West Midlands Ambulance Service
University NHS Foundation Trust

AGENDA

TITLE OF MEETING: Meeting of the Board of Directors

Wednesday 26 July 2023 at 10:45 hours
To be held at the Sandwell Hub, Shidas Lane, Oldbury or by electronic means through Microsoft Teams software and invitation will be sent upon request to the Trust Secretary – phil.higgins@wmas.nhs.uk

Membership

Prof. I Cumming*****	Chair	Non Executive Director (Chairman)
Prof. A C Marsh*****	CEO	Chief Executive Officer
Ms W Farrington Chadd*	WFC	Non Executive Director (Deputy Chair)
Ms C Beechey	CB	People Director
Ms M Brotherton	MB	Non-Emergency Services Operations Delivery & Improvement Director
Mr J Brown	JB	Integrated Emergency & Urgent Care & Performance Director
Mr M Docherty*	MD	Interim Director of Nursing
Mr M Fessal*	MF	Non Executive Director
Mr N Henry	Nhen	Paramedic Practice & Patient Safety Director
Prof. A. Hopkins*	AH	Non Executive Director
Mr N Hudson	NHud	Emergency Services Operations Delivery Director
Mrs J Jasper*	JJ	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
Ms K Rutter*	KR	Director of Finance
Dr R. Steyn*	AW	Interim 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 D Scott	DJS	Interim Organisational Assurance Director
Mr K Prior	KP	NARU Director
Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms R Farrington	RF	Staff Side Representative

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	Timings
01	**Welcome, apologies and Chairman's matters**		Chairman	Verbal	05 minutes
02	**Declarations of Interest**				
	To enable declarations to be made, of any conflict of interest members may have in relation to any matters contained within the agenda for this meeting.		Chair	Verbal	
03	NARU Update by Keith Prior, National Ambulance Resilience Unit Director.		CEO	Paper 01	10 minutes
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 meetings of the Board of Directors held 31 May 2023.		Chair	Paper 02	05 minutes
05B	Board Log and any matters arising from the Minutes not on the Agenda for this meeting.		Interim Organisational Assurance Director	Paper 03	05 minutes
06	**Chief Executive Officers Reports**				
06a	To receive the report of the Chief Executive Officer.		CEO	Paper 04a	10 minutes
	Action	To receive and note the contents of the paper seeking clarification where necessary.			
06b	Executive Scorecard and ICS Scorecard relating to performance for the month of June 2023.		CEO	Paper 04b-1 Paper 04b-2	05 minutes
	Action	To receive the Scorecards.			
06c	Emergency Preparedness, Resilience and Response (EPRR) Update.		CEO	Paper 04c	05 Minutes
	Action	To receive the update.			

Item No	Description		Lead	Paper No	Timings
06d	Category 2 Trajectory Update.		Integrated Emergency & Urgent Care Performance Director	Paper 04d	10 Minutes
	Action	To receive the report and approve the submission.			
06e	Emergency & Urgent Recruitment 2023 / 2024		CEO/ People Director	Paper 04e	10 Minutes
	Action	a) To receive a report from the People Director. b) Ratify the revised E&U recruitment plan for 2023 / 2024 as follows: 1. Graduate Recruitment (140) 2. Student Paramedic Recruitment (180)			
07	**Month three financial update**				
07a	A financial update from the Director of Finance.		Director of Finance	Paper 05	10 minutes
	Action	To receive a report from the Director of Finance.			
08	**Quality Reports**				
08a	Combined Clinical Directors Quality Report July 2023.		The Interim Medical Director/ Paramedic Practice and Patient Safety Director/ Interim Director of Nursing	Paper 06a	10 Minutes
	Action	To receive the report			
08b	Board Assurance Framework & Significant Risks.		Interim Director of Nursing	Paper 06b	10 Minutes
	Action	To receive and approve the Board Assurance Framework & Significant Risks.			
09	**FTSU Guardian**				
	• The FTSU Guardian report • Confirmation of updated strategy with National Guardian's changes incorporated. • Action plan update		FTSU Guardian	Paper 07	05 Minutes
	Action	To receive and approve the Strategy and the Action Plan			

Item No	Description		Lead	Paper No	Timings
10	**Operations Update**				
10a	Non-Emergency Services Operations Delivery & Improvement Director Update.		Non-Emergency Services Operations Delivery & Improvement Director	Verbal	05 minutes
	Action	To receive and note the update.			
10b	Integrated Emergency & Urgent Care & Performance Director Update.		Integrated Emergency & Urgent Care Performance Director	Paper 08a	05 minutes
	Action	To receive and note the update.			
10c	Emergency Services Operations Delivery Director Update.		Director of Performance & Improvement	Paper 08b	05 minutes
	Action	To receive and note the update.			
11	**Governance**				
11a	Well Led Review Report and Action Plan		Interim Organisational Assurance Director	Paper 09a	10 Minutes
	Action	To receive the report and approve the Action Plan.			
11b	Review of Governance Structure and Approval of the Terms of Reference.		Governance Director &Trust Secretary/ Interim Organisational Assurance Director	Paper 09b	10 Minutes
	Action	a) To review the Governance Structure. b) To approve the Terms of Reference submitted.			
12	**Board Committee Reports and Minutes**				
	Action	a) Audit Committee: I. To receive the Minutes of the of the Meeting held on 6 June 2023. II. To receive a report of the Chair of the Audit Committee on matters considered at the meeting of the Committee held on 18 July 2023.	Chair of Audit Committee	Paper 10 a Paper 10 b	10 minutes

Item No	Description		Lead	Paper No	Timings
		III. To receive the Annual Report of the Audit Committee. b) To receive the Minutes of the Quality Governance Committee held on 24 May 2023	Chair of QGC	Paper 10 c Paper 10 d	
13	**New or Increased Risks Arising from the Meeting**				
14	**Board of Directors Schedule of Business**				
	To receive the Schedule of Business and Development Sessions.		Trust Secretary	Paper 11	
	Action	To review and note the Board Schedule of Business			
15	**Any Other Business** (previously notified to the Trust Secretary)		Chair		
16	**Review of Guiding Principles**		Trust Secretary	Circulated by email for response	
17	**Date and time of the next meeting:** **The next meeting will be on** **Wednesday 25 October 2023 from 10:00 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)

National Ambulance Resilience Unit
NARU

NHS

National Ambulance Resilience Unit (NARU)

Trust Board Presentation

July 2023

Keith Prior QAM

Director, National Ambulance Resilience Unit

Assistant Chief Officer, WMAS

National Ambulance Resilience Unit
NARU

NHS

What is NARU?

- Part of NHS
- Commissioned by NHSE
- Hosted by WMAS
- Responsible for the ‘Ambulance Service Interoperable Capabilities’ in England

National Ambulance Resilience Unit
NARU

NHS

Interoperable Capabilities

- Safe Working at Height
- High Risk Confined Space & Unstable Terrain
- Water Operations
- Specialist Operational Response to CBRN
- High Consequence Infectious Disease
- Marauding Terrorist Attack
- Support to Security Operations
- All-Terrain Vehicle Operations

National Ambulance Resilience Unit
NARU

NHS

Operationally Delivered via

- NARU 27.5 WTE in the Team
- HART - 15 teams across England (c750 staff)
- SORT – 290 staff per Amb Trust (c2900 staff)
- Command (Operational, Tactical & Strategic)

National Ambulance Resilience Unit
NARU

National Risk Assessment & National Risk Planning Assumptions


Cabinet Office

National Risk Register
Of Civil Emergencies
2017 edition

National Risk Register 1


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Guidance

Risk assessment: how the risk of emergencies in the UK is assessed

How the level of risk posed to the UK is assessed nationally and locally, covering the National Risk Assessment and National Risk Register.

Published 20 February 2013
From: Cabinet Office

National Ambulance Resilience Unit
NARU

NHS

Maintaining Interoperability

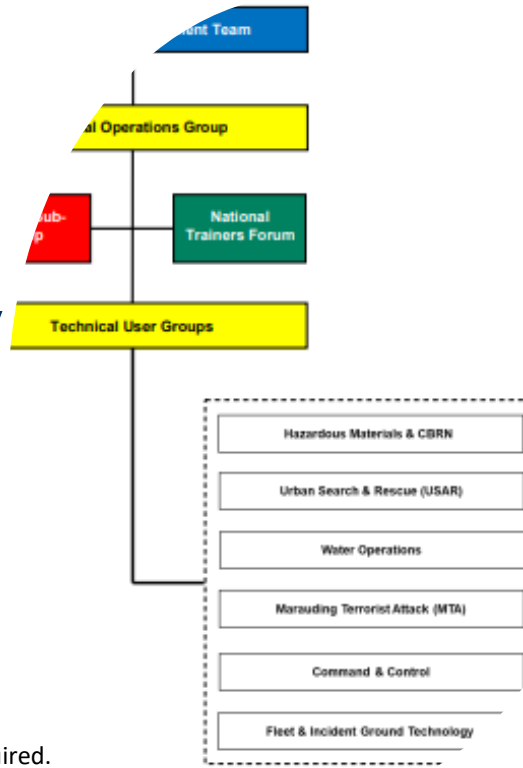
- Education and Training
- Equipment Evaluation and Procurement
- Safe Systems of Work
- Clinical Competencies
- Standards, Compliance and Quality Assurance

National Ambulance Resilience Unit
NARU

NHS

Other Responsibilities

- Support to National Ambulance Coordination Centre
- Mutual Aid
- Support to NHSE and wider NHS
- Provision of SME to support National Policy Groups
- Multi-Agency Interoperability



National Ambulance Resilience Unit
NARU

NHS

Governance

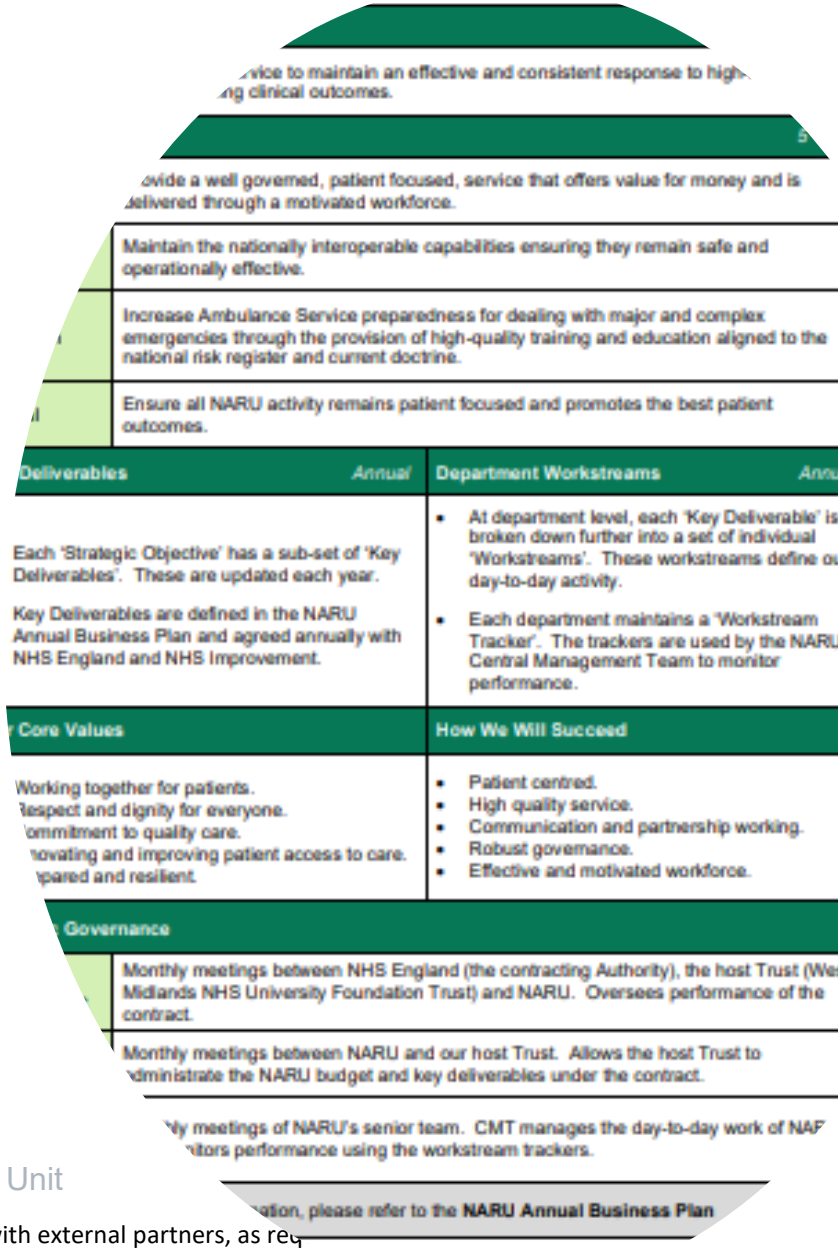
- 3y Contract 2020 can be extended to 2025 – New Tender
- NHSE Steering Board
- NHSE Contract Management Board
- WMAS Delivery Board
- EMB

National Ambulance Resilience Unit
NARU

NHS

Strategic Direction

- Set by NHSE Steering Board
- 5-year Strategic Aims and Objectives
- Key Deliverables and Work Stream Outputs
- Annual Business Plan and Annual Report



National Ambulance Resilience Unit
NARU

NHS

Recent Challenges and Successes

- Audit of Ambulance Trusts
- SORT Implementation
- Strategic Review of HART
- Support to Man Arena Inquiry
- Support for CWG - cut 1CUT 1 MIX DOWN on Vime

National Ambulance Resilience Unit
NARU

NHS

23/24 Priorities

- Implementing Lessons from MAI
- Roll out of New MCV
- New National HART Vehicles
- Mass Cas Triage System (TST & MITT)
- Tender for NARU Contract

National Ambulance Resilience Unit
NARU

NHS

Any Questions?

Thank You

www.naru.org.uk

Produced by: Keith Prior, Director, NARU
Email: keith.prior@wmas.nhs.uk

Minutes of the Meeting of the Board of Directors held on 31 May 2023,
at 11:00 hours, via Microsoft Teams

Present:		
Prof I Cumming*	Chairman	Non-Executive Director (Chairman)
Prof A C Marsh*	CEO	Chief Executive Officer
Ms C Beechey	CB	People Director
Mrs M Brotherton	MB	Non-Emergency Services Operations Delivery & Improvement Director
Mr J Brown	JB	Integrated Emergency & Urgent Care & Performance Director
Mr M Fessal*	MF	Non-Executive Director
Mr N Henry	NHen	Paramedic Practice & Patient Safety Director
Prof. A Hopkins*	AH	Non-Executive Director
Mr N. Hudson	NH	Emergency Services Operations Delivery Director
Mrs J Jasper*	JJ	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 K Rutter*	KR	Director of Finance
Ms D Scott	DJS	Interim Organisational Assurance & Clinical Director
* Denotes a voting member appointed pursuant to the Constitution of the West Midlands Ambulance Service NHS Foundation Trust In attendance by means of Microsoft Teams and at Trust HQ:		
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Mrs P Wall	PW	FTSU Guardian (part of meeting)
Ms R Farrington	RF	Staff Side Representative
Mr L Jones-Keyte	LJ	Member of Staff
Ms K Knowles	KK	

05/23/01	**Welcome, Apologies and Announcements**	
	Apologies for absence received from Dr Alison Walker and Mrs Wendy Farrington-Chadd	
05/23/02	**Declarations of Interest**	
	There were no conflicts of interest declared by anyone attending the meeting in relation to any matters on the agenda. The Governance	

	Director/Trust Secretary informed the Board that the Registers will now be published on the website.	
	Resolved:	
	a) That the Board of Directors received the Registers of Directors Interests. b) That the Board of Directors received the Registers of the Governors Interests.	
05/23/03	**Questions from the Public**	
	None received.	
05/23/04	**Board Minutes**	
	To agree the Minutes of the meetings of the Board of Directors held on 29 March 2023.	
	Resolved:	
	That the Minutes of the meeting of the Board of Directors held 29 March 2023 be approved as a correct record.	
05/23/05	**Board Minute 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).	
	Action 03/23/05b – NHS Delivery Plan for Recovering Urgent & Emergency Care. The 30 minutes category 2 response was now included on the Executive scorecard. On this basis the Board agreed that this item could be discharged.	**Discharged**
	Action 01/23/18 – Ambulance Decision Areas (ADAs). The Non-Emergency Services Operations Delivery & Improvement Director gave a verbal update and informed the Board of Directors that the ADAs are fully embedded across Acute Trusts, and this is working well. Positive feedback has been received from patients, Acute Trust Staff and the CQC. Mr Fessal pointed out that the ADAs are not in all Trusts and asked what was happening with the other Trusts. The Non-Emergency Services Operations Delivery & Improvement Director explained that ADAs have been offered to all Trusts. New Cross Hospital have only	

	been for a few months with their own model. Birmingham & Solihull ICB are very keen to substantiate the West Midlands Ambulance Service ADA model and a business case is being submitted to their Board in this regard. On this basis the Board agreed that this item could be discharged.	**Discharged**
	Action -1/23/20 – Safeguarding Business Case. The Executive Management Board (EMB) has approved the establishment of the Head of Safeguarding within the Paramedic Practice & Patient Safety Directorate and post has been advertised. On this basis the Board agreed that this item could be discharged.	**Discharged**
	Action – 03/23/28c – Freedom to Speak Up Action Plans. The update on the business case is included in the paper submitted for today's meeting. On this basis the Board agreed that this item could be discharged.	**Discharged**
05/23/06	**Chief Executive Officer (CEO) Update**	
	A report of the Chief Executive Officer was submitted. The Chief Executive outlined the salient matters contained in the report and informed the Board that the Violence Prevention & Reduction Standard (VPRS) provides a risk-based framework that supports a safe and secure working environment for NHS staff. West Midlands Ambulance Service University NHS Foundation Trust (WMAS) is required to review its status against the Violence Prevention & Reduction Standard and provide Board assurance that we have met it twice a year. Peer to Peer review was presented to the Association of Ambulance Chief Executives (AACE) in February 2023. There are 56 standards. WMAS is at 94.64% compliance, only one other ambulance Trust above 60%. The Trust is currently working to achieve 100%. The Trust's peer review was undertaken by the London Ambulance Service. The CEO said the Trust will continue to do everything it can to protect our staff. The CEO informed the Board of Directors that the annual costs of running the new Sandwell Hub, minus the savings from the closures of West Brom Hub, the HART base, CAS sites, distribution centre & the Academy is £500k. These costs only include running costs, and not the net book value costs associated with the sale of any property. The CEO explained that the Covid-19 Public Inquiry Chair wrote to the Trust asking for a range of information which has now been submitted. The CEO had met with the Freedom To Speak Up (FTSU) Ambassadors along with the FTSU Guardian and Executive Lead. The CEO informed the Board that over 300 staff joined the recent All Staff Briefing.	
	Resolved:	
	a) That the contents of the report be received and noted	

