

Bundle People and Culture (Open Session) 9 May 2024

Agenda attachments

- 00 PCC OPEN – Agenda – 9 May 2024
- 0 09:30 – OPENING ITEMS
- 1 Chair's welcome, apologies and confirmation of quorum
- 2 Declarations of Interest
Board Member Register of Interests–Updated 2024–03–27–Published.xlsx (nhs.wales)
- 3 Minutes of last meeting – 20 February 2024
ITEM 03 Unconfirmed OPEN PCCmins 20 February 2024
- 4 Action Log and Matters Arising
ITEM 04 PCC Action Log (Open)
- 5 09:35 – Director of People and Culture Update
ITEM 05 PCC Director Update
- 6 09:45 – Operations Quarterly Report Q4
ITEM 06 Operations Quarterly Report for Committees 23–24 Q4 FINAL
- 6.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
- 7 09:55 – Staff Story
- 8 10:25 – NHS Staff Survey
ITEM 08 Staff Survey – PCC
- 9 10:40 – People and Culture Plan Metrics Update
ITEM 09 PC Plan Metrics Update Mar 24
ITEM 09a PCC Quantitative PCP Metrics Mar 2024
ITEM 09b Appendix 3 – ES – Cultural Reviews
ITEM 09c Appendix 4 – Disciplinary Deep Dive
- 9.1 11:00 – COMFORT BREAK
- 10.1 11:10 – Workforce Scorecard
ITEM 10.1 Workforce Performance Scorecard
ITEM 10.1ai Summary – People and Culture KPIs March 2024
ITEM 10.1a ii Plan
ITEM 10.1a iii Resource
ITEM 10.1a iv Educate
ITEM 10.1a v Engage
ITEM 10.1a vi Data Refs
ITEM 10.1b Appendix 1c MIST 202324
- 10.2 Monthly Integrated Quality and Performance Report
ITEM 10.2 MIQPR SBAR PCC February March 2024
ITEM 10.2a Annex 1 MIQPR PCC February March 2024
- 11 11:25 – Health & Safety Report
ITEM 11 Q4 2023–24 Health and Safety Performance Report v0.1
ITEM 11a Annex 2 Health Safety and VA Q4 Report
ITEM 11b Annex 3– Compliance Register Priority List
- 12 11:40 – Staff Development Outline Plan
ITEM 12 People Development Plan
- 12.1 11:55 – LUNCH
- 13 12:35 – Risk Management and Board Assurance Framework Report
ITEM 13 Risk Management Report
- 14 12:45 – Deep Dive on Risk 201 Reputational Risk
- 15 13:05 – Audit Tracker & Audit Reports
Internal Audit Reports:
Retention of Staff
Seatbelt Action Plan
ITEM 15 Audit Tracker to Committees – Q4 Reporting – May–June Reporting
ITEM 15.1 Audit Tracker 2.0 Q4 January–March 2024 – (Finalised 250424)

- ITEM 15.1a Audit Tracker 2.0 Q4 January–March 2024 – (Finalised 250424)
- ITEM 15.2a Retention of Staff_Final Internal Audit Report V2
- ITEM 15.2b WAST_2324-012_Seatbelt Action Plan_Final Internal Audit Report
- 16 13:15 – Policies for Approval
 - ITEM 16 Policies for Committee Approval – PCC 090524
 - ITEM 16a Homeworking Policy v3.5 290424
- 17 13:20 – Committee Cycle of Business, Priorities & Monitoring Report
 - ITEM 17 SBAR on Cycles of Business 24–25
 - ITEM 17a CoB Annex 1
 - Item 17a.1 CoB Annex 1 notes
 - ITEM 17b CoB Annex 2 Monitoring Report
- 18 13:30 – WASPT Highlight Report
 - ITEM 18 WASPT AAA Report 19 February 2024 (1)amended
 - ITEM 18a WASPT Annual Return 2023–24
- 18.1 CONSENT ITEMS
- 19 Staff Story Driver Diagram
 - ITEM 19 Staff Story Driver Diagram
- 20 Committee Highlight Report – 20 February 2024
 - ITEM 20 People and Culture Committee Highlight Report February 2024 (3)
- 20.1 CLOSING ITEMS
- 21 13:40 – Key messages for Board/Actions/Decisions
- 22 Reflections of Meeting
- 23 Any Other Business
- 24 Date of Next Meeting – 15 August 2024



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OPEN MEETING OF THE PEOPLE AND CULTURE COMMITTEE

Held on Thursday 9 May 2024 from 09:30 to 13:50

Meeting held in person and virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's Welcome, apologies, and confirmation of quorum	Information	Ceri Jackson	Verbal	5 mins
2.	Declarations of Interest	To State Conflicts	Ceri Jackson	Verbal	
3.	Minutes of last meeting – 20 February 2024	Approval	Ceri Jackson	Paper	
4.	Action Log and Matters Arising	Review	Ceri Jackson	Paper	
5.	Director of People and Culture Update	Information	Angie Lewis	Paper	10 mins
6.	Operations Quarterly Report Q4	Information	Sonia Thompson	Paper	10 mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
7.	Staff Story – A view of Front Line Leadership	Discussion	Angie Lewis Matthew Jones	Presentation	30 mins
8.	NHS Staff Survey	Discussion	Angie Lewis	Paper	15 mins
9.	People and Culture Plan Metrics Update	Assurance	Angie Lewis	Paper	20 mins
COMFORT BREAK (10 Minutes)					
10.	10.1 Workforce Scorecard	Assurance	Angie Lewis	Paper	15 mins
	10.2 Monthly Integrated Quality and Performance Report		Alex Crawford		



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No.	Agenda Item	Purpose	Lead	Format	Time
11.	Health & Safety Report	Assurance	Liam Williams	Paper	15 mins
12.	Staff Development Outline Plan	Assurance	Angela Lewis	Paper	15 mins
LUNCH BREAK (40 Minutes)					
13.	Risk Management & Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 mins
14.	Deep dive on Reputational Risk 201	Assurance	Estelle Hitchon	Presentation	20 mins
15.	Audit Tracker & Audit Reports Internal Audit Reports: <ul style="list-style-type: none"> Retention of Staff Seatbelt Action Plan 	Assurance	Alex Payne Angie Lewis Sonia Thompson	Paper	10 mins
16.	Policies for Approval: Homeworking Policy	Approval	Julie Boalch Angie Lewis	Paper	5 mins
17.	Committee Cycle of Business 2024/25 & Monitoring Report	Approval	Julie Boalch	Paper	10 Mins
18.	WASPT Highlight Report (including Annual Report)	Assurance	Angie Lewis	Paper	10 Mins
CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.					
19.	Staff Story Driver Diagram	Information	Angie Lewis	Paper	-
20.	Committee Highlight Report – 20 February 2024	Information	Julie Boalch	Paper	
CLOSING ITEMS					



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No.	Agenda Item	Purpose	Lead	Format	Time
21.	Key Messages for Board/ Actions/Decisions	Discussion	Ceri Jackson	Verbal	10 mins
22.	Reflections of Meeting	Discussion	Ceri Jackson	Verbal	
23.	Any Other Business	Discussion	Ceri Jackson	Verbal	
24.	Date of Next Meeting: 15 August 2024	Information	Ceri Jackson	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Sonia Thompson	Assistant Director of Operations, EMS
Estelle Hitchon	Director of Partnerships & Engagement
Alex Crawford	Assistant Director of Planning and Transformation
Liam Williams	Executive Director of Quality and Nursing
Ceri Jackson	Committee Chair and Non-Executive Director
Angie Lewis	Director of People and Culture
Alex Payne	Corporate Governance Manager

**UNCONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE MEETING
 (OPEN SESSION) HELD REMOTELY VIA MICROSOFT TEAMS ON 20 FEBRUARY
 2024**

Chair: Paul Hollard

Member:

Paul Hollard

Bethan Evans

Hannah Rowan

Non-Executive Director and Chair

Non-Executive Director

Non-Executive Director

Prescribed Attendee:

Lee Brooks

Alex Crawford

Christian Fox

Estelle Hitchon

Angie Lewis

Trish Mills

Andy Swinburn

Chris Turley

Jonathan Turnbull-Ross

Damon Turner

Executive Director of Operations

Assistant Director of Planning and Transformation (left after 11/24)

Trade Union Partner

Director of Partnerships and Engagement

Director of People and Culture

Board Secretary

Executive Director of Paramedicine

Executive Director of Finance and Corporate Resources

Assistant Director of Quality

Trade Union Partner

Attendee:

Darren Anthony

Julie Boalch

Sarah Davies

Colin Dennis

Dr Catherine Goodwin

Melfyn Hughes

Ceri Jackson

Alison Kelly

Osian Lloyd

Caroline Jones

Kathryn Cobley

Sara Mills

Alex Payne

Liz Rogers

EMT2 Staff Member (left after 02/24)

Head of Risk/Deputy Board Secretary

People and Culture Directorate Business Manager

Trust Chair

Assistant Director Inclusion, Culture and Wellbeing

Welsh Language Services Manager

Non-Executive Director (only for 07/24)

Business and Quality Manager

NWSSP Internal Audit

Corporate Governance Officer

Head of Inclusion and Engagement

Head of Culture and OD

Corporate Governance Manager

Deputy Director of People and Culture

Apologies:

Joga Singh	Non-Executive Director
Tim Cahalane	Trade Union Partner
Ian James	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

01/24 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the hybrid meeting of the People and Culture Committee noting that some members, including the Trust Chair and the Executive Lead were in the room, with others attending via Teams.

Apologies were recorded from Joga Singh, Tim Cahalane, Ian James, and Liam Williams.

02/24 STAFF STORY

Angie Lewis welcomed Darren Anthony to the meeting and thanked the Management Team for allowing him time to join the meeting whilst on shift.

Darren Anthony had completed the Level 4 Diploma for Associate Ambulance Practitioners, which is the accredited education programme for EMT2 roles, and went on to win the Skills for Health Apprentice of the Year award in recognition of his achievement. This showed the importance of continued learning.

Darren Anthony shared his background prior to starting work with the Welsh Ambulance Services NHS Trust (WAST). He worked for Gwynedd Council in the local leisure centres starting out as a young apprentice before becoming a lifeguard and teaching swimming to both adults and children. He then moved to senior management and qualified as a personal trainer, although his passion remained with teaching children, which he recognised was a transferable skill and helped him during his training with WAST.

Having previously applied to WAST 13 years earlier and being successful, it came at a difficult time in his personal life, and he declined the offer at that time. He applied again and was once again successful and became part of EMT 7 in September 2022. He praised the IT, resources and tutors although did say that some additional practical training would have been beneficial, together with issuing the workbooks earlier. Recognising he didn't want to just pass the course he wanted to excel, he was determined to prove himself. He then became the student of the course followed by 'Apprentice of the Year', which was a huge achievement.

Darren Anthony was proud to work for WAST and everything it offered and was hoping to gain an opportunity to progress to become a Paramedic. He appreciated the policies, procedures, development, and support that the organisation offers.

Members congratulated Darren Anthony on his achievement and thanked him for sharing his inspirational story, determination, commitment, and enthusiasm. They also wished him well in his application to become a paramedic.

RESOLVED: That

- 1) The suggested improvements to the training be taken back to the team; and**
- 2) the inspirational story was welcomed by members.**

03/24 DECLARATIONS OF INTEREST

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

RESOLVED: That no new declarations were received.

04/24 MINUTES OF PREVIOUS MEETING, ACTION LOG AND HIGHLIGHT REPORT

The Minutes of the Open meeting held on 16 November 2023 were considered and agreed as a correct record.

Lee Brooks confirmed that action 57/23 was part of Connected Support Cymru and in terms of meeting the grant requirements, it was positive. Recruitment was underway for Community Welfare Responders in Cardiff and Swansea. He also confirmed that a webinar to build third party relationships was encouraging. He advised Committee that more detail would be included within the quarterly report in future. The action was closed due to the progress being reported via the quarterly report in future.

Committee confirmed that action reference 60/23 around the Welsh Language Speakers could be closed as the detail would be contained within the Annual Report.

The final action reference 63/23, a deep dive into disciplinary themes and trends was reference on within the People and Culture Metrics report programmed for this meeting. Members also noted that the disciplinary case management audit would be shared soon, therefore agreed to close the action on that basis.

RESOLVED: That the

- 1) **minutes of the meeting held on 16 November 2023 were approved; and**
- 2) **Actions 57/23, 60/23 and 63/23 as set out above were closed.**

05/24

DIRECTOR OF PEOPLE AND CULTURE DIRECTION UPDATE

The Director of People and Culture highlighted the successful joint sexual safety workshop given to 140 colleagues on 9 January 2024. The workshop aimed to share the knowledge and learning around dealing with sexual safety issues and creating a safe environment in the workplace. Working closely with legal and risk also raised understanding and knowledge within WAST.

Colleagues were aware of the recent publication of the ambulance services in England Cultural Review, with the emphasis now for the Trust to focus on its culture and psychological safety. Additional engagement on the Freedom to Speak Up raising concerns would be focused on.

The Trust was delighted to have been shortlisted for the CIPD Wales Award for Equality and Diversity with a meeting to be held with judges on 21 February, and results announced on 15 March. The Trust had been open around the ongoing progress, with more work still to do.

Angie Lewis had also attended a CPD day for year one and year two students at Glyndwr University, along with Andy Swinburn. Their feedback was positive and particularly highlighted the support of their practice educators.

Training had been ongoing around workforce planning with a significant number of managers. A further iteration of the Strategic Workforce Plan would be presented at the next meeting, as a key requirement for the organisation. Angie Lewis also referenced an online event which would be held on 8 March for International Women's Day.

Damon Turner confirmed the workshop in February was both challenging and positive, and queried if information on leavers would be shared with managers. Angie Lewis confirmed that some data was provided within the culture metrics report and that an audit had recently taken place which would be shared. She agreed to share information with Trade Union Partners around upcoming themes relating to leavers. She also noted that funding has been made available by Health Education and Improvement Wales (HEIW) for two years for a retention lead for all Health Boards and Trusts, a role to which Paola Spiteri had been appointed for WAST.

RESOLVED: That the update from the Director of People & Culture was noted.

06/24 OPERATIONS QUARTERLY REPORT

Lee Brooks drew out pertinent aspects for Members, which included the more detailed update in relation to the Manchester Arena Inquiry within the report with good progress made on the recommendations with action 27/68 now complete.

The ten second triage and major incident triage tool was set to go live on 1 April which was not without a significant undertaking in promoting Mandatory in-Service Training (MIST). The Senior Operations Team were comfortable that sufficient staff would have been through MIST by that time.

Lee Brooks was pleased to inform members that recruitment to the Resourcing, Rostering Systems Manager post had been successful which would allow the Trust to further review the benefits of GPRS and allow the movement of timesheets onto an electronic system working with the Electronic Staff Record (ESR) interface the GRS Everbridge interface and the GRS CAD interface.

The Executive Leadership Team had committed additional budget for the next financial year for EMS Coordination, which would see the design of a career structure from a Band 3 Call Handler to the Executive Director of Operations post. The Organisational Change Policy (OCP) for this change was hoped to get underway soon. Members welcomed the career development model for operational staff.

A considerable number of Emergency Medical Staff Coordination employees were recognised through the Emergency Medical Dispatcher of the year process, with many shortlisted and some winners too.

RESOLVED: That the Operations Quarterly Report was noted.

07/24 STRATEGIC EQUALITY PLAN, ANNUAL WORKFORCE EQUALITY MONITORING REPORT 2022/23, ANNUAL GENDER PAY GAP REPORT 2022/23 AND ANTI-RACIST WALES ACTION PLAN

A presentation by Kat Cobley was delivered to Members which covered several Equality Diversity and Inclusion (EDI) related papers, their purpose and progress to date, and their relevance to the People and Culture Plan.

It was recognised that Equality, Diversity, and Inclusion was evident in everything the Trust does. With improvements in the use of Equality Impact Assessment, policy development and digital forms being developed, the re-establishment of the EDI Steering Group to monitor the Strategic Equality Plan (SEP) objectives, there was much work ongoing.

Kat Cobley wished to update Members on progress to date and focus on the future plans, with a discussion on the role of the People and Culture Committee and the Non-Executive Directors in the overall EDI agenda.

Trust staff were leading on sexual safety work and worked closely with national staff networks in this regard. A number of conferences that Kat Cobley had attended were well presented in terms of raising issues around EDI and challenges faced by those who were disadvantaged in our society.

Work was ongoing to develop the carers passport scheme and the staff disability network was working to support neurodiverse staff in the workplace as well as being aware of service users too. Finally, warm WAST welcome sessions had been introduced for staff, to emphasise the positive aspects of being a member of WAST.

SEP

Under the requirements of the Equality Act 2010: The Public Sector Equality Duty (PSED), the Trust was required to publish a Strategic Equality Plan (SEP) and a set of objectives by 31 March 2024 which would demonstrate how the Trust would;

- eliminate discrimination, harassment and victimisation and other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who do not;
- foster good relations between people who share a protected characteristic and those who do not.

This work involved a review of the previous SEP and the progress made against the objectives. The new four-year plan and objectives must be informed by the relevant information that is already held, followed by consultation and engagement with staff, service users and stakeholders, in particular, those with a protected characteristic, Welsh speakers and other minority groups or those who are vulnerable. The SEP should also consider the findings published in the Equality Human Rights Commissions' 2024 Report 'Is Wales Fairer?'. The responsibility for meeting the requirements and giving due regard to the PSED lies with all employees, senior leaders, and board members.

Based on the information the Trust has and the feedback received during consultation and engagement, a SEP for 2024-2028 has been drafted with the following overarching strategic equality objectives:

- Designing Equitable Services
- Leading by Example
- Being an Employer of Choice
- Creating Allyship

During the consultation period no further comments were received which required changes to the draft SEP and objectives. However, feedback had suggested that there was a need for the Trust to produce an easy read version alongside the plan for people whose first language wasn't English or Welsh. Plans were in place to explore options to create an easy read version and a video animation to provide an overview of the SEP.

Gender Pay Gap Report and Workforce Equality Monitoring Report 2022/23

The gender pay gap reporting requirements and equality monitoring data requirements are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

As an organisation that employs more than 250 people the Welsh Ambulance Services NHS Trust must publish and report specific information about our gender pay gap both on our own website, and the Government's website.

As a public sector body, the Trust is required to publish workforce data and assess the diversity of the workforce in relation to the population we serve. This information is pulled from our Electronic Staff Record system and the TRAC system.

In 2022-2023 our gender pay gap was 5.4%. This compared favourably to other NHS Wales organisations with some of these between 20-25%. It also sits in the middle of the table comparison between UK Ambulance Trusts, whose gender pay gap reports range from 0.85% (North East Ambulance Service) to 10.77% (North West Ambulance Service).

In 2022-2023, there was a small increase in the diversity of our workforce in relation to the number of staff with a disability, those who identify as LGBTQ+, and those from a Black, Asian, and Minority Ethnic background.

Both the Annual Workforce Equality Monitoring Report 2022-2023 and the Annual Gender Pay Gap Report 2022-23 will be published on the Trust website prior to the deadline on 31 March 2024 and would sit alongside the Strategic Equality Plan Annual Report for 2022-2023, which had already been approved and published.

When assessing whether our workforce is reflective of the population we serve, there were some shortfalls in the following areas:

Non-White population in Wales 6.2% (Census data 2021)	WAST Staff from BAME background 1.83%
People with a disability in Wales 21.1% (Census data 2021)	WAST Staff with a disability 5.93%

The non-White population figures and the people with a disability in Wales figures include children and people over the age of 65 and is not reflective of the general working age population. The data above is Wales-wide. The population percentages for the non-White category are much higher in urban areas of Wales, in particular Cardiff, Newport and Swansea.

Work was already ongoing to increase diversity in the workforce via a number of initiatives such as the inclusive recruitment programme and the implementation of the actions set out in the Anti-Racist Wales Action Plan. The inclusive recruitment programme should also focus on attracting higher numbers of staff with a protected characteristic in our urban areas to be more reflective of the local populations. Funding had been made available to introduce Retention Leads within NHS Wales organisations who will be contributing to the development of inclusive recruitment and retention initiatives in 2024-2025.

Whilst the gender pay gap has not worsened over the past six years, the gender pay gaps still exists within the Trust despite the actions taken to improve our female staff experience in the workplace. The Trust will continue to implement initiatives which focus on encouraging career progression amongst our female staff and are continuing to support women's health in the workplace via staff networks and policy development, e.g. All Wales Menopause Policy, Shared Parental Leave Policy, Flexible Working Policy, etc. Actions will focus on engagement with our female staff to understand the reasons behind the gender pay gap. This work would also link to our actions around increasing psychological and sexual safety in the workplace.

Anti-Racist Wales Action Plan

Much discussion around the development of the action plan had taken place and an update was provided on where the Trust was with the actions set out within that plan for NHS Wales organisations.

An intense active bystander and allyship training module was developed and delivered to staff as part of the actions set out in the Anti-Racist Action Plan (ARWAP). This training covered discrimination and allyship for all of the protected characteristics, not just race and ethnicity. The Trust is passionate about this and believes that educator education and raising awareness of the challenges faced by some of those people with a protected characteristic is paramount to helping people change their behaviours and really display the behaviours that the Trust would want to see being displayed.

In March 2022, following a lengthy planning and consultation period, Welsh Government published its vision to achieve an Anti-Racist Wales by 2030. A

detailed action plan sets out the actions needed to improve the experiences of Black, Asian, and Minority Ethnic individuals.

In the health section of the plan, there are five specific goals with nine specific actions for NHS Wales Boards and organisations with agreed timelines for implementation between July 2022 and December 2023.

Welsh Government have requested that progress against the ARWAP actions be included in the bi-annual SEP update, which is presented as part of the NHS Wales Performance Framework Policy Assurance. It is also recommended that NHS Wales organisations include a progress update in their annual Strategic Equality Annual Reports which are published on our website.

The Equality Leadership Group (ELG) which consists of EDI Managers across NHS Wales continue to share best practice and discuss the implementation of the ARWAP at its bi-monthly meetings. The ELG has maintained links with Welsh Government and engaged in discussions around some of the challenges in implementing the actions. The Report included highlights, further actions together with risks.

Annual progress updates on the Trust's progress against the ARWAP actions will be included in the Annual Strategic Equality Plan Report which will be approved by the People and Culture Committee and the Board prior to publication.

Members endorsed the plan and reiterated the need to ensure implementation includes SMART actions and is outcome-focused to demonstrate the impact of the initiatives to the lives of our people. It was noted that the performance reporting on cultural themes and workforce KPIs would draw out that impact and the themes, but that work was required to ensure they are connected in a way that the Committee and the Board can see progress of these important initiatives. The role of Non-Executive Directors (NEDs) as champions was also discussed and Hannah Rowan, EDI NED champion sought to have more guidance on how she and other NEDs might most appropriately support initiatives throughout the year, over and above monitoring the plan.

RESOLVED: That

- 1) the Committee received and endorsed the SEP 2024-2028;**
- 2) the Committee received and endorsed the 2022-23 Gender Pay Gap Report & 2022-23 Workforce Equality Monitoring Report; and**
- 3) the Committee noted the ARWAP report.**

The new More Than Just Words plan 2022-27 was launched by the Minister for Health and Social Services in August 2022. The five-year plan was developed following an independent evaluation of the first More Than Just Words five-year plan.

Welsh language featured in the IMTP for 2024-27 and Members will have an opportunity to review the full IMTP at a Board development session later this month and at Trust Board in March, however the intention for 2024/25 is to build an environment in which the Welsh language can flourish. This will ensure focus is on cultural change as well as standards compliance.

Trish Mills explained about the great work that was ongoing across the organisation with Welsh language, including significant activity in 111 regarding improving the trajectory for answering calls in Welsh, with some raising confidence tutors planned to spending time in this area. An improving trajectory on the answering of calls in NEPTS could also be seen.

Details of the mandatory Welsh Language Awareness Course was going to be promoted more in quarter four to improve the uptake.

The in-house Welsh language translation service had started with a soft launch which was well received, with more to do on moving away from using external providers.

The annual meeting with the Welsh Language Commissioner's Office had been held recently and Melfyn Hughes, Welsh Language Manager and Trish Mills were able to report that WAST was one of the only organisations in Wales that had reached 100% on recruitment, bilingual recruitment, and job descriptions.

It was recognised that within the report there are many quotes from patients and their families which justified the importance of Welsh language being built into what we do at WAST. Members commended the work and focus on the Welsh language and noted the update and the More Than Just Words 2022-23 Annual Report

RESOLVED: That the

- 1) Welsh Government's More Than Just Words Annual Report 2022-23 was noted; and**
- 2) Committee received assurance against the Trust's progress in delivering its commitments to the plan.**

09/24 WORKFORCE PRIORITIES RELATED TO IMTP

Angie Lewis reminded Members of the proposed priorities presented to the Committee in November and how the People and Culture Directorate had been challenged to manage aspirations and ambitions in a more realistic way.

The report presented today was more deliverable and allowed space for business-as-usual activity and unforeseen issues.

The number of objectives for inclusion within the IMTP had been significantly reduced. The remaining items would be managed in an alternative way whilst the three headings of Culture, Capacity and Capability had been maintained.

Members were challenged on what good looked like and what the Trust was aiming for; an example, of which was leadership development. How would people know what good would look like.

It was noted that most of the metrics were quantitative rather than qualitative measures and Members requested a focus on evaluating the impact of initiatives and the markers of success.

RESOLVED: That the IMTP 2024-27 objectives and metrics for the People and Culture Directorate were approved, subject to ongoing conversations relevant to the wider Plan.

10/24 PEOPLE AND CULTURE PLAN METRICS UPDATE TO INCLUDE CULTURAL THEMES- PRIORITIES FOR 2024/25

The agreed metrics to measure the impact of the People and Culture Plan were presented under the Plan's headings of Culture, Capacity and Capability giving a holistic evaluation of the Plan's effectiveness in enhancing organisational culture, fostering a sense of belonging and optimising the capabilities of our people. The themes reflected the Plan's goals of improving organisational culture, creating a sense of belonging and developing the skills of our people.

Members commended the approach and noted that whilst what our people were telling us was sometimes difficult to hear, it was important to show we are listening and responding. Members highlighted the progress made in the last 18 months, such as:

- Having richer and more frequent feedback from staff and students through surveys and roadshows.
- Increasing the awareness and reporting of employee relations issues, such as culture reviews and grievances, and supporting people to come forward and

raise concerns.

- Engaging the executive leaders in regular discussions and actions on people and culture metrics and challenges.
- Applying compassionate practices for individuals affected by organisational changes or employee relations processes.
- Reducing sickness absence rates in some regions and learning from their best practices.
- Promoting proactive health surveillance and addressing the main causes of absence, such as mental health and musculoskeletal problems.

The report also acknowledged the areas where more work was needed, such as:

- Building trust and confidence among staff and students to speak up and share their views.
- Ensuring that all colleagues feel safe and respected in the workplace.
- Achieving the target of 6% sickness absence by April and maintaining it.
- Continuing to monitor and improve the impact of the People and Culture Plan on organisational performance and wellbeing.

RESOLVED: That the

- 1) Insights shared were commented on;**
- 2) Content of the report was noted; and**
- 3) Alternating reporting of quantitative and qualitative data approach was agreed.**

11/24

WORKFORCE SCORECARD & MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT

The Monthly Integrated Quality and Performance Report ("MIQPR") and the Q3 Quarterly Workforce scorecard showed that continued system pressures including handover delays remained a significant pressure on our people.

The Committee noted a welcomed increase in Personal Annual Development Reviews (PADR) and the focus of the senior leaders on improving statutory and mandatory training compliance.

MIQPR

It was noted that sickness absence in 111 was high and that a cultural review was underway to look at this. Angie Lewis agreed to bring a paper to the next meeting which would look at the ongoing cultural reviews and identify the actions taken.

Low vaccination rates among patient-facing staff were a concern.

Members noted good performance on unit hours produced and abstraction rates.

Andy Swinburn agreed to take a paper to the Quality, Patient Experience and Safety Committee around the continued deployment of Cymru High Acuity Response Unit (CHARU), aiming to illustrate progress, activity, and deployment.

RESOLVED: That

- 1) the People and Culture Performance Scorecard report was received and commented on; and**
- 2) the MIQPR was considered by the Committee.**

12/24

RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

The aim of the report was to provide assurance to Members in respect of the management of the Trust's principal risks, particularly the risks relevant to the Committee's remit. Controls in place against each principal risk could be viewed in the Board Assurance Framework.

The risks were presented to Trust Board in January 2024 with Risks 223 (*the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) being dynamically reviewed as system pressures continued. With respect to the risks for this Committee, members noted:

Risk 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). Whilst good progress is being made to reduce sickness absence, a decision has been made to keep the risk rating under review. The controls and assurances have been strengthened and a suite of new mitigating actions have been identified during the last review.

Risk 201 – Damage to the Trust's reputation following a loss of stakeholder confidence remains at 20 (4x5). Whilst the score remains unchanged and remains high, the risk has been strengthened to describe the difficulties in progressing the Trust's long term strategic ambition because of lack of stakeholder confidence and support. Additional controls and mitigations have been articulated to support this change.

Risk 163 – Maintaining effective and strong Trade Union partnerships increased score to 20. Additional mitigating actions reflecting the WASPT effectiveness review, the new ToR and operating arrangements for the group were discussed and it was noted that the actions detailed in the ACAS action plan will be aligned to this risk in the next review.

Risk 558 deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences remains

unchanged and scores 15 (3x5).

Risk 199 Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with health and safety statutory legislation as reported to the November 2023 Trust Board, this had achieved its target risk score of 10 (2x5). This was due to the demonstrable work undertaken across the Trust in relation to the Working Safely Programme and Health & Safety. The risk had therefore been de-escalated to the directorate register and will be monitored by the Executive Director and team on a quarterly basis.

RESOLVED: That

- 1) Members considered and discussed the report;**
- 2) the increase in risk score of Risk 163 from 16 to 20 was noted;**
- 3) the de-escalation of Risk 199 from the Corporate Risk Register to the Directorate Risk Register as this has reached its target score of 10 (2x5) was noted; and**
- 4) the ratings and mitigating actions for each principal risk was noted.**

13/24

HEALTH AND WELLBEING PLAN

The draft Health and Well-being Plan 2025-2029 was received for comment. The draft plan set out the principles for the approach to improving the health and well-being of our people and to provide strategic leadership to the Trust's health and well-being activities.

The Committee noted that a consultation process with various stakeholders was planned to inform its development, and that a holistic approach to the plan would be taken as opposed to focusing just on individual well-being support initiatives. The Committee asked that the Well-being Team consider the accessibility of the document to ensure it's easy to understand and apply.

RESOLVED: That the Committee commented on the draft plan.

14/24

ANNUAL EFFECTIVENESS REVIEW

The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and prepare an annual report which will be presented to Audit Committee in April, and then to the Trust Board in May.

Annual effectiveness reviews are designed to evaluate the effectiveness of the Board and its Committees, review operating arrangements, and proposing changes to improve Committee's support, challenge, scrutiny, and oversight responsibilities.

Whilst the Duty of Quality is demonstrated by adopting a continuous improvement methodology to the Board and its Committees throughout the year, the annual effectiveness review was an opportunity to formally review membership, review the work of the Committee during the year, and set the Committee's priorities for the coming year.

A review of the Terms of Reference provided an opportunity for the Committee to ensure it was comfortable with the focus and direction.

The report included responses to the questionnaires completed by members, a draft Annual Report from the Committee to the Board and proposed marked up changes to the Terms of Reference. As a result of the response to a questionnaire completed by Members and attendees, changes had been proposed to the Committee's operating arrangements and its Terms of Reference, one of which was to formalise the procedure for Chair's Actions.

Members agreed that the Committee effectively discharged its responsibilities under its terms of reference and that the annual report was a true reflection of its operating arrangements in 2023/24. Areas of good practice and improvement were noted and these will be rolled up into a schedule for the Board of cross-Committee improvements.

Priorities for the Committee for 2024/25 were agreed as follows:

- (a) Impact of wellbeing initiatives on our people;
- (b) Culture of conversations with a focus on communication and conversations with managers and their people;
- (c) A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives;
- (d) The Trust's approach to development of our people.

Paul Hollard and Bethan Evans reflected on the journey of the Committee over the past four years which had seen focus in more essential areas.

RESOLVED; That the

- 1) the draft Annual Report was reviewed and endorsed;**
- 2) changes to the terms of reference as set out in the annex were endorsed;**
- 3) the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report were confirmed; and**
- 4) priorities for the Committee for 2024/25 were set.**

18/24 AUDIT TRACKER AND INTERNAL AUDIT REPORT

The Audit Tracker was reviewed, and the Committee noted the good progress in closing recommendations, with approximately 11% closed or due to close in Quarter four.

Retention of Staff Internal Audit

The reasonable assurance 'Retention of Staff' Internal Audit report was received, with key matters arising including finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention. The roll out of moving on interviews was welcomed.

RESOLVED: That

- 1) the good progress made in closing recommendations was noted; and**
- 2) the Retention of Staff Internal Audit Report was received.**

19/24 ALL WALES FLEXIBLE WORKING POLICY AND HOMEWORKING POLICY

The Committee approved two policies; those being the All-Wales Flexible Working Policy and the Homeworking Policy. There were no comments or issues raised.

RESOLVED: That the All-Wales Flexible Working Policy and Homeworking Policy were approved.

20/24 WASPT HIGHLIGHT REPORT

The WASPT highlight report was presented following their meeting on 15 December 2023, with members noting discussions related to:

- The EMS establishment with an agreement that emergency ambulance lines would not be taken down but that a one-off relief gap created.
- Detailed discussion following a report with the results of air monitoring for diesel exhaust emissions at seven emergency departments in Wales and the actions taken to reduce exposure and the risk to staff.
- Agreement on an approach to the Infection Prevention & Control Policy with regard to carrying snacks, as well as other IPC related issues.
- The actions agreed in partnership with Advisory, Conciliation and Arbitration Service in 2022 are on track.
- The sub-structures established to report into WASPT are doing so with escalations making their way through where appropriate.

Damon Turner confirmed the positive nature of the discussions and the direction of travel, whilst recognising there was still some fragility.

RESOLVED: That the WASPT highlight report was received.

21/24 CYCLE OF BUSINESS MONITORING REPORT

The priorities and cycle of business monitoring report was noted. The Committee's cycle of business was on track with no escalations required.

RESOLVED: That the update was noted.

22/24 KEY MESSAGES FOR BOARD

Any messages for Trust Board would be included in the highlight report from the Committee.

24/24 ANY OTHER BUSINESS

As this would be Paul Hollard's final meeting as Chair of the Committee and as a Non-Executive Director for the Trust. Members thanked him for his contribution, support, curiosity and challenge of the work of the Committee and wished him well.

Estelle Hitchon also confirmed that she would be joining the Academy Wales Expert Panel on Public Sector Leadership.

25/24 DATE OF NEXT MEETING

The next meeting is scheduled for the 9 May 2024.

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

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
57/23	17 August 2023	Operational Report	NHSCT grant award - for the Committee to receive an update in the future as it part of the volunteering strategy and how it'll be used to develop a Community Welfare responder role.	Lee Brooks	20/02/2024 9 May 2024	Update for May meeting - information is included within the quarterly report. Verbal Update to be received at the meeting. <u>Update at Feb 24 meeting</u> - this is part of Connected Support Cymru and is currently meeting the grant requirements. Adverts have gone out <u>Community Welfare Responders in the Cardiff and Swansea</u>	Complete
Qu 01/24	8 February 2024	MIQPR	ACTION TRANSFER TO PCC: With respect to the conversation around PADRS, it was asked that the People & Culture Committee (PCC) discuss the approach regarding PADRS / compliance and the sickness absences rates (within the MIQPR discussion at PCC).	Angie Lewis	9 May 2024	Update for May meeting - the update will be covered within the Workforce Scorecard item on the agenda	Complete
11/24 (a)	20 February 2024	MIQPR	The Committee when reviewing the MIQPR in February particularly around111asked that a Cultural Review Report regarding hotspots be brought to the May meeting.	Angie Lewis	9 May 2024	Update for May meeting - this is included within the People and Culture Plan Metrics Item.	Complete
11/24 (b)	20 February 2024	MIQPR - Transfer to Quest Committee	ACTION TO TRANSFER TO QUEST Andy Swinburn agreed to take a paper to the Quest Committee around the continued deployment of Charu, aiming to illustrate progress, activity and deployment	Andy Swinburn	1 May 2024	Caroline Jones transferred the action to the CGO for Quest Committee (21.02.24)	Complete
07/24	20 February 2024	Items 8-10	Hannah Rowan, EDI NED champion sought to have more guidance on how she and other NEDs might most appropriately support initiatives throughout the year, over and above monitoring the plan.	Kat Copley	9 May 2024	Update for May meeting - Kat Copley met with new P&C Committee Chair to discuss. Ceri Jackson will explore options for EDI awareness to be included in NED induction. NEDs to use own personal areas of expertise and interest to support EDI initiatives. NED EDI objectives also included in the review of WAST Chair Objectives document to strengthen NED involvement and support for EDI initiatives.	Complete

Director Update: *People & Culture*

PEOPLE AND CULTURE
COMMITTEE

9TH MAY 2024



ANGIE LEWIS
DIRECTOR OF PEOPLE &
CULTURE

Culture

We are excited about the continued progress of the Culture Champions (CCs) Network and the positive impact they will make in shaping our organisational culture. In response to valuable feedback from a recent survey, we are actively refining the purpose and expectations of the network. This includes a focus on increasing visibility and establishing a programme of support and development opportunities designed to empower CCs in their roles. Central to the purpose of CCs is the role modelling of positive behaviours to enable individuals and teams to be 'OUR Best'. CCs also serve as coaches and mentors to their colleagues, contributing significantly to our internal capacity for delivering lasting cultural transformation.

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

Whilst we didn't win the CIPD Award for our Sexual Safety work, I had the pleasure of spending the evening celebrating our achievements and discussing our plans with two of our Voices Advocates, Kayleigh and Chay (pictured).



We had a great opportunity to engage with colleagues on the critical issue of workplace safety at the recent CEO Roadshows. Our focus centered on the significant aspect of psychological safety, highlighting its profound importance in creating a positive work environment. It was so positive to see colleagues engaging in these discussions and sharing their insights, all of which will help shape our plans to improve.



I am delighted to share the fantastic outcomes from our recent Trade Union Partnership development sessions (pictured). We have now completed three sessions, each met with incredibly positive feedback. Specifically, the "walking in each other's shoes" exercise resonated deeply with everyone involved. This exercise has been instrumental in fostering empathy, understanding, and a stronger sense of collaboration between all parties. I am truly encouraged by the strides we are making together, and I look forward to continuing this journey of mutual growth and partnership.

Capacity

We are delighted to share that we recently re-rendered Health Assured as our Employee Assistance Programme and are now offering 8 sessions of counselling to our colleagues who require it. We are collecting feedback on this service to ensure that our people receive a quality experience.

The rollout of the new Occupational Health system, OPAS G2, is progressing nationwide through all-Wales task groups. We can now send and report clinical outcomes for psychological interventions via the system. Our next steps involve integrating suicide risk assessment information and patient experience questionnaires for quality assurance and improvement. Managers have received guidance through drop-in sessions, with more support sessions planned to ensure all colleagues can effectively use the new system.

Capability

Work to support implementation of Clinical Supervision across EMS, Advanced Practice and Ambulance Care has commenced, with a focus on how the Trust delivers a programme that helps achieve our ambition for an ethos of continuous improvement within our clinical workforce. A cross-directorate approach with a rich range of supervision opportunities will enable colleagues to develop their reflective practice in a supportive and affirming way. A bespoke training package will ensure our supervisors and supervisees are positioned to get the most out of the experience and provides a further opportunity for the Education & Development team to provide value adding CPD into the offer for colleagues across the range of clinician roles.

ELT recently spent a facilitated development day (pictured) together and considered feedback from the recent 360 exercise in detail. We focused on areas of strength, different views of the stakeholders who contributed and areas for development. It was a valuable session and the information we received will help us improve our overall approach and performance. We intend to repeat the exercise in 12 months' time and hope to see positive improvements. The feedback will support our commitment to continuous learning and development.



ELT colleagues during a recent team development day

The development of a Leadership Behaviours Framework and an aligned Development Framework (OUR WAST WAY) is a significant initiative currently underway. This project represents a major step forward for us in establishing a comprehensive framework that enables targeted leadership development for leaders and managers at various stages of their careers. By integrating coaching and mentoring opportunities along with succession pathways, we aim to embed an inclusive, compassionate, and collaborative leadership culture.

A presentation outlining the project scope and objectives was recently shared with the Executive Leadership Team, to gather valuable input and insights. Currently, we are in phase 1 of the project and working with an external partner (Leaderful Action) who have specific expertise in this area, to define 'what good leadership looks like' in our organisation. We will be actively engaging key stakeholders in these discussions to ensure alignment with our values and strategic objectives and we are excited about the potential impact of this initiative in shaping the future of leadership at WAST.

In line with our commitment to enhance organisational capability and capacity in relation to Change Management, I'm pleased to share that another accredited programme was delivered earlier this month, with 12 colleagues successfully completing the training. These colleagues will shortly be inducted into our growing Change Champions Community, in order to support us with delivering on our plans and aspirations.

The Trust has officially been granted University Status after a five-year effort involving colleagues across the organisation. This recognition highlights our significant role in educating and developing our people and contributing to research in pre-hospital care. The new status enables us to better fulfill our commitment to the Wellbeing of Future Generations Act and offer more fulfilling career paths; it also enhances our ability to attract top talent, ensuring continued service to the people of Wales. This milestone marks one of the most significant changes since the Trust's inception in 1998.

Challenges & Risks

- Increasing workload
- Significant change across the organisation

Coming Up

- Introduction of full time, dedicated Guardian role
- Implementation of a dedicated Investigation Team



GIG
CYMRU
NHS
WALES

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

OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2023-24 Q3 (Jan – March 2024)

National Operations & Support

Manchester Arena Inquiry (MAI)

Progress on the MAI workstream continues toward completion of the outcome. The Chairman of the Inquiry has set out that each organisation including all ambulance Trusts should review their capacity to respond to a mass casualty incident, make recommendations to their NHS commissioners relating to additional resources and that commissioners must then give urgent and close consideration to these recommendations. Having undertaken a series of workshops and evidence gathering exercises, including data modelling, three reports will be produced which will detail:

- Our Capability to Prepare
- Our Capability to Respond
- Capability of Specialist Assets

These three reports will recommend what additional resources are required to effectively plan and respond to a mass casualty incident in Wales. This will form a financial submission which will then work through the governance route between May and July 2024. This will include Operations Senior Leadership Team, the Executive, Board Development, Finance and Performance Committee and finally Trust Board. All of these will be held in closed sessions. To aid familiarisation for trade unions partners prior to Board Development and Committee meetings, colleagues will be invited to attend the Operations Senior Leader Team consideration of papers.

Welsh Government and EASC have been briefed during the process and are set to receive the final submission on completion of the internal governance route.

Community Welfare Responders (CWR)

There are currently 8 active teams of CWRs across Wales, operating as part of the Connected Support Cymru (CSC) initiative. We held our first CWR onboarding event in February with a number of volunteers invited to attend the recruitment courses in February and March in Cardiff and Swansea respectively.

January saw the first webinar for CSC reaching out to stakeholders for recruiting partner organisations. This was well attended, and a list of over 180 expressions of interest has been collated

with some of these volunteers offered places on the Cardiff and Swansea training courses. The initial phase of CSC will focus on growing numbers of CWR responders. Support Officers are also supporting the awareness courses for the roll out of LUSCII technology in care homes across North Wales.

NHSCT Grant Award

Following the funding from NHSCT in June 2023, the Volunteering team was able to recruit Support Officer posts to support the on-boarding and operational support for CWR responders. These posts were recruited to in January 2024 and will undertake stakeholder engagement as well as being involved in LUSCII projects in Care homes. As part of the NHSCT bid, observation kits for volunteers have been funded to enable this new role to become operational.

Resourcing, EMS Coordination and Quality

Accredited Centre of Excellence (ACE) status with the International Academies of Emergency Dispatch (IAED)

The Trust has fallen below the standard for centre of excellence accreditation set by the IAED for the last reporting period (quarter). This is because the non-compliance of random 999 call audits finalised at 8.7% for the quarter which is above the 7% threshold set by the IAED. Broken down by month between January and March 2024, this equated to 7%, 10% and 9% non-compliance respectively. An analysis of the issues impacting compliance, and an accompanying action plan has been developed between Operations Quality and EMS Coordination, and this is being considered at Senior Operations Team (SOT) on 23 April 2024 before formal escalation to Senior Leadership Team (SLT). Colleagues should further anticipate these outputs also being shared within our quality meeting structures. The Operations Quality department has been working closely with the IAED to identify the issues and develop actions to make improvements. Following approval, the action log will be submitted to the IAED as part of the requirement set by the IAED Remediation & Revocation Policy. The process allows the Trust 3 months to return to compliance and a further 3 months if not achieved within the first 3 months.

HM Coroners

EMS Coordination/Operations Quality received an influx of coroner request during Q4 which has resulted in an increased backlog of statements. Capacity within Operations Quality (OQ) has been realigned where possible to support with the construction of statements and a robust QA process is in place to ensure that accurate statements can be reviewed and signed by the Service Managers/Head of Service for serving to HMC. Whilst 9 of the outstanding 30 coroner statements have breached the requested return date, these are all at some point in the QA process. All other outstanding statements are not yet due, and the OQ team is completing these alongside other investigations (concerns and nationally reportable incidents (NRIs) etc.).

Resource - Relief Planning Pilot

During Q4, relief planning pilot progressed to a 5 week notice period for shift allocation across all areas of operations. The group have met to review the impact and are pleased to report that annual leave compliance in line with resourcing policy has improved in comparison to the same position last year. To further support the pilot and staff it was agreed that the remaining staff would be afforded an extended deadline of last week in April to increase compliance or discuss mitigating circumstances with line manager. The agreement in partnership is to commence allocating leave to the remaining non-compliant staff by resourcing prior to publication of rosters which will align with the next phase of the pilot during Q1 to provide a 6 week notice period for shift allocation.

MIST Booking contractual hours (CPD) monitoring.

During Q4, the MIST booking process has been reviewed in collaboration with Education and Development, EMS and Ambulance Care. The process now incorporates Resourcing approving bookings to ensure compliance with working time regulations and resourcing policy as well as capturing MIST hours contribution to contractual hours monitoring (CPD hours). Further work is ongoing to expand the process to capture the remaining CPD hours afforded to EMS and ACA2 colleagues.

Work Management Portal

Workflow/Request system (Work Management Portal) is in early stages of development utilising O365 as a platform. Once development and testing is complete in Q1/2, this will introduce a centralised web based work request system that will enable staff and management to track progress on resourcing work/information requests (replace emails). It will also provide insight, data, and intelligence on resourcing departmental demand to identify areas for both system and service improvement, automation, and quality. It will promote the Resourcing brand as one team servicing four operational functions and will be a move forward in providing resilience and equity of service across the functions.

Estates

Plans for Estate work in Llangunnor were signed off in March 2024 with a view to complete the estates strategy in Q2 of 24/25. The estates plan in the North was also signed off in March 2024 with a delivery quarter of Q3 following the feedback from capital management colleagues. We do however stay alert to lesser contractor availability in North Wales which we understand could impact the timeline.

Call Handler Recruitment

As part of the recruitment process, a total number of 29 staff members were recruited in January 2024 with a plan to further recruit in Q2 24/25. This additional capacity within EMSC has resulted in capacity being over established in our EMD function rectifying the position previously reported.

Culture

Culture initiatives including regular drop-in sessions for staff are now regularly offered. The engagement with staff offers the opportunity to engage with Service Managers and Head of Service directly with the intention of promoting a positive culture within the CCC and EMS Coordination.

Demand and Capacity

The restructure of the EMSC leadership was agreed in principle at ELT in January 2024. The restructure will bring EMSC in line with other Directorates within Operations. The new leadership model will also support the delivery of the demand and capacity recommendations from ORH. The recommendations include a Single Allocator Model, Boundary changes and Roster review for the DCM's and Dispatcher teams. The OCP is expected to commence in Q1 and it is exciting to see, for the first time in WAST, the potential for a management and support structure with role opportunities at all levels offering a career pathway within EMSC.

Operations Quality OCP

The Operations Quality (OQ) OCP has concluded, and final job evaluations and recruitment have begun. Interviews have been scheduled for the Locality Manager, OQ post which will have some of the coroner responsibility for the department/directorate alongside the Service Manager, OQ. The Support Officer and third Learning & Development Coordinator posts are awaiting approval on Trac, and the Quality Improvement Manager and Quality Audit Manager posts are awaiting job evaluation. It is anticipated that once these posts are in place, the department will have the capacity to push forward with the required SOP reviews.

Emergency Medical Service

Challenges

Lost Hours to Handover

Delayed transfer of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service with timely response to calls. The total amount of lost hours in January 2024 were 26,985, February 2024 at 23,896 and March 2024 at 23,403. The impacts of these delays and associated system pressures are regularly discussed at Committee and Trust Board.

Red and Amber Performance

As we notice a continued very poor position in transfer of care delays, this is ultimately being translated into a deteriorating Red performance and delayed response to our most critical patients. On the whole, the Red performance continues to fall well short of 65% in all Health Board areas. This is under constant scrutiny within the EMS Response and EMS Coordination teams to improve the level of response in this area.

The Amber median trend has remained relatively constant; however, recent deterioration has been evident. A reduction in handover delays would support our response to these patients and prevent escalating through the Clinical safety Plan (CSP) with further response implications to this category of patients, especially amber 2 patients.

General Update

Quality & Support Days

These days have proven invaluable in supporting operational staff in the promotion of key indicators and expectations relating to many elements of quality behaviour within Trust premises, on ambulance vehicles, and relating to the member of staff personally.

The subject areas covered include seat belt and safety harness use, Dress Code Policy, IP&C, and cultural awareness. These days are supported by all grades of operational manager/leader and further promote visibility to staff.

An MS Form is completed for each interaction with an operational crew or station visit during the support day which serves to provide assurance of compliance against the requirements.

Three Q&S days have been held so far, with all aspects of the Operations leadership teams involved. Themes and trends are to be collated and fed back through the senior leadership team.

End of Shift OVERRUNS

While it is noted that the level of investigation of over 2 hour end of shift overruns have improved, along with the uptake of utilising the options available to reduce the end of shift overrun, work progresses on a number of initiatives to further reduce end of shift overruns to support the wellbeing of staff. Despite rising handover delays in recent months, the average length of overrun has remained a levels lower than 12-15 months ago.

Financial Savings Plan 2024/25 Overtime Allocation

The 2023/24 FSP concluded successfully with original savings assumptions mainly achieved and overtime allocation following suit. The new savings requirements have been announced for the 2024/25 period with similar savings assumptions modelling almost complete. To support the routine day-to-day overtime allocation an 'Overtime Allocation SOP' has been approved and currently in use to support this now business-as-usual process.

Ambulance Care

IMTP

UCS Transformation Plan

An action plan was implemented in March 2024 to oversee delivery, numbers, and the development of rosters for consultation and work was completed to develop a new code set for Urgent Care Service. Communications were completed and issued alongside engagement sessions. The recommendations will be presented to ELT in April 2024.

General Update

Recruitment

The Ambulance Care OCP which commenced in 2023 has recently seen all the positions recruited into. This will allow Ambulance Care to now progress with the service improvements the new structure was designed to achieve.

CMP (Capacity Management Plan)

An updated Capacity Management Plan has recently been approved by the Executive (following engagement with commissioners) enabling greater capability to manage the thousands of patient journey requests. Go live is scheduled for May 2024.

Integrated Care - CSD

Challenges

Integration of Systems

The integration of the telephony system within CSD involved various complexities, including ensuring smooth integration with existing systems, providing adequate training to staff, adjusting operational procedures, and ensuring accuracy in reporting. These challenges likely arose due to the intricacies involved in transitioning to a new system while maintaining uninterrupted service and data accuracy. Despite the overall challenges faced by the service, additional BI reporting has given additional metrics to support intelligence and reporting.

Capacity and Leadership support

Sufficient leadership support for operational activities has posed some challenges due to a high volume of staff on sickness absence and/or those on supported return to the workplace. To bridge this gap and to offer members of the wider team an opportunity for professional growth we have implemented an Operation Manager development programme which has been well received.

Inbound Contact Centre Concept

Traditionally focused on outbound calling, the solidification of an inbound contact centre concept in CSD has grown significantly in this quarter. CSDs Remote Clinical Support for Newly Qualified Paramedic crews, Community Responders, as well as the pilot to support Police colleagues potentially facing long waits on scene has taken considerable reorganisation of "on duty" activity. Focus on managing call answering in a timely manner has led to the creation of a specialist desk to deal with this inbound work. However, this has taken core staff away from the traditional role of Consult and Close and with other roles such as Screening and Enhanced Screening in escalation alongside the commitment to 24/7 Red Review provision has meant that our ability to significantly improve on our Consult and Close percentage has been challenged.

IMTP

Consult and Close

The Consult and Close rate rose in the quarter but did not exceed 14.3%. Work continues with staff and teams to focus on activity levels to improve triage rates. Work continues on the use of ECNS to reduce triage durations. The service is also committed to offering the provision of a 24/7 Red Review and Remote Clinical Screening during high levels of escalation.

ECNS

The process to improve clinical outcomes in ECNS is in place with auditors and practice educators to identify and support those whose outcomes/conversions are comparatively lower. Guidance was released in Q4 to improve the efficiency of the ECNS triage process to optimise time taken per triage.

General Update

PTAS

A video was completed in collaboration with ABUHB and CVUHB health boards to increase the use of PTAS to consult and close. As part of the strategy to move away from a local SOP to a guidance document used by Health Boards, The SOP has been removed with a view to be updated and circulated as a Guidance document to disseminate.

Integrated Care – NHS 111 Wales

Challenges

Demand Levels & Operational Productivity

NHS 111 Wales call demand in Q4 was 10% up on Q3. Recent weeks have continued to see higher demand than we saw for much of December. This level of demand is 14.6% above the level the service is resourced to answer.

Through Q4 we have seen 9-10% of our staff abstracted consistently for CAS replacement training. Despite those abstractions we answered 9% more calls in Q4 than we did in Q3. The increase in calls answered despite higher abstractions can be attributed to the use of agency call handling resources and the introduction of virtual queuing. The level of calls answered in Q4 was 5.6% above funded levels.

Workforce capacity

Recruitment was curtailed during the SALUS implementation period and again during the CAS replacement project. Consequently 111 is under established and this is impacting operational production. Plans are in place to return to full establishment through Q1 and Q2.

IMTP

Dental Services Transformation

The funded operating model for four health boards has been built and is confirmed following work with Health Boards, Six Goals Programme and the Chief Dental Officer for Wales. This model will be going live on the 30th April 2024 along with the replacement CAS. Unfunded activity for the remaining health boards has now been ended following a phased and agreed roll back of those services.. The development of "Once for Wales" options in the unfunded areas continues with Health Boards and the Six Goals Team. This work is included as part of the Operations Transformation work outlined in the 24-27 IMTP.

Increased Available Pathways

A pathway to enable WAST 111 staff to pass calls to 111 Press 2 teams was will go live as part of the rollout of the new CAS system at the end of April 2024.

A trial of direct booking from 111 to Urgent Primary Care Centres in two Health Boards commenced in this quarter. Referral volumes have been lower than expected however this has been predominantly attributed to a very narrow inclusion criteria. In the next quarter we will work with HBs and other stakeholders to broaden the criteria.

General Update

CAS Replacement Project

Significant focus and effort has been focussed on the replacement CAS solution. The solution remains on track for go live on the 30th of April 2024.

Considerable activity has taken place across Operations, Digital and QSPE Directorates to ready the technical infrastructure, train our people and re-design every process within 111.

AGENDA ITEM No	8
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

NHS WALES STAFF SURVEY

MEETING	People and Culture Committee
DATE	9 May 2024
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

1. The purpose of this report is to:

- Provide an understanding of how the Trust is using Staff Survey data to improve employee experience and organisational culture;
- Demonstrate how staff survey results indicate stress and burnout as a key organisational issue;
- Demonstrate the links between addressing stress and burnout and our overarching People and Culture ambitions;
- Provide an overview of how we intend to develop collaborative action plans to address stress and burnout, in response to these survey findings.

KEY ISSUES/IMPLICATIONS

- Indicators of stress and burnout evident within Staff Survey results;
- Links between colleague health and wellbeing, organisational culture and organisational performance;
- Focus on stress and burnout due to it impacting colleagues across the entire organisation, regardless of role / profession / geographical location;
- Continuing to work with Directorate Leads and Trade Union Partners to involve colleagues in developing meaningful, impactful actions in response to organisational and local level survey findings.

RECOMMENDED

That the Committee:

- **NOTE** the contents of the report; *and*
- **COMMENT ON** insights shared.

REPORT APPROVAL ROUTE
<ul style="list-style-type: none"> • PCC 09.05.24

REPORT APPENDICES
Appendix 1: SBAR – NHS Wales Staff Survey

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

Appendix 1: SBAR: NHS Wales Staff Survey

SITUATION

2. The purpose of this report is to:

- Provide an understanding of how we are using Staff Survey data to improve employee experience and organisational culture;
- Demonstrate how staff survey results indicate stress and burnout as a key organisational issue;
- Demonstrate the links between addressing stress and burnout and our overarching People and Culture ambitions;
Provide an overview of how we intend to develop collaborative action plans to address stress and burnout, in response to these survey findings.

BACKGROUND

3. The findings from the recent NHS Wales Staff Survey indicate high levels of stress and burnout within WAST, echoing a broader trend across the NHS and reflecting intelligence gathered from recent engagement exercises including CEO Roadshows, Moving on Interviews and anecdotal feedback.

ASSESSMENT

Why are we focussing on stress and burnout?

4. Stress and burnout are shown to have a profound impact on both individual wellbeing and organisational effectiveness. Identifying and addressing stress and burnout is a crucial step in our work to improve colleague experience, allowing us to create an environment where colleagues can thrive, thereby enhancing morale, performance and retention rates; this in turn increases the likelihood of successfully delivering on our ambitious organisational strategies and ultimately, enables better patient care and experience.
5. By improving working conditions and overall employee experience, we create a mutually reinforcing cycle wherein increased engagement leads to even better experiences, i.e., as we invest in colleague wellbeing, our people become more deeply involved, thereby elevating overall experience and, in turn, reinforcing their engagement.

What do the Staff Survey results tell us about stress and burnout?

6. In addition to other feedback sources (e.g. CEO Roadshow Menti results and Moving On Interview responses), the Staff Survey data reveals alarming signs of stress and burnout, such as:
 - a. 73% came to work in the last 3 months, despite not feeling well enough to perform their duties;
 - b. 61% reported that their work frustrates them;
 - c. 56% always / often feel worn out at the end of the working day;
 - d. 53% always / often feel burnt out because of work;
 - e. 52% always / often find work emotionally exhausting;
 - f. 52% reported feeling unwell in the last 12 months as a result of work-related stress;
 - g. 46% always / often feel exhausted at the thought of another day at work;
 - h. 43% reported unrealistic time pressures.
7. Whilst these findings represent the experiences of a small portion of our workforce (23%), the significant *non-response rate* provides further intelligence and as such, it is important to understand its underlying reasons; failure to do so limits our potential to truly improve colleague engagement and enhance employee experience.
8. Whilst lack of awareness about the survey, its importance or how responses could influence organisational change, and logistical barriers such as time constraints or technical difficulties may have played a role for some colleagues, we must recognise that a portion of this group will have *chosen not to participate*, due to disengagement; this, in itself, is an indicator of stress and burnout.
9. Similarly, cultural factors of which we are already aware (such as fear of reprisal and a perception that concerns are dismissed rather than addressed) likely affected participation rates. This lack of trust signals low levels of psychological safety and an organisational culture where stress and anxiety thrive. Such an environment erodes trust, stifles open communication and inhibits the ability to address issues effectively, leading to colleagues not speaking up, experiencing a sense of isolation and subsequently disengaging.

10. Recognising stress and burnout as developmental in nature also highlights the significance of seemingly positive responses in the staff survey, such as the willingness of our people to go the extra mile. Whilst dedication and commitment are commendable traits, continuous over-giving without adequate self-care can contribute to stress and burnout. It is therefore important to interpret such responses through a nuanced lens, understanding that whilst they may signify high levels of engagement, they potentially mask a risk for stress and burnout if left unchecked. Acknowledging this interplay between dedication, stress and burnout enables us to focus on creating a culture that values balance, self-care, and sustainable work practices, thereby safeguarding against the detrimental effects of unchecked overexertion and simultaneously responding to continued feedback from colleagues regarding excessive workload and significant pressure.

What do we need to do?

11. Extensive evidence demonstrates that burnout is a response to workplace stress and as such, interventions are required at both organisational and individual levels. Literature recommends implementation of strategies at primary (organisational), secondary (individual) and tertiary (rehabilitation) levels. Whilst secondary and tertiary level interventions will be a key focus within our Health and Wellbeing Plan, it is vital that we develop plans aimed at preventing stress and burnout (primary interventions) in collaboration with the people experiencing this, in order to effectively identify risks and respond with appropriate interventions.

12. Recognising that this is a key, recurring theme, we propose to work with Directorate Leads and Trade Union Partners to develop meaningful action plans aimed at addressing stress and burnout at organisational and local levels. We intend to utilise the staff survey results as a platform from which we can increase awareness and understanding of stress and burnout and by leveraging the survey findings, we can:

- a. Demonstrate to colleagues that we are listening;
- b. Work with colleagues, Directorate Leads and Trade Union Partners to develop meaningful local actions that respond to local needs and issues;
- c. Demonstrate our commitment to improving colleague experience and organisational culture; *and*
- d. Reassure colleagues of our commitment to acting on colleague contributions.

13. Working with colleagues across the organisation to develop impactful actions serves as a strong starting point, aligning with our ongoing work in relation to:

- a. Enhancing our approach to colleague involvement and engagement, linked to:
 - i. development of our Internal Communications Strategy;
 - ii. implementing our pulse survey plan;
 - iii. continuing to build our staff networks and communities;
 - iv. embedding change management practices throughout the organisation.

- b. Developing resources to support managers to effectively support their teams and have compassionate, effective conversations.

14. This work is inextricably linked to our ongoing cultural transformation work, including leadership and management development, equality, diversity and inclusion and workplace safety, all of which come together to enable realisation of our target organisational culture.

15. Stress and burnout forms just one area of focus for us, applicable across the entire organisation; we will continue to work with Directorate Leads and Trade Union Partners to develop meaningful, impactful actions in response to local findings.

16. With the next NHS Wales Staff Survey due to be undertaken in September 2024, it is vital that we work quickly to make use of this valuable data and information, to demonstrate to our people that we are actively listening and responding with purpose, in a bid to increase engagement levels for the next survey (thereby providing further, rich intelligence on which we can base our decisions and plans). Focussing on the universally applicable issue of stress and burnout enables us to undertake actions that will positively impact all colleagues.

RECOMMENDED

17. That the Committee:

- a. **NOTE** the contents of the report; *and*
- b. **COMMENT ON** insights shared.

AGENDA ITEM No	9
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	4

PEOPLE AND CULTURE PLAN METRICS UPDATE

MEETING	People and Culture Committee
DATE	9 May 2024
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

1. The purpose of this report is to:
 - provide Committee members with an update against several of the previously agreed quantitative People and Culture Plan metrics, in order to provide a high level indication of the impact of our People and Culture Plan;
 - provide members with an update in relation to ongoing Culture Reviews across the Trust; *and*
 - provide assurance regarding our approach to disciplinary case management in the form of a “Deep Dive” report

KEY ISSUES/IMPLICATIONS

2. PCC is asked to:
 - **RECEIVE** and **COMMENT ON** progress to date.

REPORT APPROVAL ROUTE

- **ELT 27.03.24**

REPORT APPENDICES

- Appendix 1:** SBAR – People and Culture Plan Metrics Update
- Appendix 2:** People and Culture Plan Metrics Update
- Appendix 3:** ES – Cultural Review Update
- Appendix 4:** Disciplinary Deep Dive

REPORT CHECKLIST

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

Appendix 1: SBAR: People and Culture Plan Metrics Update

SITUATION

3. The purpose of this report is to:
 - provide Committee members with an update against several of the previously agreed quantitative People and Culture Plan metrics, in order to provide a high level indication of the impact of our People and Culture Plan;
 - provide members with an update in relation to ongoing Culture Reviews across the Trust; *and*
 - provide assurance regarding our approach to disciplinary case management in the form of a "Deep Dive" report.

BACKGROUND

4. Following discussion at the August meeting of the People and Culture Committee, it was agreed that updates will be shared with Executive Leadership Team every 2 months, to demonstrate progress in terms of implementation and impact of our People and Culture Plan. As agreed, these updates will alternate between a focus on quantitative and qualitative metrics; this item focusses on quantitative metrics.

ASSESSMENT

5. The summary document contained within **Appendix 2** provides an overview of quantitative data currently available.
6. Of particular interest is the continued reduction in turnover rates month on month; this translates into a higher retention rate of talent and suggests improvements in terms of employee satisfaction and organisational culture.
7. Given that this is an organisational turnover rate, data has been scrutinised by staff group, to ascertain whether this downward trend is reflected across all areas.

A deeper look demonstrates that this downward trend is not uniform across the organisation; specifically, upward trends are evident within both Allied Health Professional (AHP) and Nursing and Midwifery staff groups. Notably, turnover rates for nursing and midwifery roles surpass those of AHPs significantly; this highlights challenges specific to nursing retention which are already being explored and addressed within our People and Culture Plan, and as part of the wider NHS Wales Retention programme.

8. Going forward, it is crucial that we focus on identifying and addressing the factors that contribute to turnover across different staff groups, utilising the rich data and information that we are collecting regularly to inform our ongoing People and Culture Plan.
9. Notes to accompany dataset within **Appendix 2**:
 - * Baseline figure references the 2020 Staff Survey completion rate for WAST
 - ** Completion rate as at 25.10.23 (following launch on 16.10.23)
 - *** Final completion rate (survey closed 27.11.23)
 - **** Grey (neutral) coloured arrows used as a reminder to treat increases / decreases against these metrics with caution; an increase could be associated with increased confidence for our people to report concerns and not necessarily an indicator of poor cultural health.
10. The paper contained within **Appendix 3** provides members with a progress update in relation to ongoing cultural reviews across the Trust.
11. The paper within **Appendix 4** provides the Committee with an overview of work undertaken in relation to Disciplinary case management, to provide assurance regarding our continued focus.

RECOMMENDED

12. That PCC:

- **RECEIVE** and **COMMENT ON** progress to date.



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OUR PEOPLE AND CULTURE METRICS

March 2024

	<i>Baseline</i>	Sept 23	Mar 24	
Culture				
Staff Survey Completion Rate:	39%	9.12% **	23.2% ***	↑
Network Membership:	N/A	184	202	
Disciplinary Cases:	28	28	32****	↑
Formal Requests for Resolution:	15	8	13	↑

Capacity

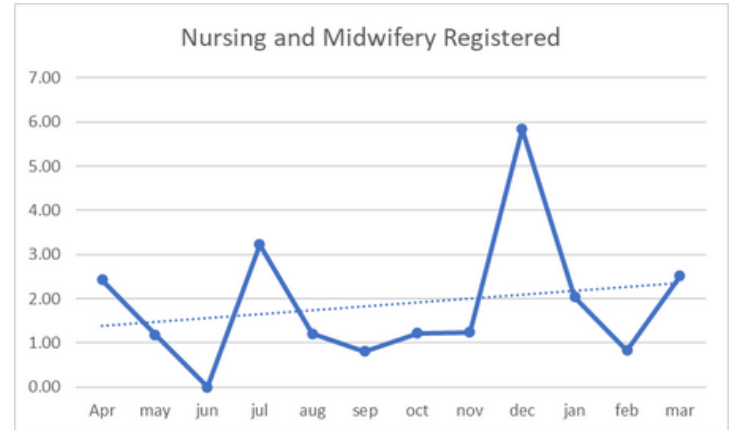
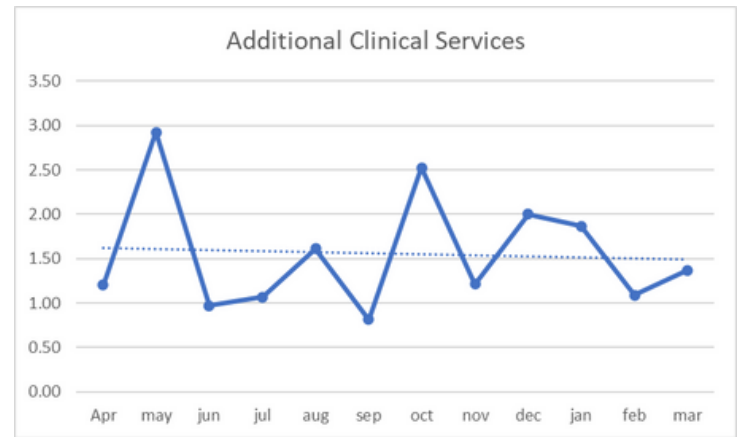
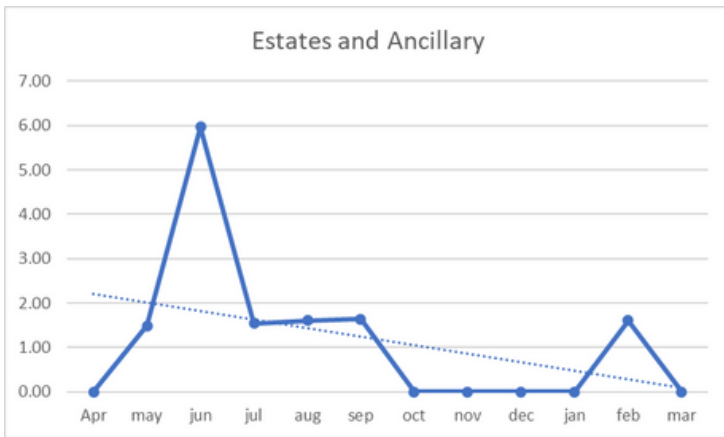
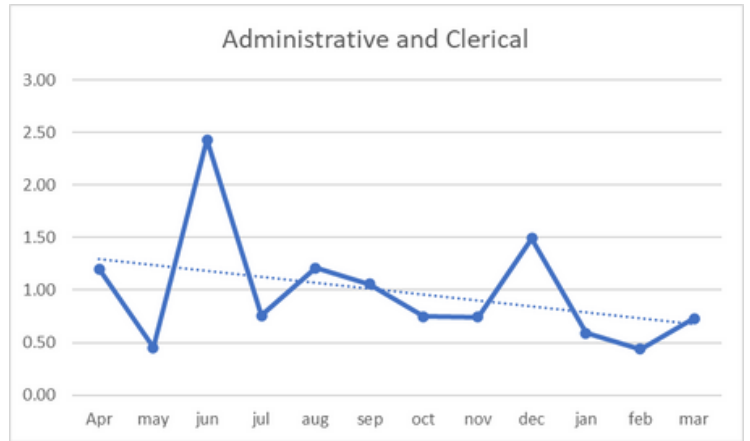
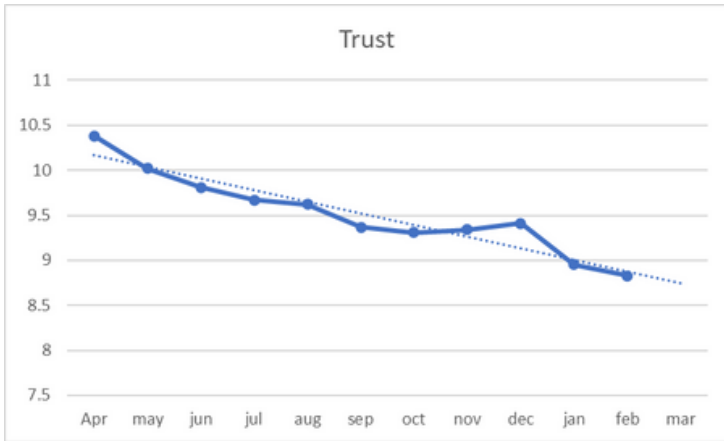
Turnover:	9.81%	9.37%	9.12%	↓
Sickness (12 Month Rolling):	8.78%	8.69%	8.52%	↓
Sickness (In Month):	7.5%	8.78%	7.67%	↓

Capability

MIST Compliance:	N/A	15.5%	92%	↑
Stat Mand Compliance:	78.73%	79.71%	81.2%	↑
PADR Completions:	73.5%	70.72%	79.51%	↑

Capacity

A deeper look at Retention: %s by month, 2023-2024





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AGENDA ITEM No	9b
OPEN	OPEN
No of ANNEXES ATTACHED	0

CULTURAL REVIEWS

MEETING	People and Culture Committee
DATE	9 May 2024
EXECUTIVE	Angela Lewis - Director of People and Culture
AUTHOR	Sara Mills
CONTACT	sara.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. At the heart of Team Cultural Reviews is our commitment to creating a work environment where each team member can flourish, contribute their best, and feel a genuine sense of belonging. We know the significance of a healthy team culture in driving our collective success and the positive impact it has on WAST's service delivery transformation.
2. The purpose of this paper is to provide an update on progress of Team Cultural Reviews currently underway.
3. Recommendation to note the progress made.

KEY ISSUES/IMPLICATIONS

- CSD Team Cultural Review**
4. We are working with an external partner, Honne who specialise in organisational culture work. This is to ensure that the process is objective. Their wealth of experience will also help us to identify areas of improvement and implement positive changes effectively. Honne have previously worked with WAST on development of 'Our Best' behaviours and have worked with other frontline healthcare and 'blue light' organisations.
 5. To date the review has involved 121 meetings with senior leaders and CSD management, the launch of a Team Culture Survey to all CSD colleagues, administered by Honne ensuring confidentiality and achieving a response rate of over 70%, indicating a high level of engagement and interest. Upcoming activity includes listening groups with CSD colleagues at various locations to

further capture their perspectives and experiences. Subsequently, a comprehensive report outlining team feedback and recommendations will be shared initially with the CSD leadership team and then cascaded down to managers and team members.

EMSC Team Cultural Review

6. In EMSC the review is being undertaken internally by the People & Culture Team working in partnership with TU Partners and EMSC management. A survey has been sent to all EMSC colleagues to gather feedback on insights into colleague experiences and perceptions of work issues as raised by TU Partners. While the response rate is at 15%, we acknowledge the importance of every response received; we also acknowledge that this response rate is much lower than the CSD survey facilitated by Honne, which indicates there is something for us to learn regarding trust and the use of an external party / survey platform.

7. Next steps involve the Director of People and Culture visiting all EMSC sites to engage with EMSC colleagues in culture focused discussion groups with the aim to further understand the feedback received. Following this exercise actions will be identified in partnership with TU partners, EMSC management and team members and then monitored through the EMSC Culture Group.

8. The purpose of Team Cultural Reviews is to empower staff to have their voices heard, learn from each other's experiences, articulate their own experiences and ideas, collaborate in shaping the future, and actively contribute to the desired change. Working in partnership, we are committed to addressing the challenges highlighted by both colleagues and TU Partners, ensuring that concerns raised during these reviews are listened to and responded to effectively, drawing on external expertise where appropriate.

REPORT APPROVAL ROUTE

- **PCC 09.05.2024**

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)	YES	Financial Implications	YES
Environmental/Sustainability	N/A	Legal Implications	YES

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



AGENDA ITEM No	9c
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

Disciplinary Deep Dive

MEETING	People and Culture Committee
DATE	9 May 2024
EXECUTIVE	Angela Lewis, Director of People and Culture
AUTHOR	Hilary Caffrey-Matthews, People Services Leader
CONTACT	Hilary.caffrey@wales.nhs.uk

EXECUTIVE SUMMARY

The Trust’s People and Culture Plan 2023-2026 contains the following high-level action; Improve the effectiveness and application of our internal **people processes (getting the basics right)**.

This report aims to provide assurance to the People and Culture Committee regarding:

1. Our ongoing collaboration both internally and externally to improve the effectiveness and safety of our internal disciplinary process, learning from Just Culture principles, and further embedding Compassionate Practices for All;
2. The level of scrutiny we are affording this work;
3. How we have developed our approach to ensure that colleagues are treated fairly and compassionately, and their best interests are protected during difficult processes such as disciplinary investigations.

RECOMMENDED: This report is provided for assurance. The Committee is asked to **NOTE** and **COMMENT** on the information presented.

KEY ISSUES/IMPLICATIONS

The report highlights the following key points:

1. Metrics associated with the disciplinary process;
2. Work undertaken to ensure the management of disciplinary issues is undertaken in a way that is fair, consistent and without discrimination;
3. Evidence of support, guidance, training, and resources in place to enable the adoption of compassionate practices within the disciplinary process.

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REPORT APPROVAL ROUTE
People and Culture Committee - 9 th May 2024

REPORT APPENDICES
Appendix 1 - SBAR

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

Appendix 1: SBAR

SITUATION

1. As of April 2024, the Trust has **43** open disciplinary cases (including those at initial assessment stage), which is a significant increase on the **15** open cases reported at the launch of Compassionate Practices for All in November 2022. The purpose of this report is to provide further insight into this increase and demonstrate how we have developed our approach within the organisation to ensure that colleagues are treated fairly and compassionately, and their best interests are protected during difficult processes such as disciplinary investigations.

BACKGROUND

2. The Trust adopted the All-Wales Disciplinary Policy in 2017 which provides the mechanism for disciplinary issues and states that all employees will be treated fairly, and with dignity and respect.
3. Compassionate Practices for All was launched in November 2022, an interactive training event to illustrate how employee investigations can have a major impact on the person at the centre of the process, as well as those

involved more widely (e.g. managers, investigation officers, witnesses, and colleagues).

4. The key recommendations of the Compassionate Practices approach centre around a) reducing timescales associated with undertaking investigations and b) enabling application of the Fast Track process where appropriate, for issues of minor misconduct.
5. As a result, the Trust's Compassionate Practices for All Implementation Plan was formed in partnership. This has been designed to both inform and change future employee disciplinary investigation practices so that harm to both employee and the organisation is minimised.

ASSESSMENT

6. Disciplinary data demonstrates that since the interactive Compassionate Practices training event in November 2022 and the subsequent launch of the Compassionate Practices for All Implementation plan in 2023, disciplinary case numbers have risen considerably, albeit the average duration of a disciplinary case has more than halved to a total of **99** days.
 - i) In April 2024, there were **43** open disciplinary cases, which is a significant increase to the **15** open disciplinary cases which was reported at the launch of Compassionate Practices for All in November 2022.
 - ii) A total of **74** new disciplinary cases opened during 2022/2023 compared with **108** new disciplinary cases in 2023/2024, an increase of **46%**.
 - iii) The number of new disciplinary cases fluctuated slightly each month during 2023/2024.
 - iv) In November 2022, the average length of a disciplinary case was reported as **201** days, compared to an average length in 2023/2024 of **99** days.
 - v) Of the **136** disciplinary cases opened during 2023/2024, **60** cases related to inappropriate behaviour, with **36.6%** of cases categorised as of a sexual nature (police and safeguarding involvement).
 - vi) Total number of Fast Track cases during 2023/2024 is confirmed as **18**, this is an increase from **15** in 2022/2023.

vii) The total number of dismissals in 2023/2024 for gross misconduct is confirmed as **9**, which is an increase from **7** in 2022/2023. Reason for dismissal is categorised below:

- **1 x Fraud**
- **4 x Inappropriate Behaviour**
- **3 x Misconduct**
- **1 x Other Allegation**

viii) A rise in Employment Tribunal cases was seen, from **2** claims submitted in 2022/2023, to **7** submitted in 2023/2024. It should be noted, however, that this increase in number is still viewed as relatively low given the size of the organisation.

