# Bundle People and Culture (Open Session) 9 May 2023

Agenda attachments

ITEM 0 PCC OPEN - Agenda - 9th May 2023.docx

1 09:30 - Chair's Welcome, apologies, and confirmation of quorum (Verbal) PH

2 09:31 - Declarations of Interest (Verbal) PH

*https://ambulance.nhs.wales/files/publications/annual-reports/2022/board-member-register-of-interests-2023/*

3 09:32 - Minutes of last meeting (Paper) PH

ITEM 3 OPEN P and C mins 14 March 2023.docx

4 09:34 - Action Log and Matters Arising (Paper) PH

ITEM 4 OPEN People and Culture Action and Decisions Log.xlsx

5 09:35 - Director of Workforce and OD Update (Paper) LR

ITEM 5 PCC Director Update May 2023.pdf

6 09:45 - Operations Quarterly Report (Paper) LB

ITEM 6 Operations Quarterly Report for Committees 22-23 Q4 Final.pdf

7 09:55 - Staff Story (Verbal) AL

8 10:15 - People and Culture Plan (Paper) LR

ITEM 8 ES People and Culture Plan 2023-26.docx

ITEM 8.1 Appendix 2 - People and Culture Plan.pdf

ITEM 8.2 Appendix 3 - Enabling Framework.pdf

ITEM 8.3 Appendix 4 - Rich Picture - DRAFT.jpg

ITEM 8.4 Appendix 5 - IMTP Priorities.docx

9 10:30 - Speaking Up Safely (Paper) CG

ITEM 9 ES - Freedom to Speak Up PCC May 2023.docx

ITEM 9.1 Appendix 1 - Speaking Up Safely TFG Closure Report March 2023.docx

10 10:40 - Corporate Risk Register & Board Assurance Framework (Paper) TM

ITEM 10 Risk Management Report PCC 090523.pdf

ITEM 10.1 Appendix 1 BAF Guidance April 2023.docx

11 10:50 - WASPT Advisory Group Highlight Report (Paper) LR

ITEM 11 WASPT AAA Report 13 April 2023.docx

12 11:00 - Engagement Framework Delivery Plan Update and Reputation Audit (Presentation/Verbal) EH

13 11:15 - Cycles of Business (Paper) TM

ITEM 13 SBAR for PCC on Cycles of Business 2023-24.docx

ITEM 13.1 Annex 1 P&C Cycle of Business 2023-24.pdf

ITEM 13.2 Annex 2 P&C Cycle of Business 2023-24 - Monitoring Report.pdf

13.1 11:25 - Comfort Break

14 11:40 - Monthly Integrated Quality and Performance Report (Paper) AC

ITEM 14 MIQPR SBAR PCC March 2023.docx

ITEM 14.1 Annex 1 MIQPR PCC March 2023.pdf

15 11:50 - Workforce Performance Scorecard Report (Paper) LR

ITEM 15 ES - Workforce Performance Scorecard.docx

16 12:00 - Improving Attendance Project Progress Update (Paper) LR

ITEM 16 Managing Attendance Summary Report PCC 23.05.09.docx

ITEM 16.1 Appendix 1 - Improving Attendance Presentation PC Committee 09.05.23.pdf

17 12:10 - Flu Incentive (Paper) AS

ITEM 17 Seasonal Influenza Campaign SBAR 2022-23 for PCC.DOCX

ITEM 17.1 End of Season Flu Report 2022-23 - Final.pdf

18 12:20 - Wales Anti-Racist Action Plan Update (Paper) CG
ITEM 18 ES - Anti Racist Action Plan - PCC May 23.docx
ITEM 18.1 Appendix 1 - Anti-racist action plan WAST.pdf
ITEM 18.2 Appendix 2 - Anti-racist action plan WAST Timeline Updated.pdf
ITEM 18.3 Appendix 3 - Welsh Government LGBTQ+ Action Plan for Wales WAST Report.pdf

19 12:30 - Retention and Exit Interviews (Paper) LR
ITEM 19 PCC Report - Recruitment Data breakdown for candidates from minority communities.docx
ITEM 19.1 PCC Report Exit Interviews Report 23.05.09.docx

20 12:40 - Health and Safety Update (Paper) LW
ITEM 20 Exec Summary Q4 2023 Health and Safety Performance Report PCC V1.docx
ITEM 20.1 Appendix 1 Statutory and Mandatory Training.docx
ITEM 20.2 Appendix 2 Health, Safety and V&A Monthly Report Q4 2022.pdf

21 12:50 - Welsh language standards compliance update (Paper) MH
ITEM 21 SBAR Welsh Language Framework.docx
ITEM 21a Annex 1 Welsh Language Framework.docx

22 13:00 - Internal Audit Tracker (Paper) JB
ITEM 22 Executive Summary PCC Audit Tracker 090523.docx

23 13:10 - Policy update (Verbal) JB

24 13:20 - Staff Story Update (Paper) CG
ITEM 24 Faz Story Update.pdf

25 13:21 - People and Culture Committee Highlight Report (Paper) TM
ITEM 25 People and Culture Committee Highlight Report March 2023 Final.docx

26 13:23 - Local Counter Fraud Service referral flowchart (Paper) LR
ITEM 26 ES - Counter Fraud.docx
ITEM 26.1 Appendix 1 - Process map for counter fraud cases.docx

27 13:25 - Summary of Actions & Decisions, and Reflection (Verbal) PH

28 13:30 - Issues to be raised at Board (Verbal) PH

29 13:32 - Any Other Business (Verbal) PH

30 13:34 - Date of next meeting: 8th August 2023

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

**OPEN MEETING OF THE PEOPLE AND CULTURE COMMITTEE**
**Held on Tuesday 09 May 2023 from 09.30 to 13.35**
Meeting held virtually via Microsoft Teams

## AGENDA

| No. | Agenda Item | Purpose | Lead | Format | Time |
|---|---|---|---|---|---|
| **OPENING ITEMS** | | | | | |
| 1. | Chair's Welcome, apologies, and confirmation of quorum | Information | Paul Hollard | Verbal | 5 mins |
| 2. | Declarations of Interest | To State Conflicts | Paul Hollard | Verbal | |
| 3. | Minutes of last meeting | Approval | Paul Hollard | Paper | |
| 4. | Action Log and Matters Arising | Review | Paul Hollard | Paper | |
| 5. | Director of People and Culture Directorate Update | Information | Liz Rogers | Paper | 10 mins |
| 6. | Operations Quarterly Report | Information | Lee Brooks | Paper | 10 mins |
| **ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION** | | | | | |
| 7. | Staff Story | Discussion | | Verbal | 20 mins |
| 8. | People and Culture Plan | Endorse for Board Approval | Liz Rogers | Paper | 15 mins |
| 9. | Speaking Up Safely | Assurance | Catherine Goodwin | Paper | 10 mins |
| 10. | Corporate Risk Register & Board Assurance Framework | Assurance | Trish Mills | Paper | 10 mins |
| 11. | WASPT Advisory Group Highlight Report | Assurance | Liz Rogers | Paper | 10 mins |
| 12. | Engagement Framework Delivery Plan Update and Reputation Audit. | Assurance | Estelle Hitchon | Presentation/verbal | 15 mins |
| 13. | Cycles of Business | Approval | Trish Mills | Paper | 10 mins |
| **COMFORT BREAK – 15 MINS** | | | | | |
| 14. | Monthly Integrated Quality and Performance Report | Assurance | Alex Crawford | Paper | 20 mins |
| 15. | Workforce Performance Scorecard Report | Assurance | Liz Rogers | Paper | |
| 16. | Improving Attendance Project Progress Update | Assurance | Liz Rogers | Paper | 10 mins |

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|---|---|---|---|---|---|
| 17. | Flu Incentive | Discussion | Andy Swinburn | Paper | 10 mins |
| 18. | Wales Anti-Racist Action Plan Update | Assurance | Catherine Goodwin | Paper | 10 mins |
| 19. | Retention and Exit Interviews | Assurance | Liz Rogers | Paper | 10 mins |
| 20. | Health and Safety Update | Assurance | Liam Williams | Paper | 10 mins |
| 21. | Welsh language standards compliance update | Assurance | Melfyn Hughes | Paper | 10 mins |
| 22. | Internal Audit Tracker | Assurance | Julie Boalch | Paper | 10 mins |
| 23. | Policy update | Assurance | Julie Boalch | Verbal | 10 mins |
| **CONSENT ITEMS** | | | | | |
| 24. | Staff Story Update | Information | Catherine Goodwin | Paper | 5 mins |
| 25. | People and Culture Committee Highlight Report | Information | Trish Mills | Paper | |
| 26. | Local Counter Fraud Service referral flowchart | Information | Liz Rogers | Paper | |
| **CLOSING ITEMS** | | | | | |
| 27. | Summary of Actions & Decisions, and Reflection | Discussion | Paul Hollard | Verbal | 5 mins |
| 28. | Issues to be raised at Board | Discussion | Paul Hollard | Verbal | 5 mins |
| 29. | Any Other Business | Discussion | Paul Hollard | Verbal | |
| 30. | Date of next meeting: *8th August 2023* | Information | Paul Hollard | Verbal | |

## Lead Presenters

| Name | Position |
|---|---|
| Julie Boalch | Head of Risk/Deputy Board Secretary |
| Lee Brooks | Executive Director of Operations |
| Alex Crawford | Assistant Director of Planning |
| Paul Hollard | Committee Chair and Non-Executive Director |
| Angie Lewis | Director of Workforce & OD |
| Trish Mills | Board Secretary |
| Liz Rogers | Deputy Director of Workforce & OD |
| Liam Williams | Executive Director of Quality and Nursing |

# UNCONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE MEETING (OPEN SESSION) HELD REMOTELY VIA MICROSOFT TEAMS ON 14 March 2023

**Chair: Paul Hollard**

**PRESENT:**

| | |
|---|---|
| Paul Hollard | Non-Executive Director and Chair |
| Alex Crawford | Assistant Director of Planning |
| Bethan Evans | Non-Executive Director |
| Dr Catherine Goodwin | Assistant Director Inclusion, Culture and Wellbeing |
| Ian James | Trade Union Partner |
| Jo Kelso | National Ambulance Training College |
| Angie Lewis | Director of Workforce and OD |
| Trish Mills | Board Secretary |
| Ross Hughes | NWSSP Audit and Assurance |
| Alex Payne | Corporate Governance Manager |
| Jeff Prescott | Corporate Governance Officer |
| Bronwen Rebelo | Organisational Development Manager |
| Liz Rogers | Deputy Director of Workforce and OD |
| Kia Stevenson | Workforce and OD Project Manager |
| Andy Swinburn | Director of Paramedicine |

**APOLOGIES:**

| | |
|---|---|
| Hannah Rowan | Non-Executive Director |
| Paul Seppman | Trade Union Partner |
| Lee Brooks | Executive Director of Operations |
| Chris Turley | Executive Director of Finance and Corporate Resources |
| Joga Singh | Non-Executive Director |
| Liam Williams | Executive Director of Quality and Nursing |
| Julie Boalch | Head of Risk and Deputy Board Secretary |

## 01/23 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed all to the meeting of the People and Culture Committee and advised that the meeting was being audio recorded. Apologies were recorded from Julie Boalch, Hannah Rowan, Chris Turley, Lee Brooks, Paul Seppman, Joga Singh, Estelle Hitchon and Liam Williams.

## 02/23 DECLARATIONS OF INTEREST

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

**RESOLVED: That no new declarations were received.**

## 03/23 MINUTES OF PREVIOUS MEETING AND ACTION LOG

The Minutes of the Open meeting held on 29 November 2022 were considered and agreed as a correct record. The Action log was considered, reviewed, and updated.

**RESOLVED: That the Minutes of the meeting held on 29November 2022 were AGREED.**

## 04/23 DIRECTOR OF WORKFORCE & OD UPDATE

Angie Lewis gave an update on recent developments within the Workforce and Organisational Development Directorate. Members received the report and noted the challenges which had resulted from industrial action as well as the opportunities and positive developments which had taken place since the last report. These included the change management training and the placement programme for Paramedic Science degree students, aimed at broadening understanding and enhancing learner experience.

**RESOLVED: That the update was NOTED.**

## 05/23 OPERATIONS QUARTERLY REPORT

The Operations quarterly report was presented as read with Members invited to raise any questions or observations. Members observed that the report had previously been discussed at other Committees and no queries were raised.

**RESOLVED: That the update was NOTED.**

## 06/23 STAFF STORY

Angie Lewis and Dr Catherine Goodwin introduced the staff story along with Bron Rebelo who gave a presentation around the Sexism and sexual safety at work survey, focussing particularly upon sexism, sexual safety and misogyny within the Trust. Members were shown a short video in which colleagues from across the Trust spoke of their experiences and the effect that these experiences had upon them. It was noted that such issues were not unique to the Trust and had been seen in high profile cases across various sectors, such as the police and other services.

Bron Rebelo then spoke of her own experiences and her journey over the last three years, citing the importance of people listening and understanding without disempowering her by trying to resolve the issues for her.
The presentation made it clear that while there were issues regarding sexism, sexual safety and misogyny within the Trust, the organisation had taken the important step of recognising and acknowledging the issues and more importantly, had begun the process of addressing them and working towards establishing organisational and behavioural change. This change in attitudes and organisational behaviour would be key to making a real difference to colleagues within the service.

Following the presentation, Members thanked Bron Rebelo for her courage in speaking to the Commiittee and openly discussing her experiences. Members noted that the trends identified in the presentation had also been seen in other organisations, giving a clear indication that the problems were not unique to the Trust and that organisational change and a shift in the behaviours and attitudes of people would be required to bring about real and lasting change.
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**RESOLVED: That the staff story was NOTED.**

*Bron Rebelo left the meeting.

## 07/23 SEXISM AND SEXUAL SAFETY AT WORK UPDATE

The Sexism and Sexual safety at work update was covered in the previous item as part of the staff story. The upate report was presented as read and no further questions were raised.

**RESOLVED: That the update was NOTED.**

## 08/23 SPEAKING UP SAFELY UPDATE

Trish Mills provided the Committee with an overview of the work underway to develop a framework for raising concerns and speaking up. Members were informed that the Speaking Up Safely Task and Finish Group had been formed to develop the framework and this work had now been completed.

The work would now transition to the Workforce and Organisational Development Directorate with Angie Lewis as the Senior Responsible Owner.

Angie Lewis informed Members that in her view, the Speaking up Safely work formed part of the Trust's broader work around cultural and organisational change and this work would continue in partnership with Trade Union colleagues to give an additional level of confidence to colleagues, while at the same time, providing an alternative platform for staff to raise concerns. An action was agreed for an update to be given at the next meeting of the Committee on this topic.

**RESOLVED: That the update was NOTED.**

## 09/23 PEOPLE AND CULTURE Plan 2023-26 and IMTP DELIVERABLES

Angie Lewis Shared the key People and Culture plan and activities articulated within the Trust's 2023-26 IMTP, including the Equality and Welsh Language plans.

These included the continued building and articulation of the Trust's desired culture, sustaining focus on improving wellbeing, embedding partnership working and improving the working environment, including where and how staff work.

The IMTP identified emerging priorities such as building on the employee experience to attract and retain a diverse workforce, developing a recruitment and retention plan that supported all roles in the organisation, and continuing to build an effective employee brand while improving the effectiveness and application of the Trust's internal people processes.

Angie Lewis informed Members that this work was ongoing, and a further update would be provided at the next meeting of the People and Culture committee in May.

Members received the update and commented on the work being undertaken, stating the aims and objectives were very clear, necessary, and well set out within the plan.

**RESOLVED: That the update on the People and Culture 2023-26 IMTP deliverables was NOTED.**

## 10/23 WASPT ADVISORY GROUP HIGHLIGHT REPORT

Trish Mills provided an update on the key areas discussed at the last WASTP meeting held on January 25th 2023. No alerts were identified for the attention of the Committee although advisories were given around industrial action, progress on the establishment of WASPT sub-structures and progress on elements of the IMTP 2023-26, relating to 'Our People' which centred around culture, capacity and capability. The Terms of Reference for the group had been reviewed and were due to be presented to the Board for approval in May.

Risks related to the IMTP were also discussed at the meeting including financial risks, capability, ongoing wider system pressures, and potential commissioning landscape changes.

Members received the report and welcomed the reconveing of the WASPT group and the important work it was undertaking.

**RESOLVED: That update was NOTED.**

## 11/23 CORPORATE RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

Trish Mills introduced the Corporate Risk Register and Board Assurance Framework and updated Members on the key risks identified for the Committee's attention.

Members were informed that the principal risks had been presented to the Trust Board on 26 January 2023. However, the risk review schedule and governance routes agreed by the Audit Committee had been delayed due to operational pressures including industrial action, as well as absence within the Corporate Governance Team. Whilst updates had been received on actions for some of the principal risks, there had not yet been an opportunity to complete the work aroung these by the Corporate Governance Team although all endeavours would be made to formally review the risks prior to the March 2023 Board.

Members received the update and noted the challenges and pressures currently being faced by the Corporate Governance Team.

**RESOLVED: That the contents of the report were CONSIDERED.**

## 12/23 IMPROVING ATTENDANCE PROJECT PROGRESS UPDATE AND INTERNAL AUDIT REVIEW ON ATTENDANCE MANAGEMENT

Liz Rogers introduced the Improving Attendance Project Progress Update and Internal Audit review on attendance management as read, and provided updated figures and data for the Committee.

The report showed that sickness had decreased in January across the Trust and early indications were that February would see an overall decrease in sickness absence. The number of individuals off with long Covid also continued to remain low.

Members received the report and noted that Anxiety, stress, depression. and other psychiatric illnesses were the single biggest cause of absence and given this, it was asked whether staff were taking advantage of the support offered by the Trust's Wellbeing services. Liz Rogers confirmed that there was a significant demand from staff for those services and recent data supported this position with no drop off in usage. An action was agreed for a further update to be provided at the next PCC meeting on 09 May 2023.

**RESOLVED: That presentation and update were NOTED.**

## 13/23 MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT

Alex Crawford presented the Monthly Integrated Quality and Performance Report (MIQPR) as read, and focussed on the key areas and issues that were relevant to the Committee.

Members were informed that the report contained information on 24 key indicators and in many areas, these continued to reflect a poor picture in terms of the quality and safety of the service that the Trust could provide to patients in the 111 and Emergency Medical Services (EMS) pathways.

Patient demand across the 111 and EMS services had increased with exceptionally high call demand in both services, however, other factors such as the continuation of the Covid-19 variants, levels of abstractions (including Covid-19 related absence) and extreme handover lost hours, continued to impact on the Trust. Numerous other factiors including Post-production lost hours and industrial action had also impacted significantly on the Trust's ability to respond to incidents. Members received the report and acknowledged the pressures and difficulties being faced by the Trust which in turn, were impacting upon patient experience and organisational performance. Liz Rogers and Andy Swinburn commented on the efforts and challenges involved with recruiting new clinical staff to the Trust and noted that while new clinical staff would help to ease the strain upon services, the limited availability of suitable candidates and competition from other ambulance services and Health Boards for these skills meant that recruitment was extremely challenging.

**RESOLVED: That the January 2023 Integrated Quality and Performance Report and actions being taken to determine whether:**

**1. The report provided sufficient assurance.**

**2. Whether further information, scrutiny or assurance was required, or**

**3. Further remedial actions were to be undertaken through Executives was CONSIDERED.**

## 14/23 WORKFORCE PERFORMANCE SCORECARD REPORT

Angie Lewis gave a brief overview of the Workforce Performance scorecard and drew Members' attention to key areas including the ongoing work around recruitment and retention, and the re-branding of Continuing Professional Development (CPD) training to Mandatory In Service Training (MIST), to ensure that employees understood and appreciated the importance of statutory and mandatory training requirements.

In other areas, PADR compliance had continued to increase and was currently at around 79%, while open employee relations cases had also seen a positive shift with the number of cases reducing month on month; which was likely a result of the roll out of Compassionate Practices workshops and training.

Members received the report and commented on the positive updates on PADR compliance, employee relations cases, and the changes to statutory and mandatory training.

**RESOLVED: That the update was NOTED.**

## 15/23 ANNUAL EQUALITY REPORT AND GENDER PAY GAP REPORT

Dr Catherine Goodwin provided the Committee with updates on the Trust's Annual Equality and Gender Pay Gap reports. The equality report showed a small increase in Black Asian, Minority Ethnic groups and Mixed Ethnicity groups within the Trust from 1.18% to 1.34%. The number of female employees increased by 2% from 46.2% to 48.2%, disability staff groups increased from 4.69% to 5.20% and Lesbian, Gay and Bisexual groups increased 4.49% to 4.54%.

Overall, this demonstrated that the Trust was generally representative of the people it served although more work was required, particularly around Black Asian, Minority Ethnic groups and Mixed Ethnicity groups.

The Gender pay gap report showed that disappointingly, the gap had increased, and although the Trust had a very even split of male and female employees (51.1% male to 48.9% female), the women's mean hourly rate was still 6.7% lower than the mean rate for males.

Members received the reports and noted the overall position of the Trust while observing that work would continue in terms of recruiting people from underrepresented groups, while also working to reduce the gender pay gap.

**RESOLVED: That the contents of the reports were NOTED and ENDORSED.**

## 16/23 ANNUAL COMMITTEE EFFECTIVENESS REVIEW REPORT

Trish Mills updated Members on the Annual Committee Effectiveness Review, including responses from questionnaires, proposed changes to operating arrangements, , amendments to the Committee's Terms of Reference, and the Annual Report to be presented to the Trust Board.

Members received the update and commented on the importance of reflecting upon the Committee's effectiveness and listening to feedback. and responses from Members and the questionnaires. Members then confirmed and approved the recommendations set out within the report.

**RESOLVED: That:**

**1. The Committee's terms of reference at Annex 3 were REVIEWED and ENDORSED,**

**2. the proposed changes to operating arrangements in response to issues raised in questionnaires were CONFIRMED,**

**3. the People and Culture priorities in the IMTP for 2022/23 were SET; and**

**4. the annual report at Annex 2, noting the requirement for some further adjustment following the current meeting was APPROVED.**

## 17/23 HEALTH AND SAFETY UPDATE

Jonathan Turnbull-Ross presented the Health and Safety update as read, pulling out key points for the Committee's attention and asking Members to note that:

• There has been focused attention on RIDDOR incidents within the Trust in order to meet reporting timescales that hat resulted in a compliance increase of 47% in Q3 from Q2.

• Statutory Health and Fire Safety training compliance was below the Trust and Welsh Government standards. Managers were to encourage staff to bring their training levels up to Trust expectations.

• Workplace Risk Assessment compliance was at 71.8%. However, further work was ongoing to improve the standard of these assessments to ensure they were suitable and sufficient;

• Prosecutions were recently issued to Powys Teaching Health Board and Cwm Taf Morgannwg University Health Board by the Health and Safety Executive for respective breaches of Section 2 and Section 3 of the Health and Safety at Work Act 1974.

Members received the report and noted the challenges ahead for the Health and Safety team. The Committee commented on the improvements which had been seen within the department in recent years, and commended the team for their proactive response in relation to health and safety issues which had recently been raised around diesel fumes caused by ambulances waiting for extended periods outside emergency departments.

**RESOLVED: That the update and key points of the report were NOTED.**

## 18/23 INTERNAL AUDIT: AUDIT TRACKER AND INTERNAL AUDITS REVIEW

Trish Mills gave an overview of the Audit tracker and Internal audits review. The report provided assurance that recommendations contained in internal and external audit review reports were being addressed in a timely manner.

Members were informed that there were six overdue actions that fell within the remit of the Committee. Two related to the Attendance Management review and were proposed to be closed; one had been requested to move to March 2023 from December 2022; and the remaining three recommendations related to the Recruitment Practices – EDI and the Collaboration reviews, which all now had revised dates proposed.

**RESOLVED: That the update was NOTED.**

## 19/23 PEOPLE AND CULTURE COMMITTEE HIGHLIGHT REPORT

The People and Culture Committee highlight report was presented as read and for information purposes only, having previously been circulated to Members for review. No further queries were raised by Members.

**RESOLVED: That the higlight report was NOTED.**

## 20/23 SUMMARY OF ACTIONS AND DECISIONS, AND REFLECTION

Paul Hollard reflected on the day's discussions and invited Members to comment on the meeting before reviewing any actions which had been agreed.

Members reflected upon the scale of discussions and the wide range of topics which had been covered, commenting that it had been a strong, positive and productive meeting which had helped drive forward the desired goals of the Committee and cultural change that the organisation strived for.

Follow up actions were agreed around the staff turnover data and the exit interview pilot. These were to be given at the next meeting in May.

**RESOLVED: That Members reflected upon the meeting and resulting actions were AGREED.**

## 21/23 ISSUES TO BE RAISED AT BOARD

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

## 22/23 ANY OTHER BUSINESS

There was no other busines.

## 23/23 DATE OF NEXT MEETING

The date of the next meeting is 09 May 2023.

**PUBLIC ACTION LOG**

**WELSH AMBULANCE SERVICES NHS TRUST - People and Culture Committee**

| Ref | Date | Agenda Item | Action Note | Responsible | Due Date | Progress/Comment | Status |
|---|---|---|---|---|---|---|---|
| 12/23a | 14 March 2023 | Improving Attendance Project Progress Update and Internal Audit review on attendance | An action was agreed for a further update on absences to be provided at the next PCC meeting on 09 May 2023. | Liz Rogers | 9 May 2023 | | Open |
| 08/23a | 14 March 2023 | Speaking up safely update | An update is to be given at the next meeting of the Committee regarding the Sexism & Sexual Safety at work survey. | Catherine Goodwin | 9 May 2023 | | Open |
| N/A Passed over from Charitable Funds Committee | 30 January 2023 | Bids Highlight Report | People and Culture Committee to discuss the flu vaccine incentive as there were feelings that staff should not need to be incentivised in the role they undertake and that incentivising can be tricky. | Paul Hollard | 9 May 2023 | 14/03/23 - Item to be added to next PCC Agenda as a standalone item for full discussion and consideration from committee members. | CLOSED |
| 77/22 | 29 November 2022 | Staff Turnover Deep Dive | Look at exit data and try to map instances where an individual is still employed by WAST and has simply changed roles as opposed to actually leaving the Trust. The purpose of this is to root out occasions where it appears that someone has left the Trust and is included in the turnover data when in reality, the are still with the Trust, just in another role. | Liz Rogers | 9 May 2023 | 14/03/23 - Verbal update provided by Liz Rogers setting out the initial observations and trends from exit interviews. | CLOSED |
| 71/22 | 29 November 2022 | People Plan and IMTP Deliverables | Look into the reasons (if possible) as to why all 58 recent applications from people identifying as being from Ethnic Minorities were unsuccessful and at what stage of the process their applications failed. | Liz Rogers | 9 May 2023 | 14/03/23 - Verbal update provided by Liz Rogers. Further update to be provided at the next PCC meeting on 09 May 2023. | Open |

**DECISION LOG**

**WELSH AMBULANCE SERVICES NHS TRUST BOARD**

| Ref | Date | Agenda Item | Decision/Approval |
|---|---|---|---|
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Open
Complete
Closed
Not Due

# Director Update: *People & Culture*

PEOPLE AND CULTURE COMMITTEE

9TH MAY 2023

ANGIE LEWIS

DIRECTOR OF PEOPLE & CULTURE

## Our Successes and Challenges: March - May

- Presentation of our Sexual Safety work to external colleagues, leading the way and sharing learning
- Extremely positive Big Bang NQP Recruitment Event with 80 successful candidates identified
- First accredited Change Management Training programme delivered by ChangeQuest with excellent feedback from attendees
- Development of Bystander Training, to support our EDI agenda and enable our culture change ambitions

***Mobile Testing Unit Celebration and Awards Ceremony***

We're pleased to share our recent Directorate name change, from Workforce & OD to People & Culture. By changing our name, we are emphasising our commitment to creating a workplace where our colleagues feel valued, supported, empowered and are central to what we do. This change also reflects the importance of putting people first, and creating a positive workplace culture as a key driver of employee engagement, retention, continuing development and performance.

Flu planning commenced from an OH perspective – agreement to order vaccines directly, and agreement of a 15% sale or return (which has not been previously agreed / available), meaning that if we do not use all vaccines ordered, we can return up to 15% of those ordered, rather than being charged for unused vaccines and these being wasted.

We have successfully procured LMS365 - a Learning Management System that operates inside Microsoft365 enabling all WAST staff to engage with learning content in a familiar and intuitive environment, in response to repeated feedback from our people about access issues. LMS365 will provide a platform that directs individuals toward their learning as well as providing an open library of resources that individuals can access independently to support their ongoing professional practice. Welsh Government has recently mandated a number of learning programmes for all NHS and Social Care staff providing WAST with an ideal opportunity to use LMS365 or ESR as their preferred eLearning environment. LMS365 also enables WAST to provide its own bespoke content and plans are underway for hosting our Digital Skills for Business and Managers Essential Toolkit programmes - initiatives that upskill our workforce and drive performance and productivity gains.

Focused discussions at recent CEO Roadshows around people and culture, particularly in relation to Industrial Action, have provided invaluable insight and enabled us to engage with colleagues on these important issues.

Literacy, Numeracy and Digital Literacy skills are core enabling competencies. The Wales Essential Skills Toolkit (WEST) is a diagnostic and formative assessment system - until now WAST has relied on access via Higher Apprenticeship contract holders, restricting the benefit it provides to those selected for the Apprenticeship scheme. Having access for all WAST staff means we can widen the reach to include more colleagues. All Ambulance Care and Ambulance Response inductees will use the system to generate their Individual Learning Plan. This will inform the Education & Development team of the support required as colleagues progress and enable signposting to more suitable external Basic Skills providers. The tool is available for all WAST staff (self-referral as well as employment support by line managers). Staff within Education & Development will be available to coach colleagues as they develop their skills and obtain their Essential Skills qualifications required for a number of our roles and progression opportunities.

***Llandrindod Wells - Sexual Safety presentation to Joint Emergency Services Group***

The last industrial action day was held on 20th March and as a result of ongoing negotiations with Welsh Government, the Unions had agreed to pause further industrial action to allow dialogue to continue. As published, all industrial action pay deductions were processed in March 2023. All employees received the 1.5% non-consolidated pay increase in March salary, and it has been agreed the further 1.5% consolidated will be paid in May.

WAST was awarded enhanced status of our Gold Award for Corporate Health Standard, on the 17th March 2023. We have also renewed our Employee Assistance Programme (Health Assured), ensuring our people can access 24/7 support and counselling. Our volunteers can now also access the helpline.

Wellbeing support has continued throughout the month, with drop in sessions, OH van visits to A&E's, mental health, wellbeing and resilience workshops, stress workshops, Circle of Support and Women's Health Group.

Applied for and gained Centre Status to deliver ILM qualifications across Leadership & Management (Levels 2-4 initially) and Coaching & Mentoring (Level 5 initially). The Trust has supported staff wishing to gain ILM qualifications previously (over 100 Higher Apprentices on a Leadership & Managment route) but had found increasingly that our external providers were unable to match the programmes to the Trusts needs. Gaining our own Centre Status enables design/co-design, delivery, assessment and evaluation that meets the needs of the Trust as it evolves with a genuine focus on the skills, knowledge and understanding that WAST people need to deliver our service, now and into the future.

Partnership design and delivery of CSD specific training saw colleagues engage with a CPD day in the Immersive Suite in Matrix House - this is the first of a series of sessions where we look to enable staff who rarely get to use the facilities in the Workforce Education & Development Centres in innovative ways. The Education & Development team were present at the annual NQP Big Bang recruitment drive in April providing clinical and driving equipment familiarisation, Advice & Guidance and a QR Trail competition that not only encouraged engagement with all of the other functions of WAST in attendance but also could get 4 lucky winners off to a smooth start to their lives as Paramedics with the aide of a Littmann stethoscope! A bit of fun and a great way to demonstrate the breadth of opportunity available in the Trust.

As we continue our work supporting working carers, we are delighted to share we will be launching the availability of the Jointly app to all at TeamWAST including our wonderful volunteers on the 6th June during Carers Week 2023. Jointly was developed by Carers UK and designed in consultation with unpaid carers. It combines group messaging, to-do lists, other useful features, including medication lists, calendars and more. Put simply, Jointly makes communication and coordination between those who share the care easier to manage.

# OPERATIONS DIRECTORATE
# QUARTERLY REPORT FOR COMMITTEES
# 2022-23 Q4 (Jan – Mar 2023)

## National Operations & Support

### Challenges

**1. Industrial Action**

1.1 Since mid-December, there has been 11 days of industrial action. This spans three trade unions – Royal College of Nursing (RCN), Unite and GMB Union. The combined action on 20 February 2023 was significantly more impactful on the Trust's ability to provide safe services compared to previous dates, in-spite-of the additional support provided by the military and the intensive planning process. Discussion with WAST and the trade unions has resulted in a proposed set of non-pay initiatives which will be subject to further dialogue in early May 2023.

**2. Manchester Arena Inquiry (MAI)**

2.1. In June 2021 and November 2022, The Hon. Sir John Saunders published reports from the Manchester Arena Public Inquiry. Three separate volumes have now been published. The WAST EPRR team has not had the capacity to receive, review, consider and plan a response to the 149 recommendations contained in volumes 2 and 3 of the report. Capacity in the team has been exacerbated by the planning process for industrial action and winter pressures which have followed quickly on from the death of Her Majesty Queen Elizabeth in September 2022 and the subsequent arrangements for King Charles's proclamation ceremony in Cardiff. However, funding of 2 posts on a 12-month basis has been protected to receive, review, and plan a response to all MAI recommendations and provide network links with partners across Wales and other UK ambulance Trusts. The recruitment process for the first manager post is now completed and the second support post will follow imminently.

**3. Covid Inquiry**

3.1. Work is underway to prepare documentation and submissions for the Covid Inquiry. The preparation of submissions, whilst potentially could be sporadic, is capacity consuming, across the Directorate, and requires involvement of our most senior team members.

## IMTP

### 4. Covid-19 Mobile Testing Unit Closure

4.1. At the end of March, the contracts with Welsh Government and DHSC came to a natural close. These contracts to provide mobile covid-19 testing for both NHS staff and the general population of Wales commenced in August 2020, initially to undertake PCR testing. Since then, we have carried out more than 75,000 tests across 72 test sites in Wales, including carparks, community centres, prisons, and fun fairs, with staff working outside in all kinds of weather. Our MTUs have been the only testing team that have undertaken assisted lateral flow tests before training staff and handing over to local authorities. In all, 161 staff have worked across our MTUs, of which 42 have now successfully secured roles within the Trust. On 27th March, we celebrated the success of the MTUs with a thank you event and afternoon tea. It was a pleasure for our Assistant Director of Operations, National Operations & Support to receive personal correspondence from the Minister, Eluned Morgan, thanking colleagues for their contribution.

## General Update

### 5. Governance

5.1. The audit plan for the Directorate concluded with the finalisation of three audits all of which received a reasonable assurance rating, covering Major Incident Preparedness, Hazardous Area Response Team (HART), and Immediate Release Directions. All three reports have been tabled at and received by Audit Committee.

### 6. Exercise Mighty Oak

6.1. At the end of March, WAST participated in a three-day Tier 1 multi-agency exercise encompassing a four-day power outage scenario. This was the first time that WAST had tested the feasibility of planning for a wide-reaching power outage, and the first time that our strategic command capability was physically located in the Emergency Co-ordination Centre Wales (ECCW) in Cardiff, rather than co location in Local Resilience Forum areas. An exercise debrief will take place in due course.

### 7. Analgesia Issued to Volunteers

7.1. In January 2023, approval was given for analgesia (pain relief) to be issued to volunteer Community First Responders (CFRs). This is part of a phased roll out of pain relief to volunteers, which commenced with oral paracetamol for acute pain in adult patients until a WAST crew arrives. This will be followed by a roll out of Penthrox in April/May, which has commenced across staff and volunteers. This is an exciting development for our CFRs who experience protracted on scene times with patients who experience pain. The roll out of Penthrox to volunteers is a first for any UK ambulance Trust.

## 8. Volunteer Recruitment

8.1. The plan to increase numbers of volunteers has successfully increased CFR teams by more than 130 new volunteers trained during 2022/23. There will be an additional 30 more volunteers trained in the new financial year due to phasing into April. Recruitment into the volunteer management and support team has also progressed well.

## 9. Closure of Senior Business Continuity Planning Team (SBCPT)

9.1. The end of March saw the closure of the oversight group SBCPT which was convened to manage the impact of winter, including winter pressures, weather, potential power outage and industrial action. Given that the immediate risks from these challenges have largely passed, Executive Management Team accepted a recommendation from SBCPT that closure would follow on 23 March, except for the oversight of industrial action which will continue to function for the duration of the span of the industrial action.

## Resourcing & EMS Coordination

### Challenges

**10. EMD Recruitment and Retention**

10.1. Recruitment and Retention continues to be a challenge for EMS Coordination despite the previous quarterly update indicating that we had recruited a further 20 EMDs. The external attrition rate for the 2022/23 fiscal year ended at 21.57%, an increase of almost 6%. This does not include internal staff movements because of career pathways which also had a significant impact during the same time. Staff starting in EMS Coordination have moved on to have careers in ODU, Ambulance Care and 111. Recruitment to other roles within EMS Coordination is generally achieved through recruitment internal to the department, and this has left the Emergency Medical Dispatcher (EMD) establishment under pressure again. A further 40 EMDs have just been recruited for cohorts starting in May and June and recruitment events are scheduled for July and August to support recruitment prior to the winter period. The impact of this constant high level of recruitment is seen in the experience of mentor support new EMDs and the capacity of the Learning and Development team to complete quality improvement training.

**11. Concerns**

11.1. The workload for the Operations Quality Concerns Team remains high (283 tasks). The Operations Quality Team continue to work closely with the Putting Things Right Team to prioritise work to meet deadlines and requests. There has been a significant improvement in the status of outstanding concerns investigations, with a 55.7% reduction during Q1. The demand from Coroners across Wales continues to be a significant factor in the ongoing workload and commitment for the team, however, it should be noted that 47% of the outstanding Coroners work is directly related to a delayed response. The team are currently exploring ways of eliciting wider organisational support for the Coroner related demand.

**12. EMSC Reconfiguration**

12.1. The EMS Coordination Reconfiguration Project has been ongoing since 2018, and the current key work streams include:

- Roster review: a collaborative review of rosters in partnership across Wales to better match our staffing profiles to demand and support our teams' wellbeing
- Boundary changes: to provide an improved balanced workload for dispatch staff and greater resilience to the service
- Broader ways of working: an assessment to provide improved productivity and effectiveness while improving processes and procedures for QPS

12.2. Whilst the initial Roster Review for EMDs was completed and implemented the impact of Industrial Action has meant that the other projects were paused during Qtr 4. This was because of the limited management capacity within EMS Coordination focussing on Industrial Action planning and operational/tactical command. These projects, subject to IMTP prioritisation, may restart during Q1 of 2023/24 with Roster Reviews

being planned for Allocators and Dispatchers. Broader ways of working have started to explore changes in the operational model within EMS C and ORH have been commissioned to revisit the modelling provided as part of the Demand and Capacity review to inform the boundary changes review.

## IMTP

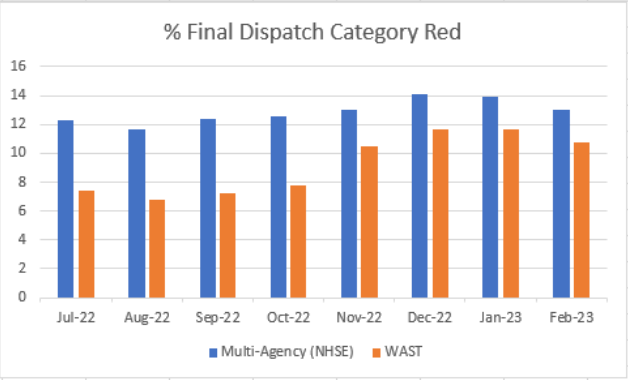
### 13. Managing Attendance at Work

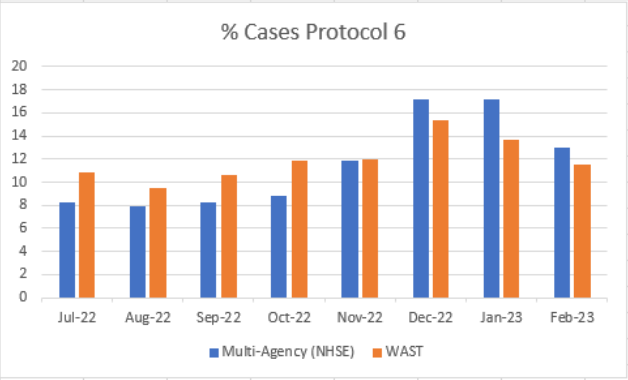
13.1. The absence FTE % for EMSC in 2021/22 fiscal year was 13.48% having reached a peak of 17.08% in January 2022. Following considerable focus by the teams across each of the EMSC centres the absence reason for 2022/23 fiscal year ended at 11.31% for the year having reduced to <8% for February and March. This was in line with our agreed trajectory for sickness absence improvement. Trajectories have now been cast for the next fiscal year to achieve an 8% average.

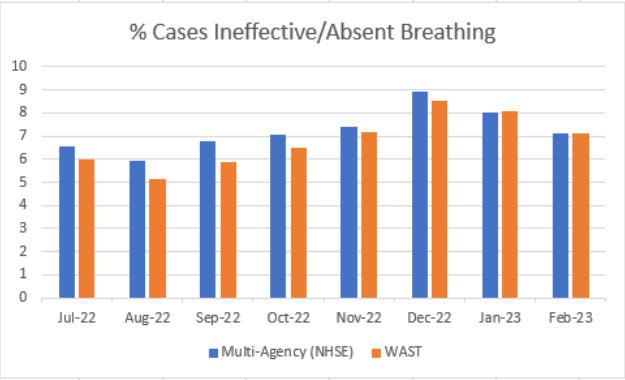
## General Update

### 14. Priority Dispatch

14.1. The Priority Dispatch Corporation (PDC) report sets out WAST's % of RED category calls in comparison to the % seen in English trusts which use MPDS (Multi-Agency (NHSE)). The Dispatch Cross Reference (DCR) Review Group sits under the Clinical Priority Assessment Software (CPAS) group and undertakes regular reviews of response assignment for the codes within the Medical Priority Dispatch System (MPDS) to ensure the most appropriate clinical response is provided.



14.2. The Welsh Ambulance Services NHS Trust (WAST) proportionately has lower RED category calls than English trusts (as an average). The slight close of the gap seen from November 2022 is due to changes made to some fitting, falls and haemorrhage codes to RED. Where WAST was reporting a higher % of Protocol 6 (breathing problems), English trusts are now reporting more. This is because Protocol 36 was still running in England, but as this has now been switched off a portion of these calls now sit in Protocol 6.

## 15. MPDS Audits

15.1. WAST is required to undertake a percentage of 999 call audits to maintain its accreditation with the International Academy of Emergency Dispatch (IAED). Due to industrial action and the refocus of staff and resources, an Overwhelming Events request was submitted to the IAED for Q1 (Jan, Feb and Mar). The Overwhelming Events request was accepted by the IAED and so the reduction in completed audits during Q1 will not affect the Trust's reaccreditation, which is due this summer.

## 16. Control Room Solution

16.1. In line with the Emergency Services Network (ESN) programme, and in collaboration with the Ambulance Radio Programme (ARP), EMS Coordination has supported the roll out of a new Integrated Communication Control System (ICCS) provided by Frequentis. The LifeX solution has now been implemented early in Q1 following a brief delay in Q4 due to IA. WAST is the first large scale ambulance service in the UK to go-live on the new platform (Isle of Wight has been piloting the solution on a smaller scale).

16.2. ICT colleagues, EMS Coordination teams and the ESMCP project managers worked in collaboration with ARP and system suppliers Frequentis to ensure infrastructure, operational plans and testing was completed to the standard WAST required to lead the UK with this innovative cloud-based product.

16.3. Positive feedback has been received from all stakeholders on the well organised focussed and pragmatic approach taken by WAST to deliver this innovative digital transformation.

## 17. IAED President Visit

17.1. Integrated Care and EMS Coordination colleagues were pleased to host a visit by Brian Dale, President of the International Academy of Emergency Dispatch during March 23. Positive feedback was received around the joint working between the teams within WAST and the exciting changes being piloted within the Clinical Support Desk following the introduction of ECNS. Teams took the opportunity to talk about opportunities to expand the use of MPDS in EMS Coordination as well as exciting developments expected this year through the release of Version 14 which will include a new Protocol (41) for 'Callers in Crisis'. This will help EMDs support patients in mental health crisis through specially scripted questions and advice; an important step forward in supporting our patients with challenging mental health needs.

## 18. Intelligent Routing Platform

18.1. As a result of a significant and sustained increase in 999 activity levels, coupled with an increase in COVID related absence among ambulance control room staff, call answering times for 999 calls became challenged. It would be fair to say this was more the case in England compared to Wales. Ambulance trusts in England and Devolved Administrations therefore collaborated to improve pre-existing mutual support arrangements to provide support for patients experiencing extraordinary delays.

18.2. Call routing technology – technology that is in use in other large call handling settings – has been developed to automate and improve the speed and accuracy of existing manual practices to identify the services best placed to provide support most quickly. This enhances ambulance service infrastructure and interoperability at a UK wide level, as well as building further 999 call handling resilience for extraordinary events such as major incidents, extreme weather events and sudden localised technology failures. For this reason, we felt that Wales, through WAST, should be included in this solution.

18.3. Pre-existing mutual support arrangements agreed by CEOs of ambulance services in England and Devolved Administrations have been carefully balanced to ensure that any mutual support provided to other services does not create undue increased clinical risk for the services providing support. The development of technology sought to replicate those supports and contingency arrangements. It is referred to as the Intelligent Routing Platform (IRP).

18.4. When a 999 call is not able to be answered by the service covering the geographical area, the IRP is configured in a way to find a call handler anywhere in the UK to answer that call. The service which answers the call should have at least two agents available and newer configuration prevents the same service managing consecutive calls for support. Should there be a total loss of call answering capability by any ambulance service, the IRP will immediately flow 999 calls elsewhere for support without manual intervention by British Telecom. The incident detail is recorded by the answering service and then technology permits an electronic transfer of that incident from one service to another. Lastly on the platform, this technology has been funded and supported by NHS England and made available to all UK services in the interest of resilience across the UK. It is a fantastic example of collaborative UK-wide solution delivery when used as intended.

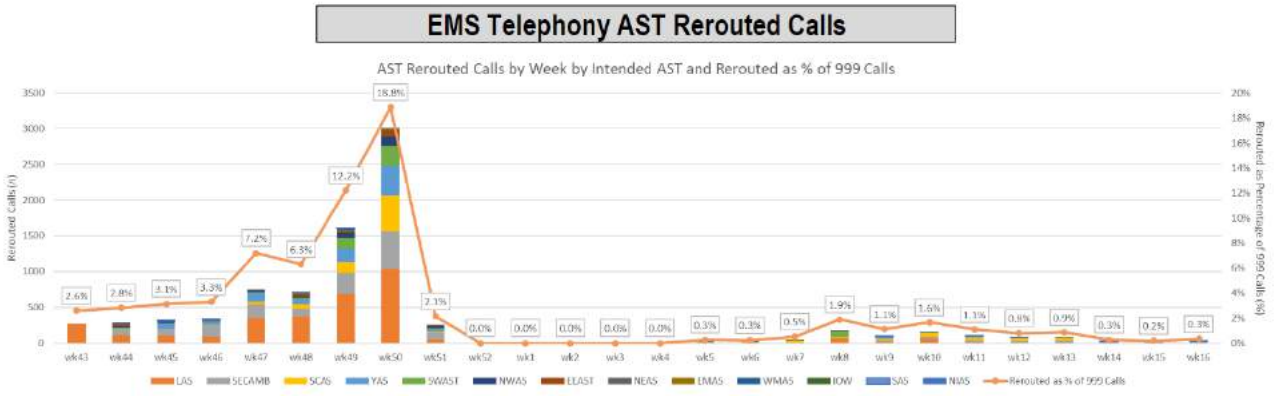
### WAST Experience of IRP

18.5. The IRP was made live around October 2022 and WAST has very closely monitored impacts. As extreme pressure materialised through winter, it was evident that WAST was managing a larger proportion of overflow activity, and this impeded our ability to respond to 999 calls from within our community in Wales. At peak, in the region of 18% of our weekly activity was answering calls for other services and this was not sustainable, particularly as our support was bolstering recruitment challenges elsewhere in England. We therefore temporarily suspend our inclusion in the IRP in

December 2022 whilst the UK ambulance sector could consider planned and coordinated supports for those ambulance services in most need.

18.6. In February this year, WAST reinstated our inclusion in the IRP following some system rule changes and a UK-wide consensus that IRP was not to be utilised as a solution to broader recruitment challenges. Since returning to IRP, no more than 2% of our weekly call answering activity is for other services, which has been much more manageable alongside a reduced call answer wait time for our 999 users in Wales. It remains, however, that we answer more calls than we export, which is testament to sustaining the best call answering teams we can. NHS England has also since provided a payment representative of the activity handled by WAST and going forward the agreement between ambulance services includes options for cost recovery if considered appropriate.

18.7. The graph below shows the weekly volume of 999 calls rerouted to and answered by WAST with a very obvious peak and now sustained period of levelling off.



# Emergency Medical Service

## Challenges

### 19. Continued System Pressure

19.1. Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 32,098 hours were lost in December 2022, 23,526 in January 2023, 19,113 in February, 28,637 in March and provisionally pending verification, 23,083 in April 2023. The impacts of these pressures is regularly discussed at Committee and Trust Board.

## IMTP

### 20. EMS Roster Review

20.1. All EA and UCS rosters are now live and the project team is now gathering together to finalise the lessons learned and project benefits. This is due to be completed before the end of June 2024 and the project will be closed formally.

20.2. CHARU is now growing in number with circa 60 Paramedics due to be in CHARU roles by mid May 2023. The decision was made to commit to further growing the numbers to the full modelled position of 153FTE (11.5FTE contributed by Senior Paramedics) and recruitment has begun in earnest.

## General Update

### 21. Industrial Action

21.1. Already expressed above, the impact of Industrial Action across EMS should not be underestimated.

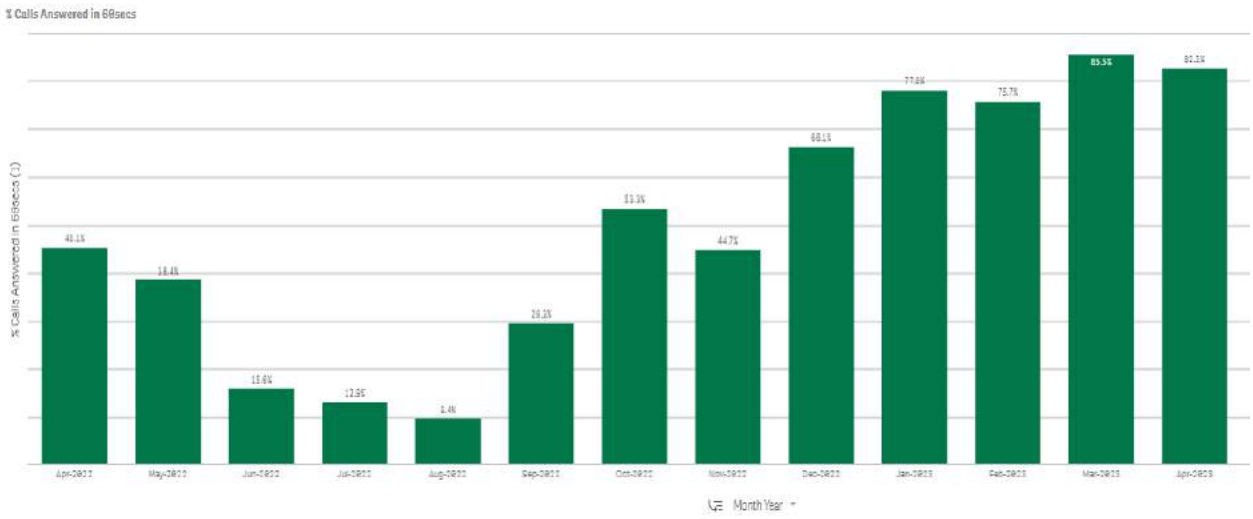
# Ambulance Care

## Challenges

### 22. Net Centre Journey Booking Service Performance

22.1. Performance for the NET centre had been particularly challenged throughout quarters 1-3. Although early signs of an improvement had been observed in Quarter 3, the measures for Quarter 4 demonstrate that the service is now routinely operating at a very high standard.

22.2. There are still pressure points at certain times of the day where demand exceeds capacity. However, a roster review will complete in Q1 to minimise these. The chart below shows the percentage of calls answered within 60 seconds for the period 1st April 2022 to 30th April 2023.




## IMTP

### 23. Cleric Upgrade

23.1. February saw the implementation of the NEPTS CAD system to a new version of the Cleric system. The new product is hosted externally within the cloud, removing some the risks previously logged around the design and stability of the current infrastructure.

23.2. The new product opens up the possibility of establishing improved access for Health Care Professionals as well as providing a secure platform to build a patient zone, which will allow patients to book online, update/review their bookings and see where their transport is as opposed to ringing a WAST Call centre.

## General Update

### 24. ACA 2 Recruitment

24.1. In July 2022 the Urgent Care Service was transferred to the management of the Ambulance Care team. To address the UHP gap, which mainly emanated from losses to EMT recruitment and challenges recruiting candidates with the appropriate driving licence category, the team established a new scheme offering candidates employment which included training to achieve the required C1 licence classification. By the end of Quarter 3 when the last course completed, 113 additional ACA2's had been recruited, including 86 employed through the C1 scheme. The scheme will have successfully closed the UHP gap in addition to supporting the recruitment process for the additional 100 staff.

### 25. NEPTS Vehicles

25.1. The past financial year has seen the roll out of a number of new or refreshed vehicle types across the fleet. This includes a refresh of our Renault Master vehicle and a replacement for our small vehicle fleet to a Transit Custom vehicle. The new vehicles include features that will improve patient experience and safety as well as providing additional capacity and operational efficiency.

25.2. A new B-Class Ambulance Care vehicle will also go live in April 2023. This vehicle can be used across NEPTS & UCS services and will be a new concept for the service.

## Integrated Care

### Challenges

**26. Consult and Close in WAST edging to 15%**

26.1. Coupled with the increased demand for service and since the new calendar year, an increased rate of consult and close activity in CSD, 111 and with APP and HB partners has on days exceeded 18% and monthly edging very close to 15%. There is a risk in achieving 15% in periods of low calls and the overall demand on clinicians on duty while supporting other services such as remote clinical support, red review, clinical screening and enhanced clinical screening despite good establishment.

**27. SALUS**

27.1. Capita has proposed a revised final delivery plan with a go-live date of 20th November 2023. It is hoped this allows the system to be in place ahead of winter pressures. The timeline is tight, and training will require abstractions of staff. We await approvals to grow call handling capacity to absorb as much of this abstraction as possible.

### IMTP

**28. Use of Video Consultation in Clinical Support Desk**

28.1. Following the implementation of the video element of ECNS, the next stage of implementation would be to introduce the note sharing function which is currently being scoped with a view to implement the ability to securely share the consultation record itself. This work is contingent on further IT security and GDPR work to comply with.

**29. Clinical Support Desk Roster and Resourcing Review**

29.1. A review has been undertaken and roster option developed and put out for vote. A new roster approach has a proposed go-live in Q1. Further resourcing work is ongoing to build said rosters, align lines and develop a SOP for Resource to follow. Engaging with the team is creating an opportunity to develop an approach that is service and people appropriate.

### General Update

**30. 111 Adastra Update**

30.1. While the business continuity incident has ended for the Health Boards and Adastra systems have resumed, the new “Concentrator” which joined the Adastra system to the WAST has been successfully built and deployed in February 2023. The sterling efforts of our teams ensured we sustained services during what was an extended period of disruption.

| | |
|---|---|
| **AGENDA ITEM No** | **8** |
| **OPEN or CLOSED** | **OPEN** |
| **No of ANNEXES ATTACHED** | **5** |

# Our People & Culture Plan 2023-26

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9th May 2023 |
| **EXECUTIVE** | Angela Lewis, Director of People and Culture |
| **AUTHOR** | Sarah Davies, People and Culture Directorate Business Manager |
| **CONTACT** | sarah.davies31@wales.nhs.uk |

## EXECUTIVE SUMMARY

The purpose of this paper is to present the People and Culture Plan to PCC, for endorsement prior to approval at Trust Board.

**RECOMMENDED:** The Committee is asked to **RECEIVE** and **ENDORSE** the plan for approval by Trust Board.

## KEY ISSUES/IMPLICATIONS

| **Activity** | **Timeframe** |
|---|---|
| Present to People and Culture Committee for endorsement | 9th May 2023 |
| Present to Board for Approval | 25th May 2023 |
| Adoption and Implementation | 26th May 2023 |

## REPORT APPROVAL ROUTE

**Executive Management Team 03.05.23**
**People and Culture Directorate Business Meeting 04.05.23**
**People and Culture Committee 09.05.23**

## REPORT APPENDICES

**Appendix 1:** SBAR
**Appendix 2:** People & Culture Plan
**Appendix 3:** Enabling Framework: Year 1 Actions
**Appendix 4:** Rich Picture
**Appendix 5:** IMTP People and Culture 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) | N/A | Financial Implications | YES |
| Environmental/Sustainability | N/A | Legal Implications | YES |
| Estate | N/A | Patient Safety/Safeguarding | YES |
| Ethical Matters | YES | Risks (Inc. Reputational) | YES |
| Health Improvement | YES | Socio Economic Duty | N/A |
| Health and Safety | YES | TU Partner Consultation | YES |

**Appendix 1: SBAR**

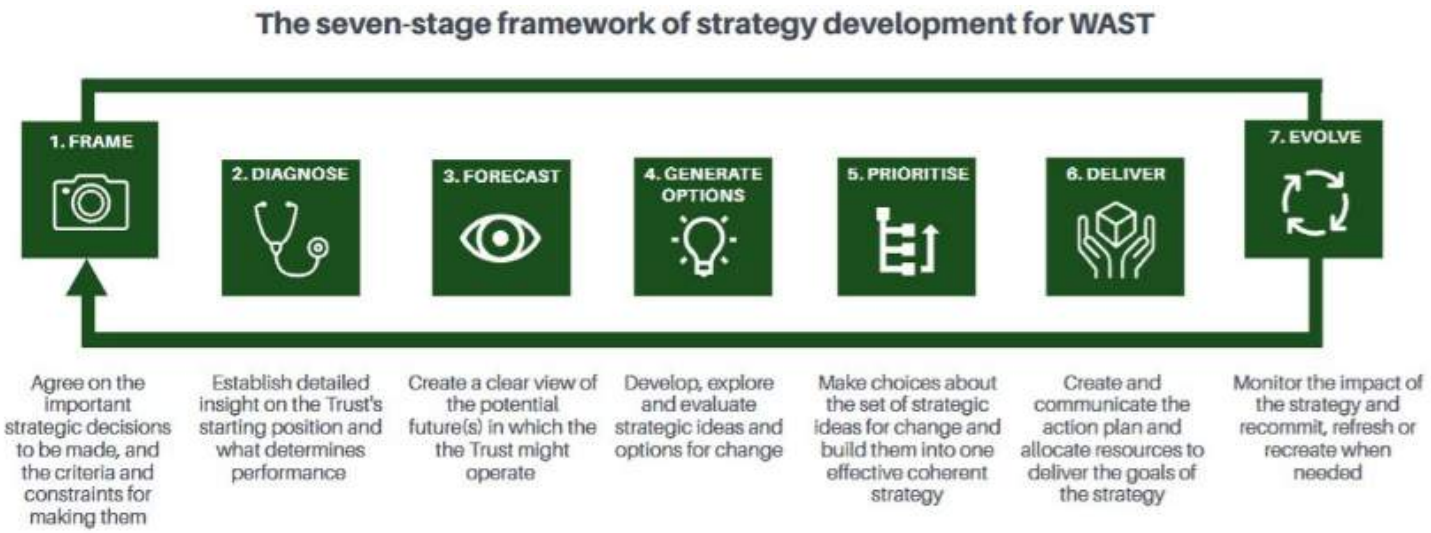
**SITUATION**

1. The purpose of this paper is to present the People and Culture Plan to People and Culture Committee, for endorsement prior to submission to Trust Board for approval.

**BACKGROUND**

2. The Plan has been developed using the seven-stage framework of strategy development for WAST (**Fig. 1**), in which co-production and engagement form a fundamental part of the development process.

**Fig. 1:**




3. Consultation and socialisation has taken place with Trade Union Partners, Trust Committees, Executive Management Team, Assistant Director Leadership Team, People and Culture Directorate, Non-Executive Directors and teams across the organisation, with feedback reflected in the final version. We have also sought input from external experts on culture change, the Royal College of Paramedicine, and WOD directors from within NHS Wales, and the wider Ambulance Service across the UK.

## ASSESSMENT

4. Our People and Culture Plan (**Appendix 2**) comprises a single overarching narrative document, underpinned by an enabling framework (contained within **Appendix 3**), clearly outlining our ambitions in relation to Equality, Diversity and Inclusion, Culture and Behaviours, Wellbeing, Leadership and Management and Education and Training . This Plan is designed to be agile and dynamic in nature, with actions for years 2 and 3 to be formulated during the first year of delivery, in response to the evaluated impact of the preceding year's actions. The Plan centres around the 3Cs (Culture, Capacity and Capability) and is underpinned by The King's Fund's ABCs of Core Needs at Work (**Fig. 2**).

**Fig. 2:**


5. A "rich picture" has also been developed, with the aim of bringing to life our culture change vision for what it will look and feel like to work in WAST in three years' time; the current draft is contained within **Appendix 4**.

6. For assurance regarding alignment, our high-level People and Culture priorities as articulated within the 2023/26 IMTP are presented within **Appendix 5**.

7. Pending approval by Trust Board on 25th May, the Plan will be officially launched on 26th May, with key activities outlined below:

| | |
|---|---|
| **Organisational Messaging** | Launch Pack to be issued via email, comprising:<br>• Message from Director of People and Culture and Non-Executive Lead for People and Culture<br>• People and Culture Plan<br>• Rich Picture<br>• Link to Sway overview of People and Culture Plan<br>• Details of an organisation-wide 'Ask Angie' session<br>• Invitation to provide feedback via designated email address<br>• Link to intranet page, where performance and progress will be shared on a quarterly basis |

| | |
|---|---|
| | The following will also be developed and shared:<br>• Posts via Siren and Yammer<br>• People and Culture Plan podcast<br>• Summary of personas work |
| **People and Culture Directorate-specific Messaging** | Launch Pack to be issued by email to directorate, comprising:<br><br>• Letter from Director of People and Culture and Non-Executive Lead for People and Culture<br>• People and Culture Plan<br>• Rich Picture<br>• People and Culture IMTP Deliverables<br>• Link to Sway overview of People and Culture Plan<br>• Details of a Directorate-specific 'Ask Angie' session<br>• Invitation to provide feedback via designated email address<br>• Link to intranet page, where performance and progress will be shared on a quarterly basis |

**RECOMMENDED:**

8. People and Culture Committee is asked to:

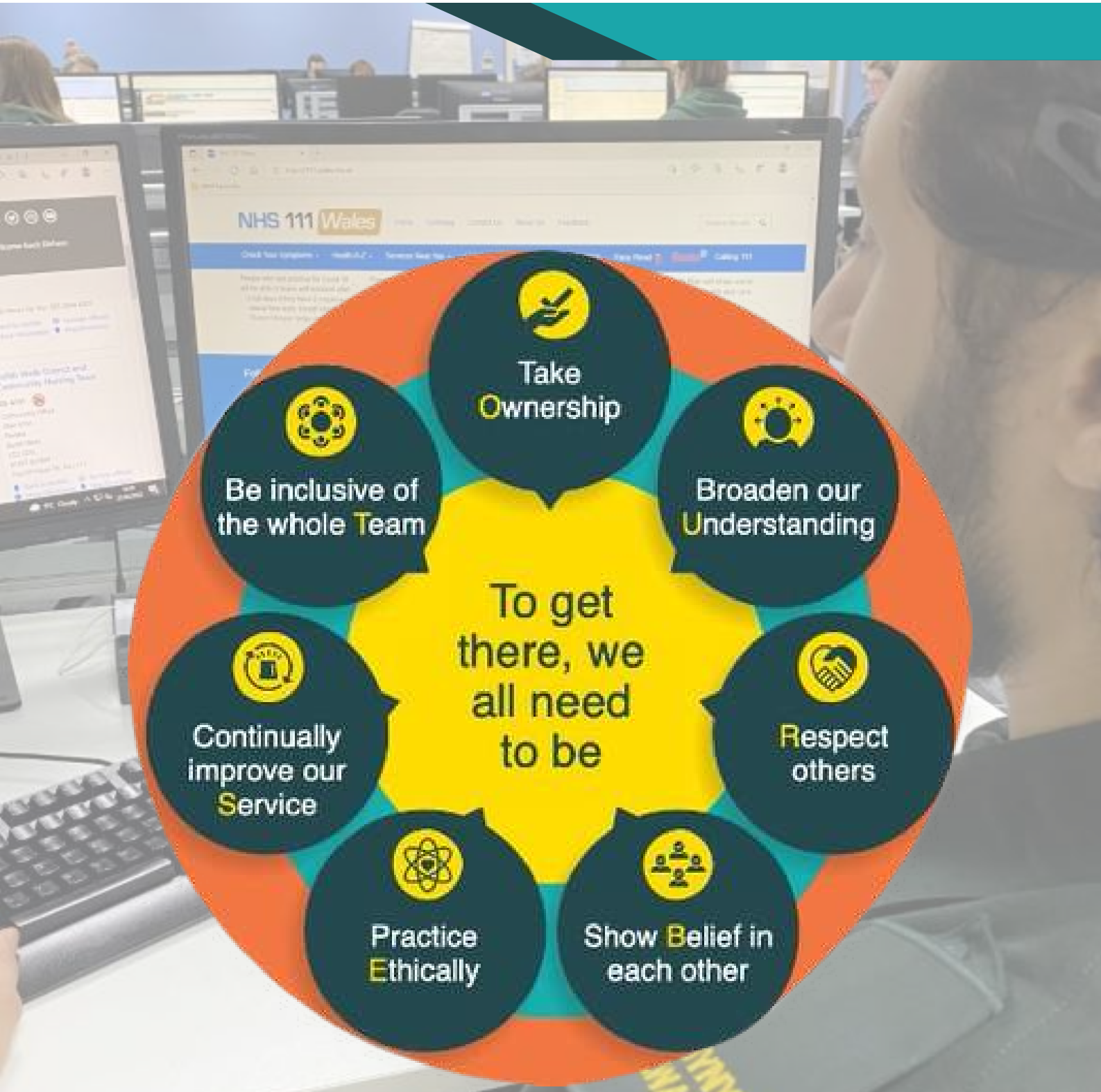
    - **RECEIVE** and **ENDORSE** the plan.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

# OUR PEOPLE AND CULTURE PLAN

2023-2026


NHS 111 Wales
To get there, we all need to be
Take Ownership
Broaden our Understanding
Respect others
Show Belief in each other
Practice Ethically
Continually improve our Service
Be inclusive of the whole Team

# OUR BEST

# Foreword

## Paul Hollard

*Non-Executive Director*

**As the Non-Executive Lead for People and Culture and Chair of the People and Culture Committee, I am pleased to support the Trust's People and Culture Plan.**

At the heart of our success is our commitment to creating an environment that attracts, retains, and develops exceptional talent and expertise. Our people are our greatest asset, and it is vital that we continue to invest in them.

This plan is the result of extensive collaboration between our leadership team, our staff, and external experts. It outlines our strategic priorities and initiatives for the coming years, which are designed to support our staffs' growth, development, and wellbeing. We know that the world of work is rapidly evolving, and our plan reflects our commitment to adapt and innovate to ensure that we remain a great place to work.

Our People and Culture Plan is not just a document; it is a living, breathing commitment to our staff and the Trust's success. We will measure our progress, celebrate our successes, and learn from our challenges along the way. With this plan, we aim to foster a culture of excellence, collaboration, and inclusivity that will enable us to achieve our goals and deliver exceptional care to our patients and support our partners and stakeholders.

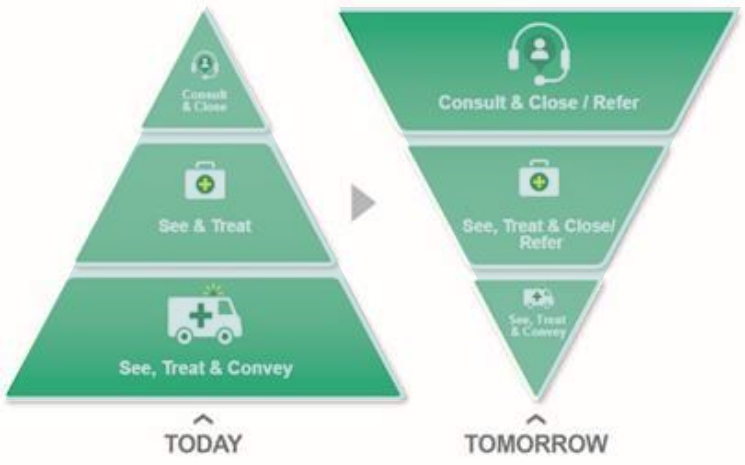
I want to thank all those who have contributed to this plan, and I look forward to working with you to bring it to life. Together, we will build a great future for our people.

# Message from **Angela Lewis**

## *Director of People and Culture*

It is with immense pride that I introduce the 2023-2026 Welsh Ambulance Services NHS Trust (WAST) People and Culture Plan which will drive whole organisation culture change. Alongside my People and Culture Directorate colleagues, with our #TeamWAST workforce, we will facilitate the delivery of the 2030 Organisation Strategy and the Transition Plan by focussing on and supporting colleagues, including our wonderful volunteers, in all roles and in all parts of the service. Ultimately, we want to ensure we all work in a culture of belonging, support and growth.

Our recently developed, clear purpose statement gives a shared sense of identity and understanding across the organisation and reinforces the value of every role and the contribution of all our people.


WAST aims to be the single point of access for all unplanned healthcare in Wales and to do this we need a dynamic, innovative culture that embraces change and technology, and attracts and retains people who have the capacity and capability to deliver our shared goal to serve the people of Wales. We are transforming our services by reducing our traditional role of taking patients to hospital and increasing the role of remote assessment and providing expert advice to patients, developing fast track pathways and delivering more see and treat at home.

This plan clearly lays out our ambition to create a positive working environment where everyone can bring their whole self to work, actively contributes and is proud to work for #TeamWAST. The jobs our people do are extremely challenging and we are committed to ensuring that the surrounding infrastructure is as accessible and streamlined as possible (getting the basics right). We will ensure we cherish what is already exceptional about our culture and look for ways to support all colleagues on our change journey.

**I look forward to meeting colleagues as we deliver the plan, and I am excited for the coming years.**

# Our Focus

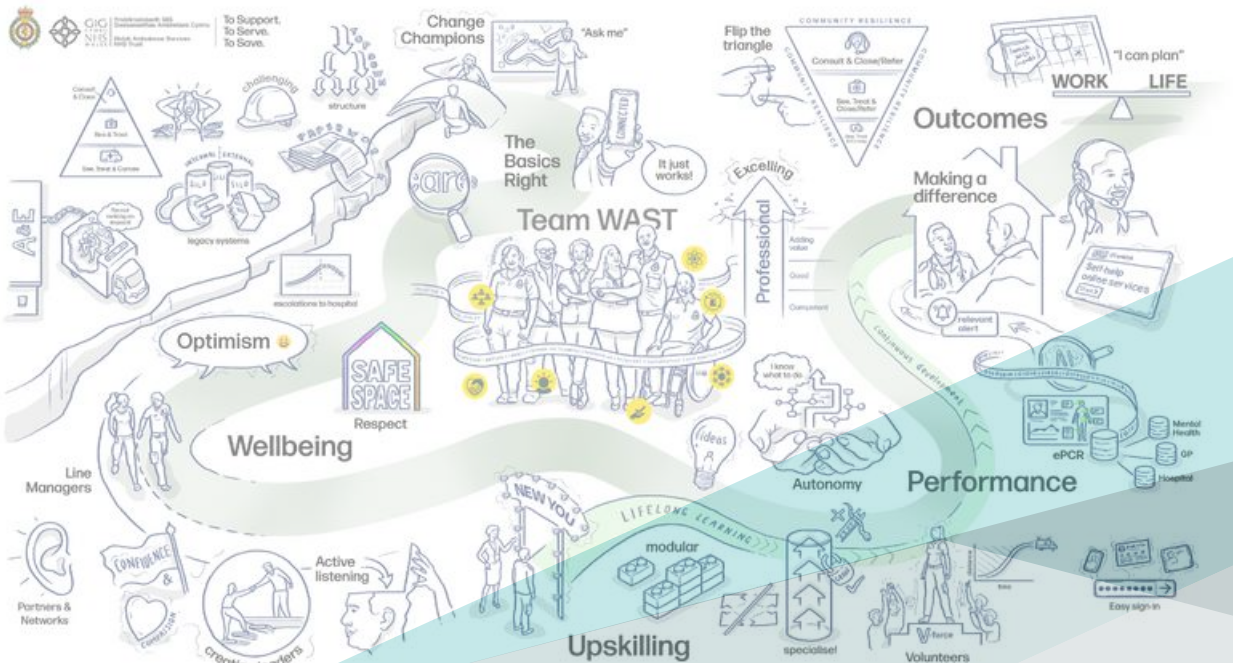
Our focus is our people's lived experience, it is at the heart of what we do. Our aim is that we all feel valued, supported and able to deliver the best service to the people of Wales.

Our People and Culture Plan mirrors what is happening across WAST. The People and Culture team is flipping our service model by focusing on three key areas, our culture, our capacity and our capability (more on this below). We will work more widely across the organisation and maximise the skills of the People and Culture team in a joined-up way with colleagues across WAST. This plan recognises the team's full range of skills and expertise and how these skills can be best applied to create a positive experience for all of #TeamWAST.

## *What does that future vision for our culture look like?*

It is truly inclusive, positive and rewarding. We are committed to our professionalism and organisation behaviours. We all feel we belong, irrelevant of our backgrounds. We live our values and they are embedded through the ways we work and how we treat others, both colleagues and patients. From applying for a job, all the way through our employment journey, all of #TeamWAST see, feel and hear our shared behaviours because we live them. People can grow and develop with supportive challenge and do the best work of their careers. All our people feel welcome, respected and valued. We strive to be an organisation that not only embraces equality but demonstrates inclusion is all aspects of our delivery. *See **Appendix A** for our rich picture, which brings this vision to life.*

We will deliver the training, education and support to leaders and managers to equip and enable them to meet the needs of a diverse workforce. Working for an ambulance service is demanding with significant external pressures but by supporting each other and striving for this culture we can create a work environment that allows everyone to flourish. Aligned with this is our commitment to delivery of our Strategic Equality Objectives and implementation of **'More Than Just Words'**, moving towards the Welsh language 'Active Offer'.



In March 2022, we were proud to launch the refresh of the #TeamWAST behaviours. These behaviours, #OurBest, are at the heart of what we do and how we work together. They are linked directly to our core areas of focus for the next three years - the 3 Cs – **C**ulture, **C**apacity and **C**apability within the context of the King's Fund **ABC** framework for our colleagues, building opportunities for **A**utonomy, developing the sense of **B**elonging and connectedness and ensuring that colleagues feel they can make a valuable **C**ontribution to the organisation.


***The Kings Fund 2022***

As people are the core of our service we will ensure their core needs of work, as outlined by the King's Fund, are met and we have built our People and Culture Plan around these - **Autonomy**, **Belonging** and **Contribution.**

# Autonomy

The future of work for #TeamWAST is flexible within a culture that allows and accepts everyone to be themselves at work. Cultivating a culture of autonomy includes creating a culture based on trust and loyalty resulting in decreased turnover and higher levels of performance. Colleagues will feel respected and trusted to do their work to the best of their ability. They will become more competent and confident in their roles and feel they have more control over their daily tasks, improving team effectiveness and innovation.

Ensuring that teams have clear objectives aligned to the organisation priorities will provide direction and colleagues will be able to see how their work fits into the bigger picture. This will lead to increased motivation, creativity and a commitment to wider organisational goals.

A comprehensive Induction Programme will provide all the information that a new colleague or a colleague changing roles will need. It will equip them with the tools they need to lead effectively. Through this programme we will create and communicate a clear vision and purpose. Our workforce will embrace change, be highly skilled, proud of their profession and able to positively support the people of Wales

# Belonging

We want all of our people to feel connected and cared for. Teams and individuals throughout WAST will be supported to create an inclusive, compassionate, and connected culture.

Our approach to foster belonging will focus on making every individual feel respected and treated fairly in an inclusive work environment. We will also forge a stronger link between belonging and our organisational performance by strengthening colleagues' connections with their teams and developing their sense of contribution to meaningful, shared goals.

We will nurture a sense of belonging and inclusion, by coaching managers on how to be inclusive leaders, noticing when exclusion is happening and understanding and promoting how to become true allies for those with a quiet, or no, voice. Our vision is for all of our people to feel a strong sense of belonging in terms of their team, their profession and the organisation as a whole.

# Contribution

Ensuring a manageable workload, professional leadership and high quality development opportunities are supported by our organisation.

We will celebrate and recognise the value of both individual and team contribution to organisation goals . Consulting regularly through our staff networks and partnership forums will ensure coproduction of the future vision continues to evolve.

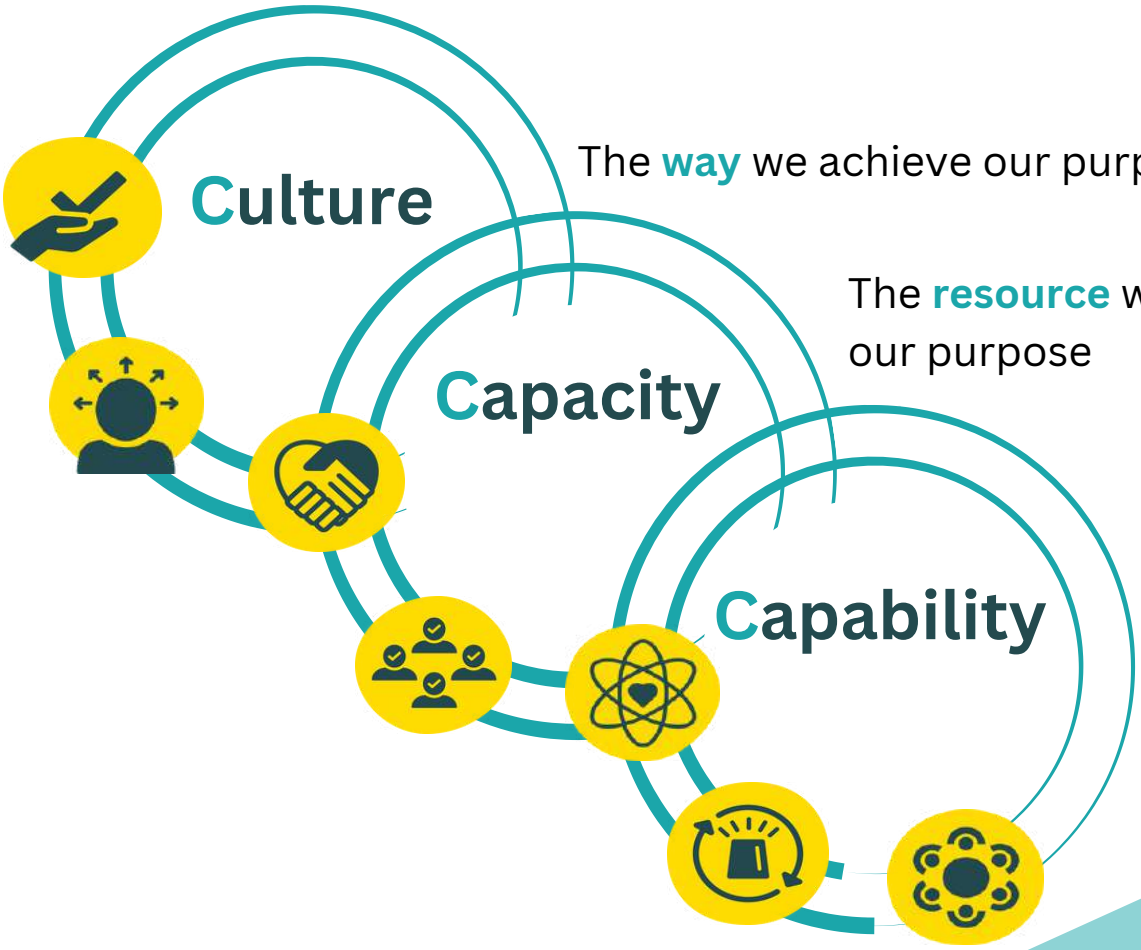
Ensuring equity in access to ways to contribute is also key; inclusion at every point is vital to the success of our organisation. We will make space for everyone to be able to contribute and amplify the voices of people with different experiences.