05/23/07	**Executive Scorecard & ICS Scorecard relating to Performance for the Month of April 2023**	
	The Executive Scorecard of KPIs for the month of April 2023 was submitted. The key indicators and trends were set out for review by the Board. The indicators covered operational performance, finance, workforce, and high-level clinical indicators. The scorecard was submitted in addition to the Trust Information Pack which contains Trust wide performance data and information and is circulated separately to the Agenda.	
	Resolved:	
	a) That the Executive Scorecard be received and noted.	
05/23/08	**Licence Conditions**	
	The Governance Director/Trust Secretary said the paper is as presented and provides the Board of Directors with an update on the changes to the NHS Provider Licence Conditions. These changes reflect the changes to the statutory and operating environment within which the Trust now operates. This means the shift of emphasis from economic regulation and competition to system working and collaboration. The proposed changes will bring the licence up to date, reflecting the new legislation and supporting providers to work effectively as part of the integrated care systems (ICSs). A full copy of the licence is available upon request and will be published on the Trust's website.	
	Resolved	
	a) That the changes to the Licence Conditions were noted and received.	
05/23/09	**Report of the Director of Finance**	
	The Director of Finance gave an update and informed the Board that the draft end of year accounts for 2022/23 were produced and submitted to NHSE before the required deadline and the Trust's external auditors are now undertaking their review and assurance of the statements and supporting information. The audited statements will be presented for approval at the Trust's Audit Committee on 6 June. The Director of finance reminded the Board that the Trust Board has delegated this approval authority to Audit Committee. The Director of Finance confirmed that External Audit have raised nothing. The Director of Finance informed the Board of Directors that at Month 1 (2023/24) there was a limited submission required by NHSE. This covered staff costs and a summary of the overall income and expenditure position. The	

	Trust's information is included in the Black Country ICB reporting. Key points to note are: • Reported surplus £238k – this is against a planned surplus of £189k. • This position assumes that the level of income represented in the plan will be fully agreed – these contract discussions are still ongoing with WM systems. • The reported spend is below plan due to the current recruitment and overtime restrictions in place. • Capital spend is below plan at month 1 due to no purchases made during the month – this funding will be fully utilised over the financial year. The Director of Finance explained that the month 1 finance information is included in the Trust pack circulated separately to Board Members and is also available on the Trust's website. The Chairman asked about the completion of the audit for 2022/23. The Director of Finance explained that External Audit started the process late and have asked to go up to just before 6 June to complete the audit. The Director of Finance said there is nothing the Board needs to be aware of as of today. Mrs Jasper said as Chair of the Audit Committee she keeps in regular contact with the Director of Finance. There are no red flags or heads up from the Auditors. Mrs Jasper reminded Board Members that the meeting on 6 June will be the formal sign off for the accounts and she asked for confirmation from her Non-Executive Director (NED) colleagues that they have reviewed the accounts and if they have any questions to please raise these before the meeting on 6 June. The Chairman agreed it was important to have the assurance from the NEDs.	
	Resolved	
	a) That the contents of the report be received and noted.	
05/23/10	**Quality Reports – Combined Clinical Directors Quality Report – May 2023**	
	The combined Clinical Directors Report for May 2023 was submitted. The Paramedic Practice & Patient Safety Director explained that hospital handover delays are still having an impact and have not reduced to pre-covid levels yet. For April 2023 there were just over 10,000 lost hours. There are 57 serious incidents (SIs) open which is a significant drop to previous months. TheTrust has seen a reducing trend of serious incidents being reported du ring the month of April, this trend is in line with the reducing number of hospital handover delays. This demonstrates a direct correlation to hospital handover delays, with delayed response remaining the highest trend for these investigations.	

In relation to patient safety reporting and following a full review of information, the Trust identified a gap in reporting regarding 'open' patient safety incidents, finding 7,919 historically reported incidents had not been formally closed, dating back to 2016. A formal executive review and recovery plan was immediately enacted, and this identified that incidents had been reported, although not closed appropriately. In completing the formal closure of the identified incidents, patient harm levels did reduce from previous reporting. Robust processes have been implemented to increase the visibility of open cases to Trust committees and ensure this does not happen again. The information and learning from this incident have been shared with Commissioners and the Care Quality Commission in being open.

The Paramedic Practice & Patient Safety Director said in relation to the plans to improve mental health the Business Case approved by EMB supports the implementation of deliverables in line with expectations laid out within the NHS Long Term Plan following extensive discussions and negotiations with West Midlands ICBs and NHS England over the last 12 months. It seeks to introduce additional specialist resourcing and enhanced mental health education for staff to improve the delivery of care to patients presenting to the ambulance service with mental health needs. This will be achieved through:

- Mental Health Clinicians embedded in the Clinical Validation Team.
- 6 Mental Health Response Vehicles (5 Operational plus one for resilience).
- Mental Health Clinical Education and Improvement officers developing and delivering a programme of mental health education and quality improvement.

The revenue costs of this project are to be fully funded by external investment from each of the six West Midlands Integrated Care Boards from Mental Health Investment Standard funding allocations. This business case is proposed on the assumption that formal contractual arrangements will be finalised before any new costs are incurred and approval is sought on this basis. The Director of Finance is supportive provided that the funding is agreed within the agreed timeframe. The business case was approved by EMB in principle subject to the following items being clarified:

- Funding is received.
- Confirmation of the number of Educators required.
- Clarification on who owns / manages this.

The Board will be advised if there is any update to this proposal, but the Board is requested to approve the recommendation of the EMB subject to funding. The Paramedic Practice & Patient Safety Director informed the Board that if the funding is not there, we will have to make

	modifications to our plan. Mr Fessal asked about the Met Police Force announcement and if we knew if the West Midlands Police Force were considering this and what impact that would have in our area. The CEO said that what the Met have done the Police have been talking about for some years now. The Police stepping away is a good thing in relation to what the patient needs. This will provide consistency across the UK which is especially important. The CEO said we will continue to work very closely with the Police as there will still be some patients that need Police support. The Paramedic Practice & Patient Safety Diretcor explained that this model is about growing our own specialist paramedics so they will become the expert as they go through their training. The Board of Directors approved the mental health business case. The Chairman pointed out in the paper it refers to one of the longest waits for Cat 1 being 3 hours 11 minutes and another refers to Cat 1 for a medical minor. The CEO said that medical minor is how NHS Pathways has recorded that. The longest wait of 3 hours 11 minutes this will be checked and reported back to the Board. The Interim Organisational Assurance & Clinical Director informed the Board that the Trust received 24 formal complaints in April 2023 compared to 55 in April 2022. This equates to 1 complaint for every 20,000 emergency calls received, 1 complaint for every 7,500 incidents and 1 complaint for every 10,000 non-emergency patient journeys. The Parliamentary Health Service Ombudsman (PHSO) released new guidance regarding NHS complaints. We are checking that we are up to date with the changes and will report back to a future meeting on this. The Trust received 183 compliment letters in April 2023 compared to 169 in April 2022.	
	Resolved	
	a) That the contents of the report be received and noted. b) That the Board of Directors approved the recommendation of the EMB in relation to the proposals for Improving the Response to Mental Health Business Case at a cost of £3.8M in 2023/24 and £3.8M with revenue costs in 2024/25 (and recurrently thereafter) of £3.8M subject to funding being made available within the timeframe to implement the proposal. c) That the Paramedic Practice & Patient Safety Director would check on the reference to a long wait of 3 hours 11 minutes for Cat 1 and report back to the Board.	**NHen**
05/23/11	**Public Health Strategy**	

	The Interim Organisational Assurance & Clinical Director said that WMAS has a strong vision to deliver the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies. To achieve this, the Trust is required to work proactively and collaboratively with partner agencies to meet the needs of the communities it serves and to develop and deliver preventative initiatives that will improve the health and health outcomes of the population of the West Midlands. WMAS recognises that public health aims to continuously improve the physical and mental health outcomes, in addition to the wellbeing of people within a population by focussing on prevention, thus reducing health inequalities, and improving health outcomes. This document captures our organisations strategic ambition to embed public health approaches and preventative methods into the culture of the West Midlands Ambulance Service. To monitor progress in relation to public health workstreams, the terms of reference document for the Professional Standards Group (PSG) has been updated to acknowledge the delivery of a quarterly public health update, which will be presented and received in the format of the public health annual programme. The public health annual programme seeks to provide the group with an update and oversight of the public health agenda, including progress on individual workstreams, including areas and gaps in assurance. The Chairman said the document was excellent – making every contact count should resonate with us all. The Chairman asked in relation to training if there was enough focus on prevention or whether its more on treatment. Should we lobby to see if more we can be doing. The Chairman had talked to a crew about how they gelt about having public health conversations. Professor Hopkins said that what we will have in the standards required is a section on public health. We need to follow this up with the education providers to see if it is aligned to our strategy. New Universities should be given our strategy as the students need to be assessed on this. There should be discussions with Universities on a regular basis. Mrs Jasper said she had never seen a connection between public health and understood we need to get it out there that prevention is better than going to A&E. Mrs Jaspers concern was that this required buy in from the ICB as this must fit in with their strategies as well. Mrs Jasper agreed with Professor Hopkins that this needed adding into the curriculum for paramedics. The Chairman asked for thanks to be passed back to the Medical Director and Head of IPC who had put this strategy together.	
	Resolved:	
	a) That the contents of the report be received and noted. b) That the Board of Director approved the Public Health Strategy.	
05/23/12	**Quality Account**	

	The Head of Strategic Planning was asking the Board of Directors to approve the document today and delegate authority to the EMB at its meeting on 13 June to approve the final version incorporating any further statements and the final formatting. The draft Quality Account is enclosed for review and approval. Achievement of the priorities agreed for 2022/23 are reported within the document along with all other updates in respect of activities across the Trust. The new priorities for 2023/24 are also identified. There is no national guidance for Quality Accounts this year, but the documents are still to be created and published by each Trust according to the normal schedule. Whilst there is no updated guidance, it has been clearly stated that there is no requirement for external audit of the document. At the time of writing, some statements from stakeholders are yet to be received. All statements received prior to publishing will be incorporated into the final version. Some final formatting will also be completed before publication, including the addition of graphics for aesthetic purposes.	
	Resolved	
	a) That the contents of the paper be received and noted. b) That the Board of Directors endorsed the recommendation of the Quality Governance Committee and approved the content of the Quality Account and authorised its publication.	
05/23/13	**Departmental Annual Reports**	
	The Paramedic Practice & Patient Safety Director informed the Board that the leads of key corporate functions have produced the following reports to cover a summary of activities and achievements during 2022/23 and an overview of priority work areas for 2023/24. The following reflects the groups and committees where each report has been reviewed and approved. 1. Controlled Drugs and Medicines Management (Approved by PSG and QGC) 2. Infection Prevention & Control (Approved by HSRE and QGC) 3. Maternity (Circulated to PSG by email for approval by 26/05/2023, approval at QGC subject to PSG comments) 4. Patient Experience (Agreed at LRG and Approved by PSG and QGC) 5. Safeguarding, including Prevent (Agreed at LRG and Approved QGC) 6. Making Every Contact Count (Circulated to PSG by email for approval by 26/05/2023, approval at QGC subject to PSG comments) 7. Security Management (Approved by HSRE and QGC) 8. Health & Safety (Approved by HSRE and QGC) 9. Patient Safety (Agreed at LRG and Approved by PSG and QGC)	

	10. Clinical Audit (Agreed at CARPG and Approved by PSG) 11. Research (Agreed at CARPG and Approved by PSG and QGC) 12. Learning From Deaths (Agreed at LRG and Approved by QGC). We have continued to use a standardised template for most of these reports with the same structured content. This means that whilst they remain standalone documents, if viewed together, they will have the same corporate branding and layout, supporting ease of reference. Once approved, they will be published on the Trust's website, supporting the Quality Account.	
	Resolved:	
	a) That the Board of Directors approved the draft annual reports previously circulated to Board Members.	
05/23/14	**Board Assurance Framework (BAF) & Significant Risks**	
	The Interim Organisational Assurance & Clinical Director informed the Board that the following two risks remain as 25: • PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times. • EOC – 016 - Stacking of incidents at times of high demand. The risks are reviewed regularly. The BAF format will be updated to align with best practice.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That the Board of Directors approved the Board Assurance Framework and Significant Risks.	
05/23/15	**Report of the Freedom To Speak Up (FTSU) Guardian**	
	The Freedom to Speak up Guardian gave an update and informed the Board that it is the responsibility of the Guardian to feed back to the Board. As part of ongoing collaboration with NHS England, since the approval of the updated FTSU Strategy by the Board of Directors in January 2023, the following suggestions have been received from NHS England: • A note to cover the work the Trust is carrying out to ensure all leaders will have the knowledge and understand the skills required to handle FTSU issues effectively. • How experiences of detriment will be measured and also how the Trust will check it is improving over time.	

	• Some data measures. i.e., increased numbers of staff speaking up in hotspot areas or in areas with targeted communications via Ambassadors. • Planned training for all leaders/managers. The action plans that were presented at the March meeting of the Board of Directors has been updated to reflect progress to date and work planned within the next quarter. This takes account of the comments received from NHS England in respect of the Strategy. These will be presented back to the Board as we move forward. The business case was presented to the EMB yesterday. The FTSU Guardian said they have assessed their workload and proposed one additional WTE. This will go back to EMB following some further work. In relation to the Reflection and Planning Tool and to support the Trust's improvement journey, the Board of Directors invited the National Guardian's Office and NHS England to carry out a development session. This interactive session took place on 10 May 2023 and enabled discussion on matters including perceived barriers to speaking up, managing conflicts and opportunities for improvement within WMAS. The outcomes from the session will be reflected in the Trust's Reflection and Planning tool which will be presented at the meeting of the Board of Directors in October 2023, this is consistent with the requirement for Boards to receive by 31 January 2024. The Chairman thanked the FTSU Guardian for her helpful update. The Strategy & Engagement Director (as the FTSU Executive Lead) informed the Board that the first session with Professor Hopkins as the new FTSU NED lead took place a few weeks back. They reviewed the open cases and good discussions took place. The Strategy & Engagement Director thanked the FTSU Guardian for all the work she has been doing in this area. The Strategy & Engagement Director explained that the final review and update is taking place on the business case, and this will then be submitted to the Financial Investment Group. The CEO has been clear that he would like the adverts to be out by the end of June. Professor Hopkins pointed out that it is worth noting that the NGO did endorse the approach the Trust is taking. We should be assured by that and reassured of the actions we continue to take. The uptake on FTSU training will be especially important. Professor Hopkins said as part of our work we will look to see what else we have and what impact this will have on our organisation. Culture – its about making sure every voice is heard. This is an evolutionary process, and we are part of the way through this. Professor Hopkins gave her thanks to the FTSU Guardian and FTSU Executive Lead for the work they have done and continue to do. Professor Hopkins pointed out that the training as it is rolled out will provide people with other mechanisms to raise issues. The Chairman thanked the FTSU Guardian and the Team of Ambassadors. Mrs Kooner thanked the FTSU Team for all the hard work on this agenda item. From the Staff Survey results it is clear there is still more we need to do but with the	

	extra resource hopefully we can get there. The FTSU Guardian thanked the Board of Directors for their kind comments and support. The Board of Directors gave approval for the changes to be made to the Strategy but asked that the Strategy is brought back to the Board for final sign off.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That the Board of Directors approved the additions to the Strategy based on the NHSE comments but asked that the Strategy be brought back to the Board for final sign off.	**PW**
	Operations Update	
05/23/16	**Non-Emergency Services Operations Delivery & Improvement Director Update – Michelle Brotherton**	
	The report was as submitted. The Non-Emergency Services Operations Delivery & Improvement Director informed the Board that there was a decrease in overall activity throughout April, mainly due to the two bank holidays and reduction in outpatient activity but an increase in mobility. The Trust failed 12 x KPI's overall on the Cheshire, Sandwell & West Birmingham, Coventry & Warwickshire, and Birmingham contracts. Conversations are ongoing with commissioners regarding funding. All PDR's and mandatory training have been planned for 2023/24.	
	Resolved:	
	a) That the contents of the paper be received and noted.	
05/23/17	**Emergency Services Operations Delivery Director Update**	
	The report of the Emergency Services Operations Delivery Director was submitted. The Emergency Services Operations Delivery Director advised the Board that performance remains challenged due to hospital handover delays and abstractions. Activity continues to be down. Sickness for April was 3.12%. PDRs are currently at 62%. Skill mix remains strong. Attrition was down for April. The Chairman pointed out that it had been suggested to him that EPR is the right way to go but it takes longer to complete than the paper records. This is causing increased down time due to completing the EPR. The CEO reported that when Dr Andy Carson was Medical Director, we undertook a review of the job cycle times pre and post EPR. The job cycle times had reduced. Overall it did not add anything to the job cycle times.	
	Resolved:	

	a) That the contents of the paper be received and noted.	
05/23/18	**Integrated Emergency & Urgent Care & Performance Director**	
	The report was as submitted. The Integrated Emergency & Urgent Care & Performance Director gave an update and informed the Board that the during April the mean performance remained challenged across all performance standards, except for Category 1 90 percentiles. Category 1 mean performance showed marginal improvement to 08:05, from 8:10 in March. The mean position for category 2 incidents has improved to 27:11, from 31:48 and category 3 also improved to 127:02, from 153:33 during March. Despite the ongoing work to support hospital handover delays and the improvements seen in lost hours, the impact of hospital handover delays on the Trust's ability to respond to patient in a timely manner continues to effect response times. We are not going to achieve the 30 minutes target. During April, the Trust reported no two-minute delays answering emergency calls. The Trust continues to report the lowest number of 2-minute delays across all English ambulance Trusts, despite support offered through IRP and individual call answer support agreements. PDRs and mandatory training are progressing well. The Integrated Emergency & Urgent Care & Performance Director advised the Board that the Trust continues to support other ambulance Trusts, answering 1,131 emergency calls from outside the WMAS region during April. Discussions are currently ongoing with East Midlands Ambulance service to prove them with significant support to enable then to train all their call taking staff in NHS Pathways for a go live in October 2023. Early estimates suggest that the assistance is likely to be around the 110k calls, generating approximately £1.6m into the Trust. Broadly speaking WMAS would be assisting with circa 1,000 calls a day until the end of October. Clinical validation of category 3 & 4 emergencies remains a key function to support the overall emergency demand and to ensure patients receive an appropriate response. The Trust achieved a hear and treat (H&T) rate of 16.6% during April. A review of the recontact rates for H&T patients demonstrates only 9.3% of patient required further 999 assessment within 48 hours during April. The sustained low rate of recontacts, and the outcomes there of, demonstrates the safe practice of the clinical validation team. This is reflected in the low number of serious incidents reported in relation to CVT triage. Sickness remains too high, and we are working closely with HR to lower this. The Chairman said some of the data included in the report is interesting and he asked if any of the Cat 3 and 4 data is shared with other parts of the system that might be able to help us with this. 28% of people redirected to primary care that is a significant number of people. The Integrated Emergency & Urgent Care & Performance Director said the data is shared locally as often as we can. We need to consider if we are	

