisations tailored to workplace hazards, including Tuberculosis (TB), Measles-Mumps-Rubella (MMR), Varicella, Hepatitis B, Diphtheria/Tetanus/Polio, Hepatitis A, and Pertussis.

5.4.2 Health screening: targeted health screenings for new healthcare workers and employees at risk, focusing on workplace hazards such as TB, Hepatitis B, Hepatitis C, and HIV.

5.4.3 Sharps and Body Fluid Contamination Management: Offering prompt, evidence-based management of needlestick injuries and other body fluid contamination incidents, including the guidance and provision of post-exposure prophylaxis when required.

5.4.4 Infectious Disease Advice: Advising staff who are symptomatic or have had contact with an infectious disease and facilitating access to necessary prophylaxis or treatments as appropriate.

5.4.5 Mass Vaccination Programs: Coordinating and delivering large-scale vaccination initiatives, including annual immunisation programs such as the flu vaccine and response to pandemic situations where required.

5.4.6 Occupational Health collaborates closely with the Infection Prevention and Control Team to ensure robust processes are in place, minimising the risk of infection and safeguarding the health of employees, colleagues, and the general public. This partnership ensures a proactive, preventative, and responsive approach to infection prevention and management.

5.5 Health Assessment During Employment / Attendance Management

Health assessments in the workplace are conducted to evaluate employees' fitness for their roles, addressing issues such as sickness absence, work related health concerns, or considerations for ill health retirement. The goal is to ensure employees can safely perform their duties, and to provide guidance on rehabilitation, suitable work adjustments, or retirement when appropriate. Occupational health offer:

- Early access to support for staff through management or self-referral.
- Health assessments to determine employees' fitness while at work, upon returning from prolonged absences, or following significant illness or injury.
- Recommendations on employees' fitness for work and any reasonable adjustments.
- Coordination of case conferences with a multidisciplinary team.

Employee consent is required before any health assessment is undertaken, and appointments will not be received or triaged without it. In rare cases where staff may face challenges in accessing the digital OH system, tailored workarounds can be implemented on a case-by-case basis. This process will always prioritise transparency and verbal consent to ensure the staff member is fully informed and in agreement with their Occupational Health referral.

5.6 Wellbeing

Support for employees and volunteers as per the Trust's Health and Wellbeing Plan 2025-2029.

5.7 Seasonal Activity

The service will look to support the business by providing activity in line with peak activity and national awareness campaigns. Annual seasonal activity includes the winter flu campaign and large recruitment intakes i.e. newly qualified paramedics.

5.8 Links with General Practitioners and Specialists

Occasionally, with the consent of those covered by this policy, additional information may be requested from or shared with specialists or general practitioners to support effective care, diagnosis, and treatment.

Where applicable, Public Health Wales' Health Protection Team provides specialist public health advice on infectious disease control. They collaborate closely with the NHS, local authorities, and other agencies to help reduce the spread of infectious diseases in Wales.

The Health Protection Team delivers the All-Wales Acute Response Service (AWARe), which manages all notifiable disease reports during standard working hours. Outside of these times, an on-call team is available to address urgent health protection issues. This includes providing immediate or urgent public health action for healthcare professionals reporting notifiable diseases. If such criteria are met, the Health Protection Team can be contacted directly by telephone on **0300 00 300 32**.

[AWARe/ Health Protection Team - Public Health Wales](#)

5.9 Representation on Relevant Groups and Committees

Occupational health staff will be represented on appropriate strategic and operational groups and committees to advise on issues of work health within the Trust, and at national forums e.g., Health & Safety Group, Health & Wellbeing strategy, Infection Prevention, Immunisation, Flu, all Wales Occupational Health Forums.

6. TRAINING AND IMPLEMENTATION

- 6.1 Training will be based on a training needs analysis. Training will be suitable and sufficient to enable staff to identify hazards and risks they may face in the workplace and how to deal with them. This approach applies to all staff.
- 6.2 Training should be based on the level of competence required for the service areas individuals involved and level of expertise required.
- 6.3 WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.
- 6.4 Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

- 6.5 All clinical staff within occupational health will adhere to the continuous professional development required as per the registered clinical body for their profession.
- 6.6 Occupational health staff will be required to remain up to date with training for the clinical tasks for their roles such as health surveillance and immunisation. They will be involved in the training of new and junior staff along with students, sharing their knowledge and skills.

7. IMPACT ASSESSMENTS

7.1 Equality Impact Assessment

The purpose of the EqIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation, religious belief, human rights and Welsh Language. The Equality Impact Assessment (EqIA) for this policy has been reviewed with no negative outcomes identified.

7.2 Ethics, Equality, and Diversity

- 7.2.1 Special consideration of ethical standards in occupational health arises because of the unique role in advising two parties, thus differing from those of other clinical specialists and general practitioners.
- 7.2.2 To attain the highest standards of professional behaviour and practice, the department will apply appropriate ethics in line with the 'Guidance on Ethics for Occupational Physicians' published by the Faculty of Occupational Medicine.
- 7.2.3 Other professional ethics will also be applied, e.g. Nursing and Midwifery Code of Conduct, Royal College of Nursing Confidentiality: Guidance for Occupational Health Nurses. Occupational health recognises the importance of Equality and Diversity in respect of its responsibilities as an employer and as a provider of health care services. Services and practices are designed and carried out fairly in accordance with equality and human rights legislation (Equality Act 2010).

7.3 Welsh Language Impact Assessment

- 7.3.1 Under the Welsh Language (Wales) Measure 2011, including the Welsh Language Standards, the Trust ensures the Welsh language is treated no less favourably than English.
- 7.3.2 To comply with these standards and the Trust's Compliance Notice, specific policies and documentation must be published in Welsh, particularly those related to:

- Workplace behaviour
- Health and well-being
- Salaries and benefits
- Performance management
- Absence from work
- Working conditions and patterns

7.3.3 WAST employees are encouraged to use Welsh, and Occupational Health consultations are available in Welsh. Additionally, occupational health correspondence and key forms, such as pre-placement and management referral forms within the digital platform OPAS G2, will be accessible in Welsh once the All-Wales configuration is finalised.

7.4 Counter Fraud

The Welsh Ambulance Services University NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility Service <https://cfa.nhs.uk/report-fraud> Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

7.5 Records Management

7.5.1 All Occupational Health and Wellbeing records kept in digital form are held securely according to the Data Protection Act 1998.

7.5.2 Occupational Health records and wellbeing related records will be kept for a minimum of 3 years after termination of employment.

Except if statute requires as below:

- Vaccination records retain for 10 years after conclusion of treatment.

7.5.3 Statutory records will be retained for a period specified in the legislation. Notes related to COSHH Regulations, Noise at Work Regulations, Hand Arm Vibration Regulations: 40 years.

- Notes related to Ionising Radiation (IRMER): 50 years from the date of last entry or age 75, whichever is the longer,
- Asbestos regulations – 50 years

7.5.4 Access to notes and reports will be in line with Access to Medical Reports Act 1988, Data Protection Act 1998, and the Access to Health Records Act 1990.

- 7.5.5 Any subject access requests or Freedom of Information requests will be processed in line with the Trust policy.
- 7.5.6 The Trust recognises the importance of sound records management arrangements for both clinical and corporate records. The Trust's records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations.
- 7.5.7 Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

7.6 Information Governance

- 7.6.1 Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.
- 7.6.2 The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.
- 7.6.3 Annual team operational objectives for the Occupational Health Service are set, as well as annual individual PADR objectives.
- 7.6.4 All clinical staff will be registered with the relevant clinical body for their profession.
- 7.6.5 Occupational Health data reports will be submitted to the Health and Safety Group, people and culture business committee and all Wales groups as required.

8. ROLES AND RESPONSIBILITIES

8.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation

8.2 Directors

The Executive Directors are responsible for ensuring teams have access to policies, and that processes are effectively communicated to promote compliance. They are also accountable for ensuring that an effective

Occupational Health Policy that aligns with the trusts broader objectives is in place, including employee welfare, workplace safety and adherence with legal standards.

8.3 Service Managers / Clinical Leads / Locality Managers

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access the Occupational Health Policy as this applies to all employees and volunteers.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation; and to contact Occupational Health for support with this if required
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.
- Investigate breaches of this policy with collaboration from People Services.

8.4 Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document.
- Ensuring that a copy of this policy is readily available/accessible to all staff.
- Ensuring information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.
- identify specific staff training needs on the implementation of new or updated documents.
- Considering and implementing guidance provided by Occupational Health in the management of temporary and long-term health conditions in the workplace. If recommended adjustments cannot be accommodated, they must escalate any concerns to Occupational Health and People Services.

8.5 All Staff

Employees have a duty to co-operate with the Occupational Health Service in the implementation of this policy and to undergo screening and immunisation as advised. They are expected to:

- Report to their manager and Occupational health, any medical condition, which they believe is connected to their work and report any significant medical conditions, which may affect their ability to carry out their duties.
- Self-refer as appropriate to the Occupational health service to obtain advice in confidence.

- Inform their manager/deputy if they have been in contact with or are symptomatic of a communicable infection.
- Contact Occupational health for advice from if they become unusually vulnerable to infection or immunocompromised e.g. by steroids, chemotherapy/radiotherapy, or HIV.
- To take ownership/responsibility for their own health and well-being.
- Ensure that Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

8.6 Occupational Health Team

- Has responsibility for the effective implementation of this policy and will review the policy when guidance changes or as indicated by review date.
- Will develop Standard Operating Procedures for specific elements of the scope of the Occupational Health Service.

9. AUDIT, MONITORING AND COMPLIANCE

- 9.1 Patient information is recorded on the Occupational Health All Wales procured electronic management system.
- 9.2 Reports on statistical data will be provided to the people and culture management team and reported through the Health & Safety Group on a quarterly basis.
- 9.3 A monthly audit plan will be established to assess whether key performance indicators (KPIs) set by the All-Wales Tripartite Group have been met. Audit reports will be shared with the People and Culture Committee, the National Health and Safety Forum, and Infection Prevention and Control (IPC) forums as appropriate. Additionally, findings will be communicated to Public Health Wales and the Welsh Government when required. Any necessary actions identified through the audits will be implemented to ensure compliance. This process is essential for safeguarding workforce health and protecting both staff and patients.
- 9.4 Documentation audits will be undertaken at least annually for clinical practitioners.

10. REFERENCES

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11. APPENDICES

Appendix 1	All Wales Scope of Service and Minimum Service Standards and KPI's from All Wales tripartite group

Appendix 1

All Wales NHS Occupational Health (OH) Scope of Practice and Minimum Service Standards

There are several different models of OH across NHS Wales, including integrated OH models with Staff Wellbeing where resources are utilised across the two services, stand-alone OH services and one regional model with the integration of OH across two Health Boards. The seven Health Board based services, along with WAST, are now all utilising OPAS G2 as their operating systems. This has facilitated some standardised processes and (eventual) reporting as a result of All Wales NHS OH collaboration.

As part of the National workforce Implementation Plan and as part of the delivery of our 2022-4 collective agreement, Welsh government is working in social partnership with NHS Wales Employers and health trade unions to support the development of an NHS Wales Occupational Health Model with the aim of ensuring equitable access to high quality OH services for NHS employees throughout Wales.

Table 1 below outlines the services that form the core services within the model, although it is recognised that there are some currently not delivered by all services.

Table 2 below provides minimum service standards which have been developed aligned to the core service specification – again it is recognised that these may not currently be delivered by all services.

As part of the returns required under Welsh Health Circular (2024) 017 “Implementation of the Non-pay Elements of the 2022-4 Collective Agreement”, Health Boards and Trusts are asked to provide baseline reports against the core specification and minimum standards.

Additionally, attached is the Faculty of Occupational Medicine ‘Safe Effective Quality Occupational Health Services (SEQOHS)’ standards. Health Boards and Trusts are asked to provide assurance that they have plans in place to undertake the agreed internal self-assessment against these standards by 30th November 2024, with a view to developing plans to achieve accreditation by 2027 as part of their IMTPs for 2025 - 2028.

The returns will be utilised to assist in developing all Wales standards, workforce modelling and next steps in supporting accreditation

Table 1 Core Specification

Activity	Scope of activity
Doctor Management Referral	· Independent medical opinion and advice from an Occupational Health physician based on assessment of complex medical cases with specific advice regarding employee fitness, workplace adjustments, the relationship of the health issue to the employee's work, and likely expectations of how the health condition might progress · Virtual or face to face consultation between employee and OH Physician · Writing for GP or specialist report where appropriate, written medical report with relevant information on the medical condition and evidence-based recommendations
Nurse Management Referrals	· Assessment of cases by Nurse with specific advice regarding employee fitness, workplace adjustments, the relationship of the health issue to the employee's work, and likely expectations of how the health condition might progress · Virtual or face to face consultation between employee and OHA · Writing for GP or specialist report where appropriate, written report with relevant information on the medical condition and evidence-based recommendations
Pre-employment health assessments	· Upon return of pre-employment health questionnaire, a pre-placement health assessment for employees is undertaken in order to identify any adjustments to support the employee within their role. · Following provision of health clearance, immunisation review is undertaken to identify immunisations required for the role
Vaccinations	· A range of Occupational vaccination programmes offered, including Hep B, MMR and BCG
Sharps injury / contamination incident management	· Assessment following report of injury to OH · Obtain serum save at time of incident with appropriate follow-up blood tests following the incident
Management of outbreaks of communicable diseases	· Provide advice on exclusion from work for communicable diseases · Undertake contact tracing · Liaise with managers regarding work-place exclusions

	· Provide prophylaxis where required
Health Surveillance	· Health surveillance programme requested by manager following completion of risk assessments · Undertake assessments for skin, noise, hand and arm vibration and respiratory · Provide fitness outcome letter to the manager
Self-referrals	· Provide work related advice to employees and signpost to relevant support services
Nurse Advice	· Provide advice to employees on a range of health concerns including menopause, infectious diseases and musculoskeletal (MSk) issues
Skin Assessments	· Undertake assessments on staff reporting skin related issues, providing advice on adjustments and good skin care · Refer to dermatology when appropriate
Contributing to organisational polices concerning OH&WB	· Review and contribute to organisational polices related to protecting the health and wellbeing of staff
TB Screening	· Screening for tuberculosis for staff who have travelled within high risk areas with appropriate follow-up for positive results and referral to respiratory
NMC verification	· Undertake health assessment and provide conformation of health status to NMC
Heli-Pad Medicals	· Undertaken for organisations requiring this
Driver's Medicals	· Drivers Medicals Group 1 and 2 where relevant
Ionising Radiation Medicals	· These are essential/core for the organisation but may be managed by non-OH services
Night Workers Assessment	· Night workers assessment undertaken as required
Physiotherapy Management Referrals	· Physiotherapy Management Referrals undertaken as required
Occupational Therapy Management Referrals	· Occupational Therapy Management Referrals undertaken as required
Working at heights Medical	· Working at heights Medical undertaken as required

Table 2 - Minimum Service Standards

The following minimum service standards have been developed aligned to the core service specification.

1. Service Developments	1.1	OH, departments will develop high quality services around the organisation and its people, demonstrating benefits to the organisation through related reporting processes whilst ensuring compliance with relevant legislation, standards and policies.
	2.1	Management referral processes and related information will be accessible and available to all managers via WAST & the Health Board's communication systems
2. Management Referral Support	2.2	The 1 st offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time.
	2.3	Where consent is agreed during consultation, the report will be sent to the manager on the same day of the appointment KPI that this is achieved 80% of the time.
	2.4	The OH report will inform the manager of the staff member's health status, based on the specific queries in the referral, with advice, recommendations and adjustments that may support the staff member to return to work/remain in work.
	2.5	The Occupational Health service will notify the employing manager of non-attendance at management referral appointments.
3. Staff self-referral support	3.1	OH, services will provide self-referral advice, support and relevant signposting for all staff. Self-referral processes will be communicated through the Health Board's communication systems
	3.2	When an individual self-refers, an appointment with the relevant OH staff member will be provided within 29 calendar days. KPI that this is achieved 80% of the time
	3.3	Advice, support and signposting when appropriate will be provided to the staff member to support their health and work needs

4. Pre-employment health assessment	4.1	All employees are issued with a pre-placement questionnaire as part of the pre-placement process, on completion, the questionnaire will be made available to Occupational Health and advice on reasonable adjustments will be provided where applicable
	4.2	Completion of the health assessment will enable clearance for 'standard clearances' within 7 calendar days KPI that this is achieved 80% of the time. <i>This does not include pre-employments which require additional or enhanced clearance, for example, EPP workers, staff who declare health issues and international recruitment.</i>
	4.3	The TRAC system will be updated to show recruitment and the employing manager of non-attendance at pre-employment assessments.
5. Health Surveillance	5.1	Using HSE and COSHH guidance, managers will undertake risk assessments to identify health related risks and inform OH services of staff requiring health surveillance. Upon receipt of assessment, OH will specify and undertake the surveillance required. Upon completion, a report will be forwarded to the manager advising on fitness for work and any further follow-up.
	5.2	Where required, Individuals will be offered an appointment for Health Surveillance within 29 calendar days of receipt of questionnaire KPI that this is achieved 80% of the time.
	5.3	The Occupational Health service will notify the employing manager of non-attendance at Health Surveillance appointments
6. Record Keeping Standards	6.1	All employee/clients must hold one active record within OPASG2
	6.2	All clinical and non-clinical interactions with the employee, referring manager or any 3 rd party (whether by telephone, face to face, email or letter) must be captured/uploaded within the clinical record following the Department Standard Operating Procedures (SOPs). Records must be accurate, factual, objective and minimise the use of subjective statements
	6.3	All entries in a record must be recorded, wherever possible, with the involvement of the employee/client and recorded in a language that the employee/client can understand. Abbreviations (other than those agreed) must not be included in any records.
	6.4	Records, (electronic and paper) must be retained, stored and destroyed as per Welsh Government guidance: NHS WALES RECORDS MANAGEMENT CODE OF PRACTICE 2021 (www.gov.wales)



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University NHS Trust

Recruitment & Selection Policy

Policy Number:	058	Version No:	19.15 Draft	Supersedes:	19.13 Draft
Date of Approval:	TBA	Review Date:	3 years from date of approval	Impact Assessments Completed:	10/07/2024
Classification of Document:	Employment	Type of Document:	Policy	Approved by:	People and Culture Committee
Brief Summary of Document:	This policy and associated process and guidelines are set out to ensure that recruitment to the Welsh Ambulance Services University NHS Trust, is managed in a consistent and equitable way, based on objective assessment of candidates against the requirements of the job and complies with legal requirements and best practice.				
Scope:	This policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees.				
To be read in conjunction with:	Recruitment & Selection Process Recruitment & Selection Guidance Transfer Policy Organisational Change Process Policy Disclosure and Barring Service Check (DBS) Guidance for Managers				
Owning Committee	People and Culture Committee				
Policy Lead: Trade Union Lead:	Charlie Boshier Mark Marsden	Job Title:	Recruitment Manager Trade Union Partner		
Executive Director:	Carl Kneeshaw	Job Title:	Director of People		