# The 3 Cs

**'We will all enjoy a long, healthy and happy working life.'**

***2030 Strategy***

This plan supports the ABC of core needs in work outlined in the previous section through the three broad areas of **Culture**, **Capacity** and **Capability**.




The **way** we achieve our purpose

The **resource** we need to achieve our purpose

The **skills** we need to achieve our purpose

# Culture

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

***2030 Strategy***

Our culture is demonstrated through our behaviours and purpose. Our culture focuses on creating an environment where wellbeing, compassion and a positive enriching employee experience are at the heart. **We will continue to build and articulate our desired culture and share with colleagues across the organisation.** This will bring it to life and help colleagues feel that they belong, they are valued and feel that they can contribute to the long-term success of the organisation.

Our work around equality, diversity and inclusion supports our plans to create an environment where colleagues have autonomy in their work, feel a deep sense of belonging and are confident to raise concerns, to make decisions and have control in their roles. **Alongside this we will seek opportunities to improve the working environment including where and how people work.**

Establishing what we cherish in WAST, the cultural aspects we want to keep and also understanding what needs to change means we can develop our healthy culture and ensure that our plan supports its development.

Digital maturity will support our people to become more customer-centric, inclusive, and agile. We will achieve this by creating new opportunities for streamlining processes, improving the employee experience and exploring new services and business models. We will foster a culture which includes listening, open dialogue, empowering people to feel confident in making decisions and to contribute and encourage and support them to develop.

We will review our approach to communicating and engaging with our people, seeking regular feedback and sharing information across the organisation in a meaningful and accessible way. **Embedding working in partnership with trade union colleagues will be front and centre in this.** Importantly, every interaction will reflect our cultural DNA. The Health and Wellbeing of our people will remain a key organisational priority and **we will sustain our focus on improving wellbeing**. We will ensure there is regular evaluation of impact and benefits of the huge range of interventions we provide. This emphasis on health and wellbeing will complement our ongoing commitment to improve attendance and will be supplemented by simple people management policies, proactive management and tailored responses to absence management.

# Capacity

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

***2030 Strategy***

Capacity is about ensuring we have the right people in the right place at the right time with the right skills and the right cost and can adapt to a changing work environment. We must demonstrate we are truly an employer of choice, as potential colleagues have a wide range of options available to them. **We will build on the employee experience to attract and retain a diverse workforce and develop a recruitment and attraction plan that supports all roles in the organisation and continue to build an effective employee brand.**

Our exciting plans to turn the service on its head and reduce conveyance to the Emergency Department will also provide capacity for new roles, new pathways, and innovative thinking. Innovative teams are diverse teams, and we are committed to taking action to increase diversity throughout our service. We will increase resource, engagement and participation by effectively using networks, partnerships and technology. These connections contain the key people who will become our change agents, modelling the behaviours and mindsets of our desired culture. These will be people who are motivated by wanting to do their best, have passion and purpose and who can view the organisation from many different perspectives. These change agents are key to our cultural success, driving organisation-wide collaboration, breaking down siloes and increasing engagement with culture change initiatives. Our plans involve a real **focus on continuous improvement, seeking to increase value, reduce burden, waste and inefficiency, ensuring we get the basics right and that our processes are seamless and fit for purpose** alongside projects such as improving attendance. This commitment to improving employee experience includes reviewing current and potential working models to provide more flexibility for our people.


# Capability

## 'Our leaders will be compassionate, collaborative and courageous'

## *2030 Strategy*

Capable people are at the heart of our vision for the future. Development through training and education, leadership and management, coaching and mentoring, and management is essential to ensure our people can work to the highest professional levels and are comfortable, competent, and confident to make decisions. **For our leaders and managers, there will be a continued focus on enhancing capability** by ensuring they have the knowledge, skills, and agility to deal with complexity and respond to the changing needs and aspirations of a diverse workforce. 360 degree feedback will be used to gather insight, inform development plans, increase self awareness and to encourage open, honest communication. **Increasing capability and expertise around change management and digital is also a key area of improvement for us over the next few years**.

**Focusing on professions will be at the heart of our plans to promote the importance of each profession and ensuring skill levels reflect those professions**. Our goal is to ensure our people feel supported to make decisions to consult and close at scene, or signpost to a more appropriate pathway. We will enable this by supporting and developing a capable workforce that conveys fewer people to Emergency Departments. Building interpersonal skills to develop cross sector relationships, increase ability to listen, hear and understand other services in Wales and move away from our historical reliance on command and control structures is essential for the cross service delivery of the future. It is crucial to support digital learning and expertise, maximise efficiency, challenge our traditional ways of working and paper based frameworks whilst promoting and demonstrating change management skills across the organisation. #TeamWAST has the potential; it is our job to provide the support structures to allow our people to shine and to promote innovation, inclusion, wellbeing and ensure excellent employee experience to ensure excellent patient experience.

# Context

**Operational pressures are the single biggest risk to the delivery of this plan**. We commence this programme of work knowing the complexity of the risks associated with our current environment and we are committed to focusing on the things we can control, whilst working with our external partners to effectively influence across the system.

Our people are still feeling the effects of the pandemic and with considerable ongoing system pressures and the period of significant uncertainty and disruption regarding industrial action, relationships with Trade Union partners has been challenged in a way not experienced for a long time. We are committed to working with our trade union partners and taking the learning from this experience and reflecting on it will be at the heart of our engagement. Our continued emphasis on wellbeing, embedding compassionate leadership and practices and having a meaningful constructive dialogue on the things which can make a positive difference with our TU colleagues will be key to us being able to thrive and succeed. We recognise that there will be more challenging issues and things we disagree on, but we will agree a way of working through those issues to the benefit of our people, patients and the organisation.

We are confident that our partnership framework and strong relationships will enable us to focus together on improving the working environment, providing the right tools and streamlining processes and practises to ensure there is a direct and positive impact on the daily lived experience for all our staff.

Loss of good staff, increased workloads

Digital Capability Limitations

Operational pressures

Financial landscape

Reputation, Media Interest

Organisational capacity

Capacity to innovate

RISKS

Staff engagement and morale

CASC Confidence in WAST's ability to deliver

Industrial Action

Incorrect prioritisation


Inadequate Programme resources / structure

Staff Wellbeing

Meeting Financial & Statutory obligations

# Evaluation

Attendance

Employee Relations

Line Manager interest in team wellbeing

Engagement Score

PADR

Statutory & Mandatory Training

OH & Wellbeing Usage

Recruitment

Diversity Monitoring

Qualitative Feedback

Awards and Accreditation

Internal promotion and development

Network membership

# Appendices

**Appendix 1**: Our **Rich Picture** - *a visual representation of how it will look and feel to work in WAST upon delivery of this Plan*

**Appendix 2: Year 1 Action Plan** - *this document articulates the actions we need to take during 2023-24 to start our journey; the overall Plan is designed to be dynamic and flexible in nature and as such, the actions for years 2 and 3 will emerge as we progress, continually linking back to the 3Cs and ABC framework*

# Feedback

## We want to know what you think – *what can we do better?*

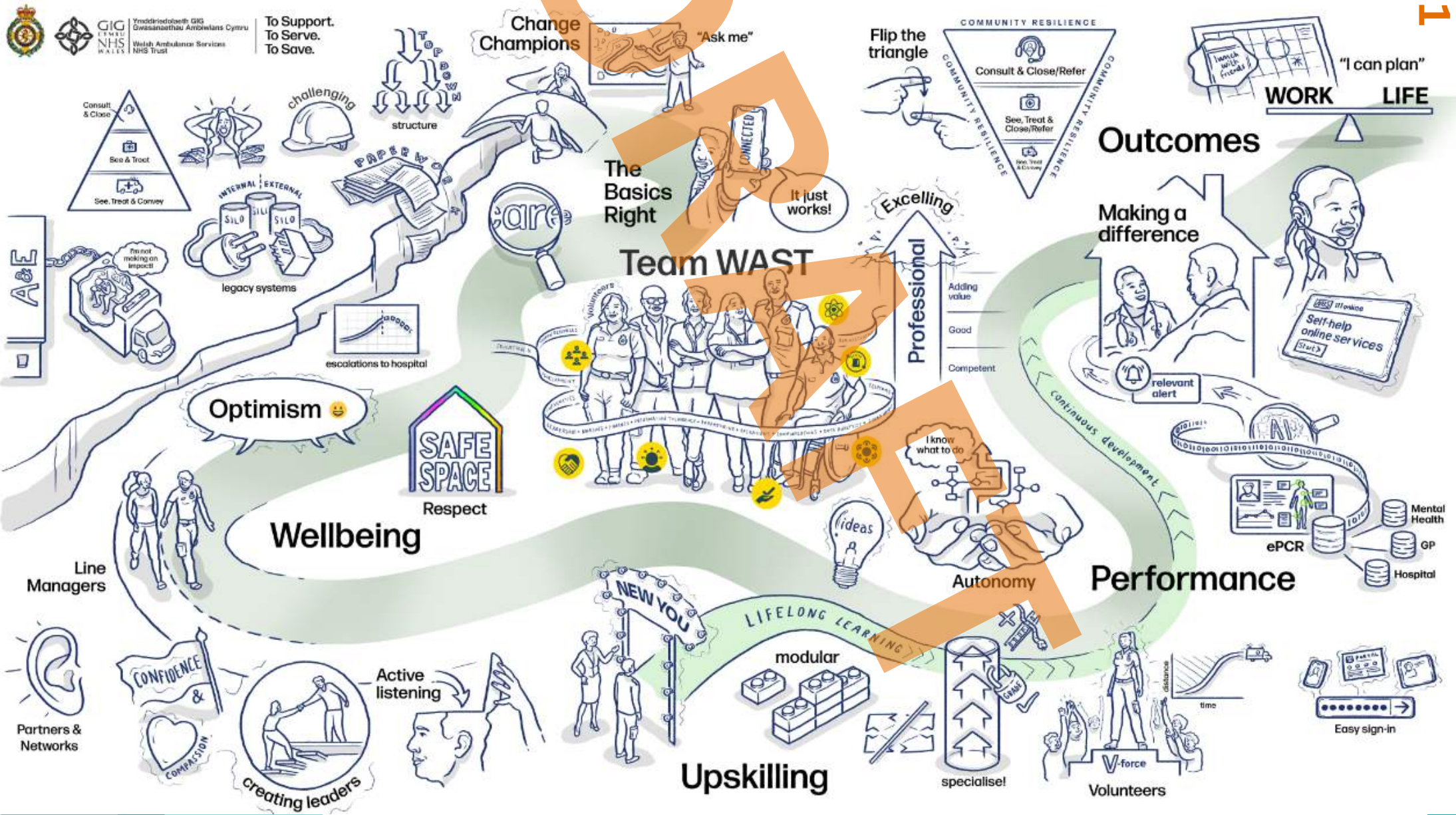
Please email **amb_culture@wales.nhs.uk** if you have any comments or suggestions or questions at any point over the life of this plan.

***Thank you for reading.***

*'To enable health care staff to deliver high quality compassionate care and to flourish, all must work together to create positive, supportive, compassionate, and inclusive workplaces'*

**Prof. Michael West, 2021**

Appendix 1



# Appendix 2

## Year 1: High Level Actions

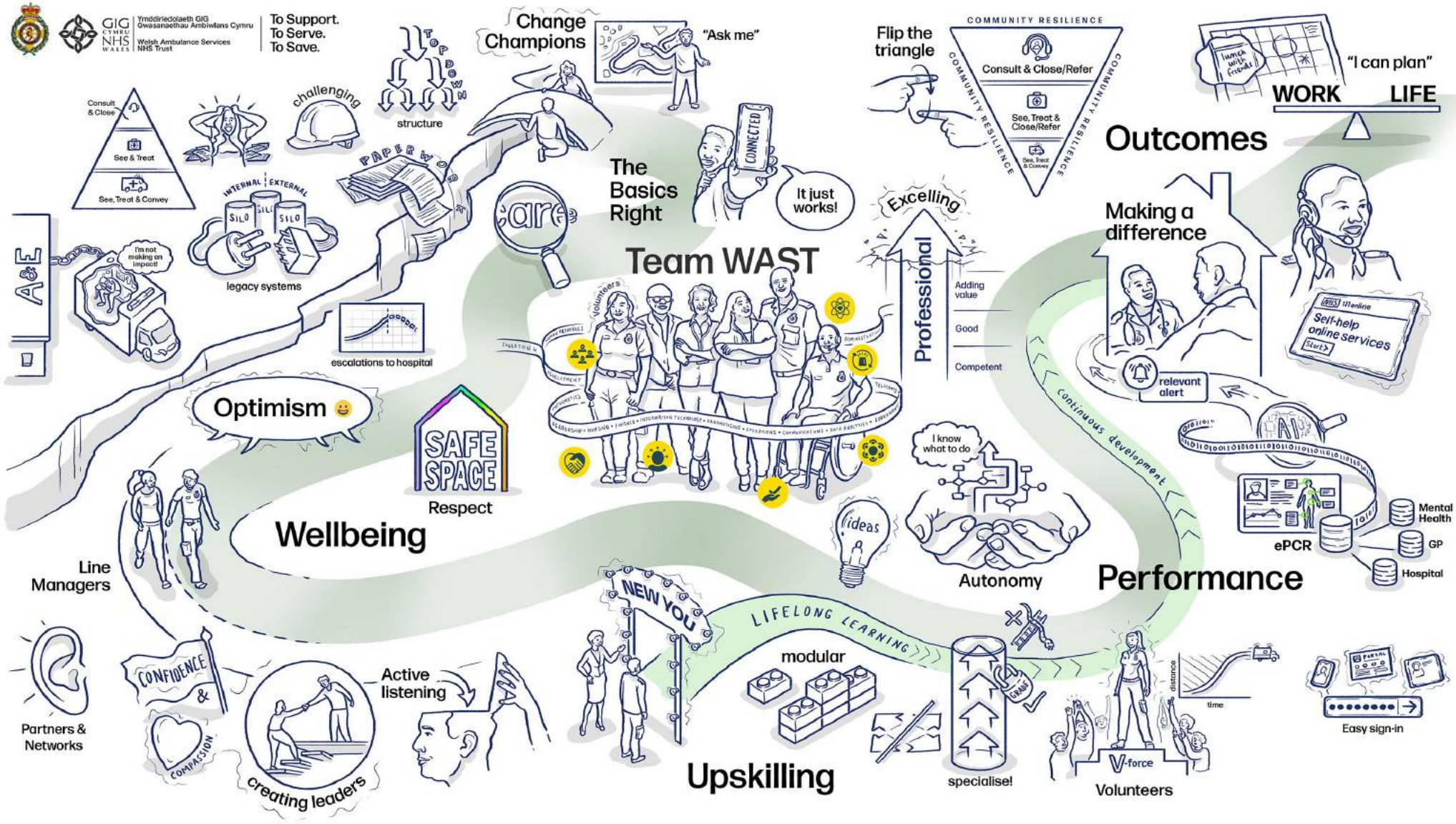
| | |
|---|---|
| **Culture** | Continue to build and articulate our **desired culture**<br><br>Sustain our focus on **improving wellbeing**<br><br>Embed **partnership working**<br><br>Improving the **working environment** including where and how you work |
| **Capacity** | Build on the employee experience to **attract and retain a diverse workforce**<br><br>Develop a **recruitment and attraction plan** that supports all roles in the organisation and continue to build an effective employee brand<br><br>Improve the effectiveness and application of our internal **people processes** (**getting the basics right**)<br><br>Year 2 of the **Managing Attendance** programme |
| **Capability** | Continued focus on enhancing **management and leadership** capabilities<br><br>Increase **change** capacity expertise<br><br>Commitment to development for all **professions**<br><br>Digital capability and improving the **digital experience** for all staff (Digital Workplace) |

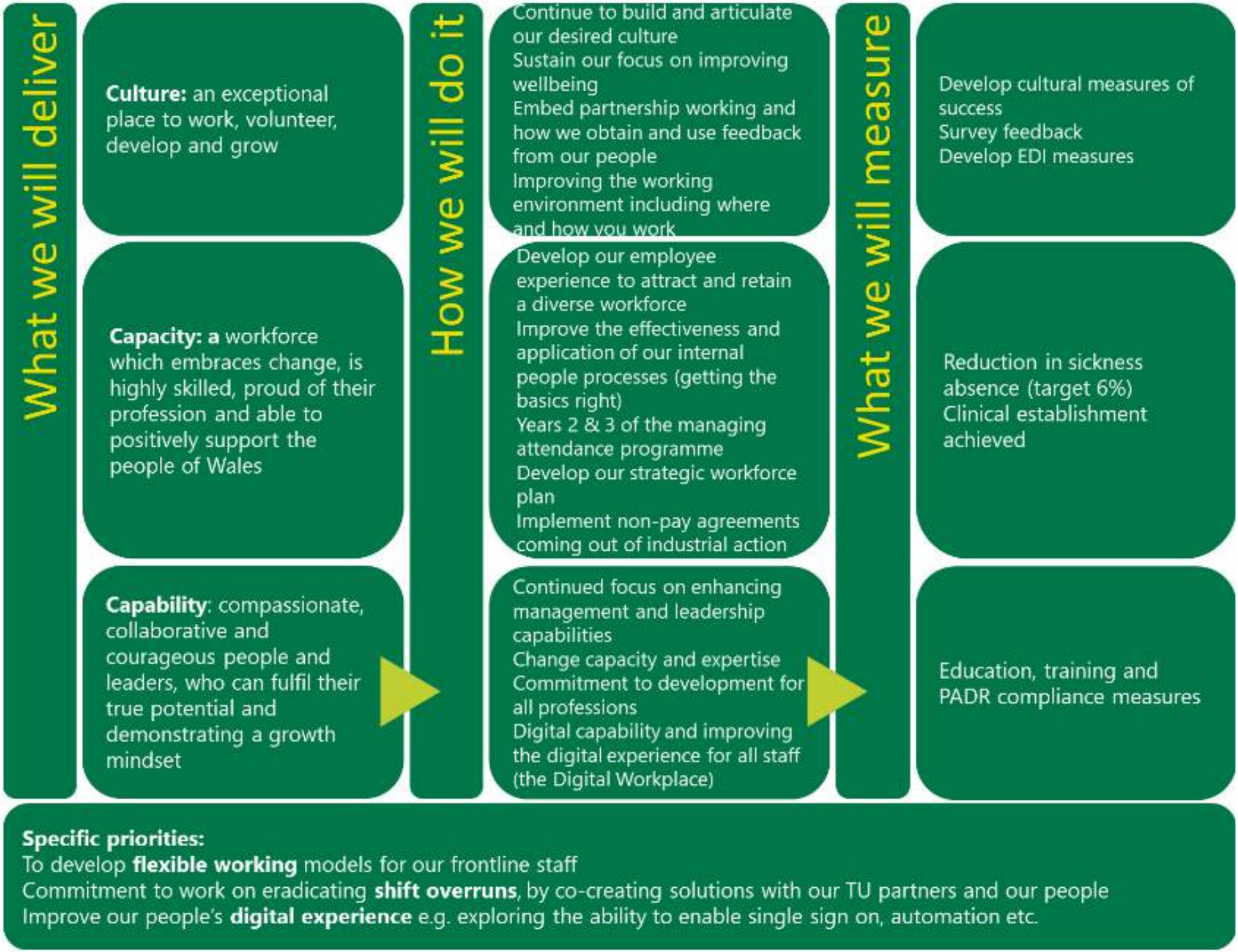
Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

| 3Cs | Del | Objective | Ref. | High Level Action |
|---|---|---|---|---|
| Culture | Create an environment where colleagues have autonomy in their work, feel a sense of belonging, and are confident to make decisions, put forward ideas and raise concerns | **Develop and articulate our target culture** and continue to embed our organisational behaviours and values through a range of people related activities. Bringing to life what it will feel like to work in WAST in three years time, with a clear road map of how we will get there. This will be key to achieving buy in, improving engagement and maintaining momentum. This will be closely aligned to the longer term strategic vision of inverting the triangles. | 1 | Articulate what we mean by culture, assess current culture and establish a baseline against which we can measure progress; focus on what we will cherish and what will change – engaging and communicating across the organisation, so all staff can see what it means for them and how WAST will look and feel different over the three year period |
| | | | 2 | Connect with organisations that are considered to already have great cultures, so we can assess and learn from their experiences |
| | | | 3 | Build on existing cultural DNA work and reinforce our new behaviours in all people related activities |
| | | | 4 | Produce a rich picture of our future desired WAST culture (incorporating stakeholder feedback and insight gained) |
| | | | 5 | Develop and agree clearly defined Strategic Equality Objectives, nsure these are threaded through all of our people and culture activities and develop, gain approval, implement range of anti disc plans in line with WG agenda |
| | | | 6 | Build on opportunities for colleagues across WAST to be early adopters and champions of culture change, for example allyship programme and other staff networks |
| | | Sustain our **focus on improving wellbeing**, delivering on the actions articulated within our Wellbeing Strategy and supporting the Working Safely agenda | 7 | Evaluate impact of current wellbeing offer and interventions and share the findings to ensure they continue to meet the needs of the organisation |
| | | | 8 | Actively promote the interventions using a range of channels to ensure all staff know what is available and how to access |
| | | | 9 | Ensure specific actions that are referenced in the Health and Wellbeing Strategy are delivered |
| | | Focus on increasing levels of **psychological safety** for all our colleagues, building on the sexual safety work, All Wales Speaking Up Safely Guidance and EDI agenda, making a demonstrable organisational commitment to promote a sense of belonging for all colleagues | 10 | Support the development of the WAST Voices network |
| | | | 11 | Embedding Freedom to Speak Up |
| | | | 12 | Assessing feedback and evidence from a range of channels to evaluate examples where colleagues do feel safe to bring their whole self to work and those examples where this is not the case |
| | | | 13 | Implement recommendations from the upcoming Internal Audit re: behaviours and psychological safety |
| | | Improve the **effectiveness and safety of our internal disciplinary, capability and resolution processes**, learning from Just Culture principles and further embedding Compassionate Practices for All. | 14 | Train and support WAST managers in compassionate practices to change behaviours and approaches towards employee relations' processes. Improve employee experience and avoiding escalations where unnecessary supporting people to learn from mistakes. |
| | | | 15 | Coach managers to work through processes and policies in a compassionate way to reduce the volume of disciplinaries and R&R cases and to undertake practices faster, closing down cases at the appropriate stage. |
| | | | 16 | Evaluate impact of Compassionate Practices approach in terms of behaviour change, timeframes and impact on those involved. |
| | | | 17 | Implement recommendations arising from Internal audit re -Compassionate Practices (scheduled Q3) |
| | | Embed and demonstrate the **refreshed partnership working arrangements** and behaviours with Trade Union partners and managers, regularly reviewing and reflecting and leading change together | 18 | Implement ACAS recommendations |
| | | | 19 | Maintain safe services throughout periods of Industrial Action as far as possible |
| | | | 20 | Implement actions to positively change dynamic for partnership working. |
| | | **Amplify employee voices, utilising our networks, Roadshows and pulse surveys**, to ensure colleagues have the opportunity to influence, temperature check how people are feeling and act on feedback, concerns and ideas. | 21 | Build on sexual safety work |
| | | | 22 | Implement pulse surveys to enable evaluation and measurement of People and Culture interventions |
| | | | 23 | Continue to reinforce and socialise behaviours, referencing in a range of materials and discussions (including Roadshows and cascade approach) |
| | | | 24 | Extend and promote a range of networks to give colleagues an opportunity to express views and influence |

| | | | | |
|---|---|---|---|---|
| Capacity | We will ensure we have the right people in the right roles, at the right time, with the right skills, to enable WAST to realise its ambitious service redesign plans | Develop our employee offer and improve the employee experience to attract and retain a diverse and representative workforce | 25 | Develop a recruitment and attraction plan that supports all roles in the organisation and continues to build an effective employee brand |
| | | | 26 | Identify the 3 biggest issues across the organisation that are impacting on our colleagues' lived experience within WAST and consider actions that can be taken to address (flexible working, overruns, digital experience) |
| | | | 27 | Utilise a range of creative recruitment tools and techniques to broaden the diversity and number of applicants for roles, including embedding smarter and flexible ways of working |
| | | | 28 | Foster a culture of continuous conversations, creating a sense of belonging for all colleagues |
| | | | 29 | Continue to build and adapt our exit interview process, to ensure we are proactively utilising insight to shape the employee offer and to address any barriers or issues that arise. |
| | | Review and improve our organisational onboarding processes, to ensure new colleagues are equipped with the necessary knowledge and tools to operate effectively and confidently from day one | 30 | Review and improve induction and onboarding processes taking into account the whole recruitment journey for successful candidates – identifying quick wins and areas that require more detailed changes |
| | | | 31 | Evaluate impact of improved onboarding processes using feedback from new recruits and managers |
| | | Find opportunities to improve **people related policies and processes placing an emphasis on simplicity, accessibility and the impact on the end user** | 32 | Root and branch review of all people related polices (top 3) and processes with an assessment using the simplicity, accessibility, regularity and customer feedback criteria. |
| | | | 33 | Identification of top three processes that need to be changed with a timeline for delivery (link to Managers' Essential Training) |
| | | Develop and implement a **strategic workforce plan linked to an organisational development, education and training plan** that defines the shape and skill mix of the workforce needed to deliver our long-term ambitions including transferrable and digital skills. | 34 | Production of overarching strategic workforce plan with specific operational strands related to recruitment numbers, skills mix, demographics |
| | | | 35 | Support the Strategic Workforce Plan with comprehensive organisational development, education and training plans with a focus on transferable Employability Skills and Digial Skills and incorporating Apprenticeships |
| | | Continue delivery of the Trust's Managing Attendance plan | 36 | Implement recommendations from the recent Internal Audit into Managing Attendance |
| | | Undertake continuous improvement activities, seeking to increase value, reduce burden, waste and inefficiency, ensuring we get the basics right and that our processes are seamless and fit for purpose | 37 | Delivery of Financial Sustainability Programme |
| | | | 38 | Actively promoting opportunities to put forward ideas and make changes to processes and utilising current systems that support this aim (WIN) |
| Capability | We will focus on ensuring our people are suitably skilled and qualified, can work at the highest level of their scope of practise and are comfortable to make decisions within their control. | Build on our learning and development offer for leaders and managers across the organisation to ensure this supports the changing culture and reinforces the ABC | 40 | Develop, deliver and evaluate a bespoke accredited WAST Leadership & Management programme - Managers' Essential Programme |
| | | | 41 | Implement 360 for senior leaders and utilise development tools to support building high performing teams |
| | | | 42 | Support managers to increase visibility, role modelling authentic, compassionate leadership and demonstrating our values and behaviours |
| | | Implement a range of interventions that support people to take **personal responsibility** for their own learning and development, with an emphasis on understanding the importance of CPD and being part of a profession | 43 | Implement LMS365 with value adding impact evident content in an accessible format |
| | | | 44 | Identify career pathways by profession; Reinforce importance of professions and professional development |
| | | | 45 | Develop a succession planning approach that identifies individuals with aspiration and potential for promotion to key roles |
| | | Improve our talent management approach to **succession planning** for future senior leadership posts | 46 | Delivery of accredited and non-accredited change management training |
| | | Continue to enhance **change capacity and expertise** across the Trust to support and enable the organisation to deliver its transformational plans and demonstrate the impact | 47 | Evaluate impact of change management training |
| | | | 48 | Utilisation of specific change management tools and techniques to support people related change activities |
| | | Appropriately respond to **legislative changes** associated with skills and capability | 49 | Assessment of forthcoming legislative changes and potential impact with clearly defined action plans and timeframes to ensure delivery |


Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust
To Support.
To Serve.
To Save.
Change Champions
"Ask me"
Flip the triangle
COMMUNITY RESILIENCE
Consult & Close/Refer
See, Treat & Close/Refer
See, Treat & Convey
"I can plan"
WORK
LIFE
Outcomes
Consult & Close
See & Treat
See, Treat & Convey
challenging
structure
TOP DOWN
PAPER WORK
INTERNAL
EXTERNAL
SILO
legacy systems
A&E
I'm not making an impact
escalations to hospital
The Basics Right
CONNECTED
It just works!
care
Team WAST
Volunteers
Excelling
Professional
Adding value
Good
Competent
Making a difference
111online
Self-help online services
Start
relevant alert
AI
Mental Health
GP
Hospital
ePCR
Optimism
SAFE SPACE
Respect
Wellbeing
Line Managers
I know what to do
Autonomy
ideas
Continuous development
Performance
Partners & Networks
CONFIDENCE
&
COMPASSION
creating leaders
Active listening
NEW YOU
LIFELONG LEARNING
modular
specialise!
GRADE
Upskilling
V-force
Volunteers
distance
time
Easy sign-in


What we will deliver
Culture: an exceptional place to work, volunteer, develop and grow
Capacity: a workforce which embraces change, is highly skilled, proud of their profession and able to positively support the people of Wales
Capability: compassionate, collaborative and courageous people and leaders, who can fulfil their true potential and demonstrating a growth mindset
How we will do it
Continue to build and articulate our desired culture
Sustain our focus on improving wellbeing
Embed partnership working and how we obtain and use feedback from our people
Improving the working environment including where and how you work
Develop our employee experience to attract and retain a diverse workforce
Improve the effectiveness and application of our internal people processes (getting the basics right)
Years 2 & 3 of the managing attendance programme
Develop our strategic workforce plan
Implement non-pay agreements coming out of industrial action
Continued focus on enhancing management and leadership capabilities
Change capacity and expertise
Commitment to development for all professions
Digital capability and improving the digital experience for all staff (the Digital Workplace)
What we will measure
Develop cultural measures of success
Survey feedback
Develop EDI measures
Reduction in sickness absence (target 6%)
Clinical establishment achieved
Education, training and PADR compliance measures
Specific priorities:
To develop flexible working models for our frontline staff
Commitment to work on eradicating shift overruns, by co-creating solutions with our TU partners and our people
Improve our people's digital experience e.g. exploring the ability to enable single sign on, automation etc.

| | |
|---|---|
| **AGENDA ITEM No** | **9** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **1** |

# Freedom to Speak Up 2023

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9 May 2023 |
| **EXECUTIVE** | Angela Lewis<br>Director of Workforce and OD |
| **AUTHOR** | Dr Catherine Goodwin<br>Assistant Director Inclusion, Culture and Wellbeing |
| **CONTACT** | Catherine.goodwin@wales.nhs.uk |

## EXECUTIVE SUMMARY

- This paper outlines the current plan to roll out the freedom to speak up process in WAST.
- It includes as an appendix the closing report for the task and finish group.

## KEY ISSUES/IMPLICATIONS

- As an organisation we need to ensure there are a variety of pathways for our people to raise concerns.
- Our goal is to work towards our people being able to raise concerns within their teams, with their managers openly and safely.
- We acknowledge that may not always be possible, so alternatives need to exist.
- The voices network is one of these options.
- We propose introducing freedom to speak up guardians.
- The speaking up in confidence platform will also be an option.
- The main concern that is frequently voiced is regarding malicious reporting.
- The evidence from other organisations using confidential reporting indicates this is not a common issue.

## REPORT APPROVAL ROUTE

**People and Culture Directorate Business Meeting 04.05.23**
**People and Culture Committee 09.05.2023**

## REPORT APPENDICES

**Appendix 1**
*T&F Closing Report*

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

**Speaking Up Safely in WAST**

A consistent finding in WAST over the last few years in a range of surveys, including our listening exercise for the new behaviours (2021/22), the Swansea University Wellbeing Study (2021), the Inclusion network survey (2020) and of course our most recent Sexism and Sexual Safety Survey (2022) has been that we have to provide space to listen and build trust.

We are working towards becoming an inclusive psychologically safe organisation and one component of this is to provide multiple pathways for everyone to feel they can raise concerns. Our goal is for the vast majority of issues to be resolved as soon as they appear, and our people and culture plan will further enable this with the emphasis on culture and increasing the capability of our people to feel confident challenging behaviours that do not align with our behaviours.

Reverse mentoring will increase understanding, bystander training will increase confidence and raising awareness of microaggressions will enable all of us to reflect on our own behaviour. Our voices network provides people with a safe space and support to talk through options. Our TU partners will advocate for members.

However, we also need to provide our people with other confidential pathways and the introduction of both guardians and the working in confidence platform will fulfil this role. The importance of both these options has been demonstrated in England with the recent report, highlighting the need to address some serious concerns within the sector, that without this mechanism may not have found a voice. Our own sexual safety survey also revealed issues that we had not been fully aware of, including many people contacting us outside of the survey due to concerns about confidentiality with an online internal form. Just 9 people gave us their contact details in the survey such is the anxiety about consequences of speaking up. This was also highlighted at the recent roadshow where there was a request for a bullying survey similar to the sexual safety one, suggesting that our people still don't feel safe enough to report this through our current mechanisms. It also raises the issue that we need to reflect and review what we do when someone has spoken up.

This process needs to be considered alongside other workstreams, such as the behaviours, the anti-discrimination plans as well as our sexual safety work, inclusion network, compassionate practices, managers essentials, health working

relationships, safeguarding, patient safety and the forthcoming All Wales Speaking Up Safely document.

**Current Position**

The task and finish group has come to an end and the closing report can be found in Appendix one. The SRO for the project has now moved to the Director of People and Culture. Having learned from other organisations, the adoption of “guardian roles” is seen as a helpful way to embed a FTSU platform. These people need to already have good relationships, be trusted and approachable people and we are requesting a small amount of protected time for them to carry out this essential role. It is envisaged there would be a max of 4 who would be our pathways on specific themes. We know from other services that having only one guardian can be isolating and overwhelming, so we want to ensure they are supported, including through peer support. The responsibility for implementing this support will be with the workplace wellbeing team. All guardians will receive training.

The Wales Wide Speaking Up Safely process is being finalised and once that is published we will adopt that policy, there is no date for this as yet but WAST is part of the working group and has developed some of the toolkits in partnership.

**The Platform**

There has been an explicit ask from the voices network for a confidential concern reporting mechanism and switching on the platform would provide this. The most recent demonstration of the platform assumed prior knowledge and sight of the platform and we have arranged for a repeat of the initial introduction which demonstrated its flexibility and simplicity. The platform has multiple functions and options and we would seek to provide a simple interface for our people to use should they choose to do so.

There will be an option for completely anonymous reporting. The guardians will be able to engage in a dialogue with people messaging and provide space to build trust with the aim that the individual is able to access the support they may need.

**Process**

We are developing a flow diagram to be used to ensure colleagues understand how the Freedom to SU platform and guardians fits with our wider framework of avenues available to colleagues to raise concerns. Our goal is to make it as simple and straightforward as possible. The process will follow this path:

- Concern Identified
- Website link for easy to find information
- Speak to Manager
- Contact Guardian
- Use platform
    - Work Email
    - Other Email
    - None
- Review

**Considerations**

The concern that is most raised is that of vexatious claims. I think it's important to highlight that this is very uncommon, the role of this process is to provide a safe space for people to report concerns; by contacting the guardian either direct or through the platform when they are unable to do so through another route. It helps mitigate bias such as views about individuals, for example, mental health, demeanour, background etc that might impact our responses.

The role of the guardian is to build trust and support with individuals and very quickly any vexatious claims would be quickly identified. It is not a one-off report to be investigated, it is a process, a journey to a better workplace.

**Next Steps**

- Demonstration of the platform.
- Appoint guardians and provide initial training.
- Confirm review group membership.
- Switch the platform on as we launch our Practice Ethically behaviour.
- Communications plan.
- Review at monthly intervals.
- Develop a plan to fully evaluate the platform, with a particular focus on how this will support culture change.
- Continue to engage with other organisations who have implemented the platform and identify lessons learned.

# TASK AND FINISH GROUP
# CLOSURE REPORT

| | |
|---|---|
| **Name of Group** | Speaking Up Safely Task and Finish Group |
| **Chairs** | Trish Mills and Catherine Goodwin |
| **Date Established** | 25 July 2022 |
| **Date Closed** | 7 March 2023 |

## Background

1. The Speaking Up Safely Task and Finish Group was established in July 2022. Its primary purpose was to undertake a review of current raising concerns arrangements and develop a framework for staff to speak up which supports staff, addresses barriers to speaking up, encourages a positive culture of speaking up and ensures matters raised are used as opportunities for learning and improvement.

2. The Co-chairs were Trish Mills, Board Secretary, and Catherine Goodwin, Assistant Director, Inclusion, Culture and Wellbeing.

3. The Group reported to the Assistant Directors Leadership Team (ADLT) and also provided update reports to the People and Culture Committee on a regular basis.

4. All task and finish groups must 'finish' and therefore the purpose of this close out report is to advise the ADLT of the activity and recommendations of the Group and confirm the ongoing ownership of actions.

## Role and Remit of the Task and Finish Group

5. The Group's terms of reference were approved by the Assistant Directors Leadership Team (ADLT) and are set out at Appendix 1.

6. The role and remit of the Group was to:
   - Consider and understand the current framework for staff to raise concerns and how the Board is receiving information on themes and learning from the sources across the Trust.
   - Identify and establish a comprehensive framework and supporting infrastructure for raising concerns that incorporates the new online platform.
   - Consider and agree the full extent to which the platform will be used for, i.e., whether it is solely for raising concerns or whether it will also serve as a discussion board for improvement ideas.
   - Consider and develop, with the providers, the consolidated case management element of the platform including reporting, dashboards, and outputs for learning and improvement.

- Consider, design and embed the Survey module that will be used to understand the culture of the organisation and take forward learning.
- Administer a soft launch of the platform that will include testing, feedback and promotion.
- Facilitate and monitor the onboarding process of the system within the Trust.
- Design an outline communications plan prior to and during launch.

**Activity and Actions of the Group**

7. The Group met nine times and its work spanned the following:

(a) Developed a detailed work plan centred on the speaking up safely framework, the Work in Confidence (WiC) platform, and communication and engagement;
(b) Received demonstrations of WiC to discuss issues of confidentiality, anonymity, registration, safeguarding, central overview and categories of conversations;
(c) Discussed the law related to protected disclosures and detriment;
(d) Reviewed the current speaking up safely arrangements through a number of scenarios to understand the pathways that currently exist;
(e) Discussed ways in which the WiC platform would act to supplement, not usurp current arrangements and opportunities to have conversations when issues arise;
(f) Had the opportunity to see the dashboards, surveys and case management functionality of WiC;
(g) Looked at the speaking up safely guardian model in England via the National Guardian's Office, as well as how that model is implemented at Health Boards in Wales;
(h) Reviewed job descriptions for speaking up safely guardians;
(i) Received a presentation on the implementation of WiC and guardian model at Betsi Cadwaladwr University Health Board (BCUHB) and Hywel Dda University Health Board (HDUHB);
(j) Discussed the establishment and working of the triage group that reviewed Datix entries in the incident module that are earmarked as 'confidential'; and
(k) Received updates on the progress of the All Wales Speaking Up Safely Framework;

<u>Speaking Up Safely Framework</u>

8. There is recognition that a robust framework of policy, procedures, education and training must be in place to provide confidence that staff have a means by which to 'speak up', but they also have confidence that the Trust will appropriately 'listen up' and 'follow up'.

9. A new policy framework is in development by an all Wales group however it is not clear when that will be finalised. It is not anticipated that WAST will develop a stand-alone policy but will rely on the All Wales Procedure for Raising Concerns which was approved by the People and Culture Committee in November 2022 and await development of the new framework. This procedure superseded the previous NHS Wales Whistleblowing Policy.

10. It was agreed that WAST would benefit from a speaking up safely guardian model and that the job descriptions, evaluation criteria and other promotional materials from BCUHB and the National Guardian Office were a good starting point.

11. WiC was procured in 2022 and provides a confidential third party platform to allow colleagues to speak up in safety when they feel unable to raise a concern through the usual channels of communication. Colleagues will continue to be encouraged to raise concerns to their line manager in the first instance. The categories of concerns are customisable and the group agreed that in the first instance they would include:

    - Management and leadership
    - Bullying and harassment
    - Patient safety/quality of care
    - Staff safety
    - Systems and processes
    - Behaviour/relationships
    - Equality, Diversity and Inclusion (racial discrimination)
    - Equality, Diversity and Inclusion (sexual harassment)
    - Infrastructure/environment
    - Other

12. It was also agreed that colleagues should be given the opportunity to register for WiC with a registration code, an email (work or non-work), or directly to the platform with no email.

<u>Further planning and implementation</u>

13. The Group recommends that the implementation of the speaking up safely framework is transitioned from the Group to the Workforce and Organisational Development Directorate (WOD) with the Director of Workforce and Organisational Development as the senior responsible officer. This has been agreed with Angie Lewis.

14. The speaking up safely framework is part of the IMTP 2023-26 and its development and implementation is a priority for the People and Culture Committee for 2023/24. Monitoring and oversight will therefore be with that Committee, and the Finance and Performance Committee for IMTP deliverables.

15. The specifics related to the speaking up safely guardians, including the number of guardians, their job description, evaluation process for interested parties, reporting and profile will be included in the IMTP work. Likewise, the reporting, dashboards, case management, survey, and other functionality of WiC will be rolled out in keeping with the timelines set out by WOD.

**Recommendation**

16. The ADLT is requested to consider the transition of the speaking up safely framework from the Group to WOD with immediate effect, noting that this work will be monitored via the IMTP and People and Culture Committee work plan.

17. The Co-Chairs wish to thank all members of the Group for their time and enthusiasm for this very important work and the ADLT for their support.

**Appendix 1**

# Freedom to Speak Up Task & Finish Group
# Terms of Reference

## 1. BACKGROUND

1.1 The Freedom to Speak Up Task & Finish Group has been established by the Welsh Ambulance Services NHS Trust (WAST) to assist the Trust in continuing to build on its culture of openness, respect, and inclusion, and promote the organisation's values and behaviours.

1.2 This will be the primary forum which will undertake a review of the current mechanisms and processes for staff raising concerns across the organisation and, thereafter, seek to establish a comprehensive raising concerns framework for staff. The framework will help to protect patient safety and quality of care, improve the experience of staff, and promote learning and improvement.

1.3 The Trust has purchased an electronic web/mobile confidential dialogue platform that will enhance speaking up and assist the Trust to strengthen its current arrangements for staff to speak up anonymously.

1.4 This online platform will help to build a healthy, inclusive, compassionate culture that enables healthy working relationships, where everyone feels they have a voice, control, and influence and can raise concerns safely and without detriment.

## 2. PURPOSE

2.1 The primary purpose of the Freedom to Speak Up Task & Finish Group is to undertake a review of current raising concerns arrangements and develop a framework for staff to speak up which supports staff, addresses barriers to speaking up, encourages a positive culture of speaking up and ensures matters raised are used as opportunities for learning and improvement.

2.2 The group will give consideration to of all types of concerns, complaints and issues and the various mechanisms within which these are currently dealt with and how they are analysed and reported.

2.3 The group will consider the appropriate path for any concerns raised via the Freedom to Speak Up process that may have Patient Safety and/or Health and Safety implications.

2.4 It will locally design and administer the roll out of the Speak Up In Confidence software platform across WAST as part of the revised framework.

2.5 The Task and Finish Group will be time limited. It is intended that the Group will complete its work within 8 months.

2.6 Advice will be provided to the Assistant Directors Leadership Team/Executive Management Team as appropriate where action/changes are required to take forward the work of the Group.

## 3. ROLE AND REMIT

3.1. The role and remit of the Task and Finish Group will be to:

- Consider and understand the current framework for staff to raise concerns and how the Board is receiving information on themes and learning from the sources across the Trust.
- Identify and establish a comprehensive framework and supporting infrastructure for raising concerns that incorporates the new online platform.
- Consider and agree the full extent to which the platform will be used for, i.e., whether it is solely for raising concerns or whether it will also serve as a discussion board for improvement ideas.
- Consider and develop, with the providers, the consolidated case management element of the platform including reporting, dashboards, and outputs for learning and improvement.
- Consider, design and embed the Survey module that will be used to understand the culture of the organisation and take forward learning.
- Administer a soft launch of the platform that will include testing, feedback and promotion.
- Facilitate and monitor the onboarding process of the system within the Trust.
- Design an outline communications plan prior to and during launch.

## 4. MEMBERSHIP

4.1. Membership of the Task and Finish Group will comprise of:

- Trish Mills, Board Secretary (Chair)
- Catherine Goodwin, Interim Director of Workforce and OD
- Julie Boalch, Head of Risk/Deputy Board Secretary
- Hilary Caffrey, People Services Leader
- Karina Galli, Data Protection Compliance Manager
- Estelle Hitchon, Director of Partnerships & Engagement
- Steve Johnson, Head of Patient Safety
- Jonathan Jones, Assistant Corporate Secretary (Chief Executive's Office)
- Mark Marsden, Trade Union Partner
- Caroline Miftari, Head of Quality Assurance
- Hugh Parry, Trade Union Partner
- Liz Rogers, Deputy Director of Workforce & OD
- Nicola White, Head of Health & Safety
- Sara Williams, Workforce Policy and Governance Lead
- Judith Bryce, Assistant Director of Operations
- Melfyn Hughes, Welsh Language Manager
- Keithley Wilkinson, Head of Inclusion and Engagement

4.2. Interested parties, identified by Members, will be invited to attend the group to progress specific development or to assist the group with the discharging of these terms of reference.

4.3. Deputies may attend in the absence of a member, and it will be the member's responsibility to ensure that the deputy is appropriately briefed and able to contribute to the process.

## 5. FREQUENCY OF MEETINGS

5.1. The Task and Finish Group will meet every 4 weeks, or as required.

## 6. SECRETARIAT AND MEETING ARRANGEMENTS

6.1. Secretariat will be provided by the Corporate Governance Team.

6.2. The agenda will be agreed with the Chair.

6.3. Members of the group are free to submit agenda items with notice given as far in advance as is possible to enable the Chair to consider their inclusion.

6.4. The agenda and accompanying papers will be circulated approximately 3-5 days prior to the meeting.

6.5. Action notes of each meeting and agreed actions will be circulated within one week of the meeting.

## 7. CLOSE

7.1. The Task and Finish Group will conclude its work when the actions have been completed and no later than eight months.

7.2. The Task and Finish Group will prepare a final report on the project to include recommendations confirming the ongoing 'ownership' of actions/products where required.

## 8. RELATIONSHIPS WITH OTHER GROUPS

8.1. Members are responsible for ensuring the Directorates they represent are kept informed of the activities of the group. They will also ensure they represent the views of the Directorates, as appropriate.

8.2. The Task and Finish Group will provide progress reports to the Assistant Director Leadership Team.

8.3. The group will link with other Welsh NHS Organisations that have purchased this system to learn lessons from their design process and roll out stages.

8.4. A key relationship is with South Central Ambulance Service in relation to Freedom to Speak Up Guardians.

| | |
|---|---|
| **AGENDA ITEM No** | **10** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **5** |

# RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9th May 2023 |
| **EXECUTIVE** | Trish Mills, Board Secretary |
| **AUTHOR** | Julie Boalch, Head of Risk/Deputy Board Secretary |
| **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 6 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 principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annexes 2 and 3.

4. The principal risks were presented to the Trust Board on 30th March 2023 and are updated as at 30th April 2023. Each risk has been reviewed in full during this period, including controls, assurances, gaps and mitigating actions.

5. A simple guidance note (Appendix 1) has been developed to assist Board and Committee members to interpret the BAF, address some of the issues raised in the Structured Assessment and provide proportionate challenge on actions to mitigate the risks and their intended impact.

**RECOMMENDATION:**

6. **Members are asked to consider the contents of the report.**

## KEY ISSUES/IMPLICATIONS

7. The key issues are set out in the Executive Summary above.

| REPORT APPROVAL ROUTE |
|---|
| 8. The BAF was considered by:<br><br>• EMT – 3rd May 2023<br>• ADLT – 4th May 2023 |

| REPORT ANNEXES |
|---|
| • Annex 1 - Summary table describing the Trust's Corporate Risks.<br>• Annex 2 – Scoring Matrix<br>• Annex 3 – Frequency of Risk review<br>• Annex 4 - Board Assurance Framework<br>• Appendix 1 - Guidance on Interpreting the 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<br><br>QuEST | The Trust's inability to reach patients in the community causing patient harm and death | **IF** significant internal and external system pressures continue<br><br>**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community<br><br>**RESULTING IN** patient harm and death | Director of Operations | **25 (5x5)** → |
| 224<br><br>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<br><br>**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<br><br>**RESULTING IN** patients potentially coming to harm and a poor patient experience | Director of Quality & Nursing | **25 (5x5)** → |
| 160<br><br>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<br><br>**THEN** there is a risk that there is a reduced resource capacity<br><br>**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience | Director of Workforce & Organisational Development | **20 (5x4)** → |
| 201<br><br>PCC | Damage to Trust reputation following a loss of stakeholder confidence | **IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations<br><br>**THEN** there is a risk of a loss of stakeholder confidence in the Trust<br><br>**RESULTING IN** damage to reputation and increased external scrutiny | Director of Partnerships & Engagement | **20 (4x5)** → |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| 557<br><br>PCC | Potential impact on services as a result of Industrial Action | **IF** trade unions take industrial action in response to the national pay award<br><br>**THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business<br><br>**RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation | Director of Workforce & Organisational Development | **16 (4x4)** → |
| 199<br><br>PCC | Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation | **IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance<br><br>**THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments<br><br>**RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation | Director of Quality & Nursing | **15 (3x5)** → |
| 558<br><br>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<br><br>**THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST<br><br>**RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm | Director of Workforce & Organisational Development | **15 (3x5)** → |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| 163<br><br>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<br><br>**THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised<br><br>**RESULTING IN** a negative impact on colleague experience and/or services to patients. | Director of Workforce & Organisational Development | **12 (4x3)**  |

**Annex 2 -** Risk Scoring Matrix

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

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

**Annex 3 -** Frequency of Risk Review

| Risk Score | Review Frequency | Risk Rating |
|---|---|---|
| 15 – 25<br>Red | Review monthly | High |
| 8 – 12<br>Amber | Review quarterly | Medium |
| 1 – 6<br>Green | Review every 6 months | Low |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 21/03/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 22/04/2023 | ➡ | |

| IF | THEN | RESULTING IN | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| significant internal and external system pressures continue | there is a risk of an inability and/or a delay in ambulances reaching patients in the community | patient harm and death | Inherent | 4 | 5 | 20 |
| | | | Current | 5 | 5 | 25 |
| | | | Target | 2 | 5 | 10 |

IMTP Deliverable Numbers: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26

| EXECUTIVE OWNER | Director of Operations | ASSURANCE COMMITTEE | Quality, Safety and Patient Experience Committee |
|---|---|---|---|

**Risk Commentary Q4 2022/23**

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 as a result of the Trust not being able to reach patients in the community.

There were over 28,000 hours lost outside EDs in March 2023, a comparable figure to the pre Christmas delays. Whilst there has been improvement in some Health Board areas (Cardiff and Vale where there has been a corresponding improvement in red performance), other Health Board continue to experience protracted delays. 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 main 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.

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 educes emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative 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 |
|---|---|
| 1. Patient Flow Co-Ordination based in the Grange University Hospital | **Internal**<br>**Management (1st Line of Assurance)**<br>1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU |
| 2. Regional Escalation Protocol | 2. Daily conference calls to agree RE levels in conjunction with Health Boards |
| 3. Immediate release protocol | 3. 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) |
| 4. Resource Escalation Action Plan (REAP) | 4. 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. |
| 5. 24/7 Operational Delivery Unit (ODU) | 5. 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. |
| 6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans | 6. Same as 5 - 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. |
| 7. Limited Alternative Care Pathways in place | 7. 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. |
| 8. Consult and Close (previously Hear and Treat) | 8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023. |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 21/03/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 22/04/2023 | | |

| 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 |

| | |
|---|---|
| 9. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation | 9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs. |
| 10. Clinical Safety Plan | 10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group |
| 11. Recruitment and deployment of CFRs | 11. Volunteers are another resource for response, Volunteer |
| 12. ETA scripting | 12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data |
| 13. Clinical Contact Centre (CCC) emergency rule | 13. CCC Emergency Rule is policy that has been signed off by Execs. |
| 14. National Risk Huddle | 14. 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. |
| 15. | 15. |
| 16. Summer/Winter initiatives | 16. Monitoring through SLT and STB |
| 17. CHARU implementation | 17. Monitored via the EMS project Board |
| 18. National Transfer & Discharge Model | 18. |
| 19. Conveyance Reduction | 19. This is part of the weekly performance review and aligned to Care Closer to Home Programme |
| 20. Access to Same Day Emergency Care (SDEC) for paramedic referrals | 20. This forms part of the handover improvement plans in place with Health Boards, however assurance is limited given that the acceptance of paramedic referrals is low ( less than 1%) and inconsistent. |
| 21. Mental Health Practitioners in cars | 21. |
| 22. Roll out of ECNS | 22. Reported through QuEST |
| 23. Clinical Model and clinical review of code sets | 23. Reported through QuEST |
| 24. Remote Clinical Support Strategy | 24. Strategic Transformation Board – IMTP deliverable |
| 25. 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) | 25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP) |
| 26. Information sharing | 26. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports. |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system | None immediately identified but subject to continual review |
| 2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow | |
| 3. Covid capacity streaming | |
| 4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding | |
| 5. Local delivery units mirroring WAST ODU | |
| 6. Handover delays link to risk 224 | |
| 7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues. Despite a reduction in delays over January and February, current handover delays have demonstrated a deteriorating picture with March delays at December levels | |
| 8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data. | |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 21/03/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 22/04/2023 | | |

| 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 |

| | |
|---|---|
| 9. 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 6 months there is a low confidence in attaining this. | |
| 10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration | |
| 11. Patient Flow Co-ordinators - Health Boards to consider the value of deploying PFCs at emergency departments to aid flow | |
| 12. Handover Improvement Plans agreed between WAST and Health Boards | 12. Handover Improvement Plans have been replaced by ICAPS and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays |
| 18. | 18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work |
| 21. | 21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream |
| *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: |
|---|---|---|---|
| 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 - Paused | |
| 3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters | Assistant Director of Operations EMS | Complete | Majority of EMS rosters complete and implemented |
| 4. Transition arrangements post pandemic | Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair) | Complete 30/08/22 | Transition complete |
| 5. 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 Workforce & OD | TBA | |
| 6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22] | Assistant Director of Operations, Integrated Care | 31.03.23 Complete | Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023. |
| 7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22] | Assistant Director of Operations, National Operations & Support | Complete | System in place and ongoing. |
| 8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22] | Director of Operations / Operations Senior Leadership Team | Complete | In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level. |
| 9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22] | Assistant Director of Operations, National Operations & Support / National Volunteer Manager | Complete 21.03.23 | Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023. |
| 10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22] | | | |
| 11. 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 | Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative. Falls service in place with enhanced day and night provision; Utilisation of resources reviewed at weekly performance meetings by Operations SLT. |

| Risk ID 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 | Date of Review: | 26/04/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 26/05/2023 | | |

| IF | THEN | RESULTING IN |
|---|---|---|
| patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments | 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 | 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: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

| EXECUTIVE OWNER | Director of Quality & Nursing | ASSURANCE COMMITTEE | Quality, Safety and Patient Experience Committee |
|---|---|---|---|

**Risk Commentary Q4 2022/23**

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 due to handover of care delays. There were over 2,883 +4 hour patient handovers in December 2022; the target being 0 from September 2022. Currently < 0.025% of the Trust's demand is going into Same Day Emergency Care currently is <0.025% (modelling 4%). 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 main 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. The Joint Investigation Framework (pilot phase) to embed with good engagement from system partners.

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) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (LHB CEOs) ***by September 2022***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs)
d) 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)
e) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer)

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st 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 Delivery Unit under the Joint Investigation Framework which is currently in pilot phase and an evaluation is to be undertaken in quarter 1 2023/24 by EASC. 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 – the pilot is in progress ,.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. |
| 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 monitors, reports 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 *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership.<br><br>WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours. | 5. Monthly Integrated Quality and Performance Report |
| 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. |

| Risk ID 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 | Date of Review: | 26/04/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 26/05/2023 | | |

| 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 |

| | |
|---|---|
| 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. |
| 9. 24/7 operational oversight by ODU with dynamic CSP 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 |
| 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. |
| 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. Integrated Quality and Performance Report (December 2022 overall 84% - mandatory training target just below target at 84.6%. |
| 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 *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (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.<br><br>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<br>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." | 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 March 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports. |
| 16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023 (soft launch). | 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 February 2023 is 'Implementing and operationalising'. |
| | **External Sources of Assurance**<br>**Management (1st 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) and Joint Executive Team (JET) meeting 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. |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. | 1. |
| 2. | 2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 30 (as of 07.03.2023) overdue nationally reportable incident investigations. |
| 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*. | 3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. 2,098 hours were lost in December 2022, an increase compared to 18,773 lost hours in December 2021. |

| Risk ID 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 | Date of Review: | 26/04/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 26/05/2023 | | |

| **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 |

| | |
|---|---|
| 4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*. | 4. Strengthening of patient safety reports and audit processes as e PCR system embeds. |
| 5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*.<br><br>5. (b) Protracted timescales in the 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 – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*. | 5. 15-minute handover target is not being achieved pan-Wales consistently. Fit to Sit programme is not progressing currently. |
| 6. Variation pan Wales / England as position not implemented across all emergency departments*. | 6. |
| 7. | 7. |
| 8. Variation pan Wales / England as position not implemented across all emergency departments*. | 8. Health & Care Standards self – assessment in progress. |
| 9. Variable response pan Wales / England. WAST have minimal control on this at patient level*. | 9. |
| 10. | 10. |
| 11. Variable response pan Wales / England. WAST have minimal control on this at patient level*. | 11. |
| 12. | 12. |
| 13. Transition to ePCR impacting on data temporarily | 13. |
| 14. 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*. | 14. HIW approve and sign off WAST elements of recommendations. |
| 15. | 15. |
| | **External Gaps in Assurance**<br>1. Lack of escalation and response to AQIs by the wider urgent care system and regulators |
| | 2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group* |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board. | Chief Executive Officer | • Completed | • 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<br>• WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held.<br>• The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board. |
| 2. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project | WAST QI Team (QSPE) | • TBC - Paused | • Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF). |
| 3. 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 | • Q4 2023/24 | • Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level.<br>• Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety dashboards. |
| 4. Continued Health Board interactions – my next patient, 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. |
| 5. HIW Improvement Plan / Workshop– WAST inputs / influencing improvements | Assistant Director of Quality & Nursing | • Completed | • No further requests from HIW to date. |

| Risk ID 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 | Date of Review: | 26/04/2023 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 26/05/2023 | | |

| 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 |

| | | | |
|---|---|---|---|
| Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care. | | | |
| 6. Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*. | Executive Director of Quality & Nursing | • Q3 2023/24 | • Revised joint investigation approach agreed and now in pilot phase.<br>• Meeting April 2023 cancelled by EASC due to system pressures. |
| 7. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation | Director of Workforce & Organisational Development | • Q3 2023/24 | • Strong focus from Executives with detailed updates to EMT every two weeks.<br>• Estimated year end position is +90 FTEs against the target of 100.<br>• Overall across the whole establishment, this equates to a vacancy factor of just 0.5%, |
| 8. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE | Director of Paramedicine | • Q4 2023/24 | • Bid not successful. Feedback received from Welsh Government that will be incorporated into future bids. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start.<br>• 17 trainee APPs expected to "tip out" of training in Jun-23. Currently they have not been offered contracts and the Trust risks losing some of them.<br>• Some additional funding available to bid against for AHPs (bid submitted by May 2023). |
| 9. Transition Plan | Chief Executive Officer | • Q2 2023/24 | • Formally submitted to Commissioners in December 2021. As above +100 FTEs secured although non-recurring at this point in time.<br>• Also as above, funding for additional APPs not secured via Value Based Healthcare fund; however, decision of Trust to proceed with take up of 18 MSC places anyway.<br>• Further discussions as part of IMTP 2023-2026 have been undertaken on additionality into next year, with letter written to the CASC about what further full time equivalent additionality it could recruit and train if funding was available in 2023/24 (maximum 100). |
| 10. Overnight falls service extension | Executive Director of Quality & Nursing | • June 2023 | • Night Car Scheme extension agreed to 31 March 2023 (2 regional resources)<br>• Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through Jan-Mar 2023. Good progress has been made on this.<br>• Falls level 1 and 2 impact evaluation report completed - presenting to Clinical Quality Governance Group (CQGG) 18 Jan-2023. |
| 11. Consideration of additional WAST schemes to support overall risk mitigation through winter | Director of Operations | • Q2 2023/24 | • Good progress on Performance Improvement Plan (pip) There were only 15 PIP actions live in Dec-22, so the PIP closed down and the remaining actions transferred into other assurance mechanisms like this report.<br>• Specific seasonal and strike structures stood up.<br>• Trust demonstrating continued focus and creativity on approach to seasonal and strike mitigations. |
| 12. National 111 awareness campaign | Director of Partnerships and Engagement<br>Director of Digital | • Q4 2022/23 | • The national awareness campaign is now fully live through to the<br>• end of the financial year.<br>• The second phase was launched in Q4 28 Feb-23 and included a new TV ad on ITV, S4C and Video on Demand (ITV Hub, Sky, All4). This phase also includes a digital radio advert, social media.<br>• (Organic and paid), influencer activity, case studies, and out of home advertising on digital billboards across Wales along high traffic carriageways.<br>• National toolkit containing key messages and social media assets distributed to stakeholders.<br>• Campaign ending end of March 2023. |
| 13. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 (soft launch with Welsh Government Roadmap in place) with supporting monitoring and oversight systems in place and embedded. | Executive Director of Quality & Nursing | • Q3 2023/24 | • Monthly updates to progress against actions following the baseline assessment and readiness returns.<br>• Key policies updated and approved.<br>• Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. |
| 14. Virtual Ward | Executive Director of Quality & Nursing | • Q2 2023/24 | • A proposed innovative "eyes on" service provided by the third sector (organisation and volunteers), supported by the Clinical Support Desk and supported by technology.<br>• The proposed service will support patient safety and improved hospital flow.<br>• The Trust has completed a business case at pace, which has been sent to the CASC for consideration. |
| 15. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands. | Executive Director of Quality & Nursing | • July 2023 | • To commence consultation phase by May 2023. |

| 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: | 14/04/2023 | TREND | 20 (5x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2023 | | |

| IF there are high levels of absence e.g. sickness and alternative duties | THEN there is a risk that there is reduced resource capacity | RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience |
|---|---|---|

| | Likelihood | Consequence | Score |
|---|---|---|---|
| Inherent | 4 | 4 | 16 |
| Current | 5 | 4 | 20 |
| Target | 3 | 4 | 12 |

IMTP Deliverable Numbers: 1,5, 9, 10, 12, 17, 18, 19, 20, 26, 34

| EXECUTIVE OWNER | Director of Workforce & Organisational Development | ASSURANCE COMMITTEE | People and Culture Committee |
|---|---|---|---|

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Managing Attendance at Work Policy/Procedures in place | 1. (a) Policy reviews to ensure policies and procedures are fit for purpose<br>(b) Audits by People Services on sickness |
| 2. Respect and Resolution Policy | 2. Policy reviews to ensure policies and procedures are fit for purpose |
| 3. Raising Concerns Policy | 3. Policy reviews to ensure policies and procedures are fit for purpose |
| 4. Health and Wellbeing Strategy | 4. |
| 5. Operational Workforce Recruitment Plans | 5. |
| 6. Roster Review & Implementation | 6. |
| 7. Return to Work interviews are undertaken | 7. |
| 8. Training | 8. |
| 9. Directors receives monthly email with setting out ESR sickness data | 9. |
| 10. Operational managers receive daily sickness absence data via GRS | 10. |
| 11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme | 11. |
| 12. WAST Keep Talking (mental health portal) | 12. |
| 13. Suicide first aiders | 13. |
| 14. TRiM | 14. |
| 15. Peer Support network | 15. |
| 16. Coaching and mentoring framework | 16. |
| 17. Staff surveys | 17. |
| 18. Stress risk assessments | 18. |
| 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 |
| 20. External agency support e.g. St John Ambulance, Fire and Rescue | 20. |
| 21. Strategic Equality Objectives | 21. Policy reviews to ensure policies and procedures are fit for purpose |
| 22. Volunteers | 22. |
| 23. Monthly reviews of colleagues on Alternative duties | 23. Action plans arising from meetings with colleagues implemented through monthly diarised meetings |
| 24. Manager guidance on managing Alternative duties | 24. |
| 25. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee | 25. Minuted meetings and action logs for EMT & People & Culture Committee |
| 26. Sickness audits for localities | 26. |
| 27. Additional support for areas with higher than average absence | 27. |
| 28. Review of top 100 cases | 28. |
| 29. Deep dives on specific issues and reasons for absence | 29. |
| 30. Work on getting underneath stress related absences across the organisation | 30. |
| | **External Management (2nd Line of Assurance)** |
| | 1a. All Wales review of All Wales Attendance at Work Policy |
| | **Independent Assurance (3rd Line of Assurance)** 15 |
| | 1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24) |

| 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: | 14/04/2023 | TREND | 20 (5x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2023 | ➡ | |

| 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 |

| | |
|---|---|
| | 2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24) |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. (a) Consistency and Application in Managing Attendance at Work Policy | 1. 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 | |
| | **External Gaps in Assurance**<br>None identified at the present moment |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Implementation of Improving Attendance project | Deputy Director of Workforce & OD | 31.09.23 | Underway and ongoing. Downward trajectory 8.77% for November 2022. |
| 2. Implementation of Behaviours Refresh Plan | Assistant Director – Inclusion, Culture and Wellbeing | 31.10.22 Extended to 31.05.23 | Underway and ongoing. Captured in the IMTP for the service. Impacted by IA |
| 3. Long term sickness absence deep dive | Deputy Director of Workforce & OD | 31.07.23 | Underway and ongoing. Downward trajectory in levels of long term absence |
| 4. Develop guidance for line managers to support addressing challenging conversations and change | Deputy Director of Workforce & OD | 31.07.22 Complete | Training produced and rolled out. Now BAU |
| 5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements) | Freedom to Speak Up Arrangements Task & Finish Group<br>Ownership moving to DWOD | Extended from 31.07.22 to 31.03.23. Extended to 31.05.23 | Pushed out date in terms of project plans and impact of Industrial Action.<br>21.3 The task and finish group has completed its work and the project is now going to be handed to DWOD as SRO for the work. |
| 6. Strengthen Freedom to Speak Up Arrangements policy and advice | Assistant Director of Workforce and OD | 31.05.23 | Ongoing |
| 7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements | Assistant Director of Workforce and OD | 31.05.23 | Ongoing |
| 8. Accountability meetings with senior ops managers | Deputy Director of Workforce & OD | 30.09.22 Complete and ongoing | Underway, conversations re sickness absence well established and continuing |
| 9. Attendance Management training for managers | Deputy Director of Workforce & OD | 31.12.22 Complete and BAU | Underway and ongoing – now BAU 1.11.22 |
| 10. PADR review including wellness questions | Assistant Director – Inclusion, Culture and Wellbeing | Complete | Complete. New PADR distributed October 22. |
| 11. Restart the Health and Wellbeing Steering Group | Assistant Director – Inclusion, Culture and Wellbeing | Complete | Complete – group started 17.10.22 and will meet quarterly. |
| 12. Review of top 100 cases by the team on a monthly basis | Deputy Director of Workforce and OD | Commenced and ongoing – review 30.06.23 | Underway and will become BAU |

| Risk ID 201 | Damage to Trust reputation following a loss of stakeholder confidence | Date of Review: | 21/03/2023 | TREND | 20 (4x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 21/04/2023 | ➡ | |

| IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations | THEN there is a risk of a loss of stakeholder confidence in the Trust | RESULTING IN damage to reputation and increased external scrutiny | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| | | | Inherent | 4 | 5 | 20 |
| | | | Current | 4 | 5 | 20 |
| | | | Target | 3 | 5 | 15 |

IMTP Deliverable Numbers: 2,18, 26, 34, 38

| EXECUTIVE OWNER | Director of Partnerships and Engagement | ASSURANCE COMMITTEE | People and Culture Committee |
|---|---|---|---|

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders | 1. Agendas, minutes and documents of engagement events |
| 2. Challenging of media reports to ensure accuracy | 2. Programme of daily media engagement |
| 3. Media liaison to ensure relationships developed with key media stakeholders | 3. Programme of daily media engagement |
| 4. Engagement Framework approved by the Board July 2022 | 4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs. |
| 5. Engagement Framework Delivery Plan approved by the Board January 2023 | 5. The Director of Partnerships and the Head of Strategy are working closely with colleagues from PWC to inform further detail regarding future engagement including stakeholder analysis, case for change etc. Routine stakeholder and staff engagement continues, including the recent round of Executive roadshows and WAST Live. |
| 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. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs. Outcome of recent reputation audit to be reported through EMT in April and onward, as a minimum, to PCC. |
| 7. Escalation procedure for issues to the Board | 7. Minuted meetings, action logs and Board papers |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. The delivery plan is in abeyance pending outcome of the work underway by PWC in relation to the Trust's strategic ambitions. | 5. |
| 6. | 6. |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Submit refreshed Board Engagement Framework to Trust Board for approval | Director of Partnerships & Engagement | 26.05.22 Complete | Approved July 2022 |
| 2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee | Director of Partnerships & Engagement | Complete | Considered by January 2023 Trust Board |
| 3. Monitoring internal Quality and Performance of Trust | Executive Management Team<br>Finance and Performance Committee<br>Quality, Safety and Patient Experience Committee<br>People and Culture Committee<br>Audit Committee | 31.03.23 Checkpoint Date | |
| 4. Engaging with internal and external stakeholders to develop confidence | CEO & Director of Partnerships & Engagement | 31.03.23 Checkpoint Date | Regular engagement continued with staff, TU partners and a range of external stakeholders. This is part of BAU. |
| 5. Monitoring external factors that may affect the Trust | CEO & Director of Partnerships & Engagement | 31.03.23 Checkpoint date | |

| Risk ID 557 | Potential impact on services as a result of Industrial Action | Date of Review: | 14/04/2023 | TREND | 16 (4x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2023 | | |

| | | | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| **IF** trade unions take industrial action in response to the national pay award | **THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business | **RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation | **Inherent** | 3 | 4 | 12 |
| | | | **Current** | 4 | 4 | 16 |
| | | | **Target** | 2 | 4 | 8 |

IMTP Deliverable Numbers: TBC

| **EXECUTIVE OWNER** | Director of Workforce & Organisational Development | **ASSURANCE COMMITTEE** | People and Culture Committee |
|---|---|---|---|

| **CONTROLS** | **ASSURANCES** |
|---|---|
| | **Internal**<br>**Management (1st Line of Assurance)** |
| 1. Detailed planning process in place | 1. Industrial action plan agreed and published |
| 2. Significant preparation for industrial action prior to events | 2. Documented processes and actions |
| 3. Negotiations with TU officers on derogations | 3. Communications and engagement across the organisation |
| 4. Communications with organisation on IA – regular WAST Live Q&As, briefings and updates | |
| 5. IA issues discussed and recorded at EMT and ADLT | |
| 6. ADLT and Managers co-ordinated on picket sites during IA days | |
| 7. Strategic Command arrangements and HR cover for whole of strike period | |
| 8. Lessons learned exercise after each strike day | |
| 9. Engagement with wider network to maximise system preparedness and support | **External**<br>**Independent Assurance (3rd Line of Assurance)** |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| *1.* Need to determine life and limb cover to meet our legal requirements under the Industrial Action Regulations | 1. Awaiting outcome of UNISON ballot (Feb 2023) - complete |
| 2. No control or mitigation on TU decisions on derogations | 2. |
| 3. | 3. |
| 4. | 4. |

| **Actions to reduce risk score or address gaps in controls and assurances** | **Action Owner** | **By When/Milestone** | **Progress Notes:** |
|---|---|---|---|
| 1. Maximum engagement with TU colleagues | Director of WOD | Ongoing | Daily meetings with relevant TUPs |
| 2. Negotiate the best derogations possible to protect patient safety | Director of WOD | Ongoing | Derogations negotiated for each IA day |
| 3. Consider options for external support if necessary | Director of WOD / CEO | Ongoing | Watching brief and advice being sought |
| 4. Strike Action currently paused due to negotiations but need to retain the risk and the level as no guarantee that IA will be resolved | Director of WOD | Ongoing | |

| Risk ID 199 | Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation | Date of Review: | 05/04/2023 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 06/05/2023 | ➡ | |

| **IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance | **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments | **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| | | | Inherent | 4 | 5 | 20 |
| | | | Current | 3 | 5 | 15 |
| | | | Target | 2 | 5 | 10 |

IMTP Deliverable Numbers: 1, 7, 9, 12, 16, 17, 24, 25, 26, 33, 35, 38

| **EXECUTIVE OWNER** | Director of Quality and Nursing | **ASSURANCE COMMITTEE** | People and Culture Committee |
|---|---|---|---|

| **CONTROLS** | **ASSURANCES** |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1 Systematic review and assessment of Health and Safety arrangements and Governance (All NHS Wales Health & Safety Management System - HSMS). | 1. Assessment criteria set for health and safety management system (HSMS) All Wales system). HSMS approved at ADLT in 2022. ADLT members sponsorship for all 11 management principles. |
| 2. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC) | 2. Trusts Legislative Compliance Register in place. Assessments to be reviewed in ADLT in April 2023. Monthly, Quarterly and Annual H&S performance reports to ADLT and H&S National Health, Safety and Welfare Committee. Quarterly performance reports to ADLT, EMT, PCC. Reports published on H&S webpage. H&S climate cultural survey developed to determine perception of Trust position against Bradley Curve. |
| 3. Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, - Regulation 7 'Health and Safety Assistance'. | 3. The Working Safely team ceased on 31.09.22. The approval of the transformation of the H&S function business case allowed for significant increase into the function which commenced on 03.10.22. This allowed for the new structure to be implemented. 05.02.23 Team fully embedded into the organisation. |
| 4. Health & Safety Policy and Corporate level Procedures. | 4. H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022-Q1 2023. Violence and Aggression Policy, Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in February 2023. Dangerous Substances Explosive Atmospheres (DSEAR) Procedure, Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of commencing the approval process approval during Q1 2023. Lone Worker Procedure ongoing - expectation of second draft Q1 2023. Trust wide Hazard register framework in place. Reviewed by ADLT in Q1 2023 with expectation of approval Q1 2023. |
| 5. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff. | 5. Quarterly statistics provided by ESR support team and incorporated into Health and Safety quarterly and annual Performance reports. Induction training compliance held on ESR |
| 6. 2 year rolling programme of scheduled H&S premise audits. | 6. Inspections are being undertaken in line with schedule. Ongoing. |
| 7. Risk assessments (including local risk assessments, Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments). | 7. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and previously monitored by BCRT. These are being monitored by local operations mangers. Other operational risk assessments and SOPs are held on dedicated Share-point sections. Performance metrics in place. |
| 8. Working Safely Strategic Programme Board (STB) to provide oversight of the Working Safely Action plan. Dynamic Delivery Action Group to continue to undertake actions on the Working Safely Action Plan. | 8. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored through the Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved. |
| 9. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place. | 9. Attendance and competency figures provided in a quarterly report to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee. |
| 10. IOSH Leading Safely for Directors and Senior Managers training in place. | 10. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis |
| 11. Board development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022. | 11. Diarised meeting. |
| 12. Health and Safety Management System recognised document approval routes for health and safety documentation. | 12. Approved and minuted at ADLT meeting in 2022. |
| 13. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022. | 13. Compliance metrics held on H&S team database. |
| 14. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023. | 14. |
| 15. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT in June 2023. | 15. |
| 16. | 16. Internal Audit to be undertaken in Q1 23/24 (controls 1– 10) **(External Independent Assurance (3rd Line of Assurance)** |

| Risk ID 199 | Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation | Date of Review: | 05/04/2023 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 06/05/2023 | ➡ | |

| **IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance | **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments | **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation |
|---|---|---|

| | Likelihood | Consequence | Score |
|---|---|---|---|
| Inherent | 4 | 5 | 20 |
| Current | 3 | 5 | 15 |
| Target | 2 | 5 | 10 |

| GAPS IN CONTROLS | GAPS IN ASSURANCE |
|---|---|
| 1. | **1.** Baseline audit for HSMS not to be commenced till Q1-Q2 2023 (***being addressed in Action 1)*** |
| 2. Subgroups of National H&S and Welfare Committee currently under review. **(being addressed in Action 2)** | 2. H&S Climate Cultural survey to be rolled out once political pressures (IA) reduce**.** Expectation of roll out Q1-Q2 2023/24 (***being addressed in Action 3)*** |
| 3. | 3. |
| 4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q4 2022 in Q1 2022 (***being addressed in Action 4***) | 4. (a) Review of H&S Policy is due by the end of Q1 2023 (***being addressed in Action 4)***<br>(b) Workforce Transformational change will influence content within H&S policy (***being addressed in Action 4)*** |
| 5. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 5)*** | 5. |
| 6. | 6. Two-year Schedule for H&S inspections and visits commenced September 2022. Compliance metrics, themes and trends are to be included within Monthly, Quarterly and Annual Performance Reports. ***(being addressed as part of Actions 6)*** |
| 7. | 7. (a) Current copies of risk assessments and SOPs are not available at all stations. ***(being addressed as part of Actions 7)***<br>(b) Lack of clarification over many SOPs are required until HSMS baseline audit has been completed. ***(being addressed as part of Actions 7)*** |
| 8. Operational pressures and Industrial Action on service impacting on Working Safely Programme delivery **(being addressed in Action 8)** | 8. |
| 9. Staff availability to attend training ***(being addressed in Action 5)*** | 9. Work ongoing to determine how many Managers require IOSH Manging Safely. ***(being addressed in Action 9).*** A H&S Training needs analysis has been developed and incorporated into the H&S Policy. |
| 10. Effective learning from events to be documented ***(being addressed in Action 8)*** | 10. Currently there is no structured monitoring process in place to ensure attendance on the IOSH Leading Safely course. ***(being addressed in Action 5)*** |
| 11. | 11. |
| 12. | 12. |
| 13. | 13. |
| 14. | 14. |
| 15. | 15. |
| 16. | 16. |
| 17. | 17. |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Meetings to be scheduled to undertake baseline assessment and feedback to EMT. | Head of Health and Safety | Q1-Q2 2023 | |
| 2. Meetings to be held with TU partners and AD/Head of H&S to agree arrangements for sub-groups. | Head of Health and Safety | Q1 2023 | ToR Developed and presented at National HSW Committee in Q2 2022. Further discussions requested a Charter arrangement. Draft Charter developed and presented in National HSW committee in Q3 2022. Further discussions requested by TU partners. Discussions held with OD in April 2023 to provide consideration of integrating sub -groups into WASTP. |
| 3. Assessment to be undertaken in Q1 2023 of political pressure to determine viability of conducting culture survey | Head of Health and Safety | Q1-Q2 2023 | |
| 4. H&S Policy Group meeting to be established and draft policy to be created | Head of Health and Safety | Q1 2023 | Initial meeting held in December 2022 first draft to be presented at Policy Group Meeting in January 2023 for comments from key stakeholders. Challenges with attendance due to IA. Expectation of draft Policy being presented at Policy Group to propose full consultation in May 2023. |
| 5. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates | Head of Health and Safety | Q3 2022 - Complete | Report is a standard section of Quarterly H&S Performance report to ADLT |
| 6. IT solution being investigated to collate data from inspections to enable trending and monitoring of actions generated | Deputy Head of Health and Safety | Q4 2023 | The audit proforma has been migrated onto MS Forms to allow for improved data collection. Meeting held with I.T. provider in Q4 2022 provide consideration for the development of utilisation of Power B.I systems. |

| Risk ID 199 | Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation | Date of Review: | 05/04/2023 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 06/05/2023 | ➡ | |

| IF | THEN | RESULTING IN |
|---|---|---|
| there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance | there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments | death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation |

| | Likelihood | Consequence | Score |
|---|---|---|---|
| Inherent | 4 | 5 | 20 |
| Current | 3 | 5 | 15 |
| Target | 2 | 5 | 10 |

| | | | |
|---|---|---|---|
| 7. H&S advisors will liaise with local management teams to identify risk assessments and SOP's in place and ensure visibility on SharePoint | Deputy Head of Health and safety | Q2-Q3 2023 | Ongoing action. Assessment against the HSMS Principle 3- Compliance Assurance will assist in determining what RA/SOPS are required. |
| 8. Priority Elements of Working Safely Action Plan to be identified and programme schedule presented to STB to ensure sufficient support from Operational Teams. Migrate into Annual Health and Safety Improvement Plan. | Head of Health and Safety | Q2 2023 | Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training. 05.04.23 Development of Health and Safety Improvement Plan underway. |
| 9. Review of number of line managers within the Trust to put in place a suitable schedule to roll out appropriate H&S training as determined within the training needs analysis within the H&S Policy. | Deputy Head of Health and Safety | Q2 2023 | Interim schedule in place to address known line managers. |
| **Completed Actions** | **Action Owner** | **When /Milestone** | **Progress Notes:** |
| 1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25) | Head of Health & Safety | 31.09.22 Partially completed. Long term action. | Pump and Prime phase commenced 01.09.21. Closure report for PPP presented to EMT during Q3 2022/23. Working Safely Programme to continue being monitored by STB. Four priorities determined for 2023/24- Violence & Aggression, Culture, Manual Handling and Incident Investigation. |
| 2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP) | Head of Health & Safety | 31.12.22 Partially completed. | Training delivered to Board and Executive team on 26.07.22. IA and operational pressures impacted on availability to attend during Q4 2022.Further sessions to be scheduled for Q1 2023/4- Q2 2023/24 for new members. |
| 3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP) | Head of Health & Safety | 31.12.22 Scheduled | Initially scheduled for BDD - February 2023. Rescheduled to June 2023. |
| 4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP) | Head of Health & Safety | 31.03.22 Completed | Completed- Workforce review fully implemented 03.10.22 |
| 5. Culture survey to all members of staff (forms part of WSAP) | Head of Health & Safety | 30.09.22 Partially completed | Survey developed and to be presented at National H&S Committee on 02.11.22 and SOT in December for feedback. Decision made during Q3 2022/23 to postpone survey unit political pressures ease. Expectation of roll out Q4 2023-Q1 2023/24. Political unease impacted on the roll out of the survey roll out. Expectation that survey will be rolled out during Q1-Q2 2023/4 |
| 6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP) | Deputy Head of H&S | 30.06.22 Completed | Compliance Register framework developed Q2 2022. |
| 7. An initial assessment will provide assurance on how we are complying with the legislation. | Deputy Head of H&S | Partially completed. Assurance - 01.06.22 Rolling programme of assessments – 31.12.22 | Assessments undertaken. Some outstanding estates assessments scheduled January 2023. Compliance register presented to ADLT members on 04.04.23 for feedback/agreement of assessments undertaken. |

| 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: | 14/04/2023 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2023 | | |

| IF | THEN | RESULTING IN |
|---|---|---|
| significant internal and external system pressures continue | there is a risk of a significant deterioration in staff health and wellbeing within WAST | 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: TBC

| EXECUTIVE OWNER | Director of People & Culture | ASSURANCE COMMITTEE | People & Culture Committee |
|---|---|---|---|

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Health and wellbeing strategy in place and shared across the Trust. | 1. Review undertaken of the Health and Wellbeing Strategy by Assistant Director annually. |
| 2. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme | 2. Regular review meetings with all external providers to ensure they meet requirements of the SLA contracts. Regular management information received so that trends can be monitored. |
| 3. Self-referrals or managerial referrals to Occupational Health | 3. Regular reports submitted by Occupational Health team to WOD Business Meetings for monitoring. |
| 4. Wellbeing support and training for line managers | 4. Diarised meetings, webinars and workshops in place through a rolling programme. |
| 5. Development of range of wellbeing resources for staff and line manager | 5. Tools are available on WAST intranet. Occupational Health and Wellbeing teams visit stations, A&E , CCCs and other locations regularly where operational staff are based to promote the occupational health and wellbeing offer. |
| 6. Peer support network forum | 6. Agendas and minutes of meetings produced for each meeting. |
| 7. WAST Keep Talking (mental health portal) and Sway on the Intranet | 7. Available on intranet for staff to access easily. |
| 8. TRiM | 8. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place. |
| 9. Coaching and mentoring framework | 9. Information on intranet on Learning launch pad available to all staff. |
| 10. Acting on results of staff surveys relating to staff experience | 10. Each Directorate has developed their own action plan to address staff surveys. |
| 11. HSE stress risk assessments | 11. Undertaken by managers and advice is provided on how to use them by Occupational Health team. |
| 12. KPIs are reported monthly to WOD regarding Occupational Health and Wellbeing activity | 12. Received at WOD Business Meetings monthly. |
| 13. Wellbeing drop-in sessions for CCC and 111 staff | 13. Diarised sessions in place as part of the programme. |
| 14. Fast track physiotherapy | 14. Regular review meetings with physiotherapy provider and monthly monitoring information received at WOD Business meetings. |
| 15. Specialist trauma counselling service | 15. Same as 15. |
| 16. Regular psycho-educational sessions with managers and staff | 16. Diarised sessions |
| 17. Compassionate leadership training sessions | 17. Same as 17 in place as part of the programme. |
| 18. Chaplaincy programme | 18. Training plan and minutes of meetings produced quarterly for the Wellbeing Team – to be reviewed. |
| 19. Occupational Health team inclusion in sickness and absence meetings | 19. Diarised meetings in place. |
| 20. Procure a pulse survey tool to benchmark how colleagues are feeling and get feedback on the employee experience | 20. |
| | **External - Independent Assurance -** Audit Wales – Taking Care of the Carers report in October 2021 |

| GAPS IN CONTROLS | GAPS IN ASSURANCE |
|---|---|
| | 4. Reporting on wellbeing training take up |
| 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 Health and Safety. | Lack of awareness about staff wellbeing services |
| | Effects of REAP 4 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. |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Restart the Health and Wellbeing Steering Group (link to risk 160) | Assistant Director Inclusion, Culture and Wellbeing | Completed | First meeting was on 17/10/2022. This however does not yet bring down the score of the risk as the Steering Group meeting was to re-establish a way forward. Next meeting to be scheduled within 2 months. |
| 2. Increase the education and communication with managers about stress risk assessments | Head of Health & Safety | Completed | This is part of the IOSH Managing Safety Training BAU. OH to undertake workshops with CCC managers – dates to be confirmed this week. |
| 3. Deliver the employee engagement tool into WAST | Deputy Director of WOD | 30.06.23 | Software has been procured. Planning for rollout has started |

| Risk ID 163 | Maintaining Effective & Strong Trade Union Partnerships | Date of Review: | 14/04/2023 | TREND | 12 (4x3) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 30/06/2023 | | |

| **IF** the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained | **THEN** there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised | **RESULTING IN** a negative impact on colleague experience and/or services to patients | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| | | | Inherent | 5 | 3 | 15 |
| | | | Current | 4 | 3 | 12 |
| | | | Target | 4 | 3 | 12 |

IMTP Deliverable Numbers: 2, 4, 6, 11, 20, 34

| **EXECUTIVE OWNER** | Director of Workforce and Organisational Development | **ASSURANCE COMMITTEE** | People & Culture Committee |
|---|---|---|---|

| **CONTROLS** | **ASSURANCES** |
|---|---|
| | **Internal**<br>**Management (1st 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 as a result 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 is 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 | 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 to be signed off at next WASPT meeting in June 2023 | 10. |
| | **External -** Not applicable |

| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
|---|---|
| 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. Develop an action plan from the recommendations of the ACAS report | Deputy Director of Workforce & Organisational Development | Completed 12/01/23 | Action Plan for delivery created and shared with TU Secretary for feedback from TUPs |
| 2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing | Deputy Director of Workforce & Organisational Development | Completed 12/01/23 | WASPT re-established. Third meeting scheduled T&F group undertaking work on the engagement model below WASPT through SLT and SOT is in progress with TU engagement. TU cell stood down. |
| 3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree | Deputy Director of Workforce & Organisational Development | Completed 12/01/23 | Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway |
| 4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU). | Deputy Director of Workforce & Organisational Development | Completed 12/01/23 | WASPT feeding into PCC |
| 5. Establish formal meeting structures below WASPT | Deputy Director of Workforce and Organisational Development | 30.06.2023 | Structure agreed with TUs. Sign off at next WASPT meeting. Highlight reports to be shared at WASPT |

**IMTP Deliverable Key**

| No. | IMTP Deliverable |
|---|---|
| 1 | We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19 |
| 2 | We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum |
| 3 | We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles) |
| 4 | We will work with partners to promote and expand use of 111 across Wales |
| 5 | We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team |
| 6 | We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations |
| 7 | We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience |
| 8 | We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice |
| 9 | We will increase and balance response capacity and capability across urban and rural area of Wales |
| 10 | We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients |
| 11 | We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover |
| 12 | We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience |
| 13 | We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand |
| 14 | We will develop and implement with partners an-All Wales transfer and discharge service |
| 15 | We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery |
| 16 | We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience |
| 17 | We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance |
| 18 | We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment |
| 19 | We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment |
| 20 | We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented |
| 21 | We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app) |
| 22 | Improved signposting to the most appropriate service |
| 23 | Improved digital tools and services to empower our teams to do their best |
| 24 | We will use modern technology to reduce repeat tasks and improve processes |
| 25 | Standardised information architecture and common approach to data and analytics across the organisation |
| 26 | We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation |
| 27 | Improved resilience, flexibility and interoperability for the 999-call platform |
| 28 | We will provide an improved financial plan to support our ambitions |
| 29 | Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation |
| 30 | We will deliver the Estates Strategic Outline Plan |
| 31 | We will implement the Environmental and Sustainability Strategy |
| 32 | Deliver the Fleet SOP |
| 33 | We will secure and implement Quality Management and control systems |
| **No.** | **IMTP Deliverable** |
| 34 | We will transform the way we work and engage with people |
| 35 | We will revisit and implement the Public Health Plan |
| 36 | We will implement the Clinical Strategy to support developments across our service ambitions |
| 37 | We will deliver a values-based approach |
| 38 | We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance |

Welsh Ambulance Services NHS Trust

# Guidance on Interpreting the Board Assurance Framework

Version 1.1 April 2023

# Board Assurance Framework

The Board Assurance Framework (BAF) provides assurance to the Board on the Trust's delivery of its strategic aims, outlined in its 3 Year Integrated Medium Term Plan (IMTP) and through its risk management framework.