7. The increase in disciplinary incidents (particularly those of a sexual nature) subsequent to the implementation of Compassionate Practices warrants scrutiny. It is important to note that application of Compassionate Practices does not equate to an absence of action in response to alleged misconduct. The underlying principle of compassionate practices revolves around refining people processes to create a workplace culture where the welfare of colleagues is at the heart of everything we do.
8. The increase in the number of cases of a sexual nature correlates with our increased organisational focus on increasing sexual safety, and is reflected within other UK Ambulance Services. Several cases of domestic and sexual abuse/violence have been reported to the Police/Trust's Safeguarding Team which appears to be an increasing trend.
10. Work undertaken by the Association of Ambulance Chief Executives (AACE), NHS Wales and the Trust aimed at reducing misogyny and improving sexual safety in the ambulance service have all contributed to promoting a culture that cultivates openness, psychological safety and does not accept inappropriate behaviour.
11. Likewise, the launch of the NHS Wales Speaking Up Safely Framework and the Trust's internal Freedom to Speak Up Safely process has provided colleagues with a safe platform to raise concerns, anonymously, if they so wish.
12. The number of fast-track disciplinarys completed during 2023/2024, demonstrates that in several cases the fast-track disciplinary process is appropriate because the employee has admitted misconduct or prima facie evidence exists. Fast tracking can only occur in incidents where it appears that the nature of the misconduct would only warrant a verbal or first written warning as a maximum. The number of fast track disciplinarys is encouraging and demonstrates that line managers are undertaking due diligence at the initial assessment stage of the disciplinary process, to ensure where possible

that disciplinary cases are dealt with in a timely manner, with an appropriate disciplinary outcome given.

13. Whilst disciplinary cases have risen, the average length of a disciplinary case has significantly decreased, demonstrating that in accordance with the Compassionate Practices implementation plan, our aim is to improve processes for all those involved. This has been achieved through delivery of Compassionate Practices training to managers directly involved in undertaking employee investigations and tracking learners at both 3 and 6 month intervals, to review the effectiveness of the training received.
14. Certain disciplinary cases of a more complex nature, particularly those involving police engagement, often take longer to review and resolve. These cases are subject to specific focus during regular meetings with the Chief Executive, executive colleagues and representatives from the People Services team. Meetings are also held regularly with the Trust's legal advisors, Legal and Risk (NWSSP); these have been instrumental in progressing these cases compassionately and appropriately in accordance with employment law legislation.
15. A review of the Trust's disciplinary toolkit, including initial assessment paperwork (which is currently in its trial infancy), is underway, to ensure that it reflects a more compassionate approach in terms of language and style. The aim is that all initial assessments will be undertaken in a fair, thorough, and unbiased manner, leading to appropriate outcomes for all and reduced employee harm. Strengthened documents to support the individual undertaking the welfare officer role have also been drafted and will be piloted shortly. Likewise, an investigation guide (for the employee) has been developed by colleagues in Aneurin Bevan University Health Board and will also shortly be trialled within the Trust.
16. Work continues on the review of the All-Wales Disciplinary Policy. Guiding principles to inform the development of the policy have been drafted, with the purpose of the review to develop a policy that enables NHS Wales to:
 - Maintain standards;
 - Create the conditions for a process that minimises avoidable harm to individuals going through an investigation, and others involved in the process; and
 - Minimise economic, organisational and workforce costs for organisations by making clear the policy requirements and providing the resources to ensure the consistent and efficient implementation of the policy.

It is anticipated that review of the policy will be concluded and ratified towards the latter end of 2024.

17. The anticipated trajectory for disciplinary cases is a continued rise in cases over the next 6 to 12 months, given the sexual safety and speaking up safely work we have focussed on as organisation, continuing the trend seen since November 2022.
18. To ensure that we have the most appropriate support in place and to manage the number of employee relation cases, specifically disciplinary investigations, 3 x Band 7 Investigating Officer posts will shortly be introduced into the organisation, on a 2-year fixed term basis. The role of the Investigating Officer will be to investigate highly complex and highly sensitive investigations of varying nature, in conjunction with the Trust's Policies and Procedures. These posts are seen as a welcome addition to the People Services team and it is envisaged that these will further reduce the average length of disciplinary investigations/cases.
19. In addition to these new posts, senior colleagues within the people services team will continue to coach and mentor team members and support team development, whilst creating a safe space for debriefs and lessons learnt. Likewise, for more complex cases, a formal debriefing session is convened by the Disciplining Officer, subsequent to the completion of the internal disciplinary process, in order to review the case and discuss lessons learnt. Present at the discussion should be the investigating officer, other panel members as appropriate and staff side representatives.
21. People Services colleagues have been afforded the opportunity to undertake the AACE Ambulance Profession Development 6-part online training programme, which focuses on sexual safety, and aims to further strengthen capability and understanding surrounding the subject of sexual safety in the workplace.

RECOMMENDED: The Committee is asked to **NOTE** and **COMMENT** on the content of this report.



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AGENDA ITEM No	10
OPEN	OPEN
No of ANNEXES ATTACHED	3

PEOPLE AND CULTURE PERFORMANCE SCORECARD REPORT

MEETING	People and Culture Committee
DATE	9 May 2024
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

1. The purpose of this report is to provide an overview of the key People and Culture performance data and trends (March 2024) and associated improvement actions.

KEY ISSUES/IMPLICATIONS

2. The Committee’s attention is drawn to the following areas:

- Increase in PADR completion rates;
- Continued sickness absence improvements;
- Detailed overview of Statutory and Mandatory training compliance rates, in response to a request by the Committee.

3. The Committee is asked to **RECEIVE** and **COMMENT ON** reported performance and associated actions.

REPORT APPROVAL ROUTE

- **People and Culture Committee 09.05.24**

REPORT APPENDICES

Appendix 1a: SBAR – People and Culture Performance Report for March 2024
Appendix 1b: People and Culture KPI Summary
Appendix 1c: MIST Evaluation

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed	Confirm that the issues below have been considered and addressed
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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 2024

SITUATION

4. This report provides an overview of the March 2024 key trends and improvement actions as identified in the People and Culture KPI Summary enclosed at **Appendix 1b**.

BACKGROUND

5. This paper is intended to be read in conjunction with the **Monthly Integrated Quality and Performance Report** (item **11.2**). The MIQPR provides a high level overview of performance in relation to several People and Culture indicators. This report provides a greater level of detail (both data and narrative) in relation to a wider range of workforce performance indicators.

ASSESSMENT

6. The Committee is asked to note the following headlines:
7. **Time to Hire:** The Recruitment team continues to monitor metrics including 'Vacancy creation to conditional offer', 'Time to shortlist' and 'Vacancy creation to ready for start date', which greatly impacts on our time to hire. The pan Wales target for 'Vacancy creation to conditional offer' is 44 days and we returned an average of 44.2 days within the last 3 months. The pan Wales target for 'Vacancy creation to ready for start date' is 71 days but the Trust returned an average of 68.8 days. This is due to the recruitment team working with appointing managers to close older records. The target for 'Time to shortlist' is 3 days but we are currently on 7.7 days average which is higher than we would like it to be, we have raised a query around our time to shortlist as the data looks to be incorrect, and Shared Services are subsequently looking into this for us.

As of last report, WAST has continued to improve consistently. Shared Services haven implemented the dedicated team for mass recruitment and in March our overall time to hire was 65.9 days against a target of 71 days. The 2024 Big Bang has taken place and interview scores and offers are being worked through, we

should hopefully see less of an impact on our KPI numbers due to the new mass recruitment team that has been created.

Going forward, the recruitment team will continue to work with managers to close older applicant records and will be engaging with managers at an earlier stages to continue to improve our KPIs.

8. **Job Evaluation:** January to March 2024 saw a reduction in the numbers of job descriptions being submitted to the Job Evaluation team, with 7 on file for review/evaluation in March compared to 17 in December 2023. A total of 18 job descriptions were completed between January and March 2024, taking on average 17 days to complete.
9. **Sickness Absence:** The latest ESR data for March 2024 showed a decrease in sickness absence going from 8.50% in February to 7.67% in March (IMTP target at 7%). Long term absence decreased from 6.34% in February to 5.31% in March and short-term absence increased from 2.16% in February to 2.35% in March. The indicative Trust absence for April 2024 (as of 23.04.24) shows a decrease in overall sickness absence in April to 7.37% (IMTP target at 6%) with long term absence decreasing to 4.75% and short-term absence increasing to 2.62%. Anxiety/ stress/ depression remains the most common reason for long term absence in March, with MSK and Injury/ fracture as the next highest reasons. The top reason for short term absence in March 2024 was anxiety/ stress/ depression with Injury/ fracture as the next highest reason.

10. Statutory and Mandatory Training Compliance:

Trust compliance across the reported 10 Core Skills Training Framework (CSTF), Local and Welsh Government (WG) achieved 81.2%. This is below the target of 85% and therefore warrants further investigation. The table below breaks down the various elements that combine to produce the overall figure.

Framework	Level	Staff groups	Current Compliance
CSTF	Level 1	All staff	85%
CSTF	Higher Levels	Specified roles incl EMS/AC	86%
Local and Mandatory WG	n/a	All staff	71.62%
Mandatory In-Service Training (MIST)	n/a	All ACA, EMT and Paramedic roles	92%

Taking each element separately: CSTF competencies require completion using either eLearning, accessed via ESR, or as part of the annual MIST programme. The higher level CSTF competencies are applicable only to specific roles and are

incorporated into MIST. Following conclusion of the 2023/24 MIST programme, attendee feedback is contained with **Appendix 1c**, providing Committee members with an indication of the programme's impact.

The Local and Mandatory WG element comprises of 5 separate competencies, 2 of which have been added as a requirement in the past year. The established competencies enjoy high individual compliance with the recently added items accounting for the sub-target combined performance. Those non-compliant in these specific competencies will have this drawn to their attention as part of our annual PADR process.

The difference identified in performance across the CSTF levels is partly due to most of the people who are required to maintain the higher-level competencies being able to achieve them via their annual MIST refresher programme – therefore, the higher MIST compliance is, the higher CSTF compliance is given the volume of our people accessing their learning through this route. See Appended MIST infographic for detailed evaluation of the 2023/24 programme.

2024/25 will see us introducing a new way to deliver refresher CSTF, local and mandated WG to the Trust. This will move us away from misaligned refresher cycles (currently set with no recurrence, annual, 2 yearly or 3 yearly cycles – a regime alone that causes confusion for individuals seeking to keep track of what they are required to do) to an annual process that brings to the forefront the key elements of the topics that sit behind these competencies whilst also assessing peoples comprehension, understanding and ability to apply. This process will also provide the Trust with another mechanism for delivering on our Duty of Quality.

11. **PADRs:** PADR completion rates have continued to increase, rising from 77.8% (as reported in the last Committee) to 79.51%. Engagement in the PADR process serves as a key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee development opportunities, support better communication between managers and employees, and develop a culture of accountability and continual improvement. We intend to assess PADR engagement levels across teams to pinpoint areas with higher participation rates and gather insights into effective practices and strategies for PADR participation, with the aim of supporting teams with lower participation rates.
12. **Employee Relations:** Numbers of formal ER cases since December 2023 have remained similar. In March 2024, there were 32 Disciplinary cases, with "inappropriate behaviour" cited as one of the main causes for cases. There was an increase in formal Respect and Resolution cases in March compared to February 2024 with 13 formal cases recorded. Since January 2024, the Trust is

differentiating between Respect and Relation concerns that relate to Dignity at Work and those that are Grievances. The main themes of the 13 Respect and Resolution cases were "Policy and Procedure" and "Other Harassment - DAW" as the main reasons.

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



Ymddiriedolaeth GIG
Gwasanaethau Ambiwians Cymru
Welsh Ambulance Services
NHS Trust

People and Culture KPIs March 2024

Plan

Job Evaluation

JDs currently in process: 7 ↓
JDs completed in month: 2 ↓
Ave. days to complete: 12 ↓

Recruitment

Vacancy creation to unconditional offer: 65.9 ↓

Educate

Stat Mand training compliance: 81.20% ↑

Apprenticeships

Apprenticeships in progress: 28 ↓
Apprenticeships completed: 3 ↑

Resource

Sickness

Rolling 12 month: 8.52% ↓
In month: 7.67% ↓

Wellbeing

OH referral to first offer of appointment: 4 ↓
Sickness absence attributable to MH: 27.00% ↓

Engage

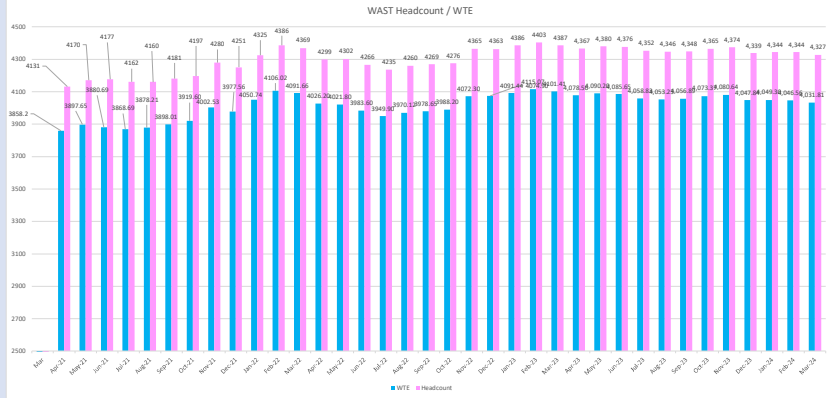
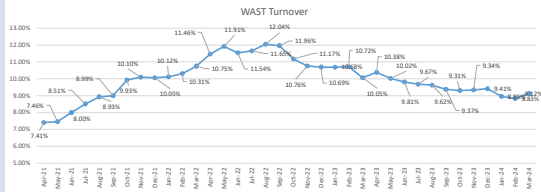
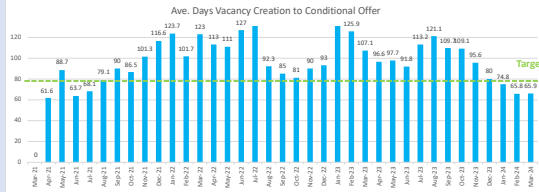
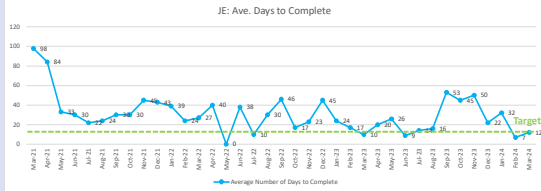
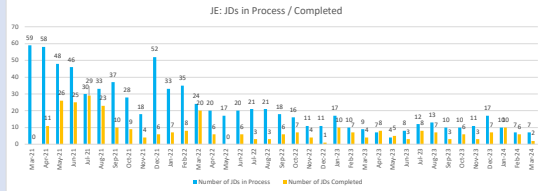
PADR Compliance: 79.51% ↑

Open ER cases: 43 ↑

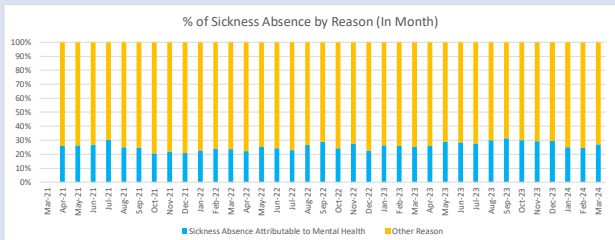
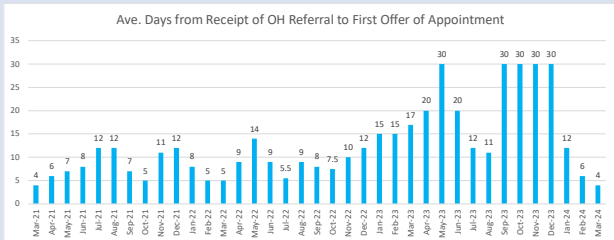
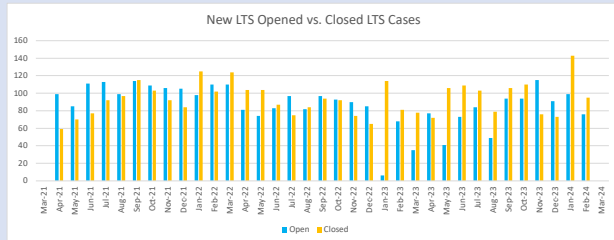
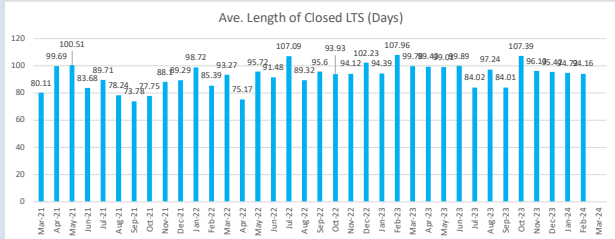
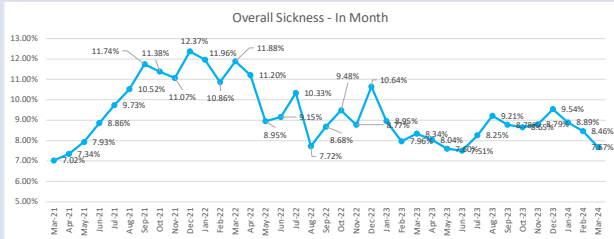
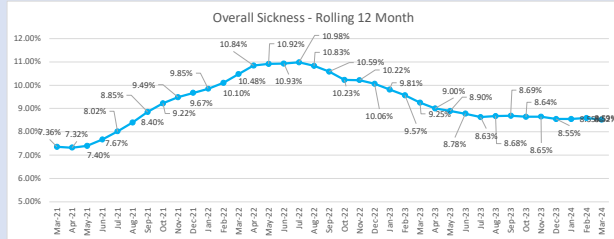
Formal requests for resolution: 13 ↑

Workplace Safety

V&A Incidents Recorded via Datix: 67 ↑

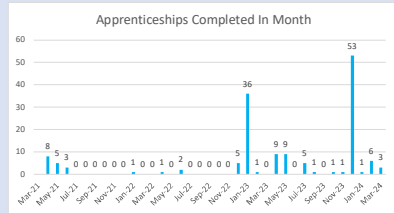
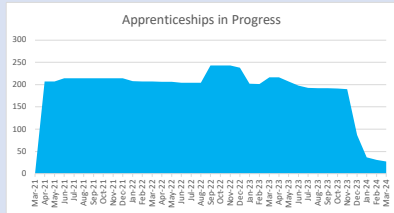
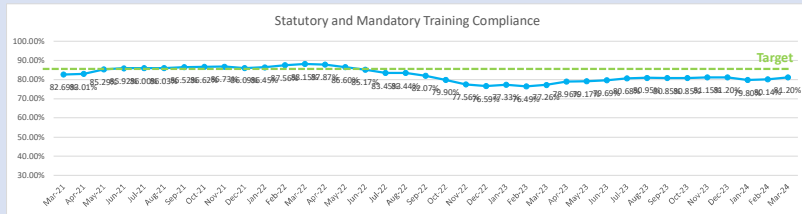


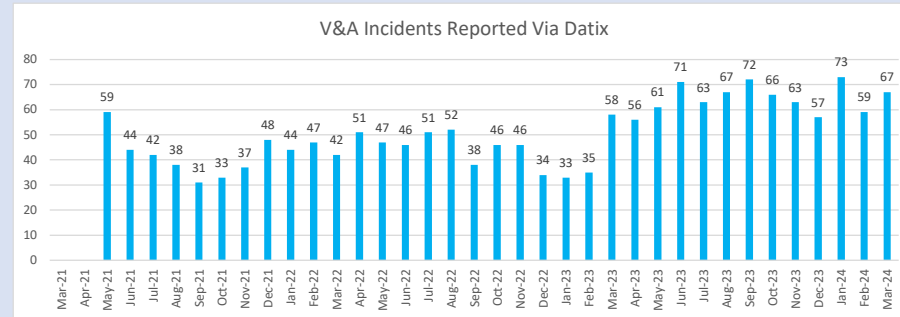
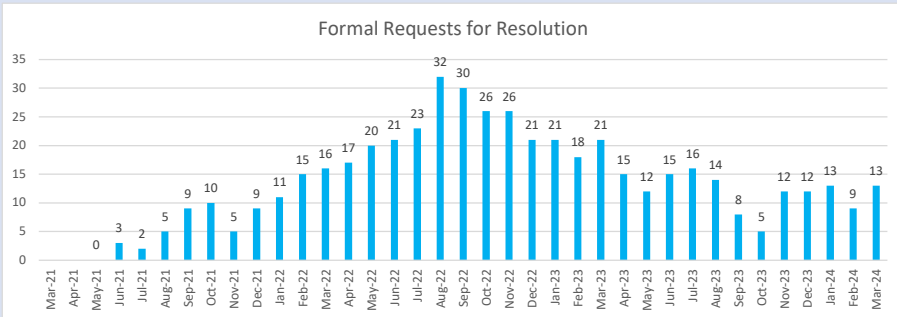
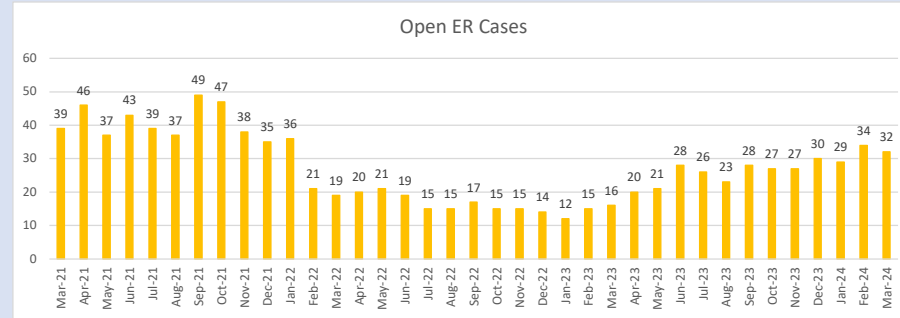
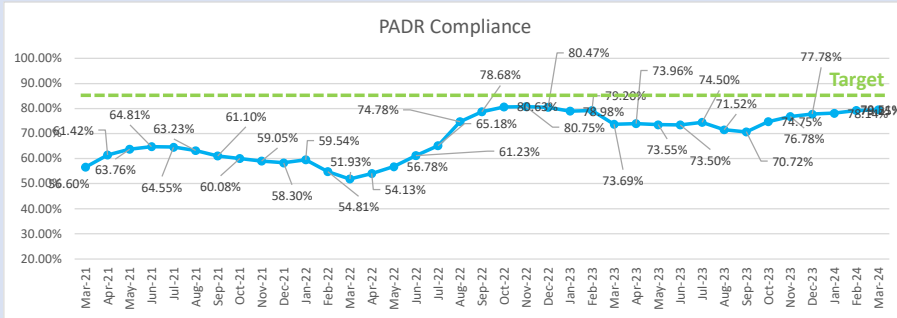
[Return to Summary](#)





[Return to Summary](#)





Ave. Number of Days from Receipt of OH Referral to Fin. Sickmess At Other Reason

Month	Compliant	Non-Compliant
Mar-21	4	
Apr-21	6	
May-21	7	
Jun-21	8	
Jul-21	12	
Aug-21	12	
Sep-21	7	
Oct-21	5	
Nov-21	11	
Dec-21	12	
Jan-22	5	
Feb-22	5	
Mar-22	5	
Apr-22	9	
May-22	14	
Jun-22	9	
Jul-22	5.5	
Aug-22	9	
Sep-22	8	
Oct-22	7.5	
Nov-22	10	
Dec-22	12	
Jan-23	15	
Feb-23	15	
Mar-23	17	
Apr-23	20	
May-23	30	
Jun-23	20	
Jul-23	12	
Aug-23	11	
Sep-23	30	
Oct-23	30	
Nov-23	30	
Dec-23	30	
Jan-24	12	
Feb-24	6	
Mar-24	4	
Apr-24		

Month	Compliant	Non-Compliant
Mar-21	85.61%	14.39%
Apr-21	84.09%	15.91%
May-21	83.22%	16.78%
Jun-21	82.87%	17.13%
Jul-21	82.03%	17.97%
Aug-21	79.21%	20.79%
Sep-21	81.00%	19.00%
Oct-21	87.20%	12.80%
Nov-21	96.00%	4%
Dec-21	99.00%	1%
Jan-22	100.00%	0.00%
Feb-22	100.00%	0.00%
Mar-22	100.00%	0.00%

Month	Compliant	Non-Compliant
Mar-21	85.61%	14.39%
Apr-21	84.09%	15.91%
May-21	83.22%	16.78%
Jun-21	82.87%	17.13%
Jul-21	82.03%	17.97%
Aug-21	79.21%	20.79%
Sep-21	81.00%	19.00%
Oct-21	87.20%	12.80%
Nov-21	96.00%	4%
Dec-21	99.00%	1%
Jan-22	100.00%	0.00%
Feb-22	100.00%	0.00%
Mar-22	97.18%	2.82%

Month	Apprenticeships In Progress	Apprenticeships Completed in Month
Mar-21	207	8
Apr-21	207	5
May-21	214	3
Jun-21	214	0
Jul-21	214	0
Aug-21	214	0
Sep-21	214	0
Oct-21	214	0
Nov-21	214	0
Dec-21	214	0
Jan-22	208	1
Feb-22	207	0
Mar-22	207	0
Apr-22	206	1
May-22	206	0
Jun-22	204	2
Jul-22	204	0
Aug-22	204	0
Sep-22	243	0
Oct-22	243	0
Nov-22	243	0
Dec-22	238	5
Jan-23	202	36
Feb-23	201	1
Mar-23	216	0
Apr-23	216	9
May-23	207	9
Jun-23	198	0
Jul-23	193	5
Aug-23	192	0
Sep-23	192	0
Oct-23	191	1
Nov-23	190	0
Dec-23	87	53
Jan-24	17	1
Feb-24	11	6
Mar-24	28	3
Apr-24		

Statutory and Mandatory Training Compliance

Month	Compliant	Non-Compliant
Mar-21	82.69%	9.87%
Apr-21	83.01%	9.33%
May-21	85.07%	11.44%
Jun-21	85.07%	11.44%
Jul-21	86.00%	11.44%
Aug-21	86.03%	12.06%
Sep-21	86.52%	13.37%
Oct-21	86.73%	8.80%
Nov-21	86.73%	3%
Dec-21	86.00%	1%
Jan-22	86.45%	0.00%
Feb-22	87.50%	0.00%
Mar-22	88.15%	0.00%
Apr-22	87.87%	
May-22	86.60%	
Jun-22	85.17%	
Jul-22	83.46%	
Aug-22	83.44%	
Sep-22	82.07%	
Oct-22	79.90%	
Nov-22	77.56%	
Dec-22	76.59%	
Jan-23	77.33%	
Feb-23	76.49%	
Mar-23	77.26%	
Apr-23	78.96%	
May-23	79.27%	
Jun-23	79.69%	
Jul-23	80.68%	
Aug-23	80.95%	
Sep-23	80.85%	
Oct-23	80.85%	
Nov-23	81.15%	
Dec-23	81.20%	
Jan-24	79.80%	
Feb-24	80.14%	
Mar-24	81.20%	
Apr-24		

ENGAGE

Month	PDQR Compliance	Open ER Cases
Mar-21	56.60%	89
Apr-21	61.42%	46
May-21	63.70%	37
Jun-21	64.81%	41
Jul-21	64.55%	39
Aug-21	63.23%	37
Sep-21	61.10%	49
Oct-21	60.00%	47
Nov-21	59.00%	38
Dec-21	58.50%	35
Jan-22	59.44%	36
Feb-22	54.81%	21
Mar-22	51.93%	10
Apr-22	54.13%	20
May-22	56.78%	25
Jun-22	61.23%	19
Jul-22	65.18%	15
Aug-22	74.78%	15
Sep-22	78.48%	17
Oct-22	80.93%	15
Nov-22	80.75%	15
Dec-22	80.47%	14
Jan-23	78.98%	12
Feb-23	79.20%	15
Mar-23	73.60%	16
Apr-23	73.66%	20
May-23	73.55%	21
Jun-23	73.00%	28
Jul-23	74.00%	26
Aug-23	71.52%	23
Sep-23	70.72%	28
Oct-23	74.75%	27
Nov-23	76.78%	27
Dec-23	77.78%	30
Jan-24	78.14%	29
Feb-24	79.45%	34
Mar-24	79.33%	32
Apr-24		

ACA1/ACA2 EMT/Paramedic

92.3% 91.7%



92% of our EMS and Ambulance Care workforce attended MIST in 2023/24. This year saw us welcome colleagues from 111 to join our MIST sessions broadening out further the interprofessional ethos we have established

99.77%

found the venue, training materials and resources appropriate and conducive to a positive learning experience



said they had **no suggestions** for improvement

56%

98%



feel they had a chance to contribute to their learning experiences



feel engaged by their tutor

We asked for feedback on your MIST experience

1721

completed surveys



71%

response rate

The overall sentiment of the comments regarding the day is positive and appreciative



TST
Seatbelts
ABD
Paediatric ALS
Clinical knowledge
Skills

Most commonly mentioned topics (positive impact)

Colleagues shared with us how they felt following their MIST day

Confident
Aware
Refreshed

Whilst the majority of our sessions have been held in our regional Workforce Education & Development Centres, we have increased the availability of sessions across our rural areas.

We want to continue this and are seeking suitable spaces for this to happen in 24/25

310
MIST sessions provided
2,239+
attendances from EMS/AC + CSD, 111, CFR, Corp



MIST 2023/24 - ROUNDUP

Every MIST session is followed up with an opportunity for colleagues to **reflect**, provide **feedback** to our Education & Development team and **feedforward** what actions they will take for their **ongoing CPD**

OUR FOCUS

ACHIEVING EXCELLENCE



WHAT NEXT? 2024/25 MIST COMMENCED ON 15.04.2024 - PLEASE BOOK YOURSELF ON

An eLearning refresher course will be available on LMS365 soon. Successful completion of it will enable a number of Core Skills Training Framework and Mandatory eLearning competencies to be achieved.



LMS365

Please send suggestions for additional CPD you'd like us to provide to us via our AMB_EandDHub@wales.nhs.uk email

AGENDA ITEM No	10.2
OPEN	OPEN
No of ANNEXES ATTACHED	1

**MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD –
February/March 2024**

MEETING	PCC
DATE	9 May 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett - Assistant Director, Commissioning & Performance Mark Thomas – Commissioning & Performance Manager Melanie O’Connor - Commissioning & Performance Officer
CONTACT	Hugh.Bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Melanie.O’Connor@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **February/ March 2024**.
2. Our response times to 999 callers remains of concern with red 8-minute performance at 48.9% in March 2024 and Amber 1 median at 1 hour and 22 minutes, which the Trust knows leads to avoidable patient harm. The Trust continues to work on actions within its control to mitigate this risk including, for example, maintaining high levels of EA production and fully rolling out the CHARU service. Work continues on an action plan to increase the consult and close rates to the target 17%, as this is modelled to have a significant impact on response times. The Trust lost nearly 23,500 hours to handover in March 2024, and this level of lost capacity is difficult to compensate for, despite all the actions being taken. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours.
3. 111 performance is broadly stabilised, but patient demand was 24% higher in March 2024, compared to March 2023, with a commissioned 4% reduction in call handlers in 2024/25. The service is in a more resilient place, but if

demand continues to remain at these levels future performance may become a concern. The immediate focus for 111 is the delivery of the new 111CAS by 30 April 2024, which is on target at this time.

4. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with oncology remaining above target and renal performance achieving its target. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25, a key efficiency.
5. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.67% in March 2024 compared to 8.50% in February 2024. The 23/24 IMTP ambition is to reach 6%, but it is unlikely that this will be achieved. The Trust will continue its focus on sickness absence. It is of note that the EMS abstractions have hit the 30% benchmark in January and February respectively, however this has increased slightly in March 2024.
6. The Trust continues with its programme of transformation as detailed in its 2024-27 IMTP, which is required in order to ensure that patients receive the right care in the right place every time.

RECOMMENDATION

PCC is asked to: -

- **Consider** the February/ March 2024 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

30.04.24 Assistant Director, Commissioning & Performance
09.04.24 PCC

REPORT APPENDICES

Appendix 1 – Top Indicator Dashboard

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

SITUATION

7. 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 **February/March 2024**.

BACKGROUND

8. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus: -
- Our Patients (Quality, Safety and Patient Experience);
 - Our People;
 - Finance and Value; and
 - Partnerships and System Contribution
9. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust’s plans (IMTP) and strategies. A revised set were agreed for 2023/24. All the updates for the revised set have now been completed, with the exception of: a metric on the duty of candour where we will need to determine our own metric whilst national reporting is agreed; completed symptom checkers; and value indicators for 111/CSD – it is likely that this one will be difficult to determine.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

- 10. Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
- 11. 999 call answering times** have declined to 34 seconds in March 2024 from 15 seconds in February 2024, not achieving the 6 second target. The 65th percentile and median performance remain very good.
- 12. 111 call answering performance remains broadly stable**, although the call abandonment performance at 11.8% in March and off target. The Trust had almost recruited up to the 198 FTE call handler commissioning control total for 2023/24 with very good levels of production. It should be noted that the Trust is anticipating a reduction in the commissioned level of call handler FTEs next year (-4%). Demand in March 2024 was 24% higher than March 2023. If this level of demand is sustained, alongside a reduction in capacity, then future call abandonment performance could start to be a concern. In the short term, there will also be a planned short term dip in staffing numbers linked to the imminent 111 CAS go live and the need to re-programme training capacity away from new recruits and towards the existing workforce on the new system. This will have some short term impact on performance.
- 13. 111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 98%. Unfortunately, response times for lower priority calls remain some way below target. This drop in performance has been affected by a rise in call demand, but also high clinician sickness absence. Clinician sickness has seen a material deterioration in March, rising to 11.8% compared to 11.3% in February. As with call handling performance, there is likely to be some further deterioration linked to staff abstracted to undertake training for the new system.
- 14. Ambulance Response** (safety / patient experience): the red 8-minute response performance for March 2024 was 48.9%, remaining below the 65% target. However, as total red demand has increased, so has the actual number of red incidents attended within 8-minutes. The Amber 1 median in March was 1 hour 22 minutes and the Amber 1 95th percentile was 7 hours 35 minutes. These long response times have a direct impact on outcomes for many patients.
- 15.** Traditionally the factors which affect response times are demand and capacity (recruitment and lost hours). Recruitment is good, see slide 20 for information on staff in post v establishment, but the lost capacity through handover at hospital remains extremely challenging. The Trust's main focus in the first half of 2024/25 is to implement a material element of the "inverting the triangle" transformation programme, before winter. This is a radical move away from a traditional conveyance model. A series of workshops are planned in early May 2024, with additional leadership capacity also being put into this area: both designed to move this at pace. Areas of focus include:-

- Further investment into the Clinical Support Desk (+23 FTEs);
- Further investment in APPs (+32 APPs);
- An updated clinical model that places more emphasis on telephone triage e.g. clinical screening, further work on timebound and planned responses e.g. , "Amber Hot" and "Amber Cold";
- Development of the integrated care model (111 clinicians and CSD clinicians);
- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.;
- Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

16. The one area of particular focus for recruitment is CHARU: with the Trust recruiting up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution (findings positive) etc.

17. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 23,403 hours were lost during March 2024. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. Performance into April has remained very challenging with days where over 1,000 hours are lost.

18. Ambulance Care (Patient Experience): Oncology performance in March 2024 was 74.20%, hitting the 70% target. Renal performance also remains above target at 75.70%. Advanced discharge & transfer journey booked in advance performance increased compared to the previous month to 86%; however, remains below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: aligning clinic patient ready times to ambulance availability and addressing oncology performance. The Trust is expecting to re-roster NEPTS transport in 2024/25 which will better align capacity with demand patterns.

19. National Reportable Incidents (NRIs) / Concerns Response: the Trust reported four NRI's to the NHS Executive in March 2024, a slight decrease from the seven reported in February 2024; and 21 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In February 2024 complaint response times improved to 56%, a significant improvement on the 35% recorded in February 2024, but remaining below the 75% target, with cases remaining complex. Reviews of lower

graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust is currently recruiting to a new structure for the Putting Things Right (PTR) team, which will increase capacity and leadership, including a new Head of Service, appointed and arriving shortly.

- 20. Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 72.85% in March 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) compliance rate increased to 21% in March 2024 compared to 14.7% in February 2024.
- 21.** The Trust is now able to report on call to door times for Stroke and STEMI patients. For March 2024 these highlight call to hospital door times of two hours and 25 minutes for stroke patients and two hours and seventeen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls as a result of the pressures and issues outlined in this report.
- 22.** In March 2024, 9,605 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 552 callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be popping up elsewhere in the system. Anecdotal evidence from health boards supports this view, but data linking planned for 2024/25 is a key enabler to properly evidence this.

Our People (workforce resourcing, experience, and safety)

- 23. Hours Produced:** The Trust produced 121,069 Ambulance Response unit hours in March 2024 and delivered an emergency ambulance unit hours production (UHP) of 93%, just short of the 95% target. Key to the number of hours produced are roster abstractions.
- 24. Response Abstractions:** EMS abstraction levels increased to 33.49% in March 2024, returning just above the 30% benchmark figure. EMS Response sickness abstractions stood at 8.17% (benchmark 5.99%).
- 25. Trust sickness absence:** the Trust's overall sickness percentage was 7.67% in March 2024, a decrease on the 8.50% recorded in February 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan.
- 26. Staff training and PADRs:** PADR rates did not achieve the 85% target in February 2024, but have been steadily improving (78.80%). Compliance for Statutory and Mandatory training increased to 81.89%.

27. People & Culture Plan: The Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook a pan-Wales round of CEO Roadshows in April 2024. Feedback from attendees will be reviewed.

Finance and Value

28. Financial Balance: The reported outturn performance at Month 12 is a surplus of £85k and the Trust achieved both its External Financing Limit and its Capital Resource Limit.

Summary

29. The indicators used at this high-level highlight that the 111, EMS and Ambulance Care performance are stable; however, 111 and EMS performance are not where the Trust would want them to be.

30. 111 has seen a clear improvement in performance over the past 12 months and the service is undoubtedly more resilient, however, the current high levels of demand plus a commissioned reduction in call handlers and clinicians may mean that the improved performance comes under pressure in 2024/25. The Trust and commissioners will need to keep the level of demand under review and determine whether a reduction in capacity will affect performance into this year.

31. EMS performance has been recognised as challenging for a long time. Transformation of our service offer is a necessity (not an option) for reducing handover lost hours along with handover reduction by health boards. The Trust also needs to continue its focus on core activities like abstractions, production and utilisation.

RECOMMENDATIONS

PCC is asked to: -

- **Consider** the February/ March 2024 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.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

February/March 2024

Annex 1 – Top Indicator Dashboard



GIG
CYMRU
NHS
WALES

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

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: April 2024

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators	Target 2023/24	2 Year Average	Feb-24	Mar-24	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.4%	6.2%	11.8%	R
111 Clinical Triage Call Back Time (P1)	90%	97.9%	95.8%	98.0%	G
999 Call Answer Times 95th Percentile	00:06	00:30	00:15	00:34	R
999 Red Response within 8 minutes	65%	50.0%	49.9%	48.9%	R
999 Amber 1 Median	00:18	01:24	01:27	01:22	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	72.1%	71.3%	74.2%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	84.2%	85.4%	86.5%	A
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.1%	14.70%	21.00%	A
Stroke Patients with Appropriate Care	95%	76.9%	73.50%	72.80%	R
Stroke Call to Hospital Door Times	Reduction Trend	02:24	2:19	2:25	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	42.7%	45.10%	40.90%	R
National Reportable Incidents reports (NRI)		5	7	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10,888	10,065	11,115	R
Concerns Response within 30 Days	75%	35.7%	35%	56%	A
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	94%	95%	93%	A

Top Monthly Indicators	Target 2023/24	2 Year Average	Feb-24	Mar-24	RAG
Health & Well-being					
Sickness Absence (<i>all staff</i>)	6.0%	8.88%	8.50%	7.67%	R
Mental Health Absence Rates	Reduction Trend	2.31%	2.07%	N/A	R
Staff Turnover Rate	Reduction Trend	10.22%	8.83%	8.73%	A
Statutory & Mandatory Training	>85%	79.06%	81.00%	81.89%	A
PADR/Medical Appraisal	>85%	73.18%	79.25%	78.80%	A
Number of Shift Overruns	Reduction Trend	3830	3944	4010	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.2%	1.7%	0.6%	R
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	30%	28.0%	28.5%	R
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.39	2.22	2.27	A
NEPTS on the Day Cancellations	Reduction Trend	19.8%	19.6%	19.8%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	13.4%	13.9%	14.0%	A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.4%	11.62%	11.46%	A
Number of Handover Lost Hours	15,000	23,296	23,896	23,403	R
NHS111					
NHS111 Dental Calls	Increasing Trend	6,488	6,995	7,277	A
Consult & Close Volumes by NHS111	Increasing Trend	1,064	800	946	G

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*)

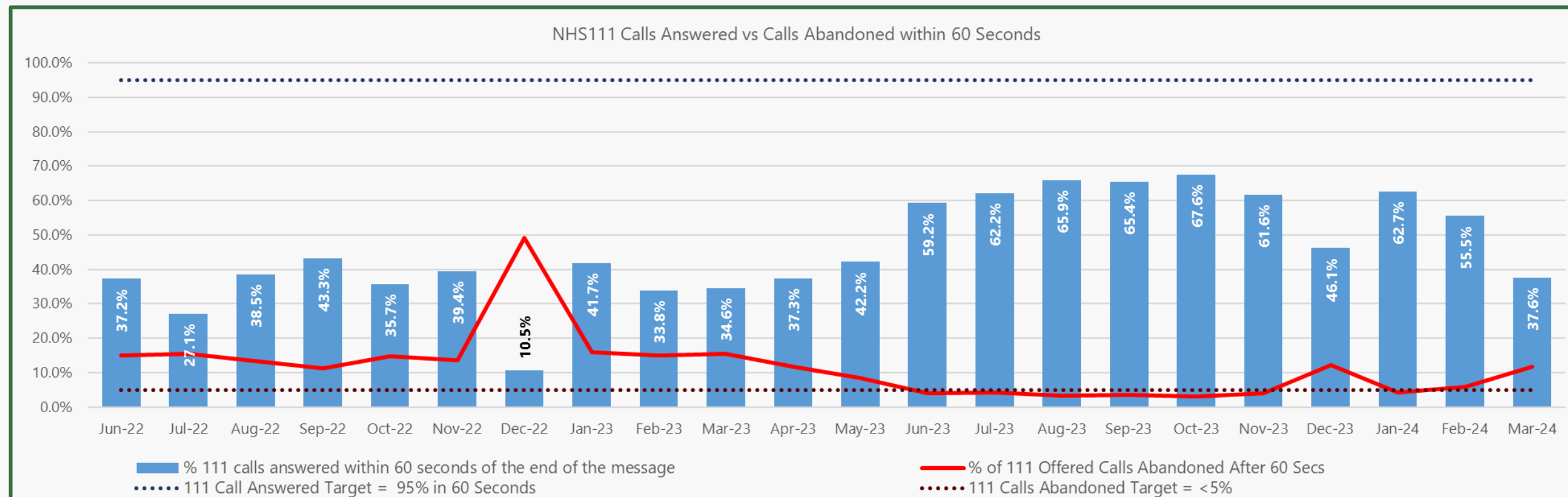
Our Patients: Quality, Patient Safety & Experience

111 Call Answering/Abandoned Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand and Call Handling Hours Produced



Analysis

The 111-call abandonment rate declined from 5.9% in February 2024 to 11.8% in March 2024 and failed to achieve the 5% target. However, this figure remains lower than the 15.4% abandonment rate seen in March 2023. This is also despite demand in March 2024 being 24% higher than in March 2023.

The percentage of 111 calls answered within 60 seconds decreased, from 55.5% in February 2024 to 37.6% in March 2024, and continues to be below the 95% target. However, once again it is an improvement on the 34.6% figure recorded in March 2023. The drop in performance during March 2024 was due to a spike in demand, to its third highest level over the past two years, but due to increased staffing levels now in place the impact on performance was far less significant than seen during previous months of higher demand.

Abstractions due to sickness absence decreased, reaffirming the longer-term downward trend, and overall, 111 abstractions remain lower (better) than benchmark.

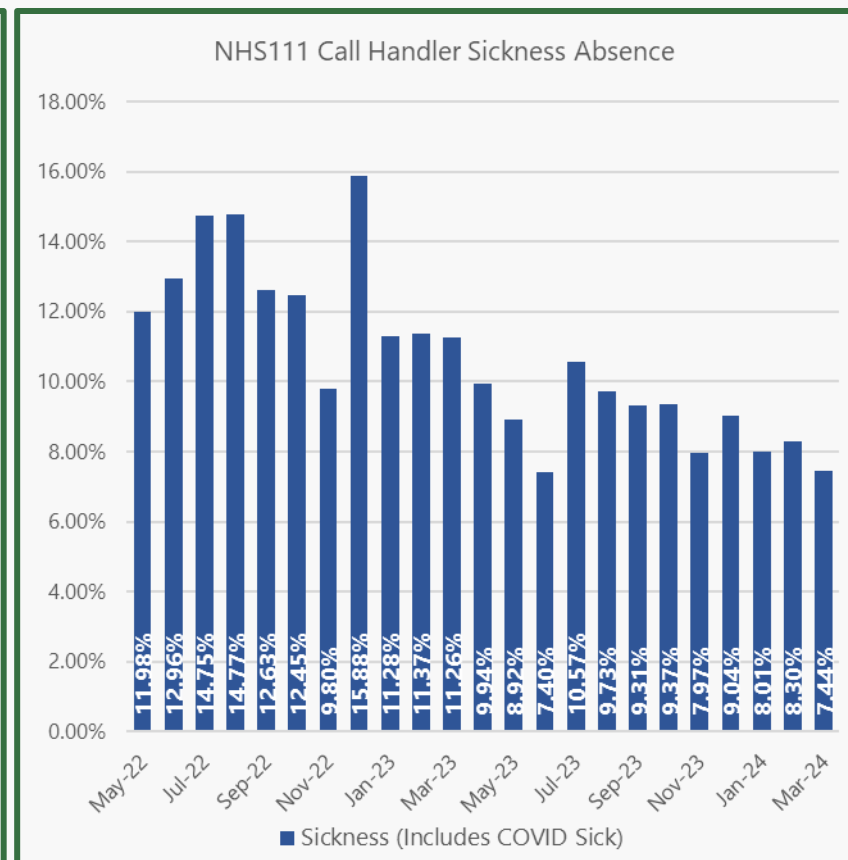
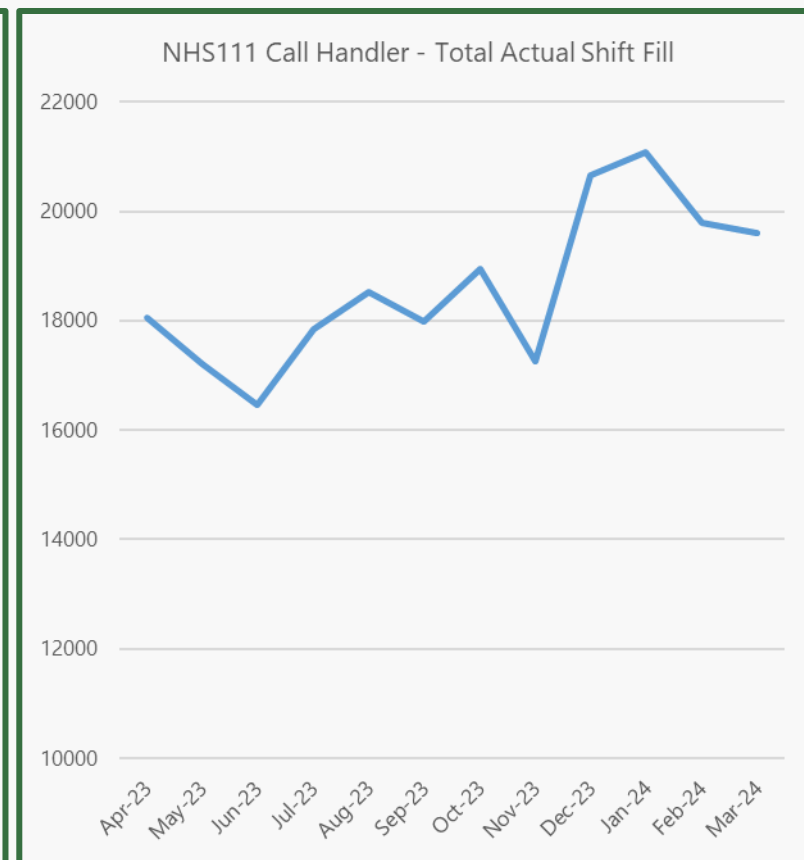
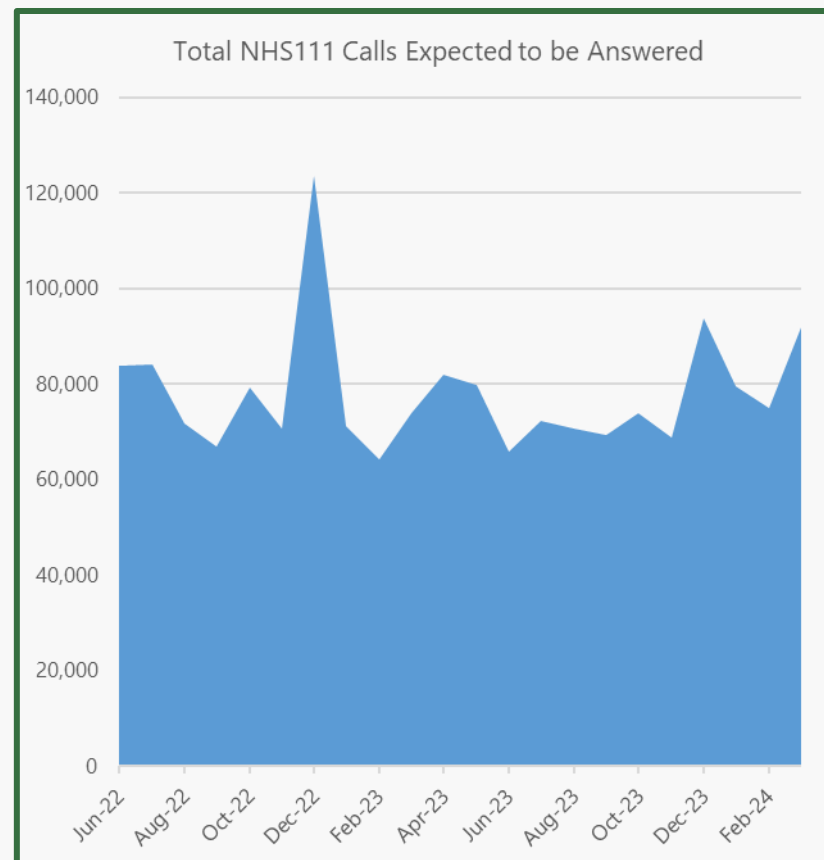
Remedial Plans and Actions

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.

- However, less call handlers will be commissioned in 2024/25 (-4%).
- Work continues sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6% by the end of 23/24.
- A roster review was planned in collaboration with the 111 commissioners to review rosters and ensure that capacity was aligned to demand, and to try and even out performance through the week. However, funding has been withdrawn, so this project is now paused. The Trust continues to press for this.

Expected Performance Trajectory

The service is much improved, but with demand increasing in the way it is and the call handlers reducing next year performance is unlikely to improve or hit the commissioned targets.

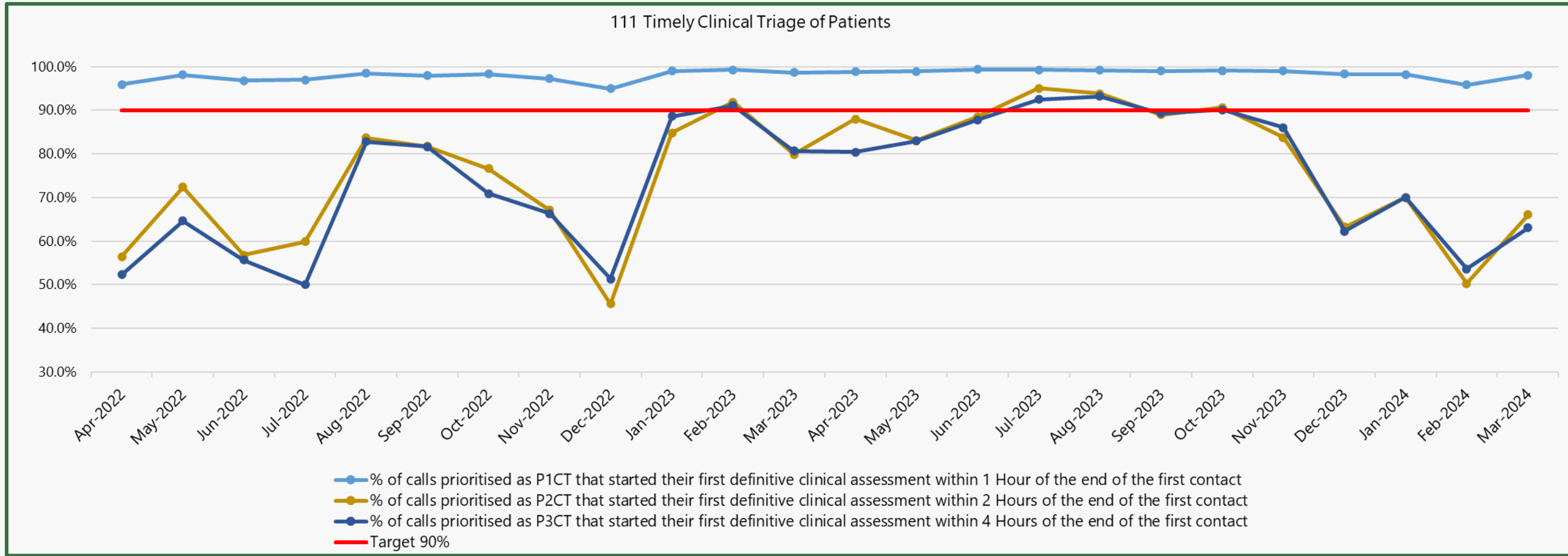


Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)



Analysis
The highest priority calls, P1CT, achieved the 90% target once again, recording 98% in March 2024.

Lower category calls both improved during March 2024, reversing a previous deterioration in performance, which was primarily due to an uplift in demand but was also compounded by staff abstractions for new systems training.

P2CT increased from 50.2% in February 2024 to 66% in March 2024, while P3CT increased from 53.6% to 63.1%.

Clinical staff capacity decreased to 9,990 hours during March 2024, a decrease of 904 hours when compared to March 2023. Clinician sickness absence also increased slightly to 11.84% in March 2024 from the 11.30% reported in February 2024.

Sickness absence management is another core component of capacity and workforce. Current levels within the 111 service, indicate that clinician absence remains higher than target in Mar-24 and further work is required.

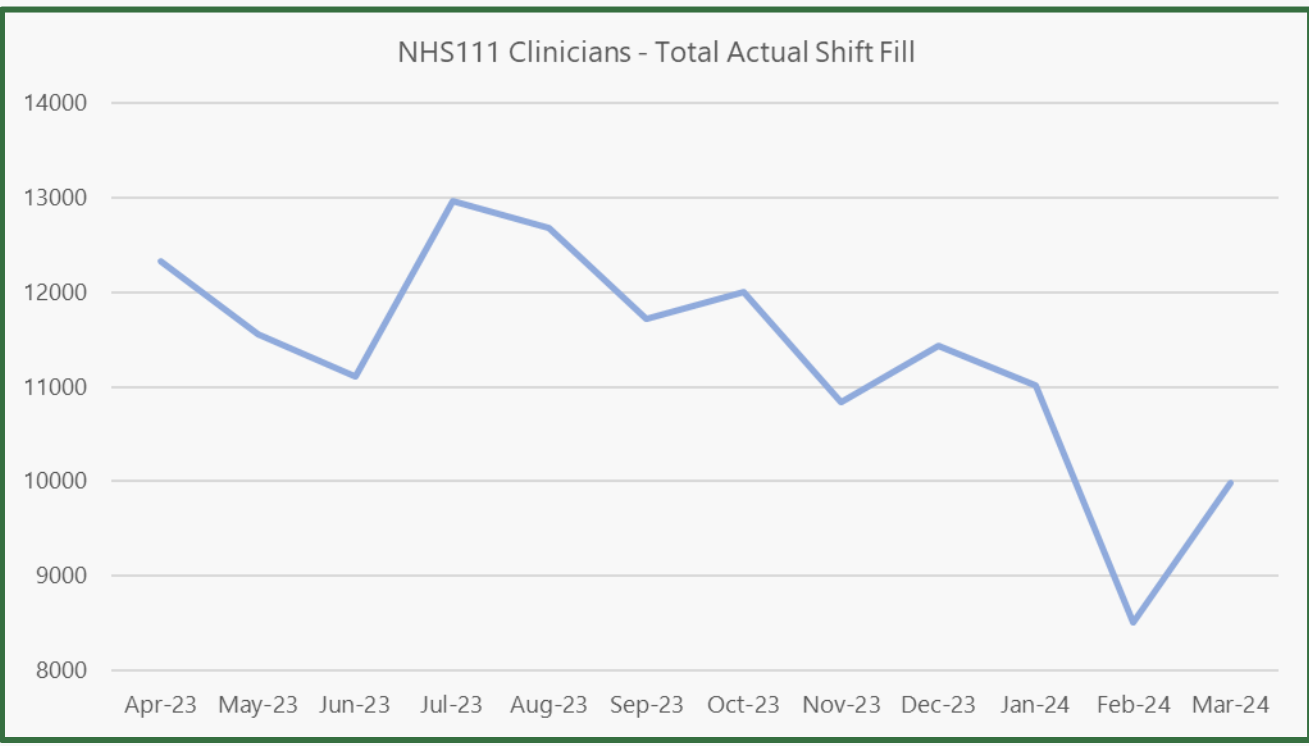
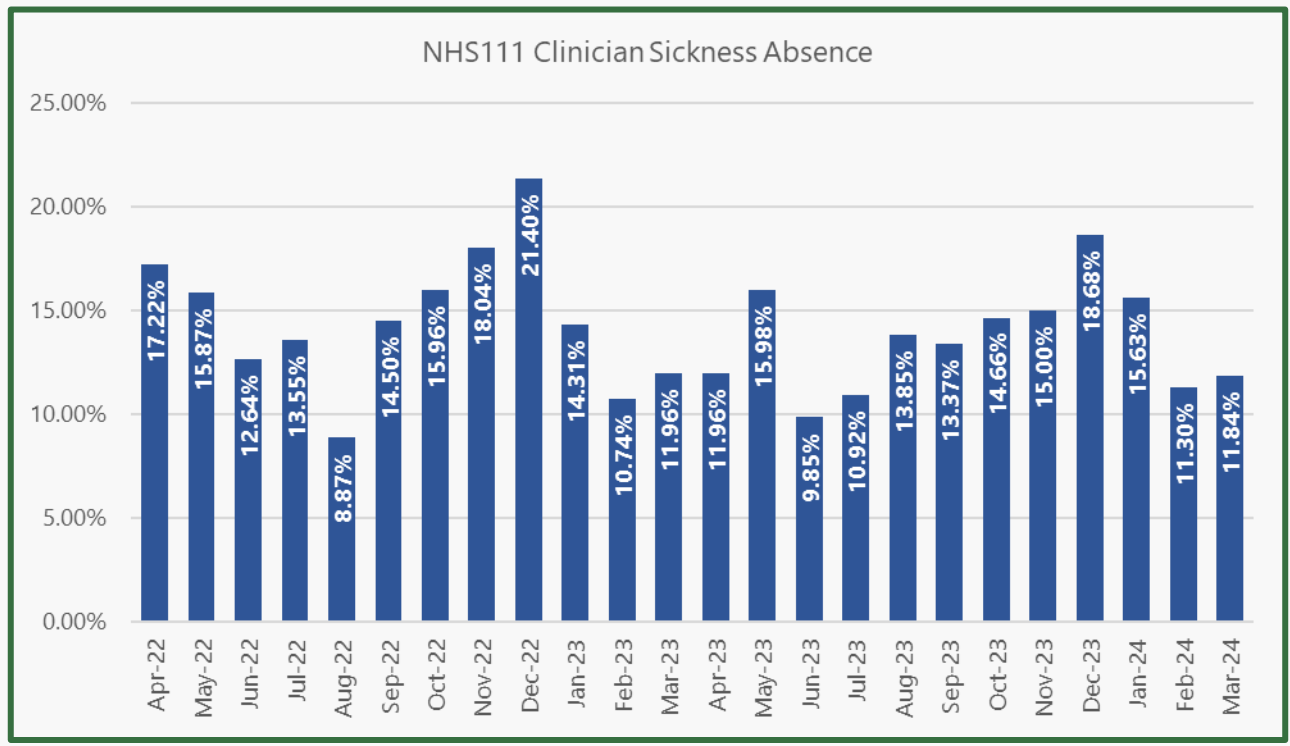
Remedial Plans and Actions
The main focus is the new 111CAS with a go live date of 30 April 2024. This is being implemented at very high pace to mitigate the non-delivery of SALUS.

The new system should deliver a range of benefits for service users and staff and improved performance, but this is not modelled currently.

Sickness levels amongst clinicians remains higher than the Trust would want, but there was a significant improvement in February.

As per the previous slide a demand & capacity review that quantifies the number of clinicians required to meet forecast demand (net of efficiencies) remains key.

Expected Performance Trajectory
The new 111CAS will bring performance benefits, however, demand is increasing materially, and the number of commissioned clinicians will be lower next year.

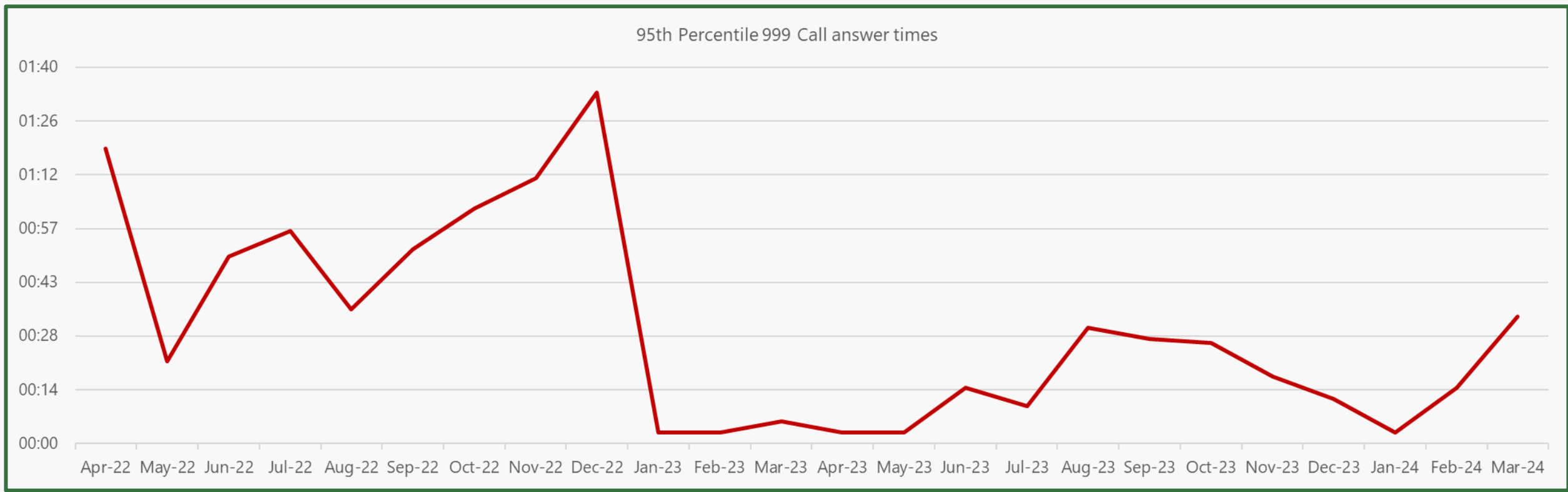
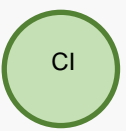


Our Patients: Quality, Safety & Patient Experience

999 Call Performance Indicators

Influencing Factors – Demand and Hours Produced

(Responsible Officer: Lee Brooks)



Analysis
 The 95th percentile 999 call answering performance increased to 34 seconds in March 2024, up from 15 seconds in February 2024, and not achieving the 6 second target for the second month in a row. The median call answer time for the 999-service remained consistent at 2 seconds.

The Trust received 44,749 emergency 999 calls in March 2024, an increase on the 41,505 calls received during February 2024.

Overall sickness abstractions within EMS Coordination has returned to a downward trajectory after a three month increase at the end of 2023. Sickness decreased to 11.68% in March 2024 from 12.59% in February 2024.

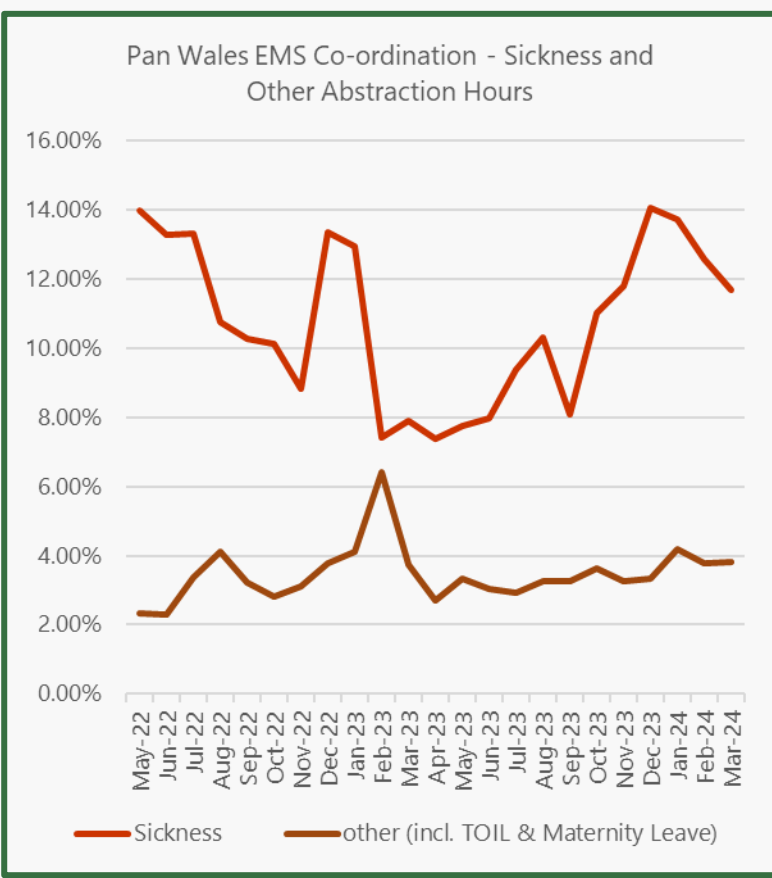
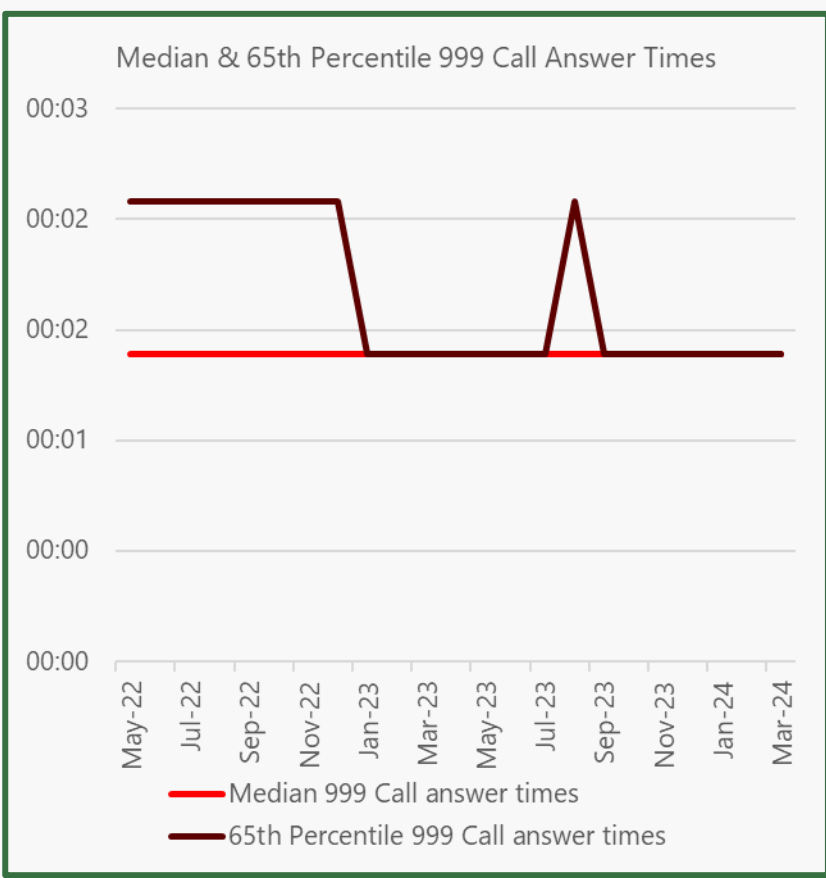
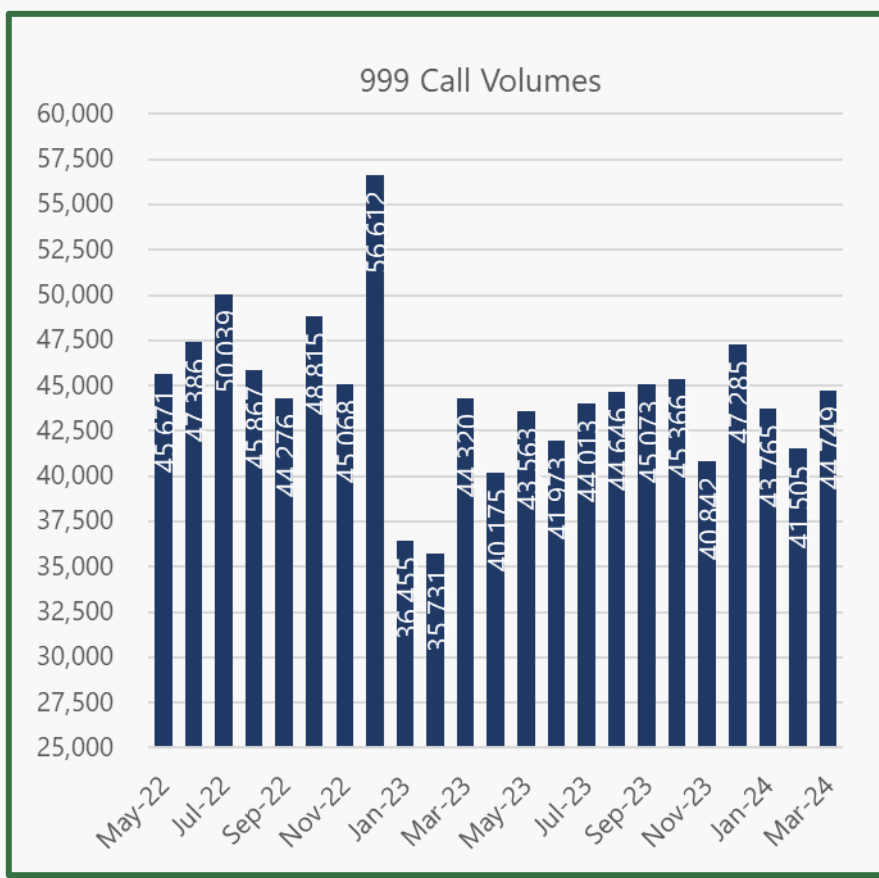
- Remedial Plans and Actions**
- Currently call taker are over established by 15.93 FTE.
 - There is a future recruitment drive planned for April to August which should provide an additional 36 (if successful in recruiting) which would mitigate against attrition.
 - Over establishment has been approved for EMSC by the Executive Director of Operations
 - Intelligent Routing Platform is now in operation following configuration changes.
 - Three workstreams are being progressed through the EMS Reconfiguration project (the complete reconfiguration has not commenced due to cost pressures required to fund the agreed model approved by ELT). This is on hold currently but will re commence in the next few weeks pending outcome and approval of a proposed new Structure for EMSC. This will require consultation.

Roster Review. Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch roster review for Allocators and Dispatchers. The workstream is now being progressed.

Boundary changes. EMS Coordination intend to realign dispatch boundaries to balance workload and pressures for individual dispatch teams. The work-stream is now being progressed.

Broader Ways of Working. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and lack of variation across centres. This workstream is now being progressed.

Expected Performance Trajectory
 The median and 65th percentile are performing very well and are stable. The above changes should provide further resilience. There is some resilience to demand increases, but this needs to be kept under review.

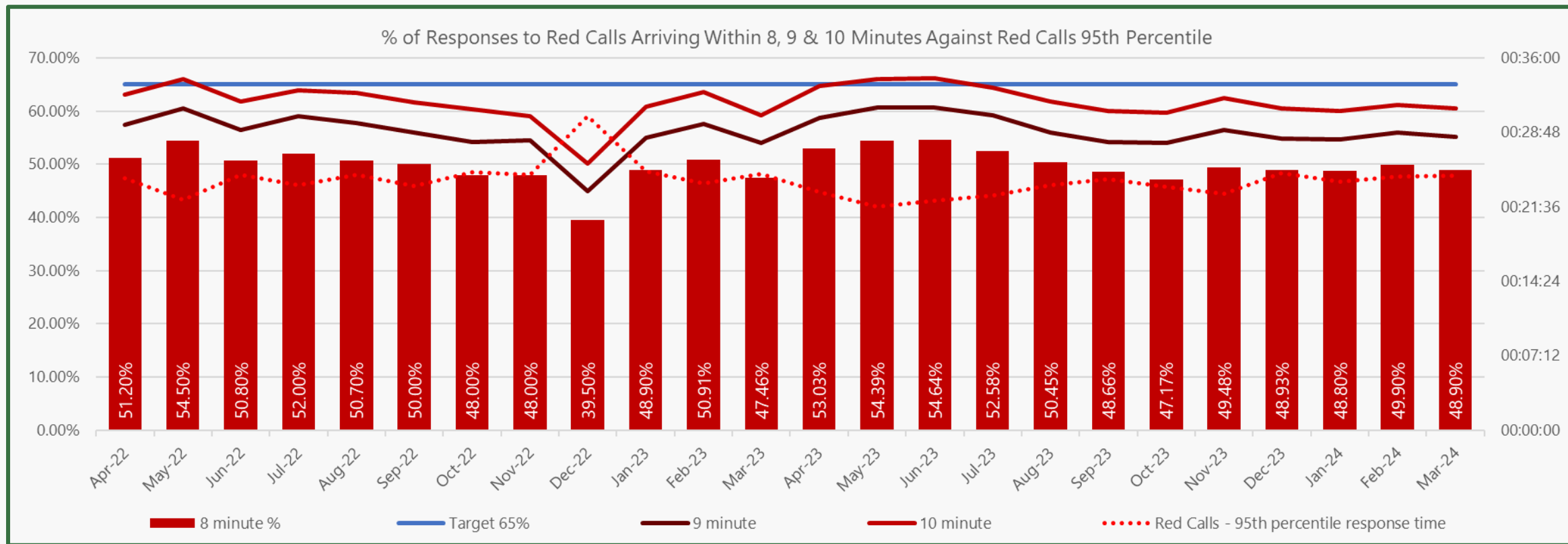
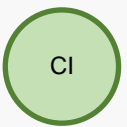


Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)



Analysis

Red 8-minute performance continues to remain below the 65% target and decreased marginally during March 2024 to 48.9%.

Red 10-minute performance for March 2024 was 60.7%, a slight reduction from 61.2% in February 2024.

The bottom right graph shows that as demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for March 2024 being 2,374. This is above the 12-month average (2,227) and would indicate that performance in this area is mirroring the rise experienced in demand during the month.