Version Control Sheet

Version	Date	Author	Summary of Changes
19.0	25/10/2018	FRC	Approved (for 18 months)
19.1	14/06/2024	Charlie Boshier	Update and revision from v.19 - Added Sponsorship - Criminal convictions – Added to driving standards and drink and drug driving convictions (DR10) - Updated the Welsh Language Measures. - Updated advice re: inclusion & diversity.
19.2	12/07/2024	Lisa Trounce	- Completion of gaps on front page - Formatting throughout - Comments added for Policy Lead to action
19.3	16/07/2024	Charlie Boshier	Actioned Comments from Lisa
19.4	19/07/2024	Lisa Trounce	- Minor formatting throughout - Policy returned to Policy Lead as unable to open link to EqIA and changes made to policy content were not showing as tracked
19.5	08/08/2024	Charlie Boshier	Updated policy resubmitted with tracked changes and formatting addressed
19.6	09/08/2024	Lisa Trounce	- Trust logo and Crown badge realigned on front cover - Version numbering corrected and Version Control Sheet updated - Task & Finish Group section amended - Significant formatting and amendment to presentation throughout policy - All references to WASUT changed to WAST - All text boxes contained in Appendix reformatted for presentation - Directions to Siren pages replaced with SharePoint links - Footer updated to include Policy No. on all pages and remove version number

Version	Date	Author	Summary of Changes
19.7	05/09/2024	Charlie Boshier	- Comments received from Policy Group actioned: - Created 5.6 Driving originally under convictions. - Added Transfer Policy to section 7 - Reworded section 7 re: skills gap analysis as there is currently no training to support this. - Added to section 7 re: need for managers to provide constructive feedback. - Added to section 7 re: Trade Union Partner participation on interview panels.
19.8	10/09/2024	Lisa Trounce	Final formatting & preparation prior to Trust-wide consultation Front cover updated Version Control Sheet updated Contents Page updated / reformatted
19.9	11/11/2024	Charlie Boshier	Comments received from Trust consultation actioned: - Added volunteers to policy scope. - Removed interview panel makeup and added to guidance. - Section 5.5 - Increased information to criminal conviction section around DBS process and clarity that checks are only undertaken to successful candidates, added link to DBS managers guidance which includes the risk assessment form. - Section 9 - Removed reference to Data Protection Bill 2018 and link to privacy notice.
19.10	19/11/2024	Lisa Trounce	Formatting of policy with post consultation updates prior to submission to Policy Group on 27/11/2024.
19.11	27/11/2024	Lisa Trounce	Comments from Policy Group 27/11/2024 recorded. Actions completed: - Version control on front cover amended. - Scope of policy on front cover and Pg7 Section 2 amended to include volunteers, other workers, etc.

Version	Date	Author	Summary of Changes
			- Approval route updated. - Section 7 Roles & Responsibilities: Chief Executive added (7.1), and 7.2 title amended to include Executive Directors. - Contents Page updated - Comments added to reflect Policy Group feedback > for action by Policy Lead.
19.12	02.12.2024	Charlie Boshier	Remaining comments from Policy Group 27/11/2024 actioned: - Separated the recruitment and selection process and guidance into separate documents. - Reviewed acronyms and law of first mention.
19.13	06/12/2024	Lisa Trounce	Final review, edit and formatting prior to updated policy going to ELT and Committee for approval.
19.14	10/12/2024	Charlie Boshier	Amendments to policy made in response to comments received during consultation: Section 5 typo amended Section 5.3 Welsh Language – reviewed with Welsh Language Services Manager Section 6 No further info to add on training Section 7.1 Roles and Responsibilities amended Section 7.2 Reworded “should” replaced by “shall” Section 8 Audit & Monitoring strengthened
19.15	16/12/2024	Lisa Trounce	Final review, edit and formatting prior to draft policy being presented to committee for approval.
Keywords	Recruitment, Selection, Interviews, Driving, Equity, Inclusion and Diversity, Disability, Welsh Language		

Task and Finish Group Members

Name	Job Title
Charlie Boshier	Recruitment Manager
Mark Marsden	Trade Union Partner
Andrew Morgan	Senior Education and Development Lead
Melfyn Hughes	Welsh Language Services Manager
Hayley Jones Dunne	OD Manager – Equality, Diversity, and Inclusion

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	14/11/2024	Kelly Holding
EqlA	10/07/2024	EqlA completed by Charlie Boshier, Kat Cobley & Hayley Jones Dunn
Welsh Language		
Environment		
Quality		

Policy Approval Route

Meeting Title	Date	Purpose/Outcome
Review Meeting	14/06/2024	To review and discuss updates
Inclusion and Diversity Meeting	09/07/2024	To review and ensure inclusion and diversity is embedded throughout the policy
Policy Group	20/08/2024	Approval/recommend approval > amendments approved for consultation
28-day Trust-wide Consultation	10/09/2024 – 08/10/2024	Trust-wide consultation/comments
Policy Group	27/11/2024	Review of post consultation changes > Pending agreed amendments, policy approved for onward travel to ELT and Committee for approval.
Executive Leadership Team	12/12/2024	Noted and endorsed subject to non-material amendments being made by TM (Section 8). Remaining query resolved following ELT.
People and Culture Committee	18/02/2025	For Approval and Adoption

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

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Contents

1. Introduction	8
2. Policy Statement	8
3. Scope	8
4. Aim & Objectives	8
5. Equity, diversity and inclusion	9
5.1 Equality Act 2010 & Worker Protection (Amendment of Equality Act 2010) Act 2023 ..	9
5.2 Disability Confident Scheme	9
5.3 Welsh Language Measure (Wales) 2011	9
5.4 Sponsorship	10
5.5 Criminal Convictions	10
5.6 Driving	10
6. Training and Implementation	11
7. Roles and Responsibilities	11
7.1 Chief Executive	11
7.2 Directors, Assistant Directors and Heads of Service	11
7.3 Appointing Manager	11
7.4 People Services	12
7.5 Recruitment Team at NHS Wales Shared Service Partnership (NWSSP)	12
7.6 Occupational Health	12
7.7 Counter Fraud	13
8. Audit and Monitoring	13
9. Data Protection / Record Keeping	13
10. References	14

1. INTRODUCTION

This policy and associated process and guidelines are set out to ensure that recruitment to the Welsh Ambulance Services University NHS Trust (WAST) is.

- managed in a consistent and equitable way.
- based on objective assessment of candidates against the requirements of the job.
- complies with legal requirements and best practice.

2. POLICY STATEMENT

The Trust recognises its employees as being fundamental to its success. A strategic and professional approach to recruitment processes help enable the Trust to attract, appoint and retain employees with the necessary behaviours, skills, and attributes to fulfil its strategic aims, and support the organisation's values.

The Policy has been developed to assist managers during the recruitment process. Advice and support are available at all stages of the recruitment process from People Services, WAST Recruitment team, Equality Diversity & Inclusion (ED&I) team and the NWSSP Recruitment team.

The process will be amended in those situations where there is a possible employment opportunity for displaced, at risk or employees with a disability. Please refer to the Trust Organisational Change Policy for guidance on displaced and at risk employees.

3. SCOPE

This policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees.

4. AIM & OBJECTIVES

- To recruit and select the right person, with the right approach, to the right job, at the right time, minimising potential disruption to service delivery.
- To ensure we have the right calibre of staff with the appropriate qualifications, skills, experience, competencies, and personal qualities to meet both present and future requirements of the Trust.
- To ensure that we strive to recruit staff whose diversity reflects the communities we serve. This will be monitored on an annual basis.
- To provide a standardised approach across the organisation to the recruitment and selection of staff, ensuring fairness, consistency, and compliance with legislation and Trust procedures.
- To become an employer of choice.
- To treat all applicants and candidates with dignity and respect at all stages of the process.
- To recruit employees who display the values and behaviours of the Trust.

5. EQUITY, DIVERSITY AND INCLUSION

The Trust is committed to ensuring that, as far as is reasonably practicable, that recruitment reflects the candidates' individual needs, and does not discriminate against individuals or groups on the grounds of any protected characteristics.

The Trust is committed to ensuring that its workforce reflects the diversity of the population it serves. This means implementing positive actions to address any gaps in the diversity of our workforce during recruitment and selection activity.

Our recruitment guidance can help staff to assess workforce diversity and outline steps that can be taken to address any gaps.

5.1 The Equality Act 2010 & The Worker Protection (Amendment of Equality Act 2010) Act 2023

This legislation is the most relevant in terms of recruitment and selection, with the aim of making sure that no one is treated less favourably when applying for a job. Please refer to guidance section.

5.2 Disability Confident Scheme

The Disability Confident Employer symbol will be used on all job adverts to show that the Trust is accredited to the scheme and encourages applications from candidates with a disability. As users of the Disability Confident Scheme, the Trust is committing to guarantee to interview all disabled applicants who meet the minimum criteria for a job vacancy.

Applicants with a disability will also be advised to inform the Trust of any reasonable adjustments they require to enable their participation in the recruitment and selection process.

5.3 Welsh Language Measure (Wales) 2011

The Trust is committed to fulfilling its obligations under the Welsh Language (Wales) Measure 2011 via its Welsh Language Standards Compliance Notice. The Trust's compliance with Welsh Language Legislation is monitored through submitting an annual report to the Welsh Language Commissioner.

In recruitment terms, the Trust will note whether the ability to speak Welsh is 'desirable' or 'essential' to comply with the Welsh Language Standards. Guidance is provided to recruitment managers on how to determine this. The Trust is committed to actively increasing our Welsh speakers across the Trust to enable us to provide a fully bilingual service.

5.4 Sponsorship

There are situations where the Trust may apply for a Certificate of Sponsorship, for a successful candidate, who does not possess the right to work in the UK. This will be determined on a case-by-case basis, with support from the Recruitment Team and People Services Team.

5.5 Criminal Convictions

The Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 applies to all appointments involving direct contact with patients for the provision of healthcare. Consequently, applicants for such appointments must declare to the Trust full written details of all criminal convictions (both spent and unspent).

The Trust will additionally undertake criminal record checks on successful candidates where it is appropriate for the role being appointed to.

The Trust undertakes not to discriminate unfairly against any subject of a criminal record check on the basis of a conviction or other information revealed.

The Trust can only ask an individual to provide details of convictions and cautions that the Trust are legally entitled to know about. Where a DBS certificate at either standard or enhanced level can legally be requested (where the position is one that is included in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 as amended, and where appropriate Police Act Regulations as amended)

All declared convictions will be considered solely in relation to the position being applied for. A risk assessment will be completed with the manager. The manager will seek guidance from people services and safeguarding where required in line with the Trust [Disclosure and Barring Service Check \(DBS\) Guidance for Managers](#).

If the entries included on the positive DBS disclosure are of a potential safeguarding concern, e.g. violent (Actual Bodily Harm (ABH), Grievous Bodily Harm (GBH), Assault, etc) or sexual in nature or related to drug offences, the appointing manager will need to discuss the case with the Head of Safeguarding, for their review and further investigation if required.

5.6 Driving

To drive a Trust vehicle a driver must:

- Hold the appropriate driving licence for the vehicle being driven.
- Satisfy driver minimum age requirements.
- Satisfy the legal eyesight standards.
- Meet all DVLA medical requirements for the category of vehicle being driven i.e. "Group 2 Medical Standards applied to all passenger carrying staff".
- Have a maximum of 3 points on entry into Service.

- Appointments which involve driving a Trust vehicle and direct contact with patients will not be considered until drink or drug driving conviction becomes spent and the conviction is removed from driving licence, after 11 years.

6. TRAINING AND IMPLEMENTATION

All staff will be made aware of this policy and copies can also be viewed on the Trust's Intranet or obtained via the WAST Recruitment team.

Training will be provided to appointing managers by WAST Recruitment Team and the Trust diversity and inclusion team on an informal basis.

Appointing Managers will also be encouraged to attend formal Trac training provided by NHS Wales Shared Services Partnership (NWSSP).

7. ROLES AND RESPONSIBILITIES

7.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

Directors, Assistant Directors and Heads of Service Directors, Assistant Directors and Heads of Service will be responsible for ensuring the Policy is implemented and the process followed within their respective departments/ directorates.

7.3 Appointing Manager

The Appointing Manager is responsible for employing the most appropriate individual/s to fill vacancies. They should recruit and select staff in accordance with the principles outlined in the Policy, process, and guidelines. Prior to recruitment the appointing manager will assess diversity within the team and will have a proactive approach to increasing diversity within the team. The Trust actively works to reflect the diversity of the population we serve. The ED&I team will be able to support managers to assess the diversity within their team appointing managers should use this information to inform appointment.

In line with the transfer policy appointing managers should be aware internal staff transfers will be considered prior to any external recruitment event taking place. Any new staff appointed should be offered the base location vacated following existing transfers under the transfer policy. However, once a base location has been offered to a recruitment candidate, please note the recruitment candidate will have priority for that base location over any new transfer requests submitted between the time the candidate is offered the base location and the date they start in their role. This is particularly relevant for large scale recruitment events where timescales may be longer than normal.

All recruitment shall be approved via the agreed establishment control process.

All recruitment is undertaken through the online application process via TRAC.

Special arrangements may be put in place for recruitment to Director posts.

In organising the recruiting panel, the Appointing Manager must ensure, where possible, that the makeup of the panel is as diverse as possible. This is to minimise the risk of unconscious bias.

Where a candidate is known to a member of the shortlisting/selection panel, this must be declared. No one is permitted to shortlist or interview a member of their own family or a known friend and any panel member who feels that their knowledge of a candidate would compromise their objectivity must withdraw from the selection process.

However, it is inevitable that the Appointing Manager will be part of interview panels for recruiting into their teams and that some existing employees, known to the manager, may apply for vacancies. In these situations, the manager will interview for roles within their teams, alongside other panel members and/or People Services to ensure balance on the panel is maintained.

Following the recruitment process appointing managers are expected to ensure candidates are offered constructive feedback and feedback to be provided in a timely manner.

7.4 People Services

Staff from People Services will notify all managers of any changes in employment law which impact on recruitment and selection as and when necessary. An updated legislation section within the Recruitment icon on the People Services page will be used for this purpose. If the legal implications of the legal changes are significant, additional training will be provided for staff.

The People and Culture Directorate will ensure that vacancy control and funding decisions in relation to recruitment, have been undertaken in accordance with establishment control.

7.5 Recruitment Team at NHS Wales Shared Service Partnership (NWSSP)

The recruitment team at NWSSP will provide administrative support to the Trust regarding the recruitment and selection of staff. NWSSP work in partnership to ensure compliance with relevant legislation, policies, and procedures.

7.6 Occupational Health

The Trust's Occupational Health Department will process employment screening and appointments as necessary, providing an appropriate clearance report on the prospective employee's suitability to work, with any adjustments as necessary, within an agreed timescale.

7.7 Counter Fraud

The Trust considers a false declaration made by an employee during their application process to be misconduct, alongside also being considered as fraudulent conduct by the Local Counter Fraud Specialist. Misconduct will normally be addressed through the Trust's disciplinary process and Counter Fraud may instigate its own investigations.

Any Incidents discovered where false or misleading information has been provided on a job application, which leads to that person successfully gaining employment with the Trust, shall be reported immediately to the Trust's Local Counter Fraud Specialist, for consideration of potential criminal proceedings under the Fraud Act 2006.

8. AUDIT AND MONITORING

People Services will perform periodic audits three yearly as a minimum of the recruitment and selection process to ensure the policy and process is consistently applied across the Trust. Audits will be reported into the People and Culture Directorate Business Meetings.

This policy will be reviewed in three years' time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

The policy notes an audit will be completed every three years as a minimum. A more frequent audit can be facilitated (especially if all recruitment is centralised as per recent recommendations via internal audit and the recent service review. Equality, Diversity and Inclusion (ED&I) reporting is undertaken through People and Culture Committee.

Data on candidate diversity will be included in the reporting in order to support an increase in diversity across the organisation. In addition to EDI elements of recruitment, Shared Services reporting on time to recruit and workforce establishment levels and other workforce data is reported through the workforce reporting into the Integrated Technical Planning Group (ITPG).

9. DATA PROTECTION / RECORD KEEPING

The confidentiality of personal information must be respected at all times by everyone involved in the recruitment process. Personal information gathered throughout the recruitment process will be stored confidentially on the electronic recruitment system and in electronic personal files and will be accessible only by individuals involved in the recruitment process on a need-to-know basis, (please note this may not be the case as there are various reasons why recruitment information may be accessed other than recruitment process. These are set out in the NWSPP recruitment Privacy Notice and [WAST staff Privacy Notice](#)), in line with the Data Protection Act 2018, UK General Data Protection Regulation.

The management and disposal of recruitment records will be in accordance with the Records Management and Records Retention & Archive policies.

10. REFERENCES

Welsh Ambulance Services University NHS Trust Welsh Language Standards, on the Welsh Language Recruitment and the Welsh Language Recruiting and appointing (Standards 106 – 109).

Disability Confident Employer Scheme and Guidance, Department of Work and Pensions, November 2016.

Equality Act 2010 and Public Sector Equality Duty.