An element of the Trust's Risk Transformation Programme was to develop a transitional BAF that focussed the Board on the key risks that might compromise the achievement of those strategic aims.

The BAF currently draws its principal risks from the Corporate Risk Register and maps them to the Integrated Medium-Term Plan deliverables and therefore, by extension, are the Trust's strategic risks.

As the Trust's risk maturity advances the current BAF template will be used to capture risks to the strategic objectives and will be cross-referenced to the principal corporate risks.

The BAF aligns principal risks, drawn from the Corporate Risk Register, the key controls, and the assurances on those controls. Gaps are identified where key controls and assurances are insufficient to mitigate the risk and subsequent actions are identified. The Board should monitor these actions as intended to close the gaps and mitigate the risks.

## COMPONENTS OF THE BAF

Elements for the Board to consider when scrutinising the BAF:

### 1. REVIEW DATE

Risks scored high (15-25) are reviewed monthly, medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months.

| Risk Score | Review Frequency | Risk Rating |
|---|---|---|
| 15 – 25<br>Red | Review monthly | High |
| 8 – 12<br>Amber | Review quarterly | Medium |
| 1 – 6<br>Green | Review every 6 months | Low |

The Board should consider whether the risk has been reviewed on time and in accordance with the governance routes agreed by the Audit Committee.

## 2. RISK ARTICULATION

An *If, Then, Resulting In* approach is used to provide a more detailed description of the risk. The Board should consider whether the cause and effect of the risk clear.

## 3. SCORING

The risk score uses the likelihood x consequence mechanism. A guide on how likelihood and consequence scores are arrived at to gauge if the score is appropriate is included in the tables in annex 1.

## 4. CONTROLS

A control is a measure that is already in place to mitigate a risk. Controls may change or be added to through regular updates. The Board will need to assure itself that these controls are effective to manage the principal risks.

## 5. ASSURANCE

Assurance provides confidence, evidence, and certainty that controls are effective. The Board should look at the control and the assurance related to that specific control to judge its effectiveness in managing the risk. As the BAF matures future iterations could include an assurance rating to support the assessment of effectiveness of controls.

## 6. GAPS

A gap in control or assurance occurs when either of these elements do not exist or that they do not effectively mitigate the risk. It may be that the control is not operating effectively to mitigate the risk. The Board should consider whether gaps are comprehensive with what is known in the current environment and whether the BAF supports the identification of the gaps or weaknesses in controls.

## 7. ACTIONS

An action is something which is intended to be done and which will limit the impact of a risk in the future. It may reduce the likelihood of the risk occurring at all. Once complete an action may become a new control. The Board should consider whether there is an associated action for each gap; are those actions on track according to their dates; and will these actions support the reduction of the risk when completed and become controls.

## RISK SCORING MATRIX

**Annex 1**

| Consequence: | 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
|---|---|---|---|---|---|
| **Safety & Well-being - Patients/ Staff/Public** | Minimal injury requiring no/minimal intervention or treatment.<br>No time off work.<br>Physical injury to self/others that requires no treatment or first aid.<br>Minimum psychological impact requiring no support.<br>Low vulnerability to abuse or exploitation - needs no intervention.<br>Category 1 pressure ulcer. | Minor injury or illness, requiring minor intervention.<br>Requires time off work for >3 days Increased hospital stay 1-3 days.<br>Slight physical injury to self/others that may require first aid.<br>Emotional distress requiring minimal intervention.<br>Increased vulnerability to abuse or exploitation, low level intervention.<br>Category 2 pressure ulcer. | Moderate injury/professional intervention<br>Requires time off work 4-14 days.<br>Increased hospital stay 4-15 days.<br>RIDDOR/Agency reportable incident.<br>Impacts on a small number of patients.<br>Physical injury to self/others requiring medical treatment.<br>Psychological distress requiring formal intervention by MH professionals.<br>Vulnerability to abuse or exploitation requiring increased intervention.<br>Category 3 pressure ulcer. | Major injury leading to long-term disability.<br>Requires time off work >14 days.<br>Increased hospital stay >15 days.<br>RIDDOR Reportable.<br>Regulation 4 Specified Injuries to Workers.<br>Patient mismanagement, long-term effects.<br>Significant physical harm to self or others.<br>Significant psychological distress needing specialist intervention.<br>Vulnerability to abuse or exploitation requiring high levels of intervention.<br>Category 4 pressure ulcer. | Incident leading to death.<br>RIDDOR Reportable.<br>Multiple permanent injuries or irreversible health effects.<br>An event which impacts on a large number of patients. |
| **Quality/ Complaints/ Assurance/ Patient Outcomes** | Peripheral element of treatment or service suboptimal.<br>Informal complaint/inquiry. | Overall treatment/service suboptimal.<br>Formal complaint (Stage 1).<br>Local resolution.<br>Single failure of internal standards.<br>Minor implications for patient safety.<br>Reduced performance. | Treatment/service has significantly reduced effectiveness.<br>Formal complaint (Stage 2).<br>Escalation.<br>Local resolution (poss. independent review).<br>Repeated failure of internal standards.<br>Major patient safety implications. | Non-compliance with national standards with significant risk to patients.<br>Multiple complaints/independent review.<br>Low achievement of performance/delivery requirements.<br>Critical report. | Totally unacceptable level or quality of treatment/service.<br>Gross failure of patient safety.<br>Inquest/ombudsman/inquiry.<br>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.<br>Unsafe staffing level (>1 day)/competence.<br>Low staff morale.<br>Poor staff attendance for mandatory/key professional training. | Uncertain delivery of key objective/ service due to lack/loss of staff.<br>Unsafe staffing level (>5 days)/competence.<br>Very low staff morale.<br>Significant numbers of staff not attending mandatory/key professional training. | Non-delivery of key objective/service due to loss of several key staff.<br>Ongoing unsafe staffing levels or competence/skill mix.<br>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.<br>Reduced performance levels if unresolved. | Single breach in statutory duty.<br>Challenging external recommendations/improvement notice. | Enforcement action. Multiple breaches in statutory duty.<br>Improvement notices.<br>Low achievement of performance/ delivery requirements. Critical report. | Multiple breaches in statutory duty.<br>Zero performance rating.<br>Prosecution. Severely critical report. Total system change needed. |
| **Adverse Publicity or Reputation** | Rumours.<br>Low level negative social media.<br>Potential for public concern. | ocal media coverage - short-term reduction in public confidence/trust.<br>Short-term negative social media.<br>Public expectations not met. | Local media coverage - long-term reduction in public confidence & trust.<br>Prolonged negative social media.<br>Reported in local media. | National media coverage <3 days, service well below reasonable public expectation.<br>Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust.<br>Increased scrutiny: inspectorates, regulatory bodies and WG. | National/social media coverage >3 days, service well below reasonable public expectation.<br>Extensive, prolonged social media. MP/MS questions in House/Senedd.<br>Total loss of public confidence/trust. Escalation of scrutiny status by WG. |

| Consequence: | 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
|---|---|---|---|---|---|
| **Business Objectives or Projects** | Insignificant cost increase/ schedule slippage. | <5 per cent over project budget. Schedule slippage. | 5–10 per cent over project budget. Schedule slippage. | Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met. | >25 per cent over project budget. Schedule slippage. Key objectives not met. |
| **Financial Stability & Impact of Litigation** | Small loss. Risk of claim remote. | Loss of 0.1–0.25% of budget Claim less than £10,000. | Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000. | Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time. | Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results. |
| **Service/ Business Interruption** | Loss/interruption of >1 hour. Minor disruption. | Loss/interruption of >8 hours. Some disruption manageable by altered operational routine. | Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations. | Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected. | Permanent loss of service or facility. Total shutdown of operations. |
| **Environment/Estate/ Infrastructure** | Minimal or no impact on environment/service/property. | Minor impact on environment/ service/property. | Moderate impact on environment/ service/property. | Major impact on environment/ service/property. | Catastrophic impact on environment/service/property. |
| **Health Inequalities/ Equity** | Minimal or no impact on attempts to reduce health inequalities/improve health equity. | Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity. | Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity. | Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity. | Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity. |

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

**WELSH AMBULANCE SERVICE PARTNERSHIP TEAM (WASPT)**
**HIGHLIGHT REPORT**

This highlight report provides the reader with details of the key areas discussed at the last WASTP 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** | 13 April 2023 |
| **Joint Chairs** | Jason Killens (in chair for 13 April meeting)<br>Mark Marsden |

**KEY ESCALATION AND DISCUSSION POINTS**

**ALERT**

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

1. No alerts from this meeting.

**ADVISE**

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

2. Progress on the establishment of **WASPT sub-structures** to ensure local issues are discussed at local levels was discussed. Governance forums include local partnership forums feeding into established operations forums with Trade Union Partners. This structure will provide opportunities for resolution and escalation, focusing WASPT on strategic issues and escalations from the most senior forum, which is the senior operations team with trade union representation. The structures are agreed and the next meeting will review their terms of reference, operating arrangements and membership with a view to approving them and establishing the required cadence of meetings and support in the local partnership forums.

3. The **IMTP 2023-26** was discussed and a Trade Union Partner has been sought to join the group preparing easy read summaries of the plan for our people and our patients. The challenging revenue and capital **financial plan for 2023/24** was also discussed together with the knock on effect of the reduced fleet replacement programme for 2023/24.

4. The issues of WAST colleagues **portering patients** at hospitals was raised and the position reiterated by Jason Killens and Lee Brooks is that WAST is not configured, funded or commissioned to provide portering services for patients and that rosters are not supportive of such extended duties. WAST colleagues should not porter patients at hospitals to scans etc., however, it was recognised that they are sometimes put in positions where conflict can arise with clinicians making the request. Rather than argue in the presence of patients, colleagues should accept the request and report the matter to local management for appropriate

escalation to the Health Board. WAST has put it's concerns to Health Boards and Jason Killens will raise the issue at the Emergency Ambulance Services Committee.

5. The Executive Director of Quality and Nursing presented an update on the issue of **diesel engine exhaust emissions**. It was noted that spikes in Datix incidents reported relating to fumes correlate with handover delays and vehicles having to run for prolonged periods of time outside the Emergency Departments and, encouragement by Trade Unions to report through DATIX as a mechanism to record for potential future industrial injury claims. Datix incidents have decreased recently and Trade Union Partners were of the view that this was due to reporting fatigue from staff who thought that reporting the matter is futile.

   It was recognised by the Trust that although assessed fume particulate levels detected in monitoring are below all identified safety standards and exceed compliance levels of the appropriate UK Health and Safety Executive (HSE) legislation, and also with EU regulations, it is nevertheless very unpleasant for colleagues and it is working to secure additional academic advice and support on any additional steps that could be taken to understand potential risk.

   It was noted that audits demonstrated that the controls put in place to manage risks on site were identifying poor compliance and that while the Trust would continue to do all it could to secure a reduction in Handover Delays and, identify additional measures to reduce fume build up, it was imperative that colleagues took the appropriate mitigation measures where at all possible.

   Notwithstanding the legislative compliance, Trade Union Partners remain concerned about the long-term effects on staff of exposure to diesel fumes and will continue to advise their members to raise Datix incident reports where they are affected.

   Handover delays remain the cause of the fumes issue and this has been raised with Health Boards. A number of agreed WAST and Health Board mitigations are in progress and the following additional actions have been remitted to the National Health and Safety Committee to progress and monitor:

   (a) Consider pull down extraction fans at Emergency Departments;
   (b) Increase internal communications to colleagues on the extensive work already carried out by the Health and Safety Team, mitigations in progress and those planned with the aim to update them and to encourage colleagues to continue to report fumes issues so that data can inform the discussions further;
   (c) Pursue a longer period of monitoring by the Bradley Environmental ISO at some of the sites where handover delays are particularly troublesome, including 24/7 monitoring and factoring in other environmental factors of the site that might be exacerbating the fumes;
   (d) Continue to identify and secure academic advice based on wider research with a view to supporting further mitigations;

(e) Continue to consider alternative heating and air conditioning sources that do not need to have the engine running to heat and cool the vehicle;
(f) Include reporting of the issue in the provider report to EASC as a consequence of handover delays
(g) Lee Brooks will continue to raise the issue with Health Board Chief Operating Officers, including at an in person meeting on 14 April.
(h) All parties to encourage staff compliance to the risk assessment and mitigation plans in place to ensure exposure is minimised.
(i) Liam Williams and Angela Lewis to liaise with Occupational Health to identify additional steps that might be taken to support staff reporting symptoms they identify as resulting from exposure to diesel fumes.

It was noted that the issues is actively being address on the specification for new vehicles.

**ASSURE**

(Detail here any areas of assurance)

6. There were no items of assurance discussed at the meeting.

**RISKS**

**Risks Discussed**: The discussion on diesel fumes relates to the risk being developed with respect to this. The risks to delivery of the IMTP and the financial position were also discussed.

**New Risks Identified**: No new risks identified.

| COMMITTEE AGENDA FOR MEETING | | |
|---|---|---|
| 1. Industrial Action | 2. WASPT Sub-structures | 3. IMTP 2023-26 |
| 4. Diesel Fumes | | |

| COMMITTEE ATTENDANCE | | | |
|---|---|---|---|
| **Name** | **13 April 2023** | **14 June 2023** | |
| **Joint Chairs** | | | |
| Jason Killens | Chair | | |
| Mark Marsden (Unison) | | | |
| **Management Representatives** | | | |
| Angela Lewis | | | |
| Lee Brooks | | | |
| Rachel Marsh | Alex Crawford | | |
| Chris Turley | | | |
| Andy Swinburn | | | |
| Estelle Hitchon | | | |
| Trish Mills | | | |
| **Trade Union Representatives** | | | |
| Paul Seppman (Unite) | | | |
| Hugh Parry (Unite) | | | |
| Sean Herbert (Unite) | | | |

| COMMITTEE ATTENDANCE | | | |
|---|---|---|---|
| **Name** | **13 April 2023** | **14 June 2023** | |
| Christian Fox (Unite) | | | |
| Carl Jones (Unite) | | | |
| Henry Garrard | Rob Morgan | | |
| Ian James (GMB) | Sharon Thorpe | | |
| Maldwyn Jones (GMB) | | | |
| Marcus Viggers (GMB) | | | |
| Carl Hardwick (GMB) | | | |
| Mark Ivey (Unison) | | | |
| Bethan Williams (Unison) | | | |
| Damon Turner (Unison) | | | |
| TBC (RCN) | | | |
| TBC (RCN) | | | |
| TBC (RCN) | | | |

| | |
|---|---|
| | Attended |
| | Deputy attended |
| | Apologies received |
| | No longer member/Not member |

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

# COMMITTEE CYCLE OF BUSINESS 2023-24

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9 May 2023 |
| **EXECUTIVE** | Trish Mills, Board Secretary |
| **AUTHOR** | Trish Mills, Board Secretary |
| **CONTACT** | Trish.mills@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. Updating of the cycle of business for this committee is the final step in the 2022/23 effectiveness reviews that were conducted in Q4. Amendments to the Committee's terms of reference agreed in Q4 have been incorporated into this updated cycle of business.

2. The cycle has been developed with direct correlation to the duties in the terms of reference. This will allow members to review the appropriateness of the proposed reports and their frequency.

3. The cycle for the Committee is a maturing document which will grow organically over the next 12 months.

**RECOMMENDATION:**

4. The Committee is asked to:

(a) Review and approve the 2023-24 cycle of business at Annex 1; and
(b) Note the cycle of business monitoring document at Annex 2.

## KEY ISSUES/IMPLICATIONS

5. There are some areas of the cycle where reporting remains to be developed including the people and culture related health and care standards compliance; speaking up safely; anti-racist Wales action plan; Welsh language standards; and partnerships and engagement. Work will continue with the relevant directors on these areas over the coming months.

| | |
|---|---|
| 6. | The committee is required to review the strategic direction of matters within its remit and to monitor their implementation. The cycle includes an annual review of the IMTP elements relevant to its remit ahead of them being approved by the Board, however the monitoring of the IMTP is within the purview of the Finance and Performance Committee. It is therefore proposed that, outside of that, reporting on the IMTP will be at the discretion of the relevant Director or at the request of the Finance and Performance Committee i.e. possibly to do a deep dive on an area that may be off track or to celebrate areas of success. |

| **REPORT APPROVAL ROUTE** |
|---|
| N/A |

| **REPORT APPENDICIES** |
|---|
| Annex 1 – Cycle of business 2023/24<br>Annex 2 – Cycle of business monitoring report |

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

## CYCLE OF BUSINESS 2023/24

### SITUATION

7. The purpose of this paper is to provide the Committee with the updated cycle of business as the final step in the 2023/24 effectiveness review process.

### BACKGROUND

8. The Committee carried out its effectiveness review in Quarter 4 2022/23. This included a review of its terms of reference, amendments to which were approved by the Committee in February 2023.

9. The final step in the effectiveness review process is the development a cycle of business for the Committee.

### ASSESSMENT

Cycle of Business

10. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework, should drive agenda setting. It also:

    10.1. allows papers to be planned in advance, giving Directors and report writers the opportunity to plan necessary pre-committee forums and align cycles of business;

    10.2. schedules compliance related reports according to legislative or regulatory timeframes;

    10.3. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;

    10.4. generates commitment to review matters that may sometimes be vulnerable to postponement;

    10.5. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;

    10.6. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and

    10.7. removes the ad hoc elements of agenda setting.

11. Whilst it is inevitable that other items will arise from time to time, the cycle allows them to be prioritised - perhaps coming later on the agenda.

12. The cycle of business at **Annex 1** has been designed to do all the above. It includes further detail on the pre-committee forums, lead presenters, purpose of reports and any relevant and/or helpful commentary. It also includes each of

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

13. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. The areas which remain to be developed include:

    13.1. As the Health and Care Standards are revised with the introduction of the Health and Care (Quality and Engagement) (Wales) Act 2022, the Committee will receive a proposal for the monitoring compliance against the people and culture standards.

    13.2. The Speaking Up Safely framework has been identified and the work fo the task and finish group is being further developed and implemented by the Director of People and Culture. An update was provided in Q1 2023/24 however regular reporting against the framework will develop throughout the year.

    13.3. The monitoring of the Trust's progress against the Welsh Government Anti-racist Wales Action Plan is in development.

    13.4. The Welsh language framework is included in the IMTP for 2023-26, however standards compliance reporting is being reviewed. The Committee received an update on the framework in Q1 2023/24 and will receive the Welsh Language Annual Report in September 2023.

    13.5. The reporting of progress against the Engagement Framework Delivery Plan is in development as this work progresses. An update was provide din Q1 2023/24.

    Work will continue with the relevant directors on these areas over the coming months.

Continued monitoring of the cycle of business

14. The cycle of business will be used to build the quarterly Committee agenda. A monitoring report will be provided to each meeting under the Consent Agenda, and where issues of escalation are required i.e. where cycle needs to be adjusted or reporting is overdue, these will be drawn out in a short paper by the Board Secretary.

15. The firs monitoring report appears at **Annex 2** for Q1 2023/24.

**RECOMMENDATION**

16. The Committee is asked to:

    (c) Review and approve the 2023-24 cycle of business at Annex 1; and
    (d) Note the cycle of business monitoring document at Annex 2.

# PCC Cycle 2023/24

| PAPER | PRE C'EE FORUM | FREQUENCY | Q1 | Q2 | Q3 | Q4 | LEAD | PURPOSE | COMMENT |
|---|---|---|---|---|---|---|---|---|---|
| **PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2023/24** | | | | | | | | | |
| **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 |
| 3.13 Monitor performance against key people and culture indicators such as sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinaries 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 | | | | | | | | | |
| MIQPR review for people and culture metrics | FPC | Annually | | | | ■ | EDSPP | Endorsement | People and culture, H&S, and Welsh Language KPIs for inclusion in MIQPR |
| Committee-specific KPIs review of metrics | TBC | Annually | | | | ■ | DPC | Approval | To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any) |
| MIQPR | EMT | Quarterly | ■ | ■ | ■ | ■ | EDSPP | Assurance | Includes balanced scorecard of all Board level metrics. See cycle notes on PADRs |
| Committee-specific KPIS | TBC | Quarterly | ■ | ■ | ■ | ■ | DPC | Assurance | TBC in what format(s)/report(s) to be presented. MIQPR and Committee KPIs to include markers of progress for cultural |
| Suspensions over 4 months report | TBC | Quarterly | ■ | ■ | ■ | ■ | DPC | Assurance | Closed session |
| Learning report | TBC | Bi-annually | | ■ | | ■ | DPC | Assurance | Cultural themes and trends report for learning. See Note 1 |
| 3.5 Ensure 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 2 | | | | | | | | | |
| End of Season Flu Campaign Report | CQGG | Annually | | | | | DP | Assurance | To include flu and general vaccination status in accordance with statutory and regulatory requirements - see Note 3 |
| 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 Standards requirements; and that professional standards of registration and revalidation are maintained | | | | | | | | | |
| Health and Safety Report | NH&S C'ee | Quarterly | ■ | ■ | ■ | ■ | EDQN | Assurance | Quarterly report on the working safely programme but MIQPR to include KPIs - see Note 4 |
| Revalidation and registration report | N/A | Annually | | ■ | | ■ | EDQN & DP | Assurance | Report from EDQN and DP confirming revalidation of registered staff - see Note 5 |
| Gender pay gap report | TBC | Annually | | | | ■ | DPC | Assurance | |
| Annual Equality Report | TBC | Annually | | | | ■ | DPC | Assurance | |
| 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 6 |
| NHS Staff survey and action plan | EMT | Annually | ■ | ■ | ■ | | DPC | Assurance | TBC if September - See Note 7 |
| WAST pulse surveys and action plans | EMT | Ad Hoc | | | | | DPC | Assurance | |
| 3.6 Ensure 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 8 |
| 3.7 Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan and monitor its implementation; champion and support the plan and the work of the EDI networks - See Note 11 | | | | | | | | | |
| Report on Anti-racist Wales Action Plan | TBC | TBC | | | | | DPC | Assurance | Reporting to Committee to be confirmed - see Note 9 |
| 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 from 23/24 and revised Welsh Language Standards reporting in development |
| Welsh language annual report | WLAG/EMT | Annually | | ■ | | | BS | Endorsement | Must be on website in September. Goes to Board thereafter in September. |
| 3.10 Ensure Trust management and Staff Side/Trade Union representatives 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 | |
| Partnership Agreements | WASPT | Ad Hoc | | | | | DPC | Endorsement | Trade union partnership agreements - See also Note 10 |
| 3.15 All matters of 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 | EMT | Ad Hoc | | | | | DPE | Review | Review partnership agreements (e.g. armed services covenant; disability partnerships) - See also Note 10 |
| 3.9 Oversee 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 Ensure the Trust has in place appropriate policies and procedures for its people; approve people and culture policies and monitor compliance | | | | | | | | | |
| 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/EMT | Ad Hoc | | | | | Various | Approval | Board to approve Raising Concerns and H&S policy (SoRD para 17) |
| 3.17 Corporate Risks are identified and appropriately manged; CRR and BAF risks for their remit are presented and Committee is assured on progress and ratings; Audit Recommendation Trackers monitored | | | | | | | | | |
| 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 | |
| 3.16 Any other matter in relation to the Committee's overall purpose and responsibilities | | | | | | | | | |
| Operational Update | N/A | Quarterly | ■ | ■ | ■ | ■ | EDO | Information | |
| WOD Update | N/A | Quarterly | ■ | ■ | ■ | ■ | DPC | Information | |
| **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 May and Board June |
| 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 May and Board June |
| Committee Cycle of Business annual refresh | N/A | Annually | ■ | | | | BS | Approval | |
| Committee Cycle of Business monthly review | N/A | Quarterly | ■ | ■ | ■ | ■ | BS | Review | Review against cycle progress at each meeting |
| Committee Review of Annual Priorities | N/A | Quarterly | | ■ | ■ | ■ | BS | Review | |
| **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 | ■ | Cycled for each meeting |
| EDO = Executive Director of Operations | | Ad hoc item - prompt for agenda setting |
| EDQN = Executive Director of Quality and Nursing | | Reporting developing |

## Cycle Notes

| | |
|---|---|
| #NAME? | See paper from 10 May 22 meeting on 'learning from cases' related to a review into investigations and how to do things differently for alignment to a just culture. Demonstrates that learning comes from such reviews.<br>It is anticipated a bi-annual cultural themes and trends report for learning will be produced, including speaking up safely, identified cultural indicators, R&R, ER cases, exit interview themes and trends etc.<br>Internal audit advisory review recommended review of leadership and management development strategy |
| **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 - in 2022 that was 60% |
| **Health and Safety** | See paper from PCC on 10 May 22 meeting which provides intro.<br>Working Safely Programme framework aligns the Trust to a Health and Safety Management System, 11 core health and safety principles developed by Heads of H&S within the NHS Wales in 2015. The programme is reflective of ISO45001. Enforcement agencies will use a wider range of evidence beyond ISO45001 but the HSE is of the view the framework enables the Trust to attain the minimum requirements prescribed in law.<br>Assurance that the health and safety management systems are effective in attaining legal compliance as well as principally improving health, safety and wellbeing through:<br>- Provision of activity-based risk assessment against high risk activities (identified through a new hazard register)<br>- Legislative compliance (through a new legislative register)<br>- Legal compliance against RIDDOR (including learning from incidents and time to submission - legal requirement)<br>- Training compliance<br>- Scrutiny of themes and trends in accidents and injury, particularly where a recurring theme is identified (V&A, slips, trips and falls, etc)<br>- Assurance that the health and safety management structure is reaching the desired objectives i.e. legislative compliance; interdependent safety culture; improved systems leading to improved staff and patient experience; reduction of risk to staff health, safety and wellbeing; increased visibility; improved quality of investigations and learning; improved engagement with TU; resilient H&S workforce.<br>- Quarterly reporting to QUEST (and EMT/ADLT)<br>- Annual Report after year end<br>Delivery on the Working Safely Programme is via IMTP however quarterly update on working safely programme to maintain visibility over 23/24 |
| **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 23/24 |
| **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 |
| | |
| | |
| **General** | **These cycles are developed with reference to the specific lines of the TOR for this Committee.**<br>**This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board** |

| PAPER | PRE C'EE FORUM | FREQUENC | Q1 | Q2 | Q3 | Q4 | LEAD | PURPOSE | |
|---|---|---|---|---|---|---|---|---|---|
| **PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2023/24** | | | | | | | | | |
| **See full cycle of business for reference to the duties in the terms of reference as they relate to Committee reports below** | | | | | | | | | |
| **MAIN ELEMENTS** | | | | | | | | | |
| People and Culture C'ee elements of IMTP | STB | Annually | | | | | DPC | Endorsement | |
| IMTP exception reporting | STB | Ad Hoc | | | | | Relevant Director | Assurance | |
| MIQPR review for people and culture metrics | FPC | Annually | | | | | EDSPP | Endorsement | |
| Committee-specific KPIs review of metrics | TBC | Annually | | | | | DPC | Approval | |
| MIQPR | EMT | Quarterly | | | | | EDSPP | Assurance | |
| Committee-specific KPIS | TBC | Quarterly | | | | | DPC | Assurance | |
| Suspensions over 4 months report | TBC | Quarterly | | | | | DPC | Assurance | |
| Learning report | TBC | Bi-annually | | | | | DPC | Assurance | |
| End of Season Flu Campaign Report | CQGG | Annually | | | | | DP | Assurance | |
| Health and Safety Report | NH&S C'ee | Quarterly | | | | | EDQN | Assurance | |
| Revalidation and registration report | N/A | Annually | | | | | EDQN & DP | Assurance | |
| Gender pay gap report | TBC | Annually | | | | | DPC | Assurance | |
| Annual Equality Report | TBC | Annually | | | | | DPC | Assurance | |
| Health and care standards | TBC | TBC | | | | | DPC | Assurance | |
| Staff Story | N/A | Quarterly | | | | | DPC | Discussion | |
| Staff Story updates | None | Quarterly | | | | | DPC | Assurance | |
| NHS Staff survey and action plan | EMT | Annually | | | | | DPC | Assurance | |
| WAST pulse surveys and action plans | EMT | Ad Hoc | | | | | DPC | Assurance | |
| Speaking Up Safely Report | TBC | TBC | | | | | DPC | Assurance | Q1 update provided |
| Report on Anti-racist Wales Action Plan | TBC | TBC | | | | | DPC | Assurance | Q1 update provided |
| Reporting on Welsh Language Standards | WLAG | Bi-annually | | | | | BS | Assurance | Q1 framework (not standards) report |
| Welsh language annual report | WLAG/EMT | Annually | | | | | BS | Endorsement | |
| WASPT AAA report | WASPT | Quarterly | | | | | DPC | Assure/Escalate | |
| Partnership Agreements | WASPT | Ad Hoc | | | | | DPC | Endorsement | |
| Partnerships & Engagement Report | TBC | Bi-annually | | | | | DPE | Assurance | Q1 framework updated provided |
| Partnership Agreements | EMT | Ad Hoc | | | | | DPE | Review | |
| NHS Workforce Model | Workforce Planning Grp | TBC | | | | | DPC | Endorse | |
| Workforce Plan aligned to IMTP | Workforce Planning Grp | Annually | | | | | DPC | Endorse | |
| Report from policy group | Policy Group | Annually | | | | | BS | Assurance | |
| Policies for review and approval | Policy Group/EMT | Ad Hoc | | | | | Various | Approval | |
| 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 | |
| Operational Update | N/A | Quarterly | | | | | EDO | Information | |
| WOD Update | N/A | Quarterly | | | | | DPC | Information | |
| **GOVERNANCE** | | | | | | | | | |
| Committee effectiveness review annual report | Audit/Board | Annually | | | | | BS | Approval | |
| Review of Terms of Reference | Audit/Board | Annually | | | | | BS | Approval | |
| 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
DP = Director of Paramedicine
BS = Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Presented as cycled/ad hoc item considered at agenda setting
Deferred
Reporting developing

| | |
|---|---|
| **AGENDA ITEM No** | **14** |
| **OPEN or CLOSED** | OPEN |
| **No of ANNEXES ATTACHED** | 1 |

# MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – March 2023

| | |
|---|---|
| **MEETING** | People & Culture Committee |
| **DATE** | 09th May 2023 |
| **EXECUTIVE** | Rachel Marsh – Executive Director of Strategy, Planning and Performance |
| **AUTHOR** | Hugh Bennett – Assistant Director of Commissioning and Performance<br>Mark Thomas – Commissioning & Performance Manager<br>Nicola Quiller – Senior Commissioning & Performance Analyst |
| **CONTACT** | Hugh.bennett2@wales.nhs.uk<br>Mark.Thomas12@wales.nhs.uk<br>Nicola.Quiller@wales.nhs.uk |

## EXECUTIVE SUMMARY

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **March 2023** (with the exception of sickness, where February 2023 is reported).

This report contains information on 26 key indicators. The indicators used at this high-level show a worsening of system pressure, in particular, handover lost hours and therefore declining quality and performance for the Emergency Medical Service (EMS). 111 was more stable, having recovered from the extreme levels of demand in December, but abandonment remains a problem. The Non-Emergency Patient Transport Service's (NEPTS) performance is stable. Overall the picture remains a poor one in terms of the quality and safety of the service that the Trust can provide to its patients.

**RECOMMENDATION**

Trust Board is asked to: -

- **Consider** the March 2023 Integrated Quality and Performance Report and actions being taken and determine whether:

  a) The report provides sufficient assurance.

  b) Whether further information, scrutiny or assurance is required, or

  c) Further remedial actions are to be undertaken through Executives.

## 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 **March 2023.**

## BACKGROUND

2. This Integrated Quality & Performance Report contains information on 26 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

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

4. As previously agreed, the metrics which form part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (Integrated Medium Term Plan - IMTP) and strategies. This annual review is complete and was endorsed at the July 2022 Finance & Performance Committee with a further annual review now planned for Q1 2023/24.

## 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** answering times have been challenged through significant increases in call demand through the year; however, in March 2023 the median and 65$^{th}$ percentile performance were good. The **95$^{th}$ percentile performance declined to a six second answer** time, which is still a high level of performance. An Intelligent Routing Platform (IRP) was switched on in November 2022, which enables BT to re-route 999 calls between different ambulance services in the UK. These re-routed 999 calls accounted for up to 9% of the Trust's daily 999 demand. This percentage continued to increase during December 2022 and on the 21 December 2022 it was suspended, which is a clear factor in the uplift in the Trust's performance. The IRP has now been switched back; however, call volumes at present through this stream are low.

7. No additional funding was secured into 2022/23 for 999 call handlers (demand/relief gap 39 FTEs). A re-roster has been completed within the existing resource envelope.

8. **111 call answering performance remains poorer** than the Trust would want. December 2022 saw unprecedented levels of demand and poor performance. Performance did improve in January, but has since declined in February and March to 28.7% and 29.3% respectively and remains substantially off target (95%). Negotiations with commissioners earlier in the year suggested that the Trust has broadly the right number of commissioned and funded call handlers in post; however, there has been a recent agreement to uplift numbers by 10 WTE and work is ongoing to recruit these additional staff. Further work is required to reduce capacity lost through sickness absence, aligning capacity with demand and improving the efficient use of resource. A priority is now re-rostering 111, which will involve a further consideration of the required FTEs to meet demand, the best way to service the demand e.g. dynamic v fixed rosters and implementation of.

9. **111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls the Trust has **seen a decline** in March 2023's P2 and P3 call back times, falling below the 90% performance target. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies. An urgent set of actions within a focused plan are now in place to increase clinician numbers. This includes the introduction of a new base for staff within the Cardiff area, a more focussed recruitment campaign and consideration of expanded numbers of clinical professions. The Trust is currently in dialogue with 111 commissioners on the 2023/24 establishment for 111 clinicians.

10. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for March 2023 was 47.5%, a decline when compared to February 2023, and still far below the target of 65%. The Amber 1 median was one hour 36 minutes (ideal 18 minutes) and the Amber 1 95$^{th}$ percentile was seven hours 37 minutes. These long response times have a direct impact on outcomes for many patients. Actions within the Trust's control include:

    Capacity:

    - Recruitment: the Trust received an additional £3m non-recurring funding in 2022/23 which has allowed the Trust to target the recruitment of 100 FTEs over and above the existing establishment. The Trust had delivered most of the additionality by the end of quarter four with an overall vacancy level of less than 1%. It should be noted that the Trust's 2023-2026 IMTP is predicated on funding for the additionality being recurring, but this is not secure at this time. Some additional funding has also been made available to pilot an Amber Virtual Ward in partnership with St John Cymru.

    - Additional Unscheduled Care Service (UCS) Capacity: the Trust has made additional funding available for third party capacity. Four vehicles a day, seven days a week have been secured with funding through to the end of the financial year.

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

- The Ambulance Response roster review completed its go live in November 2022. This has been a complex large-scale project involving 1,800 staff, 146 rosters, and 60 working parties. This will have had the equivalent performance impact of +72 FTEs. A project evaluation is being undertaken, but is delayed due to no project manager or project support at this time.

- A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks).

- Discussions with trade union partners on a range of other potential workforce efficiencies have paused due to industrial action.

Demand Management

- The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate, achieving 13.8% in March 2023.

Red Improvement Actions

- The full roll out of the Cymru High Acuity Response Units (CHARUs). Recruitment and training is being undertaken at pace with the aim to fully populate the CHARU rosters keys (153 full time equivalents – FTEs, less a Senior Paramedic contribution of 11.5 FTEs). The Trust is commissioned for 52 FTEs currently, so the 89.5 FTEs is an internal movement between the emergency ambulance roster and the CHARU rosters, not additional resource.

- The clinical screening of Red calls. This is being undertaken within additional resource, when possible, but ideally clinical screening, as previously modelled, would require additional FTEs. A further request to model the balance between consult & close v clinical screening is currently being actioned.

- A more efficient response logic. This is complex and is currently being worked through between the Clinical & Medical Directorate and Operations.

- The modelling of the impact of these changes (complete).

**11.** One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 28,620 hours were lost in March 2023, an increase compared to the +19,000 hours lost in February 2022. The levels are so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. Despite urgent and high-level discussions taking place between the Trust, Health Board CEOs and the Minister, required improvements have not been made. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, which is providing food for thought for WG about arrangements in the six other health boards. Immediate Release figures for March 2023 were: Red 246 accepted and 19 declined; and Amber 1 160 accepted and 397 declined.

12. **Ambulance Care (formally NEPTS) (Patient Experience)**: performance remains above target for enhanced renal patient arrivals prior to appointment. Discharge performance improved to 83% (target 90%). Overall demand for the service continues to increase, although it has not yet recovered to pre-CoVID-19 levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport) and addressing oncology performance. The Unscheduled Care Service (UCS), part of Ambulance Care, is currently being rebased via a modelling exercise.

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported 3 NRIs to the Delivery Unit in March 2023, compared to twelve in February 2023; fifteen serious patient safety incidents were referred to health boards in March 2023. It should be noted that the relatively small numbers may represent a delay in referral across rather than an actual drop in numbers of serious cases. In March 2023 complaint response times remained low at 20%, failing to meet the 75% target. In the main, many of these incidents will be because of continued longer response times and the actions outlined above therefore are key. The Trust has put more capacity into the Putting Things Right (PTR), which has had a positive impact for the Legal Team and Concerns Administrators responding to patients and families by email and telephone, however, vacancies and the level of concerns continues to severely affect the team. The Trust is concerned for the welfare of the team, given the nature and volume of what colleagues are reviewing. Consideration is being given to what further support can be provided in terms of the team's welfare; and an organisational change process discussion is due to start in April 2023.

14. **Clinical outcomes**: the Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the Computer Aided Dispatch (CAD) and quality assure metrics. The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 72.2% in March 2023**,** below the 95% performance target. The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. Work is ongoing on the new call to door time-based metrics for STEMI and Stroke using the following roll out plan:

    - Q3 (Oct – Dec 2022) – criteria to define 'call to door' and a reporting dashboard were determined.
    - Q4 (Jan – Mar 2023) – the data will be tested internally to include data from April 2022.
    - April-June 2023 – approve for ASI reporting.

Our People (workforce resourcing, experience, and safety)

15. **Hours Produced**: The Trust produced 119,092 Ambulance Response ambulance unit hours in March 2023. Emergency ambulance unit hours production (UHP) was 95% in March 2023, achieving the 95% target. CHARU UHP remained static month on month at 86% in March 2023 (note this is 86% of the commissioned

level, which is not the full roll out, which would halve this number). Key to the number of hours produced are roster abstractions, which remain above benchmark, but are reducing i.e. improving, and the completion of planned recruitment into the CHARUs and the 101 FTEs. It is important to note that the Trust is not fully funded for the CHARU service (52 FTEs v a modelled need of 153 FTEs).

16. **Response Abstractions:** abstraction levels increased to 39% in March 2023, remaining higher than the 30% benchmark. A deep dive is being organised on abstractions. EMS Response sickness abstractions stood at 10.75% in March 2023 (benchmark 5.99%).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 8.94% in February and improved to 7.99% in March 2023. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level.

18. **Staff training and PADRs:** PADR rates did not achieve the 85% target in March 2023 (72.1%), compliance for Statutory and Mandatory training also dropped significantly below the target achieving 73.69%. The reasons for this decline in Statutory & Mandatory training are being reviewed with a possible reason being new courses.

Finance and Value

19. **Financial Balance**: The Trust has reported outturn performance for February 2023 with a surplus of £12,000, and a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

20. **Post-production lost hours**: the efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. Dialogue between the Trust and TU partners on options for change has paused due to industrial action.

Partnerships/ System Contribution

21. **Shift left:** much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 13.8% in March 2023, close to the Trust's 2022/23 IMTP ambition of 15%.

22. The Trust **conveyed** 35% of patients to emergency departments in March 2023. This figure needs to be treated with caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In March 2023, over 9,600 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 709 callers. In the longer term, as the Trust knows, the system needs to transform if it is to become more sustainable. A formal programme to

take forward “inverting the triangle” has been established. The Trust has proceeded with growing the numbers of APPs in training. The current focus is on developing a “strategic case for change” and a stakeholder engagement process.

Summary

**26.** The indicators used in this high-level report paint a continued poor picture in terms of the quality and safety of the EMS. 111 call answering rates remain problematic, but the clinician call back rates are above or close to target. Ambulance Care NEPTS performance is stable with the UCS being rebased through a modelling exercise. EASC, WG and the 111 Programme Board were very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited and is expected to worsen significantly in 2023/24. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however, for EMS and Ambulance Care (UCS) the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result, all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. It remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation and that further actions to shift patient demand left are supported.

## RECOMMENDATIONS

Trust Board is asked to: -

- **Consider** the March 2023 Integrated Quality and Performance Report and actions being taken and determine whether:

  a) The report provides sufficient assurance.

  b) Whether further information, scrutiny or assurance is required, or

  c) Further remedial actions are to be undertaken through Executives.

| REPORT APPROVAL ROUTE | |
|---|---|
| **Date** | **Meeting** |
| **03 May-23** | **Executive Management Team** |
| **09 May-23** | **People & Culture Committee** |

| REPORT APPENDICES |
|---|
| **Appendix 1 – Top Indicator Dashboard** |

| REPORT CHECKLIST | | | |
|---|---|---|---|
| **Confirm that the issues below have been considered and addressed** | | **Confirm that the issues below have been considered and addressed** | |
| EQIA (Inc. Welsh language) | x | Financial Implications | x |

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

Welsh Ambulance Services NHS Trust

# Monthly Integrated Quality & Performance Report

March 2023

## Annex 1 – Top Indicator Dashboard


GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

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Annex 1 – Top Indicator Dashboard
Version 1.0
Released: April 2023

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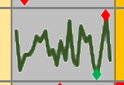
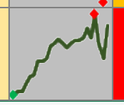
by Commissioning & Performance Department

# Section 1: Monthly Indicators / Top Indicator Dashboard

| Top Monthly Indicators | Target 2022/23 | Baseline Position (2021/22) | Feb-23 | Mar-23 | 2 Year Trend | RAG |
|---|---|---|---|---|---|---|
| **Our Patients - Quality, Safety and Patient Experience** | | | | | | |
| NHS111 Abandoned Calls | < 5% | 18.60% | 14.9% | 15.4% |  | R |
| 999 Call Answer Times 95th Percentile | 95% in 00:00:06 | 00:52 | 00:03 | 00:06 |  | G |
| 999 Red Response within 8 minutes | 65% | 55.2% | 50.9% | 47.5% |  | R |
| 999 Amber 1 Median | 00:18 | 01:10 | 00:55 | 01:35 |  | R |
| Stroke Patients with Appropriate Care | 95% | TBD | 76.6% | 72.2% |  | R |
| Acute Coronary Syndrome Patients with Appropriate Care | 95% | TBD | 35.7% | 35.2% |  | R |
| Renal journeys arriving within 30 minutes of their appointment (NEPTS) | 70% | 79% | 71% | 72% |  | G |
| Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS) | 90% | 81.00% | 78.5% | 82.6% |  | A |
| National Reportable Incidents reports (NRI) | Reduction Trend | 5 | 12 | 3 |  | A |
| Concerns Response within 30 Days | 75% | 61% | 24.0% | 20.0% |  | R |

| Top Monthly Indicators | Target 2022/23 | Baseline Position (2021/22) | Feb-23 | Mar-23 | 2 Year Trend | RAG |
|---|---|---|---|---|---|---|
| **Our People** | | | | | | |
| **Capacity** | | | | | | |
| EMS Abstraction Rate | 29.92% | 42.00% | 35% | 39% |  | R |
| Hours Produced for Emergency Ambulances | 95% | 95.0% | 95% | 95% |  | G |
| **Health and Wellbeing** | | | | | | |
| Sickness Absence *(all staff)* | 8.00% | 10.48% | 7.99% | - |  | G |
| EMS Operations Sickness Rates | 8.00% | 7.76% | 8.63% | 10.75% |  | R |
| Staff Turnover Rate | Reduction Trend | 8.71% | 10.86% | 10.38% |  | A |
| Statutory & Mandatory Training | >85% | 82.3% | 60.10% | 65.05% |  | R |
| PADR/Medical Appraisal | >85% | 60% | 78.7% | 72.1% |  | A |
| **Value** | | | | | | |
| Financial balance - annual expenditure YTD as % of budget expenditure YTD | 100% | 100% | 100.00% | - |  | G |
| Post-Production Lost Hours (EA, RRV, UCS) | Reduction Trend | TBD | 8057 | 9916 |  | R |
| **Partnerships / System Contribution** | | | | | | |
| NHS111 Consult and Close | Increasing Trend | TBD | 949 | 973 |  | A |
| Combined 999 & NHS111 Consult & Close | 15.0% | TBD | 14.2% | 13.8% |  | A |
| % Of Total Conveyances taken to a Service Other Than a Type One Emergency Department | Improvement Trend | 11.92% | 10.05% | 11.11% |  | A |
| Number of Handover Lost Hours | 25% reduction from Oct-21 | 15,955 | 19,110 | 28,620 |  | R |

**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)

# Our Patients: Quality, Patient Safety & Experience
# 111 Call Answering/Abandoned Performance Indicators

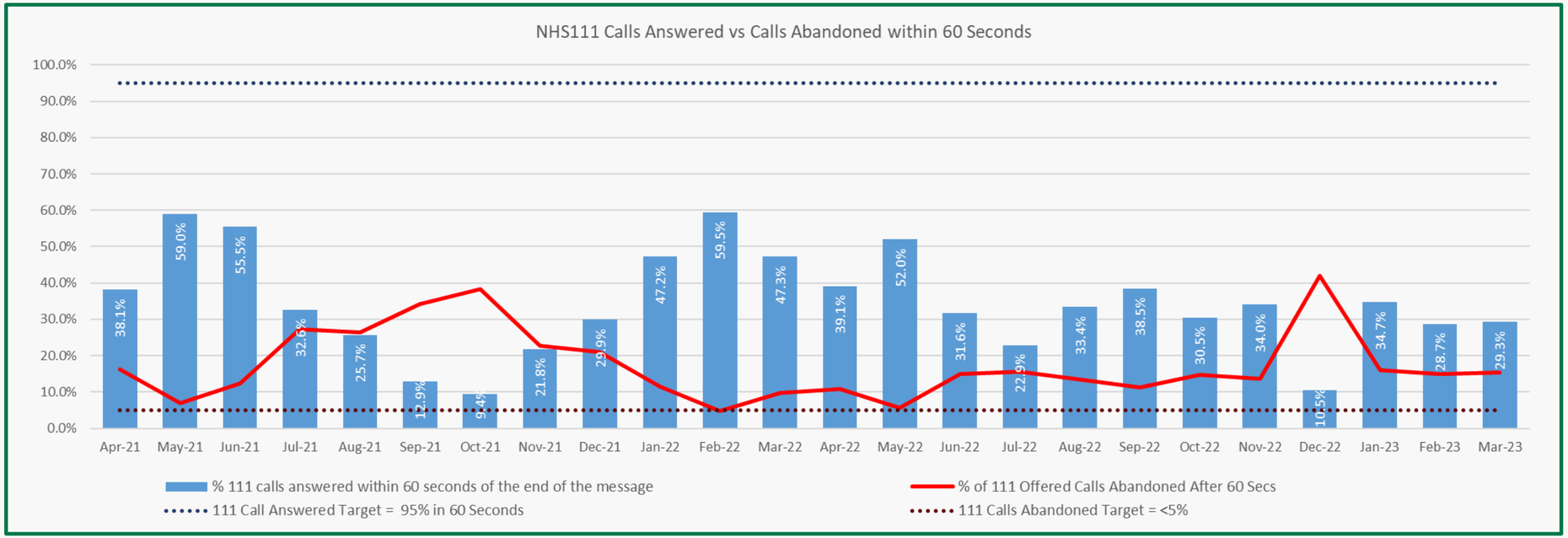
(Responsible Officer: Lee Brooks)

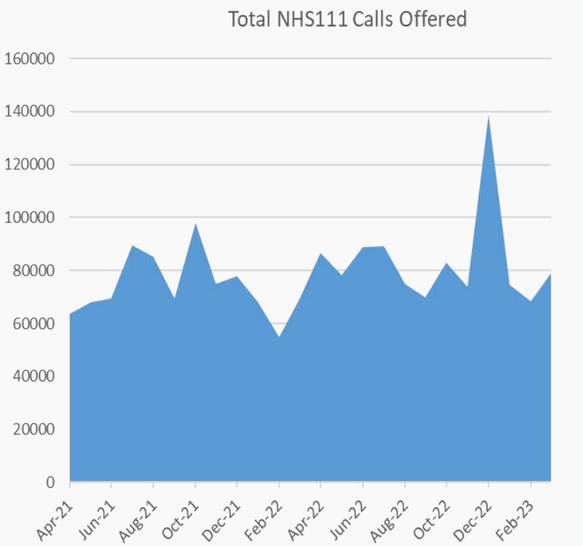
R

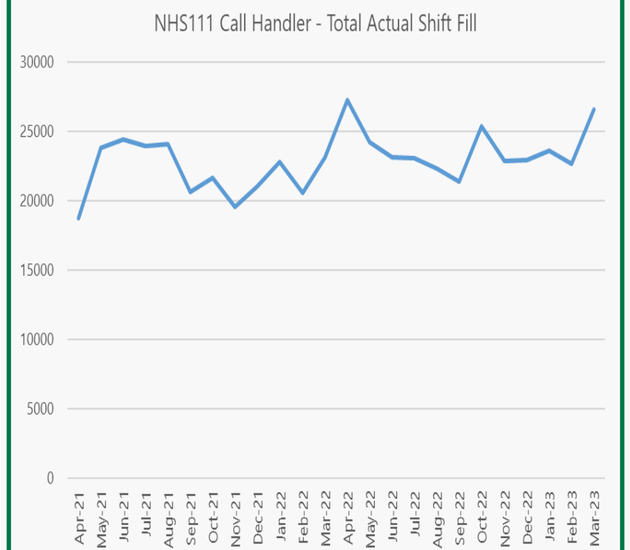
FPC

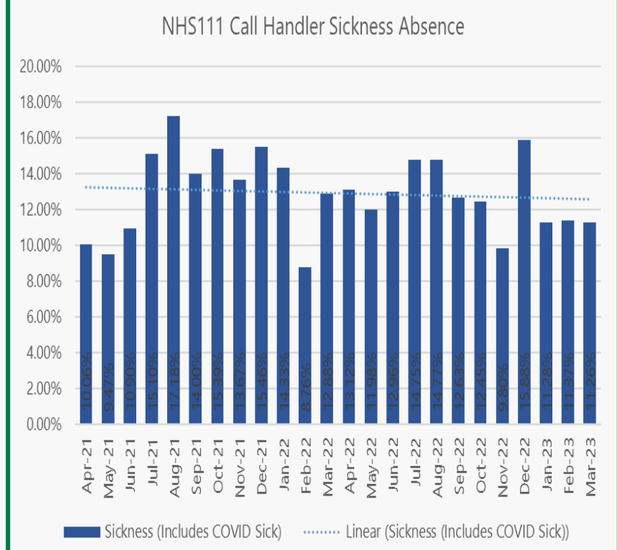
## Influencing Factors – Demand and Call Handling Hours Produced

NB: Feb-23 Abstraction data not yet published




**Analysis**

**111 call abandonment is a key patient safety indicator** for the service. **March 2023** saw an abandonment rate of 15.4%, a decline when compared to February 2023 (14.9%), therefore failing to meet the 5% target. However, March 2023 also saw 111 call demand increase when compared to February.

**The percentage of 111 calls answered within 60 seconds of the end of the message increased in March 2023 to 29.3%.**

Capacity (staff hours) has generally been increasing in line with the recruitment plan; however, this is impacted by sickness abstractions for Call Handlers (including COVID-19 Sickness) which remains higher than the agreed trajectory at 10.77%.

December 2022 saw the service receive unprecedented demand which resulted in a Business Continuity incident issued. Calls reached as high as 3000-4000 calls during weekdays in late December with weekends seeing highs of over 6000 calls a day. The weekend between Christmas and New Year saw the highest demand, recording over 8000 calls on the Sunday. The demand resulted in infrastructure systems not being able to support the number of calls and immediate resolutions were required to keep the service online. This included changing the call waiting length along with additional servers being installed to meet the demand.

**Remedial Plans and Actions**

The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency.

- Agreement has been reached with commissioners that 188 WTE call handlers will be funded in 2023/24. The Trust is currently 21.25 FTE short of establishment; however, all these vacancies have been appointed to.
- Work continues on sickness absence in line with the Trust's managing absence work programme
- Work with the 111 commissioners to review rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore call times are related to clinician availability. At present there are high levels of vacancies in this area.

**Expected Performance Trajectory**

As call handler numbers broadly reach commissioned levels, call answering times will only be further improved through efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line).
If high demand levels persist, performance will continue to be affected due to levels of call handlers and clinicians not matching the demand.

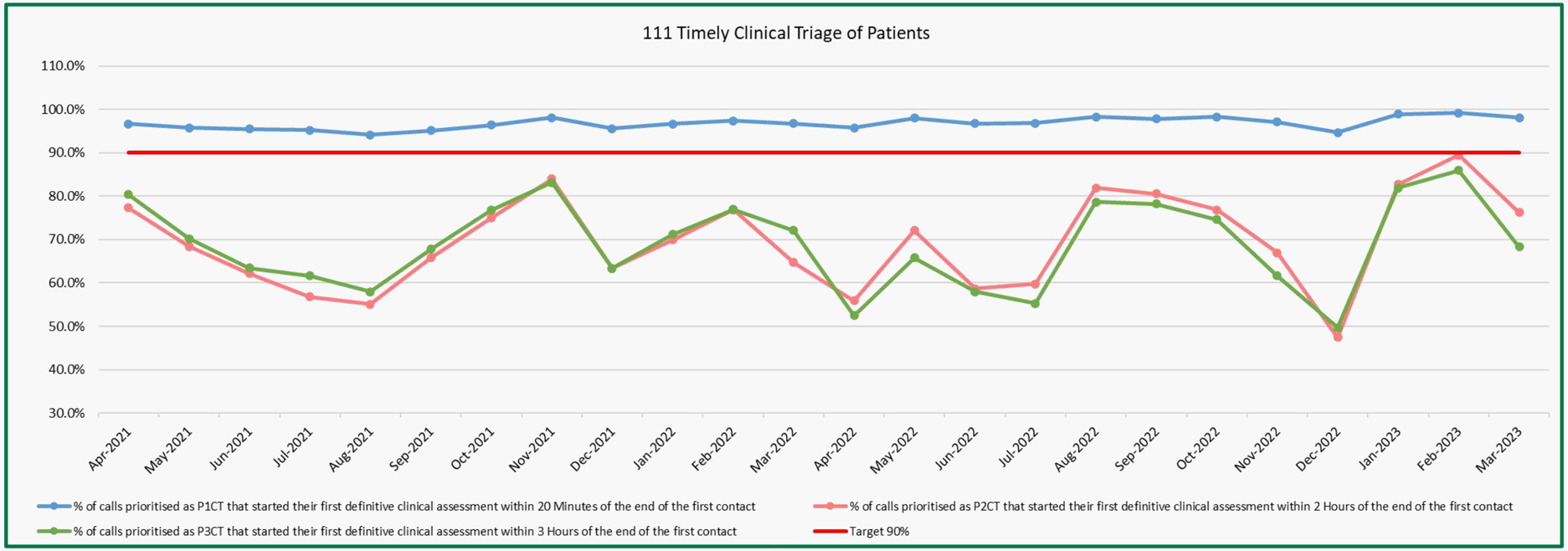
# Our Patients: Quality, Safety & Patient Experience
# 111 Clinical Assessment Start Time Performance Indicators

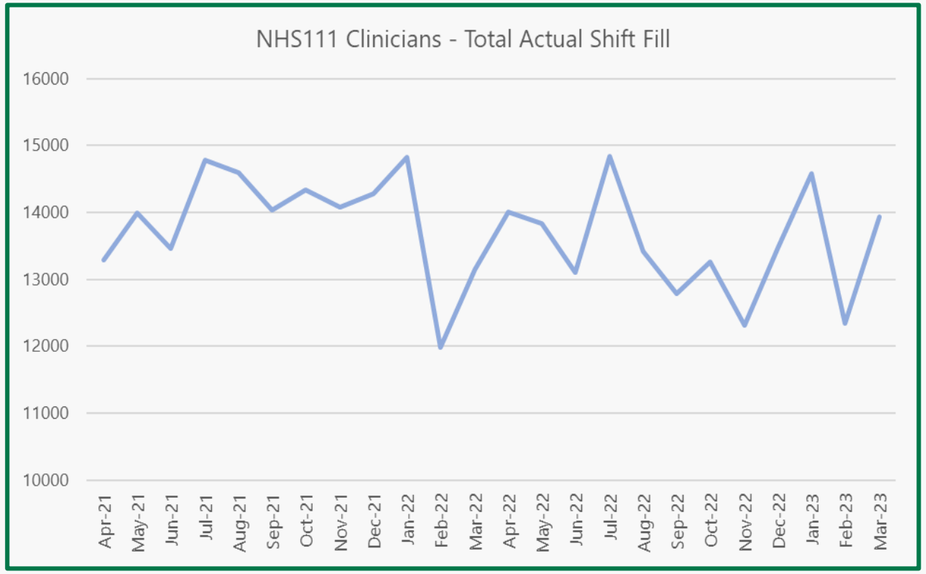
(Responsible Officer: Lee Brooks)

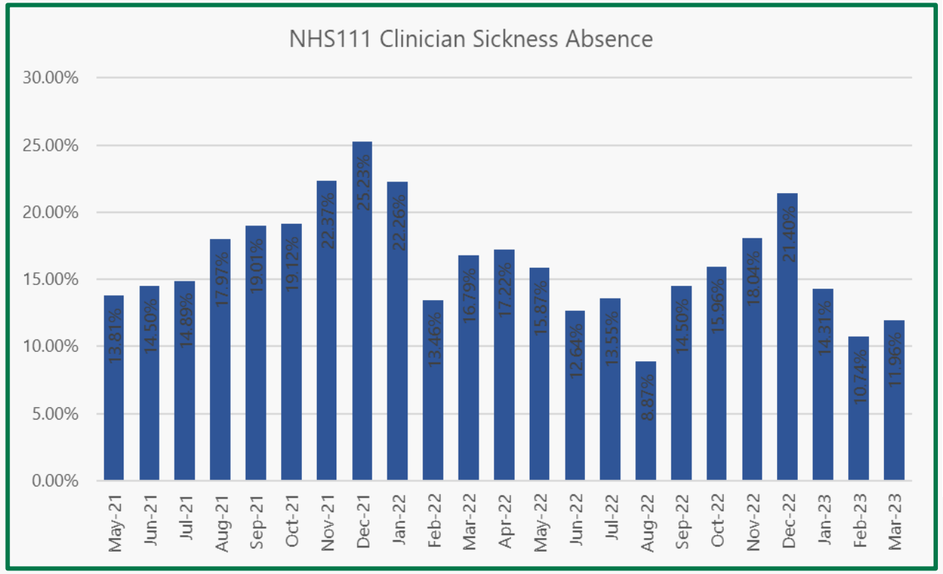
P1CT G

FPC

## Influencing Factors – Demand and Clinical Hours Produced




**Analysis**

The performance of **111 calls receiving a timely response to start their definitive clinical assessment saw an increase across the priorities. The highest priority calls, P1CT, continues to achieve the 90% target (which it has done for the past 2 years), although the figure for March 2023 decreased slightly to 98.1%.**

For lower category calls (P2CT & P3CT) the figures were just shy of the 90% target in February 2023, but both saw reductions in March 2023, with P2CT falling to 76.2% and P3CT to 68.3%. Following unprecedented levels of demand in December 2022 (138,782), call volumes have since reduced, with the March 2023 figure being 79,169.

Recruitment and retention of clinical staff continues to be a key issue.

13,935 hours were filled by clinicians in March 2023, an increase when compared to the 12,342 seen in February 2023. Clinician sickness absence increased from 10.74% in February 2023 to 11.96% in March 2023.

**Remedial Plans and Actions**

The main driver for improved performance will be the correct number of clinicians in post to manage current and expected demand. At present 104.4 FTE nurses and paramedics are in post, with a vacancy rate of 35.6 FTEs (13.5 clinicians have been appointed). Urgent actions have been put in place to increase recruitment, including:

- Utilisation of other clinicians to fill vacancies;
- Maximising opportunities through remote / agile working;
- Review of existing staff bases including agreement to creating an additional Cardiff base, operational from mid December;
- Review of service model following Adastra outage / BCI;
- Targeted recruitment drive, which has commenced.

**Expected Performance Trajectory**

Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Although urgent actions are now in play, as set out above, performance is likely to remain below expected levels until towards the end of Q4. Demand for the 111 service is also more difficult to forecast as it is often linked to government announcements or media coverage.

# Our Patients: Quality, Safety & Patient Experience
# 999 Call Performance Indicators

(Responsible Officer: Lee Brooks)

G

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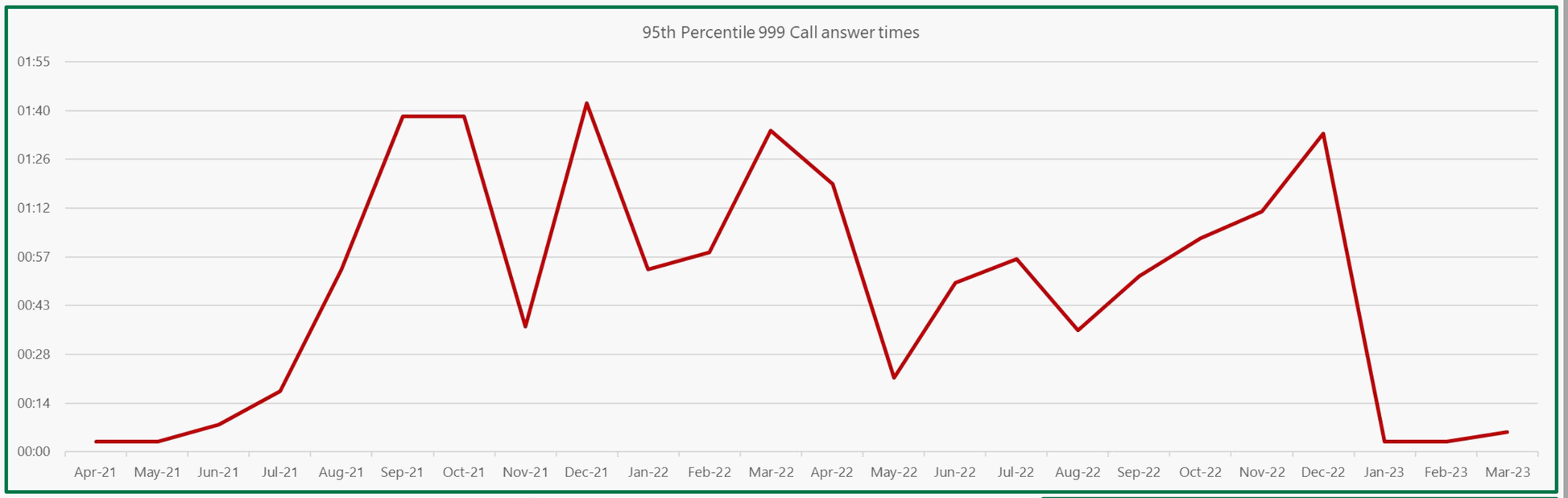
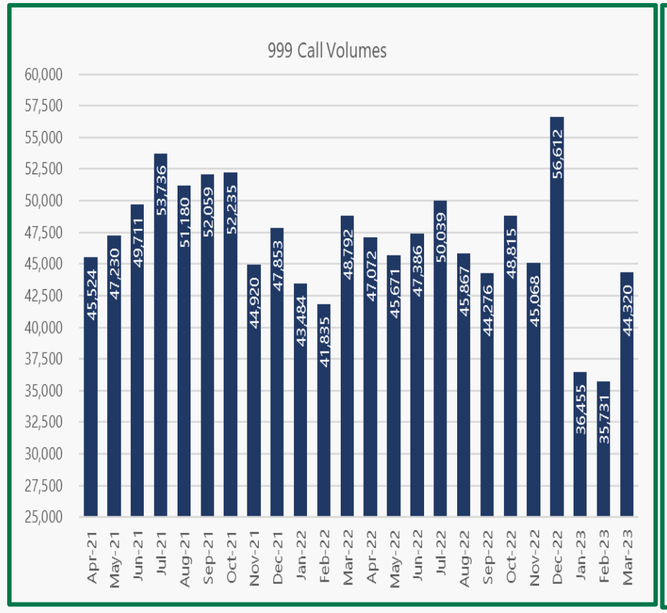
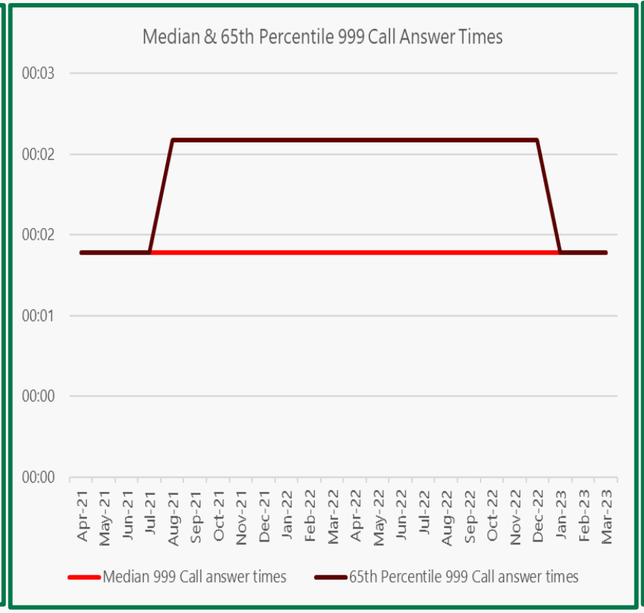
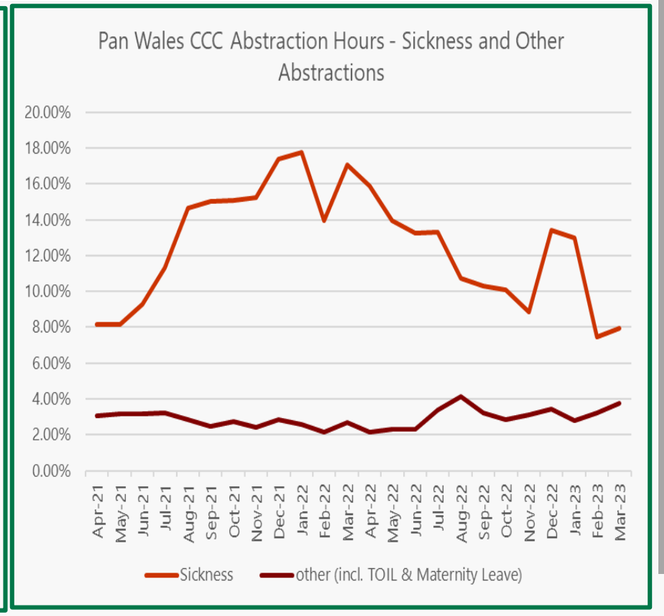
CI

## Influencing Factors – Demand and Hours Produced




**Analysis**

**The 95th percentile 999 call answering performance increased to 6 seconds which remains within the 6 second target. This continues to be a significant improvement compared to the 1 minute 34 seconds seen in December 2022, but a marginal decline when compared to the 3 seconds achieved in both January and February 2023.**

The median call answer time for 999 services remains consistent at 2 seconds.

The Trust received 44,320 emergency 999 calls in March 2023, an increase from the 35,731 calls received in February 2023. This increase, along with a small rise in sickness abstractions, impacted slightly on the Trust's ability to answer calls in a timely manner. However overall sickness abstractions are on a downward trajectory, and the figure within EMS Co-ordination pan-Wales remained below 8% for the second consecutive month (7.92%).

**Remedial Plans and Actions**

- EMS Coordination meet twice weekly to review demand profiles and align staffing levels appropriately.
- No additional funding is available this year to increase numbers of call handlers.
- Increased pressure and sustained levels of 999 demand is impacting on staff attrition and wellbeing.
- EMD FTE is currently 111.34 against a funded establishment of 111.76.
- Intelligent Routing Platform is now in operation following configuration changes
- Additional EMD training cohorts are scheduled for May start dates with further recruitment scheduled for September.
- The final work-streams of the EMS Reconfiguration project have been re-started (these have been delayed by the pandemic and escalation levels).

**Expected Performance Trajectory**

January, February and March 2023 performance almost met required targets for % answered in 6 seconds; however, there is a 39 FTE gap between the modelled current requirement and funded establishment and there is no more funding available.

# Our Patients: Quality, Safety & Patient Experience
# Red Performance Indicators

## Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

65% R

95% R

QUEST

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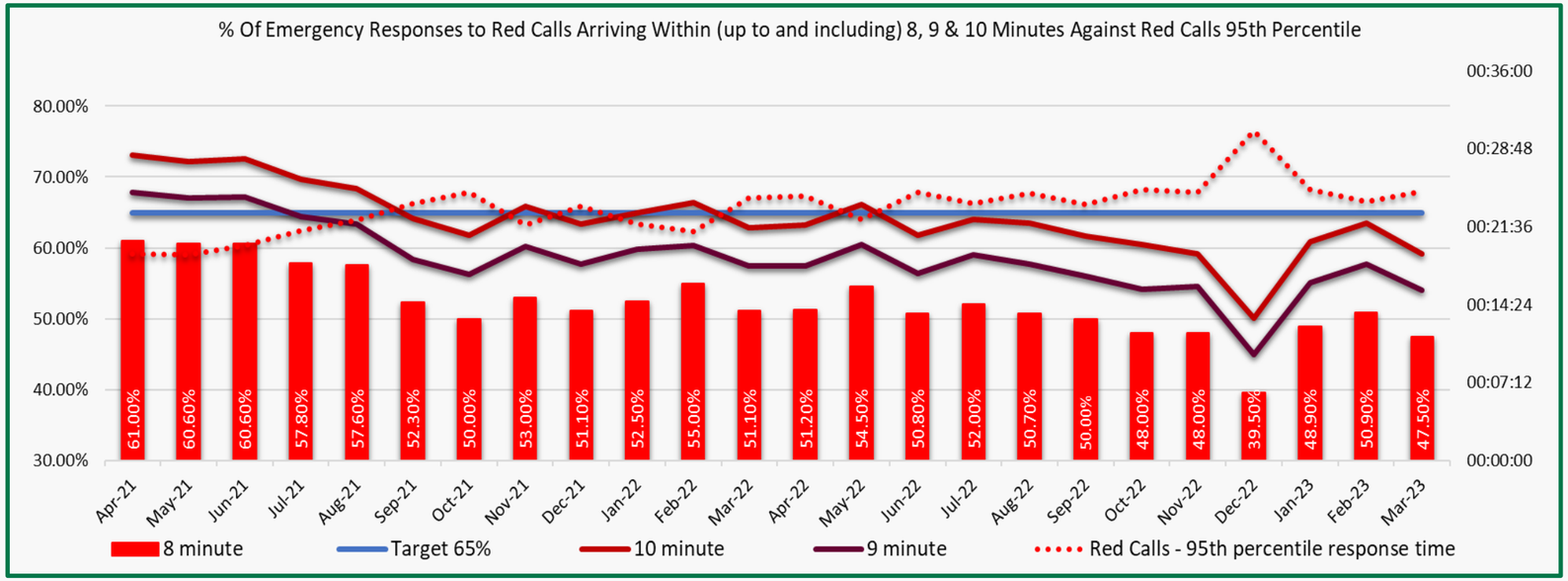
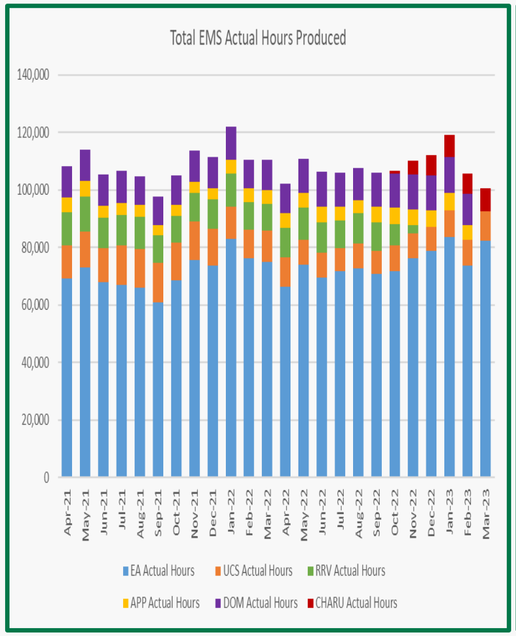
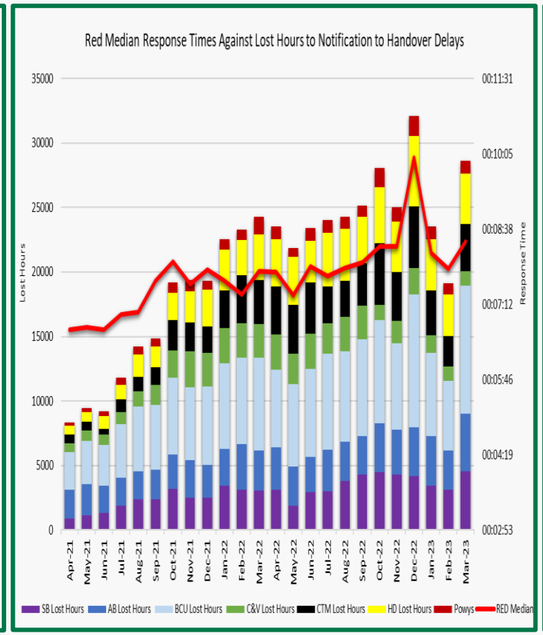
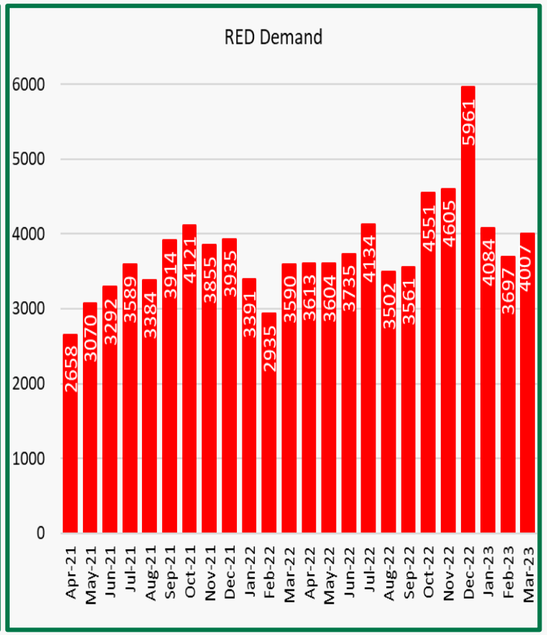
CI




**Analysis**

**Red performance declined in March 2023, with Red 8 minute performance falling to 47.50% and remaining below the 65% target;** which has not been achieved since July 2020. Although there was variation between the health boards, none of the seven achieved the 65% target. Red 10-minute performance was 59.2% in March 2023, a decline when compared to the 65.35% achieved in February 2023.