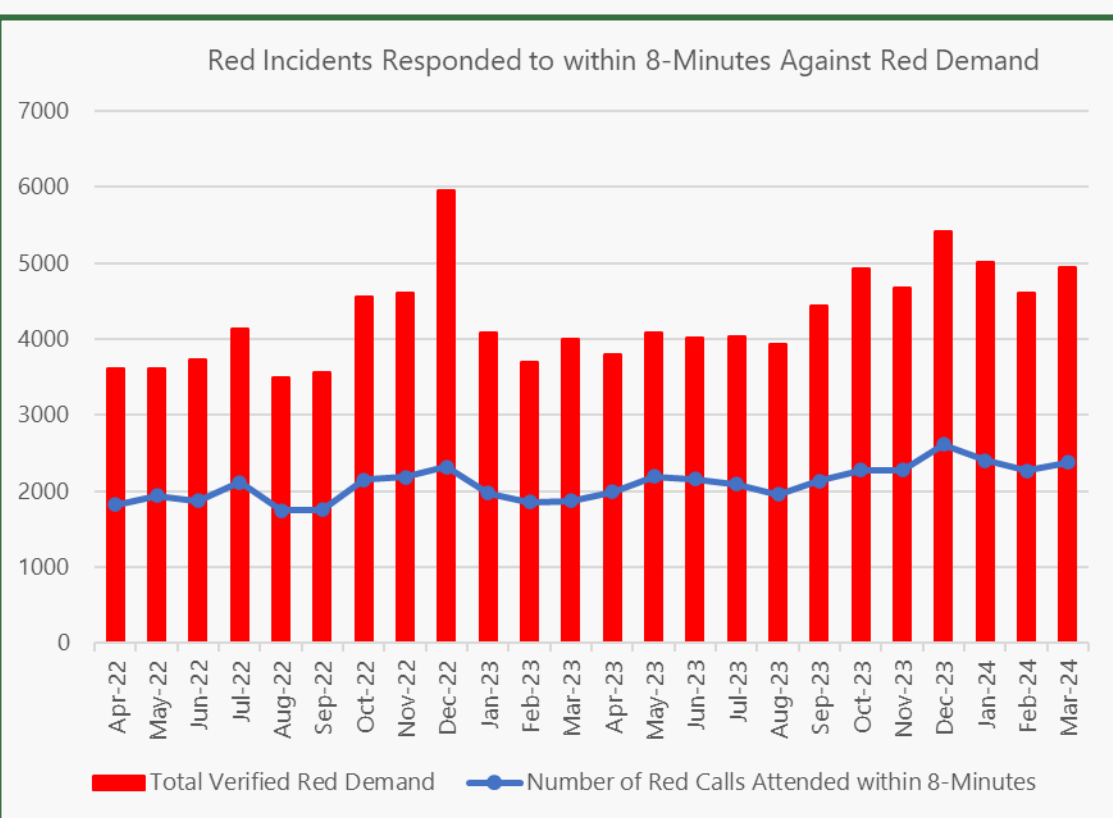
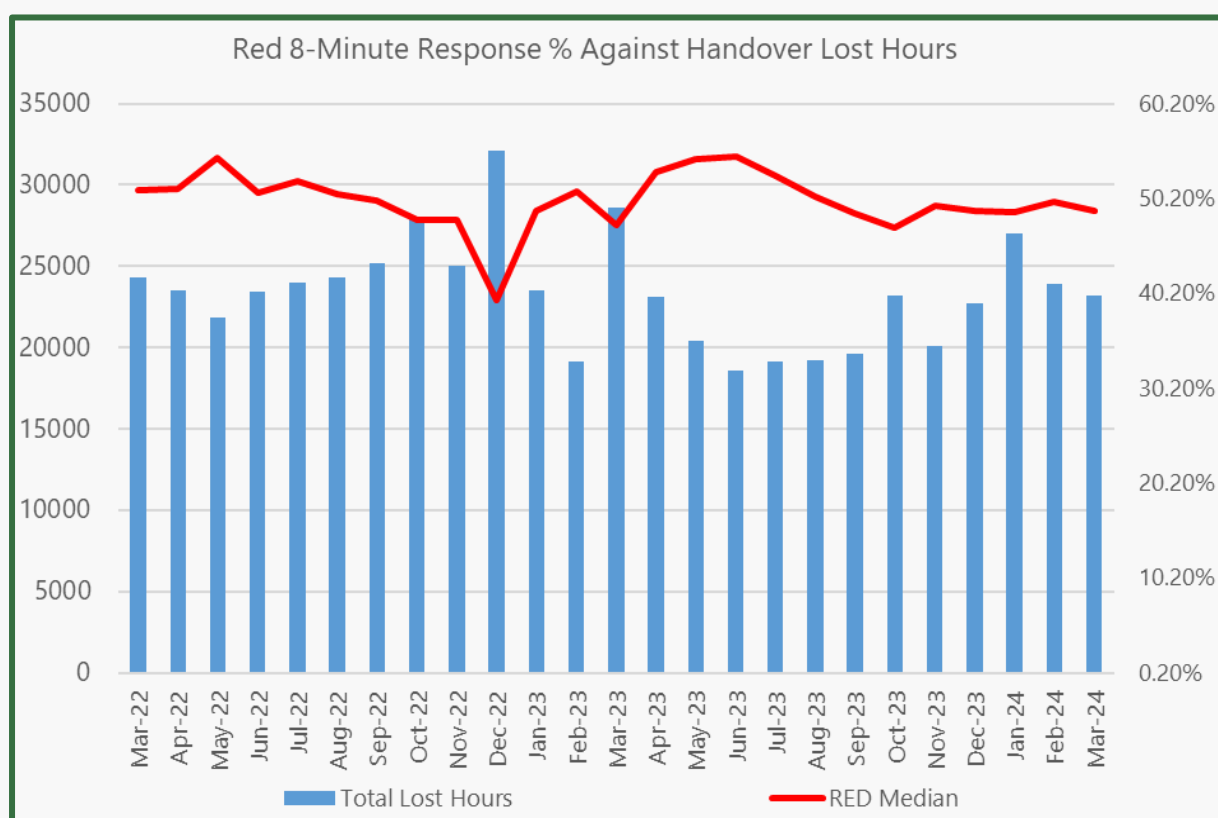
The lower left graph demonstrates the correlation between overall Red performance and hospital handover lost hours. March 2024 (23,176) saw a decrease on the 28,620 recorded in March 2023, and this is despite a significant rise in the number of red incidents this March compared to last.

Remedial Plans and Actions

- The main improvement actions are:
- To maintain commissioned establishment levels overall. Funding for the +100 now secure.
 - Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas. Further actions to address;
 - Continued focus on production and abstractions);
 - The rapid deployment, before winter 2024/25, of the inverting the updated clinical model (triangle inversion) e.g. red screening, Amber Hot, Amber Cold etc.

Expected Performance Trajectory

Modelling has been completed for Spring 2024. This continues to indicate a level of Red performance below target (most likely scenario 52%) and Amber 1 (one hour and 12 minutes). This modelling includes changes already operationalised and some further improvements but does not include the major change to the clinical model i.e. this will not come on stream in Q1.



*NB: Data correct at time of abstraction

Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

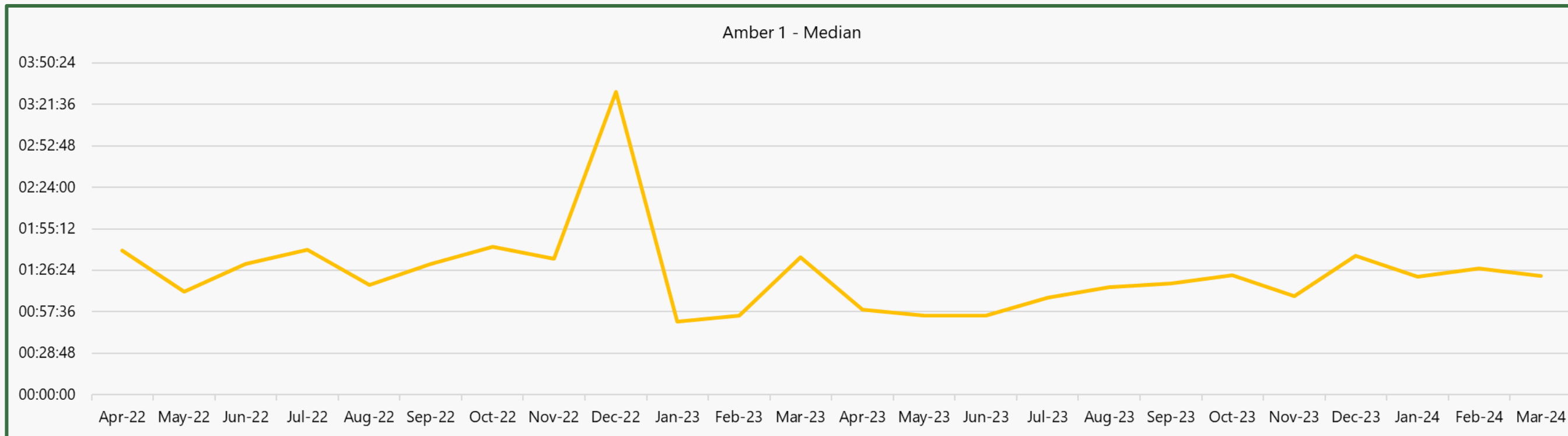
(Responsible Officer: Lee Brooks)

R

CI

FPC

QUEST



Analysis

Amber 1 median performance time improved slightly during March 2024 to 1 hour 22 minutes, from the 1 hour 27 minutes recorded in February 2024. Although this figure is lower than the 1 hour 35 minutes recorded for March 2023, it is against a month of higher Amber demand (+187) and an unprecedented level of hours lost to handover at hospitals. The ideal Amber 1 median response time remains at 18 minutes, although this has yet to be achieved during the 3-year reporting period.

The Amber 1 95th percentile decreased slightly during March 2024 to 7 hours and 35 minutes from 6 hours 51 minutes in February 2024.

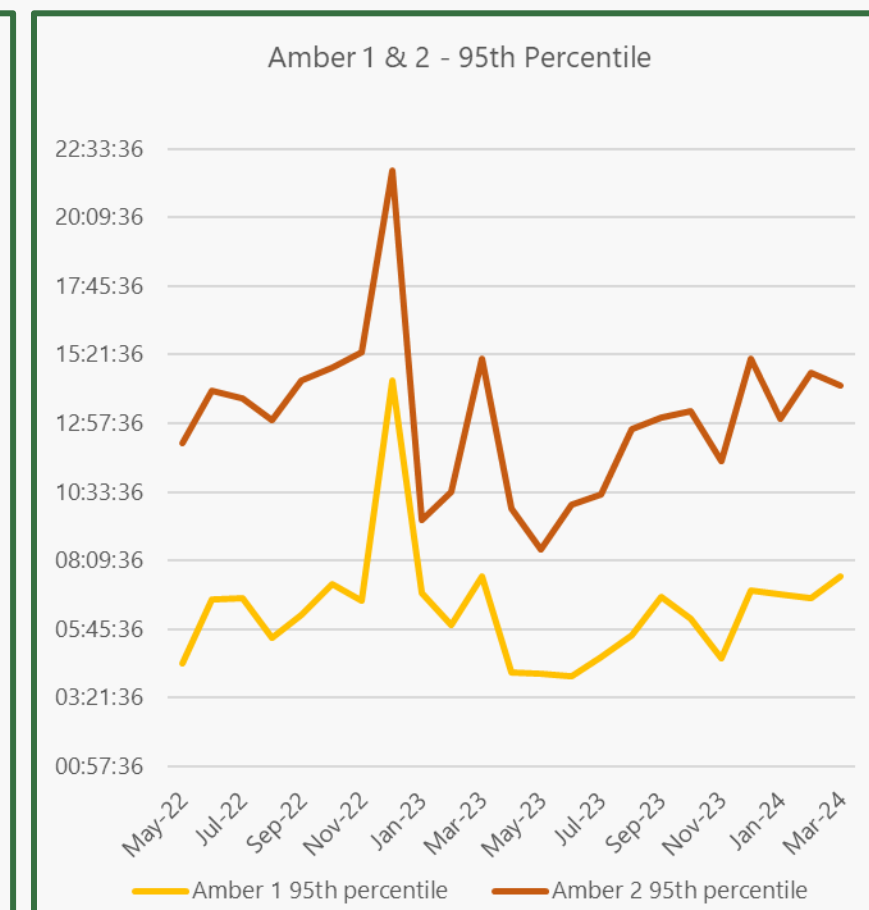
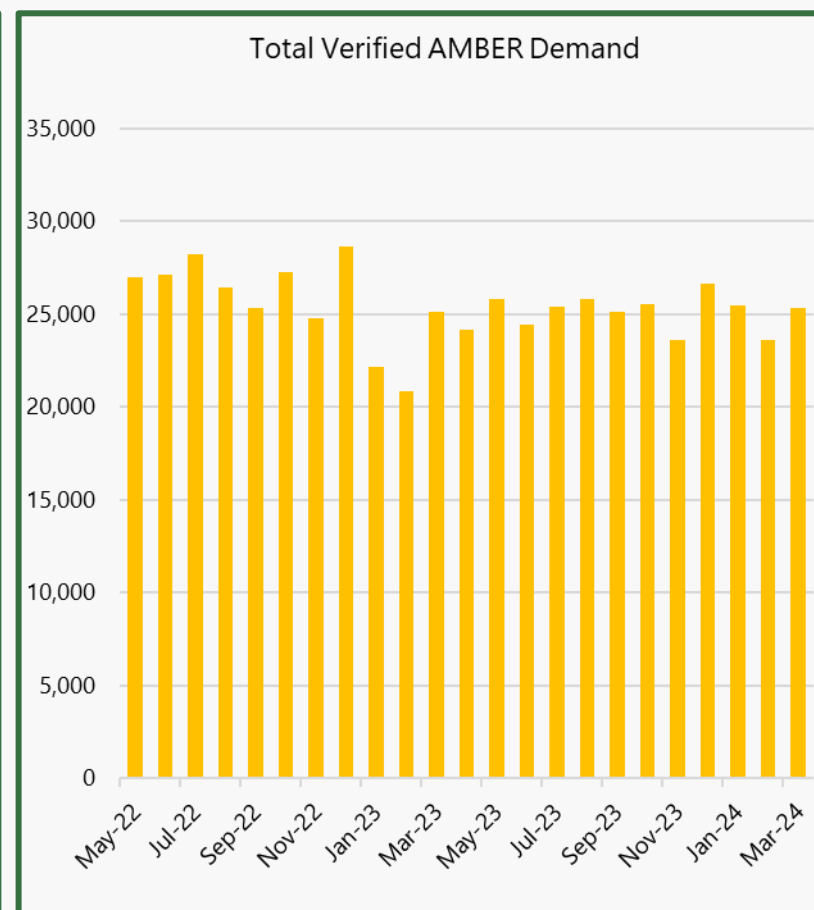
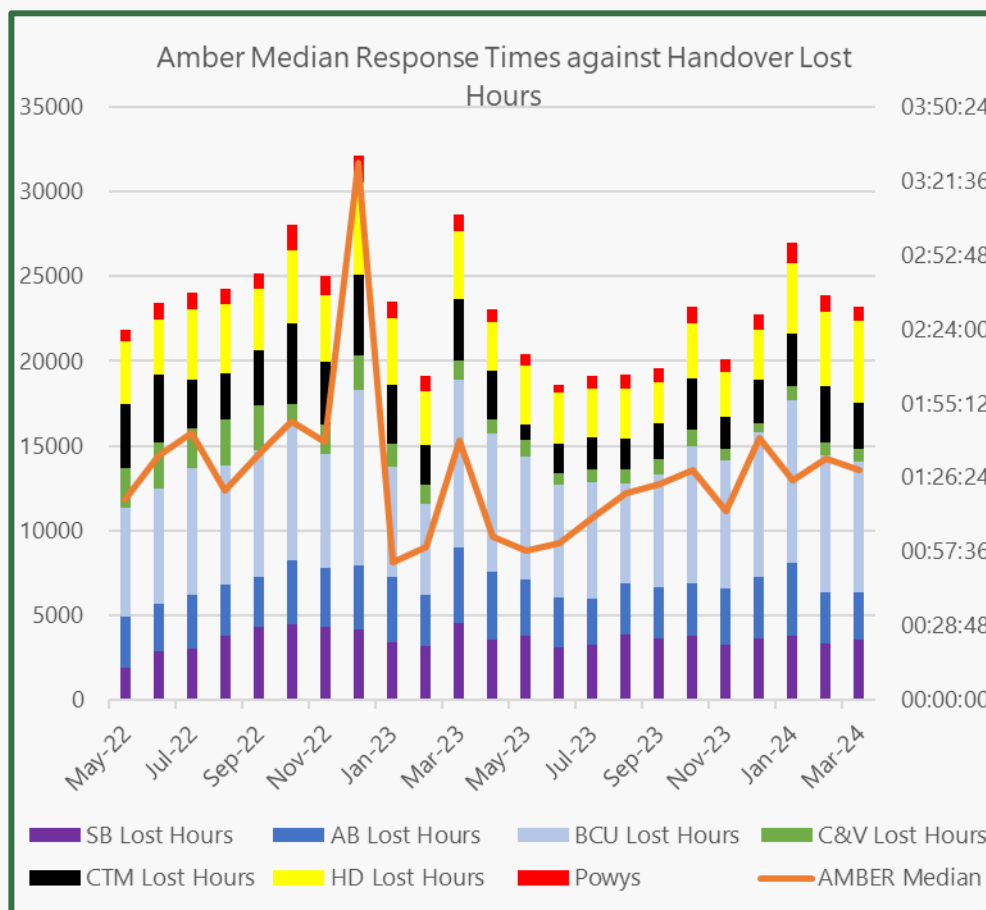
As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

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

Expected Performance Trajectory

The 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. This programme is now coming to an end, but the Trust is now well advanced with the strategic EMS Demand & Capacity Review.



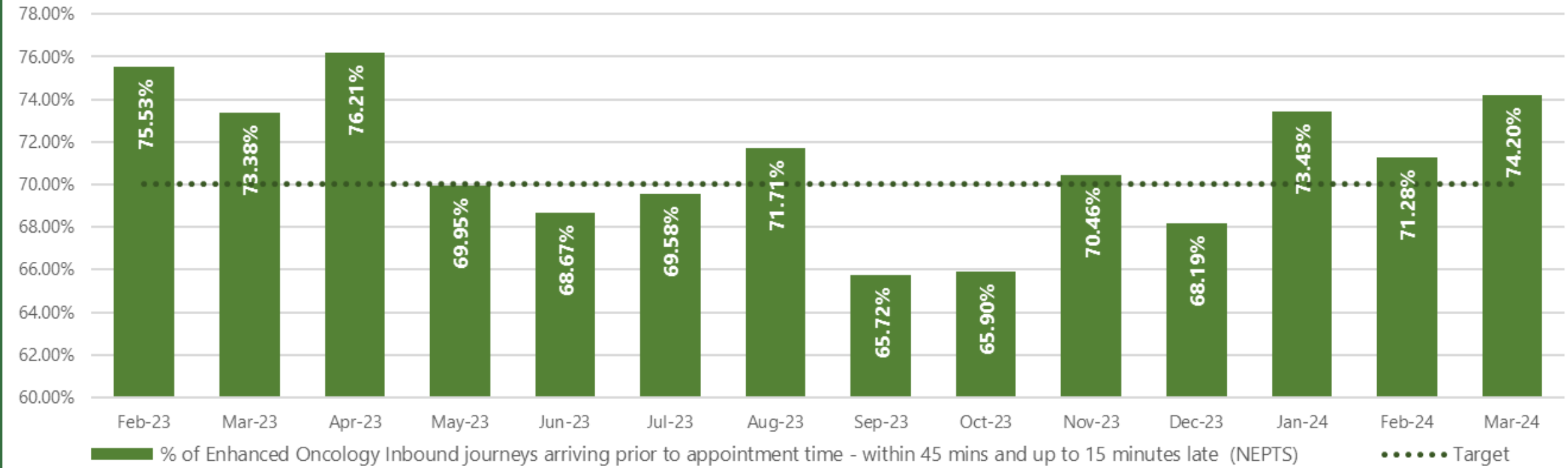
Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Oncology **G** Welsh Calls **R** FPC CI

% of Enhanced Oncology Inbound Journeys Arriving Prior to Appointment Time - within 45 mins and up to 15 minutes late



Analysis

Ambulance Care (NEPTS element) performance increased during March 2024. 74.20% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, an increase from 71.28% in February 2024, still achieving the 70% target. Enhanced Renal journeys, saw a slight increase, from 73.69% in February 2024 to 75.70% in March 2024 and continues the pattern of the last two years of exceeding the agreed performance standard.

The recent good performance of the enhanced service has been achieved despite continual growth in the sector, mainly driven by renal activity increasing.

The NEPTS service continues to be completely committed and focused on improving both timeliness and service quality and is currently trialling a focused service matching oncology patients up with dedicated drivers which has returned an initially positive set of outcomes. In addition, investment has been made in Oncology transport within areas of traditional poor performance,

Call volumes answered decreased in March 2024 (16,939) compared to February 2024 (18,067). The average speed of call answering improved slightly in March 2024 (00:03:01) for the second consecutive month compared to February 2024 (00:03:59).

ACA1 (NEPTS) sickness decreased slightly in March 2024 to 11.37% compared to 12.65% in February 2024. However, ACA2 (UCS) sickness increased to 10.06% in March 2024 compared to 9.73% in February 2024.

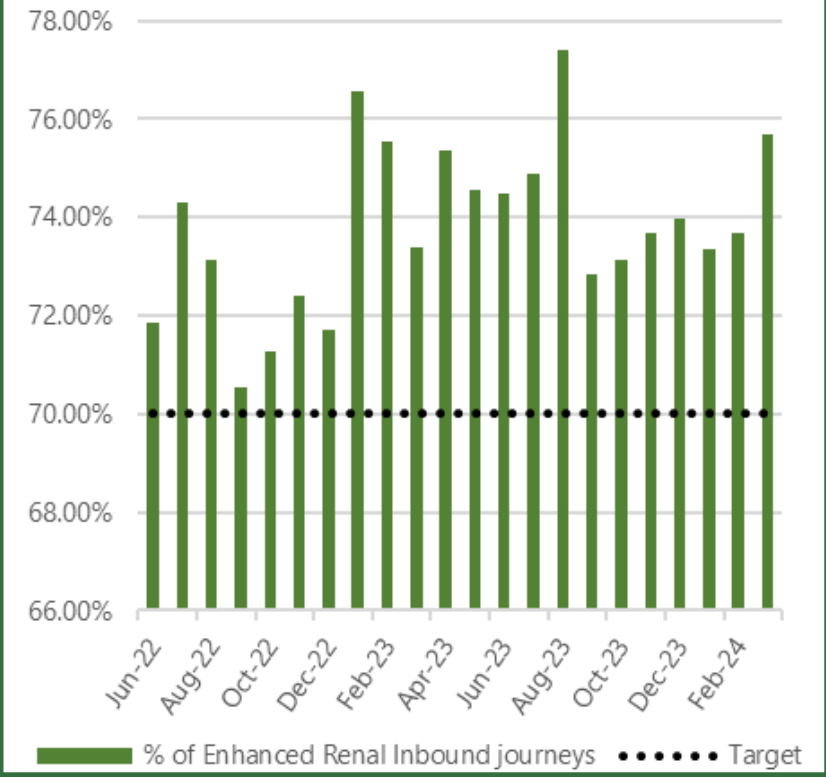
Remedial Plans and Actions

- The journey booking team are reviewing both the existing service standards, which are uncontracted historical measures and not fully funded. This has already been discussed with the NEPTS DAG.
- Opening hours and delivery methodology are also being reviewed to establish a more focused resource profile compared to demand.
- Sickness is a particular area of focus and enhanced monitoring processes have been implemented.

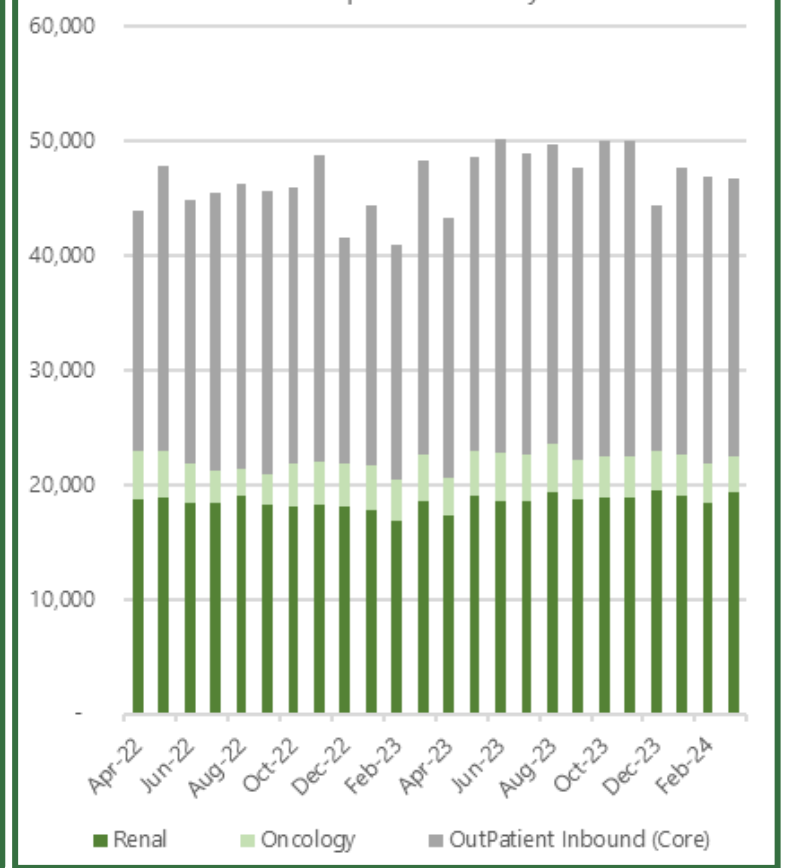
Expected Performance Trajectory

It is anticipated that, as we work through the attendance at work policy actions, sickness will begin to improve.

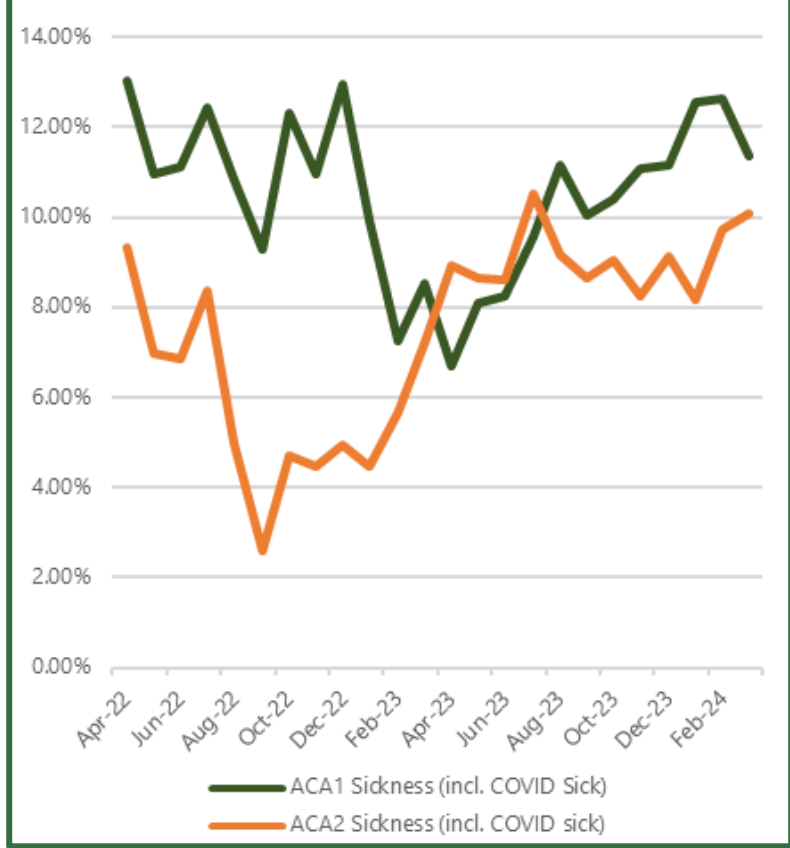
% of Enhanced Renal Journeys Arriving within 30 Minutes Prior to their Appointment Time and not Late (NEPTS)



NEPTS Completed Journey Runs



Pan Wales Ambulance Care Sickness Abstractions



Our Patients: Quality, Safety & Patient Experience

(Responsible Officer: Andy Swinburn)

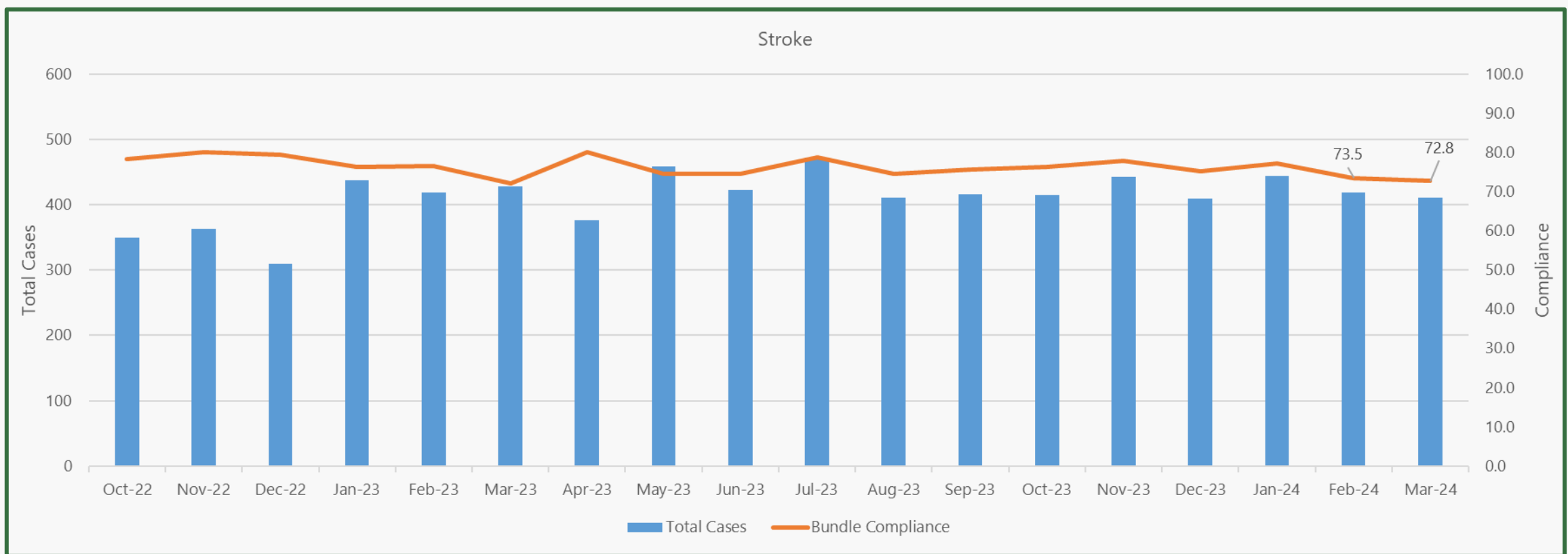
ROSC/Stroke/STEMI
A

Self-Assessment:
Strength of Internal
Control: Moderate

QUEST

Clinical Indicators

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



Analysis

The percentage of suspected stroke patients receiving an appropriate care bundle in March 2024 was 72.8%, a decrease from the 73.5% recorded in February 2024. This was against a total case number of 411 during the month of March. There is a correlation between documenting FAST and the care bundle, this will inform the improvement plan.

The ROSC rate for March 2024 was 21% an increase from 14.7% in February 2024. This was against a total case number of 253 during the month of March. The highest rate recorded since the implementation of ePCR was seen in August 2023, achieving 23.8%.

Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this may include response times, bystander resuscitation and response type/numbers.

As a result of the recent decline in ROSC at hospital, the Clinical Intelligence & Assurance Team undertook work to understand the reason. This so far has identified an improved clinical picture as information is documented in the narrative and not the specific ePCR fields for CIs reported on using raw data. Draft data was presented at CIAG in April 2024 and a further update and option appraisal will be presented at CIAG in May 2024.

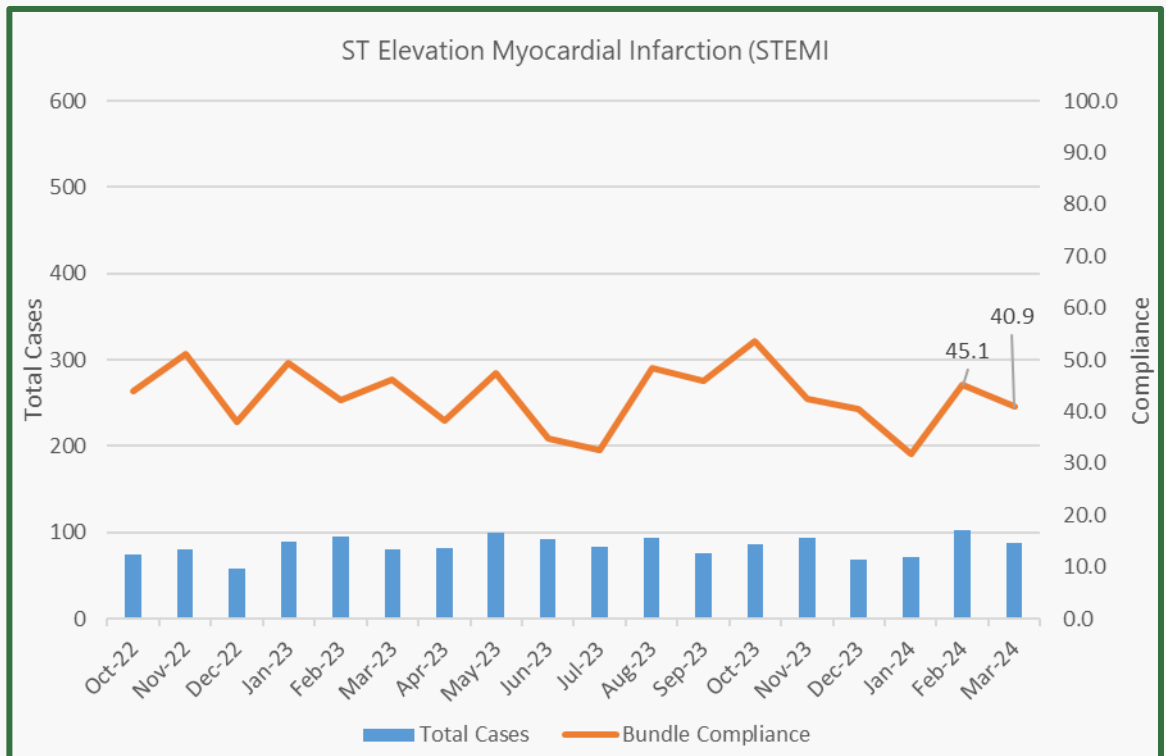
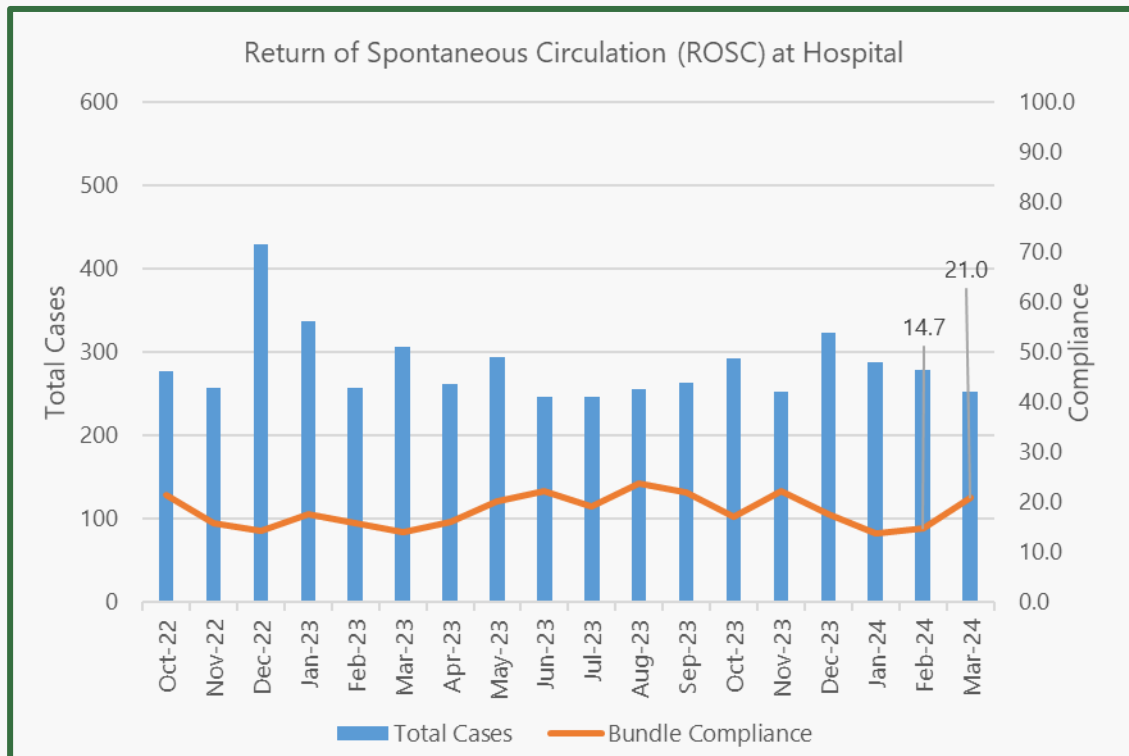
The percentage of suspected STEMI patients receiving an appropriate care bundle in March 2024 was 40.9%, a decrease from 45.1% in February 2024. This was against a total case number of 88 during the month of March. There is a correlation between documenting of analgesia and the care bundle, this will inform the improvement plan.

All Clinical Indicators remain within the normal bundle control limits

Updates to the User Interface for the ePCR were rolled out in December 2023, including some of those that affect the CIs. We continue to work with the suppliers for the remaining changes.

Following the switch to ePCR, the way data is collected when with the patient has changed. Automated Clinical Indicator reports are generated from data directly inputted onto ePCRs by clinicians. There are theoretical advantages to the new process, however this has not yet been realised with the monthly results. A recovery plan has been implemented to improve compliance to the reports.

As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:
 Design of the User Interface
 Clinician interaction with the ePCR
 Accuracy of the scripting to extract the data from the data warehouse to create the report



Our Patients: Quality, Safety & Patient Experience

(Responsible Officer: Andy Swinburn)

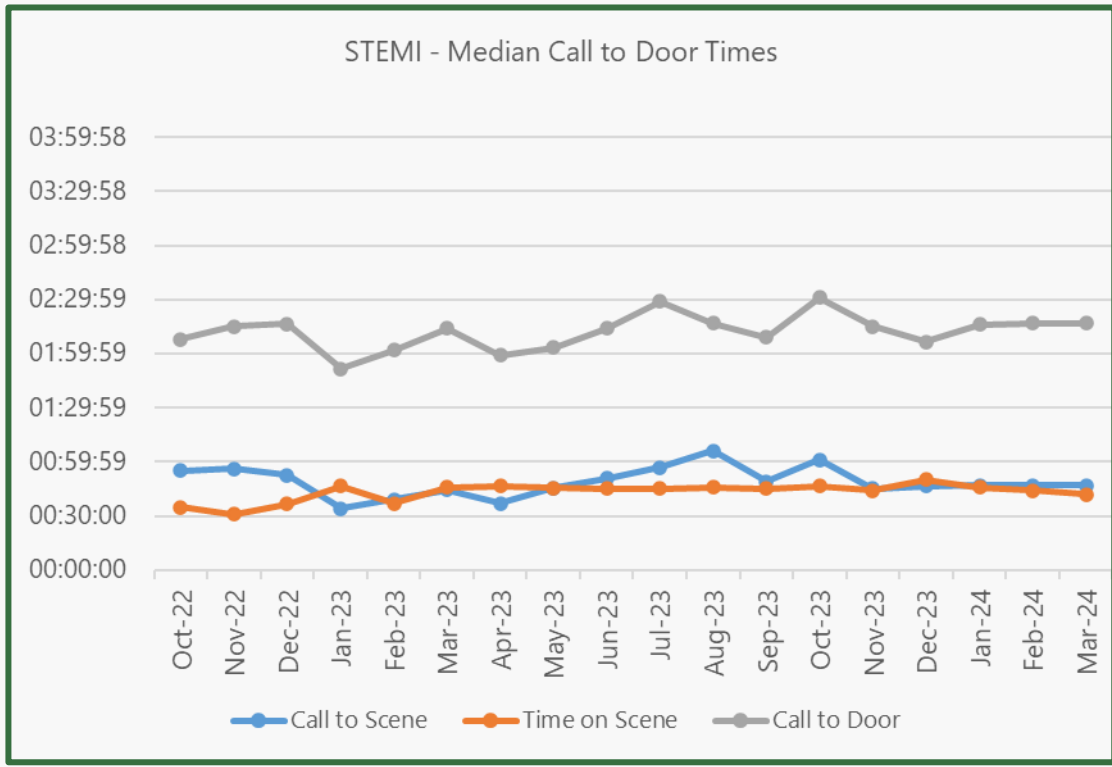
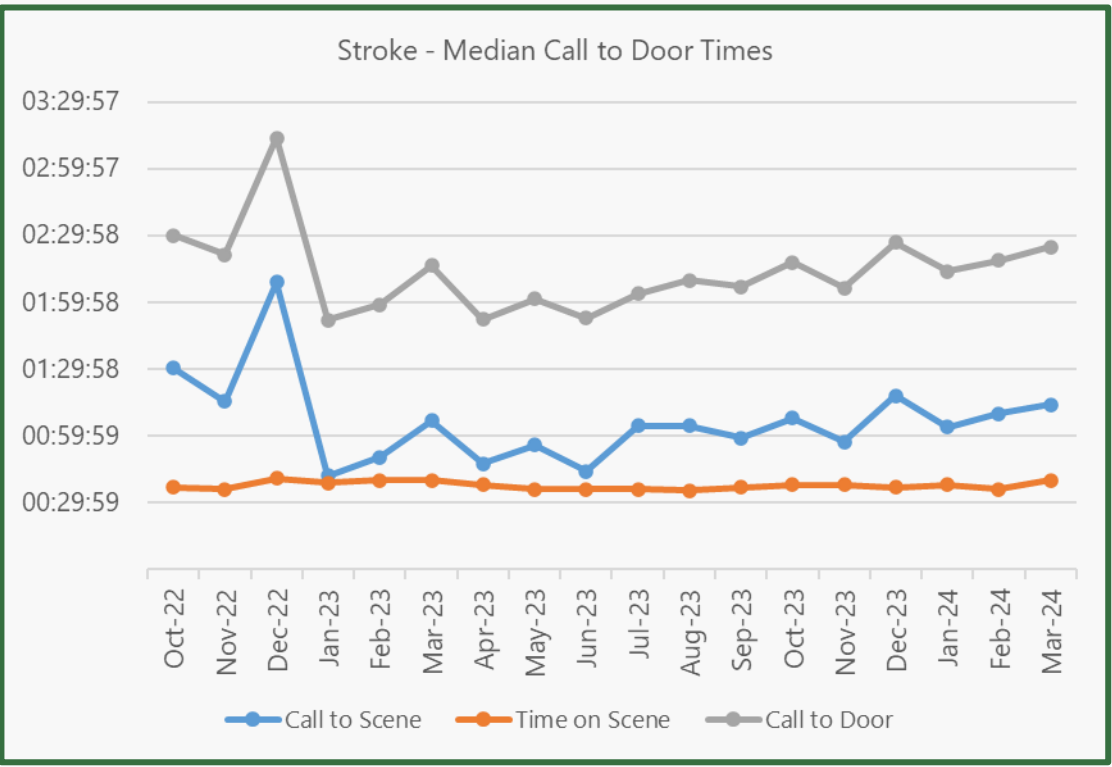
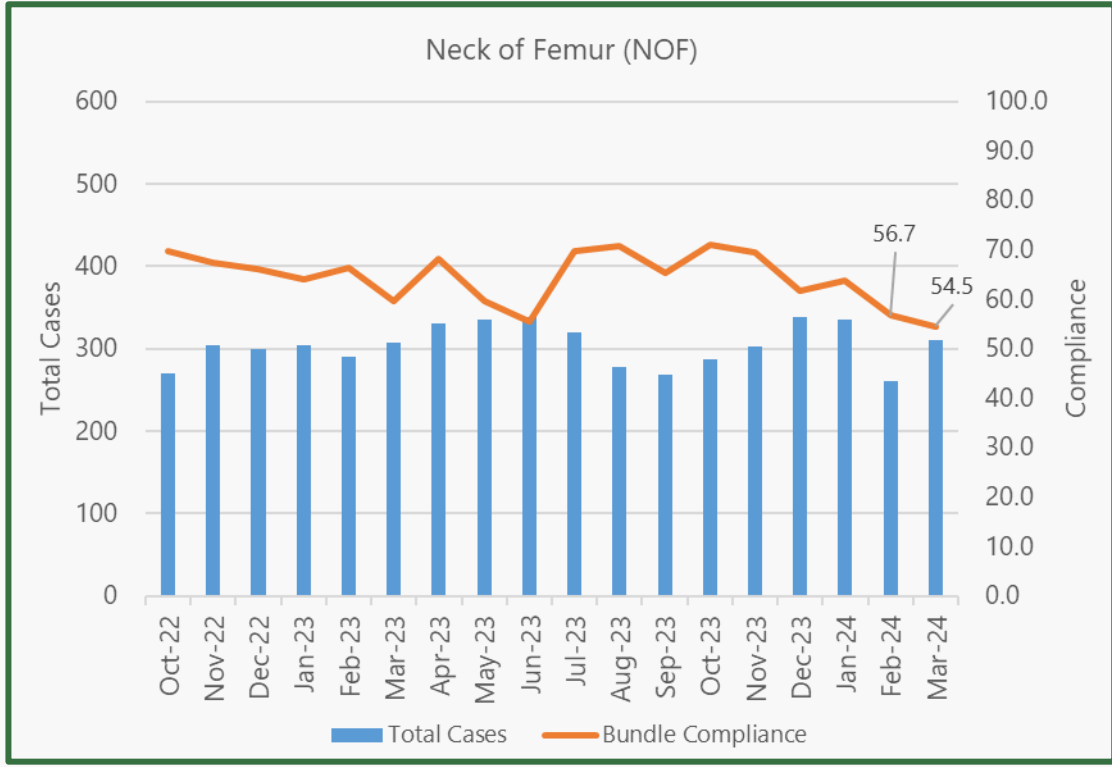
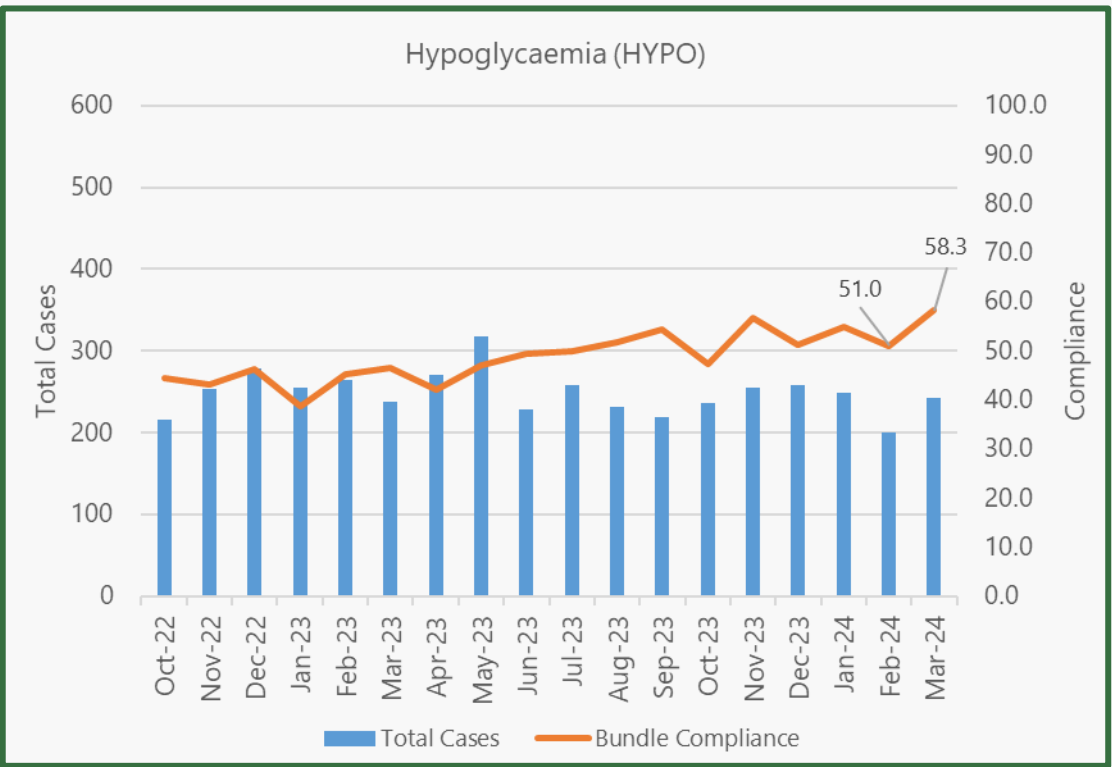
Door to Door
A

Self-Assessment:
Strength of Internal
Control: Moderate

QUEST

Clinical Indicators

Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)



Analysis

The percentage of hypoglycaemic patients receiving an appropriate care bundle in March 2024 was 58.3%, an increase from 51% in February 2024. This was against a total case number of 242 in March. There is a correlation between documenting BM readings and the care bundle, this will inform the improvement plan.

The percentage of #NOF patients receiving an appropriate care bundle in March 2024 was 54.5%, a decrease from 56.7% in February. There is a correlation between documenting pain score and analgesia and the care bundle which will inform the improvement plan.

Clinical Indicators relating to call to door times for STEMI and Stroke are now reported on as part of the Ambulance Service Indicators reported to EASC. These show the breakdown for:
 Time the call started to time of arrival at scene
 Time on scene of the conveying vehicle
 Time the call started to time of arrival at hospital

Remedial Plans and Actions

- A recovery plan has been implemented to improve the CI compliance; actions include:
 - Full deployment at pace of the CI Improvement Plan
 - Focussed communication with WAST clinicians to use the bespoke ePCR boxes for CIs
 - Supporting Senior Paramedics to have conversations about CIs
 - Health Board focussed clinical workshops to promote understanding of CIs and care bundles
 - Invest in resources to utilise Natural language Processing, a form of AI to interrogate clinical narrative
 - Review scripting in a structured way for each CI bundle, monitor and repeat annually
 - Implementation of the clinical supervision policy to embed CIs
 - Plan resources required to provide clinical data at an individual level to all clinicians

The Trust's introduction of the Cymru High Acuity Response Unit model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and is our main response to improve Return of Spontaneous Circulation (ROSC) rates. Since May 2023 there has been an increase in numbers and availability.

Expected Performance Trajectory

The ePCR Compliance Approval Group are exploring options to improve ePCR completion and compliance to CIs with prompts when an ePCR is being closed to enable clinicians to easily return to the required filed for completion. This will be implemented in a stepwise approach.

This, along with continuing improvements in clinical supervision and the support of SPs working with the Clinical Improvement and Clinical Intelligence and Assurance Teams should increase compliance rates.

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

(Responsible Officer: Liam Williams)

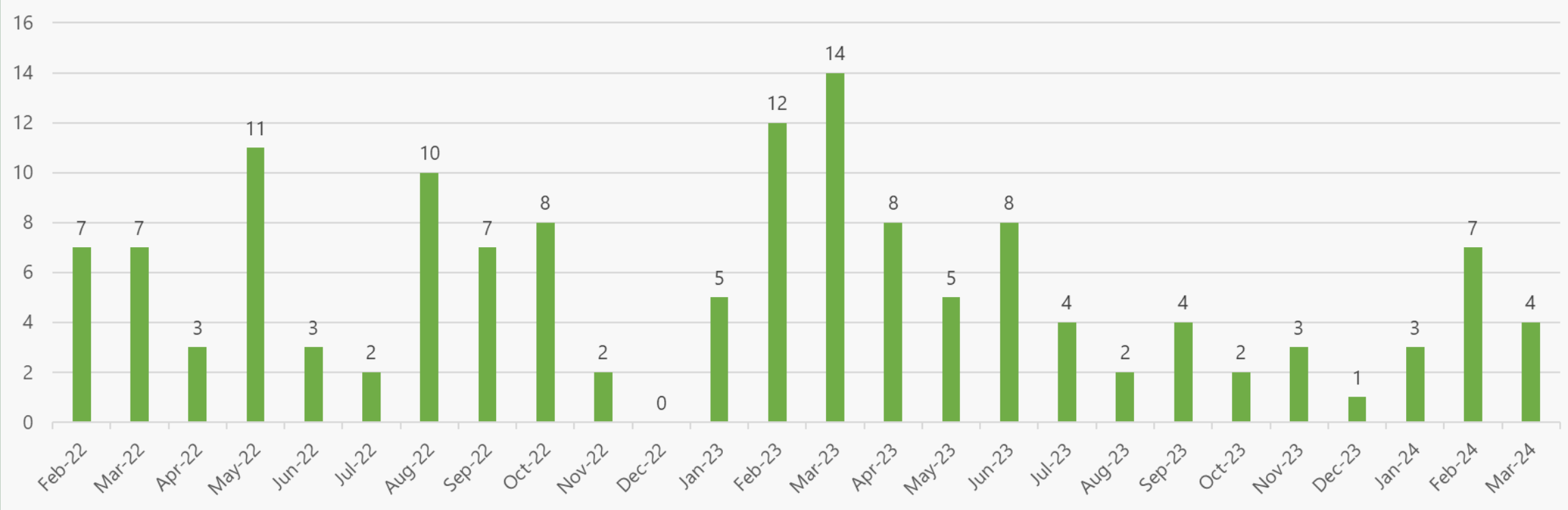
Concerns: **A**

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

QUEST

Health & Care Standard
Health - Safe Care / Timely Care

Number of National Reportable Incidents (NRIs) Reported to the NHS Executive - All Wales



Analysis

The percentage of responses to concerns in March 2024 is 56% against a 75% target (30-day response) which is an increased position but is expected to reduce ahead of stabilising by quarter 3 due to new staff education and training. 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 has slightly decreased with 109 complaints being received and processed in March 2024. These complaints are frequently complex with our concerns administrators taking lengthy calls from distressed patients or family members for up to one hour per call. Five (5) Serious Case Incident Forums (SCIF) were held during the month and 34 cases were discussed. Following discussion 4 serious patient safety incidents were reported to the NHS Wales Executive and 21 serious cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received 1 referral from a Health Board under the Joint Investigation Framework during the period. Learning from the Joint Investigation Framework process remains limited with Health Boards citing high levels of escalation as causal factors.

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 and contact patients and families as appropriate and metrics will be included in the MIQPR from April 2024.

Themes relating to serious patient safety incidents reported to the NHS Wales Executive (Delivery Unit) as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation and predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme.

In March 2024, 787 patients waited over 12 hours for an ambulance response and 63 compliments were received from patients and/or their families.

Remedial Plans and Actions

A range of actions are in place:- Good progress is being made in recruitment to posts following the Putting Things Right organisational change process. New staff require induction, education and training which takes existing resource. A recovery plan will be presented at the Clinical Quality Governance Group in April 2024.

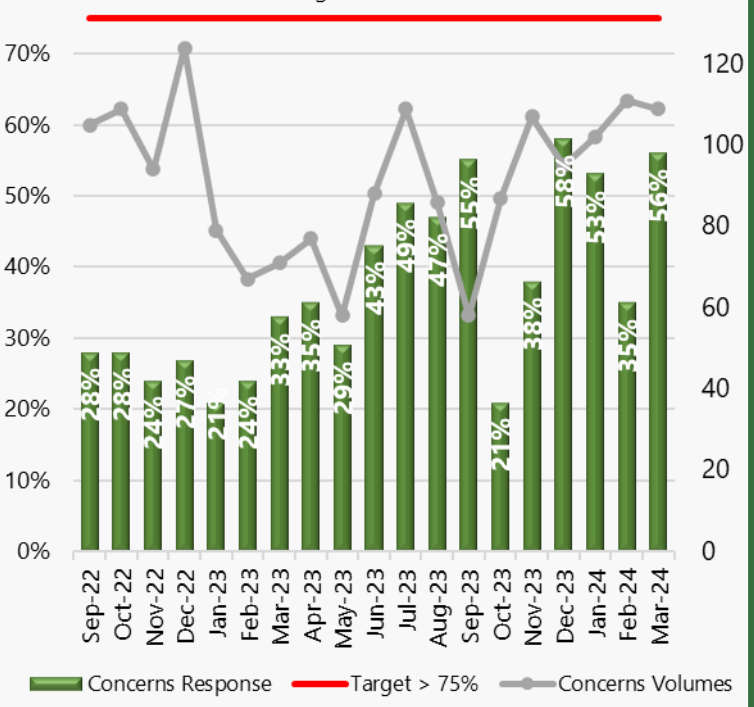
Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions, both are considered at Board sub-committee level and at Trust Board.

The key strategic action is the EMS Operational Transformation Programme.

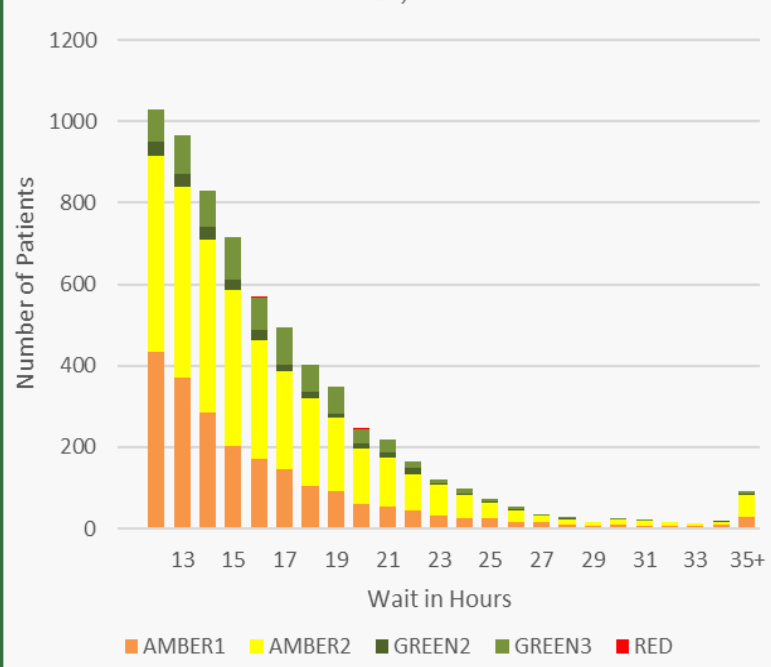
Expected Performance Trajectory

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 which are detailed on the Corporate Risk Register.

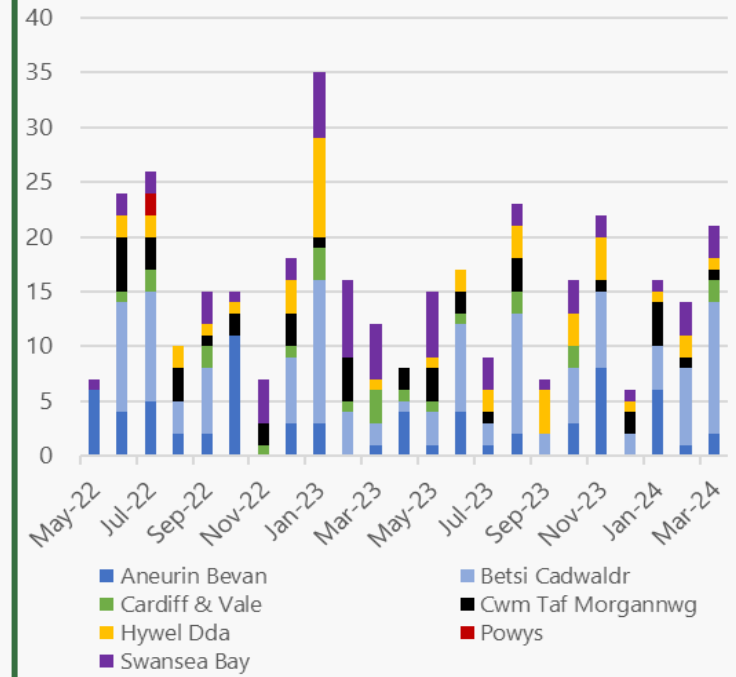
% of concerns with a response within 30 working days against volumes



Number of Patient Waits over 12 hours by Priority Type Cumulative Position over last 12 months (Feb-23 to Mar-24)



Number of Incidents reviewed at the SCIF reported to the Health Board on the Joint Investigation Framework (JIF).



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

Our Patients: Quality, Safety & Patient Experience

Patient & People Safety Indicators

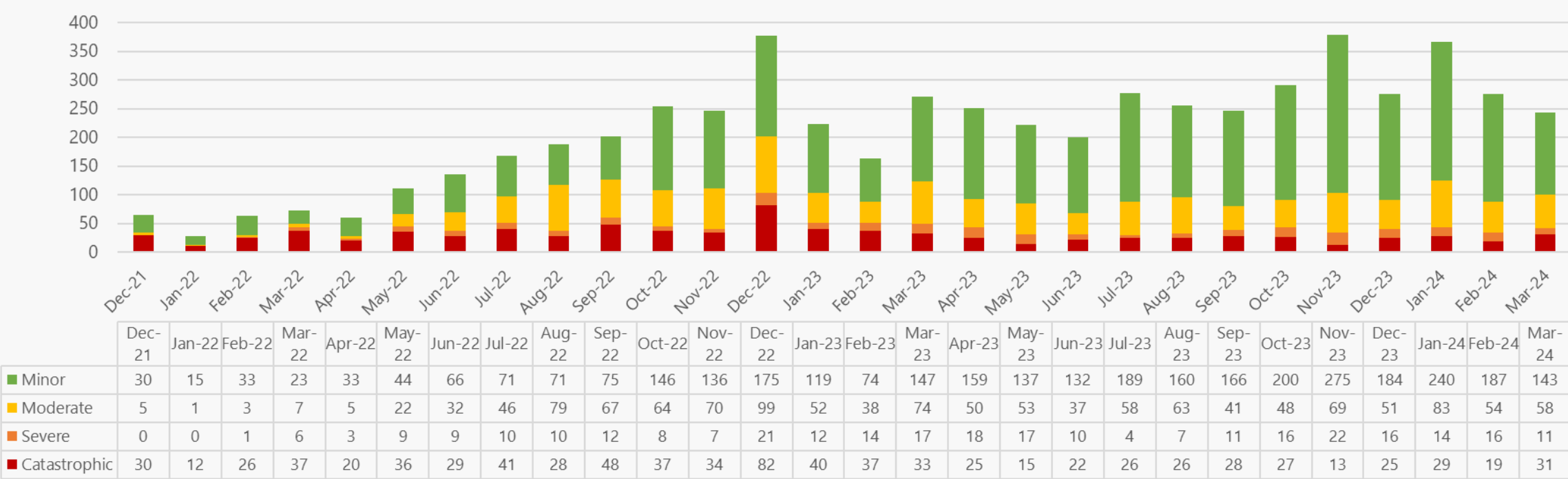
Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

(Responsible Officer: Liam Williams)

Health & Care
Standard
Health – Safe Care

Number of incidents Received on Datix system within the reporting month, by Harm grading (Volumes Received)



Analysis

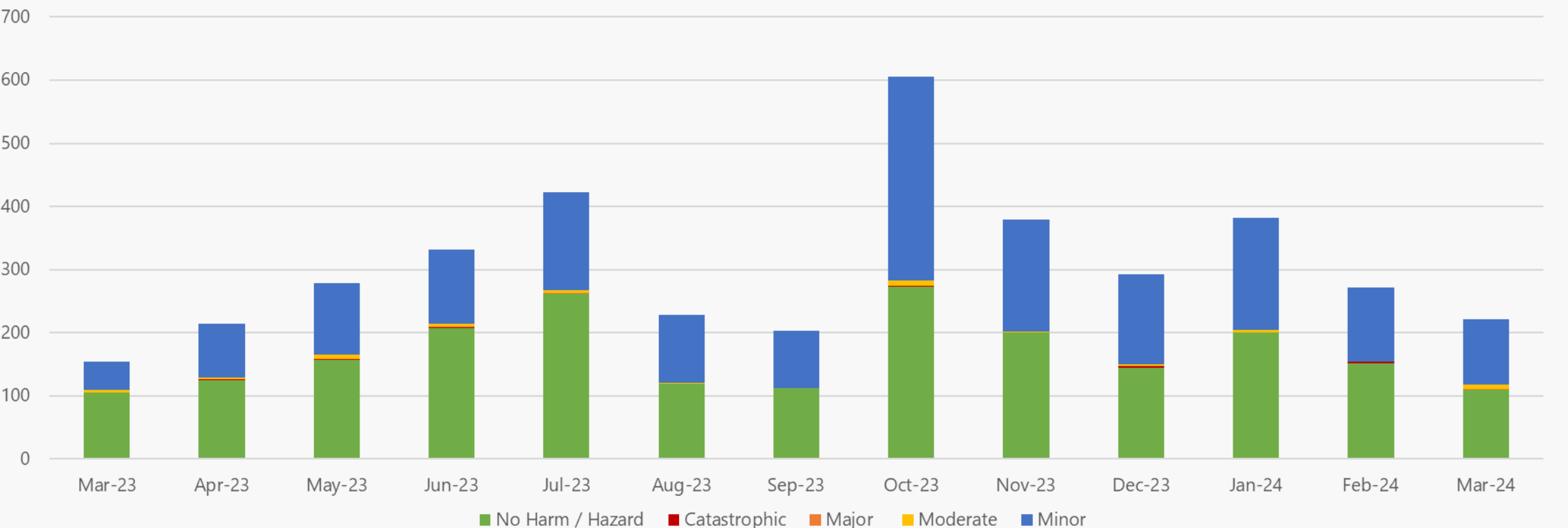
Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed. All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported and further work to develop a dashboard is in progress. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

- No harm or hazard – 40
- Minor harm – 143
- Moderate harm – 58
- Severe Outcomes – 11
- Catastrophic – 31

(*NB: Volumes received).

The bottom graph highlights the 222 Incidents that were closed on the Datix system in March 2024. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

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



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 Putting Things Right concerns which are frequently complex. The combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service has meant additional activity for the Putting Things Right Team. There is also a backlog of MPDS audits currently. The EMSC team are working hard to conclude these as soon as possible.

The Putting Things Right Team organisational change process is progressing, and final posts will be recruited to by July 2024. This new structure has taken into consideration the Trust's local and national priorities and resources to meet the needs of patients and families. It is envisaged that the new structure will take some time to become established. A recovery plan will be presented to Clinical Quality Governance Group at the April 2024 meeting.

The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards and the aggregation of data and information to inform patterns, trends and learning opportunities as part of the quality management system.

Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the Putting Things Right processes.

**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

Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

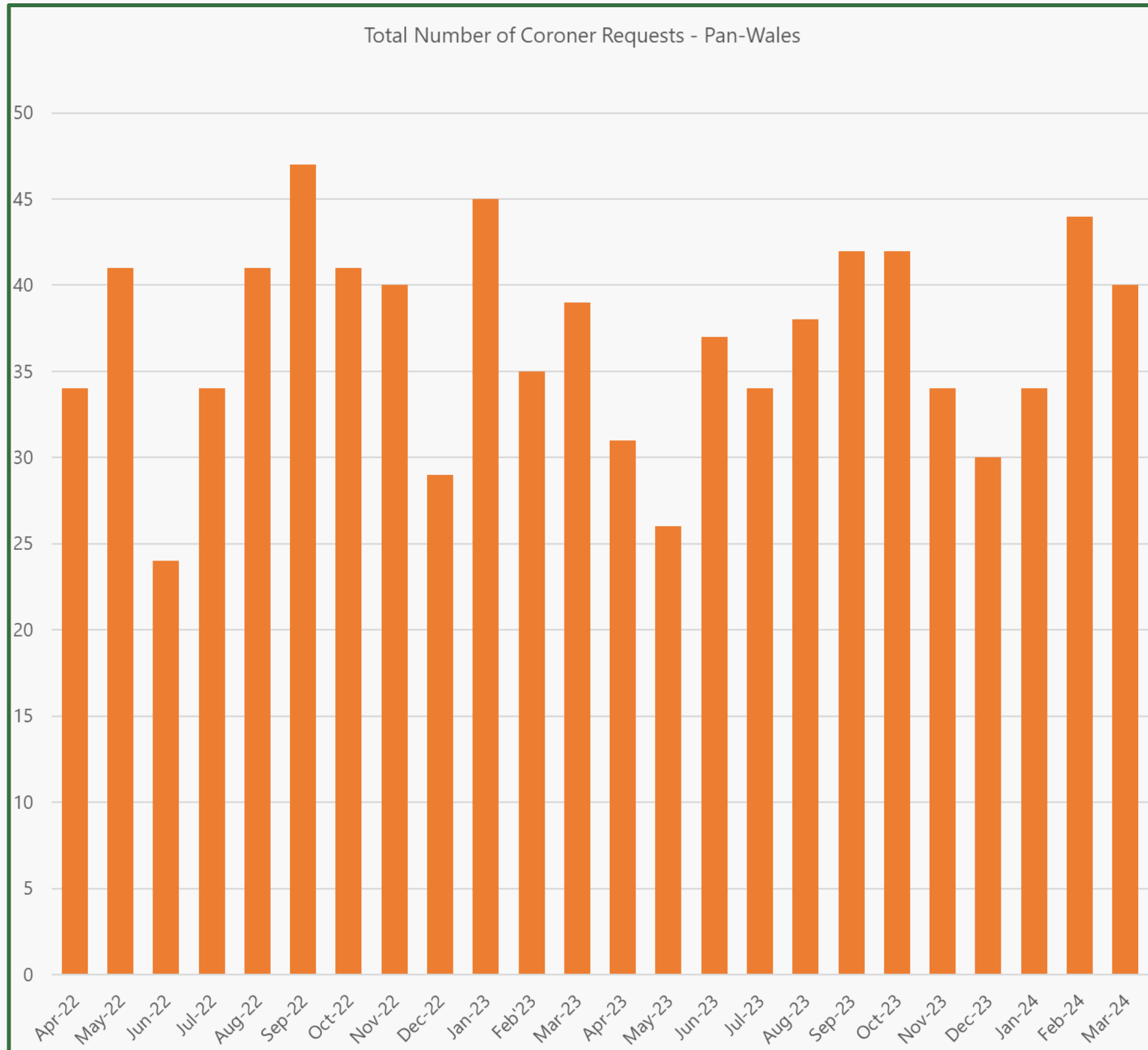
Coroners
Self-Assessment:
Strength of
Internal Control:
Moderate

Mortality
Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

Health & Care
Standard
Health – Safe Care

Total Number of Coroner Requests - Pan-Wales



*NB: Temporary graph at All-Wales level: The Trust is currently unable to report Coroner requests at Health Board level due to the implementation of the new Datix system

Analysis

Coroners: The complexity of the cases remains high, with multiple statements and actions per approach. This is in addition to the work required to manage cases where the Trust has been given IP status. The number of cases in which the Trust is an IP raised in April 2023 and continues higher, we now consider this to be the new normal. Cases continue to be registered and distributed. Delayed statement requests are escalated to ensure that the Trust does not receive a Schedule 5 summons.

Ombudsman: There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru. A deeper dive into the cases has been undertaken and will be reported as part of the next quarter report. The Ombudsman is considering issues surrounding joint investigations and the issues of elderly patients laying on floors waiting for ambulances.

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 as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. Feedback from the Medical Examiner Service in respect of themes and trends include timeliness in response to patients in the community, handover of care delays and patients on the end-of-life care pathway being conveyed to acute care.

Currently the focus of the Medical Examiner Service 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 Medical Examiner Service from April 2024. An increase in activity for requests / reviews for the Trust is expected when this occurs.

Remedial Plans and Actions

Coroners: There continues to be additional work due to the ongoing recovery of the Trust solicitor/claims manager, who is unable to travel for long distances. A temporary staff member's contract has been extended to the end of April 2024 to try and minimise the impact of the additional work. The Legal Services Team is not yet fully staffed following OCP, and work continues to ensure that the Team is fully formed as soon as possible.

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

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews aligning to the national approach. This includes consideration of the resources required in the new Putting Things Right (PTR) Team structure with additional roles included in the Patient Safety Team. Recruitment to the new structure is expected to be completed by July 2024. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues. The Patient Safety Team are engaged in the meetings lead by the Once for Wales Datix Cymru Team who are developing the Datix Cymru Mortality Module. The Learning from Deaths Forum, chaired by the Assistant Director of Quality & Nursing is established and is currently meeting on at least a quarterly basis, with oversight and reporting to the Clinical Quality Governance Group. Following the finalisation of the All-Wales National Mortality Framework which will include the processes in primary care, the Learning from Deaths Forum will oversee the updates to the Trust's Framework.

Expected Performance Trajectory

Coroners: This level of activity seems to be the new normal and will continue to be monitored.

Ombudsmen: Learning has been placed in a PTR, for sharing pan Wales.

Mortality Review: Whilst the multiple benefits of the Medical Examiner Service 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 by the end of April 2024 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 escalated following screening and reviewed via PTR processes internally through the Serious Case Incident Forum. Following the recruitment to the new PTR Structure (expected by May 2024) improvements in the timely review of MES referrals is expected.

Our Patients: Quality, Safety & Patient Experience

Safeguarding, Data Governance & Public Engagement Indicators

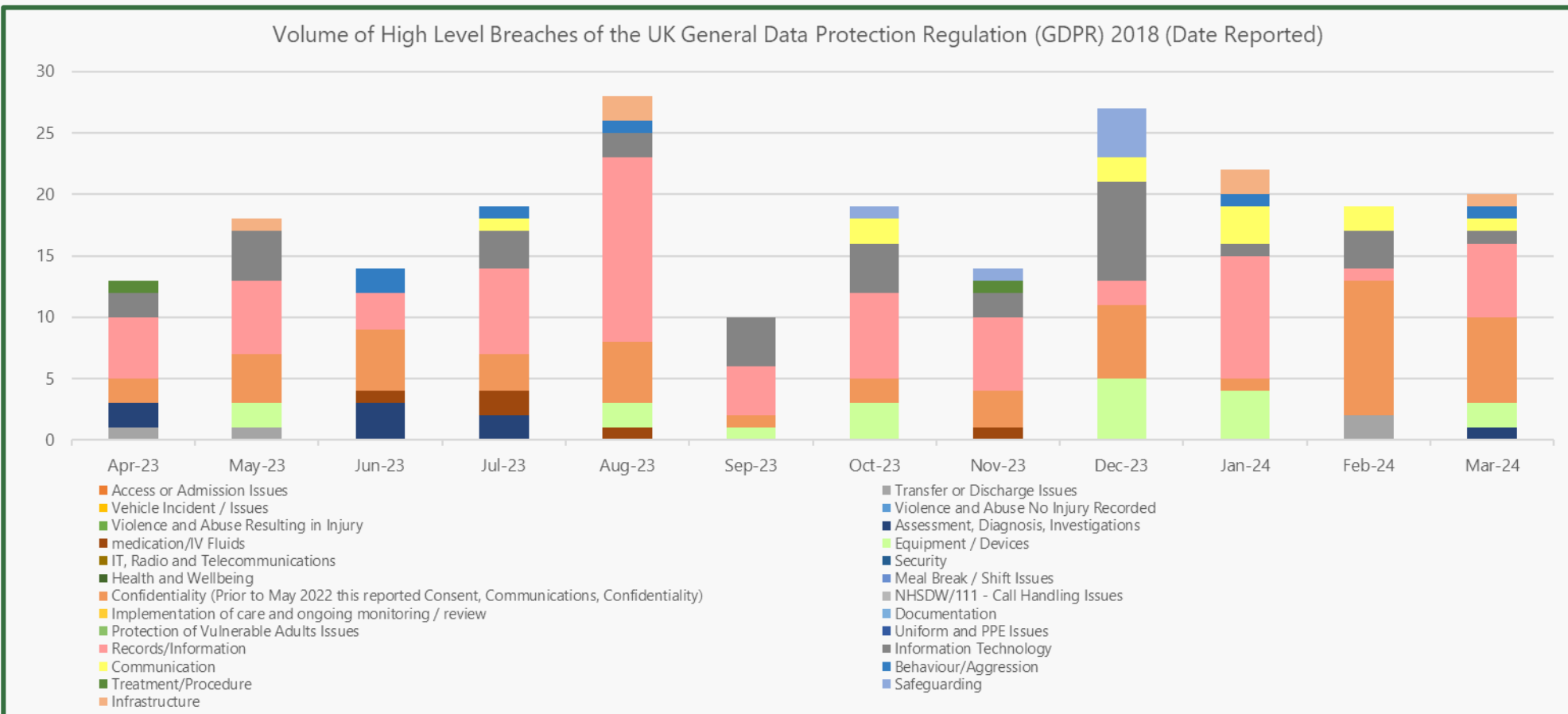
(Responsible Officers: Jonny Sammut & Liam Williams)

Self-Assessment:
Strength of Internal Control:
Strong

QUEST

Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works



Analysis

Safeguarding: In March 2024 staff completed a total of 203 Adult at Risk Reports, 92% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 565 referrals were received and processed to the local authority during this reporting period. There have been 251 Child Safeguarding Reports in March 2024, 94% of these were processed within 24 hours.

Data Governance: In March 2024, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 7 related to IG/Confidentiality, 6 Records/Information, 2 equipment/devices, 1 Communication, 1 Information Technology, 1 behaviour, 1 Infrastructure, and 1 Assessment Investigation and Diagnosis.

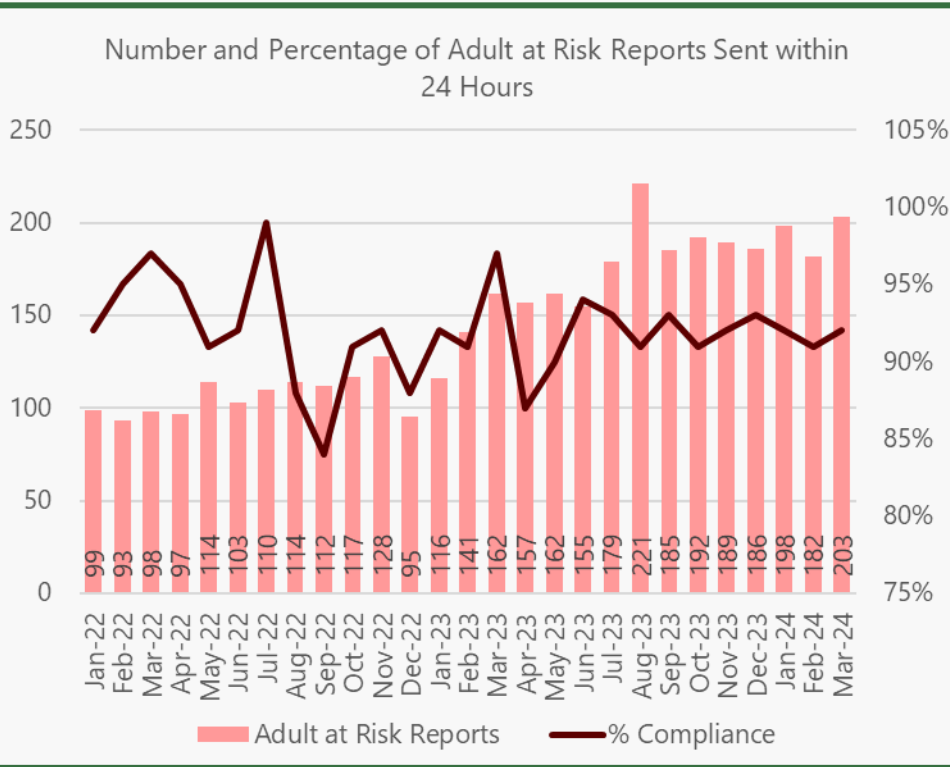
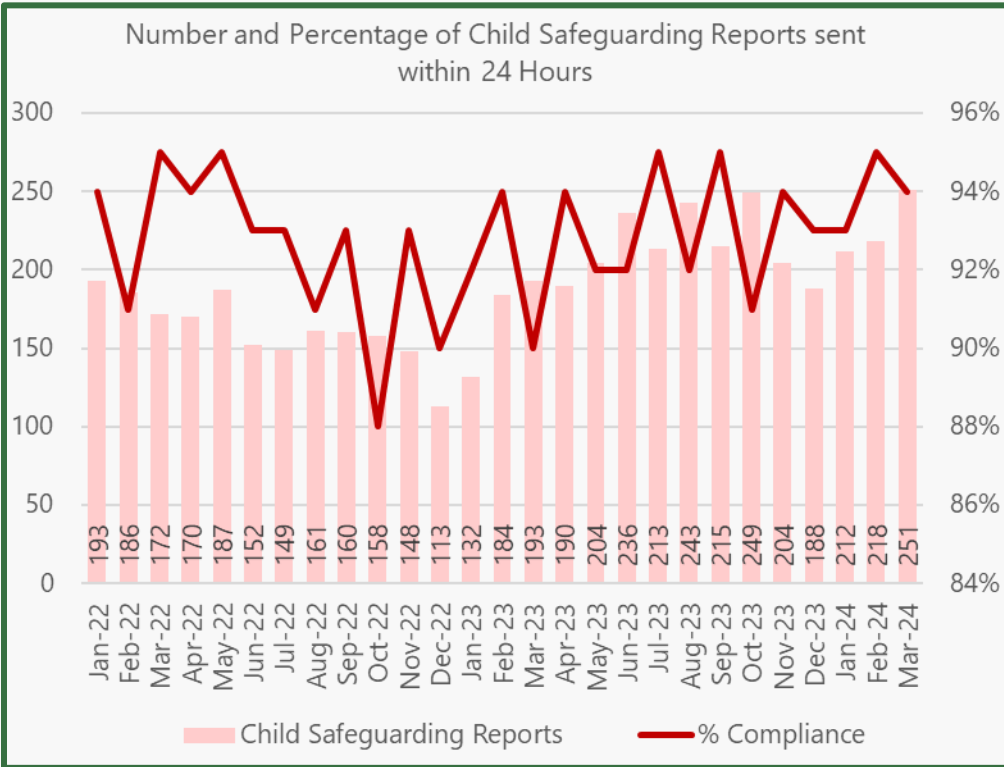
Public Engagement: During March, the Patient Experience and Community Involvement Team attended 24 community engagement opportunities, engaging with approximately 652 people. This month engagement has included attendance at an Aneurin Bevan University Health Board led 'Big Conversation' event talking to members of the public about their experiences of grief, bereavement, death and dying. We celebrated International Women's Day at a community event in Newport with a focus on building resilience and confidence in women. We attended an event in support of the UN International Day for the Elimination of Racial Discrimination where we promoted the new WAST Welcome Pack for people whose first language isn't English or Welsh. In addition, we continued to meet and engage with colleagues from Llais and have had introductory meetings with Care & Repair Cymru to explore ways of future partnership working. We have also continued on our co-production journey by attending workshops led by Co-Production Wales, sharing emergent practice and learning from real-life examples. Through the month we also continued to use engagement events as an opportunity to promote Patient Experience Surveys, asking people to provide feedback about their interactions with our services. We acknowledge that response rates to some of these surveys remains low and isn't truly reflective of all patient's experience, though we are working with colleagues to try and increase return rates. Engagement and survey outcomes remain largely consistent and tell us that people find calling 999 a stressful experience, our questioning is repetitive, and people don't understand why they need to repeat the process if they re-dial 999 to check on an ETA. But people continue to tell us that they are generally happy with the clinical care they eventually receive and that our staff are reassuring and professional. 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 longer than wanted delays when waiting for their transport home following their appointment. We have also seen an increase in people complaining about short notice cancellation of transport, leaving some with no option but to miss their much-needed hospital appointment.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support 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 20-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to review and provide advice on reported incidents.