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Welsh Ambulance Services
University NHS Trust

Occupational Immunisation & Screening Policy

Policy Number:	085	Version No:	0.12 Draft	Supersedes:	New Policy
Date of Approval:	TBA	Review Date:	3 years from date of approval	Impact Assessments Completed:	28/07/2024
Classification of Document:	Employment	Type of Document:	Policy	Approved by:	People and Culture Committee
Brief Summary of Document:	The immunisation policy ensures that WAST staff and volunteers receive appropriate vaccinations based on their roles and exposure risks, protecting both employees and patients from preventable diseases. Regular assessments and updates keep the policy aligned with current health standards and regulatory requirements.				
Scope:	This policy outlines the assessment and management of immunisation status for all staff, volunteers, and contractors in clinical and non-clinical patient-contact roles within WAST. It ensures immunisations appropriate to their role and exposure risk are offered at recruitment or during employment. The policy also provides guidance for clinicians administering immunisations and governs the operational management of all vaccines used by the Trust				
To be read in conjunction with:	• Medicines Management Policy • Infection Prevention and Control: Sharps Policy safe use and disposal • Infection Prevention & Control Policy Elimination of Healthcare Associated Infections • Control of Substance Hazardous to Health Policy and Procedure • Health And Safety Policy • Maternity and Adoption Leave Policy / New and Expectant Mothers Risk Assessment Procedure • Access to Personal Information Policy • The Green Book: Immunisation Against Infectious Disease (Department Of Health) Greenbook title page and index (publishing.service.gov.uk) • RCN Immunisation Knowledge and Skills Competence Assessment Tool • Yellow Card (Medicines & Healthcare products Regulatory Agency) Yellow Card Making medicines and medical devices safer (mhra.gov.uk) • Data Protection Policy				
Owning Committee	People and Culture Committee				
Policy Lead:	Kim Crichton	Job Title:	Occupational Health Manager		
Trade Union Lead:	Marcus Viggers		Trade Union Partner		
Executive Director:	Carl Kneeshaw	Job Title:	Director of People		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	28/07/2024	Kim Crichton	Draft submitted following consultation from T&F group
0.2	07/08/2024	Lisa Trounce	Note to Policy Lead as policy on old template – contents of new policy to be transferred to new template. Version number and Version Control updated Formatting
0.3	09/08/2024	Kim Crichton	Contents of new policy transferred to new template and sections completed as indicated.
0.4	09/08/2024	Lisa Trounce	Front Sheet formatted to fit on one page Version Control Sheet updated Formatting throughout (justification/alignment of paragraphs/bullet points, all sub-headings changed to lower case, insertion of lines between paragraphs). Comment requesting Policy Lead provide a paragraph under section 10 re: audit and monitoring.
0.5	13/08/2024	Kim Crichton	Section 10 updated regarding audit and monitoring. Version on front cover amended. Version Control Sheet updated
0.6	02/09/2024	Kim Crichton	Comments supplied by Policy Group actioned:
0.7	10/12/2024	Kim Crichton	Title revised to include immunisation and screening Section 6 updated section to include serological screening. 6.1 added section regarding EPP workers and serological assessment required. 6.2 altered wording. 6.5 extract from the green book revised to remove 'children' and remain adult focused as policy is aimed at staff members. 6.6 added mhra yellow card information, and link within reference section. 6.7 alteration to wording. 6.8 alteration to wording as advised within PG.

Version	Date	Author	Summary of Changes
			Section 7 and 8.7 combined within main heading 7 training and implementation. 9.3 wording revised. Section 10 specific reporting forums listed Section 11 references updated/added
0.8	16/12/2024	Lisa Trounce	Final review, edit and formatting prior to draft policy going out for Trust-wide consultation. On front page Executive Director changed from Angela Lewis to Carl Kneeshaw
0.9	23/01/2025	Kim Crichton	Post consultation changes: - Scope updated to reflect paragraphs 3 & 4, - Paragraph 6, acronyms outlined at time of introduction. 6.3.1 Reasons for direction to Medicines Management Policy added. 8.2 Wording updated to include Welsh offering within service in reference to EqIA. 8.2 Wording amended 9.2 Wording amended 8.6.1 Reference to Data Protection Policy regarding information governance. Also added to items to be read in conjunction with.
0.10	24/01/2025	Lisa Trounce	Updated policy reflecting relevant post consultation comments formatted in readiness for Policy Group on 31/01/2025. Version Control Sheet amended to reflect Policy Group now reports to ADLT not ELT.
0.11	01/02/2025	Lisa Trounce	Post consultation tracked changes accepted, front cover updated, and approval route updated, in readiness for onwards travel to ADLT to recommend approval by Committee.
0.12	03/02/2025	Lisa Trounce	Following ADLT approval, policy prepared for onwards travel to Committee for approval and adoption
Keywords	Immunisation, vaccines, occupational health, wellbeing, surveillance		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	28/07/2024	Kim Crichton / Marcus Viggers
EqIA / Welsh Language		
Environment		
Quality		

Task and Finish Group Members

Name	Job Title
Kim Crichton	Occupational Health Manager
Lynda Bogunovic	Occupational Health Business Manager
Marcus Viggers	Trade Union Partner
Kelly Holding	Data Protection Compliance Manager

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	20/08/2024	Review prior to consultation - Pending amendments policy approved for consultation
28-day Consultation Period	16/12/2024 – 13/01/2025	Trust-wide consultation
Policy Group	31/01/2025	Review post consultation - Approved for onwards travel to ADLT to recommend approval by Committee.
Assistant Directors Leadership Team (ADLT)	03/02/2025	Approved - Recommended for approval and adoption by Committee
People and Culture Committee	18/02/2025	For Approval and adoption

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb.Policies@wales.nhs.uk

Contents

1. Introduction	6
2. Aim.....	6
3. Scope.....	6
4. Policy Statement.....	6
5. Objective	6
6. Occupational Immunisation Policy Outline.....	6
6.1. Immunisation and Testing Requirements in Employment	7
6.2. Immunisation Recommendations by Staff Groups	7
6.3. Patient Group Directives (PGD).....	9
6.4. Administration and Storage of Vaccines	9
6.5. Contra-indications to Immunisation	10
6.6. Adverse Events Following Immunisation	12
6.7. Anaphylaxis	13
6.8. Employees Who Decline Immunisation or Fail to Seroconvert Following Immunisation	13
6.9. Post-exposure Management.....	14
7. Training and implementation.....	14
8. Impact Assessments.....	14
8.1. Equality Impact Assessment.....	14
8.2. Welsh Language Impact Assessment	15
8.3. Environmental Standards and Impact Assessment.....	15
8.4. Counter Fraud.....	15
8.5. Records Management	15
8.6. Information Governance	16
8.7. Health and Safety	17
9. Roles and Responsibilities.....	17
9.1. Chief Executive.....	17
9.2. Directors	17
9.3. Service Managers / Clinical Leads / Locality Managers	17
9.4. Line Managers	18
9.5. All Staff	18
10. Audit and Monitoring	19
11. References.....	19

1. INTRODUCTION

Welsh Ambulance Services University NHS Trust (WAST / 'the Trust') acknowledges its duties under the Health and Safety at Work Act 1974 to protect, as far as is reasonably practicable, the health, safety and welfare of its staff. Risk assessment, as required by the Management of Health and Safety at Work Regulations and the Control of Substances Hazardous to Health Regulations 2002, identifies that NHS staff may be exposed to infectious agents in the course of their work and should be appropriately protected. Furthermore, the Trust also has a responsibility to reduce the risk of infection to patients.

2. AIM

The aim of this policy is to ensure that those joining WAST or transferring to a new role within the Trust, have received appropriate Occupational Health Clearance before a start date is agreed, which includes immunisation in order to reduce the risk of vaccine preventable disease within the workplace. The policy aims to comply with public health guidelines and legislative requirements and to protect the health and wellbeing of all staff, volunteers and patients.

3. SCOPE

All employees and volunteers will be offered immunisation appropriate to their occupation/employment and exposure risk as identified at recruitment stage, or during the course of their employment.

4. POLICY STATEMENT

This policy sets out the requirements and arrangements for the assessment of immunisation status of any individuals undertaking paid or unpaid duties, or as part of a contractual arrangement within WAST involved in direct clinical and non-clinical contact with patients.

5. OBJECTIVE

To ascertain the immunity status of all employees before commencement of employment, and to offer a comprehensive immunisation programme, according to their type of role. The purpose of the Occupational Immunisation Policy is to protect employees and patients from illness associated with communicable disease where possible.

6. OCCUPATIONAL IMMUNISATION POLICY OUTLINE

Individual immunisations will operate under Patient Group Directives (PGD) and their associated Standard Operating Procedures (SOP's) for the Occupational Health Service. The following policy guidance applies to all immunisations and serological screening for employment within WAST.

6.1. Immunisation and Testing Requirements in Employment

- 6.1.1 This policy complies with UK and Welsh Government policies. Certain tests of immunity and immunisations are specified for certain groups of employees.
- 6.1.2 A healthcare worker who is new to the NHS and who will perform Exposure Prone Procedures (EPP) or existing staff who are new to EPP, must be tested for hepatitis B surface antigen (HBsAg), Hepatitis C Antibody (HCV) and HIV. And results must be from an identified validated sample (IVS).
- 6.1.3 Health Clearance for EPP work will be given by Occupational Health after pre-placement health assessment. Existing EPP workers will be screened again by WAST occupational Health if they are unable to provide adequate documentary evidence in the form of verified reports from accredited laboratories or Occupational Health Departments.
- 6.1.4 EPP duties cannot be commenced until clearance has been given. Where EPP work is an essential element of a post and the relevant criteria are not met, managers will be informed accordingly, although confidentiality about the specific reason for non-clearance will be maintained.
- 6.1.5 All staff are reminded of their professional obligations to protect the health of patients and to seek expert advice if they think they may be infected with or have placed themselves at risk of a blood borne virus. employees who refuse to comply with testing will be considered unfit for EPP.
- 6.1.6 Where EPP staff are found to be infected with a blood borne virus, further advice should be sought from UKAP.

6.2. Immunisation Recommendations by Staff Groups

- 6.2.1 Based on the assessment of immunisation evidence and history provided, Occupational Health offers vaccinations according to the employee's work role, to ensure protection against identified workplace hazards.
- 6.2.2 Immunisation recommendations and their associated schedules are updated at intervals in the "Green Book", which is available online (Department of Health, 2021).
- 6.2.3 Staff involved in direct patient care - This includes staff who have regular clinical contact with patients and who are directly involved in patient care, are recommended to be offered, or have evidence of the following:
- Measles, Mumps, Rubella (MMR)
 - Diphtheria, Tetanus, Polio
 - Pertussis (for those in contact with infants)
 - Hepatitis B
 - BCG

- Varicella (Those with a definite history of chickenpox or herpes zoster can be considered protected. Healthcare workers with a negative or uncertain history of chickenpox or herpes zoster should be serologically tested and vaccine only offered to those without the varicella zoster antibody)
- Influenza (seasonal)
- Covid-19 (delivered and indicated nationally, by priority groups)

6.2.4 Non-clinical staff in healthcare settings - This includes non-clinical ancillary staff who may have social contact with patients but are not directly involved in patient care:

- Measles, Mumps, Rubella (MMR)
- Diphtheria, Tetanus, Polio
- Hepatitis B
- BCG
- Varicella (Those with a definite history of chickenpox or herpes zoster can be considered protected. Healthcare workers with a negative or uncertain history of chickenpox or herpes zoster should be serologically tested and vaccine only offered to those without the varicella zoster antibody)
- Influenza (seasonal)
- Covid-19 (delivered and indicated nationally, by priority groups)

6.2.5 It is important to recognise Laboratory and pathology staff within the policy, as we work towards a unified, One Wales model to Occupational Health Services.

6.2.6 Laboratory and other staff including mortuary staff who regularly handle pathogens or potentially infected specimen.

6.2.7 Staff handling specific organisms - For some infections, the probability that clinical specimens and environmental samples of UK origin contain the implicated organism, and therefore present any risk to staff, is extremely low. For these infections, routine immunisation of laboratory workers is not indicated. Staff handling or conducting research on specific organisms and those working in higher risk settings, such as reference laboratories or infectious disease hospitals, may have a level of exposure sufficient to justify vaccination:

- hepatitis A
- Japanese encephalitis
- Cholera
- meningococcal ACW135Y
- smallpox
- tick-borne encephalitis
- typhoid
- yellow fever
- influenza
- varicella

6.3. Patient Group Directives (PGD)

- 6.3.1 Please see the Trust's Medicines Management Policy - [Medical & Clinical Services Policies \(sharepoint.com\)](#) for an outline of the occupational health PGD's within the trust.
- 6.3.2 All master copies of Trust PGDs will be held by the Trust Head of Medicines Management. PGDs are required to be reviewed every three-years to ensure they remain up to date and fit for purpose.
- 6.3.3 PGDs will be distributed to the relevant Trust Registrants electronically. They will be required to read and confirm their competency to work within the scope of the PGD by completing an electronic authorisation (via MS Forms).
- 6.3.4 A register of all authorised registrants and their PGD competencies will be maintained by the Clinical Administration team.
- 6.3.5 Individual PGD compliance is also recorded on the Electronic Staff Record (ESR) Authorised professionals are also required to retain hard copies of all PGDs for their own records to support their clinical practice.

6.4. ADMINISTRATION AND STORAGE OF VACCINES

- 6.4.1 Please see the Trust's Medicines Management Policy - [Medical & Clinical Services Policies \(sharepoint.com\)](#) regarding the directed storage and administration of vaccines.
- 6.4.2 All Clinicians administering vaccines within the Occupational Health Department are professionally accountable for their own actions and will adhere to their professional body guidelines i.e. Nursing and Midwifery Council (NMC)/Health and Care Professions council (HCPC), on accountability and administration of medicines.
- 6.4.3 All clinical staff will receive specific training regarding vaccine administration and be trained and competent in anaphylaxis management. Adrenaline must always be available when administering vaccines.
- 6.4.4 Occupational health professionals will be familiar with immunisation procedures recommended in The Green Book; and will undertake immunisation knowledge and competency assessment prior to administering vaccinations and will undergo annual audit of such.
- 6.4.5 Occupational Health professionals administering medication under patient group directives should re-read the directive frequently to up-date their knowledge.
- 6.4.6 Prior to administration of immunisations, informed consent will be sought and recorded, the absence of contra-indications to vaccine administration confirmed, the pregnancy status of women established, and the recipient must be made aware of any adverse reactions.

- 6.4.7 The deltoid region of the upper arm is the preferred site for most workplace immunisation, unless indicated otherwise. If any immunisation programme is interrupted, it should be resumed and completed as soon as possible.
- 6.4.8 Different vaccines must never be mixed in one syringe; any two vaccines administered on the same visit should ideally be given in a different arm, or at least 2.5 cm apart in one arm.
- 6.4.9 For each type of immunisation, the Green Book provides detailed guidance on which vaccines may be administered at the same time, intervals between administering different vaccines, and concurrent immunisation with blood products (Department of Health, 2021).
- 6.4.10 The vaccine name, dose, expiry date and compatibility must be checked prior to all immunisations. Whilst injecting, observation should be maintained to ensure no adverse reactions arise.
- 6.4.11 All vaccines must be stored in the original packaging in the designated pharmaceutical refrigerator at between 2°C and 8°C. A daily record of fridge temperature (including maximum and minimum temperatures) will be maintained for audit purposes. Guidance on maintaining a cold chain should be adhered to.
- 6.4.12 All vaccines must be stored correctly with protection from light. Adverse changes of temperature and ultra-violet light can affect the efficiency of the vaccine and potency cannot be guaranteed. **Vaccines must never be frozen.**

6.5. Contra-indications to Immunisation

- 6.5.1 Immunisations are contra-indicated in all individuals who have had a confirmed anaphylactic reaction to previous vaccinations containing the same antigen, or to any component of the vaccine e.g. gelatin or the antibiotics neomycin, streptomycin and polymyxin B. Live vaccines may be contra-indicated in individuals who are pregnant or immunosuppressed.
- 6.5.2 The Occupational Health Professional will establish that there are no contra-indications to immunisation prior to administration of vaccine, including specific contra-indications for each vaccine group. Detailed information can be found in the Green Book chapters on Contra-indications and Special Considerations.
- 6.5.3 Vaccines must not be given to individuals who have primary or acquired immunodeficiency, this includes (Primary or Acquired Immunodeficiency Contra-indicating Immunisation (Department of Health, 2021):
- Immunosuppression due to acute and chronic leukaemia and lymphoma (including Hodgkin's lymphoma)
 - Severe immunosuppression due to HIV/AIDS (for BCG, the vaccine is contraindicated in all HIV positive individuals)

- Cellular immune deficiencies (e.g. severe combined immunodeficiency, Wiskott-Aldrich syndrome, 22q11 deficiency/DiGeorge syndrome)
- Being under follow up for a chronic lymphoproliferative disorder including haematological malignancies such as indolent lymphoma, chronic lymphoid leukaemia, myeloma and other plasma cell dyscrasias (list not exhaustive)
- Having received an allogenic (cells from a donor) stem cell transplant in the past 24 months and only then if they are demonstrated not to have on-going immunosuppression or graft versus host disease (GVHD).
- Having received an autologous (using their own stem cells) haematopoietic stem cell transplant in the past 24 months and only then if they are in remission.

6.5.4 Live vaccines should not be administered to individuals on immunosuppressive therapy (Immunosuppressive Treatment Contra-indicating Immunisation (Department of Health, 2021):

- Those who are receiving, or have received in the past 6 months, immunosuppressive chemotherapy or radiotherapy for malignant disease or non-malignant disorders
- Those who are receiving, or have received in the past 6 months, immunosuppressive therapy for a solid organ transplant (with exceptions, depending upon the type of transplant and the immune status of the patient)
- Those who are receiving or have received in the past 12 months immunosuppressive biological therapy (e.g., anti-TNF therapy such as alemtuzumab, ofatumumab and rituximab) unless otherwise directed by a specialist
- Those who are receiving or have received in the past 3 months immunosuppressive therapy including: - those on high-dose corticosteroids (>40mg prednisolone per day) for more than 1 week; adults on lower dose corticosteroids (>20mg prednisolone per day) for more than 14 days; adults on non-biological oral immune modulating drugs e.g. methotrexate >25mg per week, azathioprine >3.0mg/kg/day or 6-mercaptopurine >1.5mg/kg/day - specialist advice should be sought prior to vaccination.

6.5.5 Some inactivated vaccines such as influenza are actively recommended for pregnant women as they can prevent severe complications during pregnancy or to the new-born infant. Other inactivated vaccines should be administered to pregnant women where protection is required during the pregnancy.

6.5.6 If exposure to infection can be avoided until after the mother delivers, deferring vaccination will reduce the chance of any pregnancy complication being incorrectly attributed to vaccine exposure. Live vaccines are contraindicated during pregnancy as a precaution therefore live vaccines should generally be delayed until after delivery.

6.5.7 Temporary deferral of immunisations are recorded on the employees occupational health record; and employees can be recalled for vaccination at a later date.

6.5.8 Appropriate risk assessment for new and expectant mothers are advised as per the Maternity and Adoption leave policy.

6.5.9 There will be other, albeit few occasions when deferral of immunisation is required. If an individual is acutely unwell (for example with a fever above 38.5 C), immunisation may be postponed until they have fully recovered. This is to avoid wrongly attributing any new symptom or the progression of symptoms to the vaccine.