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

Red demand over the past 2 years had seen a steadily increasing trend, which was outside of normal expected variation, and was impacting upon response times. This reached a peak in December 2022, with demand recorded at 5,961, however, the first 3 months of 2023 have seen reductions in this figure, with March 2023 recording 4,007 incidents. Red demand continues to remain above levels recorded for the same period last year.

The lower centre graph demonstrates the correlation between overall Red performance and hospital handover lost hours. After peaking at over 32,000 lost hours in December 2022, this area did show a significantly improving picture in January 2023 (23,525) and February 2023 (19,110), however, it has declined once again in March 2023, with lost hours increasing to 28,620. This level continues to have an impact on overall service.

There are other factors which affect Red performance, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues. Industrial Action days will also affect performance.

**Remedial Plans and Actions**

The main improvement actions are:

- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23 (off target by end of Jan 2023, but most delivered by the end of Mar 2023);
- Full roll out of the Cymru High Acuity Response Unit (CHARU);
- Potential changes to the response logic and clinical screening of calls;
- Reduce hours lost through sickness absence via managing attendance programme – trajectory for improvement in place as part of Integrated Medium Term Plan (IMTP) (8% by Mar-23/6% Mar-24);
- Health Board handover reduction plans are in place;
- Improving efficiency; the role out of new Response rosters provided the equivalent of 72 WTE additional staff (action complete);
- A clinical review of Red demand using ePCR data (initial findings reported to EMT);
- Tactical responses linked to escalation including: clinical managers responding, DOMs responding, targeted overtime on demand hot spots(actioned);
- Modelling of full roll out of Same Day Emergency Care (SDECs) by health boards and further modelling on Red improvements (completed).

**Expected Performance Trajectory**

The Red modelling estimates a 7% point improvement in Red 8 minute performance if CHARUs are fully rolled out and associated Red improvement actions are delivered.

*NB: Data correct at time of abstraction

# Our Patients: Quality, Safety & Patient Experience
# Amber Performance Indicators

(Responsible Officer: Lee Brooks)

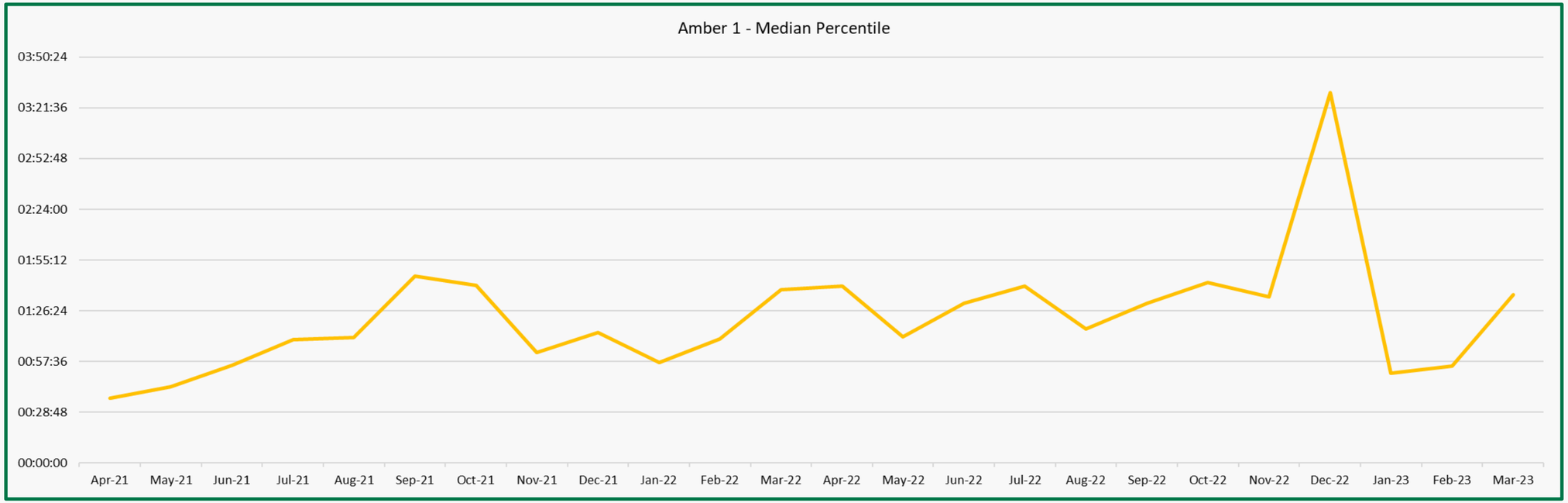
R

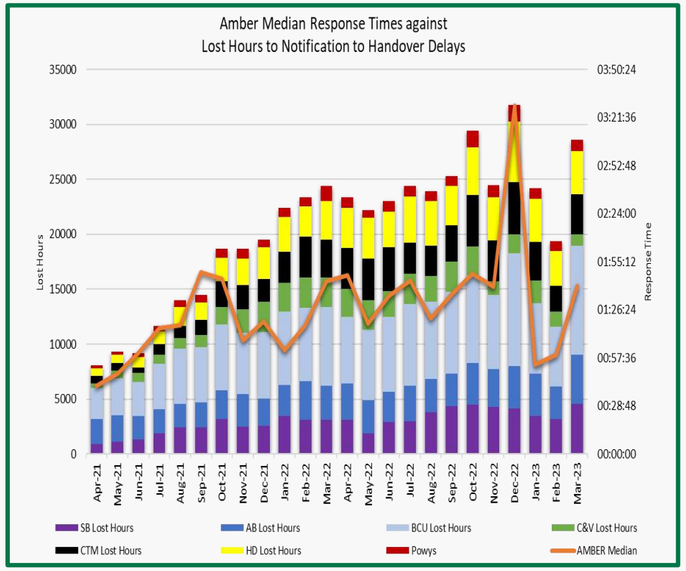
FPC

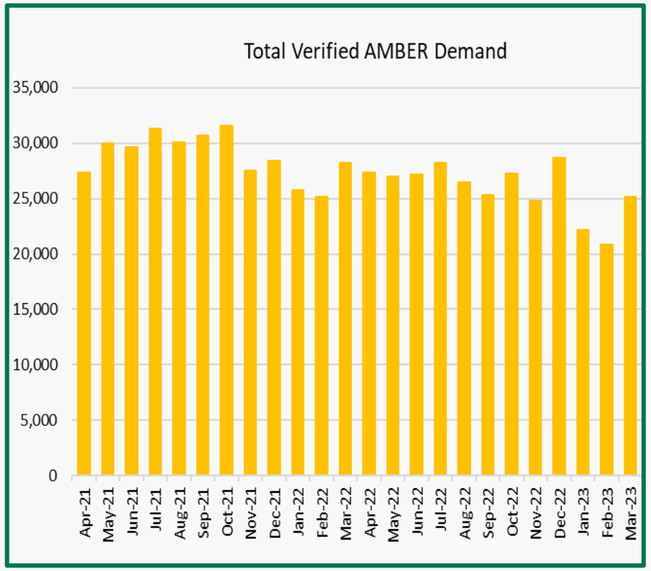
CI

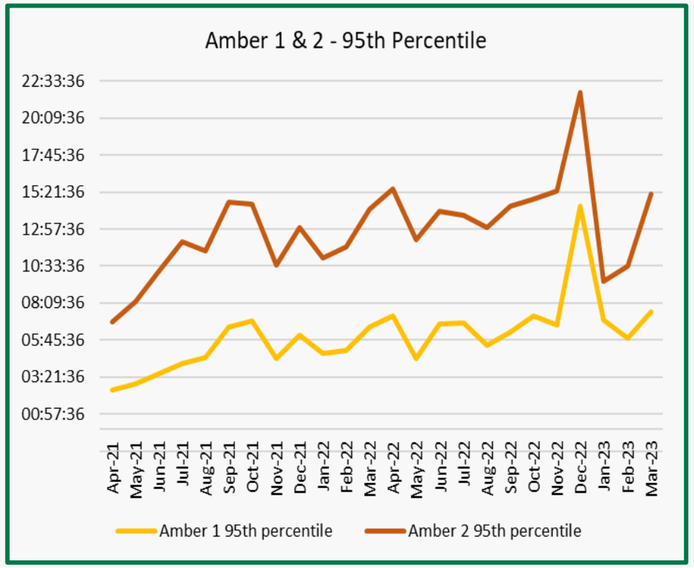
QUEST

## Influencing Factors – Demand, Hours Produced and Hours Lost




**Analysis**

Following a significant improvement in the Amber 1 median response time for January & February 2023, it declined in March 2023 to 1 hour 35 minutes. The ideal Amber 1 median response time is 18 minutes. The 95th percentile also declined returning once again to over 15 hours for the first time since November 2022 (the ideal is 40 minutes).

There were still some very long patient waits in March 2023, with 849 patients (all categories, not just Amber) waiting over 12 hours. Although this is a significant reduction compared to the 2,064 seen in December 2022 it is an increase when compared to the 389 recorded in February 2023.

Amber demand increased in March 2023 to 25,122 verified incidents.

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

**Remedial Plans and Actions**

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

**Expected Performance Trajectory**

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

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

# Our Patients: Quality, Safety & Patient Experience
# Clinical Outcomes Indicators

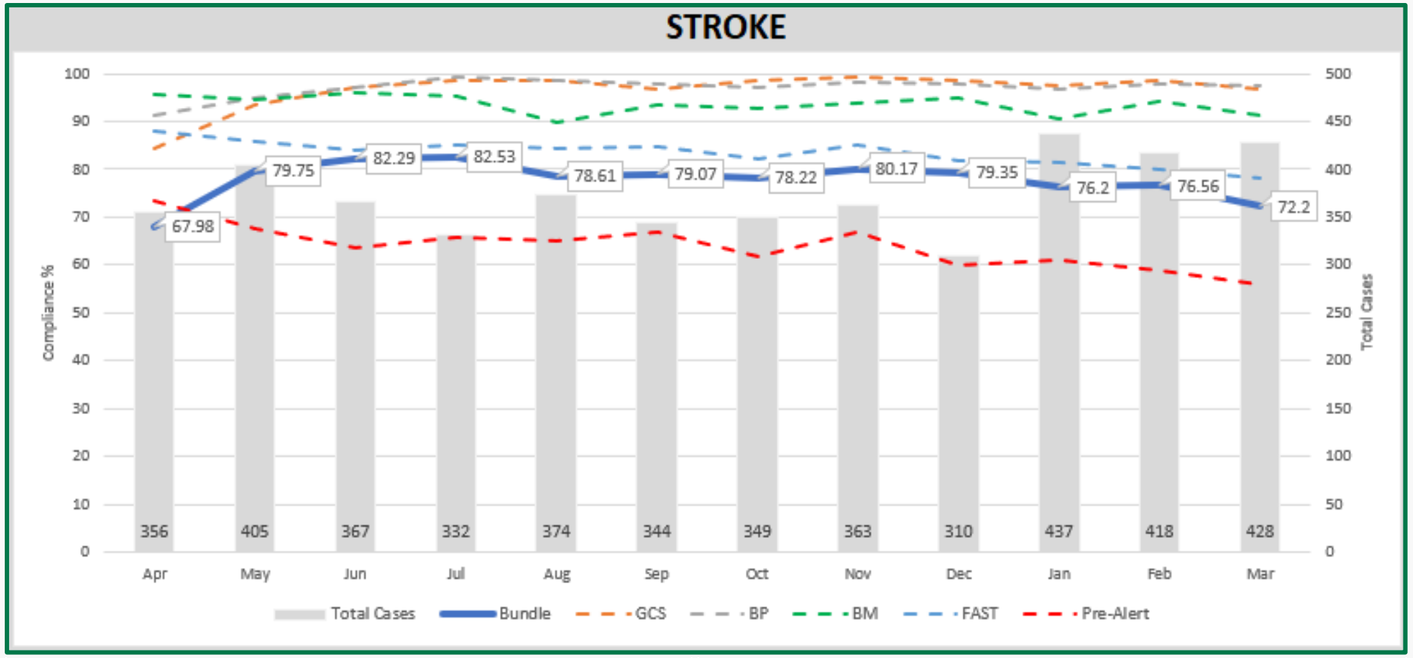
(Responsible Officer: Andy Swinburn)

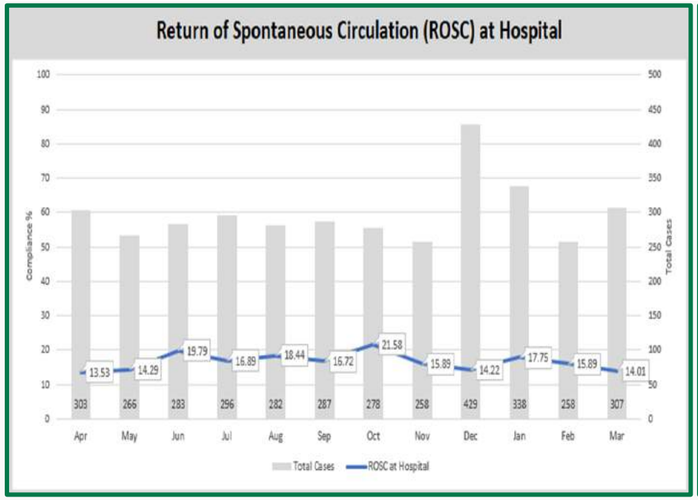
Stroke/Hip Fracture/Hypo glycaemic. R

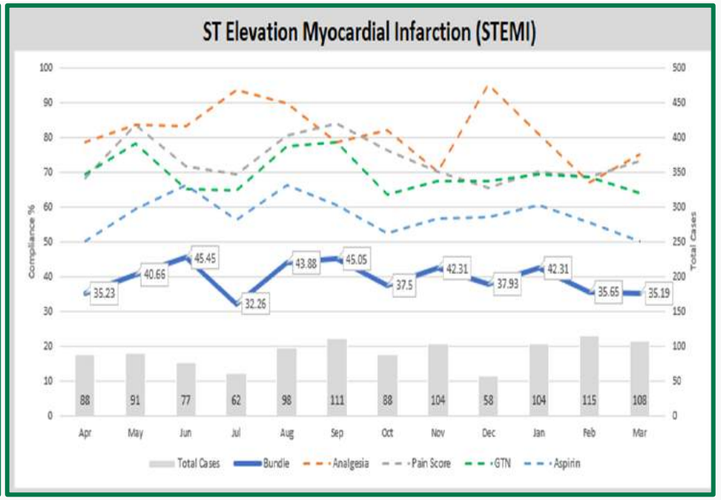
Self Assessment: Strength of Internal Control: Moderate

QUEST

## Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, Acute Coronary Syndrome Patients with Appropriate Care




**Analysis**

The Trust currently uses ePCR to report five clinical indicators (CI) to the Emergency Ambulance Services Committee (EASC) , Fractured Neck of Femur (#NOF), Stroke, ST elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return Of Spontaneous Circulation (ROSC at hospital). Work continues to develop and quality assure these metrics.

It is likely that as the system continues to embed within clinical practice, and as users continue to get used to an adjusted workflow that data points might be missed. An improvement approach has been taken and a series of 'Top Tips' posters have been circulated and specifically shared with Senior Paramedics to support their conversations with WAST clinicians as part of the ride-out process. This is based on deep dive quality assurance audits conducted for each of the CIs and reported through the Clinical Intelligence Assurance Group prior to approving publishing CI data as Ambulance Service Indicators to EASC. In addition, the deep dive quality assurance audits are contributing to recommending improvements that can be made to the ePCR user interface to enable better data capture in future versions of the application, change requests have been submitted to Terrafix and are being processed.

**Remedial Plans and Actions**

The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. The Clinical team are focussing on reporting of key clinical indicators and themes within reporting to ensure that good clinical practice is captured and reported.

New agreed indicators for this year (commissioning intention) include:
(1) Call to door time for STEMI and Stroke and;
(2) Reporting on Outcomes (by response type).
There is a lot of work required to agree and then report on these indicators:

**Q3 (Oct – Dec 2022)**

(1) Discussions commenced between the CIAT/HI/NCCU to define 'call to door' and 'at hospital' for the STEMI & Stroke time-based metrics. The various data points available are not always consistently available for all calls so options on the best approach will be discussed and decided on at the CIAG.
(2) Establish initial requirements with the NCCU for Reporting on Outcomes (by response type), this may be by staff grade, patients conveyed or not conveyed. Initial consideration is to use Stroke and #NOF data.

**Q4 (Jan – Mar 2023)**

(1) Work continued with CIAT/HI/NCCU to decide on the most appropriate data points, taking into consideration those used by English Ambulance Trusts to look at potentially comparing like-for-like data.
HI have produced sample data (December 2022) for discussion at CIAG which has representation from the NCCU.
Review potential data points for use as test data/discussed with NCCU.
Test reporting with initial data points/discussed with NCCU.

**Q1 (Apr - Jun 2023)**

(1) Agree criteria and reporting format for STEMI and Stroke time based metrics.
Develop the time-based metrics dashboard and test the data internally to include data from April 2022
Approve time based metrics for ASI reporting.
(2) Submit sample data (December 2022) to CIAG for the Reporting on Outcomes (by response type).

The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients. This has been in place since October 2022 in some areas.

**Expected Performance Trajectory**

As shown throughout the UK, the implementation of CHARUs will aid the Trust in successfully increasing ROSC rates. Once CHARU has been implemented fully it is anticipated that ROSC rates should increase.

# Our Patients: Quality, Safety & Patient Experience
# Ambulance Care Indicators

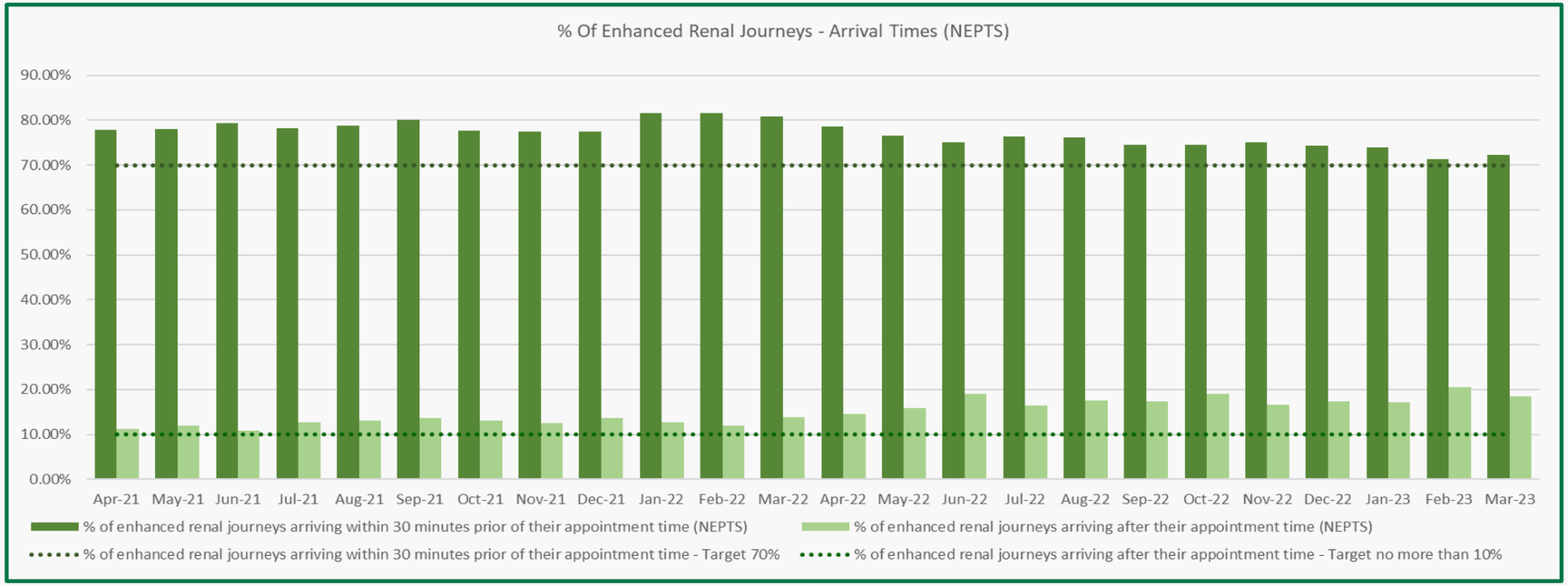
(Responsible Officer: Lee Brooks)

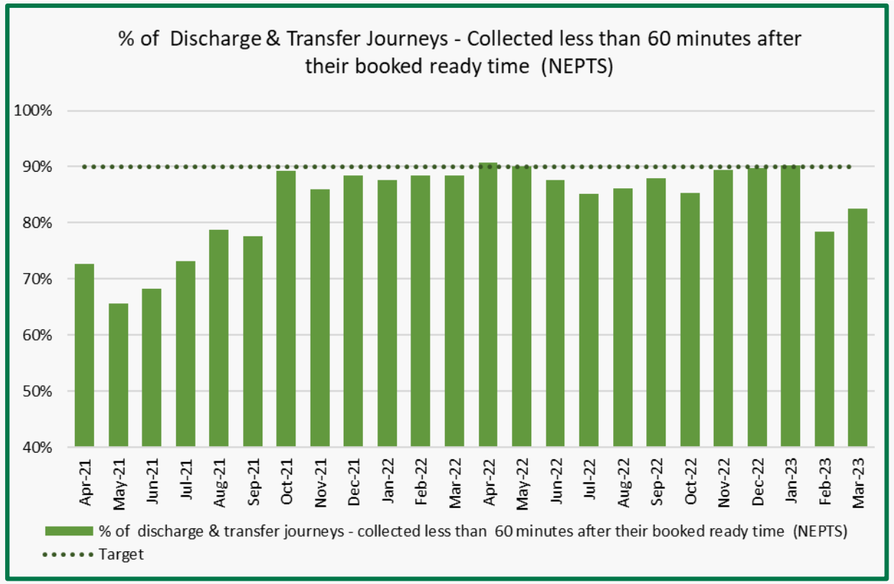
| Renal | D&T |
|---|---|
| G | A |

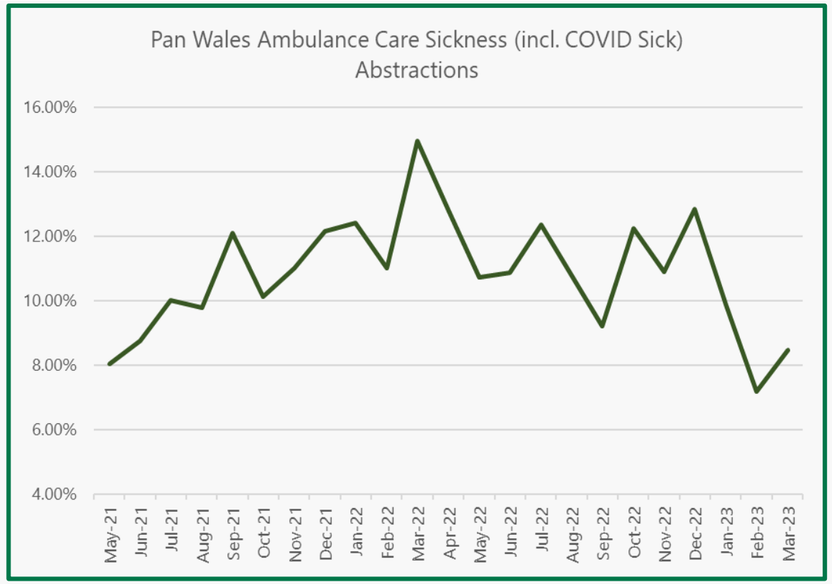
FPC

CI

## Patient Experience




**Analysis**

**Ambulance Care (NEPTS element) performance improved marginally during March 2023.** 72.3% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target, and up from 71.4% the previous month.

83% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, the second consecutive month where the 90% target has not been achieved.

Key factors affecting these indicators are demand and capacity:

- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but generally it is still not quite at pre-pandemic levels.
- Increased pressure on the unscheduled care system has increased the volume and proportion of on the day, short notice bookings for discharge & transfers
- As the Trust continues to emerge out of pandemic response and the health system is "re-set" it is anticipated that further demand increases will be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.
- Days of continuing Industrial Action have adversely affected the Trust's capacity during the past few months.

**Remedial Plans and Actions**

- D&C Project: currently awaiting feedback from tests of change for revised roster keys. Once received, the draft PID will be completed. Aim was to deliver by November 2022, but delayed linked to escalation levels.
- NEPTS Operational Improvement: Discharge Lounge trial restarted in April 2021. This will help in the development of an improved booking process.
- Transfer and Discharge Service: work is in progress with regards to the modelling (ToR created and data collection almost complete with weekly project call now in place).
- Transport Solutions: Training of Health Boards for the online booking system was completed in December 2022, and going forward telephone bookings from HCP's will no longer be accepted. A position paper on eligibility is being created and has been discussed with NCCU with the view of then sharing with WG.
- Updated NEPTS performance parameters went live in April 2023, these will separate out on the day and advance booked journeys. At present most bookings are made on the day, which makes it difficult to respond to within the times allowed. A focus on pre-planned discharge should support work being completed by working groups 5&6 of the 6 goals programme board

**Expected Performance Trajectory**

At present, the uncertainty around demand as HB's move through system recovery following the pandemic, with the potential addition of austerity and a move to different performance parameters, means that it is difficult to forecast performance. WAST will continue to work with the HB's through the commissioning DAG (NCCU) to deliver the best performance possible for the patient. It is likely that the service will experience both positive and negative fluctuations of performance until activity normalises across the system.

# Our Patients: Quality, Safety & Patient Experience
# Patient National Reportable Incidents & Patient Concerns

(Responsible Officer: Liam Williams)

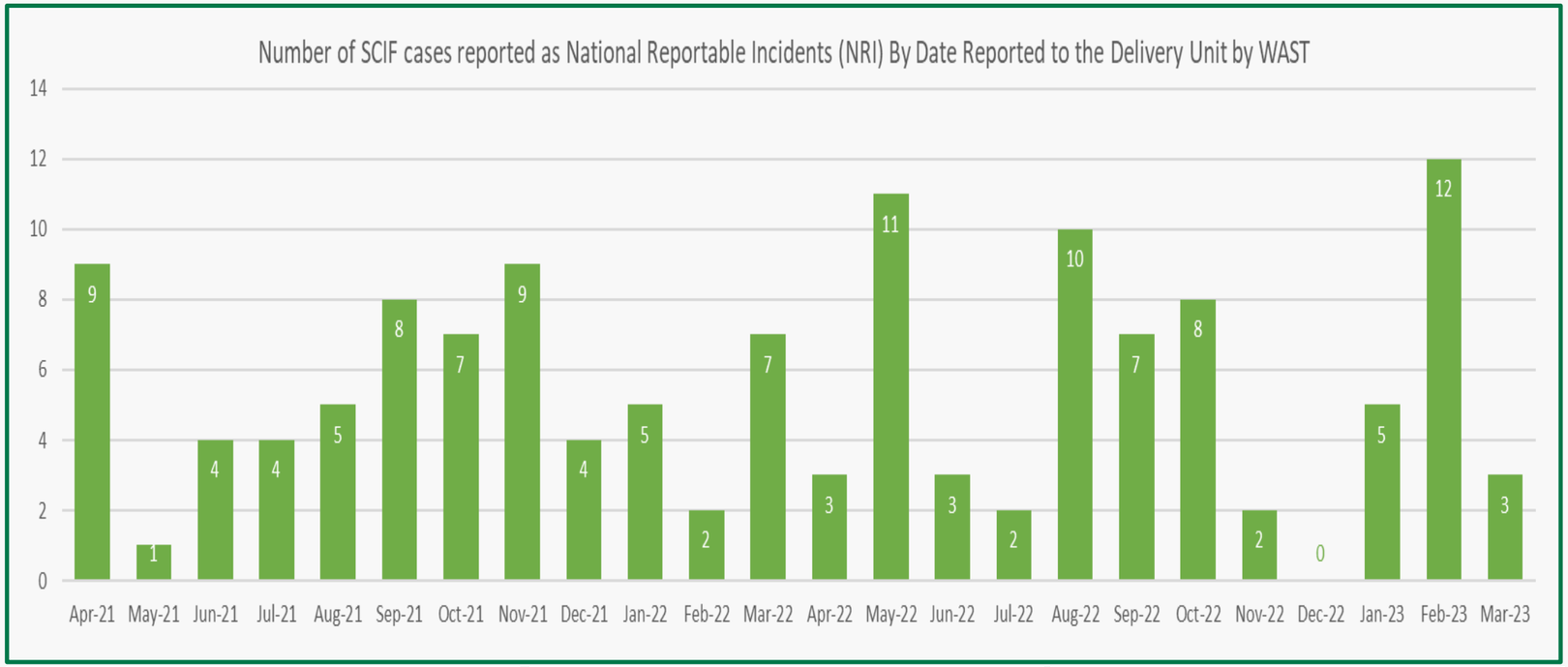
NRI. A

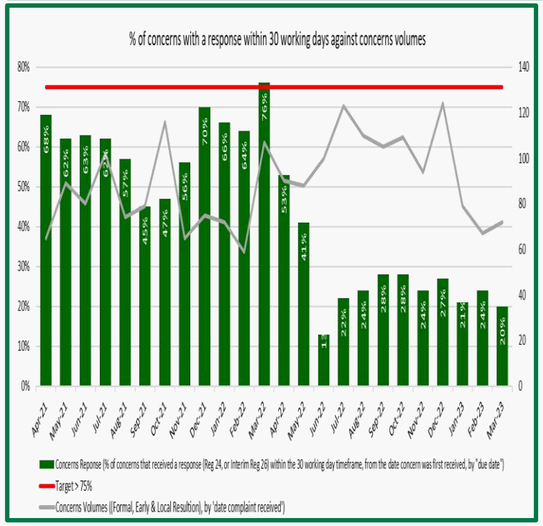
**Self Assessment: Strength of Internal Control: Moderate**

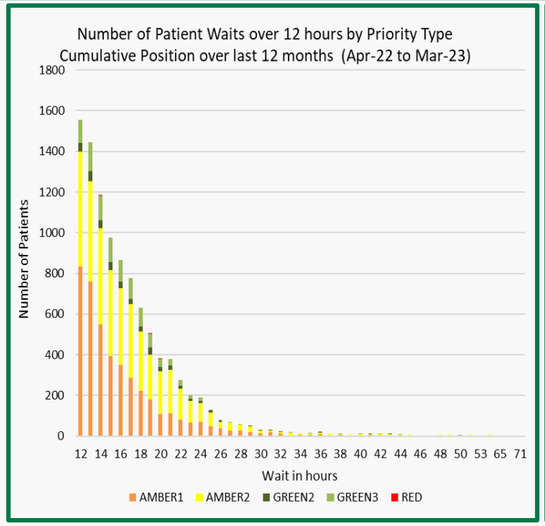
QUEST

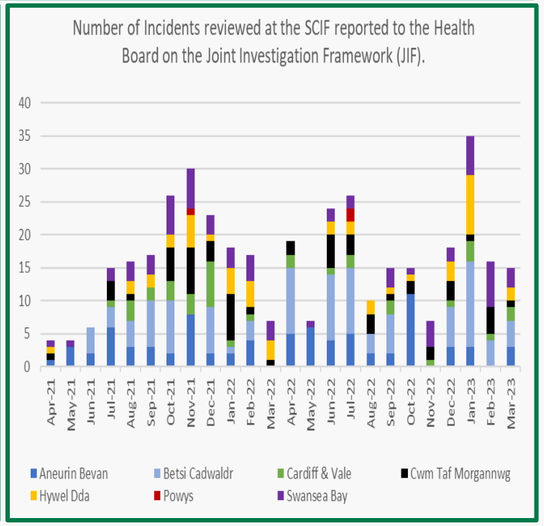
Health & Care Standard
Health - Safe Care / Timely Care

## Responses Indicators




**Analysis**

The percentage of responses to concerns in March 2023 decreased to 20% against a 75% target. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns continues to decrease with 52 complaints being received in March 2023, however these complaints are frequently complex with the concerns administrators frequently taking lengthy calls from distressed patients or family members.

Six Serious Case Incident Forums (SCIF) were held during the month and thirty-two cases were discussed. Following discussion three serious patient safety incidents were reported to the NHS Wales Delivery Unit and fifteen cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received three referrals from Health Boards under the Joint Investigation Framework during the period.

Themes relating to serious patient safety incidents reported to the NHS Wales Delivery Unit as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation.

In March 2023 there was 1 NRI relating to Red calls, 2 relating to Amber calls and 0 in relation to Green calls. There were 2 NRIs prioritised as Amber that should have been Red. As reported earlier, in March, 847 patients waited over 12 hours for an ambulance response, a significant increase month on month, also an increase when compared to 802 in March 2022, but an increase compared to 86 in March 2021.

39 Compliments were received from patients and/or their families in March 2023, a decrease compared to the previous month (36).

**Remedial Plans and Actions**

A range of actions are in place:-
Recruitment, redeployment and assessment of workload and where to best place resources continues corporately and within the EMS Co-ordination Team. An organisational change process is planned across the putting things right functions in quarter one 2023/24. Additionally, we are working closely with the Trust's Wellbeing Team to understand what additional support can be provided to staff across the PTR functions.

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions.

The Joint Investigation Framework pilot (to replace the 'Appendix B' process) continues to have good engagement from system partners overall.

Immediate improvement actions following the SCIF include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates.

The Trust is due to submit the quarter 4 complaints return to Welsh Risk Pool on 14.04.2023 which will be validated and subsequently forwarded to Welsh Government in line with nationally revised reporting requirements.

The key strategic action is the EMS Operational Transformation Programme.

**Expected Performance Trajectory**

The Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge impacting on the quality and safety of care to patients in the community and those delayed outside of hospitals awaiting transfer to definitive care.

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

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

***NB: Complex Case Review will always report 1 month in arrears*

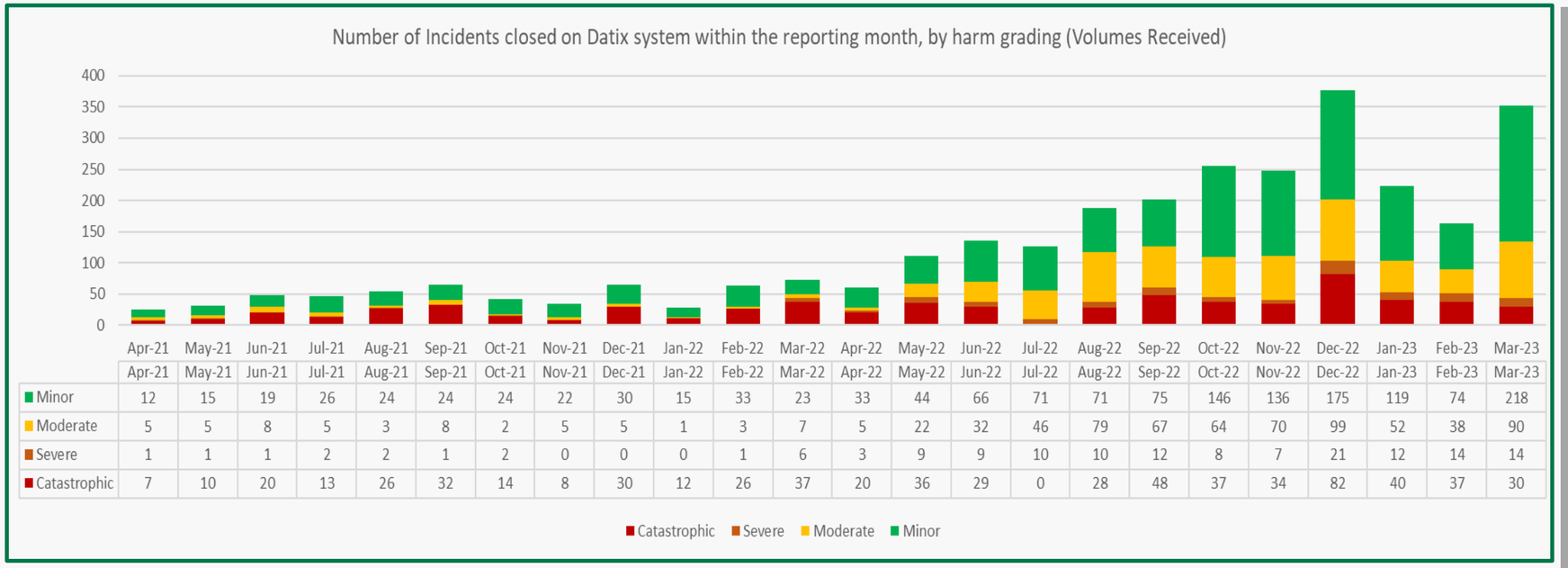
# Our Patients: Quality, Safety & Patient Experience
# Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

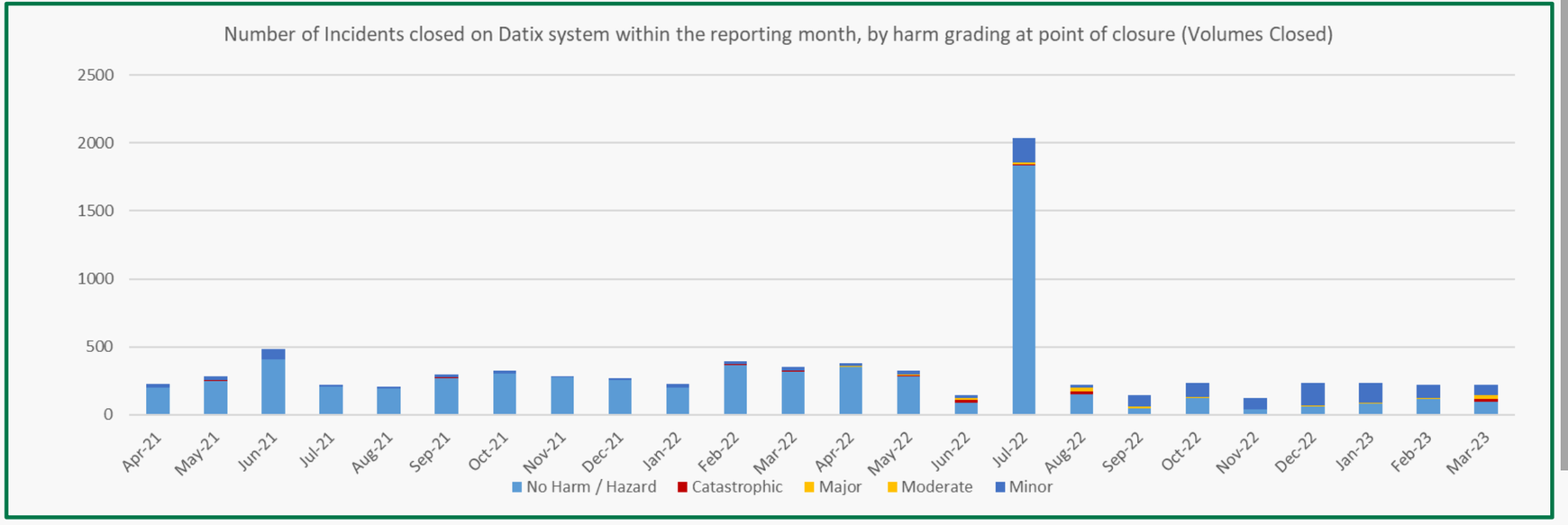
**Self Assessment: Strength of Internal Control: Moderate**

PCC

Health & Care Standard
Health – Safe Care




| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minor | 12 | 15 | 19 | 26 | 24 | 24 | 24 | 22 | 30 | 15 | 33 | 23 | 33 | 44 | 66 | 71 | 71 | 75 | 146 | 136 | 175 | 119 | 74 | 218 |
| Moderate | 5 | 5 | 8 | 5 | 3 | 8 | 2 | 5 | 5 | 1 | 3 | 7 | 5 | 22 | 32 | 46 | 79 | 67 | 64 | 70 | 99 | 52 | 38 | 90 |
| Severe | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 0 | 0 | 0 | 1 | 6 | 3 | 9 | 9 | 10 | 10 | 12 | 8 | 7 | 21 | 12 | 14 | 14 |
| Catastrophic | 7 | 10 | 20 | 13 | 26 | 32 | 14 | 8 | 30 | 12 | 26 | 37 | 20 | 36 | 29 | 0 | 28 | 48 | 37 | 34 | 82 | 40 | 37 | 30 |




**Analysis**

Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour (2023) and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported.

- No harm or hazard – 160
- Minor harm – 218
- Moderate harm - 90
- Severe Outcomes - 14
- Catastrophic - 30

(*NB: Volumes at the point of closure).

The bottom graph highlights the 228 Incidents that were closed on the Datix system in March 2023. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

**Remedial Plans and Actions**

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of PTR concerns which are frequently complex. Additionally, during periods of escalation and industrial action members of the team undertook roles outside of their PTR functions. It is expected that implementation of Duty of Candour, Duty of Quality and the Medical Examiner Service will also involve additional activity for the PTR team.

An organisational change process is planned during quarter 1 2023/24 which will consider our local and national priorities and resources to meet the needs of our patients and families, aligning to the Duty of Quality and Duty of Candour requirements which came into force on 1 April 2023.

**Expected Performance Trajectory**

The Trust will continue to identify quality and safety improvements through the PTR processes.

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

*Data source: Datix*

# Our Patients: Quality, Safety & Patient Experience
# Coroners, Mortality and Ombudsmen Indicators

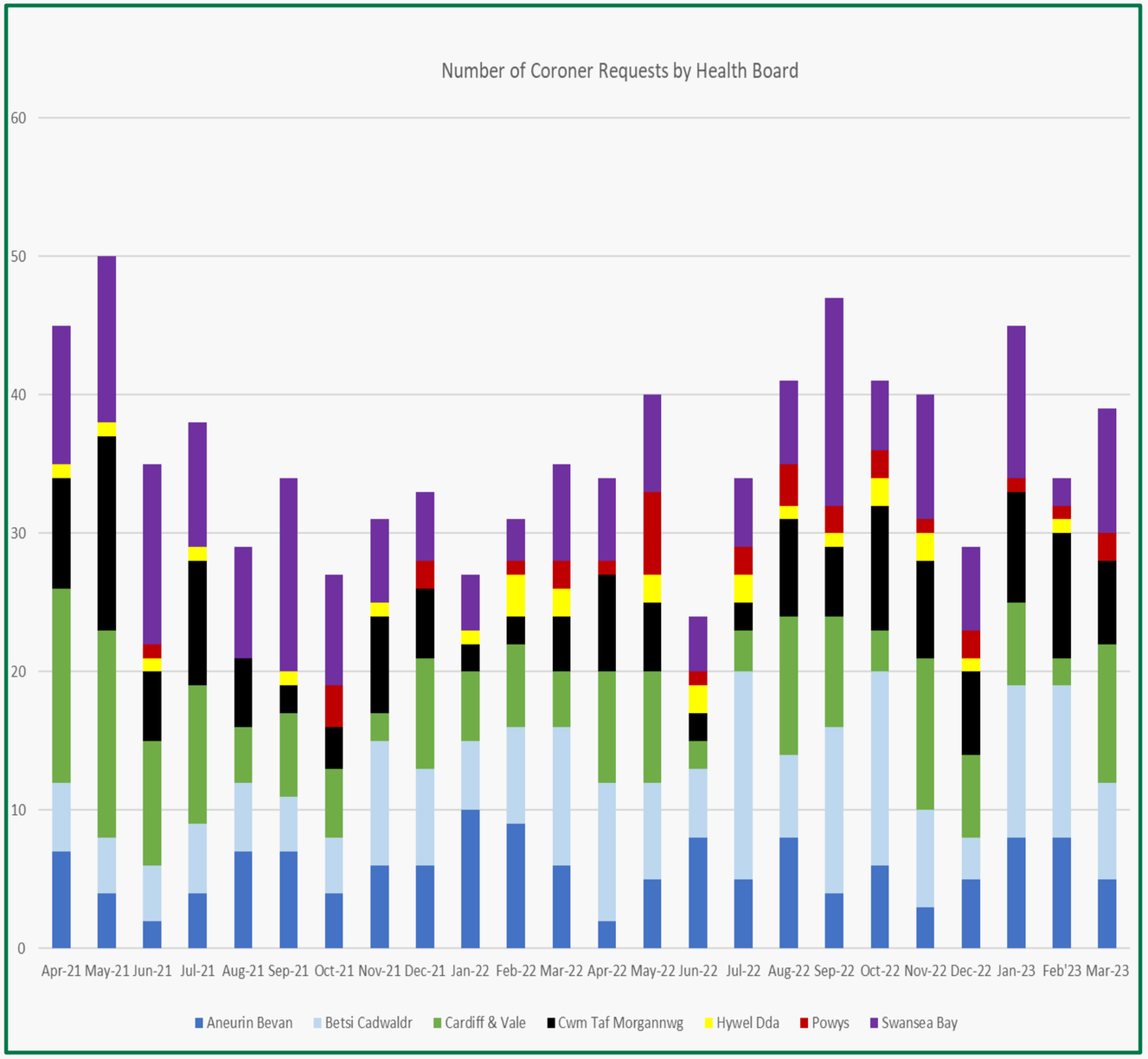
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care




**Analysis**

***Coroners:*** The number of in month request continues to be higher than pre pandemic. Pre pandemic a financial year saw 244 cases in 2019/2020. Last financial year saw 450 requests being received. This increased number of approaches is now the norm, rather than the exception. The complexity remains high, with multiple statements per approach, The Trust has responded to a Regulation 28 this month within the 56-day target.

At the end of March 2023 there were 451 claims open; these relate to Personal Injury (75 Claims); Personal Injury - Road Traffic Accidents (59 Claims), Clinical negligence (124 claims); Road Traffic Accident (177 claims) and Damage to Property (16 claims).

***Ombudsman:*** There are currently 12 open Ombudsman cases in March 2023. At present cases are not being investigated, which supports the Trust's actions. Intermediate actions are being agreed to close without full investigations by the Ombudsman.

***Mortality Review:*** The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues. Data and information is also provided by the Trust as required to the Medical Examiner Service (MES) to inform their reviews of deaths in acute care. To date the Trust has not received any requests to undertake a Level 2 mortality reviews of patients in our care under the new processes in place across NHS Wales. Currently the focus of the MES is undertaking mortality reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the MES from September 2023.

The NHS Wales Delivery Unit (DU) is leading a thematic review of 'do not attempt cardiopulmonary resuscitation' (DNACPR) processes across Wales in May 2023 with WAST representation (End of Life Care Lead). The DU are also arranging a meeting with representatives of the All-Wales Mortality Group to look at defining what should be considered under the "sieve and sort" Stage 1 mortality reviews.

To date the Trust has not received any triggers from the MES to undertake a Level 2 mortality review.

**Remedial Plans and Actions**

***Coroners:*** Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are now being arranged into 2024. The temporary clerical support has now ceased and whilst the Team had now recruited to vacancy, and following some training , the numbers on hand will be maintained. The Team is also moving to the Datix Cymru system within the next 3 months and what we can record and report on will be affected, for example we will not be able to identify the cases where there is a potential for the Trust to become an IP.

***Ombudsmen:*** The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach as requested by the ME'S. The All-Wales Mortality Working Group led by the NHS Wales Delivery Unit meets at least bi-monthly which has WAST representation.

**Expected Performance Trajectory**

***Coroners:*** Learning has been placed in a Patient Safety Newsletter, for sharing pan Wales.

***Ombudsmen:*** Whilst the multiple benefits of the ME process are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been reviewed via PTR processes internally.

*Data source: Datix*

*Mortality Reviews Data source: Internal Web Application*

# Our Patients: Quality, Safety & Patient Experience
# Safeguarding, Data Governance & Public Engagement Indicators

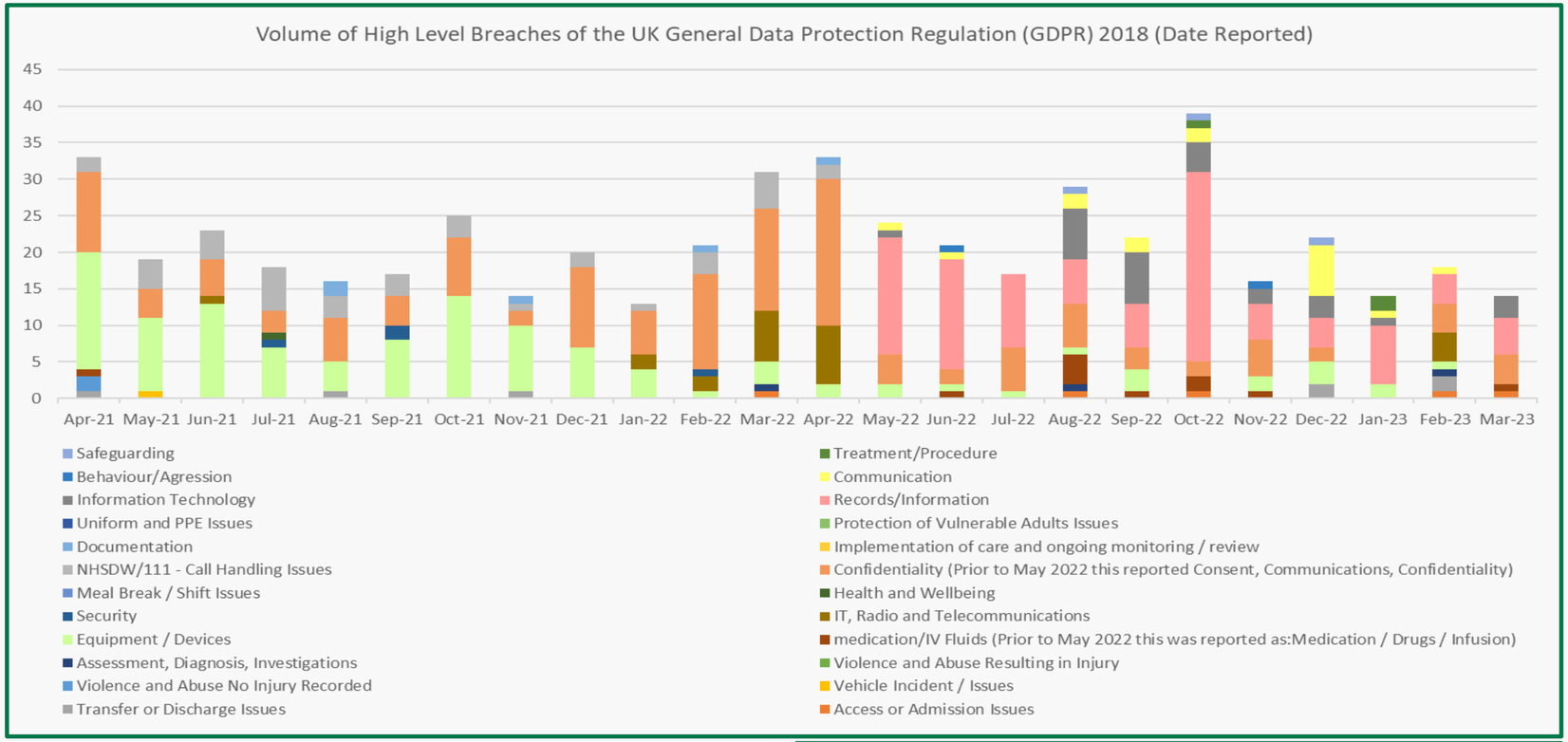
(Responsible Officer: Liam Williams)

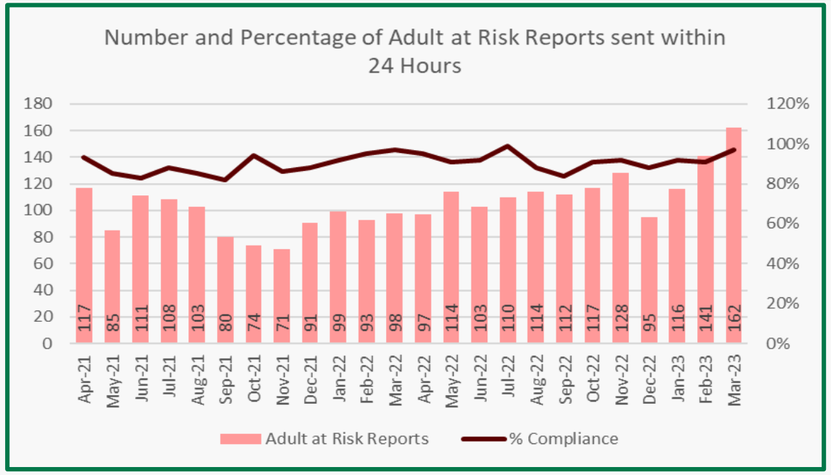
**Self Assessment: Strength of Internal Control: Moderate**

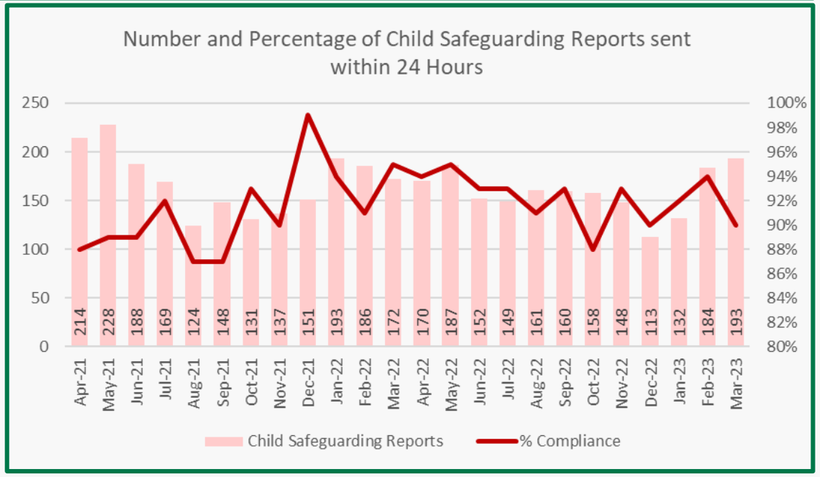
QUEST

Health & Care Standard
Health – Safe Care

*Safeguarding Data source: Doc Works*




**Analysis**

***Safeguarding:*** In March 2023 staff completed a total of 162 Adult at Risk Reports, 97% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 471 referrals were received and processed to the local authority during this reporting period.

There have been 193 Child Safeguarding Reports in March 2023, 90% of these were processed within 24 hours.

***Data Governance:*** In March 2023 there were 14 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 14 breaches, 1 related to medication / IV Fluids, 3 Information technology, 5 records/information, 4 confidentiality, and 1 Access / Admission.

***Public Engagement:*** During March, the Patient Experience and Community Involvement Team attended 8 community engagement opportunities, engaging with 135 people. At engagement events throughout the month, we continued to place an emphasis on sharing information about pressures being experienced by the Trust and were able to provide information about other services people can access in their communities. During March we also continued to make a series of Patient Reported Experience Surveys (PREMS) available, asking people to provide feedback about their interactions with our services. Outcomes of our engagement results collected from surveys remain consistent and tell us that people continue to be concerned that help will not be available when they need it and that people have experienced delays after calling 999. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive, but experience long delays when making their initial telephone booking.

**Remedial Plans and Actions**

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

***Data Governance:*** During the reporting period, of the 14-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). The IG team has provided advice and determined remedial actions for reported incidents where appropriate.

***Public Engagement:*** Community involvement and engagement with patients/public will form an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECI 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. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. In April we will begin to role out the new 'Once for Wales' Patient Experience Recording solution Civica. Civica will enable us to improve our patient experience reporting but will rely on us increasing the amount of PREMS data we capture. We are working with colleagues across the Trust to identify suitable processes to ensure our patients and service users are offered opportunities to share their feedback with us.

**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 submission for the FY22-23 IG Toolkit opened in February 2023 and is due to close on 30th June 2023. Work continues on collating the evidence required for the submission.

***Public Engagement:*** All feedback received has been shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement.

**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*

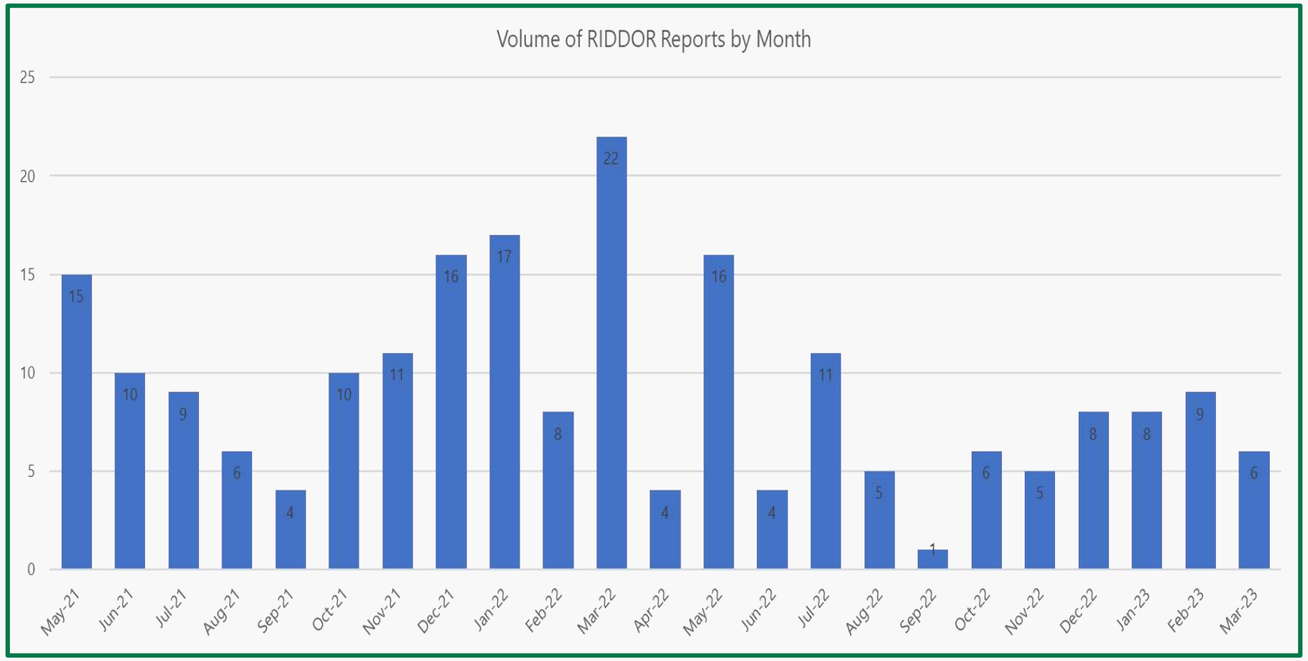
# Our Patients: Quality, Safety & Patient Experience
# Health & Safety (RIDDORS) Indicators

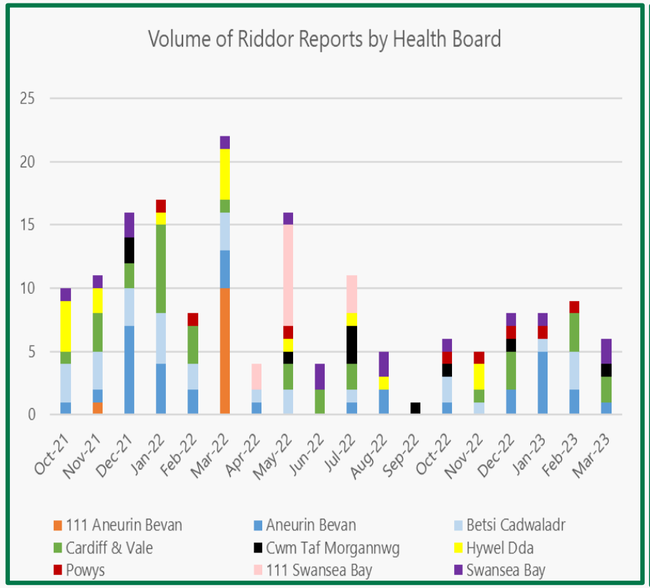
(Responsible Officer: Liam Williams)

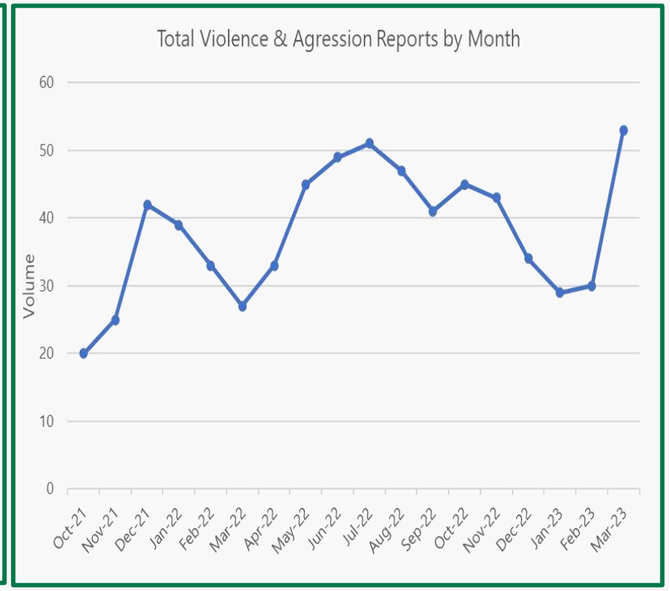
**Self Assessment: Strength of Internal Control: Moderate**

PCC

Health & Care Standard
Health – Safe Care




**Analysis**

**RIDDOR:** The weekly Datix meeting undertaken by the Health, Safety and V&A Team is continuing to have a positive impact on the reporting of incidents to the HSE under RIDDOR and additionally identifying incidents that require more in-depth investigation. It is of note that of the 18 manual handling incidents recorded in March 2023, 2 resulted in RIDDOR reports to the HSE. Also of note is that there were 4 sharps incidents reported during the month and these continue to be monitored to assess the need to report them to the HSE should a member of staff develop an illness related to the incidents.

Risk 199 is currently rated as 15. The review of the risk rating will be undertaken in Q1 2023/24 to assess impact of the revised Health and Safety Policy and Safety Annual Improvement Plan on controls identified in the risk.

Trend for RIDDOR incidents showed a decrease during March 2023 with 6 reports to the HSE in February however the incidents shows an increase in severity.

There was one report for a specified injury (Scalping ) when a sliding door came off the runner on the vehicle being used and 1 report for a patient injury (Ankle Fracture) during the month.

83% reports were completed within the reporting timeframes the reduction in reporting was due in part to the effects of annual leave within the department and other Directorates.

**Violence and Aggression:** There has been a sharp up-turn in the reporting of V&A incidents for the month of March with 53 incidents of violence and aggression toward staff reported during the month. Incidents relating to aggressive and threatening behaviour rose to 23 for the month from 13 in February. The reason for this is being investigated by the V&A Manager to identify potential controls to minimise the effect on staff.

Support for staff in preparing victim impact statements is ongoing and court outcomes are being recorded and communicated to senior team.

Work is ongoing in the development of further DATIX dashboard to allow for further scrutiny into V&A incidents at Health Board levels to allow for strategic interventions where required.

There were 0 fines, prosecutions and improvement or prohibition notices in March 2023 as no issues requiring contact with the Health & Safety Executive

**Remedial Plans and Actions**

**RIDDOR:** A review of the number, nature and severity of manual handling incidents across the Trust is underway to identify any common causation within the incidents. This will inform an improvement plan for manual handling aimed at educating staff on the correct use of equipment and lifting techniques.

An in-depth investigation is being carried out into the specified injury reported for the "Scalping" of a member of staff to identify the mechanism of injury and apply the learnings across the vehicle fleet.

RIDDOR performance continues to be presented in monthly reports and service units business meetings.

**Violence and Aggression:** The V&A Manager's strategic review in relation to V&A processes within the Trust is still ongoing with the work to date beginning to inform the evaluation report is being prepared. The timescale for the report has been extended to the end of Q1 2022/23 to ensure accuracy of the information within the report.

Collaborative working with Training team regarding V&A training is continuing with the aim of improving the current training to better support staff.

Reestablishment of working relationships with all four Welsh police forces is working well with contacts made pan Wales providing valuable insight into the investigations made in relation to V&A incidents.

**Expected Performance Trajectory**

**RIDDOR:** Reporting performance remains higher than 80% due to the efforts of the Health and safety team in conjunction with Line managers the development of Power BI tools further improve the reporting rate as inconsistencies due to fluctuation as investigations are closed out and associated coding's changed.

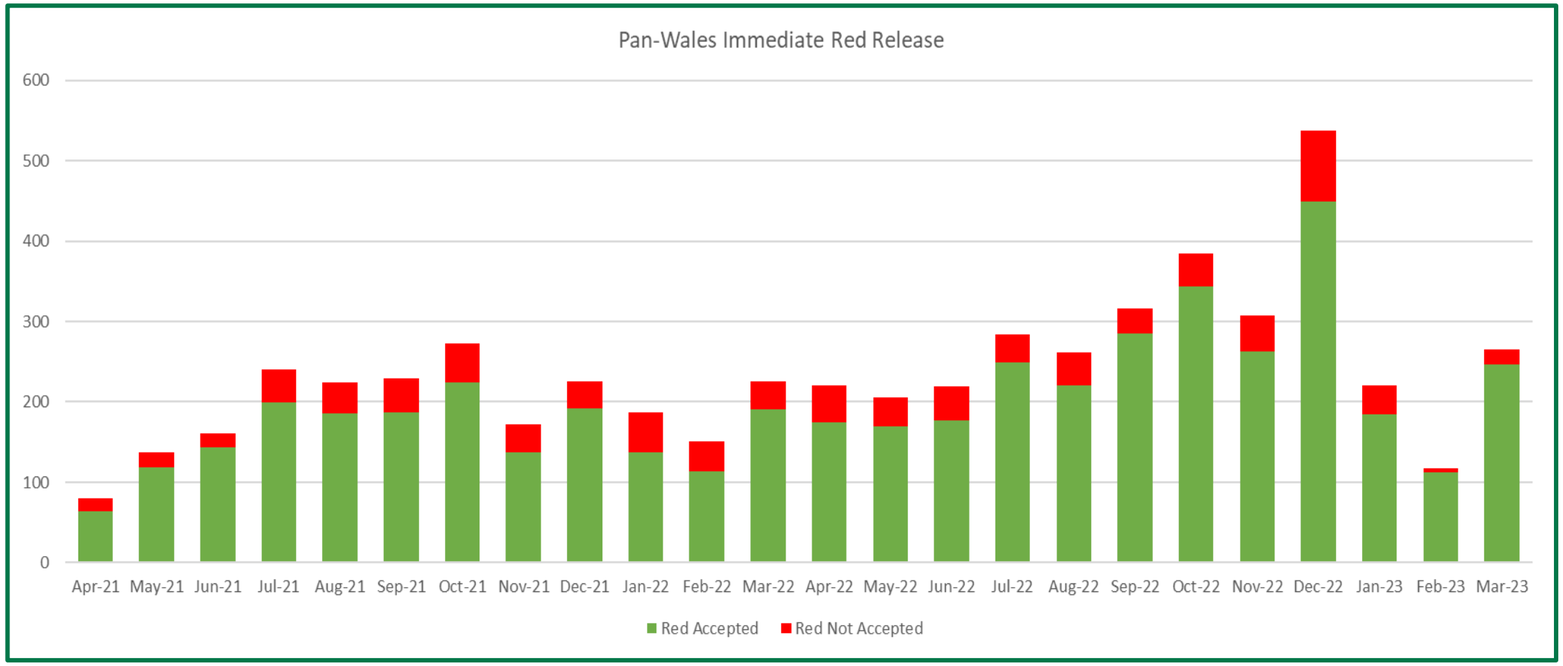
**Violence and Aggression:** Work is underway in the development of further DATIX dashboards to allow for further scrutiny into V&A incidents to influence strategic interventions where required.

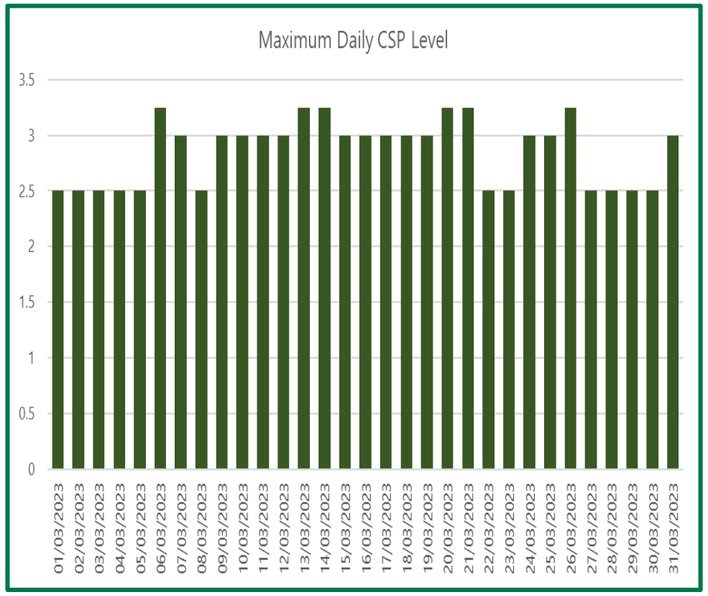
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

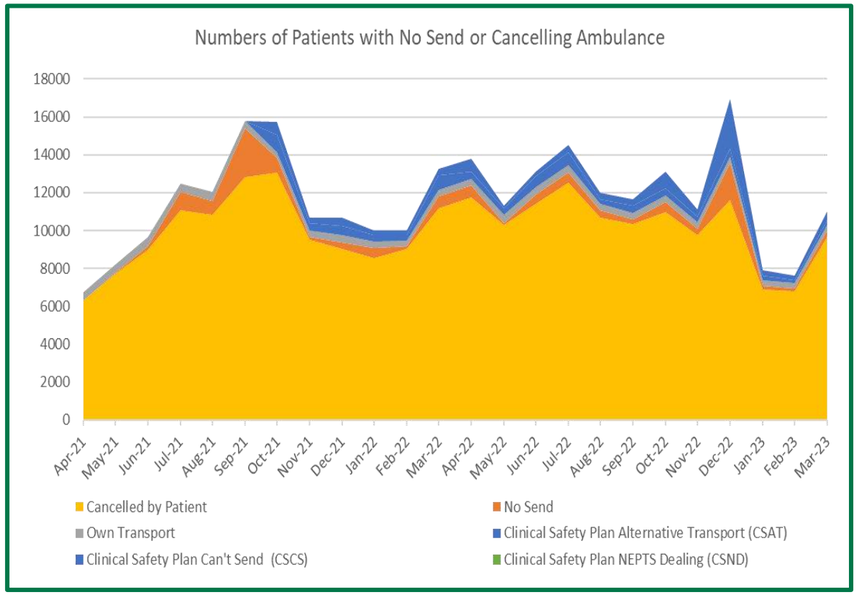
*Data source: Datix*

# Our Patients: Quality, Safety & Patient Experience
# Escalation and Patient Experience

(Responsible Officer: Andy Swinburn) TBD FPC




**Analysis**

There were 822 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in March 2023. Of these 246 were accepted and released in the Red category,19 were not accepted. In conjunction to this, 160 ambulances were released to respond to Amber 1 calls, but 397 were not.

In March 2023, 234 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 474 were stopped as a result of CSP Can't send options. In addition, 9,650 ambulances were cancelled by patients (including patients refusing treatment at scene) and 292 patients made their way to hospital using their own transport.

In March 2023 CSP levels for the Trust were:

| CSP Level | No Of Days in February 2023 | RED | AMBER 1 | AMBER 2 | GREEN | HCP |
|---|---|---|---|---|---|---|
| 0 | 0 | Business as Usual | | | | |
| 1 | 0 | Respond | Respond | ETA – Alt Transport<br>Respond to Exceptions | | |
| 2a | 0 | Respond | Respond | ETA – Alt Transport<br>Respond to Exceptions | | |
| 2b | 0 | Respond | 65th ETA Script<br>ALT Transport<br>Respond to Exceptions | | | |
| 2c | 12 | Respond | 65th ETA Script<br>ALT Transport<br>Respond to Exceptions | Can't Send<br>Respond to Exceptions | Can't Send<br>Pass to ROU or EMG | |
| 3a | 13 | Respond | 90th ETA Script<br>ALT Transport<br>Respond to Exceptions | Clinical Screening | Can't Send | Can't Send |
| 3b | 6 | Respond | Clinical Screening | Can't Send | Can't Send | Can't Send |
| 4a | 0 | Clinical Screening | | Can't Send | Can't Send | Can't Send |
| 4b | 0 | Clinical Screening | Can't Send | Can't Send | Can't Send | Can't Send |

**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 have commenced with Health Boards, the Commissioner and the Trust and performance is reviewed monthly with questions posed to Health Boards regarding immediate release and handover reduction plans and actions.

**Expected Performance Trajectory**

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for this through a range of measures including the use of forecasting and modelling.

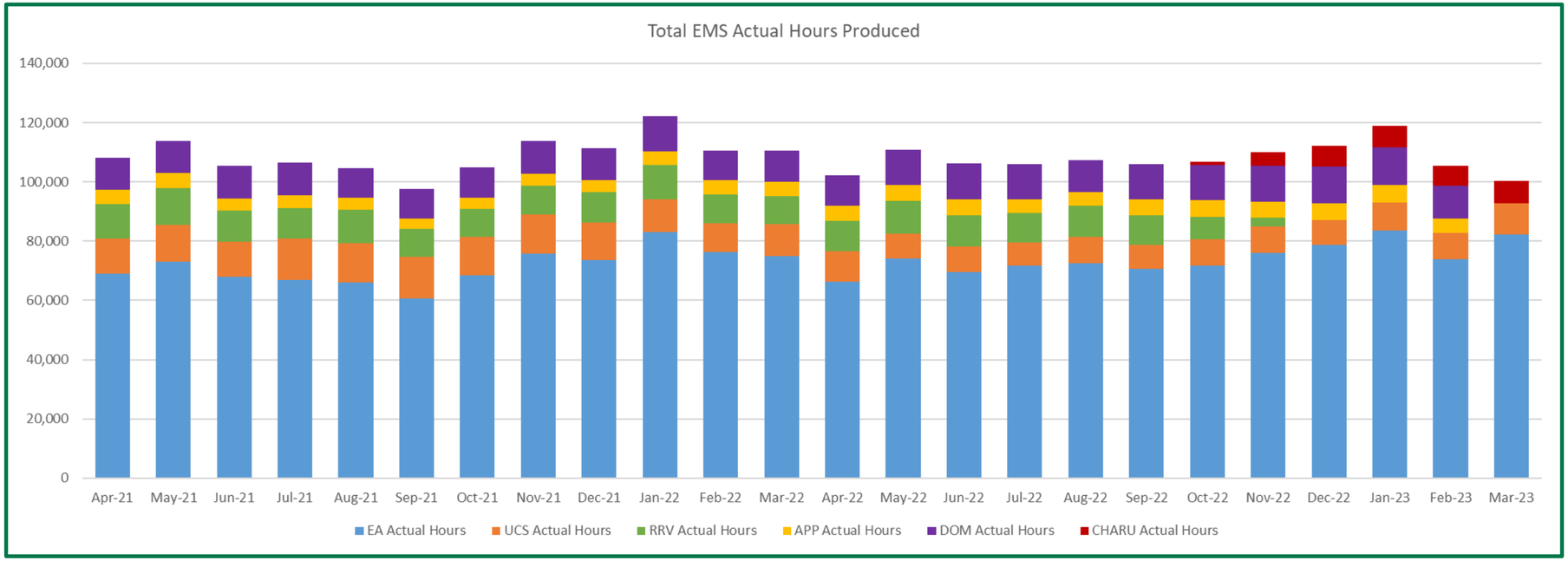
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

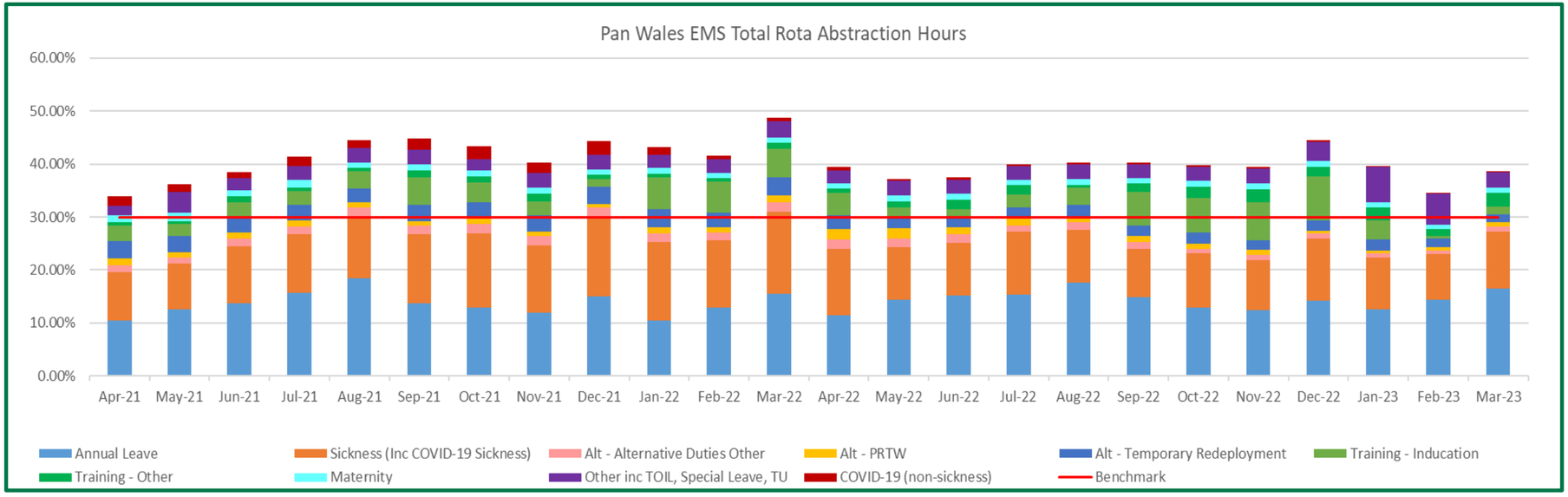
# Our People
# Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

| EA Production | Abstractions |
|---|---|
| G | R |

CI PCC FPC




**Analysis**

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In March 2023, total abstractions stood at 38.61%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 16.54% and sickness at 10.75%. Sickness abstractions for March 2023 were lower when compared to the previous year (15.47%). COVID-19 (non-sickness) related abstractions decreased again in March 2023 when compared to the previous month and when compared to the same period last year accounting for 0.08% of overall abstractions.