Public Engagement: Community involvement and engagement with patients/public forms 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 PECEI 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 PECEI 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. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us. We have escalated our concerns to barriers which are preventing us from directly contacting patients to colleagues at the Welsh Risk Pool who oversee implementation of the Once for Wales Civica & Datix systems. We are seeking their advice on a way forward. WAST's Information Governance Team has also contact the Information Commissioner's office who are reviewing the situation for us and will provide further guidance.



Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission for FY23/24 was submitted end of March. An Improvement Action Plan will be developed in readiness for the next submission in March 2025.

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

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

Our Patients: Quality, Safety & Patient Experience

Health & Safety (RIDDORS) Indicators

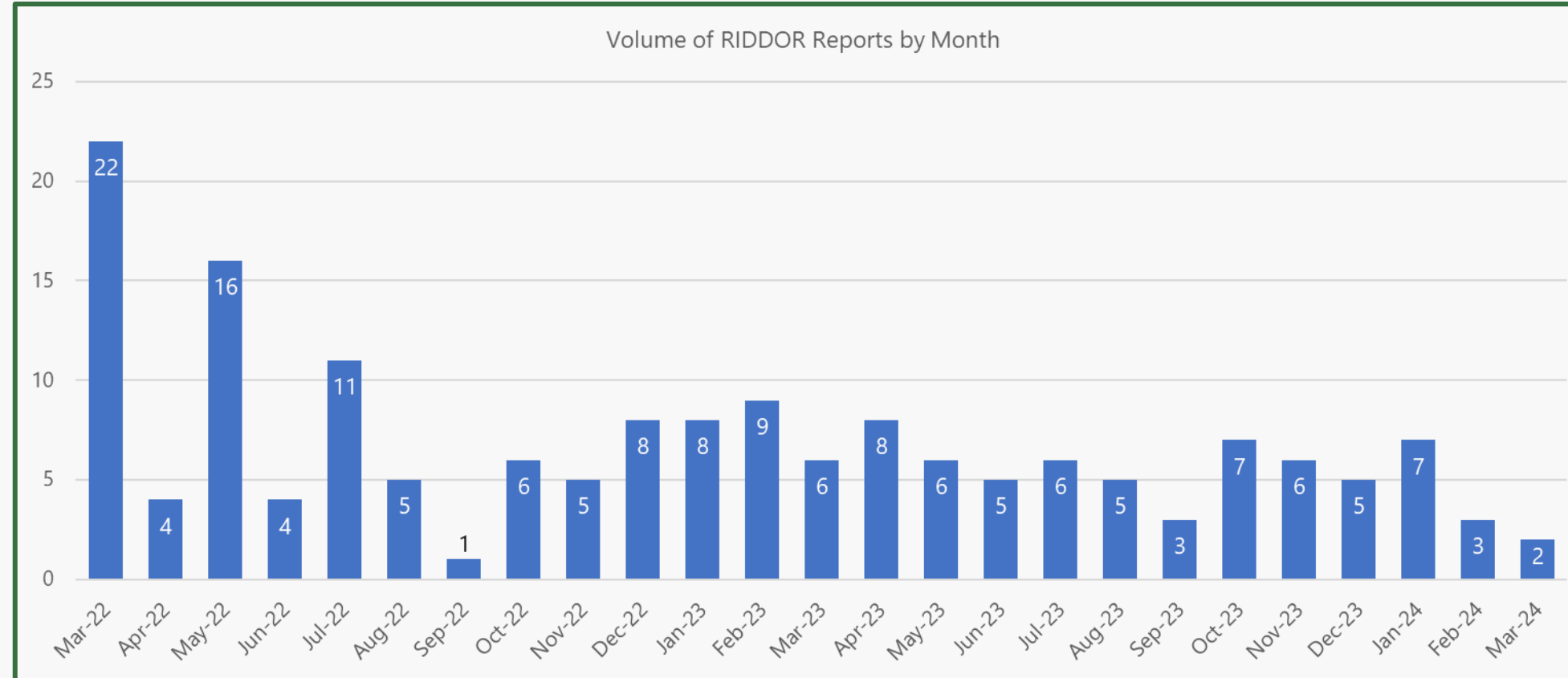
(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

Health & Care
Standard
Health – Safe Care

Volume of RIDDOR Reports by Month



Analysis

RIDDOR: There were 2 incidents requiring reporting under RIDDOR during March. All were related to staff being absent from work for over 7 days because of their injury that resulted from manual handling activities.

100% of the reports were completed within the reporting required time frames. Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales. Manual handling continues to be the highest category of incidents reported under RIDDOR.

Violence and Aggression: A total of 53 incidents have been reported of V&A in March. 6 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 47 for the month.

There were 3 reports for inappropriate sexual behaviour 1 verbal and another behavioural. 14 incidents were reported as Moderate in harm and 23 noted as low harm which continues the higher trend seen since August 2023.

Verbal abuse continues to be the major category of reporting received with aggressive and threatening behaviour toward staff still at high levels. Several Individuals convicted of violence an aggression toward staff from previous incidents have been convicted and sentenced in March.

No fines, prosecutions or notices were issued from the Health and Safety Executive (HSE) during March.

Remedial Plans and Actions

RIDDOR: A new DSE/Manual Handling Advisor has been appointed and they are undertaking an analysis of the manual handling incidents within the Trust to identify areas for continuous improvements.

Violence and Aggression: The V&A Team have visited the 111 call centres and completed visit to the CCC areas to gain a better understanding of the incidents of verbal abuse received and the challenges of reporting the incidents on Datix. The aim is to ensure more consistent reporting and investigation to ensure the physical and mental safety of our staff.

We are assisting EMS – Mental Health to RA The impact of RCRP

Expected Performance Trajectory

RIDDOR: As recommendations from the manual handling review are implements the number of incidents are projected to fall.

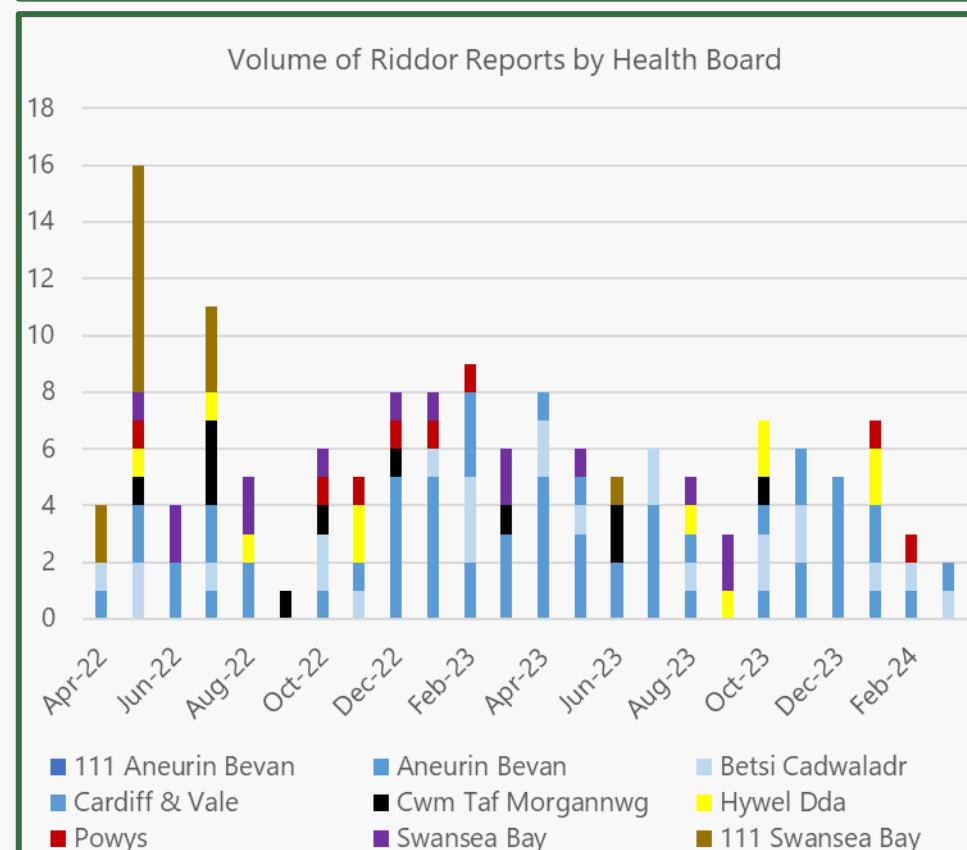
Violence and Aggression: The impact of RCRP Police attendance at welfare/mental health calls may result in an increase reporting of V&A incidents as staff try to deal with unstable patients. This is a national concern and has been raised at NAVSEG. All Police forces are implementing a phase approach to not attending calls as previously experienced .. only if there is immediate threat to life.

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

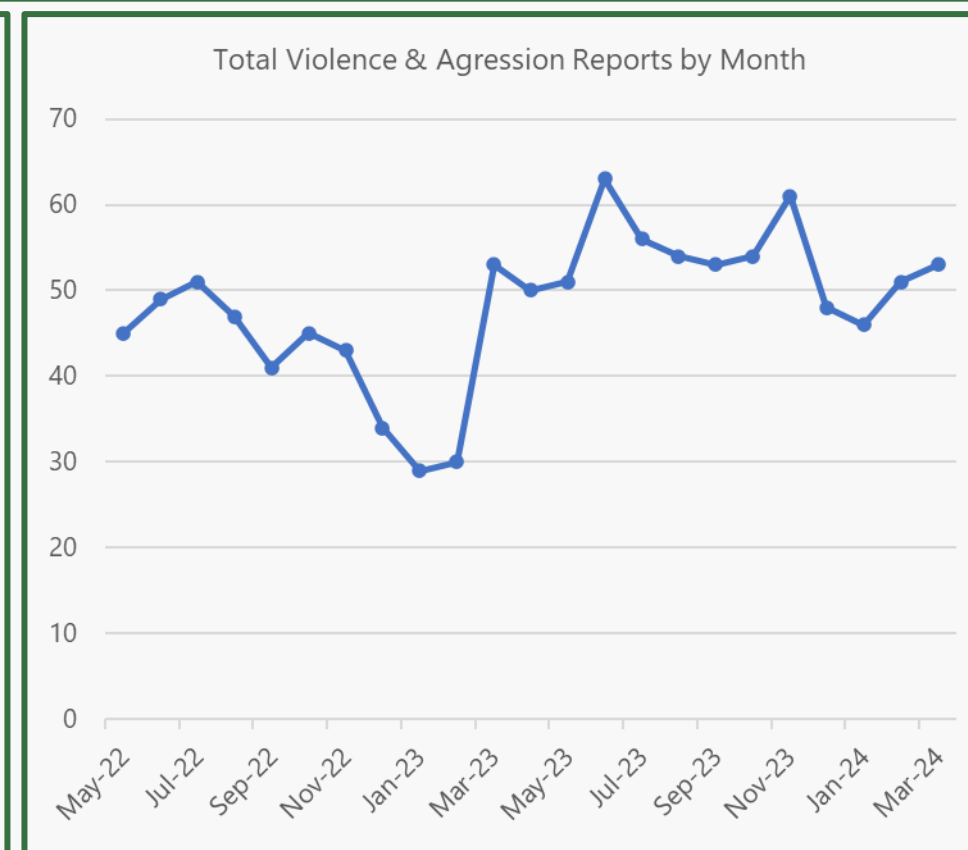
Data source: Datix

Welsh Ambulance Services University NHS Trust

Volume of Riddor Reports by Health Board



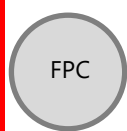
Total Violence & Agresion Reports by Month



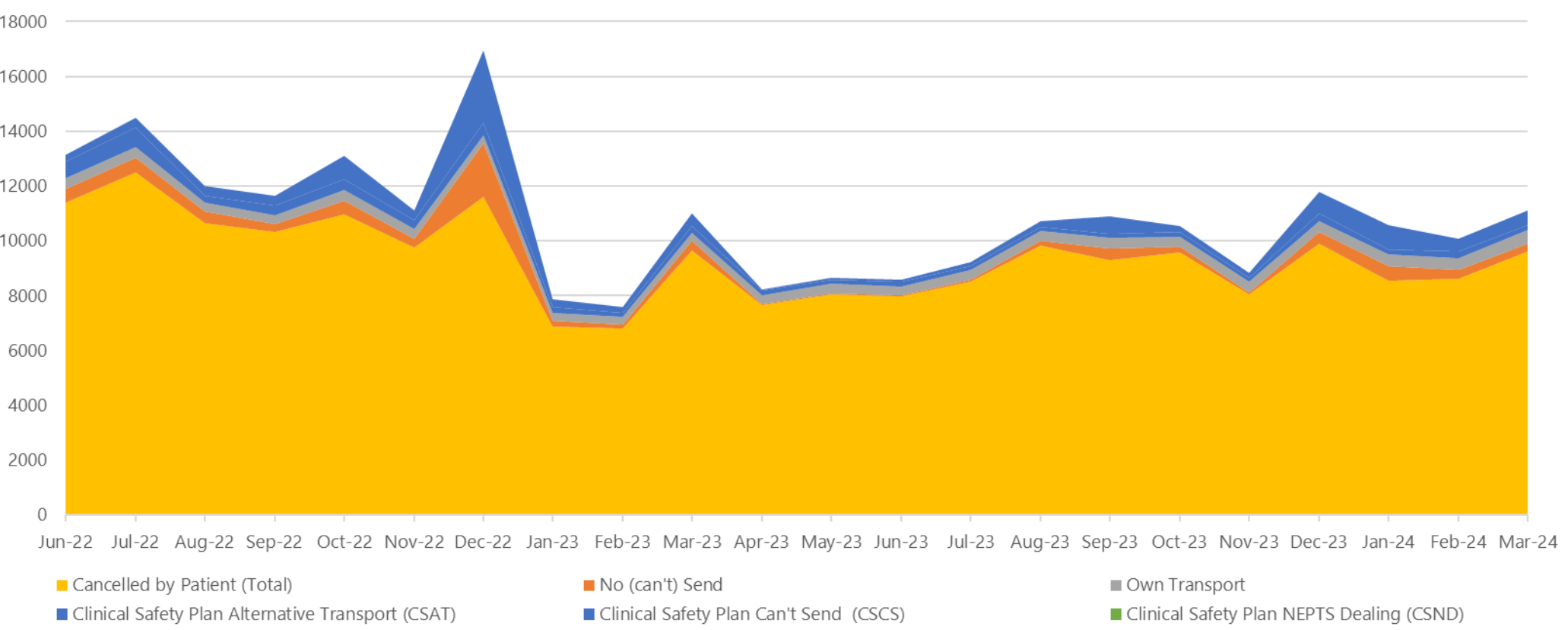
Our Patients: Quality, Safety & Patient Experience

Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn)



Numbers of Patients with No Send or Cancelling Ambulance



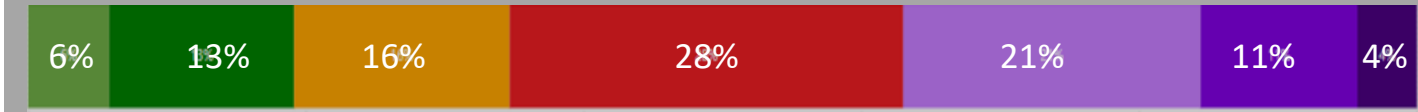
Analysis

In March 2024, 169 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 552 were stopped due to CSP 'Can't Send' options. In addition, 9,605 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from 8,623 in February 2024 and 479 patients made their way to hospital using their own transport.

There were 662 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in March 2024. Of these 177 were accepted and released in the Red category, with 5 not being accepted. Further to this, 152 ambulances were released to respond to Amber 1 calls, but 328 were not.

The graph in the bottom left shows that in March 2024 of the 6,105 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (915 patients) would experience no harm, 53% (3,235 patients) would experience low harm, 23% (1,404 patients) would experience moderate harm and 9% (549 patients) would experience severe harm.

In March 2024 CSP levels for the Trust were:



Remedial Plans and Actions

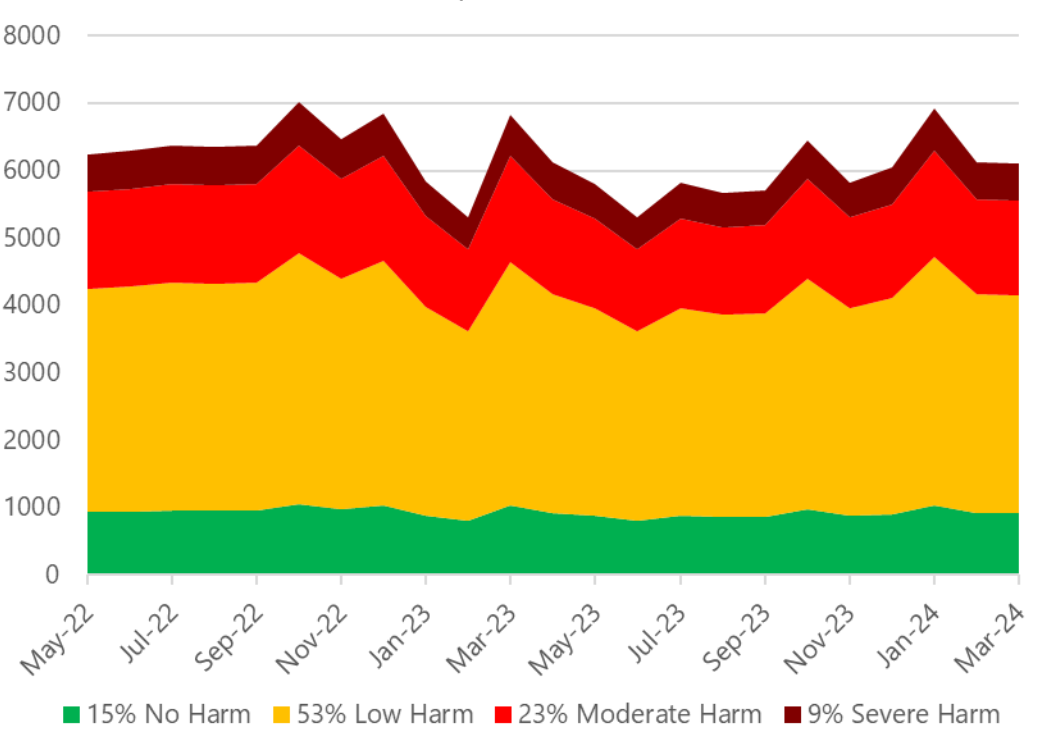
Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings 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

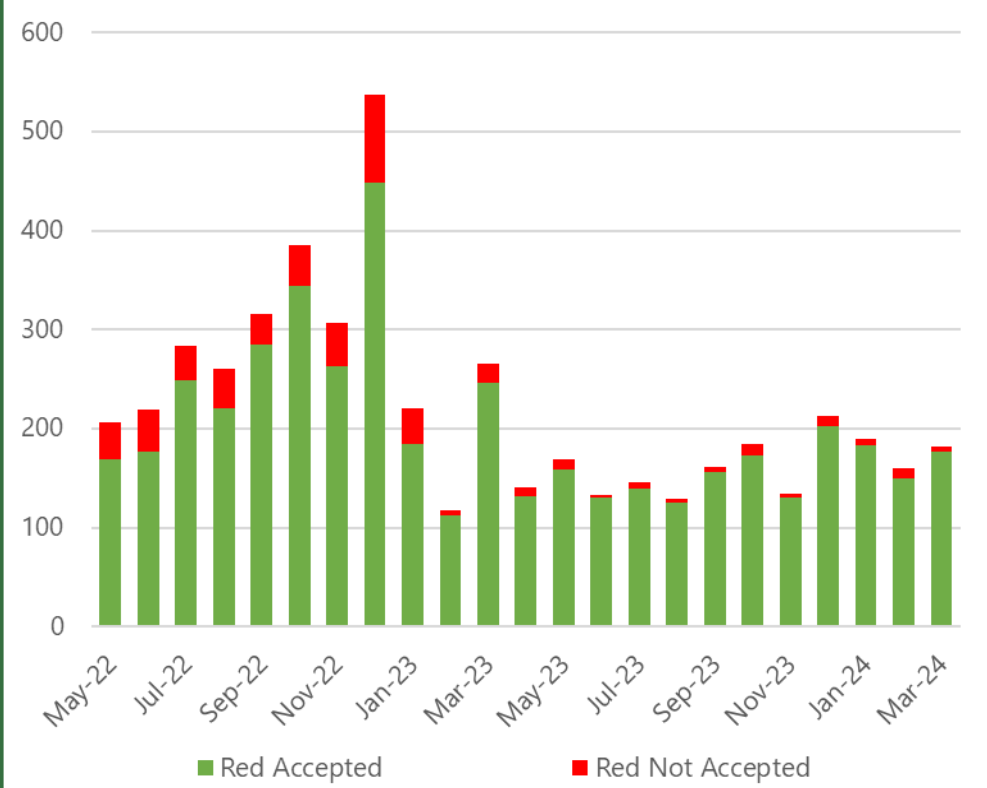
The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for 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*

Modelled Harm Coming to Patients Who Wait Over 60 Minutes for a Hospital Handover



Pan-Wales Immediate Red Release



Our Patients: Quality, Safety & Patient Experience

Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

Health & Care
Standard
Health – Safe Care

Analysis

Within the NEPTS survey the responses provided did not hit the benchmark in relation to the questions 'How long did you wait for your transport to take you home after your appointment and 'Were you happy with the transport you received', therefore not providing the level of service the patient expected. However, 92% in the 111-survey confirmed they took the advice given by NHS 111 Wales.

It is acknowledged that the small number of respondents for the 999 and 111 surveys does not provide a great enough response to reflect a true patient experience picture, but work is currently underway to develop a process that will increase response rates and make them more meaningful.

Remedial Plans and Actions

We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

Response rates to the 999 and 111 surveys are low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes, but we are working consistently to develop a process that will help increase these response rates. An updated DPIA is nearing completion and will soon be submitted to the ICO for their consideration and advice about a way forward around us of SMS text messages to distribute survey requests to service users. However, we are not completely relying on this approach and have been looking at alternative methods of distribution also. We have met with colleagues at South East Coast Ambulance Service who have successfully placed QR codes in the back of all their EMS vehicles to increase patient feedback and we plan to explore use of the same model here at WAST. We have been working closely with the Trust's Falls Improvement Lead, and in March we launched a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder. Patients who are left at home with no further intervention required are left an invitation to share their experience with us by completing a survey. The invitation contains a QR code that can be scanned to access an online survey, contact details for the Peci Team are also included allowing people to request a hard copy survey is sent to them. So far just over 20 people have completed a survey with all respondents rating their experience with the Falls service as 'Very Good'. Capturing service user experience through the use of surveys is a mandatory requirement and a new reporting framework is submitted to the NHS Executive and Welsh Government on a monthly basis outlining how many surveys have been completed.

Expected Performance Trajectory

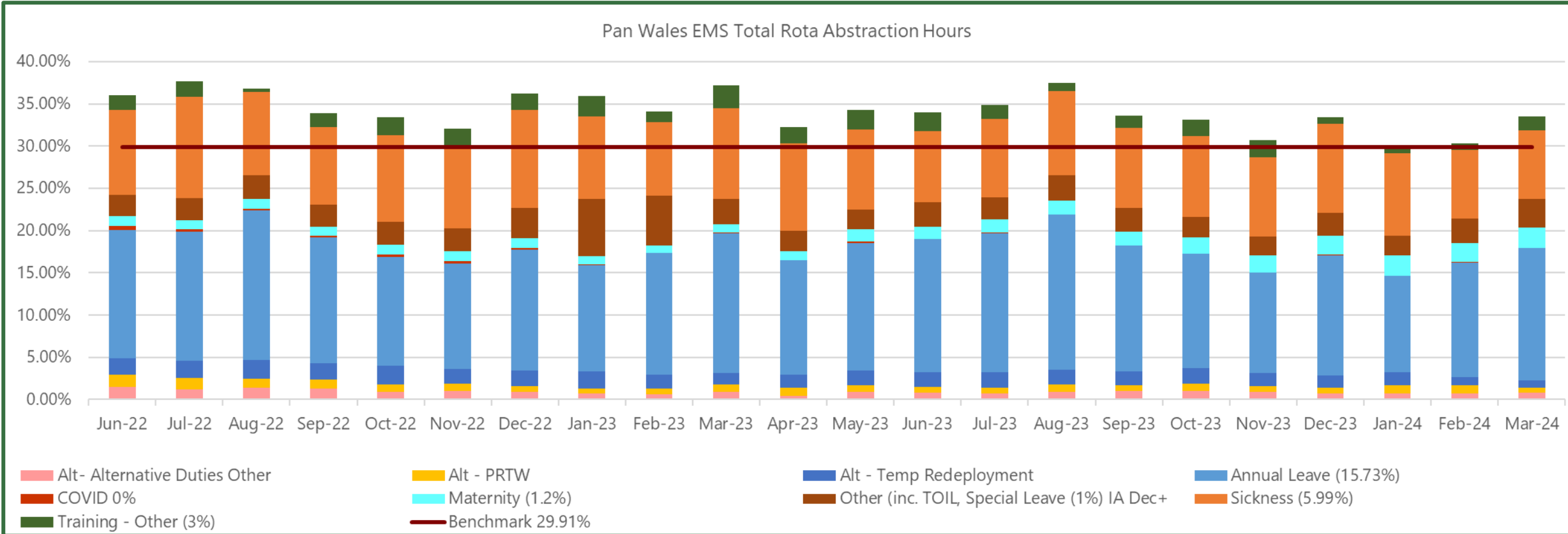
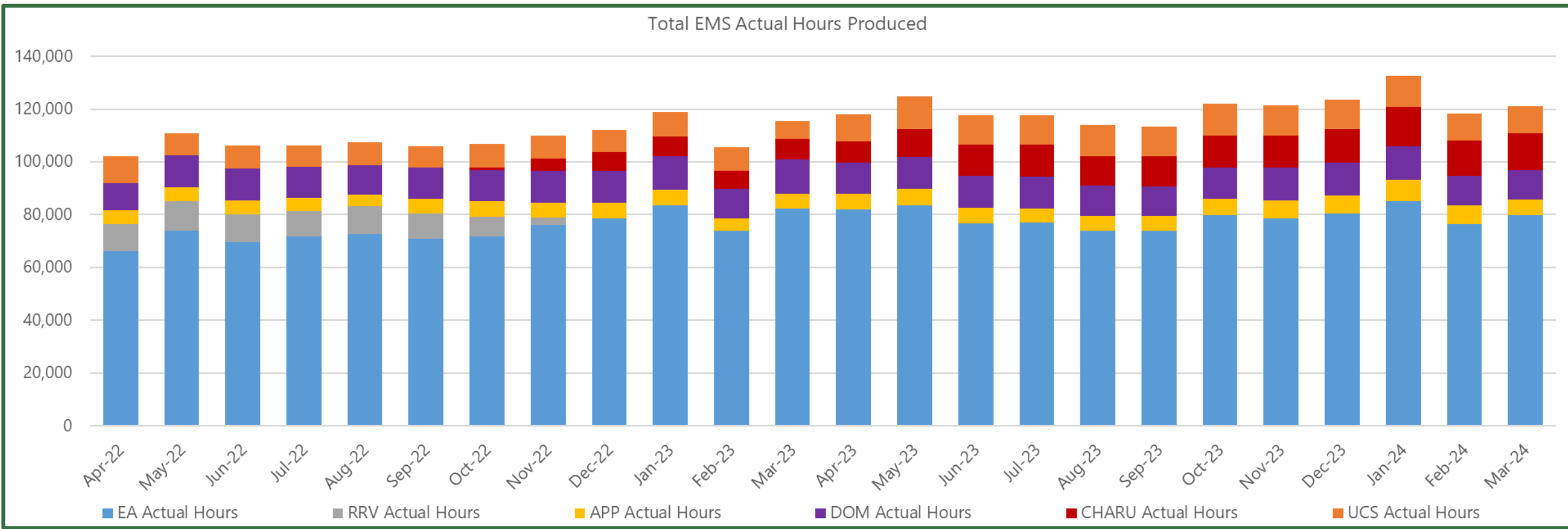
Work to further integrate our systems with Civica to push email/text surveys to patients. Using Other methods of survey delivery such as QR codes in EMS vehicles to compliment this, with an overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data through experience surveys.

March 2024		
NEPTS (132 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	85
999 (39 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	69
The 999-call taker who answered your call explained what was going to happen next.	85	74
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	65
The length of time I waited for an ambulance to arrive was acceptable.	85	43
111 (38 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	55
Did you follow the advice given to you by NHS 111 Wales?	85	92
Would you consider using NHS 111 Wales again?	85	67
WAST Overall - Friends & Family Test	Ranked from very poor to very good.	
How was your overall experience with the service today?		
o Ambulance care	81.58% Good	12.28% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	50.00% Good	27.78% Poor
o EMS (including CSD and Falls Response)	61.70% Good	21.79% Poor
o NHS 111 Wales Online	58.06% Good	29.03% Poor
* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.		

Our People Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions	CI	PCC
A	R		FPC



Analysis

The total hours produced is a key metric for patient safety. The Trust produced 121,069 hours in March 2024, compared to the 115,647 hours produced during March 2023 (2024 a leap year). The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. In March 2024, total EMS abstractions (excluding Induction Training) stood at 33.49%. This was an increase from the 30.33% recorded in February 2024 meaning the Trust remains above 30% (which is the benchmark figure). The highest proportion of abstractions was due to annual leave at 15.62% followed by sickness at 8.17%. This figure for sickness abstractions for March 2024 was a decrease when compared to the same month last year (10.75%).

Emergency Ambulance Unit Hours Production (UHP) achieved 93% in March 2024 which equated to 79,699 Actual Hours. This is a 3% decrease on the Actual Hours produced during March 2023.

CHARU UHP achieved 154% (13,744 Actual Hours) compared to 160% in February 2024 (this is the commissioned level not the modelled level). This equates to 76% UHP of the full roll out requirement against the agrees rosters.

Remedial Plans and Actions

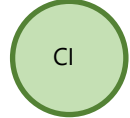
- Continued focus on managing attendance across the Trust and managing abstractions from rosters.
- Full roll out of CHARUs.
- Continued focus on staff in post to establishment, aiming for 95% benchmark.
- Smoothing of staff between urban and rural areas.

Expected Performance Trajectory

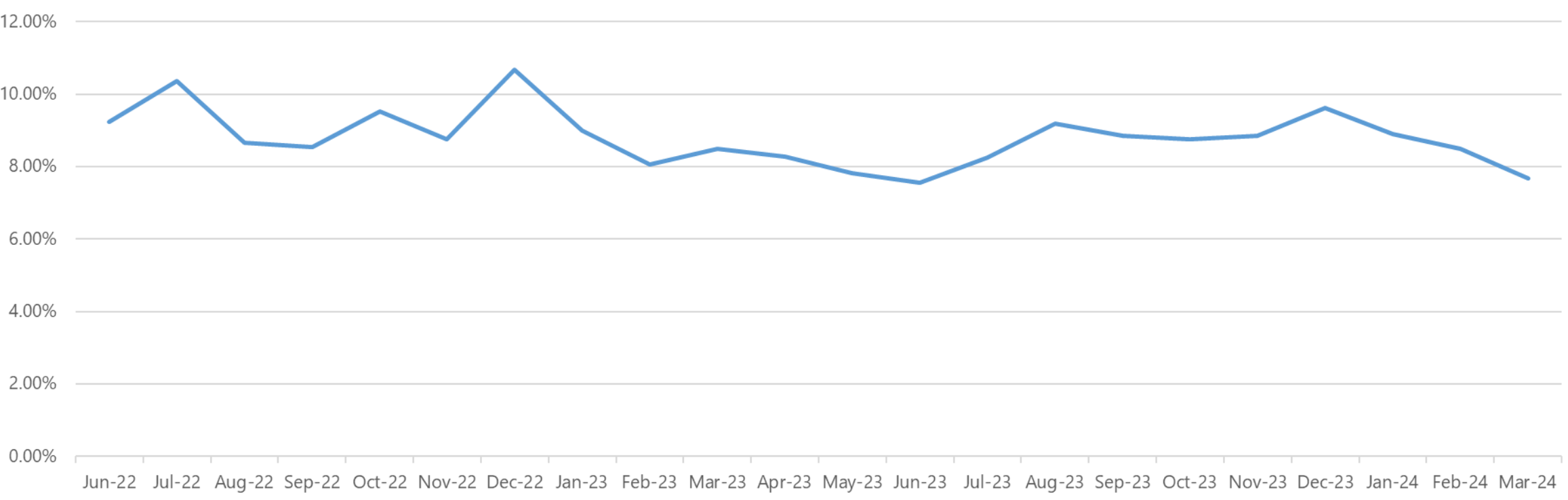
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust has an ambition to reduce sickness to 6% and abstractions to 30% by March 2024, which would further boost production; however, the handover levels are extreme, and the rosters are simply not designed to cope with over 23,000 lost hours; they were predicated on 6,000 hours.

Our People Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)



Monthly Sickness Absence (All Directorates)



Analysis

There was a decrease in overall sickness absence rates between February 2024 and March 2024, dropping from 8.50% to 7.67%.

Long term absence decreased from 6.10% in January 2024 to 5.66% in February 2024, however short-term absence increased marginally from 2.78% in January 2024 to 2.80% in February 2024.

The highest reason for short term absence in February 2024 was Anxiety/ Stress/ Depression, other musculoskeletal problems and cold, cough, flu-influenza.

Absence due to Mental Health has had an upwards trajectory since June 23, however, is now at 2.07%, which is back in line with figures seen during the early part of 2023.

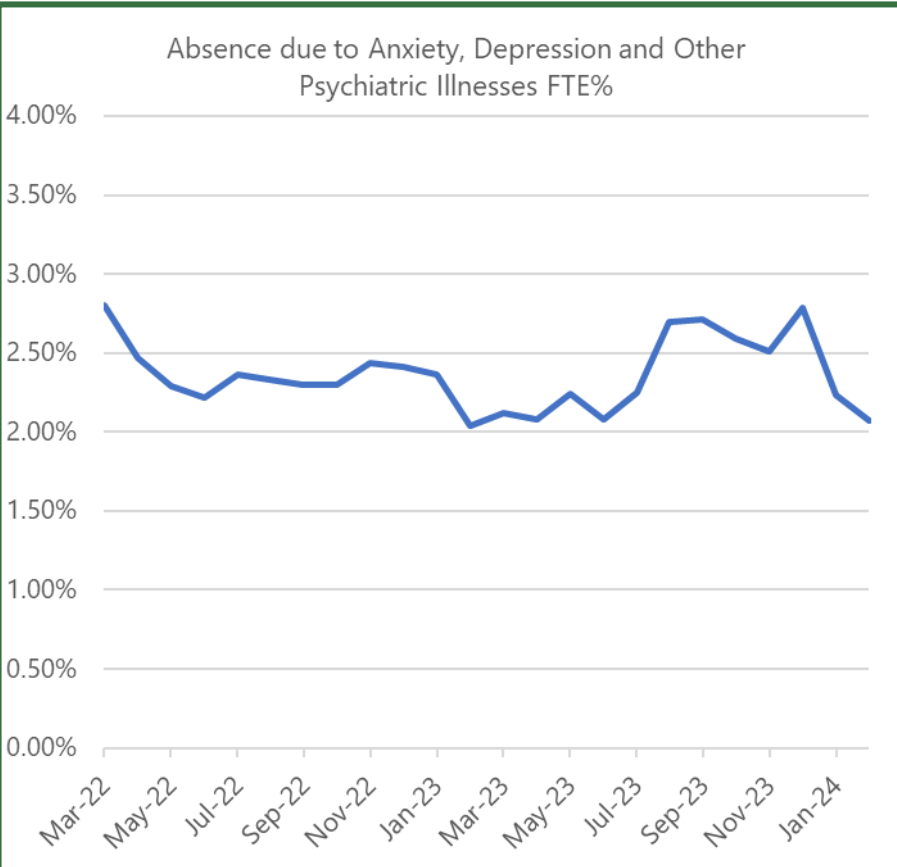
Remedial Plans and Actions

- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support. Three MAAW training sessions have been scheduled for April, June & September 2024.
- Three bitesize training sessions have been scheduled for March 2024 whilst we continue to develop the use of e-learning for the sessions through the use of LMS365.
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

Expected Performance Trajectory

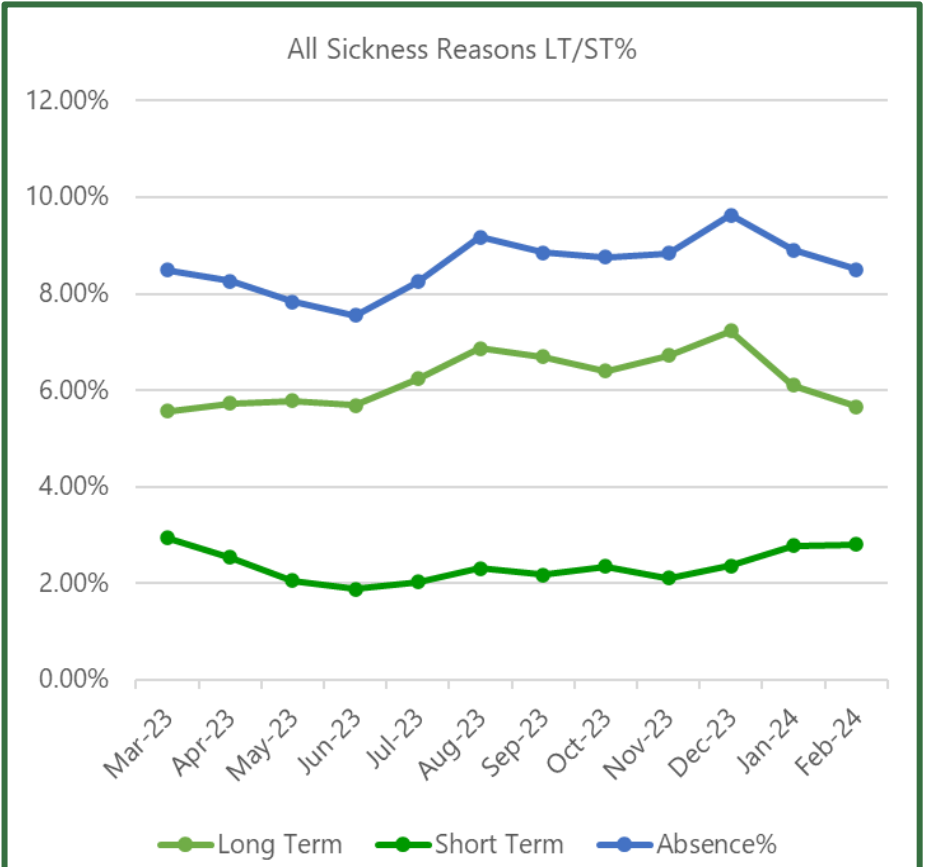
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

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



Average working days lost per FTE (Annual)	
19.56 days	
Single Month Absence %	
8.46%	
Long Term	Short Term
5.66%	2.80%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding back)
2.07%	0.97%

February 2024

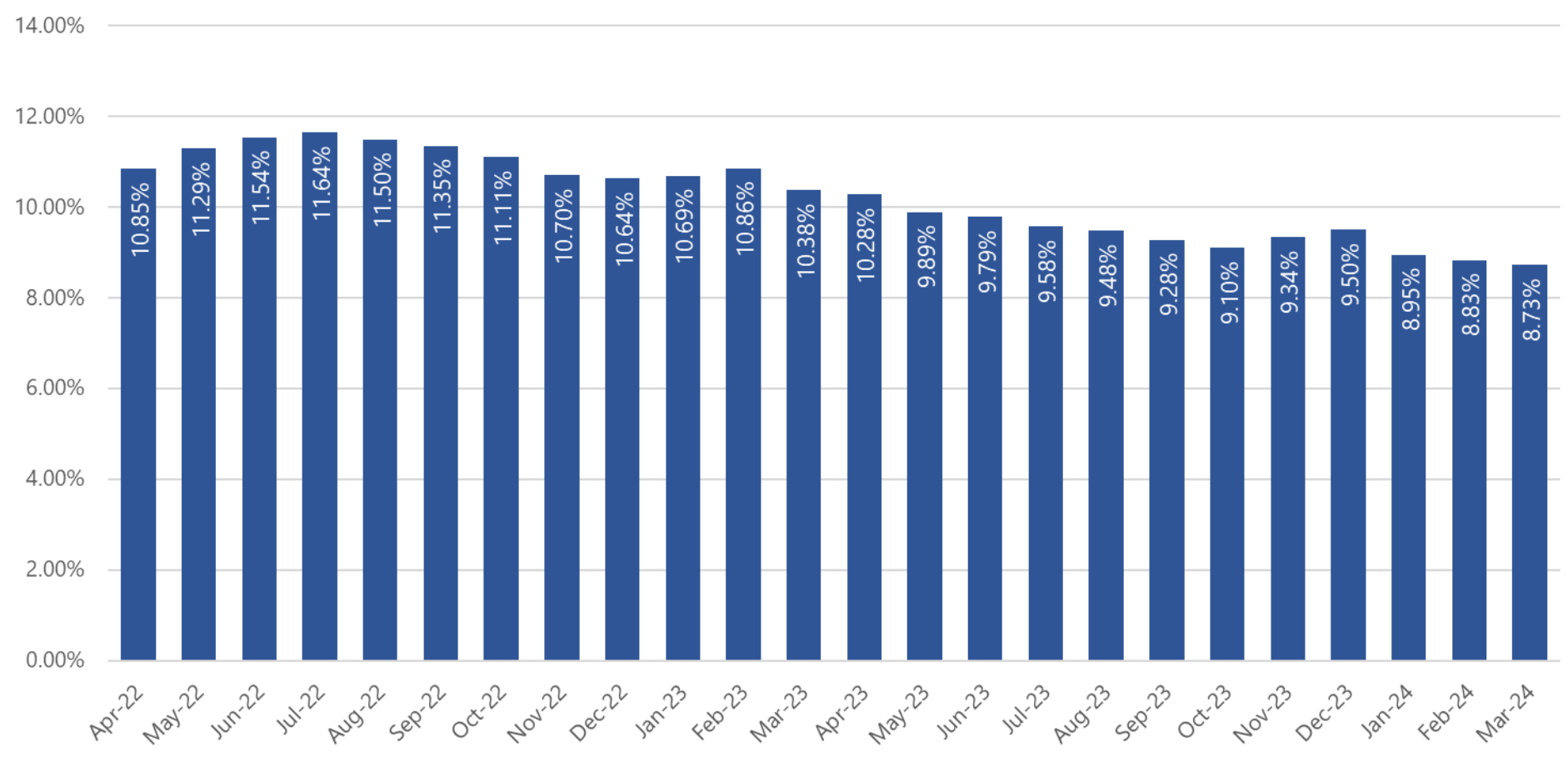


Our People Capacity - Turnover

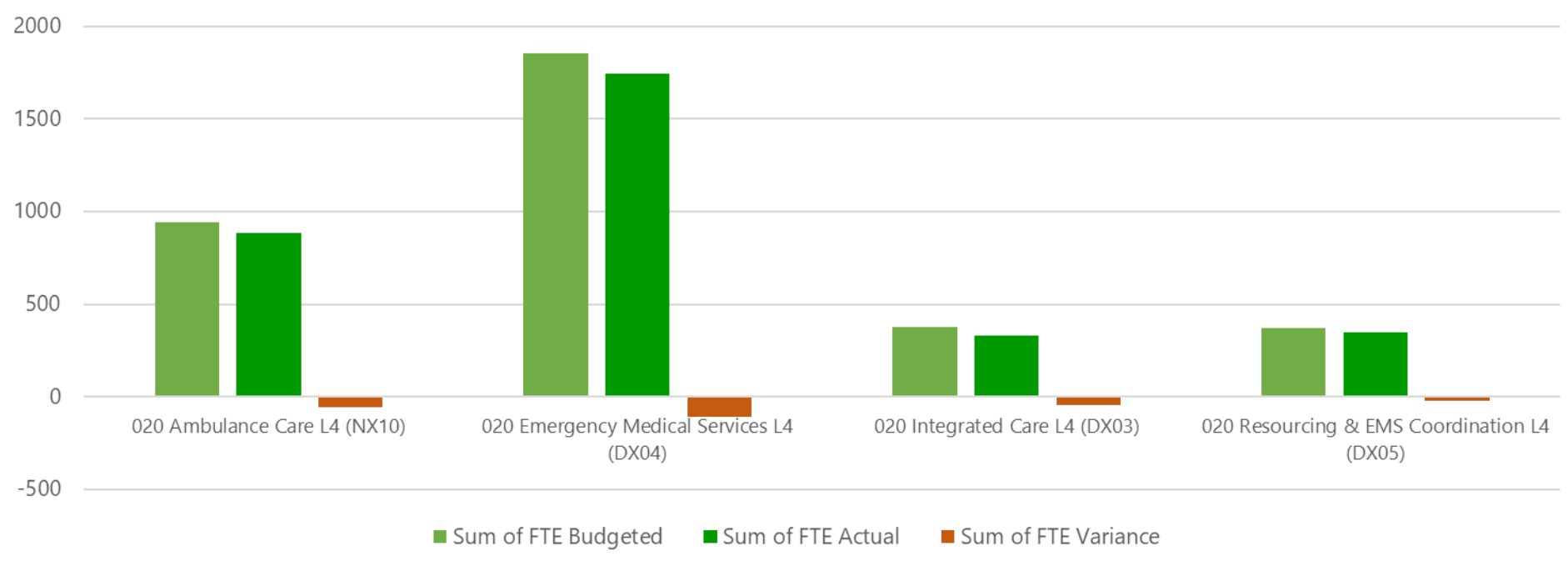
(Responsible Officer: Angela Lewis)

Turnover
A

Staff Turnover Rate FTE (% Employees leaving the Organisation) (12m)



FTE as of 08/04/2024



Analysis

Staff turnover rates in March 2024 were 8.73%, which is a slight decrease from the 8.83% recorded in February 2024, and rates have generally been declining since they peaked in July 2022. March saw 35 leavers (29.35 FTE) from WAST compared to 26 in February and 27 in January. (Turnover in months at the end of the quarter are generally higher). This was unbalanced with 16 joiners (14.35 FTE) in March. Of those leaving, the majority were from Ambulance Care (5 people) and Emergency Dispatchers (5 people). 9 leavers were due to retirement, 3 were granted flexible retirement, 5 were dismissals, 1 due to the end of a fixed term contract and 17 were resignations

Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023, however, the average figure for March 2024 was 41 minutes compared to 43 minutes and 13 seconds in February 2024. Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

Our occupational health waiting times have greatly improved, our KPI of 10 working days from receipt of management referral to first offer of appointment is met and currently colleagues are waiting for approximately 5 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is currently 2 days. All referrals and enquiries are triaged to ensure prioritisation of anything that requires urgent attention. We have welcomed 2 new colleagues to the Occupational Health and Wellbeing Team, Janice Shawcross, Office Manager and Amanda Fletcher-Brown, Administrator.

Remedial Plans and Actions

We continue to improve our data collection through Our MI system (Opas G2), so that we can produce accurate and reliable data. We have defined our standard reports, i.e. which reports need to be run regularly, on a daily, weekly or monthly basis, etc. Also, building our own customised reports for which we can report on themes and trends and identify areas that may require additional support. From this information we can complete appropriate analyses and target our Occupational Health and Wellbeing provision (including themes/promotional events) in an appropriate way. Our MI reports can be used to support strategic decision-making regarding the service, also to provide impact analysis and highlight value for money. We are still working closely with the Welsh health boards to standardise our reporting. The Wellbeing team continue to support colleagues and managers who are facing large-scale changes through holding regular meetings and facilitating drop-in sessions for colleagues.

We are currently offering support to managers through scheduled events; Occupational Health - Guidance on Management Referrals. We have facilitated two events already; attendance has been good at both.

Our provider for our Employee Assistance Programme has now been appointed and a launch will be conducted in May/June. Our self-booking option for Occupational Health referrals has proved extremely popular and has improved the service for everyone whilst streamlining processes for the team, creating capacity to address other projects.

We continue to evaluate the service through gathering feedback from our colleagues, we are improving this process by updating our questionnaire and will be circulating this through Opas G2.

The clinical team continue to support People Services and managers through sickness absence meetings. Team members from OH/Wellbeing/TRiM continue to promote the service using our Occupational Health & Wellbeing vehicles, also through presenting to new starters within WAST and through attendance at managers' meetings. The team continue to deliver Drop-in sessions across all our Clinical Contact Centres, (CCCs) dates for 2024 have been advertised. These are delivered in person at the CCCs and online via Teams.

The REACT (Recognise, Engage, Actively Listen, Check Risk, Talk) training is still proving popular, new dates have been advertised on Siren. The Wellbeing team will be present at each of the CEO roadshows in April, promoting the service and providing advice and guidance to colleagues.

We are still in the process of writing the Health and Wellbeing strategy for 2025/29. The team has implemented outcome measures and integrated them into OPAS G2, our MI system, this means that we will be sending questionnaires to colleagues around mental health assessment measures. The Health Surveillance programme is starting with HAVS at the fleet workshops - H&S are beginning a scoping exercise on the equipment used.

We continue to plan for the pilot Health Check Programme Health Diagnostics, which is still in process to look at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. We are continuing MMR audits for frontline staff.

Expected Performance Trajectory

The People and Culture Strategy will continue with its wellbeing focus. We are currently in the process of writing the WAST Health and Wellbeing strategy for 2025/29.

The wellbeing provision is regularly reviewed to ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement.

Our tender process for an EAP has been successful and a provider will be appointed. The contract will be in place for 2 years. The team are currently evaluating the In Work Support programme, (currently funded by Welsh Government), to which the team have been referring colleagues for physiotherapy. We are monitoring turnaround times/general quality of service for our colleagues.

The team will be promoting the service and raising awareness of the OH and Wellbeing offer at each of the CEO roadshows in April.

Our People Culture - Staff Vaccination Indicators

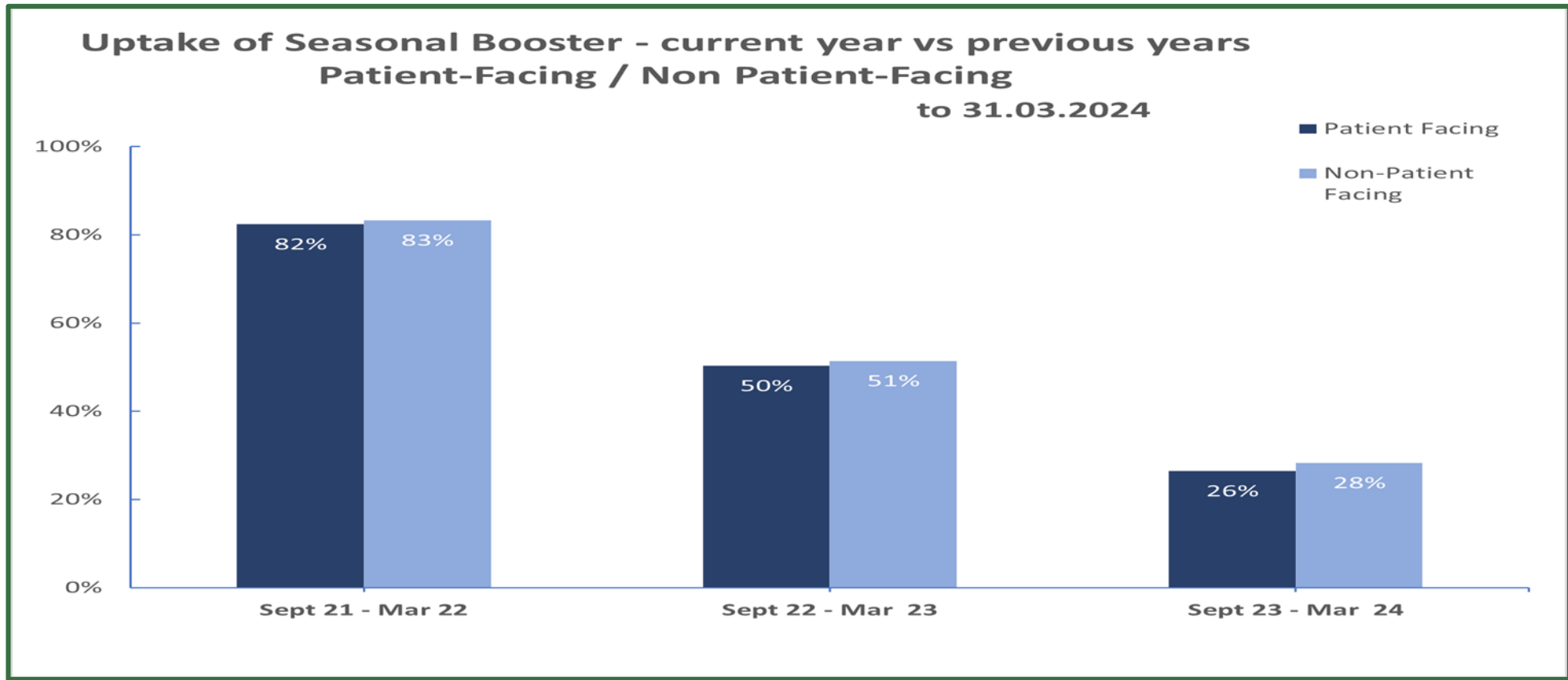
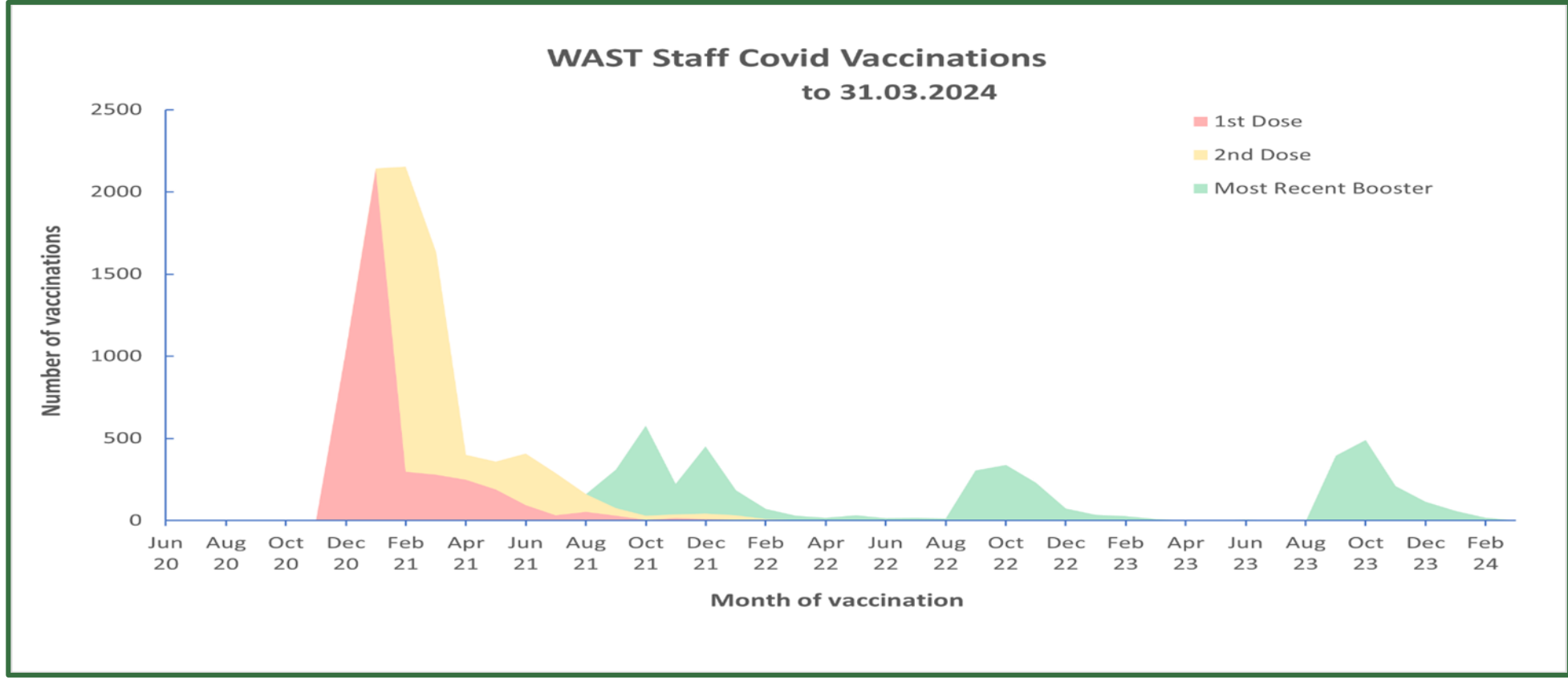
(Responsible Officer: Angela Lewis)

Self-Assessment:
Strength of Internal
Control: Moderate

PCC

Health & Care
Standard
- Health (PPI)

CI



Analysis

Flu: The target set out by Welsh Government is to improve on last year's flu vaccination uptake. However, this was unfortunately not met during this year's campaign. The Trust's final uptake of staff vaccinated was 36.5% of WAST staff, which is a decrease of 8% from last year's campaign. The number of patient facing staff that are recorded as receiving the vaccine for the 2023-24 campaign has also noticeably decreased by 15.2%, reporting 31.1% at the end of the campaign. This equates to 820 out of 2639 being recorded as having the flu vaccine during this campaign, in comparison to 1171 out of 2527 during the previous campaign. This is reported alongside a 44.2% engagement rate for the organisation and for those that engaged via Microsoft Form, 36.5% decided to receive the vaccination this year. The remaining 7.7% decided to decline the flu vaccine and opt-out. The Charitable bid for an incentive of vouchers has had a positive effect on the engagement rate of staff completing the form. 11.3% (491 WAST staff) completed the form to state they have had the vaccine elsewhere during this campaign, in comparison to 6.8% (289 WAST staff) in the previous campaign, therefore, a 4.5% increase.

COVID-19: As of the end of March 2024, 93% of Patient-Facing staff have received both the first and second COVID-19 vaccination dose. As of the end of March 2024, 93% of Patient-Facing, and 92% of Non-Patient-Facing, staff have received the second COVID-19 vaccination dose. 85% of Patient-Facing, and 84% of Non-Patient-Facing, staff have received at least one of the Covid-19 boosters offered in the last 3 years.

As of the end of March 2024, 26% of Patient-Facing, and 28% of Non-Patient-Facing, staff have received this season's Covid-19 Booster. The season started in September 2023. This is compared to 50%/51%, respectively, for the equivalent time period in 22/23 and 82%/83%, respectively, for the equivalent time period in 21/22.

Remedial Plans and Actions

Flu: The 202/24 WAST Flu campaign ended at the end of February 2024. The end of season report has been shared and discussed at the Clinical Directorate Business meeting and ELT.

COVID-19: The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30th March 2023. Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

Expected Performance Trajectory

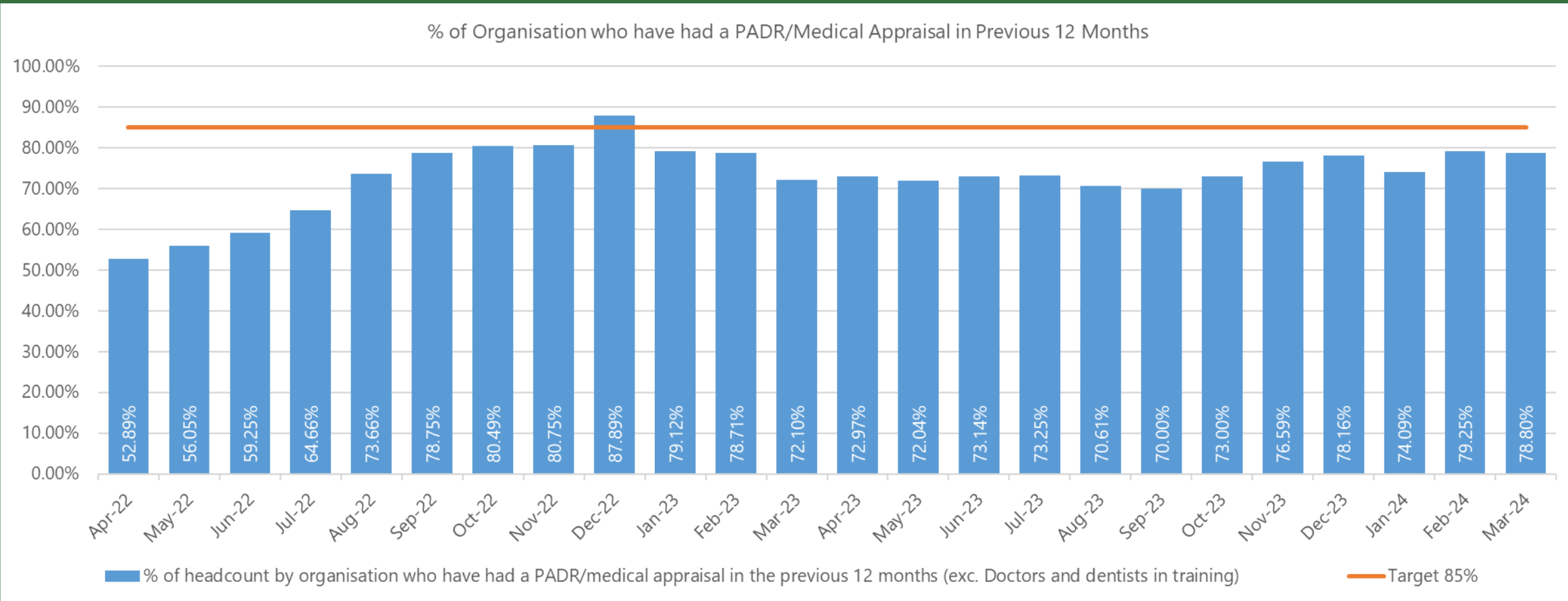
It is evident via the report that lessons have been learnt from this campaign and consequently, there is an extensive list of areas that require continued development for future flu campaigns.

***NB: COVID Vaccinations for the past 2 years have only reported using the WAST definition of Frontline Patient Facing employees and therefore only includes those employed within Emergency Services, and Patient Transport Services..*
****NB: Flu data accurate at time of publication and subject to change / COVID-19 vaccination data correct at time of publication and subject to change.*

Our People Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR	Stat & Mand	CI	PCC
A	A		
Health & Care Standard Health – Staff & Resources		Self-Assessment: Strength of Internal Control: Strong	



Analysis

PADR rates for March 2024 78.80% decreased slightly when compared to the previous month to 79.25% and remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, but the current rates are 9.2% higher than the same month last year.

In March 2024 Statutory & Mandatory Training rates reported a combined compliance of 81.89%; with only Dementia Awareness (93.34%) and Moving & Handling (92.25%), achieving the 85% target. Equality & Diversity (82.69%), Fire Safety (77.26%), Safeguarding Adults (76.96%). Violence Against Women, Domestic Abuse & Sexual Violence (74.99%), Information Governance (73.46%), Paul Ridd (68.58%), Welsh Language Awareness (61.01%) and Fraud Awareness (58.86%), all remain below this 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 time of reporting, annual Mandatory In-Service update programmes have been accessed by 88% of colleagues across ACA, EMT and Paramedic roles. Those absent from work access this programme on their return to practice providing assurance of their up-to-date knowledge and skills.

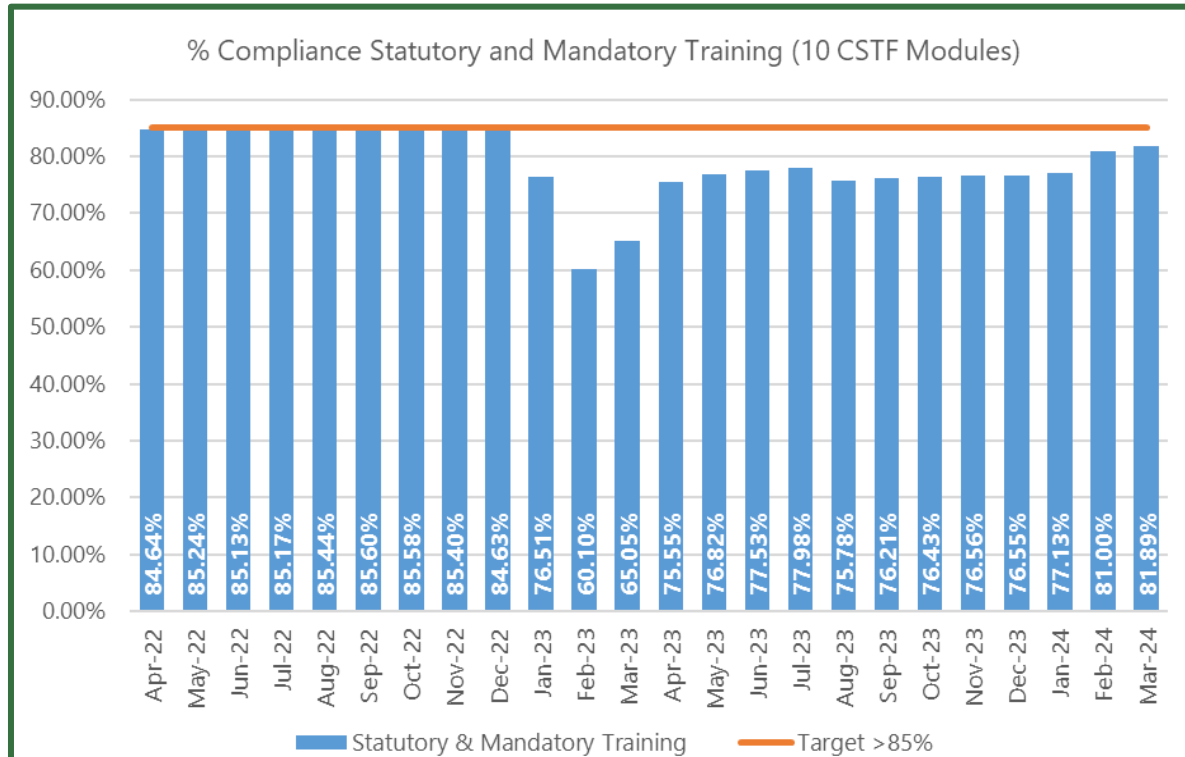
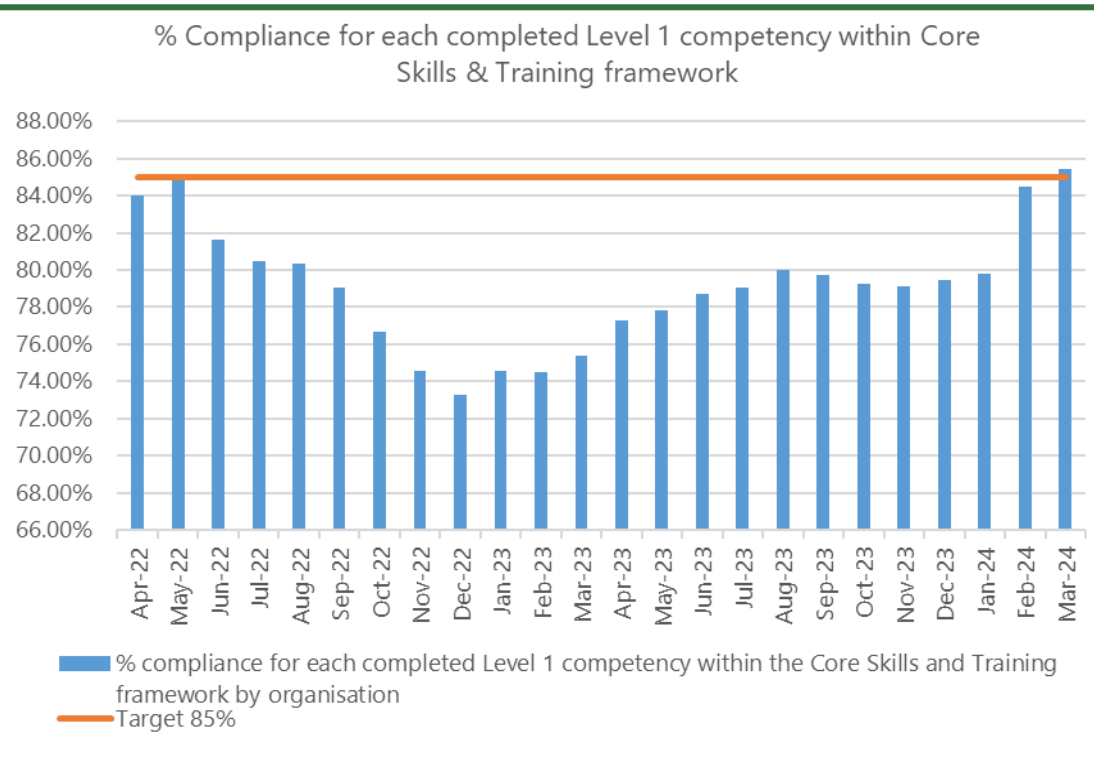
Progress toward 85% target for mandatory competencies introduced in 2023/24, namely Welsh Language Awareness, Fraud Awareness and the Paul Ridd Learning Disability awareness is falling short on the first anniversary of their reporting; this is a disappointing position and targeted focus will be applied to these 3 competencies in the early part of 2024/25.

There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly LMS365 environment enabling easier access to these reportable competencies and the wider suite of Ambulance Service specific learning hosted outside ESR.

Expected Performance Trajectory

Performance is improving as compliance has risen.

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

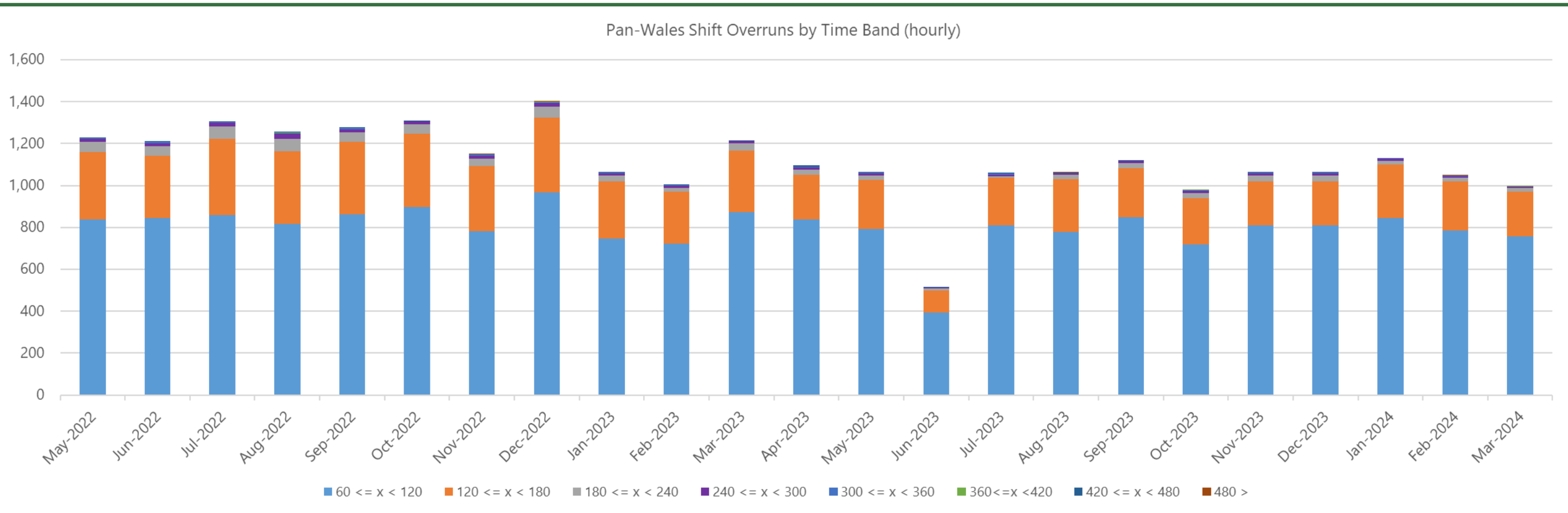
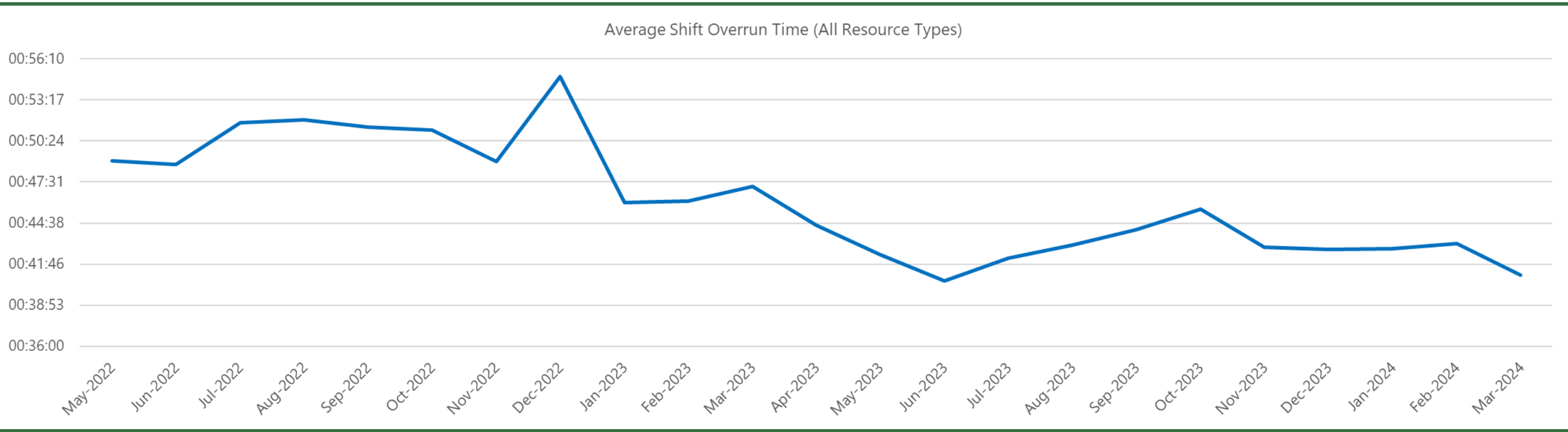
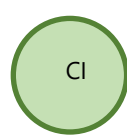


Our People

Health and Well-being – Shift OVERRUNS

(Responsible Officer: Angela Lewis)

Overruns
R



Analysis
Shift overrun average times have been steadily increased between June and October 2023, but have since varied. The average figure for March 2024 was 41 minutes compared to 43 minutes and 13 seconds in February 2024.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 73.2% of the total. 20.2% fall within the 61 to 120-minute category, 5.7% in the 121 to 180-minute category, 0.5% in the 181 to 240-minute category and 0.3% in the 241 minutes and over category.

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

As part of the Trust’s winter resilience planning, it is introducing “pods” at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

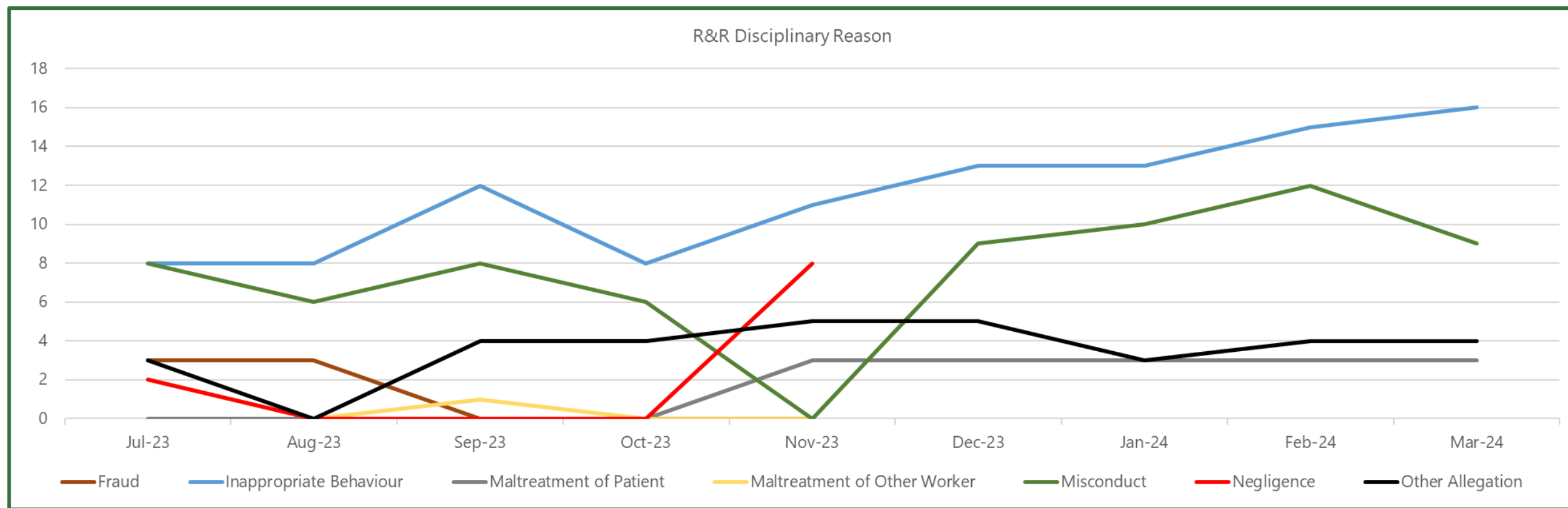
Expected Performance Trajectory
Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

Our People

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

(Responsible Officer: Angela Lewis)

Self-Assessment:
Strength of Internal
Control: Moderate



Analysis

There were 32 open formal disciplinary cases recorded at the end of March 2024, a slight decrease compared to the month of February 2024 where 34 open cases were recorded. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were 13 open formal Respect and Resolution cases submitted by employees, an increase from the number recorded in February. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

In February, 38.5% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 65% in February 2024, while the volume of applications also decreased, from 123 to 78.