6.5.10 The presence of a neurological condition is not a contraindication to immunisation but if there is evidence of current neurological deterioration, deferral of vaccination may be considered, to avoid incorrect attribution of any change in the underlying condition. The risk of such deferral should be balanced against the risk of the preventable infection, and vaccination should be promptly given once the diagnosis and/or the expected course of the condition becomes clear.

6.6. Adverse Events Following Immunisation

6.6.1 Employees should be given advice about adverse events that they can expect and how to manage them. Most side-effects of immunisation are mild and resolve quickly.

6.6.2 Fevers over 37°C are not uncommon but are usually mild, employees can be advised regarding appropriate paracetamol or ibuprofen administration.

6.6.3 Local reactions at the immunisation site are usually self-limiting and do not require treatment.

6.6.4 Suspected vaccine-induced adverse reactions will be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) via the Yellow Card scheme; and completion of a DATIX may also be required in some instances. Adverse events following immunisation can be categorised as:

Programme related

- Wrong vaccine, wrong dose, wrong diluents, out-of-date drugs, wrong time interval, incorrect storage (this is not an exhaustive list). In these circumstances it is inappropriate to report to MHRA. Reporting via local incident reporting is sufficient.

Vaccine induced

- Localised pain, swelling at injection site - These reactions occur commonly after immunisation and should be anticipated. They do not contra-indicate further doses of immunisation with the same vaccine or vaccines containing the same antigens.
- Systemic adverse reactions - including fever, malaise, myalgia, irritability, headache and loss of appetite. Systemic reactions may start within a few hours or occur up to seven to ten days after certain vaccine (e.g. measles). They do not contra-indicate further immunisation with the same vaccine or vaccines containing the same antigens.
- Idiosyncratic responses - include idiopathic thrombocytopenic purpura (ITP) and anaphylaxis immediately after vaccination. When there has been a confirmed anaphylactic reaction to a dose of vaccine this contra-indicates further vaccination with the same vaccine or a component of that vaccine.
- Coincidental reactions - These are not true adverse reactions to immunisation or vaccines but are only linked because of the timing of their occurrence. These do not

contra-indicate further doses of immunisation with the same vaccine or vaccines containing the same antigens.

- Unknown - Insufficient evidence to classify as one of the above.

6.7. Anaphylaxis

- 6.7.1 All Occupational Health clinical staff who administer vaccines will be trained in anaphylaxis diagnosis and management; and training will be recorded via employee NHS electronic staff record. All occupational health technician and nursing staff involved in immunisation should be able to distinguish an anaphylactic reaction from fainting or panic attack.
- 6.7.2 All Occupational Health clinical staff responsible for immunisation must be familiar with, (having received recent training or updates yearly) in adult resuscitation.
- 6.7.3 A protocol for anaphylaxis management and appropriate medications must always be available whenever vaccines are delivered.

6.8. Employees Who Decline Immunisation or Fail to Seroconvert Following Immunisation

- 6.8.1 Initially, individuals who decline immunisations will be provided with evidence-based information highlighting the importance of the protection vaccination offers to healthcare employees.
- 6.8.2 The broader public health implications will also be highlighted, including the protection of the employee, patients, colleagues, and the wider health system.
- 6.8.3 Employees may decline vaccinations for various reasons, such as pregnancy, health conditions, religion, or personal beliefs (this list is not exhaustive). In such cases, adjustments to their duties may be required to ensure workplace safety.
- 6.8.4 For staff declining the hepatitis B vaccination or failing to achieve immunity following vaccination, those performing Exposure-Prone Procedures (EPP) will not be permitted to continue in such roles unless they attend Occupational Health for annual blood testing to confirm they have not become carriers of the virus.
- 6.8.5 Given the occupational exposure risks associated with these situations, the Occupational Health Department has a duty to inform line managers about any employment implications.
- 6.8.9 Decisions regarding the commencement or continuation of workplace duties will be based on the outcome of an individual risk assessment.
- 6.8.10 In some cases, it may be necessary to temporarily or permanently redeploy employees who lack immunity to specific diseases. Such decisions will follow a thorough risk assessment and involve discussions with the employee, their line manager, and People Services colleagues, in line with the Redeployment Policy.

6.9. Post-exposure Management

- 6.9.1 Also see the Trust's Infection Prevention and Control (IPC) Policy - [Quality, Safety & Patient Experience Policies \(sharepoint.com\)](#)
- 6.9.2 Specific additional measures may sometimes be required following an incident where exposure to an infected individual, pathogen or contaminated instrument occurs.
- 6.9.3 Advice should be sought from occupational health on an individual basis if this occurs. Occupational health may be required to consult with local health-board microbiologist or other appropriate consultant in these circumstances.
- 6.9.4 Advice on post-exposure management is contained in the relevant chapters in the green book.

7. TRAINING AND IMPLEMENTATION

- 7.1 Occupational Health Professionals are required to be compliant and up to date with their professional body registration; the relevant immunisation skills and competencies framework, Basic Life Support and anaphylaxis training which is to be recorded within the employee NHS electronic record system.
- 7.2 Occupational health professionals will be involved in the training of new and junior staff along with students and seasonal peer vaccinators, sharing their knowledge and skills.
- 7.3 Occupational Health Professionals should read and be familiar with the detailed guidance found in Immunisation Against Infectious Disease (also called the "Green Book") (Department of Health, 2021) keep up to date with its published guidance, and of other publications listed in this policy.
- 7.4 WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.
- 7.5 Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

8. IMPACT ASSESSMENTS

Trust policies are not approved without an Equality Impact Assessment (EqIA) or a Welsh Language Impact Assessment being undertaken as this process has been developed to help promote fair and equal treatment in the delivery of services.

8.1. Equality Impact Assessment

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we

provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010), Human Rights and the Welsh Language. As part of the development of this policy, an EQIA was undertaken to ensure the policy maintained the Trust's equality standards. No negative outcomes were identified as part of the EQIA.

8.2. Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, will be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Trust's Welsh Language Services Officer. Employees are encouraged to use Welsh, and Occupational Health consultations and appointments are available in Welsh. Additionally, occupational health correspondence and key forms, such as pre-placement and vaccination reports and literature within the digital platform OPAS G2, will be accessible in Welsh once the All-Wales configuration is finalised

8.3. Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO₂ emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services University NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

8.4. Counter Fraud

Anti-Fraud and Corruption Concerns

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility Service <https://cfa.nhs.uk/report-fraud> Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

8.5. Records Management

8.5.1 Occupational Health and wellbeing records kept in digital form are held securely according to the Data Protection Act 1998.

8.5.2 Occupational Health records and wellbeing related records kept in paper form will be kept for a minimum of 3 years after termination of employment.

Except if statute requires:

- Vaccination records retain for 10 years after conclusion of treatment.

8.5.3 Staff can request a copy of their immunisation records, this falls under the Trust Access to Personal Information Policy, and to access, the following information is required:

Home Address

Home email address (as unable to send this information to a work email address)

DOB

ESR/Payroll number as confirmation of ID.

8.5.4 The Welsh Ambulance Services University NHS Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

8.5.5 Staff immunisation records are stored within the occupational health online platform – Opas G2.

8.6. Information Governance

8.6.1 Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

8.6.2 The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust. This Policy should be read and applied in conjunction with the Data Protection Policy to ensure lawful and effective information governance. The Occupational Health digital system, Opas G2 was implemented on an All-Wales basis to include requirements of encryption, access controls, audit logs, and training; this is also supported by Design and Data Protection Impact Assessments (DPIA).

8.6.3 Annual team operational objectives for the Occupational Health Service are set, as well as annual individual PADR objectives. Immunisation targets are also highlighted by the Chief Medical Officer for Wales based on risks and trends identified in both local and national communities.

8.6.4 All clinical staff will be registered with the relevant clinical body for their profession.

- 8.6.5 Occupational Health data reports will be submitted to the Health and Safety Group, people and culture business committee and all Wales groups as required.

8.7. Health and Safety

- 8.7.1 The immunisation policy is designed to ensure strict compliance with health and safety regulations as identified in the health and safety at work act and the green book.
- 8.7.2 This policy recommends that all staff receive appropriate vaccinations based on their specific roles and exposure risks.
- 8.7.3 By adhering to these guidelines, we aim to protect our employees, patients, and the broader community from preventable diseases, thereby maintaining a safe and healthy working environment.
- 8.7.4 Regular reviews and updates of the policy ensure it remains aligned with current health standards and regulatory requirements.

9. ROLES AND RESPONSIBILITIES

9.1. Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

9.2. Directors

The Executive Directors are responsible for ensuring teams have access to these policies and that processes are effectively communicated to promote compliance. They are also accountable for ensuring that an effective occupational immunisation Policy that aligns with the trusts broader objectives is in place, including employee welfare, workplace safety and adherence with legal standards.

9.3. Service Managers / Clinical Leads / Locality Managers

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.

9.4. Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document.

This includes ensuring that:

- Copies of the Trust policies are readily available and accessible to all staff.
- Information is disseminated on a regular basis
- Staff have read and understood the relevant documents and are aware of any new guidance or revisions.
- The identification of specific staff training needs on the implementation of new or updated documents.
- Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

9.5. All Staff

Employees have a duty to co-operate with the Occupational Health Service in the implementation of this policy and to undergo screening and immunisation as advised.

They are expected to:

- Report to their manager and Occupational health, any medical condition, which they believe is connected to their work and report any significant medical conditions, which may affect their ability to carry out their duties.
- Self-refer as appropriate to the Occupational health service to obtain advice in confidence.
- Inform their manager/deputy if they have been in contact with or are symptomatic of a communicable infection.
- Contact Occupational health for advice from if they become unusually vulnerable to infection or immunocompromised e.g. by steroids, chemotherapy/radiotherapy, or HIV.
- To take ownership/responsibility for their own health and well-being.
- They comply with the provision of this policy and where requested to demonstrate such compliance. Failure to comply will be dealt with under the Trust's Disciplinary Policy as appropriate.
- Ensure Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Safeguard their practice in line with policies in use across the Trust and specific to their area of work.
- Provide Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

10. AUDIT AND MONITORING

- 10.1 Compliance with this policy will be assessed through intermittent audits focusing on specific elements, such as reviewing immunisation records and monitoring vaccination status across WAST.
- 10.2 Reports generated from these audits will be shared with the People and Culture committee, National Health and Safety forum and IPC forums as appropriate; Public Health Wales, and the Welsh Government as required.
- 10.3 Necessary actions will be taken based on audit findings to ensure compliance. This process is vital for maintaining a healthy workforce and protecting both staff and patients.

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[Yellow Card | Making medicines and medical devices safer](#)

[UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses \(UKAP\) - GOV.UK](#)



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Welsh Ambulance Services
University NHS Trust

Equality Impact Assessment (EqIA) Policy

Policy Number:	110	Version No:	0.15 Draft	Supersedes:	N/A (New Policy)
Date of Approval:	TBA	Review Date:	3 years from date of approval	Impact Assessments Completed:	Yes
Classification of Document:	Corporate	Type of Document:	Policy	Approved by:	People and Culture Committee
Brief Summary of Document:	This policy provides a framework to ensure that the Trust develops the necessary capability to undertake robust impact assessments to meet the requirements of the Public Sector Equality Duty, the Equality Act 2010, the Socioeconomic Duty, the Armed Forces Act 2022, and the Welsh Language Standards. It will also ensure that the Trust operates in line with the principles of the Human Rights Act 1998. The policy aims to ensure that due regard is given to the diverse needs of staff and service users and that these needs are identified, considered and embedded into organisational decision-making and the development of policies and strategic plans. It also aims to ensure that Board Members and other decision makers are clear about their respective responsibilities in relation to undertaking and scrutinising equality impact assessments to assist with the development, planning, delivery and review of policies and practices which take into account the diverse needs of staff and service users.				
Scope:	This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees.				
To be read in conjunction with:	Strategic Equality Plan People and Culture Plan Welsh Language Policy				
Owning Committee	People and Culture Committee				
Policy Lead: Trade Union Lead:	Kathryn Cobley Christian Fox	Job Title:	Head of Inclusion and Engagement Trade Union Partner		
Executive Director:	Angela Lewis Carl Kneeshaw	Job Title:	Director of Culture Director of People		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	09/05/2024	Kathryn Cobley	Development of master draft policy
0.2	09/05/2024	Lisa Trounce	• Contents of draft policy transferred to latest template with new Crown badge and logo, amended header and correct colours. • Policy number advised. • Version Control Sheet updated. • Comments supplied throughout draft policy for Policy Lead to action.
0.3	13/05/2024	Kathryn Cobley	▪ Key search words expanded. ▪ Completion of Impact Assessment Review table ▪ Task and Finish Group Members populated. ▪ Approval route updated. ▪ Queries raised in comments actioned
0.4	14/05/2024	Lisa Trounce	• Front page updated re: version number. • Version Control Sheet updated. • Name of TFG Member (Charlie Bosher) corrected. • Job Titles of TFG members corrected. • Policy No. and Name added to footer. • Some formatting (paragraph spacing) • Minor grammar correction under 8.1 • Contents page refreshed.
0.5	21/05/2024	Lisa Trounce	• Front page and version control sheet updated • Comments added detailing amendments agreed at Policy Group on 21/05/2024 for Policy Lead to action.
0.6	21/08/2024	Kathryn Cobley	• Previous references to 'Training' under S7 and S8 now merged under section 7 • S9 'Roles and Responsibilities' amended to ensure these are relevant to policy • S10 'Audit & Monitoring' strengthened
0.7	25/08/2024	Lisa Trounce	• Front cover and version control updated • Final formatting prior to consultation

Version	Date	Author	Summary of Changes
0.8	04/09/2024	Julie Boalch	Roles & Responsibilities amended - Head of Risk / Deputy Board Secretary removed, and Executive Directors section amended.
0.9	04/09/2024	Lisa Trounce	Front cover and version control updated prior to consultation
0.10	21/10/2024	Kathryn Cobley	Consideration and inclusion of consultation comments.
0.11	21/10/2024	Lisa Trounce	Final edit and formatting prior to submission to Policy Group
0.12	31/10/2024	Lisa Trounce	Formatting prior to submission to ELT and Committee for approval
0.13	01/12/2024	Kat Cobley	Amendments effected following discussion with Director of Corporate Governance: - Strategic Decisions definition added into section 3. - Changes made to impact assessment sections to reflect decision outcomes in section 8. - Added in section 9.2 to outline responsibility of the Board.
0.14	18/12/2024	Lisa Trounce	Front cover amended to name both Director of Culture and Director of People, plus version control updated and comments removed, in readiness for onwards travel to ADLT, then PCC for approval.
0.15	03/02/2025	Lisa Trounce	Following ADLT approval, policy prepared for onwards travel to Committee for approval
Keywords	Equality, Assessment, Impact, Socioeconomic, Duty, Equality, Discrimination		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	--	N/A
EqIA / Welsh Language	09/05/2024	Kat Cobley
Environment	--	N/A
Quality	--	N/A

Task and Finish Group Members

Name	Job Title
Catherine Goodwin	Assistant Director of Inclusion Culture and Wellbeing
Kat Cobley	Head of Inclusion and Engagement
Paola Spiteri	Retention Lead / Disability Staff Network Chair
Catherine Wynn Lloyd	Carers Peer Support Network Chair
Faz Tahir	AACE BME Network Rep
Gareth Thomas	PECI Manager / LGBTQ+ Staff Network Chair
Sara Mills	Head of OD and Culture
Lynda Bogunovic	Occupational Health Business Manager
Jo Kelso	Head of Education and Development
Laura Hurford	Workforce & OD Senior Administrator
Charlie Bosher	Recruitment Manager
Melfyn Hughes	Welsh Language Services Manager
Beth Eales	Communications Officer
Christian Fox	Trade Union Partner
Hugh Parry	Trade Union Partner
Gareth Parry	Operations Manager – Community Services
Joanne Rees Thomas	Service Manager, Ambulance Care (Central)
Dylan Parry	Health & Safety representative

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
EDI Steering Group	18/01/2024	Comments requested via email 12/02/2024 and 07/03/2024
Policy Group	21/05/2024	Recommend for consultation
28-day Policy Consultation Period	04/09/2024 – 02/10/2024	Trust-wide consultation of draft new policy
Policy Group (post consultation)	23/10/2024	Recommend for Approval
Policy Group	18/12/2024	Review of further amendments made post consultation
Assistant Directors Leadership Team	20/01/2025	Approved - Recommended for Approval by Committee
People and Culture Committee	18/02/2025	For Approval and Adoption

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

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Contents

1. Introduction	7
2. Policy Statement	8
3. Scope	9
4. Aim	10
5. Objectives	10
6. Equality Impact Assessment Policy	10
6.1. What is equality impact assessment?	10
6.2. Why do we undertake Equality Impact Assessments?	11
6.3. When do we undertake Equality Impact Assessments?	12
6.4. Proportionality	12
6.5. Adopting a proactive approach to Equality Impact Assessment	12
7. Training and Implementation	13
8. Impact Assessments	13
8.1. Equality Impact Assessment	13
8.2. Welsh Language Impact Assessment	13
8.3. Environmental Standards and Impact Assessment	14
8.4. Counter Fraud	14
8.5. Records Management	14
8.6. Information Governance	14
9. Roles and Responsibilities	14
9.1. Chief Executive	14
9.2. Directors	15
9.3. Directors of People and Culture	15
9.4. Heads of Service	16
9.5. Service Managers / Clinical Leads / Locality Managers	16
9.6. Line Managers	16
9.7. The Diversity and Inclusion Team	17
9.8. The Patient Experience and Community Involvement (PECI) Team	17
9.9. Procurement and Commissioning Staff	17
9.10. Trade Unions and Staff Side Representatives	17
9.11. All Staff	17
10. Audit and monitoring	18
11. References	18

1. INTRODUCTION

The Trust has a statutory duty to comply with all equality related-legislation. This includes:

- Equality Act 2010
- Public Sector Equality Duty (Wales)
- Socio-economic Duty (Wales)
- Human Rights Act 1998
- Wellbeing of Future Generations Act 2015
- Armed Forces Act 2022
- Welsh Language Measure 2011

The Equality Act 2010 and the Public Sector Equality Duty (Wales)

In line the requirements of the Equality Act 2010 and the Public Sector Equality Duty (Wales), all decisions relating to our service provision must take account of potential impacts for people who have a protected characteristic. It is illegal to discriminate against someone due to:

- Age
- Disability
- Race and Ethnicity
- Sex
- Gender Reassignment
- Sexual Orientation
- Religion and Belief
- Pregnancy and Maternity
- Marriage and Civil Partnership

Other groups of interest may need to be involved to highlight how decisions may impact them. Impacts may be both positive and negative. Through our planning and engagement work, we will ensure that different groups have the opportunity to be involved and participate by making engagement accessible to them.