	going to tell patients to self-care how do we get the message out there. The CEO thanked all three Operations Directors for working so well in such a challenging environment. The CEO pointed out that the Trust is the best in the Country for call answering and he thanked Ms Farrington for this achievement and her leadership which is acknowledged and appreciated.	
	Resolved:	
	a) That the contents of the report be received and noted	
	Report of the People Director	
05/23/19	**Staff Survey Results**	
	The People Director gave an update and advised the Board that the 2022 Staff Survey was carried out by Picker Europe Ltd for WMAS. The survey opened on 21 September and closed on 25 November 2022. 2,768 staff responded to the survey giving a response rate of 39%. This is compared to 44% in the 2021 survey. An overview of the results for WMAS compared to other Ambulance Trusts is shared in this report as well as an analysis of the free text comments left by 841 staff. The average response rate for all Ambulance Trusts is 50% compared to 53% in 2021. Across the NHS the response rate is 48% compared to 50% in 2021. There was a significant decrease in the number of BAME staff responding to the survey on this occasion. 179 BAME staff returned the questionnaire in 2022, compared to 226 in the 2021 staff survey. The following was noted: • Most improved area was 'we are always learning'. • Staff engagement and morale – the score remained the same. • W work flexibly scored significantly lower than the previous year. This is likely due to the rota change that took place during the year. The People Director informed the Board that a Trust wide Staff Survey Action Plan is in place, and this was presented to the EMB in February and was approved. All localities have been advised to share the staff survey results with their staff and listen to suggestions and recommendations from staff to create a Local Action Plan. Most Local Action Plans have been submitted to the Staff Survey response Action Group. It was agreed for the Organisational Development Team to conduct a culture review during April through various staff conversations at different sites. These have been carried out. There are planned sessions for Senior Managers in June. To allow the opportunity for more people to provide their feedback about the culture review, a Survey Monkey questionnaire will be shared with staff in June, with the same questions asked during face-to-face staff conversations. All the data	

	collected will be collated and shared with EMB in due course. Mr Fessal advised the Board that we are looking at EDI slightly differently this year. The EDI Lead is leading on this. Other conversations are taking place regarding the workforce and budgeted plans. The Chairman said that he tends to rely more on the free text rather than the tick boxes. A lot of the free text comments were very positive, but the health and wellbeing (HWB) comments are an outlier and red. The Chairman asked if there was anything we could or should be doing in this regard. The People Director informed the Board that HWB road shows are taking place on all sites at present. The launch of the HWB website has been very positive. Staff are utilising this and engaging with it. The People Director said this ais about using lots of different tools and the website. The Chairman noted the need to follow up on the comments as they come out during the year, and he was keen to do something that shows staff the Board are listening. The People Director agreed and said they will carry on giving updates on a regular basis.	
	Resolved a) That the contents of the report be received and noted.	
05/23/20	**Board Committee Meeting Minutes**	
	The following minutes were submitted: a) Performance Committee – To receive the Minutes of the meeting held on 23 February 2023. b) People Committee – To receive the Minutes of the meeting held on 27 February 2023. c) Quality Governance Committee – To receive the Minutes of the meeting held on 22 March 2023. <u>Performance Committee</u> Mr Khan advised the Board that the minutes of the meeting held on 23 February 2023 are submitted today. Another meeting was held on the 25 April, but those minutes will not be approved until the July meeting. Mr Khan said the Trust is working in an incredibly challenging environment financially and the position remains challenged. The Finance Team have worked hard to get to the year-end position, and he wished this noting. Mr Khan wished to pass on his thanks to the three Operational Directors and their Teams for the work they are doing. Mr Khan said regarding patient safety the impact on our colleagues as well as the impact on HWB and sickness absences is huge. We need to be mindful of cultural issues as well. There is space for optimism with some improvements is being seen. It does remain however an incredibly difficult working environment.	

	People Committee Mr Fessal advised the Board that a meeting took place last week. There was discussion around the reduction in overtime which is the right thing to do financially but this is causing issues for people and their HWB. Quality Governance Committee Mr Fessal informed the Board that a meeting had taken place this week. Mr Fessal explained that at the previous meeting discussion took place around clinical audits. There are a number of action plans we are trying to work through. Professor Hopkins advised the Board that at the meeting on 24 May there was a great deal of work ongoing regarding the clinical audit data. There are a lot of system issues. Regarding the quality report Professor Hopkins thanked everyone who had supported the accurate reflection of the Trusts main business.	
	Resolved:	
	a) That the Minutes of the Performance Committee held on the 23 February 2023 be received. b) That the Minutes of the People Committee held on 27 February 2023 be received. c) That the Minutes of the Quality Governance Committee held on 22 March 2023 be received.	
05/23/21	**New or Increased Risks**	
	No new or increased risks were identified.	
05/23/22	**Board of Directors Schedule of Business**	
	The Schedule of Business was submitted.	
	Resolved:	
	a) That the Board Schedule of Business be received and noted.	
05/23/23	**Any Other Business**	
	23a – Step Down IPC Measures	
	The Interim Organisational Assurance & Clinical Director gave an update on the step-down level 3 letter received from NHS England. The EMB received an update yesterday on the IP&C step-down changes associated with the coronavirus pandemic, and to move the organisation to a state of business-as-usual, with the ability to adapt and flex measures accordingly to increased disease prevalence and/or outbreak control. The following step-down areas were outlined:	

1. Hub cleaning arrangements
2. Thermal Digital Cameras
3. Universal Mask Use
4. Testing Changes

1. Hub Cleaning Arrangements

Following a review of the COVID-19 mitigating IPC measures, the Trust is now in a position as part of its return to business-as-usual approach to reduce enhanced cleaning arrangements across the Trust. This instruction will see the cessation of chlorine derivative products used as standard across all touch point areas, however, will remain part of the contractual deep clean arrangements during winter months or periods of increased prevalence or outbreak control measures. There is an imminent release of NHS Cleanliness Standards for Ambulance Services, and this step-change will align the Trust with the pending guidance release, in addition to existing guidance released by the Association of Ambulance Chief Executives on behalf of the National Ambulance Service IPC Group.

The IPC Recommendation is to accept the step-down of enhanced cleaning measures and return to a business as-usual approach in line with the Churchill cleaning contract agreement, as of 1 July 2023.

2. Thermal Cameras

During the height of the pandemic, WMAS took steps to purchase thermal digital detection equipment, situated at the entrance of all Trust sites to monitor external body temperature and to offer enhanced surveillance to help detect symptoms of COVID-19. It is understood that at the time, the COVID-19 Incident Director advised the Trust to purchase the equipment under a waiver agreement, with no contract in place to support. It is to be noted that the company from which the equipment was purchased from has become less responsive to WMAS requests, with communications becoming increasingly less frequent and more difficult to achieve, although they have moved away from this type of technology and remain focused on traditional CCTV. Following the pandemic step-down guidance offered by the World Health Organisation and NHS England, and in accepting that respiratory illnesses are endemic amongst the population in the UK, there is no longer a requirement to monitor/detect body/core temperature of staff entering the workplace and is not endorsed as a mitigating control measure by IPC. Potential costs to remove:

- Estates (decorating/remedial work) - £6,900
- IT (Smithsons) - £3,600
- Total – Approx £10,500

IPC Recommendation: is for Option 4 – to follow a programme of works over five years, that will remove hardware as each site is redecorated,

lending to cost efficiencies. This option was approved by the Director of Finance.

3. Mask Use

There is no longer a mandatory requirement for frontline patient facing staff to wear face masks in all settings however, the following principles will apply:

- Universal mask wearing (FRSM or equivalent transparent mask) for all staff and patients/escorts/carers is now optional in the clinical setting (unless in high risk identified areas, or where local risk assessments deems it necessary.
- Although there is no longer a requirement for staff to wear FRSM for all cases, face masks should still be worn where it is indicated following a dynamic risk assessment i.e., infections transmitted via the droplet route e.g., respiratory viruses, TB etc, outbreak on station, or where the hierarchy of controls cannot be applied or where staff wish to do so.
- FRSMs should be worn by staff when knowingly, routinely, or primarily undertaking duties with immunocompromised or immunosuppressed patients when a risk assessment deems it necessary.
- Whilst FRSMs are no longer mandated in the non-clinical setting, staff may continue to do so. This should be based on risk assessment and local situational awareness e.g., masks in Contact/Control Centres, high sickness levels, outbreaks on station.
- All operational/clinical staff groups, or those conveying patients on behalf of the Trust i.e. voluntary/private hire drivers, must continue to wear a FRSM if conveying patients who are vulnerable i.e. immunosuppressed, immunocompromised (for example, renal or patients receiving cancer treatment).

The IPC Recommendation is – to accept the recommendation and return to a dynamic risk assessment basis to determine the level of IPC precautions needed per each case i.e. respiratory infection, vulnerable patient, or exposure to blood or body fluids.

4. Testing Changes

Changes to COVID-19 Staff Testing are complex as there appears to be contradictions within the guidance. Mr Jones said the way we deal with COVID-19 infections in WMAS has been based on information from UKHSA, NHS Employers and AACE. The changes, when applied mean the following changes for the organisation:

Healthcare staff who have symptoms of a respiratory infection are no longer asked to test for COVID-19 The guidance gives clear advice for

	staff who have respiratory symptoms; and it should be noted that symptoms of respiratory infections now include: • continuous cough • high temperature, fever, or chills • loss of, or change in, your normal sense of taste or smell. • shortness of breath • unexplained tiredness, lack of energy • muscle aches or pains that are not due to exercise. • not wanting to eat or not feeling hungry. • headache that is unusual or longer lasting than usual • sore throat, stuffy or runny nose • diarrhoea, feeling sick or being sick. It was noted that staff will want to do a LFT so if they do test positive, they will not have to go under a sickness abstraction. Mr Jones said that the benefits are for staff who do test positive the is no requirement for two negative LFTs to return to work. Jeremy Brown said this is more confusing than it was before. Mr Jones pointed out that non-clinical staff could return to work on day 6. Ms Beechey informed the EMB that they are pushing nationally for the NHS Employers guidance to be reviewed as it is very contradictory. The EMB approved the four recommendations.	
	Resolved:	
	a) That the contents of the update be received and noted. b) That the Ops Notice once issued would be circulated to Board Members.	**DJS/ PH**
05/23/24	**The Date of the next meeting**	
	Wednesday 26 July 2023 at 10:00 hours	
	There being no other business for this meeting the Chairman brought proceedings to a close and thanked members for their attendance.	

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Paper 03

Public Board Action Log

Minute Reference	Notes and Any Actions Required	Action by	Timescale	Progress/Evidence
10/22/15	**Financial Strategy** That comments on the draft financial strategy as submitted be sent to the Interim Director of Finance and the updated strategy submitted back to a meeting of the Board.	**KR**	**July 2023**	Director of Finance to update the Board at the meeting
03/23/21	**Review of 25 Graded Risks to Consider Reducing the Risk Score** The Strategy & Engagement Director referred to the copy of the Lightfoot Review undertaken was 14 years ago and whether as part of the financial planning that the Trust seek to do another review with Commissioners. The Interim Director of Finance said it is not unreasonable to request such a review again so that we can establish what the requirements are to deliver the performance criteria set out by NHS England. The issue underpinning this was whether we have the funding to be able to get to the patient quickly and provide them with the right level of service. The Chairman indicated this was an excellent idea and asked the Interim Director of Finance to follow up on another review, and report to a future meeting of the Board.	**KR**	**July 2023**	discussions are ongoing with the ICB and the Board will be kept up to date
05/23/10	**Combined Clinical Directors Quality Report – May 2023** Longest waiting times - the Paramedic Practice & Patient Safety Director would check on the reference to a long wait of 3 hours 11 minutes for Cat 1 and report back to the Board.	**NHen**	**July 2023**	The Paramedic Practice and Patient Safety Director will update the Board at the meeting.

Minute Reference	Notes and Any Actions Required	Action by	Timescale	Progress/Evidence
05/23/15	**Freedom To Speak Up Strategy** The Board of Directors approved the proposed additions to the Strategy based on the NHSE comments but asked that the Strategy be brought back to the Board for final sign off.	**PW**	**July 2023**	Included in the Papers for todays meeting and the Board are requested to discharge this outstanding action.
05/23/23a	**Step Down IPC Measures** The Ops Notice once issued would be circulated to Board Members.	**DJS/PH**		Completed and the Board are requested to discharge this outstanding Action.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06a MONTH: July 2023 PAPER NUMBER: 04a

Chief Executive Officer's (CEO) 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. Business Continuity Policy 2. CEO Meetings – 22 May to 14 July 2023	
Related Trust Objectives/ National Standards	**Current Strategic Objectives:** • SO1 – Safety Quality and Excellence (our commitment to provide the best care for patients) • SO2 – A great place to work for all (Creating the best environment for all staff to flourish) • SO3 - Effective Planning and Use of Resources (continued efficiency of operational and financial control) • SO4 - Innovation and Transformation (Developing the best technology and services to support patient care) • SO 5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care) **National Standards** • 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.

1. Business Continuity Policy

West Midlands Ambulance Service University NHS Foundation Trust (WMAS) is committed to having in place a Business Continuity Policy as required under the Civil Contingencies Act (2004) and the NHS Commissioning Board Business Continuity Management Framework (service resilience) (2013) and the National Ambulance Resilience Unit (NARU) EPRR Service Specification (2012). This Business Continuity Policy provides the framework within which WMAS can comply with the Business Continuity requirements of our patients and stakeholders by aligning the Business Continuity Management Programme with ISO22301:2019. The Business Continuity Policy ensures WMAS can continue to deliver a minimum level of service to our patients and stakeholders in the event of any disruption. WMAS is committed to meeting legal and regulatory requirements and continual improvements of the Business Continuity Policy. It is the intention of the WMAS to fully align to all requirements as stated in ISO22301:2019 to deliver an effective Business Continuity Management System. The Business Continuity Policy has been updated following updates to the NHSE EPRR Core Standards and is available upon request.

2. Chief Executive Officer Meetings – 22 May to 14 July 2023

Staff

- All Staff Briefing
- Chaplains Meeting
- Audit Committee Meeting
- Andy Watson's Funeral
- Network Chairs Meeting
- Staff Long Service Award Ceremony
- Excellence in the Community Award Ceremony
- Director of Performance & Improvement Shortlisting
- Community response Managers Meeting
- Efficiency & Transformation Group
- All Staff Briefing
- Director of Performance & Improvement Interviews

National Meetings

- NHS England - UEC Check In
- NHS England – Senior Leadership Team Development Day
- Marc Thomas, NHS England
- NHS England – UEUC Away Day Working Group
- Sarah-Jane Marsh – NHS England

- NHS England – UEC Recovery Programme Board – National Delivery Advisors Meeting
- NHS England & Ambulances – Covid Inquiry Meeting
- Andy Ford, CQC
- Minister Quince & Minister Philip
- NHS England IEUC Away Day
- Association of Ambulance Chiefs Executives Strategy Meeting

Regional Meetings

- Patrick Vernon & Karen Grinsell, Birmingham & Solihull ICB
- Staffordshire MPs
- David Loughton, Royal Wolverhampton Hospital
- Mark Axcell, Black Country ICB
- Andy Street, Mayor of the West Midlands
- Danielle Oum & Phil Johns, C&W ICB
- Harriet Baldwin MP
- Peter Axon & David Pearson, Staffs & Stoke ICB

Professor Anthony C. Marsh
Chief Executive Officer
July 2023

NHS
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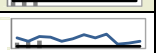
University NHS Foundation Trust

Executive Performance Dashboard
June 2023

Activity and Performance

Measure	Month	YTD	Monthly Trend
Category 1 - Mean Target 7 mins	08:18	08:12	
Category 1 - 90th Target 15 mins	14:34	14:29	
Category 1 T - Mean Target 19 mins	09:34	09:27	
Category 1 T - 90th Target 30 mins	17:00	16:57	
Category 2 - Mean Target 18 mins	36:48	32:18	
Category 2 - 30 mins Target 30 mins	36:48	32:18	
Category 2 - 90th Target 40 mins	82:44	71:16	
Category 3 - Mean Target 60 mins	167:54	151:41	
Category 3 - 90th Target 120 mins	442:59	386:03	

Measure	Month	YTD	Monthly Trend
Category 4 - Mean Target 180 mins	210:57	177:08	
Category 4 - 90th	585:39	454:29	
HCP 2hr - 90th	737:40	663:10	
HCP 4hr - 90th	993:59	908:41	
Call Answer (999 only) 95th	00:00	00:02	
Number of 2 min call delays	4	12	
Number of Handovers >60 minutes (ED only, including cohorts)	4033	11093	
% of Handovers < 30 mins (ED only, including cohorts) Target 95%	74.8%	76.7%	
% of Handovers < 15 mins (ED only, including cohorts) Target 65%	33.7%	34.9%	

Workforce

Measure	Month	YTD	Monthly Trend
Sickness (Target - top quartile of all Amb Services)	4.4%	4.4%	
Appraisals (YTD)	62.6%	62.6%	
Mandatory Training E&U (YTD)	24.4%	24.4%	

Measure	Month	YTD	Monthly Trend
Mandatory Training PTS (YTD)	35.4%	35.4%	
Number of Freedom to Speak up Enquiries	5	13	

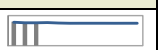
Clinical Quality & Safety

Measure	Month	YTD	Monthly Trend
Total Incident Forms	816	2518	
No. of RIDDORS	9	24	
No. of Verbal Assaults	128	410	
No. of Physical Assaults	44	178	
Complaints	43	109	
PALS	199	483	
Compliments	177	566	

Measure	Month	YTD	Monthly Trend
Patient Safety (Total)	418	1214	
Patient Safety Harm	63	183	
Being Open (low harm only)	27	97	
Duty of Candour (moderate harm and above)	12	39	
Serious Incidents	18	59	
Claims	2	11	

Financial

Measure	Month	YTD	Monthly Trend
EBITDA £million (Plan £27.60m)	1.59	6.15	
Delivery of CIP Programme £million (Target £12.7M)	1.64	3.72	
Capital Expenditure £million (2023/24 £14.6m)	0.95	0.95	

Measure	Month	YTD	Monthly Trend
Better Payment Practice Code	94.1%	94.1%	
Agency Spend	0	0	

Clinical Quality & Safety

Measure	Month	YTD	Monthly Trend
Return of Spontaneous Circulation At Hospital (Comp)	Not required in month	46.46%	
Cardiac Arrest Survival to discharge (Comp)	Not required in month	18.48%	
Post ROSC Care Bundle	Not required in month	68.25%	

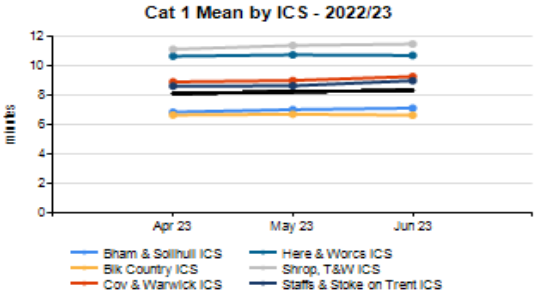
Measure	Month	YTD	Monthly Trend
STEMI Care Bundle	98.09%	96.85%	
Stroke Diagnostic Bundle	99.55%	99.34%	

PTS

Measure	May-23	YTD	Monthly Trend
Achieved KPIs	0	57	

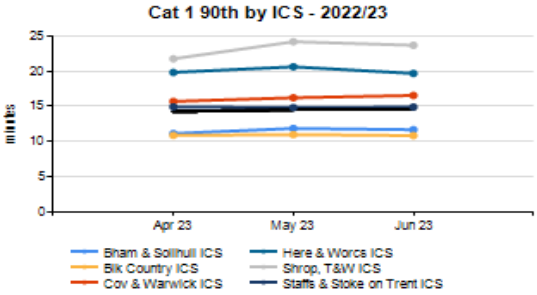
Measure	May-23	YTD	Monthly Trend
Failed KPIs	0	12	

