West Midlands Ambulance Service
University NHS Foundation Trust

AGENDA

TITLE OF MEETING: Meeting of the Board of Directors

Wednesday 27 January 2021 at 10.00 hours
In view of the current National Emergency and the guidance on maintaining social distancing this meeting will be convened by electronic means through Microsoft Teams software.

Membership

Prof. I Cumming*****	Chair	Non Executive Director (Chairman)
Mr A C Marsh*****	CEO	Chief Executive Officer
Mr A Yeaman*****	TY	Non Executive Director (Deputy Chairman)
Mr C Cooke*	CC	Director of Strategic Operations and Digital Integration
Mr M Docherty*	MD	Director of Nursing and Clinical Commissioning
Ms W Farrington Chadd*	WFC	Non Executive Director
Mr M Fessal*	MF	Non Executive Director
Mr M Khan*	MK	Non Executive Director
Mr V Khashu	VK	Strategy & Engagement Director
Mrs N Kooner*	NK	Non Executive Director
Mr M MacGregor	MM	Communications Director
Mrs L Millinchamp*	LJM	Director of Finance
Mrs K Nurse*	KN	Director of Workforce and Organisational Development
Mrs C Wigley*	CW	Non Executive Director
Dr A. Walker*	AW	Medical Director

* Denotes a voting member appointed pursuant to the Constitution of the West Midlands Ambulance Service NHS Foundation Trust

Directors are reminded to submit their apologies in advance of the meeting.

In attendance

Ms Lisa Bayliss Pratt	LBP	NED appointee & observer
Ms C Beechey	CB	People Director (Designate)
Ms Claire Finn	CF	Director of Finance (Designate)
Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Mr P. Higgins	PH	Governance Director & Trust Secretary
Mr S Gardner	SG	Staff Side Representative
Mr A Proctor	AP	EPRR & Quality Improvement Director
Mr J Williams	JW	Tactical Incident Commander Lead
Mr A Deakins	AD	Paramedic

All attendees to this meeting must be aware that access may be given to all minutes and associated documents under the Freedom of Information Act 2000.

Item No	Description	Lead	Paper No/ Comments
01	**Welcome, apologies and Chairman's matters**	Chairman	Verbal
02	**Patient/Staff Experience** **a) Operation Durga – Feedback** **b) Handover delays – Staff Perspective**	CEO	Presentation Verbal
03	**Declarations of Interest**		
	To declare any conflict of interest members may have in any matters contained within the agenda for this meeting.	Chair	Verbal
04	**Any Questions from the Public relating to matters to be discussed at this Board of Directors meeting.**	Chair	Verbal
05	**Board Minutes**		
05A	To agree the Minutes of the meeting of the Board of Directors held 28 October 2020	Chair	Paper 01
05B	Board Action Log	Chair	Paper 02
05C	To confirm the action already taken by the Board of Directors pursuant to Standing Order 4.10.2 "Written motions" – **Approval to publish The WRES Data analysis** The Wres Data Analysis and appendices attached were required to be published by no later than the end of December 2020. As a consequence the Chairman agreed that given the timescales for publication the Board's review of the content and endorsement to publish the documents should be undertaken by written motion. The Board are now requested to confirm the action taken in confirming the publication of the WRES Data and appendices by the deadline.	Trust Secretary	Papers 03 a, b & c
06	**Ockenden Report - WMAS Action plan**		
	This report presents the assurance and actions required of WMAS following the publication of the Ockenden Report on 10th December 2020	Director of Nursing and Medical Director	Paper 04
	Action a) The Board are requested to note the Report b) Approve the Action Plan c) Agree that reporting against the Action Plan will be through the Professional Standards Group and Quality Governance Committee		

Item No	Description		Lead	Paper No/ Comments
		d) Identify a Non-Executive Board Level champion.		
07	**Chief Executive Officers Update Report**			
	To receive the report of the Chief Executive Officer.		CEO	Paper 05
	Action	To note and determine as appropriate the matters contained within the report.		
08	**Director of Finance Report**			
	To receive a report from the Director of Finance.		Director of Finance	Paper 06
	Action	To receive the report		
08a	**Ambulance Fleet Procurement**			
	Action	To authorise the procurement of replacement ambulance vehicles	Director of Strategic & Digital Integration	Paper 06a
09	**Quality Report**			
	To receive a report of the Director of Nursing and Medical Director including Serious Incidents Update and Learning from Deaths Report.		Director of Nursing and Medical Director.	Paper 07
	Action	To receive the report		
10	**Director of Workforce & Organisational Development Report**			
	To receive a report of the Director of Workforce & Organisational Development		Director of Workforce & Organisational Development	Paper 08
	Action	a) To receive the report and seek clarification as necessary. b) Consider and approve the content of the attached Board Skills Matrix for publication in the Trust's Annual Report 2020 / 2021.		
11	**Operational Performance Report**			
	To receive a report from the Director of Strategic Operations and Digital Integration		Director of Strategic Operations and Digital Integration	Paper 09
	Action	To receive the report		
12	**Draft Operating Plan and Integrated Care System development update**			
	Action	To receive and note the report.	Strategy & Engagement Director	Paper 10
13	**Strategic Plan Development - Update**			

Item No	Description		Lead	Paper No/ Comments
	Action	To receive and note the update	Strategy & Engagement Director	Paper 11
14	**Board Assurance Framework**			
	Action	To receive and approve the BAF	Director of Strategic Operations and Digital Integration	Paper 12
15	**Quality Improvement Framework Process**			
	Action	To receive and note the report	EPRR & Quality Improvement Director	Paper 13
16	**Board Committee Meeting Minutes**			
	Action	a) Audit Committee - To receive the Minutes of the Meeting held on the 23rd September, and 10th November 2020. b) Quality Governance Committee - To receive the Minutes of the Meetings held on the 19th October 2020. c) People Committee - To receive the Minutes of the Meeting held on 17th September 2020	Chair of Committee	Paper 14a Paper 14b Paper 14c
17	**New or Increased Risks Arising from the Meeting**			
	Action	To receive and note the risks	Chair	Verbal
18	**Board of Directors Schedule of Business**			
	To include the Council of Governors Schedule of meetings and Development Sessions			Paper 15
	Action	To review and note the Board Schedule of Business	Secretary	
19	**Any Other Business** (previously notified to the Trust Secretary)		Chair	
20	**Review of Guiding Principles**		Secretary	Circulated by email for response
21	**Date and time of the next meeting:** **The next meeting will be on** **Wednesday 31st March 2021 at 14:00 hours**		Chair	

Please note: Timings are approximate.
Preferred means of contact for Any Other Business items:
Phil Higgins, Trust Secretary (phil.higgins@wmas.nhs.uk)

Minutes of the Meeting of the Board of Directors held on 28 October 2020, at 1000 hours, via Microsoft Teams

Present:

Prof I Cumming*	Chair	Non-Executive Director (Chair)
Mr A C Marsh*	CEO	Chief Executive Officer
Mr A Yeaman*	AY	Non-Executive Director
Mrs C Wigley*	CW	Non-Executive Director
Mr M Khan*	MK	Non-Executive Director
Mrs N Kooner*	NK	Non-Executive Director
Mrs L Millinchamp*	LJM	Director of Finance
Mr M Docherty*	MD	Director of Nursing & Clinical Commissioning
Mr M MacGregor	MM	Communications Director
Mr C Cooke*	CC	Director of Strategic Operations & Digital Integration
Mr V Khashu	VK	Strategy & Engagement Director
Dr A Walker*	AW	Medical Director

***** Denotes a voting member appointed pursuant to the Constitution of the West Midlands Ambulance Service NHS Foundation Trust

In attendance:

Mr P Higgins	PH	Trust Secretary
Miss K Freeman	KAF	Private Secretary
Mr S Gardner	SG	Staff Side Representative
Ms C Beechey	CB	Head of HR

ITEM	Board of Directors Meeting – 28 October 2020	ACTION
10/20/01	**Chairman's Introductions, Apologies and Announcements**	
	Apologies were received from Mrs Jacynth Ivey, Mrs Wendy Farrington-Chadd, Mr Mohammed Fessal and Mrs Kim Nurse. The Chairman informed the Board that the Trust has following a very robust appointments process led by the Chairman and Governors and that the Trust has made two excellent Non-Executive Director (NED) appointments. Lisa Bayliss-Pratt a nurse by background and Pro-Vice-Chancellor at Coventry University will be joining the Trust on 1 April 2021. Mrs Bayliss-Pratt will be joining Board Meetings from January 2021 as an observer and as part of the induction process. The Chairman was delighted to announce that Mohammed Fessal has also been appointed as NED. Mr Fessal was known to the Trust through his placement under the NHSI NEXT Scheme. Mr Fessal will now be an Associate NED until he takes up a voting role on 1 January 2021 when Mrs Ivey steps down from the Board. The Chairman explained that Carla Beechey has been appointed as the new People Director and takes up post on 1 April 2021.	

	The Chairman informed the Board that the revised Governance arrangements agreed by the Board in July have now been implemented and the Governors have agreed to the changes to its membership which means that the public elected Governors has reduced by a third, the appointed Governors have been reduced to two and staff governors numbers remain unaltered. The relevant changes are being made to the Constitution.	
10/20/02	**Declarations of Interest**	
	There were no conflicts of interest declared by anyone attending the meeting in relation to any matters on the agenda.	
10/20/03	**Questions from the Public**	
	There were no questions from the Public. The Chairman pointed out the need to consider how we maintain transparency and probity by not meeting in public during the period of the pandemic. We are continuing to publish the non confidential papers on the website and we also invite questions from the public at Board meetings. There was the suggestion that the Chairman and Chief Executive Officer would post something on the salient decisions taken and publish it on the website. The alternative suggestion was that the Trust considers streaming the meeting in a similar fashion to the Annual Meeting. The Director of Strategic Operations & Digital Integration was happy to work on a technical solution with the Trust Secretary and Communications Director. The Strategy & Engagement Director suggested the Trust looks at best practice from other Trusts in terms of maintaining transparency of public meetings in the current climate. The Chairman explained that NHS England have now moved to a situation where they record their Board Meetings and then put it on their website along with the agenda. The Chairman asked the Communications Director, Strategic Operations & Digital Integration Director, Trust Secretary and Strategy & Engagement Director to meet and consider options for how this could be done differently. Update to the next Board Meeting.	
	Resolved:	
	a) That the Communications Director, Strategic Operations & Digital Integration Director, Trust Secretary and Strategy & Engagement Director to meet and consider options for how this could be done differently. Update to the next Board Meeting.	**MM/CC/ PH/VK**

10/20/04	**Board Minutes – 27 May 2020**	
	The minutes of the meeting held on 27 July 2020 were submitted.	
	Resolved:	
	a) That the minutes of the meeting held on 27 July 2020 be approved as a correct record subject to the following amendment: • 7/20/03 – The BAME presentation was provided by Members who sit on the ONE Network rather than from the ONE Network.	
10/20/05	**Board Log**	
	The Board Log that contains the schedule of matters upon which the Board have asked for further action or information to be submitted. Matters on this log can only be deleted through resolution of the Board. (For the avoidance of doubt unless specified below all matters contained on the Board log will remain on the log until the Board resolves that the matter can be discharged).	
	Resolved:	
a)	In relation to continued minute 07/20/10 – Cyber Security. The CEO had sent the cyber security paper to Mrs Farrington-Chadd. On this basis, it was agreed that the matter could be discharged.	**Discharged**
b)	In relation to continued minute 07/20/13 – Winter Planning. The CEO confirmed that the Winter Plan had undergone an Equality Impact Assessment. The new strategic objectives have been included in the Winter Plan. On this basis, it was agreed that the matter could be discharged.	**Discharged**
c)	In relation to continued minute 07/20/19 – Board Assurance Framework. The Director of Nursing & Clinical Commissioning confirmed that all new and reviewed risks appear on the Risk Changes form for the HSRE Committee. No concerns raised regarding any risks which have not been captured. On this basis, it was agreed that the matter could be discharged.	**Discharged**
10/20/06	**Chief Executive Officer (CEO) Update**	
	A report of the Chief Executive Officer was submitted. The CEO explained that the Data Security Protection Toolkit (DSPT) was submitted on 30 September 2020. Due to the size of the submission this is not included in the papers today but a copy was available from the Trust	

	Secretary. The CEO informed the Board that PTS continue to meet all performance targets and 85% of discharges are being undertaken in less than two hours. In relation to 999 call answering the CEO explained that some of the numbers are concerning and are being monitored. Yorkshire Ambulance Service had a major Covid outbreak in one of their Control Rooms and most Ambulance Services are taking calls for them. The CEO explained that EMB received a report proposing that all permanently employed staff are given an additional annual leave day to complement their ordinary Annual Leave quota. This was in recognition of the work undertaken during the Covid 19 Pandemic. The leave could be taken at any time between the agreed date and the end of the financial year (31 March 2021). This matter has previously been discussed with the Board of Directors who signalled their support and is brought today for ratification by the Board. Mr Gardner thanked the Board for the extra days holiday which will go down well with staff. The Chairman pointed out that last time discussion took place about using this extra day on your birthday day. The CEO confirmed that this was discussed but it did not work. It was agreed by the EMB that the extra day would just be allocated this financial year. The Director of Finance confirmed that the extra day is to be used before 31 March 2021. The CEO confirmed the WRES data was published on the website at the end of August 2020. The Chairman asked if the WRES data was published and the CEO confirmed it was. The CEO explained that cyber security remains a major piece of work for the Trust and one of its top priorities. The CEO explained that the Draft Executive Performance Scorecard is included for review. The version attached has been reviewed and it is submitted for endorsement. If the Board are content it will go live from the next meeting. It is a dynamic document that will develop as the Board sees fit. The Chairman valued comments on the Draft Executive Performance Scorecard and asked Board Members to forward any comments on this to the CEO.	
	Resolved:	
	a) The contents of the papers be received and noted. b) That the Board of Directors endorsed the proposal to provide an extra day's holiday for all permanently employed staff. c) That the Board of Directors endorsed the action of the Chairman & CEO in publishing the WRES data at the end of August 2020. d) That the Board of Directors endorsed the submission of the DSPT at the end of September 2020.	

	e) That any comments on the Draft Executive Performance Scorecard be sent to the CEO.	**ALL**
10/20/07	**Director of Finance Report**	
	The Director of Finance gave an update and reported that an interim financial regime was put in place in response to the Covid-19 pandemic. This system has remained in place up to 30 September 2020 and will continue in a slightly revised format for months 7 to 12 up to 31 March 2021. The Director of Finance confirmed that the Trust has met its required break-even position for the first 6 months of 2020/2021 with an approved Covid reclaim of £20.6m and with no unplanned top-up adjustment required. The Trust has continued to monitor its detailed financial performance against the draft budget that was agreed by the Board of Directors in March 2020. NHSE/I set a separate budget for each organisation under the Block Contract arrangement and the Trust reports the financial position against this budget to NHSE/I monthly. The Director of Finance reported a positive variance against plan of £18.6m due to the agreed Covid re-imbursement. In March, the Board of Directors agreed a Capital Programme of £24.76m for the year but since 1 April 2020 the Trust has been required to work within the allocated Black Country and West Birmingham STP capital envelope. The total of the plans submitted by the STP Provider Trusts and CCGs now agrees to that capital envelope, however the funding position of £12.8m spent by the Royal Wolverhampton NHS Trust to provide additional ward capacity at the beginning of the pandemic remains unresolved and if no Covid capital support is confirmed, the STP organisations will have to meet this cost between them. The trust had already pre-authorised a lot of its plans as the purchase of the Headquarters building at Millennium Point had already been completed, orders for vehicles for the year were already placed and the vehicles were in build, GDE funding requirements had to be met, and urgent IT projects were already underway. Further expenditure on projects to ensure social distancing on Trust sites have also needed to be agreed. On 30 September, the Trust had spent £15.4m of its Capital Programme compared with budget of £15.9m, a shortfall of £0.5m against the planned position which was due to phasing of delivery of vehicles. The Director of Financer informed the Board that the closing cash balance on 30 September was £64.5m against a plan of £22.0m. The balance included the advance payment of £26m received under the interim financial regime and paid to all provider Trusts to ensure that suppliers could be paid promptly during the pandemic to maintain essential supply lines to the NHS. The Trust Debtors' position is also positive against plan by £8m as most of the long-standing debt has been cleared, and this has improved the Trust cash position against plan. At month 6 the Trust had achieved CIP savings	

	of £1.58m which was £11k below plan but still represented 73% of the required total for the year. Mrs Wigley asked about the extra ward capacity at the Royal Wolverhampton Hospital and the impact on the STP capital funding "envelope". The Director of Finance had raised this issue with the Regional Team recently who said it was for the Trust to raise with Commissioners. This had been raised with Commissioners with no positive solution proposed. Mrs Wigley pointed out that as this moves forward the funding impact needs to be brought to the Board as the Board must be involved in these discussions. The Director of Finance agreed. The Chairman asked the Director of Finance to ensure the Board are kept updated. The Chairman noted the Trusts healthy cash position and asked for clarity on the current cash position. The Director of Finance informed the Board that the Trust has always had a strong working cash balance and she expected it to be £30-35M net of capital spending. The Chairman asked if there were any risks in relation to the forecast position. The Director of Finance explained that the prediction of the balance sheet are not always accurate, and accruals, provisions and debtors can improve it. The Director of Finance informed the Board that the financial regime for Months 7-12 will be similar, and this will continue until the end of the Financial Year. The Covid top up funding has now been moved to the local STP and the Trust is aligned to one STP. Estimated additional Covid costs for the 6 months are £13.7m. This reduces the monthly expected top-up to c£2.2m and reflects the decrease in costs for the 111 Surge Cell which are expected to be funded separately. The 2 efficiency adjustments are £1.86m (1%) and £1.2m (additional) which have been shown as reduced Covid expenditure and unidentified CIP, respectively. Additional funding for 111 First was to be excluded as NHSE/I are dealing with this separately. The cost of additional staff required for Winter, Covid and Acute activity increases as discussed at the Board of Directors in July and amounting to £6.3m has been included as an unfunded cost pressure and is one of the deficits making up the overall STP deficit of £27.13m. WMAS Directors are meeting with Regional leaders to press for this funding to be allocated. There is agreement at the STP that if the funding is agreed it will all be offset against the WMAS deficit bringing the Trust plan to breakeven provided that the efficiency gains can be made. The Chairman asked the Director of Finance to keep the Board fully updated on any changes good or bad as this is one of the Trust's key risks.	
	Resolved:	
	a) That the contents of the paper be received and noted.	

10/20/08	**Quality Report**	
	The Director of Nursing & Clinical Commissioning explained that this report is the first presented in the format of an integrated quality report. It is currently a developing report that will be improved over time to reflect all aspects of quality into one report. The report provides a high level of assurance by way of the systems and processes in place to measure and monitor our quality assurance and provides a robust framework to support our clinical quality governance. The Director of Nursing & Clinical Commissioning explained that Statistical Process Control has been included in the Clinical Indicators on page one as an added piece of information. There have been fewer serious Incidents (SIs) this year compared to the previous year. The Trust has struggled with keeping on top of these, but two additional members of staff will be joining the Team to assist with these, and two additional Learning Review Groups have been arranged to review the SIs. Regarding Learning from Deaths, the Trust only has to review a sample of deaths but has reviewed all deaths. The Director of Nursing & Clinical Commissioning informed the Board that the Trust will meet the CQUIN target (90%) for staff flu vaccinations and is currently at 60%. The number of safeguarding referrals has increased. There have been numerous changes to Clinical Pathways. Mr Yeaman thanked the Director of Nursing & Clinical Commissioning and the Medical Director for the excellent report with better data to focus on. The Chairman asked regarding clinical complaints if it was possible to have an update on how many complaints were upheld and how many were not with more information on specific issues. The Medical Director confirmed this was discussed at the Quality Governance Committee (QGC) and she would bring this information back to the next meeting.	
	Resolved:	
	a) That the contents of the report be received and noted. b) That an update on how many clinical complaints were upheld and not upheld and the specific issues would be reported back to the next meeting.	**AW/MD**
10/20/09	**Director of Workforce & Organisational Development Report**	
	A report of the Director of Workforce and Organisational Development was submitted. The Head of HR informed the Board that the People Committee had met for the first time on 17 September 2020 and the matters considered are set out in the attached report. The Trust has vaccinated 59.76% of staff and the final 3,000 vaccines are due on 2 November. Completion of the Staff	

	Survey is currently at 43.9%. The Trade Union Facility Time return was published on 30 September 2020.	
	Resolved:	
	a) That the contents of the report be received and noted.	
10/20/10	**Operational Performance Report**	
	A report of the Director of Strategic Operations & Digital Integration was submitted. The Director of Strategic Operations & Digital Integration informed the Board that the Trusts performance continues to be strong. PTS continue to do an excellent job meeting all operational KPIs on each of its seven PTS Contracts. 111 were under significant pressure in early September but demand had settled to a normal level by the end of the month. The Chairman congratulated and thanked the Director of Strategic Operations and Digital Integration and the entire Team for the level of performance the trust is continuing to sustain at this very difficult time it is very impressive.	
	Resolved:	
	a) That the contents of the report be received and noted.	
10/20/11	**Winter Plan**	
	The Trust's Winter Plan for 2020/21 was submitted. The Director of Strategic Operations & Digital Integration informed the Board that this was the final version of the Winter Plan which had been seen previously. The CEO informed the Board that the biggest concern to the Trust was handover delays. The Director of Strategic Operations & Digital Integration agreed and pointed out that 20% of crews were delayed outside hospitals during the current week. Handovers Delays would be added to the agenda for the next NEDs Meeting for a more detailed briefing. The Chairman pointed out that the Trust could not go into Winter with 20% of its crews delayed at hospitals with the likely impact on patient quality and care. Mr Khan informed the Board that this was an issue discussed at the Performance Committee and he was pleased that it had been raised today. Mr Khan confirmed that the Performance Committee would continue to monitor the situation.	
	Resolved:	

	a) That the contents of the paper be received and noted. b) That approval be given to the Trust's 2020/2021 Winter Plan as submitted. c) That Handovers Delays would be added to the agenda for the next NEDs Meeting.	**PH**
10/20/12	**Freedom to Speak Up Guardian Report**	
	The Director of Nursing & Clinical Commissioning informed the Board that the submitted paper provides assurance to the Board that FTSU is being progressed appropriately and effectively in the Trust. This is through the work and activities of the Guardian supported by the Executive Director (ED) and Non-Executive Director (NED) FTSU Leads, and advocates. Reporting arrangements are detailed, together with regional and national updates. Mrs Wigley explained that she had raised with the CEO that the People Committee has not been receiving details of the concerns raised. The CEO provided Mrs Wigley with the paper that recently went to the Executive Management Board (EMB). It was agreed that this paper should also be submitted to the Board.	
	Resolved:	
	a) That the contents of the report be received and noted.	
10/20/13	**Board Assurance Framework (BAF)& Significant Risks**	
	The Board Assurance Framework and salient Risks was submitted. The Director of Nursing & Clinical Commissioning informed the Board that there have been several changes to the BAF since using the new format, with owner review, risk reduction and escalation to the BAF for several risks pertaining to all Strategic Objectives. All changes are currently in red on the document to ensure ease of identification. It has been noted that there remains confusion around expectation and requirements. Therefore, it has been decided that a more simplified process will be implemented to include a SharePoint site with clear and easy instruction, including simple review to offer greater assurance and simplified reporting. It is expected that this new format will be operational by the end of October, which will also include process notes and a guidance document to each Committee to ensure full understanding of expectations and requirement. The Chairman asked for the BAF to be submitted to the Board on a regular basis to enable the Board to review in detail.	
	Resolved:	
	a) That the contents of the papers be received and noted. b) That the BAF be included on the Board schedule of business.	**PH**

10/20/14	**Commissioning Intentions**	
	The Director of Nursing & Clinical Commissioning explained that there were currently no commissioning cycle at present. The current commissioning financial model is a block contract and it is believed that this will continue going forward. The risk to the Trust is if activity goes up how does the Trust get the resources for this. The whole agenda is around keeping patients out of hospital. The Chairman noted the need to keep this item at the top of the Board's agenda. The impact of commissioning on the Trust and what this will look like in future.	
	Resolved:	
	a) That the contents of the update be received and noted.	
10/20/15	**Cyber Update**	
	The Director of Strategic Operations & Digital Integration informed the Board that the paper provides an update on cyber security activities within WMAS. Specific work areas are highlighted as well as progress against audit activity. The document provides insight to the level of threat from email sources and highlights future activities to continue to defend the Trust against cyber threats. On average, 13% of the email received by WMAS is malicious.	
	Resolved:	
	a) That the contents of the paper be received and noted.	
10/20/16	**Body Worn Cameras (BWC)**	
	The Trust Secretary explained that as part of a commitment to the NHS Long Term Plan, the government announced a funding package for the provision of body worn cameras as part of a pilot within the ambulance sector. The proposals specified that an amount of £8 million over 5 years would be made available to Trusts to undertake a Body Worn Camera trial. The initial pilot split the ambulance services into 3 phases the first of which was due to commence in 2018 /19. In September 2019, in anticipation of receiving funding, the Trust commenced its own small BWC trial by purchasing 30 cameras and locating them in 3 hubs (Erdington, Dudley, Hollymoor). The cost to the Trust for the initial purchase of cameras and associated costs was £15k. In September 2020, as part of phase 2 of the pilot, the Trust received notification that it would receive funding of £215k prior to the end of the 2020/21 financial year. The Trust Secretary pointed out that this needs to be seen in the context of the growing violence and aggression to staff. The Board has a duty of care to its staff and it was felt that BWCs is a deterrent in compiling evidence. There is also an issue with	

	the sentences being received and the use of BWCs will help with this in compiling evidence to assist in prosecutions. Procurement options are currently under consideration. The overall cost of the Body Worn Camera pilot will be reported following the outcome of a tender exercise. Despite the promise of an £8 million commitment, there is no guarantee that further funding will be provided by NHS England either for the purchase of extra cameras or for the ongoing annual storage and warranty costs. The Trust Secretary informed the Board that with effect from 1 November 2020 Safety and Security will be moving to The Strategic Operations & Digital Integrations portfolio to enable implementation operationally. The Chairman pointed out that we talked about complaints and optimal care and need to consider what role BWCs must play if we are looking at how staff have responded. In Johannesburg there is a camera on every resus bed could the Trust use that technology for anything similar to assist with clinical care. The Medical Director confirmed that technology is in place in some Emergency Departments in the UK as well. The Medical Director pointed out that the cameras the Trust are trialling are not suitable band width to capture certain data. As Caldicott Guardian the Medical Director had no issues with this and said this could be looked at going forward. The Director of Strategic Operations & Digital Integration informed the Board that Staff Side would have a view on this. The BWC is activated when the button is pressed the battery life would become a real issue. The BWC is on standby and only activated when there is an issue. The Trust would struggle with storage of data. The Chairman understood this was not possible at this stage but noted this would be kept under review for the future as it became operational. The Chairman was keen to see what could be done in the future. The CEO informed the Board that EMB had discussed this item last week and agreed to keep the board updated. John Kelly attends EMB regularly. An update will be provided for the Board early in the New Year.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That this item would be added to the Board agenda for an update in the New Year.	**PH**
10/20/17	**Board Committees**	
	The paper was as submitted. The draft Terms of Reference for the Board and its Committees were submitted and approved for review by the Committees. Since the last meeting of the Board in July 2020 the	

	Committees have met with a primary task of reviewing the Terms of Reference and "fine tuning" them pending approval by the Board.	
	Resolved:	
	a) That the contents of the papers be received and noted. b) That the Board approved the Governance structure as set out in Appendix A. c) That the Board approved the Terms of Reference attached as appendices B to F to this report: • The Performance Committee • The People Committee • The Quality Governance Committee • The Audit Committee • The Remuneration and Nominations Committee	
10/20/18	**Audit Committee Minutes**	
	The minutes of the Audit Committee Meeting held on 14 July 2020 were submitted.	
	Resolved:	
	a) That the minutes of the Audit Committee Meeting held on 14 July 2020 be received and noted.	
10/20/19	**Quality Governance Minutes**	
	The minutes of the Quality Governance Committee Meetings held on 11 May and 22 July 2020 were submitted.	
	Resolved:	
	a) That the minutes of the Quality Governance Committee Meetings held on 11 May and 22 July 2020 be received and noted.	
10/20/20	**Former Resources Committee Minutes**	
	The minutes of the Former Resources Committee Meeting held on 16 July 2020 were submitted.	
	Resolved:	
	a) That the minutes of the Former Resources Committee Meeting held on 16 July 2020 be received and noted.	

10/20/21	**Remuneration & Nominations Committee**	
	The summary report was submitted.	
	Resolved:	
	a) That the contents of the report be received and noted.	
10/20/22	**New or Increased Risks Highlighted Today**	
	Risks highlighted today as follows: • Finance – Months 7-12	
10/20/23	**Board of Directors Schedule of Business**	
	The Schedule was as submitted.	
	Resolved:	
	a) That the Board Schedule of Business be received and noted.	
10/20/24	**Any Other Business**	
	There was no other business.	
10/20/25	**Date and time of the next meeting** **27 January 2021 – 14:00 hours**	

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Paper 02

Board Action Log

Minute Reference	Notes and Any Actions Required	Action by	Timescale	Progress/Evidence
10/20/03	**Questions from the Public** The Communications Director, Strategic Operations & Digital Integration Director, Trust Secretary and Strategy & Engagement Director to meet and consider options for how this could be done differently. Update to the next Board Meeting.	**MM/CC/ PH/VK**	**January 2021**	To implement a solution which will utilize Microsoft Teams App. from the March 2021 Board meeting.
10/20/06	**Draft Executive Performance Scorecard** Comments on the Draft Executive Performance Scorecard be sent to the CEO.	**ALL**	**November 2020**	Comments were requested and will be included within the March 2021 Board agenda. The Board are requested to delete this from the Action Log
10/20/08	**Quality Report** An update on how many clinical complaints were upheld and not upheld and the specific issues would be reported back to the next meeting.	**AW/MD**	**January 2021**	5 Justified, 49 Not justified, 8 Part justified. 2 escalated to S.I, 1 being investigated by the Police. The majority, had an element relating to the following: (56) related to patient care, followed by (49) patient assessment and (30) non conveyance. There was an action at Professional Standards Group for the justified cases to be reviewed which will be discussed at the next meeting of the Group on

Minute Reference	Notes and Any Actions Required	Action by	Timescale	Progress/Evidence
				28 January 2021 The Board are now requested to discharge this item from the Log.
10/20/11	**Winter Plan** Handovers Delays would be added to the agenda for the next NEDs Meeting.	**PH**	**December 2020**	Completed. The Board are requested to delete this from the Action Log
10/20/13	**Board Assurance Framework** The BAF be added to the agenda for a few months for a detailed review.	**PH**	**January 2021**	An agenda item for this meeting and included in the schedule of business. The Board are requested to delete this from the Action Log
10/20/16	**Body Worn Cameras** This item would be added to the Board agenda for an update in the New Year.	**PH**	**January 2021**	Included on the agenda for the Confidential agenda in view of the pending procurement exercise. The Board are requested to delete this from the Action Log

WRES ACTION PLAN 2020-2021

Introduction

The current WRES Action Plan has considered the results of the 2019-2020 data analysis and shows the TRUST has improved against a number of the key indicators (these are shown in summary below. The Action Plan for 2020-2021 is predicated on this data and focuses on those criteria where the Trust wishes to improve further.

Data from 2019- 2020 indicates the following against each indicator: (Data attached as Appendix 1)

INDICATOR 1 - % of Staff in each Pay Band – for Clinical and Non-Clinical Staff comparing data for White and BME staff for the periods to March 2019 and March 2020

The data is shown separately for **clinical** and for **non- clinical** staff, in each of the AfC bands, plus staff in the Very Senior Managers [VSM] or Medical and Dental pay frameworks.
Our data shows if the percentage of BME staff in each pay band is more or less than the overall percentage for all BME staff in that year.
Clinical BME Staff number have increased from 245 (5.91%) in March 2019 to 389 (7.57%) in March 2020.
For Non-Clinical BME Staff, the increase has been more substantial, from 81 (7.23%) in March 2019 to 270 (18.93%) by March 2020.

INDICATOR 2 - Relative likelihood of staff being appointed from shortlisting across all posts comparing data for White and BME staff

This measure is the relative likelihood of **White** staff being appointed from shortlisting compared to **BME** staff
A figure above "1" would indicate that white candidates are more likely than BME candidates to be appointed from shortlisting
As at March 2019 this rate was **1.41**, however by March 2020 this rate had improved substantially to **1.17**

INDICATOR 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation comparing data for White and BME staff

This measure is the relative likelihood of **BME** staff entering the formal disciplinary process compared to **White** staff, as measured by entry into a formal disciplinary investigation
This indicator will be based on data from a two year rolling average of the current year and the previous year

A figure above "1" would indicate that BME staff members are more likely than white staff to enter the formal disciplinary process

Our data at **0.8,** shows that **BME** staff are less likely to be involved in a disciplinary investigations compared to their White colleagues
Further exploration of the data, the numbers show that 7 BME staff were disciplined in the 24- month period compared to 78 White colleagues

INDICATOR 4 - Relative likelihood of staff accessing non-mandatory training and CPD comparing data for White and BME staff

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Our data shows the relative likelihood of **White** staff accessing this type of training is **1.28**. March 2019 this rate was **1.03.** This means that slightly less **BME** staff are accessing non-mandatory training than their White colleagues

INDICATOR 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months comparing data for White and BME staff

The data is extracted directly from the NHS staff opinion survey results for 2019 and are used to calculate this percentage

Our survey data reports that **White** colleagues experience a higher % of harassment, bullying and abuse from patients, than our **BME** colleagues

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Our data reports that feedback given by staff to this question shows that 67.90% of **BME** staff do believe the Trust provided equal opportunities for career progression or promotion. For **White** colleagues, their satisfaction rate was slightly higher at 77.00%.

INDICATOR 8 - In the last 12 months have you personally experienced discrimination at work from Manager/Team leader or other colleagues? Comparing data for White and BME staff

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Our 2019 staff opinion survey response stated that **15.8%** of **BME** colleagues[30 from 196 total BME respondents] said they had personally experienced discrimination at work. Compared to 8.80% **White** colleagues [264 from 3009 total White respondents]

INDICATOR 9 - Percentage difference between the organisations' Board voting membership and its overall workforce

The data indicates there has been an overall increase in the number of BME voting Board Members rising from **23.1%** as at March 2019 to **30.8%** as at March 2020.
This compares favourably against the overall workforce % of **6.00%** in March 2019 and **9.8%** as at March 2020.

The WRES Action Plan for 2020-2021 has a strong focus on ensuring consistency of practice and culture change to support the improvements and enhancement of the indicators shown. The focus has robust support from the BME ONE Network who have been consulted on priorities. (WRES Action Plan attached as Appendix 2)

INDICATOR 1 - % of Staff in each Pay Band – for Clinical and Non-Clinical Staff

comparing data for White and BME staff for the periods to March 2019 and March 2020

Reporting period as at March 2019					Reporting period as at March 2020				
BME % for WMAS = 6.08%	Clinical Staff		Non-Clinical Staff		BME % for WMAS = 9.80%	Clinical Staff		Non-Clinical Staff	
AFC Band	BME	White	BME	White	AFC Band	BME	White	BME	White
Band 1	22.86%	74.29%	8.00%	88.00%	Band 1	0.00%	100.00%	12.50%	87.50%
Band 2	10.77%	87.12%	6.18%	92.66%	Band 2	9.98%	90.02%	8.09%	91.91%
Band 3	4.73%	93.20%	6.49%	93%	Band 3	10.13%	89.87%	31.77%	68%
Band 4	7.48%	92.27%	6.54%	90.77%	Band 4	8.03%	91.97%	7.21%	92.79%
Band 5	5.39%	92.49%	13.43%	86.57%	Band 5	5.83%	94.17%	22.45%	77.55%
Band 6	3.44%	92.70%	7.20%	92.00%	Band 6	4.34%	95.66%	8.00%	92.00%
Band 7	2.94%	91.91%	8.22%	91.78%	Band 7	17.33%	82.67%	15.28%	84.72%
Band 8a	0.00%	100%	13.33%	76.67%	Band 8a	5.88%	94%	16.67%	83.33%
Band 8b	7.14%	86%	0.00%	92%	Band 8b	12.50%	88%	8.33%	92%
Band 8c	25.00%	75.00%	8.33%	92%	Band 8c	14.29%	85.71%	12.50%	88%
Band 8d	0.00%	0%	0.00%	100%	Band 8d	50.00%	50%	0.00%	100%
Band 9	0.00%	100%	0.00%	100%	Band 9	0.00%	100%	0.00%	100%
VSM	50.00%	50%	0.00%	100%	VSM	0.00%	0%	0.00%	100%
Medical & Dental	10.34%	89.66%	0.00%	0.0%	Medical & Dental	27.12%	72.88%	0.00%	0.0%
Headcount	245	3904	81	1039	Headcount	389	4752	270	1156
Percentage	5.91%	94.09%	7.23%	92.77%	Percentage	7.57%	92.43%	18.93%	81.07%

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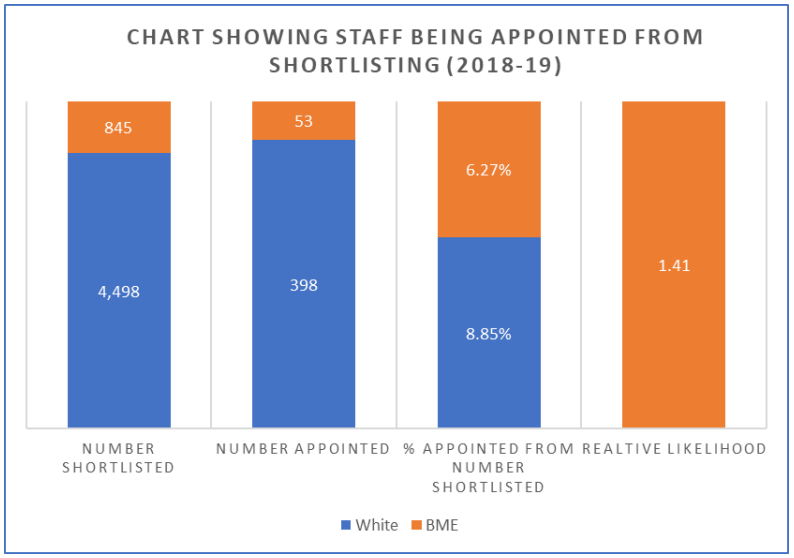

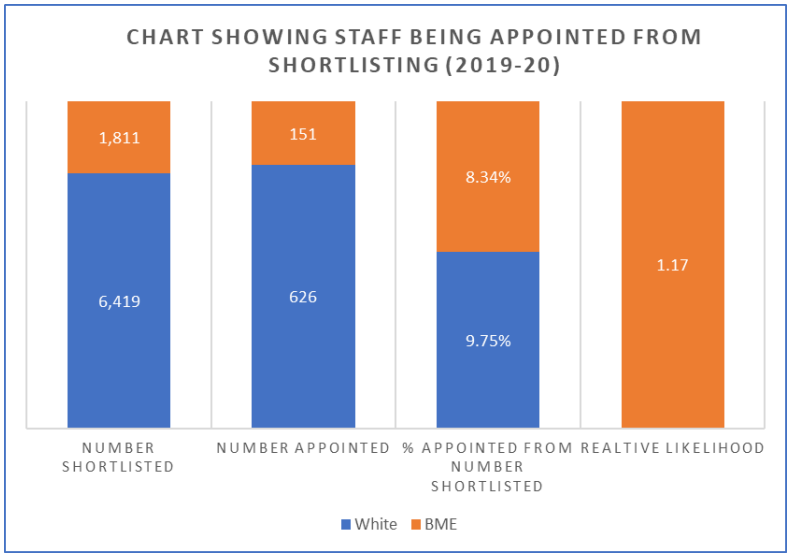

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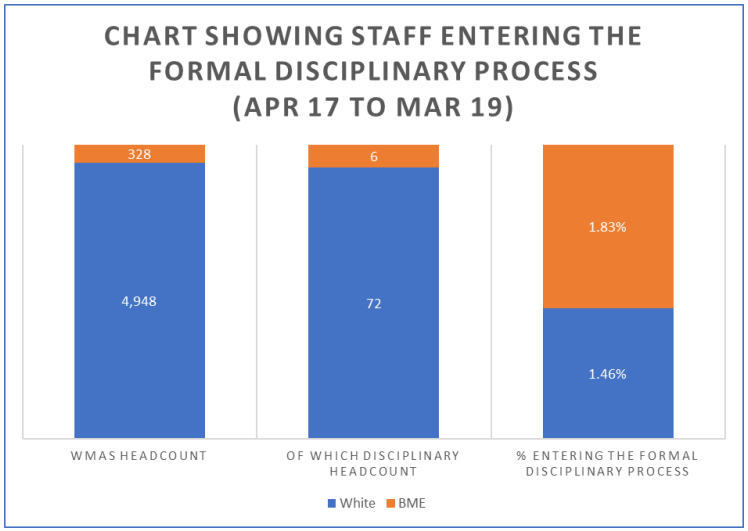

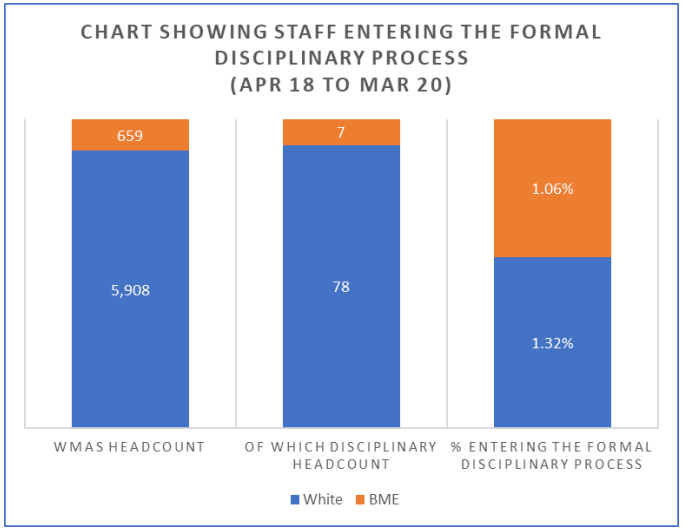

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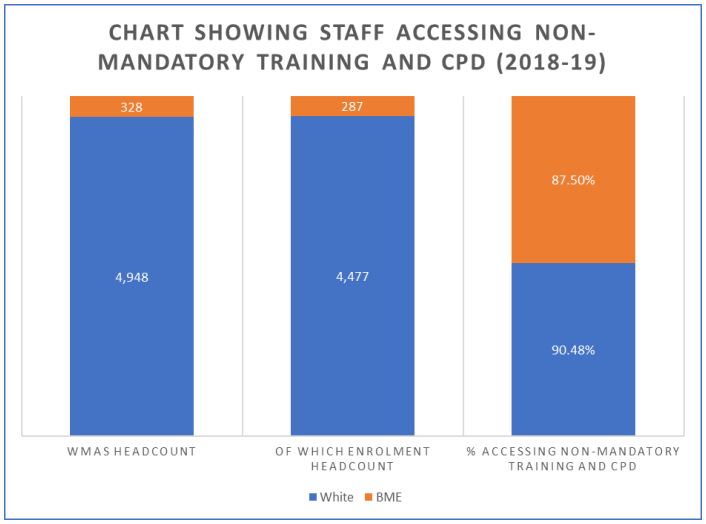