Of the 78 total applications from under-represented groups in March 2024, 43 were in the category of Ethnicity, 22 within Disability and 13 within Sexual Orientation.

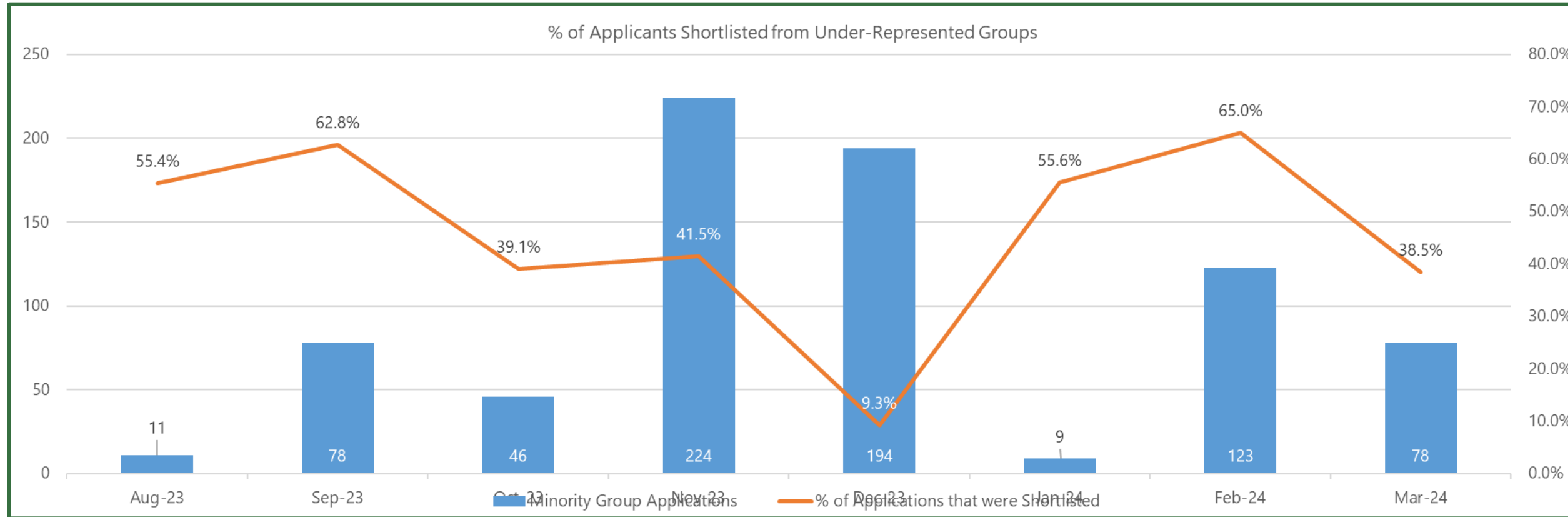
Remedial Plans and Actions

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

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events.

Expected Performance Trajectory

Continue to monitor levels, no trajectory for this measure.

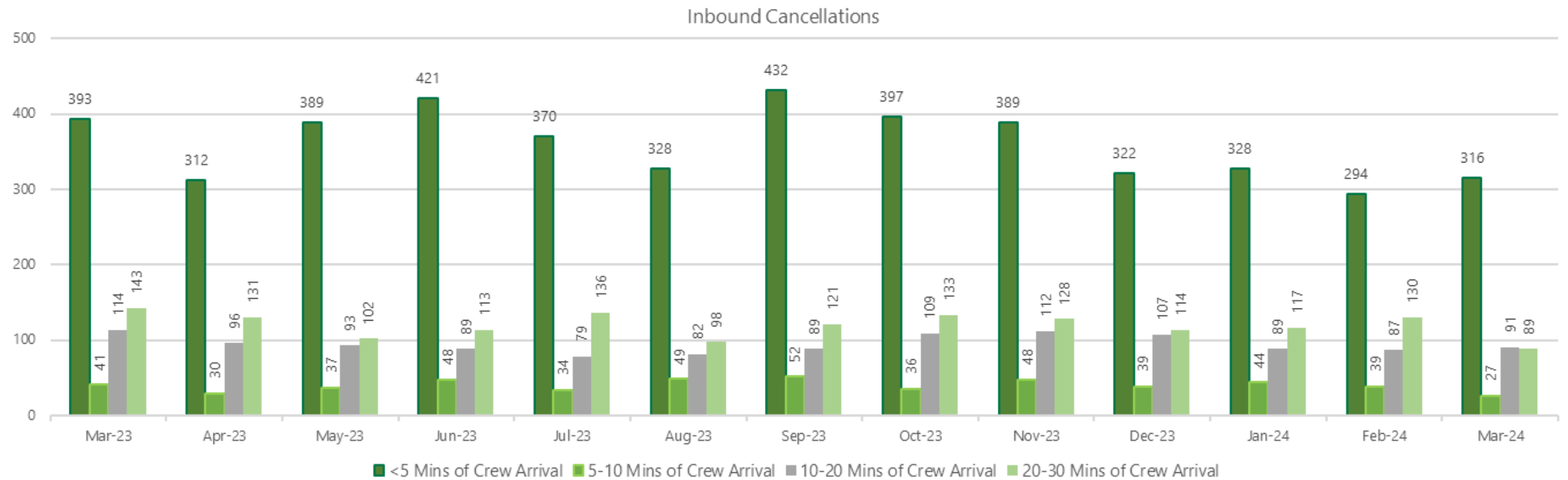


Finance, Resources and Value

Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
A



Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in March 2024 to 316, compared to 294 in February 2024. The total number of cancellations within 30 minutes decreased from 550 in February 2024 to 523 in March 2024.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In February 2024 there were 98 cancelled by patient* entries made within 5-minutes of crew arrival an increase compared to the previous month (88). The top reasons for less than 5-minute cancellations included: 36 patient not located, 16 too ill to travel and 10 no appointment. During the past 15 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Same day cancellations increased slightly from 19.6% in February 2024 to 19.8% in March 2024.

Remedial Plans and Actions

As described last month, work is well advanced with Hywel Dda to develop a direct link between their PAS system and our CAD but has been delayed by an extended focus on the MDCS system from the system team. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

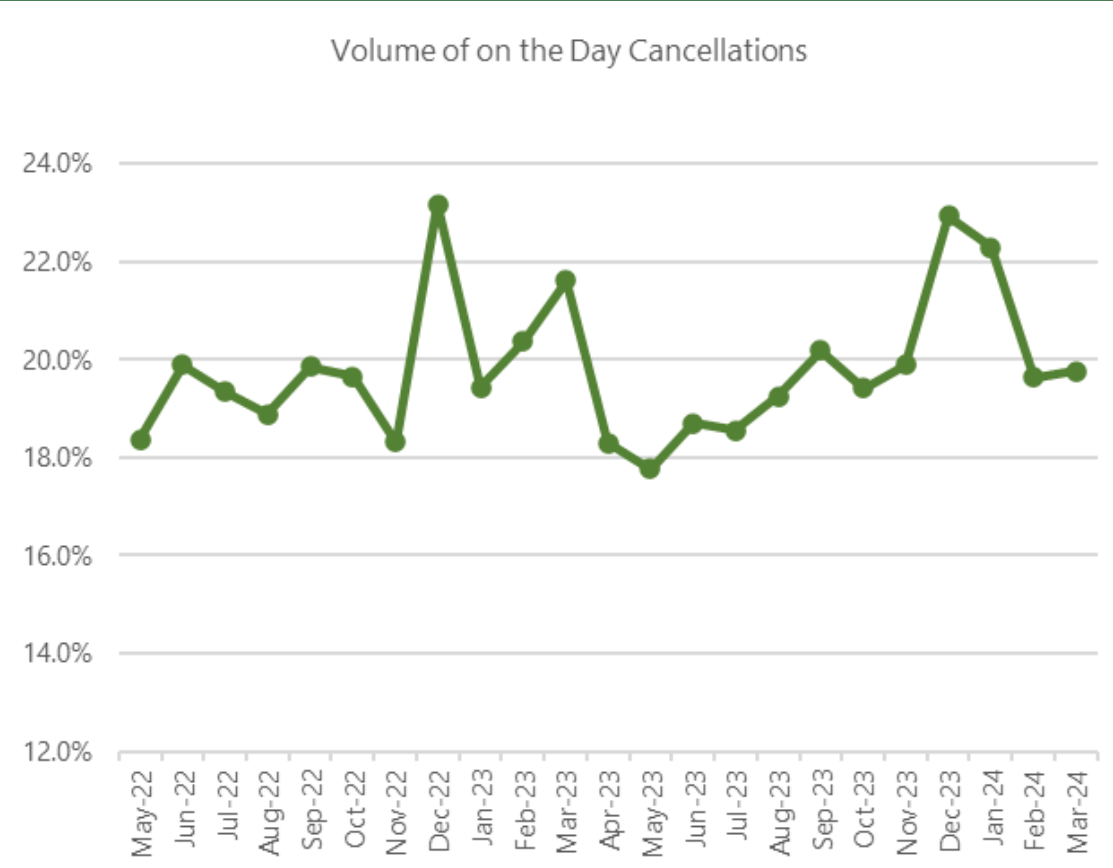
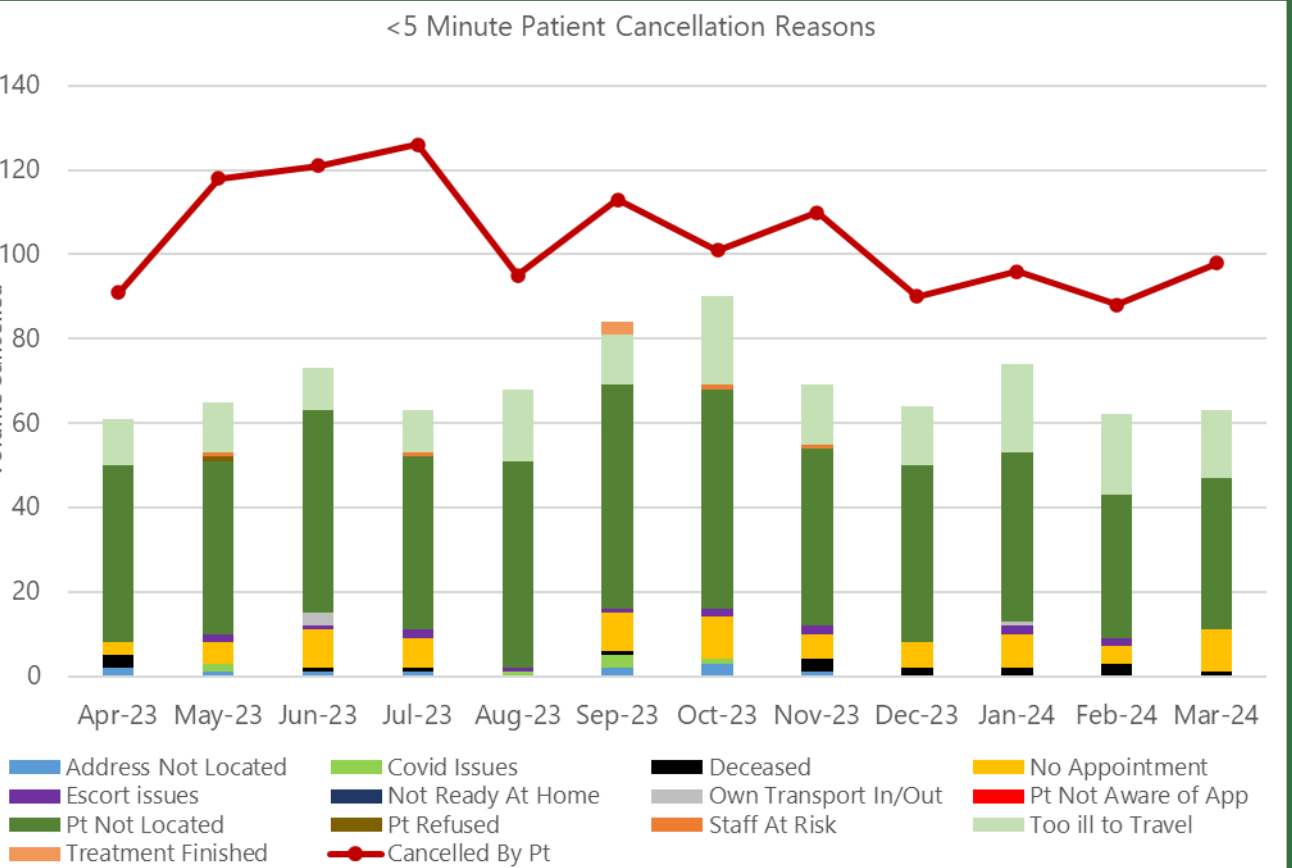
This work is at an advanced stage and should go live in Q1, once evaluated and, if successful we will explore a wider geographical rollout.

Expected Performance Trajectory

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

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

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



Finance, Resources and Value

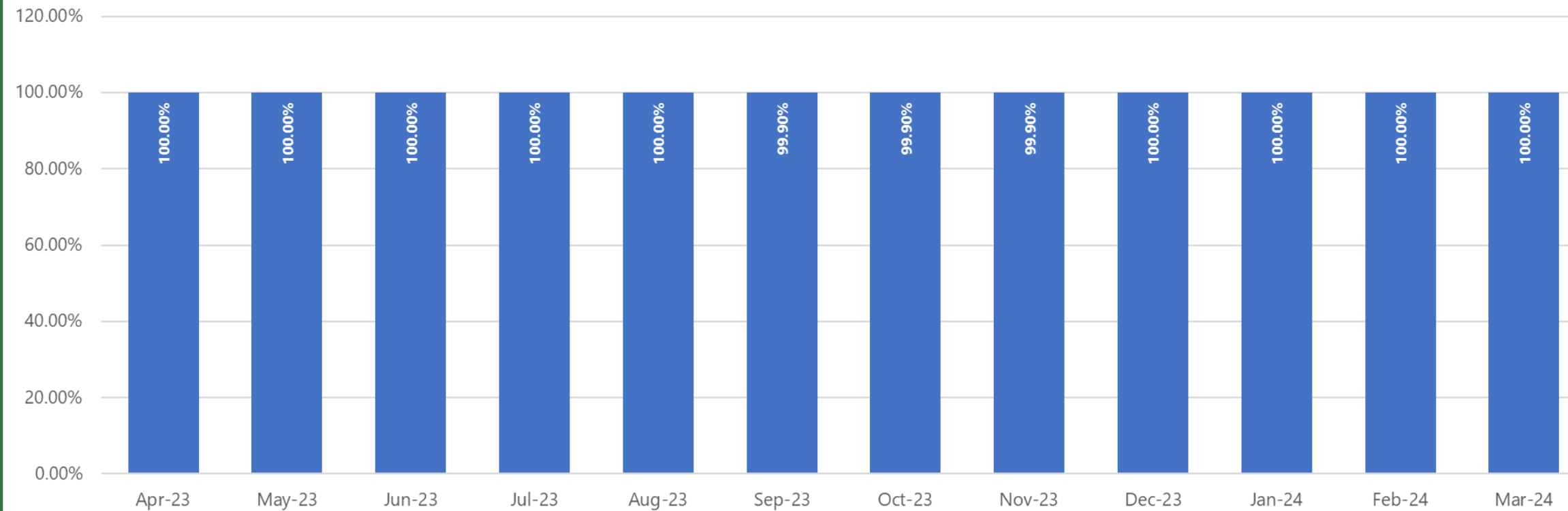
Value - Finance Indicators

(Responsible Officer: Chris Turley)

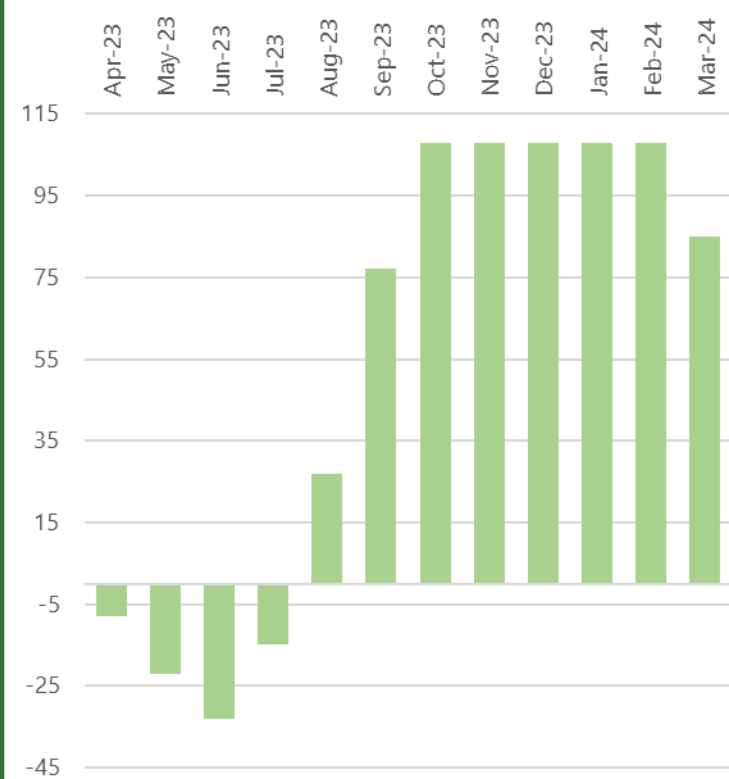
G

FPC

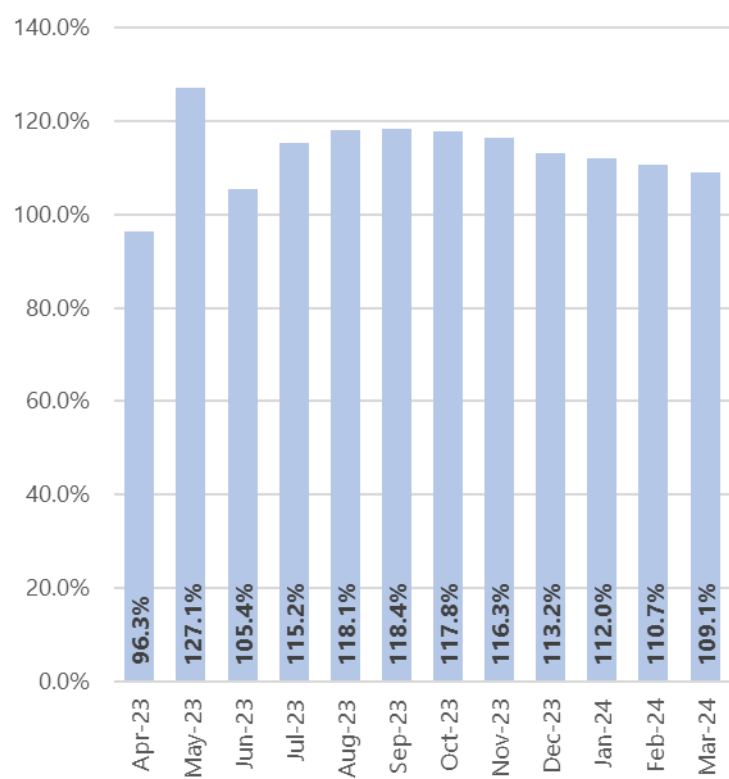
Financial Balance - Annual Expenditure YTD as % of Budget Expenditure YTD



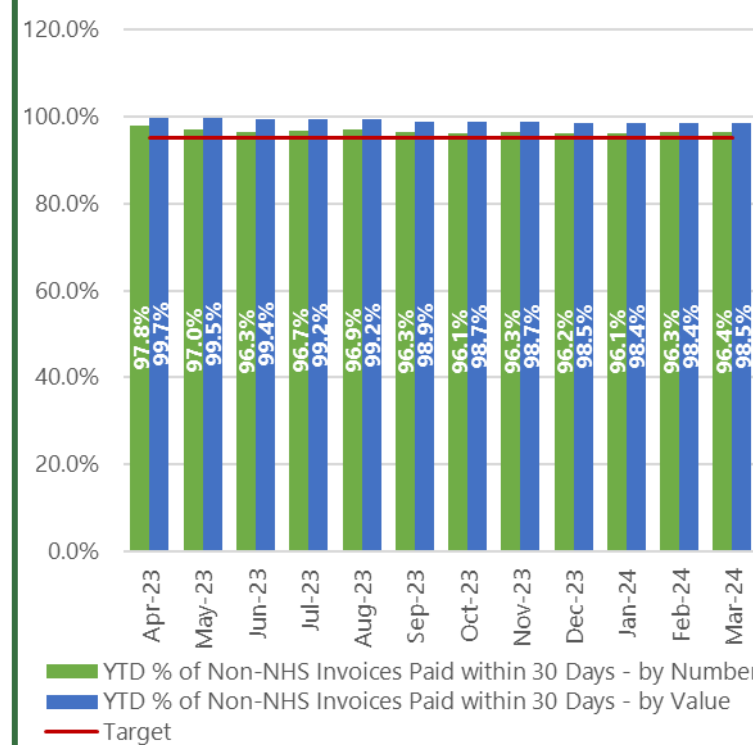
Actual Trust Surplus/(Deficit) YTD - £000



Actual Savings YTD as % of Planned Savings YTD



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



Analysis

The reported outturn performance at Month 12 is a surplus of £85k.

For Month 12 the Trust is reporting planned savings of £6.000m and actual savings of £6.547m (an achievement rate of 119.1%).

The Trust's cumulative performance against PSPP as at Month 12 is 96.4% against a target of 95%.

At Month 12 the Trust achieved both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust has reported a breakeven position (subject to audit); however, as the Trust moves into 2024/25 key areas of focus include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).

- A continued focus on the Trust's financial sustainability programme.

- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and

- An improved approach to benefits realisation

Expected Performance Trajectory

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

Finance, Resources and Value

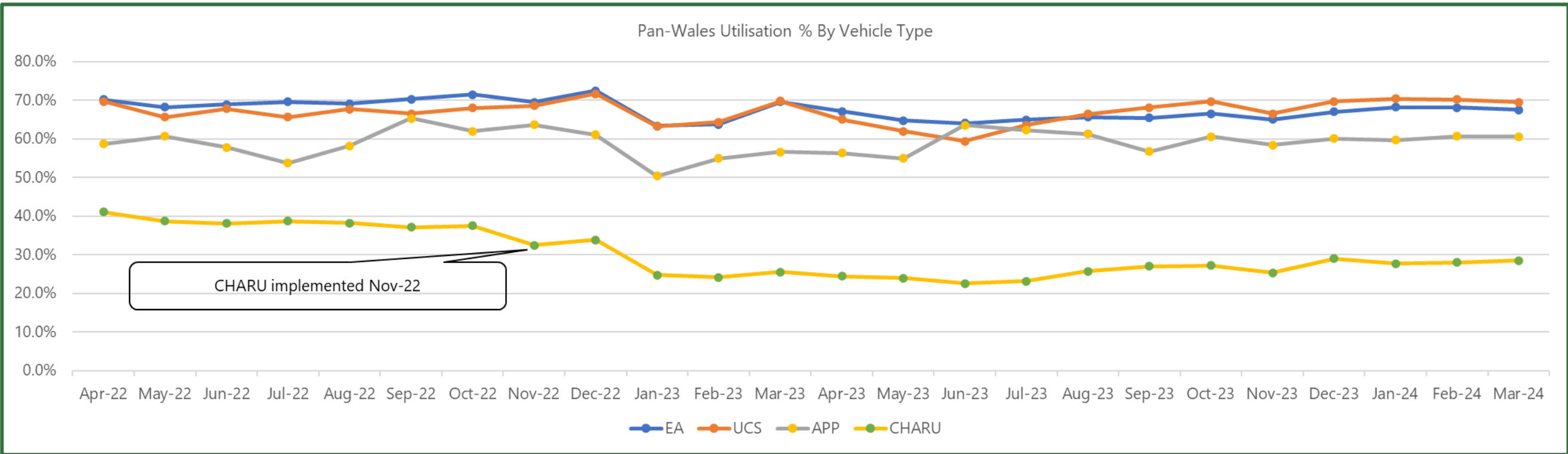
EMS Utilisation & Average Job/Shift Times

(Responsible Officer: Lee Brooks)

Job Cycle
A

CHARU Utilisation
R

FPC



Analysis

Pan Wales Utilisation metrics in March 2024 were 58.8% for all vehicles types, increasing from January 2024 (58.6%). UCS achieved the highest rate during the month at 70.2% while EA was at 68.1%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in March 2024 decreased to 2 hours 13 minutes for EAs, to 2 hours and 46 minutes for UCS and CHARU decreased to 54 minutes. The average for APPs increased to 1 hour and 26 minutes.

Overall average jobs per shift was 2.27 in March 2024, indicating a slight increase from February 2024 (2.22). EAs 2.37 jobs per shift, UCS crews 2.20 jobs per shift This is less than half of what would be ideal and a product of handover delays.

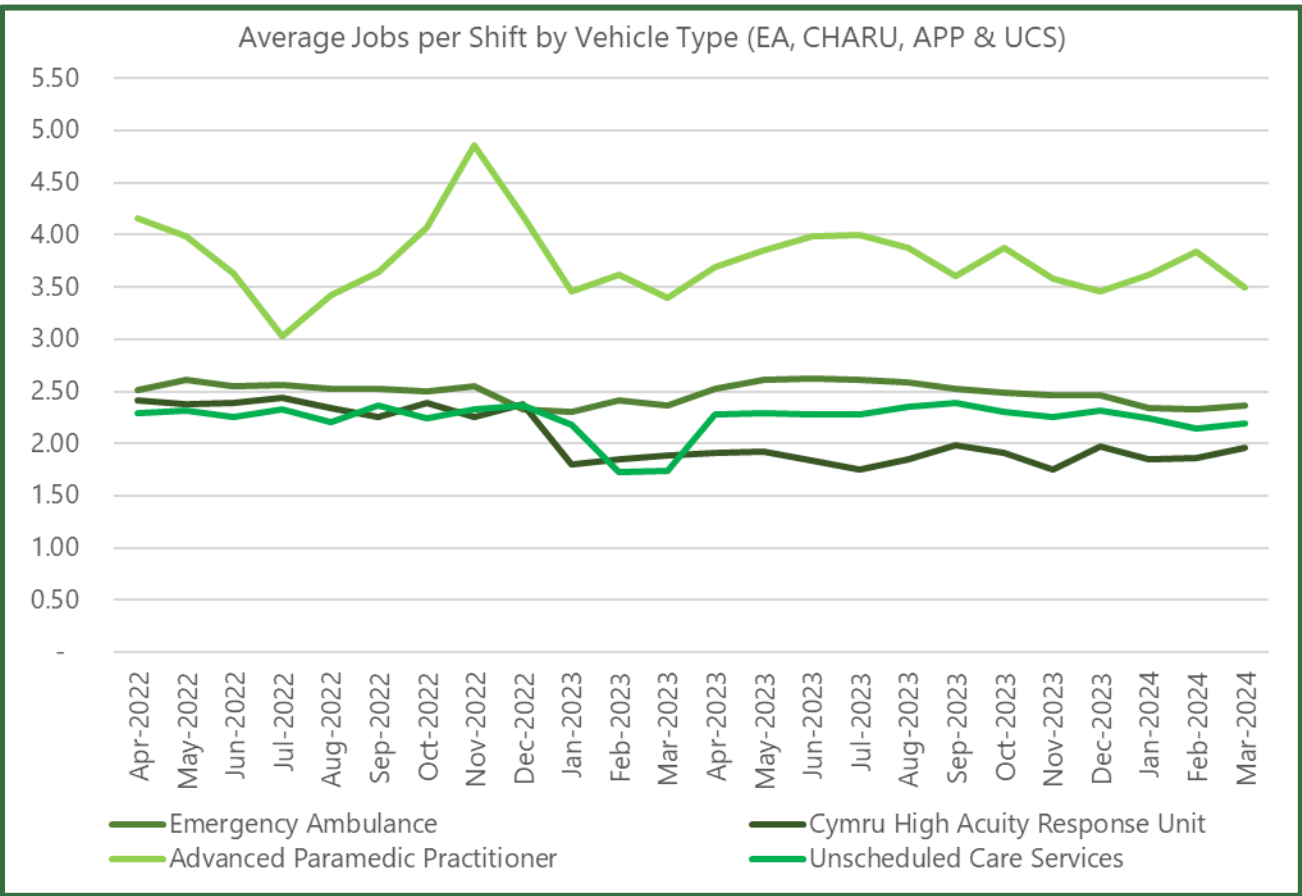
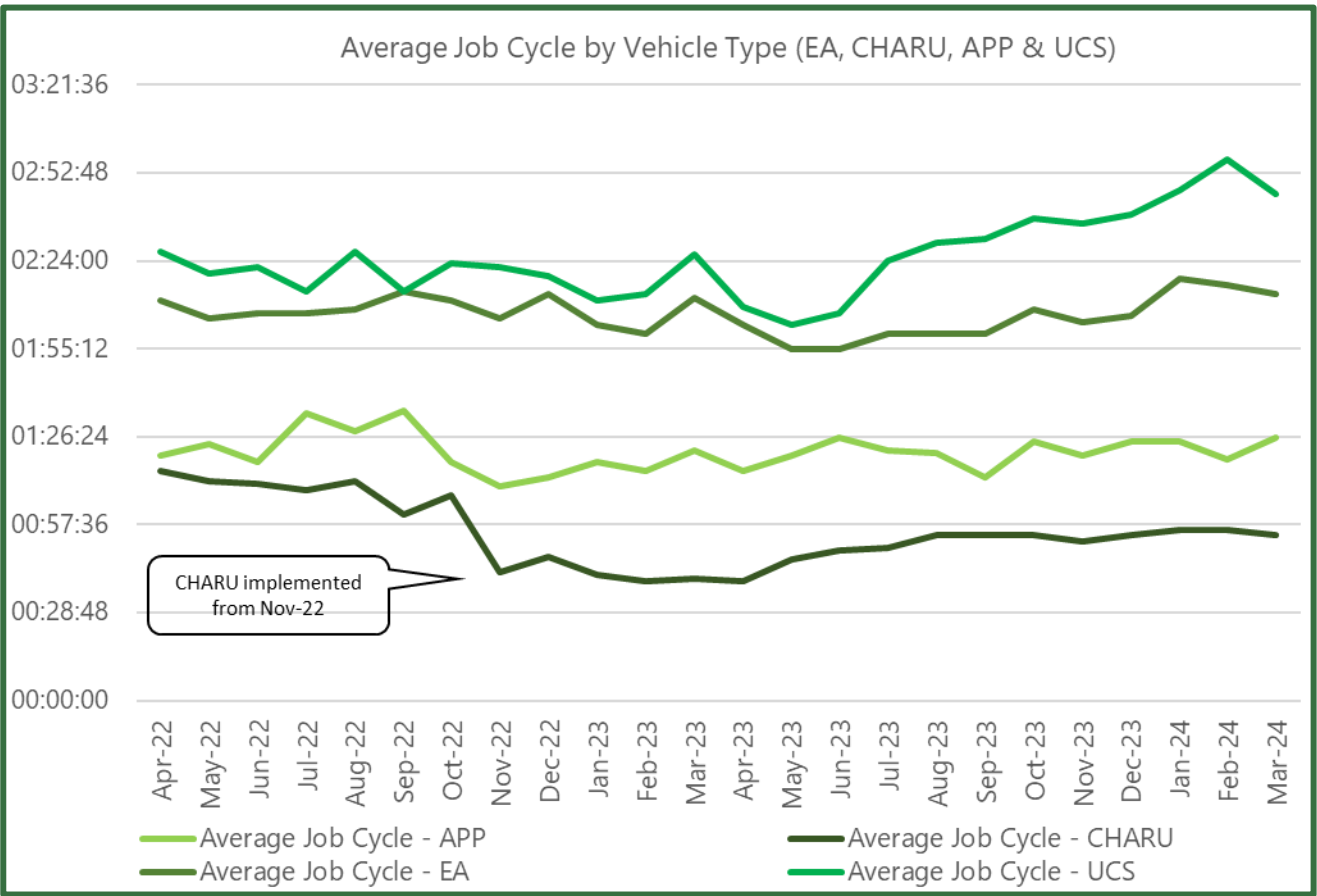
APPs attended on average 3.50 jobs per shift, and CHARU's 1.96 jobs per shift. This CHARU utilisation rate and shifts per job is a particular area of concern.

Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays. For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster. CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs. Further analytical work being undertaken.

Expected Performance Trajectory

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



Partnerships / System Contribution

NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

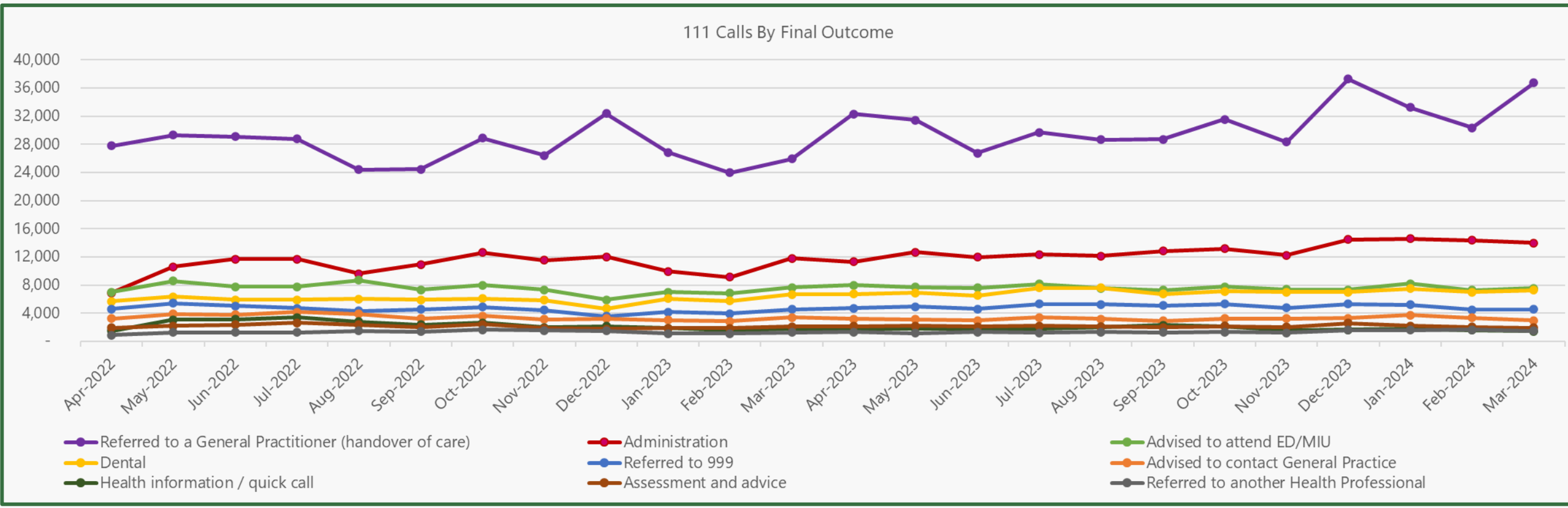
Influencing Factors – Demand and Clinical Hours Produced

Dental
A

C&C
Volumes
G

FPC

(Responsible Officer: Lee Brooks)



Analysis
During March 2024, 77,865 calls were received into the 9 categories displayed in the graph opposite, an increase compared to the 72,011 received during February 2024.

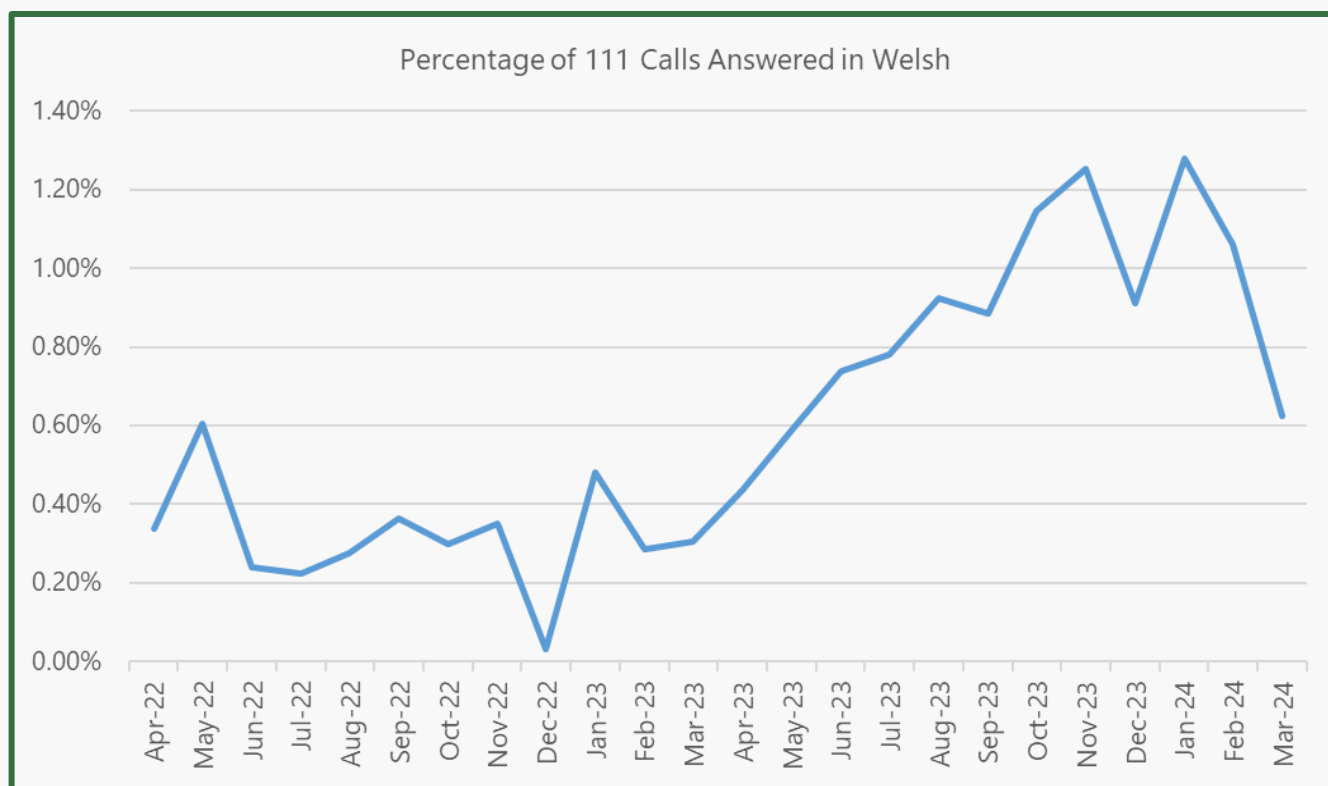
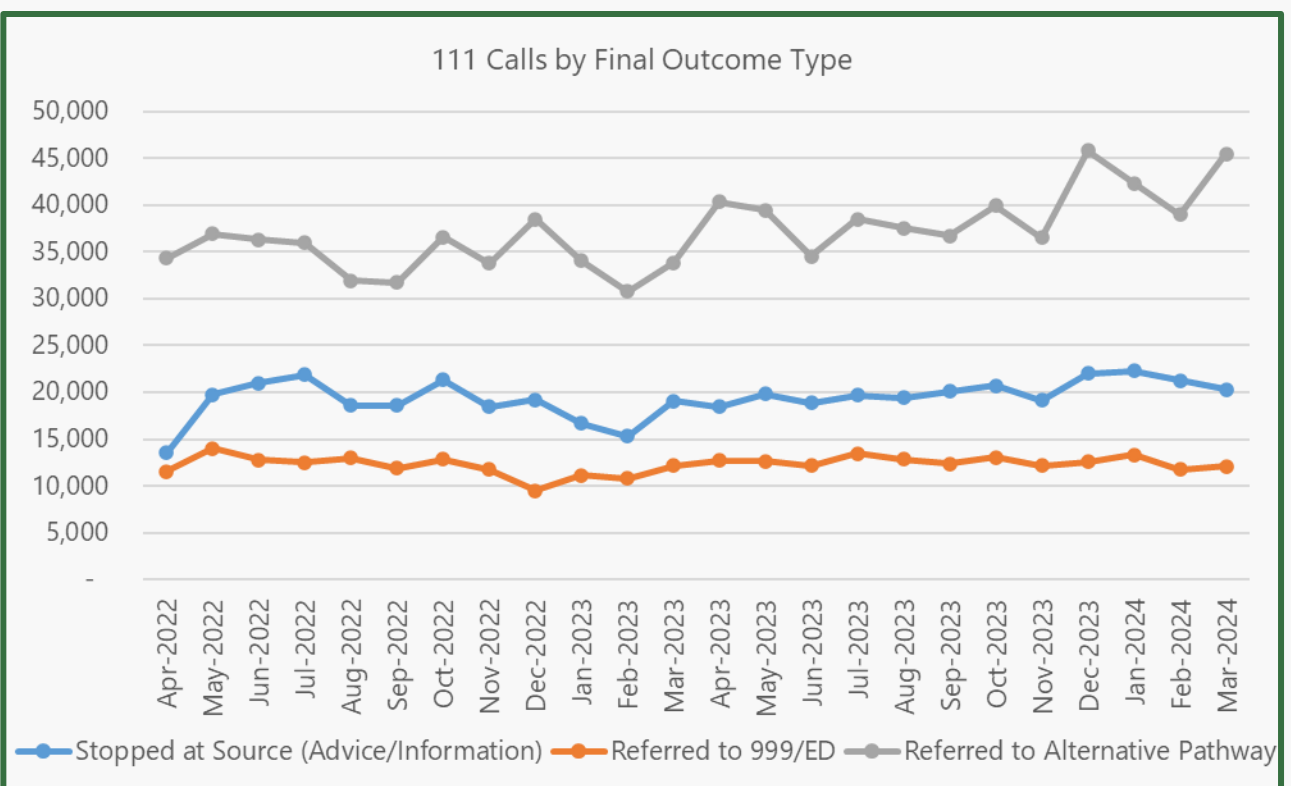
Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 47.15% of all calls during March 2024.

As the bottom left graph highlights, in March 2024, 20,294 calls into 111 were provided with information or advice, with no onward referral, an increase from the 21,288 in February 2024, and an increase from the 19,066 during March 2023.

The percentage of 111 calls answered in Welsh decreased from 1.06% in February 2024 to 0.63% in March 2024. This equated to only 27.2% of all 111 calls being offered in Welsh being answered, a decrease from the 52.2% answered in February 2024.

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

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

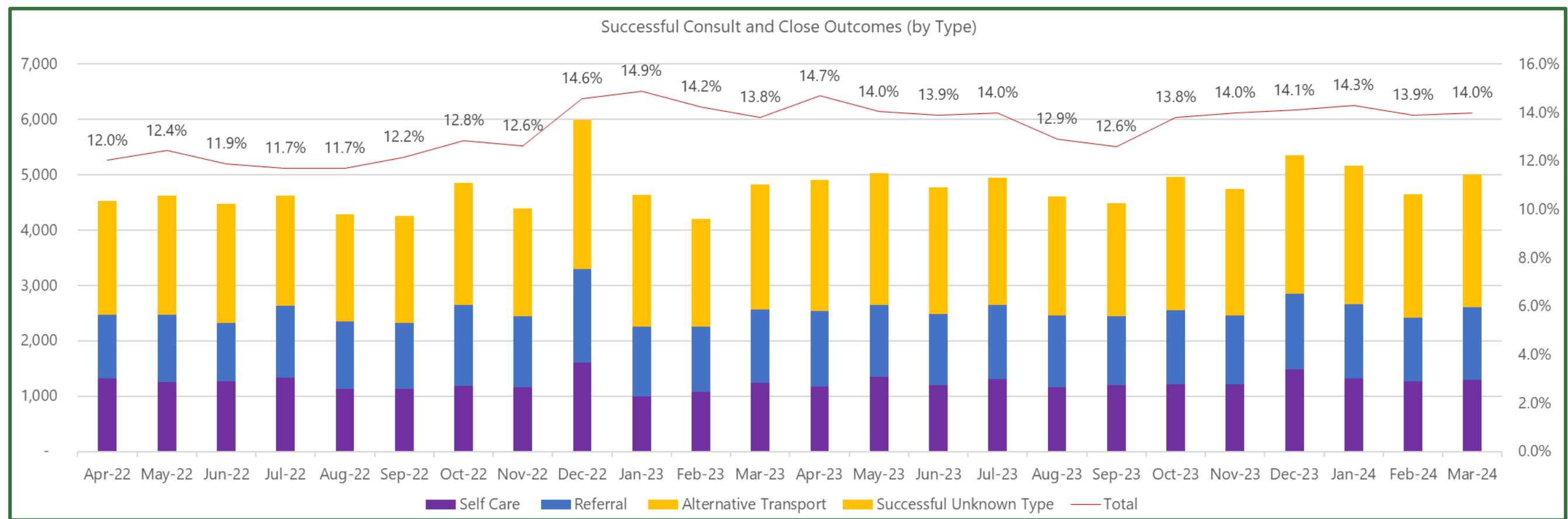


Partnerships / System Contribution Consult & Close Indicators

(Responsible Officer: Lee Brooks)

C&C
A

FPC



Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (10.3%), NHS111 (2.7%), WAST APP (0.7%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.3%) achieved 14% in March 2024, remaining consistent with seen during February 2024, however remaining short of the new 17% IMTP ambition. In March 2024, the number of 999 calls resulting in a Consult and Close outcome was 4,992, up from 4,656 in February 2024.

Of the calls successfully closed in March 2024, 1,294 patients received an outcome of self-care; 1,318 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,385 were advised to seek alternative transport services to acquire treatment.

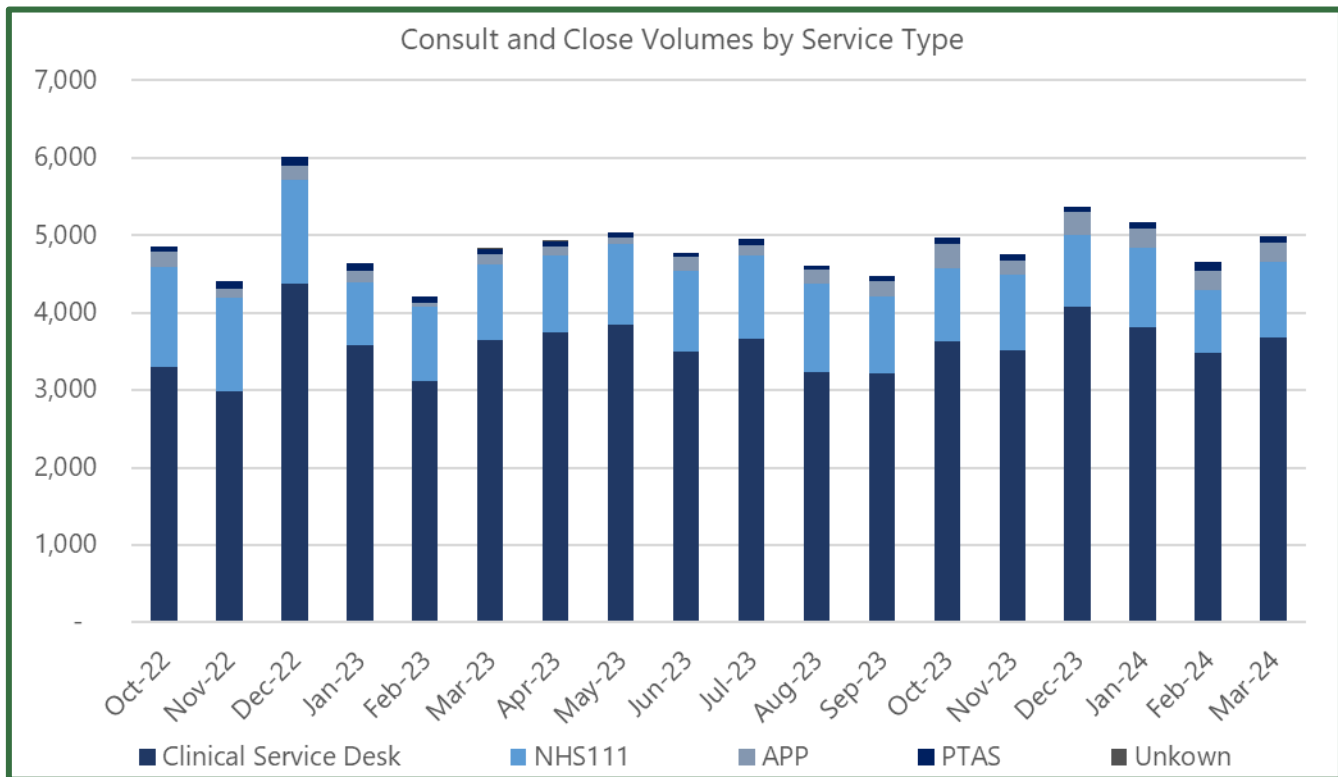
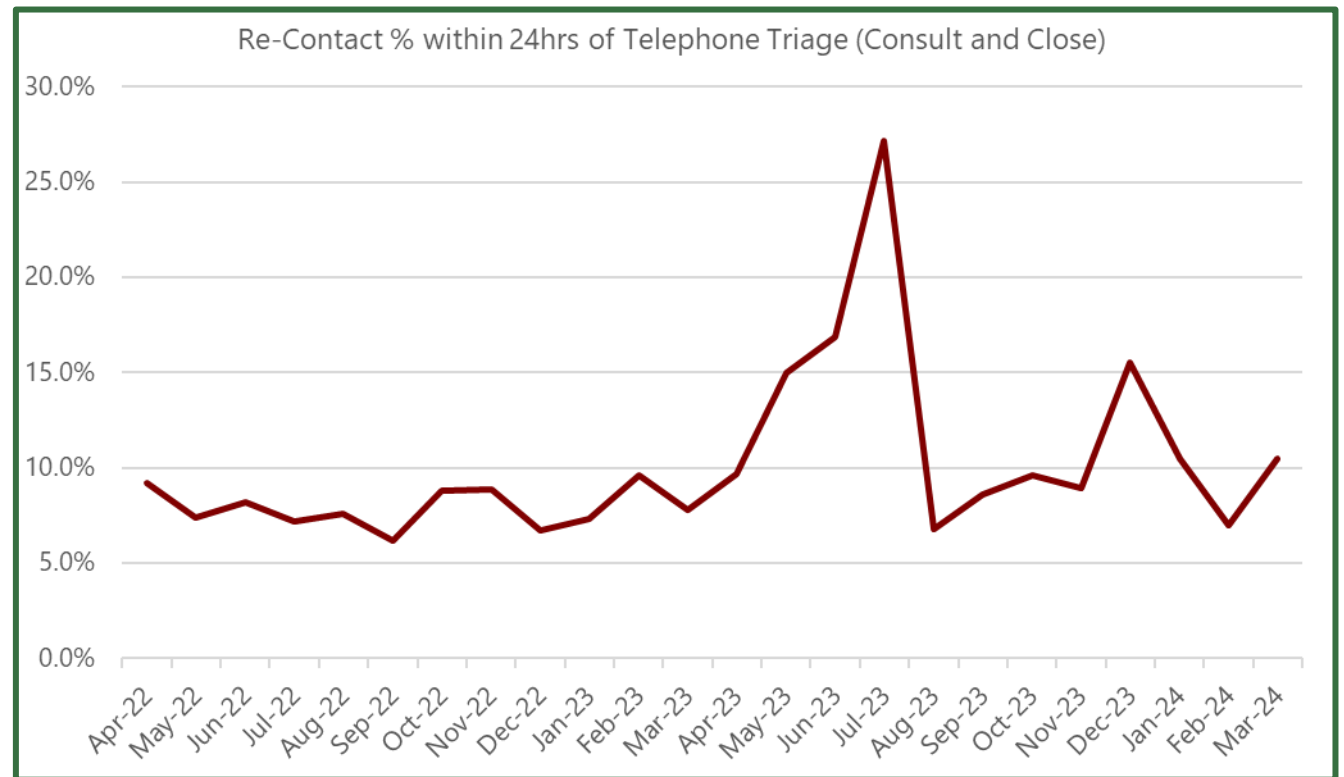
Re-contact rates in March 2024 were 10.5%, an increase on the 7% seen in February 2024.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling.
- Implementation of 15 recommendations from commissioner review.
- Progressing process with 111 to pass calls electronically from CSD, saving time.
- Recruitment of additional 23 FTEs for 24/25.
- Future Service Model transformation workshops arranged for early May.

Expected Performance Trajectory

Further improvement is expected linked to CSD staff attendance (reduced absences and less vacancies). The ambition remains 17%.



Partnerships / System Contribution

Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

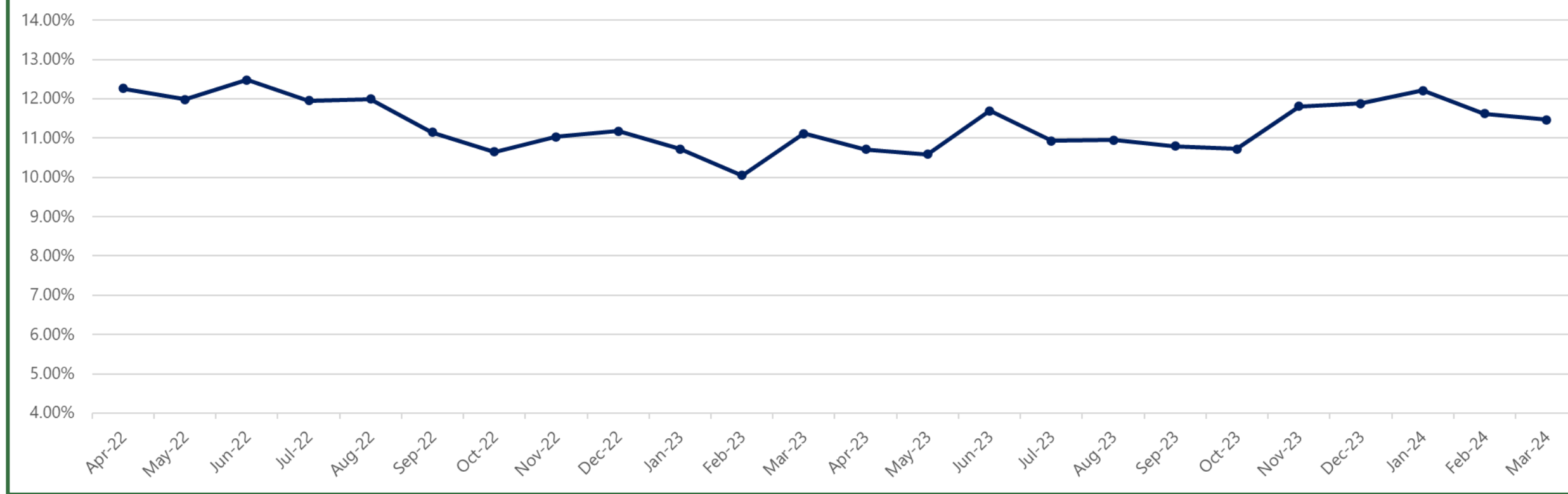
Conveyances

A

FPC

Ministerial Measure

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



Analysis

In March 2024 11.46% of patients (1,646) were conveyed to a service other than a Type One ED, while 35.65% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased slightly, from 3,599 in February 2024 to 3,717 in March 2024.

APP conveyance rates increased slightly to 42.6% in March 2024, after experiencing a generally increasing trend since June 23.

Patients conveyed to SDEC's decreased from 0.17% in February 2024 to 0.15% in March 2024.

Remedial Plans and Actions

Continued provision of information to external stakeholder about the effectiveness of SDECs.

Further investment in the APP workforce in 2024/25 (+32 APPs).

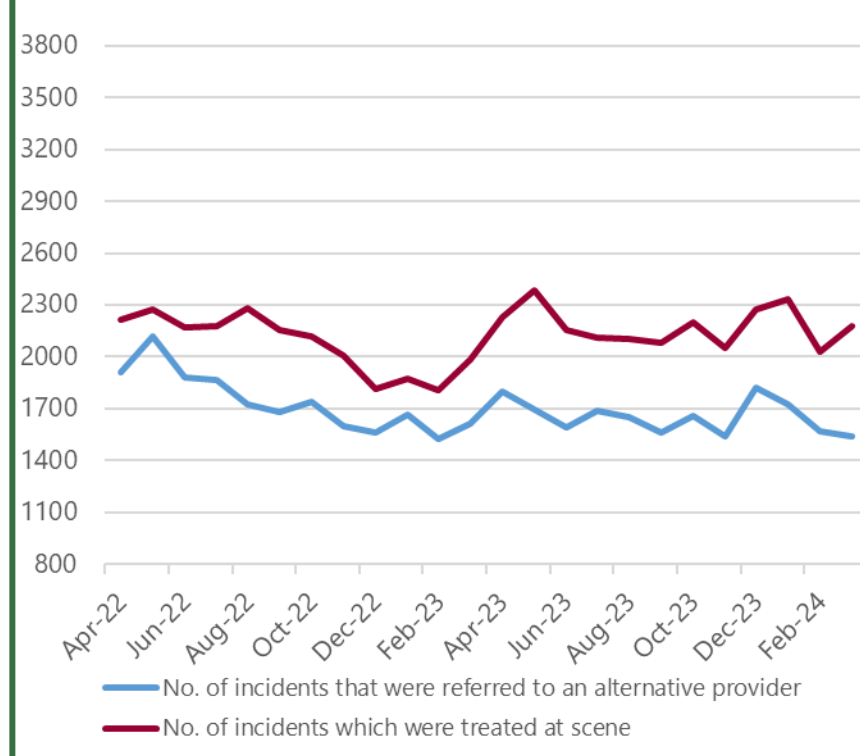
Establishment of APP Recruitment Task & Finish Group, with focus on re-rostering to demand keys, improved placement (training) experience, more certainty for TAPPs about where they will be located.

Review of performance systems for APPs to improve data quality.

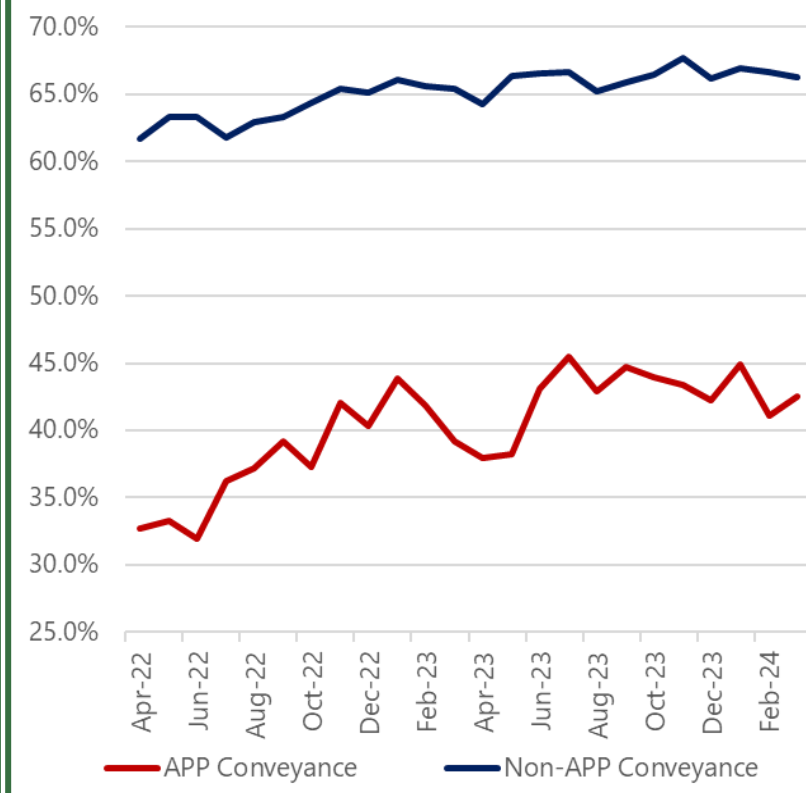
Expected Performance Trajectory

The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to fully invert the triangle with health boards significantly reducing handover e.g. 12,000 hours or 7,000 hours, alongside varying levels of investment. Further in year tactical modelling for winter will be required to determine a performance trajectory for 2024/25. This cannot be undertaken at this point in the year.

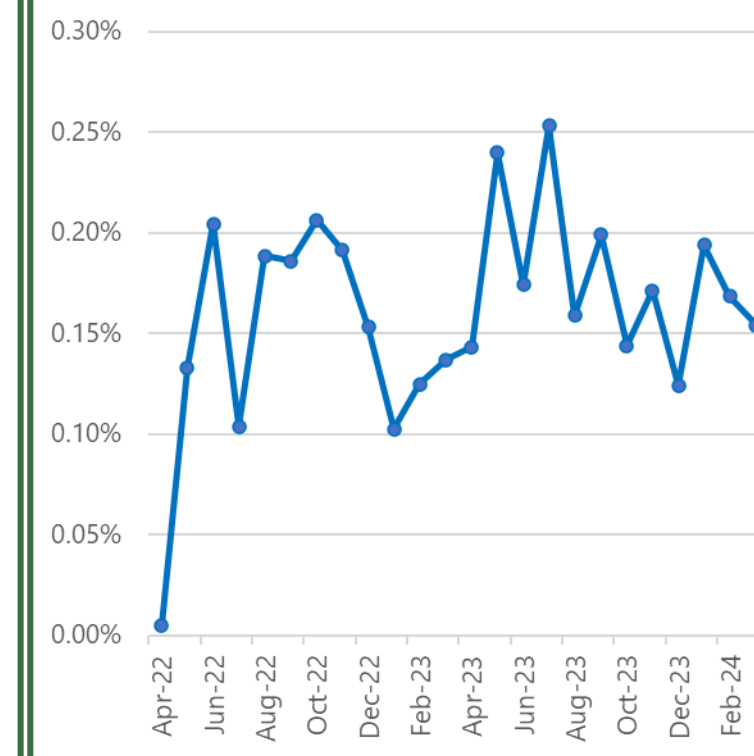
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



APP vs Non-APP Conveyance Rates



% Patients Conveyed to SDEC Units Pan-Wales



Partnerships / System Contribution Handover Indicators

(Responsible Officer: Health Boards)

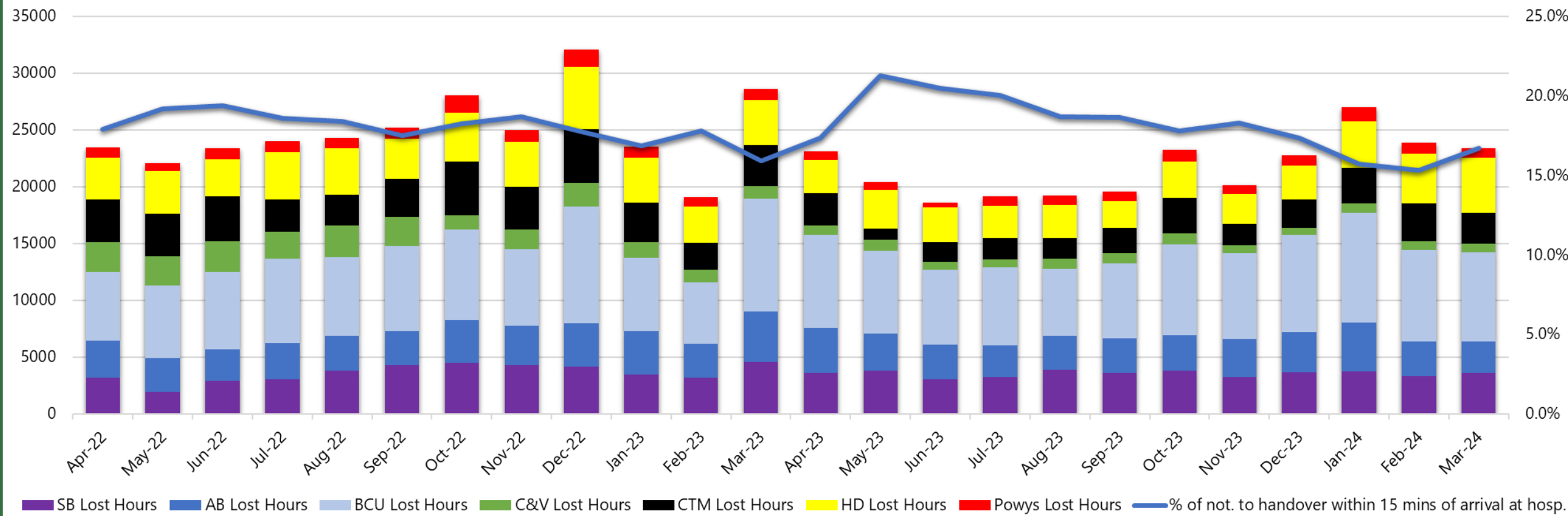
Lost Hours

R

CI

QUEST

Notification to Handover Lost Hours by Health Board



Analysis

260,398 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Apr-23 to Mar-24), compared to 299,636 over the same timeframe the previous year. There were 23,403 hours lost in March 2024, a slight decrease from the 23,896 lost in February 2024 (although over 2 more days). March 2024 levels were 5,217 hours below where they were during February 2023 (28,620).

The hospitals with the highest levels of handover delays during March 2024 were:

- Morriston Hospital (SBUHB) at 3,449 lost hours
- Wrexham Maelor Hospital (BCUHB) at 3,302 lost hours
- The Grange University Hospital (ABUHB) at 2,598 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,564 lost hours
- Glangwilli Hospital (H DUHB) at 2,329 lost hours

Notification to handover lost hours averaged 755 hours per day during March 2024 compared to 823 hours a day in February 2024.

In March 2024, the Trust could have responded to approximately 7,383 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).

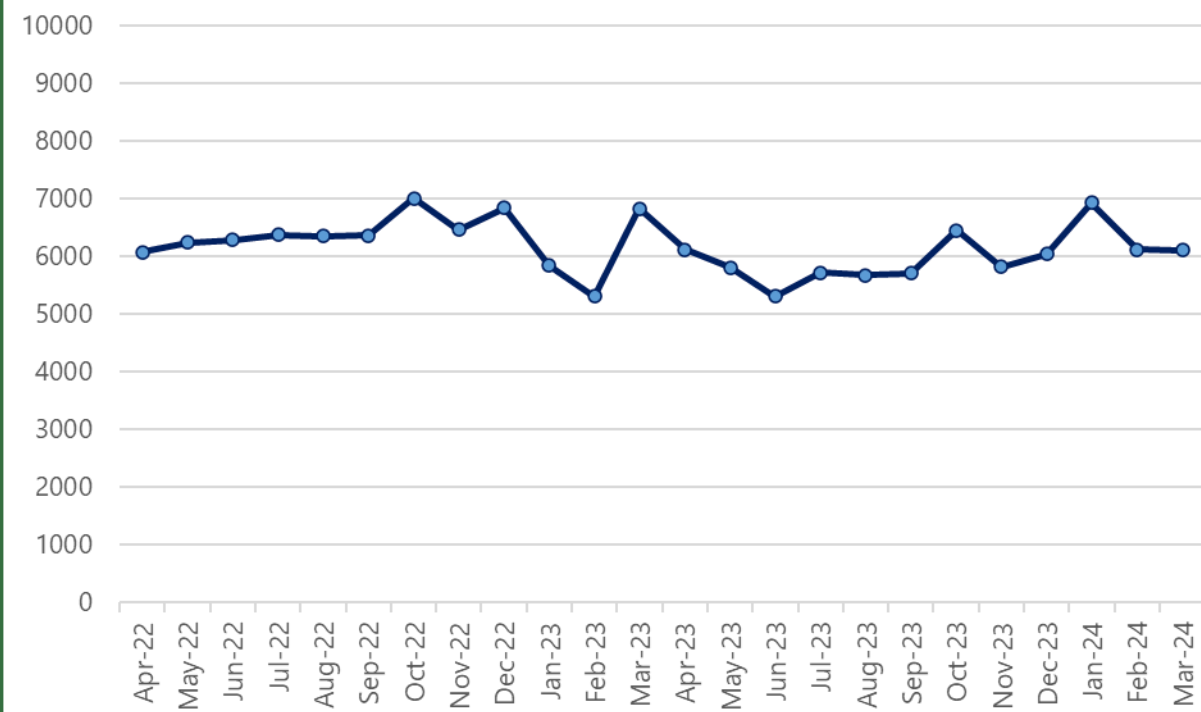
Expected Performance Trajectory

The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,000 hours lost to handover delay. There would need to be a 70% reduction in handover levels in 2024/25 for this to be achieved.

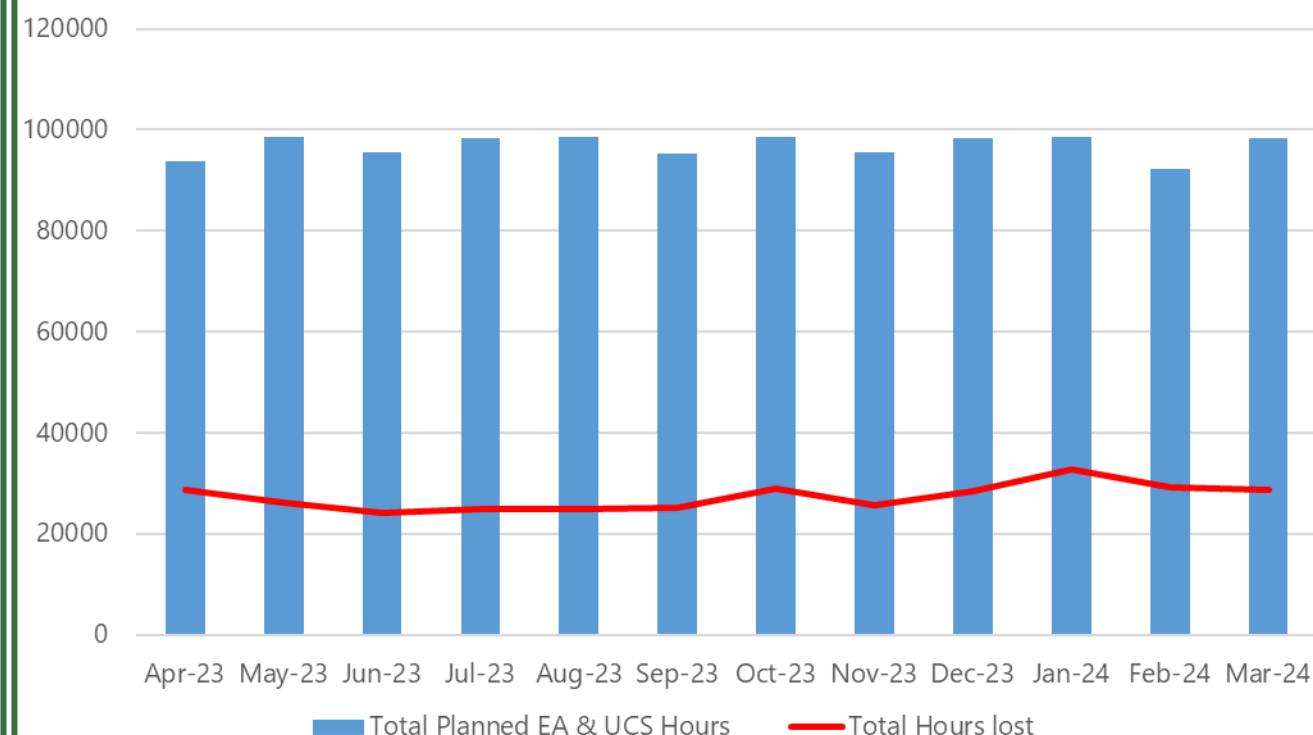
We may expect to see some further handover reduction in 2024/25, but achieving the one-hour Welsh Government target would require a massive improvement.

**NB: Data correct at time of abstraction.*

Handover Rates Over 1 Hour (including first 15 minutes)



Total Planned hours VS Total Hours Lost



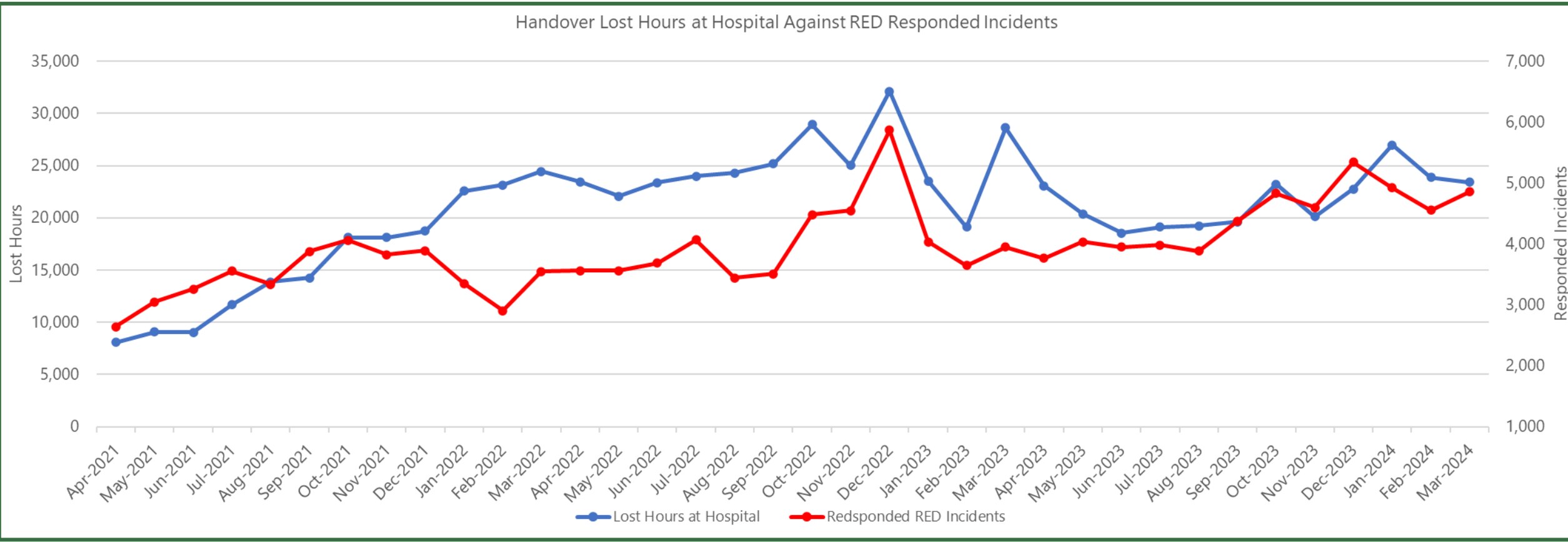
Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI

QUEST



Analysis
 The top graph highlights that as handover lost hours have increased since March 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

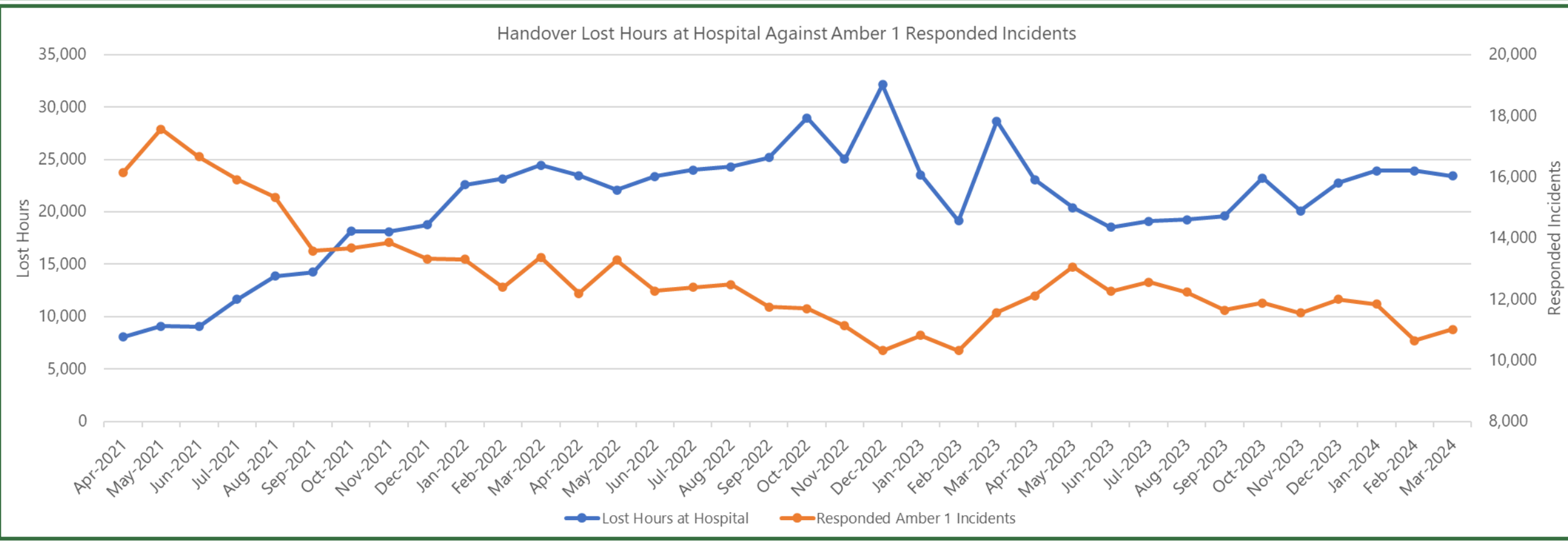
However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill, although during December 2023 Amber 1 responses also increased slightly when compared to November 2023.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

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.

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	Health 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). (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	Ambulance Response FTEs in Post	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	Financial Balance – Annual Expenditure YTD as % of budget Expenditure	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.		
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	111 Consult and Close	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust’s Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	999 / 111 Hear and Treat	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	% Incidents Conveyed to Major EDs	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	Number of Handover Lost hours	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	Immediate Release requests	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls



GIG
CYMRU
NHS
WALES

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

AGENDA ITEM No	11
OPEN	OPEN
No of ANNEXES ATTACHED	2

Q4 2023/24 HEALTH AND SAFETY PERFORMANCE REPORT
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MEETING	People and Culture Committee
DATE	9 May 2024
EXECUTIVE	Executive Director of Quality and Nursing
AUTHOR	Head of Health and Safety
CONTACT	Nicola White nicola.white3@wales.nhs.uk

EXECUTIVE SUMMARY

1. 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 2023/24.
2. Data within this report and within the accompanying slide pack is up to 31 March 2024, as reported onto DATIX Cloud and may be subject to change as investigations are closed. Data retrieved from DATIX Cloud on the 31 March 2024.
3. PCC is requested to note the following:
 - The rolling workplace risk assessment compliance reached 100%, at the end of Q4 2023;
 - RIDDOR compliance for Q4 2023/24 was 94%;
 - Statutory Health and Safety, Violence and Aggression, Fire Safety and Manual Handling training compliance continue to be below Trust’s and Welsh Government standards. All staff are encouraged to bring their training levels up to Trust expectations. Compliance is monitored via the relevant business meetings for managers’ awareness and to encourage staff to raise their compliance levels.
4. PCC is to be assured that:

- The Trust is maintaining a focus on responding to staff and Trade Union concerns about diesel fume exposure.
- A third tranche of environmental surveys has been procured at seven priority sites. This tranche will extend the monitoring process to a one-off 24-hour period. However, this is scheduled for June 2024 due to a period of increased demand the from the provider.