Executive ICS Scorecard
June 2023



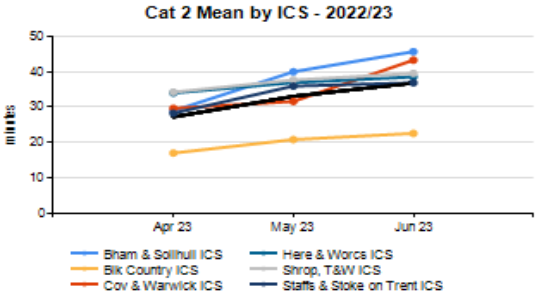
Priority	ICS	MTD	QTD	YTD
Cat 1 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	7:06	6:59	6:59
	NHS BLACK COUNTRY ICS	6:37	6:39	6:39
	NHS COVENTRY AND WARWICKSHIRE ICS	9:15	9:02	9:02
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	10:40	10:40	10:40
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	11:27	11:18	11:18
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	8:58	8:44	8:44
	WMAS	8:18	8:12	8:12

-------- WMAS



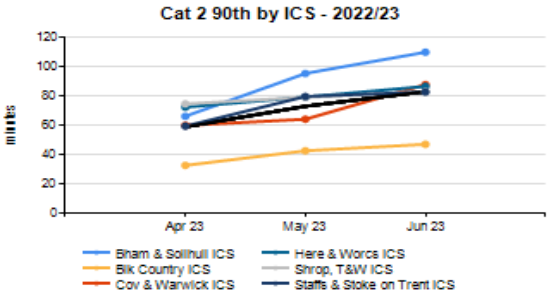
Priority	ICS	MTD	QTD	YTD
Cat 1 90th	NHS BIRMINGHAM AND SOLIHULL ICS	11:41	11:36	11:36
	NHS BLACK COUNTRY ICS	10:51	10:56	10:56
	NHS COVENTRY AND WARWICKSHIRE ICS	16:32	16:05	16:05
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	19:39	19:57	19:57
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	23:39	23:15	23:15
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	14:54	14:54	14:54
	WMAS	14:34	14:29	14:29

-------- WMAS



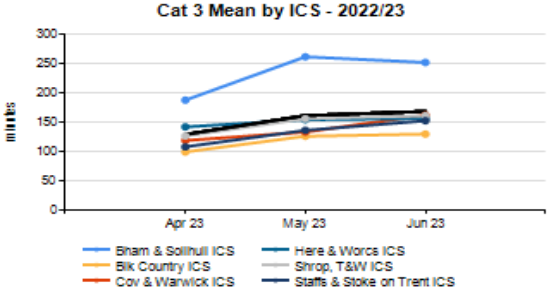
Priority	ICS	MTD	QTD	YTD
Cat 2 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	45:36	38:01	38:01
	NHS BLACK COUNTRY ICS	22:33	20:08	20:08
	NHS COVENTRY AND WARWICKSHIRE ICS	43:13	34:38	34:38
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	38:29	36:24	36:24
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	39:28	37:03	37:03
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	36:49	33:38	33:38
	WMAS	36:48	32:18	32:18

-------- WMAS



Priority	ICS	MTD	QTD	YTD
Cat 2 90th	NHS BIRMINGHAM AND SOLIHULL ICS	109:29	89:08	89:08
	NHS BLACK COUNTRY ICS	46:47	40:11	40:11
	NHS COVENTRY AND WARWICKSHIRE ICS	87:25	70:07	70:07
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	86:11	78:41	78:41
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	82:44	78:40	78:40
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	82:23	73:23	73:23
	WMAS	82:44	71:16	71:16

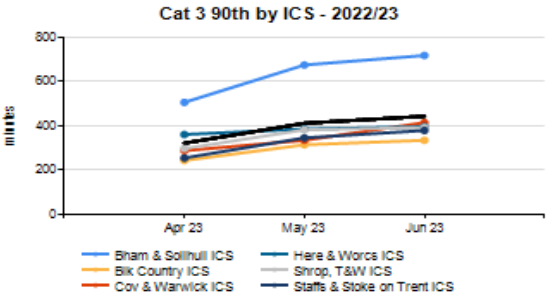
-------- WMAS



Priority	ICS	MTD	QTD	YTD
Cat 3 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	251:04	231:10	231:10
	NHS BLACK COUNTRY ICS	129:18	117:14	117:14
	NHS COVENTRY AND WARWICKSHIRE ICS	161:31	136:37	136:37
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	155:43	150:12	150:12
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	160:36	147:27	147:27
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	151:58	130:53	130:53
	WMAS	167:54	151:41	151:41

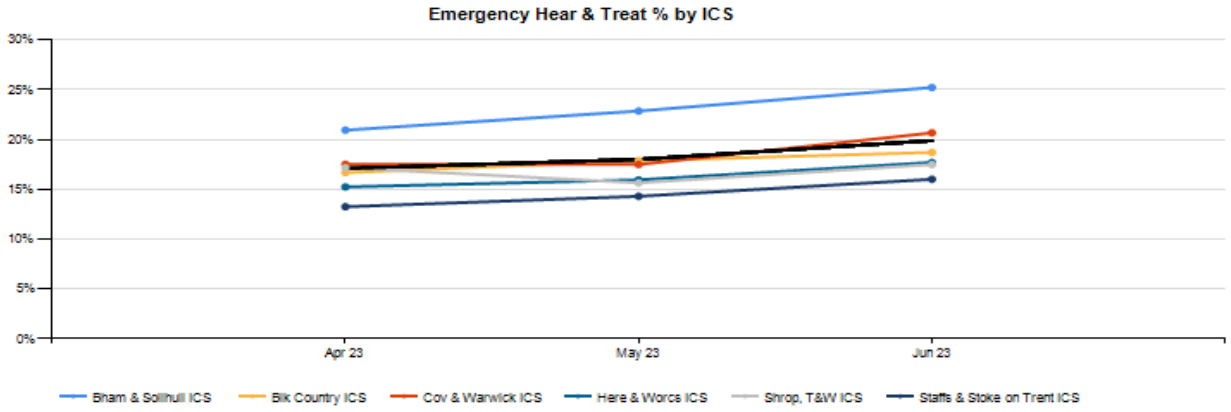
-------- WMAS

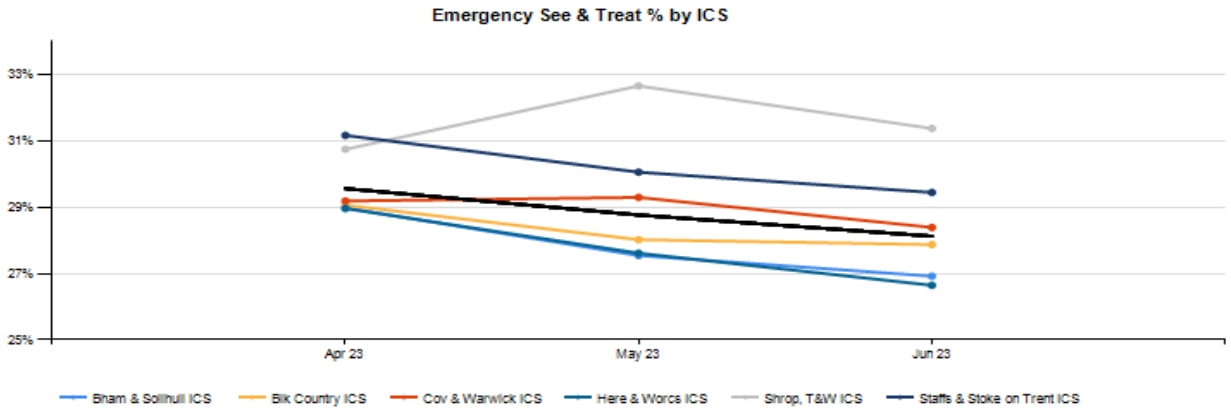
Executive ICS Scorecard
June 2023

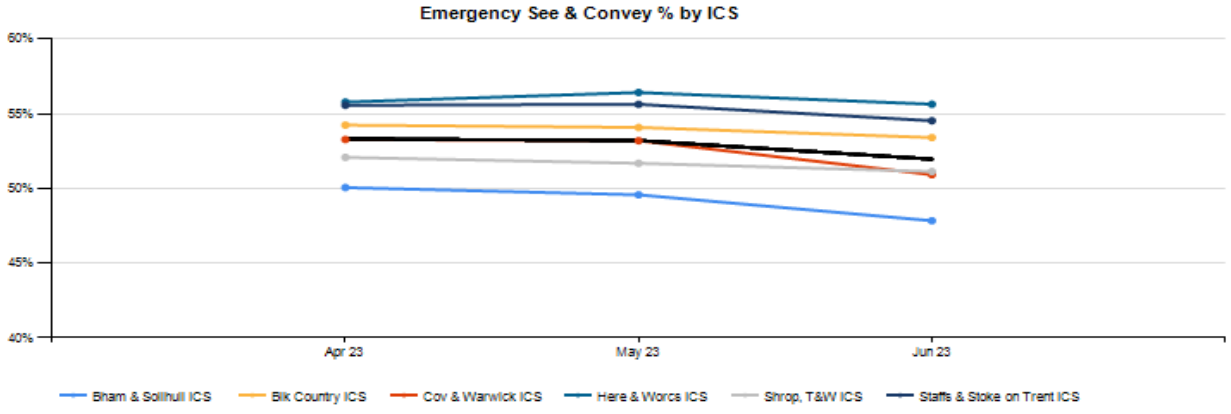


Priority	ICS	MTD	QTD	YTD
Cat 3 90th	NHS BIRMINGHAM AND SOLIHULL ICS	716:51	629:48	629:48
	NHS BLACK COUNTRY ICS	334:27	292:07	292:07
	NHS COVENTRY AND WARWICKSHIRE ICS	414:01	336:29	336:29
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	396:00	381:46	381:46
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	392:18	368:18	368:18
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	378:37	321:55	321:55
	WMAS	442:59	386:03	386:03

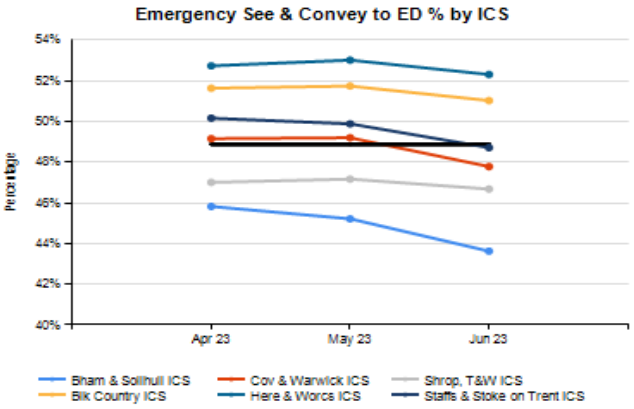
-------- WMAS

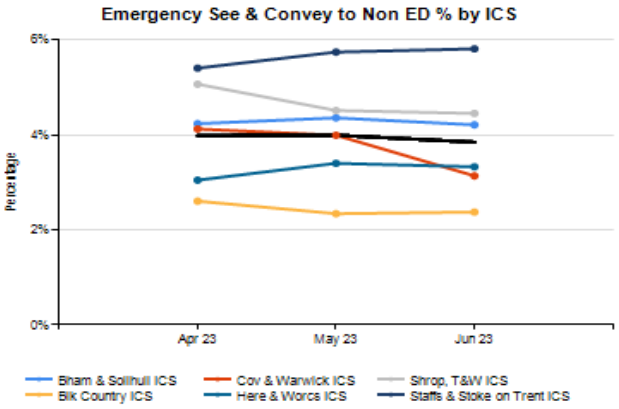


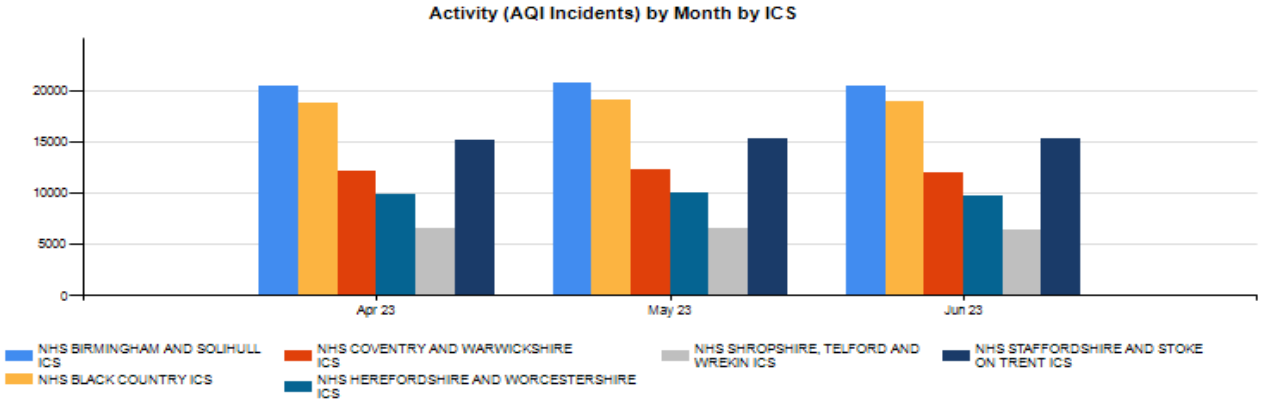


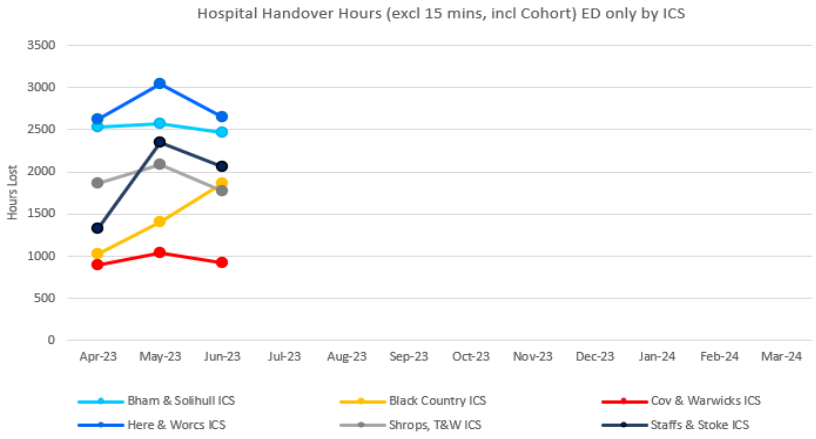


Executive ICS Scorecard
June 2023









Birmingham and Solihull ICS - New Queen Elizabeth Hosp, Good Hope, City (Birmingham), Heartlands, Birmingham Childrens, Solihull
Black Country and West Birmingham ICS - Russells Hall, New Cross, Walsall Manor, Sandwell
Coventry and Warwickshire ICS - Uni Hospital Cov & War, George Elliot, Warwick
Herefordshire and Worcestershire ICS - Hereford County, Worcestershire Royal, Alexandra
Shropshire, Telford and Wrekin ICS - Princess Royal, Royal Shrewsbury
Staffordshire ICS - Royal Stoke Univ Hosp, County Hospital (Stafford), Burton

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06C MONTH: JULY 2023 PAPER NUMBER: 04C

Update on Emergency Preparedness, Resilience and Response (EPRR)	
Sponsoring Director	Chief Executive Officer
Author(s)/Presenter	James Williams – Head of Emergency Planning
Purpose	Reports attached provide an update to the Board on EPRR matters.
Previously Considered by	Executive Management Board – EMB
Report Approved By	Chief Executive officer

Executive Summary

The Executive Management Board has received quarterly update papers on EPRR matters including workforce, activity, responses, resilience, work plans and forward look. The paper is attached to inform the Board of the key EPRR matters.

Related Trust Objectives/ National Standards	Maintain compliancy to: • NHSE EPRR framework • Civil Contingencies Act 2004 • National Ambulance Resilience Unit (NARU) Key Lines of Enquiry (KLoE)
Risk and Assurance	Maintain compliancy to: • NHSE EPRR framework • Civil Contingencies Act 2004 • National Ambulance Resilience Unit (NARU) Key Lines of Enquiry (KLoE)
Legal implications/ regulatory requirements	Maintain compliancy to: • NHSE EPRR framework • Civil Contingencies Act 2004 • National Ambulance Resilience Unit (NARU) Key Lines of Enquiry (KLoE)
Financial Implications	There are no financial implications affecting any of the reports.
Workforce & Training Implications	None
Communications Issues	None identified, all plans, updates, reviews are communicated across the organisation ensuring commanders and staff are situationally aware.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06C MONTH: JULY 2023 PAPER NUMBER: 04C

Diversity & Inclusivity Implications	None
Quality Impact Assessment	Undertaken as part of the feedback and review of scoring received.
Data Quality	James Williams – stored centrally (Teams 365)
Action required The Board are asked to note the detail in papers provided, which provide assurance to the Board regarding EPRR activity.	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06D **MONTH: JULY 2023** **PAPER NUMBER: 04D**

TITLE OF REPORT: Category 2 submission	
Sponsoring Director	IEUC & Performance Director
Author(s)/Presenter	Jeremy Brown
Purpose	To inform the Board of the latest version of the Category 2 improvement submission.
Previously Considered by	Executive Management Board
Report Approved By	The Chief Executive

Executive Summary

The report below details the Trusts predicted Category 2 performance based upon a number of factors that will influence this forecast, namely:

- Reduced hospital handover delays which have been forecast by the ICB's themselves that need to be sustained throughout the year.
- Operational output that meets the incoming 999 emergency demand.
- A clinical validation team that reduces the overall response demand sufficiently to enable improved ambulance availability to respond to category 2 patients quickly and without delay.
- Sufficient call handling numbers in place to answer 999 calls without delay in order to triage effectively with the information provide to accurately categorise the call.

The report is submitted to the ICB on a monthly basis with the previous months' prediction updated with actual details.

Related Trust Objectives/ National Standards	Category 2 performance forms part of the National standards and the Trusts own strategic objectives.

Related Trust Objectives To meeting which of the Trust's objectives does the proposal contribute:	Please tick relevant objective
SO1 – Safety Quality and Excellence (our commitment to provide the best care for patients)	**X**
SO2 – A great place to work for all (Creating the best environment for all staff to flourish)	
SO3 - Effective Planning and Use of Resources (continued efficiency of operational and financial control)	**X**
SO4 - Innovation and Transformation (Developing the best technology and services to support patient care)	**X**
SO 5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care)	**X**

Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☒	Inclusivity	☒

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: **MONTH:** **PAPER NUMBER:**

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	Accountability ☐
Risk and Assurance	There are associated risks with failed performance that could affect patient safety, organisational reputation and the failure to achieve Category 2 performance could effect the national trajectories also. The monthly submissions will continue to be visible to EMB members where performance in general is reported. In addition, there is a more in-depth discussion around performance undertaken through the performance committee.
Legal implications/ regulatory requirements	Legal advice has not been sought when preparing and submitting the data. The information request has come directly from NHS England via the ICB.
Financial Implications	Additional money the sum of £24.6 million pounds has been provided from NHSE to support the improvement in Category 2 performance. This is part of a larger funding stream nationally that has been proportionately shared across the England ambulance trusts.
Workforce & Training Implications	NHSE are monitoring closely the Trusts operational output with scrutiny of our workforce recruitment likely should the operational output decrease.
Communications Issues	Not directly applicable.
Diversity & Inclusivity Implications	No direct implications at this stage.
Quality Impact Assessment	Covered as part of the overall Trust strategy.
Data Quality	Back ground papers can be supplied if required. Supporting information is available through the Trust information pacl which has been collated by the business intelligent unit and other trust data systems. Information is also available through the national ambulance performance data.
Action required To note the content of the submission.	