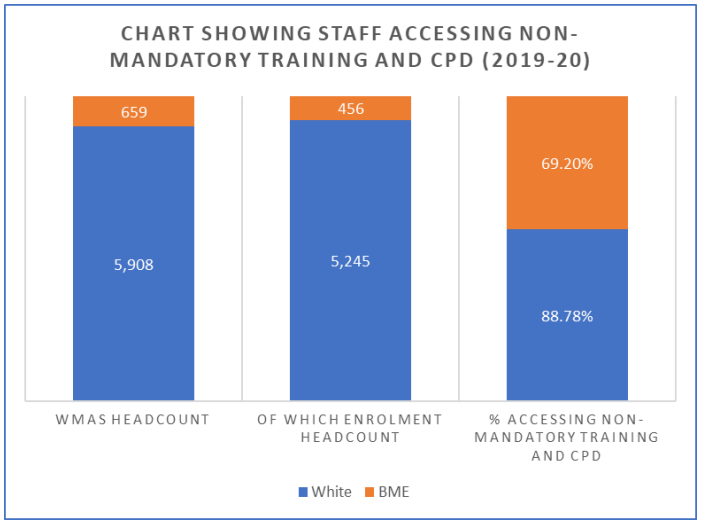

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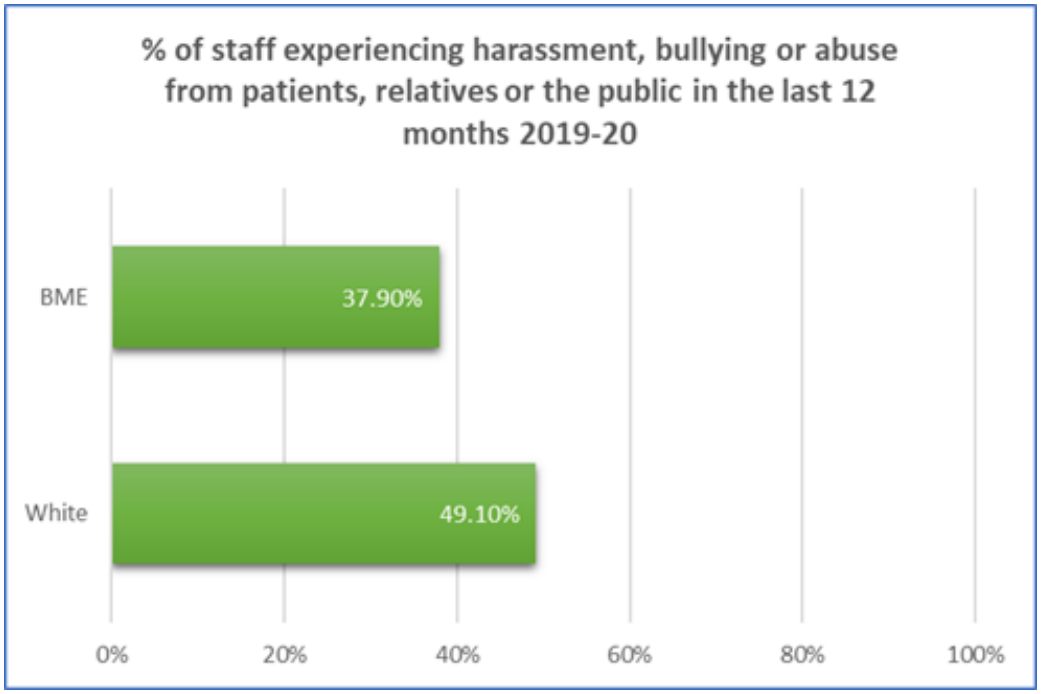

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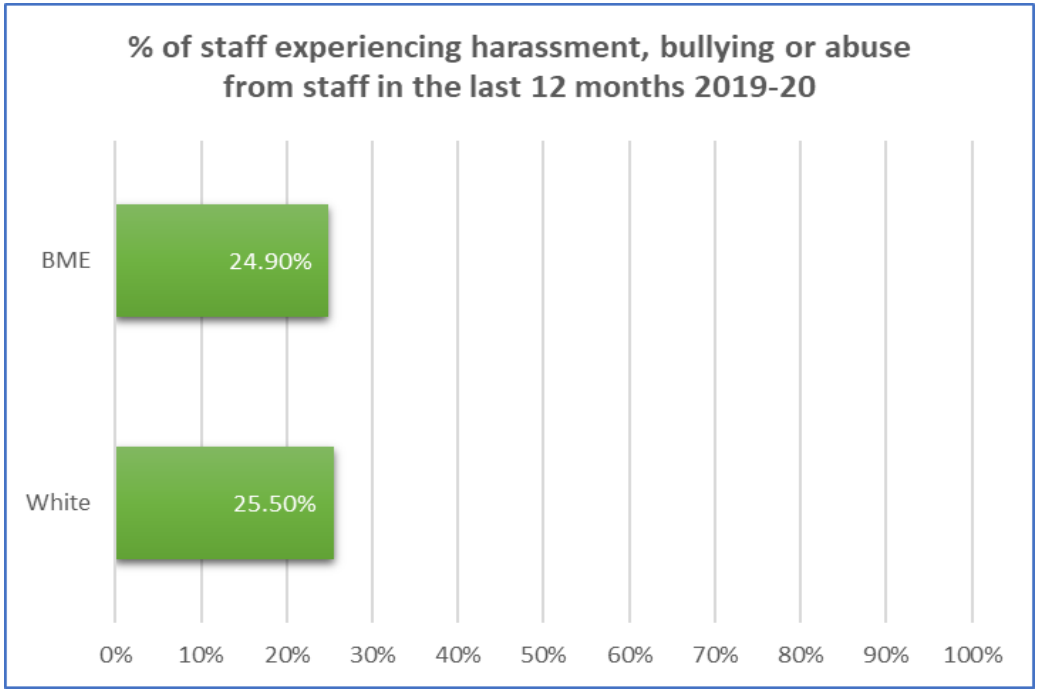

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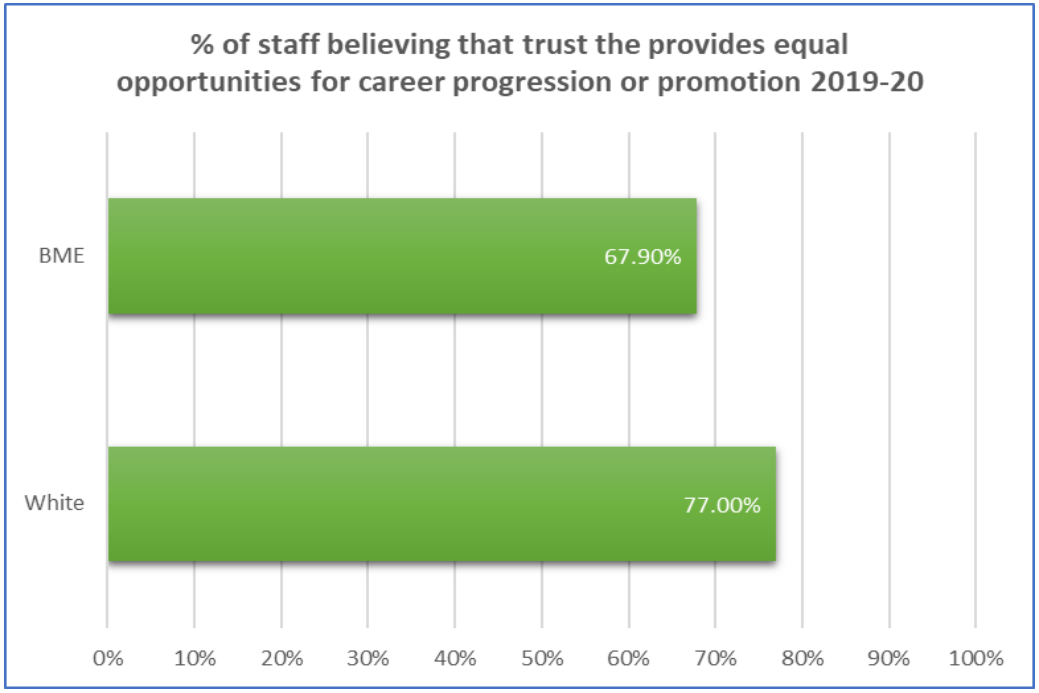

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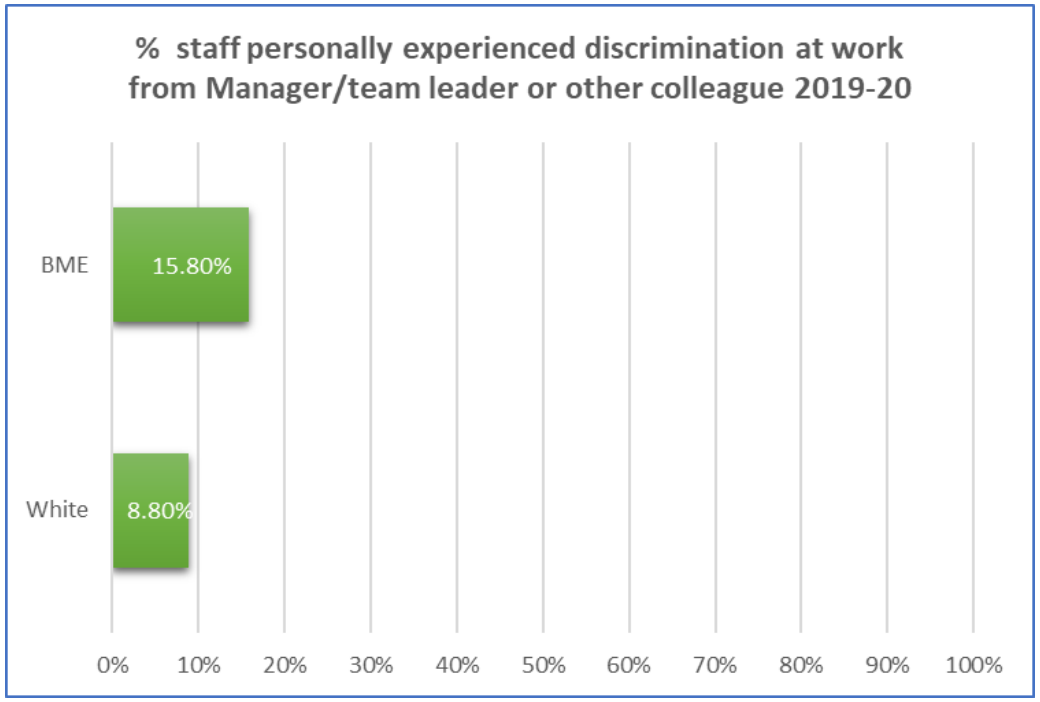

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This compares favourably against the overall workforce % of **6.00%** in March 2019 and **9.8%** as at March 2020.

	2018-19		2019-20	
% by Ethnicity	**White**	**BME**	**White**	**BME**
Total Board Members	76.9%	23.1%	69.2%	30.8%
Voting Board Members	76.9%	23.1%	69.2%	30.8%
Executive Board Members	83.3%	16.7%	100.0%	0.0%
Non-Executive Board Members	71.4%	28.6%	50.0%	50.0%
Overall Workforce	91.7%	6.0%	87.8%	9.8%
Difference (Total Board - Overall Board)	-14.8%	17.0%	-18.6%	21.0%

Definitions:

Board & Voting membership – membership in this context includes all members of the Board irrespective of whether they are executive or non-executive members.

Executive membership – An executive board member is an employee of the organisation and sits on an organisation's board of directors and advises current organisational management on specific operations, e.g. Medical Director or Finance Director, as opposed to a non-Executive board member who is a member of the board of directors of the organisation who does not form part of the executive management team.

WRES Action Plan 2020-2021 - Objective 1

1	To achieve our aim: of continuing to increase the number of BME staff across the Trust in all areas we will prioritise the following objectives	To deliver our objectives we will:	Outcome and measurement	Responsible Lead	Date for Completion	Progress	RAG
1.1	Positive Action interventions	Increase the number of BAME applicants . Carry out at least 3 engagement events focused on BME potential applicants	Year on year increase of BME applicants with clear date reports	Carla Beechey Loiuse Jones	Quarterly		
1.2	Increase the % number of BAME applicants converting to appointments	Carry out at least 3 access courses supporting BAME increase in proportion of BAME appointments	Outcome reports	Carla Beechey Loise Jones	Quarterly		
1.3	Share good practice from across the blue light services	Ensure examples of good practice on BME recruitment and attraction strategies are shared with HR	Reports to DISAG	Pam Brown	Jun-21		
1.4	Continue support and develop the BME ONE network	Work with the Chair to increase membership and participation of BME staff Develop priorities for year 3. Ensure members are involved in the delivery of the WRES action plan where appropriate	Increased membership and involvement. Report to D&I Steering Group. Be involved in WRES Action plan production and delivery where applicable	Pam Brown	Mar-21	.	

WRES Action Plan 2020-2021 - Objective 2

2	To achieve our aim: To continue to support programmes for BME staff which will open opportunities at higher banding levels we will prioritise the following objectives	To deliver our objectives we will:	Outcome and measurement	Responsible Lead	Date for Completion	Progress	RAG
2.1	Promotion of current frameworks and processes that support BME career progression through non-mandatory and CPD development opportunities.	Specific invitations to BME staff at all levels for appropriate development programmes from the OD Team and from the CEO	Year on year increase of BME engagement with relevant OD programmes	Barbara Kozlowska	Quarterly		
2.2	Regular review of current frameworks and processes that support BME career progression through non-mandatory and CPD development opportunities with ONE Network to ensure fitness of purpose.	Promotion of relevant programmes to ONE Network	Increase engagement with the One Network	Barbara Kozlowska	Quarterly		
2.3	Ensure all PDR reviewers and reviewees understand and use the development and talent pool process effectively.	On going training and support	Reports arising from actions	Barbara Kozlowska	Quarterly		
2.4	Agree relevant metrics for BAME development with Head of D & I and WRES expert.	Agreed metrics and reported to DISAG	Reports to Disag	Pam Brown Gerald Dixon Barbara Kozlowska	Jul-21		

WRES Action Plan 2020-2021 - Objective 3

3	To achieve our aim: We will ensure that staff work in an environment where they are free from Discrimination, Bullying, Harassment and Violence and where staff treat each other with Dignity and Respect we will prioritise the following objectives	To deliver our objectives we will:	Outcome and measurement	Responsible Lead	Date for Completion	Progress	RAG
3.1	To promote a culture where bullying, harassment, discrimination and violence will not be toerated	The Trust Board to nominate champions for each Network	Zero tolerance is promoted and Board Champion invited to network meetings	Pam Brown	May-21		
3.2	That Head of EDI and Clinical Director develop a programme for the purpose of developing cultural clinical insights into patient care based on “Closing the Gap” - Reducing Inequity in Care	Develop a Trust wide initiative and training package that links clinical issues to cultural competence	Shared with clinical and non-clinical staff across the whole Trust	Pam Brown Alison Walker	Quarterly		
3.3	Create a safe environment for discussion of incidents relating to bullying and harassment	Create a flow chart for victims of abuse to ensure a standardized mechanism to support staff is understood Develop a group of ‘buddy’s’ – to include BAME / LGBT staff who have knowledge and personal experience in this area and can provide peer – peer support	Reduction in the gap between the number of staff from Protected Characteristic groups reporting they experience Bullying, harassment, discrimination and violence	Nathan Hudson	Mar-21		
3.4	Understanding the issues surrounding reported episode of violence and aggression against BME colleagues by members of the public.	regular monitoring of ER 54's . Actions taken by each hub to ensure consistency	Analysis of data reported	Matt Brown	Quarterly		

WRES Action Plan 2020-2021 - Objective 4

4	To achieve our aim: To continue to enhance quality and diversity in the governance of the Trust, with emphasis on patient experience and safety and clinical effectiveness we will prioritise the following objectives	To deliver our objectives we will:	Outcome and measurement	Responsible Lead	Date for Completion	Progress	RAG
4.1	To encourage applications to serve as a Director of the Trust either as an Executive or a Non-Executive when positions become vacant	To use external support as necessary to encourage diverse applicants and promote roles through community activities	Higher levels of appointments and applicants when roles become vacant	Chair	Sep-21		

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM 06 MONTH: January 2021 PAPER NUMBER 04

The Ockenden Report (10th December 2020) WMAS Action plan in response to the Ockenden Report	
Sponsoring Director	Mark Docherty – Executive Director of Nursing and Clinical Commissioning
Author(s)/Presenter	Mark Docherty Stephanie Henry
Purpose	To provide a summary of the Ockenden Report and the WMAS action plan arising from the report.
Previously Considered by	None
Executive Summary This report presents the assurance and actions required of WMAS following the publication of the Ockenden Report on 10th December 2020. Although most actions are aimed at hospital led maternity services, it is right that WMAS uses this opportunity to assure the Board that robust actions are being taken to ensure the maternity services we provide are safe and robust.	
Related Trust Objectives/ National Standards	All
Risk and Assurance	The actions taken will ensure that our maternity services are as safe as possible, and women understand the risks associated with births away from an acute hospital.
Legal implications/ regulatory requirements	Maternity care is a significant risk area for WMAS and improvements in this area will minimise litigation risks.
Financial Implications	None identified
Workforce & Training Implications	Improving workforce knowledge of maternity care is important as well as consideration of the clinical support to maternity cases that are managed by WMAS.
Communications Issues	None identified
Diversity & Inclusivity Implications	WMAS provide a universal service across the West Midlands Region that is equally accessible to all.
Quality Impact Assessment	All actions will lead to improved quality in midwifery care offered by WMAS.
Data Quality	None identified
Action required **The Board is asked to:** To note and discuss the content of this report To ratify the action plan Agree that the action plan will be reported through the Professional Standards Group (PSG)	

OCKENDEN REVIEW OF MATERNITY SERVICES

Background

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The report was published on 10 December 2020.

https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

Purpose of this WMAS Report

The West Midland's Ambulance Service does not directly provide maternity services, and as much of the report is aimed at hospital based maternity and obstetric services many of the recommendations are not directly relevant to an emergency ambulance service or urgent care provider.

WMAS do however get called to women who are in labour and who may have complications of labour. We have considered the report and the most senior clinicians in our organisation have considered the assurance required to ensure we are delivering the best possible care, as well as learning from the Ockenden report to identify any further actions that WMAS can take to improve care in this area.

Introduction

West Midland's Ambulance Service do not offer a maternity service. Only in cases where pregnancy / labour or birth have deviated from the norm, do women choose to seek medical advice and guidance from the pre-hospital emergency services for themselves or their newborn baby via 111 or 999.

The serious complications and deaths resulting from the substandard maternity care provided at Shrewsbury and Telford Hospital between 2000-2019 has had an everlasting impact on families and their loved ones. Although, it may appear that this report is more applicable towards hospitals, as an emergency ambulance service providing pre-hospital maternity care, it is essential we respond to at least 4 of the 7 Immediate and Essential Action's (IEA) highlighted within the Ockenden Report which apply to our trust.

In addition, there are generic relevant issues that are highlighted in the report and these are highlighted in the enclosed action plan.

Action Plan

The WMAS Lead Midwife has drawn up an action plan based on the Ockenden Report. This has been agreed with senior clinicians within the organisation and it is proposed that this action plan starts the formation of a maternity action plan that becomes the dynamic document against which all maternity actions are logged. This will form an assurance document that can be reported to the Professional Standards Group and the Quality Governance Committee for onward reporting to the Board.

Ockenden Report (2020) WMAS Review of Immediate and Essential Actions

	Immediate and Essential Actions	WMAS Current position	Any Further WMAS Action	Date	Risk
1. Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly.	N/A	None	N/A	
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	All Serious Incidents (SI's) are shared through West Midlands Ambulance Services (WMAS) reporting and Governance Process' up to Trust Board level. Incidents are presented and reviewed at the Learning Review Group (LRG) along with patient safety reports, HM Coroners cases, Learning from Deaths, claims and patient experience complaints investigations. The reviews provide assurance that recommendations are appropriate, and risks are identified. Shared learning then occurs as completed reports are forwarded to the appropriate organisations / external agencies HM Coroner, Police, Safeguarding etc.	WMAS to share any maternity incidents or concerns with the LMS	Immediate	
2. Listening to Women and their Families	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Patient surveys are currently in use within the trust, but these are generic and or specific to maternity services. voice heard, about our involvement with their care	Going forward we will devise a maternity specific survey / feedback report form. To help give all women and their families who receive maternity care from WMAS, the opportunity to have their	Jan 2021	
	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly	WMAS has an identified lead Director for maternity services and employs a specialist Lead Midwife. There is currently no Non-Executive Director identified with a remit to support the Board level Champion. The Medical Director takes an Executive lead on Obstetric matters.	WMAS to consider identifying a Non-Executive Board Level champion.	March 2021	

3. Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	N/A	None	N/A	N/A
	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	Our Clinical Manager – Maternity Lead / Trust Midwife provided ad hoc training sessions to all ambulance Hub's within the West Midlands region prior to Covid-19. Direct teaching of AAP students within our in-house training Academy. Inclusion of Obstetric Emergencies / introduction of Misoprostol on a recent mandatory training programme. Following recent social distancing guidance and restrictions, multiple virtual training opportunities for operational staff have been put in place. Including live MDT online Neonatal Training in conjunction with Consultant Paediatrician from a local trust accessible to all staff. Further development of maternity training videos / webinars that are accessible via our online learning portal. Various ongoing MDT training proposals with Local Maternity and Neonatal Systems (LMNS), local trusts and universities within the region.	None	N/A	N/A
	Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	WMAS doesn't get specific funding for maternity staff training	N/A	N/A	
4. Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	N/A	None	N/A	
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	N/A	None	N/A	
5. Risk Assessment throughout pregnancy	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	N/A	None	N/A	

6.Monitoring Fetal Wellbeing	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	N/A	None	N/A	
7. Informed Consent	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	At present we do not have written information on our website detailing what routine practice and procedures maternity patients are expected to receive from the trust, if and when an ambulance is called to a maternity case.	WMAS to add written information on the trust website about: • when it is appropriate to use an emergency ambulance service during Pregnancy, Labour & Birth • A brief overview of what to expect from us as ambulance service (clarifying paramedics practice as per JRCALC guidance which is a very different scope of practice to what women would receive from her named midwife) • Information about the safe conveyance / transportation of Mothers & their Babies consistent with WMAS policy • The need for the patient to provide their electronic pregnancy record to the WMAS staff upon arrival on scene where possible	Jan 2021	

Ockenden Report (2020) WMAS Review of Relevant Issues in Report

	Other Issues for WMAS Action	WMAS Current position	Any Further WMAS Action	Date	Risk
	There must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is our call to action	WMAS has a robust Learning Review Group and a Learning from Deaths process. All actions are captured, and a log is kept of completion of actions.	None	Immediate	
	The review team have also found inconsistent multi-professional engagement with the investigations of maternity serious incidents at the Trust	WMAS investigations of serious incidents and deaths are fully investigated utilising relevant professionals	None	Immediate	
	We have found clear examples of failure to learn lessons and implement changes in practice	WMAS has a robust Learning Review Group and a Learning from Deaths process. All actions are captured, and a log is kept of completion of actions.	None	Immediate	
	One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust	WMAS triangulates evidence from complaints, serious incidents and other intelligence to identify any trends and themes and these are scrutinised at various levels in the organisation.	WMAS will actively seek further feedback from service users.	January 2021	
	In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth. There is evidence from interviews with women and their families, that it was not explained to them in case of a complication during childbirth, what the anticipated transfer time to the obstetric-led unit might be.	WMAS already provide information to SATH and the CCGs to enable them to share this with women.	WMAS will supply additional information to SATH to enable them to inform women of the impact if an ambulance is required, so that women can give informed consent when opting for a home birth or one in a Midwifery Led Unit.	January 2021	
	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance.	WMAS already provide information to SATH and the CCGs to enable them to share this with women.	WMAS will supply additional information to SATH to enable them to inform women of the impact if an ambulance is required, so that women can give informed consent when opting for a home birth or one in a Midwifery Led Unit.	January 2021	
	The clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	The workload associated with serious incidents is kept under review and additional resources are allocated if possible.	To continue to monitor workload associated with serious incident investigations.	Ongoing	
	Follow up letter sent after discharge which states: 'If you would like to come and have a chat with me about the death of your baby…' There were no words of condolences or sympathy within the body of the letter.	WMAS ensure that all response letters and Duty of Candour are sensitive to recent loss, compassionate and offer condolences.	None	Ongoing	

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
All Serious Incidents (SI's) are shared through West Midlands Ambulance Services (WMAS) reporting and Governance Process' up to Trust Board level. Incidents are presented and reviewed at the Learning Review Group (LRG) along with patient safety reports, HM Coroners cases,	Learning Review Group oversee the delivery of agreed actions	Reporting through the Learning Review group	WMAS to share any maternity incidents or concerns with the LMS	Simon Taylor Immediate	None	Action is immediate

Learning from Deaths, claims and patient experience complaints investigations. The reviews provide assurance that recommendations are appropriate, and risks are identified. Shared learning then occurs as completed reports are forwarded to the appropriate organisations / external agencies HM Coroner, Police, Safeguarding etc.						

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Patient surveys are currently in use within the trust, but these are generic and or specific to maternity services. voice heard, about our involvement with their care	Patient survey results will be reported to Quality Governance Committee	Learning Review Group will oversee actions resulting from the surveys	Going forward we will devise a maternity specific survey / feedback report form. To help give all women and their families who receive maternity care from WMAS, the opportunity to have their	Marie Capper Immediate	None	Immediate action
WMAS has an identified lead Director for maternity services and employs a specialist Lead Midwife. There is currently no Non-Executive Director identified with a remit to	Confirmation of the nominated non-executive director to Trust Board	On-going assessment of effectiveness and annual appraisal	WMAS has identified a Non-Executive Board Level champion.	CEO Immediate	None	Immediate action

support the Board level Champion. The Medical Director takes an Executive lead on Obstetric matters.						

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Our Clinical Manager – Maternity Lead / Trust Midwife provided ad hoc training sessions to all ambulance Hub's within the West Midlands region prior to Covid-19. Direct teaching of AAP students within our in-house training Academy. Inclusion of Obstetric Emergencies / introduction of Misoprostol on a recent mandatory training programme. Following recent social distancing guidance and restrictions, multiple virtual training						

opportunities for operational staff have been put in place. Including live MDT online Neonatal Training in conjunction with Consultant Paediatrician from a local trust accessible to all staff. Further development of maternity training videos / webinars that are accessible via our online learning portal. Various ongoing MDT training proposals with Local Maternity and Neonatal Systems (LMNS), local trusts and universities within the region.						
WMAS doesn't get specific funding for maternity staff training						

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
At present we do not have written information on our website detailing what routine practice and procedures maternity patients are expected to receive from the trust, if and when an ambulance is called to a maternity case.	Action plan to be overseen by the Executive Management Board and reported to Trust Board	WMAS will seek feedback from service users	WMAS to add written information on the trust website about: • when it is appropriate to use an emergency ambulance service during Pregnancy, Labour & Birth • A brief overview of what to expect from us as ambulance service (clarifying paramedics practice as per JRCALC guidance which is a very different scope of practice to what women would receive from her named midwife)	Marie Capper January 2021	None	WMAS will take quick action to mitigate risk

			• Information about the safe conveyance / transportation of Mothers & their Babies consistent with WMAS policy • The need for the patient to provide their electronic pregnancy record to the WMAS staff upon arrival on scene where possible			

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
N/A	N/A	N/A	N/A	N/A	N/A	N/A

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

Maternity Lead – Stephanie Henry

Reports to – Executive Director of Nursing and Clinical Commissioning, Mark Docherty

Supported by Obstetrics Lead – Executive Medical Director, Dr Alison Walker

Supported by Lead Paramedic for Emergency Care, Jason Wiles

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 07 MONTH: January 2021 PAPER NUMBER: 05

Chief Executive Officer's Report	
Sponsoring Director	Chief Executive Officer
Author(s)/Presenter	Anthony C Marsh – Chief Executive Officer
Purpose	This report provides an update from the Chief Executive on national matters and an update on key issues within the organisation as listed under the Executive Summary.
Previously Considered by	Not Applicable, except for items and actions arising from the Executive Management Team.
Report Approved By	Chief Executive Officer

Executive Summary

This report includes:

1. Non-Emergency Patient Transport – Key Performance Indicators
2. Over 2-minute 999 Call Answering Update
3. CEO Meetings – 19 October 2020 to 15 January 2021

Related Trust Objectives/ National Standards	**Current Strategic Objectives:** • Achieve Quality and Excellence • Accurately assess patient needs and direct resources appropriately • Establish our market position as an emergency healthcare care provider • Work in partnership • The Trust reports against the National Ambulance Service Standards, as well as its clinical standards. These are reported as part of the Trusts Information Pack to each meeting of the Board. • The Trust must also remain compliant with the standards set out in its CQC Registration, which includes the use of resources risk assessment.
Risk and Assurance	The NHS is facing financial and activity challenges, and the Trust needs to ensure it has robust arrangements in place to meet it financial and operational targets and obligations in line with its strategic direction.

	Risks are captured on the Board Assurance Framework and Risk Register. Assurance can be provided through discussions and evidence provided at the Board of Directors through its pillar committees.
Legal implications/ regulatory requirements	To maintain compliance with both regulations and the conditions of licence and registration from the Regulators. No legal advice has been sought or required in the construction of this report.
Financial Implications	There are no immediate financial planning implications arising from this report, apart from those already in place (Budget/Cost Improvement Programme etc.) which have been agreed at the Executive Management Board meetings.
Workforce & Training Implications	Only those noted in the paper.
Communications Issues	To ensure relevant items from this paper are communicated as appropriate to internal and external stakeholders.
Diversity & Inclusivity Implications	Not applicable at this stage.
Quality Impact Assessment	No new QIAs required at this time.
Data Quality	The Trust Information Pack contains further information on performance, which has been collated by the Business Intelligence Unit and other Trust data systems. Information has also collected from national ambulance performance data.
Action required The Board of Directors is asked to: • Receive and note the contents of the paper seeking clarification where necessary.	

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 07 MONTH: January 2021 PAPER NUMBER: 05

1. Non-Emergency Patient Transport Services– Key Performance Indicators

Appendix 1 shows the Non-Emergency Patient Transport (PTS) performance against the agreed Key Performance Indicators (KPIs) for April to December 2020 for each Contract. I am pleased to report all targets are being achieved each month.

2. Over 2-minute 999 Call Answering Update

Call answering performance has been very strong. The Trust continues to report the lowest 2-minute call answering delays in the country.

Trust	April	May	June	July	August	Sept	October	November	December	Year To date
WMAS	**4**	**8**	**3**	**3**	**12**	**1**	**5**	**8**	**6**	**50**
EoE	16	34	5	24	20	12	37	18	61	**227**
EMAS	55	11	54	61	92	342	212	193	111	**1131**
LAS	1909	10	5	83	70	169	56	94	4699	**7095**
NEAS	18	69	52	34	101	153	188	222	94	**931**
NWAS	79	2	0	0	10	106	515	42	15	**769**
SCAS	90	24	39	58	111	57	185	154	399	**1117**
SECAMB	5	2	222	292	37	96	56	44	124	**878**
SWAST	0	17	15	11	34	45	28	82	77	**309**
YAS	166	159	148	64	125	298	4429	1130	1070	**7589**

3. Chief Executive Officer Meetings – 19 October 2020 to 15 January 2021

Staff

- Senior Command Team
- John Mallinson's Funeral
- ONE Network
- Carole Petty's Funeral
- FTSU Advocates Development Session
- Staff Side Representatives
- NEDs Meeting
- Council of Governors

National Meetings

- NHS England / NHS Improvement Ambulance Covid-19 Daily Cell
- Association of Ambulance Chief Executives – Covid-19 / Winter Pressures Meeting
- NHS England / NHS Improvement Severe Covid Response Cell Meeting
- NHS England / NHS Improvement Handover Delay Review Meeting
- NHS England / NHS Improvement UEC Transformation Priorities Forum
- Ann Ford & Heidi Smoult, CQC

- NHS England / NHS Improvement C3/4 Pilot – Bi-Weekly All trust Meeting
- NHS England / NHS Improvement Directors for Emergency & Elective Care Meeting
- NHS England / NHS Improvement Ambulance Data Set Project Board
- NHS IMAS Strategic Advisory Board
- NHS England / NHS Improvement Ambulance Review Implementation Board
- Craig Harman, St John Ambulance
- Mike Shanahan & Stephen Groves, NHS England
- NHS England / NHS Improvement YAS Resilience Meeting
- NHS England / NHS Improvement SWASFT Follow-Up Meeting
- Lord Carter
- NHS England / NHS Improvement CQI Meeting
- Martin Flaherty & Daren Mochrie, Association of Ambulance Chief Executives
- Association of Ambulance Chief Executives – Ambulance Chief Executives Group
- CQC National Emergency Medicine Speciality Forum
- NHS England / NHS Improvement STaR Board Workstream
- NHS England / NHS Improvement CEO Advisory Group
- NHS England / NHS Improvement Make Ready & Hub & Spoke Working Group
- NHS England / NHS Improvement Video Consultation Group
- NHS England / NHS Improvement EU Transition
- NHS England / NHS Improvement Emergency Care Prioritisation Advisory Group
- Association of Ambulance Chief Executives – Council Meeting
- NHS England / NHS Improvement Digital Strategy Meeting
- Diane Scott, The Ambulance Service Charity
- NHS England / NHS Improvement eDCA Meeting
- JESIP Interoperability Board Meeting
- NHS England / NHS Improvement Joint Ambulance Improvement Programme Board

<u>Regional Meetings</u>

- David Rosser, University Hospitals Birmingham
- Gavin Williamson MP
- Sandwell & West Birmingham CCG – Provider/Commissioner Forum
- Nigel Huddleston MP
- St John Ambulance, Stafford County Priory Group
- Hanna Sebright & Roger Pemberton, Midlands Air Ambulance Charity

Professor Anthony C. Marsh
Chief Executive Officer
January 2021

Non-Emergency Patient Transport Services

2020-21 Performance

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Cheshire, Warrington & The Wirral	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
EPS Arrival														
% Arriving within 60 minutes prior.	90%	94.25%	94.52%	94.63%	94.21%	94.34%	93.46%	94.59%	93.99%	93.75%				94.30%
% Arriving on time	Info	95.29%	94.93%	95.20%	94.73%	94.75%	94.54%	95.25%	95.15%	94.82%				95.14%
Planned Arrival														
% Arriving within 60 minutes prior & 15 mins after appt	90%	95.51%	96.08%	94.80%	95.23%	94.97%	93.95%	92.66%	94.92%	94.30%				94.52%
% Arriving on time	Info	97.96%	97.68%	96.61%	96.54%	95.97%	95.75%	95.40%	96.85%	95.83%				96.34%
EPS Departure														
% Collected within 60 minutes	85%	99.19%	99.65%	99.34%	98.95%	98.48%	98.64%	97.61%	98.88%	98.72%				98.79%
% Collected within 90 minutes	90%	99.86%	99.93%	99.93%	99.73%	99.80%	99.64%	99.43%	99.65%	99.77%				99.71%
Planned Departure														
% Collected within 60 minutes	80%	94.77%	94.68%	94.74%	94.18%	93.94%	92.72%	91.91%	93.37%	94.02%				93.47%
% Collected within 90 minutes	90%	98.02%	97.90%	97.37%	97.31%	97.57%	96.34%	96.13%	97.64%	97.55%				97.10%
Unplanned Departure														
% Collected within 60 minutes	75%	96.50%	95.65%	94.03%	90.92%	88.45%	83.84%	78.84%	86.60%	87.67%				88.92%
% Collected within 90 minutes	85%	98.54%	98.51%	96.57%	95.62%	94.16%	91.54%	87.26%	93.12%	94.98%				94.14%
EPS Time on Vehicle														
On vehicle is <60 minutes.	85%	99.06%	99.30%	99.45%	98.99%	98.15%	97.16%	98.08%	98.21%	98.72%				99.07%
Planned Time on Vehicle														
On vehicle is <60 minutes.	80%	96.35%	96.71%	96.35%	96.73%	95.49%	95.49%	95.66%	96.90%	95.26%				97.90%
UnPlanned Time on Vehicle														
On vehicle is <60 minutes.	80%	97.03%	97.51%	98.19%	96.62%	95.77%	95.94%	97.61%	97.76%	96.67%				97.99%

Sandwell and West Birmingham	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Inward Journeys - All Activity														
60 minutes before and 15 minutes late	info	91.8%	84.6%	84.0%	90.0%	98.8%	94.2%	65.0%	60.0%	55.0%				60.4%
Too Early + KPI Window (With Exemptions)	90%	100.00%	97.40%	95.40%	96.60%	96.40%	96.00%	95.00%	97.30%	97.20%				97.30%
Outward Journeys - Planned (OP, AT, DP & Dis.)														
collection < 60mins (of scheduled / ready time)	75%	**94.20%**	**97.10%**	92.60%	91.50%	89.50%	91.20%	87.90%	91.50%	86.40%				**90.20%**
collection < 90mins (of scheduled / ready time)	95%	97.10%	97.10%	98.20%	95.80%	97.00%	96.80%	95.00%	97.10%	95.00%				96.60%
Outward Journeys - On Day (OP, AT, DP & Dis.)														
collection < 60mins (of scheduled / ready time)	60%	83.80%	87.80%	85.50%	72.30%	67.60%	76.30%	63.00%	66.00%	60.00%				74.50%
collection < 120mins (of scheduled / ready time)	95%	96.70%	98.40%	98.70%	95.00%	95.10%	95.80%	95.00%	95.00%	95.00%				95.80%
Transfers														
collection < 90mins (of scheduled / ready time)	75%	100.00%	na	na	100.00%	100.00%	90.00%	100.00%	na	100.00%				97.50%
collection < 120mins (of scheduled / ready time)	95%	100.00%	na	na	100.00%	100.00%	100.00%	100.00%	na	100.00%				100.00%
Home Visits														
< 30 mins before outward collection time	90%	na	na	100.00%	na	na	100.00%	100.00%	100.00%	100.00%				100.00%
< 30 mins after inward collection time	90%	na	na	100.00%	na	na	100.00%	100.00%	100.00%	100.00%				100.00%
Within 10 miles of destination < 60 mins	90%	98.30%	100.00%	99.60%	98.10%	98.30%	100.00%	98.20%	98.90%	99.30%				98.50%
Within 11-20 miles of destination < 90 mins	90%	100.00%	100.00%	100.00%	100.00%	100.00%	98.50%	98.90%	100.00%	98.60%				99.50%

Wolverhampton & Dudley	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Inward Journeys - All Activity														
60 minutes before and 15 minutes late	info	91.6%	93.8%	97.2%	97.5%	94.7%	94.2%	77.0%	78.1%	76.0%				69.5%
Too Early + KPI Window (With Exemptions)	90%	98.10%	98.10%	96.50%	97.60%	95.40%	95.00%	95.00%	98.40%	98.10%				95.30%
Outward Journeys - Planned (OP, AT, DP & Dis.)														
collection < 60mins (of scheduled / ready time)	75%	**98.30%**	**97.90%**	96.10%	95.60%	94.70%	94.50%	94.10%	94.40%	92.50%				95.10%
collection < 90mins (of scheduled / ready time)	95%	99.40%	99.40%	99.00%	98.20%	97.80%	97.70%	97.10%	97.70%	96.80%				98.00%
Outward Journeys - On Day (OP, AT, DP & Dis.)														
collection < 60mins (of scheduled / ready time)	60%	85.10%	90.30%	89.20%	82.50%	77.30%	72.80%	66.70%	68.80%	64.70%				77.80%
collection < 120mins (of scheduled / ready time)	95%	97.30%	99.50%	100.00%	97.30%	95.70%	95.00%	95.10%	95.20%	95.10%				96.10%
Transfers														
collection < 90mins (of scheduled / ready time)	75%	100.00%	96.30%	100.00%	92.90%	97.90%	92.30%	91.80%	90.80%	85.00%				93.10%
collection < 120mins (of scheduled / ready time)	95%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	100.00%	95.00%				98.90%
Home Visits														
< 30 mins before outward collection time	90%	100.00%	100.00%	na	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
< 30 mins after inward collection time	90%	100.00%	na	na	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				93.30%
Within 10 miles of destination < 60 mins	90%	99.70%	99.70%	100.00%	99.50%	99.50%	100.00%	98.40%	99.40%	99.50%				99.40%
Within 11-20 miles of destination < 90 mins	90%	99.90%	99.90%	100.00%	99.90%	99.10%	99.20%	100.00%	99.90%	99.90%				99.80%

Walsall PTS	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Inwards: Outpatients														
< 60 mins before & 15mins after appointment time	info	92.7%	90.9%	89.4%	91.5%	90.7%	91.2%	90.1%	88.0%	88.4%				90.3%
Too Early + KPI Window (With Exemptions)	90%	97.20%	94.80%	92.2%	95.0%	93.5%	92.7%	92.7%	92.9%	91.10%				93.00%
Outwards: Outpatients														
Patients collected < 60 mins after agreed pick-up time	75%	100.00%	97.70%	89.6%	84.4%	82.2%	78.8%	76.5%	78.9%	75.00%				80.70%
Patients collected < 90 mins after agreed pick-up time	90%	100.00%	100.00%	96.0%	95.5%	96.8%	95.5%	94.7%	97.3%	93.70%				96.00%
Discharges: (Inc. Transfers & After Treatment)														
Discharged < 60 mins	60%	84.50%	92.30%	84.2%	77.0%	70.2%	63.4%	60.0%	60.2%	60.00%				70.70%
Discharged < 120 mins	80%	97.10%	99.80%	98.6%	96.2%	95.1%	88.7%	83.3%	91.3%	80.80%				91.20%
Time Spent On Vehicle														
Planned mileage < 10 miles and < than 60 mins	90%	98.70%	98.70%	98.5%	98.3%	98.3%	98.5%	98.1%	98.7%	99.10%				98.50%

Black Country Partnership (BCP) PTS	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Inwards: Planned (all categories)														
< 15mins after appointment time	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%
Inwards: Planned (Admission, Day & OPs)														
> 30mins before & <15mins late	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%
Outwards: Planned (all categories)														
Collection < 60mins after ready time	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%
Planned mileage < 10 miles, < 60 mins on vehicle	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%

Non-Emergency Patient Transport Services

2020-21 Performance

West Midlands Ambulance Service
University NHS Foundation Trust

Coventry & Warwickshire PTS	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Renal Contract [LOT 2]														
Renal: Response Times: Outpatients														
<15 miles, Collected from home < 90mins before appointment.	90%	97.00%	95.00%	95.00%	96.00%	97.00%	97.00%	97.00%	96.00%	96.00%				96.00%
>15 miles, Collected from home < 120mins before appointment.	95%	98.00%	96.00%	97.00%	97.00%	97.00%	97.00%	97.00%	96.00%	96.00%				97.00%
Renal: Arrival Times: For Outpatients														
Arrive < 60 mins before appointment time.	95%	98.00%	98.00%	97.00%	97.00%	97.00%	97.00%	97.00%	98.00%	96.00%				97.00%
97														
Collection < 60 mins of request.	95%	98.00%	97.00%	97.00%	97.00%	97.00%	97.00%	97.00%	96.00%	96.00%				97.00%
Collection < 4 hours of request.	95%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.00%				99.00%
Renal : Time on Vehicle														
<60 minutes for journeys < 12 miles of the destination Trust.	95%	99.00%	98.00%	96.00%	98.00%	98.00%	98.00%	97.00%	97.00%	96.00%				97.00%
<120 minutes for journeys >12 miles (unless out of area).	95%	99.00%	99.00%	97.00%	97.00%	98.00%	98.00%	99.00%	100.00%	96.00%				98.00%
Main Contract [LOT 1]														
Response Times: OP, Admissions and Day Cases														
<15 miles, Collected from home < 90mins before appointment.	90%	97.00%	97.00%	96.00%	97.00%	97.00%	97.00%	96.00%	97.00%	96.00%				97.00%
>15 miles, Collected from home < 120mins before appointment.	95%	98.00%	98.00%	97.00%	96.00%	97.00%	97.00%	97.00%	100.00%	96.00%				97.00%
Arrival Times: For Outpatient Appointments, Admissions and Day Cases														
Arrive < 60 mins before appointment time.	95%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	97.00%	98.00%	96.00%				98.00%
Planned Outwards														
Collected <60 mins of request.	95%	97.00%	98.00%	98.00%	97.00%	98.00%	98.00%	97.00%	97.00%	96.00%				98.00%
Home Visits: Collected <30 mins of request. (out)	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				n/a
Home Visits: Collected <45 mins of request. (in)	95%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a				n/a
On Day Booking														
Collected <4 hours of request.	95%	99.00%	98.00%	98.00%	100.00%	98.00%	100.00%	100.00%	100.00%	97.00%				99.00%
End of Life: Collected <2 hours of request.	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
Time on Vehicle														
<60 minutes for journeys < 12 miles of the destination Trust.	95%	98.00%	98.00%	97.00%	97.00%	98.00%	98.00%	98.00%	96.00%	98.00%				98.00%
<120 minutes for journeys >12 miles (unless out of area).	95%	98.00%	98.00%	97.00%	97.00%	98.00%	97.00%	98.00%	100.00%	98.00%				98.00%

Pan Birmingham PTS	KPI	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Inwards: Planned														
Not Late for Appointment (includes too early)	90%	93.00%	95.90%	94.00%	94.10%	94.50%	93.50%	92.30%	93.70%	93.50%				93.80%
Inwards: On-Day (GP Urgents)														
< 120mins of agreed collection time	90%	-	100.00%	-	-	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
Outwards: Planned														
Collection < 60mins of scheduled/ready time	90%	96.70%	97.70%	95.90%	95.80%	95.10%	93.80%	94.50%	94.90%	94.30%				95.40%
Outwards: On-Day														
< 120mins of agreed collection time	90%	97.70%	98.30%	96.80%	93.90%	91.50%	90.00%	90.10%	90.40%	90.20%				93.20%
Outwards: On-Day (Quick Response)														
< 60mins of agreed collection time (Eds & Assess. Areas)	95%	96.90%	97.40%	96.20%	95.90%	95.00%	95.00%	95.00%	95.00%	95.00%				95.70%
Time Spent On Vehicle														
< 60mins within a distance of 15 miles	95%	98.90%	99.00%	98.90%	98.90%	98.80%	98.50%	98.80%	98.90%	98.70%				98.20%
Renal Dialysis Performance - For Info Only														
Inwards: Planned														
Not Late for Appointment (includes too early)	90%	92.80%	96.10%	94.20%	94.90%	95.50%	94.60%	95.30%	95.40%	95.30%				94.90%
Outwards: Planned														
Collection < 30mins of scheduled/ready time	90%	90.60%	90.30%	90.00%	90.00%	90.00%	90.00%	95.60%	96.10%	96.10%				92.10%
Time Spent On Vehicle														
< 60mins within a distance of 15 miles	95%	99.50%	99.50%	99.60%	99.60%	99.60%	99.50%	99.30%	99.60%	99.50%				99.50%

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 08 MONTH: JANUARY 2021 PAPER NUMBER: 06

Director of Finance Report	
Sponsoring Director	Director of Finance
Author(s)/Presenter	Director of Finance
Purpose	To apprise the Board of Directors of the financial position of the Trust as at 31 December 2020, the forecast for the remaining 3 months of the Financial Year and the Planning Arrangements for 2021/22.
Previously Considered by	EMB
Report Approved By	Director of Finance

Executive Summary

The paper sets out the funding framework in place for the current Financial Year and details the financial position of the Trust as at 31 December 2020 together with the overall financial position of the host STP. The Board is asked to note this position together with the forecast position at 31 March 2021.