**Emergency Ambulance Unit Hours Production (UHP) was 95% in March 2023** (82,212 Actual Hours), therefore achieving the 95% benchmark. CHARU UHP achieved 85% (7,715 Actual Hours) compared to 81% in February 2023 (this is the commissioned level not the modelled level, which would halve the UHP). The total hours produced is a key metric for patient safety. The Trust produced 119,092 hours in March 2023, which is higher than the figure produced in February 2023, but February saw hours affected by the shorter month and the industrial action days which took place.

**Remedial Plans and Actions**

The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks.

The Trust has a budgeted establishment of 1,761 FTEs for 2022-23.. The vacancy rate is less than 1%.

The Trust is currently widening out its focus on sickness absence to look at all abstractions recognising that abstractions are already regularly reviewed in Operations performance meetings.

**Expected Performance Trajectory**

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to EMT. A further meeting to deep dive and finalise the Trust's position for 2023/24 has been arranged for 17 May 2023.

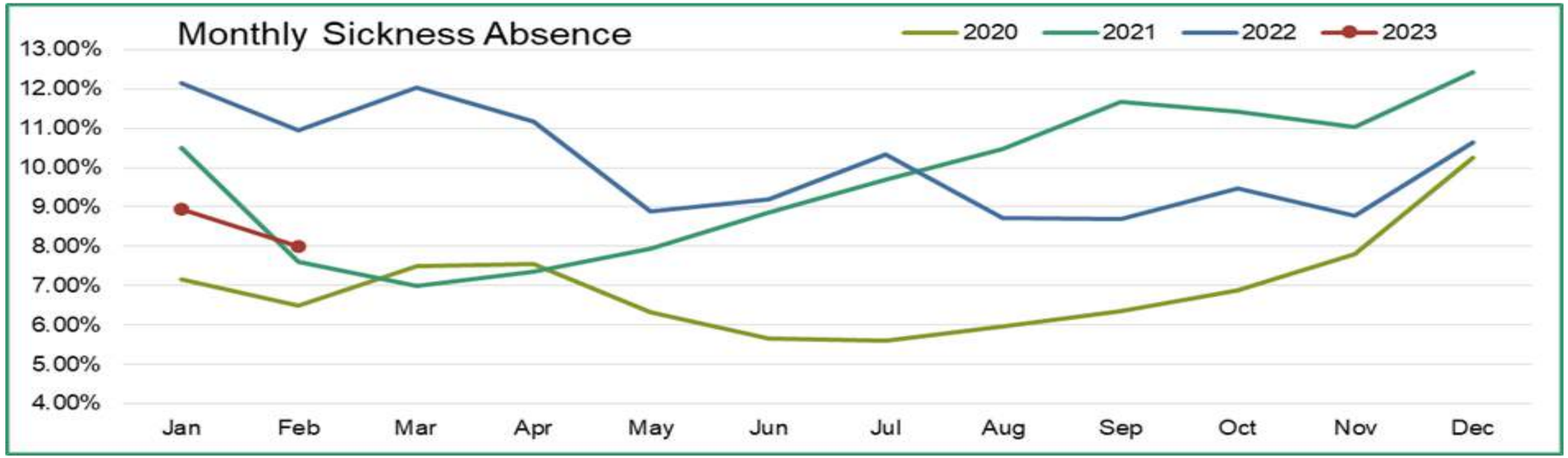
# Our People
# Health & Wellbeing - Sickness Absence Indicators

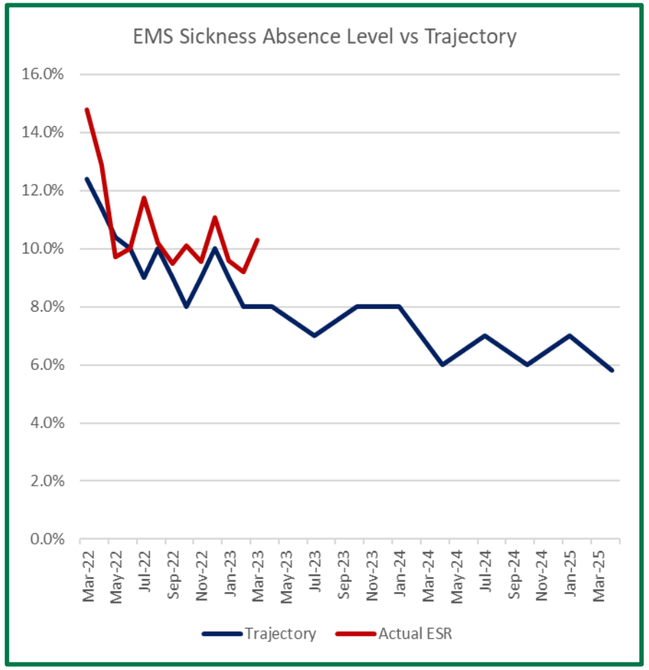
(Responsible Officer: Angela Lewis)

G

CI

NB: Sickness data will always be reported one month in arrears (except for ESR reported Sickness Trajectory)

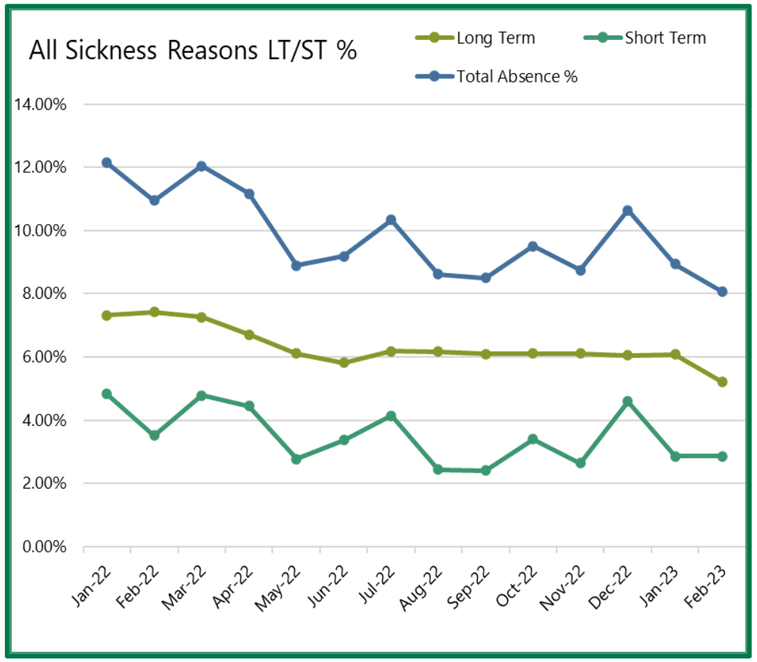



| Average working days lost per FTE (Annual) |
|---|
| 21.86 days |
| **Single month Absence %** |
| 7.99% |

| Long Term | Short Term |
|---|---|
| 5.76% | 2.22% |
| **Mental Health** | **Other MSK** |
| (S10 Stress/Anxiety) | (excluding Back) |
| 2.24% | 1.12% |

February 2023




**Analysis**

There was a decrease in sickness absence in February, going from 8.94% to 7.99%, the lowest level since June 2021. Indicative figures show an increase in March to 8.43%, with an increase in short term absence (3.58%). Long term absence shows a continued decrease at 4.86%.

The number of long COVID cases continues to decline with 3 colleagues absent (as of 04 April 2023) with long Covid compared to 15 in July 2022.

February 2023 noted a decrease in both long term and short-term absences.

**Remedial Plans and Actions**

- Targeted support continues to be directed to current 'hotspot' areas with ongoing reviews in one HB area. Senior Manager review meetings to track sickness and provide support are undertaken each month.
- Further MAAW training and bitesize training sessions have been scheduled for April & May 2023.
- Long term sickness case management continues and indicative figures for March 2023 show a decrease to 4.91% from 5.76% in February.
- Indicative figures for short term absence in March 2023 shows an increase to 3.57% from 2.22% in February. The highest reason for short term absence was COVID related.
- Long COVID cases are reducing – 3 compared to 15 in July 2022, with comprehensive plans developed.
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences
- Physiotherapy: 43 referrals were received in February 2023; this was 10 more than January 2023.
- Average length of time from referral to first contact: 0.85 days.
- Average age of those referred is 48, with shoulder issues being the main reason for referral. At the point of referral, 42% of employees were off work, 5% were on amended duties and 53% were at work on full duties
- Health Assured (EAP): 48 calls to the helpline in February

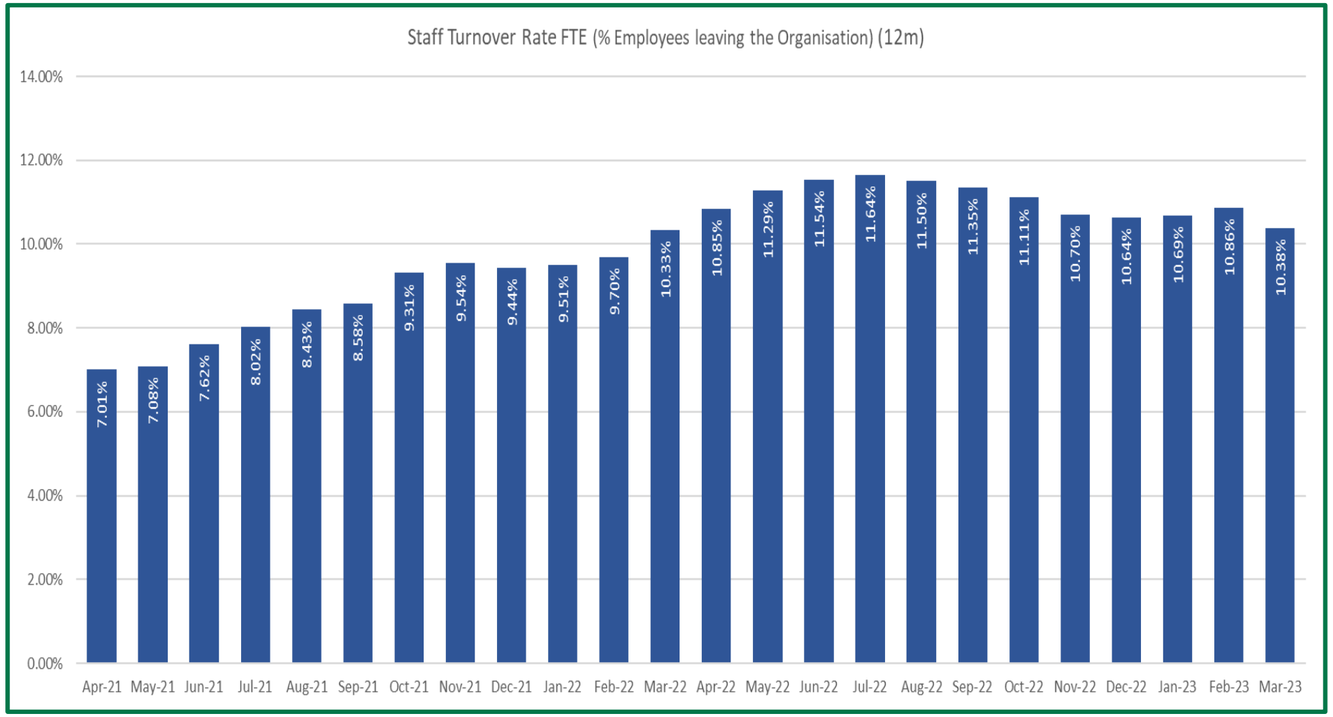
**Expected Performance Trajectory**

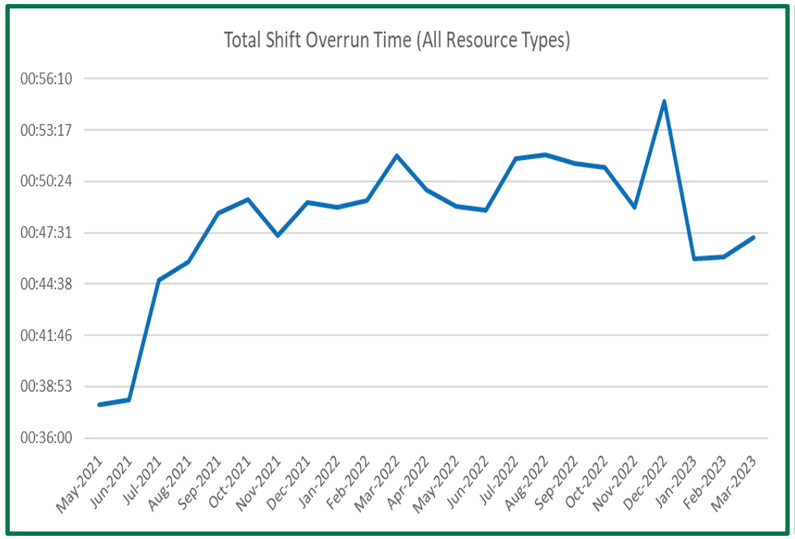
The Trust is aware that some staff may need more time to recover due to long-CoVID-19 and may require a longer phased return to work alongside putting in place other supporting mechanisms. Work is also ongoing to consider the mental health aspects of COVID-19 and working from home and the Trust is actively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

# Our People
# Health and Wellbeing - Turnover

(Responsible Officer: Angela Lewis)

A




| March 2023 | FTE by Month |
|---|---|
| Org L4 | 2023 / 03 |
| 020 Ambulance Care L4 (NX10) | 901.89 |
| 020 Emergency Medical Services L4 (DX04) | 1,800.47 |
| 020 Integrated Care L4 (DX03) | 430.13 |
| 020 National Operations & Support L4 (DX02) | 152.72 |
| 020 Resourcing & EMS Coordination L4 (DX05) | 342.99 |
| 3,628.20 | |
| **Ambulance Response:** | **1,543.80** |
| **020 Ambulance Care L4 (NX10) ACA2/Team Leaders** | **290.79** |

**Analysis**

Staff turnover rates in March 2023 were 10.38%. In comparison staff turnover rates were 10.33% in March 2022. As highlighted previously the number of staff leavers has increased over the last 3 years with rates remaining high, but relatively static, between 10.3% and 11.7% over the past year. These rates were considerably lower pre-pandemic. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

Colleague wellbeing remains a focus for WAST. Colleagues are managing a number of challenging issues at the minute with industrial action, the cost of living crisis and fatigue all being concerns. The Trust has been awarded enhanced status of our Gold Award for Corporate Health Standard, demonstrating that colleague wellbeing remains a high priority. EAP support for colleagues has been renewed, to ensure our people can access support 24/7 and have access to counselling. The Trust have arranged for speakers to come in to present to the women's health group, focusing on nutrition and are delivering regular workshops for colleagues on stress, and wellbeing and resilience to support, and are looking at ways to increase the support that we provide.

**Remedial Plans and Actions**

Accessible financial wellbeing support is available to colleagues through a dedicated page on Siren. The page links to a short video presentation outlining available support, ideas shared through the digital suggestion box which remains open to all colleagues (including our volunteers) and broader employee benefits information. A podcast has been recorded with the Money & Pensions Service and will be shared through communications platforms in April 2023.

The WAST Voices Network held its first Advocate meeting in March 2023 and activity continues relating to themes of misogyny and sexual safety within the organisation. Reverse mentoring relationships have been established and the impact of these will be measured after 2 sessions of Senior Leaders hearing from lived experience of these issues. The network have a collaborative event with North West Ambulance Services taking place in April.

Work around improving the preparedness of new colleagues has begun and we now facilitate group discussions around anti racism and sexual safety at all welcome sessions. We are also capturing organisational culture experiences through the 3 months check in carried out with all new colleagues. The allyship programme continues to be rolled out for current colleagues and where required, team interventions taking place.

A volunteer wellbeing package has been put together and the OD Team are running monthly evening Warm WAST Welcome sessions for new volunteers.

2nd Carers passport training arranged for 17th May - Carers week workshop being arranged for 8th June. Theme suggested by the unofficial carers network.

WAST Outdoors initiatives being trialled.

**Expected Performance Trajectory**

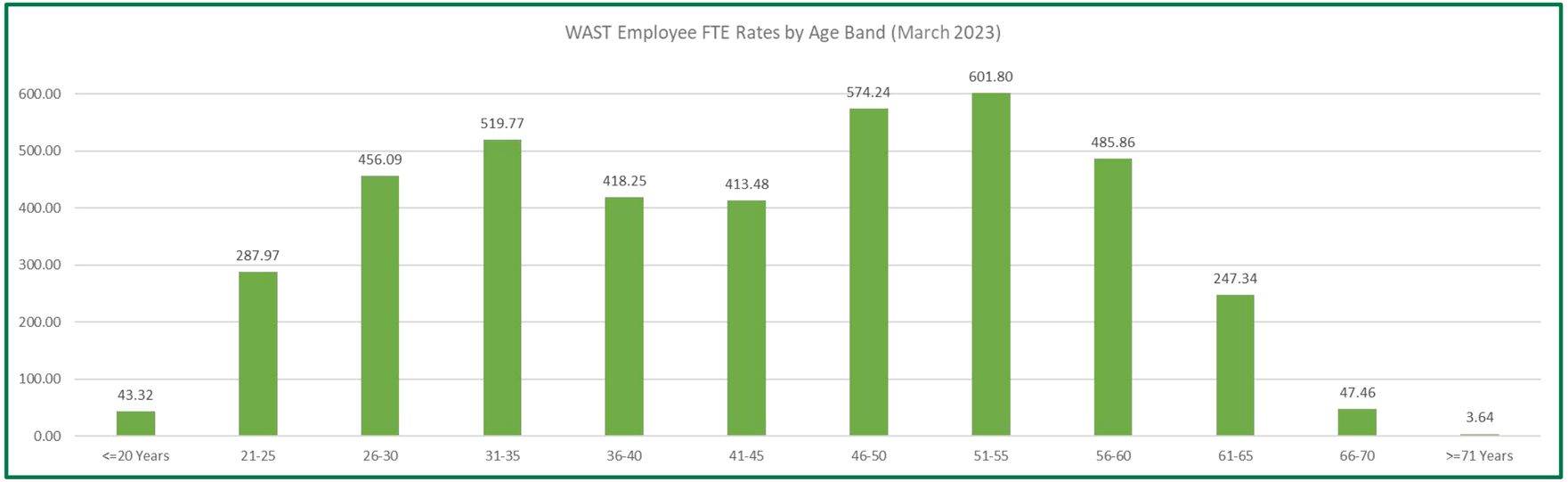
The situation regarding wellbeing of staff remains challenging, many of the difficulties and frustrations are difficult to influence and change. Management development will continue with a focus on people skills and support with robust wellbeing offers so colleagues know where to get support. The People and Culture Plan will continue to highlight that employee experience and culture contribute to overall wellbeing.

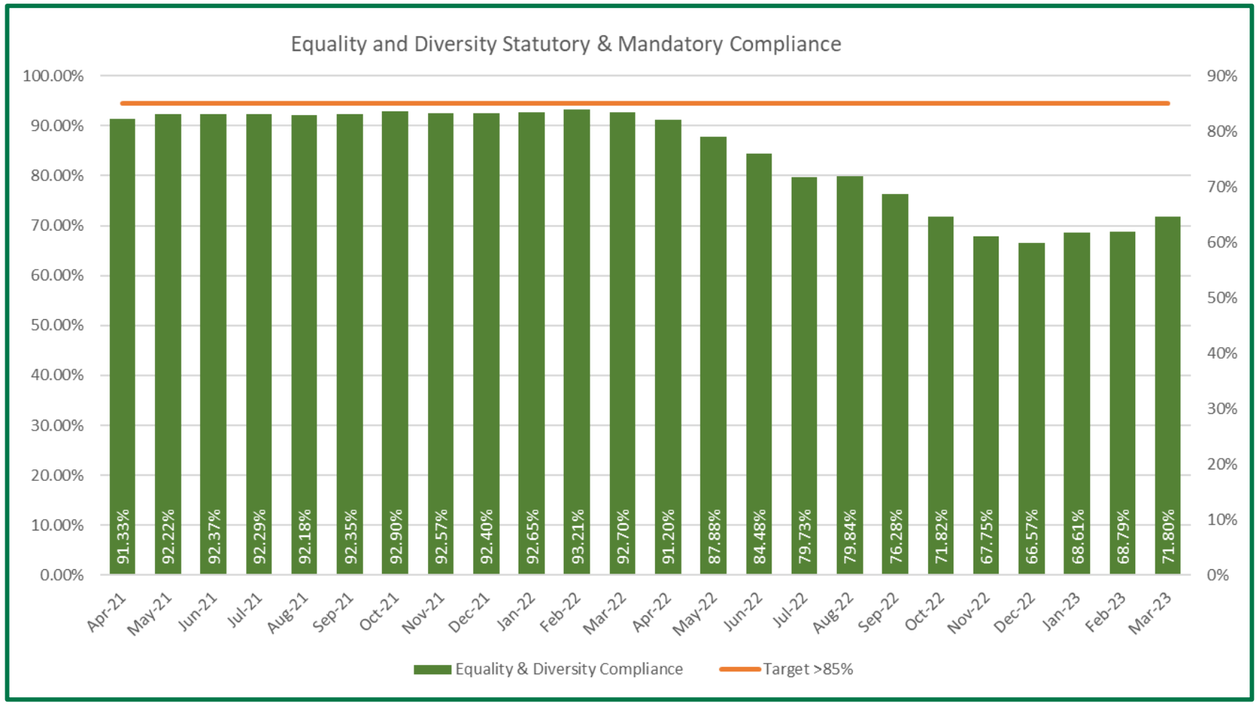
The wellbeing offer is regularly reviewed and fully described on SharePoint.

# Our People
# Inclusion and Engagement

(Responsible Officer: Angela Lewis)

CI




| March 2023 | Female | Male |
|---|---|---|
| Band 2 | 1.20 | 1.39 |
| Band 3 | 17.13 | 14.30 |
| Band 4 | 8.48 | 10.57 |
| Band 5 | 5.04 | 4.20 |
| Band 6 | 12.05 | 13.10 |
| Band 7 | 2.93 | 5.08 |
| Band 8 - Range A | 0.91 | 1.29 |
| Band 8 - Range B | 0.51 | 0.36 |
| Band 8 - Range C | 0.19 | 0.51 |
| Band 8 - Range D | 0.13 | 0.13 |
| Other | 0.23 | 0.27 |

**Analysis**

**In March 2023 of the 4,740 employees at the Trust, 0.95% fall in the under 20 category and 0.38% in the over 71 age category. 86.50**% of staff employed at the Trust define themselves within the White ethnic grouping; with 71.77% of staff identifying within the White, British category, 0.8% within black ethnic groups, 0.34% within Asian ethnic groups and 0.70% are of mixed heritage. 0.11% of staff fall into other ethnic groups. 4.32% fall in the unspecified category and 7.91% have not stated their ethnicity.

As of March 2023, 71.18%, of staff have completed mandatory Equality and Diversity Training a slight increase compared to February, however still failing to meet the 85% target.

Gender pay as a percentage of the workforce indicates that in March 2023 for those employed within bands 2 - 5 employment is more equally distributed, with 31.86% of females and 30.46% of males fulfilling those roles; however, there are higher levels of men employed within the more senior grades. 14.98% of females are employed in Band 6 and 7 roles compared to 18.19% of males and of those employed within Band 8 roles 1.73% are females and 2.28% are males.

**Remedial Plans and Actions**

The Trust has published a selection of 15 minute engaging and effective Skills Boosters films, via the Learning and Development intranet page on Siren. These cover a range of topics including Equality, Diversity & Inclusion; Leadership; Personal Effectiveness and Support & Wellbeing to support staff learning and development and to enable individuals to be the very best that they can be.

Plans are underway to support Stress Awareness month in April 2023 to raise awareness of the causes and cures for the modern-day stress epidemic. Presentations are planned on various dates throughout April 2023 for staff to learn about the REACT (Recognise, Engage, Actively Listen, Check risk and Talk about specific actions) on and Understanding Stress, Trauma & Burnout.

**Expected Performance Trajectory**

The Trust listened to feedback from communities, stakeholders and over 4,000 colleagues to develop seven new behaviours to ensure we can always be our best and is more committed than ever to improving the future and embracing new ways of working. These behaviours have been explored and promoted at the CEO roadshow and work to continuing promoting them continues.

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

# Our People
# Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

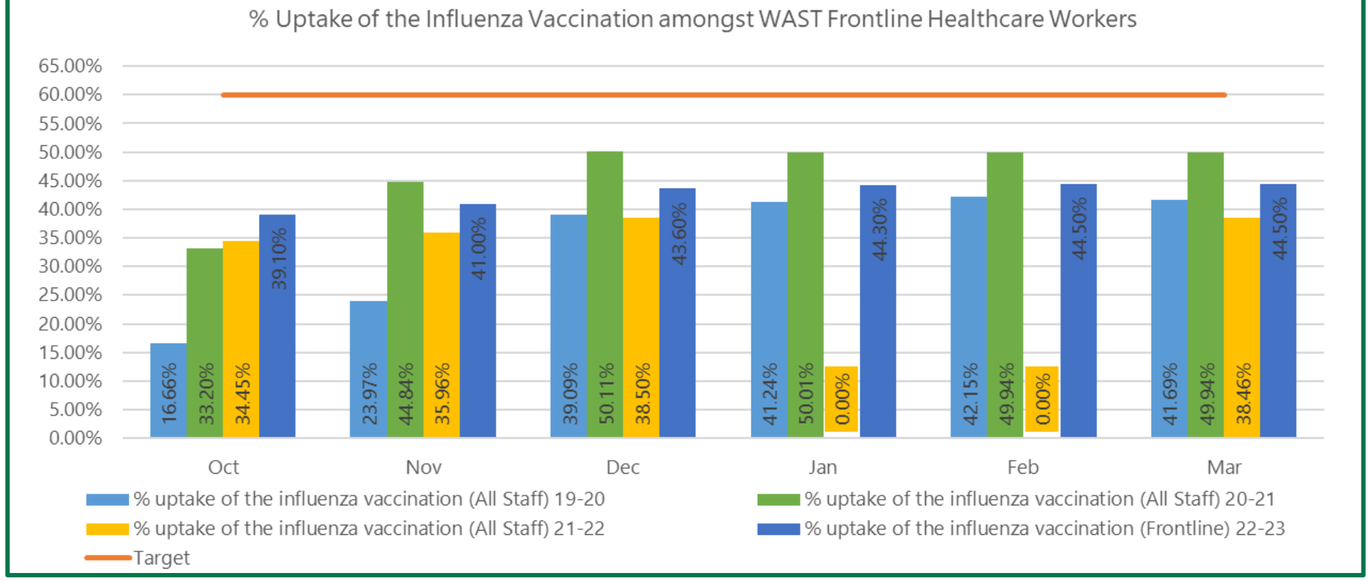
Self Assessment: Strength of Internal Control: Moderate

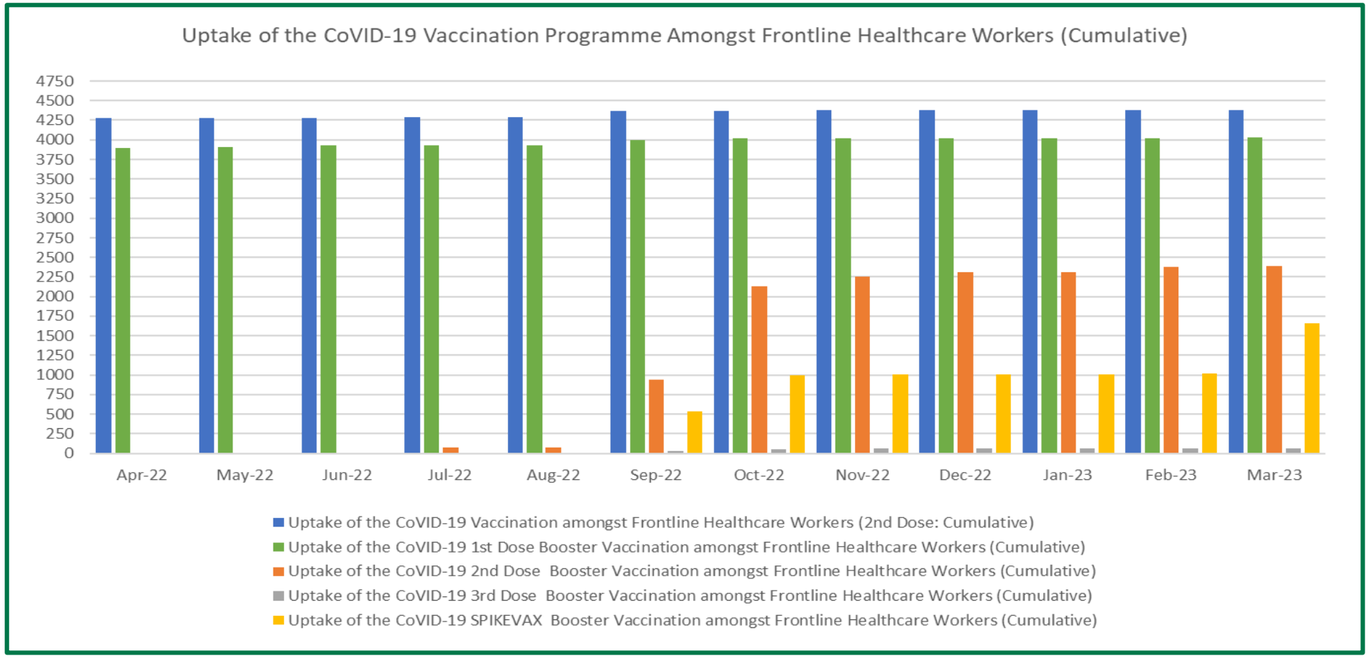
Flu R

PCC

CI

Health & Care Standard - Health (PPI)




**Analysis**

***Flu:*** The 2022-23 Flu Campaign has officially come to an end, concluding data collection as of 28th February 2023. During the campaign 1,813 flu vaccines administered by Occupational Health Vaccinators and Peer Vaccinators (including flu vaccines administered to PHW staff / Students / HCS staff etc.) Of these vaccines administered within the Trust, 1,601 were received by WAST staff. There was a further 289 given to staff elsewhere (i.e. GP surgery, COVID Booster setting) therefore a total of 1,890 WAST staff received the vaccination against flu, equating to 44.5% of the overall workforce. Additional engagement was received from 247 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, concluding the campaign with 50.3% engagement rate.

Both the vaccine uptake and Microsoft Form engagement surpassed that experienced in the previous campaign last year, 2021-22. There was a 6% increase on vaccinations and a 9.6% increase in engagement. Patient facing staff specifically saw a 46.3% uptake of the vaccine this year (a 5.2% increase from last year).

***COVID-19:*** As of March 2023, front line (Patient Facing and Non-Patient Facing staff), 94% (4,404) of staff have received a first dose COVID-19 vaccination, 94% (4,377) have received a second dose and 37% (1,664 Staff) have received the SPIKEVAX booster vaccination.

**Remedial Plans and Actions**

***Flu:*** Following a full review of this year's campaign, recommendations have been devised based on some of the key areas of learning and development. The aim is to streamline current processes, remove duplication of effort and improve engagement with the workforce. It is evident that positive steps have been made, and a number of the lessons learnt from the previous campaign have been implemented. However, there is a range of areas that require continued development for future campaigns. Planning for the next Flu Campaign is expected to start shortly, earlier than ever before.

***COVID-19:*** Welsh Government have been involved in discussions between the four UK Chief Medical Officers (CMOs) regarding the UK Covid-19 alert level. This alert level system has been in operation since May 2020. Its function is to clearly communicate, to the public and across governments, the current level of direct Covid-19 risk. Since September 2022, we have been at level 2. The four UK CMOs have agreed it is appropriate to pause the alert level system. It will be suspended on 30 March.

Routine testing will be paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools over the (2023) spring and summer.

**Expected Performance Trajectory**

The 2022-23 Flu campaign has now concluded. The Trust will continue to monitor influenza and COVID-19 through intelligence gathered by the Forecasting & Modelling Group on a weekly basis. Any learning from southern hemisphere countries will be shared and used for modelling purposes for the 2023-24 winter flu season.

**NB: Due to a technical error in the downloading of data for the Trust are unable to report monthly flu data for January & February 2022.*
***NB: COVID Vaccinations are reported using the WAST definition of Frontline Patient Facing employees and therefore includes those employed within Clinical Contact Centres.*
****NB: Flu data accurate at time of publication and subject to change / Spikevax vaccination data correct at time of publication and subject to change.*

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

# Our People
# Health and Wellbeing - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

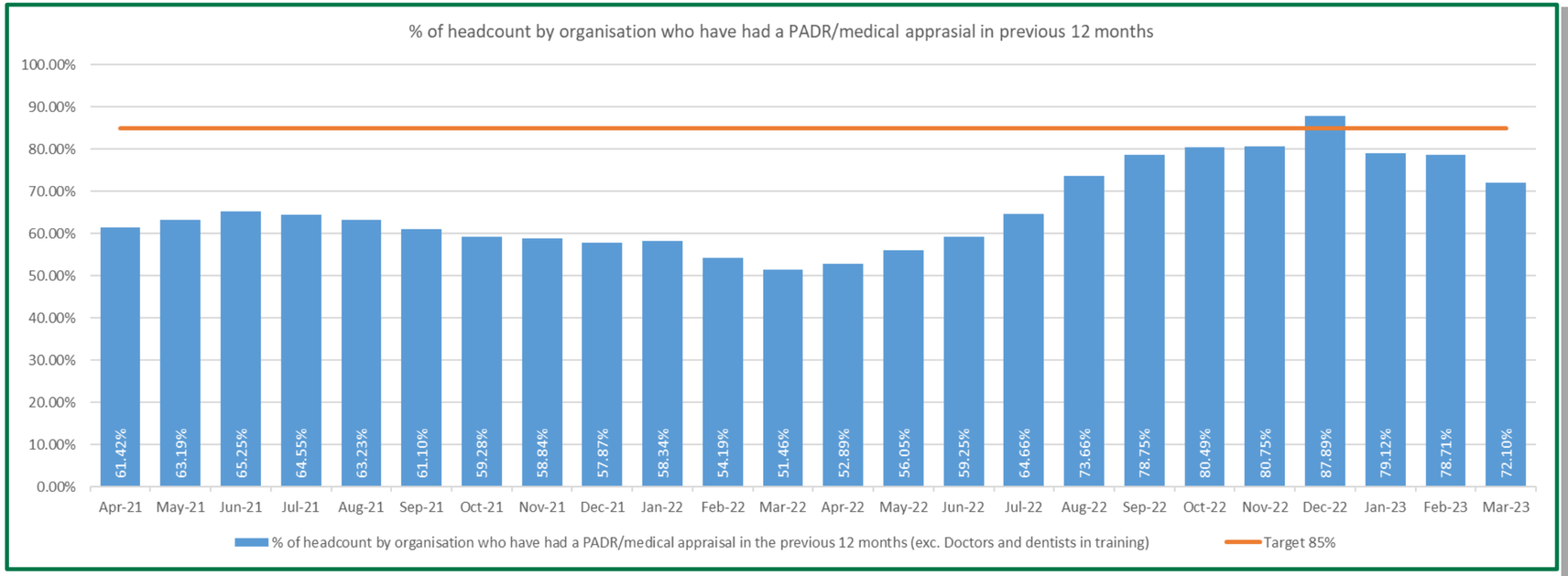
A

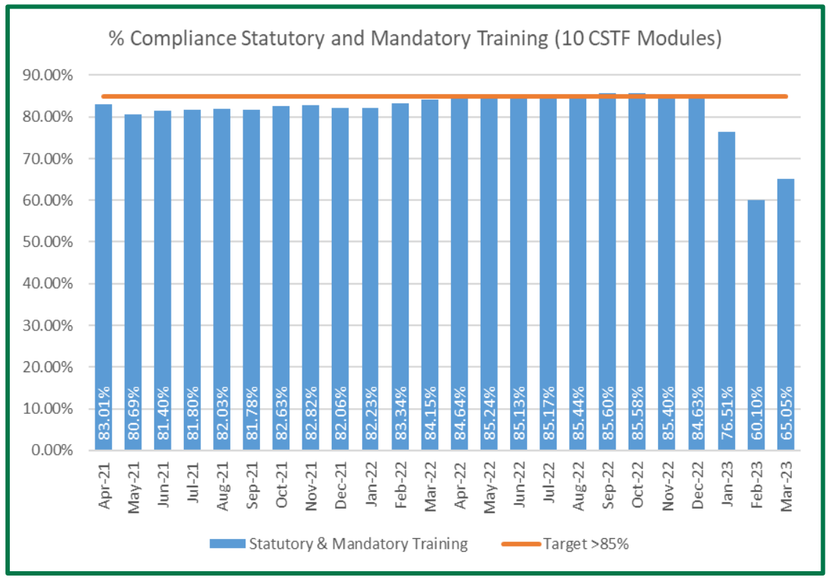
Self Assessment: Strength of Internal Control: Strong

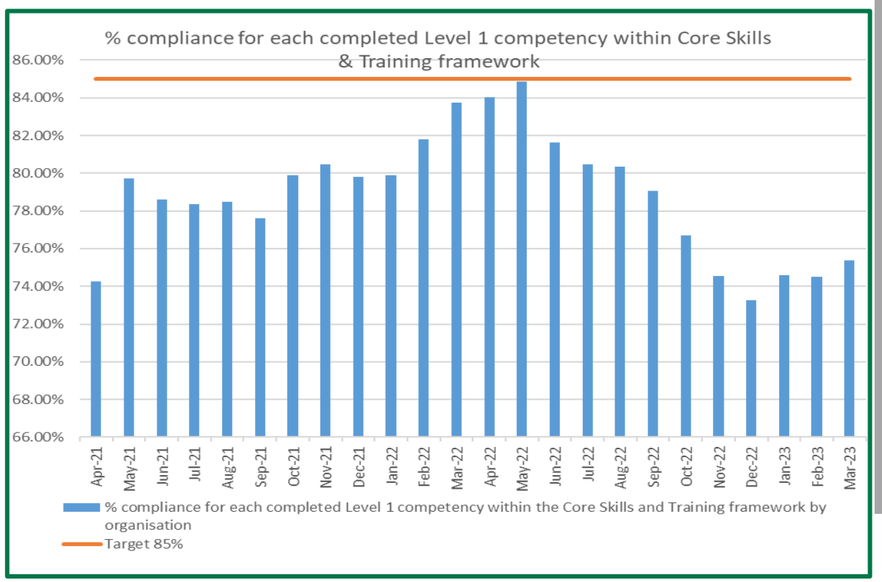
CI

PCC

Health & Care Standard
Health – Staff & Resources




**Analysis**

PADR rates for March 2023 declined compared to the previous month to 72.10%, therefore failing to achieve the 85% target. Over the reporting period this target was only achieved once in December 2022, although current rates are much higher than the same period last year.

In March 2023 Statutory & Mandatory Training rates reported a combined compliance of 73.69%; only Safeguarding Adults (90.88%) and Dementia Awareness (89.60%) modules achieved the 85% compliance target; however, Violence Against Women, Domestic Abuse & Sexual Violence (84.58%), Moving & Handling (77.46%), Fire Safety (72.42%), Equality & Diversity (71.18%), Information Governance (70.29%), and Paul Ridd (30.07%) fell below the 85% target.

There are currently 15 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table below:

**Remedial Plans and Actions**

At the time of reporting, (mid-April 2023) 417 of 1,836 EMS colleagues (22.7%), 30 of 284 ACA2 (10.56%) and 81 of 540 ACA1 colleagues (15.00%) have completed MIST Training days. Sessions continue to be facilitated Pan-Wales through the Education and Training Team, who Continue to manage and monitor these via the online booking system accordingly.

From the 01st April 2023 e-learning mandated by Welsh Government in relation to Welsh Language will be added to all colleagues' compulsory competencies via ESR. Communication to ensure colleagues are prepared and aware of this continues to be circulated via Siren and Yammer.

**Expected Performance Trajectory**

The Statutory & Mandatory compliance needs to be addressed, but further analysis of the cause is required before an improvement trajectory can be set.

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

*Data source: ESR*

# Finance, Resources and Value
# Finance Indicators

(Responsible Officer: Chris Turley)

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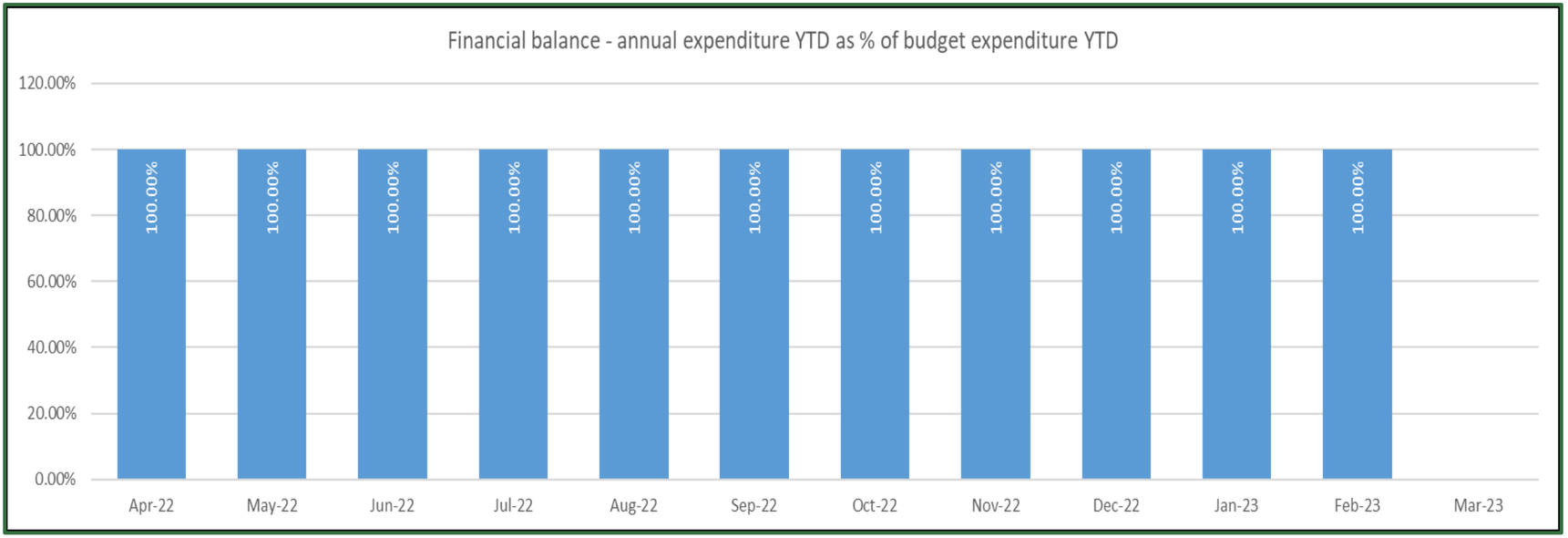
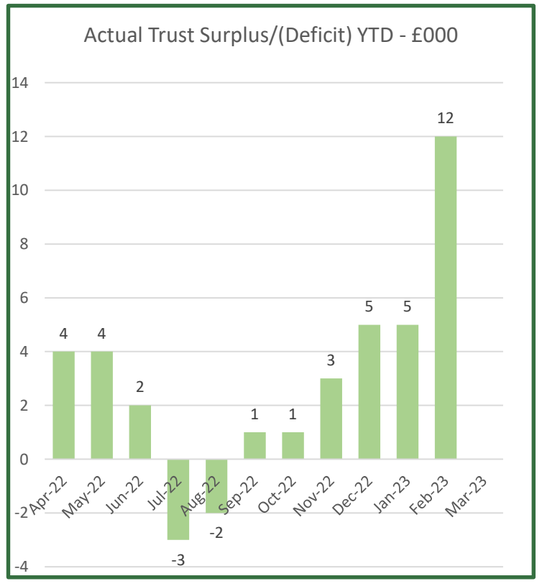
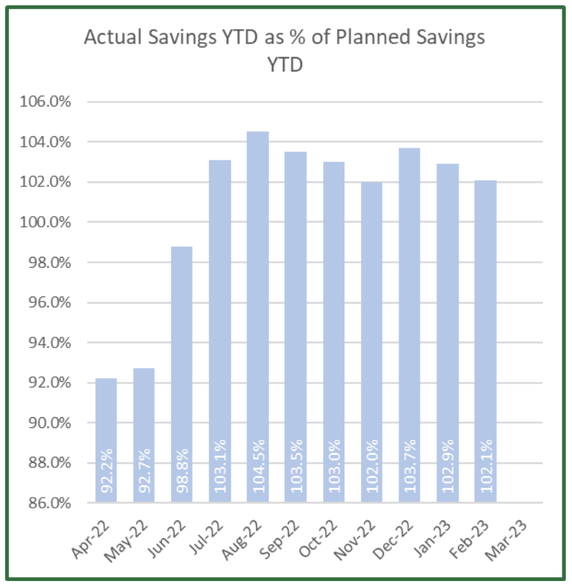
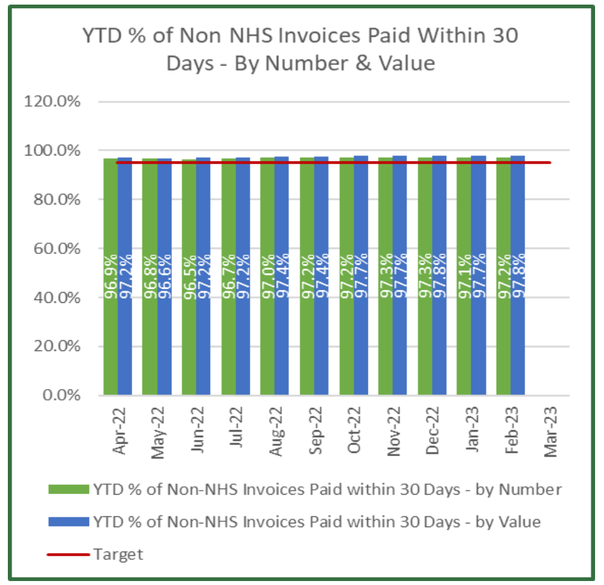
*NB: March 2023 update unavailable due to 2022-23 Year end processes




**Analysis**

The reported outturn performance at Month 11 is a surplus of £12k, with a forecast to the yearend of breakeven.

For Month 11, the Trust is reporting planned savings of £3.942m and actual savings of £4.025m (an achievement rate of 102.1%).

The Trust's cumulative performance against PSPP as at Month 11 is 97.2% against a target of 95%.

The agency spend in February 2023 (0.5%) remained the same as January 2023 (0.5%).

**Remedial Plans and Actions**

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

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

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

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

**Expected Performance Trajectory**

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2022/23 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2023/24 financial year.

# Finance, Resources and Value
# Resource and Value Indicators

(Responsible Officer: Chris Turley)

Decarbonisation
A

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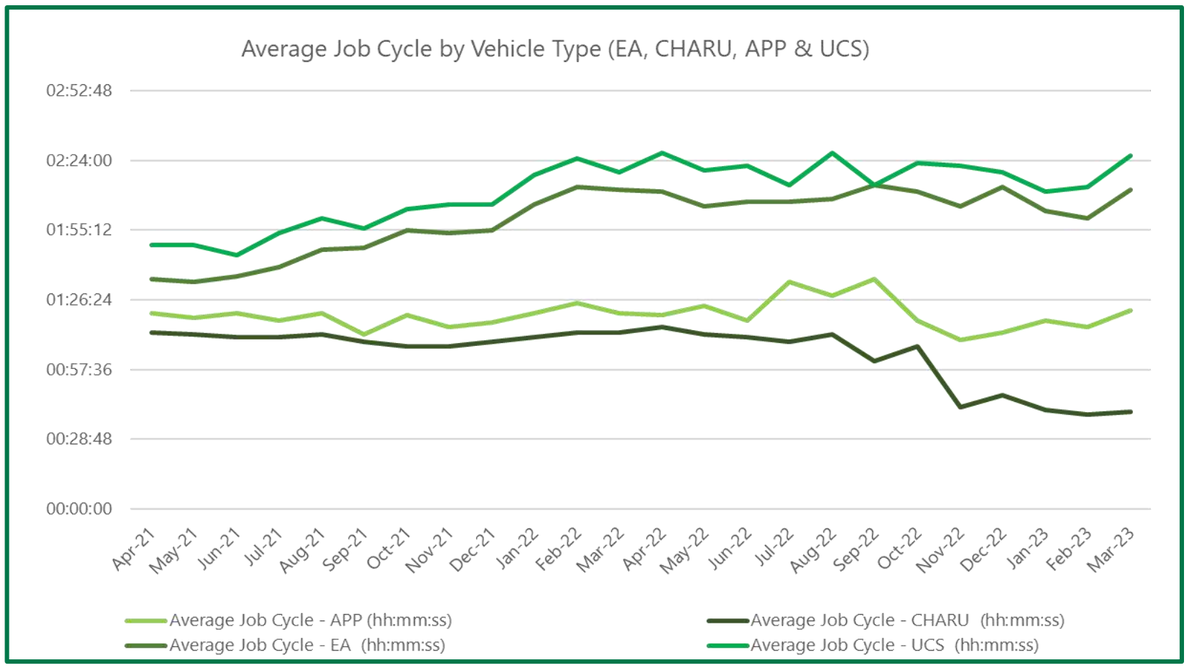


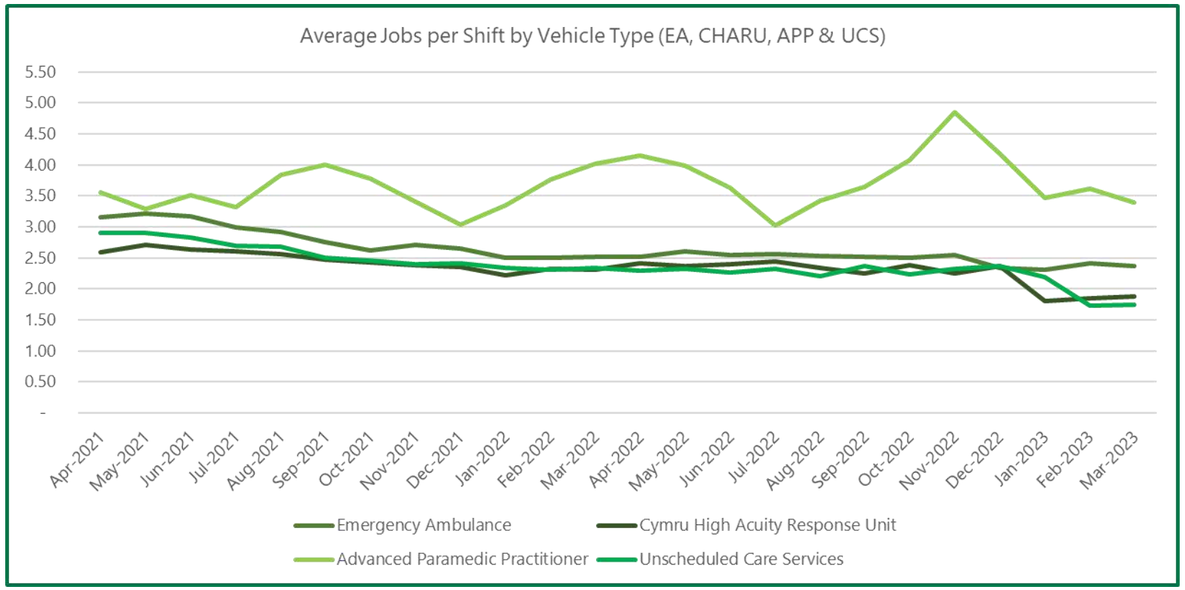


**Value – Job Cycle and Volume**

**Analysis**

As demonstrated in the top graph, the average job cycle decreased in March 2023 for all vehicle types. EA calls averaged 2 hours 12 minutes while UCS crews saw their average increase to 2 hours 26 minutes.

Average jobs attended by all crew types increased in March 2023, except for EA and APP crews. APPs attended on average 3.40 jobs per shift, EAs 2.37 jobs per shift, UCS crews 1.74 jobs per shift and RRV's 1.88 jobs per shift.

Overall average jobs per shift has remained relatively static for EA, CHARU and UCS throughout the past year, following a period of decline during 2021. In comparison average jobs per shift for APPs is on a fluctuating, but generally increasing trajectory.

**Remedial Plans and Actions**

The increase in average job cycle time since 2021 can be attributed to numerous factors including the introduction of ePCR and increasing hospital delays (staff pre-empting and packaging patients in readiness for long waits and patients waiting longer for an ambulance response therefore requiring more treatment/assessment). These times are monitored at Weekly Performance Meeting and local work to establish appropriate efficiency initiatives is ongoing

**Expected Performance Trajectory**

The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not been seen.

**NB: Average jobs per shift only includes data where the full shift worked is less than 20 hours.*
*Total shift hours currently includes the meal break for the shift*
*Total shift hours also includes Postproduction Lost Hours*

NB: CHARU data is not yet available

**Resource - Decarbonisation**

**Analysis**

Delivery of the capital programme in 2023/24 sought to maximise decarbonisation aspects associated with investment. Examples include PV panels and battery storage at Bridgend Ambulance Hub, PV panels, battery storage and installation of air source heat pump within the development of the SE Fleet Workshop, and other energy saving schemes such as LED lighting, glazing and building management systems where possible during the last quarter of 2023/24. The Trust's EV charging network (initially to support implementation of 23 PHEV car-based response vehicles) developed from minimal provision to 67 chargers over 54 sites.

**Remedial Plans and Actions**

WAST Decarbonisation Action Plan is currently reporting internally as Amber. Estates and Facilities Advisory Board funding in 2023/24 and 2-24/25 will allow for investment in further infrastructure and decarbonisation schemes across a range of sites. Plans for Building Management Systems, and a design guide for retrofit of estate continue to be developed. However, further funding will be required. The Trust has completed a scoping exercise for electrical capacity requirements across the WAST estate and work is ongoing with Welsh Government Energy Services on rapid EV charging. The Programme Board was established in January 2023 and met again on 24th April 2023, and continues to develop its work programme and risk management approach.

**Expected Performance Trajectory**

The Welsh Government targets of a net-zero position by 2030 pose real and complex challenges for WAST. In response to this, a key action over the next year will be to develop our Sustainability and Infrastructure Strategic Outline Programme, which will outline the financial and resource implications for the move to a carbon-neutral ambulance Trust. This will need significant input from our colleagues across the Trust and will require additional investment within the Finance and Corporate Resources Directorate to manage this. The relevant business cases in support of Estates and Fleet developments will continue to reinforce the importance of this agenda, and to push us towards a position of carbon neutrality, maximising our use of new technology and responding in a flexible and agile way to the changing external environment.

# Value / Partnerships & System Contribution
# EMS Utilisation & Postproduction Lost Hours Indicators

(Responsible Officer: Lee Brooks)

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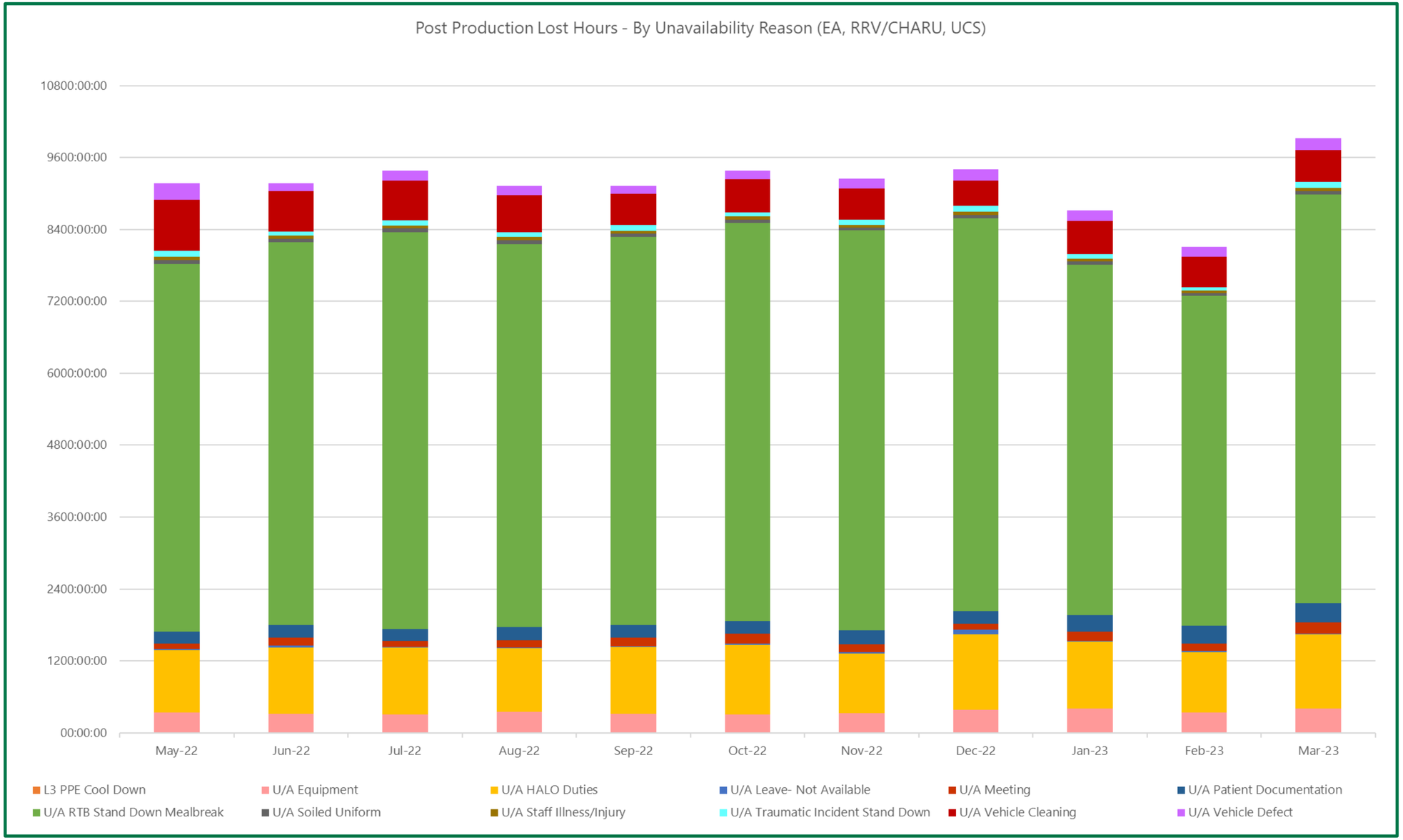


**Analysis**

**There were 9,916 postproduction lost hours (PPLH) across EA, RRV/CHARU, APP & UCS vehicles in March 2023;** an increase when compared to February 2023 (8,106). PPLH are due to numerous factors, as outlined in the bar chart which demonstrates they have remained relatively consistent from May 2022 (the month a retrospective fix was undertaken for the under-reporting of U/A RTB Stand Down Meal-break code). There was an increase in hospital handover delays in the month of March 2023 to 28,620 hours (up from 19,110 in February 2023) which is indicative of the increase in PPLH relating to U/A RTB Stand Down Meal-break.

**Remedial Plans and Actions**

The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting. In relation to the U/A RTB Stand Down Meal-break reason, the rest break automation initiative has been paused due to industrial relations. The Trust plans to revisit this once the industrial dispute with Welsh Government has concluded.

**Expected Performance Trajectory**

The current data needs to be treated with a degree of caution. As stated above, the Trust will not be able to eliminate PPLH. Although delayed handover hours outside EDs have improved slightly from December 2022, the lost hours for March 2023 were extreme, meaning resources are returning to base for rest predominantly outside of the rest break window, resulting in an unavailable status being assigned.

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

# Partnerships / System Contribution
# NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
## Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

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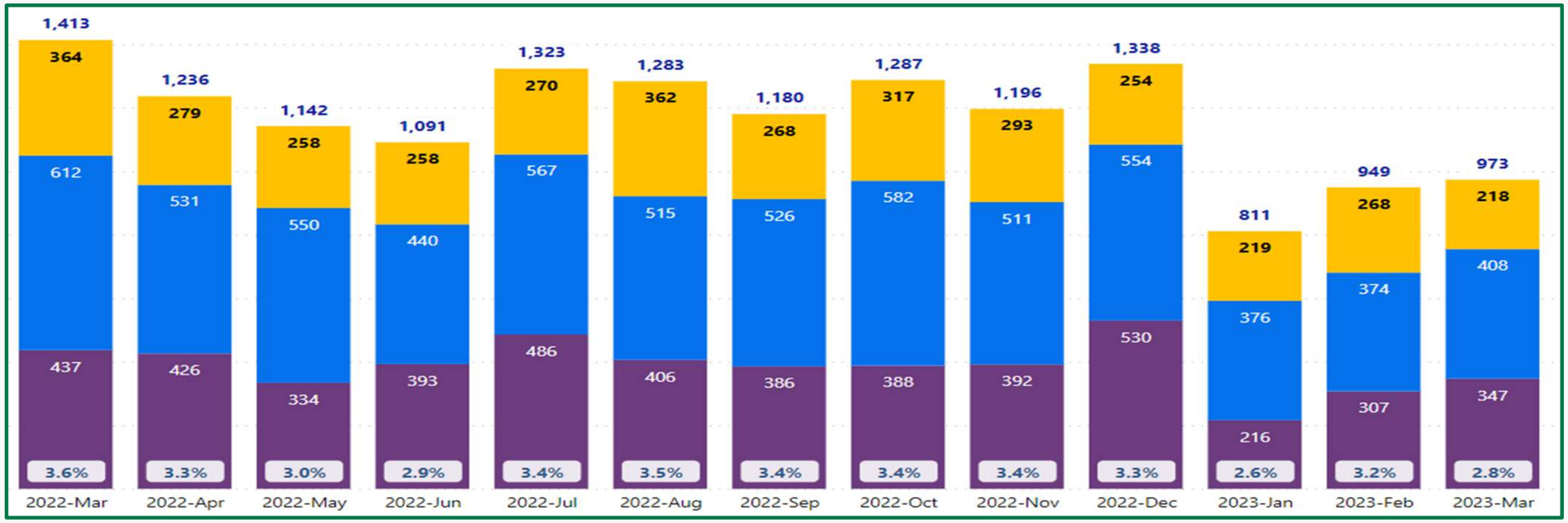


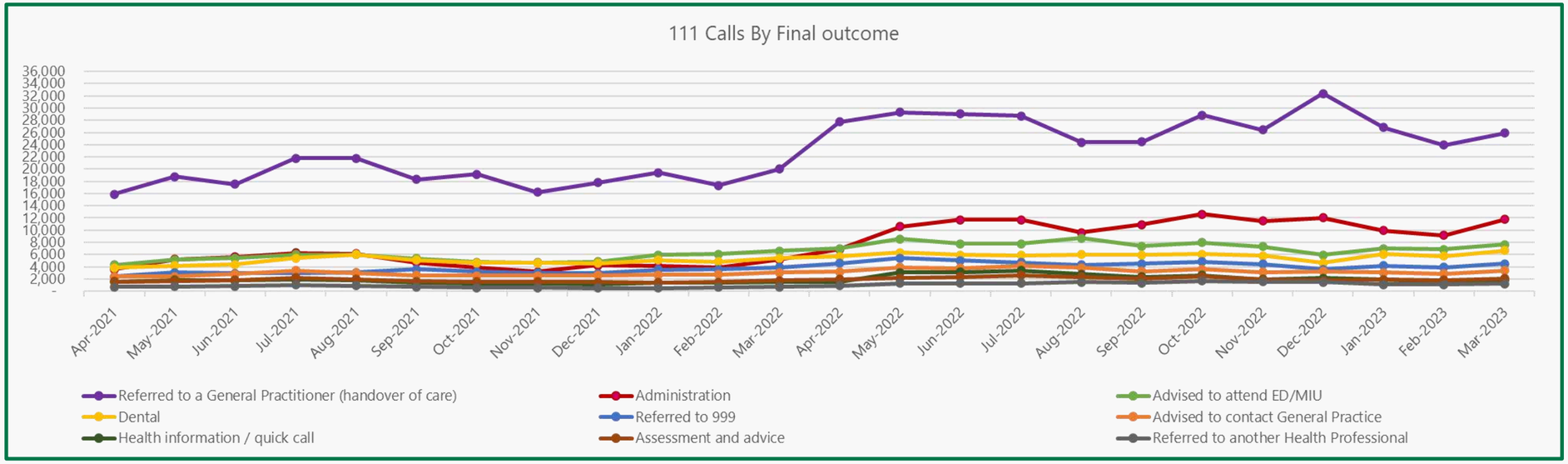


**Analysis**

The top graph depicts the outcomes against 999 calls where secondary triage is performed by NHS111 Consult and Close.

As demonstrated in the top graph in March 2023 alternative transport was the top outcome for calls handled by NHS111 followed by referral and.

65,070 calls were received into the 9 categories displayed in the bottom graph during March 2023, an increase when compared to 56,917 received in February 2023; and more in line with the average volume of calls received in the last 6 months.

**In March 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 40% of all calls.**

**Remedial Plans and Actions**

The new Consult and Close dashboard is now complete and live, enabling the Trust to report more meaningful and specific data in relation to calls ending in alternative transport, referral and self care.

The use of video consultation has been implemented and is now live, early indications show this to be a useful tool.

**Expected Performance Trajectory**

The Trust currently have a target to consult and close 15% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2 by increasing the current target to 17% by the end of Quarter 1 2023/24 through internal efficiencies. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

# Partnerships / System Contribution
# Consult & Close Indicators

(Responsible Officer: Lee Brooks)

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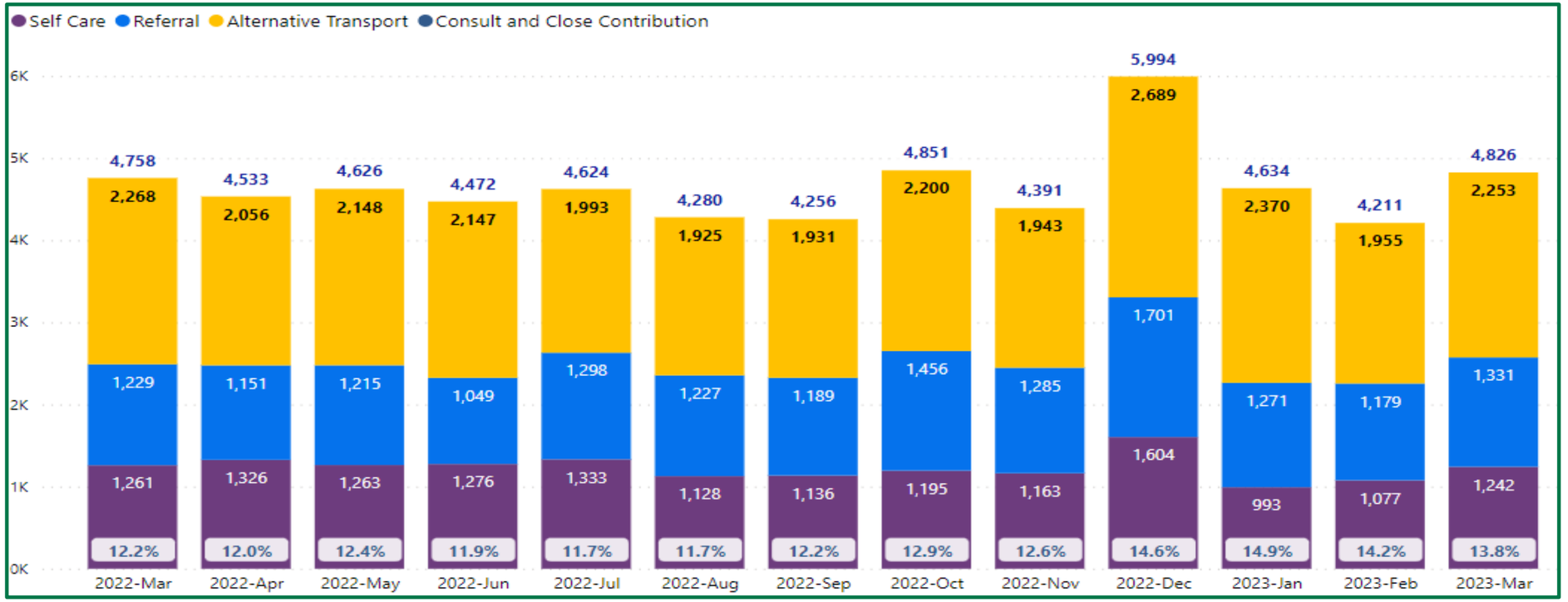
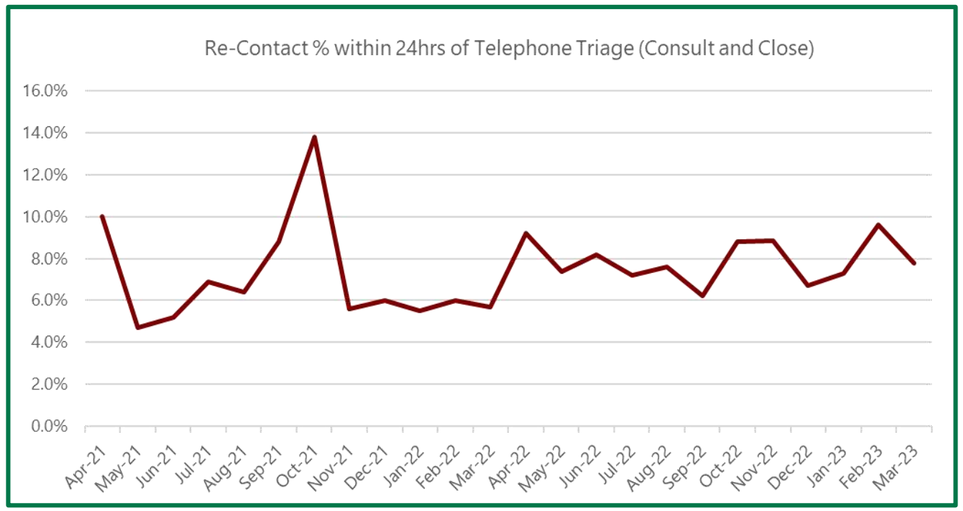
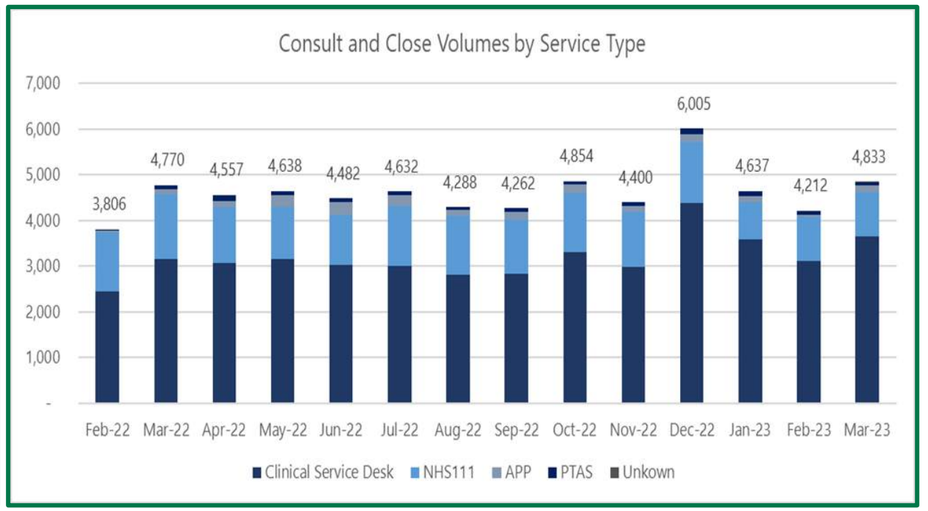



**Analysis**

**Consult and Close** with contributions from Clinical Support Desk (CSD) (10.4%), NHS111 (2.8%), as well as WAST APP (0.4%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 13.8% performance in March 2023 which was a slight decline on the 14.2% obtained during February 2023 just short of the new 15% target figure. Although more 999 calls resulted in a Consult and Close outcome (4,826 up from 4,211) the number of 999 incidents was also higher leading to the lower percentage.

Of the calls successfully closed in March 2023, 1,242 patients received an outcome of self care; 1,326 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,250 were advised to seek alternative transport services in order to acquire treatment.

**Re-contact rates in March 2023 were 7.8%,** an increase compared to 5.7% in March 2022 and 7.1% in March 2021.

**Remedial Plans and Actions**

- The team are undertaking process maps of the work that they do in order to identify where improvements can be made.
- Red Review of 999 calls to confirm appropriate category selection continues to be a high priority for CSD in addition to Consult and Close activity.
- Discussions are ongoing to identify additional resources required on top of Consult & Close priorities.

**Expected Performance Trajectory**

The current target for this year is 15% hear and treat rate for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling.

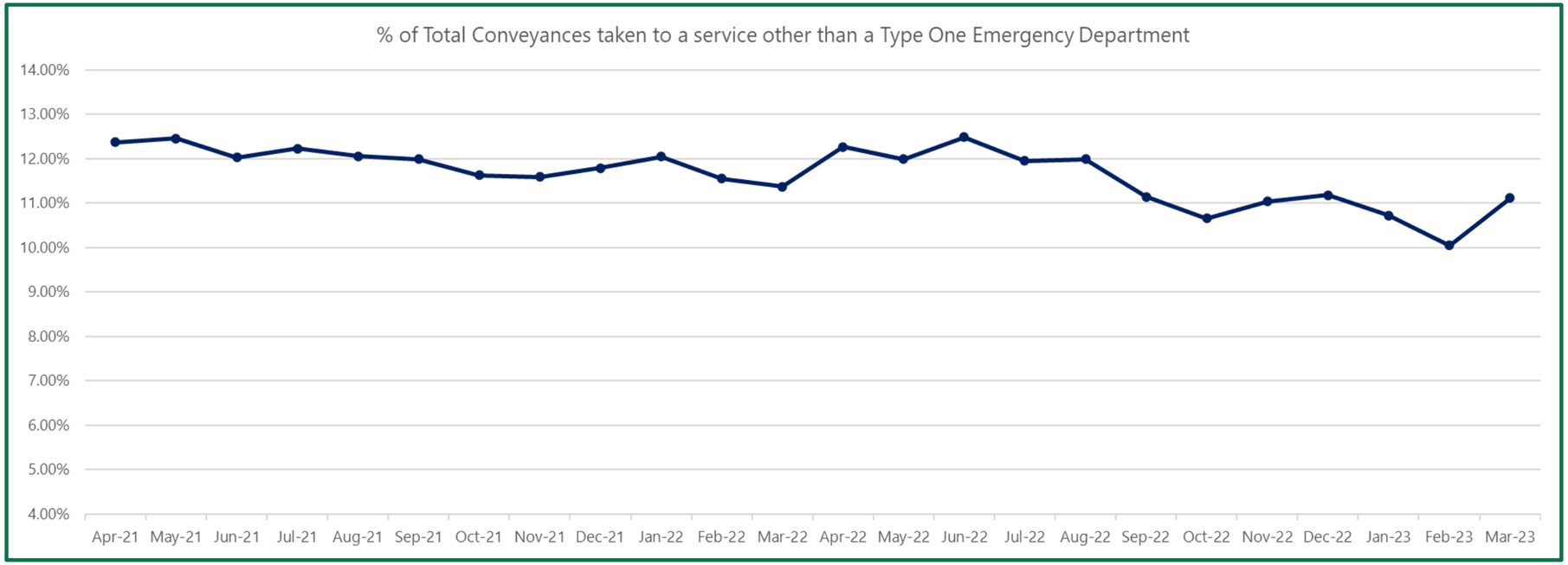
# Partnerships / System Contribution
# Conveyance to ED Indicators

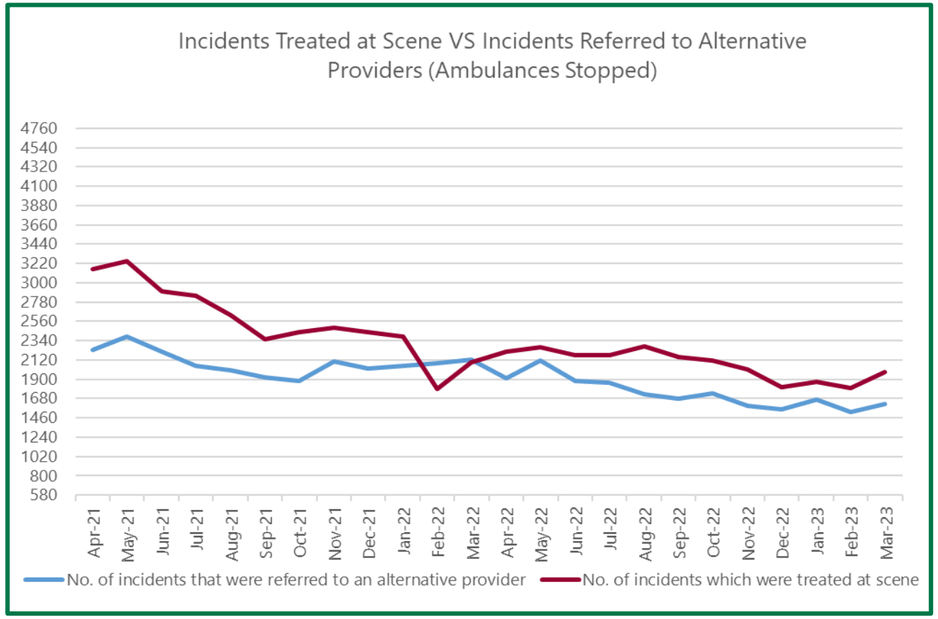
(Responsible Officer: Andy Swinburn)

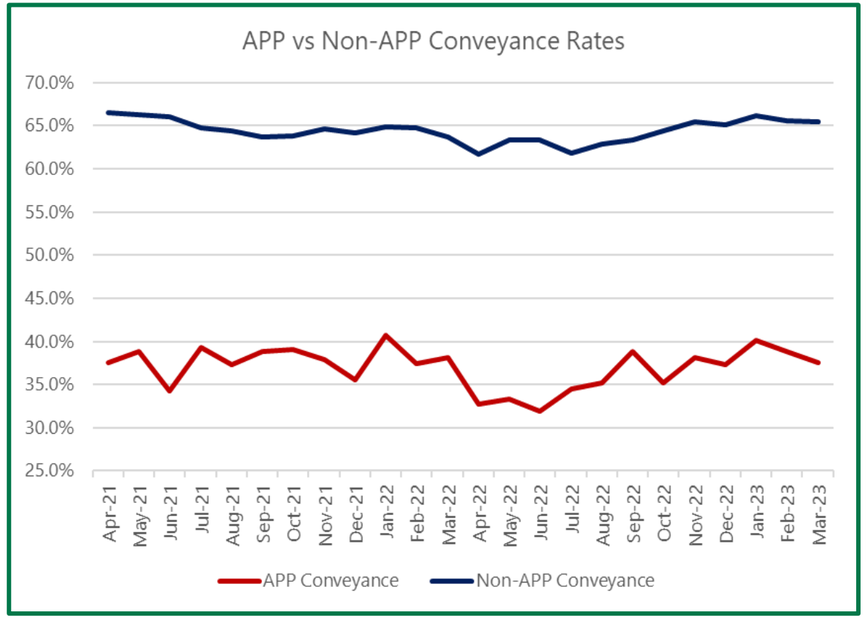
A

FPC

Ministerial Measure




**Analysis**

**In March 2023 11.11% of patients (1,524) were conveyed to a service other than a Type One ED**. Although not shown here, the percentage of patients conveyed to EDs increased compared to the same period last year. In March 2023 conveyance to EDs as a proportion of total verified incidents was 34.80% (compared to 32.21% in March 2022).

The combined number of incidents treated at scene and referred to alternate providers increased slightly during March 2023, from 3,330 in February to 3,599 in March 2023. 1,615 incidents were referred to alternative providers and 1,984 incidents were treated at scene.

There has been a general increase in APP conveyance rates in recent months, due to several factors: -

- CSP means the right jobs are not always there for APPs to alter or influence the disposition.
- The tasking of APPs has changed, moving away from APPs reviewing the stack to mandatory code sets.
- There has been an increase in respiratory patients of all ages over the last quarter who have been poorly and required hospital admission.

**Remedial Plans and Actions**

The Trust has modelled the use of same day emergency care (SDEC) services and identified that they could take an estimated 4% of EMS demand; it is currently less than 0.25%. This modelling has been provided to both EASC and WG. The percentage increase in conveyance to services other than EDs is a Ministerial Priority. The Trust's ability to improve this figure is dependent on pathways that are open to the Trust, for example, SDECs.

Utilisation of APP resources will continue to be monitored as part of weekly performance reviews and evaluation of the appropriate APP code-set will be undertaken through the Clinical Prioritisation and Assessment Software (CPAS) group.

**Expected Performance Trajectory**

The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well. This modelling indicates a reduction in patients conveyed of 1,165 per week but is predicated on large scale investment in APPs (470 v a starting position of 67).