Ambulance Trust Planning Return: *Additional Information*

Input Instructions	Please complete all sections below following the guidance set out in the 'Completion Key'. Please ensure the data is completed in line with the definitions detailed in the 'Instructions & Definitions' tab.
Ambulance Service:	WMAS

Completion Key	
= to complete with forecast for 2022/23	= to complete with forecast for 2023/24

DCA & RRV Fleet	2023/24	Change	% Change	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Indicative DCA Deliveries	85	-85	-100.0%												
Indicative RRV Deliveries		0	No Change												

Note: Please ensure the number of DCA's & RRV's are projected based on those approved by the Ambulance Trust board and order placed.

Activity & Performance	2022/23	2023/24	Change	% Change	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
All Incidents (AQI A7)	1,009,433	1,039,716	30,283	3.0%	81,098	87,336	84,217	89,416	83,177	83,177	86,296	87,336	92,535	93,574	84,217	87,336
Incidents with Face-to-Face Response (AQI A56)	848,650	874,110	25,460	3.0%	68,181	73,425	70,803	75,173	69,929	69,929	72,551	73,425	77,796	78,670	70,803	73,425
C2 Mean (Format = hh:mm:ss)	00:48:56	00:27:32	- 00:21:24		00:27:12	00:33:00	00:37:10	00:25:00	00:25:00	00:24:00	00:29:00	00:29:00	00:28:00	00:24:00	00:25:00	00:24:00
Total Time Lost to Handover Delays (over 15m) (Seconds)	943,596,000	652,719,600	-290,876,400	-30.8%	34,372,800	40,510,800	39,146,400	56,178,000	54,918,000	54,817,200	63,864,000	62,496,000	72,547,200	59,414,400	58,114,800	56,340,000
Average Handover Time (Format = hh:mm:ss)	0:43:36	0:36:49	- 00:06:47		0:28:01	0:30:59	0:30:33	0:37:00	0:38:13	0:38:10	0:41:16	0:40:20	0:42:57	0:37:15	0:39:21	0:37:38
Calls Answered (AQI A1)	1,252,858	1,290,444	37,586	3.0%	117,038	126,449	130,658	110,978	103,235	103,235	107,107	108,397	114,849	116,140	104,526	108,397
Call Answer Mean	7	5	-2		2	2	0	5	5	5	5	5	5	5	5	5

Ambulance Trust Planning Return: *Input*

Input Instructions	Please complete all sections below following the guidance set out in the 'Completion Key'. Please ensure the data is completed in line with the definitions detailed in the 'Instructions & Definitions' tab.
Ambulance Service:	WMAS

Income (£m)	2022/23	2023/24	% Change
Baseline	398	334	-16%
Indicative National Allocation (not to be treated as final)		24.6	

Completion Key	
	= to complete with forecast for Q4 2022/23
	= to complete with actuals for 2022/23
	= to complete with forecast for 2023/24
	= to leave blank
	= NHSE prepopulated, see definitions tab

Capacity		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Baseline	Call handlers FTE (inc OT, bank etc)	303	301	301	301	301	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300
	Clinicians in EOC FTE (inc OT, bank etc)	150	150	150	150	150	150	150	150	150	150	150	150	110	110	110	110	110	110	110	110	110	110	110	110
	Total DCA resource hours	204,769	213,732	204,636	209,251	211,324	198,750	200,167	201,812	206,941	204,604	182,865	207,785	*189,475*	*166,869*	*169,356*	*192,008*	*194,653*	*193,154*	*192,584*	*196,251*	*213,122*	*207,661*	207,335	206,439
	Total RRV resource hours	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Additional capacity utilising indicative national funding	Call handlers FTE (inc OT, bank etc)													155	150	145	140	135	130	130	130	130	130	130	130
	Clinicians in EOC FTE (inc OT, bank etc)													46	46	46	46	46	46	46	46	46	46	46	46
	Total DCA resource hours													16,790	16,790	16,790	16,790	16,790	16,790	16,790	16,790	16,790	16,790	16,790	16,790
	Total RRV resource hours													-	-	-	-	-	-	-	-	-	-	-	-
Total	**Call handlers FTE**	**303**	**301**	**301**	**301**	**301**	**300**	**300**	**300**	**300**	**300**	**300**	**300**	**455**	**450**	**445**	**440**	**435**	**430**	**430**	**430**	**430**	**430**	**430**	**430**
	Clinicians in EOC FTE	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**156**	**156**	**156**	**156**	**156**	**156**	**156**	**156**	**156**	**156**	**156**	**156**
	Total DCA resource hours	**204,769**	**213,732**	**204,636**	**209,251**	**211,324**	**198,750**	**200,167**	**201,812**	**206,941**	**204,604**	**182,865**	**207,785**	**206,265**	**183,659**	**186,146**	**208,798**	**211,443**	**209,944**	**209,374**	**213,041**	**229,912**	**224,451**	**224,125**	**223,229**
	Total RRV resource hours	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06E MONTH: JULY 2023 PAPER NUMBER: 04E

Title	**E&U Recruitment 2023 / 2024**
Sponsoring Director	Carla Beechey, People Director
Author(s)/Presenter	Carla Beechey, People Director Anthony Marsh, Chief Executive Officer
Purpose	This paper provides the Trust Board an overview of the current E&U workforce projection and proposed recruitment requirements for 2023 / 2024
Previously Considered by	Executive Management Board - 27th June 2023
Report Approved By	Carla Beechey, People Director Anthony Marsh, Chief Executive Officer

Executive Summary:

The E&U workforce plan for 23/24 was developed based on the clinical staff deployment requirements to meet operational demand. This took into account the E&U establishment at the beginning of the year, less abstractions and forecast attrition. The abstractions considered include training, annual leave, sickness absence and hospital handover delays all at current averaged rates.

The Trust board approved in January 2023 421 Student Paramedics and 130 Graduate Paramedics would be put into the recruitment plan for 23/24.

Following this decision, the Trust board agreed to submit a balanced budget plan to the Black Country ICS, this obviously impacted the revenue available to spend on staffing. The ICS also instructed a cap spend for 23/24 based on the outturn pay bill for 22/23.

A subsequent decision was therefore made to cease all overtime and freeze all recruitment apart from the Graduate Paramedic recruitment.

Finance, HR and operations have been meeting regularly to monitor and review the financial position and revise the budgeted establishment figure for 23/24 and associated workforce plan.

In month 3, E&U reported a year to date £1.8m underspend on pay. This underspend is on top of the year-to-date CIP target (which has been delivered in full) and is underspent against the cap which was transacted at the start of the year to ensure the starting 23/24 budget was no more than 22/23 financial outturn position.

All other things being equal, if the current contracted staff numbers were to remain the same throughout the financial year, the Division would continue to deliver the same surplus position (and CIP) but in order to do this, action would need to be taken now regarding future student and graduate recruitment to offset the current and expected rates of attrition.

Whilst this is positive from a financial perspective, operationally we would continue to lose core operational hours through the lack of recruitment, the ability to meet the cat 2 performance standards of 30 min for 2023/24 would be hindered, and patient safety through winter and quarter 4 would continue to be significant.

Although activity is down from the previous year, without recruiting to the student paramedic programme, the WTE year end position will strategically place the Trust in a negative workforce number at the start of 24/25, compared to the start of 23/24 by circa 160 staff, only relying on Graduate Paramedic recruitment.

Equally, whilst the E&U position is positive year to date it should be noted that at present this considerable underspend is being used to support the wider trust position with certain Divisions (namely Commercial) and the trust income position (primarily due to no income being received against the handover funding) showing a negative variance to plan which overall are resulting in the trust only just delivering a small surplus above plan.

Table 1

FULL DIVISION

	M3 - YTD position		
	Budget	**Actual**	**Variance**
Operational	**45,794,068**	**42,968,601**	**2,825,466**
Non operational	2,257,848	3,492,040	- 1,234,192
Resilience	2,477,954	2,272,079	205,875
Shows & events	46,690	69,384	- 22,694
	50,576,559	**48,802,104**	**1,774,455**

Table 2

FRONTLINE OPERATIONAL ONLY

	M3 - YTD position		
	Budget	**Actual**	**Variance**
Operational	45,794,068	42,968,601	2,825,466
E&U CIP target YTD at month 3	- 1,386,002	-	- 1,386,002
	44,408,066	**42,968,601**	**1,439,464**
Average actual WTE	**3,517**		

We would finish a year end position at 3,366 if we were to just continue with graduate recruitment (140) only. This would leave the Trust 163 less staff than the start position in April 2023.

The following table demonstrates the impact on staffing levels if we were to commence Student Paramedic recruitment (180) from August 2023, bi monthly intakes of circa 45 students until March 2024, and Graduate Recruitment (140) finishing with a year end position of 3546.

Grad and SP from August		Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Employed at start of month	FTE	3,522	3,529	3,506	3,494	3,466	3,480	3,472	3,516	3,518	3,532	3,532	3,546
Starters (+)	FTE	25	1	0.9	0	42	20	72	30	42	30	42 (shadow course)	30
Leavers (-)	FTE	-13	-18	-14.86	-27	-27	-27	-27	-27	-27	-27	-27	-27
Transfers out	FTE	-6	-6	1	-9	-9	-9	-9	-9	-9	-9	-9	-9
Transfers in	FTE	2	0	0	8	8	8	8	8	8	8	8	8
Net increase / (decrease)	FTE	7	-23	-13	-28	+14	+8	+44	+2	+14	+2	+14	+2
Employed at end of month	FTE	**3,529**	**3,506**	**3,494**	**3,466**	**3,480**	**3,472**	**3,516**	**3,518**	**3,532**	**3,532**	**3,546**	**3,548**

Without the CIP the budgeted establishment is 3,623 for year end, however with the CIP its 3,546 which would include both Graduate and SP recruitment from August 2023.

We continue to have the option of utilising E&U front line overtime to increase resourcing levels, however only doing this would still leave us in a reduced WTE at the end of the year, therefore reducing substantive employees resourcing availability and also the number of people available to carry out such overtime in addition for increased flexibility in resource profiling.

As per normal arrangements, attrition levels will continue to be monitored throughout the year and any variation reflected in the cohort intake numbers of students in the latter part of the year.

EMB on 27th June 2023 considered the content of this report and approved the revised E&U recruitment plan for 2023 / 2024 as follows:

- Graduate Recruitment (140)
- Student Paramedic Recruitment (180)

The recruitment team will work to recruitment as many Graduate Paramedics as possible offsetting any under achievement of Student Paramedic recruitment and keeping within the WTE 3546 at year end.

Related Trust Objectives/ National Standards	Safety, Quality and Excellence (1) A great place to work for us all (2) Effective Planning and use of resources (3)
Risk and Assurance	The report provides assurance and the actions taken to mitigate any risk identified. Risks to delivery are as follows: • Reduction in the number of applications received and the quality of candidates • New starters not having their C1 driving licence upon commencement of employment and / or in time for their emergency blue light driving course.

	• Withdrawals in candidates due to failing OH pre employment clearances or DBS checks. • Significant variation in forecast attrition. • Significant variation in forecasted demand / activity / abstractions.
Legal implications / regulatory requirements	All actions are compliant with the Equality Act 2010 and Employment Law.
Financial Planning	All actions contained within this report have been considered and are in line with the financial plan for 2023/2024. Funding for education and training is secured via various streams, Health Education England, Apprenticeship Levy Income and staff contributions.
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] and Finance System.

Action required by the Board:

Members are requested to consider the content of this report and ratify the revised E&U recruitment plan for 2023 / 2024 as follows:

- Graduate Recruitment (140)
- Student Paramedic Recruitment (180)

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 07 MONTH: JULY 2023 PAPER NUMBER: 05

Finance Update 2023-24	
Sponsoring Director	Director of Finance
Author(s)/Presenter	Karen Rutter – Director of Finance
Purpose	To update the Board on 23-24 progress to date
Previously Considered by	n/a – this paper is for update purposes only
Report Approved By	Karen Rutter – Director of Finance

Executive Summary

2022-23 Financial Statements
The audited statements were presented to and approved at Audit Committee on 6th June with the External Audit opinion. The statements are required to be laid before Parliament and this was confirmed, by the DHSC Parliamentary Affairs Team, to have taken place on 3rd July.

2023-24 Month 03 (June 2023)
Results for the first quarter of this financial year show that the Trust is delivering to plan although there are a number of risks which need to be recognised.
The Trust's information is included in the Black Country ICB reporting to NHS England.

Key points to note are:

- Reported surplus £134k – this is against a planned surplus of £41k
- This position assumes that the level of income represented in the plan will be fully agreed. Contract discussions are ongoing with ICBs with a focus on Black Country and Birmingham & Solihull with regard to their Patient Transport Services.
- The reported spend is below plan due to the current recruitment and overtime restrictions in place
- Capital spend is below plan at month 03 although the majority of the procurement for fleet items is underway. It is expected that the capital allocation will be fully utilised.
- The Trust is delivering the FIP/CIP due to efficiencies and improvements identified alongside the overtime and recruitment restrictions in place
- E&U planned operational overtime increased during the last week of June although strict criteria has been applied. These costs have been reflected in the month 3 position but are minimal. Continuation of the overtime and associated cost will be monitored.

- The underlying income position continues to be in deficit due to funding pressures requests to ICBs which have not yet been agreed. Contract discussions are continuing with all systems. However, under recovery against income plans is being fully mitigated by tight control of expenditure, notably overtime reductions and the vacancy levels due to the current recruitment restrictions.
- The cash position is satisfactory but below plan due to the debtors balance being higher than usual. Work has been undertaken to recover the older debts, including some large invoices outstanding from ICBs.

Please note that the Month 03 finance detailed information is included in the Trust Information Pack

NHSE scrutiny

There are a number of reviews taking place across 8 ICBs, one of which is Black Country.

The Trust is currently working with the ICB and a recovery partner who are conducting a balance sheet review with records assessed for the previous 5 years to 2022-23.

The review is of all organisations in the BC system and the aim is to:

- identify inconsistent accounting treatments and reporting approach,
- establish a structured and consistent approach going forward to facilitate better collaborative system working,
- identify potential opportunities to deliver non-recurrent financial flexibilities in 23-24 and/or the future.

Any outcomes will be reported to future Board meetings.

Related Trust Objectives/ National Standards	Provision of relevant and timely information to the provided assurance of the financial control and governance of the Trust highlighting any key risks.
Risk and Assurance	Risk that the Trust fails to operate adequately and effectively if the Board are not updated with relevant information. Specific risks to the delivery of breakeven include: • Securing robust contracts and income from ICBs • Inflationary elements to supplier contracts • Ensuring the delivery of the full CIP programme
Legal implications/ regulatory requirements	Robust financial records and processes are required to be in place to ensure that the Trust is operating within the required financial framework to meet audit standards.
Financial Implications	Failure to deliver to plan agreed with and reported to NHSE would result in the Trust failing in it's statutory duties.

Workforce & Training Implications	None to date
Communications Issues	None
Diversity & Inclusivity Implications	Not directly applicable within the context of the report.
Quality Impact Assessment	None
Data Quality	All data held in Trust systems

Action required

To note the update contained in this paper.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08A MONTH: July 2023 PAPER NUMBER: 06A

Interim Executive Medical Director Paramedic Practice and Patient Safety Director Interim Executive Director of Nursing Quality Report	
Sponsoring Director	Paramedic Practice and Patient Safety Director
Author(s)/Presenter	Dr Richard Steyn Interim Executive Medical Director. Nick Henry, Paramedic Practice and Patient Safety Director. Mark Docherty, Interim Executive Director of Nursing
Purpose	The report is presented to the Board as a joint report by the WMAS Clinical Directors to give the Board assurance on the clinical quality agenda. It is an integrated report that has been developed to provide a single reporting mechanism to the Board on all clinical quality issues.
Previously Considered by	Trust Board as monthly report
Report Approved By	Paramedic Practice and Patient Safety Director

Executive Summary

This 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 report highlights specific areas that the Board need to be sighted on:

- Patient handover delays have improved, but hours lost to operational activity continue to result in patient harm and the impact of these delays resulting in long patient waiting times also causes harm, including death.
- As a result of long delays, the number of serious incidents involving serious harm or death remains significant, and the risk rating therefore remains at a 25.
- Trends and themes for serious incidents also include management of calls and inappropriate discharge on scene.

Related Trust Objectives Supports the monitoring against our strategic objective to achieve:	Please tick relevant objective

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08A MONTH: July 2023 PAPER NUMBER: 06A

SO1 – Safety Quality and Excellence (our commitment to provide the best care for patients)	X
SO2 – A great place to work for all (Creating the best environment for all staff to flourish)	X
SO3 - Effective Planning and Use of Resources (continued efficiency of operational and financial control)	X
SO4 - Innovation and Transformation (Developing the best technology and services to support patient care)	
SO5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care)	X

Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☒	Inclusivity	☒
	Accountability	☒		
Risk and Assurance	The report is presented as a document that provides 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. Patient handover delays are creating a financial pressure for the Trust.			
Workforce & Training 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.			
Diversity & Inclusivity Implications	The report will highlight any diversity and inclusion issues as 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. Data has been sourced from the WMAS portal ORBIT and from the WMAS contract monitoring report.			

Action required:
The Trust Board is asked to:

1. Receive and note the integrated quality report.
2. Gain assurance on the quality agenda and the robustness of the quality governance processes.
3. Note the continued risks of patient harm being caused as the result of long handover delays and resultant actions.

Introduction

The Trust strives to provide the best quality and care for our patients, and a safe environment for our staff to work in. One of our main focus areas continues to be patient and staff safety and wellbeing issues related to the high number of Hospital Handover Delays, resulting in long waiting times for patients, and for those who are wating in the community for an ambulance response.

Patient Handover Delays

The issue of patient handover delays continues to remain above pre-pandemic average of 7,000 hours, with June seeing over 12,000 hours lost.

Integrated Care Systems (ICS) continue to support the Trust to reduce long patient delays with a focus to improve Category 2 performance as part of the national NHSE priorities. Due to the continued delays, the Board Assurance Framework (BAF) continues to be graded as a 25.

Serious Incident Investigation Work

The Trust has seen a continued reducing trend of serious incidents being reported during June and this is 61% less than May 2022.

Outgoing NHS to NHS concerns

Outgoing NHS to NHS concerns new process has seen an increasing number being reported by our staff year to date. Historically the Patient Safety team would not be sighted on the number being reported as staff raised these concerns independently of the department. Currently there are 149 of these concerns awaiting responses from the ICB, with 40 waiting since April that have been escalated.

Safeguarding update

This month has seen the appointment to the additional Trust Board supported structures to the safeguarding team, this has seen Nikki Albutt being successful in becoming the Head of Safeguarding and Prevent. There was also the appointment of Mindy Jhamat to the position of Safeguarding Manager, leaving 2 positions to complete the departmental additions.