The paper also sets out the revised planning and funding arrangements for the 2021/22 Financial Year together with the anticipated timeframes. The Board is asked to note these new arrangements and the progress currently being made in setting expenditure budgets for the Trust.

Risk and Assurance	Risk to achievement of Financial Duties if no agreed financial plan in place
Legal implications/ regulatory requirements	Requirement to complete financial accounts and to submit financial plans that meet NHSE/I conditions.
Financial Implications	Potential failure to meet financial duties if agreed plans are not in place
Training & Workforce Implications	Financial plan is aligned with Workforce Plans
Communications Issues	Not directly applicable
Diversity & Inclusivity Implications	Not directly applicable

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 08 MONTH: JANUARY 2021 PAPER NUMBER: 06

Quality Impact Assessment	A patient Quality Impact Assessment will be undertaken for CIP proposals for 2021/22 once confirmed
Data Quality	Director of Finance
Action required The Board is asked to note the financial position as at Month 9.	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FT

REPORT OF THE DIRECTOR OF FINANCE TO THE BOARD OF DIRECTORS

INCOME AND EXPENDITURE PERFORMANCE

SUMMARY POSITION AS AT 31 DECEMBER (PERIOD 9) 2020-21

FINANCIAL YEAR 2020-21

At 1 April 2020 an interim financial régime was mandated in the NHS in response to the Covid-19 pandemic. Although originally seen as a short-term temporary measure, the system remained in place up to 30 September 2020 and now continues in a slightly revised format for months 7 to 12 up to 31 March 2021.

Under the regime, for months 1 to 6 all provider Trusts received Block Contract funding calculated by NHSE/I based on activity and expenditure levels in months 8 to 10 of financial year 2019-20. All Trusts were to break-even with allowable additional Covid costs reimbursed retrospectively and any balancing adjustment needed to meet the break-even requirement similarly reimbursed as a top-up.

As noted above, the Interim Financial Regime will now continue to the end of the 2020-21 Financial Year. However, going forward the responsibility for agreeing budgets and providing Covid top-up funding has been devolved to the local STP systems. Although Ambulance Trusts provide a service to all STPs in their Region, each Trust has been allocated to one individual STP. WMAS is allocated to Black Country and West Birmingham STP which also comprises 4 Acute Trusts and Community/Mental Health services.

Each of the Black Country STP organisations, both Commissioners and Providers, have been required to submit their plans for Months 7-12 of 2020-21. The plan submitted for WMAS is the plan originally agreed by the Board of Directors in March 2020 with the following adjustments:

- Estimated additional Covid costs for the 6 months of £13.7m. This reduces the monthly expected top-up to c£2.2m and reflects the decrease in costs for the students returning to university.
- Income has been adjusted to the actual Block Contract values confirmed by NHSE/I. Only very minor changes to the amounts received for Months 1-6.
- The combined plans of the STP totalled more than the allocated Control Total so to reduce the deficit each Provider Trust has been required to include a 1% efficiency target and then a further efficiency target split on a fair shares basis. For WMAS the 2 efficiency adjustments are £1.86m (1%) and £1.2m (additional) which have been shown as reduced Covid expenditure and unidentified CIP respectively.
- Additional funding for 111 First was to be excluded as NHSE/I are dealing with this separately
- The cost of the additional staff requirement anticipated for Winter, Covid and Acute activity increases as discussed at the Board of Directors in July, and amounting to £6.3m, has been included as an unfunded cost pressure and is one of the deficits making up the overall STP deficit of £27.13m. There is agreement at the STP that if additional funding is agreed for WMAS it will all be offset against the WMAS deficit

bringing the Trust plan to breakeven provided that the efficiency gains noted above can be made.

NHSE/I set a separate budget for each organisation under the Block Contract arrangement and the Trust reports the financial position against this budget to NHSE/I on a monthly basis. This budget is now reflected in the Director of Finance Report.

I am pleased to advise that the Trust met its required break-even position for the first 6 months of 2020-21 with an approved Covid reclaim of £20.6m. In Months 7-8 the Trust achieved a slightly better than plan position with an overspend of £1,715k at 30 November which was £388k better than the expected position of £2,103k overspent. A number of positive movements in month 9, including a significant VAT rebate, improved income agreements for PTS social distancing and continued lower costs of operational student support have contributed to significant improvement in the position at 31 December with an overspend in the month of £78k against a planned deficit for the month of £1.03 m.

The table below summarises the overall Income and Expenditure position against the NHSE/I Budget at Month 9:

	Plan £m	**Actual £m**	**Variance £m**
Operating income	250.8	278.4	+27.6
Operating expenditure	(247.0)	(271.8)	(24.8)
Operating Surplus/(Deficit)	**3.8**	**6.6**	**2.8**
Non-operating income	0.1	0.0	(0.1)
Non-operating expenditure	(7.0)	(8.8)	(1.8)
Other gains including asset disposal	0.0	0.4	0.4
Total	**(3.1)**	**(1.8)**	**1.3**

Significant Issues to note are:

1. In total **income** shows a positive variance against plan of £27.6m due to the agreed Covid re-imbursement and additional training income received.

2. The overspend on **operating expenditure** is the additional Covid costs incurred net of fuel savings delivered by the BP scheme in place from April to June.

'**Post-EBIDTA' issues and Forecast Position**

3. There were no material Post EBITDA issues to report

4. The Black Country STP submitted a planned combined deficit plan for the year of £27.1m which included the WMAS forecast overspend of £6.3m based on projected workforce requirements to meet Winter and anticipated Covid surge activity. The STP remains under significant pressure to reduce its projected overspend position. All of the organisations in the STP agreed to review their forecast positions and to reduce forecast deficits as far as possible. Given the more positive WMAS Month 9 position, likely further agreements around 'social distancing' costs for PTS patients being appropriately met by the PTS Commissioners, a further VAT refund to be received in March and agreement from NHSE/I to fund the NACC running costs, the forecast for Months 10-12 has been revised to breakeven against plan. This still leaves a deficit for the year overall of c£2m which can only be reduced if income is received, as the Trust was assured, to cover the costs of the national 111 surge cell. The draft STP position at Month 9 following review of forecasts by all of the Trusts and CCGs is now reduced to £14.1m.

DELIVERY OF COST IMPROVEMENTS

5. The Trust had a number of key CIP schemes covering Patient Transport Services, operating staff, non-pay expenditure and management cost savings, designed to secure £2.27m of CIPs in 2020-21.

6. At month 9 the Trust had achieved savings of £1.997m which was £27k above plan and represented 88% of the required total for the year.

CAPITAL AND WORKING CAPITAL

7. In March, the Board of Directors agreed a Capital Programme of £24.76m for the year but since 1 April 2020 the Trust has been required to work within the allocated Black Country and West Birmingham STP capital envelope. The total of the plans submitted by the STP Provider Trusts and CCGs now agrees to that capital envelope, however the funding position of £12.8m spent by the Royal Wolverhampton NHS Trust to provide additional ward capacity at the beginning of the pandemic was additional to the planned spend and was unresolved. Without national Covid capital support, the STP organisations will have to meet this cost between them. All of these organisations had naturally already committed a proportion of their capital plans before this position was identified and further urgent capital requirements have also needed to be actioned. This limited the scope of the STP to meet the Royal Wolverhampton costs if their Covid funding bid was rejected. WMAS had the highest level of pre-commitments as the purchase of the Headquarters building at Millennium Point had already been completed, orders for vehicles for the year were already placed and the vehicles were in build, GDE funding requirements had to be met, and urgent IT projects were already underway. Further expenditure on projects to ensure social distancing on Trust sites have also needed to be agreed. The STP has now been advised that a bid of £9.3m for the RWT wards has been agreed by the Regional COVID Capital Team and forwarded for national approval. If this is received, the STP Control Total gap is reduced to £2.5m and work is continuing to identify opportunities to close this.

At 31 December, the Trust had spent £20.4m of its Capital Programme compared with budget of £22.7m, a shortfall of £2.3m against the planned position which was largely due to the delay in agreement to the overall STP plan and to the Budget phasing for the RRVs delivery. The Trust expects to deliver its full plan by 31 March.

As part of the revised planning for Months 7-12, the cash flow was re-set to reflect the continuing Interim Financial Regime now expected to remain in place up to 31 March 2021. The closing cash balance at 31 December was £75.98m against a plan of £54.67m. The balance included the advance payment of £26m received under the interim financial regime and paid to all provider Trusts to ensure that suppliers could be paid promptly during the pandemic in order to maintain essential supply lines to the NHS. NHSE/I have now confirmed that this advance payment system will not continue in 2021/22 with the final advance being made in February 2021 for March 2021. Trusts will then be required to manage their own Working Capital as previously. The Trust is confident that it will be able to maintain its strong liquidity position.

The Trust Debtors' position remains positive against plan as most of the long-standing debt has been cleared, and this has improved the Trust cash position against plan. The cash balance still includes a proportion of the £4.5m pass-through monies received in October via NARU which needs to be paid out to all the English Ambulance Services and for which invoices are still awaited.

FINANCIAL YEAR 2021-22

NHSE/I have advised within the past 2 weeks that the Interim Financial Regime will be rolled forward for at least the first 3 months of 2021-22 in order to ensure that NHS organisations can continue to concentrate all staff resources on dealing with the pandemic. There will be no Planning work undertaken in the final quarter of 2020-21 and Planning Guidance will not be issued until early April. Revenue income for Q1 of 2021-22 will not be advised until mid-March at the earliest, but Capital planning may be able to be completed at an earlier stage. There will be minimal requirement for central returns to be completed, but the Final Accounts timetable will be in line with previous years and only in exceptional circumstances will an organisation be able to apply for an extension to this.

Revenue budgets will be allocated on a 'system envelope' approach based on CCG allocations and 'Blended Payment' will be the default contractual mechanism. Capital will be allocated to STPs as in 2020-21 with a local system 'envelope' and overall Control Total. It is expected that these amounts will be published in February with plans not due in until April.

Although the income levels for the Trust will not be known for some weeks, work has been ongoing to prepare expenditure budgets for the new Financial Year. Pay and Non Pay Budgets are ready for review and detailed discussions have identified a draft list of Efficiency proposals. A draft 5 year Capital Plan has been submitted to the STP and a preliminary STP Capital Plan for 2021-22 will be available for discussion by the Directors of Finance at their next meeting.

CONCLUDING COMMENTS

8. The Trust saw a positive financial performance in the first 9 months of 2020-21. Despite the significant unplanned operational changes due to Covid 19, financial control has remained strong, the plan requirement was met in Months 1-8 and exceeded in Month 9, and the CIP programme and Capital Programme were delivered.

9. The Finance Directors of the STP Trusts and CCGs have agreed that there should be a Risk Sharing Agreement drafted to enable actions to assist any organisation that cannot meet their plans and this will be dependent on an Open Book approach. Trusts performing better than plan will need to return funding to the STP to re-distribute.

10. Continued close monitoring and control of expenditure in the Trust will be required to deliver the plan as submitted and progress reports will be reviewed at EMB and at the Performance Committee.

Linda Millinchamp

Executive Director of Finance

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08A MONTH: JANUARY 2021 PAPER NUMBER: 06A

Replacement Emergency Ambulance Programme 2021/22	
Sponsoring Director	Craig Cooke
Author(s)/Presenter	Craig Cooke
Purpose	To authorise the procurement of 86 replacement vehicles to enable delivery timescales as set out in the report attached.
Previously Considered by	EMB
Report Approved By	Craig Cooke

Executive Summary

EMB are recommending the procurement of 86 replacement vehicles.

The Trust has placed orders for the construction of replacement of leased vehicles and to enable the construction and delivery in a timely manner, the Board are requested to authorise progressing delivery of the vehicles.

It will not be possible to wait beyond 31 January to place these orders and commitments with suppliers, without affecting the timely delivery of the new vehicle to replace the outgoing leased assets.

Related Trust Objectives/ National Standards	Maintaining fleet below 5 year age profile
Risk and Assurance	If we do not make decisions around the areas contained within this paper there is a risk to our supply of new/replacement Emergency Ambulances is affected.
Legal implications/ regulatory requirements	Legal advice has not been sought on this specific matter, although there is in place appropriate contracts.
Financial Implications	The Director of Finance will update the Board at the meeting.
Workforce & Training Implications	N/A
Communications Issues	N/A

Diversity & Inclusivity Implications	N/A
Quality Impact Assessment	Not undertaken although delivery of the vehicles will enable the Board to maintain its service delivery.
Data Quality	Documentation is held by either the Director of Strategic & Digital Integration

Action required

The Board are asked to consider the attached paper and authorise the Director of Strategic & Digital Integration to proceed with the procurement of 86 replacement vehicles from the firms listed at a cost of £9.11m.

Replacement Emergency Ambulance Programme 2021/22

The Board has previously approved the decision to extend the contract for the conversion of Emergency Ambulances under the tender, taking advantage of the 1 3rd and final year extension for the ambulance conversion work.

The plan for 2021/22 requires 86 Emergency Ambulances requiring replacement. The Trust has placed orders for 86 the Fiat Ducato van chassis in late November 2020, given the delivery timescale are 6months to deliver and avoid any post Brexit price changes.

The Trusts needs to commence building these Emergency Ambulances in April in readiness to take delivery of the new asset before the lease expires on the current vehicles in life. In order to progress and gain commitment from suppliers, the Trust needs to place orders with the following companies, total value equals £9.11m:

a) VCS – vehicle conversion
b) Stryker – stretchers and carry chairs
c) Zoll – defibrillator equipment
d) Prometheus – Ventilators
e) Ferno - manual handling equipment
f) Mangar – patient lifting equipment

It is important to make a commitment now with VCS the conversion company, so commitments in their factory build slots is secured and ensure WMAS don't lose the available slots. Once WMAS issue a PO, then agreement for the build dates can be secured.

The remaining supply companies are quoting longer lead times due to Covid-19 and the Brexit scenario and there is also a risk that price movements occur prior to April 1 if commitments are received from the Trust.

It will not be possible to wait beyond 31 January to place these orders and commitments with suppliers, without affecting the timely deliver of the new vehicle to replace the outgoing leased assets. Whilst this may seem relatively low impact, the lease companies are not willing to enter into short-term lease extensions any longer because the market is buoyant for ex WMAS Emergency Ambulance assets, and typically require a minimum 6mths lease extension.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09 MONTH: January 2021 PAPER NUMBER: 07

Quality Report	
Sponsoring Director	Mark Docherty, Executive Director of Nursing and Clinical Commissioning.
Author(s)/ Presenter	Mark Docherty, Executive Director of Nursing and Clinical Commissioning. Dr Alison Walker Executive Medical Director
Purpose	The report is presented to the Board to give the Board assurance on the clinical quality agenda. It is an integrated report that will be developed to provide a single reporting mechanism to the Board on all clinical quality issues.
Previously Considered by	Quality Governance Committee 20 January 2021
Report Approved By	Mark Docherty, Director of Nursing and Clinical Commissioning.

Executive Summary

This report is presented in the format of an integrated quality report. It is currently a developing report that will be improved over time to reflect all aspects of quality into one report.

The report provides a high level of assurance by way of the systems and processes in place to measure and monitor our quality assurance and provides a robust framework to support our clinical quality governance.

Related Trust Objectives/ National Standards	Supports the monitoring against our strategic objective to achieve quality and excellence.
Risk and Assurance	The report is presented as a document that gives Board assurance and highlights areas of clinical risk.
Legal implications/ regulatory requirements	The report highlights the areas where we have a statutory duty to report.
Financial Implications	There are no direct financial implications raised in this report.
Workforce Implications	None in the context of this report.
Communications Issues	The contents of this report are not confidential and have been provided to multiple people inside and outside the organisation. Much of the information is in the public domain.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09 MONTH: January 2021 PAPER NUMBER: 07

Diversity & Inclusivity Implications	The report will highlight any diversity and inclusion issues as or if they arise.
Quality Impact Assessment	The report will highlight any quality impact assessments as they arise.
Data Quality	The data used in the report has been provided and quality assured ahead of publication in Board papers.

Action required

The Board is asked to:

1. Note the new approach to presenting an integrated quality report to the Board.
2. Receive the report.
3. Gain assurance on the quality agenda and the robustness of our quality governance processes.

COVID-19

There are well known ongoing and increasing concerns around rising infection rates and hospital including critical care admissions across the region. WMAS continues to play a significant role in the COVID response.

WMAS is at the forefront in the immunisation of staff and currently more than 50% of staff have received their initial vaccination.

COVID-19 Outbreaks

We have managed a small number of outbreaks across our estate. We have a robust mechanism of outbreak management, including establishment of an Incident Management Team. Chaired by the Executive Nurse in his role as the Director of Infection Prevention and Control (DIPC) and have involved Operations staff and other WMAS staff, NHSE/I, Local Authority, Public Health England, CCG.

The WMAS response to the outbreaks we have managed have been held up as an exemplar model .

Support and Communication with Staff

All members of the team have been working from home during the COVID-19 pandemic. This provides a challenge and an opportunity. The following systems have been put in place for example:

- Meetings organised via MS Teams
- Regular staff briefings and welfare checks, initially every day at 11am, now every Monday, Wednesday and Friday at 11am
- All staff issued with appropriate IT, including laptops, RAP devices etc
- Staff have been issued with necessary desks, chairs etc
- Individual face to face meetings held with social distancing where necessary
- All staff were sent a handwritten Christmas card

Education

The MSc in Paramedic practice is developing jointly with the HRD and Keele University. WMAS is represented on the project Board. This is 4 year programme for new students, we are also looking for progress opportunities for our paramedics to access HEI courses to support Urgent Care developments and care.

Ockenden Report

Following the publication of the Ockenden Report on 10 December 2020, we have been reviewing the Action required of WMAS to support the significant improvements in care that are required. This is a separate Board Paper for the Board assurance.

Patient Handover Delays

The issue of patient handover delays continues to deteriorate. Action is being taken with individual hospitals and NHSE/I to address this problem. There are additional risks as a result of COVID that have arisen, including patients being held on ambulances for prolonged periods of time. We continue to work to minimise the risk, but we believe that this is now one of the biggest risks that our organisation faces.

Clinical Pathway Changes across the Region

COVID-19 has brough unique challenges that have resulted in clinical pathway changes in hospitals across the region for example:

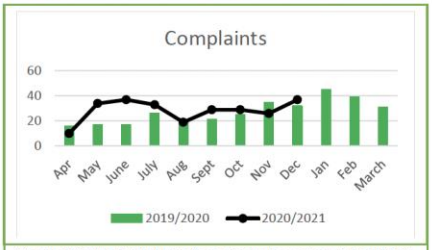
- Paediatrics in Birmingham and Solihull going to the Birmingham Children's Hospital
- Paediatrics in Sandwell and West Birmingham going to the Birmingham Children's Hospital
- Sandwell and West Birmingham haematology Oncology patients to go to City Hospital, Birmingham
- Shropshire and Telford paediatric patients to go direct to the paediatric ward at Princess Royal Hospital, Telford
- Coventry and Warwickshire minor injuries to Rugby St Cross Hospital

We have set up a robust process for agreeing, managing and communicating pathway changes through the issue of clinical notices.

Formal Complaints

Patient Experience

Formal Complaints	Last reported month (Dec 2020)	Year to date 2019-20 Total	Year to date 2020-21 YTD
WMAS	37	208	258



Year to Date the Patient Experience Team has acknowledged 99.6% of its complaints within 3 working days. The Trust has responded to 100% of cases within 25 working days.

For the month of December, we saw 32 complaints received in December 2019 compared to 37 in December 2020.

The main reason for a complaint was Clinical Care = 20

Of the cases closed year to date:

34= *Justified*,

38 = *Part Justified*,

144 = *Not justified*

In December 2020, the Trust undertook:120,566 Emergency Calls, which equates to 1 Complaint for every 40,189 calls received.

96,768 Emergency Incidents, which equates to 1 Complaint for every 4,207 Incidents.

66,238 Non-Emergency Patient Journeys, which equates to 1 complaint every 16,560 journeys

134, 827 IUC Calls answered, which equates to 1 complaint every 19,261 calls

Informal (PALS)	Last reported month (Dec 2020)	Year to date 2019-20 Total	Year to date 2020-21 YTD
WMAS	190	1630	1562

For the month of December, we have seen a decrease of 3 from 193 in December 2019 to 190 in December 2020.

The main reason for an informal concern being raised was as follows:

Attitude and Conduct – 35

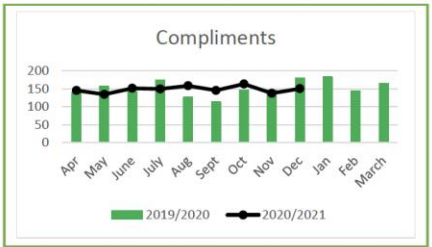
Loss and Damage – 32

Call Management – 31

Of the Cases closed year to date –

346 = *Justified*,
234 = *Part Justified*,
662= *Not justified*
40 = N/A

Compliments	Last reported month (Dec 2020)	Year to date 2019-20 Total	Year to date 2020-21 YTD
WMAS	150	1323	1332



Compliments: There have been 150 compliments received compared to 180 the previous year a decrease of 30 (16.7%)

Friends and Family Test

The FFT question is available on the Trust website: '**Thinking about the service provided by the patient transport service, overall how was your experience of our service?**':

Response	December	YTD
Very Good	31	37
Good	6	8
Neither Good or Poor	3	4
Poor	2	3
Very Poor	0	0
Don't Know	0	0
Total	**42**	**52**

42 responses were completed through the online PTS survey or face to face surveys. The Patient Transport Service conveyed 66, 238 people during this month.
The Discharge Survey: 32 responses have been received to date. 150 patients were targeted in December 2020 another 150 are planned for the end of January 2021 and the final 150 patients will be surveyed the end of March 2021.

Patient Safety

Patient Safety Incidents

Total Patient Safety Incidents	Last reported month (Dec 20)	Year to date 2019-20	Year to date 2020-21
WMAS	306	2342	2353

For the month of December, there were 306 patient safety incidents reported. This is an 24% (60) increase on the same month for last year.

Service Delivery (E&U & EOC) had 200 patient safety incidents which accounts for 65% of the total. The main themes are.

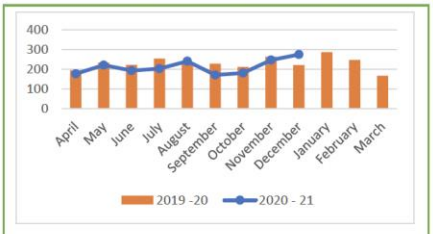
- Patient injury following a fall whilst in our care.

PTS had 98 patient safety incidents which accounts for 32% of the total reported. The main themes are.

- Avoidable injuries whilst in WMAS care, injury due to collision/contact with an object.

IUC/111 had 8 patient safety incidents which accounts for 3% of the total reported. The main themes are.
No new themes identified.

No Harm Incidents	Last reported month (Dec 20)	Year to date 2019-20	Year to date 2020-21
WMAS	220	2054	1998



For the month of December, there were 220 no harm incidents.

Service Delivery accounts for 65% (179) of the total of no harm patient safety incidents.

PTS accounts for 32% (88) of the total of no harm patient safety incidents.

IUC/111 accounts for 3% (7) of the total of no harm patient safety incidents.

Harm Incidents	Last reported month (Dec 20)	Year to date 2019-20	Year to date 2020-21
WMAS	32	288	355

Level of Harm	December 2020
Low	28
Severe	4
Total	32

The top trend for low harm incidents, relate to harm caused due to avoidable injuries caused to patients e.g. skin tears during moving and handling and injury due to collision/contact with an object.

Service Delivery accounts for 66%, PTS 31% & IUC/111 3% of the total of patient harm incidents.

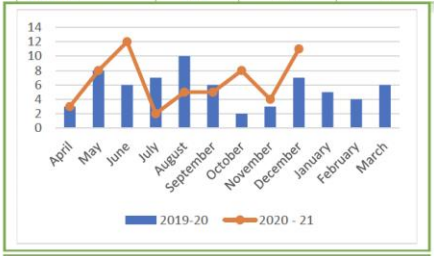
Serious Incidents

- There were 11 serious incidents reported in December
- 4 incidents resulted in moderate harm or above

Serious Incidents and Duty of Candour

Total number of serious incidents reported

	Last reported month (Dec 20)	Year to date 2019-20	Year to date 2020-21
WMAS	11	42	58



There were 11 serious incidents reported in December 2020.

2020/22881	Unrecognised airway blockage
2020/22972	Missed Pelvic Fracture
2020/22979	Delayed VF shock
2020/22983	LFD arrest no ALS drugs
2020/23619	Discharge of 21 YOF bilateral amputation
2020/23634	PTS - AED incorrect defib pads
2020/23703	EOC - Delay in dispatch
2020/24665	Failure to treat and convey an ACS patient
2020/24705	EOC - delay in dispatch to category 2 call
2020/24778	EOC - Incorrect address - paed resp arrest
2020/24904	EOC - Delay due to incorrect address to fitting patient

- There are currently 29 serious incidents open on StEIS.
- 9 SI's are currently over the time frame. 1 is due to an ongoing police investigation with the others being due to work volume.
- 12 requests for SI closure were made since the last report.
- 11 SI's have been raised during December.

Moderate harm and above

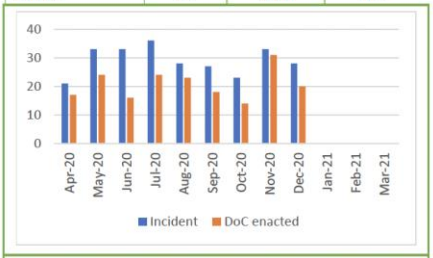
	Last reported month (Dec 20)	Year to date 2020-21
WMAS	4	83

Duty of Candour has been enacted in 75% of cases where moderate harm or above has been caused, this is because at the time of reporting, NoK (Next of Kin) details are not always known.

Multiple reporting of the same incident also reduces the compliance.

Low harm

	Last reported month (Dec 20)	Year to date Total number of incidents	Year to date Number of incidents being open completed
WMAS	28	270	199



There have been 28 incidents where low harm has been caused to a patient.

Out of these, evidence of 'Being Open' can be provided for 20 of the incidents (71.4%).

Incident Reports

Incident Reports

Total Incidents Reported

	Last reported month (Dec 20)	Year to date 2019-20 April - Mar	Year to date 2020-21 April – Dec
WMAS	1022	8323	8,444

Over 40,000 ER54's received since implementation

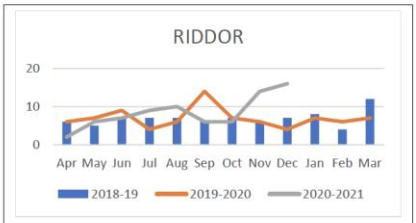
2020 saw over 10,000 incident reports received for the Trust, with several months reporting over 1,000. There has been a continuing increase with incidents now almost double what they were for the same period last year.

Monthly Trend Analysis reports continues to be shared at both Senior Management Team and Operational Management Team and relevant actions reviewed.

The Health, Safety and Risk Management framework is currently in DRAFT format, but will introduce both Risk and Incident Report audits to ensure accuracy, management and learning from all incidents

RIDDOR

	Last reported month (Dec 20)	Year to date 2019-20 April - Mar	Year to date 2020-21 April - Dec
WMAS	16	83	76



RIDDOR trends and themes are reviewed at both Senior and Operational management team meetings, and are reported regularly through the Health, Safety, Risk and Environment Group.

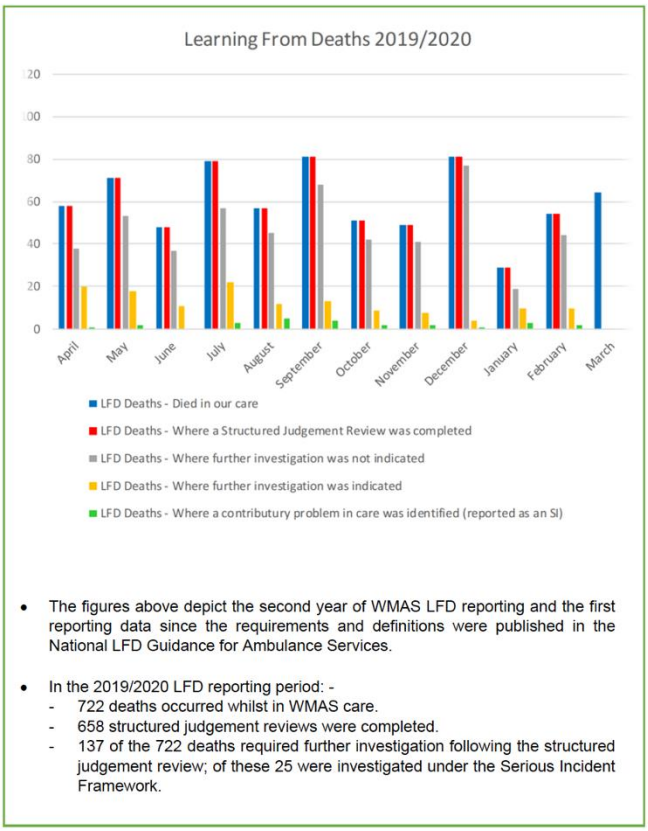
14 Reports – There has been an increase RIDDOR regarding skin conditions due to increased PPE due to COVID-19. All ER54's are reviewed to ensure where WMAS Staff members tests positive, where workplace exposure is identified it is reported (as per SN-071)

Relevant post incident work is completed monthly, including liaison with the HSE, discussions with Managers and Staff and Root Cause Analysis where relevant.

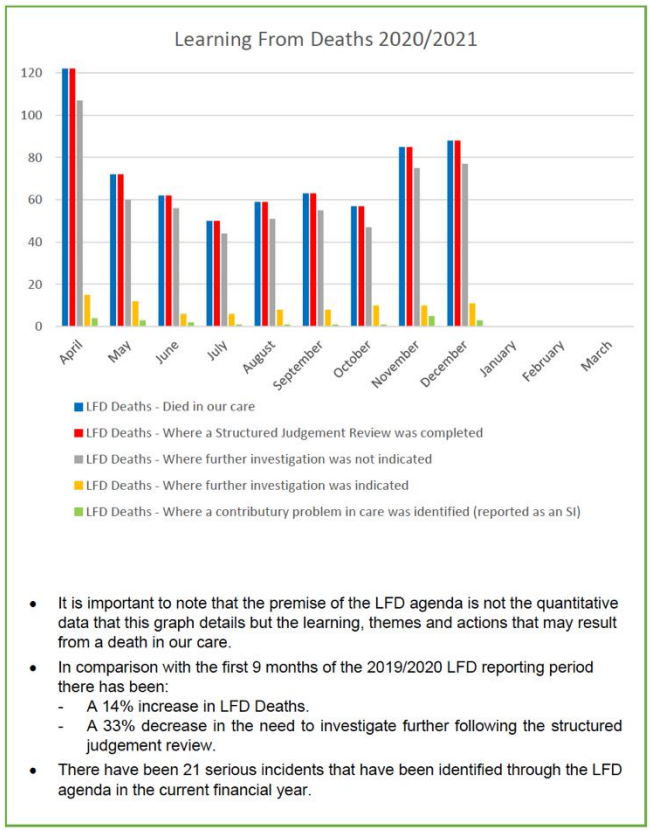
Learning from Deaths

The National Quality Board guidance, which applies to Ambulance Service NHS Trusts and Foundation Trusts, requires the Board to receive quarterly information on deaths. This is achieved through a paper which specifies, in relation to the Learning from Deaths (LFD) agenda: the number of deaths, the number of case reviews (Structured Judgement Reviews (SJRs), the number of case reviews that have required further investigations, the number of investigations where the trust may have contributed towards the death (serious incidents), the cumulative total of these figures and vitally any subsequent learning, themes and actions that have occurred.

Learning from Deaths (LFD)



- The figures above depict the second year of WMAS LFD reporting and the first reporting data since the requirements and definitions were published in the National LFD Guidance for Ambulance Services.
- In the 2019/2020 LFD reporting period: -
  - 722 deaths occurred whilst in WMAS care.
  - 658 structured judgement reviews were completed.
  - 137 of the 722 deaths required further investigation following the structured judgement review; of these 25 were investigated under the Serious Incident Framework.

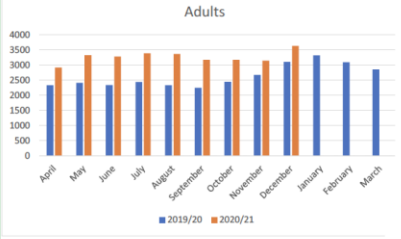


- It is important to note that the premise of the LFD agenda is not the quantitative data that this graph details but the learning, themes and actions that may result from a death in our care.
- In comparison with the first 9 months of the 2019/2020 LFD reporting period there has been:
  - A 14% increase in LFD Deaths.
  - A 33% decrease in the need to investigate further following the structured judgement review.
- There have been 21 serious incidents that have been identified through the LFD agenda in the current financial year.

Safeguarding

Safeguarding Referrals

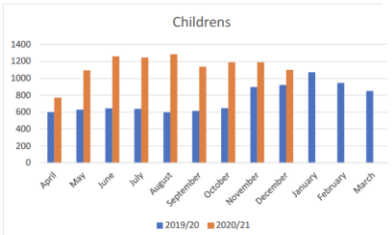
Total Adult Safeguarding Referrals	Last reported month (Dec 20)	Year to date 2019-2020 April to Dec	Year to date 2020-2021 April to Dec
WMAS	3637	22357	29426



Adult Safeguarding- these figures are for referrals for 18 years and older and include adult care concerns. The referrals are received from E&U staff, PTS staff and anyone else in the organisation. Comparison to previous years for the same time period.

There is a 17% increase in the number of adult care/welfare and adult safeguarding referrals sent December 2020 compared to December 2019. There is work underway to reduce the number of referrals across the board, with education to staff relating to an enhanced understanding of the criteria for a safeguarding referral, and specifically the distinction between a true protection referral and one highlighting a care and or welfare concern. The change of reporting from the Commercial Call Centre to the Emergency Operations Centre has increased the number of safeguarding referrals.

Total Child Safeguarding Referrals	Last reported month (Dec 20)	Year to date 2019-2020 April to Dec	Year to date 2020-2021 April to Dec
WMAS	1098	6175	10261



Child Safeguarding Referral- these figures are for under 18 years old.

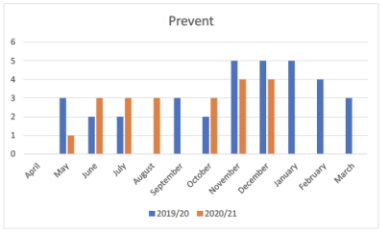
Comparison to previous years for the same time period.

There is a 19% increase in the number of child safeguarding referrals sent December 2020 compared to December 2019.

This is an increase and further work is required with our partner agencies to understand and analyse this increase.

The change of reporting from the Commercial Call Centre to the Emergency Operations Centre has increased the number of safeguarding referrals.

Total PREVENT Referrals	Last reported month (Dec 20)	Year to date 2019-2020 April to Dec	Year to date 2020-2021 April to Dec
WMAS	4	22	21



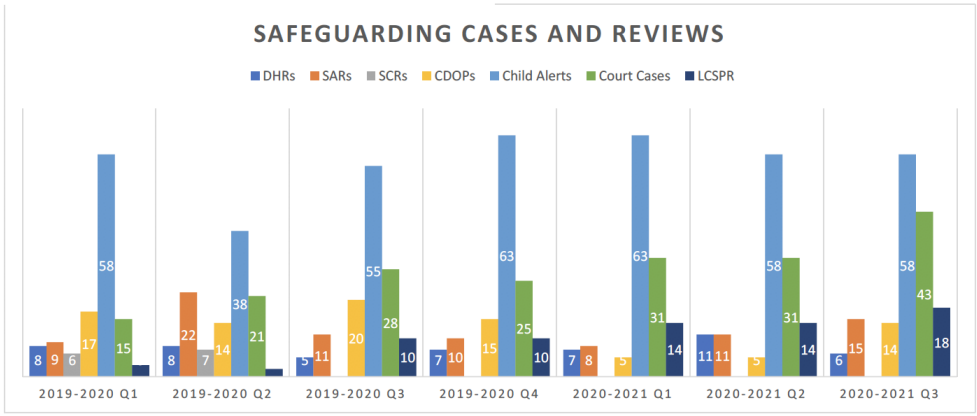
Prevent Referrals are made where there are concern an individual is being radicalised for extremism.

Quarterly Prevent reports are submitted to NHS England via Unify2. This demonstrates compliance with contractual requirements and legislative requirements.

The Trust has been rated as Category 1 by NHS England for Prevent Assurance. There are three levels and Category 1 means the highest, the Trust is in the top category and is compliant.

The numbers remain low so a % increase does not assist in these low numbers

Safeguarding Case and Reviews



DHR's - Domestic Homicide Review

The Home Office definition for a (DHR) is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by: (a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) A member of the same household as them self.

There has been an increase of 1 DHR in Q3 against the same period last year.

SAR's - Safeguarding Adult Review

There is reasonable cause for concern about how a LSCB member organisation or other agencies providing services, worked together to safeguard an adult, And

The adult has died, and the LSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

There has been an increase of 4 SARs from Q3 against the same period last year.

SCR's - Serious Case Reviews

Is defined in Working Together 2015 as when:

(a) Abuse or neglect of a child is known or suspected; and

(b) Either the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

LCSPR's – Local Child Safeguarding Practice Reviews

LCSPR's replaced SCR's as of September 2019.

WMAS have received 18 LCSPR's in Q3 2020/21.

There has been an increase in 12 LCSPR's against the same period last year.

CDOP's Child Death Overview Panel

The Local Safeguarding Children's Boards (LSCB's) are responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a (CDOP). Within the West Midlands there are 14 CDOP's Groups.

In Q3 there has been a decrease of 6 CDOPs against the same period last year.

Child Alerts – Internal WMAS named case

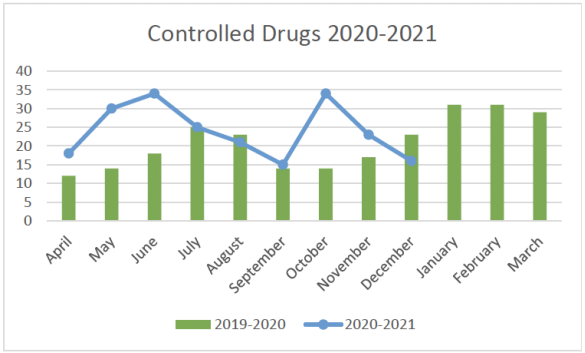
These are internally named cases where WMAS has been involved in an incident where an under 18-year-old has either died or has significant life changing injures. Where a child dies this may become a (Child Death Overview Panel) CDOP for WMAS.

There has been an increase in 3 Child Alert from Q3 against the same period last year.

Medicines Management

CONTROLLED DRUGS

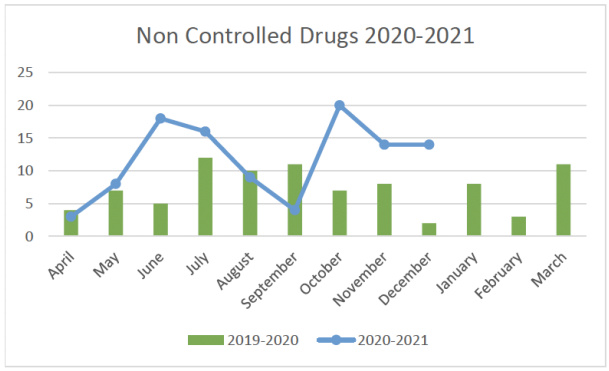
Total Controlled Drugs Incidents (CDI's)		Year to date
Last reported month (Dec 20)	2019-2020 April-Dec	2020-2021 YTD
16	160	216



CONTROLLED DRUGS MEDICINES ER54

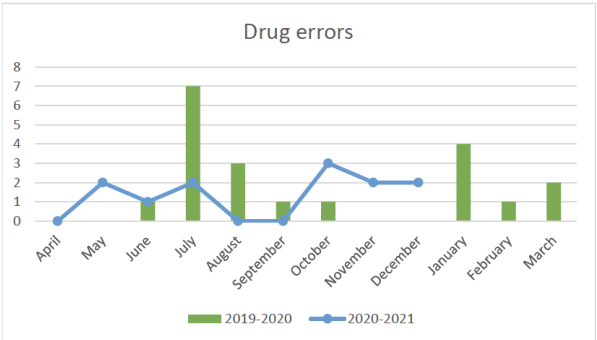
Total Medicines Management related ER54's		Year to date
Last reported month (Dec 20)	2019-2020 Apr- Dec	2020-2021 YTD
14	106	66

There has been an increase in the total number of ER54s, due to increased activity.