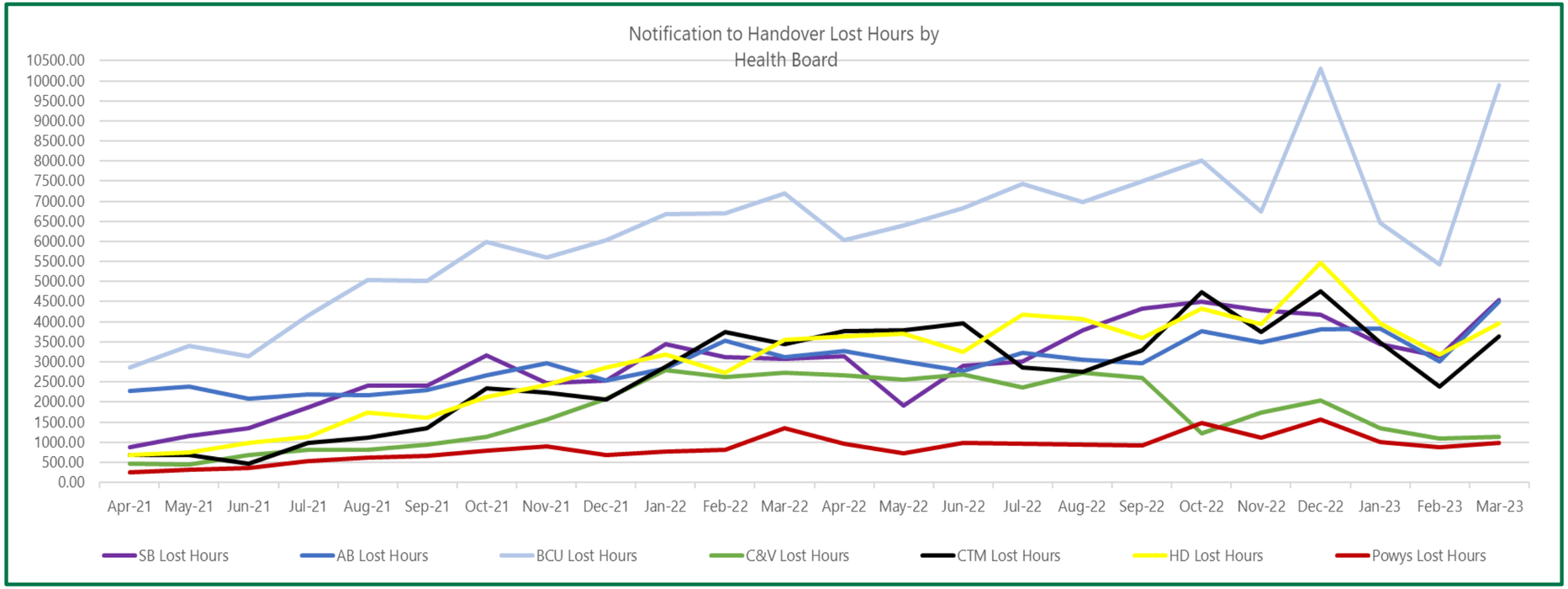
**NB: Data correct on the date and time it was extracted; therefore, figures are subject to change.*

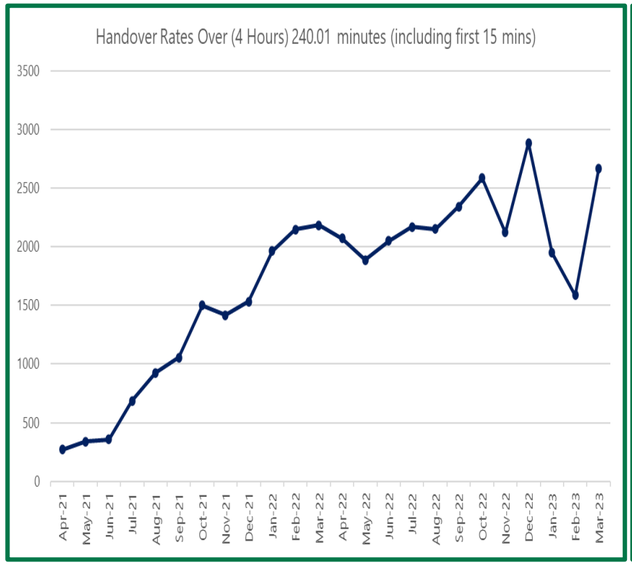
# Partnerships / System Contribution Handover Indicators

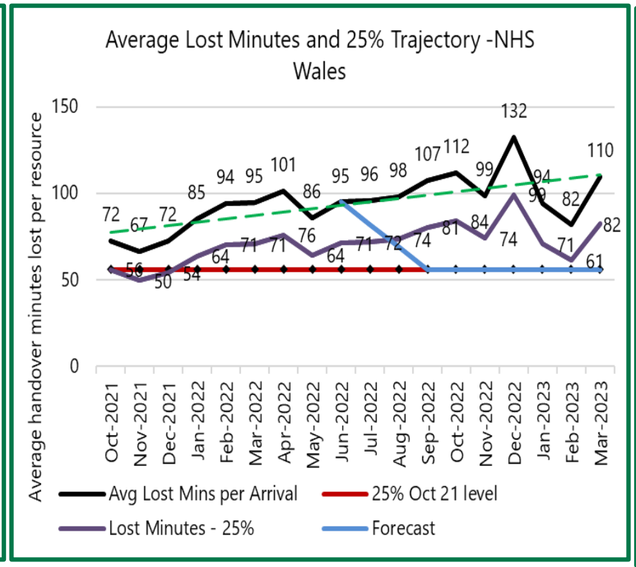
(Responsible Officer: Health Boards)

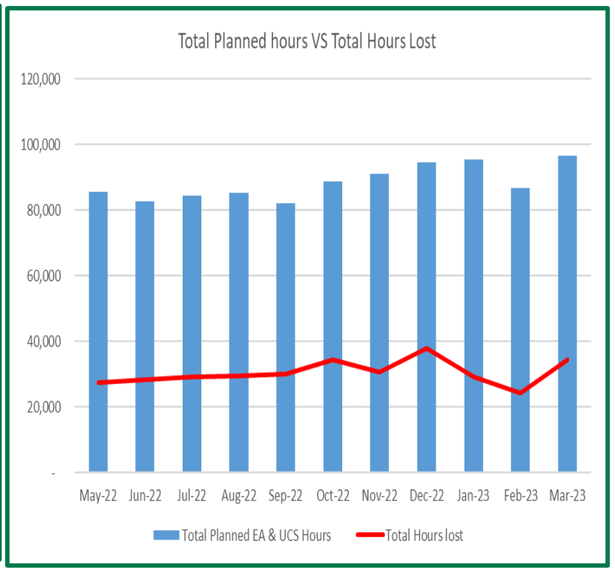
R

CI QUEST




**Analysis**

**299,636 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Apr-22 to Mar-23), compared to 191,461 over the same timeframe the previous year.** 28,620 hours were lost in March 2023, an increase from the 19,110 lost in February 2023 and a higher volume than the 24,479 recorded for March 2022.

The hospitals with the highest levels of handover delays during March 2023 were:

- Morriston Hospital (SBUHB) at 4,368 lost hours
- Glan Clwyd Hospital Bodelwyddan (BCUHB) at 4,345 lost hours
- The Grange University Hospital (ABUHB) at 4,171 lost hours
- Maelor General Hospital (BCUHB) at 3,044 lost hours

Notification to handover lost hours averaged 923 hours per day during March 2023 compared to 683 hours a day in February 2023. There were 2,669 handovers over 4 hours Pan-Wales in March 2023 an increase compared to March 2022 (2,186) and March 2021 (208).

In March 2023, the Trust could have responded to approximately 9,028 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

**Remedial Plans and Actions**

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government / Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve.
Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.
The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR). 60 ideas have been received through the WIIN platform from staff in August 2022.

**Expected Performance Trajectory**

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

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

# 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).<br>(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.<br>ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot. | **Post Production Lost Hours** | Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22). |
| **Renal Journeys arriving within 30 minutes of their appointment (NEPTS)** | Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time. | **111 Consult and Close** | Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response. |
| **Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)** | Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time. | **999 / 111 Hear and Treat** | Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services. |
| **National reportable Incidents (NRI)** | Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare. | **% Incidents Conveyed to Major EDs** | Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents.<br>(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 |

| | |
|---|---|
| **AGENDA ITEM No** | **15** |
| **OPEN or CLOSED** | **OPEN** |
| **No of ANNEXES ATTACHED** | **2** |

# PEOPLE AND CULTURE PERFORMANCE SCORECARD REPORT

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9th May 2023 |
| **EXECUTIVE** | Angela Lewis - Director of People and Culture |
| **AUTHOR** | Sarah Davies – People and Culture Directorate Business Manager |
| **CONTACT** | Sarah.davies31@wales.nhs.uk |

## EXECUTIVE SUMMARY

The purpose of this report is to provide an overview of the key People and Culture performance data and trends (March 2023) and associated improvement actions.

## KEY ISSUES/IMPLICATIONS

The Committee's attention is drawn to the following areas:

- Increase in sickness absence for March, but indicative figures denoting a reduction for April 2023;
- Impact of Industrial Action on delivery of MIST training (affecting Statutory and Mandatory training compliance rates);
- Conclusion of the 2022-23 Flu vaccination programme, with 44.5% uptake.

The Committee is asked to **RECEIVE** and **COMMENT ON** reported performance and associated actions.

## REPORT APPROVAL ROUTE

- **Noted** at People and Culture Business Meeting (04.05.2023)

## REPORT APPENDICES

**Appendix 1a:** SBAR – People and Culture Performance Report for March 2023
**Appendix 1b:** People and Culture KPI Summary

## REPORT CHECKLIST

| Confirm that the issues below have been considered and addressed | | Confirm that the issues below have been considered and addressed | |
|---|---|---|---|
| EQIA (Inc. Welsh language) | N/A | Financial Implications | YES |
| Environmental/Sustainability | N/A | Legal Implications | YES |

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

***Appendix 1a: SBAR: People and Culture Performance Report for March 2023***

**SITUATION**

1. This report provides an overview of the March 2023 key trends and improvement actions as identified in the People and Culture KPI Summary enclosed at **Appendix 1b**.

**BACKGROUND**

2. This paper is intended to be read in conjunction with **Agenda Item 14 – Monthly Integrated Quality and Performance Report**. The MIQPR provides a high level overview of performance in relation to the following People and Culture indicators:

    - PADR completion rate;
    - Statutory and Mandatory training compliance;
    - Sickness absence rate.

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

**ASSESSMENT**

3. The Committee is asked to note the following headlines:

4. **Time to Hire:** Vacancy control to conditional offer (time to hire) represents the time it takes for a recruiting manager to update Trac with a vacancy up till the time a conditional offer is made to the successful applicants. Currently the pan-Wales target is 44days and WAST has been improving consistently, returning a figure of 46.4days in January, 43.6 days in February and 34.6 days in March 2023. This figure could be improved by ensuring that steps such as shortlisting and giving outcomes are within the targets set. Currently the target for shortlisting is 3 days and we came in at 2.9 days and the target for delivering outcomes is 3 days and currently WAST is at 10 days. WAST has implemented a vacancy control panel to help manage recruitment across the Trust. This will be closely monitored to ascertain the impact on achieving our KPIs. Alongside this will be a continuous drive to ensure managers are aware of the implications of any delay during recruitment on our KPIs.

5. **Job Evaluation:** 6 job descriptions are currently in the JE process. Of these, 5 will be proceeding to the next available job matching panels and one is awaiting action or response from the requesting manager. 9 JDs that were on the register for an extended period have been archived pending further action by requesting managers. The team are aware of a further 7 JDs which are in the development

stages. During March 4 job descriptions were successfully completed, taking on average 10 days to complete, which is a significant improvement compared to previous months. A new All-Wales JD template has now been agreed and has been implemented for new JDs.

6. **Sickness Absence:** There was an increase in sickness absence in March going from 7.99% in February 2023 to 8.33%, which is due to an increase in short term sickness, with Covid related absences as the highest reason. Long term sickness decreased from 5.72% (February) to 5.36% (March). Short term sickness increased from 2.23% (February) to 2.98% (March). April indicative absence (as of 20.04.2023) for the Trust is 8.03%, with long term sickness continuing to decrease (5.36% in March, 4.50% in April) and short-term sickness increasing (2.98% March, 3,53% April, with Covid related absences as the highest reason). Regular sickness absence management meetings have continued with particular focus in hot spot areas.

7. **Vaccination Rates:** The flu vaccination programme for 2022 – 2023 concluded at the end of March 2023. 44.5% of all staff engaged with the vaccination programme by having a flu vaccination (up 6% on 2021-22), of which 46.3% of front-line staff had the vaccine (up 5.2% on 2021-22). Whilst an improvement for WAST, this is below the Government target of 60% uptake by staff. The data is now to be analysed so that areas with less uptake can be targeted in the next season to build on and increase uptake, and information as to why staff did not wish to have the vaccine will be used to formulate an education programme for next season. Planning meetings to commence for next season campaign in July 2023. The Covid19 Autumn Booster vaccination programme has ended having been offered to a reduced number of groups (front line patient facing staff, those over 50 years of age and vulnerable groups). The Spring Covid19 Booster programme is not extended to Health Care Workers and we await the decisions regarding the Autumn campaign regarding eligible groups**.**

8. **Statutory and Mandatory Training Compliance:** Completion of S&M training at level 1 for the ten CSTF (Core Skills Training Framework) topics was at 77.26% for the Trust at the end of March 2023; this is the figure reportable to WG against a target of 85%.

   The 2022/23 CPD program underwent a transformation into MIST as its format was changed to a scenario based, interactive day with attendance from all roles across Ambulance Care and Ambulance Response. Learners have responded positively to the changes evidenced in individual feedback on the experience. To accommodate EMS recruitment requirements during Q2 and 3, MIST was delayed until Q4; there was some disruption to delivery related to Industrial Action during this time. This has meant MIST for 2022/23 topics has continued into Q1 of 2023/24 with provision to accommodate 100% of those requiring it planned in during April and May. To date, 42% of those requiring MIST have attended.

   Work is underway on finalising MIST for 2023/24 with EPRR, ABD and Mental Capacity highlighted as particular areas to be included based on learning from events affecting the Trust and the wider Ambulance Service.

Communications to be issued to remind staff of the need to take ownership for their MIST/e-Learning on ESR line managers will be encouraged to have discussions with their teams to address any shortfalls.

9. **PADRs**: Completion rates across the organisation have increased to 73.69% - an increase of 8.51% on the figure reported at the last meeting of the People and Culture Committee and an increase of 14.42% over the last year. A manager's toolkit to support colleagues and managers through the PADR process has been developed and launched. The last phase of implementation of the new PADR process which involves transfer of this form to ESR, enabling PADR data and information to be fully reportable, to inform organisational training and intervention plans had to be paused due to staffing however it is envisaged this will be available by the next committee meeting.

10. **Employee Relations:** A slight decrease in the last quarter, to 37 cases in total. The number of disciplinary cases has increased marginally to 16 cases, however there are currently only 2 employees who have been suspended for over four months. In addition, a steady number of formal respect & resolution cases submitted with the total number of cases rising to 21 at the end of March. Following Compassionate Practices for All training, we are currently working on a plan to reduce the number of investigations undertaken over the next 12-month period along with reducing the average length of time for investigations. In addition, we are looking to provide more support and wrap around care for individuals and for those leading investigations. We are also looking to develop a restoration programme to help support individuals back into the organisation.

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

| | |
|---|---|
| **AGENDA ITEM No** | **16** |
| **OPEN or CLOSED** | **OPEN** |
| **No of ANNEXES ATTACHED** | **1** |

# IMPROVING ATTENDANCE AT WORK

| | |
|---|---|
| **MEETING** | **People and Culture Committee** |
| **DATE** | **9th May 2023** |
| **EXECUTIVE** | **Angela Lewis, Director of Workforce and OD** |
| **AUTHOR** | **Liz Rogers, Deputy Director of Workforce and OD** |
| **CONTACT** | **Liz Rogers, Deputy Director of Workforce and OD** |

## EXECUTIVE SUMMARY


The attached presentation sets out the sickness absence data, up to and including February 2023. The continual monitoring and focus on sickness absence has enabled support and access to internal and external interventions contributing to the decreasing absence rates.

February 2023 reported Trust wide sickness absence had decreased to 7.99% (lowest rate since May 2021), seeing a decrease in short term as well as long term absence.

Whilst indicative data for March 2023 suggests there will be a slight increase in absence rate to 8.43%, this is predominantly due to a rise in short term Covid-19 absence.

In addition to management of sickness absence training for managers, further bespoke training and support has been undertaken with additional sessions booked across Ambulance Care and Resource and EMS Response. This intervention has contributed to the reduction in absence across these Directorates.

The average length of days during a period of sickness has seen a reduction to 21.86 days compared with 24.8 days in April 2022.

A deep dive into mental health absence data has been undertaken. The Trust saw an increase in mental health related absence levels from 20.20% in January 2022 to 25.71% January 2023. Mental health absence is made up of 94% front line colleagues and 6% non-front line. This is an interesting figure to consider. The Team will review trends, what further information can be established and the actions to reduce this.

Colleagues within the age bracket of 46 - 60 years have higher levels of absence and the top reasons for absence are mental health, MSK, Respiratory and heart conditions.

| KEY ISSUES/IMPLICATIONS |
|---|
| The Committee is asked to:<br>• **NOTE** the detail set out in the attached PowerPoint deck |

| REPORT APPROVAL ROUTE | | |
|---|---|---|
| **WHERE** | **WHEN** | **WHY** |
| SLT | 18th April 2023 | Information and discussion |
| EMT | 19th April 2023 | Information and discussion |
| P&C Committee | 9th May 2023 | Information and discussion |

| REPORT APPENDICES |
|---|
| Appendix 1 Improving Attendance Update February 2023 |

| 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 |

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust


# Improving Attendance Update

## P&C Committee Date April 2023

# Improving Attendance Programme

## EXECUTIVE SUMMARY

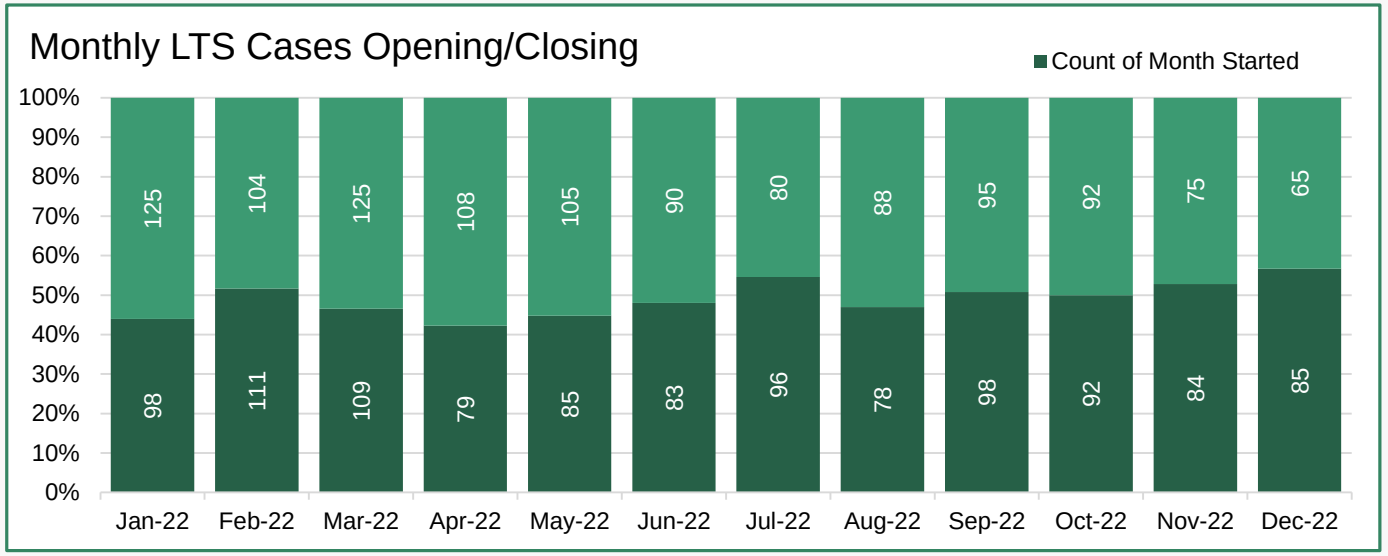
- The figures reported in this presentation are official to 28 February 2023. Figures for March 2023 are indicative.
- There was been a rise in short term absence in February but overall absence is down.
- Indications are March will see a larger increase, with Covid as the highest reason for absence, particularly in EMS in North Wales & South Central.
- March indicative absence for the Trust is 8.43%, with long term at 4.86%, and short term at 3.58%.
- March indicative EMS long term absence is 6.05% and short term is 4.18% (Total 10.18%).
- Anxiety/ stress/ depression remains the highest reason for absence across the rolling 12 mths, with MSK the second highest reason for absence.

| | Trust Absence FTE % | Operations FTE % | Absence FTE |
|---|---|---|---|
| 07/22 | 10.35% | 11.31% | 12,676.47 |
| 08/22 | 8.72% | 9.47% | 10,559.77 |
| 09/22 | 8.68% | 9.38% | 10,138.28 |
| 10/22 | 9.48% | 10.26% | 11,721.25 |
| 11/22 | 8.77% | 9.44% | 10,599.37 |
| 12/22 | 10.65% | 11.40% | 13,475.88 |
| 01/23 | 8.85% | 9.49% | 11,292.27 |
| 02/23 | 7.99% | 8.76% | 9262.98 |

# Analysis: Sickness Absence – Overview

## December 2022

| Average working days lost per FTE (Annual) | |
|---|---|
| 22.96 | days |
| **Single month Absence %** | |
| 10.64% | |
| **Long Term** | **Short Term** |
| 6.05% | 4.60% |
| **Mental Health** | **Other MSK** |
| (S10 Stress/Anxiety) | (excluding Back) |
| 2.41% | 1.13% |

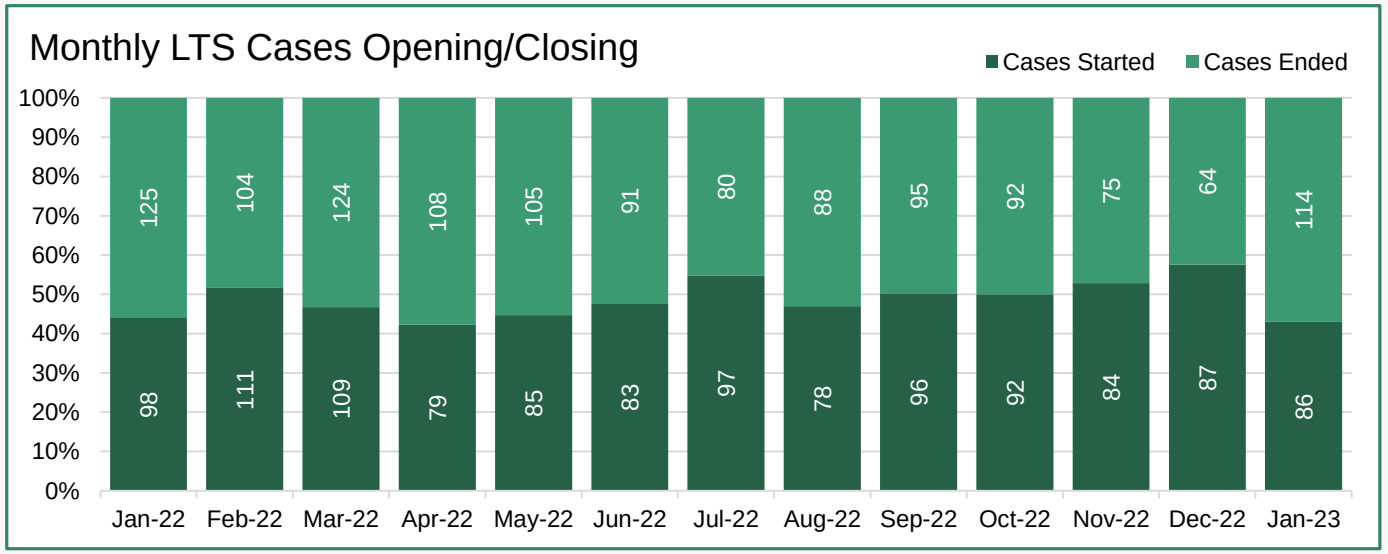



| Absence Reason | Headcount | Abs Occurrences | % | Abs FTE% |
|---|---|---|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 165 | 169 | 22.6 | 2.41% |
| S13 Cold, Cough, Flu - Influenza | 333 | 339 | 13.2 | 1.41% |
| S15 Chest & respiratory problems | 169 | 173 | 10.7 | 1.13% |
| S12 Other musculoskeletal problems | 79 | 79 | 10.6 | 1.13% |
| S27 Infectious diseases | 164 | 166 | 8.9 | 0.95% |
| S11 Back Problems | 44 | 44 | 5.8 | 0.62% |
| S25 Gastrointestinal problems | 157 | 161 | 5.7 | 0.60% |
| S28 Injury, fracture | 34 | 34 | 3.9 | 0.41% |
| S21 Ear, nose, throat (ENT) | 51 | 51 | 3.0 | 0.32% |
| S99 Unknown causes / Not specified | 37 | 37 | 2.9 | 0.31% |

# Analysis: Sickness Absence – Overview

## January 2023

| Average working days lost per FTE (Annual) | |
|---|---|
| 22.38 | days |
| **Single month Absence %** | |
| 8.94% | |
| **Long Term** | **Short Term** |
| 5.69% | 3.25% |
| **Mental Health** | **Other MSK** |
| (S10 Stress/Anxiety) | (excluding Back) |
| 2.35% | 1.04% |

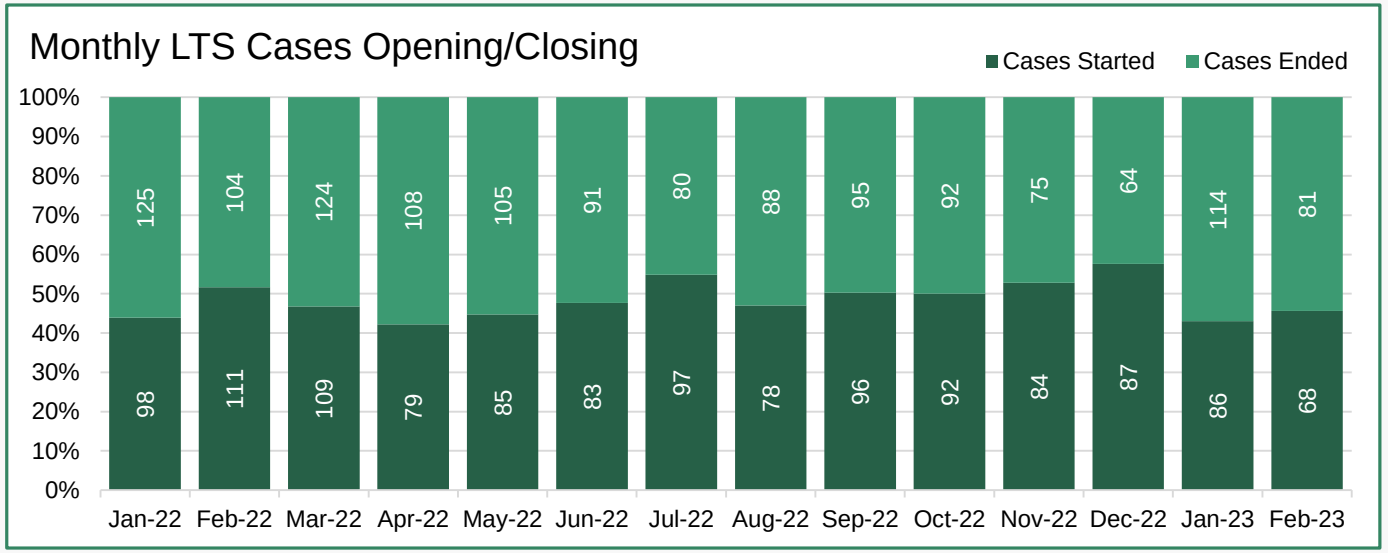



| Absence Reason | Headcount | Abs Occurrences | % | Abs FTE% |
|---|---|---|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 168 | 171 | 28.6 | 2.36% |
| S12 Other musculoskeletal problems | 77 | 78 | 12.6 | 1.04% |
| S13 Cold, Cough, Flu - Influenza | 184 | 185 | 11.3 | 0.94% |
| S15 Chest & respiratory problems | 79 | 80 | 6.4 | 0.53% |
| S11 Back Problems | 46 | 46 | 5.8 | 0.48% |
| S25 Gastrointestinal problems | 113 | 116 | 4.9 | 0.40% |
| S19 Heart, cardiac & circulatory problems | 27 | 27 | 4.8 | 0.39% |
| S99 Unknown causes / Not specified | 39 | 39 | 4.1 | 0.34% |
| S28 Injury, fracture | 28 | 28 | 3.5 | 0.29% |
| S21 Ear, nose, throat (ENT) | 47 | 49 | 3.3 | 0.27% |

# Analysis: Sickness Absence – Overview

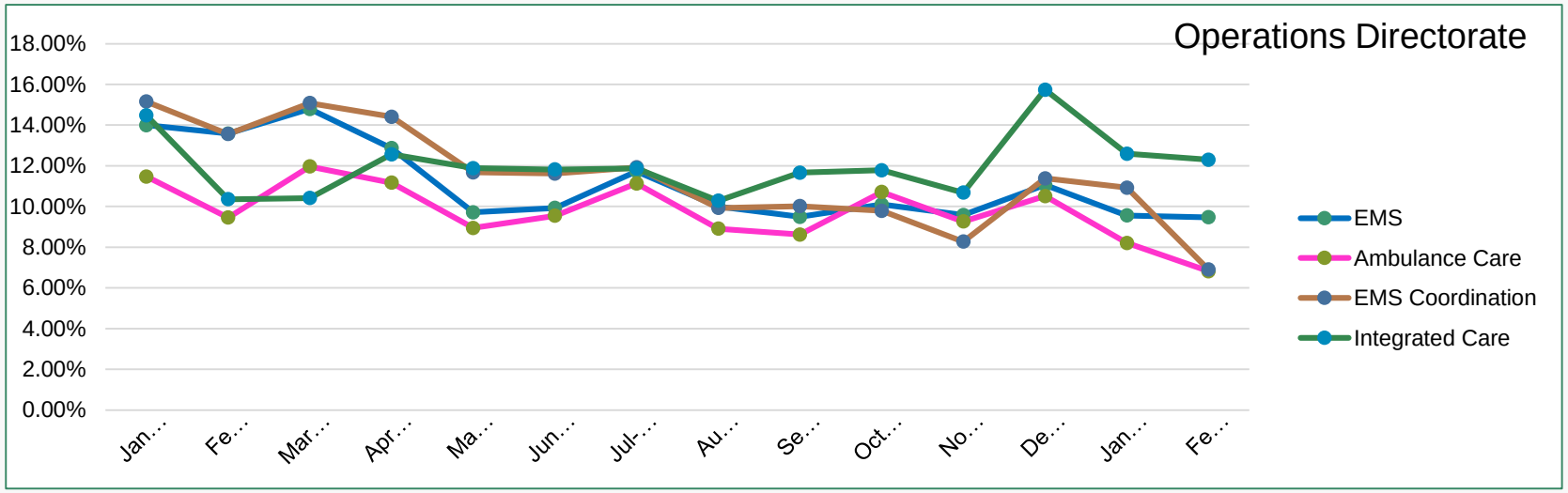
## February 2023

| Average working days lost per FTE (Annual) | |
|---|---|
| 21.86 | days |
| **Single month Absence %** | |
| 7.99% | |
| **Long Term** | **Short Term** |
| 5.76% | 2.22% |
| **Mental Health** | **Other MSK** |
| (S10 Stress/Anxiety) | (excluding Back) |
| 2.24% | 1.12% |



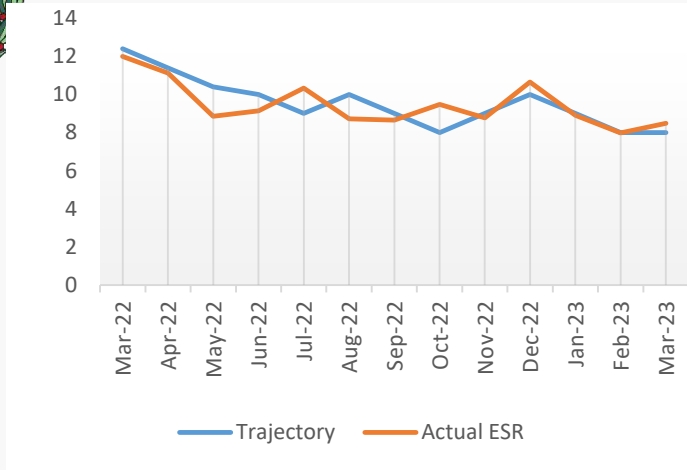

| Absence Reason | Headcount | Abs Occurrences | % | Abs FTE% |
|---|---|---|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 148 | 150 | 26.0 | 2.04% |
| S12 Other musculoskeletal problems | 69 | 69 | 12.9 | 1.01% |
| S11 Back Problems | 46 | 49 | 7.2 | 0.56% |
| S13 Cold, Cough, Flu - Influenza | 103 | 105 | 7.1 | 0.56% |
| S25 Gastrointestinal problems | 113 | 114 | 6.4 | 0.50% |
| S15 Chest & respiratory problems | 64 | 64 | 6.3 | 0.50% |
| S19 Heart, cardiac & circulatory problems | 25 | 25 | 5.3 | 0.42% |
| S27 Infectious diseases | 55 | 55 | 4.4 | 0.35% |
| S99 Unknown causes / Not specified | 38 | 38 | 4.0 | 0.31% |
| S21 Ear, nose, throat (ENT) | 33 | 33 | 2.9 | 0.23% |

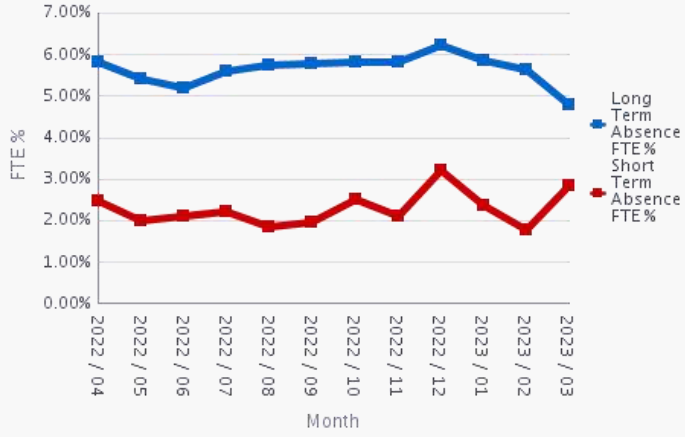
# WAST Sickness Absence February 2023 – 7.99% Trust; 8.76% Operations



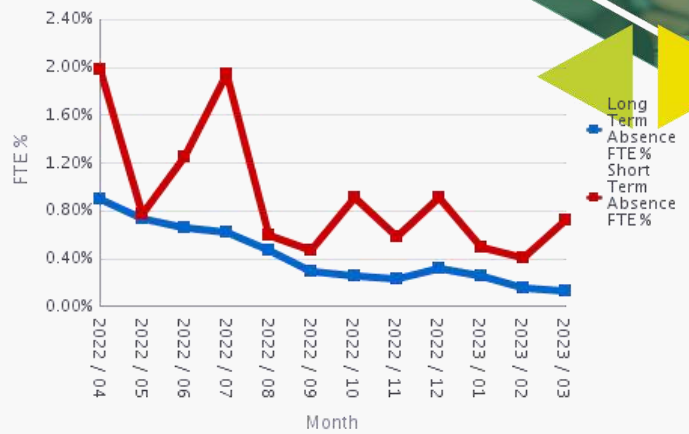

| | EMS | Ambulance Care | EMS Coordination | Integrated Care |
|---|---|---|---|---|
| Jan-22 | 14.00% | 11.47% | 15.16% | 14.48% |
| Feb-22 | 13.59% | 9.46% | 13.56% | 10.35% |
| Mar-22 | 14.80% | 11.96% | 15.08% | 10.41% |
| Apr-22 | 12.86% | 11.17% | 14.41% | 12.56% |
| May-22 | 9.71% | 8.95% | 11.67% | 11.89% |
| Jun-22 | 9.93% | 9.54% | 11.62% | 11.82% |
| Jul-22 | 11.73% | 11.13% | 11.92% | 11.87% |
| Aug-22 | 10.00% | 8.91% | 9.93% | 10.28% |
| Sep-22 | 9.49% | 8.62% | 10.01% | 11.66% |
| Oct-22 | 10.10% | 10.71% | 9.79% | 11.78% |
| Nov-22 | 9.58% | 9.26% | 8.27% | 10.68% |
| Dec-22 | 11.06% | 10.51% | 11.38% | 15.74% |
| Jan-23 | 9.56% | 8.21% | 10.93% | 12.59% |
| Feb-23 | 9.47% | 6.82% | 6.90% | 12.30% |

# Trust Wide MAAW Analysis

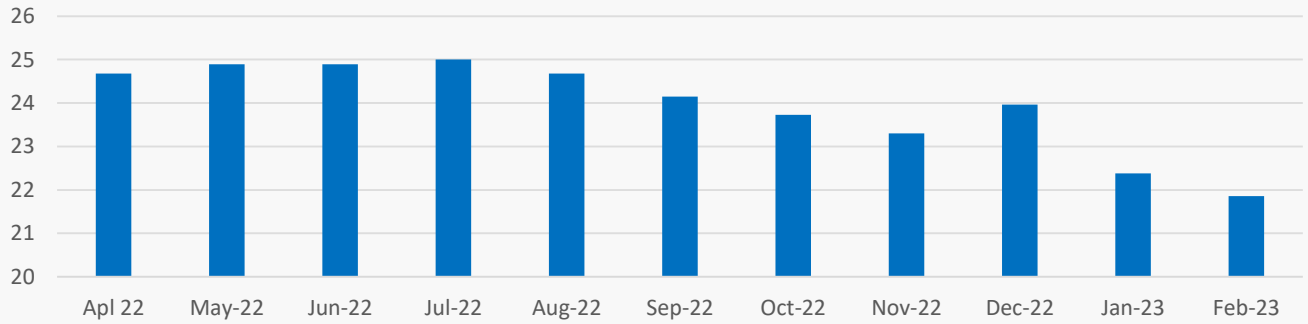



COVID Analysis

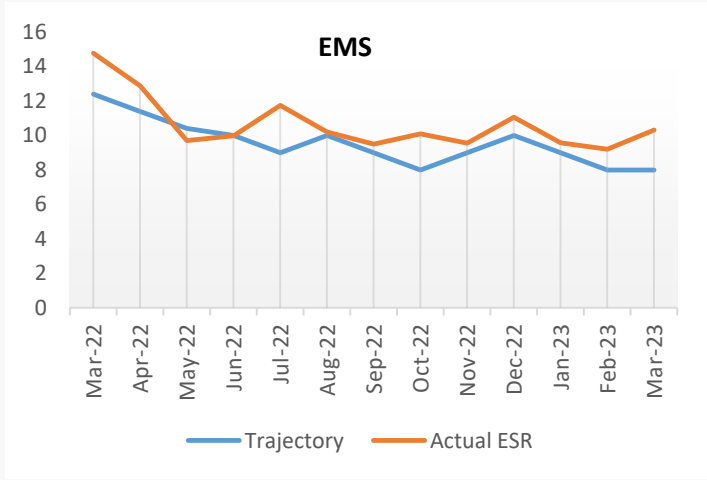


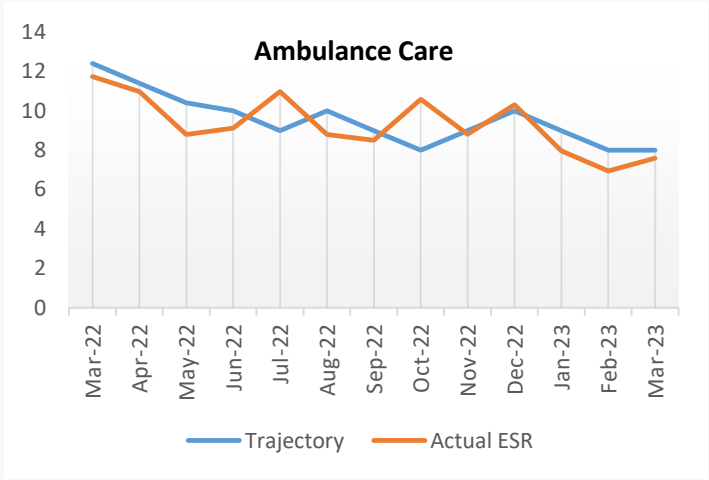

**Average number of days lost per FTE**

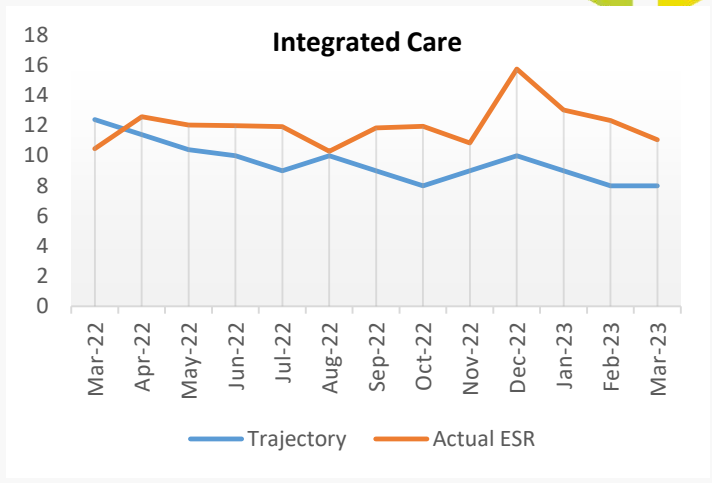


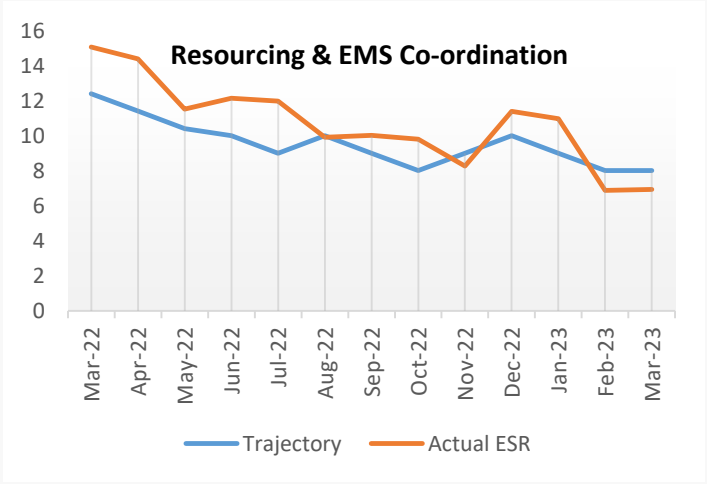

- Sickness decreased in February across the Trust and was in line with the trajectory
- Early indications are that March will see an increase in sickness absence (decrease for long term, with an increase in short term sickness, with a rise in short term Covid absences.
- The number of individuals off with long COVID continues to remain low (currently 3 as of 04.04.2023)

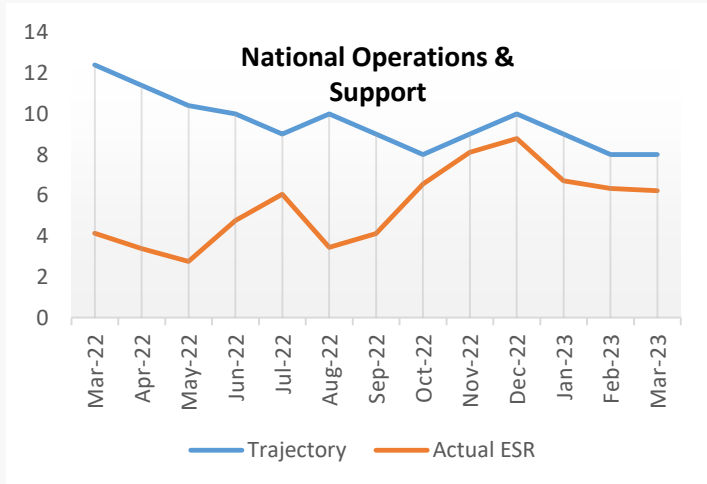
# Actual vs Trajectory (March figures are indicative)



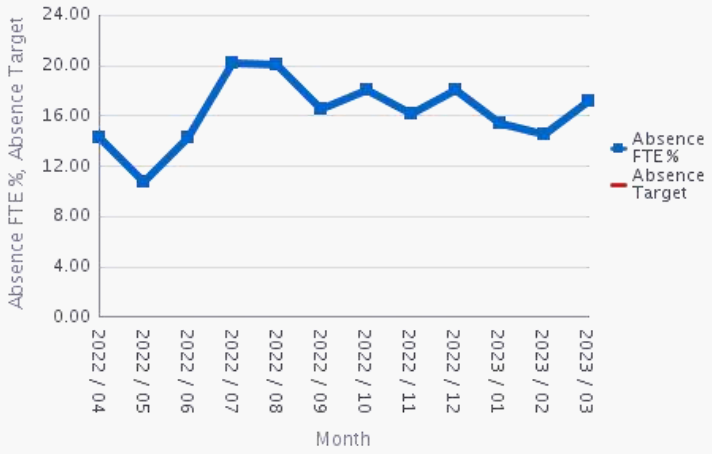



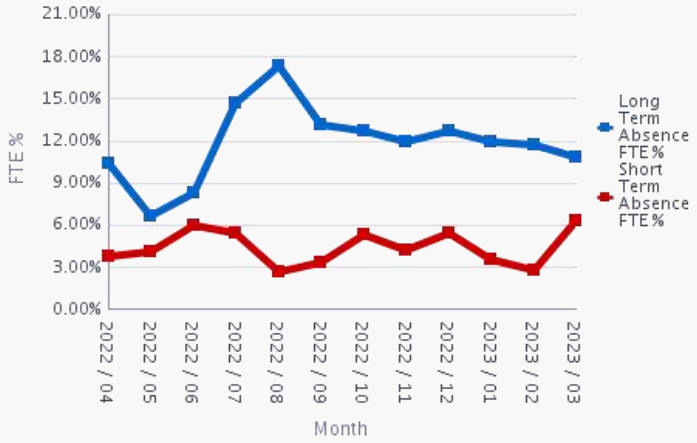



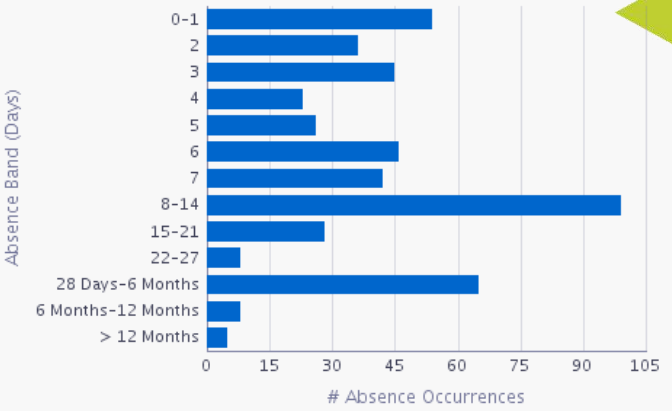



# Current Hotspot: EMS CTM




| Absence Reason | Headcount | Abs Occurrences | Abs Days | % |
|---|---|---|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 30 | 36 | 1,566 | 16.3 |
| S15 Chest & respiratory problems | 69 | 87 | 1,266 | 13.2 |
| S12 Other musculoskeletal problems | 18 | 19 | 1,209 | 12.6 |
| S28 Injury, fracture | 22 | 23 | 1,159 | 12.1 |
| S27 Infectious diseases | 59 | 68 | 886 | 9.2 |
| S11 Back Problems | 21 | 21 | 741 | 7.7 |
| S99 Unknown causes / Not specified | 30 | 47 | 487 | 5.1 |
| S25 Gastrointestinal problems | 46 | 51 | 414 | 4.3 |
| S17 Benign and malignant tumours, cancers | 1 | 1 | 303 | 3.2 |
| S98 Other known causes - not elsewhere classified | 28 | 34 | 292 | 3.0 |
| S31 Skin disorders | 6 | 6 | 287 | 3.0 |
| S13 Cold, Cough, Flu - Influenza | 32 | 33 | 269 | 2.8 |

- Sickness declined in CTM in February (both long and short term).
- Early indications show a continued decline in long term absence in March 2023 but an increase in short term absence, with Covid the highest reason for this increase.

| Month | Short Term Absence FTE % |
|---|---|
| 2023 / 01 | 1.30% |
| 2023 / 02 | 1.41% |
| 2023 / 03 | 2.23% |

# COVID 19 - Attendance Management

- Reduction in number of colleagues off LTS due to long COVID

| | No. of colleagues off with Long COVID | No. of colleagues off 100+ days with Long COVID |
|---|---|---|
| 14.09.2022 | 12 | 6 |
| 29.09.2022 | 11 | 6 |
| 25.10.2022 | 6 | 4 |
| 22.11.2022 | 5 | 5 |
| 12.01.2023 | 9 | 6 |
| 31.01.2023 | 6 | 5 |
| 06.03.2023 | 3 | 3 |
| 04.04.2023 | 0 | 3 |

- The number of COVID absences declined in January, with a rise in February and a further increase in March

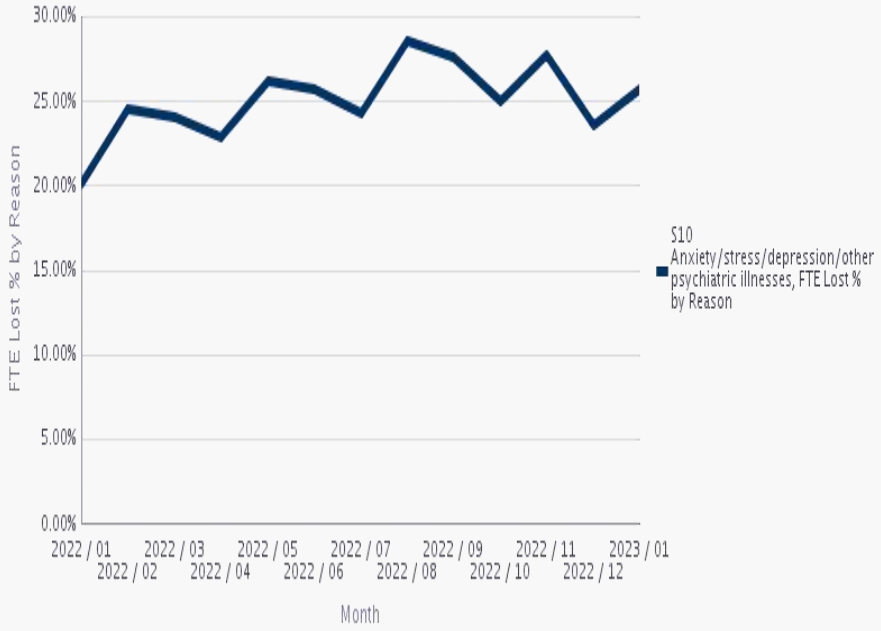
| | 26.08.22 | 29.09.22 | 23.10.22 | 22.11.22 | 22.12.22 | 12.01.23 | 25.01.22 | 20.02.23 | 12.03.23 | 18.03.23 | 02.04.23 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FTE% of colleagues off due to COVID | 1% (31) | 1% (38) | 2% (53) | 1% (34) | 2% (67) | 1% (40) | 0.7% (22) | 0.9% (32) | 1.4% (43) | 1.6% (48) | 1.5% (45) |

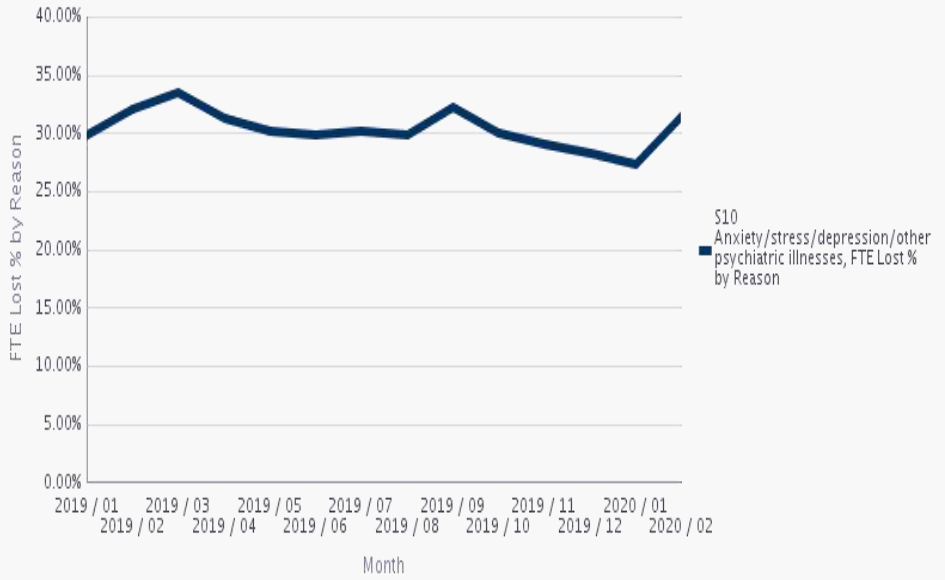
# Improving Attendance Programme

- February, saw the lowest level of sickness absence since May 2021 going from 8.94% to 7.99%, with a decrease in both long term and short term absences.
- Long term sickness case management continues and indicative figures for March 2023 show a decrease to 4.91% from 5.76% in February.
- Indicative figures for short term absence in March 2023 shows an increase to 3.57% from 2.22% in February.
- Concentrated support for EMS CTM continues. January & February 2023 showed a decline in sickness absence, indicative figures for March 2023 show an increase in short term sickness, with Covid related absences as the highest reason.
- Managing Attendance at Work training sessions have been scheduled bi monthly from April 2023 to December 2023.
- Further bitesize training sessions have been scheduled for April 2023 and May 2023
- Bespoke MAAW training sessions have been delivered by People Services Advisors to managers and team leaders in EMS, Ambulance Care and Resource & EMS Response areas.

# Stress related absences

- Data taken from ESR on 16.02.2023 and is a percentage of all absence reasons.
- Stress related absences have increased in the last year, from 20.20% in January 2022 to 25.71% in January 2023.
- August 2022 at 28.57% & November 2022 at 27.74% show the highest increase over the last 12 months.
- 51% of stress related absences were short term (up to 28 days) with 49% being long term.




| | FTE Lost % by Reason |
|---|---|
| | S10 Anxiety/stress/depression/other psychiatric illnesses |
| 2022 / 01 | 20.20% |
| 2022 / 02 | 24.56% |
| 2022 / 03 | 24.04% |
| 2022 / 04 | 22.85% |
| 2022 / 05 | 26.26% |
| 2022 / 06 | 25.72% |
| 2022 / 07 | 24.29% |
| 2022 / 08 | 28.57% |
| 2022 / 09 | 27.59% |
| 2022 / 10 | 24.97% |
| 2022 / 11 | 27.74% |
| 2022 / 12 | 23.61% |
| 2023 / 01 | 25.71% |

# Potential drivers

- We are not able to identify if the stress related absences include stressors from employees' personal circumstances.
- The percentage of stress related absences recorded are higher for frontline employees at 94% than for admin & clerical employees at 6%
- Drivers for work related stress absences include; missed meal breaks, overruns, handover delays.
- Datix submitted for work related stress set out in table below:

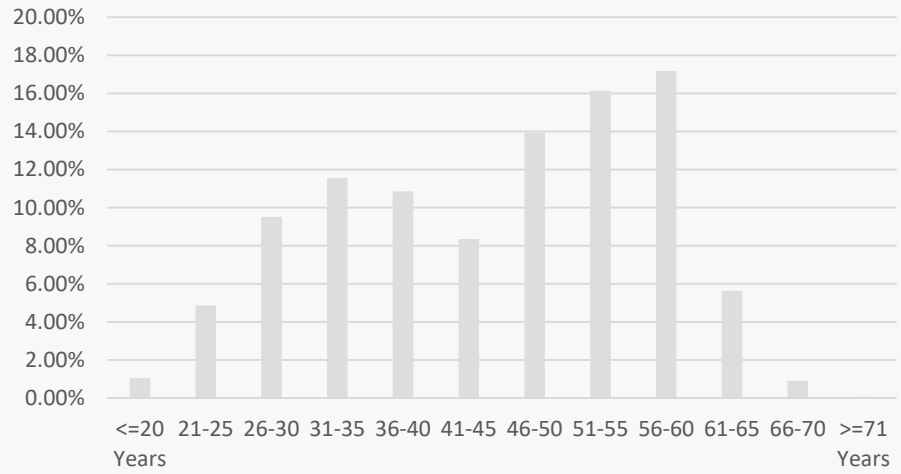
| Number of datix incidents reported - work related stress | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Feb-22 | Mar-22 | Apl 22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 |
| 8 | 5 | 7 | 8 | 4 | 0 | 4 | 7 | 11 | 10 | 10 | 7 |

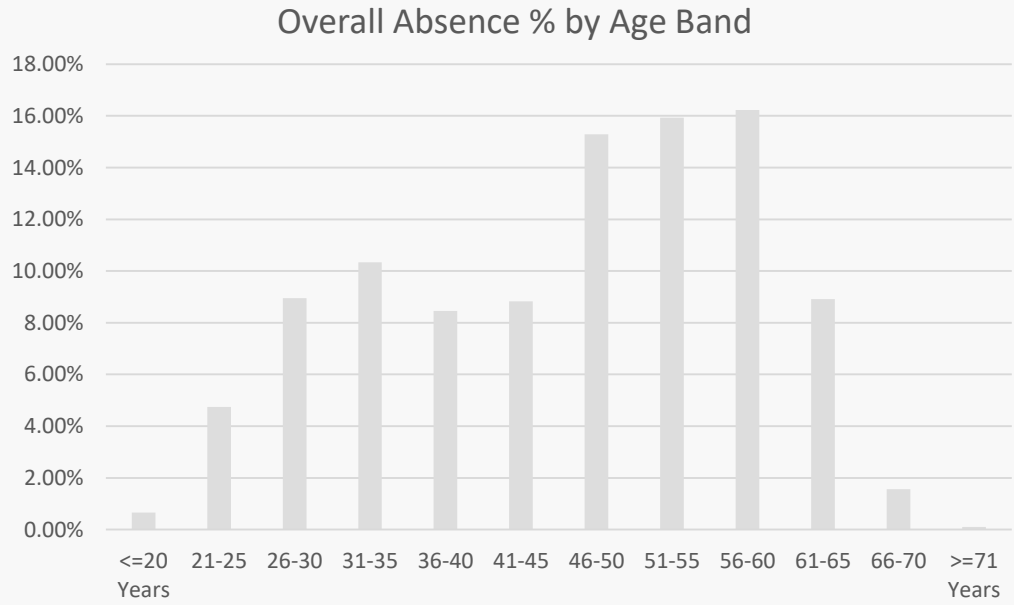
- Low levels of reported stress related absence for non frontline staff could be due to presentism and work pressure

# Breakdown by age group

The chart below sets out stress related absences by age group (2022/23). This identifies high levels of stress being reported between the age bracket of 46yrs to 60yrs age group.

Absence for these age groups also increases for back problems, musculoskeletal problems, chest & respiratory problems and heart & circulatory problems.



# Health Assured Employee Assistance Programme

**Annual Report provided in February 2023 covering the period February 2022 to January 2023**

- Welsh Ambulance Service Trust had 933 calls in the reporting period, with the majority of calls (94.8%) being counselling related

- The report provides an annualised utilisation figure of 20.5% (estimated for a 12 month period)

- Calls are split in to 36 categories with the following being the highest:

    - Anxiety – 294 for the year, with highest numbers recorded in Feb 2022 and Jan 2023
    - Low mood – 87, with highest numbers recorded in July & August 2022
    - Bereavement – 79, with highest numbers recorded in September & November 2022
    - Depression – 78, with highest numbers recorded in February & June 2022

# Next steps – what we can do to reduce work related stress

- Further work on getting underneath the data and what it tells us
- Review of main causes of stress (handover delays, overruns etc)
- Review opportunities to reduce incidents with proactive support (OH)
- Continue to promote and signpost employees to support available
- Promote the use of work place stress risk assessments to prevent absence and to support a RTW
- Focus on ‘Keep me in work’ programme in line with Managing Attendance at Work Policy
- Tailored adjustments to support employees, e.g.. reduced hours, adjust start/ finish time, amending duties
- Develop a strategy to enable employees in their later stages of career to move to other roles to support wellbeing whilst still contributing to WAST

| | |
|---|---|
| **AGENDA ITEM No** | **17** |
| **OPEN or CLOSED** | |
| **No of ANNEXES ATTACHED** | **1** |

# SEASONAL INFLUENZA CAMPAIGN 2022-23 FINAL REPORT

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 09 May 2023 |
| **EXECUTIVE** | Andy Swinburn<br>Director of Paramedicine |
| **AUTHOR** | Ruth Lemin<br>Project Support Officer |
| **CONTACT** | Ruth.Lemin@wales.nhs.uk |

## EXECUTIVE SUMMARY

The aim of this report is to provide information and detail of the Seasonal Influenza Campaign 2022-23 and the uptake of the flu vaccination this year.

The Trust's final uptake of WAST staff vaccinated against the flu was 44.5%, a 6% increase from last year's campaign. There was also an increase seen in the uptake of patient-facing staff which was 5.2% higher on last year, ending the campaign with 46.3% receiving the vaccine.

There has been a number of influencing factors on the Flu Campaign this year including reporting mechanisms of vaccination settings, operational pressures / industrial action, withdrawal of flu vaccination incentive and communication with staff. The report explores more detail of the constraints that were experienced and how they may have influenced the delivery of the campaign.

Following the closure of the campaign, recommendations have been produced that were established from the learning and key areas of improvement noted. Full detail can be found in the End of Season report attached in the Appendices. Future aims include streamlining current processes, improving engagement with the workforce and inclusion of the flu vaccination incentive.

| KEY ISSUES/IMPLICATIONS |
| --- |
| **Reduced uptake of vaccine amongst Trust due to:**<br>• Continued impact of COVID-19 to uptake and recorded data of the Flu Campaign<br>• Removal of the Flu Incentive Programme<br>• Operational pressures and industrial action |

| REPORT APPROVAL ROUTE |
|---|
| **Clinical Directorate Business Meeting – 17 April 2023 – For Information**<br><br>**Executive Management Team – 26 April 2023 – For Information**<br><br>**People & Culture Committee – 09 May 2023 – For Information** |

| REPORT APPENDICES |
|---|
| **End of Season Report 2022-23** |

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

## SITUATION

1 The Welsh Ambulance Services NHS Trust (WAST) are required together with the rest of NHS Wales to offer all members of staff the opportunity to receive the seasonal influenza vaccine. Although the vaccine isn't mandatory, Welsh Government (WG) have a target of 60% of patient facing staff to receive the vaccine.

2 This is the third year that the coordination of the flu vaccine roll out to staff has been overseen by the Clinical Directorate.

3 The increased vaccinations over recent years, due to COVID-19, may have created a vaccine fatigue among the WAST workforce. All implications are addressed specifically in Appendix 1 during the End of Season Influenza Report.

4 The continued circulation and new variants of Covid-19 in the lead up to and throughout the flu campaign period has presented specific challenges and identified a situation in which a successful flu campaign would be especially important. Covid-19 is addressed specifically in the end of season report (Appendix 1)

## BACKGROUND

4 The previous Flu Campaign in 2021-2022 saw a decrease in the uptake of the flu vaccine among WAST staff.

5 Two channels were created on Microsoft Teams as a digital venue to host documents for the campaign. The first one was specifically designed for the Project Admin and the Occupational Health team to share needed data and files. While the second had the addition of Flu Leads from each area, Communication representative and Assistant Director for Clinical Delivery. The second channel focused on planning elements of the campaign as well as updates and an online meeting space.

6 The digital flu form was designed and created by the Project Lead with support from Health Informatics and approved for use by Data Governance. The form was uploaded to the intranet (Siren) and Yammer platforms for ease of access.

7 The incentive for the flu vaccination was not offered during this campaign, for the first time in three years after an unsuccessful bid to the Charitable Funds Committee.

8 Regular communications were sent to staff across the Trust's platforms advising them to check the Intranet for details of where they could get the vaccine. If cancellations of clinics were experienced, staff were advised of the situation and the opportunities to re-arrange.

9 Towards the end of the campaign the Project Lead began Maternity Leave. Support was provided by other members of the Clinical Directorate to help close the campaign. However, due to unforeseen circumstances there was a slight delay in access to the data.

## ASSESSMENT

10 The impact of COVID-19 on the Flu Campaign has significantly decreased compared to previous years. Although, as explained in more detail in the Appendix, there is still a long term effect being experienced. Whether that be from vaccine fatigue experienced by WAST staff or the effect on vaccination settings chosen by staff.

11 There has been a considerable increase in the uptake of the flu vaccination with an overall increase of 6% from last year's campaign, 44.5% of WAST staff. Majority of areas across the Trust saw an increase in their uptake.

12 A number of colleagues did not engage with the form to advise whether they have had the vaccine elsewhere or would like to opt out of receiving the flu vaccine.

13 There were a number of issues considered that may have impacted on the success of the flu campaign:

Reporting Mechanisms

14 WAST do not have the permissions and ability to access the Welsh Immunisation System (WIS) where data is held for those staff who received their vaccination through the mass vaccination centres. A number of staff may choose to receive their flu vaccination alongside a COVID-19 booster. Unfortunately WAST would not receive this information unless staff voluntarily fill out the dedicated Microsoft Form.

15 There is currently no interface that links ESR with our COHORT system where our staff health information is recorded. Manually uploading the data to ESR is a time-consuming process for the workforce systems team.

16 A short term issue was experienced with data retrieval from the Microsoft Forms due to a minor access problem. This did create a delay in the project team's ability to report on the flu vaccine uptake to Public Health Wales and various WAST reporting structures for a short time.

Operational Pressures

17 Due to the significant operational pressures on the service and industrial action, there was some cases where limited availability was experienced for the peer vaccinators. There is potential that pressures and a decrease in peer vaccinators from original numbers at the start of the campaign may have impacted the ability to deliver vaccinations to WAST staff.

Communication and Engagement

18 There was an engagement rate of 50.3% of WAST staff, of those that completed the Microsoft Form 88.4% decided to receive the flu vaccination.

19 Staff engagement is once again an issue. Only around half of staff in post are engaging with the campaign by way of completing the flu consent/opt out form.

There is a need to address communications surrounding those who wish to decline the vaccination and that they will not be discriminated against when this confidential information is registered on the system.

20 The Flu Incentive Programme was not offered to WAST staff during the 2022-23 Flu Campaign after an unsuccessful bid.

**RECOMMENDED: That**

**1. The findings and issues documented in the seasonal influenza campaign 2022-2023 are noted**

## APPENDIX

End of Season Flu Report 2022-23 - Fina

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

# Clinical Directorate

## End of Season Report

## Seasonal Influenza Campaign 2022-23

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# Executive Summary

This report has been designed to provide information surrounding the Seasonal Influenza Campaign 2022-23 and detail the uptake of the Flu Vaccine this year within the Welsh Ambulance Services NHS Trust (WAST).

The Trust's final uptake of staff vaccinated was 44.5% of WAST staff, which is an increase of 6% from last year's campaign. The number of patient facing staff that are recorded as receiving the vaccine for the 2022-23 campaign has also noticeably increased by 5.2%, reporting 46.3% at the end of the campaign.

Following the review of this year's campaign, recommendations have been devised that are based upon some of the key areas of learning and improvement. They aim to streamline current processes, remove duplication of effort and improve our engagement with the workforce.

# 1. Influencing Factors

When analysing the Flu Campaign that took place this season and comparing to previous campaigns undertaken by the organisation it is important to consider influencing factors that occurred. This includes the consideration of vaccine fatigue and industrial action experienced. A large amount of COVID-19 messaging over previous years, particularly in 2020, may have encouraged a higher percentage of uptake. Staff could now be experiencing fatigue and less likely to voluntarily receive further vaccines. Planned strike days may have also had an unforeseen impact on the latter stages of the campaign.

## 1.1 Continued Impact of COVID-19

As seen in the previous campaign, it is expected that COVID-19 is continuing to impact on the Flu Campaign within WAST. Now, this is particularly in relation to the vaccination setting of choice, with many staff receiving the influenza vaccine within a COVID-19 booster setting. This data is not currently available to WAST and could lead to a large amount of unreported data. The project relies on staff recording a response on the Microsoft Forms platform to advise of any vaccinations had elsewhere. If colleagues do not record using this feature, then the data will not be included within the uptake for WAST.

## 1.2 Flu Vaccination Incentive

The Capital Bid for the Flu Vaccination Incentive was declined for this year's campaign. The requested incentive was for a total £2,700, with those who have received the vaccine to be placed into a prize draw to be eligible to win a range of vouchers.

The Panel reviewed the application for a second time but were not supportive of the bid. The impact on colleagues taking up the offer of the vaccine was agreed, however, couldn't advise of concrete evidence that the incentive would increase the overall uptake.

Flu vaccinations are not mandatory for staff therefore the emphasis could be best focused on the accuracy of the records held by the Trust. The data collection from the Microsoft Form regarding the vaccine uptake could be incentivised. It is suggested the next campaign planning can include a scheme to the 2023/24 Bids Panel to incentivise the

completion of the Microsoft Form, whether that be from receiving the vaccine in any setting or opting out of the flu vaccination. All those engaging with the available Microsoft Form will be eligible to enter the prize draw for a chance to win a voucher.

## 2. End of Campaign 2022-23

The Flu Campaign within the Trust came to an end on 28 February 2023, when the collection of data ceased. However, colleagues are still able to receive vaccines as requested until 31 March 2023 although any vaccinations received during this time will not be recorded within the following report.

### 2.1 Vaccine Uptake

A summary of the flu data for the 2022-23 campaign can be seen in the table below which demonstrates an increase in the number of WAST staff receiving the vaccine in comparison with last year.

| Flu Data as of 28th February 2023 | | | | |
|---|---|---|---|---|
| **Staff Group** | **Staff In Post** | **Received Vaccine** | **% Of Group** | **+/- On Last Year** |
| **Total WAST** | **4251** | **1890** | **44.5%** | **+ 6.0%** |
| **Total Patient Facing** | **2527** | **1171** | **46.3%** | **+ 5.2%** |
| NEPTS Patient Facing | 769 | 353 | 45.9% | + 8.5% |
| EMS Patient Facing | 1758 | 818 | 46.5% | + 3.9% |

*Table 1. Final flu data for the current campaign 2022-23*

This is the third year that data has been captured digitally through Microsoft Forms which has allowed for continual oversight of the vaccine uptake throughout the campaign. It also enabled all stakeholders of the project to be provided with a weekly summary and update of the campaign's progress.

| Flu Data as of 28th February 2023 | | |
|---|---|---|
| **Staff Group** | **% Of Group** | **% Engaged via MS Form** |
| **Total WAST** | **44.5%** | **50.3%** |
| **Total Patient Facing** | **46.3%** | **54.3%** |
| *EMS* | | |
| Aneurin Bevan | 42.8% | 47.0% |
| Betsi Cadwaladr | 42.4% | 46.6% |
| Cardiff & Vale | 42.7% | 52.8% |
| Cwm Taf | 40.1% | 51.3% |
| Hywel Dda | 40.2% | 49.6% |
| Powys | 65.1% | 81.4% |
| Swansea Bay | 53.8% | 63.2% |
| Resilience / Business Continuity | 90.7% | 100.0% |
| *NEPTS* | | |
| Aneurin Bevan | 40.7% | 42.1% |
| Betsi Cadwaladr | 39.5% | 43.9% |
| Cardiff & Vale | 41.3% | 62.7% |
| Cwm Taf | 62.0% | 69.6% |
| Hywel Dda | 53.0% | 65.1% |

| | | |
|---|---|---|
| Powys | 62.8% | 81.4% |
| Swansea Bay | 44.7% | 53.7% |
| *Directorates* | | |
| Board Sec / Corp Governance | 16.7% | 100.0% |
| Capital & Estates | 36.8% | 42.1% |
| Clinical | 72.2% | 85.2% |
| Complaints & Claims | 47.6% | 52.4% |
| Education & Development | 17.9% | 21.4% |
| EMS Resourcing & Coordination (CCC) | 39.7% | 40.2% |
| Finance | 54.5% | 57.6% |
| Health & Safety | 45.5% | 54.5% |
| ICT / Digital (inc. HI) | 52.6% | 54.4% |
| Integrated Care (NHSD, 111, CSD) | 38.8% | 40.4% |
| National Fleet | 53.2% | 61.7% |
| Partnership & Engagement | 75.0% | 75.0% |
| Quality & Nursing | 48.4% | 48.4% |
| Strategy, Planning & Performance | 100.0% | 100.0% |
| Workforce & OD (inc. OH) | 71.0% | 79.0% |

*Table 2. Breakdown of the vaccine uptake for the 2022-23 campaign.*

## 2.2 Campaign Engagement

During the Flu Campaign 2022-23 an updated Microsoft Form (MS Form) was introduced to record staff receiving the vaccine in a WAST setting, recording vaccinations received in an alternative setting, or opting out of receiving the vaccine altogether. If receiving the vaccination through WAST this is completed by the peer vaccinator and for those receiving it elsewhere or opting out, this was completed by the staff member themselves. This year's form was a more streamlined version to further encourage individuals to complete the form and report their decision. This MS Form saw 2,137 individual entries, meaning 50.3% of WAST staff engaged with the Flu Campaign. Of the 50.3% that engaged with the MS Form, 88.4% were engaging to consent or record they were receiving the vaccine and 11.6% opting out.

## 2.3 Data analysis

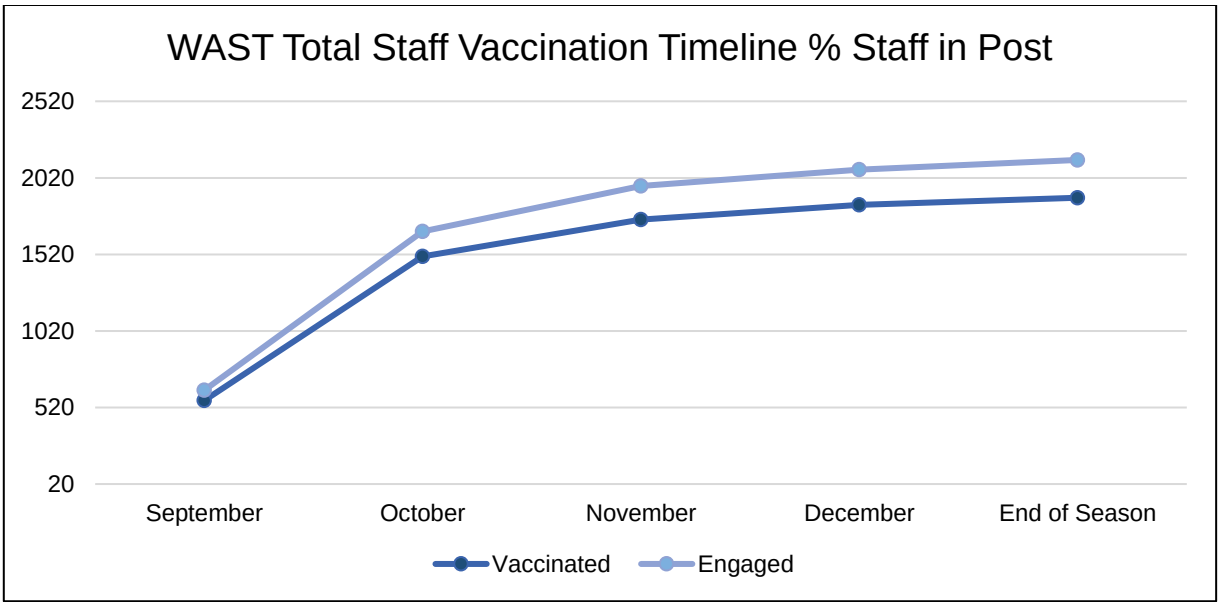


*Figure 1. Timeline of vaccinations in 2022-23 Flu Campaign*

As seen in *Figure 1* the most notable increase in WAST staff receiving the vaccine and interacting with the campaign was during October 2022 and this is reflective of previous year's results. This indicates that the beginning of the campaign was crucial for the numbers of staff vaccinated, with October being the first full month of vaccinations for the organisation. As the campaign progressed, the results plateaued. However, there was a considerable amount of staff vaccinated in September when taking into account the start date later on in the month. Due to an unexpected public holiday, vaccines were delivered a week later than expected, resulting in many clinics not beginning until the last week of September commencing 26th. All vaccinations were received on one delivery date for this campaign and were distributed accordingly, limiting the wait time for vaccination deliveries from suppliers.

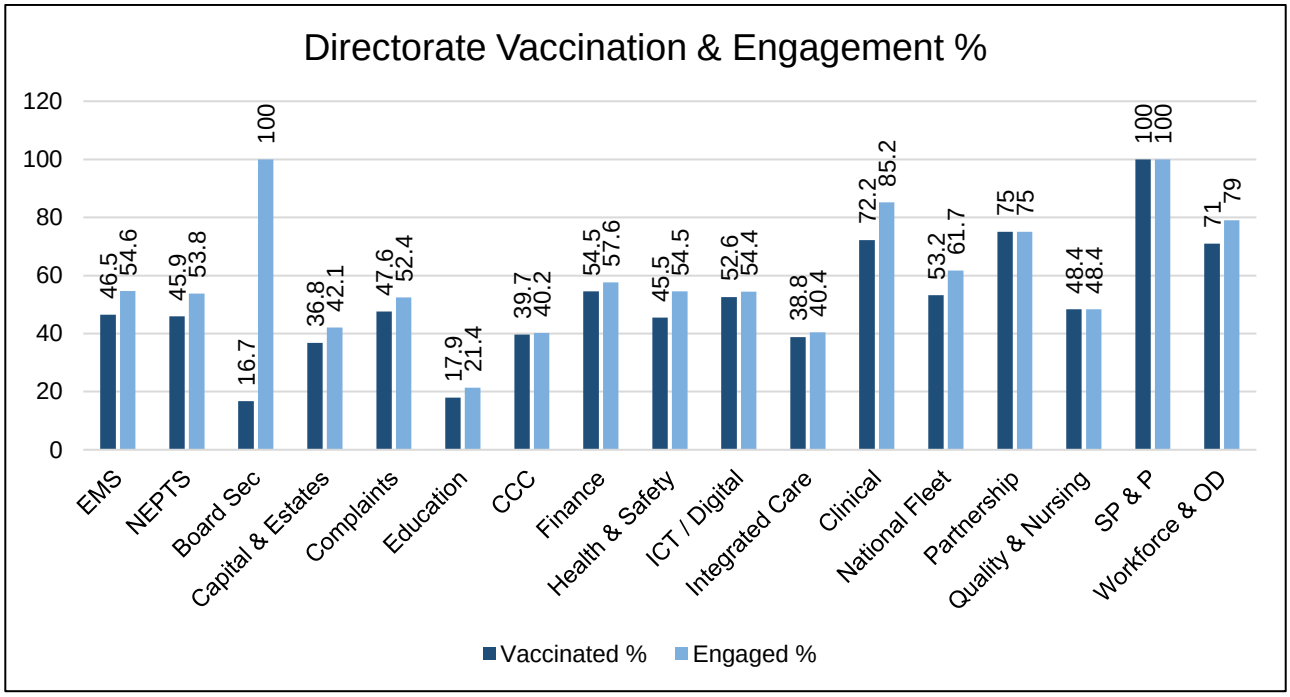


*Figure 2. Vaccination and engagement rate for Directorates within WAST*

*Figure 2* illustrates that the majority of Directorates recorded similar results for both vaccinated and engagement, although there are Directorates that do have a noticeably increased engagement rate as seen in Board Secretary. This data confirms that only a small number of staff are using the MS Form to advise of opting out of the flu vaccination.

Only two Directorates reported a 100% engagement rate with the Microsoft Form: Board Secretary and Strategy, Planning and Performance. Following these was the Clinical Directorate with 85.2%.