As far as possible, when we make a strategic decision, develop a strategy, service, policy or procedure or do anything else that affects our service users or staff, we will do so in a fair, accountable and transparent way taking into account the needs and rights of all of those who might be affected. One of the ways in which we do this is through a robust approach to equality related impact assessments, undertaken at the earliest opportunity before any strategic decisions are made.

Welsh Language

The Welsh Language Act 1993 and subsequent Welsh Language Measure 2011 have led to the implementation of a set of Welsh Language Standards for public sector bodies with which the Trust must comply. Some of the standards refer to the requirement to undertake an impact assessment to assess the impact of our policies and plans upon the Welsh language and culture, Welsh speakers and the opportunity to use Welsh.

Armed Forces Act 2022

The Trust must consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life.

The Trust must consider their unique experiences when accessing and using public services compared to the general population, thinking about their unfamiliarity with civilian life, frequent moves around the country and the subsequent difficulties in maintaining support networks.

Unpaid Carers

An unpaid carer is someone who provides unpaid care for a friend or family member who due to illness, disability, a mental health condition or an addiction cannot cope without their support. It is widely recognised that unpaid carers will be impacted by the decisions we make about our policies and plans. Therefore, we have taken the decision to assess the potential impact upon unpaid carers as part of our equality impact assessment.

Socio-economic Duty (Wales) and Other Vulnerable Groups

The Socio-economic Duty aims to encourage better decision making and ultimately deliver better outcomes for those who are socio-economically disadvantaged. The definition of socio-economic disadvantage refers to those living in less favourable social and economic circumstances than others in the same society.

The Duty places a legal responsibility on the Trust when we are making strategic decisions to be able to demonstrate that it has paid due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage, paying particular attention to reducing health inequalities.

People who experience socio-economic disadvantage may not have a protected characteristic. For example, lone parents, students and the homeless are much more likely to be affected by socio-economic disadvantage. Therefore, it is essential that we assess the impact upon these individuals and vulnerable groups as part of our wider equality impact assessment process.

2. POLICY STATEMENT

The Trust is committed to ensuring that equality impact assessment is undertaken at the earliest opportunity to inform decisions about its strategies, policies and services. Undertaking an equality impact assessment will ensure that the impact upon different

communities, individuals or groups are fully considered and any potentially discriminatory impacts may be mitigated prior to implementation.

Assessing for impact also affords the opportunity to enhance any identified potential or actual positive impacts.

3. SCOPE

This policy applies to the way in which the Trust carries out all of its activities in relation to both staff and service users. The policy applies to all staff across the Trust who are involved in the impact assessment process. This includes Board Members and decision makers who must have a responsibility to scrutinise equality impact assessments and ensure that due regard has been given in line with the requirements of legislation.

Strategic decisions and WAST policies require thorough scrutiny to ensure they align with the principles of equality, and our duty of quality.

An Equality Impact Assessment (EqIA) must be conducted as part of the process for making strategic decisions or approving policies. It should be included with documents presented to decision-makers, ensuring it is completed before any decisions are finalised.

What is a strategic decision?

There is no one definition that relates to impact assessments, however the Equality Act 2010 says that decisions of a strategic nature will be those which affect how WAST, as a public body, fulfils its intended statutory purpose over a significant period of time. It does not include routine day-to-day decisions. Such decisions are usually delegated to senior management or the Trust Board.

An EqIA ensures that all significant decisions are made with an informed awareness of their potential impacts on diverse groups, especially concerning equality.

It will cover the full range of functions, activities and decisions relating to both staff and service users which can include:

- Long term overarching WAST strategy and any reviews of this strategy
- Directorate/speciality specific plans that align to the long term strategy and reviews of these plans, for example the Digital Plan, or the Strategic Workforce Plan
- Integrated Medium Term Plan
- Strategic/long term financial plan
- Organisational Change Policy plans for directorates or services and similar plans that affect our people
- WAST policies
- Service change and development of public services
- Major business cases of a strategic nature
- Closure of stations or offices/places of work
- Major procurement and commissioning decisions

For the purpose of this policy document, the term 'policies and plans' will be used throughout to encompass all of the above.

We may also need to assess the impact on protected groups due to the implementation of a policy when it has been developed by another authority, for example a Welsh Government national strategy. Although in most cases these decisions and policies will have been assessed for any impact by the other authority, it is important that we ensure that they are also assessed in the context of the Trust and the population that we serve.

Discussions around equality impact assessment must be an integral part of the decision-making process from the beginning and should inform the decision-making process in accordance with evidence gathered.

4. AIM

The aim of this policy is to provide a framework to ensure that equality and human rights principles are identified and considered in everything we do by embedding equality considerations into organisational decision-making and policy development processes. It also aims to ensure that Board Members and staff are clear about their respective responsibilities in relation to undertaking and scrutinising equality impact assessments to assist with the development, planning, delivery and review of policies and practices which take into account the diverse needs of staff and service users.

5. OBJECTIVES

- To embed equality impact assessment into the decision-making process for Boards, Committees and other relevant groups
- To ensure staff understand why equality impact assessment should be undertaken
- To ensure staff have access to the appropriate templates and toolkits to enable high quality assessment and subsequent scrutiny to be carried out
- To ensure staff have access to advice and support when undertaking equality impact assessment
- To build capacity and capability across the organisation to undertake robust equality impact assessments

6. EQUALITY IMPACT ASSESSMENT POLICY

6.1. What is equality impact assessment?

Equality impact assessment is a process which requires the Trust to consider the effects of its policies and plans on different communities, individuals or groups. It is a legal requirement and is not optional. It involves:

- Anticipating or identifying the impact of our policies and plans on individuals or groups of service users/employees

- Making sure that any negative effects are eliminated or minimized
- Maximising opportunities for promoting positive effects

Equality impact assessment is crucial to improving the quality of the services we provide, and to ensure that they meet the needs of those using them. It enables the Trust to consider the effects that its decisions, policies or services have on people on the basis of their 'protected characteristics'.

The Equality Act 2010 extends protection from discrimination to a person who may be associated with another person who has one of the protected characteristics. For example, if someone is discriminated against because they are an unpaid carer for a disabled child or older person, then they will be able to claim disability discrimination by association. Similarly, if an employee is subjected to bullying and harassment because they are friends with a gay person, then they too are protected under the Act. These factors will therefore need to be taken into consideration when undertaking equality impact assessments.

6.2. Why do we undertake Equality Impact Assessments?

Equality impact assessments are a good practice method of analysing what we are doing, or planning to do, through the lens of people with a protected characteristic. As well as being a specific legal requirement, there are a number of positive aspects of equality impact assessment including:

- **Service improvement:**
 - focusing on meeting the needs of disadvantaged groups can result in improved services that benefit everyone.
 - ensuring decisions are cost-effective by facilitating effective targeting of resources to meet identified needs.
- **Reducing health inequalities:**
 - helping to identify whether we are excluding different groups from any of our current or proposed policies and plans and eliminating any direct or indirect discrimination including institutional discrimination.
 - assisting the Trust to consider adjustments, alternative options or measures that might address any adverse impact.
 - identifying potential improvement areas that enable staff and managers to make better informed decisions about policies and plans.
- **Creating an accessible and inclusive environment for staff and service users and building a positive reputation for the Trust:**
 - helping the Trust to make better informed decisions about policy, practice and service delivery.
 - giving the Trust a better understanding of the needs and aspirations of our employees and the communities we serve.
 - increasing opportunities to promote inclusion and build a diverse, skilled workforce.

6.3. When do we undertake Equality Impact Assessments?

Equality impact assessment must take place at the earliest opportunity from the outset, which may be during the drafting of a new or revised policy, or as part of the proposal of a new plan or review of service. It must not be considered as an additional task to be undertaken after the policy or plan has been developed, or as a means of justifying decisions that have already been made.

Equality impact assessment means adopting the principles of developing policies which are informed by evidence.

6.4. Proportionality

The legal requirement to conduct equality impact assessment applies the principles of relevance and proportionality. Some equality impact assessments will be simpler than others. Others may result in the need to undertake more in-depth consultation and engagement and further review of the proposal. More thorough equality impact assessment will be required when:

- The impact is found to be potentially discriminatory under equality or anti-discrimination legislation
- Any equality groups or communities are identified as being potentially disadvantaged or negatively impacted by the policy or plan
- The policy or plan is assessed to be of high significance

Further information to help people decide when to undertake a more thorough equality impact assessment is available on the Trusts intranet which has links to further advice and guidance from the Equality and Human Rights Commission.

6.5. Adopting a proactive approach to Equality Impact Assessment

Meeting the Public Sector Equality Duties in Wales and providing services tailored to meet the needs of our staff and communities involves a whole organisation approach. Everyone throughout the organisation is expected to be mindful of how they can contribute to creating an inclusive environment and providing equitable services, with dignity and respect.

The Trust's behaviours and Strategic Equality Plan have clear links to this policy. All staff are obliged to adhere to the policy and will be required to complete an equality impact assessment which is evidenced when submitting policies and plans for approval. A list of the strategic decisions which require an Equality impact assessment can be found in section 3. Some staff members have more specific roles as described in section 9.

7. TRAINING AND IMPLEMENTATION

Training on how to undertake an equality impact assessment is available online via SIREN. 1-1 training and group training is also delivered by the Diversity and Inclusion Team. Comprehensive guidance and templates can be found on SIREN: [Equality Impact Assessments \(sharepoint.com\)](#)

Feedback on all training developed and delivered by the Equality, Diversity and Inclusion is welcomed. Feedback will be used to review the training content and amendments made as required.

Staff should familiarise themselves with the equality impact assessment process beforehand. Staff are also advised to contact a member of the Diversity and Inclusion Team for help and support in undertaking an equality impact assessment.

The equality impact assessment process should not be undertaken by one person alone and staff are advised to involve key colleagues responsible for the development of strategic decisions, along with those affected by the procedures as appropriate.

WAST is committed to providing high quality evidence based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

Any policy specific training would need to be devised by the Policy Lead and subject matter expert.

8. IMPACT ASSESSMENTS

8.1. Equality Impact Assessment

An equality impact assessment, inclusive of Welsh Language Impact Assessment has been undertaken prior to this policy's approval to help promote fair and equal treatment in the delivery of services. It is the responsibility of the Policy Lead to ensure that impact assessments are undertaken during development or review of a policy. No potential negative impacts were identified during the equality impact assessment. The impact assessment indicated positive impacts upon all groups as it will encourage all staff who are developing policies and plans to identify the impact, put in place mitigating actions to help eliminate discrimination, and make amendments to policies and plans where necessary.

8.2. Welsh Language Impact Assessment

A Welsh language impact assessment was undertaken as part of the equality impact assessment. This policy provides guidance and support to staff to help them identify the

impact of policies and plans upon Welsh speakers and the Welsh language. It asks staff to make amendments to policies and plans or to implement mitigating actions where the impact assessment has identified any potential negative impacts.

8.3. Environmental Standards and Impact Assessment

This policy does not require an environmental standards impact assessment.

8.4. Counter Fraud

This policy does not require a counter fraud impact assessment.

8.5. Records Management

A record of equality impact assessments undertaken will be managed by the Head of Inclusion and Engagement and the Policy Group.

8.6. Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

9. ROLES AND RESPONSIBILITIES

9.1. Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

The Chief Executive will have overall responsibility for ensuring that all reasonable steps are taken to prevent unlawful discrimination and the promotion of equality within the Trust.

9.2 Trust Board

In accordance with points 7.4.4 of the Standing Orders the Board must receive an equality impact assessment when making a strategic decision. 7.4.4. of the Standing Orders says No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate)

that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

9.2. Directors

Directors are responsible for the effective management of and compliance with this policy.

Directors will have overall responsibility for ensuring that a corporate and co-ordinated approach to equality impact assessment exists. They will influence the culture of the organisation in how they set strategic direction, review performance and ensure good governance of the organisation by ensuring that:

- A corporate and co-ordinated approach to equality impact assessment exists
- The requirements of the policy are implemented in full
- There are effective working practices in place in relation to equality impact assessment
- The effectiveness of the policy is evaluated through the receipt and consideration of regular reports directly or through appropriate delegated Committees

Proposals and reports presented to Board are scrutinised with due regard to legislative requirements of equality impact assessment.

9.3. Directors of People and Culture

The Directors of People and Culture will be responsible for building equality considerations into workforce policies and procedures and promoting a supportive environment for staff. This will include:

- Ensuring workforce policies and practice that are fair and equitable
- Ensuring guidance and training which promotes equality, diversity and inclusion is available for all staff within the Trust
- Ensuring that information gathered in the Annual Workforce Equality Report is appropriately analysed and can provide evidence to inform equality impact assessment as appropriate.

Ensuring mechanisms for engaging effectively with staff, including Staff Networks in order to facilitate robust feedback to inform equality impact assessments of the Trust's policies and plans. Engagement is key to ensuring the needs of protected groups are being considered within the Trust's workforce and our communities

9.4. Heads of Service

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.

Heads of Services and Managerial Staff will be responsible through their work to oversee the design, delivery, quality and effectiveness of the organisation's functions. This will include:

- Leading by example and adopting a pro-active approach to eliminating discrimination and advancing equality by promoting equality impact assessment and ensuring that it is undertaken as and when appropriate
- Ensuring that the all staff are aware of and able to access the appropriate procedures, advice and guidance in this regard
- Ensuring that staff have access to appropriate support/training to carry out their responsibilities under this policy.

9.5. Service Managers / Clinical Leads / Locality Managers

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.

9.6. Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document. This includes ensuring that:

- Copies of the Trust policies are readily available and accessible to all staff.
- Information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.
- The identification of specific staff training needs on the implementation of new or updated documents.
- Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

9.7. The Diversity and Inclusion Team

The Diversity and Inclusion Team will be responsible for raising awareness and building capacity around equality impact assessment. This will include:

- Promoting, supporting and co-ordinating the mainstreaming of equality impact assessment policy and practice across all Trust functions and services
- Providing focussed advice, support and guidance to staff undertaking equality impact assessments
- Advising, assisting and providing positive support to all staff in the development and implementation of policies, procedures and working arrangements to meet the aims and objectives of this policy

9.8. The Patient Experience and Community Involvement (PECI) Team

The Patient Experience and Community Involvement Team will be responsible for finding ways to effectively engage with patients and their Carers, as well as the wider population, including marginalised communities. Providing accessible mechanisms for dialogue and feedback will be essential to assist the Trust to find out more about the needs of patients and staff with protected characteristics to inform equality impact assessments.

9.9. Procurement and Commissioning Staff

Procurement and Commissioning staff will have a responsibility to build equality impact assessment into their procedures to ensure fair and equitable procurement practices.

9.10. Trade Unions and Staff Side Representatives

Trade Unions and Staff Side Representatives will support engagement with staff to facilitate feedback to inform equality impact assessments and ensure the needs of protected groups within the workforce and within our communities are being considered.

9.11. All Staff

Are responsible for ensuring that:

- They comply with the provision of this policy and where requested to demonstrate such compliance.

- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

All staff undertaking or contributing to equality impact assessments must be mindful of the provisions of this policy and contribute to developing and maintaining a robust process for equality impact assessment across all functions of the Trust.

All staff have responsibility and ownership of the equality impact assessment process, including any actions that arise from the assessment. This includes managers and staff who develop new or modify existing policies, strategies, procedures etc.

10. AUDIT AND MONITORING

The Equality, Diversity and Inclusion Steering Group will be responsible for audit and monitoring the policy. When required, equality impact assessments will be discussed during the quarterly meetings and appropriate advice provided to equality impact assessment authors.

The Policy Group will provide assurance that all policies which are submitted to the group for review will have undergone equality impact assessment prior to final approval by the group.

Summary information on equality impact assessments undertaken by the Trust will be included in the Strategic Equality Plan Annual Report.