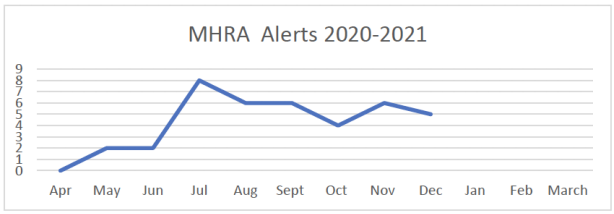


Total Drug Errors, wrong route, wrong dose etc		Year to date
Last reported month (Dec 20)	2019-2020 April-Dec	2020-2021 YTD
2	13	12

There have been two reports of incorrect drug or dosing errors in December.



MHRA Alerts		Year to date
Last reported month (Dec 20)	2019-2020 April-Dec	2020-2021 YTD
5	n/a	39



None of the medicines referenced within the 5 alerts were procured or distributed by WMAS.

Corrective and Preventative Actions (CAPA)		Year to date	
	Last reported month (Dec 20)	2019-2020 April-Dec	2020-2021 YTD
WMAS	0	1	0

There were no issues of concern reported for Wholesaler Dealer Authorisation activities.

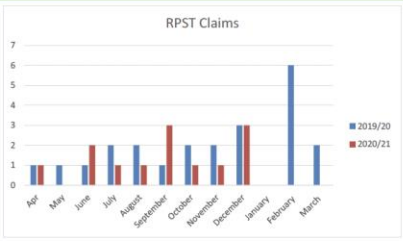
Claims and Coroners Cases

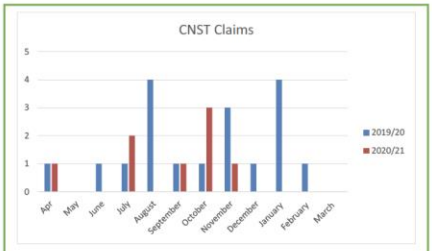
Claims and Coroners

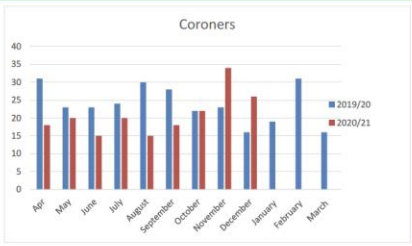
RPST (Risk Pooling Schemes for Trusts)	Last reported month Dec 20	Year to date 2019-20	Year to date 2020-21
WMAS	3	23	13

CNST (Clinical Negligence Scheme for Trusts)	Last reported month Dec 20	Year to date 2019-20	Year to date 2020-21
WMAS	0	17	8

Coroners Requests	Last reported month Dec 20	Year to date 2019-20	Year to date 2020-21
WMAS	26	286	188







RPST (Risk Pooling Schemes for Trusts)
The Risk Pooling Schemes for Trusts is the collective name for two separate schemes covering non-clinical risks, the Liabilities to Third Parties Scheme (LTPS) and the Property Expenses Scheme (PES).

- The Trust has seen no change in RPST claims received in December 2020-2021 compared to the previous year.

CNST (Clinical Negligence Scheme for Trusts)
These are defined as allegations of clinical negligence and/or a demand for compensation made following an adverse clinical incident resulting in personal injury, or any clinical incident, which carries significant litigation risk for the Trust. Such claims may be made by a patient (or their relative).

- The Trust has seen a decrease of 1 CNST claims received in December 2020-2021 compared to the previous year.

Coroners Requests
West Midlands Ambulance Service covers the following areas for Coroners

- Birmingham and Solihull
- Black Country
- Coventry
- Herefordshire
- Shropshire, Telford & Wrekin
- South Staffordshire
- Stoke on Trent & North Staffordshire
- Warwickshire
- Worcestershire

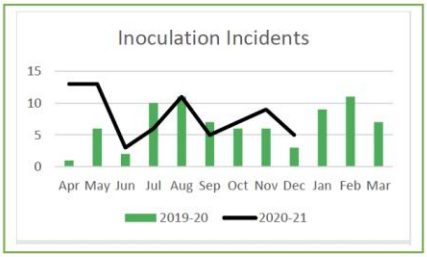
Infection Prevention and Control

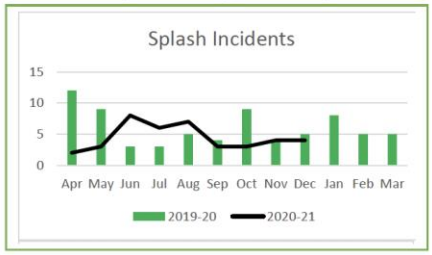
Infection Prevention and Control

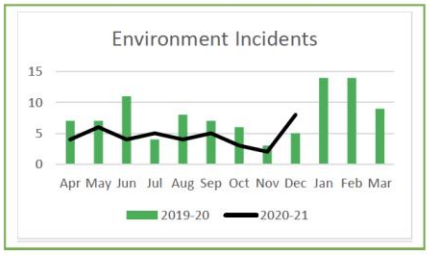
Inoculation Incidents	Last reported month (Dec 20)	Year to date Comparison 2019-20	Year to date Comparison 2020-21 Apr-Dec
WMAS	5	79	72

Splash Incidents	Last reported month (Dec 20)	Year to date Comparison 2019-20	Year to date Comparison 2020-21 Apr-Dec
WMAS	4	72	40

Environment Incidents	Last reported month (Dec 20)	Year to date Comparison 2019-20	Year to date Comparison 2020-21 Apr-Dec
WMAS	8	95	41







Inoculation Incident Key Performance Indicator:
By the end of 2020/21 all inoculation incidents shall be reported and managed through the incident reporting system with results reported through the Health Safety Risk & Environment Group.

Inoculation incidents are classed as any sharp object that penetrates the skin causing an injury. The highest risk of these are injuries that cause a puncture wound that involved an item contaminated with blood or bodily fluids.

Clinical Team Mentors (CTM) at each hub perform 10 cannulation audits per month. These audits are completed at point of care and input using the EPRF platform. Weekly Brief articles supported by clinical notices are published routinely to support the reduction of sharps related incidents.

December 2020 saw 5 inoculation incidents. These incidents include used cannulas, intramuscular needles and an injury caused by a glass ampoule. 4 of these injuries carry a risk of contamination.

All inoculation injuries are supported through SALs and regular local management welfare checks. Incident reporting of inoculation related incidents is encouraged through the Incident and Audit Framework.

Splash Incident Key Performance Indicator:
By the end of 2020/21 all splash incidents shall be reported and managed through the incident reporting system with results reported through the Health Safety Risk & Environment Group.

A splash injury is an accidental or purposeful spraying of blood or body fluids onto exposed mucocutaneous surfaces. The Trust also reports on incidents where of near miss where blood may splash onto the face and near to the eyes, mouth or nose.

Many splash incidents could be avoided if Personal Protective Equipment (PPE) had been worn to protect the member of staff's face. Appropriate PPE is available on the vehicles in the response bag and the IP&C pack and in the cupboard above the stretcher in vehicles.

December 2020 saw just 4 splash incidents. These include the patients' blood/bodily fluid entering the face and/or eyes of treating clinician.

Incident reporting of sharps related incidents is encouraged through the Incident and Audit Framework.

Environment Incident Key Performance Indicator:
By the end of 2020/21 all environment incidents shall be reported and managed through the incident reporting system with results reported through the Health Safety Risk & Environment Group.

The cleanliness of the environment is important to support infection prevention and control, help reduce the incidence of healthcare associated infections and ensure service user confidence.

Environmental incidents capture the general cleanliness of premises, vehicles and management of clinical waste.

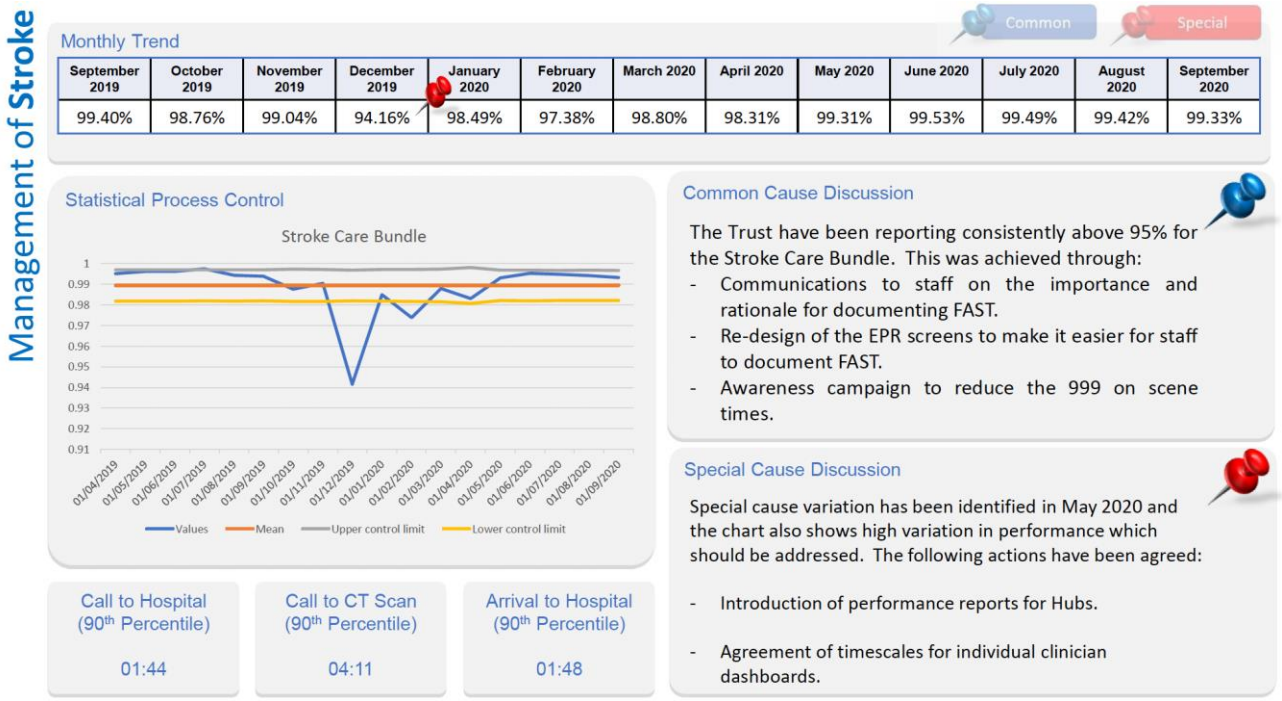
December 2020 saw 8 environmental related incidents. These include reports of exposure to an infectious disease and clinical waste concerns.

Personal Protective Equipment (PPE) is available on all vehicles and in the green response bag to mitigate risk of exposure to identified infectious pathogens.

Incident reporting of environmental related incidents is encouraged through the Incident and Audit Framework.

Clinical Indicators

- WMAS performance against the clinical indicators overall is very good and is being maintained despite the pressures of the global pandemic
- WMAS is starting to use Statistical Process Control to help understand variation in performance (example below)



CQUIN

The nationally defined CQUIN scheme covering the period for April 2020 to March 2021 includes the following schemes:

- CCG5 – Staff Flu Vaccinations
- CCG16 – Access to patient information at scene

All national indicators must be adopted where the relevant services are in scope for each contract, and their value should be equally weighted across the CQUIN funding available. The published value of all CQUIN Schemes was set out at 1.25% of the contract. Where fewer than three national indicators are readily applicable to a particular contract, as is the case for the ambulance sector, CCGs may offer additional local CQUIN indicators (of appropriate number and complexity, proportionate to the scale of the contract). No local schemes have currently been identified.

Indicator Title	Target	Quarter 1	Quarter 2	Quarter 3	Year to Date
CCG2: Staff Flu Vaccinations	90 %	Not applicable		84.88%	84.88%
CCG16: Access to Patient Information at Scene	5%	24.9%	43.1%	52.4%	40.5%

The report provides the progress update in respect of each of the above schemes for quarter 3. Since publication of the national requirements, the consequences of Covid19 resulted in contracting arrangements being halted. Block contracts were implemented for the first half of the year and the payments for CQUIN schemes currently do not apply. The Trust will continue to monitor progress against the two schemes and submit performance accordingly.

Additional Information of Directors Activity

Medical Director

- Meetings to progress joint College of Paramedics and WMAS CPD events, the first will be on maternity emergency care in 2021.
- October '20 ONE Network meeting to share national and Trust "Closing the Gap" workstreams and to receive feedback on a national CTG presentation.
- Joint meetings with the MAA Clinical Director to progress specific workstreams and clinical developments.
- Meetings with WMAS and MAA clinical leads to progress plans to have CCPs as prescribers.
- Updated guidance on the WMAS management of Acute Behavioural Disturbance based on national guidance also written by the Medical Director.
- 27th October presenter - JRCALC and College of Paramedics online Study day, (JRCALC Chair intro, Acute behavioural disturbance presentation plus discussion room and "Closing the Gap" JRCALC reducing inequity in care for patients with darker skin tones presentation, panel member for Q&As)
- Completed the Advanced Caldicott Guardian Course.
- Completed CPD on Managing Unconscious Bias
- Meeting with the GMC Employer Liaison Service lead to discuss WMAS Responsible Officer (Medical Revalidation) systems.
- Represented NASMeD at a national meeting with a family whose son died from Acute Behavioural Disturbance (ABD) in another region.
- Met with national police leads to standardise guidance on ABD across police and ambulance systems and guidelines.
- Joint work with GIRFT (Getting it right first time) NHSE lead to develop a process to evaluate levels of harm from hospital handover delays.
- Attended national medicolegal conference.
- Attended National Ambulance Service Research Group meeting as the NASMeD lead.
- Meeting to progress NIHR research as WMAS co-applicant on prehospital analgesia in trauma.
- Research meetings with the WMAS Head of Research on progressing specific research trials.
- Author of national ABD rapid tranquillisation guideline approved by NASMeD.
- Regional and National Medical Directors groups calls related to Covid-19
- NASMeD meetings and regular national escalation meetings.
- Chair national Frontline Clinical Cell meetings weekly.
- Reviewer of publications for the Emergency Medicine Journal.
- Meeting with AACE IPC lead on updating cardiac arrest clinical guidelines during the pandemic.
- Nonmedical Prescribing policy development meetings.

Clinical Commissioning and Nurse Director:

- Completed 3 yearly revalidation with the NMC
- Regular attendance at the Quality, Governance and Risk Directors meeting hosted by the Association of Ambulance Chief Executives
- Learning from COVID hosted by the National Ambulance Commissioners Group
- Participation in the Regional Emergency Department Clinical Directors meeting
- Regional Chief Nurse Updates
- Meeting with CQC to advise them on key line of enquiry for their Provider Collaboration Reviews
- Attendance at the Shrewsbury and Telford Hospitals Safety Oversight Group
- Meetings on the South Warwickshire ED avoidance pathways
- Shropshire, Telford & Wrekin STP Acute Reconfiguration Implementation Group
- Meeting with the project team of the 4 year MSc Paramedic Science course at Keele University
- National Hospital Handover Delays monthly updates
- NHS Shropshire Clinical Summit
- Joint work with Public Health England on their injury surveillance
- Representation at the Think 111 Programme Steering Boards

Medical and Nurse Directors

- Led joint system change with the GP commissioning lead to change the process for sign off of SI reviews to reduce workload for the Risk Team at WMAS and provide additional Director level assurance for Commissioners.
- Set up quarterly Learning Review Themes and Trends reviews.
- Joint meetings with NHSE regional leads to progress joint working on rotational paramedics, working in partnership with the Director for Strategic Engagement.
- Engaged with NHSE Regional Director leads to escalate and re-escalate the patient harms from hospital handover delays for patients on ambulances, those in the community awaiting 999 ambulances that were held outside Acute Trusts and the impact on WMAS staff.
- Joint WMAS and EMAS meeting with Midlands NHSE on the Virtual COVID ward systems regionally.

Mark Docherty
Director of Nursing Commissioning

Dr Alison Walker Executive
Executive Medical Director and Clinical

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10 MONTH: January 2021 PAPER NUMBER: 08

Title	**Workforce and Organisational Development Report**
Sponsoring Director	Kim Nurse, Executive Director of Workforce and Organisational Development
Author(s)/Presenter	Carla Beechey, Head of Human Resources
Purpose	To provide an update and assurance on the work of the Directorate.
Previously Considered by	Executive Management Board

Summary

This report is submitted to the Board of Directors to advise on the matters considered and actions taken with regards Improving People Practices, specifically disciplinary and investigatory processes.

The paper covers the review carried out and the actions undertaken by the Trust providing the required assurance.

The report also covers the required annual review of the Board Skills Matrix for consideration, approval and publication in the Trust's Annual Report 2021.

Related Trust Objectives/ National Standards	Strategic objectives 1 and 2.
Risk and Assurance	The report provides assurance and the actions taken to mitigate any risk identified.
Legal implications / regulatory requirements	All actions are compliant with the Equality Act 2010 and Employment Law.
Financial Planning	There are no financial risks associated directly within this report.
Workforce Implications	All workforce implications and actions within the report comply with employment legislation and Trust policies and procedures.
Communications Issues	There are no specific communications issues to be actioned from this report.
Equality and Diversity Implications	All reports are compliant with regulations governing equality and in line with the requirements of The Equality Act 2010. No adverse equality and diversity matters have been identified.
Quality Impact Assessment	All quality impacts are addressed within the report.
Data Quality	Electronic Staff Record system [ESR].

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10 MONTH: January 2021 PAPER NUMBER: 08

Action required by the Committee/Group

a) Members of the Board of Directors are requested to consider the content of this report, raising any areas of clarification or exploration, as necessary.

b) Members of the Board of Directors are requested to consider and approve the content of the attached Board Skills Matrix for publication in the Trust's Annual Report 2020 / 2021.

Improving People Practices

Baroness Dido Harding, Chair, NHS Improvement wrote to all NHS Trust Chairs and Chief Executives in a letter dated 23rd May 2019 (**attached at appendix A**).

The letter was as a result of work undertaken by a "task and finish" advisory group who had reviewed and considered the findings of the Verita inquiry following the tragic death of an NHS employee, Amin Abdullah.

Consequently guidance was produced and provided in relation to the management and oversight of local investigation and disciplinary procedures. Trusts were asked to review and assess this against current local procedures and processes and make the necessary adjustments where required.

This guidance was set out in the following 7 areas of recommendations:

1) Adhering to best practice
2) Applying a rigorous decision-making methodology
3) Ensuring people are fully trained and competent to carry out their role
4) Assigning sufficient resources
5) Decisions relating to the implementation of suspension / exclusions
6) Safeguarding people's health and wellbeing
7) Board-level oversight

An action plan was developed detailing West Midlands Ambulance Service (WMAS) practical implementation of the 7 recommendations. A copy of the action plan is attached at **appendix B** and confirms all actions are have been completed.

The Trust's disciplinary policy has recently been updated and is attached for reference **(Appendix C).**

The Executive Management Board receives quarterly disciplinary oversight data and the People Committee receives employee relation casework activity which includes disciplinary cases as a standing item.

Board Skills Matrix

The Board is required to annually review its Skills Matrix to ensure that the make-up of the Board is complete and appropriate in terms of undertaking the stewardship of Trust.

Knowledge and Application of Diversity and Inclusion has been added as a skill area to the 2020 / 2021 audit report.

The Board are asked to consider and approve the content of the attached matrix for publication in the Annual Report 2020 / 2021 **(Appendix d).**

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Learning Lessons to Improve our People Practices Action Plan

Indicator	Recommendation	Descriptor	Actions	Date	Lead	Progress	RAG
1	2 & 5	Decision making evidence	Decision making risk assessment / matrix to be produced and implemented for suspensions, investigations, panels and outcomes.	31/12/2019	Carla Beechey	Documents created, circulated for use, in place and being used.	
2	3	Investigation Training	Ensure all appropriate managers have undergone formal investigation training	31/03/2020	Carla Beechey	Masterclass training took place in June and July 2020	
3	1	Allegation Forming	Mills and Reeve to deliver an allegation forming masterclass to HR practitioners and managers	31/12/2019	Carla Beechey	Training took place on 13/09/2019	
4	6	Welfare contact assigned and detailed in suspension / investigation letter	Welfare assigned and contact details included in suspension / investigation correspondence	Immediate	Carla Beechey	In place	
4	6	Welfare contact added to investigation / suspension log	Welfare contact and when last contact made to be added to suspension / investigation log	Immediate	Carla Beechey	In place	
5	1 - 7	Case Management System	Case management system to be explored to increase efficiencies in ER processes	31/12/2019	Kim Nurse and Carla Beechey	Business case approved - system in place.	
6	6	Welfare Officer Role	Explanation of roles and expectations crib sheet to be produced as manager guidance and circulated	30/11/2019	Carla Beechey	Document created and circulated.	
7	3	Manager observation of ET's	Managers to attend ET to observe and learn from cases	Ongoing	Carla Beechey	Dates of suitable cases shared from Mills and Reeve	
8	7	Weekly suspension update	CEO, Exec Director of Workforce and Ops Directors receive weekly suspension update	Immediate	Carla Beechey	In place	
9	1	Consistency Checking	Director Leads / Head of HR to carry out quarterly review of cases	31/10/2019	Carla Beechey	Meetings diarised	
10	6 & 7	Wellbeing Guardian	Assign an Executive Wellbeing Guardian	31/12/2019	Kim Nurse	Executive Director of Workforce and OD assigned	
11	7	Fast Track Disciplinary Process	Pre action Exec overview of fast track requests	Immediate	Kim Nurse	In place	
12	7	Disciplinary EMB Report	Bi-Annual Disciplinary Cases Report to be reviewed at EMB	Ongoing	Kim Nurse	Produced and submitted to EMB.	
13	4	Sufficient Resources	Consider removing investigators from roles during investigation process	Ongoing	Kim Nurse	Considered on individual case by case basis	
14	3	Panel Training	Ensure managers have undergone disciplinary panel training		Carla Beechey	Training scheduled 19th January 2021	
15	1	Disciplinary Policy	Disciplinary policy to be available on public internet site	31/12/2020	Carla Beechey	In place.	

DISCIPLINARY POLICY AND PROCEDURE

DATE APPROVED:	**8 December 2020**
APPROVED BY:	**Workforce Development Group**
IMPLEMENTATION DATE:	**December 2020**
REVIEW DATE:	**December 2023**
LEAD DIRECTOR:	**Director of Workforce and Organisational Development**
IMPACT ASSESSMENT STATEMENT:	**No adverse impact on Equality or Diversity**

Document Reference Number:	**Policy – 022 (Version 7)**

Change Control:

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Document	Disciplinary Policy & Procedure
Version	Severn
Owner	Director of Workforce and Organisational Development
Distribution list	All
Issue Date	December 2020
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Author	Head of Human Resources

Change History:

Date	Change	Comment/Approved by
For previous change history, please refer to version 5 of this document.		
April 2017	Reviewed with suggested changes.	Head of HR
03 May 2017	Changes required.	Policy Group
01 June 2017	Further changes required.	Policy Group
06 July 2017	Further changes required.	Policy Group
05 October 2017	Approved to take to RPF.	Policy Group
11 October 2017	Not agreed and requested to go back to Policy Group.	Regional Partnership Forum
02 November 2017	Approved to take forward to RPF.	Policy Group
23 November 2017	Agreed.	RPF
11 January 2018	Agreed for implementation.	Workforce Development Group
September 2020	Reviewed	Head of HR
October 2020	Reviewed	Policy Group
November 2020	Reviewed with suggested changes	Policy Group
December 2020	Agreed	Regional Partnership Form
December 2020	Agreed for implementation	Workforce Development Group
Renumbered from HR – Procedure – 004 due to change in referencing document procedure		

CONTENTS

1 Purpose

1.1 It is to the mutual benefit of both the staff and the management of the Trust that an agreed procedure is available for achieving and maintaining standards of conduct. This procedure observes current employment legislation and the ACAS Code of Practice on Disciplinary and Grievance.

1.2 This procedure has three main objectives, the first is, when necessary, to improve the conduct of staff, the second is that management endeavour to take corrective action as appropriate and where necessary, and the third objective is to ensure that poor conduct is dealt with reasonably and consistently across the Trust through a system of warnings.

1.3 All employees will have the right, if they wish, to be represented by a work colleague or a Trade Union representative, at all stages of the policy / procedure. However, the person accompanying the employee may not act in a legal capacity during any hearing/meeting.

1.4 Where this policy is required for an accredited trade union representative, the Trust's Trade Union Recognition Agreement will be followed.

1.5 It is the responsibility of management to ensure staff are aware of this policy and procedure. It is the responsibility of staff to ensure that they are familiar with the contents of this policy and procedure.

1.6 The Human Resources Department will provide advice and guidance concerning the procedure for all parties.

2 Scope

2.1 The Policy & Procedure applies to all employees of the West Midlands Ambulance Service University NHS Foundation Trust (hereinafter known as "the Trust") and supersedes any other Disciplinary Policy & Procedures currently in place in the Trust.

2.2 This document would not normally apply to issues of capability, sickness absence or clinical competence. These are dealt with in separate policies/ procedures. However, it is noted that in cases of Clinical Misconduct, an investigation under the Disciplinary Policy may be necessary.

2.3 Specific measures are in place to counter potential fraud and these are detailed in the appropriate Trust Policy.

2.4 The Trust will endeavour to resolve matters within the context of this procedure within reasonable timeframes. This will normally be 3 months, although some cases may extend beyond this timeline.

2.5 Conduct issues referred from the Investigation Policy related to misconduct will be dealt with through this policy and procedure. Any investigation that

commenced or took part under a different policy, ie the Investigation Policy will continue, and will form part of the investigation process in this Policy and Procedure.

2.6 Instigating Managers may consider the use of a Root Cause Analysis, in line with the agreed mechanisms within the Trust, either before, during or after an investigation.

3 Investigation

All matters investigated within this procedure will use the following principles:

3.1 The Manager who commissions the investigation will be known as the Instigating Manager who will appoint an Investigation Team.

3.2 The Investigation team shall comprise:

- The individual who will lead the investigation into the allegation(s) and will be known as the "Investigating Officer". This will be a person with sufficient seniority and experience and will be a higher ranked officer than the individual being investigated to deliver a competent investigation.

- A nominated individual, supporting the Investigating Officer as required.

- A welfare support officer should be allocated to the suspended member of staff.

3.3 All members of staff will be informed of investigation meeting(s) in writing, with a minimum of 48 hours' notice (unless agreed between all parties to take place earlier), together with the allegations being investigated (anonymised as appropriate) and where appropriate, PRF, anonymised. The offer of a welfare officer will also be made at this time. The staff member will have the right to identify their preference. This will also be the case when suspension occurs.

3.4 Reasonable time will be allocated to members of staff and their representative prior to the interview for preparation.

3.5 The purpose of investigation meeting is to gather evidence relating to the allegations under investigation.

3.6 Questions will primarily be asked by the Investigating Officer.

3.7 Records will be made of all investigation meetings and of statements made by the employee and the employee will be asked to sign, date and return the notes to the Investigating Team. A copy will be made available to the employee. This process should be completed on the same day as any interview unless mutually agreed.

3.8 Where appropriate the Investigating Officer may request a statement from a witness without interviewing them in person. This statement should be signed and dated by the witness (this may be accepted in the form of an email statement from a secure personal account). This does not negate the need to interview the witness if required but the witness should be advised that they may be called to attend the disciplinary hearing and maybe questioned by those present at the hearing.

3.9 At the conclusion of the investigation, the Investigation Team will produce a report and issue it to the Instigating Manager for review. Advice will be sought from Human Resources where required for procedural matters.

3.10 Where an employee raises a grievance during a disciplinary process, the disciplinary process may be temporarily suspended in order to deal with the grievance" and that "where the grievance and disciplinary cases are related, it may be appropriate to deal with both issues concurrently.

3.11 The employee may, during the investigation, be given and take the opportunity to accept responsibility for a breach of conduct, under a "quick resolution". A full investigation may be forestalled by the individual submitting a full and detailed explanation for their conduct. This approach could be via management, but most likely requested by the employee or their representative. The Instigating Manager will consider whether a 3.11 resolution is appropriate or whether to continue with the ongoing formal disciplinary process. In respect of a 3.11 meeting a single disciplinary sanction may be applied, with the prior agreement of all parties, and conducted by the Line Manager, upon advice of the Instigating Manager (where these two roles are separate), with a member of the Human Resources Department present. Disciplinary sanctions available under this paragraph 3.11 range from verbal warnings to final written warnings. By their nature, 3.11 discussions are "without prejudice" and should not form part of the Investigation Pack, any other documentation, or be verbally referred to at a later date should the 3.11 not be accepted

4 Suspension

4.1 Suspension will only be taken:

- in cases of alleged gross misconduct.
- to protect patient / staff safety, or Trust property; or
- to allow for an unbiased investigation, where the Trust considers that presence of the staff member at work might interfere with the investigation.

4.2 Suspension is a neutral act, at full pay (in line with the individual's contract i.e as per NHS Terms and Conditions.)

4.3 Suspension will be considered as a "last resort" action following consideration of any other alternatives, which may be available such as temporary alternative duties.

4.4 Any decision to suspend will be sanctioned by a Senior Manager / equivalent / above, although the action may be delegated to a manager, and formally confirmed in writing within 3 working days. Every effort will be made to ensure a TU Representative is available at the time of suspension.

4.5 Suspension may occur at any point during an investigation as per 4.1.

4.6 The individual may be reinstated at any point during the investigation if the manager initiating the suspension is of the view that the reasons for suspension are no longer appropriate.

4.7 Suspension is precautionary, pending the outcome of the investigation or disciplinary proceedings should they ensue. No record will be kept on the personal file, of any suspension, which does not lead to disciplinary action.

4.8 An employee who is suspended for longer than 4 weeks shall have the right to submit a written request for a review of their suspension through the Senior Manager in conjunction with the Head of Human Resources; a written reply will be given to the employee and/or Representative.

5 Counter Fraud and Security Management Service

5.1 It is important for all staff to be aware that some forms of misconduct could potentially be considered 'fraudulent' under criminal law, and could lead to criminal prosecution as well as disciplinary or civil action. Examples could include (but are not limited to) deliberately making false or exaggerated mileage claims on travel expenses forms; making false claims on timesheets for hours not actually worked; making false statements about, or forging documentation relating to, qualifications/references when applying for a particular job; working elsewhere whilst off sick; or obtaining financial or other property/services of the Trust by deception.

5.2 Where a disciplinary issue of possible fraud of this nature is being considered, the Instigating Officer must discuss the matter in the first instance with Trust's Local Counter Fraud Specialist (LCFS). Depending on the exact nature and scale of the possible misconduct, it may be that a criminal investigation into the activities of the employee is considered necessary. In such cases, commencing disciplinary action at the outset may not always be appropriate, especially if it would alert the employee to any criminal investigation and lead to the possible altering or destruction of evidence of potentially criminal activity. In any such situation, decisions on the way to proceed should only be taken after consultation with the LCFS, the Director of Finance and the Director of Workforce and Organisational Development.

6 Police Investigation

6.1 Any individuals under investigation by the Police are duty bound to inform their manager of this, and to provide information about the police investigation. It may be necessary or appropriate for the Trust to also investigate under this policy and procedure, but all cases will be considered on an individual basis.

6.2 If remanded in custody, or where bail conditions are imposed which prevent an employee from being available for work, in their contracted or any alternate role they may not be entitled to receive pay during the period of any remand/bail conditions. This will be determined on a case by case basis. This does not stop the right of an employer to investigate the issue for any implications on the employment of the member of staff. (see 4.3 also).

Please also refer to the Managing Safeguarding Allegations Policy and Procedure.

7 Record Keeping

7.1 A record must be made and retained of all action taken at every stage of this procedure.

8 The Disciplinary Hearing

8.1 On completion of the investigation a report detailing the Investigating Officer's findings is submitted to the Instigating Manager. A decision as to whether to convene a disciplinary hearing or not, will be made by the Instigating Manager, who cannot participate on the disciplinary panel.

8.2 The employee must be given a minimum of 14 calendar days advance notice that they are attending a disciplinary hearing. A copy of the investigation report will be provided to the employee. The employee must submit to the Chair of the panel any additional evidence or documentation they wish to be considered, and the names of any witnesses they will be calling, such information to be provided not less than 3 working days in advance of the hearing. Any documentation not submitted within these timeframes will be considered by the panel at their discretion.

In the instance of a complex case, or where there is a large investigation pack/report, the employee may request additional time prepare.

8.3 Patient details must be anonymised in the documentation issued to all parties, at the disciplinary hearing and any subsequent appeal. Further appropriate details may be made available to the employee during the investigation meetings so that the employee can identify the incident/patient in question.
Where possible, original documents should make up the digital pack and not scanned documents.

8.4 Every effort will be made to ensure that employees and their representatives are able to attend hearings as per the Recognition Agreement. In the event of any employee, or their representative being unable to attend, the hearing will be re-arranged, providing the employee with 5 calendar days' notice, or rearranged as mutually agreed. In order to ensure a timely resolution of the issue, unless there are wholly exceptional circumstances, hearings will only be re-scheduled twice in total. Failure to attend on the second occasion will mean that the case may be heard in the employee's absence and considered on the evidence available to the panel.

8.5 The disciplinary hearing will be chaired by an appropriate manager not directly involved with the management of the employee. Panel membership will be a minimum of two persons with a member of Human Resources department also being present to provide advice on areas of law, procedure and consistency. The HR member will not be a decision- maker on the panel. The Investigation will be presented with the supporting facts and material. The procedure to be followed appears at Appendix 1.

8.6 Whilst the procedure is designed to be a series of progressive warnings it may be necessary to proceed directly to the use of a written or final written warning, or even dismissal, depending upon the seriousness of the offence and therefore this procedure allows for any appropriate sanction to be imposed as the panel considers appropriate.

9 Outcome of Disciplinary Sanction

9.1 With the exception of a 3.11 outcome, a hearing will precede the award of a disciplinary sanction.
In determining the level of sanction consideration will be given to the employee's length of service, past performance, and other mitigating factors which may be relevant.

9.2 Formal Verbal Warnings:
For a minor offence(s) a formal verbal warning may be given. This warning will make it clear that further misconduct will render the employee liable for further disciplinary action involving more serious consequences.

9.3 First Written Warnings:
For a more serious offence a first written warning may be given for a first offence, or for the repetition of a lesser offence after a formal verbal warning has previously been given, a first written warning may be given. This will set out the nature of the offence and informs the employee that further misconduct is liable to result in further disciplinary action under this procedure.

9.4 Final Written Warnings:
A final written warning may be given for first offences of a serious nature or for an offence after a first written warning has been given. This warning will set out the nature of the offence and informs the employee that further misconduct of any sort would render them liable to further action under this procedure and could result in dismissal.

9.5 Time Limits:

The length of time a warning remains active on an employee's record will be determined by the Manager and / or Panel after considering all relevant facts, but will normally fall within the following guidelines:

	Verbal Warning	Norm: 3 Months but maybe extended to 6 months
	Written Warning	Norm: 6 Months but maybe extended to 12 months
	Final Warning	Norm: 12 Months

Once expired, it will be removed from all files relating to the individual.

The law of double jeopardy means that a second disciplinary process for the same offence cannot take place unless in the most extreme and serious of cases.

9.6 Level of Authority:

A Senior Operations Manager / Head of Department / equivalent / above will chair the disciplinary panel.
A Senior Operations Manager / Head of Department / equivalent / above has the authority to dismiss.

10 Dismissal

10.1 Where an employee who has a final written warning and commits a founded further act or acts of misconduct, the employee may be liable to dismissal with pay in lieu of notice.
Where summary dismissal is warranted, then the dismissal will take immediate effect and will not attract pay in lieu of notice.

10.2 The Chief Executive Officer and Executive Directors may only be dismissed by the remuneration committee chaired by the Chairman of the Trust.

10.3 The result of the hearing, and details of the right of appeal, will be confirmed in writing within five working days.

10.4 In circumstances where there is evidence indicating that a registered individual's fitness to practice has been impaired, the Trust has a duty to notify the matter to the relevant professional body, e.g. Health Care Professions Council (HCPC).

Also consideration should be given to whether an Independent Safeguarding Authority Referral form should be completed in relation to the following areas:

- Harmed or poses a risk of harm to a child or vulnerable adult
- Satisfied the harm test; or
- Received a caution or conviction for a relevant offence

11 Appeals

11.1 An appeal may be made after the imposition of a disciplinary sanction. The appeal will involve a review of the sanction imposed.

11.2 The employee is required to appeal in writing, citing the grounds for the appeal. These could include a perceived unfairness of the decision, the severity of the penalty, new evidence coming to light, or procedural irregularities. Any appeal should be made within 7 calendar days, 14 calendar days for dismissal, of the employee receiving written notification of disciplinary action. All appeals must be in writing and addressed to the Director of Workforce and Organisational Development.

11.3 The disciplinary hearing will be chaired by an appropriate manager not directly involved with the management of the employee. Panel membership will be a minimum of two persons with a member of Human Resources department also being present to provide advice on areas of law, procedure and consistency. The HR member will not be a decision- maker on the panel. The Investigation will be presented with the supporting facts and material. The procedure to be followed appears at Appendix 2.

In all cases of dismissal, the appeal will be chaired by a Director of the Trust. In all other cases, the appeal panel will be chaired by a manager of equal or higher seniority to the chair of the disciplinary hearing.

11.4 The employee shall have the right of appearing personally before the appeal panel or represented by a work colleague or Trade Union representative, or alternatively submitting written representation.

11.5 At appeal the panel may decide to uphold, reduce the penalty or dismiss the sanction.

11.6 Where new evidence is presented either by management or the employee, the appeal panel, in consultation with staff side where appropriate, will determine how best to proceed.

11.7 The Procedure to be followed at a Disciplinary Appeal Hearing is attached at Appendix 2.

12 Gross Misconduct

12.1 This is regarded as misconduct of such a nature that it fundamentally breaches the contractual relationship between the employee and the employer and justifies management in no longer accepting the continued presence of the employee at the place of work.

12.2 The following list provides examples of offences which are normally regarded as gross misconduct:

- Theft, fraud, deliberate falsification of records
- Patient abuse
- Fighting, assault on another person

- Deliberate damage to organisational property
- Serious incapability through alcohol or being under the influence of illegal drugs
- Serious negligence which causes unacceptable loss, damage or injury
- Serious act of insubordination
- Unauthorised entry to computer records.
- Bringing the Trust into disrepute
- Bribery
- Covert recording of meetings / conversations
- Actions of professional misconduct, including where the regulator has taken action.

12.3 This list is neither exclusive nor exhaustive. Whether or not a particular action constitutes an offence, which falls into this category, will depend upon a number of factors including the degree of seriousness and the responsibilities of the employee. Management action following an offence will take into account any extenuating circumstances together with the employee's previous record.

13 Action Short of Dismissal

Decision to offer a downgraded post:
In some cases, the downgrading of an individual may be considered as an alternative to dismissal following a disciplinary hearing. However, a post of a more suitable grade would have to be available. In such circumstances, the employee should be informed that as an alternative to dismissal there is the option of alternative employment which would be subject to the following conditions:-

- That the individual agrees to a variation to their contract of employment.
- That if the post offered is of a lower grade and with altered conditions of employment, protection arrangements would not apply.
- Where the employee accepts the alternative offer of employment there is no reason for appeal consequently the right of appeal would be waived.
- A final written warning would automatically be issued and remain on the employee's file for 12 months, and as a condition of the warning the employee will not apply for any higher graded posts in the Trust during the time of the warning.
- That the employee be given time to consider their decision on the offer of alternative employment and has 24 hours in which to respond.

Appendix 1 - Procedures to be adopted at Disciplinary Hearings

Management report / documents relevant to the disciplinary matter will be provided, two weeks in advance of the hearing. The member of staff may also provide evidence / documentation if they wish and should be within 3 working days of the hearing.
The Chair of the panel will outline the procedure to be observed including that no audio or video recordings are permitted and detail the allegations to be heard. The procedure is as follows:

1. The presenting officer shall state the management case and call any witnesses.
2. The panel hearing the matter and the employee or employee's representative shall be entitled to question the presenting officer, and any witnesses present, in relation to their evidence.
3. The presenting officer may re-examine their witnesses on any matter referred to in the examination by the panel hearing the matter, the employee or employee's representative.
4. The employee or employee's representative shall be entitled to reply to management's case. It is important that any submission is the employee's view or recollection of the incident and not the representative's view or opinion.
5. The employee or employee's representative shall state the case for the employee and call any witnesses.
6. The panel hearing the matter and the presenting officer(s) shall be entitled to question the employee, their representative and any witnesses called in relation to their evidence.
7. The employee or employee's representative may re-examine their witnesses on any matters referred to in the examination by the panel hearing the matter or the presenting officer.
8. The presenting officer and the employee or their representative may sum up their cases if they so wish. When this occurs, the employee or their representative has the right to speak last. No new matter or evidence may be introduced at this stage.
9. Nothing in the foregoing procedure shall prevent the panel hearing the matter from inviting the representative of either party to elucidate or amplify any statement they may have made; or from asking them questions as may be necessary.
10. The panel hearing the matter may at their discretion adjourn a hearing in order that further evidence may be produced by either party, or to allow for a more appropriate panel to be assembled.
11. No statement of previous acts of misconduct by the employee or the issue of a formal warning or warnings unrelated to the alleged offence(s) on which the disciplinary action is based shall be made until after the panel has reached a decision as to whether the allegations are proven or not.
12. Having heard the matter in full, the panel shall consider the merits of the case and make their decision in private. The decision of this panel will be made known at the earliest opportunity, to be confirmed in writing within 5 working days or as soon as possible thereafter.

Appendix 2 - Procedures to be adopted at Disciplinary Appeal Hearings

Management report / documents relevant to the disciplinary matter will be provided, two weeks in advance of the hearing. The member of staff may also provide evidence / documentation if they wish, within 3 working days of the hearing.

The Chair of the panel will outline the procedure to be observed including that no audio or video recordings are permitted and detail the allegations to be heard. The procedure is as follows:

1. The employee or employee's representative shall state their case and call any witnesses.
2. The panel hearing the matter and the presenting officer(s) shall be entitled to question the employee, their representative and any witnesses called in relation to their evidence.
3. The presenting officer shall state the management case and call any witnesses.
4. The panel hearing the matter and the employee or employee's representative shall be entitled to question the presenting officer, and witnesses, in relation to their evidence.
5. The presenting officer may re-examine their witnesses on any matter referred to in the examination by the panel hearing the matter, the employee or employee's representative.
6. The employee or employee's representative may re-examine their witnesses on any matters referred to in the examination by the panel hearing the matter or the presenting officer.
7. The presenting officer and the employee or their representative may sum up their cases if they so wish. No new matter or evidence may be introduced at this stage.
8. Nothing in the foregoing procedure shall prevent the panel hearing the matter from inviting the representative of either party to elucidate or amplify any statement they may have made; or from asking them questions as may be necessary.
9. The panel hearing the matter may at their discretion adjourn a hearing in order that further evidence may be produced by either party, or to allow for a more appropriate panel to be assembled.
10. Having heard the matter in full, the panel shall consider the merits of the case and make their decision in private. The decision of this panel will be made known at the earliest opportunity, to be confirmed in writing within 5 working days or as soon as possible thereafter.