Tables – Serious Incident Summary Dashboard

The table gives an overview of the SI's reported status, by departments and totals at the end of June. None are overdue and there are no overdue recommendations.

Serious Incident Summary Dashboard

Total Serious Incidents 2020 - 2024		%
SI's Declared	805	100%
SI's Open	34	4%
SI Closure Req	28	3%
SI's Closed	728	90%
SI's Stand Down Req	1	0%
SI's Stood Down	14	2%
Not Open but Query raised by ICB	9	1%
Total	805	100.0%

Total Open SI's by Single Area		%
A&E	3	10%
PTS	1	3%
IEUC	25	86%
Other	0	0%
Total	29	100%

Total Open SI's by Multiple Area		%
A&E Multiple	1	17%
A&E+IEUC	4	67%
PTS+IEUC	1	17%
IEUC Multiple	0	0%
Total	6	100%

SI's Split by Harm 2020-2024		%
Death	10	1%
Severe	685	85%
Moderate	19	2%
Low	41	5%
No Harm	50	6%
Total	805	100%

Summary Actions	May-23	Jun-23
No. New SI's Open	17	18
No. SI's Req Closure	29	32
No. SI's Closed by ICB	41	20
No. SI's Req Stand down	0	0
No. SI's Stood Down by ICB	1	0

Open SI's by Year		Overdue
2020-2021	1	0
2021-2022	0	0
2022-2023	1	0
2023-2024	32	0
Total	34	0

The table below shows the status of ER54 Incidents reported year to date, providing their status as closed or at the various stages in their open status.

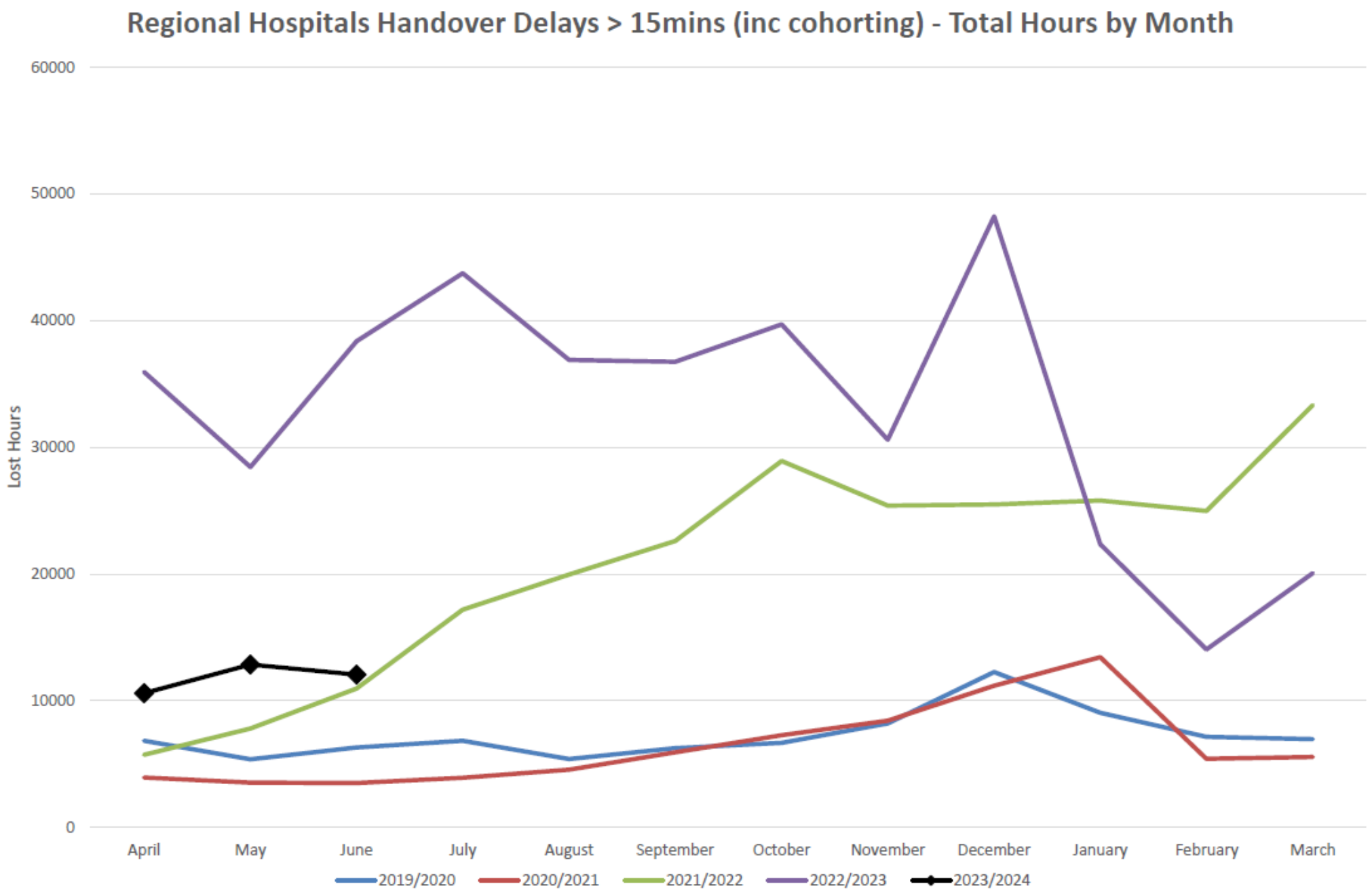
Year to Date ER54 Incidents by Status

% Open	% Closed
26%	74%

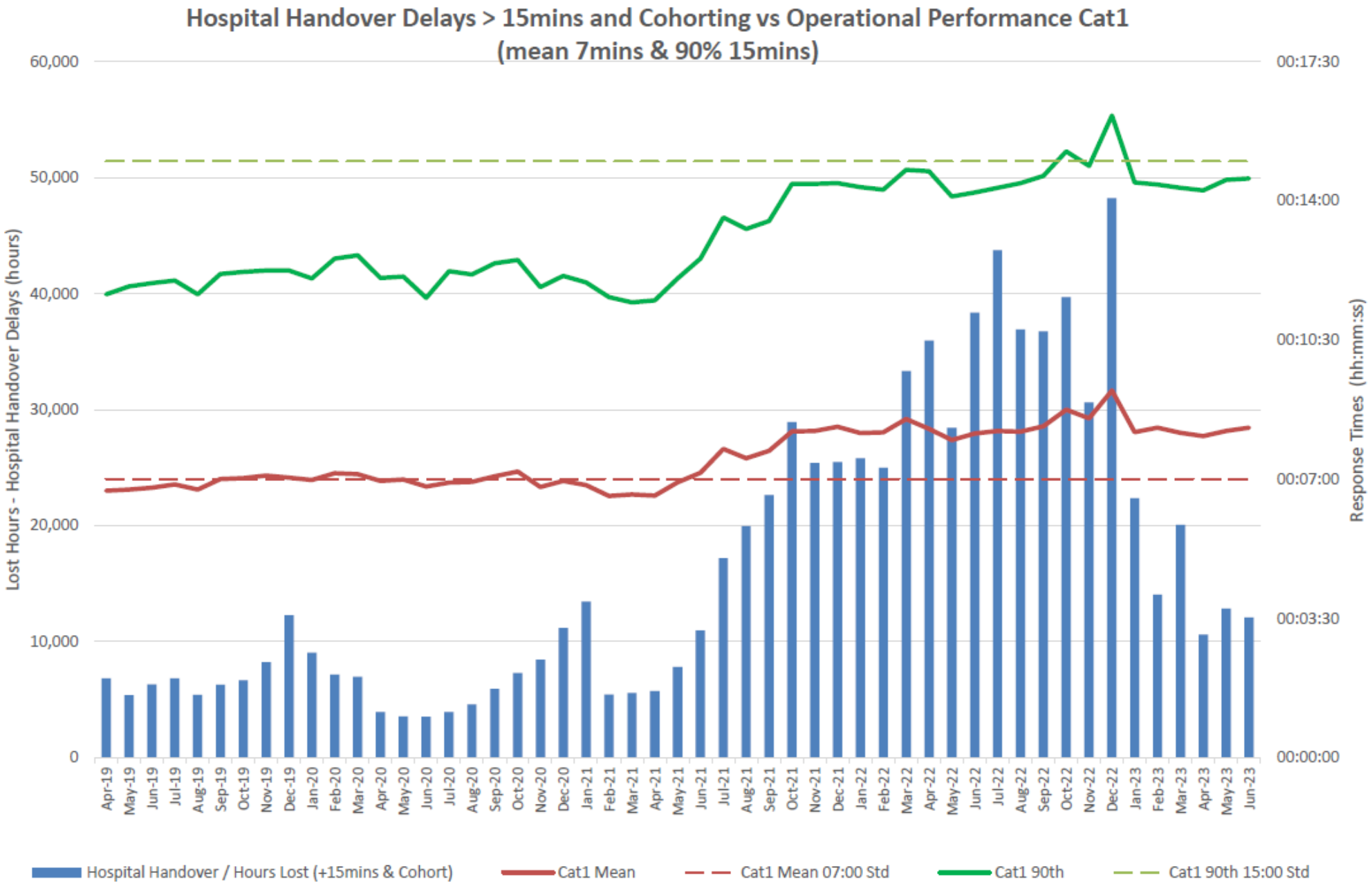
	Open	Closed	NHS to NHS Awaiting review	Under investigation	Awaiting Managers actions	Awaiting department response	Awaiting review as Potential SI	Serious Incident Under Investigation	Total
Detail of Status	15	902	149	4	93	41	3	10	1217

The oldest open ER54s are from April 2023 of which there are 3, this excluding the outgoing NHS to NHS concerns which the Trust.

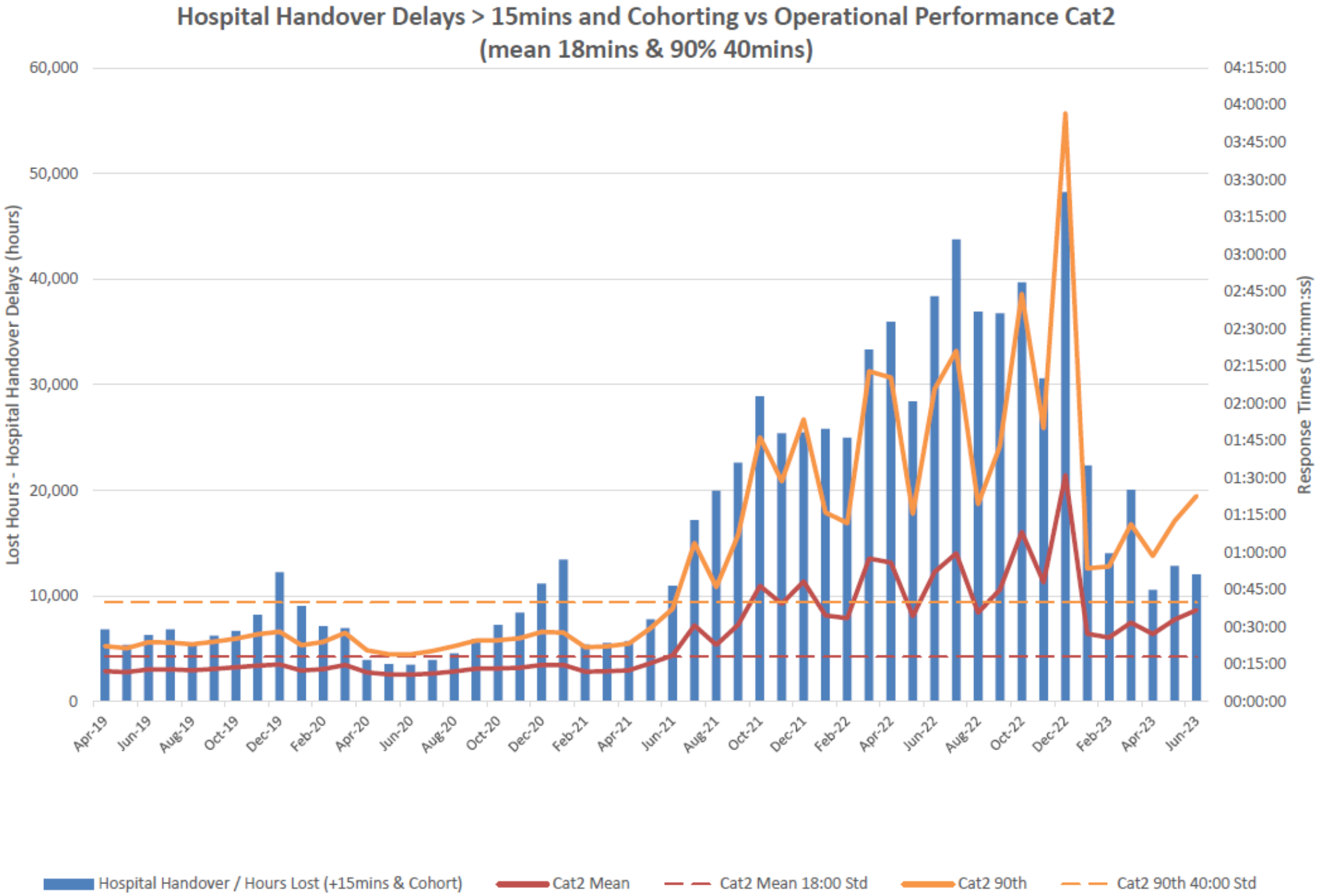
Graph – Time lost due to handover delays exceeding 15 minutes and cohorting for the last 5 financial years



Graph – Time lost due to handover delays exceeding 15 minutes and cohorting – Impact on Cat 1 performance



Graph – Time lost due to handover delays exceeding 15 minutes and cohorting – Impact on Cat 2 performance



Patient Conveyance

WMAS continues to undertake significant work with the Clinical Navigator service in the Emergency Operations Centre; this involves the assessment of Category 3 and Category 4 incidents to see if they can receive care through alternative pathways that are more suitable to the patient.

The non-conveyance for the Trust remains steady with less than half of all 999 patients are conveyed to an ED.

May 2023			Hear & Treat		See & Treat		See & Convey		Conveyed To ED		Conveyed To Non ED	
ICS	Call Volume	AQI Incident Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
NHS BIRMINGHAM AND SOLIHULL ICS	34,196	20,242	4,631	22.9%	5,575	27.5%	10,036	49.6%	9,153	45.2%	883	4.4%
NHS BLACK COUNTRY ICS	26,304	18,508	3,312	17.9%	5,186	28.0%	10,010	54.1%	9,576	51.7%	434	2.3%
NHS COVENTRY AND WARWICKSHIRE ICS	17,576	11,839	2,073	17.5%	3,468	29.3%	6,298	53.2%	5,825	49.2%	473	4.0%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	14,898	9,720	1,552	16.0%	2,684	27.6%	5,484	56.4%	5,153	53.0%	331	3.4%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	9,568	6,288	985	15.7%	2,053	32.6%	3,250	51.7%	2,966	47.2%	284	4.5%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	21,881	14,704	2,105	14.3%	4,419	30.1%	8,180	55.6%	7,335	49.9%	845	5.7%
ICS Total	124,423	81,301	14,658	18.0%	23,385	28.8%	43,258	53.2%	40,008	49.2%	3,250	4.0%

Year To Date			Hear & Treat		See & Treat		See & Convey		Conveyed To ED		Conveyed To Non ED	
ICS	Call Volume	AQI Incident Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
NHS BIRMINGHAM AND SOLIHULL ICS	65,124	40,060	8,784	21.9%	11,318	28.3%	19,958	49.8%	18,235	45.5%	1723	4.3%
NHS BLACK COUNTRY ICS	50,961	36,713	6,352	17.3%	10,476	28.5%	19,885	54.2%	18,976	51.7%	909	2.5%
NHS COVENTRY AND WARWICKSHIRE ICS	34,216	23,468	4,112	17.5%	6,862	29.2%	12,494	53.2%	11,541	49.2%	953	4.1%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	29,039	19,261	3,008	15.6%	5,447	28.3%	10,806	56.1%	10,184	52.9%	622	3.2%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	18,453	12,540	2,059	16.4%	3,975	31.7%	6,506	51.9%	5,905	47.1%	601	4.8%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	42,308	29,275	4,039	13.8%	8,959	30.6%	16,277	55.6%	14,644	50.0%	1633	5.6%
ICS Total	240,101	161,317	28,354	17.6%	47,037	29.2%	85,926	53.3%	79,485	49.3%	6,441	4.0%

Table – Longest waiting times June 2023

Category 1					
CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	1:07:14	DY12	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Arrest Peri Arrest	Cat1
[redacted]	0:49:21	LD7	POWYS TEACHING LHB	Category 1	Cat1
[redacted]	0:47:34	SY7	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Medical	Cat1
[redacted]	0:47:13	SY13	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Medical	Cat1
[redacted]	0:46:05	SY7	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Arrest Peri Arrest	Cat1
[redacted]	0:45:53	DE6	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Unstated	Cat1
[redacted]	0:44:57	SY8	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Medical	Cat3
[redacted]	0:43:58	SY11	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Overdose	Cat1
[redacted]	0:43:16	LD7	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Unconscious	Cat1
[redacted]	0:41:44	SY13	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Arrest Peri Arrest	Cat1

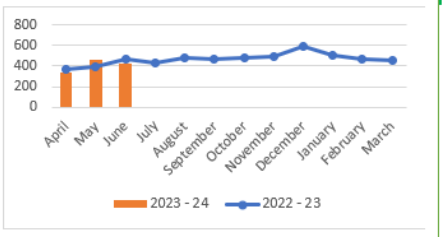
Category 2					
CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	9:32:29	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Chest Pain Cardiac Back Pain Pb	Cat2
[redacted]	9:30:03	CV6	NHS COVENTRY AND WARWICKSHIRE ICS	Breathing Problems	Cat2
[redacted]	9:24:48	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Medical	Cat2
[redacted]	9:23:35	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Allergic Reaction	Cat2
[redacted]	9:20:23	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Medical Minor	Cat2
[redacted]	9:17:39	B79	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical	Cat2
[redacted]	9:15:41	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Overdose	Cat2
[redacted]	9:11:58	CV21	NHS COVENTRY AND WARWICKSHIRE ICS	Breathing Problems	Cat2
[redacted]	9:08:14	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Stroke Neurological	Cat2
[redacted]	8:54:05	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Bleeding	Cat2

Category 3					
CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	35:40:28	B10	NHS BIRMINGHAM AND SOLIHULL ICS	Trauma	Cat3
[redacted]	33:14:10	B23	NHS BIRMINGHAM AND SOLIHULL ICS	Mental Health	Cat3
[redacted]	31:10:43	WS15	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Fall Injuries Unknown	Cat3
[redacted]	30:28:55	B34	NHS BIRMINGHAM AND SOLIHULL ICS	Fall Injuries Unknown	Cat3
[redacted]	30:15:35	B75	NHS BIRMINGHAM AND SOLIHULL ICS	Concern For Welfare	Cat5
[redacted]	30:08:31	B14	NHS BIRMINGHAM AND SOLIHULL ICS	Trauma	Cat3
[redacted]	29:48:12	B27	NHS BIRMINGHAM AND SOLIHULL ICS	Assault Domestic	Cat3
[redacted]	29:19:41	B42	NHS BIRMINGHAM AND SOLIHULL ICS	Medical	Cat3
[redacted]	28:32:07	B27	NHS BIRMINGHAM AND SOLIHULL ICS	Medical	Cat3
[redacted]	28:10:06	B20	NHS BIRMINGHAM AND SOLIHULL ICS	Fall Injuries Unknown	Cat3

Category 4					
CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	33:22:02	B92	NHS BIRMINGHAM AND SOLIHULL ICS	Trauma	Cat4
[redacted]	25:31:13	ST3	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical	Cat3
[redacted]	24:27:38	B79	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Fall Injuries Unknown	Cat5
[redacted]	23:14:39	B18	NHS BIRMINGHAM AND SOLIHULL ICS	Fall Injuries Unknown	Cat4
[redacted]	20:55:45	WV11	NHS BLACK COUNTRY ICS	Trauma	Cat5
[redacted]	20:32:38	WR2	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Medical Minor	Cat5
[redacted]	20:12:20	B93	NHS BIRMINGHAM AND SOLIHULL ICS	Trauma	Cat5
[redacted]	19:34:30	B14	NHS BIRMINGHAM AND SOLIHULL ICS	Trauma	Cat3
[redacted]	19:28:06	B26	NHS BIRMINGHAM AND SOLIHULL ICS	Fall Injuries Unknown	Cat4
[redacted]	19:25:27	WV12	NHS BLACK COUNTRY ICS	Trauma	Cat4

Patient Safety

Total Patient Safety Incidents		Year to date	
	Last reported month (June 23)	2022-23	2023-24
WMAS	418	468	1214



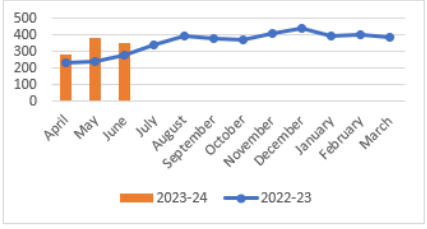
For the month of June, there were 418 patient safety incidents reported. This is a 11% decrease on the same month last year.