11. REFERENCES

Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Public Sector Equality Duty (Wales)

Welsh Language Measure 2011

Human Rights Act 1998

Socio-economic Duty (Wales)

Armed Forces Act 2022



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Bank Worker Policy

Policy Number:	059	Version No:	0.14 Draft	Supersedes:	New Policy
Date of Approval:	TBC	Review Date:	3yrs from date of approval	Impact Assessments Completed:	Yes - EQIA
Classification of Document:	Employment	Type of Document:	Policy	Approved by:	People & Culture Committee
Brief Summary of Document:	To provide clear advice, support and guidance to managers and bank workers to set out effective arrangements for recruitment and effective utilisation of bank workers. The aim is to support and assist managers who engage bank workers and set out the process for use of and support to bank workers who engage with the Welsh Ambulance Services University NHS Trust.				
Scope:	This Policy applies to all managers employed by the Welsh Ambulance Services University NHS Trust and workers who engage with the Trust.				
To be read in conjunction with:	Welsh Ambulance Services University NHS Trust and NHS All Wales Policies				
Owning Committee	People and Culture Committee				
Policy Lead: Trade Union Lead:	Michelle Morse Henry Garrard	Job Title:	People Business Leader Trade Union Partner		
Executive Director:	Carl Kneeshaw	Job Title:	Director of People		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	February 2024	Michelle Morse	Creation of Document
n/a	29/02/2024	Michelle Morse	Task & Finish Group Meeting
0.2	April 2024	Michelle Morse	Incorporating changes following meeting in partnership with management, People Services and Trade Union Partners. Main changes included: updating department names, change Grievance to Respect & Resolution, change "removal of bank agreement" to "review of bank agreement", amendment of timeframe for managers to review bank work undertaken, updated legislation in relation paid annual leave
0.3	01/05/2024	Michelle Morse	Review of draft policy with Senior People Services Leaders. Clarified that policy applies only to bank workers.
n/a	08/05/2024	Michelle Morse	Task & Finish Group Meeting
n/a	20/05/2024	Michelle Morse, Kathryn Cobley, Henry Garrard	EQIA discussion
n/a	05/06/2024	Michelle Morse Henry Garrard	EQIA undertaken
0.4	05/07/2024	Michelle Morse	Updated policy shared with Task & Finish Group members for final review/ comments
n/a	01/08/2024	Kelly Holding	Data Protection review of policy
0.5	14/10/2024	Michelle Morse	Policy transferred to new Trust template, layout re-order and document formatting. Completed policy checklist completed.
0.6	05/11/2024	Michelle Morse	Final check of policy and update bank agreement.
0.7	20/11/2024	Lisa Trounce	Review and formatting prior to presentation to Policy Group. Changes made include: Header of front cover changed to reflect latest policy template

Version	Date	Author	Summary of Changes
			• Front cover amended re: related papers, link to Professional Registration Policy added, committee written in full, names and roles updated. • Version control sheet formatted/updated • Key words added • Task & Finish Group members roles amended • Policy Approval Route amended/updated • Disclaimer text moved to inside text box • Formatting throughout (paragraph spacing and numbering, indentation/justification) • Contents page updated/formatted • Comments added on pg13 re: Roles & Responsibilities and Audit & Monitoring for Policy Lead to review, consider and action.
0.8	27/11/2024	Lisa Trounce	Feedback from Policy Group 27/11/2024 recorded: • Version control on front cover amended • Comments added for Policy Lead to action • Version control sheet updated • Contents page updated
0.9	02/12/2024	Michelle Morse	Comments from Policy Group 27/11/2024 actioned: • Front cover amended to reflect policy to be read in conjunction with relevant WAST and NHS All Wales Policies. • Pg 7 Section 6 'Annual Leave' reworded • Pg 9 Link to the ACAS website added to section 12.1.2 'Respect & Resolution' • Pg 13 Section 17.5 added to reflect roles and responsibilities of 'Bank Workers'. • Pg 13 Section 18 'Audit and Monitoring' – sentence added to be more specific.
0.10	05/12/2024	Lisa Trounce	Version Control Sheet updated. Final review, formatting and edit prior to 28-day Trust-wide consultation.
0.11	16/01/2025	Lisa Trounce	Confirmed no consultation comments received. Front cover and Version Control Sheet both updated in readiness for

Version	Date	Author	Summary of Changes
			presentation of post consultation policy to Policy Group on 31/01/25.
0.12	22/01/2025	Michelle Morse	Further amendments made to section 13 'Bank Agreements' at the top of page 11 re: bank assignments.
0.13	01/02/2025	Lisa Trounce	Post consultation tracked changes accepted, front cover updated, and approval route updated, in readiness for onwards travel to ADLT to recommend approval by Committee.
0.14	03/02/2025	Lisa Trounce	Following ADLT approval, policy prepared for onwards travel to Committee for approval
Keywords	Bank, Worker, Entitlement, Pay, Agreement. Allocation, Work		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	01/08/2024	Kelly Holding
EqIA / Welsh Language	06/05/2024	Melfyn Hughes

Task and Finish Group Members

Name	Job Title
Michelle Morse	People Business Leader
Steve Williams	Interim Service Manager, EMS (North)
Rob Brunnock	Service Manager, EMS Coordination (South East)
Joanne ReesThomas	Service Manager, Ambulance Care (Central & West)
David Hyde	Locality Manager, CSD
George Williams	Locality Manager, 111
Danni Green	Resource Manager, South East
Sharon Thorpe	GMB Trade Union Partner
Henry Garrard	Unison Trade Union Partner

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Bank Worker Task & Finish Group	29/02/2024	To discuss policy review and make amendments as required
Review of draft policy	01/05/2024	Review of draft policy with Senior People Business Leaders
Bank Worker Task & Finish Group	08/05/2024	Review draft policy
EQIA preparation	20/05/2024	EQIA discussion
EQIA	05/06/2024	EQIA Completed
Bank Worker Task & Finish Group	05/07/2024	Review draft policy
Policy Group	27/11/2024	Review and approve to go out for Trust-wide consultation
28-day Trust-wide Consultation	05/12/2024 - 02/01/2025	Staff comments and feedback
Policy Group	31/01/2025	Review post consultation - Approved for onwards travel to ADLT to recommend approval by Committee.
Assistant Directors Leadership Team	03/02/2025	Approved - Recommended for approval and adoption by Committee
People and Culture Committee	18/02/2025	For Approval and adoption

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

Contents

1. Introduction and Aim	7
2. Scope	7
3. Bank worker Policy	7
4. Rates of Pay and Banding	7
5. Remuneration	8
6. Annual Leave	8
7. Sickness	8
8. Maternity / Adoption / Paternity Entitlements	8
9. Pension	9
10. Continuous Employment	9
11. Requirements for Maintenance of Skills / Professional Registration	9
12 .Adherence to Trust Policies	9
12.1 Conduct, Disciplinary and Respect & Resolution procedure	9
12.1.1 Disciplinary Procedure	10
12.1.2 Respect & Resolution	10
13. Review of Bank Agreement	10
14. Process for Allocation of Work	11
15. Training and Development	11
16. Impact Assessments	12
16.1 Equality Impact Assessment	12
16.2 Welsh Language Act 1993 and Welsh Language Measure (Wales) 2011	12
16.3 Counter Fraud	12
16.4 Records Management	12
16.5 Information Governance	13
17. Roles and Responsibilities	13
17.1 Chief Executive Officer	13
17.2 Directors	13
17.3 People Services Directorate	13
17.3 Resource Department / Resource Co-ordinator	13
17.4 Department / Line Managers	14
17.5 Bank Workers	14
18. Audit and monitoring	14
19. References	14

1. INTRODUCTION AND AIM

The purpose of this policy is to set out effective arrangements for the recruitment and effective use of bank workers who are not employed by the Trust and are solely engaged as bank workers.

The main aim of the policy is to ensure that all managers, teams and departments within the Trust who use bank workers are aware of the correct process and procedure to engage a worker and that bank workers are managed appropriately and effectively.

2. SCOPE

The policy applies to all individuals working directly for the Trust on a bank basis and managers who engage bank workers.

3. BANK WORKER POLICY

This document sets out the policy of the Welsh Ambulance Services University NHS Trust (hereafter referred to as 'The Trust') in connection with the recruitment, utilisation and deployment of its bank workers, enabling an individual to work on a casual/ad hoc basis by mutual agreement between the Trust and the individual and to receive appropriate payment and benefits whilst working.

Bank workers are engaged for each individual assignment only there is no overarching engagement.

Bank workers will not, in legal or contractual terms, be considered to be employees of the Trust.

The objectives of the policy are:

- (i) To provide clear advice, support and guidance to managers on the use of bank workers
- (ii) To ensure bank workers are fairly utilised when engaging with the Trust.

4. RATES OF PAY AND BANDING

All bank workers will be paid at the minimum point of the Agenda for Change (A4C) band for the assignment that they are completing, unless they have accrued a higher increment for their bank work or there is a legitimate business case for paying an individual at a higher rate (e.g. highly specialist knowledge, retire and returning employees, individuals with previous reckonable NHS experience).

Authorisation for payment above the minimum point must be requested from the relevant People Services Leader via an incremental credit application. Rates paid for work undertaken as a bank worker are paid at plain time, with unsocial hours (USH), if applicable.

5. REMUNERATION

The hourly payment for work undertaken will be comparative to the Agenda for Change Band for the duties undertaken. All bank workers will receive payment in line with the payment schedule of the NHS Organisation with which they engage.

Increments will be awarded after every 488 hours (equating to 13 weeks – considered to be the equivalent to a full year's hours for the average bank worker, working 1 shift per week) or after each year's engagement on the bank, whichever is the latter, i.e. bank workers would not be able to receive more than one incremental rise in any 12 month period.

6. ANNUAL LEAVE

Annual Leave for bank workers will be calculated and paid as per statutory leave element of 5.6 weeks per annum, calculated pro rata on a monthly basis during their engagement and at the end of their period of engagement (paid monthly at 12.07% multiplied by number of hours worked).

7. SICKNESS

Bank workers are not entitled to receive occupational sick pay for any absence due to ill health. However, bank workers may be eligible to receive statutory sickness pay (SSP) if they meet the relevant criteria for that scheme. The www.gov.uk website provides information on eligibility criteria for SSP.

Bank workers are required to notify the Trust if they are unable to provide bank cover through ill health as soon as possible and within 24 hours of the commencement of the shift. If bank workers are sent home from a shift as a result of illness they will be paid for the completed hours worked.

The Trust reserves the right to refer the bank worker to Occupational Health as and when required.

If an injury or adverse incident occurs within the workplace, a DATIX form should be completed immediately.

8. MATERNITY/ ADOPTION/ PATERNITY ENTITLEMENTS

Bank workers are not eligible for occupational maternity, adoption or paternity entitlements. Bank workers may be eligible to receive statutory pay if they meet the relevant criteria for that scheme.

The www.gov.uk website provides eligibility criteria for these entitlements.

9. PENSION

Bank workers may join the NHS pension scheme only if eligible, but if not will be automatically enrolled into the nominated pension provider, the Government National Employment Savings Trust (NEST).

10. CONTINUOUS EMPLOYMENT

Any work undertaken by an individual for the Trust under a bank agreement will not count towards continuous or reckonable service for the purpose of NHS employment. A bank worker is engaged for the period of the assignment only.

11. REQUIREMENTS FOR MAINTENANCE OF SKILLS / PROFESSIONAL REGISTRATION

If the role requires state registration, bank workers will be responsible for ensuring they are registered. Proof of their continued professional registration must be produced on request. Failure to maintain registration may lead to termination of the assignment and removal from the bank register on the grounds of failure to comply with the statutory requirements.

Disclosure and Barring Service (DBS) checks will be undertaken as required.

The bank worker must notify the relevant line manager if they are subject to any Police investigation, criminal charge or conviction (including cautions, driving offences and endorsements), professional investigation, safeguarding investigation, suspension or disciplinary investigation in any other role.

The bank worker must notify the relevant line manager if there are any changes to their health which may impact on their ability to undertake work. In addition, the bank worker must notify the relevant line manager if they receive any driving restrictions from the DVLA.

12. ADHERENCE TO TRUST POLICIES

Whilst actively engaged for work with the Trust, the bank workers will be expected to abide by Trust policies, health and safety standards, clinical guidelines and Standard Operating Procedures applicable to the role and area of work.

12.1 Conduct, Disciplinary and Respect & Resolution procedure

Registrants are expected to follow their relevant professional code of conduct at all times. All workers are expected to adhere to the Trust values and behaviours and demonstrate professionalism at all times. In the event of concerns arising regarding a workers conduct or performance, the following will apply:

12.1.1 Disciplinary Procedure

Should any misconduct or capability issue arise, whether by a registrant or other Bank Worker, the case will be dealt with in a timely manner, within one month of the initial assessment, unless there are exceptional circumstances. There will not be any need for a formal investigation report although a thorough examination of the known facts will take place. An investigating officer will not, therefore need to be appointed, but in serious cases may be. Examples of misconduct (which is not exhaustive) are listed in Appendix 1 of the All Wales Disciplinary Policy.

If the manager feels that there is a complex issue it should be discussed internally in respect of professional escalation procedures and risks assessed accordingly.

A fair process should be followed in line with the ACAS Code of practice on disciplinary and grievance procedures. This includes:

- Establishing the facts of each case
- Informing the bank worker of the problem
- Allowing the bank worker to be accompanied to any meeting
- Deciding on the appropriate action, which may be:
 - to take no action
 - issue an informal warning
 - issue a formal warning which goes on the bank worker's file
 - Removal from the Bank Register
- Providing an opportunity to appeal

12.1.2 Respect & Resolution

All Respect & Resolution concerns will be handled in line with the ACAS Code of Practice on disciplinary and grievance procedures www.acas.org.uk . Bank workers should contact the relevant line manager, who will deal with the concern informally in the first instance.

13. REVIEW OF BANK AGREEMENT

Failure to present for duties or frequent cancellation of booked shifts without acceptable reasons could lead to removal from the bank register.

The bank agreement between the Trust and the individual may be revoked by either party at any time whilst the worker is not engaged on an assignment.

Bank workers should notify the Trust's Resource Department and the relevant line manager if they are no longer available for work and do not wish to remain on the bank database.

The bank register will be reviewed quarterly and workers who have not undertaken any assignments for a period of three months may be reviewed by the relevant line manager and removed from the bank database and [end the bank assignment on ESR](#).

Bank workers will be required to provide proof that they meet the competencies of the work they will undertake. If a bank worker has not undertaken any work for a period of time, they will be required to undertake competency testing.

NB: ESR automatically marks bank assignment statuses as 'Inactive Not Worked' where there has been no pay for bank work over a 4-month period. These assignments will still need to be [manually ended](#) if appropriate where they have not previously reviewed.

Bank workers who fail to comply with the standards, policies or protocols of the Trust or who fail to fulfil the full requirements equivalent to the Job Description and Person specification may be removed from the bank database. Bank workers who fail to attend and complete annual mandatory/ statutory training/ CPD will automatically be removed from the bank database.

Managers will review any work undertaken by bank workers on a quarterly basis and arrange to meet with any bank worker who has undertaken regular work to determine whether the bank agreement is suitable. A bank worker should not be used for long term cover and if appropriate, a fixed term contract should be considered.

14. PROCESS FOR ALLOCATION OF WORK

All work for Emergency Medical Service (EMS), Ambulance Care and Emergency Medical Service Coordination (EMSC) will be available on GRS, and Integrated Care on WFM, for up to a 28 day period.

Work for any Corporate department/area will be notified by the relevant manager.

Recording and approval of hours worked (Paper or Electronic)

- Each bank worker is expected to complete a timesheet at the end of each shift or assignment period worked or where training is undertaken, which will require authorisation by the relevant manager.
- All responsible staff must sign off bank shifts for payment of shifts worked.
- This is a budget approval process and therefore payments will only be made for approved shifts.

15. TRAINING AND DEVELOPMENT

Payment for attendance at orientation, induction and initial mandatory training will be made. Any attendance for annual training required by the Trust and/or regulatory body will be paid.

Continuing Education and Training

Qualified Nurses and Allied Health Professionals (AHPs) - Qualified bank workers will be able to access advice on continuing professional development and education. They

will have opportunities to participate in the Trust's continuing education framework and in-house training programmes.

Unregistered bank workers may be able to access guidance on continuing development and may have opportunities to participate in Trust in-house training programmes relevant to the area of work.

Bank workers have a responsibility to maintain their own statutory and mandatory training. This is not the responsibility of the Trust.

16. IMPACT ASSESSMENTS

16.1 Equality Impact Assessment

The Trust recognises the diversity of its workforce. Our aim is to provide a safe environment where all bank workers are treated fairly and equally and with dignity and respect. The Trust recognises that the promotion of equality and human rights is central to its work, both as a provider of healthcare, and as an employer. This policy has been impact assessed to ensure that it promotes equality and human rights.

16.2 Welsh Language Act 1993 and Welsh Language Measure (Wales) 2011

The Trust is committed to fulfilling its obligations under the Welsh Language Act 1993 and Welsh Language Measure (Wales) 2011 via its Welsh Language Scheme. The Trust's compliance with Welsh Language Legislation is monitored through submitting an annual report to the Welsh Language Commissioner.

16.3 Counter Fraud

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. In conjunction with this policy, any suspected incidents of fraud and corruption can be reported to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, the confidential NHS Fraud and Corruption Reporting line can be contacted on 0800 028 40 60; or online reporting facility <https://cfa.nhs.uk/reportfraud>. Fraud investigations may lead to, disciplinary action, removal from the bank register, prosecution and civil recovery procedures.

16.4 Records Management

The Welsh Ambulance Services University NHS Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

16.5 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

17. ROLES AND RESPONSIBILITIES

17.1 Chief Executive Officer

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

17.2 Directors

The Directors are responsible for the effective management of and compliance with this policy.

17.3 People Services Directorate

The team within the People Services Directorate have a responsibility to ensure that the policy is followed fairly and consistently. The duties include:

- To provide guidance to managers on the administration of this policy.
- To provide guidance to managers on the recruitment of bank workers
- To administer and issue bank worker agreements.
- To advise managers where there is a concern about the health, performance or conduct of an individual who is undertaking bank work.

17.3 Resource Department / Resource Co-ordinator (Applicable to EMS, Ambulance Care, EMSC and Integrated Care)

- Bank workers will be notified of their relevant co-ordinator for the area they primarily work in.
- To maintain a database of bank workers in the rostering software.
- To maintain contact with bank workers in relation to the availability of shifts and ensure that shifts are allocated in a fair and equitable manner.
- To maintain information relating to the utilisation of bank workers and the number of shifts worked by each individual whilst ensuring compliance with the Data Protection Act.

- To monitor, in conjunction with the People Services Departments, the hours worked by bank workers to ensure compliance with the Trust's Working Time Regulations policy.
- To calculate statutory entitlements (annual leave) and any appropriate enhancements to salary based on hours worked in accordance with this policy and guidance from the People Services Department.

17.4 Department / Line Managers

- A bank worker should not be used for long term cover and if appropriate, fixed term contracts should be considered.
- To ensure bank workers and signposted to all Trust policies at local induction.
- To monitor the hours worked by bank workers to ensure compliance with the Trust's Working Time Regulations policy.
- Only engage bank workers in line with this policy.
- Ensure that all colleagues they are responsible for also comply with the policy.
- Ensure that any bank workers who have not undertaken work for a period of three months or more are removed from the bank register and [end the bank assignment on ESR.](#)

17.5 Bank Workers

Bank workers are responsible for:

- ensuring they are familiar with the policy
- ensuring they registered (if required for the role)
- notifying the relevant line manager if they are subject to any Police investigation, criminal charge or conviction (including cautions, driving offences and endorsements), professional investigation, safeguarding investigation, suspension or disciplinary investigation in any other role.
- notifying the relevant line manager if there are any changes to their health which may impact on their ability to undertake work.
- notifying the relevant line manager if they receive any driving restrictions from the DVLA.

18. AUDIT AND MONITORING

The policy lead will monitor this policy to ensure it is compliant with current legislation, is implemented effectively, and that it is reviewed in accordance with the policy review schedule. People Services will monitor and record any issues raised by managers and / or bank workers for audit purposes.

19. REFERENCES

- Equality Act 2010
- Welsh Language Act 1993 and Welsh Language Measure (Wales) 2011



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AGENDA ITEM No	21
OPEN or CLOSED	Open
No of ANNEXES	1

Committee Priorities and Cycle Monitoring Report

MEETING	People and Culture Committee
DATE	18 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed Cycle of Business for the Committee. There are no matters to escalate with respect to the Priorities.

RECOMMENDATION: -

2. **The Committee is asked to note the update.**

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1: Cycle of Business 2024/25 Monitoring Report – January 2025



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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



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COMMITTEE PRIORITIES FOR 2024/25 AND CYCLE MONITORING REPORT

SITUATION

3. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed Cycle of business. There are no matters to escalate with respect to the Priorities.