Skills Audit Matrix

The Skills Audit Matrix assesses the membership of the Board of Directors against a number of key themes and skill areas that are agreed by the Board of Directors to be required for the stewardship of the Foundation Trust. These are in addition to those obligations under regulation that the Board must have a suitably qualified finance director, nursing director and medical director. The additional essential requirements are as follows:

- Strategic Leadership and Impact and Influence
- Risk Management
- Financial Acumen
- Legal Awareness
- Public Policy
- Knowledge and Application of Diversity and Inclusion
- Directors are also required to exercise informed and sound judgment and maintain ethical, integrity and accountability standards
- At least one Non-Executive Director has an appropriate Financial Qualification
- At least one Non-Executive Director has an appropriate Clinical and Health Qualification or experience
- At least one member of the Board has a Legal Qualification.

In addition, the following desirable elements are also considered relevant:

- Corporate Communications and Media
- Commercial Focus
- Human Resource Management
-

The Skills Matrix of the Board of Directors for 2020/21 is set out below.

Non-Executive Directors

Skill	Professor Ian Cumming	Tony Yeaman	Mushtaq Khan	Jacynth Ivey (to 31.12.20)	Mohammed Fessal (from 01.01.21)	Caroline Wigley	Wendy Farrington Chadd	Narinder Kooner
Strategic Leadership	✓	✓	✓	✓	✓	✓	✓	✓
Informed and Sound Judgment	✓	✓	✓	✓	✓	✓	✓	✓
Ethics, Integrity and Accountability	✓	✓	✓	✓	✓	✓	✓	✓
Impact and Influence	✓	✓	✓	✓	✓	✓	✓	✓
Risk Management	✓	✓	✓	✓	✓	✓	✓	✓
Financial qualification							✓	
Financial acumen	✓	✓	✓	✓	✓	✓	✓	✓
Public policy	✓	✓	✓	✓	✓	✓	✓	✓

Skill	Professor Ian Cumming	Tony Yeaman	Mushtaq Khan	Jacynth Ivey (to 31.12.20)	Mohammed Fessal (from 01.01.21)	Caroline Wigley	Wendy Farrington Chadd	Narinder Kooner
Knowledge and Application of Diversity and Inclusion	✓	✓	✓	✓	✓	✓	✓	✓
Clinical and Health Experience	✓			✓	✓			
Health Experience: Non Clinical		✓	✓			✓	✓	
Legal awareness		✓	✓		✓	✓	✓	
Corporate Communications and Media		✓	✓			✓		✓
Commercial focus		✓	✓	✓			✓	✓
Human Resource Management	✓					✓		✓
Clinical Registration/ Professional Membership	Graduate Member Sports Therapy Association Chartered Scientist – The Science Council Fellow - Chartered Institute of Management Fellow - Institute of Biomedical Sciences HCPC Registered – Biomedical Scientist, PIN: BS31759	The Law Society (England and Wales) SRA ID:138630	The Law Society [England and Wales] SRA ID:26073	None	General Pharmaceutical Council – Pharmacist PIN: 2061184	Fellow CIPD	Chartered Institute of Public Finance and Accountancy	None
Professional/ Business Qualification/ Experience	MSc in Sports and Exercise Medicine PgDip in Sports and Exercise Medicine Doctor (Honorary) of Health (DH) Doctor (Honorary) of Science (DSc) Doctor (Honorary) of the University (D Univ) HNC in Biomedical Sciences	Solicitor, MBA	Solicitor (England & Wales); BSc. (Hons) Social Policy; Post Graduate Diploma in Law; Legal Practice Certificate, Post graduate Diploma in Management Studies; Certitificate in Advanced Corporate Governance.	Former General Nurse, Midwife Health Visitor. PG Diploma Collaborative Community Care.	Master of Sciences of Pharmacy Independent Prescriber Course	BA Law; Diploma in Coaching, Employment Tribunal Panelist	Qualified Accountant. BA(Hons) English Lit Certificate in Executive Coaching	Business Experience. Local Authority Councillor

Executive Directors

Skill	Anthony Marsh	Linda Millinchamp	Kim Nurse	Mark Docherty	Dr Alison Walker	Craig Cooke
Strategic Leadership	✓	✓	✓	✓	✓	✓
Informed and Sound Judgment	✓	✓	✓	✓	✓	✓

Skill	Anthony Marsh	Linda Millinchamp	Kim Nurse	Mark Docherty	Dr Alison Walker	Craig Cooke
Ethics, Integrity and Accountability	✓	✓	✓	✓	✓	✓
Impact and Influence	✓	✓	✓	✓	✓	✓
Risk Management	✓	✓	✓	✓	✓	✓
Financial qualification		✓				
Financial acumen	✓	✓	✓	✓	✓	✓
Public policy	✓	✓	✓	✓		
Knowledge and Application of Diversity and Inclusion	✓	✓	✓	✓	✓	✓
Clinical and Health Experience	✓			✓	✓	✓
Health Experience: Non Clinical		✓	✓			
Legal awareness		✓	✓			
Corporate Communications and Media	✓			✓		
Commercial focus	✓	✓	✓	✓		
Human Resource Management	✓		✓			
Clinical Registration/ Professional Membership	None	ICA – England and Wales	Chartered Institute of Personnel and Development	Registered Nurse (Adult) NMC PIN 83L3134E	GMC Registration 4210643	HCPC Registered Paramedic PIN PA02247
Professional/ Business Qualification/ Experience	National Ambulance Strategic Adivisor Extended Ambulance Aid [NHSTA] (former Paramedic) Professor (Honorary) Wolverhampton University. MSc Strategic Leadership, MBA. MA.	Chartered Accountant ICAEW B.Com (Hons) Commerce, Foreign Trade and Languages	MSc Human Resource Mangement. MBA, Post-Grad Diploma Personnel Management and Industrial Relations, Cert in Consulting Essentials. Visiting Fellow - Staffordshire University	BSc, (Hons) Nursing MSc Healthcare Commissioning	Emergency Medicine (A&E) Consultant. MB BChir, FRCEM, FIMCRCS, FRCS, FDSRCS, MA, MFSEM. Dip Health Research, Cert Medicolegal.	None

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 11 MONTH: JANUARY 2021 PAPER NUMBER: 09

Operational Performance Report	
Sponsoring Director	Director of Strategic Operations and Digital Integration
Author & Presenter	Director of Strategic Operations and Digital Integration
Purpose	The report is presented to the Board to give the Board an update on the pressures facing the service at this time and how the risks to patient care and quality are being mitigated.
Previously Considered by	This is a new and developing report structure in the light of the changes to the agenda approved by the Board at its meeting in July 2020. The last report was in October 2020.
Report Approved By	Director of Strategic Operations and Digital Integration.
Executive Summary The Board are asked to receive the report and seek clarity where required.	
Related Trust Objectives/ National Standards	Operational Performance is key to the Trust continuing to meet its obligations under the regulators national and local standards relating to quality of care.
Risk and Assurance	The report is presented as a document that gives Board assurance and highlights areas of risk. The report complements the Board Assurance Framework elsewhere on this agenda that sets out the risks to meeting our strategic objectives.
Legal implications/ regulatory requirements	The report highlights the areas where we have a statutory duty to report.
Financial Implications	There are no direct financial implications raised in this report.
Workforce Implications	This report sets out operational performance and how staff are responding to the needs of the public.
Communications Issues	The contents of this report are not confidential and have been provided to multiple people inside and outside the organisation. Much of the information is in the public domain.
Diversity & Inclusivity Implications	There are no direct implications.
Quality Impact Assessment	The report will highlight any quality impact assessments as they arise.
Data Quality	The data used in the report has been provided and quality assured ahead of publication in Board papers.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 11 MONTH: JANUARY 2021 PAPER NUMBER: 09

Action required

The Board is asked to receive the report and seek clarity from the Director of Strategic Operations and Digital Integration.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11 DATE JANUARY 2021 PAPER NUMBER 09

OPERATIONAL DELIVERY REPORT

1. EMERGENCY SERVICE

This report covers the period 1 October 2020 to 31 December 2020 including Q3 achievements and YTD position.

Overview

Committee members will have received key information updates at various Board updates in the period since the last meeting in October, including detailed updates on Covid-19 progress and Winter preparations which also outlined decisions made. It is not intended that this report will repeat much of that detail but serves to provide an update on operational performance in the third quarter of 2020/21 and also an update on other key priorities for the year 2020/21 regardless of the Covid-19 specific work which remains on-going. The main aim of the organisation has been to keep as many normal workstreams on schedule and on-track despite the Covid-19 work priorities and also ahead of the Winter which will be sustained in Q4.

Covid-19

The monthly Covid-19 summary report has been produced and published to the Directors of the Trust each month, this report has outlined the key metrics relating to Covid-19 and also a summary of key priorities being addressed as live issues.

The response to Covid-19 continues to be managed by the Senior Command Team chaired by the CEO, and the Director lead for Covid-19 (Andrew Proctor).

WMAS continues to be in stable position regarding its response to the demands of Covid-19 despite the complexity of the situation, which includes rising operational demand issues, changing policy, increasing staff abstractions and central information publications and the complex issue of high demand on PPE items.

The immediate issue which is seriously affecting WMAS relating to Covid-19 is hospital turnaround issues. In the period April to mid-June – hospital turnaround issues had been largely eradicated due to lower demand in A&E Departments, in the last six months the situation has worsened and in Q3 the situation has become critical across a number of Acute Trusts.

The other unpredictable issue for WMAS currently has been demand trend for the core 999 service. The effect Lockdown 2 had on operational demand was negligible and the second half of December onwards and to date (mid Jan) shows strong demand growth on the 999 Service (which continues to rise).

WMAS has needed to take a range of resource decisions in December and early January to ensure the Trust can maintain a safe and effective 999 response, in light

of rising demand, severe hospital delays and increasing staff abstractions (due to Covid-19).

Senior Command Team have taken action to balance the demand of activity rising and keeping other priorities delivered where possible and continues to monitor this carefully and take appropriate action.

Operational Performance Oct 2020

	Target		Month	
Priority	Mean	90%	Mean	90%
Category 1	7:00	15:00	7:11	12:31
Category 1 T	19:00	30:00	8:06	14:10
Category 2	18:00	40:00	13:23	24:43
Category 3	60:00	120:00	40:20	93:39
Category 4	-	180:00	58:48	142:11
HCP 2hr	-	-	58:22	125:52
HCP 4hr	-	-	83:29	178:24

Operational Performance Nov 2020

	Target		Month	
Priority	Mean	90%	Mean	90%
Category 1	7:00	15:00	6:48	11:50
Category 1 T	19:00	30:00	7:48	13:28
Category 2	18:00	40:00	13:39	25:29
Category 3	60:00	120:00	42:49	99:02
Category 4	-	180:00	56:46	134:41
HCP 2hr	-	-	60:20	133:34
HCP 4hr	-	-	85:25	179:25

The Trust met nearly all the operational standards in both October and November 2020, except Category 1 Mean in October (by 11seconds), WMAS remains one of few Ambulance Services in England able to meet the target consistently .

Operational Performance September 2020 / Q2 / YTD

	Target		Month		QTD		YTD	
Priority	Mean	90%	Mean	90%	Mean	90%	Mean	90%
Category 1	7:00	15:00	6:57	12:07	6:59	12:06	6:58	12:06
Category 1 T	19:00	30:00	7:57	13:44	7:57	13:49	7:53	13:44
Category 2	18:00	40:00	14:46	28:01	13:57	26:02	12:33	22:55
Category 3	60:00	120:00	47:41	110:30	43:34	100:54	31:06	68:26
Category 4	-	180:00	61:10	145:19	58:55	141:29	42:04	96:14
HCP 2hr	-	-	71:51	156:02	63:31	141:03	45:54	103:08
HCP 4hr	-	-	115:40	263:40	94:58	215:28	67:42	146:36

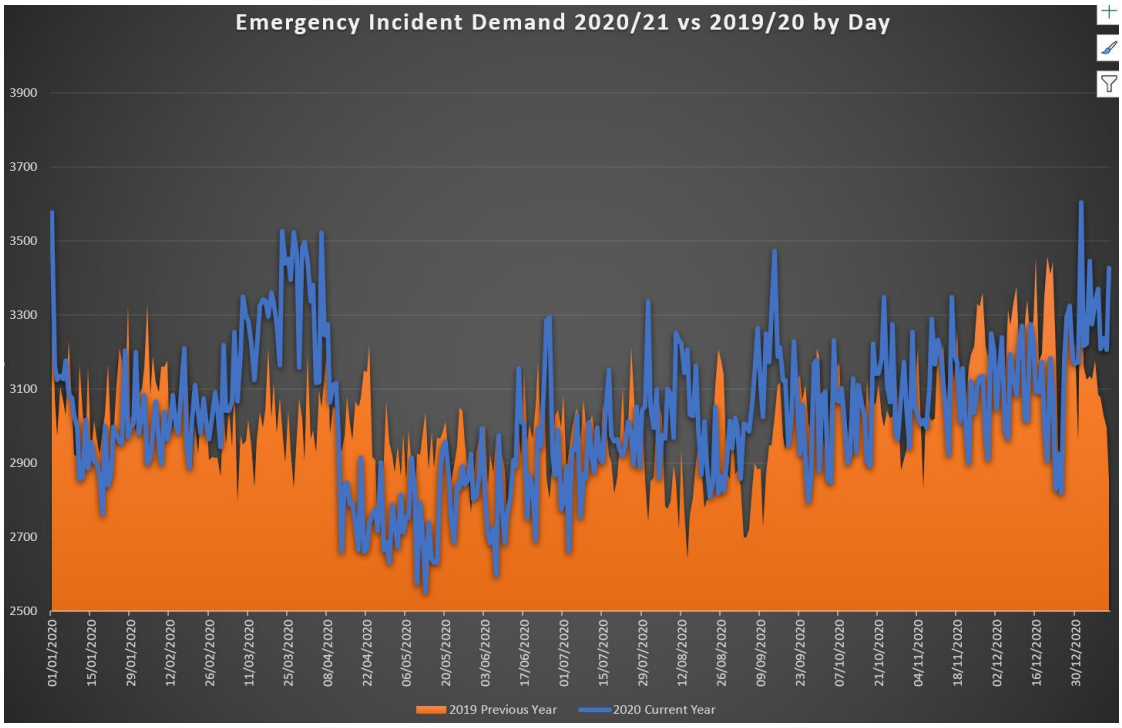
	MTD			QTD			YTD		
	Incs	Mean	90%	Incs	Mean	90%	Incs	Mean	90%
	Incs	Mean	95%	Incs	Mean	95%	Incs	Mean	95%
Call Answer (999 only)	82931	0:00	0:00	235312	0:01	0:01	673859	0:01	0:02

Despite all the complexities of operational pressures in December (both Covid-19, Hospital Handover Delays and Seasonal Demand) WMAS has met all operational targets. The only Ambulance Service in England to do so.

The Trust has met all response standards for Q3 2020/21 despite the ongoing international pandemic and a national emergency being in operation. This quality of operational delivery and consistency has served the population of West Midlands with an Emergency Ambulance Service which they can rely upon in recent months and planning for the coming months must ensure this continues to be the case in Quarter 4 which will be increasingly complex.

Operational Demand YTD

The following graph shows the demand patterns since January 1 this year. What shows is gradually rising demand from mid to late November, a very short drop for December 23/24/25, and then very rapidly rising demand from there onwards. Demand levels in early January are above the demand seen at the peak in March.



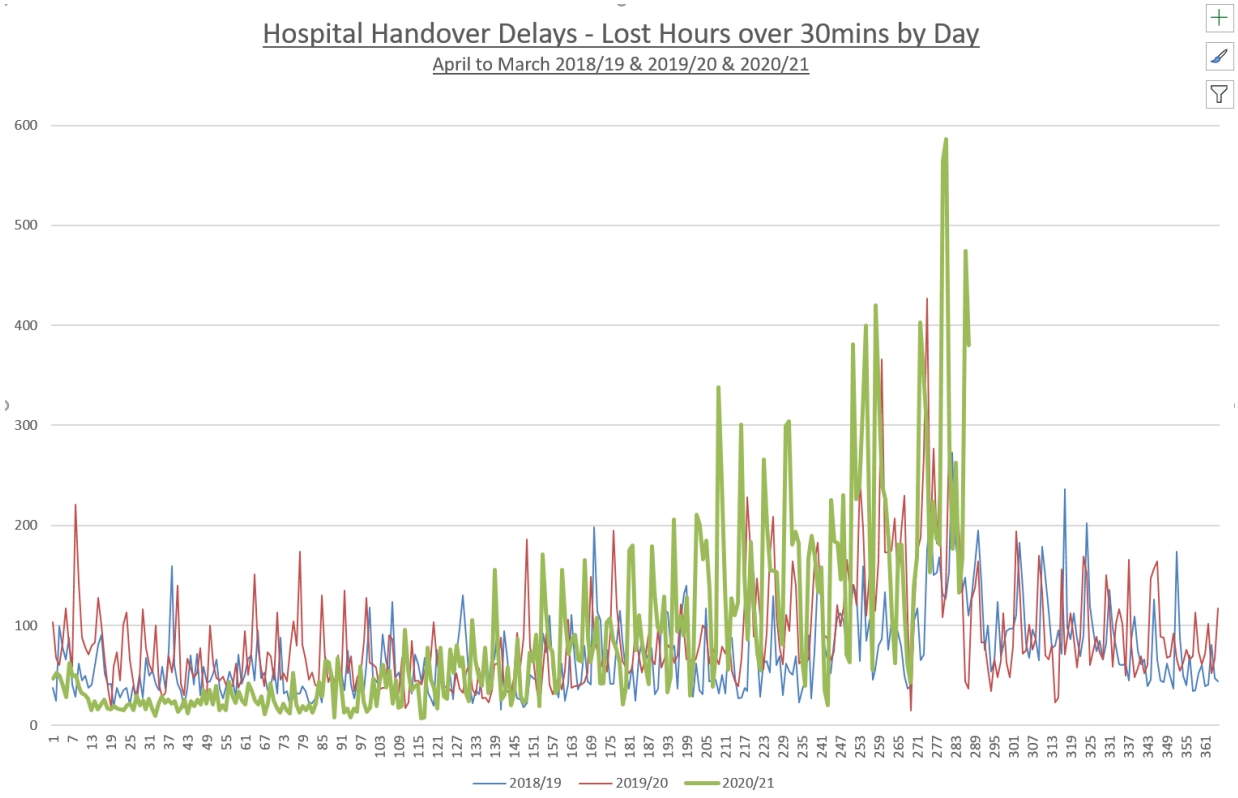
Other matters

The Trust continues to ensure the maximum resource output to meet the demand under Covid-19 and making sure each resource is Paramedic led as has previously been the case. In Oct / Nov and Dec the paramedic crew levels were 99.9% which is a very different position to other Trusts across England (both previously and under Covid-19 as other Trust deployed more and more non paramedic resource). This is proof of WMAS commitment to providing a Service which is both timely and providing the very best emergency care to patients.

Hospital Handover difficulties started to arise in June, and this situation has worsened each month thereafter. Quarter 3 has seen the issues impact significantly, more patients than ever being delayed in handover to the hospitals.

The number patients waiting more than 1hr to be handed over has doubled.

	Inc Count	% Conveyed	Conveyed Count	<30mins No.	<30mins %	30-60mins No.	30-60mins %	>60mins No.	>60mins %
October	96031	55.66%	53454	28375	53.08%	22412	41.93%	2666	4.99%
November	93690	54.16%	50738	26001	51.24%	21574	42.52%	3161	6.23%
December	97411	54.18%	52776	24988	47.35%	23329	44.20%	4459	8.45%
YTD	833894	53.55%	446510	251512	56.33%	180042	40.32%	14950	3.35%



The increasing problem of hospital handover delays is can be summarised as follows:

a) poor patient experience
b) presents a risk to the effective care of patients
c) risk of a patient becoming increasing unwell whilst waiting
d) significant loss of operational hours
e) 999 calls waiting for response

There is significant increase in the number patients delayed in handover for longer than 1hrs and many of these patients wait outside the Hospital in an Ambulance for a number of hours.

The following table shows where hospital handover delays greater than 1hr took place for December

Destination	No.of Handovers Recorded	> 1 hour	% > 1 hour	> 2 hours	> 3 hours	> 4 hours
Alexandra	2052	13	0.6%	2		
Burton	1142	145	11.7%	39	11	2
City (Birmingham)	1957	34	1.6%	9		
Good Hope	2426	222	8.3%	39	5	
Heartlands	3846	557	13.6%	173	51	12
Hereford County	1584	38	2.2%	3		
New Cross	3813	459	11.0%	136	36	7
New Queen Elizabeth Hosp	3838	367	8.4%	122	46	6
Princess Royal	1654	132	6.7%	34	5	3
Royal Shrewsbury	1505	237	13.9%	60	14	
Royal Stoke Univ Hosp	4031	312	6.3%	112	36	11
Russells Hall	3209	140	4.1%	34	6	1
Sandwell	2336	19	0.8%	1		
Uni Hospital Cov & War	3846	153	3.4%	22	2	1
Warwick	1743	32	1.7%	1		
Worcestershire Royal	2482	365	12.7%	157	74	29
				944	286	72

There has been ongoing dialogue between WMAS Executive Directors and the NHSE/I Regional Team on this worsening situation, highlighting both the patient risks and operational difficulties that this presents. The SCC and the Duty Directors continue to ensure the live situation is managed carefully and all delays are escalated appropriately to the Acute Trusts, CCGs and NHSE/I each day.

The complexity of staff abstractions due to the pandemic continues to be a challenge but normal sickness level are being maintained and well managed.

The deep cleaning of vehicles has been maintained despite the pressures of additional resource outputs and the additional Covid-19 cleaning. All vehicles have received a monthly deep clean in Make Ready, which includes a Clorex Cleaning process to kills bacteria (as demonstrated to the Board previously).

The Winter Plan and Festive plans were fully finalised and published previously. In effect WMAS has been able to maintain operational stability in a difficult period and this has been achieved through excellent planning and continuing to extended the resource being made available to the frontline – to outweigh rising demand / significant lost hours at hospital and increased staff abstractions

Annual Mandatory Training has been completed and achieved for all staff by the first week in December (complete for 2020/21). This will enable more staff to be available to frontline operations continuously January to March.

The Fleet plan for new assets coming into life has significant accelerated since the last report to the committee. All new WMAS Emergency Ambulances were delivered by December with a small number of specialist bariatric vehicles to be delivered in February. Planning has commenced around new Fleet for 2021/22 to ensure the Trust can maintain the Emergency Ambulance life below 5years and importantly commence planning towards the Commonwealth Games requirement too.

The Trust has launched the first 100% Electric Emergency Ambulance in early October. This was a first for the UK and will set the future direction of WMAS

achieving a zero-emission fleet for the future. Two new electric response cars will be brought into service in February and two electric PTS vehicles will be added in April.

2. PTS SERVICE

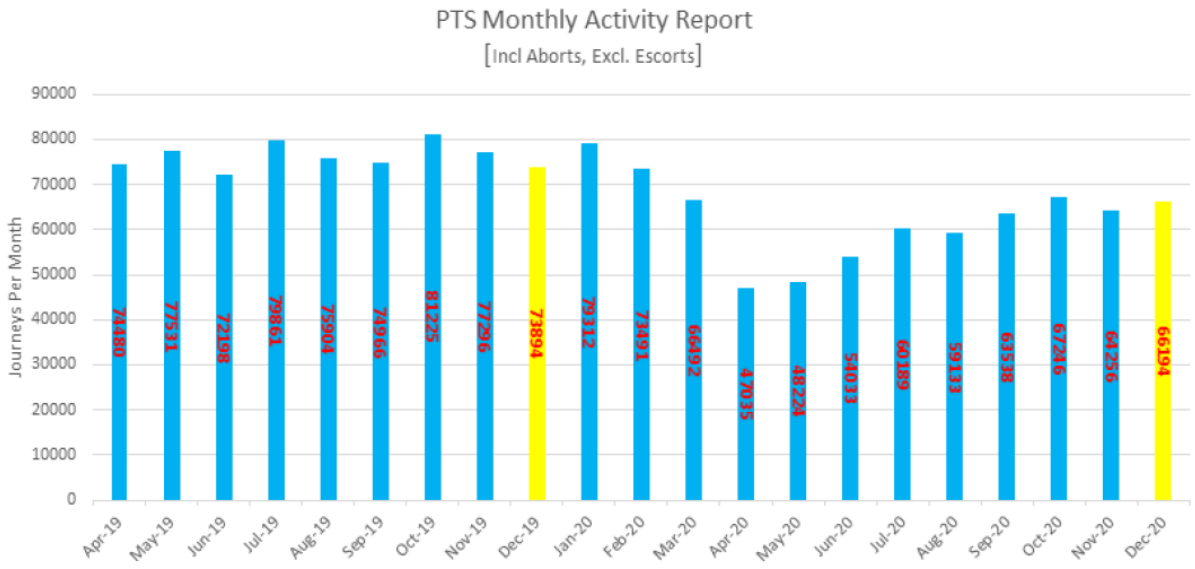
PTS has achieved all operational KPIs on each of its seven PTS Contracts held for every month in 2020/21 and YTD, this is an impressive achievement given the significant difficulties PTS are experiencing with on-day discharge demand rising and the complexity and inefficiencies due to Covid-19 arrangements within different contracts and the social distancing requirement.

PTS have implemented the national guidance and have prioritised the essential PTS journeys, focusing on 100% of discharges within 2 hrs, renal and oncology patients, there has been a return of more normal outpatient activity across contracts in recent months.

A risk assessment has been undertaken and actions implemented to achieve effective social distances on all vehicles, therefore only 1 patient can travel in a car or a wheelchair access vehicles and 2 patients in a sitter/stretcher vehicle. This is in line with national guidance recently published in regard to social distancing. This is a significant reduction in efficient use of resource for PTS – approximately 40% reduction of capacity each day.

Activity on average is at 90% of pre Covid levels (which is significant when the efficiency reduction is considered). We have modelled each contract on the additional resources required to ensure we continue to achieve KPI's on every contract in line with the revised 2-hour discharge performance and the impact of the social distancing that reduces our capacity. We have met with and written to all commissioners to advise of the additional funding required to comply with the national guidance. Birmingham and Black Country have approved our request and can confirm the following additional resources.

	WTE's	Ambulances	Taxi journeys
Birmingham	38.75	28	1751
Black Country	41.78	10	2093



Several new Contract opportunities have been pursued in recent months, whilst the Trust scored well on the quality of the submission and the operational plans, ultimately the commissioning organisations choose a cheaper provision with a private provider.

There are currently 106 wte Band 2/3 Road Staff seconded to E&U HD tier. Recruitment has been ongoing to cover these vacancies and address Covid resource issues. When Covid funding ends and if these seconded staff all return in April 21, after allowing for current vacancies and average attrition this would give an over establishment of B2/3 road staff of 72 wte (net of 16 vacancies in Cheshire). This would put significant pressure on budgets going forward.

PTS continues to progress and achieve all progress relating to non-activity requirements, for example mandatory training etc are on-track for the year, there are no risks to these achievements unless the Covid-19 situation worsens significantly.

Replacement fleet assets will be delivered into PTS between January - March for the Black Country and Sandwell Contract.

3. 111 SERVICE

The IUC answered 399,843 calls during quarter three, achieving a low abandonment rate after 30 seconds of 1.79% against a 5% target; This was a further improvement on both Q1 and Q2, despite answering 33,449 more calls than Q2.

84.2% of calls were answered within the 60 seconds, against a target of 95%. Surges in demand through changing COVID guidance, increased staffing abstractions and releasing dual trained call assessors to support emergency 999 calls being the main contributing factors.

Metric	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20	Jan-Mar 21	YTD
Call Answer Performance					
Calls Answer Performance (% Within 60 sec)	88.5%	89.9%	84.2%		87.4%
Calls Abandoned (% >30 Sec)	5.12%	2.56%	1.79%		3.06%
Calls Offered	369,495	406,475	436,648		1,212,618
Calls Answered	319,896	366,394	399,843		1,086,133
Calls Abandoned (>30 Sec)	18,915	10,414	7,810		37,139

Of the calls answered during Q3, 356,900 patients were triaged through NHS Pathways.

Metric	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20	Jan-Mar 21	YTD
Calls Triaged					
Number of calls triaged (NHS Pathways only)	320,819	343,996	356,900		1,021,715

Through the implementation of 111 First and clinical developments, significant progress has been made in reducing emergency department (ED) referrals. During Q1, 8.66% of patients were referred to an emergency department, increasing to 10.11% in Q2. This was reduced to 7.69% in Q3, 7.07% in December.

In addition to the reduction in referrals to ED, there has been a noticeable increase in the number of patients sent through validation. During Q3, 74.18% of call assessor ED outcomes were validated, increasing from 51.83% in Q2.

Metric	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20	Jan-Mar 21	YTD
A&E Referrals					
Number of Calls - Attend A&E final disposition	33,447	40,308	34,773		108,528
% of Triaged Calls - Attend A&E final disposition	10.43%	11.72%	9.74%		10.62%
Number of Calls - Attend A&E final DX **& ED service selected**	27,784	34,761	27,461		90,006
% of Triaged Calls - Attend A&E final DX **& ED service selected**	8.66%	10.11%	7.69%		8.81%
Number of ED Dispositions after initial Assessment *(Inc Dx334)*	32,686	37,642	40,482		110,810
Number of ED Dispositions Validated	19,185	19,511	30,019		68,715
% of ED Dispositions Validated	58.69%	51.83%	74.15%		62.01%

Ambulance outcomes have remained stable throughout the year, with Q3 at 13.14%, against a YTD position of 13.25%. Despite increasing activity, the volume of initial ambulance dispositions sent for clinical validation has increased from 80.74% in Q1 to 87.36% for Q3.

Metric	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20	Jan-Mar 21	YTD
Ambulance Dispatches					
Number of Cat1/2 Ambulance final disposition	26,752	29,089	32,056		87,897
Number of Cat3/4 Ambulance final disposition	16,854	15,818	14,834		47,506
Number of Total Ambulance final disposition	43,606	44,907	46,890		135,403
% of Triaged Calls - Cat1/2 Ambulance final disposition	8.34%	8.46%	8.98%		8.60%
% of Triaged Calls - Cat 3/4 Ambulance final disposition	5.25%	4.60%	4.16%		4.65%
% of Triaged Calls - Total Ambulance final disposition	13.59%	13.05%	13.14%		13.25%
No. of 999 Dispositions C3&4 after initial Assessment *Inc Dx333*	31,438	35,921	39,073		106,432
Number of 999 Dispositions C3&4 Validated	25,382	30,413	34,123		89,918
% of 999 Dispositions C3&4 Validated	80.74%	84.67%	87.33%		84.48%

The increased activity has significantly impacted upon the ability to call-back patients requiring a clinical assessment within the KPI standards. This has been challenged further by an increase in P1 activity through validation of ED and ambulance dispositions.

There has been a reduction in P1 call-back performance to 38.59% within 10 minutes, with the average P1 call-back for Q3 at 00:35:34; During Q2, P1 performance was at 51.51%.

There has been a similar reduction in call-back performance for both P2 and P3 cases, with Q3 P2 at 48.64% within 60 mins and P3 at 77.90% within 240mins.

Metric	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20	Jan-Mar 21	YTD
Callbacks					
% Number of P1 Callbacks called back within 10 minutes	59.92%	51.51%	38.59%		50.65%
% Number of P2 Callbacks called back within 60 minutes	77.64%	68.93%	48.64%		65.06%
% Number of P3 Callbacks called back within 240 minutes	96.59%	91.13%	77.90%		88.20%
Average - P1 Callbacks callback time (mm:ss)	00:17:36	00:20:32	00:35:34		00:23:50
Average - P2 Callbacks callback time (mm:ss)	00:39:41	00:51:17	01:31:19		01:00:10
Average - P3 Callbacks callback time (mm:ss)	00:53:54	01:29:18	02:08:17		01:31:55

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 12 MONTH: JANUARY 2021 PAPER NUMBER: 10

Draft Operating Plan and ICS update	
Sponsoring Director	Strategy and Engagement Director
Author(s)/Presenter	Strategy and Engagement Director
Purpose	To provide an update on the current planning framework position for 2021/22 and to update the board on ICS development.
Previously Considered by	None
Report Approved By	Strategy and Engagement Director

Executive Summary

Under normal circumstances, NHS England and Improvement (NHSE/I) would have published planning guidance by the end of December to determine the priorities and content of the upcoming planning framework. Considering the escalation of pressures upon the NHS, NHSE/I have deferred publishing the planning guidance, current indications are planning guidance will be issued in Quarter 1, 2021/22.

The immediate ask from the centre is to suspend planning activity in this quarter to release board level leadership time, to focus on the immediate pandemic response, both locally and regionally.

However, a letter was sent to Chief Executives on 23 December 2020 (*Operational Priorities for Winter and 2021/22),* which outlined the expected priorities for the coming financial year, they are expected to be included within the planning guidance.

Timescales for development and submission of plans are yet to be confirmed. Once known, the Trust will develop its submissions accordingly, copies of which will be presented to the Board review and sign off.

Linked to delivering the immediate priorities and future operating plan is the current consultation on development of Integrated care systems (ICS) which this paper will also update the board on.

Related Trust Objectives/ National Standards	All
Risk and Assurance	Through cross directorate review, this paper will provide assurance of compliance with NHS England's Shared Planning Guidance. As agreement is reached at EMB in respect of financial, operational and workforce planning arrangements, the document will be fully updated.

	The consultation on ICS development does now raise some strategic risks which WMAS will need to consider including within its Board Assurance Framework for oversight and mitigation, the paper will set out what some of them are.
Legal implications/ regulatory requirements	WMAS will provide a plan which is compliant with NHS England's Shared Planning Guidance, once it is released. No regulatory issues have been identified.
Financial Implications	The financial content will reflect the current position in respect of income, expenditure, CIPs and other cost pressures.
Workforce Implications	The Workforce Planning section will be fully updated according to the guidance when it is published
Communications Issues	Once the final plan has been submitted, the Trust is required to submit a version of the plan for publication. It is proposed that a draft version will be shared with EMB for agreement prior to submission to submission as required.
Diversity & Inclusivity Implications	The plan will be updated to reflect Diversity and Inclusivity plans
Quality Impact Assessment	No impact assessment has yet been completed
Data Quality	The Executive Directors will supply content and ratify their respective section before the final draft plan is reviewed and approved for submission

Action required

The Board of Directors is requested to note:

- The priorities identified in the letter of 23rd December 2020
- That the timescales for submission of planning returns are yet to be confirmed and that the Board will be updated as announcements are made
- An update on ICS development and the immerging risks and issues to come out of consultation exercise.

Current position on planning

The formal guidance for Operational Planning 2021/22 has not yet been released, we expect formal guidance to be issued towards the end of March 2021, however what has been confirmed *(by letter: Operational Priorities for Winter and 2021/22 released 23 December 2020)* are seven priority areas which will be rolled into Operational Planning for 2021/22, the table below sets out each of the seven priority areas and how that links to WMAS now and in the near future

Priority	WMAS specific context
1. *Restore non-Covid services* in a way which reduces variation in access and outcomes across the country.	• Whilst the priority area is focused on elective care, cancer and diagnostics, it is worth noting that the ambulance sector has also witnessed significant variation in access and performance during covid19
2. *Strengthen delivery of local people plans* and continue to make ongoing improvements in equality, diversity & inclusion, growing the workforce and designing new ways of working.	• Board has undertaken a development session on equality, diversity, and inclusion during 2020/21. • The board is also overseeing the delivering of an action plan linked to equality, diversity and inclusion. • WMAS actively engaged on the "kick start" apprentice programme. • Post covid ways of working requires further review, once we are on the other side how will we work in a way which solidifies any benefits? • Rotational paramedic role with primary care is in the early stages of development with our PCNs.
3. *Address the health inequalities that Covid-19 has exposed*. Systems will be expected to make and audit progress against the eight urgent actions set out on 31 July 2020.	• WMAS will need to be an active player across the 6 STP / ICSs to support the collective effort on reducing health inequalities – especially through things like the Making Every Contact Counts Programme. • The organisations draft strategy has also captured this as a strategic priority

4. *Accelerate the planned expansion in mental health services*, including enhanced crisis response and continuing work to minimise out of area placements.	• Mostly focused on direct investment into mental health trusts and their services • WMAS could play an expanded role here should systems wish to expand things like multidisciplinary rapid response to mental health emergencies
5. *Prioritise investment in primary and community care* to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations.	• Whilst primarily aimed at primary care and community based services in the immediate term, we know services such as 999 and 111 use NHS pathways. We may also have to deal with the additional demand delayed care and interventions create as they tip into requiring urgent and emergency care. • There is also perhaps a longer term role for WMAS if commissioned to do so around providing some aspects currently performed by primary care and community based services, for example around the remote monitoring of patients receiving longer term care.
6. *Build on the development of effective partnership working at place and system level*	• The executive team have redefined how they will link with each STP / ICS and A&E Delivery Boards – a key platform of partnership. • Place based working linkages represent a challenge to WMAS, which has gravitated towards being a regional service model, however, we remain 'local' through our hubs and operational teams.
7. *Lay the foundations for financial recovery.*	• Being part of an ICS / STP which is in deficit whilst being commissioned by all 6 STPs / ICS represents a strategic risk to WMAS • The rolling over of current block arrangements without activity being considered also represents a risk to our on-going financial stability in forthcoming years.

Next steps on planning

The board is ask to note the seven priority areas noted in the letter from the centre and also the delay in formally releasing planning guidance for 2021/22.

The board will receive a further update in March and April on the release of planning guidance and the response to this from WMAS.

The strategic risks associated with priority number 7, "*Lay the foundations for financial recovery"* will be assessed for inclusion within the Board Assurance Framework under strategic objectives three and five. They are also discussed in more detail in the following section – ICS Development and Consultation.

ICS development and consultation – the future architecture.

NHSE/I have launched a consultation process inviting discussion about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance NHS England » Integrated care systems. This is with the aim of delivering against the NHS Long Term Plan (LTP) in supporting greater collaboration between partners in health and care systems.
NHSE/I are seeking views on two options for putting ICSs on a fuller statutory footing than its original proposals (September 2019), both of which require legislative change. The first option involves creating a mandatory board/joint committee at ICS level with an Accountable Officer. The second option, which NHSE/I prefer, is a corporate NHS body at ICS level that essentially repurposes the CCG and brings its statutory functions into the ICS.

Ambulance Trusts are responding to this consultation as a collective group through the Association of Ambulance Trust Chief Executives (AACE). With respect to the two options proposed for Integrated Care Systems (ICSs), there is widespread agreement from ambulance trusts that these should be given a statutory footing from 2022 as corporate NHS bodies with commissioning responsibilities. The main proviso for this would be that there should be no duplication of regulatory activity, accountability, or function with other remaining statutory bodies such as NHSEI or the Care Quality Commission (CQC).

Ambulance services will need to be strategic *and* local partners if they are to collaborate with optimal effect.

Working locally at place level *and* as a regional provider is what ambulance trusts do now, across the country, but it is not without its challenges, and the sector is seeking clear guidance within the integrated care proposals on how this can be managed more realistically and effectively.

Section 1.19 of the consultation paper is a crucial and welcome acknowledgment that there are services that need to be organised on a regional basis due to the size, geographic footprint, and nature of the service – such as ambulance services.

The emerging consensus amongst ambulance services is that a preferred model would involve the establishment of a regional strategic commissioning board that could include representatives of each of the ICSs covered by the ambulance trust, plus consideration towards having a respective NHSEI regional team member. To minimise bureaucracy and complexity, it is suggested that a single ICS would manage, chair and administer the board but decisions could be made by the full membership.

Key risks and issues with the transition from STPs to ICSs

There are a number of challenges within the move to establish ICSs though, some of them at this stage represent strategic risks to, some which are apparent at this stage are:

- Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts get to engage with them (220 PCNs across the midlands region)
- Many ICSs are split into children's, adults', planned and unplanned care, the natural home within an ICS for a given ambulance trust is not obvious to see.
- The opportunity for "collective accountability" on performance could be helpful in addressing issues, how this would work though is ill defined.
- The devolution of workforce planning and educational commissioning could potentially have a detrimental effect on services, such as Ambulance Trusts, that operate on a regional footprint.
- Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.
- The potential loss of a lead commissioner raises the risk that ICS's focus may be directed towards acute, community, mental health and primary care provision so ability for ambulance to access national transformation funds for example or capital may continue to be constrained.
- The financial framework with the emphasis now on block contracting potentially without the ability to respect activity growth raises an obvious risk. Payment by Results has served WMAS well, a different approach to commissioning will be required.
- Changes to the Single Oversight Framework – currently WMAS at level 1 as a standalone FT, now we may be rated as part of a host ICS, whilst working across 5 others.
- CQC registration may also be an issue if a host ICS becomes a CQC registrant and has so called 'failing' providers within it. There is a strategic drive to quality assure and rate resource use at system level.
- Changes to competition law could support ambulances trusts when comes to continuity of provision with services like 111 and PTS.
- Continuity in system leadership could be destabilised as the preferred option being consulted upon by NHSE/I would see the boards of CCGs put at risk (not the teams working to them).

ICS development in the West Midlands sub region.

WMAS covers six STP / ICS footprints, whilst this consultation is live, STPs have been invited to make applications to be approved as ICSs, the original aim was for there to be full coverage of ICSs by April 2021, in the West Midlands patch, the current position on approvals is reflected in the table below:

STP Name	Approved / Not Approved / In process
Birmingham and Solihull STP	Approved as an ICS
Black Country and West Birmingham STP	Application rejected – re-submission following feedback expected imminently.
Herefordshire and Worcestershire	In process
Shropshire, Telford and Wrekin	In process
Coventry and Warwickshire	In process
Stoke and Trent and Staffordshire	In process

Next steps

As STPs are approved as ICSs, ahead of legislative changes, it is anticipated that responsibilities and duties currently undertaken by NHSE/I will be increasingly devolved to ICSs.

The whole proposal around the future of ICSs is currently out for consultation, the ambulance sector will be responding to the consultation as a collective group through AACE. The draft so far covers the risks and issues noted within this update to the board.

Depending on the outcome of the consultation and the on-going further impact of things like covid and Brexit when it comes to parliamentary time, the current intention is that legislative changes will take place during 2021, so ICSs can go live from April 2022 on a statutory footing.

NHSE/I will have to publish a consultation outcome and response to the consultation, this will be shared with the board in a further update in terms of more specific detail on how the changes will affect the ambulance sector and WMAS specifically.

The Board Assurance Framework will be reviewed, considering the risks and issues associated with ICS development in relation to the five strategic objectives.

Vivek Khashu
Strategy and Engagement Director
January 2021

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 13 MONTH: JANUARY 2021 PAPER NUMBER: 11

Draft Five Year Strategic Plan update	
Sponsoring Director	Strategy and Engagement Director
Author(s)/Presenter	Strategy and Engagement Director
Purpose	To provide an update on the development of the Trust's five year strategy
Previously Considered by	Board of Directors Strategy Sessions September 2020 and November 2020
Report Approved By	Strategy and Engagement Director

Executive Summary

Further to the Board discussions in September and November, an updated Strategic priorities Framework has been developed and is set out within this paper, it has prioritised work areas to underpin each Strategic Objective and includes the proposed new value to reflect the Trust's responsibility on environmental sustainability.

A considerable amount of engagement activity has been taking place, both with internal and external stake holders, with constructive feedback received. This is especially so from one to one staff conversations around the strategic objective 2, "creating a great place to work" and strategic objective 5 "collaboration and engagement".