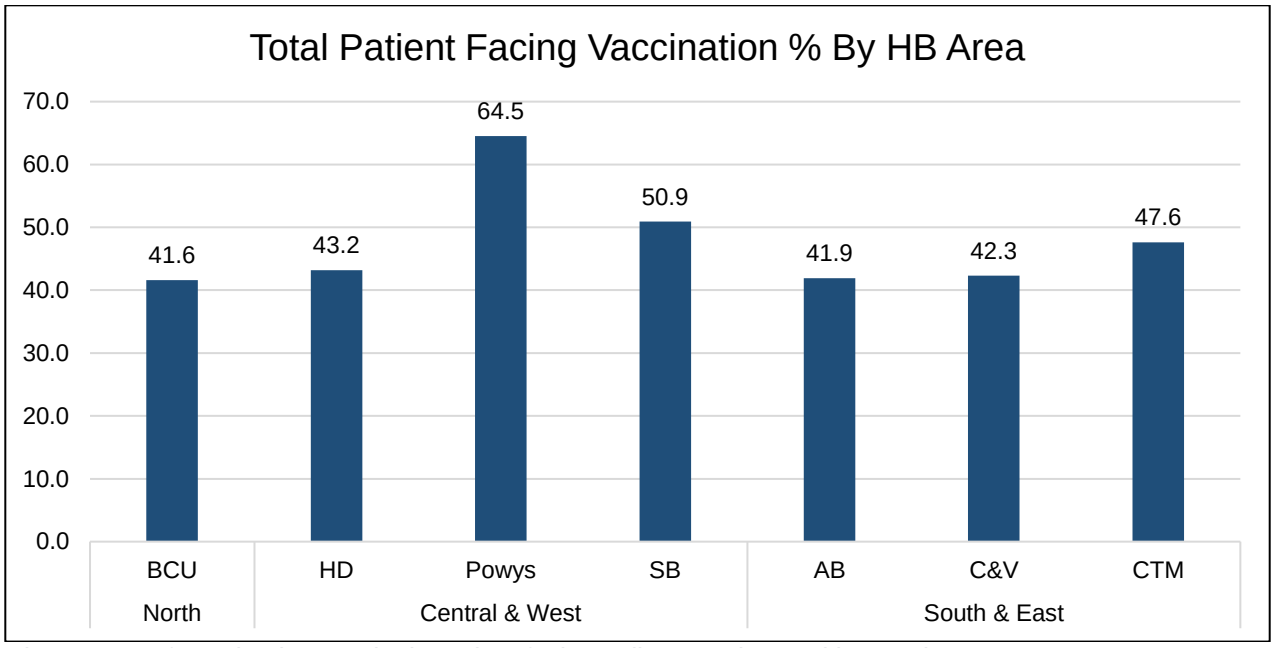


*Figure 3. % of vaccination uptake in patient facing colleagues by Health Board area*

*Figure 3* above looks at the patient facing colleagues who received the vaccine in each Health Board. The data from the MS Form notes that the patient facing staff in Powys had the highest vaccine uptake out of the seven Health Boards, over 10% higher than the remaining six. The other Health Boards saw a similar rate of vaccination with less than 10% range between them, all reaching over 40% uptake.

This is accompanied with a further graph below that breaks down the figures to show the EMS patient facing compared to the NEPTS patient facing colleagues by Health Board and Region. It shows that in majority of Health Boards, EMS and NEPTS patient facing have a similar uptake of the flu vaccination. However, in Cwm Taf it can be noted that NEPTS patient facing colleagues have a significantly higher uptake than EMS colleagues, with over a 20% difference.

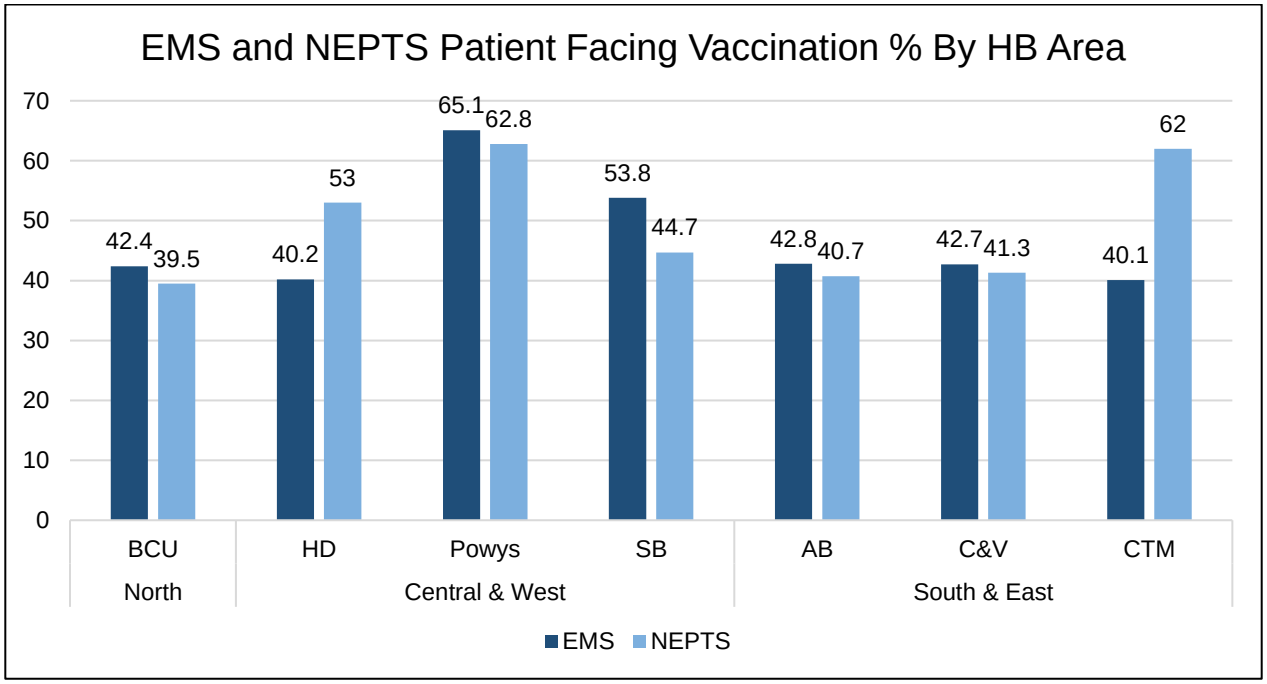


*Figure 4. Patient facing vaccination % split by EMS and NEPTS by Health Board area*

*Figure 5* gives a brief breakdown of the number of staff who have received the vaccine in each region, whether that be in a WAST setting or an alternative setting. The data shows that the highest number of vaccinated staff was in the Central and West region, but this hasn't considered the number of staff in each region. It helps to show that each region has a similar difference between those vaccinated in WAST and those total vaccinated (via an alternative setting).

In some cases this information is dependant on the staff completing the MS Form, as those who are advising of receiving the vaccine elsewhere or opting out are required to fill in their own region base. The staff receiving their vaccine in WAST will have a peer vaccinator filling out their region. This does not consider how many employees are based in each region.

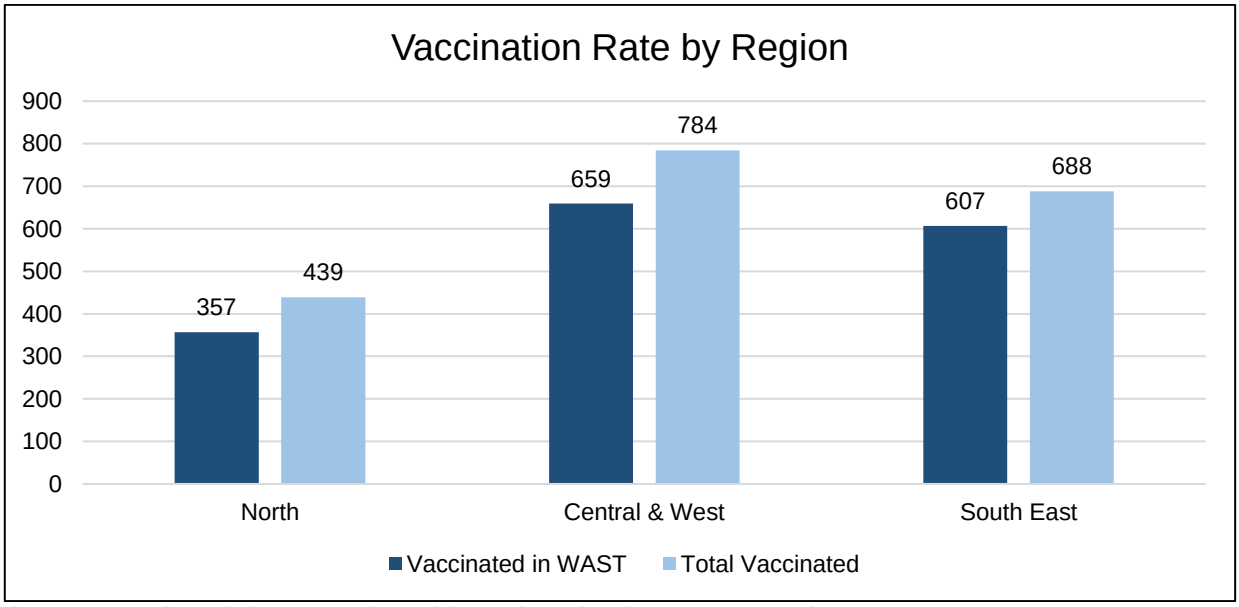


*Figure 5. Number of those vaccinated in each region from MS Form data*

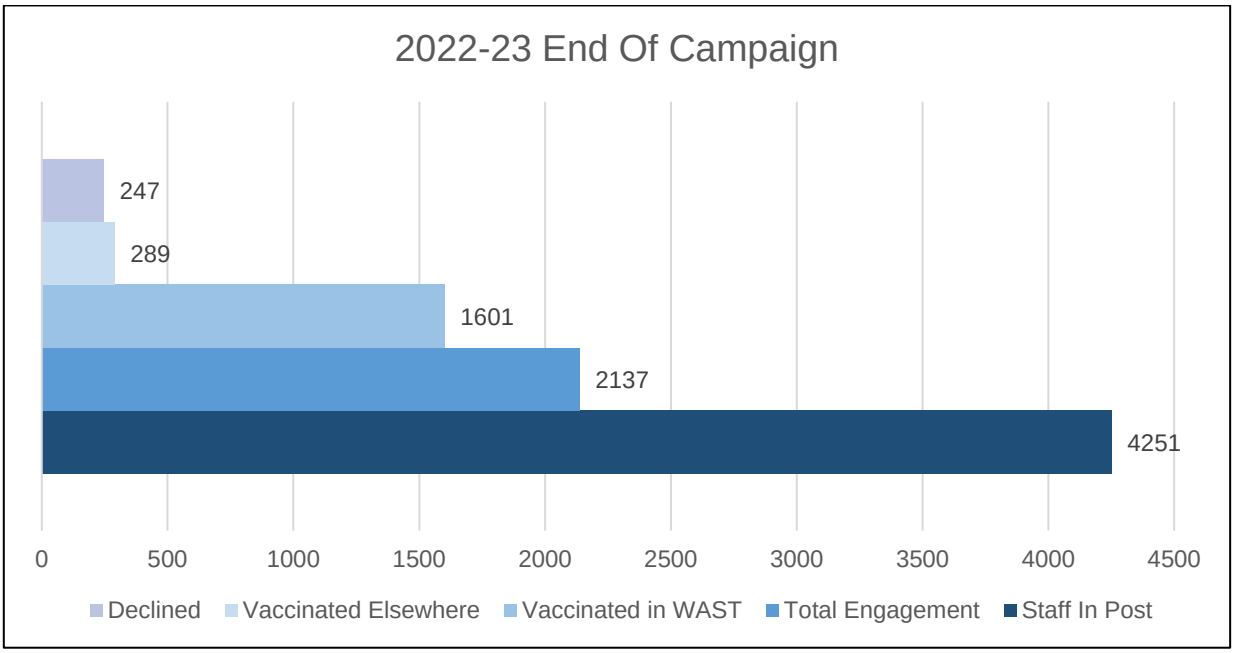


*Figure 6. Breakdown of MS Forms results for 2022-23 Flu Campaign*

The graph above shows the full vaccination and engagement of WAST colleagues throughout the 2022-23 Flu Campaign. The data has been calculated on a total of 4,251 staff, which is derived from the September 2022 staff list received at the start of the campaign. It has not considered starters and leavers throughout the campaign but instead has focused on the staff that were employed for the duration. Of the 4,251 staff, there was a total of 2,137 engagements with the Microsoft Forms used to capture the data for the Flu Campaign. As shown in *Figure 6* these 2,137 engagements can be broken down into 1,601 consenting to the vaccine in WAST, 289 receiving the vaccine elsewhere and 247 opting out of receiving the flu vaccine this year.

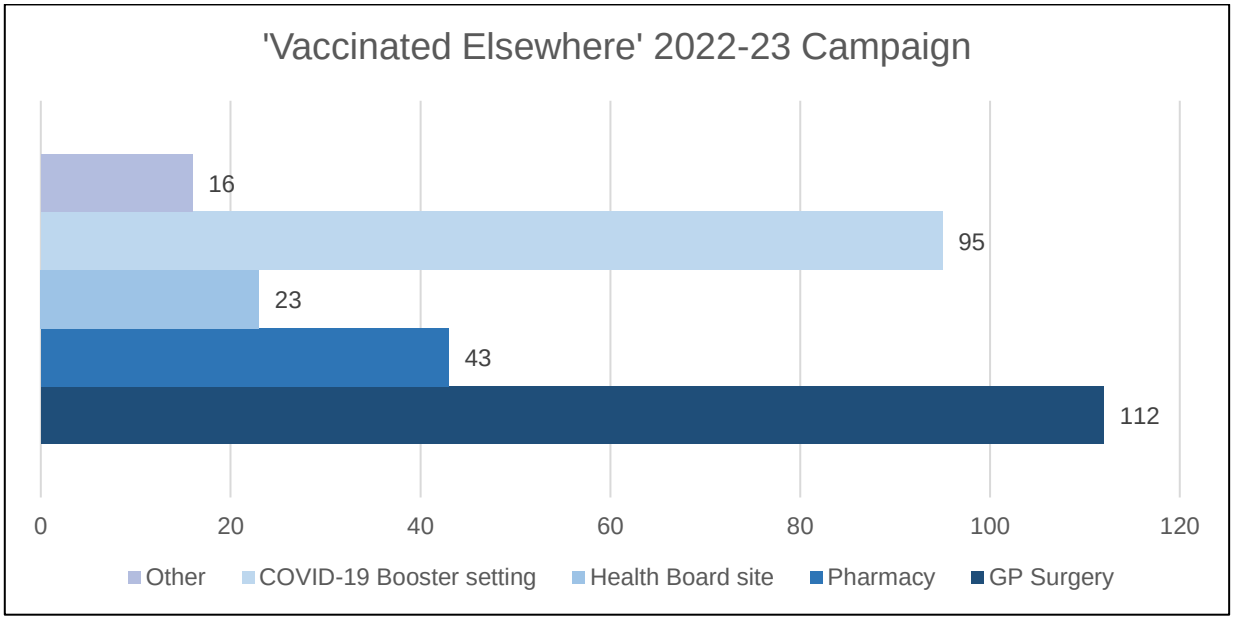


*Figure 7. Overview of those 'vaccinated elsewhere' in Flu Campaign*

In *Figure 7*, it breaks down the data received regarding those that were 'vaccinated elsewhere' and not in a WAST setting. This data suggests that COVID-19 is still having an impact on the Flu Campaign in some way with 32.9% of colleagues who go vaccinated in an alternative setting recording that it was a COVID-19 booster setting. This is from the staff that have engaged with the MS Form and creates the question as to how many other WAST staff are being vaccinated in this setting but not informing the Trust of this decision.

It comes as the second highest alternative setting that staff have chosen, only behind those getting their vaccine from a GP Surgery. It adds another popular setting for vaccines that WAST do not have the ability to access data, creating further uncertainty to the real number of WAST staff that receive the flu vaccine.

The graph below looks into the further option to the MS Forms and that is the ability to opt-out of receiving the vaccine altogether. From these responses, the reoccurring reasons can be documented as to why staff may make this choice. There are suggestions provided when completing this section of the MS Form as well as an option to write their own reason. From data in *Figure 8*, it shows a majority recorded that they 'simply do not want it' when giving reasons for declination, this resulted for 60.7% of those who did opt-out. Followed by 15.4% who expressed they 'have received a bad reaction to the flu vaccine in the past'.

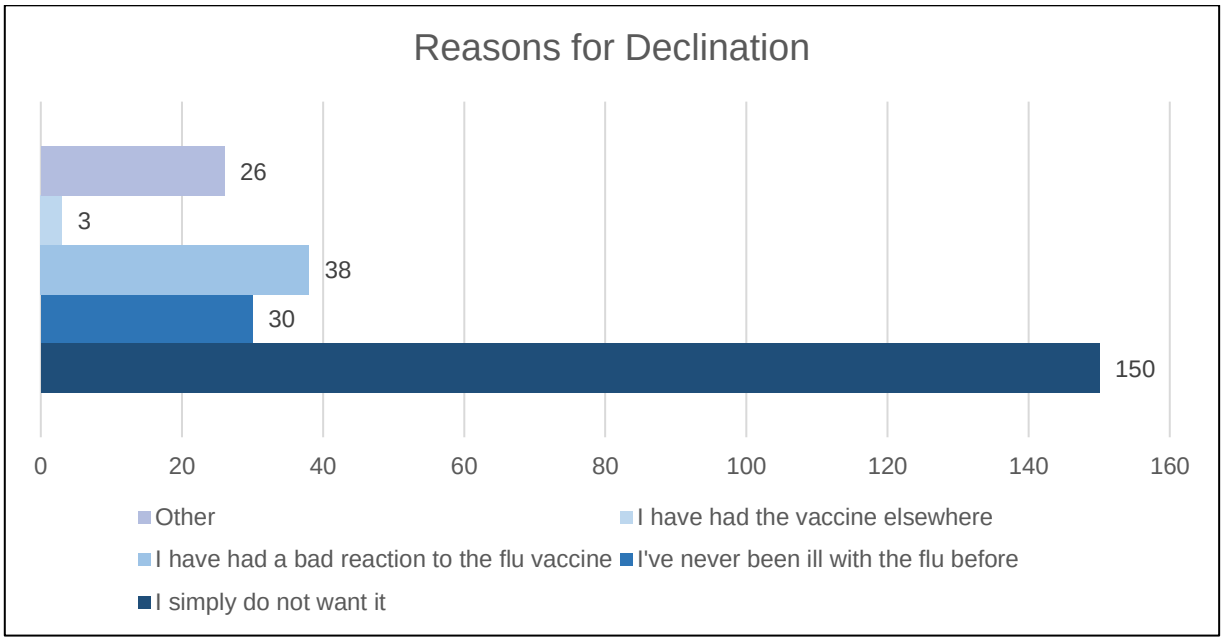


*Figure 8. Reasons specified for opting out of the flu vaccination*

## 2.4 Comparison to Previous Campaign

The data for the Flu Campaign 2022-23 was maintained and recorded differently this year in comparison to previous. This is important to note when comparing the figures to the previous two years of flu vaccinations. The Directorates have been categorised slightly differently with the intention to allow further analysis into which staff groups have received the vaccine and are engaging in the campaign. As a result of this, some areas may be showing high increases than others due to staff groups being removed and placed as their own entity.

| Flu Vaccine Uptake Comparison % Staff in Post | | | | | |
|---|---|---|---|---|---|
| **AREA** | **2020-21** | **+ / -** | **2021-22** | **+ / -** | **2022-23** |
| **Total WAST** | **50%** | - 11.5% | **38.5%** | + 6.0% | **44.5%** |
| **Total Patient Facing** | **52%** | - 10.9% | **41.1%** | + 5.2% | **46.3%** |
| *NEPTS Patient Facing* | **50%** | - 12.6% | **37.4%** | + 8.5% | **45.9%** |
| *EMS Patient Facing* | **53%** | - 10.4% | **42.6%** | + 3.9% | **46.5%** |
| EMS Resourcing & Coordination (CCC) | **45%** | - 6.0% | **39.0%** | + 0.7% | **39.7%** |
| CSD / 111 | **40%** | - 14.0% | **26.0%** | + 12.8% | **38.8%** |
| Board Secretary | **17%** | - 17.0% | **0.0%** | + 16.7% | **16.7%** |
| Capital & Estates | - | - | - | - | **36.8%** |
| Chief Executive | **28%** | + 3.6% | **31.6%** | - | - |
| Clinical | **68%** | - 9.2% | **58.8%** | + 13.4% | **72.2%** |
| Complaints & Claims | - | - | - | - | **47.6%** |
| Education & Development | - | - | - | - | **17.9%** |
| Finance | **39%** | - 7.2% | **31.8%** | + 22.7% | **54.5%** |
| ICT / Digital | **53%** | - 16.6% | **36.4%** | + 16.2% | **52.6%** |
| National Fleet | - | - | - | - | **53.2%** |
| Operations Excl. Response | **46%** | - 4.9% | **41.1%** | - | - |
| Partnerships & Engagement | **88%** | - 52.7% | **35.3%** | + 39.7% | **75.0%** |

| | | | | | |
|---|---|---|---|---|---|
| Quality & Nursing | **55%** | - 11.2% | **43.8%** | + 4.6% | **48.4%** |
| Strategy Planning & Performance | **82%** | - 45.6% | **36.4%** | + 63.6% | **100.0%** |
| WOD | **43%** | - 4.5% | **38.5%** | + 32.5% | **71.0%** |

*Table 3. Comparison of Directorate % uptake to the two previous flu campaigns.*

When comparing this year's campaign to those previously undertaken by the organisation, it is important to consider some of the influencing factors reported earlier in the document. This includes the declination of the flu incentive programme, vaccine fatigue experienced by staff, industrial action days.

In *table 3*, a comparison can be seen for all Directorates in WAST of their flu uptake figures from the previous two campaigns (2020-21 and 2021-22) and this year's campaign (2022-23). As seen between last year's campaign and this year's campaign, the percentage differences all demonstrate an increase in the number of individuals receiving the flu vaccine, whether that be in WAST or in an alternative setting. This does not consider that the change in the reported staff groups may be the reason for some of the high figures.

Some Directorates can be directly compared, with no changes in the reconfiguration of the staff group noted. This includes but is not limited to the Patient Facing, Digital, Finance and Clinical, all of which did see a notable increase in vaccine uptake.

However, the same table shows there had been a large drop in uptake after the 2020-21 campaign. In the case of some Directorates this year's campaign has equalled or surpassed the highest recorded year that took place two years ago. There are Directorates that have not managed to reach the uptake seen in 2020-21. Further direct comparison to the highest recorded uptake (2020-21) can be seen in Appendix 1.

A similar picture is seen from the comparison of engagement rates of last year and this year. The engagement remains higher than the uptake in majority of Directorates and for the total WAST staff saw a 10% increase of those who enjoyed compared to the previous year. A detailed breakdown of engagement rates for each Directorate can be found in Appendix 2.

A visual representation of the past five years campaigns in WAST can be seen below in *Figure 9*. This incorporates the uptake figures of the organisation as a whole, as well as patient facing and CCC teams. It shows a slow upward trajectory of the flu vaccine uptake over the past five years.

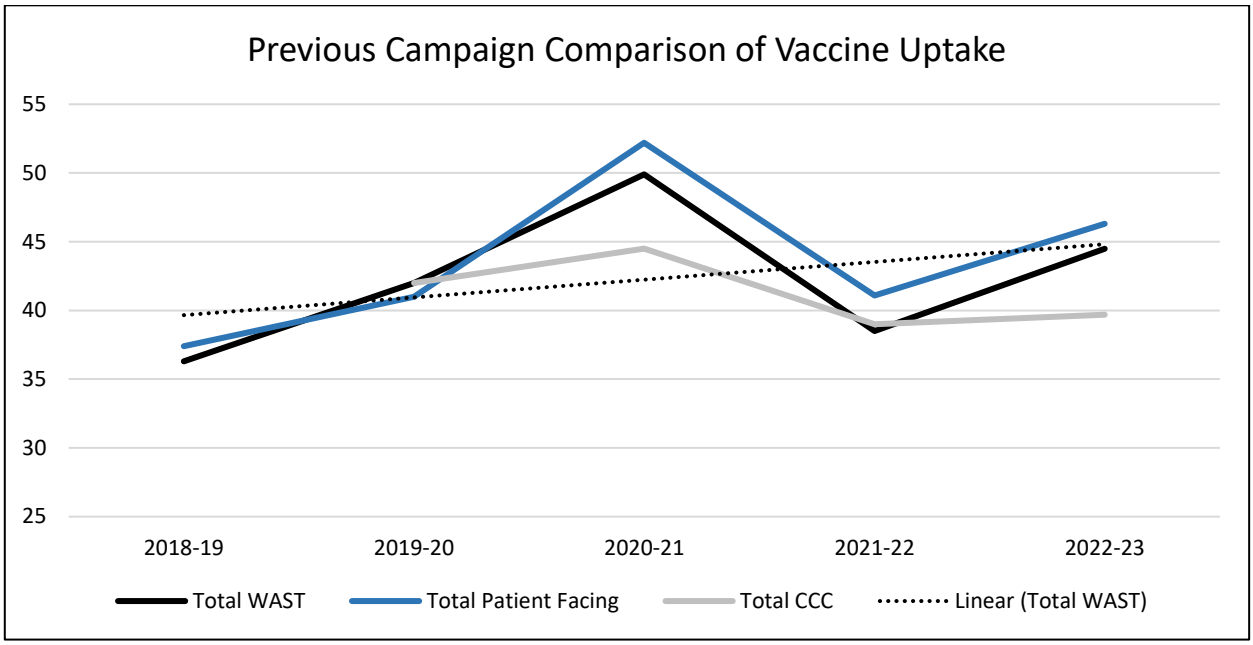


*Figure 9. Graph comparison of the previous 5 campaign uptake rates*

## 3. Data Summary

The target set out by Welsh Government is to reach a 60% vaccination rate across all colleagues. Unfortunately, this was not met during this year's campaign however an improvement was seen across the board from last year's campaign figures, reporting a final 44.5% vaccination rate for WAST.

This is reported alongside a 50.3% engagement rate for the organisation and for those that engaged via Microsoft Forms, 88.4% decided to receive the vaccination this year. The remaining 11.6% decided to decline and opt-out of receiving the flu vaccine.

Patient-facing colleagues of WAST saw a 46.3% vaccination rate that was 1.8% higher than the average figures for the organisation and a 5.2% increase from the patient-facing figures seen in the previous campaign.

## 4. Reporting

WAST do not have permissions to access the Welsh Immunisation System (WIS), meaning they do not have the ability to access the data that is held for staff who have received their vaccination through mass vaccination centres or other medical settings. The project team were also unable to attend the National Influenza Action Group (NIAG) due the discontinuation of the group. This used to form a fortnightly meeting during the flu season providing regular updates on the surveillance of flu alongside the progress in each Health Board. Therefore, the ability to obtain information from Public Health Wales is increasingly harder. Reasoning behind this is the incorporation of the flu vaccinations into the COVID-19 Booster Programme. It remains unsure if this reporting function through the NIAG meetings will reconvene next season.

The data received from the Microsoft Form for the Flu Campaign was utilised in conjunction with a full staff list supplied by ESR in September 2022. This was not updated throughout the campaign and was used as a baseline of WAST staff during the duration

of the campaign. Subsequently meaning that there may be some slight disparity in the overall results, dependant on the number of joiners and leavers during the 6-month period. This approach differs from previous years where data was recorded monthly on ESR with a report generated directly from the system which incorporated all staff movements.

A weekly summary highlight report was collated by the Project Manager and shared with all members of the Flu Programme. This allowed for continual monitoring and oversight of the progress of the campaign.

## 5. Campaign Summary

The attendance at the monthly flu campaign meetings were often diminished and underrepresented. Two flu teams channels were created; one for all members of the flu campaign and one for Occupational Health and the Project Team. This proved to be a useful tool as data was regularly updated and accessible to all.

WAST's SharePoint platforms (Siren and Yammer) were used as the main mechanism for communicating with staff throughout the flu campaign. Regular communications were sent to staff advising them of clinical details and a specific Intranet page was developed for the campaign which the nominated communications lead maintained. This year, a different approach was used by the communications team with using new and updated imagery of WAST staff receiving their vaccinations in a Trust setting to promote the campaign.

This was the first year that the campaign utilised the CEO Roadshows as an opportunity for staff to receive their flu vaccination. Enabling staff to have the vaccine at this event was well received by staff and colleagues and will hopefully form apart of future campaigns.

Incentives for vaccination uptake were not offered this year due to two unsuccessful bids to the Charitable Funds Committee.

## 6. Learning & Proposals

The following table illustrates the learning that has taken place throughout the Flu Campaign and proposals on how to use this learning to improve future flu campaigns within the Trust.

| | Learning | Proposals |
|---|---|---|
| 1 | Not all staff are completing the consent / opt-out MS Form. | A forced message booking system, to encourage staff to engage. |
| 2 | Having all data stored via MS Forms creates an easy platform to access. | A streamlined approach should be put in place to aid the process of uploading information and figures to ESR and OH Medical File System. |
| 3 | More creative ways of communicating with staff are required. | Introducing Podcasts to encourage better engagement from staff. Explore potential options with the iPad on via personal computers. |
| 4 | Not all Peer Vaccinators are completing their required competencies – ESR e- | Ensure all Peer Vaccinators who are nominated by LMs to vaccinate do firstly |

| | | |
|---|---|---|
| | learning modules (Flu One and Two), Written Instruction and Self-Assessment or Supervised Practice Form, meaning several areas had few Peer Vaccinators and therefore, little contingency when Peer Vaccinators were sick / on leave. | want to be a Peer Vaccinator early on and ensure prior to the campaign starting that required competencies are completed. |
| 5 | No confirmation that all the Flu Leads received their flu vaccination. | Encourage all Flu Leads to be advocates of the flu vaccine and willingly have the flu vaccine themselves each year. However, this is not mandatory. |
| 6 | Asking each locality how many vaccines they wished to have at the start of the campaign did not work, as many ran out early on and it proved difficult to move stock around when the campaign had begun. | Assign a certain number of vaccines to each locality area and ensure OH sites have central vaccine stock. |
| 7 | The success of flu vaccinations at the CEO Roadshows. | If the CEO Roadshows go ahead again next year during the Flu Campaign season, ensure there are enough vaccines and Peer / OH Vaccinators available at each roadshow. |
| 8 | Unable to identify exactly how many staff have had the flu vaccine elsewhere, despite 289 members of staff completing the Microsoft Form to advise it had been received elsewhere. This won't include those who have not completed the form. | Request access again to the WIS system, in order to find out how many staff have had the vaccine elsewhere. |
| 9 | Negative feedback received from Nurses/Paramedics regarding the required competencies for Peer Vaccinators. | Ensure all Peer Vaccinators are clearly made aware of the legalities to be followed when administering the flu vaccine, which means that all Peer Vaccinators must have supervised practice signed off first. |
| 10 | Incentives are a positive way to encourage the uptake of the flu vaccine. | Submit a Capital Bid to the Charitable Funds Committee again next year. |
| 11 | Many staff refuse to complete the opt-out form. | Create a separate MS Form for staff to opt-out, which can be completely confidential and does not require a staff's name. |

*Table 4. Learning experienced with proposals for future campaigns*

## 7. Recommendations

The proposals being recommended to WAST for next year's campaign include:

- The adoption of a forced message booking system that would allow for staff to book and record their vaccination. Potential systems for this have already been explored however it would also be beneficial to consider the possibility of developing something similar in-house to reduce costs.

- The implementation of a strong and creative communication strategy that commences earlier in the year. There is a need to fully maximise existing methods of staff

communication as well as exploring new methods of communication. This will allow for all staff groups to engage with the campaign.

- Encourage LMs to only choose Peer Vaccinators who are willing to complete the required Peer Vaccinator competencies (ESR e-learning modules - Flu One and Two, Written Instruction and Self-Assessment or Supervised Practice Form). Also ensure there is a contingency plan in place for each locality by having enough Peer Vaccinators for when a competent Peer Vaccinator is sick / on annual leave.

- Encourage all Flu Leads to be advocates of the flu vaccine and willingly have the flu vaccine themselves each year. An encouragement that those advocating the campaign should receive the vaccine, however, cannot be a mandatory field.

- Assign a specific number of flu vaccines to each locality area, as opposed to requesting numbers for vaccines and ensure the three Occupational Health sites (Matrix / Ty Elwy / VPH) have a central vaccine stock. This can be used for distribution when localities deplete their initial vaccines.

- Better utilisation of staff engagement opportunities such as the CEO Roadshows and ensure there are sufficient flu vaccines and Peer / Occupational Health Vaccinators at each event in order to maximise uptake.

- Occupational Health Department to again request access again to the WIS system, in order to establish how many staff have had the vaccine elsewhere, i.e. COVID booster setting or GP Surgery. All Health Boards have access to this system, however WAST has never been granted access to the system despite many requests being submitted over the past few years.

- Ensure all Peer Vaccinators are made aware of the legalities which must be followed when administering the flu vaccine, which means that all Peer Vaccinators must have supervised practice signed off first. Fortunately, 32 Peer Vaccinators have completed the supervised practice document this year, meaning that if they wish to be a Peer Vaccinator during the next Flu Campaign, they will only have to fill in the self-assessment form instead.

- Submit a Capital Bid to the Charitable Funds Committee next year requesting for incentives to be approved as a way of encouraging **all** staff to complete the Microsoft consent / opt-out Form; this is as per the feedback received from the Charitable Funds Committee this year.

- Instead of having one consent / opt-out form, create a separate MS Form for staff to opt-out, which can be completely confidential and does not require the staff member's name.

- Flu meetings commence earlier in the season i.e. July onwards. This will allow Flu leads to be made aware of who requires the competency sign off from their Peer Vaccinators early. Therefore ensuring the competencies are in place prior to the start of the flu vaccination season.

# 8. Conclusion

The Seasonal Influenza Campaign for Welsh Ambulance Services NHS Trust saw an increase in vaccination uptake for 2022-23.

Although staff engagement has been an apparent issue in current and previous campaigns, the data reflects that it does appear to be improving. The percentage of those engaging with the Microsoft Form increased by more than that of those receiving the vaccine, with a 9.6% and 6% increase retrospectively. The campaign ended with a 44.5% uptake of the flu vaccine and a 50.3% engagement rate on the Microsoft Form. Moving forward, there is a need to continually encourage staff to record their decision, whether that to be receiving or opting out, with emphasis on the anonymity that the Microsoft Form provides.

It is evident that positive steps have been made and a number of the lessons learnt from the previous campaign has been implemented. However, as seen in the recommendations, there is a range of areas that require continued development for future flu campaigns.

# 9. Appendix

## 9.1 Appendix 1

| Flu Vaccine Uptake Comparison % Staff in Post | | | |
|---|---|---|---|
| **AREA** | **2020-21** | **2022-23** | **+ / -** |
| **Total WAST** | **50%** | **44.5%** | - 5.5% |
| **Total Patient Facing** | **52%** | **46.3%** | - 5.7% |
| *NEPTS Patient Facing* | **50%** | **45.9%** | - 4.1% |
| *EMS Patient Facing* | **53%** | **46.5%** | - 6.5% |
| EMS Resourcing & Coordination (CCC) | **45%** | **39.7%** | - 5.3% |
| CSD / 111 | **40%** | **38.8%** | - 1.2% |
| Board Secretary | **17%** | **16.7%** | - 0.3% |
| Capital & Estates | **-** | **36.8%** | - |
| Chief Executive | **28%** | **-** | - |
| Clinical | **68%** | **72.2%** | + 4.2% |
| Complaints & Claims | **-** | **47.6%** | - |
| Education & Development | **-** | **17.9%** | - |
| Finance | **39%** | **54.5%** | + 15.5% |
| ICT / Digital | **53%** | **52.6%** | - 0.4% |
| National Fleet | **-** | **53.2%** | - |
| Operations Excl. Response | **46%** | **-** | - |
| Partnerships & Engagement | **88%** | **75.0%** | - 13.0% |
| Quality & Nursing | **55%** | **48.4%** | - 6.6% |
| Strategy Planning & Performance | **82%** | **100.0%** | + 18.0% |
| WOD | **43%** | **71.0%** | + 28.0% |

*Table 5. Comparison of Directorate % uptake to 2020-21 (highest recorded uptake) Flu Campaign*

The table above looks at a direct comparison from the current campaign to the uptake in the 2020-21 campaign that was running two years ago. This comparison is of significance as it featured the highest recorded uptake of the flu vaccination seen by the organisation. It represents how figures differ to a campaign seen in a higher performing year. The percentage comparison shows that a number of Directorates have decreased but also that some Directorates have increased from the campaign that saw the highest recorded vaccinated for WAST. Those that have decreased are only down slightly on these numbers. It is promising data that many Directorates are almost equalling, if not improving, from their highest vaccinated figures.

Again it is important to take into consideration that some staff groups are recorded differently than those in the 2020-21 campaign.

## 9.2 Appendix 2

| Flu Vaccine Engagement Comparison % Staff in Post | | | |
|---|---|---|---|
| **AREA** | **2021-22** | **2022-23** | **+ / -** |
| **Total WAST** | **40.7%** | **50.3%** | + 9.6% |
| **Total Patient Facing** | **43.0%** | **54.3%** | + 11.3% |
| *NEPTS Patient Facing* | **40.0%** | **53.8%** | + 13.8% |
| *EMS Patient Facing* | **46.0%** | **54.6%** | + 8.6% |
| EMS Resourcing & Coordination (CCC) | **39.0%** | **40.2%** | + 1.2% |
| CSD / 111 | **26.5%** | **40.4%** | + 13.9% |
| Board Secretary | **0.0%** | **100.0%** | + 100% |
| Capital & Estates | **-** | **42.1%** | - |
| Chief Executive | **31.6%** | **-** | - |
| Clinical | **58.8%** | **85.2%** | + 26.4% |
| Complaints & Claims | **-** | **52.4%** | - |
| Education & Development | **-** | **21.4%** | - |
| Finance | **31.8%** | **57.6%** | + 25.8% |
| ICT / Digital | **38.2%** | **54.4%** | + 16.2% |
| National Fleet | **-** | **61.7%** | - |
| Operations Excl. Response | **44.4%** | **-** | - |
| Partnerships & Engagement | **35.3%** | **75.0%** | + 39.7% |
| Quality & Nursing | **43.8%** | **48.4%** | + 4.6% |
| Strategy Planning & Performance | **36.4%** | **100.0%** | + 63.6% |
| WOD | **38.5%** | **79.0%** | + 40.5% |

*Table 6. Comparison of Directorate % engagement in 2021-22 and 2022-23.*

*Table 6* above demonstrates a comparison of the engagement rates between this year's campaign and last. As previously highlighted, the classification of Directorates has differed from one campaign to another so the comparison cannot be fully accurate as new 'areas' are present. Taking that into consideration, some + / - percentages may be exaggerated due to the addition or removal of staff groups, however the outlook is still noticeably more positive. From the comparison available, every staff group has increased their engagement with the Microsoft Form for the flu campaign compared to that seen in the previous campaign last year. Overall the engagement for total WAST staff is up almost 10% from 2021-22, with total patient facing staff seeing a 11.3% rise. It is vital that the

campaign continues to target the engagement had with the Microsoft Form, for all responses from staff whether it be receiving the vaccine in WAST, an alternative setting or engaging to opt out of receiving altogether.

It is important that the tables in the appendices take into consideration that some staff groups are recorded differently than those in previous campaigns.

| | |
|---|---|
| **AGENDA ITEM No** | **18** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **3** |

# WAST Anti Racist Action Plan 2023

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9 May 2023 |
| **EXECUTIVE** | Angela Lewis<br>Director of Workforce and OD |
| **AUTHOR** | Dr Catherine Goodwin<br>Assistant Director Inclusion, Culture and Wellbeing |
| **CONTACT** | Catherine.goodwin@wales.nhs.uk |

## EXECUTIVE SUMMARY

- This paper has three attachments:
  - The WAST anti racist action plan
  - Anti-Racist Action Plan Progress Update
  - The WAST LGBTQ+ action plan

- Although Welsh Government are producing separate plans and recommendations we feel it is helpful to promote an anti discrimination approach that highlights intersectionality by including the LGTBQ+ Action Plan in this bundle.

- The anti racist and LGBTQ+ action plans include actions for WAST that WAST own and actions that will impact WAST but we are not leading on the development.

- PCC are asked to support the implementation of the action plan recommendations.

## KEY ISSUES/IMPLICATIONS

- These plans are essential in our continued cultural journey to a truly inclusive organisation.
- Our recent staff story and the findings from the sexual safety survey reinforce our need to be proactive.
- We know that if people hold discriminatory beliefs, for example misogynistic, then they are likely to be in tolerant of difference more generally and hold other discriminatory beliefs.
- We need to always consider the impact of intersectionality.
- These issues apply to both our colleagues and our patients.

| REPORT APPROVAL ROUTE |
|---|
| **People and Culture Directorate Business Meeting 04.05.23**<br>**People and Culture Committee 09.05.2023** |

| REPORT APPENDICES |
|---|
| **Appendix 1**<br>*WAST Anti Racist Action Plan*<br><br>**Appendix 2**<br>*WAST Anti Racist Action Plan Progress Update*<br><br>**Appendix 3**<br>*WAST LGBTQ+ 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) | YES | Financial Implications | YES |
| Environmental/Sustainability | YES | Legal Implications | YES |
| Estate | YES | Patient Safety/Safeguarding | YES |
| Ethical Matters | YES | Risks (Inc. Reputational) | YES |
| Health Improvement | YES | Socio Economic Duty | YES |
| Health and Safety | YES | TU Partner Consultation | YES |

Llywodraeth Cymru
Welsh Government

# Anti-racist Action Plan

2022

Take ownership

Broaden our understanding

Respect others

Show belief in each other

Practice ethically

Continually improve our service

Be inclusive of the whole team

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# Background

The Welsh Government has made several commitments to addressing racism and promoting equity, diversity, and inclusion in Wales. In March 2020 the Welsh Government committed to creating a meaningful change in the lives of black and ethnic minority people in Wales by producing a Race Equality Action Plan. The plan is to support a vision that Wales is to become Anti-racist by 2030, where everyone is treated as an equal citizen.

The Welsh Government released the Anti-racist Wales Action Plan on June 7th, 2022, this is an all-Wales approach to move us closer, collectively to achieving the goal to make Wales anti-racist. In the Government's own words 'It would be naive to think we can completely eradicate racism in Wales, but we can start to create a culture with zero tolerance of racism, and change our systems and institutions to 'design-out' racism' (Government, 2022).

This is in line with the Welsh Government's aim to become an Anti-racist nation by 2030. As a result, we have created this document to establish the groundwork for this initiative and to utilise the agreed-upon actions as the foundation for our Trust Strategic Equality Objectives and Action Plan for 2024-28. We will also include the additional areas identified in the forthcoming Welsh Government LGBTQ+ action plan and Disability Action plan.

# RACISM AND AN ANTI-RACIST APPROACH

At Welsh Ambulance Service NHS Trust, we recognise that racism and discrimination exist in our society, and we are dedicated to taking action to combat these issues. Race is just one aspect of a person's identity, and it intersects with other aspects such as gender, sexuality, class, ability, and religion to shape our experiences of the world. We acknowledge that different individuals and groups experience racism and discrimination in unique and complex ways depending on the intersection of their identities.

This requires acknowledging the complex ways in which different forms of oppression intersect and interact, and working to dismantle systemic barriers that prevent individuals and communities from reaching their full potential. As an organisation, we are committed to taking an intersectional approach to our work and to promoting equity, diversity, and inclusion in all that we do.

We believe that everyone has the right to be treated with dignity and respect, regardless of their race, ethnicity, or cultural background. We are committed to fostering a culture of inclusivity, where everyone feels valued and empowered to reach their full potential. As an organisation, we are committed to listening, learning, and taking action to address racism and discrimination, both within our own workplace and in the wider community. We acknowledge that this work requires ongoing effort and collaboration, and we are dedicated to making meaningful progress towards a more equitable and just culture.

We need to be resolute in making meaningful and substantial changes to address racial injustice and others with protected characteristics that experience inequalities within the NHS, otherwise, it will remain a significant and unsolved problem.

# WAST Anti-racist Action Plan

THE VISION FOR AN 'EQUITABLE WHOLE SYSTEM APPROACH TO HEALTH CARE, IS FOCUSED ON THE HEALTH AND WELLBEING, BOTH OF OUR WORKFORCE AND COMMUNITIES, AND ON PREVENTING ILLNESS.

**PRIORITY LEADERSHIP**

**PRIORITY WORKFORCE**

**PRIORITY DATA**

**PRIORITY ACCESS TO SERVICES**

**PRIORITY HEALTH INEQUALITIES**

# Priority Leadership

Priority action 1.
Require anti-racist leadership at all levels by direction. All NHS Boards, Trusts, and Special Authorities to report demonstrable progress in driving anti-racism at all levels

**Develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity**

Implemention of an anti-racism plan within our organisation can create a more inclusive and equitable environment for all employees and patients. This can help to prevent discrimination and bias, and ensure that everyone is treated fairly and respectfully, regardless of their race or ethnicity. Implementation of anti-racism action plans will reduce people's experience of racism while being recruited, progressing, and working or accessing services.
December 2022

**NHS Board members should undertake an anti-racist education programme**

As a public service, WAST has a duty to ensure that all individuals receive the same level of care and treatment, regardless of their race or ethnicity. Undertaking an anti-racist education programme can help board members to better understand the experiences of people from different racial backgrounds and ensure that the NHS is providing equal care to all.

Racism is a systemic issue that permeates all aspects of society, including healthcare. Board members who undergo an anti-racist education programme will be better equipped to identify and address the ways in which racism may be present within the NHS, and to implement strategies to combat it.

Research has shown that people from ethnic minority backgrounds often experience poorer health outcomes compared to their white counterparts. By educating WAST Board members on the ways in which racism can impact patient outcomes, they can work to ensure that the WAST is providing the best possible care to all patients, regardless of their race or ethnicity.

Undertaking an anti-racist education programme can help to foster a culture of inclusivity within WAST, where individuals from all racial backgrounds feel valued and respected. This can help to improve staff morale, reduce staff turnover and ultimately lead to better patient outcomes.
December 2022

**Providing Ethnic Minority Networks with appropriate levels of resources and access to the Board.**

Establish an ethnic minority network with a direct line to Board to support annual plans and reporting via IMTP

# Priority Leadership

**The appointment of 'Executive Equality Champions and 'Cultural Ambassadors'.**

Executive Equality Champions are senior leaders within an organisation who take responsibility for promoting equality and diversity throughout the organization. They work to embed inclusive practices into the culture of the organisation and help to ensure that policies and practices are fair and accessible to all. They also act as role models and advocates for underrepresented groups within the organization and work to create a more inclusive workplace culture.

Cultural Ambassadors are individuals within an organisation who are selected to act as representatives for their culture or community. They work to promote understanding and awareness of their culture or community among their colleagues and act as a bridge between their community and the wider organisation. They can help to promote diversity and inclusion by raising awareness of cultural differences and fostering mutual understanding and respect.

Together, the appointment of Executive Equality Champions and Cultural Ambassadors can help to promote equity, diversity, and inclusion within an organisation. By providing senior leadership and visible representation for underrepresented groups, these individuals can help create a more inclusive workplace culture and ensure everyone feels valued and supported. They can also help to promote a greater understanding of cultural differences and promote greater respect and collaboration across different groups within the organisation.
September 2023

**Leadership and progression pipeline plan is designed to support the career development of staff within an organisation, and to ensure that they have equal access to leadership positions and other career opportunities. Such a plan might includee the following elements:**

Training and development: Providing targeted training and development opportunities for Black, Asian, and Minority Ethnic staff to develop the skills and competencies needed for leadership roles.

Mentoring and coaching: Providing mentoring and coaching support to Black, Asian, and Minority Ethnic staff to help them navigate the organisational culture and build the relationships and networks necessary for career advancement.

Recruitment and selection: Ensuring that recruitment and selection processes are fair and inclusive, and that Black, Asian, and Minority Ethnic staff are given equal consideration for leadership and other career advancement opportunities.

Performance management: Providing regular feedback and support to Black, Asian, and Minority Ethnic staff to help them develop and progress in their careers.

Accountability and monitoring: Establishing accountability measures to ensure that progress is being made in promoting the career development of Black, Asian, and Minority Ethnic staff, and monitoring progress against established goals and benchmarks.

By implementing a leadership and progression pipeline plan forBlack, Asian, and Minority Ethnic staff, organisations can help to address the barriers that may be preventing these individuals from advancing in their careers. This can help to create a more diverse and inclusive leadership team, which can in turn help to promote a more inclusive organizational culture and lead to better outcomes for the organisation as a whole.
September 2023

# Priority Workforce

**Complete an Independent Audit of current workforce policies with recommendations to strengthen anti-racist principles.**

Conducting an independent audit of current workforce policies with recommendations to strengthen anti-racist principles is important for identifying areas of improvement, building trust with employees and stakeholders, ensuring compliance with anti-discrimination laws, and creating a roadmap for change towards a more equitable and inclusive workplace.
December 2022

**An aspiring board members program is a training program that prepares individuals for a board of directors position.**

The program can covers a range of topics related to the responsibilities of board members, governance principles, financial management, stakeholder engagement, and other skills required to be an effective board member. The program may also offer networking and mentorship opportunities. The program can be designed to equip individuals with the necessary knowledge, skills, and experience to contribute to the success of the organisation.
December 2022

> Higher Education Institutions (HEIs) and NHS Organisations will co-design anti-racist education programmes with Black, Asian and Minority Ethnic people. Set a requirement for all NHS Staff, NHS Volunteers and students to complete redesigned anti-racist education programmes. Dec 2023

> HEIW will ensure all commissioned programmes provide evidence of anti-racist principles and reflect HEIWs Strategic Equality Plan in order to meet objectives regarding differential attainment, widening access and under-representation of Black, Asian and Minority Ethnic people in NHS Wales. Sep 2023

# Priority Data

Priority action 3: Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)

| | | |
|---|---|---|
| Improve scoped and implemented WRES to include data about NHS and Social Care Black, Asian and Minority Ethnic workforce careers. progression, leadership representation, discrimination and bullying. | High quality workforce data, underpinned by a culture where staff can be safe, and confident to provide ethnicity data and speak up against racist discrimination and practice. | 2023 |
| Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process. Sources of workforce data and intelligence will be refined including the WRES and HEIW Centre of Excellence | Welsh Government & HEIW | 2023 |
| Co-design and revise population health data collection, creating an evidence base to develop policies and provide equitable health and social care services | Report detailing how population health data collection, monitoring has been revised and the impact. Welsh Government Health and Social Services Public Health Improvements. | 2023 |

Welsh Ambulance Service Trust 2022

# Priority Access to Service

Priority action 4:
The Maternity and Neonatal Safety Support Programme, co-designed and developed with Black, Asian and Minority Ethnic people and stakeholders

**The office of the Chief Nursing Officer is responsible for this work**

- Detail and implement specific changes to maternity services that will improve outcomes and experiences of Black, Asian and Minority Ethnic women and families who experience health inequalities.
- This will include a reduction in perinatal mortality in minority ethnic people and babies.
- Improved experiences of care in pregnancy and birth including pain management in labour, by **January 2023**

# Priority Health Inequalities

Priority action 5:
Establish a dedicated working group on health inequalities to address barriers in accessing services

Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision.
**September 2023**

**Time to Change Wales"**

Public Health & Welsh government will develop and deliver an anti-racist mental health anti-stigma programme

**March 2023**

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Llywodraeth Cymru
Welsh Government

# Anti-racist Action Plan Timeline

# Priority Leadership

Priority action 1. Require anti-racist leadership at all levels by direction. All NHS Boards, Trusts, and Special Authorities to report demonstrable progress in driving anti-racism at all levels

Goal: The NHS in Wales will be anti-racist, and will not accept any form of discrimination or inequality for employees or service users.

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| All NHS Board members will undertake an anti-racist education programme and implement and report progress against personal objectives (for all Board members) to meet vision of an anti-racist Wales. | Develop our progressing Allyship Program for Board Members. Collaborate with Diverse Cymru and the Cultural Competences program. | Visible evidence of attendance and development<br>Visible change, where required, in decision making, evidencing that anti-racism, equality, diversity, and inclusion have been considered<br>Visible and transparent allyship and leadership | March 2023 Board Development session Delivered by Diverse Cymru: Improving Cultural Competence in the Workplace - 'A call to take Action rather than Rhetoric'. A Board Development program is in discussion to develop the Allyship Program, Active Bystander training is in Development | December 2022 (Delayed due to Industrial Action and winter pressures) | ArWAP |
| Appointing 'Executive Equality Champions' and 'Cultural Ambassadors | WAST to appoint an Exec Equality Champion as well as 'Equality Champions' and 'Cultural Ambassadors in the Exec Team and within PCC team, looking at intersectionality. | Identify Executive Race Champions this will be decided by Board through the Board Development Program with continued Allyship development. | | September 2023 | ArWAP |

# Priority Leadership

Priority action 1. Require anti-racist leadership at all levels by direction. All NHS Boards, Trusts, and Special Authorities to report demonstrable progress in driving anti-racism at all levels

Goal: The NHS in Wales will be anti-racist, and will not accept any form of discrimination or inequality for employees or service users.

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| Implementing a leadership and progression pipeline plan for Black, Asian, and Minority Ethnic staff | Leadership pipeline for Black, Asian and Minority Ethnic staff. | HEIW Leading | | September 2023 | ArWAP |
| Providing Ethnic Minority Networks with appropriate levels of resources and access to the Board. | Establish an ethnic minority network with a direct line to Board to support annual plans and reporting via IMTP. | Report progress via Annual Equality Report. Evidence of staff engagement and coproduction. | Incorporated into Inclusion Network due to small numbers. | September 2023 | ArWAP |

# Priority Workforce

Priority action 2: Commission an independent audit of all existing workforce policies and procedures

Goal: Staff will work in safe, inclusive environments, built on good anti-racist leadership and allyship, supported to reach their full potential, and ethnic minority staff and allies; both be empowered to identify and address racist practices.

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| Complete Independent Audit of current workforce policies with recommendations to strengthen anti-racist principles. This will specifically include policies around grievances, complaints and use of Non-Disclosure Agreements. | Register with Diverse Cymru's Cultural Accreditation Scheme as a step to ensure that it's workforce policies and procedures are developed and reviewed through an anti-racist lens. Ensure Black, Asian and Minority Ethnic representation within groups established to oversee. | Audit carried out by Diverse Cymru | Staff attending Anti-Racist Audit of All-Wales NHS Workforce Policies NHS Wales organisation who self-identify as Black, Asian or minoritised focus group with Diverse Cymru to look at all Wales NHS polices. | December 2022<br><br>WG has commissioned support via Diverse Cymru so outcomes will be identified over next 12 months. | ArWAP |
| Higher Education Institutions (HEIs) and NHS Organisations will co-design anti-racist education programmes with Black, Asian and Minority Ethnic people. Set a requirement for all NHS Staff, NHS Volunteers and students to complete redesigned anti-racist education programmes. | WAST will ensure prioritisation of training in education plans and provide support for the implementation of developed educational programs. | By promoting a broader understanding of anti-racist measures, there is a potential for decreasing incidents of discrimination among both staff and patients. | WAST also has it's own in-house training which it continues to implement, the Allyship program and has also designed the Active Bystander Training. | September 2023 | ArWAP<br>Race Equality Action Plan 2021-2024 |

# Priority Workforce

Priority action 2: Commission an independent audit of all existing workforce policies and procedures

Goal: Staff will work in safe, inclusive environments, built on good anti-racist leadership and allyship, supported to reach their full potential, and ethnic minority staff and allies; both be empowered to identify and address racist practices.

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| Each NHS organisation will commit to their involvement in the Aspiring Board Members Programme, ensuring education, mentoring and support to participants who will be from a Black, Asian and minority ethnic background. | Await further information from Academi Wales who are leading on the recruitment and matching of participants to NHS bodies. | Facilitated aspiring board member's participation. | Awaiting information from Academi Wales. | December 2022 | ArWAP |
| Ensure all WAST workforce commissioned programmes provide evidence of anti-racist principles and reflect objectives regarding differential attainment, widening access and under-representation of Black, Asian and Minority Ethnic people in NHS Wales. | Embed within the programme Talent Management Framework, leadership and management development framework, and Education and Learning strategies. | Appraisals will capture completion and participation in anti-racist education. | Allyship program is build into the managers essential program, awareness is built into the Warm WAST Welcome. | September 2023 | ArWAP |

# Priority Data

Priority action 3: Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)

Goal: Data in relation to race, ethnicity, and intersectional disadvantage will be routinely collated, shared, and used transparently, to level inequalities in health and access to health services, and provide assurance that the NHS Wales is an anti-racist and safe environment for staff and patients.

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| Implementation of the Workforce Race Equality Standard (WRES) | High quality workforce data, underpinned by a culture where staff can be safe, and confident to provide ethnicity data and speak up against racist discrimination and practice. | Implement and report on the Workforce Race Equality Standards, once scoped and agreed by Welsh Government. | Waiting for Welsh Government update. | Welsh Government September 2023 | ArWAP People and Culture |
| Improve scoped and implemented WRES to include data about NHS and Social Care Black, Asian and Minority Ethnic workforce careers. progression, leadership representation, discrimination and bullying. | Improve the quality of our workforce data and apply the Workforce Race Equality Standard (WRES) to establish an evidence base for implementing to measure change. | Ethnicity Pay Gap Report<br>Annual Equality Data Monitoring Report<br><br>Improve the capture of data in relation to the ethnicity of our patients when attending calls. | Waiting for Welsh Government update. | Welsh Government/HEIW September 2023 | ArWAP People and Culture |

# Priority Access to Service

Priority action 4:
The Maternity and Neonatal Safety Support Programme, co-designed and developed with Black, Asian and Minority Ethnic people and stakeholders

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| • Detail and implement specific changes to maternity services that will improve outcomes and experiences of Black, Asian and Minority Ethnic women and families who experience health inequalities.<br>• This will include a reduction in perinatal mortality in minority ethnic people and babies.<br>• Improved experiences of care in pregnancy and birth including pain management in labour. | The office of the Chief Nursing Officer is responsible for this work. | Publication and reporting against programme's progress. | CNO office is responsible for this work. | January 2023 | |

# PRIORITY HEALTH INEQUALITIES

PPriority action 5:
Establish a dedicated working group on health inequalities to address barriers in accessing services

| Action | Activity | Output | Progress | By When | Linked documents |
|---|---|---|---|---|---|
| Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision. | Specific actions to address inequalities. | Delivery of more culturally competent care, with improved access. | Awaiting the start of New Head of Inclusion & Engagement. | September 2023 | Welsh Government. NHS Wales Organisations. |
| Time to Change Wales" | Public Health & Welsh government will develop and deliver an anti-racist mental health anti-stigma programme. | Published programme on mental health anti-stigma. | With Time to Change Wales. | March 2023 | |

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

# Welsh Government LGBTQ+ Action Plan

Llywodraeth Cymru
Welsh Government

2023

Take ownership

Broaden our understanding

Respect others

Show belief in each other

Practice ethically

Continually improve our service

Be inclusive of the whole team

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# Introduction

On February 7th 2023 Welsh Government published its LGBTQ+ Action Plan for Wales, Together in Pride – making Wales the most LGBTQ+ friendly nation in Europe. Their plan to make Wales the most LGBTQ+ friendly nation in Europe and this was backed by a powerful statement from the First Minister of Wales Rt Hon Mark Drakeford MS.

Intersectionality is a key theme that runs through this action plan and does not just commit to change for our LGBTQ+ communities, but also the layered barriers that these individuals may experience when having to navigate their lives with additional barriers, such as seeking asylum and other protected characteristics.

The LGBTQ+ Action Plan for Wales has been established to help coordinate action by the Welsh Government and other agencies. The plan sets out an overarching vision to improve the lives of, and outcomes for, LGBTQ+ people. It includes a wide range of policy-specific actions relating to human rights, education, improving safety, housing, health and social care, sport, culture, and promoting community cohesion. In particular, through this Action Plan, the Welsh Government commits to defend and promote the rights and dignity of trans and non-binary people, and to make those communities feel welcome and included in Welsh society.

# The Vision

The Vision from Welsh Government sets out a framework that will guide us as organisations and supports us to achieve our targets in Health:

Vision: W**e will improve healthcare outcomes for all LGBTQ+ people**

**Our actions:**

- 18. Understand and improve the experience of LGBTQ+ people in the health and social care sectors.
- 19. Ensure maternity and fertility services are accessible and straightforward to use for LGBTQ+ people.
- 20. Ensure the development of the new mental health strategy takes account of LGBTQ+ people.
- 21. Publish and act on a new HIV Action Plan.
- 22. Overcome barriers to LGBTQ+ people accessing sexual health services.
- 23. Review the Gender Identity Development pathway for young people in Wales.
- 24. Continue to develop the Wales Gender Service.
- 25. Improve the data recording and change processes for maintaining trans, non-binary and intersex people's medical records

> Within healthcare settings, LGBTQ+ people feel that they may face unequal treatment and discrimination. Data states almost one in four LGBTQ+ people (23%) have at one time witnessed discriminatory or negative remarks against LGBTQ+ people by healthcare staff. 19.6% of Welsh trans respondents reported in the National LGBT Survey that their specific needs were disregarded when using or attempting to use healthcare services. While 50% Welsh sample of LGBQ+ cisgender people stated they had never shared their sexual orientation with healthcare staff.

**Welsh Ambulance Service Trust 2023**

# Actions and Key Performance Indicators for Health

The following table will clarify what we want to achieve and how we will achieve it. It will also provide an overview of the impact and changes we hope to generate. Each action will be linked to specific action owners or leads and will show a timeline for delivery and implementation.

## Health, Social Care, and Well-Being

| Number | Action | Activities | Outcome | Timeline | Owner |
|---|---|---|---|---|---|
| 18.1 Training and Workplace | Understand and improve the experience of LGBTQ+ people in the health and social care sectors | Undertake a review of existing training for NHS Wales staff on inclusive healthcare practices | LGBTQ+ people feel safe, respected, and understood when using health and social care services. | Ongoing Long Term | **NHS Wales organisations** Health Inspectorate Wales Staff Networks WG HSC Workgroup |
| | | Work with partners including the NHS Wales Partnership Forum to understand the experience of LGBTQ+ staff in the NHS workplace. Take any appropriate action (including development of training) as a result. | | Ongoing Long Term | |
| 18.2 Inspection | | Health Inspectorate Wales (HIW) to consider LGBTQ+ service users and patients in their review of inspection methodology | | Ongoing Long Term | WG Quality & Nursing Directorate WG Population Health Team WG Social Services & Integration Team WG Equality, Race and Disability KAS |

# Actions and Key Performance Indicators for Health

## Health, Social Care, and Well-Being

| Number | Action | Activities | Outcome | Timeline | Owner |
|---|---|---|---|---|---|
| 18.3 Complaints | Understand and improve the experience of LGBTQ+ people in the health and social care sectors | health bodies to record equality data, where possible, to ascertain whether LGBTQ+ people are raising complaints about their care. They should review the data and report to their equality and diversity and Equality and Safety committees | LGBTQ+ people feel safe, respected, and understood when using health and social care services. | Ongoing Long Term | WG Quality & Nursing Directorate WG Population Health Team WG Social Services & Integration Team WG Equality, Race and Disability KAS |
| | | Consider the needs of LGBTQ+ people of all ages in the process of reviewing codes of practice and statutory guidance under the Social Services and Well-being (Wales) Act 2014 and Regulation and Inspection of Social Care Wales Act 2016 | | Ongoing Long Term | WG Quality & Nursing Directorate WG Population Health Team WG Social Services & Integration Team WG Equality, Race and Disability KAS |
| | | Health Inspectorate Wales (HIW) to consider LGBTQ+ service users and patients in their review of inspection methodology | | Ongoing Long Term | WG Quality & Nursing Directorate WG Population Health Team WG Social Services & Integration Team WG Equality, Race and Disability KAS |

# Actions and Key Performance Indicators for Health

## Health, Social Care, and Well-Being

| Number | Action | Activities | Outcome | Timeline | Owner |
|---|---|---|---|---|---|
| 18.4 Outcomes and experience | Understand and improve the experience of LGBTQ+ people in the health and social care sectors | Through a review of existing research and evidence, identify the barriers facing LGBTQ+ people accessing health and social care, including any experiences of anti-LGBTQ+ attitudes, and the impact these barriers have on people's behaviours in maintaining their health and wellbeing. | LGBTQ+ people feel safe, respected, and understood when using health and social care services. | Ongoing Long Term | WG Quality & Nursing Directorate WG Population Health Team WG Social Services & Integration Team WG Equality, Race and Disability KAS |
| | | In the context of healthcare and social care, review evidence concerning the impact of certain behaviours (e.g., substance misuse behaviour, tobacco use, sexual health, and mental health) that may disproportionately affect LGBTQ+ individuals. | | Ongoing Long Term | WG Quality & Nursing Directorate WG Population Health Team WG Social Services & Integration Team WG Equality, Race and Disability KAS |
| 19. | Ensure maternity and fertility services are accessible and straightforward to use for LGBTQ+ people | Review and improve fertility referral pathways and services for LGBTQ+ people. Identify, review, and improve access for IVF, including financial costs for LGBTQ+ people. | Single sex families can access fertility treatment equally. Trans people have timely access to gamete storage that does not unduly delay a medical transition. | Long Term | Welsh Government Health and Social Services Group WG Quality and Nursing Team |

# Actions and Key Performance Indicators for Health

## Health, Social Care, and Well-Being

| Number | Action | Activities | Outcome | Timeline | Owner |
|---|---|---|---|---|---|
| 20. | Ensure the development of the new mental health strategy takes account of LGBTQ+ people. | Identify and consider the needs of LGBTQ+ people, refugees and people seeking asylum as part of engagement work to develop the Strategy. Develop actions to reduce inequalities in access and outcomes from mental health services. | LGBTQ+ people are confident that mental health services meet their needs. | Long Term | Welsh Government Health and Social Services Group WG Quality and Nursing Team |
| 21. | Publish and act on a new HIV Action Plan | Publish a draft HIV Action Plan for Wales and open consultation. Review responses and publish a revised HIV Action Plan for Wales which includes a focus on prevention, late diagnosis, education, equitable service provision, and removal of stigma. Establish an oversight group to monitor delivery of the actions within our HIV Plan. | People living with HIV feel satisfied with their quality of life and quality of care. Reduce cases of late diagnosis. Wales meets the target of zero new HIV transmissions by 2030 | Ongoing | Welsh Government Health and Social Services Group Public Health Wales (PHW) Health boards WG Health Protection |
| 22 | Overcome barriers to LGBTQ+ people accessing sexual health services | Raise awareness, through targeted campaigns, with LGBTQ+ people of available remote services, including postal testing (see HIV Action Plan for Wales). | LGBTQ+ people in all regions of Wales feel they can have easy, private, and confidential access to sexual health service | Medium Term | Welsh Government Health and Social Services Group WG Health Protection PHW Health boards |

# Actions and Key Performance Indicators for Health

## Health, Social Care, and Well-Being

| Number | Action | Activities | Outcome | Timeline | Owner |
|---|---|---|---|---|---|
| 23. | Review the Gender Identity Development pathway for young people in Wales | Ensure young people and stakeholders in Wales are engaged in the consultation on an interim service specification. Consider options for the development of a service in Wales. This will include engagement with young people, service users and stakeholders. | Trans Children and Young people in Wales can access services closer to where they live. Health services for trans children and young people are focused on clinical need and based on clinical evidence | Long Term | Welsh Government Health and Social Services Group Welsh Gender Service Welsh Health Special Services Commissioners |
| 24. | Continue to develop the Wales Gender Service | Further reduce waiting times for the Welsh Gender Service and Local gender teams. Enable GPs to initiate hormone therapy as part of the adult pathway. Understand the needs of non-binary people accessing the Welsh Gender Service | In line with Action 18, Activity 18.4 of this Plan, the overall health outcomes and experiences of trans and non-binary people will be considered. | Long Term | Welsh Government Health and Social Services Group Welsh Gender Service |
| 25. | Improve the data recording and change processes for maintaining trans, non-binary and intersex people's medical records | A broader review of the use of sex and gender markers to ensure that a change of details is carried through to other NHS demographic systems. Examine options for amending or developing digital services to achieve the above policy aims linked to greater inclusion of trans, non-binary, and intersex citizens. | Improved access to healthcare services and reduced risk of exclusion. Communication from NHS reflect the needs of trans and non-binary people. | Long Term | Welsh Government Health and Social Services Group |

# Next Steps

**Let's be ambitious!**

Welsh Ambulance NHS Service Trust, welcomes the LGBTQ+ Wales Action Plan. Our vision for our organisation is for all our people to live safe, healthy, authentic lives that are free from the fear of discrimination. And to involve our people in the 'Next Steps'.

We will:

- Engaged with Stonewall for advice and support on how we move forward.
- Involve our LGBTQ+ staff network in all our decisions and listen to their experiences within our organisation.
- Undertake a review of our existing training
- Understand and improve the experience of LGBTQ+ people in our service as highlighted in Section 18. of the Action Plan
- Involve our EDI steering group and our WAST Inclusion Network in all our work.

Make WAST a truly inclusive service.

| | |
|---|---|
| **AGENDA ITEM No** | **19** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **1** |

# Recruitment breakdown for Candidates from minority community backgrounds

| | |
|---|---|
| **MEETING** | **People and Culture Committee** |
| **DATE** | **9th May 2023** |
| **EXECUTIVE** | **Angela Lewis, Director of People and Culture** |
| **AUTHOR** | Liz Rogers, Deputy Director, People and Culture |
| **CONTACT DETAILS** | liz.rogers@nhs.wales.uk |

## EXECUTIVE SUMMARY

People and Culture Committee (PCC) requested a deep dive into recruitment data from a conversation at PCC in November regarding candidates from Black, Asian and Minority Ethnic communities and their outcomes through WAST recruitment processes.

A review of applications has been undertaken for the period April 2022 to March 2023 and the findings and analysis are included in the SBAR.

WAST receives a positive level of applications at circa 9% of all those received, against census data of 5%, but a significant number are not successful at shortlisting. Further work will be done to explore the reasons for this with some suggestions noted below. Personal data is not supplied when applications are shortlisted.

For candidates from minority ethnic backgrounds, those who get to interview stage show good levels of success with 26% being made offers.

There is recognition of the need to get upstream with some roles e.g. paramedics, and work with Swansea University on attracting a more diverse range of students into the University or look at opportunities to link into other providers with a more diverse student population.

## KEY ISSUES/IMPLICATIONS

People and Culture Committee is asked to:

- **NOTE** the options and recommendation in the report
- **NOTE** the outcomes of the review of information.
- **NOTE** that the team will work on reviewing recruitment processes to make them as accessible as possible whilst ensuring standards.
- **NOTE** that this information will be used as the benchmark to measure interventions against.

- **AGREE** to receive further updates on progress.

| REPORT APPROVAL ROUTE | | |
|---|---|---|
| **WHERE** | **WHEN** | **WHY** |
| People and Culture Committee | 09.05.2023 | Request from PCC |

## SITUATION

1. Our focus is on monitoring the number of applications we receive and on reaching into wider, diverse communities to both enhance our workforce and reflect the demography of the communities we serve. This forms a part of our bigger work around our recruitment and onboarding. We will be reviewing our recruitment processes and practices, not only for candidates from minority ethnic communities but also candidates from other backgrounds with protected characteristics, for example reviewing where there may be barriers to particular groups or how we reach into communities to encourage them to apply for posts in WAST as well as driving process efficiencies where we can.

## BACKGROUND

2. P&C Committee requested further information on the breakdown of candidates and successful recruitment from Black, Asian and Minority Ethnic community backgrounds. The question arose at a previous meeting where the numbers of candidates getting through the process was of concern.

3. A review of the data on applications from April 2022 until March 2023 has been completed by the Deputy Director and the Recruitment Team. The key findings are reported below. This work will be used as the benchmark for the recruitment project and onboarding.

4. For the purposes of this review, we have not included candidates who did not disclose their ethnicity as they may be from any background and no assumptions should be made but they are included in the total applications figure.

## ASSESSMENT

### Applications Received

5. During the reporting period April 2022 – March 2023, WAST received 9496 applications for the advertised posts. 840 of these applications were received from Black, Asian and Minority Ethic community candidates. This is 9% of applications. All Wales statistics note that in the 2021 census, 5.0% of respondents chose to write in an ethnic identity with the highest proportions of people with an ethnic identity being in mainly urban areas such as Cardiff, Newport and Swansea. Therefore, whilst we would encourage as many applications as we can, 9% is a very positive number to receive.

6. Of the 9496 applications, the team remove duplicate applications before sending on to recruiting managers. A total of 246 duplicate applications were removed. 17 of these duplicates were candidates from minority communities, leaving 817 applications from a total of 9250 applications (8.8%).

7. Of the applications processed during the reporting period, 244 are pending (currently in process), 43 of those applications are from minority community candidates (18% - double 8.8% figure). This leaves 9006 applications processed, of which, 780 are from minority community candidates (8.66%).

**Shortlisting**

8. In terms of shortlisting, a total of 4516 applications were rejected at shortlisting (50.1%). 618 were from applicants with a minority ethnic background. As a percentage, 74% of applications from minority ethnic communities received were rejected at shortlisting. This shows that 24% more applications were rejected at shortlisting from minority community candidates than all candidates. Ideally, we would want to see the same level from an equality perspective, or less.

9. This is interesting information. Shortlisting criteria will include qualification requirements, relevant experience and an assessment of the applications against the criteria noted in the person specification for the role. It will also include licence requirements for jobs requiring driving for the role. A deeper dive will be undertaken on where candidates are falling out of the process and whether there are any specifics for applicants from minority communities (and other candidates with protected characteristics). It may be that candidates are failing due to not holding the required essential qualifications or driving licence or licence category(C1) at shortlisting.

**Qualifications**

10. Job Descriptions now state the qualifications required in a more helpful way. This has been a work in progress with support from the Education and Development Team. There are a couple of posts to review. Previously GCSEs were requested whereas now it is written to identify Essential Skills at L2 in Application of Number/Numeracy & Communication/Literacy first with GCSE Welsh/English and Maths second. These qualifications are more likely to be held by individuals who did not achieve the Level 2 standard (GCES) when in statutory education but may have progressed on to Further Education where these qualifications are a core element of all full time curricula.

11. This has helped greatly to increase the number of people who hold the relevant qualifications at application stage, but candidates are at risk of being filtered out if they do not fill in their application form correctly and there is a tendency for applicants to put their highest level of qualifications in whilst we need evidence of the essential qualifications for shortlisting purposes.

12. The recruitment team refer individuals with a less straightforward sets of qualifications through to the Head of Education and Development for review. Where individuals have gaps in their education the team consider how we can support them. The default is to use experience in lieu of qualifications for individuals with pre 1988 qualifications and support them (as well as post 1988 quals) to undertake Essential Skill diagnostic assessment which provides a profile to work with and support the individual to access specialist Basic Skills education, should they be successful at interview.

13. There is a balance to be struck and we do have significant numbers of candidates applying who do not meet the essential criteria and it would be unfair to take responsibility for high failure at shortlisting stage for people who are ineligible.

**Driving and shortlisting**

14. Up until now we have carried out driving assessments on all shortlisted candidates. We are changing this so only those successful at interview will now be assessed for driving. This should increase the number of successful candidates significantly as we have identified that those who fail have under-prepared. This is despite the recruitment team being very clear that there are assessments on both driving practice and theory (based on the Highway Code). We rarely need to fail people for their driving practice if they pass the theory element.

**Interview stage**

15. Post shortlisting, 162 candidates from minority communities were left in the process i.e. 20.8% of those who applied. As a percentage of all candidates shortlisted this works out at 3.6%. 1 candidate withdrew at this stage leaving 161.

16. At interview stage, 73 of the 161 candidates (45.3%) withdrew or did not attend an interview. This compares to 1531 (31%) of all candidates not attending interview when invited. Again, this is interesting information as to why 12% more candidates from a minority ethnic community withdrew or did not attend an interview. One area to note is that in a candidate market, people will likely be applying for multiple roles across a range of organisations and may accept offers which are made quicker than those at WAST. However, an understanding of why candidates withdraw is another exercise to undertake as a part of our projects around recruitment and onboarding. If candidates are in multiple processes, why do they choose not to progress their application with WAST is the key question.

17. Of the 89 applicants from minority communities undertaking interviews, 23 candidates (26%) were successful. As a percentage, this is a positive outcome and suggests that when candidates from minority ethnic communities get to interview stage, they have good outcomes. Of the 23 successful candidates, 15 accepted the offers and 8 declined the offer. This is a percentage of 34.8% and compares to a decline percentage of 44% for all applicants demonstrating that fewer candidates from minority ethnic communities are declining offers made. Again, understanding the reasons for rejecting an offer is an area of exploration.

18. Overall, the percentage, of candidates who are successful from the applications received is 2.95% (23 offers divided by 840 applicants less the duplicates and pending apps). This is compared to 19% of total applications. Most of the applications, as noted above, are lost at the shortlisting phase (74%).

19. Using all offered application figures, those successful candidates who were offered a role is 1.3% of total applicants (1709 candidates successful at interview with 23 from minority ethnic communities) and as a percentage of those starting this is 1.6%. (15 acceptances from minority communities from 957 recruited). As a proportion we need to work on increasing this and areas around shortlisting and increasing applications are key.

**Recruitment Patterns**

20. Also reviewed was the pattern of recruitment by managers and whether there were managers rejecting all candidates from minority ethnic communities. There was no

evidence of this in the data with managers appointing candidates from a variety of backgrounds where those candidates got through shortlisting.

**What have we discovered?**

21. The review has highlighted some interesting outputs. The volume of applications is good at 8.8% based on the all Wales census data. The team will be working on how we reach into communities, schools and colleges to increase interest and applications for careers in WAST.

22. Shortlisting is the area where we are losing significant levels of candidates – 26% more than the total applications figure. It is suspected that this will be driven by a mismatch in qualifications required to those held but we will do some further work on this to better understand why candidates are not getting through shortlisting but also note the points raised above about essential criteria and candidates' responsibility to supply the information. It is important for the Committee to note that successful candidates follow a regulated qualification on induction. It is not a WAST devised construct and so candidates need to be enrolled with all indications being that they will be successful. The EMT1 programme is a Level 4 qualification and so learners need to have a very robust Level 2 learning core (their Literacy & Numeracy) if they are to have any chance of success.

23. From the period reviewed, we have lost relatively more candidates from minority communities via not responding to an invitation to attend or withdrawing than we have for all applicants. This is another area to review not only from a minority community perspective but for all applications. This is likely to be driven by candidates applying for multiple roles at the same time and accepting other offers made. The fact that candidates need to go through necessary processes such as driving assessments may impact this. This is for specific safety purposes. 2022/23 was an exceptional year for recruitment as an additional 100 colleagues were recruited above business as usual recruitment and therefore some people (not all) did have start dates for training delayed as we rolled out cohorts in Q3 and Q4.

24. The success rate for candidates who did get through shortlisting to interview is positive. 23 of 89 were offered roles with WAST. This is 26% and a significant figure based on the national statistics. However, there will be recruitment undertaken where there are no applications from minority communities or no applicants were shortlisted.

25. For some roles e.g. paramedics, there is a need to broaden this work to include our external Higher Education Institutions. Engaging with Swansea University and others on how they attract students from diverse backgrounds to apply for their degree programmes will be critical in this. Our engagement with HEIW and the funding arrangements mean that our intake is mainly through Swansea. It is more likely that students from minority ethnic communities applying for paramedicine will go to city universities and may see Swansea (and Wales) as a less attractive option. We will engage with Swansea to establish if they can share the data on their course applications.

26. Discussions on how we better engage with young people and students who may be considering a career in health but have not considered WAST are underway and with PCC's consent we will bring an update on actions and progress for noting.

**RECOMMENDED:**

That People and Culture Committee:

- **NOTE** the outcomes of the review of information.
- **NOTE** that the team will work on reviewing recruitment processes to make them as accessible as possible whilst ensuring standards.
- **NOTE** that this information will be used as the benchmark to measure interventions against.
- **AGREE** to receive further updates on progress.

| | |
|---|---|
| **AGENDA ITEM No** | **19.1** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **0** |

# EXIT INTERVIEWS IN WAST

| | |
|---|---|
| **MEETING** | **People and Culture Committee** |
| **DATE** | **9th May 2023** |
| **EXECUTIVE** | **Angela Lewis, Director of Workforce and OD** |
| **AUTHOR** | **Liz Rogers, Deputy Director of Workforce and OD** |
| **CONTACT** | **Liz Rogers, Deputy Director of Workforce and OD** |

## EXECUTIVE SUMMARY

The People and Culture Committee requested an update on progress of the Exit interview process review. The Committee requested further feedback on exit interviews post information on leavers through the MIQPR. This was subsequently supplied with further information on a breakdown of leavers being provided.

The team had initiated a review of the process and had developed an approach to deliver this.

The new process 'Moving on Interview' is currently being piloted in 3 areas of the business to test and evaluate it before rolling out across the organisation.

There is an evaluation meeting on 3rd May to review the process and receive feedback from those involved. This will be used to make any necessary changes prior to rolling out across the organisation.

## KEY ISSUES/IMPLICATIONS

The deep dive requested by P&C Committee post the delivery of the presentation into Wellbeing in September 2022has highlighted the limitations of the data held and the need for a review of the process for exit interviews.

During the pilot significantly more interviews / questionnaires have been completed.