BACKGROUND

4. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.
5. The Committee's cycle of business was approved by the Committee in May 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.
6. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.
7. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

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



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Priority	Progress
Impact of wellbeing initiatives on our people.	- The upcoming Cultural Themes and Trends Report (to be received at the February 2025 meeting) will include consideration of the employment relations cases, sickness absence and compassionate practices. There will also be a focus session (as part of the Cultural Themes and Trends item) on sickness absence received at the February 2025. - The Health and Wellbeing Plan which was received by the Committee in November 2024 - includes commentary on the Trust's approach to understanding the impact of wellbeing initiatives on our people. This Plan was subsequently approved by the Trust Board at its meeting in November 2024. - Objective 1 of the Health and Wellbeing Plan is proposed to be to "Assess and Understand the health and wellbeing of our workforce". In relation to this objective, the Trust will implement a robust assessment framework to identify and address specific stressors. The data-driven approach will provide actionable insights, enabling targeted interventions and creating a foundation for sustainable wellbeing improvements. Charity funding will be sought to support and expand these assessment tools. - Additionally, Objective 2 of the Health and Wellbeing Plan is proposed to be "Proactively promote protective health and wellbeing offers at all levels within WAST for our people and their families and ensure they are available to all". The Health and Wellbeing Plan is being received by the Committee at its meeting in November 2024 for endorsement.



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	- The Committee regularly receives the People and Culture Plan Metrics, the Workforce Scorecard, and the MIQPR, through which it will understand the impact of various wellbeing initiatives on our people. Additionally, the Committee receives the output of 'Pulse Surveys' and annual NHS Staff Survey, with the associated actions plans – both of which are programmed in the Committee's Cycle of Business.
• Culture of conversations with a focus on communication and conversations with managers and their people.	- The Trust's focus on a 'Culture of Conversation' continues. A significant aspect of our improvement strategy is moving beyond simply focusing on the completion rates of PADRs. We are working towards making every PADR conversation meaningful, ensuring that these discussions reflect our values of compassion, inclusivity, and collaboration. - This shift aligns with the development of <i>Our WAST Way</i>, a new behaviours and development framework for leaders and managers that outlines their responsibilities in creating a positive and supportive work environment. The Committee will receive updates regarding the development of <i>Our WAST Way</i> at its meeting in February 2025. The '<i>Our WAST Way</i>' intends to incorporate the importance of change management skills for our people. It is noted that the Committee received an update on development on change management initiatives in the Trust at its meeting in November 2024. - Additionally, the Committee continues to have a focus on the organisational culture, with 'Cultural Themes and Trends' reports being brought forward regularly. The Committee received this report at its meeting in August 2024. The next 'Cultural Theme and Trends Report' will be received by the Committee in



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	February 2025, in line with the Cycle of Business.
• A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives.	- The Committee has an ongoing focus on equality, diversity and inclusion – with the relevant business having been incorporated into its annual Cycle of Business. The Director of Culture will provide updates to the Committee regarding the work of the Equality, Diversity and Inclusion Steering Group (EDISG), as required. The EDISG will be supporting the implementation of the Strategic Equality Objectives from which the Director of Culture will provide assurance to the Committee. - The Trust is committed to ensuring that equality, diversity and inclusion are integral to all we do within People and Culture. Rather than viewing EDI as a separate initiative, we strive to make it a continuous golden thread that connects every workstream. By doing so, we help colleagues see and embrace EDI as foundational to our work, creating a space where decisions are influenced by our commitment to inclusion and equity. - Alongside embedding EDI into our everyday practices (through delivery of our Strategic Equality Objectives), we are committed to driving forward the successful delivery of our Statutory Action Plans. Specific initiatives will also include partnering with Higher Education Institutions to increase student diversity and launching targeted campaigns to attract candidates from a wide variety of backgrounds for the full range of career opportunities within WAST.



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	- At the August 2024 meeting the Committee received the Strategic Equality Plan Annual Report for 2023/24, the Annual Workforce Equality Monitoring Report for 2023/24, the Annual Gender Pay Gap Report for 2023/24 and the Workforce Race Equality Standards Report for 2023/24, and the Welsh Language Annual Report for 2023/24. These are the key matters of annual reporting regarding equality, diversity and inclusion.
• The Trust's approach to development of our people.	- At its meeting in May 2024 the Committee received the 'Staff Development Outline Plan' which is a deliverable of the People & Culture Plan. The aim of this is to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities. - At the May meeting the Committee were assured that mapping was underway on professions and roles, which will define skills and competencies. An update will be given to the Committee at a future date. It is noted that the 'Learning and Development' reporting is still in development. - The People and Culture Plan metrics – which the Committee receives at every meeting – includes metrics regarding the statutory and mandatory training (giving organisational compliance figures) in addition to the MIST compliance. - The People and Culture Plan metrics provided to the Committee also include qualitative feedback regarding the Trust's learning and development initiatives, which enables us to take a continuous improvement approach to the development of our people.



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Welsh Ambulance Services
University NHS Trust

9. There remain areas of reporting that are being developed which include:
- (a) Learning and development reporting;
 - (b) The Committee elements of the revised Health and Care Standards;
 - (c) The Speaking Up Safely Reporting (although a progress report on this area has been included in the Cultural Themes and Trends Report for the February 2025 Committee);
 - (d) The report on Anti-racist Wales Action Plan;
 - (e) The reporting on the Welsh Language Standards.

RECOMMENDATION:

10. The Committee is asked to note the update.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
People and Culture C'ee elements of IMTP	STB	Annually					DPC	Endorsement	Q3: Review of the 25-28 IMTP elements.
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Strategic Workforce Plan	TBC	Bi-annually	→				DPC	Endorsement	Q1: Programmed for Q1 but deferred and proposed Q2/Q4 programming for 24/25. Programmed for Q2. Q4: Update not required.
Cultural themes and trends report	TBC	Bi-annually					DPC	Assurance	Regular reporting on the Compassionate Practices Action Plan to be included.
Learning and development reporting	TBC	TBC					DPC	Assurance	
People and culture metrics annual review	TBC	Annually	→				DPC	Approval	Programmed for Q2.
MIQPR review for people and culture metrics	FPC	Annually					EDSPP	Endorsement	
People and culture metrics report	TBC	Quarterly					DPC	Assurance	Q1: Inc deep dive on disciplinary case management and cultural themes. Q3: Merged w/Workforce Scorecard.
Workforce Scorecard	TBC	Quarterly					DPC	Assurance	Q3: Merged with P&C Metrics Report.
MIQPR	ELT	Quarterly					EDSPP	Assurance	
Suspensions over 4 months report	TBC	Quarterly					DPC	Assurance	Closed session
End of Season Flu Campaign Report	CQGG	Annually					DP	Assurance	
Health and Safety Report [Note 3]	NH&S C'ee	Bi-annually					EDQN	Assurance	
Annual Health & Safety Report	NH&S C'ee	Annually					EDQN	Assurance	Q2: To include related item of 'violence and aggression report'.
Revalidation and registration report [Note 4]	N/A	Annually	→				EDQN & EDP	Assurance	Q2: NMC deferred to November 2024 Q3; EDoP advised that HCPC registration report not due until Autumn 2025.
Gender pay gap report	TBC	Annually					DPC	Assurance	
Annual Equality Report [Note 11]	TBC	Annually	→				DPC	Assurance	Timing tbc going forward.
Health and care standards	TBC	TBC					DPC	Assurance	Q4: Noted that this is developing and will come forward throughout 2025/26. Substantive update taken to QuEST.
Staff Story	N/A	Quarterly					DPC	Discussion	
Staff Story updates [Note 5]	None	Quarterly					DPC	Assurance	
NHS Staff survey and action plan [Note 6]	ELT	Annually			→		DPC	Assurance	Q1: Programmed for, as deferred from Feb 2024. Deferred from Q3 to Q4 as not available for Nov' 2024. Q4: Not programmed.
WAST pulse surveys and action plans	ELT	Ad Hoc					DPC	Assurance	Q2: To be included in the P&C metrics update should results be available.
Speaking Up Safely Report [Note 7]	TBC	TBC					DPC	Assurance	Q4: Update to be included in the Cultural Themes and Trends paper for this meeting.
Report on Anti-racist Wales Action Plan [Note 8]	TBC	TBC					DPC	Assurance	
Reporting on Welsh Language Standards	WLAG	Bi-annually					BS	Assurance	
Welsh Language Annual Report	WLAG/ELT	Annually					BS	Endorsement	
WASPT AAA report [See note re placement]	WASPT	Quarterly					DPC	Assure/Escalate	As well as minutes (effective 24/25).
Partnership Agreements [Note 9]	WASPT	Ad Hoc					DPC	Endorsement	
Partnerships & Engagement Report	TBC	Bi-annually					DPE	Assurance	Q4: Agreed not required. Will be removed from PCC CoB for 25/26 as different approach to oversight discussed with Chair, BoardSec, DPE.
Partnership Agreements [Note 9]	ELT	Ad Hoc					DPE	Review	
NHS Workforce Model	Workforce Planning Grp	TBC					DPC	Endorse	
Workforce Plan aligned to IMTP	Workforce Planning Grp	Annually					DPC	Endorse	This went to Q2 meeting as opposed to Q3.
Report from policy group	Policy Group	Annually					BS	Assurance	Q4: Agreed not necessary as position paper taken to ARAC.
Policies for review and approval	Policy Group/ELT	Ad Hoc					Various	Approval	
Board Assurance Framework	Board	Quarterly					BS	Assurance	
Corporate Risk Register - People and culture	Board	Quarterly					BS	Assurance	Q1: Deep Dive on Reputational Risk 201 programmed.
Audit Recommendation Tracker	ADLT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc					Relevant Director	Assurance	
Operational Update	N/A	Quarterly					EDO	Information	
Director of P&C Update	N/A	Quarterly					DPC	Information	Including spotlight on TUP successes and challenges from 1 April 2025
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	Q4: The ToR review will follow the effectiveness review discussion in Q4.
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
PROMPTS									
Relevant External Reports	N/A	Ad Hoc					Various	Assurance	

DPP = Director of People & Culture
EDO = Executive Director of Operations
EDQN = Executive Director of Quality and Nursing
DPE = Director of Partnerships and Engagement
EDP = Director of Paramedicine
BS = Board Secretary

Key: Pre-agenda setting

- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting

- Presented as cycled
- Ad hoc / item considered - not programmed
- Item deferred
- Reporting developing

1	Health and wellbeing	TOR 3.5 - health and wellbeing offer will be included in the People and Culture Plan and reported via the IMTP
2	Flu Vaccine	Not mandatory; WG have a target for patient facing staff
3	Health and Safety	Delivery on the Working Safely Programme is via IMTP however bi-annual updates on working safely programme to maintain visibility over 23/24
4	Revalidation	Health and Safety Internal Audit Report July 2023 - <i>There is good oversight over the Programme with regular reporting to the Programme Board and to the People and Culture Committee (PCC) but could be enhanced by noting progress against the programme's deliverables</i>
5	Staff story updates	RNC every 3 years; HCPC every 2 years; GMC every 3 years
6	Staff survey	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 agenda for the following meeting.
7	Speaking Up Safely	Staff survey goes out [Sept?] and reports end [March]. DPC will develop reporting on Speaking Up Safely through 24/25 as FTSU Guardians embed; in the meantime the cultural themes and trends captures some of this reporting. (AP): For 25/6 the timing of the PCC assurance to ARC on the FTSU arrangements (whistleblowing) needs to be considered - take to ARAC after PCC. Review for 25/26 CoB.
8	Anti-racist Wales Action plan	Wider public, third sector and Government funded private sector In relation to the leadership responsibility we hold for public, third and those private sector organisations we fund. 5 core actions identified WG will expect and will hold them to account, via our Accountability Group: 1. A strong commitment to lead from the front and demonstrate it in terms of anti-racist values, behaviours, representation at all levels of your organisations and accountability measures. 2. Participation in all decision making and senior leadership groups in a way that enables lived experiences of ethnic minority people to be heard and acted upon. 3. Achieve, at the very least, minimum requirements of the Equality Act 2010 and publish your results in an open and accessible forum/platform. 4. Ensure minimum standards and provision of culturally sensitive and appropriate services, including provision of translation and interpretation. 5. Ensure robust complaints policies and processes for racial harassment that are validated to the satisfaction of ethnic minority groups.
9	Working in Partnership	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, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership'.
10	EDI Networks	Promote the networks and Committee involvement including NED champion roles
11	Annual Equality Report (5)	SEP 2024-2028 approved March 24. 22/23 report presented in February (Q4) 24. TBC timing of this going forward. WRES reporting (national WRES report being coordinated by HEIW. WRES data will help provide baseline for future actions on ARWAP. <i>This should be a group of reports to be received in August: the SEP Annual Report, the Annual Workforce Equality Monitoring Report and the Workforce Race Standards report.</i>
	General	These cycles are developed with reference to the specific lines of the TOR for this Committee. This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board

**UNCONFIRMED MINUTES OF THE WELSH AMBULANCE SERVICES PARTNERSHIP
 TEAM (WASPT) HELD IN PRIVATE SESSION FACE TO FACE CARDIFF MRD ON
 15 NOVEMBER 2024**

PRESENT:

Christian Fox	Trade Union Partner Unite and shadowing Joint Chair (Chair of this meeting)
Jason Killens	Chief Executive and Joint Chair (via video conference)
Lee Brooks	Executive Director of Operations
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Estelle Hitchon	Director of Partnerships and Engagement
Carl Kneeshaw	Director of People
Maldwyn Jones	Trade Union Partner GMB
Marcus Viggers	Trade Union Partner GMB
Damon Turner	Trade Union Partner Unison
Alison Williams	Trade Union Partner Unite
Hugh Parry	Trade Union Partner Unite
Aimee Williams	Trade Union Partner RCN (FTO in attendance as TUP representative)

APOLOGIES:

Chris Turley	Executive Director of Finance and Corporate Resources
Mark Marsden	Trade Union Partner Unison Joint Chair
Trish Mills	Director of Corporate Governance/Board Secretary
Andy Swinburn	Executive Director of Paramedicine
Henry Garrard	Trade Union Partner Unison
Bethan Williams	Trade Union Partner Unison
Richie Bullen	Trade Union Partner GMB
Tim Cahalane	Trade Union Partner RCN

IN ATTENDANCE:

Liz Rogers	Deputy Director of People and Culture
Sara Mills	Head of Culture and Organisational Development
Julie Boalch	Assistant Director of Corporate Governance & Risk
Sara Williams	Workforce Policy and Governance Lead
Lisa Trounce	Head of Compliance & Assurance (Observing)

01/24 WELCOME AND QUORUM

Christian Fox, Chair, introduced and welcomed Carl Kneeshaw, Director of People, to his first WASPT meeting which was held face-to-face at Cardiff MRD.

02/24 DECLARATIONS OF INTEREST

None declared other than those on the record.

03/24 MINUTES OF LAST MEETING

The minutes of the meeting held on 25 September 2024 were agreed and approved as an accurate record.

Action: Approved minutes to be circulated.

04/24 ACTION LOG AND MATTERS ARISING

a) 13/24 Male Menopause Policy

Liz Rogers confirmed that information would be included in the Occupational Health and wellbeing resources so that the team were aware and could signpost colleagues for support where appropriate. Catherine Goodwin had also advised that a Webinar was planned to be arranged in the coming year to raise the profile in the organisation.

Action: Action complete and closed.

b) 22/24 Emergency Medical Technician (EMT) 2/3 - Transition Progress

It was noted that the third and final Joint Partnership Notice on the EMT 3 transition arrangements had been developed and released on 7 October 2024.

Action: Action complete and closed.

c) 23/24 Future workshop:

A WASPT workshop due to be held on 15 November 2024 to consider the potential introduction of a 36 hour working week, a without prejudice conversation, was deferred at the request of the Trade Union Partners and

would be re-scheduled for the workshop topic at the meeting in March 2025 with the outcome of the feasibility study used to prompt discussion.

It was agreed that the topic for the next WASPT workshop in January 2025 would be Health and Safety Good Culture.

Action: Topic for WASPT workshop in January 2025 confirmed as Health and Safety Good Culture and the 36 hour working week workshop to be re-scheduled for the March 2025 WASPT workshop.

d) 13/24 Spotlight Item on Siren

This action focussing on the progression of the options to address diesel fumes ahead of Winter had been published on Siren on 14 November 2024.

Action: Action complete and closed.

05/24

DIESEL FUMES

Mal Jones referred to previous discussions and had followed up on the issue of filters on the Eberspächer heaters and had been advised that the filters were not fitted as standard on the saloon heaters.

Damon Turner stated that they used to supply the heaters with the filters as standard but there was not a large uptake.

Jason Killens agreed to pick up the issue of the filters outside of the meeting to get a definitive answer on the issues raised. In addition, he would ask Liam Williams to ensure that the manufacturer's information was circulated to conclude the action on this.

Damon Turner referred to the Dyson fan heaters which were being procured and expressed his concern that there was no date for this and also that there could be potential issues with storage, due to their size. He stated that other smaller options could have been considered and there was a sentiment that the process seemed to be becoming an industry in itself.

Jason Killens acknowledged the concerns and stated that this had been discussed with Carl Kneeshaw and Angie Lewis. He had wanted to drop into the Task and Finish Group (T&F) but there had been a clash with other diary commitments. He stated that he had been in discussions with Liam Williams on these issues within the last 48 hours and gave assurance that these would be resolved.

Hugh Parry mentioned he was going to raise this under Any Other Business (AOB), but since Damon Turner had already brought it up, it was appropriate to discuss it

now. He expressed his concern and frustration over the prolonged resolution of these issues and noted that he was a member of the T&F group.

There were two actions which needed to be separated out - the Standard Operating Procedures (SOPs) which were about the storage at each site and the operation of the Fans.

Lee Brooks stated that his team had commenced work on the SOPs to operationalise the deployment of the fans and storage at a local level and they were seeking assurance locally with the Emergency Departments on this. One issue which had been flagged was the electronic installation at the Emergency Departments to be able to plug them in, which was noted as a potential risk.

Hugh Parry acknowledged that Darren Panniers had circulated a SOP which he needed to respond to. The infrastructure at the Emergency Departments was a concern however and they were seeking information from the Health Boards (HB) on this. He stated that Hywel Dda UHB had responded in this regard, but they were the only HB to do so, and they had confirmed that they would not be funding it.

Jason Killens stated that this was the first that he was aware of challenges with the infrastructure. He would discuss this further with Hugh Parry at the meeting planned for the following Monday and with Liam Williams and the T&F group on this.