One significant plank of engagement has unfortunately been delayed, this was the planned mass participation event with our staff and a separate one with our STP accountable officers, both scheduled for December. The escalation of the NHS incident related to covid19 to level five (NHS expected to be overwhelmed in the next twenty-one days), with the need to maximise front line resource in response to it via a second surge plan, whilst also having to deliver our own mass vaccination programme for our staff, has made completing both exercises within the planned timeframe not possible at this stage.

This paper will update the board on progress made to date and will set out a revised timetable for completion of our new organisational strategy considering recent events.

Related Trust Objectives/ National Standards	Having agreed the Strategic Objectives, the proposed workstreams align fully with each of the key national and local strategies, policies, and objectives
Risk and Assurance	The recently revised Board Assurance Framework links more explicitly to the Strategic Objectives. As the Strategy is developed, further work will be carried out to ensure that all risks are aligned to appropriate objectives to strengthen assurance of the level of risk in relation to each objective. Particularly in relation to strategic objectives four and five.
Legal implications/ regulatory requirements	The Strategy takes account of all relevant regulatory and legal requirements
Financial Implications	The Strategic Plan will incorporate the Trust's approved financial plan and will reflect any updates made as part of

	the planning round for 2021/22. All financial plans will be submitted separately to Performance and Audit Committees and Board of Directors according to standard arrangements.
Workforce Implications	To support the new strategic objective and ambition "A great place to work for all", the Strategy will incorporate an overview of the workforce arrangements that are articulated within the existing People Strategy and will also incorporate the agreed priority work streams. The strategy will incorporate appropriate links to the interim national People Plan and the final, when it is released.
Communications Issues	A communication plan has been updated to ensure the draft strategy is communicated to all key stakeholders. This will ensure the appropriate level of feedback is taken into consideration whilst developing the strategy. Once the strategy is approved, a method of communication with both internal and external stakeholders will be developed to ensure high level progress updates are shared to meet he needs of all key stakeholder groups.
Diversity & Inclusivity Implications	The Strategy will explicitly identify the key areas of work to progress the Diversity and Inclusivity work plan. Further detail will be included in the updated People Strategy
Quality Impact Assessment	A Quality Impact Assessment, to include the Equality Impact Assessment will be completed and submitted with the updated draft strategy.
Data Quality	The Strategy will identify the source of all key national publications which drive the Trust's work plans. Each of the Directors will provide content and review their own areas of work to provide assurance of data quality

Action required

Members of the Board are requested to:

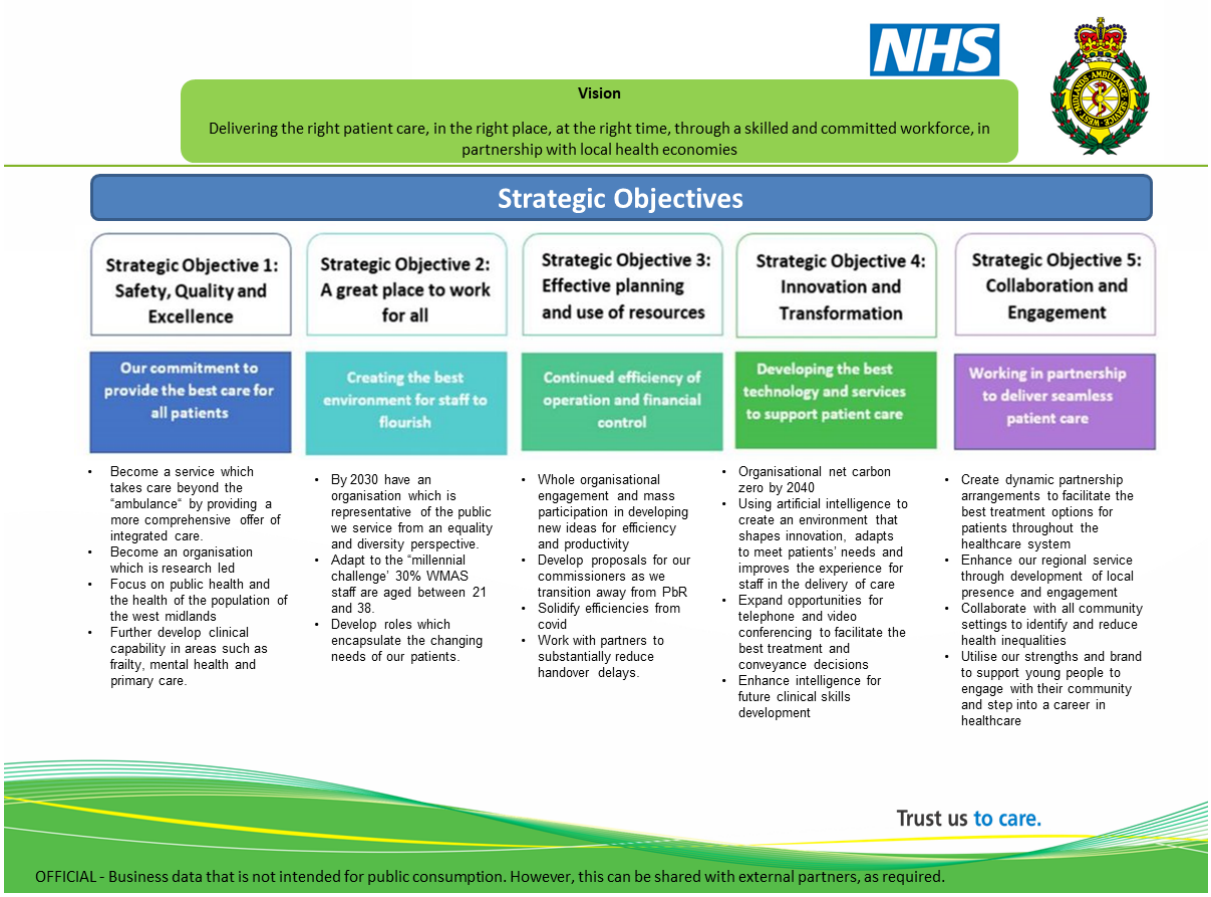
- Note the progress made engaging stakeholders since the last Board of Directors Briefing in November
- To note the deferral in seeking board approval for the draft strategy, due to the postponement in the staff and ICS / STP engagement event which needs to take place before external engagement.
- Agree that the revised plan will be presented in May for Board approval on the basis we will do a staff engagement event in March when COVID-19 related pressures should have reduced, and the incident level of the NHS deescalated.

Background

Further to the Board discussions in September 2020 and November 2020, an updated Strategic priorities Framework has been developed, with streamlined priority work areas to underpin each Strategic Objective and to include the proposed new value to reflect the Trust's responsibility in sustainability.

The outcome of the board strategy day in November was to review the strategic priorities which came out of the September session and to prioritise them into no more than three to four priorities per objective that we could engage our stakeholders with prior to adoption. The output of the November review and prioritisation is noted in figure 1.

Figure 1



An engagement plan has been agreed to ensure that all key stakeholder groups are informed of the new Strategic Objectives and can comment on the respective draft high-level priority workstreams.

The engagement plan that was reviewed and agreed by the Board in November, it focussed upon two phases, the more detailed being the first phase which seeks to engage key internal groups such as: WMAS staff, Governors, the Board of Directors, and union colleagues, with the aim of identifying any gaps in the priority work streams. The second phase is more high level and aimed at our external stakeholders, such as STPs / ICSs, Universities, Healthwatch, CQC and NHSE / I amongst others.

Engagement to date with stakeholders.

Since the Board met in November, presentations have been given and discussions had with the following stakeholders:

- Multiple one to ones with staff members following briefing into the weekly bulletins.
- Trust Council of Governors
- Trust Regional Partnership Forum
- Lead commissioner and associated Urgent and Emergency Care commissioning team
- All constituent CCGs (kindly facilitated by our lead commissioner)

The discussions were all constructive in nature, each reaching agreement on the direction of travel and supportive of it. The key items of feedback from these engagement events are summarised within the table below:

Group engaged with	**Key items of feedback**
One to one staff discussion	• Very clear and consistent feedback around the desire to extent clinical capability and skills to better meet the needs of patients through advanced practice. • Clear desire to extend the reach of what the service provides through community engagement, particularly into schools, two separate business cases / briefing papers were prepared by staff for me in advance of discussions.

Trust council of governors	• The need to engage with STPs and ICSs was deemed to be important. • Career development with advanced practice would be welcomed. • Future potential to tackle isolation through social prescribing by our staff was seen as an opportunity. • A challenge to WMAS on how we engage younger people within how we develop our strategy. • To note our stakeholders do include the third sector and fire and rescue.
Trust Regional Partnership forum	• Challenge on whether the Trust will engage with staff on the development of the strategy (will this be a Trust Board strategy Vs a staff developed and owned one) • More work to do on our values from an Organisational Development and engagement perspective, a view expressed by one union lead was that they are only used around disciplinary processes, not also as a tool to also positively recognise and reward.
Lead Commissioner	• Welcomed the opportunity to discuss and engage. • “pushing against an open door” on the strategic priorities. • Welcomed the chance to review them ahead of shaping their own commissioning intentions.
Constituent CCGs with lead commissioner	• Welcomed the opportunity to discuss and engage. • “pushing against an open door” on the strategic priorities. • Specific feedback from Shropshire around how we adapt and respond to the needs of rural populations, something not specifically clear within the priorities.

In advance of the January 2021 Trust board, the engagement plan had scheduled a whole organisational briefing with our staff, to be led by the Chief Executive and Strategy and Engagement Director, this was to inform a further refined set of priorities to the board and external stakeholders.

However, the escalation of the covid situation (the NHS now at Level 5 escalation - at risk of being overwhelmed within the next 21 days), operational pressures to maximise front line resources and deliver our own staff mass vaccination programme has led to this key engagement activity being postponed.

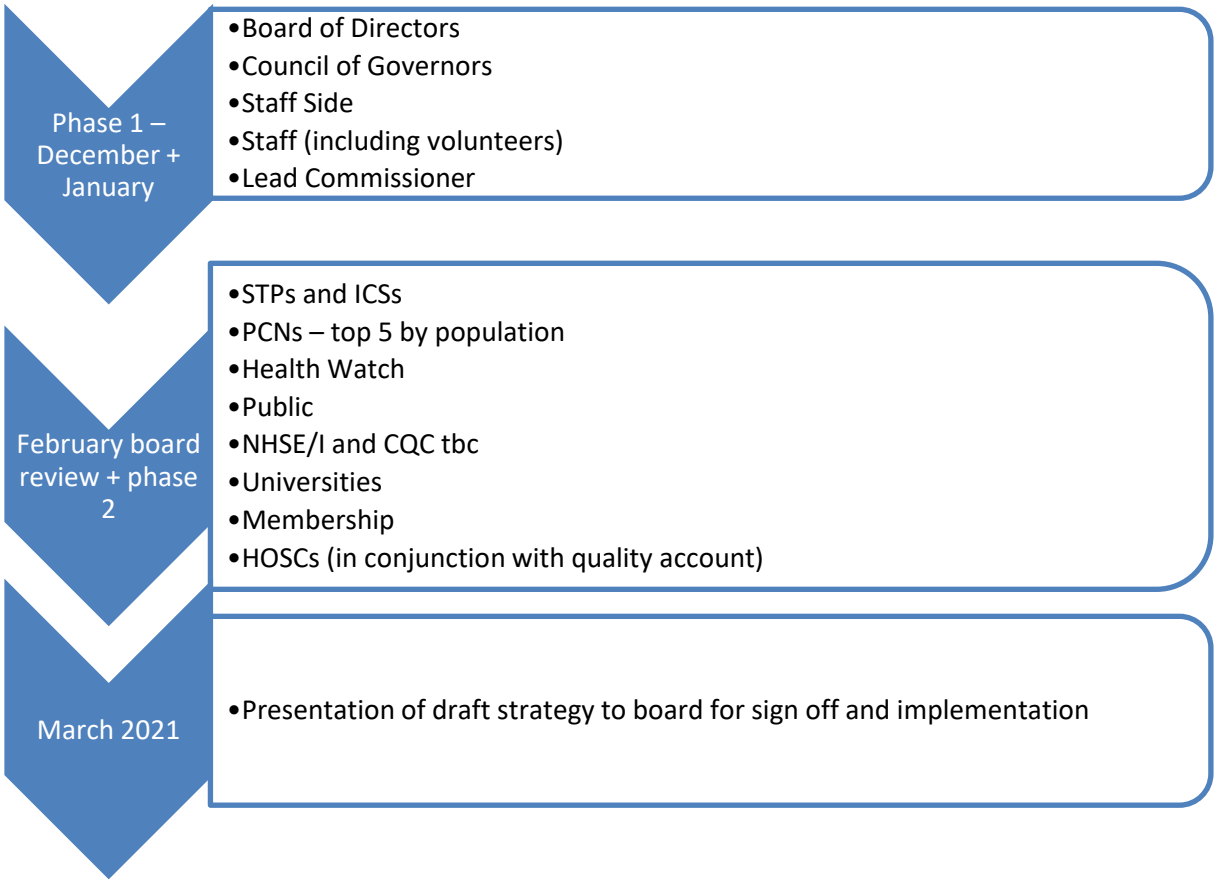
To develop a set of strategic priorities requires organisational participation and engagement, ultimately, we want and need our colleagues to feel they have contributed to its shaping and ultimately own it with us. This has been the commitment given to and by our board to our governors and union colleagues.

Whilst disappointing that the peak of covid and winter have coincided to delay its development, given it is a once in a five-year opportunity, it feels appropriate to pause and engage with our staff and partners properly, as we originally committed to.

Linked to the above context, WMAS had a slot agreed to present to the December 2020 STP Accountable Officers session with our lead commissioner on the development of our strategy. This session was unfortunately stood down by the accountable officers due to pressures and has since been rescheduled for 10th February.

The original stakeholder engagement time line presented to the November 2020 is noted in figure 2.

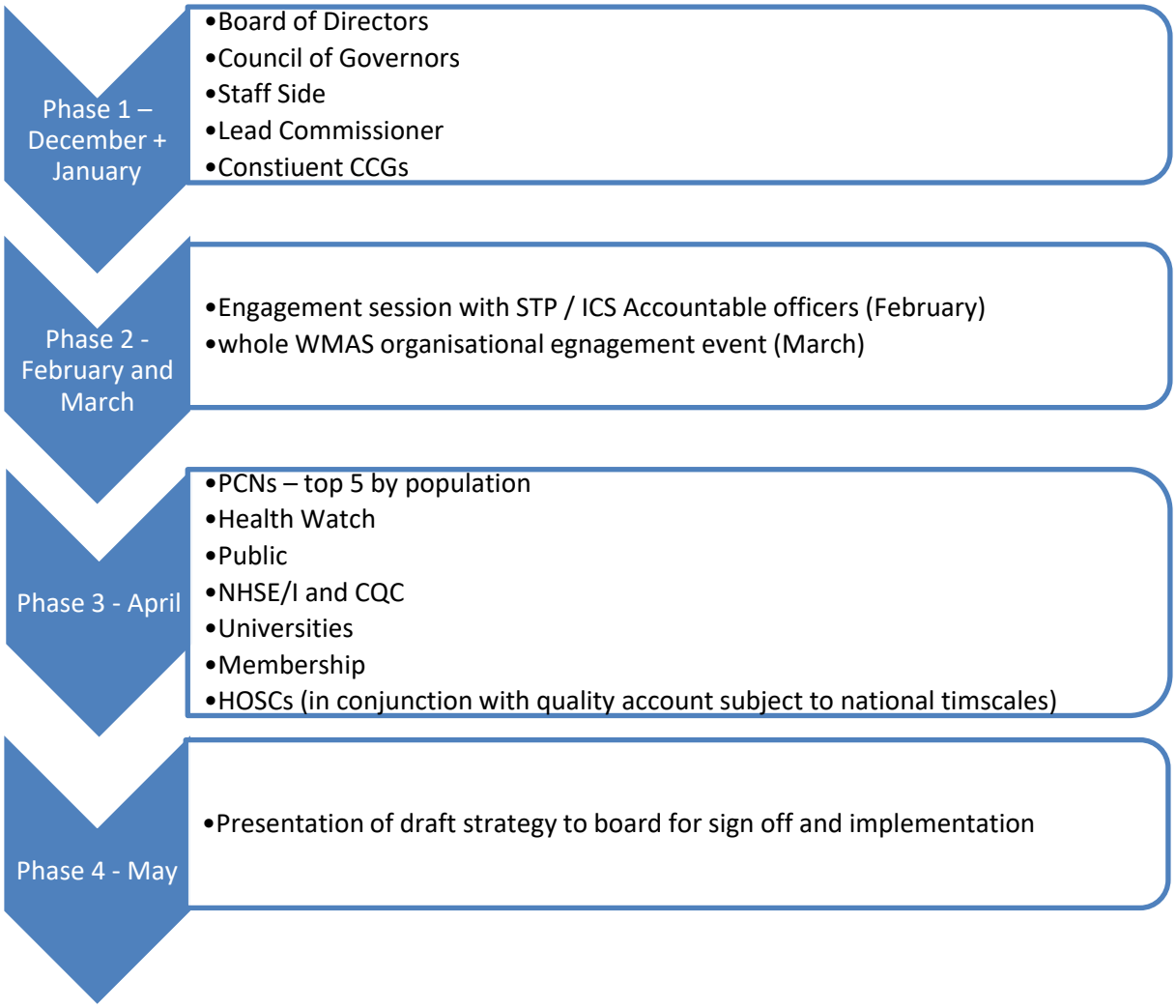
Figure 2



The recommendation is that we postpone whole organisational engagement until March, whereby we would expect the NHS national incident to de-escalate, peak of Covid pressures alongside winter should have reduced and the covid vaccination program will have concluded. By postponing our own staff engagement, that does in-turn delay going out to our external stakeholders, as the working principle is, we engage our own staff before we take our strategy to external stakeholders.

A proposed new timeline for stakeholder engagement for stakeholder engagement is noted below in Figure 3. Phase 1 has been completed, the STP / ICS AOs has been placed in phase 2, alongside our staff, purely because a date has been offered in that window, so it was an opportunity not to miss, however, it would have otherwise been done alongside other external stakeholders in phase 3.

Figure 3



Next steps

The board is asked to note progress to date in the development of our strategic priorities, whilst also accepting there has been a postponement to key elements of engagement which will delay the completion of the strategy.

The revised timetable feels like a realistic assessment of when the work can be completed, by giving enough time to meaningful engage with all key stakeholders, most notably our staff.

If the board accepts the revised timeline, an update paper will be tabled in March and April to the board in advance of presenting a final draft for review and potential sign off in May 2020.

Vivek Khashu

Strategy and Engagement Director
January 2021

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 14 MONTH: January 2021 PAPER NUMBER: 12

Board Assurance Framework (BAF)	
Sponsoring Director	Executive Director of Nursing and Clinical Commissioning
Author(s)/Presenter	Executive Director of Nursing and Clinical Commissioning and Head of Risk
Purpose	The Board Assurance framework has been revised into a new format in light of Auditor's recommendations. The Committee is being asked to discuss and agree the new format ahead of it being presented to the Board at the end of July 2020. The Committee is asked to note the risks and the actions and mitigations to control and reduce those risks
Previously Considered by	EMB, QGC, HSRE, Audit Committee
Report Approved By	Director of Nursing, Quality and Clinical Commissioning

Executive Summary

The board assurance framework (BAF) brings together in one place all of the relevant risk assessment information on the threats to the achievement of the board's strategic objectives. The effective application of board assurance arrangements and continued site of the BAF will assist management and the board to collectively consider the process of securing assurance and promoting good organisational governance and accountability.

Work continues towards an online SharePoint BAF which will provide clear understanding, greater engagement, assurance and more efficient reporting by all committees. This has been delayed due to the Digital Make Ready Project but is aimed for a March completion.

Changes to the BAF since the last Board review are;

Strategic Objective 1 –

IPC-030 – Risks associated with change of process regarding PRPH – Scoring reduced due to individual issue Hoods and other controls and requested to be removed from BAF

IPC-035 – Risks associated with bird/vermin droppings on Trust sites – Scoring increased due to failure of actions and ongoing risk – request that resource is explored regarding suitable action to remove risk

IPC-002 - **Regulatory concerns due to non-compliance with Clinical Waste Management** - Following site visits by Head of IPC, it has been identified that the

storage of clinical waste has at times exceeded the capacity provided, this resulting in waste being stored in a cage. The process set out by the regulators must be followed robustly and has been shared with Senior Operations Managers to ensure this occurs. In addition, since the removal of Vernagel granules, the Trust is unable to solidify fluids in transporting vehicles – this poses a risk of bodily fluid spillage/injury and vehicle contamination. Risk increased and to be further discussed at HSRE

PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents - There have been extensive increases in Hospital delays and patients waiting in Ambulances outside A&E Dept. During the Winter period. These delays at their worst have been recorded at 8 hours, and the impact this has on Patients waiting has been extensive. There has been work identified to ensure Hospitals are reducing the number of patients who do not have the "right to reside" and therefore ensuring reduction of Ambulances and Patients waiting. It is thought that with the additional actions, there may be a reduction in risk, however there is also a possibility that the risk may increase if demand and COVID restrictions continue to worsen

Strategic Objective 2 –
WF-028 - **The devolution of workforce planning and educational commissioning could potentially have a detrimental effect on services, –** New Risk added following discussion and review with Strategy Lead

Strategic Objective 3 –
FI-027 -The financial framework with the emphasis now on block contracting without the ability to respect activity growth - Risk added following discussion and review with Strategy Lead

Strategic Objective 4 –
ORG-082 - Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage - New Risk added following discussion and review with Strategy Lead

ORG-083 - **Investment in digital capability for ambulance services often benefit from a regional approach** - New Risk added following discussion and review with Strategy Lead

Strategic Objective 5 –
ORG-084 - The opportunity for "collective accountability" on performance could be helpful in addressing issues - New Risk added following discussion and review with Strategy Lead
ORG-085 - The loss of a lead commissioner raises the risk that ICS's focus may be directed towards acute, community, mental health and primary care provision - New Risk added following discussion and review with Strategy Lead

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 14 MONTH: January 2021 PAPER NUMBER: 12

Related Trust Objectives/ National Standards	There is a national requirement for WMAS to have a Board approved Board Assurance Framework
Risk and Assurance	The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the board's strategic objectives. It is an essential tool for boards and the effective application of board assurance arrangements to produce and maintain a BAF will help management and the board to consider collectively the process of securing assurance using a formal process that promotes good organisational governance and accountability.
Legal implications/ regulatory requirements	The completion of a BAF and ensuring risks are managed appropriately is an issue of good corporate governance
Financial Implications	There are no direct financial implications for the Committee to consider, however the BAF does address organisational financial risk.
Workforce & Training Implications	There are no direct workforce implications, however the BAF does address workforce issues.
Communications Issues	The new BAF format will need to be communicated to colleagues in the organisation.
Diversity & Inclusivity Implications	This is addressed, where appropriate in the risks identified and mitigating actions.
Quality Impact Assessment	This is addressed, where appropriate in the risks identified and mitigating actions.
Data Quality	The information in the BAF is sourced from the WMAS Risk Register
Action required The Board is asked to review, discuss and agree the changes to the BAF	

West Midlands Ambulance Service University NHS Foundation Trust Risk Matrix

Strategic Objective 1 :Safety, Quality and Excellence
Lead Director: Mark Docherty

Strategic Objective	1: Safety, Quality and Excellence	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
Principal Risks		**SR-1** - Failure to achieve Operational Performance Standards	5x4=20	5x3=15	5x2 = 10
		PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times	4X5=20	4X4=16	4x3=12
		HS-012 - Risk of staff suffering serious injury because of stab / ballistic weapons	5X3=15	5X2=10	n/a
		EP-019 – Pandemic Influenza	4X5=20	4X5=20	4X3=12
		IPC-030 - Risks associated with change of process regarding PRPH	3X3=9	3X3=9	3X3=9
		EP-027 – Risks associated with Terrorist Threats	5x3=15	5x10=10	5x10=10
		ES-002 – Control of Contractors	4x3=12	4x2=8	4x2=8
		ORG-003 – Failure to complete SI investigations within timescales	4x3=12	4x2=8	4x2=8
		PS-027 - Hospital Ambulance Liaison Officers being left in charge of patients in Hospital awaiting provision of care within the Hospital Department	4x3=12	4x3=12	4x2=8
		IPC-032 PTS Staff at risk of conveyance of suspected infectious Patients including COVID-19	4x3=12	4x2=8	4x2=8
		ORG-081 – Outbreak of COVID-19	4x5 = 20	4x5 = 20	4x4 = 16
		IPC-035 -Risks associated with bird/vermin droppings on Trust sites	4X4=16	4X3=12	4X1 = 4
		PS-128 - Stacking of incidents at times of high demand	5x4=20	5x3=15	5x2=10

Lead Committee	Health, Safety, Risk and Environment Group
Last Reviewed	January 2021
Review comments	13th July 2020 – IPC-005 Owner review (removed from BAF as below 12) 27th July 2020 – Health, Safety and Risk Committee review – all risks added to Teams site for Group to review/comment. 6th August 2020 – SR1 reviewed – more in-depth review planned for 25th August to present at EMB 11th August – ORG-003 Owner review 12th August – SR-3 reviewed (now removed from BAF as below 12), PS-027 Owner review – score increased and escalated to BAF 13th August – EP-019 Owner review 17th August 2020 – owner review of IPC-030 and IPC-031 (now removed from BAF as archived) 10th September – Newly created risk escalated to BAF regarding Outbreak of COVID at 111 – to be discussed at HSRE

						W/C 16th November – IPC-035 scoring increased, IPC-030 scoring reduced and asked to remove from BAF January 2021 – PS-128 reviewed given current climate – planned reviews of PS-074 and PS-027 to ensure current demands are reflected – HS-012 due for review January 2021 – PS-074 scoring increased to reflect current demand and issues of Ambulances and Patients waiting
	IPC-002 - Regulatory concerns due to non-compliance with Clinical Waste Management	4X3=12	4X2-8	4X1=4		

Strategic Objective 2 :A great place to work for all
Lead Director: Kim Nurse

Strategic Objective	2: A great place to work for all	**Risk Description** *What might happen if the risk materialises*	**Current Risk Score** With Controls and Assurances in Place (Consequence x Likelihood)	**Mitigated Risk Score** After Applying all Mitigating Actions (Consequence x Likelihood)	**Target Risk score** *(if deemed appropriate upon Board review)*	**Lead Committee**	Workforce Development Group
Principal Risks		**ORG-078** - COVID-Secure in the Workplace	4X3=12	4X2=8	4X2=8	**Last Reviewed**	January 2021
		WF-028 - The devolution of workforce planning and educational commissioning could potentially have a detrimental effect on services, such as ambulance, that operate on a regional footprint	4x3 = 12	4X2=8	4X2=8	**Review comments**	4th August – WF-026 Owner review (removed from BAF as below 12) 17th August – ORG-078 Owner review – risk increased due concerns – reinstated to BAF January 2021 – Updated to reflect greater controls – Risk added after review with Strategy Lead

Strategic Objective 3 :Effective Planning and use of resources
Lead Director: Linda Millincamp

Strategic Objective	3: Effective planning and use of resources	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
Principal Risk		**SR-2** The Trust fails to meet its financial duties	4X3 = 12	4X3=12	4X2=8
		FI-009 - Patient activity varies at a rate that cannot be contained within the Trust's cost base	3X4=12	3X4=12	3X4=12
		FI-023 - The current Senior Finance team are due to retire from the Trust during the same time period	3X5=15	3X5=15	3X5=15
		FI-025 - Further appeal against the "Flowers" judgment not allowed or unsuccessful will result in a financial risk to the Trust.	4X4=16	3X4=12	3X4=12
		ORG-029 - Risk of failure of Corporate IT or IT due to Cyber Terrorism	4X4=16	4X3=12	4X3=12
		FI-007 - Tariff requires year on year efficiency improvements – eg 18/19 = 2%, but 19/20 and following 3 years is 1.1% minimum.	3X4 = 15	2X5= 10	2X5 = 10
		FI-020 - The change in planning and commissioning of services on a national basis, particularly with reference to STPs, could destabilise the Trust's current business model.	4X4=16	4x3=12	4x3=12
		FI-022 - Implementation of the IFRS 16 standard for leasing of assets	3X4=12	3X3=9	3X3=9
		FI-026 - The new nationally agreed pay award is not fully funded for the Trust	5X4 = 20	5X3=15	5X3=15
		FI-027 -The financial framework with the emphasis now on block contracting without the ability to respect activity growth. PbR has served WMAS well, a different approach will be required.	4x4 = 16	4x3 = 12	4x2 = 8

Lead Committee	Audit Committee
Last Reviewed	January 2021
Review comments	23rd July – Clarification sought from Audit Committee on frequency and detail for Risks to be reviewed August 2020 – FI-007, FI-020, FI-022, FI-026 added to BAF as reviewed at 12 and Above via Senior Finance Team January 2021 – Review planned as SR-2 is currently out of date on Register – risk added following discussion and review with Strategy Lead

Strategic Objective 4 :Innovation and Transformation
Lead Director: Craig Cooke

Strategic Objective	4: Innovation and Transformation	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
Principal Risk		**ORG-082 -** Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)	4x3 =12	4x2 = 8	4x1 = 4
		ORG-083 - Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.	4x3 = 12	4x2 = 8	4x1 = 4

Lead Committee	Health, Safety, Risk and environment Committee
Last Reviewed	January 2021
Review comments	January 2021 – review at Audit Committee – inclusion of relevant risks after review with Strategy Leads

Strategic Objective 5 :Collaboration and Engagement
Lead Director: Vivek Khashu

Strategic Objective	5: Collaboration and Engagement	Risk Description *What might happen if the risk materialises*	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
Principal Risk		**ORG-084** - The opportunity for "collective accountability" on performance could be helpful in addressing issues - how this would work though is ill defined	4x3 = 12	4x2 = 8	4x2 = 8
		ORG-085 - The loss of a lead commissioner raises the risk that ICS's focus may be directed towards acute, community, mental health and primary care provision so ability for ambulance to access national transformation funds for example or capital may continue to be constrained.	4x3 = 12	4x2 = 8	4x1 = 4

Lead Committee	Workforce Development Group
Last Reviewed	January 2021
Review comments	January – review at Audit Committee – inclusion of relevant risks after review with Strategy Leads

Appendices

Strategic Objective 1 :Safety, Quality and Excellence
Lead Director: Mark Docherty

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	*Mitigating Actions*	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
IPC-030	Use of Powered Respiratory Protective Equipment (PRPH)	Decision made to reduce risk score due to implementation of controls. Operational E&U Staff have now been issued with personal PRPH Hoods, as well as relevant training which in turn has increased Staff confidence and reduced incident reporting, which includes damage and cleanliness issues.			Tolerate current risk given introduction of personal issue PRPH and reduction in incident reports	Request to agree reduction of risk and removal from BAF
IPC-035	Risks associated with bird/vermin droppings on Trust sites		Since last review, various workstreams have been explored but unfortunately with no success. SOM reports and site visits have shown that the issue is still prevalent at the identified sites posing cleanliness and infection risks, as well as compliance and organisational concerns. The risk rating has been increased based on organisational risks and potential failure of Regulatory compliance. Estates are currently working through the action plan with a view to reduce the risk		Residual risk is too high as actions have not been successful	Identification of robust actions to ensure removal of high risks
IPC-002	Regulatory concerns due to non-compliance with Clinical Waste Management		Following site visits by Head of IPC, it has been identified that the storage of clinical waste has at times exceeded the capacity provided, this resulting in waste being stored in a cage. The process set out by the regulators must be followed robustly and has been shared with Senior Operations Managers to ensure this occurs. In addition, since the removal of Vernagel granules, the Trust is unable to solidify fluids in transporting vehicles – this poses a risk of bodily fluid spillage/injury and vehicle contamination. Risk increased and to be further discussed at HSRE		Residual risk is too high, relevant regulatory requirements need to be followed and relevant actions identified are undertaken	Support actions to reduce risk – robust management at sites, consider reinstating vernagel and relevant reporting/action is undertaken at each site to conform to Regulations
PS-074	Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents		There have been extensive increases in Hospital delays and patients waiting in Ambulances outside A&E Dept. During the Winter period. These delays at their worst have been recorded at 8 hours, and the impact this has on Patients waiting has been extensive. There has been work identified to ensure Hospitals are reducing the number of patients who do not have the “right to reside” and therefore ensuring reduction of Ambulances and Patients waiting. It is thought that with the additional actions, there may be a reduction in risk, however there is also a possibility		Level of residual risk is too high, work required to reduce Risk and ensure no further escalation	

			that the risk may increase if demand and COVID restrictions continue to worsen			

Strategic Objective 2 :A great place to work for all
Lead Director: Kim Nurse

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	*Mitigating Actions*	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
WF-028	The devolution of workforce planning and educational commissioning could potentially have a detrimental effect on services, such as ambulance, that operate on a regional footprint		Potential workforce gaps based on demand/activity	Stability required based on demand	Further review required to ensure relevant tolerance and appetite	Block contract and activity impact to be reviewed

Strategic Objective 3 :Effective Planning and use of resources
Lead Director: Linda Millincamp

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
FI-027	The financial framework with the emphasis now on block contracting without the ability to respect activity growth. PbR has served WMAS well, a different approach will be required.		Financial gap based on demand/activity	Block contract stability required, with the ability to fluctuate as demand dictates	Further review required to ensure relevant tolerance and appetite	Block contract and activity impact to be reviewed

Strategic Objective 4 : Innovation and Transformation
Lead Director: Craig Cooke

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
ORG-082	Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)		Opportunities need to be explored Greater focus on the devolution process		Further review required to ensure relevant tolerance and appetite	
ORG-083	Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.		Opportunities to be explored across systems		Further review required to ensure relevant tolerance and appetite	

Strategic Objective 5 : Collaboration and Engagement
Lead Director: Vivek Khashu

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
ORG-084	The opportunity for "collective accountability" on performance could be helpful in addressing issues - how this would work though is ill defined		Further review of risks is required to ensure all factors are captured		Further review required to ensure relevant tolerance and appetite	
ORG-085	The loss of a lead commissioner raises the risk that ICS's focus may be directed towards acute, community, mental health and primary care provision so ability for ambulance		Further review of risks is required to ensure all factors are captured		Further review required to ensure relevant tolerance and appetite	

	to access national transformation funds for example or capital may continue to be constrained.					

QUALITY IMPROVEMENT FRAMEWORK

DATE APPROVED:	**(DD/MM/YYYY)**
APPROVED BY:	**Committee/Board**
IMPLEMENTATION DATE:	**(DD/MM/YYYY)**
REVIEW DATE:	**(DD/MM/YYYY)**
LEAD DIRECTOR:	**EPRR & Quality Improvement Director**
IMPACT ASSESSMENT STATEMENT:	**No adverse impact on Equality or Diversity**

Document Reference Number:	**(Issued by Document Control Officer)**

Change Control:

Document Number	(Issued by Document Control Officer)
Document	QUALITY IMPROVEMENT FRAMEWORK
Version	(Issued by Document Control Officer)
Owner	EPRR & Quality Improvement Director
Distribution list	(Who it relevant to)
Issue Date	(DD/MM/YYYY)
Next Review Date	(DD/MM/YYYY)
Author	EPRR & Quality Improvement Director

Change History:

Date	Change	Comment/Approved by
(01/12/2020)	Developed and circulated for approval	EMB Approved

CONTENTS

1 Introduction

1.1 This Quality Improvement Framework is the toolbox the organisation will use to plan, manage, monitor and review QI programmes it runs, to make improvement across the organisation in any part of the Trust for patients or for the organisation. This Framework includes the QI systems, processes and tools approved by the Trust.

1.2 Quality Improvement (QI) in health care is based on the principle of health care organisations and staff continuously trying to improve how they work and the quality of care and outcomes for patients. This requires a systematic approach based on iterative change, continuous testing and measurement, and the empowerment of frontline teams (Ross and Naylor 2017).

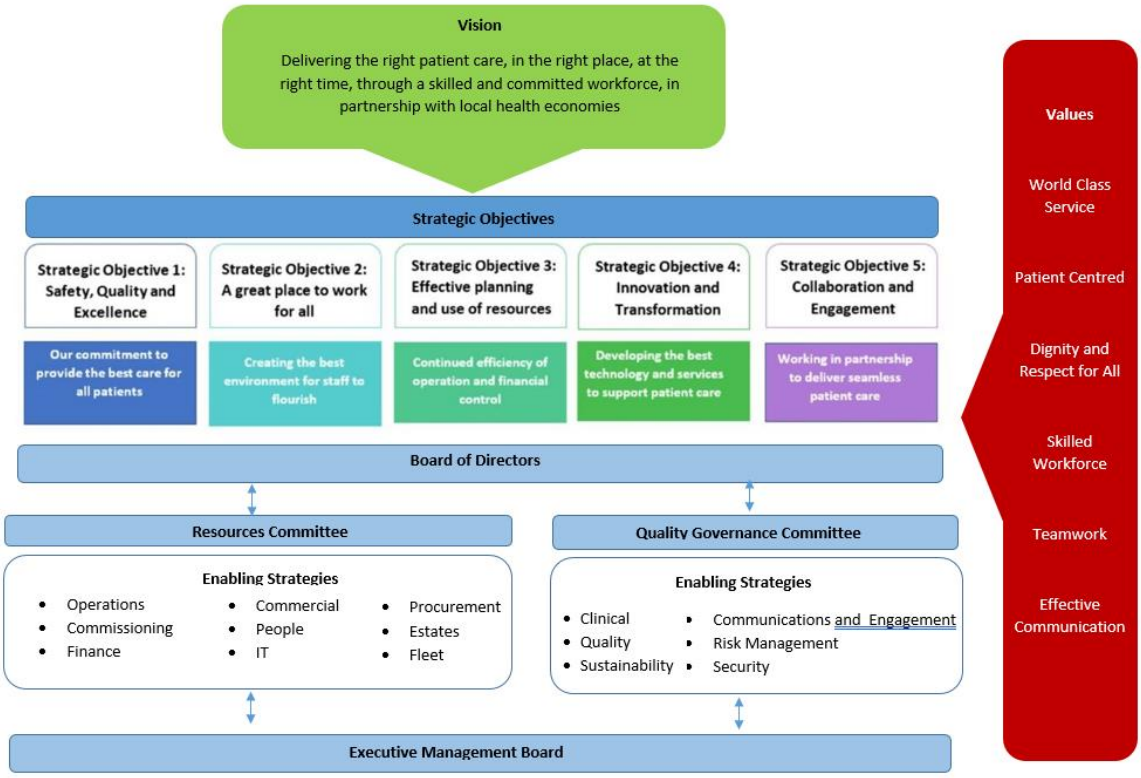
1.3 The Quality Strategy (QS) will be the overarching strategy for quality improvement in all areas of the Trust and will act as the focal point for reference for the aims and specific plans for QI over a projected period e.g. 5 years. The QS will include the links to the other Trust strategies, the processes and Committees that lead the monitoring for each Strategy, the plans to improve QI methodology, education, adoption, cultural changes needed to support QI being embedded in all the work of the Trust and the other areas related to a culture of constant Quality Improvement.

2 Vision and Values

2.1 Quality Improvement and this Framework are closely linked to the Trust's Vision, Values and Strategic Objectives. All Quality Improvement considerations, projects and initiatives should link to these as shown in Diagram 1

Figure 1: Trust Vision, Value and Strategic Objectives

2.2



3 Quality Assurance

3.1 A significant part of our assurance processes has an external focus of control. The Care Quality Commission (CQC), the healthcare quality regulator continues to inspect using its framework of 5 Key Lines Of Inquiry:

- Safe
- Effective
- Caring
- Responsive
- Well Led

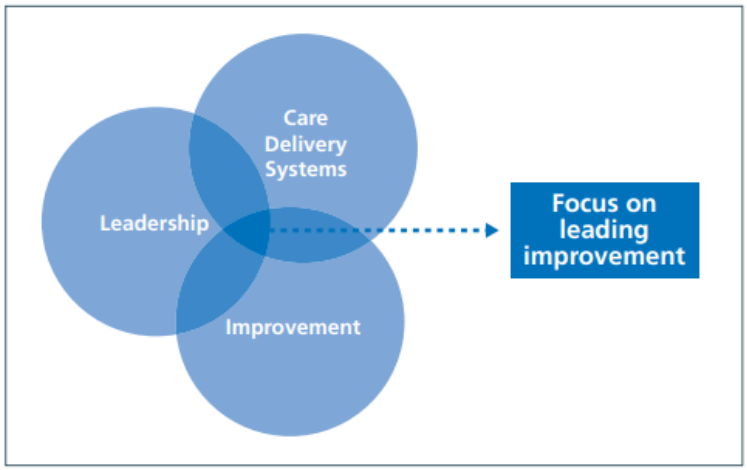
3.2 Quality Assurance work programme summary

3.2.1
- Continue with current quality assurance visits Infection Prevention and Control (IP&C), Risk Management
- Embed service user involvement in assuring and improving services
- Listening and learning
- Compliance with CQC, National Institute for Clinical Excellence (NICE), Medical Healthcare Regulations Agency (MHRA) standards
- Developing local quality and performance measurements
- Audit through frameworks such as IP&C Incident Framework and Medicines Management Framework and the Trust's Clinical Audit Plan
- Benefits Realisation Management
- The process for learning and monitoring will go through the Trusts Learning Review Group.

4 Quality improvement methodology and tools

4.1 The QSIR (Quality Service Improvement and Redesign) recognises the Leading improvement Framework

4.1 Figure 2: Leading improvement framework model



The leading improvement framework was developed as a theoretical model for a national programme. It was derived from research from the NHS, which examined the knowledge, skills, and capabilities that leaders need in order to achieve the most relevant and sustainable improvements and it has three parts.

- Leadership
- Improvement
- Care delivery systems

4.2 The Model for Improvement

The model for improvement provides a framework for developing, testing and implementing changes leading to improvement. It is based in scientific method and moderates the impulse to take immediate action with the wisdom of careful study. Using Plan, Study, Do Act (PDSA) cycles enables testing changes on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff.

4.2 When to use it

.1 When planning any improvement or change to work processes, it is essential to know what you want to achieve, how you will measure improvement and to be explicit about the idea to be tested. You may not get the results you expect so it is safer and more effective to test out improvements on a small scale before implementing them across the board.

4.2 How to use it

.2 The framework includes three key questions to answer before testing an improvement concept and a process for testing change ideas. It is these three questions we will use as the basis for making improvements.