5. For PCC it may be helpful to note that:

- The reporting of incidents for diesel fumes exposure has increased by 7% during Q4 with 47 reported. This could be attributed to requiring heating in the vehicle during the more recent colder weather;
- Sustained efforts are being undertaken by the organisation in collaboration with Health Boards and Locality Managers to mitigate/reduce fume exposure for Trust and Health Board staff;
- Despite significant work undertaken to reduce fume exposure to staff and educate on individual actions that can be taken to minimise risk, non-compliance to process behaviours are continuing to be evidenced. A schedule of *shoreline* audits is underway with the Health & Safety function with an expectation of findings to be presented to the Executive Leadership Team during Q1 2024/25.

6. It is recommended that PCC notes the content of the report.

KEY ISSUES/IMPLICATIONS

7. Work remains in progress to ensure the health and wellbeing of staff exposed to diesel fumes as a result of delays in handovers of care at hospital.
8. A tender for procuring a medium-term environmental monitoring programme went live and closed in January 2024 with no bids submitted. This is being explored with procurement to ascertain if the tender could be amended to appear more appealing to providers. Further discussion with a previous provider indicated that this could be due to the daily battery replacement required to power fixed sentinel monitors.

REPORT APPROVAL ROUTE

Senior Operations Team – 30 April 2024 (for Noting)

People and Culture Committee – 9 May 2024 (for Assurance)

National Health, Safety and Welfare Committee – 10 May 2024 (for Noting)

REPORT APPENDICES
<p>ANNEX 1 – SBAR which provides the background for this report.</p> <p>ANNEX 2 - Health and Safety Performance Metric Report Q4. Data source 31 March 2024 DATIX CLOUD.</p>

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	N/A	Financial Implications	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

9. The Alert Advise Assure Highlight Report provides a concise overview of health and safety performance throughout the organisation for the Q4 2023/24. Additionally, it provides updated positions on items where applicable as of 17 April 2024.

ASSESSMENT

ALERT / ESCALATE	<p><u>AAA Highlight Report</u></p> <p><u>Statutory /Mandatory Training Compliance</u></p> <p>1. Despite recent improvements in compliance levels, Health and Safety, Manual Handling, Violence and Aggression and Fire Safety, training continues to be below Trust expectations. Fire training sits within the remit of the Estates department. All staff are actively encouraged to improve local compliance levels.</p>
ADVISE	<p><u>RIDDOR Compliance</u></p> <p>2. During Q4, 94% of RIDDORS were submitted within HSE required timescales with an annual figure of 88%.</p> <p>3. A sustained effort is put in by the Health and Safety Advisors is maintaining a high level of reporting within the HSE time scales, but further improvement is required to attain the legal requirement (100%) consistently.</p> <p>4. For Q3 2023, the average RIDDOR compliance rate for the UK Ambulance sector was 43%. The Trust achieved the highest level of performance at 81%.</p> <p>5. Twenty-three RIDDORs were reported in Q4 2023/24. Of these, 1 RIDDOR was submitted outside of HSE requirements due to handler delays.</p> <p>6. RIDDOR performance is presented as a regular agenda item to operational business meetings and Senior Operations meetings for monitoring and local scrutiny with the relative Heads of Service.</p>

	<p>7. A breakdown of DATIX incidents including RIDDOR compliance is included (ANNEX 2).</p> <p><u>Diesel Fumes</u></p> <p>8. Health and Safety and Operational resources continue to be utilised in the management of fume exposure at Emergency Departments (EDs).</p> <p>9. The Health and Safety team continues to support Fleet department in for the potential implementation of a Dyson fan heater/cooler for installation within vehicles. An update position paper is to be presented by the Fleet team at the Trust Fleet Service Operations Project Delivery Group (FSOPDG) on 24 April 2024. The paper outlines current challenges and with recommends the establishment of a task and finish group to seek agreed solutions.</p> <p>10. Fume risk assessments conducted at EDs across Wales noted 87 additional actions to control fume exposure. Eighty-three have been completed to date, with the additional 4 medium term actions being monitored by the Health and Safety Team, in conjunction with the Health Boards and operational teams.</p> <p>11. Following a complaint made to the HSE in Q2 2023 about diesel fume exposure at the Grange Hospital Emergency Department, the Health Board responded to the HSE with mitigations undertaken and the HSE have closed the complaint with no further actions required.</p> <p><u>Trust's Hazard Register</u></p> <p>12. A bi-annual review of the Trust's Legislative Compliance Register will be undertaken during Q1 2024.</p> <p>13. The potential for increased incident rates of violence and aggression via the introduction of the 'Right Care Right Person' Programme will be added to the Hazard register for implementation of control measures.</p>
<p>ASSURE</p>	<p><u>Workplace Risk Assessment Compliance</u></p> <p>14. Compliance for Workplace Risk assessment is 100% at the end of Q4. Risk assessments are being reviewed in line with priority risk rating and being reviewed and monitored via the relevant teams.</p>

Trust Legislative Compliance Register

15. The Trust's Compliance Register continues to provide an assessed compliance score of moderate level of assurance. The Register is available for viewing on the Health and Safety functions Intranet page.
16. Areas identified requiring improvement in legislative compliance will be monitored through the Quality Management Group meetings, in which local service area management can be supported to implement improvement/actions required.
17. A breakdown following table outlines areas for priority in ANNEX 3.
18. This is a live document and will be subject to change in line with improvements, changes to action, information and intelligence on the confidence of process in place to attain compliance against a piece of legislation.
19. It is expected that, as the overall register improves, more specific risks and issues related to individual legislation will be identified and highlighted to Committee and/or managed through the Trust Risk Register.
20. Further pieces of legislation in relation to violence and aggression are currently being added, with an expectation of assessment in Q2 2024.

Corporate Risk 199

21. 'Failure to embed a culture of Interdependency resulting in a breach or harm' retains its target risk rating of 10. This risk is reviewed on a quarterly basis.

Risks closed

22. Several Directorate levels risks were subject to review and subsequently approved by the Senior Quality Leadership Team for closure in Q4:

372- Health & Safety Team - Resource Capability;

	<p>315 - Inability to confirm COVID+ status through workplace exposure in order to complete RIDDOR in a timely manner;</p> <p>385 - Risk of lack of compliance to COVID PPE requirements resulting in increased staff exposure and implications from HSE. However, it was recognised that there is evidence of staff not always utilising correct PPE and therefore agreed that a separate risk would be generated.</p>
<p>INFORM</p>	<p><u>Safe Operating procedures.</u></p> <p>23. A Lifting Equipment and Lifting Equipment Procedure has been developed and approved. This is progressing through to Senior Quality Leadership Team during Q1 2024 for noting and subsequent implementation.</p> <p>24. A Provision and Use of Workplace Equipment Procedure has been developed and approved. This is progressing through to Senior Quality Leadership Team in Q1 2024 for noting and subsequent implementation.</p> <p>25. A First-Aid Procedure has been developed and progressing through the approval process with an expectation in implementation in Q1 2024. A schedule of First Aid risk assessments has been developed and will commence during Q1 2024.</p> <p><u>Ambulance Care Liaison</u></p> <p>26. The Ambulance Care (AC) discharge area has been reconfigured at the Royal Gwent University Hospital to provide a safer point of facilitation of patients. This is as a result of continued communication with Health Board staff and the Health & Safety team following concerns from AC staff.</p> <p><u>Noise induced Deafness Case</u></p> <p>27. A litigation claim made by a member of the Trust 111Wales staff for acoustic shock was closed during Q4 by the Trust's legal team.</p> <p>28. The Claimant was seeking damages of £500,000 and costs budgeted to £140,000. The case against the Trust was dismissed and the Trust's practices, equipment and training were deemed as appropriate by the Circuit Judge.</p>

Working Safely Article

29. An article on the Trust's Working Safely Programme was published in January 2024, within the Institutes of Safety and Health (IOSH) bi-monthly magazine.
30. Subsequently, the Trust's Head of Health & Safety was approached to undertake a voluntary position of Editorial Board member for the leading worldwide Safety and Health Practitioner (SHP) magazine. This provides the opportunity to raise the profile of emergency services and the NHS.

Manual Handling (MH) and Display Screen Equipment (DSE)

31. Work is underway in the development of manual handling and DSE improvement plan. This is expected to be completed during Q2 2024.
32. A deep dive into manual handling incidents is underway to identify trend and causation factors with recommendations for improvement from both an equipment and behavioral perspective.
33. Manual handling continues to be the Trust's most reported trend for RIDDOR reporting.
34. Moving patients continues to be the uppermost category for manual handling incidents. However, incident rates have decreased during Q3 & Q4 2023/24 by 57%.
35. During Q4, 51% of MH incidents are categorised within the low harm frequency rate, with 49% as moderate harm and 0% classified as causing severe harm.

Non-Patient Safety Incidents

36. As of 17 April 2024, there 853 open incidents on DATIX Cloud. Aneurin Bevan, Swansea Bay and Hywel Dda University Health boards areas have the highest number of open incidents.
37. Incident closure compliance rates are monitored monthly Senior Operations Team meetings, Local Partnership Forums and respective business meetings.

Violence and Aggression (V&A)

38. There has been a slight decrease in the reporting of V&A incidents for Quarter 4 ending March 2024 with 150 reported during the quarter. A total 130 verbal incidents and 20 physical incidents. A breakdown of V&A incidents is included within ANNEX 2.
39. These being categorised as the following:
- 42 - no harm;
 - 74 - low harm;
 - 28 - moderate;
 - 6 - severe.
40. Severity categories are being reviewed as these are frequently mis-categorised at the time of reporting according to the reporter. Work is underway in the development of an online Incident Investigation training which will assist in improving the quality of reporting and subsequent investigations.
41. The Trust's V&A Manager continues to advise and support the Chair of The Anti-Violence Collaborative to refresh and update guidance on the Obligatory Response to Violence (ORV). The revised guidance is expected for publication and media launch with Head of NHS Wales, Welsh Government, and partners on 30 May 2024. This will be supported by the revision of the Welsh Health Circular 12/2021. The increased awareness and support of this will potentially impact positively on the number of incident reports.
42. The Trust's V&A Manager continues to work with RLDATIX to improve coding and create Mandatory fields for case outcomes to be completed prior to closure. Thus, improving quality of data reports. This is due to be implemented from April 2024.
43. The Trust's Case Manager continues to support 25 live police investigation dating from 2018 to current date. An average of 2 cases are proceeding through the courts each week.
44. A review of Violence and Aggression was undertaken in Q4-2022 - Q1 2023. The paper was presented at Senior Operations Team

	<p>(SOT) in Q3 2023 outlining an action plan for compliance and improvement. An update on actions was presented at the end of January 2024 to SOT and the names of individuals to be included in the membership have been provided to contribute to working groups.</p> <p>45. The Trust's V&A Manager is working with AACE and WAST training department to introduce an approved guidance module, and Restrictive Interventions module to supplement current provision with the aim of prevention of escalation to undesirable incidents.</p> <p>46. Five Cases have progressed through the Court legal system with support from the V&A manager, resulting in:</p> <ul style="list-style-type: none"> • Community Order/Financial Penalty – 4; • Custodial sentences - 1. <p>47. A further case for sexual assault was heard April 2024. Following a Not Guilty Plea the defendant was found Guilty and the case has been adjourned for sentencing this month.</p> <p>48. The introduction of a development opportunity for staff on restricted duties to support the V&A Case Manager with incidents is proving beneficial. A second individual has been identified to replace the initial member of staff who has taken maternity leave. This continues to allow for further scrutiny on themes and trends and providing support with investigations on RLDATIX CYMRU.</p> <p>49. Visits have been conducted at 111Wales and the Clinical Contact Centre (CCC) by the manager and case manager invited in by staff and TU partners to observe and understand workplace pressures and advise on process of risk assessment and incident reporting.</p> <p>50. The Trust's V&A manager has met with EMS lead to assist in developing Risk Assessment on the impact of Right Care Right Person, a fundamental change to working practices in terms of incident management and patient transportation. This support will continue to assist staff to place Risk on the organisation's risk register.</p>
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It is recommended that PCC notes the content of the report.

ANNEXES

ANNEX 1 – SBAR

ANNEX 2- H&S Performance Metrics

ANNEX 3 – Compliance Register Priority Actions



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru

Welsh Ambulance Services
NHS Trust

Health, Safety and Violence and Aggression Quarterly Report (Jan-Mar 2024)





Health Safety and V&A

Health and Safety

Incidents per 1000 999 Journeys

The total number of H&S incidents for the month was 149 Resulting in 10.37 Events incidents per 1000, 999 journeys during (March). The rolling 12month breakdown of these incidents is shown below

No Harm
Month 2.23



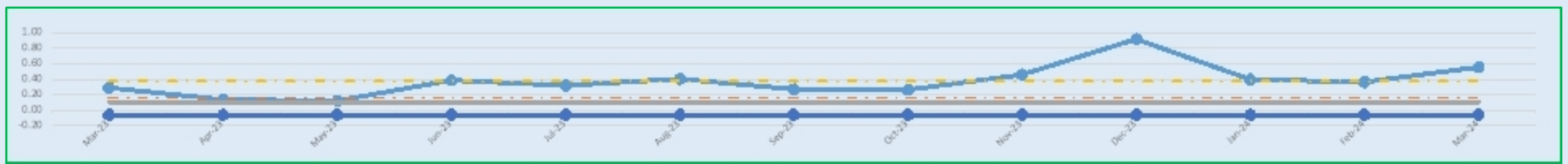
Low Harm
Month 4.18



Moderate Harm
Month 3.41



Severe Harm
Month: 0.56



Frequency Rate Mean UCL LCL

Baseline FY 21/22





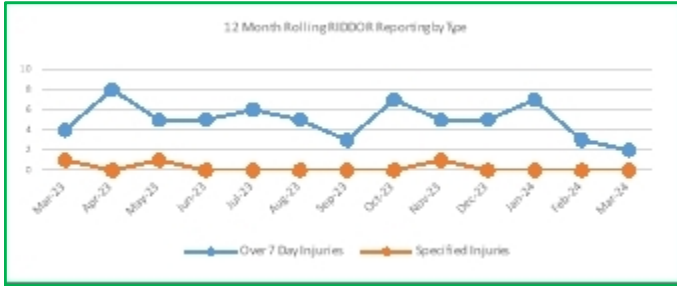
Health Safety
and V&A

Health and
Safety

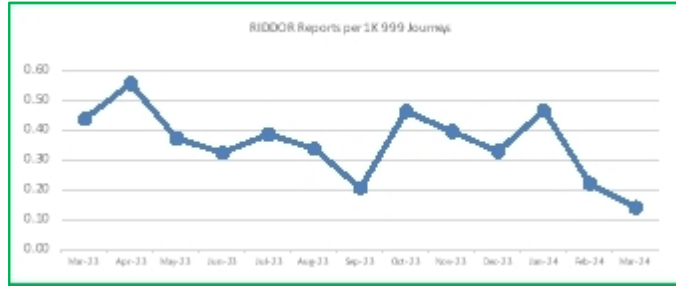
Incident Types
& RIDDOR

RIDDOR Incidents

Number of Incidents



Rate of Incidents

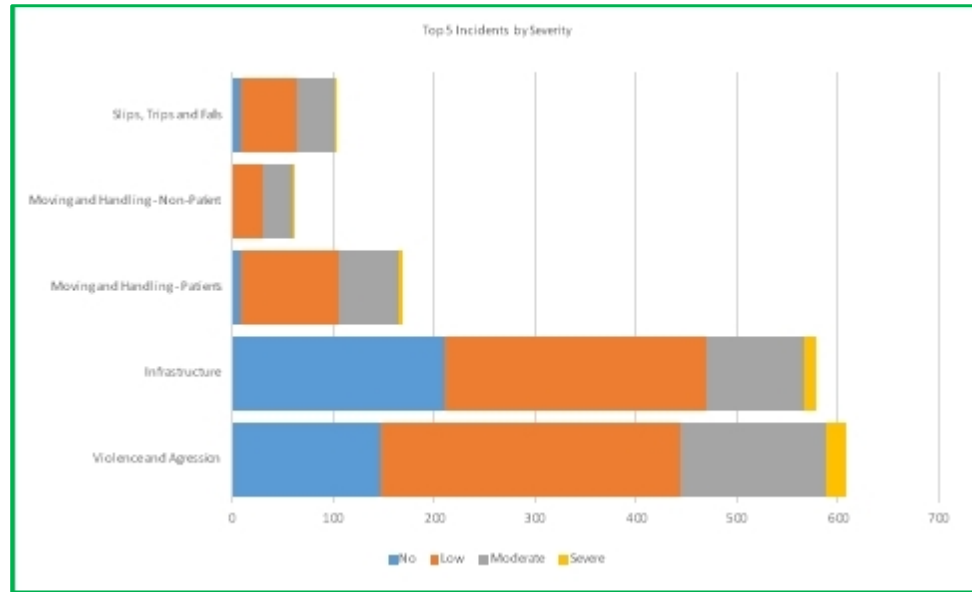


RIDDOR HSE Reporting

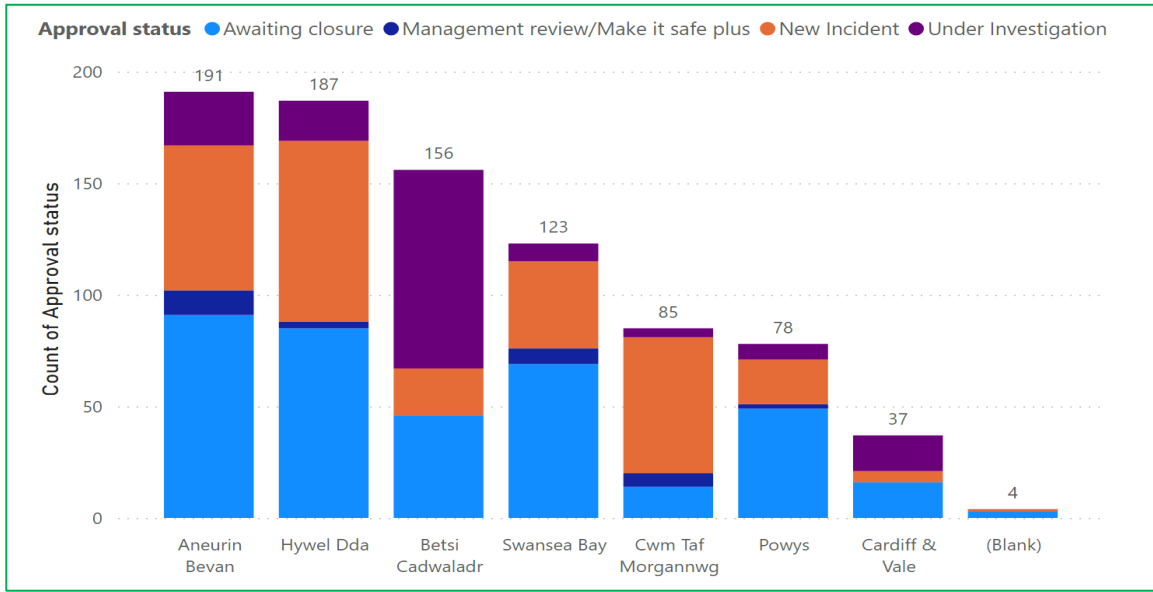


Incident Causes and Closeout Rates

Top 5 Incident Causes



Incident Closure by Health Board



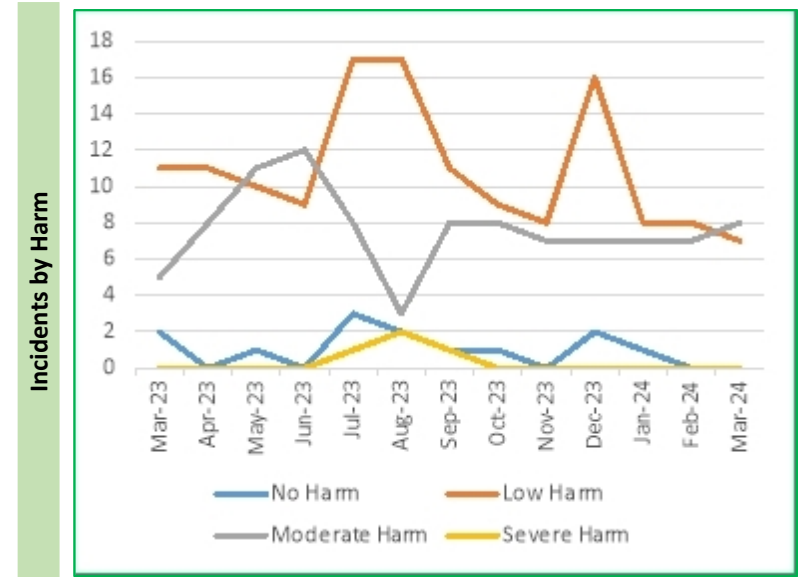
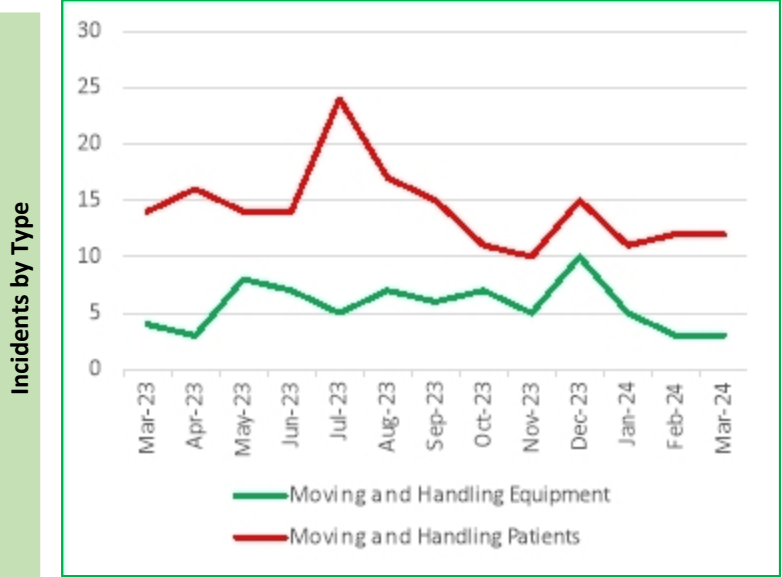
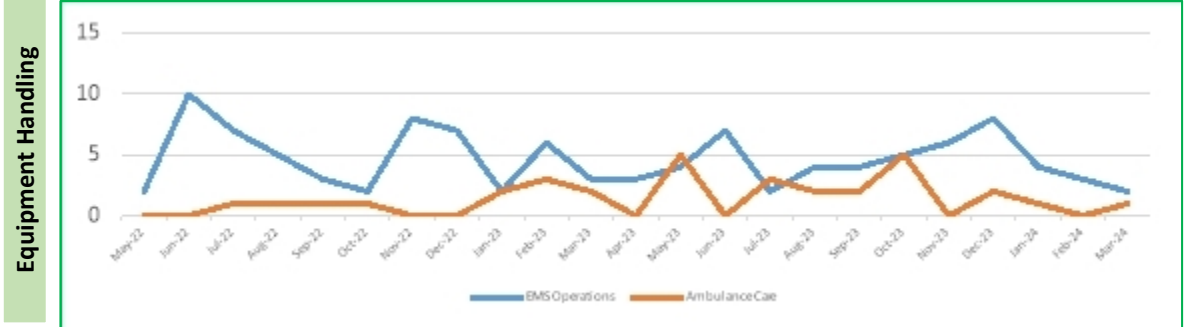
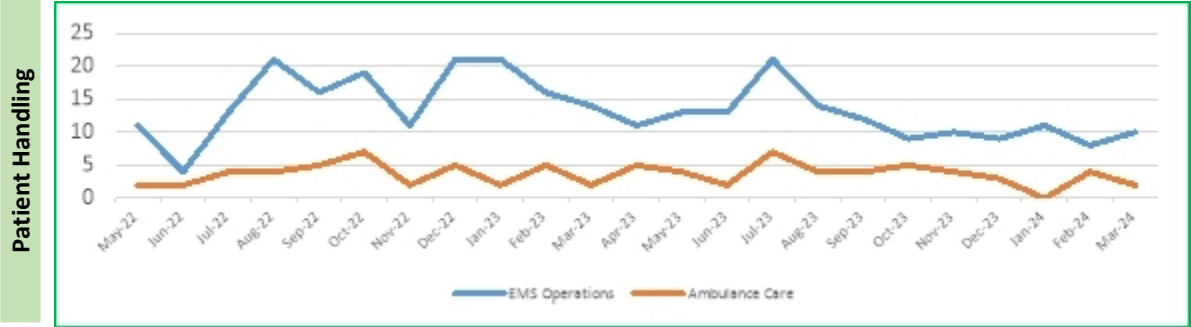


Health Safety
and V&A

Health and
Safety

MSK Incidents

Manual Handling Incident by Service





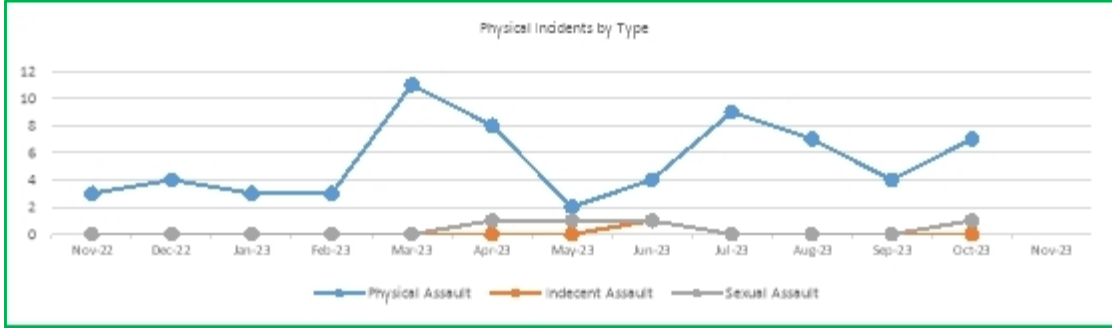
Health Safety and V&A

Violence and Aggression

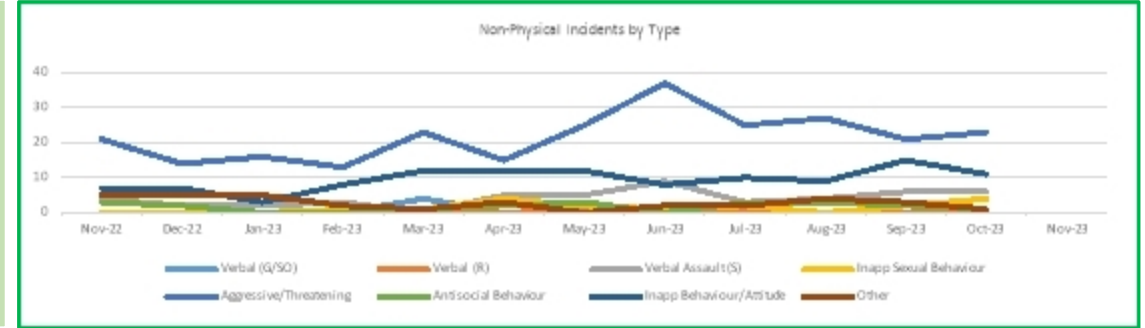
Incidents

V&A Incident Types

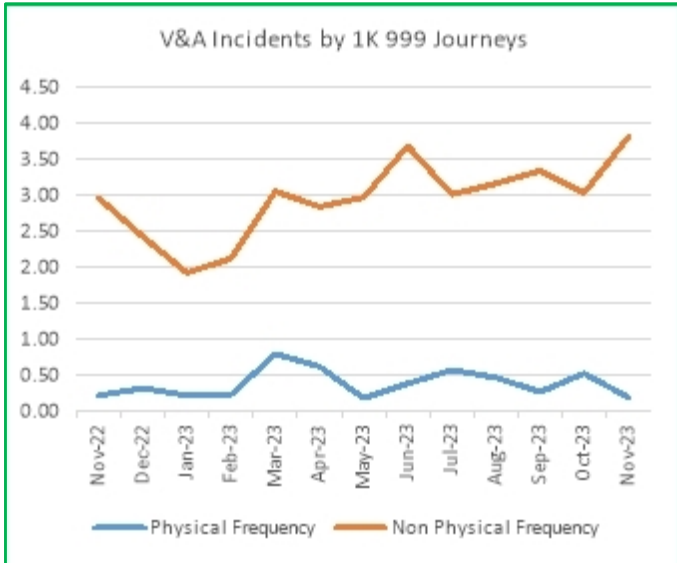
Physical Aggression



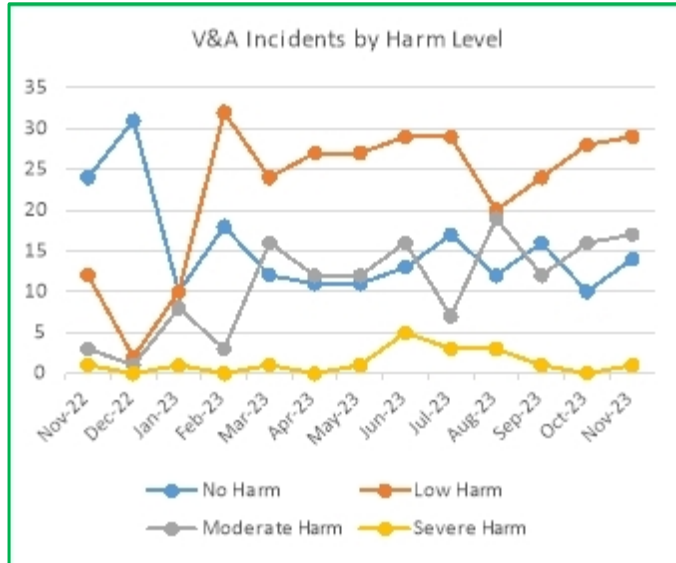
Non-Physical Aggression



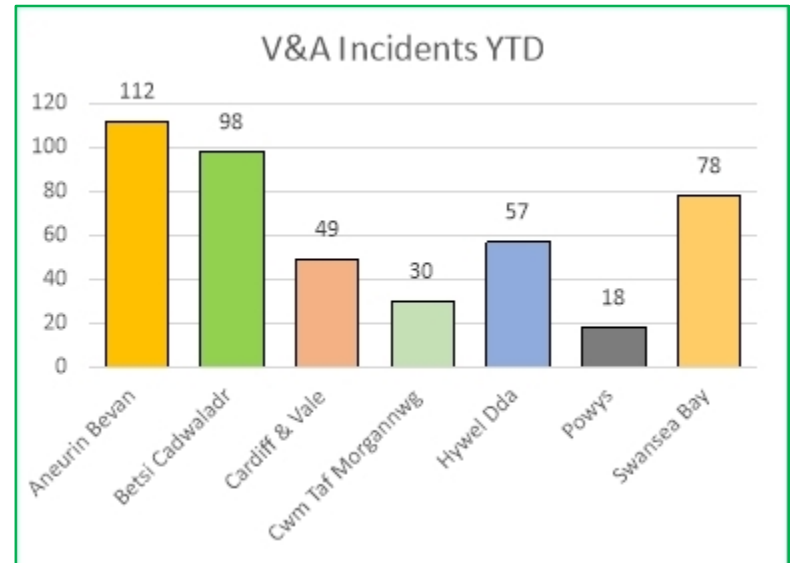
Incidents Per 1000 Journeys



Incidents by Harm



Incidents by Health Board



Compliance Register Priority Actions

ANNEX 2

Regulation	Compliance Score	Work to date
Control of Vibration at Work Regulations 2005	1.00/3	H&S team undertaking the development of procedure.
Dangerous Substances and Explosive Atmosphere Regulations 2002	1.05/3	Draft procedure developed by H&S for Estates team to review and take forward.
Pressure Systems Safety Regulations 2000	1.23/3	Requirements for the Trust are currently under review.
Health and Safety (First Aid) Regulations 1981	1.33/3	Draft procedure to be presented at Formal SOT then SQT in Feb 24 for final approval.
Control of Asbestos Regulations 2012	1.33/3	Asbestos Awareness training developed by Estates Team. Overarching Control of Asbestos Procure to be reviewed by Estates team.
Electricity at Work Regulations 1989	1.33/3	Review of requirements to be undertaken by Estates Team ahead of creating a plan of work.
Construction Design and Management Regulations 2015	1.34/3	Review of requirements to be undertaken by Estates Capital Team



AGENDA ITEM No	12
OPEN	OPEN
No of ANNEXES ATTACHED	2

People Development Plan – scene setting

MEETING	People & Culture Committee
DATE	09.05.2024
EXECUTIVE	Angela Lewis, People and Culture Director
AUTHOR	Jo Kelso, Head of Workforce Education & Development
CONTACT DETAILS	Jo.kelso@wales.nhs.uk

EXECUTIVE SUMMARY

1. A number of internal and external drivers relating to the knowledge, understanding and skill development of our people provide us with a timely review of how we develop them to best deliver our mission.

2. Our People and Culture Plan commits to development of our People Development Plan (PDP) over the second and third year of its lifespan. The PDP will be arranged to categorise our professions into Job Families and will provide a clear road map of how individuals can progress with their job family. The PDP will identify role specific competencies and skills as well as organisation wide professional proficiencies that embrace wider and softer skills in addition. Our People and Culture Plan incorporates the PDP in recognition of the role that effective staff development plays in both role specific and employee generic productivity and progression.

3. Our people development vision includes internal and external opportunities and so reads across to our Study Level Policy (in review) and our Bursary process.

KEY ISSUES/IMPLICATIONS

4. People & Culture Committee is asked to:
 - **NOTE** the content of the report;
 - **SUPPORT** the proposed approach to incorporate our Staff Development Plan into our People Development Plan

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
People & Culture Committee	09.05.2024	For information and discussion

SITUATION

5. The purpose of this paper is to socialise the People Development Plan and update committee regarding the foundational work relating to staff development currently being carried out across the Trust, in response to a number of drivers, including:
 - Retention of Staff Internal Audit findings
 - The NHS England National Thematic Review of Paramedic Training; specifically responding to skill fade concerns amongst Student Paramedics
 - Association of Ambulance Chief Executives (AACE) Clinical Supervision: a Framework for UK Ambulance Services
 - Welsh Health Circular: Nursing Preceptorship & Restorative Clinical Supervision
 - Health Education & Improvement Wales (HEIW) Continuous Professional Development (CPD) strategy for the NHS Wales healthcare workforce
 - Feedback provided to the Education & Development team following requests for suggested improvements – directly and indirectly via routes such as the Work Based Learning Group, Corporate Partnership Forum, Admin Review Recommendations Project.

BACKGROUND

6. Our People and Culture Plan lays out our ambitions to drive whole organisational cultural change using our 3 Cs – Culture, Capacity and Capability within the context of the King's Fund ABC framework for our colleagues, building opportunities for **Autonomy**, developing the sense of **Belonging** and connectedness and ensuring that colleagues feel they can make a valuable **Contribution** to the organisation. Our 2024/27 IMTP articulates our commitment to commence delivery of our People Development Plan during 2024/25.
7. On 01.04.2024, the Welsh Ambulance Services NHS University Trust (WAST) had University Status conferred. Along with the name change, we now have irrefutable recognition of our standing, commitment and contribution to **Education, Research and Innovation**.
8. What sets WASUT apart from previous recipients of University Status is our adherence to the principles of the **Learning Organisation** (team learning, shared vision, mental models, personal mastery and systems thinking) and **democratised, equitable development of all our people**, not just those in established professional or registrant roles.
9. Our Rich Picture centres around our professions with a key deliverable in years 2 & 3 of our People and Culture Plan being our **People Development Plan**. Our Plan outlines the range of opportunities we wish to support our people to engage with. This offer provides **career spanning support** - flexing and growing with the various stages individuals experience. We seek to provide opportunities to benefit individuals as well as the whole organisation as we provide support and challenge to explore how each of

us can confidently and competently operate at the top of our scope of practice whether that be in our corporate roles, Ambulance Care, Integrated Care or Emergency Medical Services.

- 10.** The People and Culture Directorate Local Delivery Plan features the People Development Plan workstream with the Work Based Learning sub-group of the Strategic Education Steering Group providing the governance route.

ASSESSMENT

11. Internal feedback provided to the Education & Development team has identified 3 themes that would provide additional value to the employee experience, specifically;

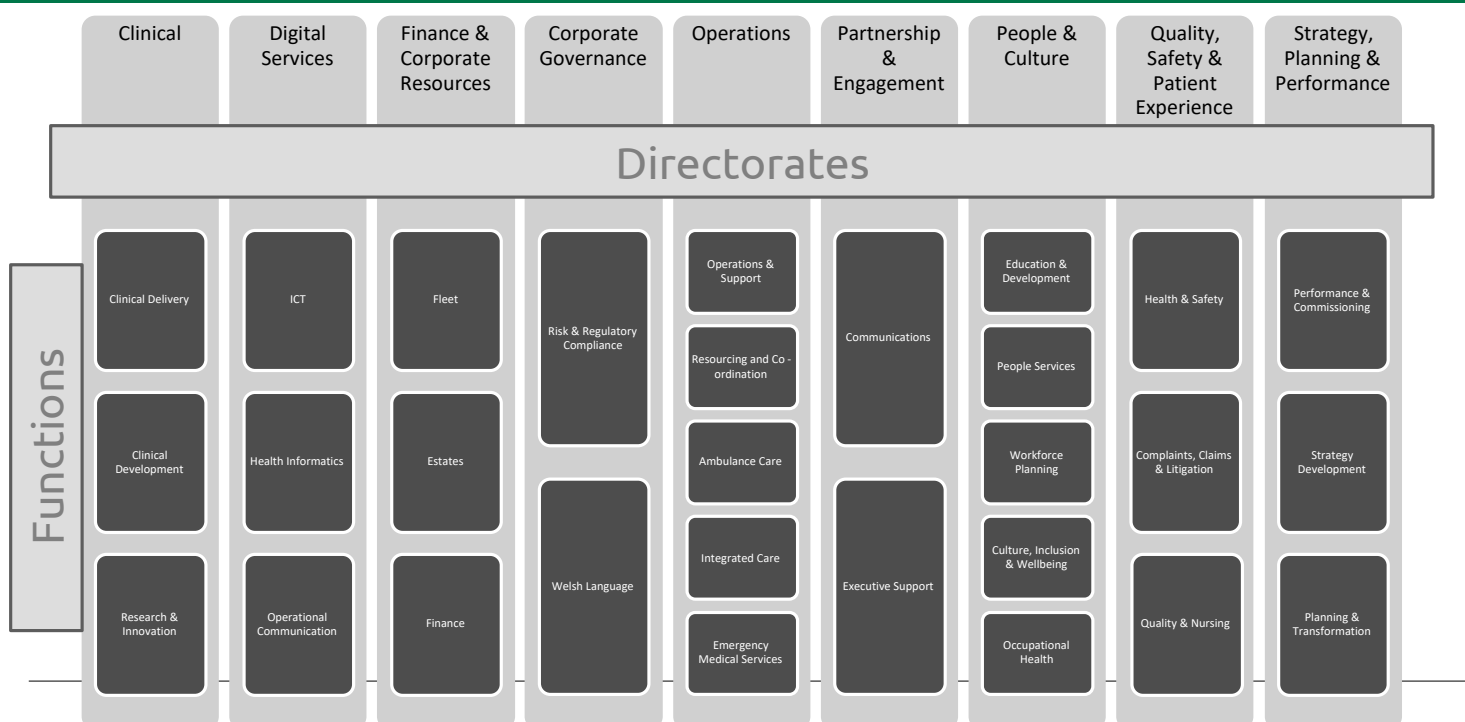
- Access to Continuing Professional Development
- Access to a learning resource hub for CPD and other learning
- Individual learning and development plans, for all roles.

12. The first two of these are in place. We recognise there is variability across the Trust when it comes to contractual arrangements related to **CPD time**. We are engaging across the wider NHS as this landscape changes. We have a **fully featured Learner Management System** in place with positive acceptance following its introduction and a commitment to continue development of a rich and interesting catalogue of topics. The last item will be one of the outputs from our People Development Plan where **individuals** will be able to **identify the development pathways** they need to access as they **move through their career**.

13. The range of professions and ‘job families’ that are in place across the Trust is wide. Our plan will enable colleagues to understand what their particular job family requires of them as well as open up the opportunity to develop professional proficiencies that improve performance, encourage growth and enable excellence in individuals work.

14. Our organisational structure generally indicates where particular job families lie. The image below is a schematic of our directorates detailing their functions.

Where these professions are in WAST



15. Additionally, we have the Administration and Project Management job families that appear in many directorates, often also working across directorates.

16. Representatives from each directorate have been identified and are working on detailing their particular job families. This detail will include role name; banding; essential **qualifications required** on entry/post entry; alignment to professional **Institutes**; skills required to perform the role and will be laid out in a ladder format to indicate **progression routes** usually associated with the job family.

Profession Matrix		
Job Family	Knowledge required	Skill required
Entry role	A, B, C	1, 2, 3
Team lead role	A, B, C & X	1, 2, 3 & 10, 20, 30

The schematic represents this.

17. The PDP will enhance the knowledge, understanding and skills of all our people by opening up to them a number of opportunities we refer to as **professional proficiencies**. These are key to us realising the ambitions encapsulated in our 3 Cs. We will deliver these using neuroaffirming approaches to bring out the true potential of each of our people; embedding our University Status commitment to democratised learning for our whole workforce. These professional proficiencies will be offered across the Trust, in addition to the job family specific developments identified in the People Development Plan. A selection from the offer is listed below:

- **Managers Essentials** – Toolkit for all colleagues with management responsibilities; How To guides relating to application of policy and implementation of procedure
- **Our WASUT Way** – our Leadership and Management programme
- **Coaching & Mentoring qualifications** – forming part of our EMS roles – EMT3, Practice Educator – available across the Trust to support leadership development
- **Study Skills for Progression** – supporting career aspirations for further study; literacy, Numeracy and Digital Literacy
- **Health & Safety** – enabling our Safety Culture commitments
- **Apprenticeships** – enhancing our in Trust offer to include Call Handlers and Business Administration alongside our established Trainee EMT programme; forging external links with quality providers for programmes outside the Trust, where required
- **Business Acumen, Change Management, Project Management, Digital Skills & Digital Literacy, Cultural Development, Professional Effectiveness** – Whole Trust benefitting proficiencies, non-role dependent
- **Supervision – this will take the form of:**
 - i. **Clinical Supervision** – EMS & Ambulance Care, Integrated Care, 111
 - ii. **Professional Supervision** – Corporate

18. PDP visualisations in appendices – appendix 1 – mapping our Job Families, skills and competencies and appendix 2 – overview of the workstream.

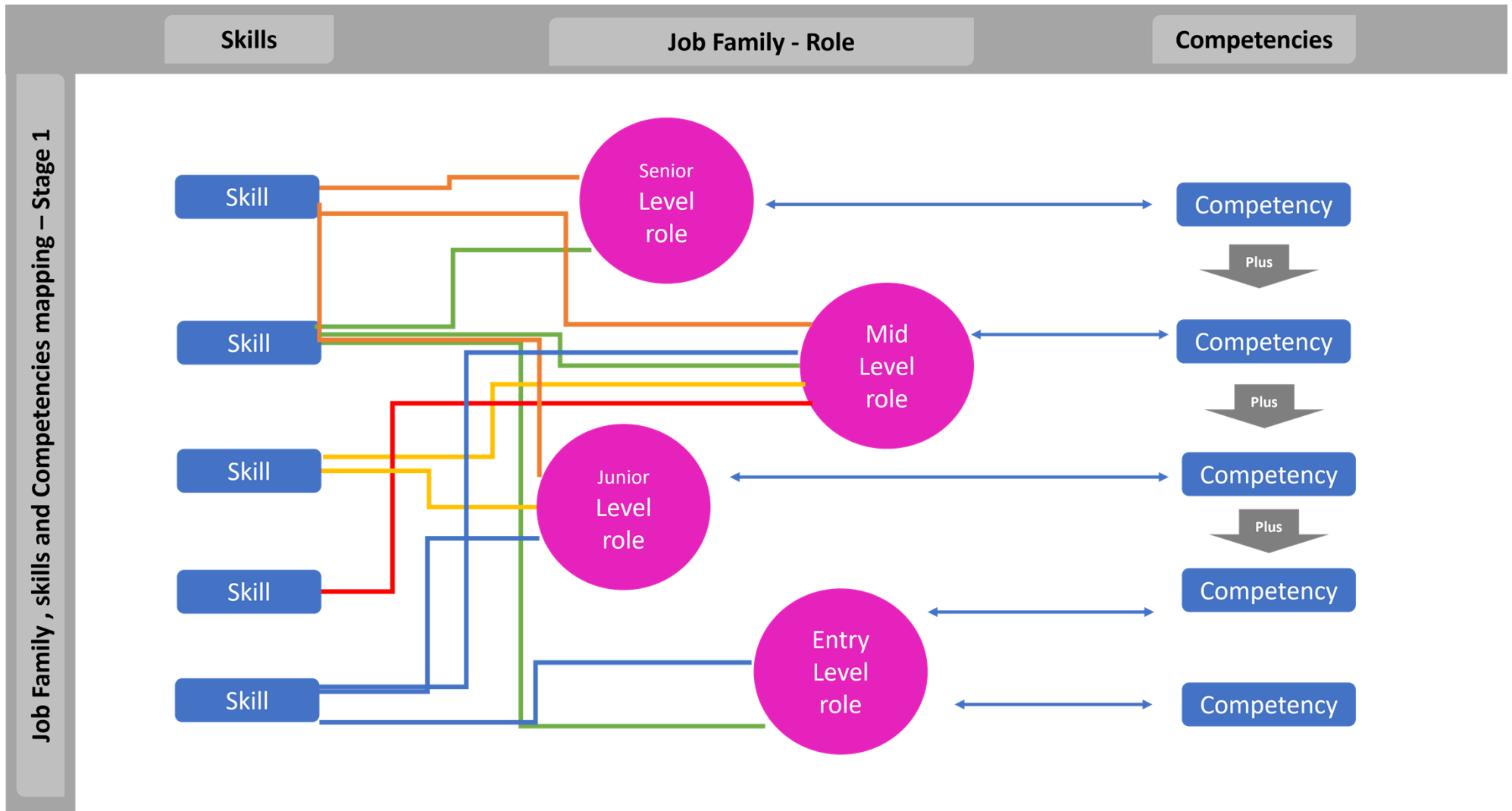
RECOMMENDED:

That People & Culture Committee:

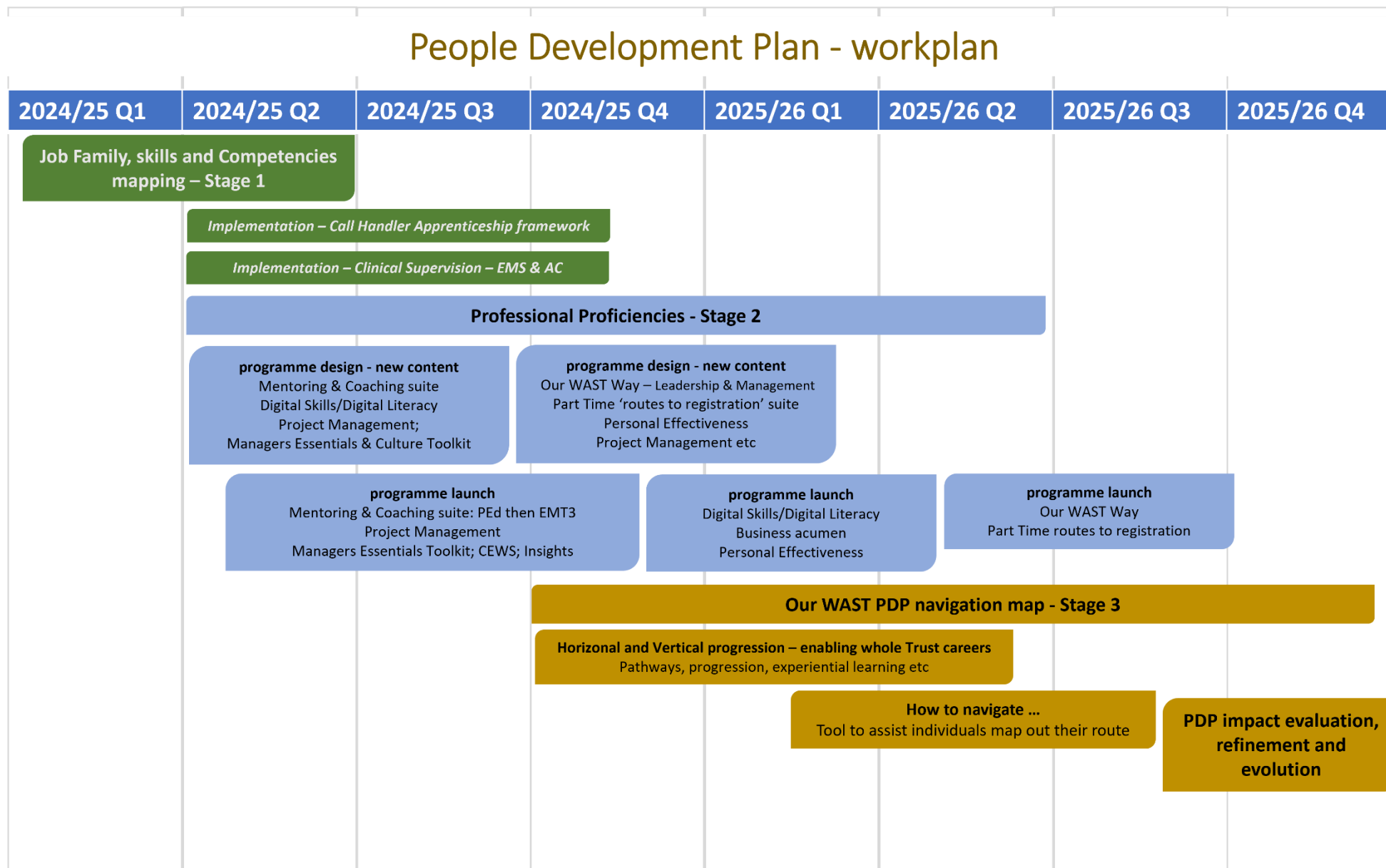
- **NOTE** the content of the report;

- **SUPPORT** the proposed approach to development of our People Development Plan

Appendix 1 - Job Family, skills and competencies mapping – stage 1



Appendix 2 – People Development Plan – overview of the workstream



AGENDA ITEM No	13
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	People and Culture Committee
DATE	9 th May 2024
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 4 risks that are relevant to Committee’s remit and additionally the Trust’s 2 highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight.
2.	A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.
3.	The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each 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 Annex 2.
4.	Each of the principal risks were presented to the Trust Board on 28 March 2024 and are updated as at 07 February 2024. These high rated risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 and the results of this review will be presented to Trust Board on 30 May 2024.
5.	Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.
6.	The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score.
7.	The Trust’s highest rated Risks 223 <i>the Trust’s inability to reach patients in the community causing patient harm and death</i>) and Risk 224 <i>(Significant handover of</i>

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, scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings as well as internal forums.

8. As reported to the March 2024 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.
9. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks will be reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.
10. Additionally, these risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally.
11. Whilst both risks remain static at the highest score of 25, it is anticipated that this will be the case for the foreseeable future as long as the Trust is in a position where it is highly likely to have an incidence of premature death or avoidable harm because of being unable to respond in a way that it would wish to. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.
12. These risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally given that their score has remained catastrophic over a significant period of time.
13. Risk 160 *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, whilst good progress is being made to reduce sickness absence, a decision has been made to keep the risk rating under review. Each of the controls, assurances and mitigating actions have been reviewed in full and strengthened during March 2024.

14. Risk 163 *Maintaining Effective & Strong Trade Union Partnerships* – It was recognised that there would need to be a period of healing across the organisation following the industrial action in 2023. Since this has ended, there has been a significant focus placed on maintaining effective and strong trade union relationships at all levels. Whilst this has helped to improve communication and understanding of different styles and approaches there is still work to do particularly in relation to clarity of roles, openness and building trust, which were key recommendations of the ACAS report. In response, a tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address these issues and has been well received. This programme of engagement and relationship building will continue throughout 2024/25. Alongside this, specific workforce issues related to potential respect and resolution processes have been addressed.
15. In relation to Risk 201 *Reputation*, whilst it is acknowledged that the rating for this risk remains high and has been static for some time given the status, the Trust is not able to de-escalate it. This risk is reviewed by the People and Culture Committee at each meeting and a deep dive was held at the last meeting in November 2023 and it was a topic of discussion at the ELT away day in December 2023.
16. As a result of these discussions, the risk summary description has been strengthened as follows:
- IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures
- THEN** there will be a loss of stakeholder confidence in the Trust
- RESULTING IN** a lack of stakeholder support for the Trust’s long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny.
17. This more closely describes the difficulties in being able to progress the Trust’s long term strategic ambition because of lack of stakeholder confidence and support. Additional controls and mitigations have been articulated to support this change during the detailed review in January 2024.
18. Risk 558 *Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures* currently remains unchanged.

RECOMMENDATION:

19. **Members are asked to consider and discuss the contents of the report.**

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE

21. The BAF was considered by:

- ADLT (05 February 2024)
- ELT (07 February 2024)
- Trust Board (28 March 2024)

REPORT ANNEXES

- Annex 1 - Summary table describing the Trust's Corporate Risks.
- Annex 2 – Scoring Matrix
- Annex 3 – Frequency of Risk review
- Annex 4 - Board Assurance Framework

REPORT CHECKLIST



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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	IF significant internal and external system pressures continue THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community RESULTING IN patient harm and death	Executive Director of Operations	25 (5x5) ➔
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	IF patients are significantly delayed in ambulances outside A&E departments THEN there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised RESULTING IN patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	25 (5x5) ➔
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	IF there are high levels of absence THEN there is a risk that there is a reduced resource capacity RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	20 (5x4) ➔
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	IF the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained THEN there is a risk that Trade Union partnership relationships increase in fragility and the ability to	Director of People & Culture	20 (5x4) ➔

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		effectively deliver change is compromised RESULTING IN a negative impact on colleague experience and/or services to patients.		
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation	IF there is an inability of the Trust to deliver its core services because of system or organisational pressures THEN there will be a loss of stakeholder confidence in the Trust RESULTING IN a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	20 (4x5) 
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	IF significant internal and external system pressures continue THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	15 (3x5) 

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

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

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death			Date of Review:	17/01/2024	TREND	25 (5x5)
				Date of Next Review:	14/02/2024		
IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
IMTP Deliverable Numbers:							
EXECUTIVE OWNER		Director of Operations	ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee		
Risk Commentary Q3 2023/24							
<p>The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments. In November 2023, over 20,126 hours were lost and 22,756 in December 2023. Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.</p>							
Improvement actions led by Welsh Government and system partners include: -							
<ul style="list-style-type: none"> a) Audit Wales’s investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E) b) Consideration of additional WAST schemes to support risk mitigation through winter (I) c) NHS Wales reduces emergency department handover lost hours by 25% (E) d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E) e) Alternative capacity equivalent to 1000 beds (E) f) Implement nationwide approach to emergency department ‘Fit 2 Sit’ (E) g) Implementation of Same Day Emergency Care services in each Health Board (E) h) National Six Goals programme for Urgent and Emergency Car (E) 							
CONTROLS				ASSURANCES			
				Internal Management (1st Line of Assurance)			
1. Regional Escalation Protocol				1. Daily conference calls to agree RE levels in conjunction with Health Boards			
2. Immediate release protocol				2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)			
3. Resource Escalation Action Plan (REAP)				3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.			
4. 24/7 Operational Delivery Unit (ODU)				4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.			
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans				5. Same as 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. On Call cover is reviewed weekly at SLT Performance Meetings.			
6. Limited Alternative Care Pathways in place				6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.			
7. Consult and Close (previously Hear and Treat)				7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in action 10.			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	17/01/2024		TREND	25 (5x5)
			Date of Next Review:	14/02/2024		→	
IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation		8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.					
9. Clinical Safety Plan		9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.					
10. Recruitment and deployment of CFRs		10. CFR numbers have grown during 2022/23 which alongside a cleanse of the volunteer database has realised 500 current active volunteers with an ambition to recruit a further 100 by end of Q4. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).					
11. ETA scripting		11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.					
12. Clinical Contact Centre (CCC) emergency rule		12. Emergency Rule is incorporated into CSP 999 levels.					
13. National Risk Huddle		13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.					
14. Summer/Winter initiatives		14. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.					
15. CHARU implementation		15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.					
16. Clinical Model and clinical review of code sets		16. Reported through CPAS and DCR Review reporting through CQGG					
17. Remote clinical support enabling discharge at scene		17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%					
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)		18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.					
19. Information sharing		19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.					
20. Completed EMS Roster Review		20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.					
21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls		21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.					
22. Transfer of Care		22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief					
23. Virtual Ward – Connect Support Cymru		23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD					

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	17/01/2024	TREND	25 (5x5)	
			Date of Next Review:	14/02/2024	➡		
IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death	Likelihood	Consequence	Score		
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
		capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.					
24. ARA – Acute Release Area - GUH		24. Live until 31 st March 2024					
25. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.		25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.					
26. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.		27. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system		1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.					
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow							
3. Local delivery units mirroring WAST ODU							
4. Handover delays link to risk 224							
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.		The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.					
6. Handover Improvement Plans agreed between WAST and Health Boards		12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays (see above)					
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals		18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.					
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	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	17/01/2024		TREND	25 (5x5)
			Date of Next Review:	14/02/2024		→	
IF significant internal and external system pressures continue		THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death	Likelihood	Consequence	Score	
				Inherent	4	5	20
				Current	5	5	25
				Target	2	5	10
		Operations – National Operations & Support					
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)		ADLT Sub-Group	30.09.22 - Superseded				
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]		Director of Paramedicine / Director of People & Culture	Extended to March 2024	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.			
4. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			Superseded				
5. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]		Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.			
6. New 2023 EMS Demand and Capacity (roster) review		Assistant Director of Planning & Performance	March 2024	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March			
7. Swansea Bay Winter actions		Assistant Director of Operations, EMS	December 2023	Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.			
8. Mental Health response pilot		Assistant Director of Operations, EMS	Not yet Active.	Pilot to commence in Aneurin Bevan Health Board area Nov 2023			
9. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.		Assistant Director of Quality Governance		Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. Phase 1 delivered through St John Ambulance Cymru, with further funding by the commissioner for a further phase via SJAC. Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.			
10. Maximise the opportunity from Consult and Close – stretch to 17%				Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities ¹² therefore continue with a review of triage processes which may lead			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death			Date of Review:	17/01/2024	TREND	25 (5x5)
				Date of Next Review:	14/02/2024	→	
IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
			to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the percentage of consult and close to 17%.				
11. Development of new model of care		Head of Strategy Development	2024/25	Development of the model remains ongoing			
12. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services		Assistant Director of Operations, Integrated Care	March 2024	Development of the model remains ongoing			
13. Palliative Care Paramedic Unit		Assistant Director of Operations	January 2024	Reducing demand via APPs – 15 th January Start.			
14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		CEO	Q4 2023-2024	<ul style="list-style-type: none"> Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. 			
15. Winter Ambulance Handover Improvement Plan Meetings		Executive Director of Operations	February 2024 (six weeks duration)	<ul style="list-style-type: none"> Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives. 			

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:	17/01/2024	TREND	25 (5x5)
				Date of Next Review:	14/02/2024	→	
IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score	
			Inherent	5	5	25	
			Current	5	5	25	
			Target	3	2	6	
IMTP Deliverable Numbers:							
EXECUTIVE OWNER		Director of Quality & Nursing		ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee	
Risk Commentary Q3 2023/24							
<p>The risk score remains constant at 25 for quarter 3 2023/24 (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 1,888 patient handovers in October 2023 which were over 4 hours. The target was originally to have zero by September 2022. In November 2023 over 20,126 hours were lost and 22,756 were lost in December 2023 Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. 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 Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. The Joint Investigation Framework in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting & Management (May 2023). Themes from system partners following review of incidents remains the consequences of high escalation levels in acute care and crowded emergency departments.</p> <p>Improvement actions led by Welsh Government and system partners include:</p> <ol style="list-style-type: none"> 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 NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) revised to March 2023/24. Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000. 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) 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 Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.				1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.			
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.				2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop 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 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.			

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:	17/01/2024	TREND	25 (5x5)
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			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6
5. Workstreams put in place to meet requirements of <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i> . Goal 4 incorporates the reduction of handover of care delays through collective system partnership. 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 NWS 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. REAP has undergone an annual review with v4.1 released in November 2023.				
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.		8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST				
9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.		9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.				
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.		10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. On Call cover is reviewed weekly at SLT Performance Meetings.				
11. Escalation forums to discuss reducing and mitigating system pressures.		11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.				
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.		12. Monthly Integrated Quality and Performance Report (October 2023 overall 76% - Safeguarding and dementia awareness remains over 91%.				
13. Clinical audit programme in place.		13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.				
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.		14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (undertaken 2021). WAST has senior representation at this meeting. 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. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time		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 November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.				

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				Inherent	5	5	25
				Current	5	5	25
				Target	3	2	6
lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets.”							
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.		16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of December 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candor Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.					
17. Clinical Support Desk First in place		17.					
18. Summer/Winter initiatives		18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.					
		External Sources of Assurance 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), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).					
		2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC					
		3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.		1.					
2.		2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 38 overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.					
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.		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. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.					
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.		4. Strengthening of patient safety reports and audit processes as e PCR system embeds.					
5. Variation pan Wales / England as position not implemented across all emergency departments*.		5. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.					
6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.		6. HIW approve and sign off WAST elements of recommendations.					
		External Gaps in Assurance					
		1. Lack of escalation and response to AQIs by the wider urgent care system and regulators					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project		WAST QI Team (QSPE)	• TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF). 16			

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2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	<ul style="list-style-type: none"> Q4 2023/24 	<ul style="list-style-type: none"> Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards. 																				
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> Monthly and as required. 	<ul style="list-style-type: none"> Monthly meetings continue to be held and networking through EDoNS. 																				
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	<ul style="list-style-type: none"> Q4 2023/24 	<ul style="list-style-type: none"> WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. 																				
5. Overnight falls service extension	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> 31.03.2024 	<ul style="list-style-type: none"> Night Car Scheme extension agreed to 31 March 2024 (2 regional resources) Utilization rates continue to be monitoring. Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023); Nighttime falls assistance 66% Utilisation (July – Oct 2023); Daytime utilisation sustained: July -August 58%. September- October 58% utilisation. Optima modelling has now been completed. The modelling clearly identifies that the level two falls' vehicles are the more effective resource. The modelling has identified an estimated need of 48 (38 day and 10 overnight) falls vehicle level 2 12 hours shifts. The modelling is now being built into the strategic (five year) demand & capacity review. 																				
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> Q3 2023/24 	<ul style="list-style-type: none"> Monthly updates to progress against actions following the baseline assessment and readiness returns. RL Datix Dashboards and KPIs under development nationally. Key policies updated and approved. Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. 																				
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> Q3 2023/24 	<ul style="list-style-type: none"> SJAC funded ended on 31 October 2023. Proof of concept using WAST CFR volunteers as CWRs is underway. Grant funding is being used to put in place roles and processes to recruit and train to new volunteer role. This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data suggesting a 35% consult & close rate for the cohort of patients covered by the pilot. The business case has now been completed and can be made available to key stakeholders. Now awaiting business case approval. The CWR will be modelled as part of the options being considered by the current EMS demand & capacity review. 																				
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> Q4 2023/24 	<ul style="list-style-type: none"> OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). 																				
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	<ul style="list-style-type: none"> Q4 2023/24 	<ul style="list-style-type: none"> Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing. Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. Workshop date confirmed in January 2024. 																				

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10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?		CEO	<ul style="list-style-type: none"> Q4 2023/24 	<ul style="list-style-type: none"> Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. 																			
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework		Executive Director of Quality & Nursing	<ul style="list-style-type: none"> Q4 2023/24 	<ul style="list-style-type: none"> Internal audit in progress. Delays due to sickness in the internal audit team. 																			
12. Winter Ambulance Handover Improvement Plan Meetings		Executive Director of Operations	<ul style="list-style-type: none"> February 2024 (six-week duration) 	<ul style="list-style-type: none"> Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives. 																			
13. Swansea Bay Winter actions		Assistant Director of Operations, EMS	<ul style="list-style-type: none"> December 2023 	<ul style="list-style-type: none"> Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter. 																			

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:		17/01/2024	TREND	20 (5x4)
			Date of Next Review:		14/02/2024	➡	
IF there are high levels of absence e.g., sickness and alternative duties.	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience			Likelihood	Consequence	Score
				Inherent	4	4	16
				Current	5	4	20
				Target	3	4	12
IMTP Deliverable Numbers:							
EXECUTIVE OWNER		Director of People & Culture	ASSURANCE COMMITTEE		People and Culture Committee		
Risk Commentary							
Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. As we move into winter, we also see increased absence due to respiratory illness and Covid. The outcome of this is to maintain the risk at a score of 20 and review the level at the end of Q4 2023/24.							
CONTROLS				ASSURANCES			
				Internal Management (1st Line of Assurance)			
1. Managing Attendance at Work Policy/Procedures in place and followed				1. (a) Audits undertaken by People Services Team (b) Outputs reviewed			
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence				2. R&Rs addressed in timely way to reduce risks of sickness absence. Compassionate Practices approach engaged. Referral of colleagues to appropriate levels of support			
3. Updated Freedom to Speak Up Policy replacing the Raising Concerns Policy- recognising issues at work may contribute to sick absence				3. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23 Freedom to speak Up Safely process introduced from the start of October 2023 including three Trust guardians.			
4. Health and Wellbeing Strategy – key document that outlines commitment to wellbeing and supportive culture				4. Regular reference to strategy to ensure themes are addressed and linked to wider people and culture plan 28/11/2023 Health and Wellbeing Strategy coming to an end in 2024 to be replaced with a new plan with a focus on employee experience in line with the All-Wales Framework and the People and Culture Plan 2023-2026			
5. Operational Workforce Recruitment Plans - provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure				5.			
6. Roster Review & Implementation- to support demand and capacity which can have an impact on absence levels				6. Roster Review for EMS completed. Review in 111 underway			
7. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required				7. Process regularly reviewed and managers provided with relevant training and coaching on process and importance of carrying out return to work interviews promptly			
8. Training on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained				8. Regular bitesize training provided for managers, adapted to reflect feedback and to ensure all aspects of managing attendance is understood			
9. Directors receive monthly email with setting out ESR sickness data - ensures ownership and awareness.				9. Monthly reporting provided with opportunity for discussion with relevant people services lead and Director			
10. Operational managers receive daily sickness absence data via GRS- ensures ownership and awareness				10. Provided daily, with opportunity for discussion with relevant people services lead and operational managers			
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support				11. Monthly reporting on services provided, volume of referrals and timeframes for accessing support.			
12. WAST Keep Talking (mental health portal) additional measures to offer support				12. Quarterly reporting on numbers accessing and regular promotion of service. Reported in MIQPR			
13. Suicide first aiders- additional layer of support				13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have access. Mental Health Team deliver this			
14. TRiM- additional layer of support				14. Quarterly reporting on access to TRiM and promotion of service Included in MIQPR			
15. Peer Support network- additional level of support				15. Promotion of network and support provided			
16. Coaching and mentoring framework- additional level of support				16. Promotion of network and support provided 28/11/2023 on pause to focus on Leadership Framework with a focus on culture and its impact on the experience of work and workplace wellbeing			
17. Staff surveys- assess levels of engagement and wellbeing				17. New HIVE survey tool will provide data on overall engagement and wellbeing 28/11/2023 the NHS Wales Staff Survey has also just closed and will provide information in the new year to inform us further.			
18. Stress risk assessments- identify measures that can be taken to address issues				18. Reference to the assessments during attendance management line manager training and to the TUS 28/11/2023 OH to lead on a refresh of stress risk assessments use			

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service		Date of Review:	17/01/2024	TREND	20 (5x4)
			Date of Next Review:	14/02/2024	→	
IF there are high levels of absence e.g., sickness and alternative duties.	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC		19. Sickness forms part of Workforce Scorecard to People & Culture Committee and is also supported by PCC deep dives into sickness. Reporting is also shared with CASC and EASC. Discussions on sickness are reported in minutes and AAA to Board				
20. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure		20.				
21. Monthly reviews of colleagues on Alternative duties		21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings				
22. Manager guidance on managing Alternative duties		22. Evidence of managers guidance in place and referenced in attendance management training				
23. Monthly report on absence to ELT and report to every meeting of People & Culture Committee via the Workforce Report and provision of deep dives when requested.		23.				
24. Sickness audits for localities- provides additional level of detail		24. Audits carried out and actions taken forward				
25. Additional support for areas with higher-than-average absence – emphasis is on understanding reasons and developing action plans		25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues				
26. Review of top 100 cases -carried out monthly		26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.				
27. Deep dives on specific issues and reasons for absence		27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management e.g. – mental health and causes 28/11/23 Recognition of the impact of employee experience and workplace conditions and link to absence. Reported to ELT for information				
28. Implementation of the Managing Attendance Project 2022-23 completed and ongoing activities maintained		28. BAU evaluating for delivery				
29. Implementation of Behaviours Refresh Plan completed		29. BAU evaluated for delivery				
30. 2023 10-point action plans shared with EMT for assurance and RAG rated to track progress quarter		30. Offers assurance to ELMT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports				
31. Work in Confidence system implemented and Freedom to Speak Up Month in October 2023 focused attention on this		31. External Management (2nd Line of Assurance)				
32. Actions from Audit of Nov 22 completed		32. Audit actions completed				
33. Strengthen Freedom to Speak Up Arrangements policy and advice and roll out of platform for raising concerns (in relation to Freedom to Speak Up Arrangements) (Having additional mechanisms in place for individuals to speak up potentially reducing work related stress and anxiety which is a key reason for absence)		33. Monitor FTSU concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.				
34. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements		34. Monitored through numbers of FTSU concerns raised and continual promotion via Comms and Roadshow Events.				
35. Health and Wellbeing Steering Group in place		35. Agendas, minutes etc.				
36. Actions identified from the Managing Attendance Audit implemented		36. Underway and now BAU – we need to say what this means by way of assurance				
37. PADR review undertaken and now including wellness questions		37. PADRs undertaken and questions asked				
		Independent Assurance (3rd Line of Assurance)				
		1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)				
		2. Audit Wales – Taking Care of the Carers report in October 2021				
GAPS IN CONTROLS		GAPS IN ASSURANCE				
(a) Consistency and Application in Managing Attendance at Work Policy		There are other factors that impact on sickness which can't be controlled				
1. 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		1. 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						

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:	17/01/2024	TREND	20 (5x4)
			Date of Next Review:	14/02/2024	→	
IF there are high levels of absence e.g., sickness and alternative duties.	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:		
1. Scrutinising on a monthly basis all long term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.		Deputy Director of People & Culture	Ongoing	Discussion on levels of long term sick absence is undertaken in a variety of forums including EASC, ELT and PCC		
2. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.		Deputy Director of People & Culture	Ongoing (training new managers)	Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases.		
3. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.		Deputy Director of People & Culture	Ongoing action	Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence		
4. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.		ADOs Operations	Ongoing action	Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence		
5. Case studies developed on examples of areas of business where attendance management has improved significantly to share learning across WAST		Deputy Director of People & Culture	31/05/24	Case studies published and discussed at leadership meetings and evidence of good practice adopted		
6. Review of top 100 cases by the wider People & Culture Team on a monthly basis (Wellbeing, OCC Health, People Services)		Deputy Director of People & Culture	Ongoing	Understanding within the wider People & Culture Directorate of cases and action plans clearly identified		
7. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST		Deputy Director, People and Culture	30/06/24	Discuss at P&C Business Meeting and share at ELT/PCC with recommendations.		
8. Ensure that the specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified		AD Q&N	Ongoing	It is on the agenda and outcomes are available for discussion at H&SC		
9. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change.		Director of People & Culture	Ongoing	Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.		
10. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.		AD of Wellbeing	To commence 30/05/24	Evaluation of pilot after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted.		

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships		Date of Review:	19/04/2024		TREND	16
			Date of Next Review:	19/05/2024		→	(4x4)
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	4	16	
			Target	4	3	12	
IMTP Deliverable Numbers:							
EXECUTIVE OWNER		Director of People & Culture	ASSURANCE COMMITTEE		People & Culture Committee		
Risk Commentary							
<p>Proposal to reduce the score because of a tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Work is well underway to seek to improve partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of P&C and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally good. However, there is a further prospective risk as discussions on pay commence for 2024/25 which are out of the gift of WAST but may result in further tension and industrial action if an offer made is not accepted by the trade unions. This is in the context of the current financial pressures for Welsh Government who are seeking to make significant savings. At a local level there are challenging issues to be managed such as EMT 2-3, demand and capacity reviews and changes to the workforce profile. When there are discussions on one area then there appears to be difficulty disengaging different issues.</p>							
CONTROLS				ASSURANCES			
				Internal 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 because of TU partner buy in			
5. Monthly Informal Lead TU representatives and Chief Executive meetings				5. Diarised meetings			
6. Staff representative management in Task & Finish Groups				6. Good attendance and commitment 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 in place and operating				8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings			
9. Quarterly Report on TU activity to People and Culture Committee				9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes			
10. Structures below WASPT in place from June 2023				10. Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.			
11. Project plan in place to support the improvement in relationships based on the ACAS report from 2022.				11. Development of mentoring and training opportunities for TUPs to support their roles.			
12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).				12. Training for local managers and TUPs in development and diarised delivery for February / March 2024.			
13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT				13. Change in senior TU personnel on a temporary basis meaning new senior TU representative needs to be brought up to speed with work on improving partnership working.			
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. 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 People & Culture	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 26 th Sept. Draft plan in			


Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:	19/04/2024	TREND	16 (4x4)	
				Date of Next Review:	19/05/2024	→		
IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained		THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	RESULTING IN a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score	
				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	Inherent	5	3	15
					Current	4	4	16
					Target	4	3	12
2. Refresh of engagement programme post Industrial Action and establish work		Deputy Director of People & Culture	30/08/23	Underway and work ongoing. Plan delivery to be completed in 2024. However, this will be subject to the national picture.	Plan agreed and being monitored via WASPT. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs . Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated.			
3. Continue the rollout of partnership training across WAST		Deputy Director of People & Culture	31.03.24					
4. Develop the next round of initiatives based on the output from recent sessions		Deputy Director of People & Culture	30.06.24					
5. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring		Deputy Director of People & Culture	30.06.24					
6. Develop consultation guidance for managers		Deputy Director of People & Culture	30.06.24					
7. Consider how we celebrate success and capture the positive learning		Deputy Director of People & Culture	30.09.24					
8. Implement a rhythm of meetings to curate and focus on relationships		Deputy Director of People & Culture	30.06.24					

Risk ID 201	A loss of stakeholder confidence that damages the Trust's reputation			Date of Review:	18/01/2024	TREND	20 (4x5)	
				Date of Next Review:	14/02/2024	→		
IF there is an inability of the Trust to deliver its core services because of system or organisational pressures		THEN there will be a loss of stakeholder confidence in the Trust	RESULTING IN a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		Likelihood	Consequence	Score	
					Inherent	4	5	20
					Current	4	5	20
					Target	3	5	15
IMTP Deliverable Numbers:								
EXECUTIVE OWNER		Director of Partnerships and Engagement		ASSURANCE COMMITTEE		People and Culture Committee		
Risk Commentary Q3 2024/25 The risk score remains constant at 20 (highly likely and catastrophic). The organisation's reputational risk is one which is long-standing and entrenched. After initial improvements in risk rating some years ago, the impact of the pandemic, long standing performance and morale issues, coupled with the levels of patient harm and poor patient experience which are being documented all result in limited opportunity to de-escalate the risk. Significant efforts are being made to address all of these factors. However, to date, the issues which contribute to reputation continue to be problematic and, therefore, militate against de-escalation of the risk for the foreseeable future. As part of the mitigation, extensive stakeholder engagement briefing, including with Welsh Government and civil service colleagues, together with politicians, commissioners and partners, media relations work, patient experience and internal communication and engagement continue, in order to build trust and credibility. The day to day experience of staff and patients, coupled with the need to further build relationships, mean the risk remains heightened. The lead Director and wider Executive Team discuss matters of reputation on a regular basis and the Trust's approach to stakeholder engagement is regularly reviewed in this context, including as it relates to support for the Trust's longer term strategy and ambition.								