E&U accounted for 58% of the total patient safety incidents, 54% of the total patient harm incidents and 48% of the 'no harm' total patient safety incidents.

PTS accounted for 23% of the total patient safety incidents, 13% of the total patient harm incidents and 25% of the 'no harm' total patient safety incidents.

EOC accounted for 19% of the total patient safety incidents, 33% of the total patient harm incidents and 17% of the 'no harm' total patient safety incidents.

No Harm Incidents		Year to date	
	Last reported month (June 23)	2022-23	2023-24
WMAS	355	277	1025

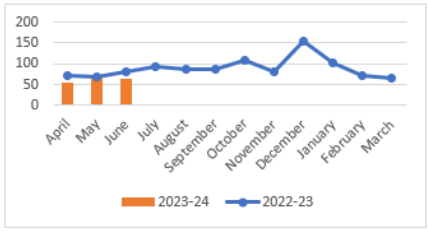


E&U accounted for 58% of the total patient safety incidents, 54% of the total patient harm incidents and 58% of the 'no harm' total patient safety incidents.

PTS accounted for 23% of the total patient safety incidents, 13% of the total patient harm incidents and 25% of the 'no harm' total patient safety incidents.

EOC accounted for 19% of the total patient safety incidents, 33% of the total patient harm incidents and 17% of the 'no harm' total patient safety incidents.

Harm Incidents		Year to date	
	Last reported month (June 23)	2022-23	2023-24
WMAS	63	80	187



	Patient Harm		No Harm		Total	
Area	Total	%	Total	%	Total	%
E&U	34	54%	207	58%	241	58%
PTS	8	13%	88	25%	96	23%
EOC	21	33%	60	17%	81	19%
Total	63	100%	355	100%	418	100%

The top trend for low harm incidents, relates to harm caused due to avoidable injuries caused to patients. E.G., skin tears during moving and handling and injuries occurring during extrication.

The top trends for severe harm incidents, relate to delayed ambulance responses and inappropriate discharge on scene.

Serious Incidents and Duty of Candour

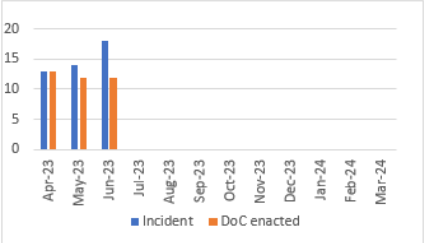
Total number of serious incidents reported		Year to date	
	Last reported month (June 23)	2022-2023	2023-2024
WMAS	18	44	59

18 SI's were registered.
32 SI's were reviewed for closure.
The Lead ICG reviewed and closed 20.

The total so far for 2023/24 – 59 (40 solely related to delayed responses). Clinical themes: Call management and inappropriate discharge.

91 potential SIs have been reviewed since 01.04.23.

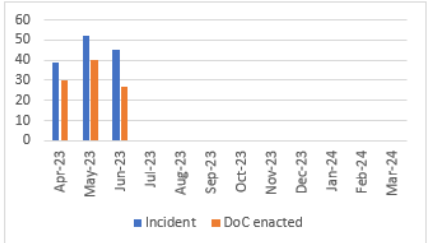
Moderate harm and above		Year to date	
	Last reported month (June 23)	Total number of incidents	Number of incidents being open completed
WMAS	17	26	34



Duty of Candour has been enacted in 52.9 % of cases where moderate harm or above has been caused during June. Delays in completion of DoC are because at the time of reporting, NoK (Next of Kin) details are not always known or the investigation has only been allocated int the last week of the month, prior to reporting.

The year-to-date figure is 83.0%

Low harm		Year to date	
	Last reported month (June 23)	Total number of incidents	Number of incidents being open completed
WMAS	63	55	184

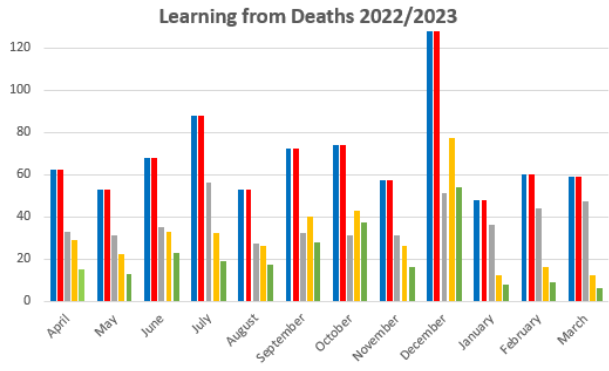


There have been 63 incidents where low harm has been caused to a patient.

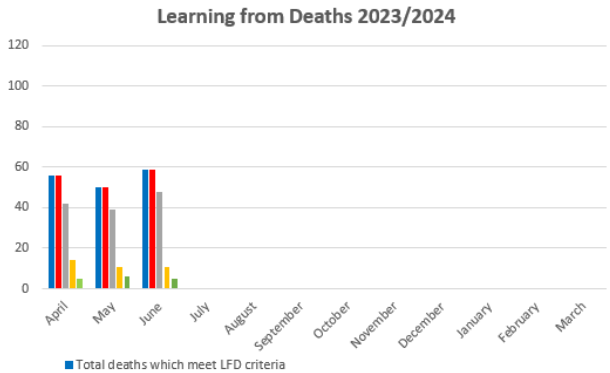
Out of these, evidence of 'Being Open' can currently be provided for 35 of the incidents (56%).

The year-to-date figure is 71.0%

Learning from Deaths



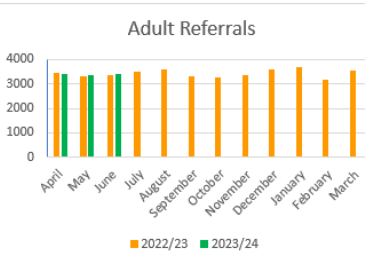
- The above is an overview of the 2022-2023 WMAS LFD reporting.
- In the 2022/2023 LFD reporting period: -
  - 844 deaths occurred which met LFD criteria for review.
  - 844 structured judgement reviews were completed.
  - 400 of the 844 deaths required further investigation following the structured judgement review; of these 262 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 the structured judgement review of deaths within scope.
- In comparison with this month of the 2022/2023 LFD reporting period, there has been:
  - A 13% decrease in overall deaths meeting LFD criteria.
  - 19% of cases required further investigation following a structured judgement review.
- During the current financial year, there have been 16 deaths investigated under the Serious Incident Framework following LFD review.

Safeguarding

Total Adult Safeguarding Referrals	Last reported month (June 23)	Year to date 2022-2023	Year to date 2023-2024
WMAS	3398	41175	10167

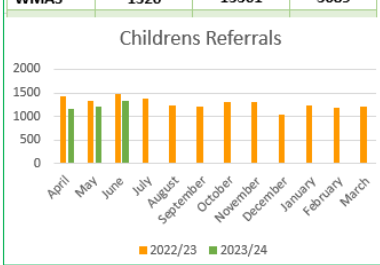


Adult Safeguarding- these figures are for referrals for 18 years and older and include adult care concerns. The referrals are received from E&U staff, PTS staff and anyone else in the organisation. Comparison to previous years for the same time period.

There is a 1.2% increase in the number of adult care/welfare and adult safeguarding referrals sent in June 2023 compared to the previous year.

As from 1st March 2023 WMAS no longer provides the 111 service for the West Midlands region this generated circa 16000 calls a month into the service. For April and moving forward this therefore is reflected in a reduction in the number of referrals made by WMAS a whole.

Total Child Safeguarding Referrals	Last reported month (June 23)	Year to date 2022-2023	Year to date 2023-2024
WMAS	1320	15301	3689

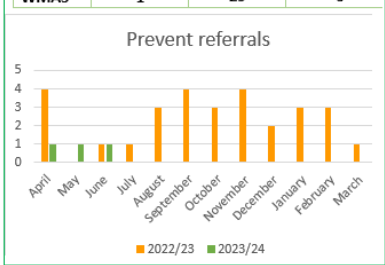


Child Safeguarding Referral- these figures are for under 18 years old. The referrals are received from E&U staff, and anyone else in the organisation. Comparison to previous years for the same time period.

June 2023 saw an 9.9% decrease in the number of referrals made compared to the same month last year.

As from 1st March 2023 WMAS no longer provides the 111 service for the West Midlands region this generated circa 16000 calls a month into the service. For April and moving forward this therefore is reflected in a reduction in the number of referrals made by WMAS a whole.

Total PREVENT Referrals	Last reported month (June 23)	Year to date 2022-2023	Year to date 2023-2024
WMAS	1	29	3

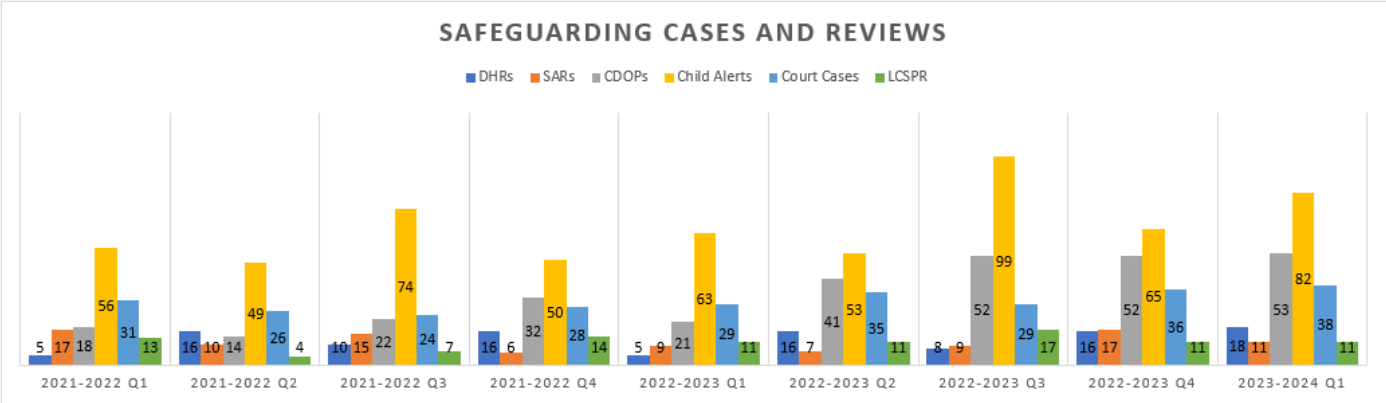


Prevent Referrals are made where there are concern an individual is being radicalised for extremism.

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



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.

The number of DHRs in Q1 has risen by 13 against the same period last year with 18 being received in 2023/24.

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 2 SARs from Q1 against the same period last year.

LCSPR's – Local Child Safeguarding Practice 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.

The number of LCSPR's has remained the same 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 Q1 there has been an increase of 32 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 of 19 Child Alerts from Q1 against the same period last year.

Court Cases

Court cases the safeguarding team can be involved with include court proceedings for child protection, abuse and or neglect.

There has been an increase of 9 court cases in Q1 against the same period last year.

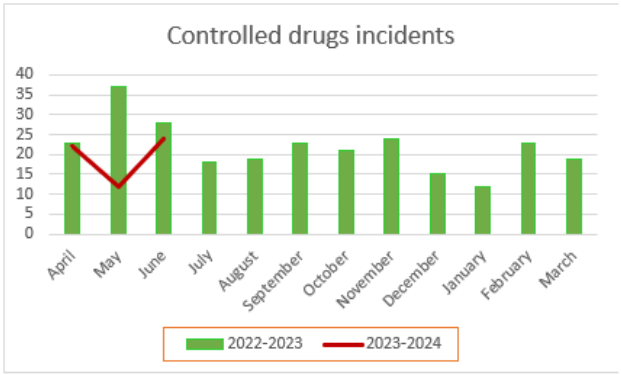
Medicines Management & Pharmacy

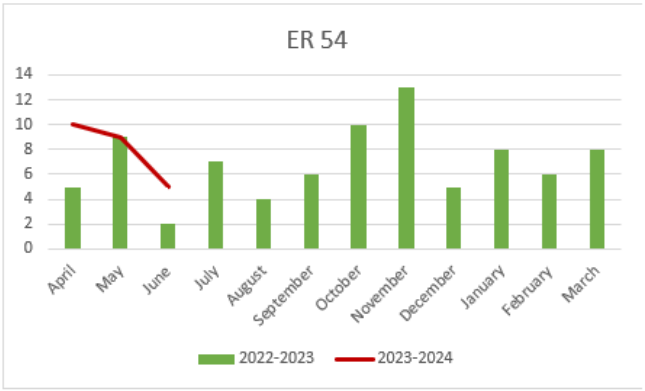
CONTROLLED DRUGS

Total Controlled Drugs Incidents (CDI's)		Year to date
Last reported month *June* 23)	2022-2023 June- to date	2023-2024 YTD
24	88	58

MEDICINES ER54

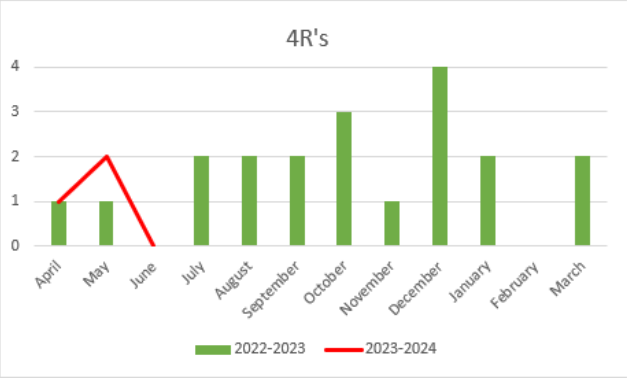
Total Medicines Management related ER54's		Year to date
Last reported month (*June* 23)	2022-2023 Apr- to date	2023-2024 YTD
5	16	24





Total Drug Errors, wrong route, wrong dose etc	Year to date	
Last reported month *June* 23)	2022-2023 June- to date	2023-2024 YTD
0	2	3

MHRA Alerts		Year to date
Last reported month (*June* 23)	2022-2023 April - to date	2023-2024 YTD
2	16	13

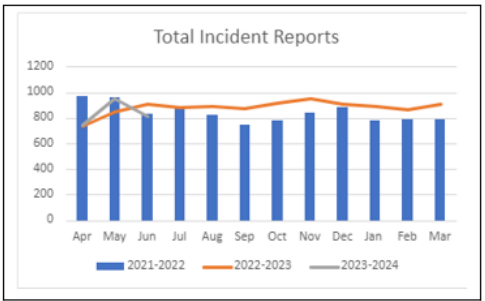


None of the medicines referenced within the alert were procured or distributed by WMAS.

Corrective and Preventative Actions (CAPA)		Year to date	
	Last reported month (June)	2022-2023 April - to date	2023-2024 YTD
WMAS	**0**	**0**	**0**

Incident Reports

Total Incidents Reported		Year to date	
	Last reported month (June 23)	2022-2023 April –Mar	2023-2024 April-June
WMAS	**816**	**10,645**	**2317**

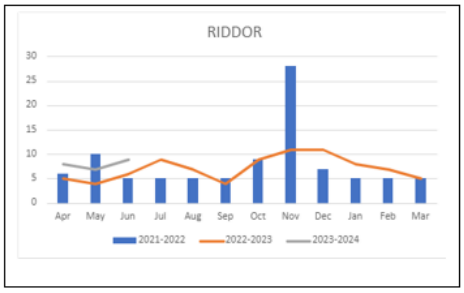


Over 75,000 ER54's received since implementation.

Current review and action around "Future Date" capture in ER54 and Orbit which is impacting reporting figures. Risk and BI Teams are analysing and will update accordingly.

ER54 Quarterly audit undertaken in March to identify gaps in compliance and best practice with increased sample size to 50 and focussing on PTS Cases – awaiting update and action plan to report to SMT and OMT

RIDDOR		Year to date	
	Last reported month (June 23)	2022-2023 April - Mar	2023-2024 Apr-June
WMAS	**9**	**86**	**24**



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. March didn't identify any trends.

Head of Risk part of national review of RIDDOR Regulations requested by HSE – aim is to update to be more Ambulance specific.

National Ambulance RIDDOR statistics show trends across all Trusts of slip, trip and falls, carry chair, and struck by object incidents – work streams to be started. WMAS best performing Trust for reporting RIDDOR within timescales with 98%.

Top 5 Incidents for Non-Patient Safety (June)

Trustwide Top 5 Types	Total
Violence / Aggression	177
Complaint	102
RTC	96
Injury	80
Equipment	62

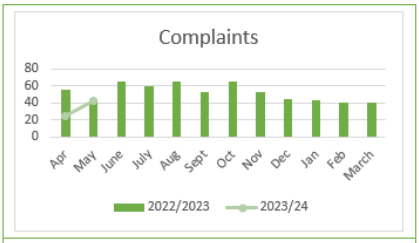
Trustwide Top 5 Categories	Total
V&A - Verbal - Intentional	73
Manual Handling – Patient & Equipment	60
Complaints – Other NHS	44
Near Miss	41
Equipment - Damage	32

The Trust Top 5 incident categories for June –

1. V&A – Verbal - Intentional – Reviewed via Security
2. Manual Handling – Patient and Equipment – Yearly review of cases planned.
3. Complaints – Other NHS – All cases reviewed by Head of Hospital Flow – NHS-NHS Process Under Review
4. Near Miss – Reviewed by Security
5. Equipment – Damage – Cases reviewed at SMT's

Patient Experience

Formal Complaints	Year to date		
	Last reported month (May 23)	2022-23 Total	2023-24 YTD
WMAS	42	100	66



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

For the month of May, we saw 42 complaints received compared to 45 in May 2022 a decrease of 3. The main reason for a complaint was Clinical = 19

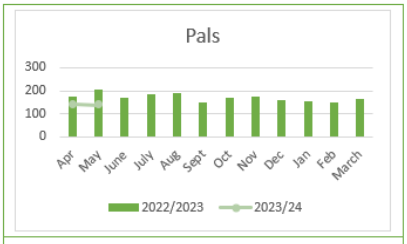
Of the cases closed to date: 7 case is justified, 6 not justified, 5 part justified, and 24 cases are still under investigation and will require to be closed by 5 July 2023.