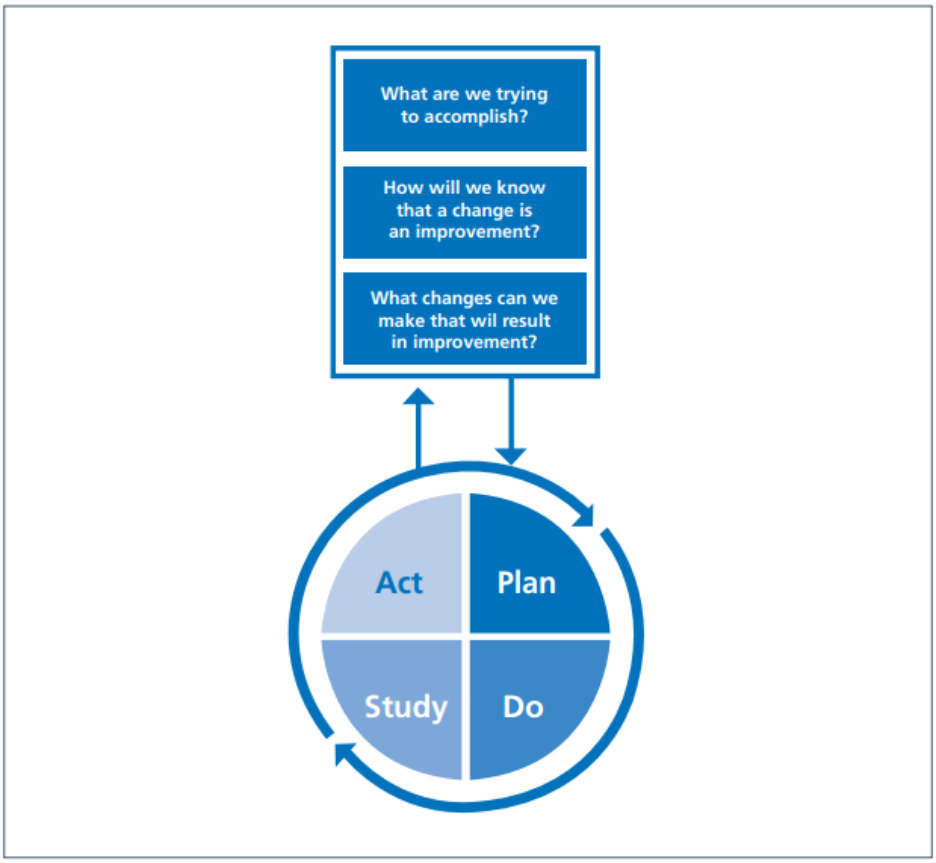
Key questions

1. What are we trying to accomplish? (The aims statement).

2. How will we know if the change is an improvement? What measures of success will we use?

3. What changes can we make that will result in improvement? (The change concepts to be tested).

4.4.3 Figure 3: The model for improvement



4.4.4 The four stages of the PDSA cycle are:

Plan – the change to be tested or implemented

Do – carry out the test or change

Study – based on the measurable outcomes agreed before starting out, collect data before and after the change and reflect on the impact of the change and what was learned

Act – plan the next change cycle or full implementation

4.4.5 More information on PDSA can be found in NHS Improvements ACT Academy, Online library of Quality, Service Improvement and Redesign tools, Plan, Do, Study, Act (PDSA) cycles and the model for improvement

4.4.6 Quality Improvement Tools
The QSIR program provides a list of suitable tools for different stages of projects, the task, tools for approach and by patient pathway which can be found here
More tools can be found in Appendix 1

5 Enabling the Framework

5.1 Enabling the framework may come from learning opportunities or developments. This framework sits under the Learning Review Group (LRG) where a learning opportunity may arise. Project management and its associated tools and techniques should be considered from the initiation to the completion of any project. Established processes for project approval and management, following PRINCE principles. This framework will strengthen these processes through introduction of the improvement methodologies detailed and referenced in this section of the Handbook of Quality and Service Improvement Tools**.**

5.2 The six-stage project management approach illustrated in figure 1 below provides a framework for managing improvement projects in the NHS. We suggest you read through this whole section before you undertake any actions relating to the stages or try using any of the tools detailed or referenced. This will help you get an overall picture of what all the stages involve. It is important to realise that this guide is a suggested approach as each project is unique.

5.3 Figure 1: The six-stage project management approach

5.4 Stage 1: Start out – what is the opportunity or problem?

Desired output: clear scope of the problem and support for the improvement activity.
The first step is to identify the service, area, pathway or process that needs to be improved. This may be identified by national initiatives, e.g. best practice tariff, targets, an individual or team, data demonstrating that a process is not consistently delivered to expected or required levels or a quality improvement enhancing patient experience.

The remaining steps and more information on Project management can be found on NHS Improvements ACT Academy, Online library of Quality, Service Improvement and Redesign tools: Project Management an overview

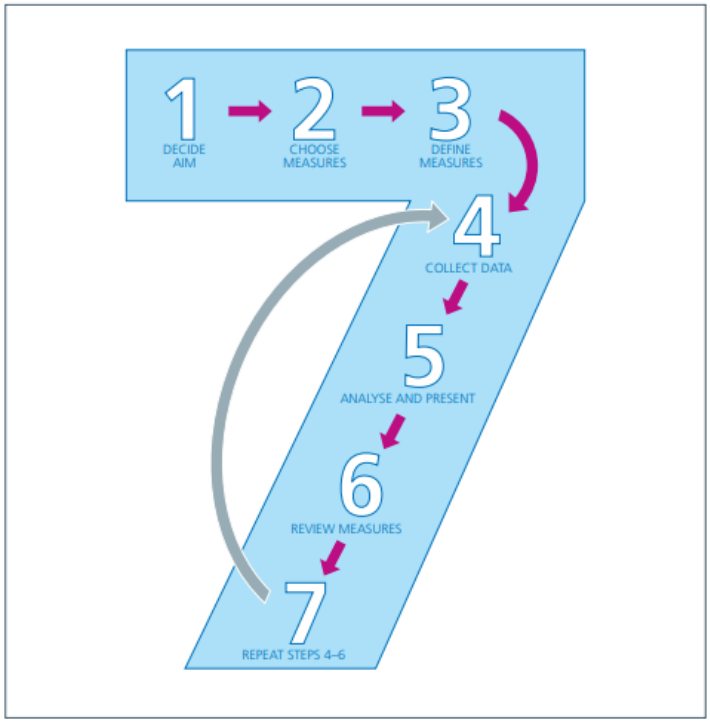
More specific tools can be found here: identifying frustrating problems, stakeholder analysis, active listening

6 Measuring Improvement

6.1 The seven steps to measurement for improvement model provides a structure and method to develop effective measures in practice. It was designed to complement the Model for Improvement and PDSA cycle

Figure 4: Seven Steps To Measurement For Improvement

6.2



6.3 Measurement should be part of the daily routine and where possible use data collection systems and presentations that already exist. This minimises the burden on staff and also maximises the chance of it being done reliably and sustainably.
Measurement for improvement and the application of the seven steps will depend on the stage your quality improvement project is currently at. More detailed information can be found in NHS Improvement's ACT Academy, Online library of Quality, Service Improvement and Redesign tools, Seven steps to measurement for improvement

6.4 Where improvements are planned through major projects, the principles of Benefits Realisation apply to support the clear identification of planned benefits and any associated disbenefits from project activity. The process (can be referenced in NHS Improvement's ACT Academy) is set out in the Trust's Benefits Realisation Strategy (Currently in development) and captures:

- Desired benefit
- Stakeholders impacted
- Enablers to realise the benefit
- Outcomes displayed if benefit is realized
- Measures (including baseline and targets)
- Who is responsible
- Target date for realisation

7 Engagement and Communication

7.1 The Communications and Engagement Strategy sets out the Trusts key stakeholders and methods of engagement. The Learning Review Group, as mentioned in 5.1 provides an established and broad basis for engagement of staff from all Directorates within the organisation and subsequent communication with wider staff groups. External communication will be determined according to specific activities and requirements of each initiative.

8 References and Further Guidance

8.1 This framework is heavily linked to the Quality, service improvement and redesign (QSIR) tools.
This is a comprehensive collection of proven quality, service improvement and redesign tools, theories and techniques that can be applied to a wide variety of situations. You can search the collection alphabetically for a specific tool or browse groups of tools using one of four categories.
https://www.england.nhs.uk/quality-service-improvement-and-redesign-qsir-tools/

8.2 The Care Quality Commissions (CQC) Key Lines of Enquiry are five questions that are asked of all care services. They're at the heart of the way the CQC regulates and they help them to make sure we focus on the things that matter to people.
https://www.cqc.org.uk/what-we-do/how-we-do-our-job/five-key-questions-we-ask

Appendices

Appendix 1
Approved Tools

- Active listening
- Affinity diagram
- Aims statement development
- Aligning improvement with strategic goals
- Benefits realisation
- Brainstorming
- Bullet proofing
- Cause and effect (fishbone diagram)
- Check sheet
- Clinical engagement
- Commitment, enrolment and compliance
- Communications matrix
- Demand and capacity – a comprehensive guide
- Demand and capacity – an overview
- Discomfort zone
- Discovery Model
- Driver diagrams (tree diagrams)
- Engagement and empowerment
- Enhanced recovery
- Fresh eyes
- Gateway criteria
- Glenday sieve – runners, repeaters, strangers
- Healthcare leadership model
- Histogram
- How to understand differences between individuals
- Identifying frustrating problems
- Influence Model
- Issues and risks management
- Leading improvement: an overview
- Leading improvement framework
- Lean – Ohno's eight wastes
- Lens of Profound Knowledge
- Lessons learnt
- Managing conflict
- Mapping the process – an overview
- Mapping: value stream
- Measurement for improvement: an overview
- Model for measuring quality care (structure, process, outcome and balancing measures)
- Modelling and simulation
- Overcoming barriers
- Pareto analysis
- Partnership working with health service users
- Patient information
- Patient stories
- Performance management
- Plan, Do, Study, Act (PDSA) cycles and the model for improvement
- Process mapping – a conventional model
- Process templates
- Project charter, brief or mandate
- Project initiation document (PID)
- Project management: an overview

- Public narrative
- Reliable design
- Report on progress
- Resistance – enabling collaboration by working with it
- Responsibility charting
- Reviving a stalled effort
- Role redesign
- Root cause analysis using five whys
- Run charts
- Safe to fail experiments
- SBAR communication tool- Situation – Background – Assessment – Recommendation
- Scatter diagram (correlation)
- Seven steps to measurement for improvement
- Simple rules – provocation
- Simple rules and breaking them
- Six Thinking Hats®
- Spaghetti diagram
- Stakeholder analysis
- Stakeholder involvement: an overview
- Statistical Process Control (SPC)
- Supporting people through change – an overview
- Sustainability Model
- Sustaining momentum
- That's impossible!
- Theory of constraints
- Thinking creatively to solve problems – an overview
- Variation – how to manage it

Minutes of the Audit Committee held on 23 September 2020, 1000 hours via Microsoft Teams

Present:

Mrs W Farrington-Chadd	WFC	Non-Executive Director (Chair)
Mrs C Wigley	CW	Non-Executive Director

In attendance:

Mrs L Millinchamp	LJM	Director of Finance
Mr J Brown	JB	External Audit
Mr T Felthouse	TF	External Audit
Mr C Knight	CK	Internal Audit
Miss Z Baker	ZB	Internal Audit
Mrs J Hill	JH	Local Counter Fraud Specialist
Mr Phil Higgins	PH	Governance Director and Trust Board Secretary
Ms M Kalea	MK	Head of Claims

Secretariat:

Mrs D Stevenson	DMS	PA to Director of Finance

ITEM	Audit Committee Meeting 22 September 2020	ACTION
09/20/01	**Welcome and apologies**	
	Apologies were received from Tony Yeaman and Mushtaq Khan. WFC welcomed members to the meeting and explained that the meeting had purely been arranged to ratify the revised Terms of Reference and membership of the Audit Committee under the Trust's new governance arrangements.	
09/20/02	**Minutes of the Last Meeting**	
	The minutes of the meeting held on 14 July 2020 were agreed as an accurate record.	
09/20/03	**Matters Arising**	
	Actions from the last meeting were noted. All action points are in progress or completed.	
09/20/04	**Terms of Reference**	
	PH outlined the revised Terms of Reference presented for review and said the membership is in line with the HFMA "NHS Audit Committee Handbook".	

	The membership should be composed of at least three members who are all Non-Executive Directors. The HFMA guidance also states that the quorum should be at least two Non-Executive Directors. The Executive Director attendance will be the Director of Finance, plus other Executive Directors and staff can be invited as determined by the Chairman of the Committee. Other regular attendees should be the Internal and External Auditors, Trust Secretary and Local Counter Fraud Specialist. The following comments were noted: **Section 2 – Membership** • Paragraph 1 – WFC and LJM recommended the following statement is added at the end of the paragraph – "***The Chair of the Audit Committee must be a fully qualified accountant***". • Paragraph 3 - LJM said that the reference to Resources Committee should be deleted as this Committee no longer exists. PH to draft some wording and send to WFC and LJM for approval. The Committee recommended approval of the Terms of Reference subject to the above amendments to present to the October Board.	
	Resolved: a) PH to revise Terms of Reference. The Committee approved the revised Terms of Reference subject to changes outlined above for onward submission to the Board.	**PH**
09/20/05	**Schedule of Business**	
	The Committee noted the revised Schedule of Business. TF requested the External Audit Plan be inserted for the January meeting. Any further amendments to be forwarded to DS.	**DS** **All**
	Resolved: a) The Committee received and approved the Schedule of Business.	
09/20/06	**Any Other Urgent Business**	
	None.	
09/20/07	**Dates of Future Meetings 2020-21**	
	• **10 November 2020, 10am.** • **19 January 2021, 10am.**	

	• **16 March 2021, 10am.**	
09/20/08	**Meeting in the absence of Officers from the Trust**	
	It was agreed not to hold a separate meeting in the absence of Officers from the Trust.	

Chair…….. Dated……

The meeting closed at 1015 hours.

Action Points – Audit Committee 23 September 2020

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
09/20/04	Terms of Reference, subject to changes, to be submitted to the Board.	**PH**	*Complete*	
09/20/05	Schedule of Business: • External Audit Plan be inserted for the January meeting. • Any further amendments to be forwarded to DS.	**DS** **All**	*Complete*	

Date of next meeting:
10 November 2020, 10am

Minutes of the Audit Committee held on 10 November 2020, 1000 hours via Microsoft Teams

Present:

Mr A Yeaman	AY	Non-Executive Director (Acting Chair)
Mrs C Wigley	CW	Non-Executive Director

In attendance:

Mrs L Millinchamp	LJM	Director of Finance
Mr J Brown	JB	External Audit
Mr T Felthouse	TF	External Audit
Mr C Knight	CK	Internal Audit
Miss Z Baker	ZB	Internal Audit
Mr G Colman	GC	Internal Audit
Mrs J Hill	JH	Local Counter Fraud Specialist
Miss E Nowell	EN	Senior Management Accountant

Secretariat:

Mrs D Stevenson	DMS	PA to Director of Finance

ITEM	Audit Committee Meeting 10 November 2020	ACTION
11/20/01	**Welcome and apologies**	
	Apologies were received from Wendy Farrington-Chadd, Mandy Kalea, Mushtaq Khan. Tony Yeaman chaired the meeting in Mrs Farrington-Chadd's absence.	
11/20/02	**Minutes of the Last Meeting**	
	Resolved: a) The minutes of the meeting held on 22 September 2020 were agreed as an accurate record.	
11/20/03	**Matters Arising**	
	Actions from the last meeting were noted.	
11/20/04	**Claims and Coroners Report, High value claims and action reports**	
	AY said he had met with M Kalea and a rolling review of all claims is now contained in a data dashboard for both clinical and non-clinical claims. This will be reported up the Audit Committee.	

	Resolved: a) The Committee received and noted the report.	
11/20/05	**Internal Audit Update**	
	<u>Progress Report</u> ZB outlined the progress report to the committee which provides a summary on the progress made against the Internal Audit Plan for 2020/21. 7 assignments have been issued as final reports and the following assurances were noted:- • **Freedom of Information – Optimal** – the whole process has been audited, there was one minor action in relation to internal reporting, and this has been rectified. • **Love2Shop Vouchers – Substantial** – the whole process was audited, three low priority actions agreed: update of procedures; return of the signing sheets; tightening of finance process. LJM said she asked ZB to look at this due to problems experienced in the past and the new procedure is working well. • **Safeguarding – Substantial** – referral process examined plus cases and reviews. One very low action agreed to update the Policy. • **Patient Experience – Substantial** – PTS survey, Friends and Family Test and Every Contact Counts audited. Actions mainly related to the PTS survey to ensure it is cascaded out to more hospitals. All other actions have been implemented. • **Fire Safety – Requires improvement** – there has been a change in the staff responsible for this area and this mainly relates to fire risk assessments (which have been carried out remotely), therefore, unable to ensure all actions from previous assessments have been completed. 11 actions have arisen from the audit. LJM said the funding for external work has been agreed. CW raised concern that this item had slipped and to ensure the Board is assured via EMB that all the actions will be carried out by December. • **GDPR – Substantial** – GC outlined the report and said that the 8 key rights of individuals were examined. The Trust has key roles in place. One recommendation relating to the inventory needs to be brought up to date. • **New Systems Security – Substantial –** GC said the Trust processes were looked at with regard to installing any new systems, no problems apart from staff installing cloud based systems and IT have agreed to enhance their procedure in relation to this.	

	Look ahead **Mental Health Act review** - ZB said the delivery of the Internal Audit plan for the year end is on track. The review on compliance with Mental Health Act – ZB said she has had some difficulty to get this scoped, and following discussions with Executive Lead and management it is proposed to remove it from the plan and use the 9 days remaining against the other reviews. AY said it may be difficult to push this back as it relates to Mental Health. ZB said there are no ambulance indicators that relate to it, with data unavailable for us to select samples from (Rob Cole currently working with Clinical Audit to establish how/ if this can be audited in the future). There is a Trust policy in place however this is more of a response to partnership organisations than something which Trust staff much comply with. **DSPT** - GC said there is a new audit approach to the DSPT and pointed out that NHS Digital have published the new audit framework for the DSPT, this is to ensure a consistency across all NHS organisations The new framework identifies 13 assertions supported by 41 evidence lines that must be reviewed. A risk rating will be given as a result of the audit and an assurance rating after looking at the evidence. **Overdue management actions** – two overdue - fire safety and patient experience. Updates since provided and actions closed. **External Quality Assessment of Internal Audit** - a full external review (rather than a self-assessment with independent external validation) will be undertaken and an external assessor, with no conflicts of interest to declare, has been appointed and work will commence in December. The Terms of Reference have been approved by LJM and WFC. **KPIs** – nothing to flag other than the lowest score is in relation to management responses. These are raised at EMB.	
	Resolved: a) The Committee received and noted the report. b) The Insight report was received and noted.	
11/20/06	**External Audit Progress Report**	
	TF outlined the report and pointed out the following • The Draft Audit Plan will be presented to the January meeting. • The new VFM standard that was issued on 15 October 2020, which is a substantial change in approach to previous VFM testing, with far greater detail and scrutiny placed at the risk assessment stage of the testing and more reporting will be required at the year end.	

	• Technical Update. • A Benchmarking analysis will be also presented to the next meeting.	
	Resolved: **a)** The Audit Committee received and noted the progress report.	
11/20/07	**LCFS Progress Report**	
	JH outlined the report to members, good progress is being made with the Work Plan and Appendix 1 shows the status of work so far. There are no ongoing live investigations at the moment to report. Two referrals have been transferred to the Security Management team, one of which related to an anonymous referral with regard to theft of data. Fraud risks are regularly reported to the Director of Finance. Two important issues were received which flagged up if there are adequate measures in place for checking changes in bank details and checking of referees for job applicants. National Fraud Initiative – work for last year's matching is completed. One individual identified as not declaring an interest. A review of Conflicts of Interest has just been started Currently awaiting issue of the Cabinet Office functional fraud standard. The Fraud Sanctions and Redress Policy has been deferred to the January meeting so that any changes in requirements with the new standards can be incorporated. Benchmarking data has been released – JH has compared all Ambulance Trusts in the country and WMAS have a lower than average case referral rate. Comparison data will be included at the next update for the committee	
	Resolved: a) The Committee received and noted the report.	
11/20/08	**Policies/Procedures for review**	
	LJM outlined the following:- **<u>SFI's (Standing Financial Instructions) and Scheme of Delegation</u>** The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust and must be adhered to by every member of staff.	

	These have been reviewed and minor changes made. The only two items to note are section 7.8 where a section on electronic tenders has been added in, and section 16 regarding patient's money and property which has been removed as it is not relevant. **Finance Procedures** These procedures have been updated and have been reviewed by the Senior Finance Team and minor amendments made to ensure they fully reflect the controls in place in the Finance department.	
	Resolved: a) The Committee approved the SFIs and Finance Procedures for onward publication.	**DMS**
11/20/09	**Items from the Performance Committee Meeting**	
	No paper received. AY asked that M Khan circulate a paper to members.	
	Resolved: b) M Khan to circulate a briefing note to members.	**MK**
11/20/10	**Items from the Quality Governance Committee Meeting**	
	AY gave a verbal update to the meeting and said that better ways of reporting and better data are being implemented. AY will arrange for a paper to be circulated with more details on this.	
	Resolved: a) The Committee received and noted the verbal report. AY to circulate an update paper to members.	**AY**
11/20/11	**Schedule of Business**	
	Noted by members. Any changes to be forwarded to DMS.	
11/20/12	**Any Other Urgent Business**	
	None.	
11/20/13	**Dates of Future Meetings 2021**	
	• 19 January 2021, 10am – **risk and assurance focused meeting. More time to be allocated for this meeting.** • 16 March 2021, 10am • 19 May 2021, 10am • 13 July 2021, 10am	

	• 9 November 2021, 10am	
11/20/14	**Meeting of the Audit Committee in the absence of Officers from the Trust**	
	Not held.	

Chair…….. Dated……

The meeting closed at 1050 hours.

Action Points – Audit Committee 10 November 2020

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
11/20/08	SFIs and Finance Procedures to be forwarded for publication on the intranet	**DMS**	*Complete*	*Sent on 10.11.20.*
11/20/09	MKh to circulate an update paper on Performance Committee to members	**MKh**		
11/20/10	AY to circulate an update paper on QGC to members	**AY**		
11/20/11	Schedule of Business: • Any further amendments to be forwarded to DS.	**All**	*Complete*	

Date of next meeting:
19 January 2021, 10am

Minutes of the meeting of the Quality Governance Committee held on 19 October 2020
In view of the current National Emergency and the guidance on maintaining social distancing the meeting was convened by electronic means through Microsoft Teams software

Present:

Tony Yeaman	(TY)	Non-Executive Director (Chair)
Mohammed Fessal	(MF)	Associate Non-Executive Director
Alison Walker	(AW)	Executive Medical Director
Mark Docherty	(MD)	Executive Director of Nursing & Clinical Commissioning
Andrew Proctor	(AP)	Quality Improvement & Compliance Director
Vivek Khashu	(VK)	Strategy & Engagement Director
Nick Henry	(NVH)	Head of Operational Information, Planning & Performance
Stephen Thompson	(ST)	Staffside Representative

In attendance:

Pippa Wall	(PW)	Interim Director of Strategic Planning
Jenny Lumley-Holmes	(JLH)	Clinical Audit Manager
Marie Capper	(MC)	Head of Patient Experience
Chris Kerr	(CK)	Head of Governance
John Kelly	(JK)	Head of Security & Safety

Secretariat:

Nicky Shaw	(NS)	PA to Executive Director of Nursing & Clinical Commissioning & Executive Medical Director

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
10/20/01	**Apologies and Introductions**	
	Apologies were received from Jacynth Ivey, Non-Executive Director and Stuart Gardner, Staffside Representative. The committee were informed AP would be late joining the meeting. The meeting was quorate.	
10/20/02	**Minutes of previous meeting – 22 July 2020**	
	The minutes of the meeting held on 22 July 2020 were submitted. ST highlighted an error on page 15, as reference is made to the 'Royal College of Paramedics' but it should read be 'College of Paramedics'.	
	Resolved:	
	That the minutes of the meeting held on 22 July 2020 be received and approved as a true and accurate record, pending the minor amendments to be made.	**NS**
10/20/03	**Action Log**	
	The QGC Action Log contains the schedule of matters upon which the QGC have asked for further action or information to be submitted. Matters on this log can only be deleted through resolution of the QGC. (For the avoidance of doubt unless specified below all matters contained on the QGC log will remain on the log until the QGC resolves that the matter can be discharged).	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	Resolved:	
	1. In relation to continued minute 03/20/5.3: Trust Board Reporting MD informed there was nothing more to update on against the Gosport Report. MD reminded the report was around the over-usage of medicines in a community setting and over a long period of time and demonstrated the lack of governance in the systems and processes. It is difficult to relate this to WMAS other than to be mindful of opiate use and he would pick this up with colleagues to see if there is anything that can be learnt from a Trust point of view. MF agreed with MD's comments that the Gosport report is not fully relevant to the ambulance sector but there is always some learning when dealing with drugs. MF added that the Controlled Drugs Accountable Officer, has advised this is still on the agenda for the CD Links and MF was happy to provide support if needed.	**MD**
	2. In relation to continued minute 03/20/08.1: Workforce Assurance Report (Action Log Nos. 2, 3 & 4) Following the recent restructure of committees and the introduction of a Peoples Committee, it was agreed the following actions would need to be transferred to the Peoples Committee to take forward: (Action No. 2) Further analysis is done on the WRES and WDES data with strategic priorities and brought back as an agenda item. (Action No. 3) KN to circulate the Hub analysis of the staff survey and this will be picked up at the next meeting to ensure the committee has the assurance it requires. (Action No. 4) The WRES & WDES data is presented alongside staff survey data and other relevant workforce data for each of the Hubs, 111, corporate services, etc. MW and AW to have a discussion a proposal/suggestion around how the committee will receive this assurance to be brought back to the next meeting. AW raised in terms of the action relating to herself and MD going forward a joint report will be presented to QGC and the Board to provide assurance in term of clinical workstreams, etc. It was requested the actions are forwarded to the Peoples Committee to be monitored.	**NS**
	3. In relation to continued minute 07/20/02: Minutes of the previous meeting – 11 May 2020 The amendments had been made to the minutes of 11 May 2020. QGC agreed to discharge this continued minute.	**Discharged**
	4. In relation to continued minute 07/20/05.1: Quality Exception Report on the Priorities of the Quality Account (QA) /Monthly Update (Action Log Nos. 6 & 7) (Action No. 6) It was noted the draft Quality Improvement Strategy/Framework had been delayed due to continued COVID work and AP is undertaking the Quality Service Improvement and Redesign (QSIR) programme to develop it further.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	MD raised this is quite an urgent piece of work as the Care Quality Commission (CQC) commented on the QI methodology therefore this needs to be formalised into a strategy/framework. AW added that a summary document is needed with the processes we believe are being used now with reference to which system is being used and this can be raised with AP when he joins the meeting. VK commented particularly for an organisation to build on an 'outstanding' rating the CQC would respect something to show the methodology and hard work used for service improvement. TY stated we need to make sure this is progressed and dealt with. (Action No. 7) AW thought she had circulated the presentation from Cliff Mann, National Clinical Director of Emergency Care but would double-check.	**AW**
	5. In relation to continued minute 07/20/5.3: Update on Staff Training in Neonatal Care MD informed this item is on the agenda but it has not progressed any further and requested that it is deferred to the next meeting where an update on midwifery services would be provided as there is a lot of work being done that the committee needs to be sighted on. AW added as part of the work the Trust is doing around maternity care generally, we are planning on holding a joint CPD event with the College of Paramedics. TY felt this workstream was important as is it an area of exposure in terms of risk to the organisation, the outcome for the patients and the financial risk when cases go wrong.	**MD**
	6. In relation to continued minute 07/20/12: New or Increased Risks highlighted at meeting The new/increased risks had been included in the Chair's Report to the Board of Directors on 27 July 2020. QGC agreed to discharge this continued minute.	**Discharged**
10/20/04	**Review Terms of Reference**	
	The Terms of Reference had been circulated. It was noted considering the recent restructure of the commit structure and in terms of there being a new Chair for the meeting, the terms of reference need to be reviewed. AW added the terms of reference was discussed at the Executive Management Board and was happy to update of the agreed changes in terms of reporting lines. It was agreed, the Executive Director of Strategic Operations & Digital Integration who was originally a member of this committee and is the Chair of Professional Standards Group should attend QGC and the Chair's Report from Professional Standards Group continue to be submitted to QGC.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	It was agreed Professional Standards Group to be added under the Inward Reporting arrangements. ST raised the terms of reference state 'staffside representatives will also be invited to attend' informing that staffside are in fact part of the group since inception and take this role seriously and do provide challenge. On that basis, ST would like to put forward that staffside are added as part of the membership. MD supported ST's comments as staffside have an equal role to other committee members. Membership was discussed further, and agreed the following to be added: • Strategy & Engagement Director • Senior Lead Paramedic (Emergency Care) • Senior Lead Paramedic (Mental Health & End of Life) It was suggested having a representative from 111, which TY agreed as we need to see 111 governance in in terms of quality and improving patient care and the impact of COVID and the effect on other services. AW stated herself and MD have spoken to the Integrated Emergency & Urgent Care Director who is happy to attend future QGC meetings to provide assurance for the 111 service. AW raised at some point the organisation needs to review the roles of the Public and Patient Groups and proposed having an expert patient who is qualified to represent all patient groups and perform a different role from inside or external bodies and this could be investigated later. MF referred to being well-led and agreed that a patient representative needs to be involved in the governance structure of the organisation from top to bottom because how can the organisation deliver the services if it does not have their opinion. It was highlighted under duties and interrelationships that 'To receive and regularly review recommendation on the adequacy of, and performance against, workforce quality governance measures, and monitor effectiveness of action plans to address adverse variances' should be included in the People Committee terms of reference. AW referred to 'Review and receive assurance from the EMB on the rigour of CIP and material service change Quality Impact Assessments, making appropriate recommendations, and escalate any concerns to the Board' asking what will QGC be doing to provide assurance from EMB on this. MD felt the wording might need to be reviewed to 'overview of the risk of our cost improvement programmes to patient care'. There was a discussion around the cost improvement programmes (CIPs) as there needs to be a robust process in place whereby QGC has sight of the CIPs and feedback is provided back from the Executive Management Board.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	ST stated it was good to new members of group raising the same concerns which have been raised previously by members in relation to the CIPs as previously when there were CIPs and redundancies, all the papers were generic and not on an individual basis therefore we need to they are looked at on an individual basis going forward to ensure they are future proof. The committee discussed the frequency of the meetings which is currently 5 per year. AW said herself and MD had discussed this as the meetings are held in January, March, May, July, October, and November. It was noted the meetings are scheduled to take place before the Board of Directors meetings to ensure the appropriate reports had gone through the governance process before being submitted to the Board. A proposal was made for the number of meetings to be reviewed based on the length of time between each meeting. MF was supportive of this as the agenda is incredibly large and it is difficult to receive assurance when there is not enough time during the meeting to go through the papers in-depth and the gap between the meetings is too long. TY said he was surprised by the amount of information being presented to be discussed today and we need to build this in the length of the meeting so there is enough time to discuss each paper. MF stated even with extensive meetings and the nature of the business, the papers need to be smarter in terms of what the committee needs to focus on. AW raised it is important everyone has read the papers beforehand and work is being progressed on the reformatting of reports which will enable committees to focus predominately on the areas where performance needs to be improved by looking at the variance. The report will highlight the positive and negative points which will direct the focus of discussions. TY stated in terms of assurance the committee receives lots of reports which need to be programmed into a workflow moving forward. This will ensure the meetings are organised and the committee are able to deep dive into the key elements that need to be covered.	
	Resolved:	
	a) That the Terms of Reference be received and agreed. b) That the amendments are made to the Terms of Reference. c) That the agreement of the Terms of Reference is included in the Chair's Report. d) That the agreed Terms of Reference are submitted to the Board of Directors meeting on 28 October 2020 for approval.	**NS** **TY** **TY**
10/20/05	**Care, Quality & Safety**	
	5.1 Quarterly Exception Report on the Priorities of the Quality Account (QA) / Monthly update	
	The Quarterly Exception Report on the Priorities of the Quality Account (QA) had been submitted.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	PW stated the monitoring of the Quality Account has been difficult so far this year on the basis what has been happening with the pandemic and many of the clinical leads were redeployed to support the Trust's response to the national emergency which has caused a delay in some of the planned workstreams and this is reflected in the document. PW gave a progress update against the agreed priorities as at Quarter 2 as follows: **Emergency and Urgent Care** The focus is on patient harm incidents and whilst we were able to report data for this quarter there has been significant data quality issues in the data having to manually breakdown the incidents into harm and no harm. It was noted there has been a downward trend in serious incidents. PW highlighted the Trust is currently looking into changing the incident reporting system to Datix which will make the more efficient and effective and easier to report from. A business case is currently being developed and will be presented to the Executive Management Board for discussion/approval. TY advised his concerns in terms of staff deployment is whilst it is important, staff have other responsibilities, and we need to look at the impact on delivering patient quality and safety. MD stated staff have done a phenomenal job as it has been a challenge in terms of the data quality issues and following redeployment getting the workload back on track along with recently were there have been issues with the RAP devices and accessing the Trust systems online. With regards to patient discharge on scene, this is being tackled from several different angles i.e. identify decision making from discharge on scene through the patient safety incidents and serious incidents as well as linking in with JLH and the Lead Paramedic (Emergency Care) regarding the discharge on scene audits which are in progress, but the results are not available at this moment in time. There are new reports being developed for data where there is recontact within 48 hours of being discharged on scene and the early results show a reduced trend. **PTS** PW inform patient harm incidents had decreased compared to the same period last year but we need to bear in mind for all elements of this report the trends for this year are different from what we would expect. The PTS model has changed for social distancing and non-emergency appointments therefore PTS undertake fewer journeys and have a different activity profile. There has been a reduction in complaints and no serious incidents relating to PTS during Quarter 2. The PTS Friends and Family Test (FFT) is in place, but the Trust does struggle to obtain responses. As part of the action to generate increased responses a face to face survey was going to be conducted during the first part of the year but because of COVID this has been put on hold until Quarter 4.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	111 The priority was set to reduce the proportion of incidents transferred from 111 to 999. PW stated this has increased significantly due to COVID-19 and the Trust being in a different position to when this priority was agreed, therefore, we need to take caution over these trends. PW stated the report provided is completely open and honest report as the purpose is to provide assurance to the committee and flag up areas of concern to the committee. TY raised one of the issues to look at as QGC is the new reporting system and asked when we think this will be in place. MD replied the intention is to have the system implemented by the end of the financial year. ST thought this was a great report as it shows the issues the crews are having out on the road which are being highlighted to Staffside on a day to day basis. There have been conversations around competencies of staff and there is an issue with the confidence of and the support given to Newly Qualified Paramedics (NQPs) as the programme has been watered down for the NQPs and there is a concern nationally around the NQPs sometimes around confidence as some are over confident and then others are under confident. The National Ambulance Partnership Forum have agreed to review the NQP programme completely as in the past there has been a robust system. The NQP framework needs to be revisited and the national element as we need to be assured we are providing individual with the support they need and then there will be less of these issues and they will be able to provide better patient care. MF raised a question on the incident reporting system as he wanted to understand the decision to move to the Datix system therefore in terms of the problems being encountered how assured are we that is it the system and the issues will be resolved/rectified by moving to a new system. MD replied the point being argued in the business case is the issue with the risk management system is there is a lot of manual processing with the data which is very prone to error whereas Datix is an automated system and feeds off a number of systems. Also, a lot of NHS organisations use Datix which aids with NHS to NHS access to data. Almost all the other Ambulance Services use Datix and WMAS is 1 of the 2 Ambulance Services who do not have the system and there is 90+ Acute Hospitals using the system as well. The information is much richer, and you have access to information systems, the only downside is that is it quite expensive to implement and to run. MF acknowledged MDs response and fully understood by the Trust would want to move to systems but highlighted Datix has lots of issues in terms of management and there is evidence the system is clunky, so it is not going to be a perfect system and staff might not want to use it therefore from a leadership perspective, this needs to be a priority to encourage use from the frontline. MF added in terms of near misses on the system this indicates something has gone wrong before actual harm can take place therefore you would expect near misses to be higher than the number of incidents.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	AP informed as part of quality improvement the current in-house built system is being reviewed. The current system has its own challenges with it being self-built and when it falls apart the fall back is different to what Datix can offer. The Trust has always been on the back foot with not having Datix as it brings several systems together i.e. policy reporting, risk reporting, IP&C, etc which we do not have currently. The organisation is able to evidence that incident reporting is in a good place and AP has had interesting conversations with the Care Quality Commission (CQC), as when we introduced our own reporting against a similar ambulance service we could not be benchmarked against them. As we have evolved Datix looks like the better solution compared to what we currently have, as Datix will support managers with reporting and provide staff with the confidence to use the reporting system. TY stated as with any system, it is down to the quality of the training and staff having confidence using it. TY highlighted if there is a lack of correlation with near misses and incident perhaps this needs to be investigated in more detail if it is felt near misses are being under-reported. AW said she has worked with Datix before and although it is not a perfect system, it would give improved functionality and support capacity and support reporting near misses. There is a robust audit process in place to monitor the actions from investigations when completed and we do that with the serious incident reporting. AW stated herself and MD are trying to review what happen with the incidents that do not met the serious incident criteria. Where she had worked previously these were coded RED AMBER GREEN with AMBER being those who do not meet the serious incident criteria but still need to be managed, reviewed, learning identified and will also progress near miss reporting.	
	Resolved:	
	That the Quarterly Exception Report on the Priorities of the Quality Account be received and approved.	
	5.2 Clinical Supervision Plan 2020-21	
	The Clinical Supervision Plan for 2020-21 had been received. NVH stated the report was ‘as read’ and on track with the salient points being highlighted as follows: • Mandatory training had to be cancelled due to increased demand in September, therefore, the completion for training had been extended to the end of November 2020. 80% of staff have completed day 1 of the mandatory training. • Mandatory workbook, currently playing catch up as there has been a delay in obtaining the information. • Clinical Supervision Shift – 81% of staff have completed. The completion date is February 2021, but the aim is to have this delivered sooner so the focus can be on winter pressures.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	Resolved:	
	That the Clinical Supervision Plan for 2020-21 be received and noted.	
	5.3 Trust Board Reporting	
	The Clinical Performance Reports had been circulated. **Clinical Performance** JLH stated the report circulated shows the Ambulance Quality Indicator (AQI) data for WMAS up to the end of August 2020 and the national data up to the end of January 2020. JLH informed there are 2 reports being presented, paper 6a is the normal report which is 'as read' and there are 2 points to be highlighted to the committee. The first being nationally the Stroke and STEMI performance has been dropping and this is because the Trust must rely on Hospitals to input data into the data set. What we wanted to understand is whether the drop in performance is due to data quality and although work is still ongoing the initial findings show the data quality is not an issue so we will be looking to implement actions to address the issue. Secondly, there have been previous discussions around the AQIs as some of these are historical and are reporting above 95% performance and there are other clinical risks which the Trust should monitoring and putting in quality improvements. On that basis, NHS England has agreed to provide some funding for a national coordinator for this data. TY raised concern where there is a dip in performance, not around the data but to better understand what we do with that, in response MD said this is where the second part comes in as it explains whether some of the dip is due to the variance within the current system i.e. 1 data point outside the normal variation might be acceptable but this is what we need to bear in mind when we react to the changes. MD did not fully understand what happened in December as 94% is still a high percentage and the important thing with Statistical Process Control (SPC) reporting is that you are able to understand a bit of the system that had a dip which might be due to activity or overstretching staff. AW agreed with what MD said, as it is difficult to remember back to December and the Stroke Care Bundle performance partly depends on where the Stroke centres are situated and if there have been any changes in the Pathways. AW suggested that we accept there was a dip in December and when the next paper is presented it will be clear why we need to make the changes being suggested and provide a better indication where there are other factors which might affect our patients. JLH confirmed the demographics of the skill mix of the crews are looked at when there is a dip depending on when it was, it could relate to a lot of students returning back from university and this is part of the audit. In terms of clinical roles, this has not been looked as previously but we can do a breakdown.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	In terms of Paper 6b, JLH reminded there were discussions at the last meeting to look at the format of the report and try to use SCP to focus discussion on the improvement work. The report is 'draft' and has been presented to the Clinical Audit Research & Programme Group and Professional Standards Group for feedback. The report only covers the Stroke AQI and the same format will be applied to the rest of the AQIs. JLH informed the second page of the report provides a background into SCP and a brief description on each of the AQIs. From the feedback received there was a request to make sure it is very clear whether the national data has been submitted and received back, or if is it local data (which it will be for the time being). Another comment was to add numbers as well as percentages and there is a table of percentages which gives a visual aid to where the discussion needs to be focused and it is clear there were issues in December. The red pin identifies there was a special cause variation and what interventions have been put in place and the blue pin aids discussion around the common cause variation. The third page shows where an intervention has taken place and whether it has reduced variation. All the data will be collated into a larger report and what we can do with the detailed report is to highlight any exceptions and focus the discussion on the relevant areas. JLH was trying to pull together some training on SCP and was not sure if the committee were aware but the Trust tried to implement this before and had mixed feedback. TY stated the report was helpful and it was good to see you can consider the data in various ways. MD commented "call to hospital time" is performing well but there is a significant delay for "call to CT scan". AW advised you would expect to see several things, as she was aware in the last 9 months since COVID began CT scanning is delayed due to COVID preparations and if it is a stroke patient then they may not be able to answer some of the questions. AW and the Lead Paramedic (Emergency Care) had discussed taking forward a system other ambulance services have in place whereby you pre-alert the Stroke team and the crew meet them at the CT scanner. There is evidence in other regions the time to CT is massively reduced and perhaps there is consideration for a Stroke strategy. VK was supportive of this approach as looking at it scientifically there will be a broader conversation at the Board of Directors and other committees when looking at the information. VK endorsed the proposal of moving into SCP reporting as other colleagues might find useful presenting reports in this way. AW raised initially QGC were supportive of the reformatting of reports submitted to these meetings only, but this new format report has also been discussed at Professional Standards Group who support the changes and feel it should be reflected in reports presented to the Board of Directors. TY agreed and felt it would be a good way to provide consistency on how data is discussed. AW suggested JLH provide the same demonstration of the new report format to the Board.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	Trust Information Pack The Trust Information Pack for October 2020 had been submitted. MD stated the salient points for QGC are there has been an increase in complaints and although at the beginning of the pandemic the public were happily clapping for the NHS, they have now gone back to writing letters of complaint and their expectations are still as high or higher than normal. It was noted activity has been high on multiple occasions, complaints may relate to response time, to the attitude of staff or clinical care of the patient. Safeguarding referrals including those from the 111 service have increased significantly. Verbal abuse of staff is higher compared to last year and this has been linked with racial abuse which is not an acceptable situation. In terms of serious incidents, there has been a very small reduction. There has been a rise in controlled drugs incidents which is linked to breakages relating to the Misoprostol packaging. AW raised 3 points, the first being duty of candour for serious incidents being around 31-32% and we do no want to be in that position with the number of discussions with families. There is some issue around capacity and obtaining next of kin details, but this needs to be monitored and improvements seen. Secondly, there has been a national increase in safeguarding incidents in the last few months and some child safeguarding incidents have been reported in the media. An 86% increase in child safeguarding referrals compared to last year is very significant and as a Trust we need to make sure we have the resilience and capacity to cope with and manage the processes which are often linked to other parts of the system. Thirdly, Misoprostol is not a controlled drug but is managed as one within WMAS and there has been a change in packaging resulting in a decrease in the number of incidents. TY stated if the issue of capacity is impacting on duty of candour and safeguarding then we need to look that resources are in place as a very important obligation as CQC is interested in duty of candour therefore this is important to focus on. ST referred to complaints in terms of staff attitude and conduct advising the Trust has to have an awareness of the bigger issues and to bear in mind some staff have a lot of personal issues and when they also experience medical issues those frustrations come out. The Trust is supporting staff with mental health awareness and there may be certain factors as there are a lot of young staff who when are put in certain situations might appear flippant compared to those staff are more experienced and deal with the situation in a different way. Therefore, it might be worth a look at the age demographics measured against the background of the complaints as it is likely these will get higher moving into the winter pressure period.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	TY raised in terms of complaints and verbal assaults we need to be seen to be doing as much as we can for the staff to mitigate the risk of them being physically or verbally attacked whilst doing their job. NVH had done a lot of work with the Head of Patient Safety to improve duty of candour and assured Operations are focused on what needs to be done and this will be monitored by the Senior Management Team to ensure duty of candour has been completed and documented. TY requested that an update on duty of candour, safeguarding and verbal assaults is brought back to the next meeting. MF wanted to raise 3 points, the first relating to Safeguarding and agreed with the points already made but sought clarification on the level 3 training and whether this is just for paramedics and clinicians or will this be extended to staff within the 111 service as there are a lot of calls coming through 111 and do we know what training have those staff had and is it appropriate. Secondly, there are 14 incidents over the timeframe, what is the update in terms of the extra role, has this started or has it been paused to support with the backlog. MD stated the Safeguarding Level 3 training is for frontline paramedics and it is a good point being raised by MF and MD will confirm what training is given to the Clinicians and the call takers. With regards to the serious incidents, there is resource for those but in summary the investigation team are stretched to the extreme and although a new member of staff was recruited there was a member of staff then off on long term sickness. All the team are back from frontline duties but this workload is not sustainable doing forward and what did not help was when all the staff were deployed into the frontline and when returning to their substantive role there was a workload backlog of 7 weeks. MF referred to the investigation team who are still stretched and stated there will be more serious incidents in the coming months, therefore, what is being done as there is a risk of staff going off with stress which will compound the situation further. ST stated this has been raised many times at this committee as a risk and at the Health, Safety, Risk & Environment Group and Regional Partnership Forum. It was noted although there is a risk assessment in place, Staffside will keep supporting management colleagues and the clinical team because we need to be careful as an organisation.	
	Resolved:	
	a) That the Clinical Performance Indicator Report and Trust Information Pack be received and noted. b) That JLH deliver the same demonstration on the new style reporting to the Board of Directors.	**JLH**
	5.4 Physical & Verbal Assaults 6-monthly Report	
	The Physical & Verbal Assaults 6-monthly Report was received.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	JK informed for this month there has been a slight decline in all areas but overall compared to 2019-20 incidents are generally rising which appears to be the case for most ambulance services. TY asked in terms of the areas where figures are rising is the Trust taking any other additional measures to safeguard staff. JK replied in terms of the physical assaults the Trust has raised some of the issues with the CPS in terms of evidence being there to prosecute but these are not being taken further. A list of cases have been sent to the CPS to look at what has actually happened and basically obtain an idea of where they are as many relate to alcohol and substance misuse but they can be convicted for alcohol related incidents. There is some co-ordinated work being done with other ambulance services around the impact on staff and what they are going through. TY informed he was involved in a national presentation last year with the NHS and other Ambulance Services which also brought together other services included the Police which was around raising awareness of the impact physical and verbal assaults have on staff. There is another similar national event being held and we need to show staff they have the support from everyone in the organisation. ST there had been a discussion a few weeks ago with JK about body worn cameras being rolled out at other Hubs as although we are in a pandemic it will not stop drinking at home therefore we need to ensure staff are protected. JK informed the Trust has been awarded £215k from NHS England and a paper is being presented to the Executive Management Board tomorrow to discuss the options that are open to the organisation to spend on body worn cameras. Unfortunately, there is not enough money for every member of staff to have a body worn camera which is what the Chief Executive Officer originally wanted. JK added he would know more information after the meeting in term of whether a contract being awarded in December depending on procurement or whether this will be procured in-house. TY asked although the Trust has been given extra money, it still has 30 cameras which can be used. JK replied yes, the body worn cameras are still at the 3 Hubs where they were trialled. ST thought the idea was to rota them around other Hubs and do an audit. In response JK advised there is a cost to move the cameras to other Hubs which is pointless as when the Trust has the go ahead for the new cameras the current cameras will be obsolete. JK confirmed if the Trust procures the new cameras itself the implementation will be extended by 7 months. ST stated this is not acceptable and this is too long a time for staff to wait.	
	Resolved:	
	That the Physical & Verbal Assaults 6-monthly Report be received and noted.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	5.5 Patient Experience Report (September 2020)	
	The Patient Experience Report for September 2020 had been submitted. MC gave a brief outline of the report advising there has been 25 formal complaints received in September which is an increase of 4 compared to the same month last year. Of the 25 formal complaints, 9 have been closed; 1 justified, 1 part justified, 7 not justified and 16 cases are still under investigation and will be closed by 4 November 2020. There were 201 PALS received during September which is an increase of 7 compared to September 2019. MC said there had been 1 response received for the Friends & Family Test (FFT) however some credit card size forms have been printed which are being handed out to patients. A face to face survey has commenced and there is a work plan for PTS who are communicating with discharge co-ordinators to target renal patients. The Discharge on Scene survey is part of the Quality Account requirement and 1 response has been received online and the team will be targeting patients by writing to them to obtain a response. MC informed work is ongoing to increase responses to surveys and it has been found that social media works well, as this was used to promote the 111 survey and 20 responses were received within a few hours. AW raised in terms of FFT, given the millions of calls received and incidents managed every year by the Trust, 7 responses is not representative and AW was aware the team are working on other ways of doing this and perhaps to consider automated telephone calls as well. AW add the Trust is keen to keep an eye on the clinical complaints in terms of whether they are justified, non-justified, etc. MC confirmed she had been asked to review the clinical complaints as an action by Learning Review Group and a breakdown will be provided at the meeting on Wednesday and to Professional Standards Group on Thursday. AP thought the report was good and you might want to consider the rise in complaints might be necessary be due to increased engagement with patients and from a proactive side investigate where it is coming from as it could be because of x, y and z. AW replied there is not an assumption that the increase in complaints is from an increase in contacts as there are other aspects as well.	
	Resolved:	
	That the Patient Experience Report for September 2020 be received and noted.	
	5.6 Update on Staff Training in Neonatal Care	
	As discussed earlier in the meeting, this agenda item will be deferred to the next meeting.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
10/20/06	**Risk**	
	6.1 COVID-19 Update & Clinical Update Report	
	The Clinical Update Report had been circulated. AW stated the report was 'as read' and happy to answer any questions. It was requested the title of the agenda item is changed to Executive Medical Director & Executive Nursing Director Update Report. The intention of the report is for AW and MD to update on more of their clinical workstreams not just those around COVID-19, through a report (where these are not reported to other Committees). TY thought it was a good idea to have a joint report which will also be presented to the Board of Directors. ST referred to discussions with St Johns Ambulance and MD informed this is a commissioner led project and was happy to catch up outside meeting with ST and AW to discuss further.	
	Resolved:	
	That the Clinical Update Report be received and noted.	
	6.2 Annual Review of the Trust's Risk Management Strategy in respect of Clinical & Quality Systems and Processes	
	The Trust's Risk Management Strategy had been received. MD stated following the recent Trust strategy day, an early review of the strategy has been initiated to ensure it captures the salient points from the day and the Trust's acceptance of risk is included. There is a planned review of the risk appetite statement which will be reflected in the Board Assurance Framework and Strategies. AW highlighted in several places it has been documented action was not required but in terms of Paramedic HALOS looking after patients in corridors this is not acceptable in terms of patient outcomes.	
	Resolved:	
	That the Trust's Risk Management Strategy be received and noted.	
	6.3 Board Assurance Framework	
	The Board Assurance Framework had been submitted. MWB advised there have been changes since the last update and these are highlighted in RED within the document. There had been some confusion around expectation and requirements, therefore, to simply the process, MWB is currently working on a SharePoint site with clear and easy instruction so that members of each committee will be able to access the risk assessments and using radio and free text boxes and leave comments against each risk in terms of whether they disagree/agree with the assurance being provided.	