Risk ID 201	A loss of stakeholder confidence that damages the Trust's reputation			Date of Review:	18/01/2024	TREND	20
				Date of Next Review:	14/02/2024	➡	(4x5)
IF there is an inability of the Trust to deliver its core services because of system or organisational pressures	THEN there will be a loss of stakeholder confidence in the Trust	RESULTING IN a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	4	5	20	
			Target	3	5	15	
CONTROLS			ASSURANCES				
			Internal Management (1 st Line of Assurance)				
1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition			1. Feedback reported via ELT, TSAG etc/				
2. Revision of engagement framework delivery plan (approved by Board Jan 2023) to reflect feedback from stakeholders and revised timelines for strategy engagement			2. Will report via strategy programme architecture plus discussion at Board development/PCC etc. Included in 2024/25 IMTP				
3. Challenging of media reports to ensure accuracy			3. Programme of daily media engagement documented on digital system				
4. Media liaison to ensure relationships developed with key media stakeholders			4. Programme of daily media engagement documented on digital system				
5. Routine stakeholder and staff engagement, including the recent round of Executive roadshows and WAST Live.			5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update)				
6. Engagement governance and reporting structures are in place			6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs.				
7. Annual deep dives on reputation in place			7. Reported to Committees, documented in minutes, action logs and papers				
8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT			8. Minuted meetings, action logs and Board papers				
9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders			9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording)				
10. Monitoring external factors that may affect the Trust			10. ELT verbally updated on a regular basis with written notes if appropriate				
11. Board oversight, scrutiny and challenge of performance, concerns, quality			11. What is the assurance that this control is effective				
12. Internal Quality and Performance monitoring in the Trust and raising system issues			12. What is the assurance that this control is effective - reports at ELT, Finance and Performance Committee, Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee				
GAPS IN CONTROLS			GAPS IN ASSURANCE				
1. The delivery plan is currently under review and is subject to further agreement			1.				
2. Managing the narrative of the media			2.				
3. Strategic collaboration – further work needed to formalise opportunities			3.				
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:		
1. Review of 2022 Engagement Framework Delivery Plan in conjunction with the Consultation Institute to reflect revised strategic ambition			Director of Partnerships & Engagement	31/03/24	Board development planned 22/02 on reputation		
2. Reputation audit year two planned			Director of Partnerships & Engagement	Q4/Q1 23/24 24/25			
3. Roll out of the revised Engagement Framework Delivery Plan			Director of Partnerships & Engagement	From Q1 24/25			
4. Reputation Audit deep dive on findings to be presented at Board Development			Director of Partnerships & Engagement	Q1 2024/25			

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:	17/01/2024	TREND	15
				Date of Next Review:	14/02/2024	➡	(3x5)
IF significant internal and external system pressures continue	THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST	RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	3	5	15	
			Target	2	5	10	
IMTP Deliverable Numbers: TBC							
EXECUTIVE OWNER	Director of People & Culture		ASSURANCE COMMITTEE	People & Culture Committee			

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:	17/01/2024		TREND	15
			Date of Next Review:	14/02/2024			(3x5)
IF significant internal and external system pressures continue	THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST	RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	3	5	15	
			Target	2	5	10	
Risk Commentary							
The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.							
CONTROLS				ASSURANCES			
				Internal Management (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. 28/11/23 Health and Wellbeing Strategy coming to a close in 2024 and new plan with emphasis on workplace experience being developed in line with the All Wales framework proposals and the People and Culture Plan 2023-2026.			
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. Network supported by Assistant Psychologist and TRiM lead. 28/11/23			
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. 28/11/23 NHS Wales Staff Survey has just closed with results due in the new year.			
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 People and culture 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 People and Culture 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. HIVE went live in September 2023.			
				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			

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:	17/01/2024		TREND	15
			Date of Next Review:	14/02/2024			(3x5)
IF significant internal and external system pressures continue	THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST	RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	3	5	15	
			Target	2	5	10	
		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 03.08.23 Group paused due to two key vacancies. Completed 26/10 /23. Steering Group in place 28/11/2023 CLOSED	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. 03/08/23 - Head of workplace Wellbeing due to be in post in October and OH Manager about to go to advert. No capacity within the team to restart the group. 26/10/23 Head of Workplace Wellbeing in Post, OH Manager starting in December. Steering Group arranged for first week of December.			
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.			



AGENDA ITEM No	15
OPEN or CLOSED	OPEN
No of ANNEXES	1

AUDIT TRACKER 2.0 – MARCH 2024 (Q4)

MEETING	People and Culture Committee
DATE	09 May 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
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EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.
2. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.
3. Of those internal audit actions relevant to this Committee, 14 have been closed in Quarter of a total of 27 (52%). This equates to 60%, as a % of those due in Quarter closed in Quarter. Of these actions due in Quarter, 9 action due dates have moved in (marked in blue) and there are none with a third revised date.
4. Of those external audit actions relevant to this Committee, 0 have been closed in Quarter of a total of 8 (only 2 of which were due in Quarter). Both of those actions have revised due dates proposed (marked in blue) and there are none with a third revised date.
5. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in August 2024.

RECOMMENDATION

6. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are the following internal audits: -

- Retention of Staff
- Seatbelt Action Plan

(b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Tracker presented to ADLT via email in April 2024.

REPORT APPENDICIES

Annex 1 – Tracker 2.0 January - March 2024 for Committee Reporting

REPORT CHECKLIST

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

SITUATION

7. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.

BACKGROUND

8. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.
9. The Handbook includes roles and responsibilities for the various stakeholders including:
 - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.
 - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.
 - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.
10. The Tracker has been updated in Quarter four following its complete revision in Quarter two. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight.
11. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year, however further work is required to consider the transition from Tracker 2.0 to Tracker 3.0 – which is a significant task.

ASSESSMENT

12. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:
 - Receive audits in their remit;
 - Monitor management actions to address recommendations; and
 - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.
13. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.
14. Of those internal audit actions relevant to this Committee, 14 have been closed in Quarter of a total of 27 (52%). This equates to 60%, as a % of those due in Quarter closed in Quarter. Of these actions due in Quarter, 9 action due dates have moved in (marked in blue) and there are none with a third revised date.
15. Of those external audit actions relevant to this Committee, 0 have been closed in Quarter of a total of 8 (only 2 of which were due in Quarter). Both of those actions have revised due dates proposed (marked in blue) and there are none with a third revised date.
16. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Quarter one with a view to closing down or revising as many as possible.
17. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.
18. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in May 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

19. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team will work closely with the points of contact as the the SharePoint Tracker 3.0 develops.

RECOMMENDATION

20. The Committee is requested to:

- (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are the following internal audits: -
 - Retention of Staff
 - Seatbelt Action Plan

- (b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Ref. No. in Audit	Recommendation	Response No. in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first	
607	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (a)	Internal conversation on whether full time representatives are appointed in WAST [see context narrative that prefaced this action in the report - too large to include]	Mar-24	Not Yet Due	24-Apr				Closed in Quarter	Updated 140324 (TM) - ELT internal discussion on this closes the action. Board Secretary was present in conversation. This recommendation should be read in the context of the audit report. The recommendation was noted but not accepted per se based on the relationship with TUPs at the current time. The management response column notes the actions committed. To note: Regarding the wider recommendation re revisiting the Facilities Agreement, we do not intend to do this as the Agreement is working for WAST. The recent Social Partnership legislation puts a duty on the organisation to consult and engage more widely rather than reducing or introducing further controls. In terms of the suggested mechanism for recording time. As per the facilities agreement the spreadsheet was included as an example. This is not mandatory and is significantly laborious and cannot be completed on an iPad. One of the senior TUPs has trialled it and we note (alongside his line manager) how difficult it is to use. TUPs are clear that it is their responsibility to maintain accurate records of their TU duty time which can be requested by the organisation. In the spirit of partnership working, relationships are based on trust and responsibility. Work on an electronic timesheet continues and this may be the long term solution, alongside the replacement to ESR. In addition a quarterly report from finance and a quarterly report from Resources will be produced to track activity. Prose to close this action.
608	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (b)	Broader discussion with TU reps regarding maintenance and development of clinical skills whilst undertaking TU duties with the aim of reaching a shared understanding [see context narrative that prefaced this action in the report - too large to include]	Mar-24	Met					Closed in Quarter	21.03.24 LR Discussion with key TU partners. 99% of TU reps undertake shifts in their substantive posts. TUPs recognise the importance of this in terms of having authenticity with their members and understanding their roles. Where a TUP is not undertaking active duties there is justification for this and it is being managed on a case basis. Propose closure.
609	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (c)	Regular discussions with senior TU reps in WAST re time for TU duties, trends and peaks in activity [see context narrative that prefaced this action in the report - too large to include]	Mar-24	Met					Closed in Quarter	Amended the date of 'ongoing' in the original deadline to March 24 and will review the conversations that have taken place at that time. 20.03.24 LR work on building effective partnerships is being successfully delivered and is ongoing. This has included conversations about the wellbeing of TUPs who undertake significant work in addition to their contracted working hours in their substantive posts. Examples of discretionary effort has been shared (where time has not been claimed). The organisation manages attendance at Committee meetings, project groups etc. by having nominated reps at meetings. A report will be generated quarterly from GRS, and Shifttrack alongside finance reports to monitor TU activity on a quarterly basis. Proposed closure on the basis that this is BAU from 01.04.24. Evidence of emails to confirm reporting have been shared as evidence.
611	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (b)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure Action: Revisit manager's responsibilities in signing off TU time with managers across WAST. [see context narrative that prefaced this action in the report - too large to include]	Dec-23	Met					Closed in Quarter	040124: Board Secretary reviewed evidence of notices to staff and proposed closure. This action refers to the action in the audit report to revisit manager's responsibilities in signing off TU time with managers across WAST. Managers have been reminded of their responsibilities under the Facilities Agreement in terms of checking timesheets.
612	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (c)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure Action: Engagement with the senior TU partners will be undertaken with the aim of reaching agreement on implementing a standardised simplified approach (in the context of IA within WAST).	Sep-24	Not Yet Due					Open	

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613	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (a)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. Action: We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time.	Nov-23	Not Met	Mar-24	Dec-24		Open	Target date moved in quarter 3 to quarter 4 (to December 2024). Dec 23 - The management response to this item was:- 'We will review whether the information could be held in ESR effectively and what the maintenance of this would be and how easily could be accessed and collected. It needs to be in one place for ease of reporting and management. It this is not a realistic option (in terms of cost) , we will explore options for alternative methods of recording total time.' This is wrapped up in the wider challenges in terms of TU relationships and therefore we want to treat with sensitivity. Facility Time is recorded in GRS and Shift Track. We don't have any reps who are not using one or other of those systems. 111 and other areas are likely transferring to GRS so all will be captured in one system. Also the potential work around electronic timesheets will also impact on record keeping. There is a potential option to record TU time in ESR but we are in the early stages of exploring this but we will give it due consideration. Our ESR lead is currently away from work. Propose an extension to March 24 when we will likely have more clarity on electronic timesheets and moving all colleagues on shifts into GRS. 20.03.24 LR update - work on electronic timesheets is ongoing. The ESR system is going to be replaced and the current options for recording time are unlikely to work well. Recommend that this is extended in line with the implementation of electronic timesheets and TUPs continue to record time and complete their Ops timesheets in the usual way and record TU activities in diaries etc until then. (Please see comments above re Social Partnership and partnership working as these are very relevant). Propose a change in date to Dec 24 re the electronic timesheet due to the sensitivity regarding negotiations with TU partners.
614	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (b)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. Action: We will review the recording of time in shift track for 111/ CSD colleagues	Nov-23	Met	Mar-24			Closed in Quarter	Closure proposed in line with narrative update.The management response to this item was:- 'We will review the recording of time in shift track for 111/CSD colleagues' Please see comments above and proposed extension to March 24. 21.03.24 LR update - This has been checked with the resources team. CSD TU time off is recorded in GRS and 111 TU partners time is recorded in Shift Track. Reports on time off can be pulled from the system on an as and when basis. We have only a handful of reps in 111. Propose closure. With effect from Q1 2024/25 we will generate quarterly reports for monitoring fro Shift track and GRS.
615	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	Medium	4.1	Accurate and timely management information detailing the time spent and cost of facility time, both on an individual basis and in total for the Trust should be generated. This information should be reviewed on a regular basis and action taken where necessary.	4.1	This is acknowledged. Our aim is to be able to provide this level of detail. However it is dependant on agreeing a standardised method of recording the time spent that is adopted by all TU's, and identifying a corporate system that will collate this information and produce accurate reports, alongside costs in a meaningful way.	Mar-24	Met				Closed in Quarter	Closure proposed in line with narrative update 21.02.24 LR - Reports on time off for TU activity can be generated from Shift Trak,GRS and Finance can generate the costs from this information. Quarterly reports have been requested from Finance and the Resources Teams. This will start on 1st April 2024 with the first quarter being 01.04.24-30.06.24. Propose to close this action. Emails with Finance and Resources leads forwarded to confirm as evidence.
631	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	1.1	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible.	1.1 (b)	Policies and Procedures will be updated in line with the Health and Safety Management System (HSMS). The HSMS will be reviewed to articulate the timeframe for the review of arrangements.	Sep-23	Not Met	Feb-24			Closed in Quarter	3.4.24 The Health & Safety Management System SBAR was tabled at Senior Quality Team on 20 March 2024 but as meeting was not quorate it was re-submitted to Senior Quality Team on 3 April 2024 and approved. Proposed for closure; proposed closure accepted. Target date moved in Q4 to April given the approval route in the Jan 24 update. Evidence of approvals from SOT will close this off Update 30.1.24: The Health and Safety Management System has been formatted into the current document template and the approval routes have been identified i.e., Senior Quality Team (21 Feb 2024 and then 20 March 2024) for approval and then Senior Operational Team (26 March 2024) for noting Target date moved in quarter 3 11.12.23: Revised target date of February 2024 (previously indicated December 2023) as Health & Safety Management System is not scheduled to be submitted to Senior Leadership Team Meeting until January/February 2024 (no date set as yet). SLT paperwork will be shared as evidence once tabled. Target date moved into quarter 28.11.23 Health & Safety Management System reviewed. To be submitted to Quality, Safety & Patient Experience Directorate Meeting, Senior Operations Team Meeting and Senior Leadership Team Meeting once approved by the Assistant Director of Quality Governance. The majority of policies are in date so will be Business as Usual. Possible extension request for December 2023. 28.09.2023: Proposed revised date Nov-23. HSMS review highlighted approval route changes that have to be agreed before other procedures can be reviewed and approved. HSMS reviewed and proposed edits being considered. The Health & Safety Policy is expected to be presented at People and Culture Committee on 16 November 2023 for ratification. The HSMS review is underway. Expectation of seeking approval at ADLT in November 23. The HSMS requires approval before other procedures can be developed/reviewed and approved.
632	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	1.2	Once approved, policies and procedures should be circulated to all staff.	1.2	Policies and Procedures will be issued via corporate communication platforms.	Mar-24	Met				Closed in Quarter	Last Updated 140324 (TM) Propose closure of this action. When policies are approved they are communicated in line with the Policy the Development of Policies. Roll out of all policies and procedures will be in line with the HSMS.

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636	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: •Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; •Wider circulation of inspection reports and a completed action plan to be shared with all action owners; •Determine the follow up process to ensure that corrective action has been taken; •Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and •Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (a)	Develop performance indicators around sharing inspections outcomes within 10 working days.	Dec-23	Not Met	Jan-24			Closed in Quarter	3.4.24 The Health and Safety Inspection Key Performance Indicators SBAR was tabled at Senior Quality Team on 20 March 2024 but as meeting was not quorate it was re-submitted to Senior Quality Team on 3 April 2024 and approved. Proposed for closure; proposed closure accepted. Last Update 5.3.24: On track. Spreadsheet of all inspections and feedback proforma being prepared. To be submitted to Senior Quality Team on 20 March 2024 for approval What will close the action: Creation of Performance Indicators on sharing inspection outcomes What will you provide as evidence for the closure: Performance Indicators Is date reasonable: Request revised date of <u>End of March 2024</u> due to current workload within team Target date moved in quarter 3 28.11.23 A centralised document library (excel spreadsheet) identifies review periods required for major legislative Policies and Procedures. It also identifies Trust wide Risk Assessments and review dates. Inspection Reports are sent out to respective Duty Operational Managers, with a meeting scheduled for 28.11.23 to ascertain how to manage actions going forward. The proposal is a Teams channel to notify responsible individuals of the actions from the Audits, which will include action owners and target dates. SOP currently in development. Extension request for January 2024.
637	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: •Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; •Wider circulation of inspection reports and a completed action plan to be shared with all action owners; •Determine the follow up process to ensure that corrective action has been taken; •Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and •Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (b)	Update the Health and Safety Management System to reflect new design.	Dec-23	Not Met	Feb-24			Closed in Quarter	3.4.24 Link to Health and Safety Management System to reflect new design shared 12 March 2024. Health & Safety Management System SBAR approved at Senior Quality Team 3 April 2024. Proposed for closure; proposed closure accepted. Target date moved in Q4 to April given the approval route in the Jan 24 update. Evidence of approvals from SOT will close this off Update 30.1.24: The Health and Safety Management System has been formatted into the current document template and the approval routes have been identified i.e., Senior Quality Team (21 Feb 2024 and then 20 March 2024) for approval and then Senior Operational Team (26 March 2024) for noting Update 5.3.24: Completed. <u>Propose closure</u> of this action What will close the action: Linked to Trust Ref 631 What will you provide as evidence for the closure: Link to updated Health and Safety Management System Is date reasonable: Yes Target date moved in quarter 3 11.12.23: Process for updating audits needs to be placed into a procedure - Not started. Propose new target date of February 2024
638	22/23	PCC	Health & Safety	Reasonable	Leanne Smith	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: •Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; •Wider circulation of inspection reports and a completed action plan to be shared with all action owners; •Determine the follow up process to ensure that corrective action has been taken; •Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and •Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (c)	Explore a digital solution to advise relevant managers of their compliance and actions.	Mar-24	Met				Closed in Quarter	Last Update 140424 (TM) Closed on the basis of the narrative below that a digital solution has been explored and is now with the digital team and will need to undergo prioritisation by them and QSPE Update 27.2.24: The Quality, Safety & Patient Experience Directorate have provided funding to procure a contractor Business Analyst to work within the Digital Directorate and principally liaising with the Infection, Prevention & Control Team; and, the Health & Safety Team to develop a clear set of user requirements across the full range of their portfolio (i.e. to document the full range of audit/inspection requirements) and related/necessary technical specification. These user requirements will be transformed into a set of high level technical design requirements and enable the fast track development of an Internal Audit Tool via an in house Development Team. What will close the action: Confirmation from the Digital Director that this work is being explored and progressed What will you provide as evidence for the closure: Evidence of a clear set of user requirements and technical specification and a commitment from the Director of Digital that the Audit Tool will form part of the wider Digital Directorate Strategy proposition for the business. Leanne Smith to provide an email confirming this Is date reasonable: Yes, in relation to the development of a clear set of user requirements and technical specification
606	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	1.1	Periodic analysis of GRS data should be undertaken to ensure all SPs are adhering to the recommended split of their shifts.	1.1	A GRS report will be generated using a randomised sample of the SP group; and this report will be submitted to the SP Steering Group.	Jan-24	Not Met	May-24			Open	Last Updated 04.04.2024 The report has been requested but has not yet been sent to Greg Lloyd but he should get it for the steering group in April - it will likely have to be a manual report run each time as someone has to break down the shifts for the group. Report to be shared as evidence once available. Revised date proposed to May24. Changed in Q4 to May24.
608	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.1(b)	A review of allocation of Ps and Ts is undertaken to ensure consistency across Wales.	2.1(b)	A review of options for reducing variances in the size of SP teams will be presented to the quarterly SP Steering Group.	Jan-24	Not Met	May-24			Open	170424: Action remaining open until business received at Steering Group. Date revised in Q4 to May24. Last Updated 04.04.2024 Recommended for closure: the main issue was in one particular area that we have now recruited into so that has reduced the team size, the additional four SPs were allocated according to the average size of the team in each of the operational areas so size variance is now at an acceptable level. This will be monitored in the Steering Group (as per updated below) and action taken again should the levels change in future.

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609	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.2	Arrangements should be put in place for the appropriate escalation of issues with ratios and ensure regular monitoring through an appropriate forum.	2.2	Team sizes and ratios will form part of a report into the quarterly SP Steering Group.	Jan-24	Met				Closed in Quarter	Last Updated 04.04.2024 Recommended for closure: This was an email from Sonia (Operations) but the action is complete as the Steering group now provides a AAA into SOT, the most updated list below. Area Team Size now Additional SP BCU 1:33 1:31 Powys 1:34 1:27 ABUHB 1:35 1:31 CTM 1:35 1:31 CV 1:29 SB 1:23 HD 1:32
611	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	3.1	Training status for all SPs should be collated and captured with regular reporting within an appropriate forum to monitor progress.	3.1	Updated reports on education progress of the SP cohorts to be brought together into a single progress report. This will be presented through the Clinical Directorate Business meeting and the Senior Operations Team.	Jan-24	Not Met	May-24			Open	Last updated: 04.04.2024 Report to be pulled together (and shared as evidence for closure) for next steering group. Revised date proposed in Q4 of May24.
612	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Medium	3.2	A training plan, and expected timeline for the required clinical skill enhancements should be established.	3.2	An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit for information. These skills will initially be for the SP group only until an assessment and audit is completed for further consideration on safety and efficacy.	Dec-23	Not Met	May-24			Open	Last Updated 04.04.2024 Steve Magee is leading this group with Huw Jackson, a timeline has yet to be identified and Jen Lloyd will pick this up with the team to implement though work has started with the identified skills. Revised date proposed of May24 in Q4. 201223 - update received however further queries raised on training plan by Board Secretary
613	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Low	4.1	The terms of reference should be reviewed to: •Include a defined pathway for escalation of issues; •Update membership to ensure representation from each locality; and •Define quorum.	4.1	The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team	Nov-23	Not Met	Feb-24	May-24		Open	Last Updated 04.04.2024 Darren Panniers chairs the group and has seen the ToR but they need approval at SOT which we hope to do after the next meeting in April (and shared for evidence). Revised date proposed of May24 in Q4. Target date moved in quarter 3. 201223 - Meetings to finalise TOR in January
614	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.1	The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.	5.1	A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development.	Feb-24	Not Met	May-24			Open	Last Updated 04.04.2024 Not yet commenced. Jen Lloyd to send reminder to Greg Lloyd for discussion at Steering Group. Revised date proposed of May24 in Q4.
615	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.2	The Trust should report regularly on the impact and effectiveness of the SP role, including analysis of their utilisation across Wales and the achievement of the wider IMTP objective.	5.2	A report including number of rideouts undertaken and the outcomes (action plans/issues resolved during the shift/documentation/CPD/NQP portfolio reviews) will be developed into a regular report into the SP Steering Group on a quarterly basis.	Jan-24	Not Met	May-24			Open	Last Updated 04.04.2024 To be done for next Steering Group in April and shared as evidence for closure. Revised date proposed of May24 in Q4.
616	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.3	Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate.	5.3	Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting.	Jan-24	Not Met	May-24			Open	Last updated 04.04.2024 To be done for next Steering Group in April and shared as evidence for closure. Revised date proposed of May24 in Q4.
654	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.1(a)	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	1.1(a)	The structure of the interview will be finalised shortly.	Mar-24	Met				Closed in Quarter	12042024: Board Sec satisfied that progress made meets action. 20.03.24 LR Good progress has been made on the Moving on Conversation work and the structure of the meetings and process documentation is finalised. There is a requirement to go to Policy Group to remove this from the list of policies as this is a process rather than a policy. The date for the next policy group was scheduled for April but this has been cancelled and we are awaiting a new date for the meeting. Post this meeting the rollout across the organisation can be completed as all the documentation is ready to go. Extension is required purely to accommodate the Policy Group meeting.
655	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.1(b)	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	1.1(b)	The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete.	Jun-24	Not Yet Due				Open	Update March 24 The trigger for an email reminder for managers was to be the exception form. When the exception form is submitted, then this would trigger a reminder email to complete a Moving on Conversation. There is an intermittent fault with the button and not all emails are being generated. However, work on this continues and alongside that, NWSSP have developed a new form which will be implemented which may resolve this problem for us.
656	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.2	The Trust should identify and confirm a clear timescale for the roll out of the 'Moving on Interview' process across the organisation.	1.2	Dates will be added to the action plan	Mar-24	Met				Closed in Quarter	Completed. Action Plan including dates provided as evidence.
657	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.3	The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process.	1.3	Guidance for managers on using the process developed and signed off	Jun-24	Not Yet Due				Open	Update from Liz Rogers: March 24. Guidance for managers (process document) has been developed. Drop in bite sized sessions will be developed for managers to attend.
658	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers / Peter Brown	Angela Lewis	Medium	2.1	The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff.	2.1	An evaluation report will be developed in association with the 111 senior team. It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures.	Sep-24	Not Yet Due				Open	

Unit Ref No.	Audit Wales or HiW Report	Year	Committee Assigned to	Item Title	Responsible Officer	Director	Priority Level	Risk Rating	Recommendation	Response by the HiW	Management Response	Agreed Outcome in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first	Overall Status
122	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett / Liz Rogers	Angela Lewis	Medium	1.1	Terms of Reference We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan (medium priority).	1.1	Chair and Vice Chair of the ITPG and Forecasting and Modelling Group will update the Terms of Reference within the context of the internal governance structures	Dec-23	Not Met	Feb-24	May-24		Date moved in Q4 to May-2024 as require approval of the respective ToR formally to close the action. 2023: The ToR for both the ITPG and F&M have been reviewed and are going through the governance approvals route. The ITPG will be revised by the group this week for endorsement and the F&M in January, so the due date has been revised to February 2024 to allow for these approvals to be received. ToR have been reviewed and agreed by the Integrated Technical Planning Group Propose closure. Evidence - updated ToR for the ITPG and F&M groups.	Open
123	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Linda Phillips	Angela Lewis	Medium	2.1	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority).	2.1	Use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data.	Sep-24	Not Yet Due					Open
124	HiW Wales or HiW Res	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(a)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority). • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible.	2.1(a)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. Excel version	Mar-24	Not Met	Oct-24		210324 LR The Workforce Transformation and Planning Team now produce a highlight report on key workforce information. Propose an extension to this action as the work on Nexus will be longer than expected. To date the following has been undertaken. Date moved in Q4 to October 2024. Project team established Initial mapping completed Currently developing what the end product will look like to work backwards to the requirements Complex exercise meaning timelines are difficult to estimate. Investment in connecting GRS, ESR and Oracle would be needed to build interfaces therefore Nexus is the solution for the time being.	Open	
125	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements		Angela Lewis		2.1(b)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority). • Explore ways to resource the management of a system to ensure an up-to-date establishment model.	2.1(b)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. Potential PowerBI version	Sep-24	Not Yet Due					Open
126	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udzeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	3.1	Evaluating workforce planning training We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme (medium priority).	3.1	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	Jun-24	Not Yet Due					Open
127	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udzeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	4.1	Recruitment support We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation (medium priority).	4.1	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May-24	Not Yet Due					Open
128	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udzeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	5.1	Metrics for People and Culture plan monitoring The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan (medium priority).	5.1	Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures	May-24	Not Yet Due			210324 Query this action here as it was requested to be removed as it was not relevant to this audit and incorrect. However, the P&C Directorate Plan has milestones and measures for 2023/4 and will have for 2024/25. CGT have further narrative regarding this action.	Open	
129	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Liz Rogers / Hugh Bennett	Angela Lewis	Medium	6.1	Benchmarking The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice (medium priority)	6.1	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	Jun-24	Not Yet Due				Open	

Retention of Staff

Final Internal Audit Report

February 2024

Welsh Ambulance Services NHS Trust



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Ymddiriedolaeth GIG
Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
NHS Trust



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Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Ross Hughes, Principal Auditor
Executive sign-off:	Angela Lewis, Director of People & Culture Directorate
Distribution:	Liz Rogers, Deputy Director of People & Culture; Julie Stokes, Head of People Services; Peter Brown, Head of Service (111)
Committee:	Audit Committee



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

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention.

Overview

We have issued reasonable assurance on this area, noting that the Trust have identified that there were shortfalls in the retention process and are introducing new initiatives across the organisation, including the moving on interview process, to strengthen arrangements.

In response to the attrition rates noted within the 111 service, we have also considered the initiatives that have been implemented to enhance retention.

The matters requiring management attention include:

- Finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and
- Evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention;

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

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 Strategies and Policies	Reasonable
2 Retention Initiatives and Outcomes	Reasonable
3 Exit Interviews	Limited
4 Reporting and Analysis	Reasonable

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

Key Matters Arising

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1 Implementation of the 'Moving on Interview' process.	1, 3	Operational	Medium
2 Effectiveness of initiatives	2	Operational	Medium

1. Introduction

- 1.1 The retention of staff is a key issue for the NHS. Whilst focus may be given to the workforce supply to create a recruitment pipeline, it is important that both new and existing staff are supported and encouraged to remain with the Trust. Good staff retention levels will be the result of a combination of actions including, for example, supporting new starters, having development and career plans in place and developing organisational cultures and values.
- 1.2 The Trust's Integrated Medium-Term Plan (IMTP) 2023-26 highlights the following workforce challenges:
- *Focussing on retention of our people to reduce the demand on attracting new candidates.*
 - *Maintaining the national 111 service and improving 111 retention.*
- 1.3 The People and Culture Committee minutes for March 2023 notes that the People and Culture Plan 2023-26 and the Trust's IMTP Deliverables identifies 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.
- 1.4 As highlighted in Audit Wales's Review of Workforce Planning Arrangements report (November 2023): *in line with broader NHS Wales, since the pandemic, the Trust has been experiencing higher levels of turnover within its operations department. The increased turnover was particularly the case with within its 999 and 111 call-answering staff, due to the challenging working environment. The Trust has also seen a general increase in staff leaving within 6-12 months of recruitment. The Trust is performing mid-table when comparing staff turnover rates across all Health Boards and Trusts in Wales for 2022-23.*
- 1.5 The potential risks considered in the review were as follows:
- The Trust is unable to consistently operate in a safe manner due to insufficient staff;
 - Additional costs incurred by the Trust as a result of requiring potential overtime / agency staff or via additional recruitment campaigns;
 - Impact on staff morale and wellbeing from increased workloads due to reduction in resource;
 - Potential negative impact on the Trusts reputation;
 - Continued reduction in the Trusts workforce including loss of key talent, as a consequence of retention issues not being monitored and relevant action not being taken; and
 - Failure to capitalise or reap the benefits of development investment in individuals.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	-	4	-	4
Total	-	4	-	4

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

Objective 1: There are relevant strategies, policies and plans in place to outline the approach to staff retention.

- 2.3 As per para 1.2, retention of staff is flagged as a workforce challenge within the Trust's IMTP.
- 2.4 To help address this challenge, the Trust has developed a People & Culture Plan 2023 – 2026 (see para 1.3), approved by Trust Board (May 2023) 'with a commitment to creating an environment that *attracts, retains and develops exceptional talent and expertise*'. The plan focuses on three key areas:
- Culture – the way the Trust achieves its purpose.
 - Capacity – the resource needed to achieve its purpose.
 - Capability – the skills needed to achieve its purpose.
- 2.5 The People and Culture Plan includes a high-level action plan where in year 1 it looks to '*build on the employee experience to attract and retain a diverse workforce.*' Targets and milestones to deliver this plan are captured within the Directorate Plan. There are circa 80 actions included and the most recent progress report shows that the directorate is on track to achieve those which relate to staff retention. Monitoring of the progress against the actions is undertaken via the People and Culture Directorate Business meeting.
- 2.6 For further details on performance metrics to monitor progress against the People & Culture Plan, see audit objective 4.
- 2.7 The Trust has a 'Policy on Pre-Exit Interviews' available via its SharePoint site. The Policy was approved by the Trust Board in July 2004 and was due for review in July 2007. However, this review had not been undertaken. The review of the policy remained overdue because there was a proposal to develop an all-Wales approach to exit interviews which then did not materialise. See **MA1**

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- 2.8 The People Services Team carried out a deep dive exercise into the exit interview process in September 2022. The outcome of this review highlighted limited data being held and an inconsistent approach applied across the Trust.
- 2.9 The issues identified were attributed to the following factors:
- Exit interviews are not compulsory and not all leavers want to complete one. (noting they will always be optional).
 - Managers do not always approach leavers to complete an exit interview, with no prompts or reminders to do so.
 - Exit interviews are paper based and not always shared centrally with the People Services Team by the manager.
- 2.10 In response to these findings, the Trust has developed a new procedure - the Moving on Interview (MOI) process. This will supersede the Pre-Exit Interview Policy and is intended to provide a better understanding of staff experience (See objective 3 for further details on the Moving on Process). This process encourages meaningful conversations between employees and their line manager; however, employees can also complete the questionnaire independently.
- 2.11 The MOI process has been piloted in three areas (111 Service and Powys EMS and Hywel Dda EMS), to test and evaluate it before rolling out across the organisation and has incorporated aspects of the People and Culture Plan (see para 2.4). The new procedure will apply to all staff, including those who move internally within the Trust. See **MA1**

Conclusion:

- 2.12 We note that the current pre-exit interview policy for the Trust has surpassed its review date by some time, however we recognise that steps are already underway to introduce a local Moving on Interview Process noting the lack of progress to develop an approach nationally. The recently implemented People & Culture Plan 2023-2026 outlines the Trust's intentions to retain and develop the workforce and progress is monitored via the People and Culture Directorate Business meeting. We therefore assign **reasonable** assurance to this objective.

Objective 2: Initiatives are in place that align to agreed strategies and plans, and outcomes are reviewed.

Organisation wide initiatives

- 2.13 As noted above, staff retention is highlighted as a challenge within the Trust's IMTP, particularly since the Covid-19 pandemic, with turnover exceeding 11% for the months between May 2022 and October 2022. The Trust has therefore looked to implement initiatives to improve the retention rate within the organisation. At the date of fieldwork, it was noted that a number of the initiatives are either still in their development stage, being piloted or still in their infancy including:
- **HIVE** – In October 2023, the Trust implemented the use of this software which allows the issue of short surveys to gather quick, confidential, real-

time information on potential challenges or issues within the organisation; allowing remedial action to be taken in a timely manner. To date the Trust has issued and closed one survey, with information being issued to the Organisational Development team for analysis. We acknowledge that the People Service team will assess the impact and benefit of the tool towards the end of the agreement.

- **Cultural Early Warning Score (CEWS)** – The development of a new toolkit for managers which is a cultural health check diagnostic. The toolkit assesses the cultural health of the team based on assigning a high/medium/low rating for sickness levels, wellbeing referrals, turnover rates, formal disciplinarys and other culture, capacity and capability indicators, and will be repeated over time to measure impact on any changes implemented. At present the toolkit is being piloted in Emergency Medical Dispatch and the People & Culture Team with the intention for further pilots in the 111 Service (January 2024) prior to roll out across the organisation by the new financial year.

2.14 Established mechanisms that have been running for a number of years include:

- **CEO Staff Roadshows** - The Trust has put on multiple roadshow events across Wales where the Trust's employees have the opportunity to engage with the Executive Team face-to-face to learn more about what the Trust is doing moving forward and what it is looking to achieve. The latest roadshow was held in November 2023 with circa 420 staff members registered to attend; and
- **WAST Live** - Staff can pre-submit questions to the Executive Team, which are then answered via a live stream. It also updates staff across the organisation on important issues, priorities, performance, challenges and subjects of interest.

2.15 We also acknowledge that the Trust have a number of other interventions, organisation-wide, to help support retention of staff, including culture reviews within individual teams; Freedom to Speak Up Safely; Sexual Safety Guiding Principles; Occupational Health support; and compassionate practices. We have, however, not reviewed these initiatives in detail during the course of our fieldwork.

111 Service Initiatives

2.16 During discussions with the senior staff within the Trust, we were informed that the 111 service has historically been an area with higher staff turnover levels. The Head of Service has undertaken work to support staff and improve retention within the service and we sought to determine the impact of such during the course of our fieldwork.

2.17 **111 Conversations** - Senior Management throughout the Trust shadowed 111 call handlers for initial 111 conversations (165 in total by the end of the initiative) to better understand the challenges being faced in their role. The conversations gave the call handlers an opportunity to relay issues, concerns or suggestions which would impact the longevity of their employment with the service.

Improvements implemented to date include around the working environment, culture, staff rosters and clearer career progression structures.

- 2.18 **Our Shared Success Framework** - a recommendation that came from the 111 conversations was that the employees wanted to know if they were doing a good job. Weekly face-to-face meetings between the call handler and supervisor are now held to review performance against a framework of indicators created by the service.
- 2.19 **Investment in Individuals** – to address the trend of staff leaving within 6-12 months with reasons cited including the poor quality of upfront training or to seek further education for a more clinical setting (nursing), the 111 service has introduced an initiative that gives the opportunity to acquire a NVQ in dealing with contact centre operations via Gower College. This allows career pathways to be built within the Trust. Management also advised that improvements have been made to initial training so that employees are better aware of the role and its requirements from the outset.
- 2.20 **111 Clinicians** – a deep dive (June 2023) into attrition levels noted that many clinicians left their post within 6 months of employment due to a lack of support after induction; they missed face-to-face contact with the patients; and there were issues with rostering. To address these issues, changes have been made including implementation of a new clinician framework of support, development and continued learning; a blend of observation shifts or rotational roles; increase in Continued Professional Development (CPD) - including the opportunity of undertaking postgraduate qualifications (MSc / PhD); and the introduction of an 'Academic Corner' in contact centres and on SharePoint, featuring academic achievements, advice, support and guidance.
- 2.21 It was noted that the majority of these initiatives are currently within their infancy and at this moment in time it is too early to undertake analysis to ascertain their effectiveness in retaining staff. However, there will be benefit to the Trust in completing this exercise in due course. See **MA2**

Conclusion:

- 2.22 The Trust has a number of initiatives in place to improve the retention of staff, however we recognise that many are currently being piloted or in their infancy and will take time to fully embed. From the review of the work undertaken, to date, within the 111 service we can see that these are having a positive effect, especially with the call handlers and clinicians; and consideration should be given to replication Trust-wide. Therefore, we assign **reasonable** assurance to this objective.

Objective 3: There is an effective leavers process in place that is clearly defined and there are tools available to support managers to process a leaver.

- 2.23 As outlined in objective 1, the Trust undertook a deep dive into its current Pre-Exit Interview policy. The exercise identified only 8% of leavers, during the timeframe reviewed, had shared a pre-exit interview centrally, meaning no meaningful

analysis could be undertaken to better understand the reasons for leaving. It was highlighted that this doesn't necessarily mean exit interviews were not undertaken and held locally. It was also noted that the pre-exit interview forms were paper based so any analysis that could be undertaken had to be done manually, which is inefficient and time consuming.

- 2.24 The Trust has therefore modernised its approach to engage with leavers, via the 'Moving on Interview' (MOI) process (see para 2.10). An electronic questionnaire has been created via Microsoft Forms which, on completion, is issued centrally to the People Services Team who can then share with the relevant team / manager as appropriate.
- 2.25 The questionnaire forms the basis of engagement work and to help understand the employees' experience throughout their employment with the Trust. The main areas of focus within the questionnaire are: 'Learning and Development', 'Working Relationships', 'Wellbeing' and 'Equality Monitoring'.
- 2.26 Individuals are encouraged to complete the questionnaire with their manager. Due to the form being electronic, they also have the option to do so by themselves and anonymously if preferred. The form can be accessed via a desktop or on a smart device via a QR code.
- 2.27 The data collated from the pilot scheme (see para 2.11) which took place between February and July 2023 highlighted an increase in the return rate from 8% to 56%. During the pilot the Trust's People Services Team had to manually collate the data to produce analysis within a highlight report.
- 2.28 The highlight report focused on the main themes and trends raised by leavers, whether leaving the Trust or moving to a new role within the organisation. This included pursuing further education, career development and progression, mental health and wellbeing, and shift patterns, and was presented to the August 2023 People and Culture Committee (see objective 4 below).
- 2.29 Going forward, the Trust has secured support from Digital Health and Care Wales (DHCW) to create a dashboard that will form the basis of ongoing regular reporting. We understand that the production of the dashboard will be automated, avoiding the time and effort involved with collating the data manually, and that DHCW are also looking to incorporate functionality that will allow individual directorates to analyse data specific to them, thus allowing the Trust and individual directorates to undertake proactive actions towards making the Trust a more attractive place to work and therefore reduce staff turnover. We were informed at the date of fieldwork closure that the dashboard has been developed and will be available imminently. We have therefore not raised a recommendation on this basis.
- 2.30 To assist in the development and implementation of the MOI process, the People Services Team has created an action plan. Whilst our review confirmed that it outlined the required actions and responsibility, it was noted that timescales for its roll out across the Trust have yet to be set. **See MA1**
- 2.31 As noted under audit objective 1, prior to the MOI process being rolled out across the Trust, the People Services Team is creating a process and guidance document

to guide managers and staff when completing the MOI. We were informed that the document will also include a link to 'working in confidence' which will allow the user to share any issues or concerns around harassment or bullying that the individual might not feel comfortable discussing in the MOI. In addition to the document, the team are also looking to create bitesize training sessions for managers and a FAQ document to support the process. **See MA1.**

Conclusion:

2.32 Although the new MOI process has yet to be implemented across the Trust, with no set date for its rollout, we recognise that positive steps have been taken in introducing the process to the organisation. The intention is that the new process will modernise exit interviews for leavers and supply the Trust with increased data for analysis to identify any trends or issues. However, noting that the process has currently only been piloted across three areas and managers' training has yet to be developed, we assign **limited** assurance for this objective.

Objective 4: Data is collected and analysed in relation to staff turnover rates plus other relative data such as exit interviews, PADR compliance, and staff engagement and staff surveys. The outcomes of which are analysed and reported on to facilitate effective monitoring of staff retention trends.

2.33 As noted under audit objective 3, to date, data from the pilot MOI process has been collated and analysed manually by the People Services Team; with the development of an automatic solution being undertaken by DHCW.

2.34 A review of People & Culture Committee (P&CC) papers identified that an Integrated Quality & Performance Report (MIQPR) is issued to each Committee meeting, as well as the Finance and Performance Committee and Board meetings. Part of the MIQPR focuses on Health and Wellbeing of the employees within the Trust including sickness absence indicators, staff turnover rates, equality and diversity, statutory & mandatory compliance and PADR completion.

2.35 In addition to the MIQPR, the following reports have been presented to P&CC:

- November 2022 – report on Exit Interviews
- May 2023 – update on the MOI process.
- August 2023 - a cultural themes and trends report, which provided analysis of the data from the MOI pilot.
- November 2023 – first quarterly People and Culture Plan metrics update providing a high-level indication of the impact of the plan under its three core headings (culture, capacity and capability). The report includes metrics on staff survey completion, staff turnover and PADR compliance.

2.36 In addition, we were informed that staff turnover rates are presented at the Executive Leadership Team. The Trust is also in the process of developing directorate level scorecards which will include a summary of key workforce metrics, in line with an action included in the Quality & Performance Management Framework work plan. The Workforce Transformation and Planning Team has

recently developed a highlight report on workforce data which is shared via the Integrated Technical Planning Group, and People Business Leaders are also available to support and provide further information to Directorates as requested.

- 2.37 The Audit Wales Review of Workforce Planning Arrangements report highlighted that: *The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice.* We have therefore not raised a recommendation at this report.

Conclusion:

- 2.38 There is sufficient reporting on turnover rates within the Trust, including via the People and Culture Committee, with a further introduction to the reporting recently via the People and Culture Plan Metrics report. The Trust is also in the process of producing directorate level scorecards and has recently developed workforce highlight reports. As recommended by Audit Wales, the Trust should undertake more regular benchmarking of its workforce performance metrics with similar organisations. We therefore assign **reasonable** assurance to this objective.

Appendix A: Management Action Plan

Matter Arising 1: Implementation of the Moving On Interview Process (Operation)		Impact
<p>The Trust's Pre-Exit interview policy was due to be reviewed in July 2007, however, this was not undertaken due to work being undertaken to implement an All-Wales approach. Due to lack of progress at a national level, the Trust undertook a deep dive into the process, from the results the Trust is looking to introduce a new 'Moving on Interview' (MOI) Process to supersede the policy.</p> <p>The MOI has been piloted in three areas of the Trust (111 Service and Powys and Hywel Dda EMS), but from review of the action plan created by the People Services Team, there is no clear timescale in which the process will be rolled out more widely across the organisation. This was in part reliant on external support to develop dashboard reporting which we understand will be made available imminently.</p> <p>The Team is also looking to create bitesize training sessions for managers and a FAQ document to support the process.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Continued reduction in the Trust's workforce including loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
Recommendations		Priority
1.1	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	Medium
1.2	The Trust should identify and confirm a clear timescale for the roll out of the 'Moving on Interview' process across the organisation.	
1.3	The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process.	




Agreed Management Action		Target Date	Responsible Officer
1.1	The structure of the interview will be finalised shortly. The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete.	31 March 2024 30 June 2024	Deputy Director of People and Culture
1.2	Dates will be added to the action plan	31 March 2024	Deputy Director of People and Culture
1.3	Guidance for managers on using the process developed and signed off	30 June 2024	Deputy Director of People and Culture

Matter Arising 2: Effectiveness of Retention Initiatives (Operation)		Impact
<p>The Trust has introduced a number of initiatives in place to improve the retention of staff. At the date of fieldwork, it was noted that a number of these are either still in their development stage, being piloted or still in their infancy. As a result, it is too early to undertake analysis to ascertain the effectiveness of the initiatives in retaining staff.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Continued reduction in the Trusts workforce including loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
Recommendations		Priority
2.1	The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff.	Medium
Agreed Management Action		Target Date
2.1	<p>An evaluation report will be developed in association with the 111 senior team.</p> <p>It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures.</p>	30 September 2024
		Responsible Officer
		Deputy Director of People and Culture & Head of Service 111 Wales

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Seatbelt Action Plan

Final Internal Audit Report

April 2024

Welsh Ambulance Services University NHS Trust



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University NHS Trust



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Committee:	Audit Committee



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

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

Executive Summary

Purpose

To review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Limited number of internal quality assurance inspections completed.
- Reporting of results of spot checks, inspections and Quality and Support days to an appropriate forum.
- Absence of monitoring of the recommendations arising from the Health & Safety investigation.
- Absence of reporting on the incident at key junctures to the Trust Board and/or its associated committees.

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

Report Opinion



Reasonable Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 Approved action plan in place	Reasonable
2 Operational Policies and Guidance on conveying patients safely	Substantial
3 Training on safety requirements	Reasonable
4 Quality Assurance arrangements to ensure compliance	Reasonable
5 Mechanisms to monitor action plan progress	Reasonable
6 Reporting to appropriate Management and Trust Committees	Reasonable

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Reporting and monitoring of Quality Assurance inspection outcomes	1, 4, 5 Design	Medium
2	Reporting and monitoring of spot checks/Quality and Support days	1, 4, 5 Operation	Medium
3	Internal Ambulance Care Quality Assurance inspections	4 Design	Medium
4	Monitoring of Health and Safety Investigation recommendations and assurance reporting to Board	6 Design	High

1. Introduction

- 1.1 The Road Traffic Act 2006 determines that seatbelts must be worn while a vehicle is in motion. An amendment was approved by the Government in 2015 to create a legal exemption from the requirement to wear seat belts for persons riding in an ambulance when it is necessary to attend to a patient. This exemption does not extend to patients.
- 1.2 Following a road traffic collision involving a non-emergency ambulance, on 8 April 2021 which resulted in the loss of a patient, it was identified that the patient had not been securely fastened using all the necessary harnesses. This has recently resulted in criminal action against the Trust's member of staff that was responsible, following their guilty plea to causing death by dangerous driving.
- 1.3 In response to this incident, an action plan was put in place by the Trust to ensure the safety of crews and patients on board Trust vehicles. These include improved safety features, a quality assurance scheme and a review of the approach to vehicle inspection and staff training. In addition to these actions, following the conclusion of the criminal investigation, additional recommendations have been made to the Trust by the coroner that will also be considered as part of this review.
- 1.4 The Trust has also undertaken a health and safety investigation (concluded August 2023) into the incident; the results of which identified additional recommendations that have also been considered as part of this review.
- 1.5 The risks considered as part of this review were non-compliance with safety regulations resulting in patient harm, financial penalties and reputational damage.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	3	-	3
Operating Effectiveness	2	1	-	3
Total	2	4	-	6

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

Objective 1: There is an approved action plan in place to improve patient safety, which reflects the lessons learned and recommendations raised externally;

- 2.3 Following the serious incident that occurred, a Road Traffic Collision Cross Directorate Group (RTCCDG) was established to undertake an initial assessment

of the incident, to determine the next steps required by the Trust and prepare an initial list of actions.

- 2.4 An internal Serious Health and Safety Incident Investigation Review was triggered to inform the RTC CDG and the wider Trust with an overview of the incident and its' conclusions and recommendations. As part of the investigation, an action plan was developed with target dates for completion.
- 2.5 We were advised that the action plan evolved as the investigation progressed, with actions being implemented before its approval to ensure the Trust was reacting and responding to recommendations as soon as possible. The initial action plan that was presented to Senior Leadership Team (SLT), a senior forum within the Operations Directorate, in July 2021 contained 13 actions; and the final version, as included in the investigation report was submitted to Executive Leadership Team (ELT) in August 2023, detailed 25 actions – 15 of which arose from the development of the initial action plan and 10 were consequential actions from addressing the original ones. We note that there was no formal approval of the action plan, however, appropriate governance arrangements were in place to ensure the existence of oversight and scrutiny. (Refer to objective 6 for further detail on governance and reporting).
- 2.6 We were provided with evidence to demonstrate the arrangements put in place to address each of the actions. Whilst we recognise that the arrangements align with the intended outputs, our review has determined that the ongoing operational implementation and sustainability of some arrangements has not been effectively captured nor monitored. **See MA1 & MA2.**
- 2.7 In May 2023, the coroner issued a report in conjunction with the criminal investigation into the incident. This report summarised that the coroner was pleased with the detailed investigation, actions and subsequent arrangements put in place by the Trust. The report identified three aspects to be considered further – two were for the responsibility of the Trust and we have confirmed as part of the audit have been acted upon; and one for the coroner, for which the Trust have not yet received an update.

Conclusion:

- 2.8 A Road Traffic Collision Cross Directorate Group was established, and an internal Health and Safety investigation initiated in response to the incident. An action plan was also developed which continued to evolve as the investigation progressed. Review of the final action plan, post completion of the investigation, identified some gaps in the completeness of the arrangements put in place to address the issues identified. A **reasonable** assurance rating has been determined for this objective.

Objective 2: Operational policies and/or guidance are in place, and accessible to staff, which clearly describe the processes and expected methods for ensuring patient safety whilst being conveyed.

- 2.9 The Driving at Work (DAW) Policy (approved by the People & Culture Committee September 2021) establishes the expected standards for emergency and non-emergency drivers across the Trust. This includes:
- Legal requirements
 - Driver training and emergency driving procedures
 - Wearing of seatbelts and subsequent exemptions
 - Carrying children in Trust vehicles
 - Duty of driver involved in Road Traffic Collision (RTC)
 - Training requirements
 - Roles and responsibilities
- 2.10 Following the incident, we note that there had not been any major changes required to the Policy during its most recent update. We note that the Policy is due for review later in 2024 and that this is currently reported as being on track to be completed on time.
- 2.11 The Policy is accessible on the Trust's intranet site and at the point of issue was shared via a Siren staff announcement.
- 2.12 The DAW policy states that drivers and passengers in Trust vehicles are required by law to wear seat belts. It also states that all patients must be secured using the appropriate harness and restraints. If such are not used due to a clinical reason or the individual refuses, then this must be recorded and documented.
- 2.13 In response to the incident, the Trust issued a safety notice (27 April 2021) on seatbelts and restraints as a reminder to Trust staff and volunteers to ensure their safety and those travelling within a Trust vehicle. This emphasised the requirement to fully utilise seatbelts and restraints when moving, handling, and conveying patients on Trust equipment and vehicles and also included a link to the DAW Policy. Further notices were also issued reiterating similar messages and directing staff to other materials on safety restraints (for further details on training, refer to audit objective 3).
- 2.14 This included a safety video which the Trust created to provide visual guidance on:
- the importance of ensuring the safety of those travelling in a Trust vehicle;
 - the risk of criminal proceedings if safety requirements are not complied with;
 - illustration of absence of seatbelts during collision;
 - illustration on the application of harnesses;
 - how to secure children in the vehicle; and
 - where an employee fails to adhere to legislation and safety procedures, employees could be at risk of prosecution.

Conclusion:

- 2.15 A Driving at Work Policy which provides guidance on several aspects of driving, including the requirement to wear seat belts, is in place and accessible to all Trust staff. Following the incident, safety notices have been issued and a safety video circulated, reiterating the requirements and importance of the appropriate use of

seatbelts and restraints. A **substantial** assurance rating is determined for this objective.

Objective 3: Appropriate training has been undertaken to ensure staff are fully versed on the safety requirements to be employed.

- 2.16 All drivers of Trust vehicles that convey patients must complete a driving course during their induction to the Trust, for which there is both an emergency response and non-emergency course.
- 2.17 The courses have been developed in partnership with FutureQuals (accredited organisation that delivers regulated qualifications across a diverse range of vocations and sectors), the Driver Training Advisory Group (regulatory body for ambulance driver training) and the Association of Ambulance Chief Executives (AACE). The courses are recognised across the UK and are the only driving courses used by all Ambulance Trusts.
- 2.18 The courses cover several areas which includes driving legislation; driver responsibilities; pre-driving checks and daily inspections; the system of car control; driving under routine and emergency response conditions; manoeuvring and reversing; safety systems; emergency response driving practices; navigation; adverse conditions; and human factors.
- 2.19 We were provided with both course timetables and were advised that while seatbelts and restraints would have been routinely included in all driver training courses previously, there is now a separately identifiable session on such. All new inductees completing the above courses since November 2021, must sign a separate form to confirm that they have read and understood the safety training in relation to seatbelts and these records are maintained by the central Professional Education & Training Team.
- 2.20 As part of the original action plan, a similar exercise was executed for all Trust vehicle drivers already in employment, whereby they had to view the safety video and read the safety notices. This was to ensure that staff were appropriately versed on the required safety measures. We were provided with the collated results which showed that as at October 2022, i.e. within a year of roll-out, 98.74% of relevant staff had acknowledged viewing and understanding the additional safety information.
- 2.21 In addition, Mandatory In Service Training (MIST) is provided by the Trust on an annual basis. This is split across two days (one day face to face and one day online learning) and includes several sessions, the content of which is tailored to the needs of the organisation. For 2023/24, a session on safety harnesses has been included, which addresses driver and attendant's responsibilities to ensure patient safety and the law and subsequent exemption parameters.
- 2.22 We were also provided with the compliance rates for MIST for 2023/24 which, as at 31 January 2024, were 65.75% Emergency Medical Service (EMS) and 64.8% Ambulance Care Services (ACS). We were advised that there was a delay in the commencement of MIST and monitoring of progress of attendance is being

undertaken with all areas on target to achieve 70% compliance by the end of the financial year.

Conclusion:

2.23 All employees that are required to drive a Trust vehicle, must complete an accredited driving course during their induction. In response to the incident, the course timetables now include a separately identifiable section on seatbelts and patient restraints which requires acknowledgement by each new driver that the training has been completed. There was also an expectation that drivers already employed by the Trust view a recap on seatbelts and harness requirements and sign to acknowledge as such; and additional training has been included within the MIST programme for 2023/24 in relation to safety requirements. A **reasonable** assurance rating is determined for this objective.

Objective 4: Quality assurance arrangements are in place to ensure compliance with policies / safety regulations.

Private Ambulance Services

- 2.24 The Trust has established a framework of approved external private ambulance services (PAS) to work alongside its own Ambulance Care Services (ACS). In order to provide assurance that PAS meet the standards required by the Trust to enable the safe conveyance of patients, the Trust's Quality Assurance (QA) Team, working with 365 Response Ltd (a private company providing support to digitise transport systems), has developed a process to undertake an initial assessment (phase 1) of providers. This involves undertaking due diligence checks across several areas, including the type and adequacy of stretchers, seats and equipment in vehicles, appropriate insurance cover and DBS checks.
- 2.25 At the date of the incident in North Wales, this QA process was still being developed; therefore the QA Team were able to incorporate additional safety requirements to further align with the Trust's internal standards. For example, all Trust vehicles are fitted with specific seats/adjustments for patient conveyance. The Trust provided all PAS organisations with a list of compliant seats and allowed a 12-month period to comply. We were advised by the NEPTS Operations Manager that the majority of companies either replaced seats or purchased specific attachments which provided the same level of safety. Those organisations who were unable to make the amendments or refused to do so, were removed from the framework and could no longer provide services to the Trust.
- 2.26 Further to the phase 1 assessments, a formal quality assurance inspection (phase 2) is undertaken for all PAS organisations. These provide a baseline assessment and involve a more comprehensive inspection to assess compliance with the Trust's standards and expectations, including a site visit, discussion with owner/director and employees and an assessment of vehicles and equipment. The inspection also examines safety and manual handling arrangements, including the adequacy and compliance of stretcher safety harness, seatbelt extenders and child safety harness. At the date of reporting, management confirmed that these assessments had been completed for the 15 active PAS organisations.

- 2.27 The QA Team maintain a dashboard which captures the dates and outcomes of inspections, issues identified and a timeline for such to be addressed. Issues are either followed up within a secondary visit (local operational managers attend the site to confirm compliance), or evidence is submitted directly to the QA team to support the improvements or rectifications made. We note, however, that the results from inspections are not currently captured effectively or reported to an appropriate forum. **See MA1.**
- 2.28 We were advised that from 1st April 2024, the Trust will enter phase 3 of the quality assurance process by introducing the Wales Ambulance Quality Standard Award (WAQSA) Framework which will involve the awarding of '3Qs'. The 1st Q will be awarded based on annual document reviews (e.g. insurances, DBS checks) and the 2nd Q will involve annual quality inspection at the PAS site (both Q's being a continuation of phases 1 and 2 as per paras 2.24 and 2.26). The 3rd Q will be based on several weighted aspects of current performance data and reviewed quarterly per provider.

Internal Arrangements

- 2.29 The QA team undertake similar inspections across the Trust's NEPTS ambulance sites of which there are 76, and if co-located with an EMS site, the assessment will provide coverage of both service areas. We were advised that the Trust aim to complete one inspection per quarter and these commenced in December 2021 as an output to the action plan. The QA dashboard has recorded only two inspections completed during 2023/24 (**see MA3**) but that the number of inspections completed in previous years were in line with expectation.
- 2.30 Following a second incident (November 2023) involving the incorrect use of seatbelts and harnesses which occurred within a Trust EMS vehicle, 'Quality and Support Days' were introduced as a means to continue to reinforce ongoing safety requirements. The first day was held in December 2023 and involved a series of unannounced spot checks where a team of operational managers attended hospital and clinical sites to observe actions and behaviours and to inspect vehicle equipment. At the date of reporting, two of these days have been undertaken (latterly January 2024) with both having a specific focus on safety restraints and harnesses. Of the 487 spot checks completed, the following areas of improvement were identified:
- Absence of seatbelt reminder stickers in ambulances (21 identified);
 - Seatbelts not in good working order (2 identified); and
 - Stretcher harness not in good working order (8 identified).
- 2.31 The results were captured and shared on the Trust's intranet site, however we note that there is an absence of information in relation to follow up arrangements to ensure that issues were addressed. **See MA2.** We were advised that the provision for these days will continue and that the frequency and focus of spot checks will be tailored based on the needs of the organisation.
- 2.32 As part of the monitoring arrangements for Paramedics and Technicians (Ps and Ts), Senior Paramedics (SPs) undertake ride-outs to analyse their performance

during a shift to measure the effectiveness of the standard of patient care being delivered. This is captured within a standardised feedback form on Microsoft Forms, which determines areas for improvement and an action plan where applicable. During the audit of the Senior Paramedic Role (report issued November 2023, Reasonable Assurance), we interviewed six SPs across all regions in Wales, who confirmed the April 2021 incident had raised awareness of the appropriate use of seatbelts and restraints. Our audit identified the need to address the disparity in the allocation of Paramedics and Technicians, to ensure appropriate level of supervision and support.

Conclusion:

2.33 The Trust has established a framework of approved external private ambulance services to work alongside its own Ambulance Care Services, where due diligence checks are undertaken to ensure providers meet the required standards. This is supplemented by an inspection process that has been developed to monitor ongoing performance of both internal and external non-emergency ambulance services. From April 2024, a quality standard framework has been introduced to monitor quality, compliance and performance at external organisations. However, we noted that only a limited number of internal inspections were completed in year. . Following a second incident which occurred recently involving a Trust EMS vehicle, Quality and Support days have been introduced to monitor safety requirements. There is a lack of reporting of the results across all the quality assurance arrangements put in place and to demonstrate that appropriate action is being taken to address issues identified. A **reasonable** assurance rating is determined for this objective.

Objective 5: Appropriate mechanisms are in place to monitor and manage progress against planned actions and their continued sustainability.

2.34 The RTC CDG was established in May 2021 to manage the different strands of response to the incident, including the preparation of the action plan and the early monitoring of progress against the subsequent implementation of arrangements. Review of the minutes for this group confirmed continued monitoring of the progress against the action plan in addition to consideration of additional actions for inclusion (for reporting against actions, refer to audit objective 6).

2.35 As per para 2.5, while the Health & Safety investigation was ongoing, emerging actions were being addressed and implemented by the Trust prior to the finalisation of the investigation report. This ensured that timely responses were being made at the earliest opportunity and we were able to confirm this through review of the relevant supporting documentation for each of the actions.

2.36 Progress against the action plan was further monitored in the meetings of the SLT. From July 2021, monthly updates were presented describing the status of actions and the current work ongoing to implement them; and by October 2021, noting that only two actions remained ongoing, reporting became less frequent. Subsequent progress updates were also presented at meetings in April and November 2022.

- 2.37 Four interim reports were also taken to ELT between June and December 2021, and the final health and safety investigation report was presented to ELT in August 2023.
- 2.38 Discussion with the Assistant Director of Operations (NEPTS) has shown that some actions represented 'one-off' arrangements (e.g. updated vehicle daily checklist, question added to patient survey to test whether patients were asked to wear a seatbelt), whilst other actions, due to their nature, have now become embedded into routine practice within the Trusts' day to day processes (e.g. vehicle audit inspections and spot checks, quarterly internal formal inspection process - refer to audit objective 4). These will in part be monitored going forward through separate arrangements, such as the Quality & Support Days (see para 2.30).
- 2.39 We note that we were not provided with evidence to support the ongoing monitoring of some completed actions having been fully embedded into Trust routine practices. **See MA1 & MA2.**

Conclusion:

- 2.40 Arrangements were in place for progress against actions to be captured and reported through to appropriate forums which included SLT and ELT. However, an assessment of the actions and subsequent arrangements has identified some potential areas of incompleteness. A **reasonable** assurance rating has been concluded.

Objective 6: Periodic reports on the progress against implementation of the action plan are produced and submitted to appropriate management and Trust committees for oversight and escalation.

- 2.41 As per paras 2.3 and 2.34, the RTC CDG was established to coordinate the immediate response to the incident with the forum, initially, meeting weekly to ensure the Trust could react to emerging issues. The group had senior attendance and it provided an informal platform for the serious and sensitive matters to be discussed. We were advised that as oversight of the action plan, and wider monitoring of the Health & Safety investigation moved to SLT in July 2021, it met less frequently. From October 2021, meeting arrangements were more informal and ad hoc; and we note that the group hasn't met since the conclusion of the investigation was reported to ELT (August 2023).
- 2.42 Alongside the monitoring of the action plan (as outlined under objective 5, para 2.36) reporting to the SLT to support the implementation of actions included:
- Presentation of the urgent notice on seatbelts and restraints
 - Actions for operational managers
 - Summary of returned receipts acknowledging having viewed the safety video and safety notices.
- 2.43 Four interim reports were also taken to ELT between June and December 2021, providing an update on the status of the criminal and internal investigations, family

liaison and independent legal advice and the wider impact of the incident on the Trust.

- 2.44 The final health and safety investigation report was presented to ELT in August 2023 which included:
- a detailed chronology of the events relating to the incident;
 - consideration as to whether procedures and processes were being followed by relevant Trust staff;
 - an assessment of the appropriateness of relevant training and development of those involved in the incident; and
 - a summary of returned receipts acknowledging having viewed the safety video and safety notices.
- 2.45 The investigation report sets out the action plan (reviewed under objective 1) and we note that all but one action had already been addressed and marked as completed, with the final one to commence in October 2023 which we have confirmed is currently underway.
- 2.46 We were advised that the monitoring and implementation of these recommendations was overseen by the Assistant Directors Leadership Team (ADLT). We have been provided with evidence to support initial arrangements (July 2023) to respond to the recommendations, which included allocation of ownership of recommendations. However, no further monitoring and oversight of the implementation of these arrangements has been undertaken at this forum. **See MA4.**
- 2.47 As part of the review, we sought to establish formal reporting mechanisms to the Trust Board and/or its associated committees. However, there is no evidence of reporting in relation to this incident having been undertaken at this level, at either open or closed sessions. **See MA4.**

Conclusion:

- 2.48 The RTCCDG was established to initiate a response to the incident and provide support and guidance to the internal health and safety investigation. Periodic reporting to SLT and ELT provided oversight of the existence, progress and closure of actions and the development of the Health and Safety investigation. Subsequent actions against conclusions and recommendations from the investigation report were allocated owners in July 2023 via ADLT but there has been an absence of any oversight and monitoring since. There is no evidence of reporting at the key junctures post the incident to Trust Board or its associated Committees. As such a **reasonable** assurance is determined for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Reporting and monitoring of Quality Assurance inspection outcomes (Design)		Impact	
<p>A dashboard is maintained which acts as a high-level tracker of the status of quality assurance inspections. This includes a summary of inspections completed (both internal and external), issues identified, a scoring system for each inspection area and target dates for actions to be addressed. We note that the records captured within the dashboard did not fully reflect the detail and outcomes of each inspection that was recorded as completed during the year, and were also advised that the information was held in a location that, for the majority of the year, was not accessible to the wider QA Team.</p> <p>Our review has also identified the absence of reporting, including on the number of inspections completed and their outcomes. We were also unable to confirm whether required actions had been followed up to confirm that any issues identified have been appropriately addressed.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> issues identified are not addressed due to inadequate recording, reporting and monitoring, resulting in recurrence of serious incidents. 	
Recommendations		Priority	
1.1	Details of the inspections completed should be accurately captured within the QA dashboard and held centrally.	Medium	
1.2	The results of both internal and external QA inspections should be reported and monitored regularly to ensure appropriate oversight of outcomes and actions identified.		
Agreed Management Action		Target Date	Responsible Officer
1.1	This action is complete. A shared central folder has been created where the quality assurance dashboard and inspection outcome reports are now stored. Access to the folder is available to all appropriate members of the team.	Complete	-

1.2	Internal inspections are reported through the Senior Operations Team (SOT) and onwards onto operations Senior Leadership Team (SLT) for assurance purposes. Delivery of any remedial actions are overseen through SOT. External inspections will be reported through SOT from April 2024.	April 2024	Karl Hughes, Head of Service, Ambulance Care Co-ordination
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Matter Arising 2: Reporting and monitoring of spot checks / Quality and Support days (Design)		Impact	
<p>Following a second incident (November 2023) involving the incorrect use of seatbelts and harnesses which occurred within a Trust EMS vehicle, 'Quality and Support Days' were introduced as a means to continue to reinforce ongoing safety requirements. The first day was held in December 2023 and involved a series of unannounced spot checks where a team of operational managers attended hospital and clinical sites to observe actions and behaviours and to inspect vehicle equipment. At the date of reporting, two of these days have been undertaken (latterly January 2024) with both having a specific focus on safety restraints and harnesses. We were advised that the provision for these days will continue and that the frequency and focus of spot checks will be tailored based on the needs of the organisation.</p> <p>The results from these inspections are available on the Trusts intranet site, however, we note there is an absence of information and reporting in relation to follow up arrangements to ensure that issues identified have been addressed.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> issues identified are not addressed due to inadequate reporting and monitoring, resulting in recurrence of serious incidents. 	
Recommendations		Priority	
2.1	Outputs from spot checks and Quality and Support days should be formally collated and reported to an appropriate forum. This should include outcomes, issues identified and subsequent progress to implement the required actions to address.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	Monitoring of themes and trends from spot checks to date and the three Quality and Support days will be collated and presented to the joint SOT/SLT meeting on 17 th May 2024 and further to the wider leadership day which will follow. Any remedial actions will be implemented and monitored through SOT subsequently.	June 24	Jon Sweet, Head of Service – Operations (Chair of Senior Operations Team (SOT))




Matter Arising 3: Internal Ambulance Care Quality Assurance Inspections (Operation)		Impact
<p>As part of the Trusts’ quality assurance arrangements, an inspection process has been developed to monitor ongoing compliance for both internal and external non-emergency ambulance service providers.</p> <p>We were advised that the number of inspections to be undertaken across the 76 Trust NEPTS sites is limited to four stations per annum. At the date of audit fieldwork, a review of the Quality Assurance Teams’ dashboard indicated only two internal inspections had been completed.</p> <p>Discussion with the QA Team has shown that resourcing issues has impacted on the number of inspections completed and their capture within the dashboard. We acknowledge that the recent appointment of a new QA Manager will increase the capacity of the team and strengthen the ability to undertake inspections and provide more coverage across Trust sites.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> issues identified are not addressed due to inadequate recording, reporting and monitoring, resulting in recurrence of serious incidents.
Recommendations		Priority
3.1	Consideration should be given to undertake a higher number of internal inspections per annum to provide sufficient coverage and assurance that the Trust is compliant with required standards.	Medium
Agreed Management Action		Target Date
3.1	The decision to include internal inspections has been driven internally by the Operations Directorate although capacity remains a limiting factor. Whilst the audit has highlighted the need to undertake a higher number of inspections, we remain committed to four per annum with more being undertaken should capacity permit.	December 2024
		Responsible Officer
		Mark Harris, ADO Ambulance Care

Matter Arising 4: Monitoring of Health and Safety Investigation recommendations and assurance reporting to Board (Operation)		Impact	
<p>The internal Health and Safety investigation report identified 11 recommendations for the Trust, which are in addition to the actions and outputs identified in the action plan. We were advised that the monitoring and implementation of these recommendations is being overseen by the Assistant Directors Leadership Team (ADLT).</p> <p>We have been provided with evidence to support initial arrangements (July 2023) to respond to the recommendations, which included allocation of action owners. However, no further monitoring and oversight of the implementation of these arrangements has been undertaken at this forum.</p> <p>We also noted a lack of evidence of reporting on the incident at Trust Board and/or its associated Committees, at either open or closed sessions.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> absence of monitoring arrangements resulting in adherence to required safety practices not being embedded. lack of assurance reporting at Board and Committee level. 	
Recommendations		Priority	
4.1	The recommendations from the Health & Safety investigation should be formally monitored through an appropriate forum to provide oversight and assurance on the satisfactory closure of the investigation.	High	
4.2	Should a similar serious incident occur in the future, assurance on the progress made by the Trust to address identified actions and recommendations and the arrangements to embed and sustain safety practices and processes should be provided at Board and Committee level.		
Agreed Management Action		Target Date	Responsible Officer
4.1	The Trust accepts this recommendation. ADLT will oversee the monitoring and compliance of the H&S investigation and provide assurance to ELT via the AAA reporting mechanism.	May 2024	Mark Harris, ADO Ambulance Care
4.2	The Trust Accepts this recommendation. Should a similar incident occur at any future point, assurance will be provided through a closed session of QuEST Committee.	Closed	-

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	People and Culture Committee	Date of Meeting	09/05/2024
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Presenting Officer	Julie Boalch, Head of Risk/Deputy Board Secretary [Chair of Policy Group]
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Policy Name	Directorate	EqIA	Date of Policy Group	Date of ELT	Points of Note
Homeworking Policy and Procedure v3.5	People and Culture	Completed No issues	23/01/2024	14/02/2024	Copy of policy attached for approval. Transferred from Audit Committee to People and Culture Committee in Jan24.
Exit Interview Policy	People and Culture	N/A	23/04/2024	08/05/2024	Policy reclassified as a SOP. Rationale approved by Policy Group and ELT.



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Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
University NHS Trust

Homeworking Policy & Procedure

Policy Number:	034	Version No:	3.5	Supersedes:	3.4
Date of Approval:		Review Date:	1 year from approval	Impact Assessments Completed:	Yes
Classification of Document:	Employment	Type of Document:	Policy	Approved by:	People and Culture Committee
Brief Summary of Document:	Homeworking is one of the flexible working arrangements operated by the Welsh Ambulance Services NHS Trust to enable recruitment and retention of staff and facilitate a healthy work-life balance. This policy aims to provide a clear understanding of homeworking and establishes a process for considering requests and ensuring the ongoing health and wellbeing of staff.				
Scope:	This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees. [EXAMPLE]				
To be read in conjunction with:	Health and Safety Policies (DSE Guidance & Procedures Lone Worker Policy Special Leave Policy Email Policy Data Protection Policy All Wales NHS Dress Code Counter Fraud Policy All Wales NHS Flexible Working Policy All Wales NHS Managing Attendance at Work Policy Records Management Policy Information Governance Policy Virtual Meeting Etiquette Information Security Policy				
Owning Committee	People and Culture Committee				
Policy Lead:	Karen Jones	Job Title:	People Business Leader		
Trade Union Lead:	Hugh Parry		Trade Union Partner		
Executive Director:	Angela Lewis	Job Title:	Director of People and Culture		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	01/11/2017	Simone Houlbrooke	New Policy
2.0	01/10/2019	Melanie Dellibovi	Policy Review
2.1	19/03/2020	Julie Boalch	Table of contents added
2.2	25/03/2020	Julie Boalch	Addition to page 18, para 15.8 relating to equipment
3.0	03/08/2023	Karen Jones	Policy Review
3.1	15/02/2024	Julie Boalch	Review and Formatting
3.2	15/02/2024	Lisa Trounce	Post ELT 14/02/2024 – some reformatting undertaken > Policy Lead to effect identified changes required
3.3	09/04/2024	Karen Jones	Tracked changes removed, tables, foot, and page number reformatted, and new version (v3.3) created for PCC in May24
3.4	24/04/2024	Lisa Trounce	Crown badge and Trust logo replaced with new, and header amended to reflect Trust's university status. Further formatting undertaken – Policy Lead to supply original appendices as those in policy are not formatted correctly.
3.5	29/04/2024	Lisa Trounce	Contents of Homeworking Policy v3.3 copied and pasted to clean policy template and issues re: formatting of tables within the appendices now resolved. TFG Membership amended: AW's title changed to AD Digital (ICT). Replacement of expired hyperlink in section 15.10 re: business rates.
Keywords	Homeworking, home, working, agile, flexible		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	21/09/2023	Kelly Holding
EqlA / Welsh Language	05/09/2023	Kathryn Cobley
Environment	05/09/2023	Part of EqlA
Quality		

Task and Finish Group Members

Name	Job Title
Karen Jones	People Business Partner
Hugh Parry	Trade Union Partner Unite
Hannah Rawlins	Health and Safety Advisor
Jan Cross	People Business Leader
Lesley Evans	Clinical Manager 111
Aled Williams	Assistant Director of Digital – ICT
Matt Dawson	Workforce Systems Assistant
Emily Syddall	Workforce Systems Development Officer

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	23/10/2023	Review and Recommend for Approval
TU Partners Team Meeting WASPT		Information
Executive Leadership Team (ELT)	14/02/2024	Recommend for Approval
People and Culture Committee	09/05/2024	Approval and Adoption

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

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1. INTRODUCTION

The Trust recognises that employees have different needs at different stages of their working lives. It accepts that rigid adherence to traditional patterns and methods of working may fail to maximise the considerable benefits, to both the employee and organisation that can be derived from flexible forms of working. The Trust also recognises that a failure to provide flexible forms of working may discriminate against people who are unable to conform to more conventional ways of working. There may be some circumstances where homeworking may be a reasonable adjustment for employees with disabilities or long term health conditions. Offering flexible approaches to employment practices, including homeworking, is therefore an important factor in demonstrating the Trust's commitment to equality and diversity in the workplace.

It is accepted that homeworking may, in some roles or for some employees, not be a workable option. Whilst there are advantages to both the employee and organisation, it should be recognised that there are general disadvantages which should also be considered.

Therefore it is essential that the content of this policy is fully discussed and agreed between relevant parties before commencing an application for homeworking. For further guidance please refer to Appendix 1.

2. POLICY STATEMENT

Homeworking is one of the flexible working arrangements operated by Welsh Ambulance Services NHS Trust (WAST) to enable recruitment and retention of staff and to support work-life balance which is essential to the health and wellbeing of our workforce

3. SCOPE

This policy applies to all WAST employees. In contrast to other flexible working requests (see the Flexible Working Policy), homeworking may, in some circumstances, need to be agreed at the outset of employment. The Trust will therefore consider applications for flexible working from all WAST employees, not just those who meet the statutory criteria. WAST will ensure that the application of any part of this policy does not have the effect of discriminating, directly or indirectly, against WAST employees on the grounds of any protected characteristic(s) or any other unjustified reason. If a manager receives a number of homeworking requests, priority will be given to those employees with a statutory right under the Flexible Working Regulations and Work and Families Act or other Equality legislation. All requests will take account of individual circumstances, however, there may be service or operational requirements which may lead to an application not being granted.

Successful operation of the policy will be dependent upon mutual trust and confidence, however on occasion, spot checks may be carried out to ensure the conditions of the agreement are being met. Any breach of the terms of agreement or policy must be

reported by the person who identifies the breach, this will be investigated and may lead to disciplinary action or immediate termination of the homeworking arrangement.

4. AIM

The aims of this policy are to provide a clear understanding of homeworking and to set out the benefits and potential challenges for both the employee and the organisation so that all aspects can be fully considered. It also sets out the procedure to follow when applying for homeworking and the points that the organisation will take into account when considering an application.

This policy is not to be confused with Agile or remote working, where employees are allocated a base, but are able to work part of their role in an agile way, via local agreements.

5. OBJECTIVES

The objectives of this Policy & Procedure are to:

- Enable a balance between improving working life balance for employees and the need to optimise service delivery,
- Provide a framework that enables homeworking applications to be managed in a fair and consistent manner,
- Ensures that all employees are treated in a manner that complies with equality and diversity legislation, principles and practice,
- Enables the wellbeing and safety of home-workers and ensures both employee and organisation meet with legal obligations.
- To support any future targeted recruitment campaigns for hard to fill posts, where recruitment may be sought outside of Wales or indeed the UK.

6. DEFINITIONS

Flexible working is any type of working arrangement that enables an employer and employee some degree of flexibility as to when, where and how work is undertaken, this includes homeworking.

Homeworking is when an employee carries out all, or part of their duties from home rather than an employer's premises. An organisation can consider homeworking being an occasional agreed day, a mix of home and office based work each week or a full time arrangement. There are three main types of homeworking arrangements available:

6.1 Permanent Homeworking

This is where an employee can apply to work permanently from home or a combination of home and office on a regular basis for all or some of their working hours. Permanent

homeworking will require a full health and safety risk assessment and may require the provision of specific equipment, however applications for permanent home working are usually a rarity.

6.2 Temporary Homeworking

This does not constitute a permanent change to the contract of employment and may be informally agreed as a temporary arrangement, for example, following occupational health advice, to support a rehabilitated return to work or to accommodate a temporary change in circumstances if the nature of the role cannot support agile working. This will be subject to a monthly review.

The employee works from home for a temporary period of time as agreed, and will revert to their normal place of work and work pattern once the period has ended or the reason for wanting to work from home is no longer applicable.

6.3 Occasional Homeworking

This is where, on an ad hoc basis, the line manager is in agreement that the employee can work from home, for example to complete a piece of work or where an employee would be more productive returning to their home, rather than Trust premises, to avoid incurring an unnecessary or lengthy journey which reduces the time available to work. This type of homeworking can be verbally agreed in line with local Agile or Remote working if your role allows. The employee and line manager may wish to agree the circumstances in which it would be acceptable for the employee to take a “last minute” decision to work from home; in these cases, an email or phone call may be made to the line manager to advise that the employee intends to work at home at that time.

It would not be appropriate to work from home when a child or dependant is unwell; if childcare provisions have broken down unexpectedly or if an employee falls ill. There are other supportive policies and solutions to consider to support in such circumstances, e.g. Managing Attendance at Work, Carers Leave or Special Leave.

Other forms of homeworking may be requested and considered by the manager, however, the principles and procedures of this policy will apply.

7. ROLES AND RESPONSIBILITIES

7.1 Employee Responsibilities

For permanent and temporary homeworking (as defined above), the applicant should request homeworking following the application process in section 9.0 of this policy and complete the homeworking request form at Appendix 2. The employee will also need to fully understand and agree to the conditions of homeworking outlined in section 9.0 and 15.0 should they wish to apply for homeworking.