Mal Jones confirmed the issue which Hugh Parry had raised regarding the electrical infrastructure as Susan Woodham had flagged it.

Estelle Hitchon confirmed as part of the discussion that she had spoken with Damon Turner and Hugh Parry and that there was a meeting planned for the following week on the proactive media release on the diesel fumes and mitigation plan for Winter.

Damon Turner enquired whether it would be possible to retro fit external sockets to the vehicles rather than using the leads through the windows. It was agreed that Lee Brooks would liaise with Chris Turley on this issue,

Action:

Jason Killens to clarify the position on the Eberspacher heater filtration system.
Liam Williams to ensure the manufacturer's information be circulated to conclude the action on this.

Lee Brooks to conclude the work on the Standard Operating Procedures for the Dyson Fans.

Jason Killens/Liam Williams to clarify the position on the electrical infrastructure and suitability at Emergency Departments.

Lee Brooks to liaise with Chris Turley on the options of retro fitting of external sockets on vehicles.

06/24

FEEDBACK ON OBSERVATIONS OF ENGAGEMENT AND REFLECTIVE SESSION TO EXPLORE HOW WE CAN CONTINUE STRENGTHENING OUR PARTNERSHIP PRACTICES

Following on from the previous WASPT meeting Sara Mills, Head of Culture and Organisational Development, attended to provide feedback on the observations of the engagement and reflective session and from the survey that WASPT members had completed.

She explained that this was part of the ACAS action plan and would explore how the team could continue to strengthen partnership practices, reinforce collaboration and joint problem-solving within the Trust and reflect on how partnership behaviours and conflict management styles were used during the meetings.

She presented information, both qualitative and quantitative, which looked at the areas shown in the table below and compared the average rating scores taken from the "Walking in Each Other's Shoes" Partnership Workshop which had taken place in February 2024 and again in September 2024 at the WASPT Meeting. She referred to the assessment tool which she and Liz Rogers had used at the partnership sessions which had rolled out across the Trust. She described how the meeting reflections, whilst not scientific, provided a temperature check of how things were, and she had converted this into an infographic which had been shared for the meeting.

	March 2024 Average	September 2024 Average
Having mutual respect	5.30	7.38
Actively listening to each other	5.10	8.54
Working from shared values	6.00	7.92
Walking in each other's shoes	3.60	7.46
Being honest and open	5.00	8.38

Being solution focused	6.70	7.62
Acknowledging each other's views	4.40	7.85
Being inclusive	4.30	8.23
Open communication and sharing	4.30	8.08
Trust	4.70	8.00

She stated that the scores indicated were good and during discussion it was accepted that it had been a challenging journey but there was recognition of the positive and collective progress so far whilst acknowledging there was still work to do to continually improve together.

Christian Fox thanked Sara Mills for her feedback and stated that it was very insightful to see the scores as presented.

Damon Turner concurred with this and stated that whilst it could be challenging, they were on a journey and that it had been referenced and recognised at the Social Partnership workshop with Welsh Government earlier in the week and also at People and Culture Committee that there was really good work ongoing in this area, which was evident.

Hugh Parry reflected to the meeting at Welsh Government and stated that this should be included in the report on Social Partnership.

Liz Rogers acknowledged there had been a great effort in this area, by both the Trade Union Partners and managers.

Jason Killens agreed that it was palpable, and a positive piece of work and whilst the analysis which had been presented was good, aside from that it felt different, and better and as close to Social Partnership as could be. He stated that he had not been able to attend the most recent workshop on Social Partnership but at one earlier in the year it felt that the Trust was ahead in some aspects of this and that six months on, with a great effort from all it felt even better.

Estelle Hitchon stated that she had not been able to attend the recent meeting due to the Staff Awards but reflecting on previous meetings and conversations there was a maturity that even though there have been bumps along the way there was the confidence to deal with this together and come out the other side.

Christian Fox stated that the conversations at Welsh Government, although in different groups, the collective view from the participants that attended from the

Trust was that we are doing really well in terms of the approach the Social Partnership.

Sara Mills agreed with all the reflections and comments and stated that this was the result of sustained effort by all and even when there are bumps in the road it was about keeping the lines of communication open. She referred to the bank account analogy with the "Deposits" as credit and the challenges and behaviours as withdrawals and ensuring that there is always enough credit.

Christian Fox thanked her for her presentation and reflections.

07/24

PROGRESS ON THE EMT 2/3 BUSINESS CASE

Jason Killens provided an update on the progress of the Emergency Medical Technicians 2/3 business case. He stated that this had been formally considered by Commissioners at the recent Joint Commissioning Committee (JCC) public meeting who had not been able to commit to fund the recurring £10m growth required for the EMT pay deal in the context of other financial commitments and pressures yet to be considered. He requested that the paper which had been presented and considered at the JCC be shared with the WASPT members and requested that Rachel Marsh arrange for this to be undertaken.

He stated that it was agreed that the in-year costs would be absorbed by the Trust to cover the back pay from November 2023 and the part year effect from November 2024 to March 2025 and in doing so this removed any flexibility to undertake other discretionary schemes before the end of this financial year. He expressed that the more significant issue was the IMTP process and that the Trust would need to put forward costed options to consider how the additional recurrent cost may be managed.

Following discussion at the WASPT meeting it was agreed that a collective Task & Finish group process would be convened to consider all the options and how these could be brought to effect linking into the IMTP process and the planning required should the agreement to fund centrally not be reached.

Three initial options were floated:

- funded in full centrally by the Commissioners or Welsh Government.
- if no agreement, strategic workforce planning in EMS to be considered. same number of posts with a different configuration with potential banding implications.

He accepted that the last two would be unpalatable and hence the need for a Task and Finish (T&F) group to plan and to consider all of the options and cost them.

Hugh Parry stated that Jason Killens had indicated that it was a risk and that it was important to get the T&F group together to look at it. Damon Turner agreed and acknowledged the communication from Jason Killens on this which was appreciated.

It was agreed that Rachel Marsh would bring a T&F group together to look at this and linked to the IMTP process. She stated that it was not a finished conversation from the meeting of the JCC, that the CEOs of the HBs had been presented with the case but need to consider it in the context of all the other things that they have to co-ordinate.

Hugh Parry enquired whether this was logged as a risk, especially if the role profiles have to be considered. Jason Killens stated that they need to look at other options first but if in time, having done that there are no other options then it would need to be flagged on the Corporate Risk Register.

Action:

Rachel Marsh to circulate to WASPT members the JCC paper that was presented and to bring together a T&F group to consider all the options and how these could be brought to effect linking into the IMTP process and the planning required should the agreement to fund centrally not be reached.

08/24

CHRISTMAS PLANNING UPDATE FROM GROUP

Lee Brooks presented an update on Christmas Planning since the last WASPT meeting. He stated that a meeting of the Christmas Planning Group had been held to urgently consider the significant operational challenges and had discussed the options to manage the challenges of the Christmas period, safeguarding both patient safety and staff wellbeing and the need for collective action to ensure the service was as safe as possible on key dates from 24 December evening to 26 December and potentially the other Bank Holidays over the period

He stated that although a partnership notice had been issued on 14 October 2024 regarding overtime for the key dates, the Unit Hours Produced (UHP) was still lower than the predicted demand.

He presented details of the Emergency Ambulance UHP for the key dates of 24, 25 and 26 December, together with the known abstractions of 24% as of 11

November 2024, and stated that based on the previous 3-year average abstraction rates he anticipated these to be around 34%.

He explained that the average overtime had been applied to the 2024 forecasted abstraction and the subsequent forecasted reduction in production equated to an average loss of

- 28 crews Christmas Eve
- 26 crews Christmas Day
- 23 crews Christmas Night
- 17 crews Boxing Day Days

He expressed concern that the prognosis was not good and reiterated the options which had been presented at the last WASPT meeting. He stated that incentivising staff was not productive; that staff were already self-rostering and that in order to protect the cap on annual leave they would need to proceed with exploring and testing the market of third-party providers, and even then there would be gaps in the roster with patient safety concerns.

There was a discussion around the use of and the rates of pay of the third party providers. Hugh Parry stated that they needed to be realistic and acknowledged that there were third party providers currently being used daily, but that staff should be given the opportunity to have the same rate of pay if it was higher. Mal Jones agreed with this and whether it was possible to have a comparison of the costs of paying for this versus the cost of incentivising staff. He stated that he did not agree that this would destabilise self-rostering.

Damon Turner stated that the full-time officers would not be in support of the proposals, but he acknowledged the need to be pragmatic. He asked if there had been a comparison of risk of the demands that were expected over the Christmas period and the hospital delays that were experienced on a daily basis. He enquired whether the Trust would match the rates that the third party providers would be paying so that staff were not disadvantaged by the process.

Jason Killens stated that in terms of pay equity, the third party providers would not have the same terms and conditions of service as the NHS, such as 30 days annual leave, sick pay up to six months on full pay and six months on half pay, to name a few therefore it was difficult to make the comparison.

Carl Kneeshaw stated that staff were employed on NHS Agenda for Change terms and conditions of service and whilst he acknowledged the Trade Unions partners view, stated that it would not be possible to pay enhanced rates as described.

Damon Turner stated that historically staff had received enhancements.

Lee Brooks acknowledged that enhanced rates had been paid last year but for all the reasons previously described he confirmed the Trust would not take this approach again. In the longer-term staff self-rostering and local discussions which better suited their needs, and their wellbeing was the way forward, whilst maintaining the annual leave levels. In terms of the third party providers, he would not accept Trust staff working for them and would ensure this did not happen.

Marcus Viggers enquired as to the timescales to commission the services of the third party providers before committing to them. Lee Brooks confirmed that they were already past this given the availability of providers and that once these were commissioned, contractually there would be no going back.

It was agreed that third party providers would be explored given the circumstances and projected shortfall in resources.

09/24

UPDATE ON WELSH HEALTH CIRCULAR IMPLEMENTATION OF THE NON-PAY ELEMENTS OF THE 2022-24 COLLECTIVE AGREEMENT

Liz Rogers reported that discussions were ongoing and actions and milestones were reported to be on track as per the Welsh Health Circular: Implementation of the Non-pay Elements of the 2022-24 Collective Agreement and confirmed that a letter had been sent to Welsh Government on 30 September in accordance with the timescales set out with the final scheduled for 31 January 2025.

She noted that positive progress has been made on the flexible working elements, with a session on the use of the Electronic Staff Record (ESR) to record applications on the ESR; the work to review of the Industrial Injury process through the Task and Finish Group. There had also been a deep dive on the Occupational Health service.

10/24

ACAS ACTIONS PROGRESS UPDATE

Liz Rogers provided a verbal update on the ACAS Action Plan highlighting the induction programme underway. She stated that there would be one further final partnership session with Sara Mills as some managers and Trade Union partners had been unable to attend previous sessions.

She stated that there were some actions from the recent social partnership workshop with Welsh Government around eLearning and that would be added to the action plan. She made reference to developing a Case Study and Podcast for future developments and confirmed that an internal social partnership

conference would be funded and delivered in March 2025, with a keynote minister and senior Trade Union colleague planned to participate.

Jason Killens confirmed that he was keen that the social partnership conference went ahead, and that March was a good time for it to be held. He stated that he would speak to Chris Turley to ensure adequate resources were made available for this important event.

11/24

111 AND CSD CPD

Aimee Williams raised the issue of the disparity between the number of 111 and CSD CPD hours which were allocated. She stated that staff in 111 received 22.5 hours for CPD whereas CSD staff had 52 hours per year.

Lee Brooks recognised that there was a difference and there was discussion on the best way and correct forum to take this forward, whether it should be picked up on the RICS agenda or separately as terms and conditions.

Action: It was agreed that management would consider the disparity between the number of 111 and CSD CPD hours and the correct forum to collaboratively address the issue.

12/24

H&S AAA ACTIVITY

The Health & Safety AAA was received for assurance with no escalations raised. Hugh Parry confirmed that the reset day had been productive with collaboration and commitment to CPD dates next year.

13/24

SLT/TU (NO MEETING IN OCTOBER) - CSD CULTURE REVIEW UPDATE

Lee Brooks reported that the Senior Leadership Team/Trade Union Partnership AAA from July 2024 had been circulated and had previously been reported at the September WASPT meeting. He stated that the group had not met in October 2024 and no escalations were raised.

He provided an update in relation to the progress of the Clinical Support Desk (CSD) Culture Review which he had commissioned and conducted by Honne. The mediator acknowledged the significant progress already made with an action plan being developed from the learning. This had now been handed to and would be progressed by Pete Brown, Assistant Director of Operations Integrated care. The next phase would be mediation with Trade Union partners and managers.

Lee Brooks suggested that if everyone was assured then it be agreed not to bring this forward to future WASPT meetings. Jason Killens agreed with this, and Damon Turner concurred that this as it was moving in the right direction and that everyone was in a good place.

14/24

CORPORATE FORUM AAA REPORT

Liz Rogers reported that the Corporate Partnership Forum (CPF) had met on 4 November 2024 with positive discussions and no specific escalations raised in the meeting. There had been a discussion on the membership of the CPF noting the significant number of consistent apologies being received and low attendance at meetings. This will be considered at the next CPF along with the frequency of meetings. She referred to the AAA reports presented, and members were updated as follows:

- IMTP - LDP plans, and directorate plans were being collated, with a draft of the Milestones for year one to go to ADLT/ELT 4 December. The plan to follow on and be presented to Trust Board, with a prioritisation workshop scheduled for January 2025. A development session will be scheduled with the Trust Board at end of March 2025.
- Health and Wellbeing Update - Health and Wellbeing Plan 2025-2029 to go to People and Culture Committee in November 2024 and submitted to the Board in Q4 of 2024/25. The Flu vaccination campaign ongoing offering vaccines across WAST sites using Occupational Health and peer vaccinators. A health diagnostics offer will be implemented in January 2025 for staff over the age of 45 (including cholesterol, blood pressure, BMI, lifestyle factors).
- Estates Update:
 - Llangunnor CCC – finished phase 1 – started phase 2 in the CCC space. Good progress on schedule.
 - Ty Elwy – 4 tenders had been received and were being reviewed; finalising the business case for ELT sign off at the end of the month.
 - Snowdon House – This was almost complete and should be concluded in the next couple of weeks.
 - Dolgellau – Still some legal issues to iron out and further scrutiny was needed. Conversations were ongoing to agree and complete the details. A contractor had been secured and work was ready to commence, subject to finalising the relevant documentation before signing the lease.
 - EFAB Projects
 - Newtown - award letter had been drafted to the contractor.
 - Pontardawe on schedule and most of the projects should be finished by Christmas, except Newtown which was expected to go into the new year.

Fire safety works are still underway.
Tredegar – A contractor has been identified

- People and Culture Update – Carl Kneeshaw the Director of People was now in post and Angie Lewis had taken up the post of Director of Culture Change and the two teams would be working seamlessly together. The People Services team were currently working on significant number of complex and challenging cases which was resource intensive. The team are looking at identifying opportunities for further resource to help with this.
- Workforce Planning Update – Linda Phillips had presented the Workforce Planning Highlight Report and the strategy has now been translated into Welsh. The team were commended for the excellent piece of work they had managed to complete in the limited time.

The output of the plan would be managed through the Strategic planning group (SPG) and the Integrated Technical Planning Group (ITPG).

- Powered Air Purifying Respirators (PAPR) – PAPR training was rolling out and colleagues are asked to encourage members to complete the training. There would also be face to face training which included a test that would also need to be completed as well as the e-learning training. Trade Union Partners were happy to do a joint notice for comms to promote the training.

15/24

AGREE SPOTLIGHT ITEM FOR SIREN COMMUNICATIONS

It was agreed that the next spotlight item in Siren would be focused on development of the social partnership, and to share the reflections infographic demonstrating the successful and positive improvements in partnership working.

16/24

AAA REPORT FROM SEPTEMBER WASPT MEETING

This item was for noting.

ANY OTHER BUSINESS

17/24

LPF AAA REPORTS

Damon Turner stated that in some instances the Trade Union partners had not had sight of the AAA reports for the LPFs before submission to the SOT meeting and requested minutes for the LPFs. Lee Brooks stated that this was the first time this had been raised and that it was the process for the AAAs that needed to be

reclarified rather than producing minutes. He agreed to remind the appropriate Chair of the process for the submission of the AAA reports, that they should be circulated to members for swift comments prior to submission to SOT meeting.

Julie Boalch stated that there was a new LMS 365 on how to produce AAAs being released which would support colleagues in the preparation of these.

Action: Lee Brooks - AAA reporting mechanisms for the LPFs AAA to be re-clarified with Chairs.

18/24

SKY COVERAGE

Jason Killens referred to the recent national Sky coverage and the feedback received. He highlighted that that the article was alluding to the issue being one of the Trust, rather than specifically that of the UK Ambulance Service and prevalent in England in the way it was framed by Association of Ambulance Chief Executives (AACE). He stated that he was commenting in his role as Chair of AACE.

Estelle Hitchon stated that it was the way it was framed and the nuance derived from the title on screen. Hugh Parry agreed that the roles need to be clear.

19/24

SUMMARY OF ACTIONS AND KEY DECISIONS FOR AAA

Diesel Fumes

- Jason Killens to clarify the position on the Eberspacher heater filtration system.
- Liam Williams to ensure the manufacturer's information be circulated to conclude the action on this.
- Lee Brooks to conclude the work on the Standard Operating Procedures for the Dyson Fans.
- Jason Killens/Liam Williams to clarify the position on the electrical infrastructure and suitability at Emergency Departments.
- Lee Brooks to liaise with Chris Turley on the options of retro fitting of external sockets on vehicles.

Progress On the EMT 2/3 Business Case

- Rachel Marsh to circulate to WASPT members the JCC paper that was presented and to bring together a T& F group to consider all the options and how these could be brought to effect linking into the IMTP process and the planning required should the agreement to fund centrally not be reached.

111 and CSD CPD

- It was agreed that management would consider the disparity between the number of 111 and CSD CPD hours and the correct forum to collaboratively address the issue.

LPF AAA Reports

- Lee Brooks - AAA reporting mechanisms for the LPFs AAA to be re-clarified with Chairs.

20/24

REFLECTIONS

Members reflected that Christian Fox had Chaired his first meeting really well which was considered a good and constructive meeting with valid points raised and addressed by all.

The Chair expressed thanks to Sara Williams, Workforce Policy & Governance Lead, for providing secretariat support to the group. This function will transfer to the Corporate Governance Team under the responsibilities of the Trust's Standing Orders.

21/24

DATE AND TIME OF NEXT MEETING

The date of the next meeting was scheduled for 27 January 2025.