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	ST sought clarification around the current and mitigating score ratings on the table as certain sections have had no audits or review undertaken therefore there is no update which appears a little confusing. MWB stated when risk assessments are conducted an initial score is identified, if no actions are mitigated then they will remain the same until actions have been undertaken which are deemed fit to cause a reduction in the scoring e.g. EP027: risk associated with Terrorist Threats has not been reviewed since the last update as the review date is not due and there have been no incidents for it to be reviewed earlier. The key is the current risk score and if mitigating actions were in place the scoring would be reduced to a 10 but this would have to be discussed at committee level to agree to change the scoring to a 10. MWB to discuss further with ST outside the meeting.	
	Resolved:	
	That the Board Assurance Framework be received and noted.	
10/20/07	**Governance/Compliance and Regulation**	
	7.1 Quarterly Review of the delivery of Clinical and Quality related Strategic and Operational Priority Objectives and Milestones	
	The report on the Quarterly Review of the delivery of Clinical and Quality-related Strategic and Operational Priority Objectives and Milestones had been circulated. PW stated purpose of the report is to monitor against each the agreed outcomes of the following enabling strategies: • Clinical Strategy • Quality Strategy • Communications & Engagement Strategy • Risk Management • Security Strategy It was noted, for Quarter 2, all milestones outlined with the papers are identified as 'on track' except the Quality Strategy which is flagged as 'AMBER' as the priorities form part of the Quality Account. All the strategies have been reviewed by the Leads and any updates have been incorporated in the report. AW highlighted there need to ensure the risk reporting system is fit for purpose and there are discussions to move to the Datix system which will provide a more effective and efficient system. PW recognised AW point on risk reporting and will ensure the paper is updated and provide a verbal update at the next meeting for the minutes. PW referred to the recent strategy day discussion noting all the information and feedback has been positive about that day there is a lot to work through. It was noted the enabling strategies which were approaching its review date have been deferred to next year with actions being taken to conduct an initial review and if the Leads identify any changes, the committee with be kept informed.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	Resolved:	
	The report on the Quarterly Review of the delivery of Clinical and Quality related Strategic and Operational Priority Objectives and Milestones be received and noted.	
	7.2 Contractual Clinical Quality Standards Compliance (CQUIN)	
	The Contractual Clinical Quality Standards Compliance (CQUIN) Report had been received. MD was pleased to report that the Trust is doing well against the 2 nationally defined CQUIN schemes: • Access to patient information at scene – the target is 5% and for Quarter 2 the Trust is currently at 43.1%. • Flu vaccination – target is 90% which will be challenging for the Trust. VK highlighted it might be worth mentioning the issue obtaining the flu vaccine and MD replied there is an issue with supply of the vaccine, and this is on the risk register. As a mitigating action staff are being encouraged to obtain the vaccine via alternative sources i.e. GP or Pharmacy and this will still receive their voucher. NVH confirmed the Trust has a further delivery of 1,000 vaccines today by 12 noon with will be distributed to the 111 service and the 2 EOCs. The vaccination programme will continue until that vaccination has gone and the Trust is doing all it can to ensure supply of the vaccine and the final batch of 3,000 should be delivered early November for vaccination of remaining staff.	
	Resolved:	
	That the Contractual Clinical Quality Standards Compliance (CQUIN) Report be received and noted.	
	7.3 Clinical and Quality Information Governance Assurance e.g. data quality reports, IG standards report	
	The Data Security Protection Toolkit (DS&PT) Report had been submitted. CK informed the Data Security Protection Toolkit is an online self-assessment for organisations to measure their performance against the National Data Guardian's 10 data security standards. The key elements to the report are that the Trust has provided against all 116 mandatory lines of the self-assessment. A cyber security group has been established who are responsible for reviewing, monitoring, and providing the evidence against the 116 lines. Several meetings have taken place to gather the evidence and the report has been submitted to the Executive Management Board on 2 occasions (8th and 22nd September) to provide them with assurance before the data was submitted.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	Resolved:	
	That the Data Security Protection Toolkit (DS&PT) Report be received and noted.	
	7.4 Annual Clinical Audit Programme Quarterly Report	
	The Annual Clinical Audit Programme Quarterly Report had been circulated. JLH advised the clinical audit programme is looked at in detail by Professionals Standards Group and the Clinical Audit & Research Programme Group are responsible for monitoring the programme and providing assurance for the 19 audits on the programme. The audit programme outlines each of the audits together with progress of the approved action plans, a record of the previous assurance level and the areas of concerns that were raised. JLH confirmed the levels of assurance i.e. adequate, insufficient follows the internal audit assurance levels and have been implemented into the clinical audit programme so everyone was looking at the same assurance levels. There is one audit report that has been delayed with is the Management of Head Injury which was presented to the Clinical Audit & Research Programme Group in September who asked for further work to be conducted. MF referred to the assurance level for the paediatric audit being insufficient asking why the reaudit is being done in 12 months and whether this is because the actions take that long. In response, JLH replied it depends upon the actions being implemented and for the paediatric audit some actions are part of the educational package which will be delivered over the next 12 months therefore we have to wait until this had been completed before a reaudit is conducted. If some actions can be implemented quicker than a reaudit would be done sooner than 12 months. MF suggested more narrative is included against the audits rated insufficient, so it is easier to understand the rationale. JLH advised the report can be developed to provide further information and provide feedback separately. AW confirmed discussions around individual audits are recorded at the Clinical Audit & Research Programme Group meeting and discussed at Professional Standards Group and can make the decision to reaudit after 6 months if things are not happening or being recorded. These discussions will come up through the reporting system from Professional Standards Group to Quality Governance Committee and the Executive Management Board.	
	Resolved:	
	a) That the Annual Clinical Audit Programme Quarterly Report be received and noted.	

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	b) That the Clinical Audit Programme provides further narrative against the audits rated insufficient, so it is easier to understand the rationale.	**JLH**
	7.5 Annual Research & Development Programme Quarterly Report	
	The Annual Research & Development Programme Quarterly Report had been received. AR advised the report is 'as read' stating the summary page shows essentially there are 11 research open studies in the Trust of which 2 have been paused because of COVID. In terms of assurance, there are 8 research studies which are GREEN and progressing well and 1 study has had a slight delay due to additional resource. The 8 studies have been reviewed and are supported by the Clinical Audit & Research Programme Group to add to the Trust's research portfolio. Of the 8 studies, 3 relate to COVID: 1 is due to start this week, 1 is due to start 2 weeks later and the third there are currently some logistical issues. It was noted the Research Team are supporting 15 studies which are in various stages of application and these will be coming online over the next few months. AW stated it was positive to note that WMAS have recruited 25% of the regions research participants for non-COVID research studies which is incredible given the small size of the Research Team and were also fully moved across into the operational system and were still able to deliver. AR stated whilst the team were operational, there was a missed opportunity for our Paramedics to be involved in a national study and this has been flagged at with the Clinical Audit & Research Programme Group and Professional Standards Group and discussion have taken place around the need to have a skeleton team running so that this does not happen again. AR raised 2 of the 3 COVID related studies involve staff testing and to deliver these studies there does need to be a skeleton team to remain on top of the workload. AW highlighted there is a lot of research governance for studies and it is important to have research presence in case anything goes wrong in a research study as well as the minimum requirements the Trust must meet as well.	
	Resolved:	
	That the Annual Research & Development Programme Quarterly Report be received and noted.	
	7.6 Learning from Deaths Quarter 2 Report	
	The Learning from Deaths Quarter 2 Report had been submitted. MD stated the report is 'as read' and will be presented at the Learning Review Group (LRG) on 21 October 2020 MD highlighted the Trust normally reviews every single death in our care, but during the first peak of COVID only a sample of cases were reviewed in March due to the frontline workload.	

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	The Trust is back to reviewing every single death case and a structure judgement review is done against those cases which gives us a lot of information and provides a high level of assurance. MD advised from reviewing the cases it was found on occasion when staff were doing a secondary survey, they were not leaving enough time between each set of observations. MD confirmed all the learning points are fed through the Learning Review Group for discussion and this is a comprehensive report providing assurance against the work being led by the Patient Safety Officer in this respect. AW referred to page 11, learning point 2.2 'to adopt the appointment of a Team Leader' advising this is not always a culture but reluctance from staff to assume this role and there is work to be done how to support clinicians and some of the actions around being a cardiac arrest team leader. MD added there is some confusion around the role of team leader being the most senior clinician on scene which is not always the right person, it needs to be the first person on scene who coordinates the cardiac check list. This will be discussed further at Learning Review Group.	
	Resolved:	
	That the Learning from Deaths Quarter 2 Report be received and noted.	
	7.7 Serious Incident Report	
	The Serious Incident Report for September 2020 had been circulated. MD informed the report is 'as read' advising the serious incidents are discussed at the Learning Review Group (LRG) meetings. Some of the issues had been discussed earlier in the meeting but due to the nature of our work, some of the common themes relate to discharge on scene i.e. inappropriately discharging or not documenting the advice given to the patient i.e. if they deteriorate to call 999 which is not always documented on the EPR. TY asked whether this is a simple tick box and MD thought it was a free text box to be completed by the crews. AW raised with the introduction and removal of tick boxes there is a danger of turning the whole of the EPR into a tick box process and the EPR should be completed more on an individual basis, therefore, more discussions need to be undertaken. ST suggested the advice left with patients and family could be an add-on at the end of the EPR. MWB replied an action from one of the serious incidents is looking at the EPR and leaving that information. ST said he has seen a sneak preview of the new EPR2 and was quite excited by what he saw and felt the new system is going to be beneficial to staff and potentially reduce the number of serious incidents as the system does not allow you to move on until sections have been completed which will act as a reminder to staff and moving forward this will be good.	

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	AW referred to "never events" on page 1 of the report, advising although unrecognised oesophageal intubation had been removed nationally, if there was an unrecognised oesophageal intubation through an Enhanced Care Platform such as an air ambulance systems or MERIT this would still need to be reported as a serious incident. AW noted the 14 serious incidents currently over time and the increase in clinical care issues which we will need to keep an eye on and monitor even though these is a very small percentage.	
	Resolved:	
	That the Serious Incident Report for September 2020 be received and noted.	
10/20/08	**Chair's Reports from Working Groups**	
	8.1 Learning Review Group (LRG)	
	The Chair's Report from the meetings held on 21 September and 22 July 2020 and Action Logs of 22 July and 29 June 2020 had been received. MD advised the reports are 'as read' and there was nothing specific to raise as a concern. The contents of the Chair's Report and Action Log were noted.	
	Resolved:	
	That the Chair's Report from the meetings held on 29 June & 1 June 2020 and Action Logs of 1 June and 27 April 2020 be received and noted.	
	8.2 Health, Safety, Risk & Environment (HSRE)	
	The Chair's Report from the meetings held on 29 September and 27 July 2020 and Action Logs of 27 July and 4 May 2020 had been received. Again, MD informed the reports were 'as read' and no specific concerns to be raised.	
	8.3 Equality, Diversity & Human Rights Steering Group	
	It was noted due to the recent governance restructure of the committee structure, the Chair's Report from Equality, Diversity & Human Rights Steering Group would be presented at the People Committee meetings.	
10/20/09	**Schedule of Business**	
	The Schedule of Business had been received.	
	Resolved:	
	That the Schedule of Business be received and noted.	
10/20/10	**Any Other Urgent Business**	
	There was a brief discussion around the frequency of meetings and whether an extra meeting should be considered before January 2021. TY gave thanks to JI as the former Chair of QGC for all her work and support for the papers which are presented to the Board.	

ITEM	Quality Governance Committee (QGC) Meeting 19 October 2020	ACTION
	AW raised the workforce agenda items needs to be moved across to the People Committee.	
10/20/11	**New or Increased Risks highlighted from the meeting**	
	No new or increased risks were highlighted at the meeting. • Incidents and Complaints – increase in reporting and the capacity of the team to response to the workload. There being no further business, the meeting closed at 12.30 pm.	
10/20/12	**Date and Time of the next meeting**	
	Wednesday 20 January 2021 at 10.00 am via Microsoft TEAMS	

These minutes were agreed as accurate on Wednesday 20 January 2021

West Midlands Ambulance Service
University NHS Foundation Trust

Paper 14C

Minutes and Actions of the People Committee held on 17th September 2020 at 100 hours via Microsoft Teams

Members:

Caroline Wigley (Chair)	CW
Jacynth Ivey	JI
Narinder Kooner	NK
Mohammed Fessal	MF
Kim Nurse	KN
Michelle Brotherton	MB
Nathan Hudson	NH

In attendance:

Carla Beechey	CB
Barbara Kozlowska	BK
Pamela Brown	PB
Stephen Thompson	ST
Pete Green	PG
Kieron Ward	KW
Damian Dixon	DD
Wendy Owen	WO
Dawn John (Secretariat)	DEJ

ITEM	Meeting held on 17th September 2020	ACTION
09/20/01	**Welcome and Apologies:**	
	Apologies: Jacynth Ivey, Michelle Brotherton, Narinder Kooner and Mohammed Fessal. The Chair welcomed everyone to the inaugural meeting of the People Committee, which has been developed following a review of structures in the Board sub committees. The People Committee will continue to keep Workforce a priority part of the Trust's agenda, maintaining high quality, standards and debate at Board level.	
09/20/02	**Declarations of Interest:**	
	No conflict of interests declared in any matters contained within the agenda for this meeting.	
09/20/03	**Terms of Reference for the People Committee:**	
	The Chair referred to section 1 of the Terms of Reference – Paper 1.	

	The purpose of the Committee is to provide assurance to the Board on the quality and impact of people management in the Trust. The Chair asked that a report on the NHS People Plan be presented at the next meeting on 19th November. **Action: Kim Nurse** It was discussed and agreed that a representative from Finance is to be added to the membership. The Chair thanked Wendy Owen for her attendance today. The Committee also suggested that a representative from NHS 111 would be helpful. The Chair will discuss with Board Secretary, Philip Higgins. **Action: Caroline Wigley** The Schedule of Business will determine as and when other members need to be present to present papers, although it was felt that it is important for everyone to be part of the ongoing discussions. It will also be pertinent to have Paul Tolley present for Education and Training developments and Maria Watson for health and wellbeing agenda input. Barbara Kozlowska will be reporting on the Staff Survey, appraisals and activity within CPD. The Chair acknowledged that it is important to maintain the strengths of collaborative and ratified working going forward.	**KN** **CW**
09/20/04	**Workforce Key Performance Indicators and scorecard:**	
	Kim Nurse presented paper 3 and 3a with the following points: • These papers are produced every month by Rachael Belleini – Workforce Manager. • We are above establishment, and this is funded by the Covid-19 funding stream, with an agreement to move back into budgeted establishment levels. • The Trust maintains a strong position on Sickness absence, which is currently below 4%, despite the current pandemic and a rise in April 2020. • Staff who were shielding have now returned, apart from 8 people who continue to be away from work for other health reasons. • The temporary workforce have now returned to Universities, with some bank retention to give flexibility at weekends. • Low staff turnover levels at 8.83%. Wider NHS is at 15%. • PDRs near completion and upload of the data onto ESR underway. • Some mandatory training is paused but continues to move ahead with all training programmes. • 11.24% of the Workforce are from a BAME background, where ethnicity is stated. Sickness levels from Covid 19 reports show that BAME staff have been less affected than their white colleagues. IP&C measures and risk assessments are working well.	

- The increase in overtime costs during the pandemic are covered by the Covid-19 funding stream. There are active discussions around demand levels and Surge 3 in terms of delivery to patients.

Damian Dixon raised the question, for clarity, that the figures presented in Papers 3 and 3a do not include PTS. KN confirmed that they do not include PTS figures. The Operational numbers show a skill mix and it may be useful to include PTS going forward.

Caroline Wigley asked Wendy Owen if there was appropriate funding for the staffing establishment. It was confirmed that the Trust is funded to break even but that the current regime is changing in September to a more prospective approach. In future, we will be paid a Covid-19 figure prospectively rather than retrospectively. We will keep within our envelope of funding. We do not know at this stage what the figure from STPs will be.

Kim Nurse responded that all Universities have been put on alert that we may request students back again. Following feedback from Staffside, this will also involve driver training courses over the October half term holiday and weekends to ensure students can move a Trust vehicle but not to the level of driving on blue lights as the DVSA do not have sufficient testing in place currently, due to the pandemic. PTS staff may also be moved over to emergency function as in a better trained position to take on driving functions.

The Government are stepping up Nightingales, bulk purchases of PPE, testing and track & trace.

The group discussed the new National initiative of people being asked to telephone 111 prior to turning up to A&E departments so that an appointment system can be established to relieve the social distancing and waiting time pressures. It is estimated that this will result in 50% more calls to 111. Mark Docherty is talking to Commissioners about what level of funding we might get to support 111.

Nathan Hudson added that PDRs for E&U are now around 97% complete. There have been high abstraction rates since children have returned to school, as staff await Covid-19 tests for themselves, and family members. We have an internal testing system with the QEH laboratories and have 5 testing sites around the region. Most tests are turned around within 24 hours. The Chair congratulated Nathan Hudson, Carla Beechey and Graeme Jones on this excellent work.

Nathan Hudson also raised the challenge in abstraction rates due to increasing demand and mandatory training, which is continuing as much as possible. However, if at any time it is needed, around 40

	crews per day could be released back into the roster. We will see an increase in new staff from the Universities by December.	
09/20/05	**Covid-19 Impact on the Workforce including implications for annual leave:**	
	Carla Beechey presented paper 4. Covid-19 has had a significant impact on the mental and physical wellbeing of our Staff. The 2 Mental Wellbeing Practitioners have reported an increase in their services. Extra resources are also in place including the Listening Centre talking therapy service. Anecdotal feedback is included in Paper 4. The pressures management are under when supporting their staff should not be underestimated. This can have a detrimental effect on the individual. The Mental Wellbeing Practitioners have built up good relationships with managers, who know they can pick up the phone to Kerry Bayliss and Sarah Greswolde at any time. Staffside are also extremely effective in picking up on any subtle changes in behaviour a manager may exhibit and raise concerns. This is a good example of management and staffside working together. The internal Covid-19 testing previously mentioned today has also gone a long way to help alleviate staff anxiety around returning to work and children returning to school. Our Physiotherapists have also seen an increase in demand when face to face appointments resumed in July. Prior to that Jo Smith produced videos and soundbites for the intranet and triaged via telephone and Microsoft Teams. Homeworkers are supported and engaged with on a regular basis. Many say they miss the emotional and social element of coming to work. IT have done an excellent job in ensuring people have adequate home office equipment. Some staff are coming into the office 1 or 2 days per week and this is managed safely with temperature checks, barriers, hand gel and facemasks. Individual risk assessments were carried out with all of the staff returning to work after shielding and reassurance given. Lifting and handling / clinical refresher courses were attended. Pete Green expressed his confidence in the Trust doing everything possible at the moment as we go into winter pressures. Communication with the Management team is good.	

	Kim Nurse added that her Directorate is awaiting approval to recruit an additional Mental Wellbeing Practitioner to help look after our staff as this service is currently overwhelmed. It is essential to be able to provide the right support at the right time. The group went on to discuss the importance of annual leave at this time so that people are ready for the months ahead. Nathan Hudson is particularly aware of this and encourages and supports his managers, joining in with each OM meeting and making the point that this is a marathon and not a sprint. A SOM will be based at each of the 15 hubs. They have all done the Mental Health First Aid training. There is a massive amount of peer support and trust within the teams. Operations and HR are embedded in the way we manage our staff with a good grip of the challenges within E&U. At this point, Damian Dixon advised the Committee that there were a number of staff within PTS who had not taken their full allocation of leave as yet this year. It will possible for them to carry some over into 2021 / 2022. Pete Green raised the concern that with demand increasing and staff working very hard we need to be aware of giving some 'down time' after traumatic jobs. Nathan Hudson gave assurance that this is done and will remind the call takers. Any individual cases can be referred to him. Kim Nurse notified the Committee that the Trust has reached the final for an HPMA Award for Management and Staffside relations. Over the years we have built up involvement, respect and collaborative working and this was showcased in a presentation. The Chair acknowledged the good relationships right across the Trust.	
09/20/06	**Pension Report:**	
	Carla Beechey referred to Paper 5. The contents and received and noted. CB will also send a link to Pete Green, with further documentation.	
09/20/07	**Gender Pay Gap Report and Action Plan:**	
	Pamela Brown presented papers 6 and 6a, the contents of which are received and noted. The main points are as follows:	

	• The Trust continues to put in place good HR policies to reduce the Gender Pay Gap. • We have commissioned the Springboard Women's Development Programme for a 2nd cohort. There is overwhelming demand with a full course and waiting list. • 50-60 women will form a Network group in 2021. Recruitment figures are equal. The Chair asked if we could start this section of the agenda by reminding people of what the Gender Pay Gap is in order to talk about initiatives, examples and find out what other organisations are doing to reduce the gap. The Chair queried how a women's network and other initiatives actually influenced the Gender Pay Gap in practice. A full discussion followed around equal pay in the public and private sectors. The Springboard programme gives women confidence and encouragement to further their careers. There are more flexible working arrangements for those who have caring responsibilities so that they do not need to stop being effective in a more senior role. The Trust also looked at specific areas where women were not encouraged i.e. mechanics and AFAs (Ambulance Fleet Assistants). This has now been addressed and we have employed our first female mechanic and have changed the title of the AFA role to Vehicle Preparation Officer to encourage more female applicants.	
09/20/08	**Diversity and Inclusion Progress Report:**	
	Pamela Brown presented Papers 7 and 7a. The salient points are as follows:- • Professor Anthony Marsh chairs the Diversity & Inclusion: Steering and Advisory Group. Updates will come to this Committee and to EMB. • There has been a significant improvement in BAME staff numbers – currently 11% across clinical and non-clinical staff. The Board voting members have a 23% BAME representation. • The Trust has published its first WDES Action Plan. 6% of staff have declared a disability. Overall 7% of Board members have declared a disability. • A Disability, Carers and Advocates Network is established with 40 members who contributed to and shaped the WDES. They have made good progress in a short time, including a dropped kerb and automated pedestrian gate at headquarters. Disabled toilets at headquarters are now for the sole use of people with disabilities and not general use.	

	• The ONE Network website is postponed but has good engagement on Facebook and WhatsApp. Regular meetings are held with Professor Anthony Marsh and a presentation was made to the Board with follow up planned at a later date. • The BME Representation, Progression and Leadership Action Plan is staffed by the Executive Board, who have made a large investment into this agenda. • An event for Black History Month has been organised in collaboration with the Fire Service and Police and will be held live at Tally Ho or via Zoom in October. This will be publicised through the Weekly Brief. • The PROUD Network also wish to organise a joint event with the Fire Service and Police for Pride 2021. PROUD have also worked with the National LGBT network on health equality and treatment. • All staff, including 97.42% of staff from a BAME background were risk assessed for Covid-19. Following guidance from NHS England, Bangladeshi staff were particularly considered. Managers were encouraged to have sensitive, positive and helpful conversations. • AACE have launched an Anti-Racist Campaign, which will feature in the Weekly Briefing. Caroline Wigley asked if we could have the BME Representation, Progression and Leadership Action Plan added to the papers for this Committee when it is mentioned please. **Action: Pamela Brown** Secondly, the Chair asked what approaches the Trust needed to take in the context of Black Lives Matter? Pamela Brown responded that following the Black Lives Matter movement, we have produced videos of our Commitment as West Midlands Ambulance Service. Pamela Brown and Barbara Kozlowska have also been running training sessions around difficult conversations. With the help and support of Nathan Hudson, more Oms and SOMs are raising issues and we are working together to resolve things. Pamela Brown has also asked to see if there are any increases in ER54s made by our staff in relation to racism. The data will show how concerns have been answered and what support given. This report will be available at the next People Committee. **Action: Pamela Brown**	**PB** **PB**
09/20/09	**Spending on CPD:**	

	Barbara Kozlowska presented Paper 8, which was received and noted It outlines the huge importance of the continued professional development of our staff. Each year BK produces a full report with detail of what the Organisational Development team do. There has been lots of good activity going on in CPD, which has not stopped during the pandemic. Engaging Leaders and Managers is working well remotely. The Chair asked for Financial figures around Spending on CPD. It would also be useful to know how many people from a BAME background are involved. BK advised that all funding comes through HEE and we have to give assurance back.	
09/20/10	**FTSU Guardian Report update and presentation:**	
	Barbara Kozlowska referred to Papers 9 and 9a. The following points were highlighted: • Staff have a range of ways in which they can speak up. E.g. Staffside, ER54s, Listening into Action groups, staff suggestion schemes and HR Managers. • More staff from BAME group are volunteering to be FTSU Advocates. • Not many formal concerns are raised. BK has dealt with 12 informally including a particular area where staff working from home were not feeling supported. The Chair advised that we need to be cautious about overlaps between staff suggestion schemes and freedom to speak up. She asked for specific details as to the concerns that had been raised without breaching confidentiality and to see the same paper that goes to EMB. BK produced two reports per year for the Board and the Learning Review Group has a report for every time it meets. A more detailed and confidential report is produced for EMB. Caroline Wigley expressed the view that the Board is to be kept fully informed and aware of any issues and concerns from staff and managers. Minutes can be handled to ensure a high level of confidentiality is maintained. A discussion followed and it was agreed that Kim Nurse and Barbara Kozlowska will work together to produce appropriate, anonymised FTSU reports for this Committee.	
09/20/11	**Any Other Urgent Business:**	

01	Kim Nurse brought to attention the Trade Union Facility Time return, which needs to be published on the website at the end of the month. It was agreed that this should be circulated for everyone to confirm they are happy with the data prior to sign off by the Board. **Action: Kim Nurse**	**KN**
02	The Chair asked for updates on the Flu Vaccination Campaign. Kim Nurse advised that the Flu Steering Board meets weekly and is on track. Our vaccine supply in confirmed and clinics will be offered in phases as follows: Phase 1 – Patient facing E&U staff only. Phase 2 – EOC/111 Phase 3 – PTS and everyone else Staff can also visit their local pharmacy for the Flu vaccination and their costs will be reimbursed by the Trust. The intelligence available on the likelihood of a Covid-19 vaccination is that the Oxford trial has paused. Medical advice is that people should have a gap between Flu and Covid-19 vaccinations.	
09/20/12	**Dates of Future Meetings 2020 / 2021:**	
	All via Microsoft Teams unless otherwise advised: Thursday 19th November 2020 Thursday 28th January 2021 Thursday 18th March 2021 Please check that these meetings are in your diaries.	

The meeting closed at 1215 hours.

Action Points – People Committee September 2020

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
09/20/03 1	The Chair asked that a report on the NHS People Plan be presented at the next meeting on 19th November. **Action: Kim Nurse**	**KN**	**Complete**	On agenda for 16 11 2020.

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
09/20/03 2	Finance and NHS 111 Membership to be reviewed. **Action: Caroline Wigley**	**CW**	**Complete**	Membership updated to include Jeremy Brown and Linda Millinchamp.
09/20/09 3	Caroline Wigley asked if we could have the BME Representation, Progression and Leadership Action Plan added to the papers for this Committee when it is mentioned please. **Action: Pamela Brown**	**PB**	**Complete**	On agenda for 16 11 2020.
09/20/09 4	Pamela Brown has also asked to see if there are any increases in ER54s made by our staff in relation to racism. The data will show how concerns have been answered and what support given. This report will be available at the next People Committee. **Action: Pamela Brown**	**PB**	**Complete**	09 11 20: Action commenced to investigate ER54s. PB will update at the People Committee on 19th November.
09/20/12.01 5	Kim Nurse brought to attention the Trade Union Facility Time return, which needs to be published on the website at the end of the month. It was agreed that this should be circulated for everyone to confirm they are happy with the data prior to sign off by the Board. **Action: Kim Nurse**	**KN**	**Complete**	Distributed to members.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 18 MONTH: JANUARY 2021 PAPER NUMBER: 15

Board of Directors Schedule of Business (And Council of Governors schedule of business)	
Sponsoring Director	Prof. Ian Cumming
Author	Governance Director & Trust Secretary
Purpose	The Board are requested to review the contents of the attached and approve the schedule of business for the year ahead.
Previously Considered by	Not Applicable
Report Approved By	The Chair of the Board of Directors

Executive Summary

The workplan of the Board is attached, also included are those development sessions that are considered appropriate for members of the Board of Directors to maintain their knowledge and skills.

The workplan of the Trust should also align with the workplans of its Committees and will require review in line with any changes in the governance structure and the Terms of Reference of the Committees.

The schedule of business is normally the responsibility of the Chair of the Board of Directors and facilitated by the Trust Secretary in consultation with EMB. It is intended, following comments made at meetings of the Board Committees that the schedule will be further reviewed to enable papers to be submitted to the Board and its Committees in a timely fashion and avoid duplication, and directors of the Trust have been requested to review the content to make sure that it is correct, relevant and timely.

Related Trust Objectives/ National Standards	All Trust Objectives
Risk and Assurance	The Code of Governance states that it is the Chair's responsibility for ensuring that directors (and governors) receive accurate and timely and clear information that is appropriate for their respective duties The Chair should ensure that the Board receives timely and considered papers, this schedule is a means of establishing specific standards in the preparation of the board papers.

	Without a robust schedule of business The Board would function inadequately without appropriate and timely information.
Legal implications/ regulatory requirements	The schedule as aimed at ensuring compliance with all regulatory requirements
Financial Implications	The schedule of business should be influenced by the Trust's financial and strategic planning and also compliance regimes to which the Trust is subject.
Workforce Implications	Workforce matters, such as the Staff Survey are included in the schedule of Business.
Communications Issues	Dates of Board of Directors meetings are advertised on the website and key partners are advised of the dates.
Diversity & Inclusivity Implications	Equality Impact Assessment complies: Equality Impact Assessment is not applicable and will be undertaken in relation to projects and programmes.
Quality Impact Assessment	Not applicable for this report
Data Quality	The schedule is influenced by the reporting and planning requirements of the Trust.
Action required The Board of Directors are requested to review the contents of the schedules attached and if appropriate approve the schedule of business for the year ahead.	

	Board Schedule of Business		Lead	25/11/20 Strategy Day	Dec-20	27/01/21	24/02/21 Strategy Day	31/03/21	28/04/21 Strategy Day	26/05/21	30/06/21	28/07/21	Aug-21	29/09/21 Strategy Day	27/10/21
Standing Items															
Apologies			Chair			✓		✓		✓	✓	✓			✓
Declarations of Interest			Chair			✓		✓		✓	✓	✓			✓
Minutes of Previous Meetings			Chair			✓		✓		✓	✓	✓			✓
Board Action Log			Chair			✓		✓		✓	✓	✓			✓
Chair's Report			Chair			✓		✓		✓	✓	✓			✓
CEO report			ACM			✓		✓		✓	✓	✓			✓
Risks arising from meetings			All	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓
Care Quality and Safety															
Annual reports	Patient Experience Report	Report through QGC	MD							✓		✓			
	EDI Annual Report	Report through QGC	PB							✓					
	Safeguarding Report	Report through QGC	MD							✓		✓			
	Infection, Prevention and Control Report	Report through QGC	MD							✓		✓			
	Patient Safefy, Duty of Candour and Serious Incidents Report	Report through QGC	MD							✓		✓			
	Research and Development Report	Report through QGC	CC							✓		✓			
	Medicinces Management Report	Report through QGC	MD							✓					
	Accountable Officer for Controlled Drugs Report	Report through QGC	MD							✓		✓			
	Annual staff survey report	Report through QGC	KN							✓		✓			
	Physical and Verbal Assaults to Staff Report	Report through QGC	PH							✓		✓			
	Better Births Annual Report	Report through QGC	MD							✓		✓			
	Freedom to Speak Up Report		MD					✓							✓
Quality Impact Assessment Report (and also any Equality Impact Assessment) Relating			LJM/AW					✓							
Governance															
Annual Governance Statement as part of the Annual Report		Confidential	LJM							✓					
Annual Budget (including capital programme and CIP programme) - Draft			LJM				✓								
Annual Budget (including capital programme and CIP programme) - Final			LJM					✓							
Review Board Assurance Framework and Significant Risks			PH/CK			✓		✓				✓			✓
Review of Register of Seals			PH							✓					✓
Review of Standing Orders and SFIs as required		Report through Audit Committee													
Reports from Commitee Chairs	Audit Committee		WFC			✓		✓		✓		✓			✓
	Annual Report of Audit Committee		WFC									✓			
	Rescources Committee		CW			✓		✓		✓		✓			✓
	Quality Governance Committee		JI			✓		✓		✓		✓			✓
	Remuneration and Nominations Committee		IC			✓		✓		✓		✓			✓
Review of Terms of Reference to Committees of the Board			PH					✓							
Annual Review of Self Assessement of Committees of the Board and their membership			PH						✓						
Review of Goverance structure of the Trust			PH					✓							
Staff Survey Action Plan Quarterly Review		Report through QGC	KN			✓		✓				✓			✓
Staff Survey Action Plan Annual Outcome Report		Report through QGC	KN							✓					
NHS Resolution Annual Scorecard		Confidential	MD					✓							
Update on NARU - KP to attend		Confidential	KP							✓					
Annual Reports	Annual Report on Health and Safety, including fire safety	Report through QGC	CK/PH							✓					
	Annual Report on procurement	Report through Audit Committee	LJM												
Serious Incidents report		Confidential	MD/ST			✓		✓		✓		✓			✓
Claims & Coroners Report		Confidential	MD/MK			✓		✓				✓			✓
Trust Information Pack															
Regular performance KPI based exception reports covering:						✓		✓		✓		✓			✓
Finance including CIPS and Capital Programme			LJM			✓		✓		✓		✓			✓
Corporate Indicators			PH			✓		✓		✓		✓			✓

Clinical Indicators		MD			✓		✓		✓		✓			✓
Operational Key Perforamnce Indicators		CC			✓		✓		✓		✓			✓
Workforce Indicators		KN			✓		✓		✓		✓			✓
Strategy & Engagement														
People Strategy (review Sept 2019)		KN												✓
Operational Strategy (review Sept 2019)		CC												
Clinical Strategy (review Sept 2019)		MD												
Quality Strategy (review Sept 2019)		MD												
Stakeholder Engagement Strategy (review Sept 2019)		PW/MM												
Commissioning Strategy (review Sept 2020)		MD												
Commercial Services Stragegy (review Sept 2020)		MB												
Operating Model		CC											✓	
HART, Academy, West Brom Estate Strategy		CC											✓	
FTSU Strategy		MD				✓								
Risk Management Strategy		PH												
Fleet Strategy		CC												
Research Strategy		CC												
Commissioning Intentions		MD												✓
Operating Plan (NHSI Submission)		PW			✓		✓							
Finance Strategy		LJM												
5 Year Strategic Plan		PW			✓		✓							
Regulatory, Guidance or Contractural														
Annual Audit Letter ISA 260	Confidential	Auditors							✓					
Annual report and accounts	Confidential	LJM							✓					
Quality Account Approval		PW/AP							✓					
Review of Register of Interests - Directors		PH							✓					
Data Security and Protection Toolkit (March - review, October - conf.of submission)		PH/CK					✓							✓
GDPR/Data Protection Officer Report		PH/CK												
Learning From Deaths Report		MD/ST			✓				✓		✓			✓
Workforce Race Equality Standard data report for publishing		CEO											✓	✓
Public Sector Equality Duty Report		CEO												
Licence Conditions		PH							✓					
Annual Meeting of Members - Agenda Approval		PH							✓					
Board Developments														
Safeguarding and Prevent	Rob Cole	Chair						✓						
General Data Protection Regulation (GDPR)	Chris Kerr	Chair	✓											
Directors role in Inclusion and Diversity	Pam Brown	Chair												
WRES Updates and Training	Pam Brown	Chair				✓				✓				
Patient Safety, Duty of Candour and Serious Incidents	Simon Taylor	Chair												
Research Development	Andy Rosser	Chair	✓							✓				
GGI Board Development Session - Darren Grayson	Chair	Chair				✓								
Downside Scenerio Planning	Mark Docherty/Linda Millinchamp												✓	
Miscellaneous Items														
Winter Plan		CC											✓	
Festive Plan		CC	✓											
EDS2 Engagement Outcome		PB					✓							
National Ambulance Service Improvement Faculty/Quality Improvement within the Trust		AP									✓			

Council of Governors Schedule of Business

The proposed schedule of business for the Council of Governors for the year ahead is tabled below. The views of Governors are requested, and we would be grateful if you could note the dates in your diaries.

The Membership and Governor Engagement Officer keeps the schedule up-to-date and any amendments will be reported to each meeting of the Council of Governors. The schedule should complement the business of the Board and its committees.

2021/22	Session Type	Salient Items of Business
February 2021	Council of Governors Meeting	• *Budget* • *Operational & Strategic Plan* • *Quality Account*