Following the submission of the request, the employee is required to meet with the manager to discuss the request in further detail. Employees will have the right to be

accompanied at the meeting by a recognised trade union partner or appropriate work colleague employed by the Trust.

Employees must ensure that they provide as much information and detail about the circumstances and requirements relating to the request in the application form to the manager, in order for their request to be given full and fair consideration.

Employees should complete Appendix 4 to apply for occasional homeworking.

7.2 Manager Responsibilities

Managers should ensure that all requests for homeworking are considered in respect of the criteria outlined in this policy and that all appropriate risk assessments are carried out accordingly. Managers should refer to the checklist in Appendix 3 prior to completing Part 3 of the homeworking request form.

Managers have a responsibility to make themselves familiar with the Homeworking Policy and Procedure. They also have a responsibility to make employees aware of the policy.

The decision to approve homeworking on a temporary or permanent basis rests with the applicant's line manager, in consultation with an appropriate senior manager. Following submission of an application for homeworking, the line manager must follow the procedure outlined in section 9.0.

Managers must inform staff that they have the right to be accompanied at the meeting by a recognised trade union partner or work colleague employed by the Trust.

Where an employee has permanent homeworking approved the manager must ensure written notification of the employee's new base is provided, as an amendment to an employee's contract of employment. The Manager will also need to complete the Homeworker section on ESR via Manager Self Service (guidance can be found [here](#)).

7.3 Trade Union Partners Responsibilities

If requested, trade union partners will offer advice and guidance to their members on an application for homeworking.

An employee will have the right to be accompanied at the meeting by a recognised trade union partner or work colleague employed by WAST.

7.4 People Services Team Responsibilities

The People Services team will offer managers advice and guidance on the process and principles to follow when considering an application for homeworking. Members of the People Services Team will, where appropriate, attend meetings with the manager and employee to discuss the application for homeworking.

8. ELIGIBILITY

When considering the suitability of homeworking, the following criteria should be considered carefully before an application or agreement of homeworking:

- Any request must not be considered in isolation, other members of a team/department must not be disadvantaged nor service compromised as a result of an approved homeworking request;
The reason for the request and suitability of the employee; the post and nature of the work required within the role. Prior to a homeworking request being made, employees must have completed all necessary training requirements and achieved a satisfactory performance at their last performance review,
- The impact of homeworking on an employee's role, e.g. supervisory responsibilities and the team/department,
- Consideration for cost, practicability, service delivery and personal performance.
- Any adverse effect on patients / employee confidentiality and security of any confidential information,
- Employee suitability and ability to work within a suitable homeworking office environment. All requests will be subject to a risk assessment.

9. APPLICATION PROCESS

9.1 Making a request for permanent or temporary homeworking

Employees are eligible to submit more than one flexible working request in a 12 month period. Each request will be considered on a case by case basis. The agreement of one request will not necessarily mean that a similar request to homeworking can be granted.

- 1) Before making a request, employees should take into account the benefits and challenges of homeworking as set out in Appendix 1.
- 2) Employees must make any permanent or temporary homeworking requests using the homeworking request form in Appendix 2 and submit to their line manager. Informal discussions prior to formal submission are also encouraged.
- 3) Following receipt of the application form at Appendix 2, the manager will acknowledge receipt of the request in writing, normally within 14 calendar days.
- 4) The manager will arrange a formal meeting to discuss the homeworking request. This meeting will take place within 28 calendar days of receipt of the request. This time limit may be extended by agreement of both parties. The manager will provide advance notice of the time, date and place of the meeting. The employee will have the right to be accompanied at the meeting by a trade union partner or appropriate workplace colleague employed by the Trust. The manager should consider a representative's availability at the time the application is submitted, wherever possible, to facilitate the arrangement of the meeting. It is the

employee's responsibility to inform their trade union representative or workplace colleague at the outset of the request and of future meetings that may take place.

- 5) During the meeting, the manager should gather full information as to why the request is being made and give full consideration to all the factors necessary to deal with the request. Managers may, where appropriate, discuss with the employee other options, making reference to the Flexible Working Policy.
- 6) In considering the request, the manager should take into account the benefits and challenges of homeworking, as set out in Appendix 1 and also refer to the checklist at Appendix 3.
- 7) Before agreeing any request, managers should consider:
 - Whether the request can be accommodated in part or in full,
 - What impact the request will have on the team's ability to provide an effective service,
 - What the team objectives are and whether these continue to be met,
 - What impact if any, the request will have on others within the department. If appropriate, the manager may discuss the request with the team members (but not the reasons for its having been made, unless the employee has given explicit consent). This will provide an opportunity to explore the impact on other team members if the request were to be approved,
 - If the homeworking is likely to incur additional costs, has approval been sought from the relevant budget holder?
 - Will the approval of home working support any ongoing recruitment for hard to fill posts?
- 8) The manager must respond to the request in writing within 14 calendar days of the meeting, by completing the second part of the homeworking request form at Appendix 2.
- 9) If the request is accepted, the manager's response will provide confirmation of agreed arrangements, this may differ from the employee's original request. This will include whether arrangements are agreed in part or full, on a temporary or permanent basis, when the homeworking agreement will commence and be reviewed, terminated or whether arrangements are agreed for a trial period. All the relevant details will be finalised in writing, copied to the employee's personal file and the People Services Hub notified. A letter to confirm the contract variation will be issued to the employee within 28 calendar days from the date of change to the employee's homeworking request being agreed.
- 10) If the request is refused, the manager's response must provide clear rationale for the decision and be clearly communicated to the employee, by the manager, in a formal meeting.

An application may be refused if an employee has failed, without reasonable cause, to provide information which the Trust considers necessary to assess whether the employees request to work from home should be granted.

Section 80(G) (1) (b) of the Employment Rights Act 1996 lists the following eight legitimate grounds for turning down a request for homeworking;

- Burden of additional costs,
- Detrimental effect on ability to meet customer demand,
- Inability to reorganise work among existing staff,
- Inability to recruit additional staff,
- Detrimental impact on quality,
- Detrimental impact on performance,
- Insufficiency of work during the periods the employee proposes to work,□
- Planned structural changes.

- 11) If the request has been refused, an employee will have the right of appeal using the process outlined in section 10.0 below.

The manager is required to keep written records of all discussions, correspondence and meetings with the employee associated with the request. All correspondence should be kept on the employee's personal file when completed.

All requests for homeworking, whether approved or refused, will be forwarded to the People Services team. This will allow the team to monitor the effectiveness of homeworking within WAST.

10. APPEALS PROCESS

If a request for a homeworking arrangement is refused, employees are entitled to receive a detailed rationale outlining the reasons for a manager's refusal and the right of appeal. This should be clearly set out using the form at Appendix 2, which should include details of the manager nominated to consider any appeal.

The appeal will be heard by the next level of manager within the department in the first instance. If this is not possible the appeal will be heard by an appropriate alternative next level of manager within the organisation.

Should an employee wish to appeal, Appendix 5 should be completed and must be submitted to the manager nominated to consider the appeal, within 14 calendar days of receipt of the outcome.

The employee must clearly state the grounds for appeal, in response to the reasons for not granting a homeworking application.

Written acknowledgement of the appeal must be provided by the Appeal Manager within 5 calendar days of receipt of the appeal.

A formal meeting to hear the appeal will take place within 14 calendar days of receipt of the appeal. If for any reason an appeal cannot be arranged within 14 calendar days then this time limit can be extended by mutual agreement of both parties.

At the appeal, the Appeal Manager will give full consideration to the employee's grounds of appeal. In addition, the Appeal Manager will also consider the rationale provided by the line manager in not granting a homeworking application, in order to determine whether the outcome was fair and balanced. Written notification of the appeal outcome will be provided by the Appeal Manager no later than 14 calendar days following the appeal meeting.

The decision of the Appeal Manager is final, there will be no further right of appeal following completion of the appeal process.

A home working arrangement will not automatically transfer to a new position

11. WITHDRAWAL OF AN APPLICATION

The line manager will consider an application for homeworking to have been withdrawn if the employee has provided written notification of the wish to withdraw.

If an employee has failed, without reasonable cause, to attend an initial meeting, or subsequent meeting convened under this procedure, on more than one occasion, an application for homeworking will be deemed to have been withdrawn. Written notification of the withdrawal will be provided by the manager.

12. MANAGING MORE THAN ONE REQUEST

Requests should be considered in the order they are received, (with the exception of requests covered by the Equality Act, 2010) based on the business needs at the time of the request. Having considered and approved the first request the manager should remember that the business context may have since changed and can be taken into account when considering a second request or future review.

If a line manager receives more than one request at any one time, they may want to have a discussion with the employees to see if there is any room for adjustment or compromise before coming to a decision.

If a line manager is unable to approve a request where a number of other employees are already working from home, the manager reserves the right to undertake a review of existing homeworking policy arrangements.

13. REVIEW OF HOMEWORKING ARRANGEMENTS

Where homeworking applications are accepted, the Trust recognises the importance of reviewing the arrangement at regular appropriate intervals.

A manager should consider whether:

- homeworking has enhanced the individual's work life balance,
- homeworking has improved patient/service provision,
- Trust has been established and maintained and not abused.

The Trust may decide, at its discretion, to carry out checks and review the homeworking arrangement at any time should it be found that the homeworking conditions and agreement are not being adhered to. Counter Fraud suggest that any staff working from home should keep a recorded time sheet, flexi checker which documents the hours worked by the employee. Additionally, keeping in touch arrangements should be made to ensure work is being delivered as expected.

14. TERMINATING A HOMEWORKING AGREEMENT

At the time of approval, a review of the homeworking agreement will be set 3 months from the commencement of homeworking to ensure that the agreement continues to operate satisfactorily. This may exclude employees who are employed within posts that require a post holder to work from home on a permanent basis.

With the exception of those employed within posts that require a post holder to work from home on a permanent basis, either party may terminate an agreement by providing written notification of termination within one month (or shorter if mutually agreed).

However, where performance issues have been identified, homeworking arrangements may be terminated or suspended with immediate effect.

Any breach of the terms and conditions laid out within the Homeworking Policy & Procedure, homeworking agreement or associated Trust policies, will lead to the immediate suspension of homeworking pending an investigation and may lead to action under the Trust's Disciplinary Policy & Procedure.

15. CONDITIONS OF WORK

15.1 Place of Work

If an employee's main place of work is at home, a nominated work base must be agreed. Home-workers may be required to attend meetings at their nominated work base as and when required by their line manager, for example to attend one to one meetings, appraisals, team meetings or for training purposes.

Whilst attending an office base permanent home-workers will not be provided with a permanent office desk and may be required to 'hot desk'.

15.2 Communication

Whilst homeworking may support employee's work life balance, some home-workers may find it difficult to establish clear boundaries between work and home life, which

could prove challenging. They may also find working at home isolating and alienating, no longer feeling part of a team.

It is therefore important that employees who are home-workers continue to feel involved in the organisation through participation in specific activities such as regular one to one meetings, team meetings, outings and training.

A structured communication plan should be discussed and agreed between the manager and employee prior to commencing homeworking to ensure homeworking arrangements are regularly monitored and reviewed. Ensuring ongoing and effective communication is also a factor to be considered when determining equipment to be provided to a home-worker. Confirmation and expectation of working time hours must be agreed,

15.3 Health and Safety

The home office environment must comply with health and safety regulations in exactly the same way as they apply in a traditional office environment. Home-workers are expected to work safely, in compliance with the Trust's health and safety policies. Advice may be sought from the trade union health and safety representative or health and safety team.

The Management of Health and Safety at Work Regulations 1999 require risk assessments to be conducted for work carried out by home-workers, with joint responsibility on the part of both the employer and the home-worker to conduct the assessments. If a homeworking environment significantly changes, an employee must immediately advise their line manager. In such circumstances, a further assessment will be required and must be carried out. Please refer to the health and safety section of the Trust's intranet for the latest version of the risk assessment.

For occasional homeworking, the employee will be required to complete the form at Appendix 4, certifying that the working environment will be safe and adequate for purpose and that all steps necessary for safe working and a safe environment are taken. Where a computer is used, this will include completion of a DSE workstation assessment form. The DSE self-assessment is completed online, by emailing Amb-healthandsafety@wales.nhs.uk. The user will then be granted access and will be sent instructions on how to complete.

Copies must be provided to the line manager so that if issues are noted, these may be addressed. The employee may also be required to take a photograph of their work environment and will need to provide it to their line manager with the assessment. A DSE assessor within the Health & Safety team should be contacted for advice on any concerns relating to a risk assessment.

As part of the risk assessment process, it is important that the planning of the work area gives thorough consideration to:

- Dimensions of the proposed work area,
- Location of doors and windows,

- Position of electrical sockets and telephone points,
- Display Screen Equipment (DSE) requirements (all employees must complete AssessRite online training and conduct a self-assessment).

In exceptional circumstances, the employer may need to visit an employee's home for example to resolve any problems identified in the risk assessment or to carry out PAT tests on Trust equipment.

It is essential that home workers take regular breaks and that they are adhering to the Working Time Regulations 1998, which state that workers do not have to work more than 48 hours a week on average, unless they choose to. Home-workers are responsible for regulating breaks in accordance with the Working Time Regulations 1998. Further information relating to the Working Time Regulations can be found at: <http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm>.

Employees are required to possess an adequate warning system, such as a smoke alarm, in the work or surrounding area that should be regularly tested. A way of escape and a small first-aid kit must also be available.

Any injuries or dangerous occurrences connected with homeworking must be reported to the Trust without delay. It is the employee's responsibility to Datix any work related incidents and notify their line manager of any changes to their home office environment or personal health that may affect their health and safety. Information relating to Datix incidents can be found on the Quality, Safety & Patient Experience Directorate pages of the WAST intranet under the Putting Things Right & Patient Safety Hub.

15.4 Confidentiality and Data Protection

Staff working with corporate and personal identifiable information (whether electronic or paper) must have received information governance training and must ensure that their training is kept up to date.

The Trust will require the employee to certify that they are able to maintain security and confidentiality of equipment and documents within the home and comply with IT security and data protection requirements. A condition for home working is that the Trust may request access to the premises for this purpose, with permission to access not being unreasonably withheld.

Wherever possible, staff should not take confidential, sensitive or personal identifiable information away from WAST premises. However, if this is unavoidable they must ensure that the information governance and IT policies are adhered to. In particular, staff should ensure that they are familiar with the procedure on transport of information and adhere to physical security requirements such as:

- Confidential conversations should be discussed where they are less likely to be overheard and screens position where it is less likely to be overseen;

- Print-outs should be collected from home printers as soon as possible and stored securely in locked drawers. Print-outs should be appropriately disposed of using a shredder (see Information Security Policy for recommendations)
- Devices and equipment should be locked away overnight or when not in use;
- Only using authorised equipment and software for work purposes (and not using unauthorised applications on personal devices to conduct work business);
- Remember to use unique and complex passwords and don't write these down.

It is essential that an employee working from home is able to maintain confidentiality of documents, computer files and equipment etc. when the home is occupied by others. In particular, only WAST owned equipment or devices may be connected to the Trust's network or hardware provided in respect of the role. No one, other than the employee may have access to the computer or to the network. Access to NHS Wales should be via a secure ID token, or VPN connection where appropriate.

The employer has the responsibility for ensuring data is properly backed up and for saving live data to the Trust's data repositories. All working practices must comply with the ICT, email, data protection and security policies of WAST.

15.5 Support

It is important that employees working from home recognise the responsibility for managing their own health and wellbeing but that they continue to be supported by their line manager. Home-workers should seek to notify their manager of any concerns about such issues as soon as possible. Likewise, managers need to be confident that they have sufficient awareness of such issues and consider them in their management and contract arrangements. Please refer to the Trust's Lone Worker Policy for further guidance.

15.6 Hours of Work

It is the responsibility of the employee and employee's line manager to ensure that the employee's contractual hours of work are adhered to. The employee's manager remains responsible for the supervision of the employee throughout their working hours. It is expected that the employee will agree the organisation of their work and deadlines to be achieved with their line manager. A record of hours work will need to be kept and submitted as per departmental process.

Employees must be available during the hours of work and may also be required to attend Trust premises at short notice. Therefore any domestic arrangements such as childcare/carer arrangements must remain in place throughout contracted hours of work.

15.7 Sickness Absence

An employee working from home must inform his/her line manager if they are sick or unable to work, in accordance with their local sickness absence reporting procedure. Employees are under obligation to adhere to the Trusts Managing Attendance at Work Policy.

15.8 Equipment

If a request for permanent or temporary home working is approved, WAST will provide the equipment necessary and this equipment will remain the property of WAST. No removable media should be used unless it has been approved for use by the Trust. The employer reserves the right to insist that all such equipment is used exclusively for use on behalf of WAST. The employer may not normally object to private use of equipment other than computers, networks and the business telephone line (where applicable) provided that there is no further cost, however this should be with prior agreement. Employees should have appropriate training on using equipment and will be responsible for ensuring that the equipment is safely maintained.

In the event of any fault with WAST ICT equipment (used for home working) the employee must log a call with the ICT service desk, and they may be required to take the equipment to ICT for repair, unless telephone support can rectify the fault. WAST would not ordinarily provide equipment for the occasional home worker, however it may be possible on an ad hoc basis to supply, for example, a lap top to enable homeworking. In the event of an ICT failure, a home-worker will be required to work from their nominated work base.

On termination of the contract of employment, WAST will have the right to recover all its property including equipment, software and copy documents and files. Without prejudice to WAST's legal right, entry to the employee's home should always be by mutual agreement. The manager must keep an up to date log of equipment and furniture etc. provided to the employee for this purpose.

It is the responsibility of a home-worker to ensure they are familiar and adhere to the Trust's Social Media and Email Use Policies.

An employee is responsible for the physical security of any WAST equipment provided to them for homeworking. Employees should not re-allocate their equipment to other members of staff without the permission of the ICT department to ensure accurate asset records are maintained. It is the employee's responsibility to report any ICT equipment that is damaged or stolen to the ICT service desk immediately. Should any ICT equipment become damaged or lost then a home-worker may be financially liable in any case of wilful neglect or damage. Accidental damage will be treated in exactly the same way as within a traditional office environment. If equipment needs to be returned to the organisation, the employee should discuss logistical arrangements with the ICT department.

15.9 Financing Homeworking

For permanent homeworking arrangements, the Trust might pay for the whole cost of the business telephone line and any broadband computer connection if this is required and provided by the Trust. The organisation will also pay the cost of maintenance and repair of this equipment. Any personal use of this equipment will need to be agreed and may have tax implications to the individual under HMRC taxable benefits homeworking rules.

In accordance with Section 18.2 of the Agenda for Change Terms and Conditions, should an employee be required to telephone the Trust premises for the purposes of work, they will be entitled to claim for the reimbursement of telephone expenses. They should keep a record of the date, time and length of the call and claim this as an expense, which the manager must authorise. The Trust reserves the right to request an itemised bill as proof of calls. The Trust will not pay any additional lighting or heating costs.

15.10 Mortgage and Insurance

Legal restrictions may prevent the use of an employee's home for business use. It is the employee's responsibility to ensure that they have confirmation from their mortgage lender, home insurance provider and/or landlord that homeworking is acceptable.

It is the responsibility of home-workers to provide adequate home buildings and contents insurance. The Trust will not accept liability for damage caused to the home or its contents. The home-worker will also be responsible for providing adequate car insurance should they need to transport any Trust property in their own vehicle.

The Trust will take responsibility for fair wear and tear and mechanical breakdown of any Trust equipment provided that the equipment has not been misused.

The Trust does not accept any responsibility for an employee who suffers any detriment, loss or legal action as a result of not obtaining the necessary permissions from their insurer, mortgage lender, landlord or local authority.

Under certain circumstances, the use of space in the home for business purposes could potentially render the property business rateable. The employee has the responsibility for verifying the position on this in individual circumstances. Further information on this is available at; www.voa.gov.uk and <https://www.gov.uk/browse/business/premises-rates>

15.11 Travel Expenses

When a permanent homeworking request is agreed, whilst the employee's home will be the main place of work, a designated work base must be agreed. The employee may be required to visit the appropriate Trust premises on a regular basis. Travel expenses will not be paid for visits to the appropriate site. For the purposes of official mileage, the nearest Trust premises will be deemed the official start point of an office journey.

When a temporary/occasional homeworking request is agreed, the employee's base will remain the appropriate Trust premises and travel from home to base will not be payable.

The HMRC provides further guidance on the possible tax implications for homeworking, this should be reviewed by an employee prior to any application to work from home.

15.12 Guidance and Support with Implementation

Further guidance and support will be available to managers and employees considering homeworking applications from the People Services team.

16. EQUALITY

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our employees reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). Please see completed EQIA.

17. AUDIT AND MONITORING

Details of all requests for homeworking and decisions reached upon each request will be reviewed at Departmental level. This information will be used for monitoring purposes, to aid future development of this policy and to meet the requirements under a policy impact assessment.

Systems will be audited and monitored in line with this policy and associated protocol.

Auditing and monitoring will only be carried out in agreement with the designated Information Asset Owner.

18. COUNTER FRAUD, BRIBERY AND CORRUPTION

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the organisation. In conjunction with this policy, staff should report any suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Such examples may be where staff are engaged in dual role employment, working for another provider whilst contracted for WAST or undertaking non work activities during work time. Such actions will not be tolerated, and would be investigated by the Local Counter Fraud Team as a consideration of Fraudulent practice. Such conduct may ultimately result in criminal prosecution, civil recovery, alongside disciplinary sanctions.

Alternatively staff may contact the confidential NHS Fraud and Corruption Reporting line 0800 028 40 60; or on-line reporting facility <https://cfa.nhs.uk/report-fraud>

Fraud investigations may lead to prosecution and civil recovery procedures, alongside internal disciplinary action.

19. RECORDS MANAGEMENT

The Welsh Ambulance NHS Services Trust recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation

and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

20. REFERENCES

Additional information and guidance can be found at the following links:

<http://www.acas.org.uk/index.aspx?articleid=1616>

<http://www.acas.org.uk/index.aspx?articleid=4853>

Information Commissioners Office at; www.ico.org.uk

Information Governance Alliance (2016) Records Management Code of Practice for Health and Social Care 2016: NHS Digital

Data Protection Act 2018;

General Data Protection Regulations 2018;

Freedom of Information Act 2000 (FOI);

Environmental Information Regulations

2004; Equality Act 2010;

Information Governance Alliance: Records Management Code of Practice for Health and Social Care 2016;

Computer Misuse Act 1990; Common Law

Duty of Confidentiality; Information Security

Management ISO 27001

21. APPENDICES

Appendix 1 – Benefits and Challenges of Homeworking

Appendix 2 – Homeworking Request Form

Appendix 3 – Homeworking Manager Checklist

Appendix 4 – Occasional Homeworking Certification Form

Appendix 5 – Homeworking Request Appeals Form

APPENDIX 1: BENEFITS AND CHALLENGES OF HOMEWORKING

There are advantages and disadvantages of Homeworking, both for the employee and the organisation. You will need to weigh up carefully all the benefits and disadvantages. Some examples of this are listed below;

For the Employee

Benefits:

- Increased employee satisfaction and productivity.
- Supports work life balance.
- Reduced time spent on daily commute,
- A reduction in carbon footprint.
- Support to remain in employment.

Challenges:

- Could lead to a sense of isolation from work colleagues.
- Challenges with maintaining boundaries between work and home life.
- Cost implications associated with business rateable tax and home insurance.

For the Organisation

Benefits:

- Increased employee job satisfaction and productivity.
- Potential for a decrease in overheads as a result of reduced office space requirements.
- Access to a wider pool of talent across geographical boundaries.
- Retention of employees who may otherwise leave for family or work/life balance reasons.
- Reduced absenteeism.
- Employees can be located closer to their service user bases, reducing travel times and costs.
- By reducing the home to work commute, homeworking supports the reduction of carbon emissions.
- To support any flexible recruitment campaigns

Challenges:

- Consider confidentiality and data security in a home environment.
- Added complexities of managing Health and Safety across a wider number of locations.
- Robust communication with home-workers to ensure full inclusivity, equal opportunity and prevention of potential feelings of isolation.
- Ensuring that staff are providing an effective service to their full potential, as they would do within the office environment, and not engaged in non-work activities.
- Resulting change if homeworking is no longer deemed appropriate.

APPENDIX 2 - HOMEWORKING REQUEST FORM



Homeworking Request Form

Note to the Employee:

You can use this form to make a request to work from home on either a permanent or temporary basis (not needed for occasional Homeworking. See appendix 4). Before completing this form, please read the Homeworking Policy & Procedure.

It will assist your manager to consider your request if you provide as much information as you can on the form. It is important that you complete all the questions, otherwise your application may be returned which will result in delay. Once you have completed the form you should immediately forward it to your line manager (keeping a copy for your own records). Your manager will then arrange a meeting with you to discuss your request. You have the right to be accompanied at the meeting by an appropriate Trade Union representative, staff representative or work colleague.

Note to the Manager:

There is a duty on employers to give thorough consideration to every application. You must arrange to meet your employee as soon as possible. However, if you are happy to grant the request without any modification, you do not need to have a meeting if agreed by mutual consent, simply complete the Application Acceptance Form. Please consider the checklist in appendix 3 and the need for a trial period prior to accepting the request.

Please note copies of all documentation should be kept on the Employee's personal file and a copy submitted to the People Services Department.

Part 1 - Employee Request	
Full Name of employee	
Payroll number	
Current Post	
Band	
Directorate/Department	
Current work base	
Line Manager	
Email/Contact Number	
Date of application	
Is this request Permanent or Temporary? (if temporary please state period of time)	
Please detail the working pattern you are requesting ie proportion of hours/days worked at home/office.	
Please provide details of the reason for your home-working application.	
Please provide details of the impact of the change requested on your role/department/team/service.	

<p>Please describe how any potential problems with a home-working agreement on your role/department/team/service can be overcome.</p>	
<p>Please describe what steps you will take to overcome challenges listed within the home-working policy, for example, home insurance, confidentiality, team meetings etc. including steps to support the maintenance of service delivery.</p>	
<p>Is your request for home-working as a result of an adjustment relating to a protected characteristic as listed in the Equality Act (2010) (please delete as appropriate) Yes / No If yes please provide details:</p>	
<p>Do you have a secondary employment and if so please provide details:</p>	
<p>I confirm that I have read and understood the home-working policy & procedure and hereby agree to the terms and conditions as set out within the home-working policy & procedure and associated policies.</p>	
Employee Name (please print):	
Signed:	
Date:	

Please provide Part 2 to Line Manager for completion

Part 2 - Receipt of request	
Date of receipt	
Date of written acknowledgement	
Line Manager Name (please print)	
Line Manager Post Title	
Line Manager Current Base	
Line Manager email/contact number	
Date(s) of meeting to discuss application	
Summary of discussion	

Part 3 - Confirmation of Application Outcome

Further to the meeting that took place on(Date), with the following attendees:

.....

.....I have considered your request to work from home.

Either:

- I am pleased to confirm that I am able to grant your request with effect from..... (date). This will be a permanent / temporary change (please delete as appropriate). If temporary, the arrangement will end on(date). If permanent, your base will be changed to your home address as of [date].
- I am able to accommodate your request with effect from..... (date) to be reviewed on(date).
- I am unable to accommodate your original request (in accordance with one or more of the 8 business reasons listed at section 9.1 (10) – Please state which reasons). However, I am able to offer an alternative which we have discussed and you agreed would be suitable to you as follows:

We also agreed the following actions/ monitoring arrangements:

Or:

The alternative could not be agreed and therefore I am sorry but I am unable to accommodate your request for the following reasons:

Date request declined:

Start date of home-working arrangements (if applicable):	
Line Manager Signature:	
Line Manager Name (in Full):	
Date:	
Employee Signature:	
Employee Name (in Full):	
Date:	

If you are unhappy with the decision you may appeal against it. Details of the appeal process are set out at section 10 of the home-working Policy & Procedure.

Notes:

- Part 1 - to be completed by Employee and forwarded to Line Manager.
 - Part 2 - to be completed by Line Manager and ESR updated to reflect Homeworking
- The form should be returned to the Employee when completed and a copy kept on their personal file.
A copy of the completed form should be sent to the People Services Team.

APPENDIX 3 – HOME WORKING MANAGER CHECKLIST

HOMEWORKING MANAGER CHECKLIST

This checklist is to be used as an aide by managers when assessing the feasibility of homeworking. Its use will promote a consistent approach across WAST.

Suitability of the employee

Is the employee:

- Able to complete work using own initiative and within established guidelines?
- Self-motivated and self-directed to meet deadlines?
- Able to manage time effectively?
- Able to work without direct supervision?
- Able to communicate well by telephone and in writing?
- Able to work in isolation from the team?
- Able to work alone without negative effect on their wellbeing?

Suitability of the role

Is the role:

- Be suitable for homeworking? (usually one that requires a high degree of personal concentrated work with very limited interaction and can be done at home in isolation from colleagues);
- Require an office base?
- Require the need for the post holder to be 'face to face' with service users?
- Be effectively completed from home without detriment to overall objectives?
- Be suitable for measurement in terms of clear outcomes/outputs?
- If approve, have an impact on other team members, and have they been consulted?
- If so, have their views been taken into account?

Equipment and responsibilities

- Does the employee have adequate equipment and access to systems to carry out the work at home?
- Has the employee been made aware of individual responsibilities including insurance, security, health and safety?
- Are you able to provide a "hot desk" for the times when the employee will need to attend WAST premises?

Managing the Employee – Guidelines for Managers

Managers may be concerned about supervision of the home worker and their productivity. However, a planned and methodical approach can make the process simpler for both sides.

You should:

- Set measurable, time defined objectives and regular opportunities for feedback.

Not take communication for granted. The employee should make sure that they are on email distribution lists for all the projects they are working on. If you are having organisational or team meetings, it is essential to encourage home workers to attend as often as possible or to phone in.

You may choose to specify in their contracts how often they should attend these meetings, within reason.

- Remember that home workers may feel more isolated so consider how you can transfer that principle of information exchange with colleagues to home workers. In addition, managers should have regular meetings with the home worker to ensure that lone working and potential isolation is not contributing to any mental wellbeing issues.
- Use online resources such as the intranet, wherever possible, to keep home workers feeling involved.
- Consider introducing a buddy system so a colleague keeps in close touch with the home worker.

The greatest challenge to managing home workers are trust and discipline. When managing a homeworking employee, remember;

- A trusted home worker will be much more productive than one who feels they are being watched all the time.
- If disciplinary issues do arise, treat them as you would any disciplinary issue.

A home worker is working in their home and they are entitled to an appropriate level of privacy. You cannot just drop round or keep phoning to check up on them. Appropriate time recording measures should be incorporated to ensure effective work hours are completed.

- Training and development must be handled in exactly the same way for home workers as on site staff. Performance development reviews should be regularly scheduled and it is usually best to arrange for meetings such as these to be conducted on WAST premises.

APPENDIX 4 - OCCASIONAL HOMEWORKING CERTIFICATION FORM

Occasional Homeworking Certification Form

I confirm that my homeworking environment will be safe and adequate for the purpose of occasional homeworking and that I will take all steps necessary for safe working and a safe environment (including completion of Appendix 5).

I confirm that while using electrical equipment provided to me by the Welsh Ambulance Services for the purpose of occasional homeworking, I will not overload any electrical extension cable or any single power point and that I will not work in a way that causes trailing cables from my work equipment to be a trip hazard.

I confirm that while working with DSE equipment, I will take suitable and sufficient breaks from keyboard work and will work using an appropriate chair and work surface.

I confirm that I will adhere to the Working Time Regulations.

I confirm compliance and adherence to the requirements of the Homeworking policy & procedure and all associated, relevant workplace policies.

Employee's Name: Date:

Employee's Signature:

Please return completed and signed form to your manager

Appeal Decision Form	
Date of Appeal Meeting:	
Following our meeting on the above date attended by.....	
I have considered your appeal against the decision to refuse your application to work from home.	
Either:	
<input type="checkbox"/>	I accept your appeal against the decision. I am therefore able to accommodate your original request to work from home as follows: (continue on a separate sheet if necessary)
<input type="checkbox"/>	I am unable to accommodate <u>you</u> original request. However, I am able to offer you an alternative solution which we have discussed and you agreed would be suitable for you, as follows:
<input type="checkbox"/>	I am sorry but I must reject your appeal on the following business ground(s);

The grounds apply in the circumstances because:

Start date of Home-working arrangements (if applicable):	
Manager Signature:	
Manager Name (in Full):	
Date:	

A copy of the completed form should be sent to the employee and the People Services Team

Please note there is no further right of appeal



AGENDA ITEM No	17
OPEN	Open
No of ANNEXES	2

COMMITTEE CYCLE OF BUSINESS 2024-25 & MONITORING REPORT

MEETING	People and Culture Committee
DATE	09 May 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Updating of the cycle of business for this committee is the final step in the 2023/24 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 (red text). 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. There are some areas of the cycle where reporting remains to be developed.

RECOMMENDATION:

4. The Committee is asked to:
 - (a) Review and approve the 2024/25 cycle of business at Annex 1; and
 - (b) Note the cycle of business monitoring document at Annex 2.



KEY ISSUES/IMPLICATIONS
As above.
REPORT APPROVAL ROUTE
N/A

REPORT APPENDICIES
Annex 1 – Cycle of business 2024/25 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



GIG
CYMRU
NHS
WALES

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

CYCLE OF BUSINESS 2024/25

SITUATION

5. 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

6. The Committee carried out its annual effectiveness review on 20 February 2024. This included a review of its terms of reference, amendments to which were approved by the Committee at that meeting.
7. The final step in the effectiveness review process is the development a cycle of business for the Committee.

ASSESSMENT

Cycle of Business:

8. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework and forward planner drives agenda setting. It also:
 - 8.1. 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;
 - 8.2. schedules compliance related reports according to legislative or regulatory timeframes;
 - 8.3. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;
 - 8.4. generates commitment to review matters that may sometimes be vulnerable to postponement;
 - 8.5. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;
 - 8.6. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and



- 8.7. removes the ad hoc elements of agenda setting.
9. 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.
10. 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.
11. 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:
- 11.1. Learning and development reporting to assure the Committee on training, education, development, and succession.
 - 11.2. Health and Care Quality Standards reporting related to people and culture.
 - 11.3. Speaking up safely reporting, which will mature as the FTSU Guardians embed. Currently this information comes through the cultural themes and trends report.
 - 11.4. Reporting on the anti-racist Wales action plan, noting that the WRES data will provide a baseline for this in 2024/25.

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

Continued monitoring of the cycle of business:

12. A monitoring report will be provided to each meeting under the consent section in the 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 Director of Corporate Governance/Board Secretary.
13. The monitoring report appears at **Annex 2** and is completed for Q1.



RECOMMENDATION

14. The Committee is asked to:
- (a) Review and approve the 2024/25 cycle of business at Annex 1; and
 - (b) Note the cycle of business monitoring document at Annex 2.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
3.1 Oversee and contribute to the development of the Trust's People and Culture Plan aligned to the 2030 Delivering Excellence Long Term Plan									
3.2 Noting that the Finance and Performance Committee oversees delivery of the Integrated Medium Term Plan (IMTP), this Committee will conduct any required deep dives into aspects of the people and culture elements of the IMTP and monitor delivery of other strategic people and culture priorities which may not be included in the IMTP									
3.3 Receive and consider projects of major strategic organisational change where there is a significant impact on our people's health and wellbeing, and cultural change									
3.12 Monitor the effectiveness of the Trust's leadership and management development and succession planning arrangements									
People and Culture C'ee elements of IMTP	STB	Annually					DPC	Endorsement	Proposed people and culture elements of IMTP to PCC for review ahead of full IMTP review by F&P and Board (inc L&M - 3.12)
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	F&P monitor delivery of strategy via IMTP. Exception reports to PCC by Director or by F&P request where required
Strategic Workforce Plan	TBC	Bi-annually					DPC	Endorsement	Receipt by the Committee for endorsement before it goes to Trust Board, and then follow up for review 6 months later.
Cultural themes and trends report	TBC	Bi-annually					DPC	Assurance	First reported in 23/24
Learning and development reporting	TBC	TBC					DPC	Assurance	Reporting to be developed in 2024/25 to assure the Committee on training, education, development & succession
3.13 Monitor performance against key people and culture indicators including but not limited to sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinarys and suspensions, turnover and recruitment; enabling deep dives to take place into specific areas of concern									
3.4 Monitor progress and seek assurance of arrangements in place to embed the Trust's behaviours, ensuring a continued journey of positive culture change									
People and culture metrics annual review	TBC	Annually					DPC	Approval	To review and agree the Committee level metrics for the coming year (i.e. those over and above MIQPR metrics)
MIQPR review for people and culture metrics	FPC	Annually					EDSPP	Endorsement	People and culture, H&S, and Welsh Language KPIs for inclusion in MIQPR
People and culture metrics report	TBC	Quarterly					DPC	Assurance	First reported in August 2023
Workforce Scorecard	TBC	Quarterly					DPC	Assurance	
MIQPR	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics. See cycle notes on PADRs
Suspensions over 4 months report	TBC	Quarterly					DPC	Assurance	Closed session
3.5 Receive assurance that there is a robust plan in place for the health and wellbeing of our people and monitor the effectiveness of arrangements in place to support and protect the mental, physical and financial wellbeing of staff. See Note 1									
End of Season Flu Campaign Report	COGG	Annually					DP	Assurance	To include flu and general vaccination status in accordance with statutory and regulatory requirements - see Note 2
3.15 Ensure the Trust is discharging its statutory responsibilities, including but not limited to health and safety, equality, diversity and inclusion; relevant Health and Care Quality Standards requirements; and that professional standards of registration and revalidation are maintained									
Health and Safety Report	NH&S C'ee	Quarterly					EDQN	Assurance	Bi-annual report on the working safely programme but MIQPR to include KPIs. See note 3
Annual Health & Safety Report	NH&S C'ee	Annually					EDQN	Assurance	Requested for inclusion from 2024/25 onwards; to be received in the August 2024 meeting.
Revalidation and registration report	N/A	Annually					EDQN & EDP	Assurance	Report from EDQN and DP confirming revalidation of registered staff - see Note 4
Gender pay gap report	TBC	Annually					DPC	Assurance	Report presented for 22/23 in Feb (Q4) 24. TBC timing of this going forward
Annual Equality Report	TBC	Annually					DPC	Assurance	See Note 11
Health and care standards	TBC	TBC					DPC	Assurance	Assurance on compliance with people related HCS (as amended with new Act)
3.6 Consider the experience of our people, including volunteers, and seek assurance of the effectiveness of mechanisms used for measuring, and for hearing and acting upon their experiences									
Staff Story	N/A	Quarterly					DPC	Discussion	Staff stories to be topical to the main issues where possible
Staff Story updates	None	Quarterly					DPC	Assurance	Closing of the loop from themes/issues raised in staff stories. Letter to staff. See Note 5
NHS Staff survey and action plan	ELT	Annually					DPC	Assurance	TBC if September - See Note 6
WAST pulse surveys and action plans	ELT	Ad Hoc					DPC	Assurance	
3.7 Receive assurance that arrangements are in place to allow staff to raise concerns in confidence, and that those processes allow any such concerns to be investigated proportionately and independently and that the learning from such concerns is considered and applied									
Speaking Up Safely Report	TBC	TBC					DPC	Assurance	Speaking Up Safely reporting being developed in 23/24 - see Note 7
3.8 Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan and be assured its implementation is monitored; champion and support the plan and the work of the EDI networks - See Note 10									
Report on Anti-racist Wales Action Plan	TBC	TBC					DPC	Assurance	Reporting to Committee to be confirmed - see Note 8
3.14 Monitor progress and seek assurance that arrangements are in place to meet the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted within the Trust									
Reporting on Welsh Language Standards	WLAG	Bi-annually					BS	Assurance	Note the WL framework is in IMTP 2024-27 and revised Welsh Language Standards reporting in development
Welsh language annual report	WLAG/ELT	Annually					BS	Endorsement	Must be on website in September. Goes to Board thereafter in September.
3.10 Receive assurance that Trust management and Trade Union Partners continue to develop and build a shared understanding and common purpose through formal and informal consultative partnership working to ensure the efficiency and success of the Trust for the benefit of all									
WASPT AAA report	WASPT	Quarterly					DPC	Assure/Escalate	
Partnership Agreements	WASPT	Ad Hoc					DPC	Endorsement	Trade union partnership agreements - See also Note 9
3.16 All matters relating to partnerships and engagement relevant to our people and culture change									
Partnerships & Engagement Report	TBC	Bi-annually					DPE	Assurance	Reporting on engagement framework for people and culture to be developed - linked to major organisational change in TOR 3.3
Partnership Agreements	ELT	Ad Hoc					DPE	Review	Review partnership agreements (e.g. armed services covenant; disability partnerships) - See also Note 9
3.9 Receive assurance on the development and implementation of the Trust's recruitment and retention plans.									
NHS Workforce Model	Workforce Planning Grp	TBC					DPC	Endorse	
Workforce Plan aligned to IMTP	Workforce Planning Grp	Annually					DPC	Endorse	Committee reviews tactical workforce plan, capacity & demand reviews; review strategic workforce plans when developed.
3.11 Receive assurance that the Trust has in place appropriate policies and procedures for its people; approve people and culture policies									
Report from policy group	Policy Group	Annually					BS	Assurance	Annual report to illustrate the policies within the remit of the committee are in date and there is full policy coverage assurance
Policies for review and approval	Policy Group/ELT	Ad Hoc					Various	Approval	Board to approve Raising Concerns and H&S policy (SoRD para 17)
3.18 The Committee will monitor the principal risks relevant to its remit and consider the controls and mitigations of related risks and provide assurance to the Board that such risks are being effectively controlled and managed.									
Board Assurance Framework	Board	Quarterly					BS	Assurance	
Corporate Risk Register - People and culture	Board	Quarterly					BS	Assurance	
Audit Recommendation Tracker	ADLT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc					Relevant Director	Assurance	
3.17 Any other matter in relation to the Committee's overall purpose and responsibilities									
Operational Update	N/A	Quarterly					EDO	Information	
Director of P&C Update	N/A	Quarterly					DPC	Information	Including spotlight on TUP successes and challenges from 1 April 2025
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	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
EDO = Executive Director of Operations
EDQN = Executive Director of Quality and Nursing
DPE = Director of Partnerships and Engagement
EDP = Director of Paramedicine
BS = Board Secretary





 Cycled for each meeting
 Ad hoc item - prompt for agenda setting
 Reporting developing

Health and wellbeing	TOR 3.5 - health and wellbeing offer will be included in the People and Culture Plan and reported via the IMTP
Flu Vaccine	Not mandatory; WG have a target for patient facing staff
	Delivery on the Working Safely Programme is via IMTP however bi-annual updates on working safely programme to maintain visibility over 23/24
Health and Safety	Health and Safety Internal Audit Report July 2023 - <i>There is good oversight over the Programme with regular reporting to the Programme Board and to the People and Culture Committee (PCC) but could be enhanced by noting progress against the programme's deliverables</i>
Revalidation	RNC every 3 years; HCPC every 2 years; GMC every 3 years
Staff story updates	Advisory Internal Audit on learning organisation - 3.1 'We recommend that staff stories are evaluated to identify and deliver actions to address the issues they raise. Agreed to be completed by person curating story. To be on agenda for the following meeting.
Staff survey	Staff survey goes out [Sept?] and reports end [March].
Speaking Up Safely	DPC will develop reporting on Speaking Up Safely through 24/25 as FTSU Guardians embed; in the meantime the cultural themes and trends captures some of this reporting
	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.
Anti-racist Wales Action plan	Standing Orders 6.0.4 says 'the Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partners responsibilities. It must ensure timely action to change, 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'.
Working in Partnership	Promote the networks and Committee involvement including NED champion roles
EDI Networks	SEP 2024-2028 approved March 24. 22/23 report presented in February (Q4) 24. TBC timing of this going forward. WRES reporting (national WRES report being coordinated by HEIW. WRES data will help provide baseline for future actions on ARWAP
Annual Equity Report	
	These cycles are developed with reference to the specific lines of the TOR for this Committee.
General	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	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
PEOPLE AND CULTURE COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
People and Culture C'ee elements of IMTP	STB	Annually					DPC	Endorsement	
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Strategic Workforce Plan	TBC	Bi-annually	→						Q1: Programmed for Q1 but deferred and proposed Q2/Q4 programming for 24/25.
Cultural themes and trends report	TBC	Bi-annually					DPC	Assurance	
Learning and development reporting	TBC						DPC	Assurance	
People and culture metrics annual review	TBC	Annually					DPC	Approval	
MIQPR review for people and culture metrics	FPC	Annually					EDSPP	Endorsement	
People and culture metrics report	TBC	Quarterly					DPC	Assurance	Q1: Inc deep dive on disciplinary case management and cultural themes.
Workforce Scorecard	TBC	Quarterly					DPC	Assurance	
MIQPR	ELT	Quarterly					EDSPP	Assurance	
Suspensions over 4 months report	TBC	Quarterly					DPC	Assurance	Closed session
End of Season Flu Campaign Report	CQGG	Annually					DP	Assurance	
Health and Safety Report [Note 3]	NH&S C'ee	Quarterly					EDQN	Assurance	
Annual Health & Safety Report	NH&S C'ee	Annually					EDQN	Assurance	
Revalidation and registration report [Note 4]	N/A	Annually					EDQN & EDP	Assurance	
Gender pay gap report	TBC	Annually					DPC	Assurance	
Annual Equality Report [Note 11]	TBC	Annually	→				DPC	Assurance	Timing tbc going forward.
Health and care standards	TBC	TBC					DPC	Assurance	
Staff Story	N/A	Quarterly					DPC	Discussion	
Staff Story updates [Note 5]	None	Quarterly					DPC	Assurance	
NHS Staff survey and action plan [Note 6]	ELT	Annually					DPC	Assurance	Q1: Programmed for, as deferred from Feb 2024.
WAST pulse surveys and action plans	ELT	Ad Hoc					DPC	Assurance	
Speaking Up Safely Report [Note 7]	TBC	TBC					DPC	Assurance	
Report on Anti-racist Wales Action Plan [Note 8]	TBC	TBC					DPC	Assurance	
Reporting on Welsh Language Standards	WLAG	Bi-annually					BS	Assurance	
Welsh Language Annual Report	WLAG/ELT	Annually					BS	Endorsement	
WASPT AAA report	WASPT	Quarterly					DPC	Assure/Escalate	
Partnership Agreements [Note 9]	WASPT	Ad Hoc					DPC	Endorsement	
Partnerships & Engagement Report	TBC	Bi-annually					DPE	Assurance	
Partnership Agreements [Note 9]	ELT	Ad Hoc					DPE	Review	
NHS Workforce Model	Workforce Planning Grp	TBC					DPC	Endorse	
Workforce Plan aligned to IMTP	Workforce Planning Grp	Annually					DPC	Endorse	
Report from policy group	Policy Group	Annually					BS	Assurance	
Policies for review and approval	Policy Group/ELT	Ad Hoc					Various	Approval	
Board Assurance Framework	Board	Quarterly					BS	Assurance	
Corporate Risk Register - People and culture	Board	Quarterly					BS	Assurance	Q1: Deep Dive on Reputational Risk 201 programmed.
Audit Recommendation Tracker	ADLT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc					Relevant Director	Assurance	
Operational Update	N/A	Quarterly					EDO	Information	
Director of P&C Update	N/A	Quarterly					DPC	Information	Including spotlight on TUP successes and challenges from 1 April 2025
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
PROMPTS									
Relevant External Reports	N/A	Ad Hoc					Various	Assurance	

DPP = Director of People & Culture
EDO = Executive Director of Operations
EDQN = Executive Director of Quality and Nursing
DPE = Director of Partnerships and Engagement
EDP = Director of Paramedicine
BS = Board Secretary

Key: Pre-agenda setting
 Cycled for each meeting
 Ad hoc item - prompt for agenda setting
 Reporting developing

Key: Post-agenda setting
 Presented as cycled
 Ad hoc / item considered - not programmed
 Item deferred
 Reporting developing



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WELSH AMBULANCE SERVICE PARTNERSHIP TEAM (WASPT) HIGHLIGHT REPORT

This highlight report provides the reader with details of the key areas discussed at the last 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 All WASPT meetings are held in person	19 February 2024
People and Culture Committee Meeting Date	9 May 2024
Chair	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. There was an update on the development of the **IMTP 2024-27** and the engagement with our patients, our people, and our stakeholders in the drawing out of priorities for 2024/25. We discussed the ways in which we might provide the right service to our patients no matter which number they call (999 or 111), noting there is still work to do in partnership on how that might work in practice to support the vision of integrated care. Some of the WASPT Trade Union Partners saw this in the Corporate Partnership Forum and will have a further opportunity to review the IMTP at a development session with the Board in February, and through Committees en route to the March Board meeting where it will be approved. It was agreed that the sequencing of the IMTP through the sub-structures will be reviewed next year to support maximum engagement.
3. The **WASPT effectiveness review** was conducted. Given the timing of the meeting, the annual report of the group will not be able to be reviewed by the People and Culture Committee in meeting before it is presented to the Audit Committee and the Board, however the review was a positive one with the following noted:
 - There was a sense that WASPT was working well after 12 months, with a good structure and rhythm of meetings and demonstrates good partnership working, notwithstanding the



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sometimes challenging issues discussed. All scheduled meetings have been held in person and have been quorate.

- On improvements, development and training opportunities, members indicated that they would like to invest time in the relationship with trade union and management members and this work has started with the Colour Insights and partnership development sessions, which it is hoped will pave the way for some of the issues raised relating to personal relationships, forging stronger links and walking in each other's shoes, to be addressed.
- Minor changes are being made to the terms of reference given that the group was only reconstituted in early 2023. Some changes to operating arrangements have been agreed:
 - Meetings will remain as bi-monthly; however an additional workshop will be added to the meeting to discuss single issues which will be more informal and free-flowing.
 - A lunch break will be incorporated to provide an opportunity to get to know each other more informally.
 - Seating of members will be mixed so we are more dispersed around the table.
 - There are several trade union/manager development sessions taking place in addition to the WASPT specific sessions held in December 2023 and February 2024.
 - We will hold specific sessions such as how to run effective meetings, understanding financial reporting and the roles and responsibilities on Committees.
 - In addition to the AAA a 'hot topics' newsflash will be introduced to help communicate partnership working.
 - Approved minutes of WASPT will be added to the People and Culture Committee agenda.
 - A Teams SharePoint channel will be used for all papers.
- It was agreed that some of the sub-structures that report into WASPT need some time to embed new practices. They will be given support to do so and effectiveness reviews in due course.

4. The issue of carry over leave and processes to do that would be taken away for clarification for operational staff. Reassurance was provided that should a few individuals miss out due to the process/ deadline, then it would still be processed retrospectively.

5. Members **reflected** there it has been a pleasant meeting with respectful discussions, and that the effectiveness review showed progress and momentum.

ASSURE

(Detail here any areas of assurance)

6. The **ACAS Action Plan** update was received with no escalations. Sessions for managers and trade union partners to improve partnership working were underway and feedback from initial sessions was positive. A range of training and development suggestions were agreed.



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7. The **Senior Leadership Team/Trade Union** (SLT/TU) met on 18 January 2024 and members were updated on the following discussions:
 - The local partnership forums (LPFs) will be the fora for discussion of regional health and safety issues with escalation to Senior Operations Team/Trade Union (SOT/TU).
 - SLT/TU will introduce an actions and decision log as well as the AAA.
 - On CSD Duty Operations Managers (DOMs) home working, it was clarified that there was not a blanket 'no' to this but there needed to be clearance first. At the WASPT meeting this was explored further with respect to visibility of DOMs and will be taken up by Jon Edwards.
 - The CSD cultural matters were discussed and as set out below this is now going to be supported by Honne looking at broad cultural issues supported by a Hive survey.
 - Overruns at various locations were discussed.
 - It was felt that trade union colleague shadowing opportunities in LPFs would be beneficial.
8. The **Corporate Partnership Forum** met on 24 January 2024 and members were updated on the following discussions:
 - Further industrial injuries update: Timeliness to be reviewed as well as the policy to ensure realistic timescales. Bitesize training for managers is being developed.
 - Workforce planning: The model was presented, and the forum was updated on engagement to date. The February meeting will include a presentation on the plan.
 - Freedom to speak up: The launch of freedom to speak up and the establishment of guardians and the work in confidence platform was discussed. This was well received, and high level themes were emerging. Some feedback was taken on board on the anonymity of the platform.
 - Service Review: Members were provided with detail on the aims of the service review.
 - Agile working guidance and the flexible working policy were discussed.
 - The Health and Wellbeing Steering Group have reformed and are developing the health and wellbeing plan.
9. There were a number of actions on the action log related to **diesel engine exhaust emissions** and **infection prevention and control** that will now be escalated where necessary to WASPT through the SLT/TU from the National Health and Safety Committee.
10. Similarly, issues related to **cultural concerns in CSD** that has been discussed at previous meetings was closed on the WASPT action log. The support that the People and Culture Team are giving CSD and the work that Honne will do on behaviours was recognised and appreciated. Any escalations on this work will come via the SLT/TU.

RISKS

Risks Discussed: No formal risks discussed from the risk register.

New Risks Identified: No new risks identified.



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IMTP 2024-27 Update	Effectiveness Review	ACAS Actions Update
SLT TU AAA report	Corporate Forum AA report	

COMMITTEE ATTENDANCE						
Name	13 April 2023	14 June 2023	30 August 2023	12 October 2023	15 December 2023	19 February 2023
Joint Chairs						
Jason Killens	Chair	Part meeting	Chair	Until 11am	Chair	
Mark Marsden (Unison)		Chair		Chair		Chair
Management Representatives						
Angela Lewis						
Lee Brooks				Mark Harris		Jon Edwards
Rachel Marsh	Alex Crawford					
Chris Turley						
Andy Swinburn			Part meeting			
Estelle Hitchon						
Trish Mills						
Trade Union Representatives						
Unite representative	Paul Seppman	Paul Seppman	Paul Seppman		Paul Seppman	
Unite representative	Hugh Parry		Hugh Parry	Hugh Parry		Hugh Parry
Unite representative	Christian Fox Carl Jones	Christian Fox	Christian Fox		Christian Fox	Christian Fox
GMB representative	Sharon Thorpe	Sharon Thorpe		Ian James		
GMB representative	Maldwyn Jones	John Phillips	Maldwyn Jones		Maldwyn Jones	Maldwyn Jones
GMB representative	Marcus Viggers	Marcus Viggers		Marcus Viggers	Marcus Viggers	
Unison representative	Rob Morgan	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrard
Unison representative	Bethan Williams	Bethan Williams		Bethan Williams	Bethan Williams	Bethan Williams
Unison representative	Damon Turner	Damon Turner	Damon Turner	Damon Turner	Keith Rodgers	Damon Turner
RCN representative						
RCN representative						
RCN representative						

	Attended
	Deputy attended
	Apologies received
	No longer member/Not member



WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (WASPT) ADVISORY GROUP ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees and Advisory Groups (of which WASPT is the sole group) evaluate their effectiveness annually and present an annual report to the Trust Board.
2. As the factors underpinning effective governance can change regular reviews of ensure governance remains fit for purpose. WASPT members agreed that with the reinstatement of the group in 2023 that an effectiveness review would be welcomed to review operating arrangements.
3. The Committee met on 19 February 2024 and reviewed its terms of reference, responses to questionnaires completed by members, and its operating arrangements. Discussions were also held with the Joint Chairs ahead of that meeting to inform proposed changes.
4. This Annual Report reflects on the effectiveness of WASPT in 2023/24 and proposes changes to terms of reference.

PURPOSE OF WASPT

5. WASPT is the forum where senior leaders, trade union partners and professional organisations work together to improve the Trust's services for the people of Wales. It is the principal partnership forum for the discussion of national priorities and strategies and where key stakeholders will engage with each other to inform, debate, and seek to agree priorities on workforce and health service issues.

6. WASPT provides the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership apply.

MEMBERSHIP AND ATTENDANCE

7. WASPT met six times as scheduled in 2023/24 and was quorate on each occasion.
8. WASPT membership consists of eight management members and twelve trade union partner members. Meetings are Chaired on rotation between the management and trade union partner members.
9. Trade union membership includes three seats for each of the four recognised trade unions (GMB, RCN, Unison and Unite). The chart below illustrates attendance of members as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings.

COMMITTEE ATTENDANCE						
Name	13 April 2023	14 June 2023	30 August 2023	12 October 2023	15 December 2023	19 February 2023
Joint Chairs						
Jason Killens	Chair	Part meeting	Chair	Until 11am	Chair	
Mark Marsden (Unison)		Chair		Chair		Chair
Management Representatives						
Angela Lewis						
Lee Brooks				Mark Harris		Jon Edwards
Rachel Marsh	Alex Crawford					
Chris Turley						
Andy Swinburn			Part meeting			
Estelle Hitchon						
Trish Mills						
Trade Union Representatives						
Unite representative	Paul Seppman	Paul Seppman	Paul Seppman		Paul Seppman	
Unite representative	Hugh Parry		Hugh Parry	Hugh Parry		Hugh Parry
Unite representative	Christian Fox Carl Jones	Christian Fox	Christian Fox		Christian Fox	Christian Fox
GMB representative	Sharon Thorpe	Sharon Thorpe		Ian James		
GMB representative	Maldwyn Jones	John Phillips	Maldwyn Jones		Maldwyn Jones	Maldwyn Jones
GMB representative	Marcus Viggers	Marcus Viggers		Marcus Viggers	Marcus Viggers	
Unison representative	Rob Morgan	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrard
Unison representative	Bethan Williams	Bethan Williams		Bethan Williams	Bethan Williams	Bethan Williams
Unison representative	Damon Turner	Damon Turner	Damon Turner	Damon Turner	Keith Rodgers	Damon Turner
RCN representative						
RCN representative						
RCN representative						

	Attended
	Deputy attended
	Apologies received
	No longer member/Not member

10. Attendance is steady and the group recognises the importance of consistent membership across the trade unions wherever possible to aid in the flow of information, but also acknowledges that this can be difficult to achieve with shifts

etc., and that there is a need for some flexibility. One RCN member has now been identified to join WASPT.

11. No changes to membership are proposed at this stage.

VIEWS ON EFFECTIVENESS

12. WASPT's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Joint Chairs, and at the 19 February meeting.

13. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Twenty six questionnaires were sent out with 12 responses being returned (a 46% return rate with an equal split between management and Trade union partner members).

14. Respondents were asked three questions:

14.1. What is WASPT doing well:

Responses indicated that WASPT:

- Allows for organisational issues to be discussed.
- Provides a vehicle for relationships to grow.
- Is a good demonstration of partnership working.
- Allows for free flowing discussions.
- Is effective in covering some challenging issues.
- Covers issues in a timely way.
- Has a meeting structure that flows well and frequency and timing is appropriate.
- Reports via the People and Culture Committee which enables the Board to be engaged.
- Is well chaired.
- Gives everyone the opportunity to engage.

14.2. What improvement could be made to the meeting or arrangements:

Responses indicated that improvements could be made in decision-making arrangements, time allocation, agenda management, and communication – specifically:

- More time needs to be allocated to meetings (feels rushed).
- Ensure agenda is relevant.
- Factor in a break.

- Focus on the item on agenda and not conflate items.
- Review meeting frequency
- Review how things are moved on outside the meeting.
- Ensure AAA appropriate for trade union partners to communicate to their members.
- Decision making with a strong link between WAST management and senior trade union representatives has not been happening.
- Keep meeting in person; alternate between in person and online.
- Mix up seating of members and not talk about 'sides' – more unification.
- Personal relationship issues should be resolved outside of WASPT to aid effective working.

14.3. What training and development needs are there for WASPT/members:

Training and development needs for WASPT members include committee effectiveness, relationship building, and understanding of finances and reports – specifically:

- Trade union/management training to start.
- Trade union and management relationship.
- Committee and meeting effectiveness.
- Finances and interpreting various reports.
- Understanding of roles.
- Communication skills.
- NED membership and reporting to Board.
- Separate governance inductions.
- Programme of development specific to WASPT.
- Executives need to be more visible to the shop floor and the lived experience.
- Be less defensive when hearing from staff and take views seriously.
- Need to hear more feedback from corporate forums – very ops focused.

15. Whilst some matters can be timed into the meetings for the year, the nature of WASPT is that it can be difficult to develop a predictable cycle of business. Having said that, the agenda is set with the Joint Chairs and the Board Secretary in advance with reference to the action log, escalations and reporting from the local partnership forum structures approved in 2023, and any issues that would benefit from a partnership discussion. WASPT's discussed the following in 2023/24:

- (a) Establishment of the **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 includes an 'Operations Stream' and a 'Corporate Stream'. Reporting on both sub-structure streams was provided throughout the year and issues escalated where necessary.

- (b) In April 2023 the **IMTP 2023-26** was discussed as was the challenging revenue and capital financial plan for 2023/24 and the knock on effect of the reduced fleet replacement programme.
- (c) In February 2024 the **IMTP 2024-27** was discussed with members engaged on the developing plan for approval by the Board in March 2024.
- (d) Several **issues were discussed** in detail, some over multiple meetings, and were subsequently reported to the People and Culture Committee on the AAA report. These included:
- Portering of patients
 - Diesel engine exhaust emissions
 - Six week relief
 - Revised pay offer and WAST specific annex
 - EMS establishment
 - Overtime restrictions
 - Study leave
 - Hive survey
 - Infection Prevention and Control Policy
- (e) Updates were provided on progress against the **actions agreed in partnership with ACAS** in 2022 and developing work with agreed target dates ranging with completion from September 2023 to June 2024. Those agreed actions are as follows:
- Complete move to WASPT and substructure, noting that is now complete and operational.
 - Workshop session on best practice (will inform partnership principles).
 - Develop partnership principles to support partnership statement.
 - Redevelopment partnership statement.
 - Develop trade union session for WAST warm welcome.
 - Rolling programme of Working Together sessions for managers and Trade Union partners.
 - Develop mentoring, coaching, and shadowing programme to share perspectives and experiences.
 - Post-meeting reviews.
 - Develop consultation sheet for managers/TUPs.

Actions are being progressed through a series of workshops with local representatives and local managers, with representation from the Chief Executive, Director of People and Culture, Trade Union Chair and Secretary. WASPT will continue to monitor progress.

(f) The **annual effectiveness review** was conducted at the February 2024 meeting.

16. The People and Culture Committee receive a highlight report from WASPT following each meeting. The Committee includes reference to this in their report to the Board. The Joint Chairs are invited to the People and Culture Committee and some of the WASPT trade union partner and management members are prescribed attendees. From February 2024 the approved minutes of WASPT will also be included in the Committee's open meeting pack.

17. The Trust Board Chair and Joint Chairs meet quarterly to discuss any issues that may arise and to keep the Trust Board Chair informed.

18. In addition to the regular bi-monthly meetings of WASPT, the following has taken place because of issues raised/matters discussed in WASPT:

- (a) Insights Preferences session.
- (b) EMS Establishment information session.
- (c) Financial Sustainability Programme quarterly updates.
- (d) Partnership Development Meeting.

SUB-STRUCTURES

19. WASPT is serviced by the operational and corporate sub-structures established in 2023. Those groups are meeting regularly and reporting in to WASPT by way of a AAA report, escalating issues where they are unable to resolve them at a local level.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

20. The WASPT Terms of Reference were revised in March 2023 shortly after the group was reconstituted. Therefore, changes are minor and include:

- 4.2 – removal of reference to review of trade union partner numbers in membership. However, trade union partner Chair will review membership to ensure that it is representative as far as possible of all major work groups and professional bodies at WAST as per the Terms of Reference.
- 5.2 – it had been anticipated that meetings might change to quarterly following the establishment of the local partnership forums, however following feedback

from the survey it is agreed that meetings will be retained on a bi-monthly cycle.

- 7.3 – codifies the position with respect to minute taking and aligns to the timetable for Board and Committee drafts.

21. The changes in the Terms of Reference are marked up in Annex 1.

22. In response to the issues raised in the survey there will be some changes to operating arrangements which include:

- Encouraging trade union partner members and management members to disburse themselves around the table during in person meetings.
- Provision of the minutes of WASPT as well as the AAA report to the People and Culture Committee in open session.
- In addition to the AAA report from WASPT being circulated to members, consideration will be given to a 'hot topics' newsflash that could be circulated by email and included on Siren. This will draw from the AAA and include a link.
- In addition to retaining the two hour bi-monthly in person meeting, an additional one hour slot will be included for a workshop on a single issue of importance. This will include a lunch break which will be a good opportunity for members to get to know each other better. This will be scheduled in as soon as possible in diaries.
- Issues raised in the survey such as the desire to walk in each other's shoes, strengthen links between Trade union partner and management members, and working on personal relationships will be addressed in different operating arrangements, but also from the partnership working development sessions that have taken place and are planned as part of the ACAS action plan.
- There is a Board Visits Standard Operating Procedure in place where Executive and Non-Executive Director visits to our people are shown. This is available for all staff at this Link (Board Member Visits Dashboard (sharepoint.com)) and is reviewed quarterly by the Executive Leadership Team and Trust Chair, and reported in open Board session annually.
- Where it is identified that the agenda may restrict timing of an item, whether that be in the agenda setting meeting with the joint chairs or the trade union partners pre-meet, the Board Secretary will review the overall timing and adjust where appropriate and with the agreement of the Joint Chairs.
- On training and development needs identified, there is a trade union partners and Board and Committee Chairs joint session agreed. Additional sessions will include:
 - How to run effective meetings.

- Committee specific induction programmes on roles and responsibilities.
- Financial reporting session.
- Introduction for individual trade union partners and staff who wish to observe Board and Committee meetings for succession or other reasons.

PRIORITIES

23. Given the nature of the issues before WASPT, which are usually topical and emerging, it was felt that it would not be appropriate to set priorities for WASPT for 2024/25. However, the focused agenda setting meetings and agile nature of preparation for meetings will continue as standard practice.

RECOMMENDATION

24. The Trust Board is requested to
- (a) Receive and note the contents of the WASPT Annual Report for 2023/24 and analysis of its effectiveness; and
 - (b) Approve the changes to the Terms of Reference.



Required Action

1. Additional opportunities for **hands on practice** within the continuous improvement-based EMT1 Scheme of Work, to improve the learner experience further
2. Continue to invest time and effort required to position WASUT learners to be recognised in **external awards events**
3. Raise the profile of the work of **Education & Development** across the Trust
4. Ensure career paths and opportunities available within the Trust are clearly articulated in our **People Development Plan**



Next Steps

Our next intake of Higher Apprentices is scheduled for Late April 2024, they will swiftly be joined on their HA journey by a further intake in May 2024.

As a Trust, we are assisting Health Education and Improvement Wales (HEIW) to steer development of Apprenticeship programmes across the NHS in Wales and look forward to commencing delivery of our own Call Handler Apprenticeship framework across 111, EMS Co-ordination and Non-Emergency Transport this FY.



Themes

- Trust roles can provide a second chance at a **career**
- **Celebrating success** using external awards is highly valued
- Education & Development function key to **career progression**

Darren's Story

Darren is a newly qualified EMT2 who joined WAST in September 2020 after working in various private and public sector jobs, including the leisure industry. Darren had applied to WAST 13 years ago but had to decline the offer due to family reasons. He was always interested in working for the service and was delighted to get another opportunity.

Darren completed the EMT1 Higher Apprenticeship Induction Programme which comprises the following qualifications: Level 4 Diploma for Associate Ambulance Practitioners, Level 3 Certificate in Emergency Response Ambulance Driving, Level 2 Essential Digital Literacy Skills and a number of Welsh at Work, and Apprenticeship related certifications.

He was determined to excel on the course and achieved the highest marks possible across all aspects of his studies. He also won the Skills Academy Wales Higher Apprentice of the Year Award for his achievement. Darren enjoyed the course and praised the tutors, the resources, and the venue. He suggested that more practical work on site would have been beneficial, especially for such a high-profile job. Darren told members that he is happy to work for WAST and appreciates the policies, procedures, development, and support that the organisation offers. He is also applying for the Part Time BSc Paramedic Science programme, which he did not expect to have a chance to do



PEOPLE AND CULTURE COMMITTEE HIGHLIGHT REPORT TO BOARD

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

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

Trust Board Meeting Date	20 February 2024
Committee Meeting Date	28 March 2024
Chair	Paul Hollard

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts from this meeting, however the meeting had a deliberate focus on **equality, diversity and inclusion (EDI)**, with the first part of the meeting exclusively given over to this important topic. The Chair welcomed other Board members to the meeting for this spotlight.

ADVISE

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

2. There was a package of information at the meeting that **focused on EDI** and its importance in the People and Culture Plan.
 - (a) The Committee heard of progress which included active bystander and allyship training, policy development, governance changes, leading on sexual safety, and carers passport were highlighted. The final **Strategic Equality Plan 2024-2028** was presented to the Committee and is before the Board at its March meeting for approval. **The Committee endorsed the plan** and reiterated the need to ensure implementation includes SMART actions and is outcome-focused to demonstrate the impact of the initiatives to the lives of our people. It was noted that the performance reporting on cultural themes and workforce KPIs will draw out that impact and the themes, but that work is required to ensure they are connected in a way that the Committee and the Board can see progress of these important initiatives. The role of Non-Executive Directors (NEDs) as champions was also discussed and Hannah Rowen, EDI NED champion sought to have more guidance on how she and other NEDs might most appropriately support initiatives throughout the year, over and above monitoring the plan.



- (b) The **Annual Workforce Equality Monitoring Report for 2022/23** and the annual **Gender Pay Gap Report 2022/23** were presented and are before the Board at its March meeting.
- (c) **The Anti-Racist Wales Action Plan** update was received. The report gave assurance to the Committee on the progress made to date and further actions required and their management within the People & Culture Directorate. Going forward, Welsh Government expect the Trust to provide bi-annual updates on progress against the ARWAP with the Strategic Equality Plan, as part of the NHS Wales Performance Framework Policy Assurance reporting.
- (a) The Welsh Government's annual report on the **More Than Just Words Action Plan for 2022/23** was presented to the Committee. Updates were also received on the Welsh Language plan for the IMTP 2024-27 and progress on initiatives in 2023/24. Members commended the work and the focus on Welsh language.
3. Key progress was celebrated with the **Director of People and Culture** and the **Quarterly Operations Directorate updates**. The Committee noted:
- A joint WAST and NWSSP Legal and Risk session was held recently on sexual safety to over 140 colleagues across NHS Wales and other organizations. Angela Lewis highlighted the importance of culture and psychological safety in light of the recent publication of the ambulance services in England culture review. WAST has been shortlisted for the CIPD Wales Awards for Equality and Diversity in relation to this work.
 - Angela Lewis attended a CPD day for student paramedics at Glendale University and was impressed by their positive feedback and support from WAST colleagues.
 - A recent Trade Union and management colleagues' workshop was positive.
 - HEIW have funded a Retention Lead role for two years which has been filled and they will look to understand the trends of why people are leaving the service, and link this back to initiatives to mitigate that.
 - The recruitment of a resourcing, rostering systems manager who will help to improve the workplace experience for staff and managers by working on the electronic solutions for timesheets and interfaces was welcomed.
 - The introduction of the five week roster and the possibility of moving to six weeks in the future.
 - The reconfiguration of EMS coordination and the creation of a career structure from band 3 to band 8B, with the support of additional budget.
 - The recognition of EMSC staff through the EMD of the year process, with many shortlisted and some winners.
4. **Darren Anthony** joined the meeting to share his story. Darren is a newly qualified EMT 2 who joined WAST in September 2020 after working in various private and public sector jobs, including the leisure industry. Darren had applied to WAST 13 years ago but had to decline the offer due to family reasons. He was always interested in working for the service and was delighted to get another opportunity. Darren completed the Level 4 diploma for Associate Ambulance Practitioners, which is an accredited education program for EMT 2 roles. He was determined to excel on the course and achieved the highest marks. He also won the Skills for Health Apprentice of the Year Award for his achievement.



Darren enjoyed the course and praised the tutors, the resources, and the venue. He suggested that more practical work on site would have been beneficial, especially for such a high-profile job. Darren told members that he is happy to work for WAST and appreciates the policies, procedures, development, and support that the organization offers. He is also applying for the paramedic qualification, which he did not expect to have a chance to do.

The committee members congratulated Darren on his achievements and asked him some questions about his experience and challenges. They also thanked him for his time, determination, commitment, and enthusiasm.

5. The people and culture elements of the **IMTP 2024-27** were reviewed with members requesting a focus on evaluating impact of initiatives and the markers of success.
6. The **draft Health and Well-being Plan 2025-2029** was received for comment. The draft plan set out the principles for the approach to improving the health and well-being of our people and to provide strategic leadership to the Trust's health and well-being activities. The Committee noted that a consultation process with various stakeholders is planned to inform its development, and that a holistic approach to the plan will be taken as opposed to focusing just on individual well-being support initiatives. The Committee asked that the Well-being Team consider the accessibility of the document to ensure it's easy to understand and apply.
7. The Committee held its **annual effectiveness review for 2023/24** and agreed changes to its terms of reference and focus for 2023/24. The annual report and proposed changes will be reviewed by the Audit Committee in April and the Board in May.
8. The Committee were pleased to **approve two policies**, those being the All Wales Flexible Working Policy and the Homeworking Policy.
9. **Reflections** on this hybrid meeting included the fact that this was the Chair's (Paul Hollard) last People and Culture Committee meeting. Angela Lewis and others thanked Paul for his support of them personally, but also the attention and focus he has given people and culture issues, noting that he had been instrumental in the establishment of the Committee. Paul himself commented on the changes he has seen and the inclusion now of the impact of our culture and behaviours. Osian Lloyd, Head of Internal Audit, also joined the meeting in person which was welcomed.

ASSURE

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

10. The **metrics** proposed to measure the impact of the **People and Culture Plan** were presented under the Plan's headings of Culture, Capacity and Capability giving a holistic evaluation of the Plan's effectiveness in enhancing organisational culture, fostering a sense of belonging and optimizing the capabilities of our people. The themes reflected the Plan's goals of improving organisational culture, creating a sense of belonging and developing the skills of our people. Members commended the approach and noted that whilst what our people are telling us is sometimes difficult to hear, it is important that we show we are listening and responding. Members highlighted the progress made in the last 18 months, such as:



- Having richer and more frequent feedback from staff and students through surveys and roadshows.
- Increasing the awareness and reporting of employee relations issues, such as culture reviews and grievances, and supporting people to come forward and raise concerns.
- Engaging the executive leaders in regular discussions and actions on people and culture metrics and challenges.
- Applying compassionate practices for individuals affected by organisational changes or employee relations processes.
- Reducing sickness absence rates in some regions and learning from their best practices.
- Promoting proactive health surveillance and addressing the main causes of absence, such as mental health and musculoskeletal problems.

The report also acknowledged the areas where more work was needed, such as:

- Building trust and confidence among staff and students to speak up and share their views.
- Ensuring that all colleagues feel safe and respected in the workplace.
- Achieving the target of 6% sickness absence by April and maintaining it.
- Continuing to monitor and improve the impact of the People and Culture Plan on organisational performance and wellbeing.

11. The **Monthly Integrated Quality and Performance Report** ("MIQPR") and the **Q3 Quarterly Workforce KPIs** show that continued system pressures including handover delays remain a significant pressure on our people. The Committee noted a welcomed increase in PADR (Personal Annual Development Review) and the focus of the senior leaders on improving statutory and mandatory training compliance. It was noted that sickness absence in 111 is high and that there is a cultural review underway to look at this. Low vaccination rates among patient-facing staff was a concern. Members noted good performance on unit hours produced and abstraction rates. An action was raised for the Quality, Patient Experience and Safety Committee to look at the way in which CHARU is mobilized given the utilization rates.

12. **WASPT highlight report** was received following their meeting on 15 December 2023, with members noting discussions related to:

- The EMS establishment with an agreement that emergency ambulance lines would not be taken down but that a one off relief gap created.
- Detailed discussion following a report with the results of air monitoring for diesel exhaust emissions at seven emergency departments in Wales and the actions taken to reduce exposure and the risk to staff.
- Agreement on an approach to the IPC Policy with regard to carrying snacks, as well as other IPC related issues.
- The actions agreed in partnership with ACAS in 2022 are on track.
- The sub-structures establishes to report into WASPT are doing so with escalations making their way through where appropriate.

13. In private session the Committee reviewed progress on four **suspensions over four months** (an increase from the previous quarter) and two cases lodged with the **Employment Tribunal** (a decrease



from the previous quarter). Members were assured on actions in place to manage these cases and an action was raised to ensure a consistent approach on payment during suspension.

- 14. The **Audit Tracker** was reviewed, and the Committee noted good progress in closing off items.
- 15. The reasonable assurance **Retention of Staff Internal Audit** report was received, with key matters arising including finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention. The roll out of moving on interviews was welcomed.
- 16. The Committee's **cycle of business** is on track with no escalations required.

RISKS

Risks Discussed: The four risks within the remit of this Committee were reviewed as 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). Whilst good progress is being made to reduce sickness absence, a decision has been made to keep the risk rating under review. The controls and assurances have been strengthened and a suite of new mitigating actions have been identified during the last review.

201 – Damage to the Trust's reputation following a loss of stakeholder confidence remains at 20 (4x5). Whilst the score remains unchanged and remains high, the risk has been strengthened to describe the difficulties in progressing the Trust's long term strategic ambition because of lack of stakeholder confidence and support. Additional controls and mitigations have been articulated to support this change.

163 – Maintaining effective and strong Trade Union partnerships increased remains at a score of 16 (4x4). Additional mitigating actions reflecting the WASPT effectiveness review, the new ToR and operating arrangements for the group were discussed and it was noted that the actions detailed in the ACAS action plan will be aligned to this risk in the next review.

Risk **558** (deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences) remains unchanged and scores 15 (3x5).

The Committee discussed risks **223 and 224** and noted the dynamic and consistent review of these risks across the Trust ensuring synergy between both.

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

COMMITTEE AGENDA FOR MEETING

Director of People and Culture Development Update and Operations Quarterly Report	Staff Story	Strategic Equality Plan
Annual Workforce Reports (Equality Monitoring Report 22/23 and Gener Pay Gap 22/23)	Anti-racist Wales Action Plan	WG More than just words annual report



Workforce priorities related to IMTP	People and Culture Plan metrics (to include cultural themes – priorities for 24/25)	Workforce scorecard and MIQPR
Risk management and BAF	Health and wellbeing plan	Annual effectiveness review
Audit tracker and Retention of staff internal audit	All Wales Flexible Working Policy	Homeworking Policy
WASPT Highlight report	Cycle of business monitoring report	

COMMITTEE ATTENDANCE				
Name	9 MAY 2023	8 AUGUST 2023	16 NOVEMBER 2023	20 FEBRUARY 2024
Paul Hollard				
Bethan Evans				
Joga Singh				
Hannah Rowan				
Angela Lewis	Liz Roberts			
Chris Turley				
Lee Brooks	Judith Bryce			
Estelle Hitchon				
Andy Swinburn				
Jonathan Turnbull-Ross	Liam Williams	Liam Williams		
Alex Crawford	Hugh Bennett			
Trish Mills				
Damon Turner				
Paul Seppman	Hugh Parry			Hugh Parry
Ian James				
Tim Chalane				
	Attended			
	Deputy attended			
	Apologies received			
	No longer member			