The Board is asked to:

- **NOTE** and **COMMENT** on the Report
- **AGREE** to receive a further report on progress later in the year.

| REPORT APPROVAL ROUTE | | |
|---|---|---|
| **WHERE** | **WHEN** | **WHY** |
| People and Culture Directorate Business Meeting | 4th May | For noting |
| P&C Committee | 29th November | For noting |

| REPORT APPENDICES |
|---|
| N/A |

| 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) | Para 5,10,11, 17 | Financial Implications | Para 5 |
| Environmental/Sustainability | N/A | Legal Implications | N/A |
| Estate | N/A | Patient Safety/Safeguarding | N/A |
| Ethical Matters | Para 5, 10, 11 | Risks (Inc. Reputational) | Report |
| Health Improvement | N/A | Socio Economic Duty | N/A |
| Health and Safety | N/A | TU Partner Consultation | Para 9 |

**SITUATION**

1. At the P&C Committee meeting in September 2022, members reviewed the MICPR deep dive output, the organisational attrition data and reasons for leaving which had increased in the last two years.

2. P&C Committee members requested further information from exit interview data and whether there was any themes or trends coming through. A report was provided at the meeting in November 2022.

**3.** A report noted the limited amount of feedback available through exit interviews and the work the team had started on reviewing the exit interview process to relaunch it. This report provides P&C Committee with a further update and assurance on actions to date.

4. There has also been a verbal update via the action log items.

## BACKGROUND

5. The purpose of an exit interview is to get real time feedback direct from the leaver. Leavers are generally more willing to share information and raise issues than those who remain and it allows constructive and structured feedback, the identification of patterns or issues which are pushing people out of the organisation. With this information, we can reflect on the reasons and look to remove those making WAST a better place to work. By reducing our turnover, we can reduce the costs of recruitment and promote team and organisational stability.

6. The WAST policy for exit interviews dates from 2007 and had not been reviewed. There was All Wales work on exit interviews which began in 2019 but this was subsequently halted as the pandemic hit and has not been restarted. The purpose of the joint work was whether there was an opportunity to use a standard process where All Wales data could be collected and collated via ESR, our HR and Payroll system. There had been no notification that this work will be reinstated and this continues. As a result of this planned joint work, internal development of the process was not pursued at that time but based on this hiatus at a national level, a plan is being developed with initial work underway to review our exit interview process. Actions are identified further on in the report.

7. Exit interview data held is limited and there are a range of reasons for this. Exit interviews are not compulsory and not all leavers want to complete one. Managers do not always approach team members to complete exit interviews and there are no prompts or reminders for them to do so. This is complicated in cases where the leaver data on ESR is sometimes not completed by the manager until after the person has left the organisation, impacting the value of an electronic trigger via ESR.

8. Those exit interview forms completed are not always sent to the People Services Team. Some are held locally e.g. on a local personnel file or by the manager and therefore can't be easily accessed to review. Only if there is a specific concern e.g. a concern or potential R&R issue coming through, are they likely to be shared directly with the People Services team for further investigation and support. Those received by the People Services Team are shared with the People Services Advisor/ Partner if issues are identified.

## ASSESMENT

9. A task and finish group from the team, in partnership, have developed a 'Moving On Interview' Process which will supersede the existing Pre-Exit Interview Policy. This process is currently being piloted within 111, Powys EMS and Hywel Dda EMS since the beginning of March.

10. As part of the development process, the T&F group analysed themes and trends in leavers' data over a 12 month period, to understand key demographics of leavers and potential push and pull factors. They also reached out to other NHS Trusts within Wales to understand their exit interview processes. Feedback from many suggested that the ESR exit interview functionality was not fit for purpose,

although there was an appetite for a digital format that could be linked to a dashboard reporting method.

11. Under the existing Pre-Exit Interview Policy, a paper questionnaire is completed compiling of four themes: reasons for leaving, flexible working, working pattern and environment, and training and development. In the Moving on Interview process, the questionnaire is completed electronically via MS Forms. The style and range of questions has also been reviewed to consist of both qualitative and quantitative questions around key themes and trends: about the role, training and development opportunities, working relationships, health and wellbeing, and equality monitoring.

12. The Moving on Interview process applies to employees who are voluntarily leaving their role, regardless of whether they are leaving the Trust or commencing a new role in another department. This process encourages meaningful conversations between employees and their line manager to clearly understand the reasons for leaving, however it recognises that employee participation is voluntary. The process also provides opportunities for employees to complete the questionnaire independently and meet with someone other than their line manager.

13. Since the commencement of the pilot (6 February 2023), 11 employees leaving the Trust from 111 have participated in a Moving on Interview, and a further 1 employee has opted out of a face-to-face interview but has completed the questionnaire independently. This equates to 50% of the total voluntary leavers in 111, which have a termination date between 6 February 2023 and 30 April 2023. Within the EMS pilot areas, 3 employees leaving the Trust have participated in a Moving on Interview, which equates to 75% of the combined total voluntary leavers in Powys EMS and Hywel Dda EMS.

14. Data from the Moving On Interviews can be exported from MS Forms into an Excel sheet, which can be filtered and manipulated for analysis purposes. The T&F group are in the process of integrating the data captured by MS Forms into a Power BI dashboard to provide more visually immersive and interactive insights.

15. A ‘user experience’ feedback session has been scheduled for 3rd May 2023 with the Heads of Service for the pilot areas and trade union representation, to understand what is working well and what could be improved. Feedback from this session will inform the final version of the ‘Moving on Interview’ Process which we will then look to begin rolling out on a Trust-wide basis.

16. The second part of the work of the task and finish group just starting are ‘stay’ interviews. A stay interview will identify what are the things to cherish in WAST. The team are now starting work on this. The priority is reviewing the findings of the new moving on interview pilot, tweaking the process and then rolling this out and embedding it across the organisation.

17. Prior to the process being rolled out across WAST an EQIA will be undertaken to check if any adjustments are needed in terms of accessibility and equity.

18. The output from the data and subsequent actions will be shared with PCC later in the year.

**RECOMMENDED**

19. The Committee is asked to:

- **NOTE** and **COMMENT** on the Report
- **AGREE** to receive a further report on progress later in the year.

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|---|---|
| **AGENDA ITEM No** | **20** |
| **OPEN or CLOSED** | **OPEN** |
| **No of Appendices ATTACHED** | **2** |

# Q4 2022/23 Health and Safety Performance Report

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9th May 2023 |
| **EXECUTIVE** | Executive Director of Quality and Nursing |
| **AUTHOR** | Head of Health and Safety |
| **CONTACT** | Nicola White nicola.white3@wales.nhs.uk |

## EXECUTIVE SUMMARY

This report will provide an update to the People and Culture Committee (PCC) on the key information in relation to health and safety performance for Quarter 4 2022/323. Data within this report is as of 6th of April 2023 as reported onto DATIX Cloud and may be subject to change as investigations are closed.

**PCC are requested to note the following**:

- There has been further recent improvement regarding timely reporting of RIDDOR incidents within the Trust however, this requires focused attention in order to meet RIDDOR reporting timescales. This has resulted in a compliance increase of a further 25% in Q4 from Q3 resulting in 83.3% for Q4**.** This improvement is because of the implementation of the workforce review. Of the 23 RIDDORs reported in Q4 2023, 2 were outside of HSE reporting requirements with the cause being Handler delays.
- An IMPT Deliverable Plan of Work for 23/24 has been developed for the Working Safely Programme.
- A further Annual Plan has been developed for improving the management of health and safety.
- Statutory Health and Safety, Fire Safety and Manual Handling training compliance are below Trust's and Welsh Government standards. Managers are to encourage staff to bring their training levels up to Trust expectations.
- The rolling Workplace Risk Assessment compliance is at 27% with 73% requiring review. Managers are to be encouraged to undertake this review. A workshop with the Health and Safety and Estates functions is scheduled in May 23 to explore improvements from themes generated from workplace audits.

**PCC is to be assured that**:

The reporting of incidents for diesel fumes exposure has reduced during Q4. However, continued sustained efforts are being undertaken by the function in collaboration with Health Boards and Locality Managers in the mitigation/reduction of fume exposure. Environmental surveys have been undertaken by external provider in Q4 2022/23.

While this report provides the Health and Safety performance within Quarter 4 2022/23, the Trust recognises that periods of high or additional support for operational demand continue to impact on resource capacity to progress with improvements to the overall Health and Safety Management System.

## KEY ISSUES/IMPLICATIONS

**It is recommended that the People & Culture Committee gives its attention to the following key issues**:

(1) Exposure to Diesel Fumes-work continues to be of concern for staff in relation the management of diesel fume.
(2) Workplace Audits are identifying areas for improvement across our estate portfolio that are being addressed through the Estates department.
(3) Means of presentation of health and safety metrics are undergoing improvement with consideration being given to the introduction of robot process automation or the introduction of Power BI systems. This will allow for further scrutiny of metrics to allow for strategic interventions where appropriate. This is being undertaken via the Digital Directorate. An Initial meeting has been held in Q4 and a specification provided to the provider.

## REPORT APPROVAL ROUTE

National Health, Safety and Welfare Committee –26th April 2023 (for Noting).
Assistant Directors Leadership Team – 2nd May 2023 (for Noting).
People and Culture Committee - 9th May 2023 (for Noting).

## REPORT APPENDICES

**ANNEXE 1** – SBAR which provides the background for this report.
Appendix 1 – Statutory and Mandatory Training Compliance.
Appendix 2- Health and Safety Performance Metrics.

## REPORT CHECKLIST

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

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

## SITUATION

1. The Alert Advise Assure Highlight Report provides a concise overview of health and safety performance throughout the organisation for the Q4 2022/23.

## ASSESSMENT

| | |
|---|---|
| **ALERT / ESCALATE** | AAA Highlight Report<br><br>Workplace Risk Assessment Compliance<br>The requirement for Workplace Risk Assessments (RA) was implemented in July 2022 transitioning from COVID risk assessments that were undertaken during the pandemic. The process requires the RAs to be completed by the Manager for the area and the TU Rep (where possible). Once completed the risk assessments are then submitted to the Health and Safety Team for assessment and feedback and saved and shared on Siren. Currently compliance is 27% with the remaining 72% requiring review.<br><br>Risk Assessment training has been developed for roll out by the Health and Safety function and will form part of the Annual improvement Plan for 2023/24.<br><br>A paper outlining 6 recommendations to improve compliance is to be presented to the Senior Operations Team in Q1 2023.<br><br>Statutory /Mandatory Training Compliance<br>Health and Safety, Manual Handling and Fire Safety training continues to be below Trust expectations. Fire training sits within the remit of the Estates department (Appendix 1). |
| **ADVISE** | Frequency Rate<br>All non-patient health and safety incidents contained with performance reports are now also being measured in frequency rates per 1000 x 999 calls to generate an 'Event incident' frequency rate. The number of 999 calls acts as a 'constant' denominator and will allow us to benchmark with other Ambulance Trusts. This frequency rate is also being utitlised within the National Ambulance Safety and Risk Forum (NARSF) against RIDDOR performance.<br><br>Following the introduction of Power BI or Robotic Process Automation in the use of data collection to hours worked by all staff, further considerations will be given to generating incident events frequencies per 1million man hours as advised by the HSE.<br><br>RIDDOR Compliance |

23 RIDDORs were reported in Q4 2023. Of those 2 RIDDORs were submitted outside of HSE requirements, this was due to handler delays. RIDDOR performance is to be presented as a regular agenda item to Operational business meetings for monitoring and local scrutiny with the relative Heads of Service.

RIDDOR compliance increased by a further 25% in Q4 from Q3 with 63.2% of RIDDORS were submitted within HSE required timescales. A breakdown of DATIX incidents including RIDDOR compliance is included (Appendix 2).

In addition to the functions weekly DATIX incident review meeting, the introduction of the 4 Health and Safety (H&S) Advisors in October 2022 has allowed for further initiatives to meet timescales are being undertaken as business-as-usual activities. These involve daily monitoring of all patient safety incidents to inform the H&S Advisors of any potential RIDDOR incidents and then the contacting of the Handler urgently (via Teams or at station) to receive an updated position in the injured party condition. Additionally, the frequent visible presence of the advisors being out in localities assist with current local knowledge and early notifications of injuries as they arise. A breakdown of RIDDOR performance is included in Appendix 3.

<u>Diesel Fumes</u>
Health and Safety and Operational resources continue to being utilised in the management of fume exposure at Emergency Departments.

Datix incidents peaked in December correlating with hours lost to hospital delays. During this period, anecdotal evidence suggests that there was an increased level of concern from Trade Union Partners in relation to Occupational Health concerns. January and February show a decline in DATIX incidents for fume exposure and also hours lost, however DATIX incidents remain stable for March 2023 despite an increase in hours lost.

A breakdown of incidents from April 2022 to present trends the highest number of incidents reported against Morriston, Glangwilli and Royal Glamorgan. Highest Health Board trends are Swansea Bay, Cwm Taf Brogannwg, followed jointly by Betsi Cadwallader and Hywel Dda. There have been 5-10 incidents raised by 3 members of members. Individual investigations are found to be lacking in detail and therefore provide limitations on any lessons learned.

The Health and Safety team have undertaken several interventions to monitor and control exposure to diesel fumes. .he Executive Director of Operations has engaged with Health Board COOs to advise of the issue, and efforts required by Health Board management teams.

| | |
|---|---|
| | Risk assessments have been undertaken on a priority basis at hospitals experiencing the highest level of reported incidents. Six task and finish groups have been set up pan-Wales working in collaboration with Health Boards to identify pragmatic solutions where applicable.<br><br>A total of 67 mitigation measures have been identified from the risk assessment process. To date 41 have been completed, with 17 in progress and 9 not yet started. Of the 9 yet to be started all sit with the associated Health Board's. Progress against the action plan is monitored within the health and safety function within the working group meetings.<br><br>During Q4 further environmental surveys were undertaken at the 7 sites with the highest reported levels of incidents. Three of these sites were found to be not to have exceed the Health and Safety Executive (HSE) Workplace Exposure Limit (WEL). Due to periods of Industrial Action the remaining 4 surveys were undertaken later than scheduled and are currently being subject to analysis with an expectation of providing an update during Q1 2023.<br><br>The next stage of interventions would require Health Board infrastructure changes to allow for exhaust ventilation systems to be installed. Discussions have been held with Estates managers at the Grange Hospital on 21st of April 22. Who are progressing a further part development phase to extend the E.D. area. This is likely to create further fume exposure. As such Welsh Government have agreed to include extraction systems for fumes.<br><br>Combustion gases and elemental carbon are not identified as respiratory sensitisers under HSE guidance. This negates the requirement for reporting potential workplace ill effects from diesel engine exhaust emissions with RIDDOR regulations.<br><br>In order to ascertain best practice work is underway in the procurement of an academic Diesel specialist to provide independent advice on diesel and fume.<br><br>Potential exposure to diesel fumes is to be considered as being added as a risk on the Corporate Risk Register in Q1 2023.<br><br>An updated position was presented by the Executive Director for Quality and Nursing at WASTP on 13th April 2023. |
| **ASSURE** | <u>Trust Legislative Compliance Register.</u><br><br>The Trusts Compliance Register was subject to review by the Assistant Directors Leadership Team (ADLT) and the assessment score of 1.98 /3 providing a moderate leave of assurance was approved by the group on 17th April 2023. The |

Register is available for viewing on the Health and Safety functions Intranet page.

Discussion to be held to establish task and finish groups during Q2 2023 to further improve areas requiring improvement.

This is a live document and may be subject to some flux in line with continuous improvements, DATIX incidents or outputs form auditing undertaken at local levels.

Further legislation is to be incorporated into the register in relation to Violence and Aggression and Infection, Prevention and Control.

Trusts Hazard Register

The Trusts Hazard Register was subject to review by the Assistant Directors Leadership Team (ADLT) and the Senior Operations Team (SOT) was approved by the group on the 17th April 2023. The register is structured in line with Human Factors taken from 'Reducing Error and Influencing Behaviour Health and Safety Guidance (HSG) 48.

The Register is available for viewing on the Health and Safety functions Intranet page.

Workplace Premise Audits

The Trust's 2-year audit schedule commenced in September 2022 with 59 audits scheduled for Q3-Q4 2022/23. Fifty H&S audits were undertaken across WAST premises. The outstanding 9 audits have been rescheduled due to limited staff availably due to industrial action. were rearranged due to staff availability.

Of the total 111 premises, 45% have been audited and received detailed action plans indicating areas of improvement. Work is ongoing to develop the best means of monitoring actions progress generated from the workplace audits.

The overall score to date with regards to the undertaking of audits to the schedule is 84% compliance with the auditing criteria. Work is also ongoing in developing the best means of presenting compliance to each category within the audit assessment criteria.

Findings to be fed back to the Estates team for their information and action where required.

| Compliance Rating | 40-60% | 60-80% | 80-100% |
|---|---|---|---|
| No of premises | 1 | 7 | 40 |

| | |
|---|---|
| | Themes and Trends<br><br>• General fire safety non-compliance (lack of alarm testing, very few drills undertaken, obstructed emergency routes). Further work is ongoing in the development of a local managers' audit which will improve local standards.<br><br>• General COSHH non-compliance (limited number of sites with COSHH folders, those present typically only have Safety Data Sheets attached).<br><br>• General storage (lack of storage room, resulting in poor storage standards i.e. storing above mezzanine decks, shelving units over stacked, lockers cannot fit all equipment, so most locker rooms have poor housekeeping) lack of storage facilities at every site resulting in items being stored incorrectly causing trip hazards, fire risks etc.<br><br>• General first aid non-compliance (few trained first aiders – reliance on paramedics. First aid boxes not maintained).<br><br>• Poor storage of clinical waste across sites – not being bagged correctly – Safety alert subsequently developed with training and environmental team on correct disposal method for clinical waste for communication across the Trust in Q4 2022.<br><br>Corporate Risk<br>199 'Failure to embed a culture of Interdependency resulting in a breach or harm'. This rating continues with t a rating of 15 since the reduction during Q1 2022. This risk is reviewed on a monthly basis. This risk will be considered for a further reduction following the findings of a health and safety audit by NWSSP in Q4 2022 and other key pieces of work expected to be undertaken in Q1 2022. |
| **INFORM** | Health and Safety Policy<br>The Trusts Health, Safety and Welfare Policy was subject to review in Q4 2022. This expected to commence the consultation approval process in May 2023.<br><br>COSHH<br>The COSHH Procedure and Training Package was approved by ADLT on 23rd of February 2023. Discussions are ongoing in relation to the delivery arrangements for COSHH training is which is expected to commence in Q2 2023. The procedure has been published on the Trusts intranet page.<br><br>The New and Expectant Mothers<br>The New and Expectant Mothers Procedure and supporting Risk Assessment was subject to approval at ADLT on 23rd of March |

2023 This procedure and risk assessment template has been published on the Trusts intranet page.

Hand Arm Vibration (HAV).
All four Health and Safety Advisors have undertaken HAV training in Q2 2023. Work is scheduled in the development of a Safe Operating Procedure and Occupational Health surveillance process within an expectation of commencing monitoring in Q2-Q3 2023.

Senior Business Continuity Planning Support
The Health and Safety function fully supported the Senior Business Continuity Planning team during Q4 2023. Some of the work developed to support the group included information on posters for;

- i-Gas
- COVID-19
- Norovirus
- Reduction of Fume at Emergency Departments.

Safer Handling
Work is ongoing in collaboration with the Training school to deliver vehicle and equipment familiarisation training for the Health and Safety function forQ1 2023. This will assist the team in analysing DATIX incidents and spotting unsafe behaviors during Ride-Outs.

Further work is underway to develop Manual Handling good practice awareness training to be incorporated into MIST mandatory training.

21 Injuries from manual handling operations were reported with all but 1 incident due to handling patients.

10 Incidents reporting of manual handling injuries from handling patients whilst using Carry-Chairs.

A review of DSE and Safer Handling was undertaken in Q4 2023 with a paper to be presented at ADLT in Q1 2023 outlining an action plan for compliance and improvement.

A breakdown of DATIX incidents is included (Appendix 2).

Violence and Aggression
There has been a sharp up-turn in the reporting of V&A incidents for the month of March with 53 incidents of violence and aggression toward staff reported during the month.

Incidents relating to aggressive and threatening behaviour rose to 23 for the month from 13 in February.

| | |
|---|---|
| | A review of Violence and Aggression was undertaken in Q4 2023 with a paper to be presented at ADLT in Q1 2023 outlining an action plan for compliance and improvement.<br><br>Safety Media<br>The following health and safety media have been developed during Q4 2023.<br><br>• Two safety videos were developed during Q4 2023.These included: Clinical Waste and Sharps Procedure. These have been posted on the Trusts our SharePoint for staff to view.<br>https://youtu.be/izBNBcuLBbI<br>https://youtu.be/sx0xsY5GkPM<br><br>• Three monthly Health and Safety newsletters |

## Statutory and Mandatory Training Q4 2022/23.

### Health and Safety

| Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|
| 4376 | 4376 | 2923 | 66.80% |

### Moving and Handling -Unit A

| Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|
| 4383 | 7104 | 5503 | 77.46% |

### Violence and Aggression- Unit A

| Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|
| 4376 | 4376 | 4249 | 97.10% |

### Fire Safety

| Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|
| 4383 | 4383 | 3174 | 72.42% |

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

# Health, Safety and Violence and Aggression Monthly Report (March 2023)

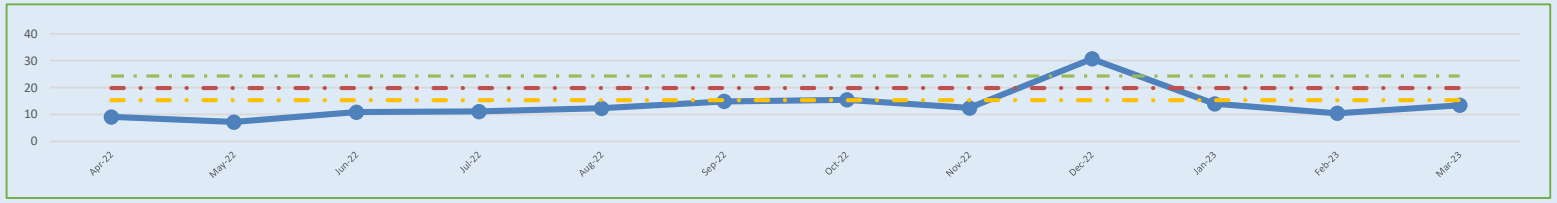
# Health Safety and V&A

## Health and Safety

## Incidents per 1000 999 Journeys

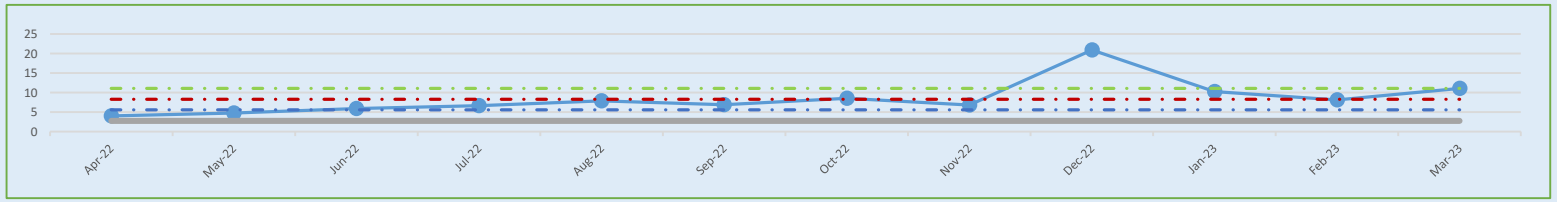
**The total number of H&S incidents for the month was 408 Resulting in 29.73 Events incidents per 1000, 999 journeys during (March). The rolling 12month breakdown of these incidents is shown below**

**No Harm**
**Month 13.41**



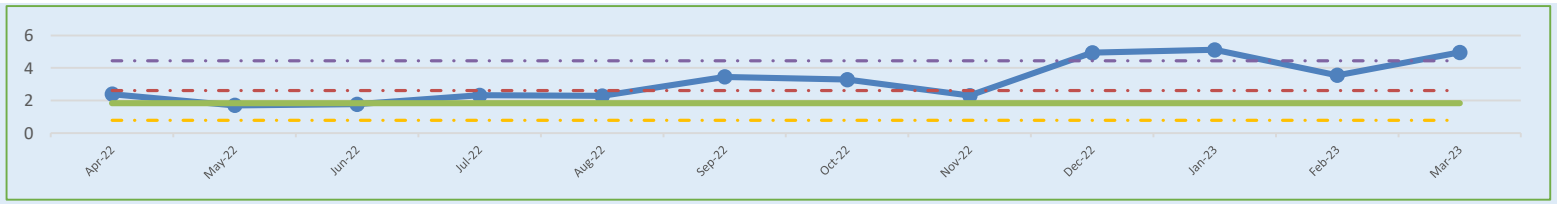

- **184 incidents were recorded in the frequency rate in the 'No Harm' category.**
- **136 recorded under protected meal breaks'.**

**Low Harm**
**Month 11.08**



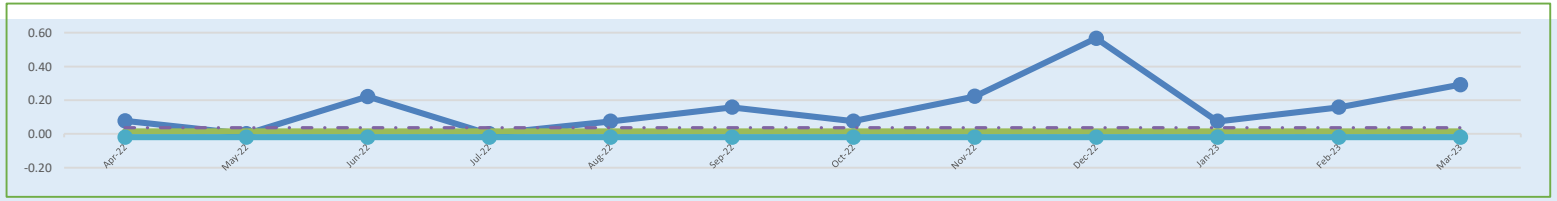

- **152 incidents were recorded the in the 'Low Harm' category.**
- **62 reported as protected meal breaks, 24 for violence and aggression and 6 for vehicles fumes.**

**Moderate Harm**
**Month 4.96**




- **68 incidents were recorded in the 'Moderate Harm' category.**
- **20 incidents reported under protected meal breaks, 16 for violence and aggression, 14 for fumes.**

**Severe Harm**
**Month: 0.29**




- **4 incidents recorded in the 'Severe Harm' category.**
- **1 injury reported struck by object.**

Frequency Rate — Mean — UCL — LCL

Baseline FY 21/22

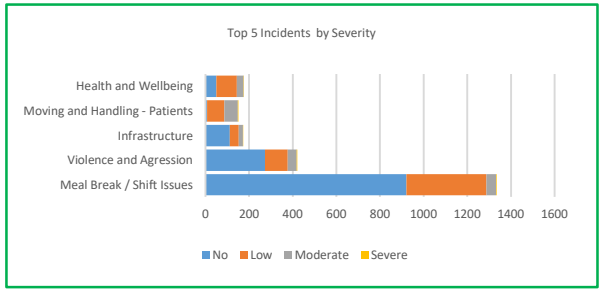
# Health Safety and V&A

# Health and Safety

# Incident Types & RIDDOR

## Incident Causes

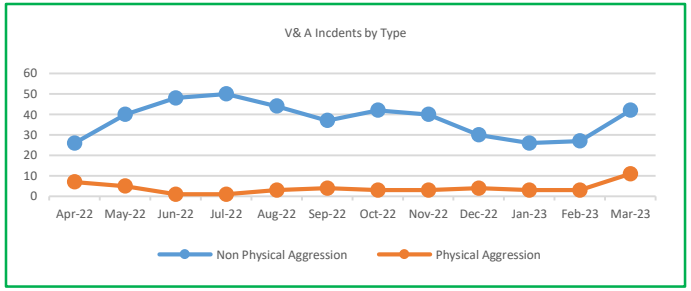
### Top 5 Incident Causes




- Missed meal breaks remains highest reported non-patient incidents. 23 incidents were noted as resulting in moderate harm in the view of the reporter.
- 21 Injuries from manual handling operations were reported with all but 1 incident due to handling patients.
- 10 Incidents reporting of manual handling injuries from handling patients whilst using Carry-Chairs

## Assaults on Staff

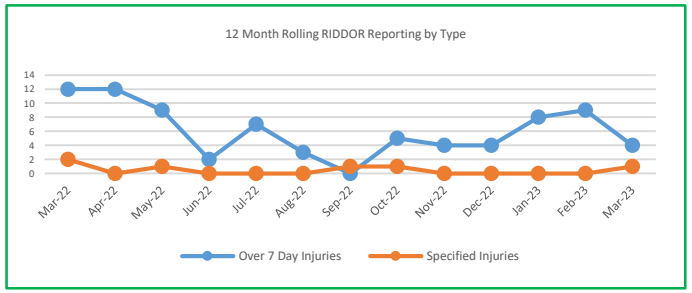
### Assaults on Staff



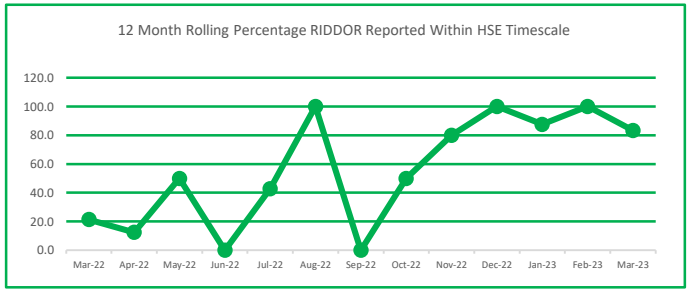

- There has been a sharp up-turn in the reporting of V&A incidents for the month of March with 53 incidents of violence and aggression toward staff reported during the month.
- Incidents relating to aggressive and threatening behaviour rose to 23 for the month from 13 in February.

## RIDDOR Incidents

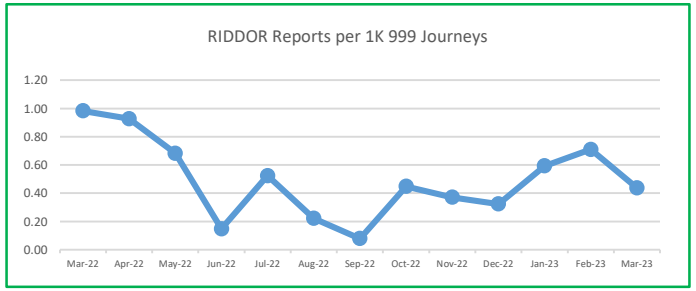
### Number of Incidents




### RIDDOR HSE Reporting

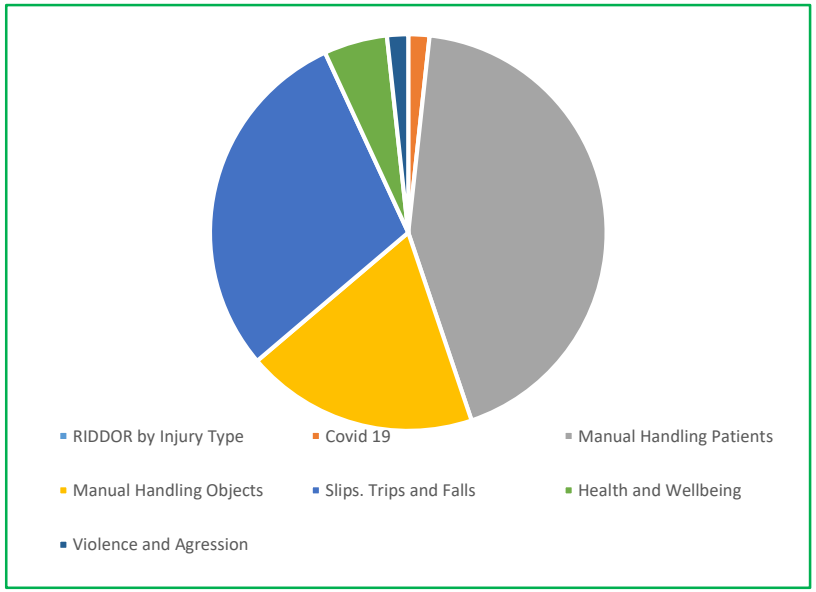



### Rate of Incidents




- The trend for RIDDOR incidents showed a decrease during March with 6 report to the HSE in February however the incidents shows an increase in severity.
- There was one report for a specified injury (Scalping ) when a sliding door came of the runner on the vehicle they were using and 1 report for a patient injury (Ankle Fracture) during the month.
- 83% reports were completed within the reporting timeframes the reduction in reporting was due in part to the effects of annual leave within the department and other Directorates.

### RIDDOR Report by Cause



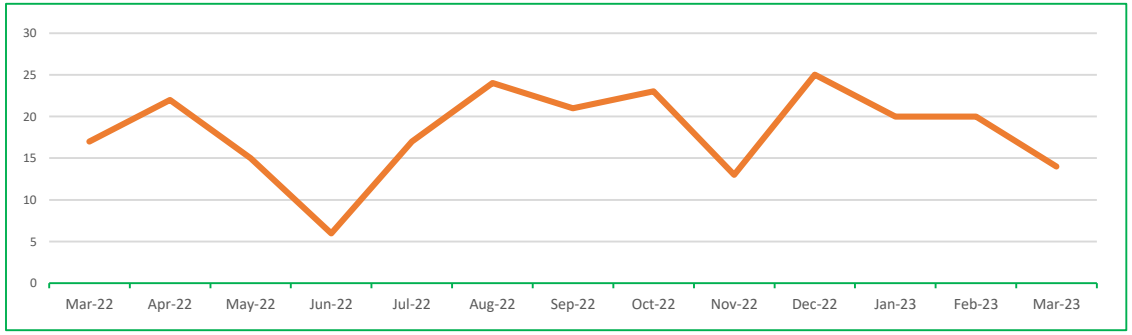
# Health Safety and V&A

# Health and Safety

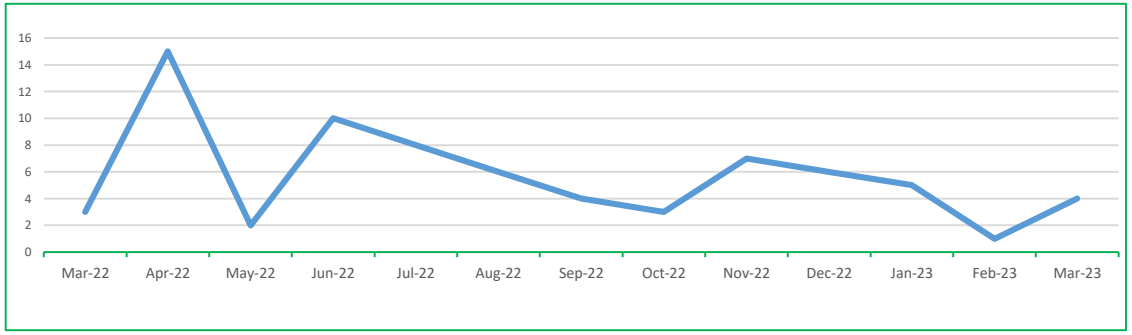
# MSK Incidents

## Manual handling Incident Types

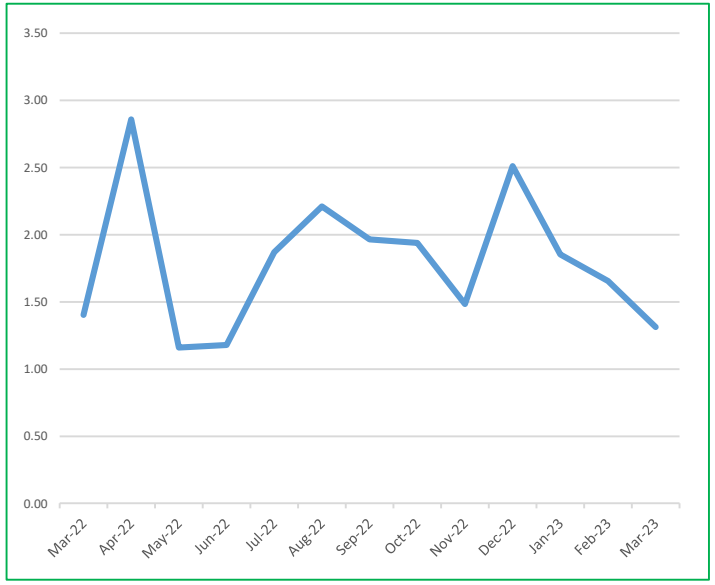
Patient Handling



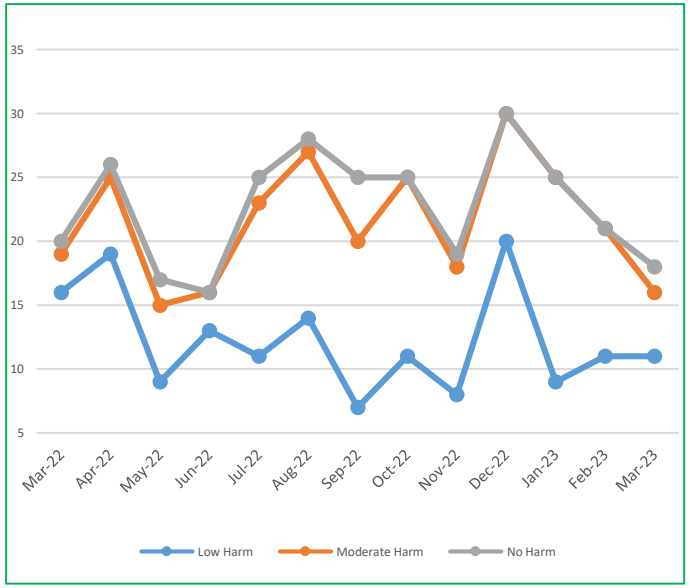

Equipment Handling




Incidents Per 1000 Journeys




Incidents by Harm




Key Updates

- 21 injuries are a result of manual handling operations were recorded during the month. Of these there were no reports of severe harm occurring and 5 reports of moderate harm.
- 10 of the incidents were noted as occurring during the use of carry chairs to move service users.
- The incident noted whilst using carry chairs noted the injuries occurred whilst either manoeuvring down steps are navigating steep driveways.
- A process for undertaking manual handling risk assessments is in development to help identify high risk operations involving moving patients with the aim of identifying suitable controls to lower the risk of injury.

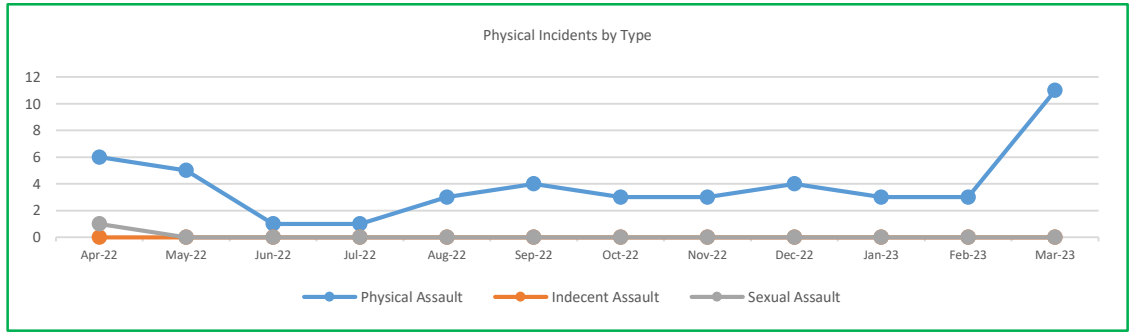
# Health Safety and V&A

# Violence and Aggression

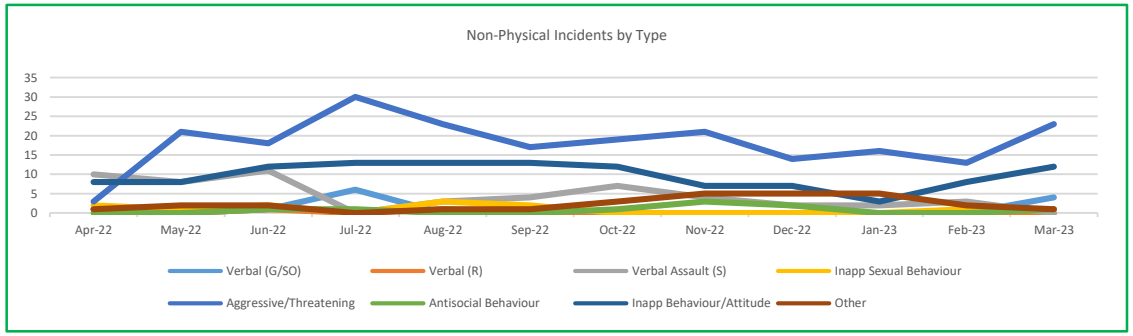
# Incidents

## V&A Incident Types

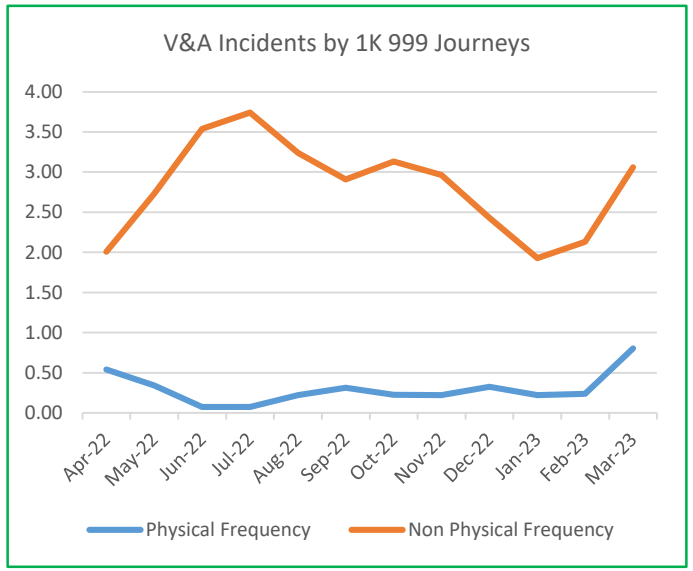
### Physical Aggression



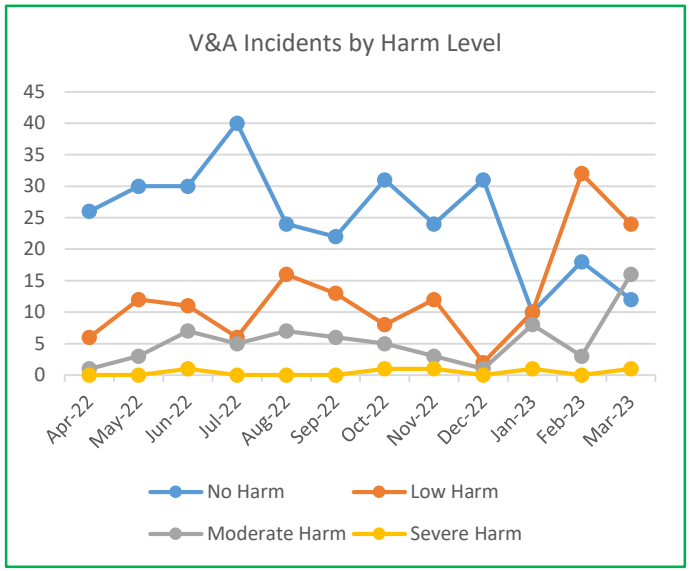

### Non-Physical Aggression




### Incidents Per 1000 Journeys




### Incidents by Harm




### Key Updates

- 42 Incidents reported of V&A non physical category- increase included incidents relating to staff on staff at HB re patient portering.
- 11 Physical assaults recorded.
- Aneurin Bevan HB Area reported highest level this month of 18
- V&A Manager submitted report on V&A review to improve prevention and reduction of future incidents
- Work continues to improve Datix coding and dashboards to improve quality of data submission and enhanced scrutiny at HB level.
- By Q2 a revised anonymous staff survey form will be available to all staff subjected to any incident of V&A to include drop down options list of race, age & gender to improve strategic interventions if required

| | |
|---|---|
| **AGENDA ITEM No** | **21** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **1** |

# WELSH LANGUAGE FRAMEWORK

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9 May 2023 |
| **EXECUTIVE** | Trish Mills<br>Board Secretary |
| **AUTHOR** | Melfyn Hughes<br>Welsh Language Services Manager |
| **CONTACT** | Melfyn Hughes<br>Melfyn.Hughes@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. The purpose of this report is to update the People and Culture Committee of the progress in developing the Trust's Welsh Language Framework with a vision to providing services that will satisfy the needs of Welsh speakers by ensuring they are able to receive services in their own language.

2. The framework will ensure there is structure, rigour, governance, and consistency for the development of the Welsh language throughout the Trust that encompasses compliance with the statutory requirements of Welsh Language Standards under the Welsh Language (Wales) Measure 2011 and delivery of the actions within the More than just words 2022-27 Action Plan. In addition, the Trust's use of translation services will be centralised with the recruitment of a Welsh language translator supported via the use of translation memory software.

**RECOMMENDATION**

**That the Committee is assured on progress in developing the Trust's Welsh Language Framework**

## KEY ISSUES/IMPLICATIONS

3. The effective implementation of actions relating to strengthening Welsh language provision is dependent on strong leadership at all levels within organisations to underpin the actions required to transform Welsh language provision for the future and improve patient care and experience.

4. 2022-23 will be a period of planning and setting foundations and an opportunity to consider the actions needed to ensure successful delivery of the plan.

5. From 2023 onwards the Minister will be holding annual progress meetings with leaders of organisations listed to deliver actions within the More than just words plan, including NHS and local authorities, to recognise achievements and consider where further progress is required.

| REPORT APPROVAL ROUTE | | |
|---|---|---|
| **WHERE** | **WHEN** | **WHY** |
| People and Culture Committee | 9 May 2023 | To note |
| | | |

| REPORT APPENDICES |
|---|
| **Annex 1 – Welsh Language 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) | Yes | Financial Implications | Not applicable |
| Environmental/Sustainability | Not applicable | Legal Implications | Yes |
| Estate | Not applicable | Patient Safety/Safeguarding | Yes |
| Ethical Matters | Not applicable | Risks (Inc. Reputational) | Yes |
| Health Improvement | Not applicable | Socio Economic Duty | Not applicable |
| Health and Safety | Not applicable | TU Partner Consultation | Not applicable |

# WELSH LANGUAGE FRAMEWORK

## SITUATION

The purpose of this report is to update the People and Culture Committee of the progress in developing the Trust's Welsh Language Framework.

## BACKGROUND

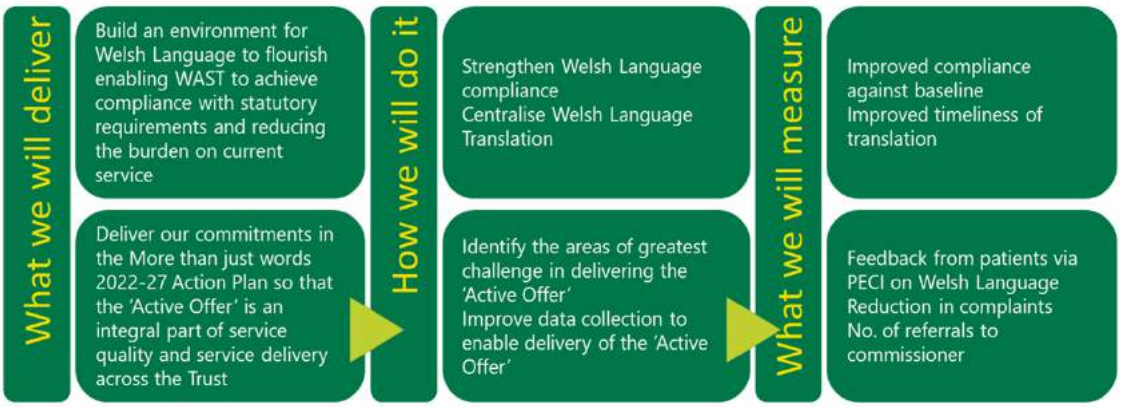
1. On 30 May 2019 the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing new Welsh Language Standards under the Welsh Language Measure (Wales) 2011 via a Statutory Compliance Notice.

2. Comply with the Welsh Language (Wales) Measure 2011 which creates new Standards to ensure Welsh speakers can receive services in Welsh to ensure that peoples' well-being outcomes are supported, and that their care and support needs, including their language need, are accurately assessed, and met.

3. More than just words is Welsh Government's strategic framework to strengthen Welsh language provision in health and social care in which the Welsh language will be normalised, and the Active Offer embedded across the Health and Social Care Sector with clear lines of accountability to deliver Welsh language plans and services.

## ASSESSMENT

4. When developing the Welsh Language Framework, Welsh Language Deliverables have been included in the Trust's Integrated Medium Term Plan (IMTP) 2023-26 that incorporates an action plan to implement the Welsh Government More Than Just Words strategy with a focus on an active offer of Welsh across our services. See **Annex 1** for Welsh Language Framework overview on compliance actions with the Welsh Language Standards and the More than just words 2022-27 Action Plan. More specificity of the Year 1 deliverables is being developed with the planning and performance team currently.



| Year 1 – Deliverables | | | | | |
|---|---|---|---|---|---|
| **Section** | **Deliverable** | **Action** | **When** | **Who** | **Progress** |
| **Compliance with statutory requirements in the form of Welsh Language Standards under the Welsh Language (Wales) Measure 2011.** | Strengthen compliance by developing a baseline for current compliance and highlight areas of concern across the system. | Set up monitoring progress via Monthly Integrated Quality & Performance Report (MIQPR) | April 2023 | Welsh Language Services Manager | Service areas identified and type of data collection agreed. HI are creating reporting template. |
| | | Mid-point checks via compliance surveys via ADLT. | June 2023 | | Survey created for compliance checks. |
| | | Annual Standards Compliance Report to the Welsh Language Commissioner | Sept 2023 | | Process for gathering information for report has commenced. |
| | | Develop Internal Welsh Language Policy | Jan 2024 | | Initial draft of policy created to be shared with Trust's Welsh Language Advisory Group. |
| | Centralising Welsh Language Translation via Recruitment of Welsh language translator. | Recruitment of Welsh language translator | April 2023 | Welsh Language Services Manager | Implementation of centralisation is dependent upon recruiting a band 5 translator. |
| | | Set up translation support mechanism. | June 2023 | | Initial discussions with NWSSP on how they can assist. |
| | | Purchase license for translation memory software to support translator. | June 2023 | | Appropriate software identified and has undergone DPIA screening checklist – full DPIA not required. |

| | | | | | |
|---|---|---|---|---|---|
| **Culture and Leadership** | Delivery of actions of the *More than just words 2022-27 Action Plan* in delivering the Active Offer as an integral part of service quality and delivery across the Trust. | Set personal performance objectives to ensure the delivery of *More than just words* so that the Active Offer is embedded in annual objectives of sector leaders, cascaded throughout the Trust and considered in relevant individual appraisals at all levels. | April 2023 | Welsh Language Services Manager | Board Secretary appointed as person to be responsible for ensuring delivery on the actions and targets set in the plan. |
| | | Gather feedback from patients. | April 2023 | | Service user feedback form on WAST bilingual services set up on website. |
| | | Improve data collection to enable delivery of the 'Active Offer'. | April 2024 | | Workforce language skills recorded on ESR – data to be used for profile/mapping of Welsh language skill levels and capacity across the workforce. 2022/23 compliance 89%. Need to increase compliance to 100%. |
| | | Provide a written update on More than just words progress with actions on a 12 month basis. | 30 June 2023 | Welsh Language Services Manager | Work commenced on gathering information for 2023 report. |

5. The Welsh Ambulance Services NHS Trust has established a Welsh Language Advisory Group to continually monitor and review the development within the Trust of the Welsh Language Standards under the Welsh Language (Wales) Measure 2011 standards that came into force on 30 May 2019.

6. This Group provides a mechanism for reviewing all aspects of the Welsh Language Standards and to ensure that satisfactory Welsh language services are maintained for all patients and members of the public who use the services of the Trust.

7. Compliance with the Welsh Language Standards, reported and monitored regularly through our Assistant Director Leadership Team, the CEO and Chair (through their accountability to the Minister) and Trust Board.

**RECOMMENDED:**

**That the Committee is assured on progress in developing the Trust's Welsh Language Framework**

# Annex 1: Welsh Language Framework

## Key areas of the framework:

## Welsh Language Standards

Compliance with statutory requirements in the form of Welsh Language Standards under the Welsh Language (Wales) Measure 2011.

On 30 May 2019 the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing new Welsh Language Standards under the Welsh Language Measure (Wales) 2011 via a Statutory Compliance Notice issued to the Trust by the Welsh Language Commissioner. The Trust's compliance requirements can be accessed via the Welsh Language Standards section on our website here.

The Standards explain how a body should treat and use the Welsh language in different scenarios, for example, when **sending correspondence**, **dealing with telephone calls**, **providing services on-line** or **face-to-face**, **formulating policies** or when **providing services internally to staff**.

## More than just words 2022-27 Action Plan

Delivery of actions of the ***More than just words 2022-27 Action Plan*** in delivering the Active Offer as an integral part of service quality and delivery across the Trust.

*The 'Active Offer' simply means providing a service in Welsh without someone having to ask for it. The Welsh language should be as visible as the English language.*

### Culture and Leadership

**Context**
Leadership is a key driver for the successful implementation of *More than just words*. We'll need strong leadership to underpin the actions to transform Welsh language provision for the future, to drive the impetus for change and create a culture where people feel empowered to use the Welsh language each day at work.

This framework sets out how together we will drive forward progress under the overarching theme of culture and leadership and the following three themes:

- Theme 1 – Welsh language planning and policies including data.
- Theme 2 – Supporting and developing the Welsh language skills of the current and future workforce.
- Theme 3 - Sharing best practice and an enabling approach.

**Key Aims**

- To embed a healthy culture of belonging for the Welsh language in health and social care and to deliver the aims and principles of *More than just words*.
- To demonstrate evidence of leadership at all levels to support the use of Welsh to deliver quality services and improved outcomes for individuals.

**Outcomes**

Positive change in culture, ethos, and attitude that Cymraeg belongs to us all and leadership at all levels support service delivery interventions to underpin the Active Offer and focus on Welsh language in practice to transform user experience.
The Welsh language will be normalised, and the Active Offer embedded across NHS and care settings with clear lines of accountability from regional partnerships to deliver Welsh Language plans and services, initially prioritising identified vulnerable groups.

## Theme 1

**Welsh language planning and policies including data.**

**Context**

Welsh language in planning and policies at national, regional and local level. It will be necessary to improve data collection processes to provide us with the basis to plan for delivering the Active Offer especially in those service areas of need, matching language skills in the workforce with the care of the individual.

**Key Aims**

- To identify and collect data and views of individuals that will provide us with the understanding and evidence base to support policy decisions and monitor progress
- Welsh planning requirements are understood and are embedded in guidance and policy.

**Outcomes**

- Greater understanding and awareness of effective service planning and delivery to embed the Active Offer.
- Delivering the Active Offer is an integral part of service quality and delivery across the Trust.

## Theme 2

## Supporting and developing the Welsh Language skills of the current and future workforce.

**Context**

Given some gaps in data and information, short-term actions could be appropriately made in relation to the current workforce and the workforce in training in order to better understand our baseline in all parts of Wales to identify the areas of greatest challenge and aid decisions on targeting priority areas. These will then be reviewed and considered further alongside the workforce planning actions set out under Theme 1.

**Key Aim**

Aligns with one set out in the Health and Social Care workforce strategy:

- ‘Our aim will be to understand, anticipate and plan to meet the Welsh language needs of health and social care students, our workforce and ultimately patients and people in receipt of care and support across Wales as we move forward.
- Supporting our workforce to deliver care using the Welsh language is a fundamental principle which must underpin every area of this Workforce Strategy.’

**Outcomes**

- Increased Welsh language capacity across the workforce to meet the language needs of individuals.
- Increased Welsh language capacity amongst new entrants within the Trust’s workforce.

## Theme 3

# Sharing best practice and an enabling approach

**Context**
Sharing best practice and learning will be critical so that we can deliver whole system change when needed. It is telling that those organisations with progressive executives leading on Welsh Language services across health and social care have made significantly greater progress.

**Key Aims**
- We'll work together with the whole sector to make sure that we design systems bilingually by default and with Welsh-speaking service users.
- We'll ensure pockets of good practice are identified, shared to influence and enable a more system wide enabling approach.

**Outcomes**
Individuals will receive a consistent Active Offer across health and social care leading to better user / patient experience and improved outcomes across Wales.

Health and social care organisations will be inspired to emulate best practice and sector-leading initiatives from other parts of Wales.

# Welsh Language Framework Overview
# (Compliance with Welsh Language Standards and More than just words 2022-27 Action Plan)

| Ambitions | Deliverable | Short Term Actions – by 2023 | Medium Term Actions – by 2025 | Long Term Actions – by 2027 |
|---|---|---|---|---|
| Compliance with statutory requirements in the form of Welsh Language Standards under the Welsh Language (Wales) Measure 2011. | Strengthen compliance by developing a baseline for current compliance and highlight areas of concern across the system. | Quarterly compliance assurance surveys via ADLT to update Standards Compliance Tracker.<br><br>Centralise Welsh Language Translation - Recruitment of Welsh language translator and purchase translation memory software to support translator. | Quarterly compliance assurance surveys via ADLT to update Standards Compliance Tracker. | Quarterly compliance assurance surveys via ADLT to update Standards Compliance Tracker. |
| Culture and Leadership. Leadership is a key driver for the successful implementation of *More than just words*. We'll need strong leadership to underpin the actions to transform Welsh language provision for the future, to drive the impetus for change and create a culture where people feel empowered to use the Welsh language each day at work. | Delivery of actions of the *More than just words 2022-27 Action Plan* in delivering the Active Offer as an integral part of service quality and delivery across the Trust. | Set personal performance objectives to ensure the delivery of *More than just words* so that the Active Offer is embedded in annual objectives of sector leaders, cascaded throughout the Trust, and considered in relevant individual appraisals at all levels. **Ref 1 MTJW** | Chair and Chief Executive to take part in WG's Leading in a Bilingual Country programme. This programme works towards embedding the spirit of *Cymraeg 2050* in organisational culture and policymaking. **Ref 3 MTJW** (WG to lead on objectives for Chairs.)<br><br>Identify workforce skills gaps in key areas and develop plans to address them. **Ref 13 MTJW**<br><br>Develop and implement a targeted Welsh language training and workforce strategy **Ref 18 MTJW**<br><br>Expect all Trust staff to follow a language awareness course **Ref 14 MTJW**<br><br>Define the level of Welsh language skills required in all job adverts. **Ref 16 MTJW**<br><br>Define the level of Welsh language skills required in all job adverts. **Ref 16 MTJW** | Develop tools to support mainstreaming Welsh language considerations into planning and policies **Ref 6 MTJW**<br><br>Gradual introduction of a minimum "courtesy" level of Welsh language skills **Ref 17 MTJW** |

Note: **Ref MTJW** refers to an action within the More than Just words action plan 2022-27

| | |
|---|---|
| **AGENDA ITEM No** | **22** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | 1 |

# AUDIT REPORT

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9th May 2023 |
| **EXECUTIVE** | Trish Mills, Board Secretary |
| **AUTHOR** | Julie Boalch, Head of Risk/Deputy Board Secretary |
| **CONTACT** | Julie.Boalch@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.

2. There are 16 Internal Audit recommendations assigned to Committee for oversight. 4 of these are complete and 4 are not yet due. 8 recommendations are currently overdue; 6 of which relate to the Attendance Management review, 1 relates to the Recruitment Practices review and 1 relates to the Collaboration review. Each of these recommendations require a progress update and revised completion dates.

3. There are 2 outstanding recommendations relating to the Taking Care of the Carers report with 1 request to extend the deadline from the agreed deadline of November 2022 to the end of September 2024 so that the Health & Wellbeing Strategy can be delivered in full. The other extension is to take account of the staff survey being further delayed until Spring 2023.

4. The Corporate Governance Team has experienced resource challenges that has precluded it from conducting confirm and challenge meetings with action owners and Executives during this reporting period to enable it to assure the Committee on progress updates and evidence of closed actions.

5. The audit tracker is currently undergoing a full review and will be available for the next Audit Committee for scrutiny. In addition, Internal Audit are undertaking their annual review of the tracker.

6. **The People and Culture Committee is requested to note the update.**

| KEY ISSUES/IMPLICATIONS |
|---|
| As set out above. |

| REPORT APPROVAL ROUTE |
|---|
| Not applicable. |

| REPORT APPENDICIES |
|---|
| Not applicable. |

| 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 |

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

# Fatehullah's Story


Given that our engagement activities have highlighted instances of discrimination, we invited one of our Corporate colleagues, **Fatehullah Tahir**, to share his experience of working in an organisation lacking in diversity in terms of ethnicity and faith. Fatehullah is a well respected member of the People and Culture Team and whilst the experiences he described are particularly uncomfortable, he has never asked for action to be taken. The themes shared highlight how important it is to continue listening to colleagues' experiences and recognising that we still have so much to learn. Providing and creating space and developing trust is crucial, so that our people feel safe to share other examples of discrimination and micro-aggressions.

## Required Action

1. Increase **cultural competencies**
2. Embrace **Anti-racist** stance and recognise that it is not enough to just not be racist
3. Continued delivery of **Allyship** programme and development of **Bystander** Training
4. Amplify employee **voices**
5. Recognise that this culture has an **adverse effect** on mental health, recruitment and retention
6. Ensure we consider access to prayer facilities at events, roadshows and development programmes

## Examples

1. No suitable space for **prayer**
2. *"You don't **look** like you're from Cardiff"*
3. Adapting "Fatehullah" to **"Faz"**

## Themes

1. Lack of understanding regarding **faith**
2. Lack of understanding regarding **micro-aggressions**
3. Colleagues having to adjust and adapt to **fit the organisation**

## Next Steps

1. Consider reviewing **bank holiday** provision (recognising these are tied to Christian holidays) and explore the possibility of implementing a more flexible approach
2. Further publicise and promote our colleague **networks**
3. Ensure we are pursuing our **Strategic Equality Objectives**

## How is Faz now?

Faz feels it was helpful to share his story which was extremely powerful for colleagues to hear but fundamentally, nothing has changed in the system. Faz is not unhappy at WAST and whilst he's pleased to see these issues being taken seriously, he like the rest of us, is aware that this kind of change is slow.

**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.

| | |
|---|---|
| **Trust Board Meeting Date** | 30 March 2023 |
| **Committee Meeting Date** | 14 March 2023 |
| **Chair** | Paul Hollard |

## KEY ESCALATION AND DISCUSSION POINTS

### ALERT

(Alert the Board to areas of attention)

1. No alerts for the Board from this meeting.

### ADVISE

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

2. A large focus of this meeting was the work undertaken and planned to continue to build and articulate our desired culture. The Board will be aware of the **sexism and sexual safety at work survey** which was launched in 2022 and the results that have been shared with WAST colleagues in a number of different fora including the October 2022 and March 2023 CEO Roadshows. The Committee welcomed Bron Rebelo, Organisational Development Manager, who has been leading much of this work and thanked her and all those who took part in the survey and in the video presentation for trusting the organisation with those experiences, which for some will not have been easy to share. It was noted that WAST was not alone in surfacing these issues, and Bron is working with NHS England and the Association of Ambulance Chief Executives (AACE) to share learning and improve sexual safety across the UK ambulance sector.

   It is imperative that WAST has more than a 'zero tolerance' attitude to sexual safety at work - as saying those words is not enough. Building trust and creating a safe space for colleagues to be heard is the starting point, and includes:

   (a) Amplifying the voices: encouraging colleagues to speak up in a way they feel comfortable knowing they will be heard. The Speaking Up Safely Task and Finish Group established in July 2022 to review the speaking up framework and propose a revised framework has finalised its work. The Workforce and Organisational Development Directorate ("WOD") will now implement recommendations for the policy framework, a guardian model, and third party confidential platform. The group's closure report and next steps by WOD will feature at the May Committee meeting;

   (b) Normalising the dialogue: each induction session for new colleagues asks the question 'what does a sexually safe organisation look like', and feedback from new colleagues is that this open discussion gives them confidence to challenge behavior and raise issues;

   (c) WAST voices network: this employee led network of advocates builds trust and provide

colleagues with an alternative way to raise concerns;

(d) Empowering through mentoring: offering affected colleagues support where they may have lost confidence or felt silenced;

(e) Listen and learn: reverse mentoring offered to senior leaders by affected colleagues to encourage a top down learning opportunity to reflect on our often unintentional biases;

(f) Allyship programme: creating a more inclusive, compassionate, and culturally responsible workforce in line with our equality, diversity and inclusion objectives;

(g) Review and improve: reviewing how we deal with concerns raised and learning from lived experiences to help make improvements; and

(h) Sexual safety charter: a soon to be launched WAST charter.

(i) Continuing to embed the new approach to managing disciplinary processes which focuses on fast tracking minor misconduct issues in partnership with our TU colleagues and places an emphasis on adopting the restorative "just culture" principles where appropriate.

The Committee will continue to focus on the cultural change at WAST and will receive the **People and Culture Plan** at their May meeting for review and then approval by the Board.

3. The emerging priorities for the **Integrated Medium Term Plan (IMTP) 2023-26** were reviewed around Culture, Capability and Capacity, including the equality, diversity and inclusion, and the Welsh language plans.

4. The Committee reflected on the challenging situation since they last met which has seen a prolonged period of **industrial action** and Winter pressures. The Committee had been scheduled to meet on 21 February but had to move the meeting on three occasions as a result of industrial action coinciding with meeting dates. The reduced attendance at today's meeting is reflective of these moves in the calendar. Whilst recognising some proactive strategic work has stalled as a result, **key progress was celebrated** with the update from the Director of Workforce and Organisational Development and the Quarterly Operations Directorate updates. The financial sustainability programme and recruitment control processes have been advanced (and this was discussed further in private session), as has paramedic placements and change management training. Senior leaders have met colleagues at stations and on the picket lines during each day of industrial action, which has provided a unique opportunity to hear from and listen to issues of concern.

**ASSURE**

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

5. The **Welsh Ambulance Service Partnership Team (WASPT)** highlight report was received and the sub-structures that feed into WASPT are still in development. These will provide opportunities for resolution and escalation at a more local level, focusing WASPT on strategic issues.

6. The **Annual Equality Report 2022/2023** was presented and is attached for Board review. The Committee noted that whilst there has been a minimal increase in diversity in our workforce it is not indicative of the population we serve and there is more to do. The role of Head of Inclusion and Engagement has now been filled and the equality, diversity and inclusion objectives, which were a focus in this meeting, will be advanced to further address this in 2023/24.

7. The **Gender Pay Gap Report 2022** was presented and is attached for Board review. Members were

disappointed that the gap had increased but recognised the work in place and planned in the IMTP to address this, including the creation of succession plans for band 8 positions, and the emphasis on improving our flexible working options , aimed at making WAST a more attractive place to work, and addressing some of the organisational barriers that were identified as part of our sexual safety survey findings.

8. The January 2023 Monthly Integrated Quality and Performance Report ("MIQPR"), the Improving Attendance Programme update and the Quarterly Workforce KPIs were reviewed. The Committee noted:

   8.1. **Sickness absence** levels were at 10.65% in December reflective of seasonal absences and illnesses but improved in January to 8.85% and the indicative figures for February have sickness absence at 8.04% which is the lowest since May 2021. A recent deep dive presented to the Executive Management Team broke down sickness by demographics and potential drivers with further work underway to look at this in more detail, particularly to work-related and personal stress absence drivers.

   8.2. The Committee was informed there is still demand for the **wellbeing offer** and good access to various options in place. Members raised concerns regarding the Putting Things Right Team and the difficult experiences of patients they are exposed to and were told that there is support for that team, with the new Duty of Candour providing more support for the team also, with detail of this coming to the March Board development session. The Committee was assured of progress against the recommendations made in the Attendance Management Internal Audit, with the May meeting reviewing the evaluation of the wellbeing offer which was a management action to the Audit Wales Structured Assessment 2022.

   8.3. With respect to **recruitment,** management was congratulated on recruiting the additional 100 front line staff. However, the challenge regarding clinical vacancies continues. The student paramedic conference will be attended by WAST this year, showcasing the organisation as a place to work and progress. Rotational models and home working are also being further explored for 111 clinicians, and a 10-year workforce plan for clinicians is being developed, given the long lead-in times.

   8.4. **PADR** (Personal Annual Development Review) rates for January 2023 declined compared to the previous month to 79.12%, therefore failing to achieve the 85% target; however, overall, they are on an upward trajectory, which the new PADR form is expected to support.

   8.5. **Statutory and Mandatory Training** rates decreased in the quarter from 82.07% in September to 79.51% in January, which is below the 85% target. Somewhat of a re-brand referring to this as continuing professional development ("CPD") is underway and sessions called MIST (missed in service training) have been scheduled to bring groups together for a more holistic approach to CPD, mixing grades in roles to enable broader discussions on scopes of practice which has proved popular.

9. A **health and safety update performance report** was received and it was noted that the reporting is evolving with the new team now fully in place for two quarters. This is beginning to show early gains around numbers of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) with the team meeting colleagues across the country, carrying out workplace risk assessments and understanding better the estates issues. An internal audit review is planned for Q4 2022/23 which will come to the Committee for assurance on the health and safety business case. An external review has taken place on diesel fumes outside emergency departments whilst our ambulances wait with patients due to handover delays, and proactive measures are being put in place to provide a better experience for staff and patients.

10. The Committee was not presented with the **audit tracker** at this meeting as the confirm and challenge meetings with action owners could not be scheduled. This was the result of resource challenges and operational pressures; however, the tracker is being updated as a priority to support the Q4 Follow Up Audit which will commence in March.

11. The Committee held its **annual effectiveness review**. Responses to questionnaires were reviewed and changes agreed to membership, terms of reference and operating arrangements. The Committee's annual report and revised terms of reference will be presented to the Audit Committee on 20 April and the Board on 26 May.

12. A new agenda item for **reflections** drew out that the meeting placed a welcomed focus on culture and improvement which ran through each agenda item, with members feeling energized and giving due recognition to progress in difficult times. Whilst the presentations were good and something the Committee wants to retain; they will in future be accompanied by a front cover report providing at a minimum a summary and what is required of the Committee.

13. In private session the Committee reviewed progress on **suspensions over four months** and was pleased to see that this had reduced to just one case. They were assured on actions in place to manage this case. Trade Union colleagues shared detail of their regular meetings with WOD to review cases each quarter which was helpful and allowed them to further support their members.

## RISKS

**Risks Discussed**: The following corporate risks were discussed however it was noted that due to team absences and operational pressures the BAF presented was current as at the January Board presentation. The two highest risks for this Committee are set out below:

**160** – high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service remains at a rating of 20 (5x4) as of 26 January. The next review of this risk will reflect the positive trajectory on sickness referred to in this report.

**201** – damage to the Trust's reputation following a loss of stakeholder confidence remains at 20 (4x5).

**New Risks Identified**: Two new risks have been added to the register.

| COMMITTEE AGENDA FOR MEETING | | |
|---|---|---|
| Director of Workforce and Organisational Development Update | Operations Quarterly Report | Staff Story |
| Sexism and Sexual Safety at Work Update | Speaking Up Safely Update | People and Culture 2023-26 IMTP deliverables |
| WASPT Advisory Group Highlight Report | Corporate risk register/BAF | Improving Attendance Project Progress Update and Internal Audit Review on Attendance Management |
| MIQPR (including deep dives for turnover and wellbeing) | Workforce Performance Scorecard | Annual equality report |
| Annual Committee Effectiveness Review | Health and Safety Update | Internal Audit Tracker and Reviews |

| COMMITTEE ATTENDANCE | | | | |
|---|---|---|---|---|
| **Name** | **10 MAY 2022** | **06 SEPT 2022** | **29 NOV 2022** | **14 MAR 2023** |
| Paul Hollard | | | | |
| Bethan Evans | From 10.50am | | | |
| Joga Singh | | | | |
| Hannah Rowan | | | | |

| | | | | |
|---|---|---|---|---|
| Catherine Goodwin | | | In attendance | |
| Angela Lewis | | | | |
| Chris Turley | | | | Navin Kalia |
| Lee Brooks | | | | |
| Estelle Hitchon | | | | |
| Andy Swinburn | | | | Until 12pm |
| Wendy Herbert | | | In attendance | |
| Liam Williams | | | | J Turnbull Ross |
| Alex Crawford | Hugh Bennett | Hugh Bennett | | |
| Trish Mills | | | | |
| Angela Roberts | | | | |
| Damon Turner | | | | |
| Paul Seppman | | Hugh Parry | | Hugh Parry |
| Craig Brown | | | | |
| Ian James | | | | Until 12pm |

| | |
|---|---|
| | Attended |
| | Deputy attended |
| | Apologies received |
| | No longer member |

| | |
|---|---|
| **AGENDA ITEM No** | **26** |
| **OPEN or CLOSED** | **OPEN** |
| **No of ANNEXES ATTACHED** | **1** |

# COUNTER FRAUD SERVICE REFERRAL FLOWCHART

| | |
|---|---|
| **MEETING** | People and Culture Committee |
| **DATE** | 9th May 2023 |
| **EXECUTIVE** | Angela Lewis, Director of People and Culture |
| **AUTHOR** | Carl Window |
| **CONTACT** | Carl.window2@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. The Local Counter Fraud Service is responsible within WAST for the delivery of all work areas connected to Fraud, Bribery and Corruption, with an overarching objective to secure a robust anti-fraud culture within the service. The service has a responsibility to educate and support all departments, alongside investigating and applying both criminal and civil sanctions for any aspects of Fraud, Bribery and Corruption identified within the service. The Local Counter Fraud Specialists (LCFS) employed within WAST work in compliance to Welsh Government directions, with reference to the Government Functional Standard GovS 013: Counter fraud.

2. Appendix 1 provides an overview and supporting illustration of the typical process for a Counter Fraud investigation. The purpose of this inclusion is to raise awareness for the committee of how Counter Fraud cases may work in parallel to those undertaken as part of a disciplinary process.

**RECOMMENDED:**

3. That the Committee **RECEIVE** and **NOTE** the summary and flowchart contained within **Appendix 1**.

## KEY ISSUES/IMPLICATIONS

**Appendix 1: Process Summary and Flowchart**

| REPORT APPROVAL ROUTE |
|---|
| **People and Culture Directorate Business Meeting 04.05.23**<br>**People and Culture Committee 9th May 2023** |

| REPORT APPENDICES |
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| **Appendix 1 - Process overview of Counter Fraud Case Progress**<br><br>The attachment within provides an overview and supporting illustration of the typical map for a Counter Fraud investigation. The attachment also gives written guidance around the parallel investigations process and how a criminal case may differ to an internal disciplinary investigation. The purpose of this inclusion is to provide awareness and understanding of how the two separate methods of investigation work, and where a joint case concern is considered in normal process proceedings. It is essential to note, that Counter Fraud case progression cannot be mapped in a template structure, as each case has its own complexities around evidence, and public interest criteria, which is considered in line with usual legal process and application of criminal investigations processes. |

| REPORT CHECKLIST | | | |
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| **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 |

**ITEM 26.1 Appendix 1**

# Counter Fraud Investigation Process Summary

The following illustration (Figure 1) presents a flow guide of how typical Fraud referrals may be taken forward. This is to be read in conjunction with the WAST Counter Fraud Policy, alongside consideration to People Services Guidance around conduct and disciplinary enquiries.

**Differences between the criminal and disciplinary processes**

A criminal investigation seeks to establish the facts about suspected criminal activity. Investigators are bound by legislation but must also be aware of other rules governing the collection and admissibility of evidence. The prosecution must prove their case to the Magistrates' Court or to the jury in a Crown Court '**beyond reasonable doubt'** before the defendant can be found guilty.

The purpose of a disciplinary investigation is to establish the facts of the case, and the standard of proof required is **'the balance of probabilities'**. Disciplinary investigations and ensuing proceedings must adhere to the Advisory, Conciliation and Arbitration Services (ACAS) Code of Practice on Disciplinary and Grievance Procedures, the ACAS Guidance on Conducting Workplace Investigations as well as any local HR policies.

It should also be noted that allegations in disciplinary proceedings would not necessarily be the same as in criminal investigations, even where both arise out of the same matter or related matters. While in some cases the matters giving rise to a disciplinary allegation may also be potential criminal offences, it is often the case that the employer frames the allegations around a breach of contract, breach of trust and confidence, lack of honesty and integrity, or damaging of the employer's reputation.

If an employee is charged with, or convicted of, a criminal offence, the employer would consider what effect the charge or conviction has on the employment relationship and the employee's suitability to do their job.

**Timing of parallel investigations**

There is no legal rule giving precedence to the criminal process over the disciplinary one, and the employer may undertake disciplinary proceedings even if a criminal investigation is ongoing. Furthermore, the Court of Appeal has held that where an employee chooses to remain silent in anticipation of criminal proceedings, the employer is entitled to draw conclusions from the evidence before them about the employee's actions, and a dismissal in this case may be fair.

It should be remembered however that the mere fact that an employee is under criminal investigation, charged with an offence or awaiting trial is not in itself always sufficient grounds for dismissal. Decisions must be based on all of the relevant circumstances. However, a disciplinary hearing should not normally take place if it would prejudice ongoing criminal proceedings. The circumstances of a case may be such that HR wishes to delay disciplinary proceedings until the LCFS has secured all

evidence for use in the criminal inquiry. Such a decision should be made in consultation with the LCFS and DOF. Delays in disciplinary proceedings do not necessarily make a dismissal unfair. In the case of Secretary of State for Justice v Mansfield.

"Where an employee facing disciplinary proceedings is at the same time being investigated by the police the employer's decision maker has a wide discretion whether to continue or postpone the disciplinary hearing. In this case the decision to postpone could not be criticised as involving unjustifiable delay."

In all cases public protection is paramount; the decision to give precedence to the criminal process over the disciplinary one must be subject to overriding public interest considerations – namely, the risk to the provision of NHS services, patients and/or the wider public caused by a delay in applying a disciplinary sanction. For example, allowing someone to remain in post during a criminal investigation could mean that individual is able to continue the alleged fraudulent activity, causing further financial loss to the NHS and, in some cases, endangering patient safety.

In serious cases (in particular where there is a high risk to patient safety), the organisation should proceed with relevant employment processes quickly while at the same time keeping the LCFS informed of any proceedings.

**Liaison responsibilities**

Coordination of parallel criminal and disciplinary investigations in order to achieve the best (most appropriate) outcomes requires regular liaison between the LCFS and HR department. The LCFS and Director of HR should meet regularly to ensure both are fully aware of the progress of each investigation. Beside routine interaction, specific consultation should occur at the following points:

All referrals received by HR that have an element of suspected fraud or corruption must be reported immediately to the LCFS and/or DOF.

Whenever parallel sanctions are being pursued, the investigating officer from HR should meet regularly with the LCFS for updates on investigations to maintain a flow of information. He/she should ensure that information is provided to the LCFS, where available, so that a fraud investigation and criminal sanctions can be pursued where appropriate.

The circumstances of a case may be such that HR wishes to delay disciplinary proceedings until the LCFS has secured all evidence for use in the criminal inquiry. However, HR should inform the LCFS whenever there are serious health and safety risks (e.g. a clinician not holding appropriate clinical qualifications) or cases involving vulnerable individuals that may take precedence over a criminal fraud investigation. In this instance, a case conference should be held to consider the specific circumstances.

Where an investigation by the LCFS relates to a case in which a breach of policy and/or procedures may have occurred, an HR officer should meet with the LCFS to discuss the case and receive documents or other materials (where lawful to do so), in order to establish if disciplinary action is required.

HR should advise the LCFS of the outcome of disciplinary hearings, as this may have an impact on the criminal sanction (for example, if the court hears that a person has not been dismissed, it could interpret this as an indication that the organisation did not take the person's actions seriously).

**Timing of referrals**

In general, it is not problematic for HR to share information obtained during a disciplinary investigation with the LCFS to help further a criminal investigation, although the LCFS should aim where possible to obtain the required information through a separate investigation. Likewise, the LCFS should usually be able to share information or material with HR that belongs to the organisation or is freely available (e.g. policies or invoices). However, disclosure of certain material, particularly where it is confidential and/or originates from a third party, can be problematic.

Therefore, there should be no routine or blanket sharing of information. As a rule, any decision to disclose information within the disciplinary investigation should be recorded by the LCFS on the NHS fraud case management system, including the rationale behind that decision. When considering disclosure in a specific case, the LCFS should consider the NHS Code of Practice on Confidentiality, the principles of the Data Protection Act 2018 (DPA) and GDPR, as well as all relevant legislation concerning criminal investigations. It is important that the CPS is totally impartial when considering questions of disclosure. If disclosure is made without an order of the court, other parties involved in the proceedings should be provided with the same documents or information.

**Disciplinary procedures -** Internal disciplinary action can run in parallel with regulatory, civil or criminal sanctions. If criminal proceedings are contemplated or underway, it is important to consult with prosecuting authorities before taking disciplinary action. Even if an employee is found not guilty of criminal charges, it may still be possible to instigate internal disciplinary procedures, subject to the organisation's policies.

**Figure 1** (overleaf) – Process flow map of Counter Fraud Investigation Process

**Figure 1 – Counter Fraud referral process**