Cases with the Parliamentary Health Service Ombudsman (PHSO) – no requests received in May 2023.

In May 2023, the Trust undertook:

- 130,213 Emergency Calls, which equates to 1 Complaint for every 10,851 calls received.
- 83,961 Emergency Incidents, which equates to 1 Complaint for every 4, 199 Incidents.
- 76,096 Non-Emergency Patient Journeys, which equates to 1 Complaint for every 9,512 journeys.

Informal (PALS)	Year to date		
	Last reported month (May 2023)	2022-23 Total	2023-24 YTD
WMAS	141	382	284



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

17 Attitude and Conduct
16 Loss/Damage
14 Information Request

Of the Cases closed to date (month) –

16= *Justified,*
16= *Part Justified,*
34= *Not justified*

Compliments	Year to date		
	Last reported month (May 23)	2022-23 Total	2023-24 YTD
WMAS	206	391	389

Compliments: May 2023: There have been 206 compliments received compared to 222 the previous year, a decrease of 16.

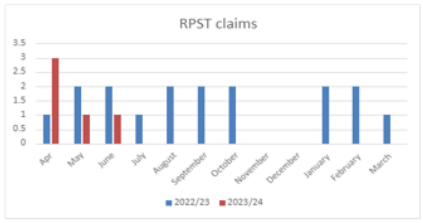
Friends and Family Test (YTD)
The FFT question is available on the Trust website: '**Thinking about the service provided by the patient transport service, overall how was your experience of our service?'**:

Response May	FFT Survey	PTS Survey
Very Good	2	3
Good	0	2
Neither Good nor Poor	0	0
Poor	0	0
Very Poor	0	0
Don't Know	1	0
Total	3	5

Discharge on Scene Results: 0 response in May 2023

Claims and Coroners Cases

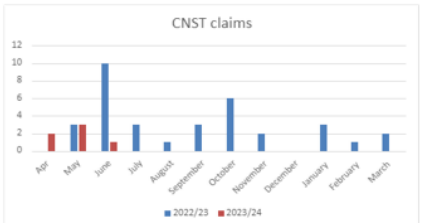
RPST (Risk Pooling Schemes for Trusts)	Year to date		
	Last reported month June 23	2022-23	2023-24
WMAS	1	17	5



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 received 1 RPST claim in June 2023. This is a decrease of 1 compared to the previous year.

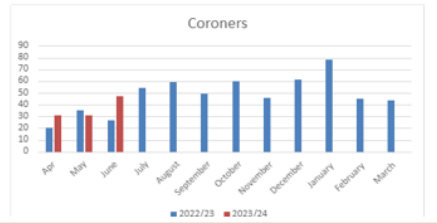
CNST (Clinical Negligence Scheme for Trusts)	Year to date		
	Last reported month June 23	2022-23	2023-24
WMAS	1	34	6



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 received 1 CNST claims in June 2023. This is a decrease of 9 compared to the previous year.

Coroners Requests	Year to date		
	Last reported month June 23	2022-23	2023-24
WMAS	47	578	109



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

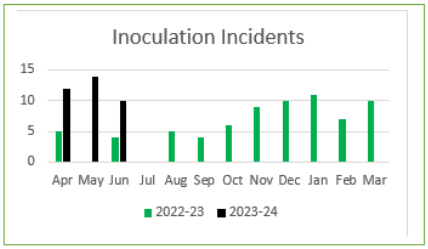
- Birmingham and Solihull
- Black Country
- Coventry
- Herefordshire
- Shropshire, Telford & Wrekin
- South Staffordshire
- Stoke on Trent & North Staffordshire
- Warwickshire
- Worcestershire

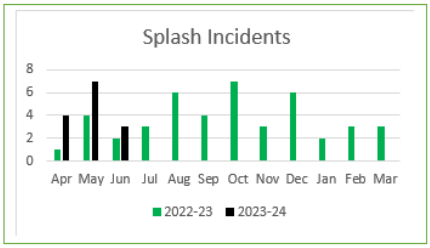
Infection Prevention and Control

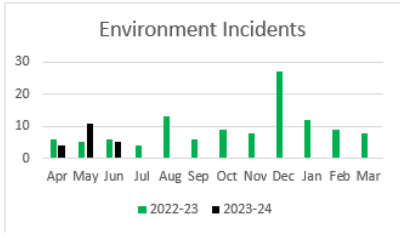
Inoculation Incidents		Year to date Comparison	
	Last reported month Jun 23	2022-23	2023-24 Apr-Jun
WMAS	10	71	36

Splash Incidents		Year to date Comparison	
	Last reported month Jun 23	2022-23	2023-24 Apr-Jun
WMAS	3	44	14

Environment Incidents		Year to date Comparison	
	Last reported month Jun 23	2022-23	2023-24 Apr-Jun
WMAS	5	113	20







Inoculation Incident Key Performance Indicator:
By the end of 2023/24 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 undertake 10 cannulation audits per month. These audits are completed at point of care and input using the EPR platform. Weekly Brief articles supported by clinical notices are published routinely to support the reduction of sharps related incidents.

June 2023 saw 10 inoculation incidents reported. These involved used cannula devices, an intraosseous needle, human bite, glass ampoule and a patients' fingernail that scratched a staff member, penetrating skin level.

Risk RAG = Red risk – 0 | Amber risk – 7 | Green Risk – 3

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

Splash Incident Key Performance Indicator:
By the end of 2023/24 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.

June 2023 saw 3 splash incidents reported. These involved blood and body fluids entering the eye/mouth of the treating clinician. A dedicated clinical notice has been released to promote the need for a continuous dynamic risk assessment and appropriate selection of PPE to mitigate the risk of splash. This includes the release of the application of the hierarchy of controls dedicated clinical notice.

Risk RAG = Red risk – 0 | Amber risk – 3 | Green Risk – 0

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

Environment Incident Key Performance Indicator:
By the end of 2023/24 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. Furthermore, this category of incident aims to capture staff members exposure to infectious disease such as Tuberculosis.

June 2023 saw 5 environment related incidents reported. Incidents involved an exposure to a patient with a suspected infectious disease, issues relating to contaminated equipment with blood or bodily fluids, damp and mould issues within a patients' environment and one immunisation issue that remains under investigation.

Risk RAG = Red risk – 0 | Amber risk – 0 | Green Risk – 5

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

Additional Information of Clinical Director's Activity

There continues a clear focus on reducing the risks to patients most importantly for those people in our communities. Hospital handover delays have not returned to pre-pandemic levels and so continue to impact on patients waiting in the community. For this reason, the risk rating on the Board Assurance Framework remains at a 25.

We have continued to work across the regional and national health systems by contributing to joint meetings on patient flow, reducing hospital handover delays and improving the responses to our patients, with clear focus from systems to support the Trust to deliver Category 2 within 30 minutes.

We are continuing our work across the region and with local partnerships to support alternative care pathways, hear and treat, review of new pathways and clinical audit around non-conveyance of patients.

The information below outlines examples of activities undertaken by the Clinical Directors since the last meeting of the Board. It is not an exhaustive list.

Interim Medical Director

- Professional Standards Group
- Senior Clinical Leads meeting
- Learning Review Group meeting
- Complaint review meeting
- NASMeD meeting
- JRCALC meeting

Paramedic Practice and Patient Safety Director

- Health, Safety, Risk & Environment Group
- Professional Standards Group
- Serious Incident Recovery Group
- Senior Clinical Leads meeting
- Controlled Drugs Accountable Officer introduction meetings.
- Interview process for Head of Safeguarding and Prevent (Appointment made)
- Regular meetings with Clinical Team
- Bi-weekly meetings line reports
- Meetings with ICBs Governance leads
- ER54 management review meetings
- Community First Responder Regional Forum
- Advancing Practice Governance
- National Ambulance Health Inequalities
- National Paramedic Directors

Interim Executive Director of Nursing

- Completed work to enable for NMC professional revalidation
- Meetings with candidates for the Executive Nurse Director post
- 1:1 meetings with team members
- Sign off of complaint letters to ensure timely and compassionate responses
- Preparation for Health Overview and Scrutiny meetings

Dr Richard Steyn
Interim Medical Director

Mark Docherty
Interim Executive Nurse

Nick Henry
Paramedic Practice and
Patient Safety Director

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08B MONTH: JULY 2023 PAPER NUMBER: 07B

BAF	
Sponsoring Director	Mark Docherty
Author(s)/Presenter	Matt Brown, Head of Risk
Purpose	The Board Assurance framework has been revised into a new format considering Auditor's recommendations. The Committee is asked to note the risks and the actions and mitigations to control and reduce those risks
Previously Considered by	Audit Committee 18 July 2023
Report Approved By	Interim Director of Nursing

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 sight of the BAF will assist management and the board to collectively consider the process of securing assurance and promoting good organisational governance and accountability.

April's report will be the last in this format and the last time it is presented monthly. As per the latest Internal Audit request, it will now be reported quarterly and in a format which IA have proposed more suitable.

Unfortunately, due to the continued delay of the DATIX project, it is unclear whether the BAF can be utilised through that software at this stage.

Changes to the BAF since the last Board review are below – requests/reminders for review have gone to Owners;

Strategic Objective 1 –

- **SR-001 -** Failure to achieve Operational Performance Standards
- **ORG-003** - Failure to complete Serious Incident (SI) Investigations within timescales resulting in reduced learning, complaints, litigation delay of update to CCG and potential further patient safety concerns
- **ORG-130** - Failure to complete the closure process on Patient Safety ER54's resulting in possible failure to manage incidents appropriately and delaying learning by failure to implement possible actions
- **ORG-140** - Impact of the removal of overtime availability on abstractions, performance, quality and achievement of mandatory workstreams resulting in failure of specific targets.

- **EOC-003 –** Clinical validation for Cat 3 and Cat 4 incidents
- **EOC-022** - Clinical validation for Cat 2 999 Calls impacting patient safety and performance
- **EOC-023** - Failed clinical contacts within IEUC resulting in delay to adequate treatment, patient deterioration, non-compliance with policy and potential litigation/complaints
- **EOC-027** - Consideration for Category 2 IEUC Closing Instructions impacting patient safety, performance and staff wellbeing
- **EP-021** - Impact of industrial action and inability to maintain service with reduced resourcing, resulting in delay and resourcing issues
- **ORG-093** - Utilisation of surge contingency as a result of COVID-19 and increased demand, and its impact on 2021/22 resourcing, training, finance and ultimately performance and potential patient delays and harm
- **PTS-041**- Shortage of staff in all NEOCs because of unfilled vacancies and a freeze on recruitment leading to risk to performance, workload, patient delay and possible harm
- **ORG-056 -** Continuity of Business as a result of global supply chain issues, resulting in the inability to source supplies, increase in costs and the impact on patient care and meeting regulatory requirements

Strategic Objective 2 –

No changes to Risks

Strategic Objective 3 –

No changes to Risks – In discussion with Finance regarding updates

Strategic Objective 4 –

ORG-082 - Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage **–** Awaiting update from Senior Finance Team risk review

ORG-083 - Investment in digital capability for ambulance services often benefits from a regional approach – To be discussed and drafted with Executive Director of Strategic and Digital Integration

Strategic Objective 5 –

ORG-084 - The opportunity for “collective accountability” on performance could be helpful in addressing issues **–** Awaiting update

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08B MONTH: JULY 2023 PAPER NUMBER: 07B

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	

Strategic Objective 1 :Safety, Quality and Excellence
Lead Director: Diane Scott

Strategic Objective	1: Safety, Quality and Excellence

	Risk Title	**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	5x5=25	5x4=20	5x3=15
	HS-012 - Risk of staff suffering serious injury because of stab / ballistic weapons	5x3=15	5x2=10	5x2=10
	EP-027 – Risks associated with Terrorist Threats	5x3=15	5x2=10	5x2=10
	ORG-003 – Failure to complete SI investigations within timescales	4x4=16	4x3=12	4x2=8
	IPC-035 -Risks associated with bird/vermin droppings on Trust sites	4X4=16	4X3=12	4X1=4
	EOC – 016 - Stacking of incidents at times of high demand	5x5=25	5x4 = 20	5x3=15
	IPC-002 - Regulatory concerns due to non-compliance with Clinical Waste Management	4X3=12	4X2-8	4X1=4
	ORG-093 - Utilisation of surge contingency as a result of COVID-19 and increased demand, and its impact on 2021/22 resourcing, training, finance and ultimately performance and potential patient delays and harm	5x3=15	5x2=10	5x1=5
	EOC-003 – Clinical Validation of CAT 3 and Cat 4 Calls	4x3 = 12	4x2 = 8	4x2 = 8
	EOC-022 - Clinical validation for Cat 2 999 Calls impacting patient safety and performance	5X3=15	5X2=10	5X2=10
	EOC-023 - Failed clinical contacts within IEUC resulting in delay to adequate treatment, patient deterioration, non-compliance with policy and potential litigation/complaints	5X2 = 10	5X2=10	5X2=10
	EOC-027 - Consideration for Category 2 IEUC Closing Instructions impacting	5X2=10	5X2=10	5X2=10

Lead Committee	Quality Governance Committee
Last Reviewed	April 2023

Reviewed Risks

EP-021 - Impact of industrial action and inability to maintain service with reduced resourcing, resulting in delay and resourcing issues.

SR-001 - Failure to achieve Operational Performance Standards

ORG-003 - Failure to complete Serious Incident (SI) Investigations within timescales resulting in reduced learning, complaints, litigation delay of update to CCG and potential further patient safety concerns.

PTS-041 - Shortage of staff in all NEOCs as a result of unfilled vacancies and a freeze on recruitment leading to risk to performance, workload, patient delay and possible harm,

ORG-056 - Continuity of Business as a result of global supply chain issues, resulting in the inability to source supplies, increase in costs and the impact on patient care and meeting regulatory requirements **–** *Risk reduced and removed from BAF.*

ORG-140 - Impact of the removal of overtime availability on abstractions, performance, quality and achievement of mandatory workstreams resulting in failure of specific targets.

EOC-003 - Clinical validation for Cat 3 and Cat 4 incidents – *Risk reduced.*

EOC-022 - Clinical validation for Cat 2 999 Calls impacting patient safety and performance – *Risk reduced.*

EOC-023 - Failed clinical contacts within IEUC resulting in delay to adequate treatment, patient deterioration,

	patient safety, performance, and staff wellbeing.				non-compliance with policy and potential litigation/complaints – *risk reduced.* **EOC-027** - Consideration for Category 2 IEUC Closing Instructions impacting patient safety, performance, and staff wellbeing. – *risk reduced* **ORG-130** - Failure to complete the closure process on Patient Safety ER54's resulting in possible failure to manage incidents appropriately and delaying learning by failure to implement possible actions. **ORG-093** - Utilisation of surge contingency as a result of COVID-19 and increased demand, and its impact on 2021/22 resourcing, training, finance and ultimately performance and potential patient delays and harm.
	ORG-029 - Risk of failure of Corporate IT or IT Telecommunications System due to Cyber Terrorism	4X4=16	4X3=12	4X2=8	
	ORG-102 - Patients held on the back of an Ambulance awaiting hospital handover for prolonged periods resulting in harm and potential litigation and adverse publicity	5X3=20	5X2=10	5X1=5	
	ORG-116 - Risks associated with undertaking Resus training online	4X3=12	4X3=12	4X2=8	
	ORG-125 - Inability to procure supplies, medicines and Clinical consumables resulting in out-of-date items, patient harm and possible litigation	4X3=12	4X2=8	4X2=8	
	ORG-126 - Failure to contact patient once clinical audit has identified inappropriate advice, resulting in patient harm, claims, adverse publicity, financial consequence, and possible regulatory concerns	4X5=20	4X4=16	4X3=12	
	HARTOD11 - Marauding Terrorist Attack Deployment	5x4=20	5x2=10	5x2=10	
	HARTODNB1 – CBRN Attack Deployment	5x4=20	4x2=8	4x2=8	
	BCM-015 - Interruption of Business Continuity as a result of failing to assess and plan accordingly, resulting in a loss of multiple WMAS sites and potential inability to run business as usual for Trust functions.	5x4=20	3x4=12	3x4=12	
	EP-021 - Impact of industrial action and inability to maintain service with reduced resourcing, resulting in delay and resourcing issues	5x4=20	5x3=15	5x3=15	
	ORG-130 - Failure to complete the closure process on Patient Safety ER54's resulting in possible failure to manage incidents appropriately and delaying learning by failure to implement possible actions.	4x3=12	4x2=8	4x2=8	
	ORG-140 - Impact of the removal of overtime availability on abstractions, performance, quality and achievement of mandatory workstreams resulting in failure of specific targets.	5X4=20	4X4=16	4X3=12	

Strategic Objective 2 :A great place to work for all

Lead Director: Carla Beechey

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)*
Principal Risks					

Lead Committee	People Committee
Last Reviewed	June 2022 (EMB)
Reviewed Risk	

Strategic Objective 3 :Effective Planning and use of resources
Lead Director: Karen Rutter

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-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-008 - Adequate procurement controls are not in place for Tenders, Waivers and SFI and SO compliance	4x3 = 12	4x2 = 8	4x2 = 8

Lead Committee	Performance Committee
Last Reviewed	November 2022

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-088 -** Devolution of resources	4x3 =12	4x2 = 8	4x1 = 4

Lead Committee	Quality Governance Committee
Last Reviewed	October 2022 – Discussion with

	to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)					Director
	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	**Reviewed Risks**	Awaiting update on whether ORG-088 and ORG-083 are still required
	ORG-087 – Proposed changes to Urgent and Emergency Care Quality and Access Standards will result in new set of measurement metrics	4X3=12	4X2=8	4X1=4		
	ORG-016 - End of Life IT Systems	4X4=16	4X3=12	4X2=8		

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)*	**Lead Committee**	People Committee
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	**Last Reviewed**	October 2022 – Discussion with Director
		ORG-087 - Proposed changes to Urgent and Emergency Care Quality and Access Standards	5X3 = 15	5X2 = 10	5X2 = 10	**Reviewed Risks**	Awaiting update on whether ORG-084 is still required

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*
EP-021	Impact of industrial action and inability to maintain service with reduced resourcing, resulting in delay and resourcing issues	As of 26th April 2023, all recognised Unions are balloting their members on the Governments pay offer. Final ballot closes on 28th April 2023 with NHS Staff council to decide on whether to accept or refuse offer on 2nd May. It is expected that if the offer is refused the Ambulance unions will begin a renewed series of industrial action and may well take a harder line on derogation's etc. As of 26th April, the next planned industrial action is Tuesday 2nd May, which includes UNITE. All updates will be monitored, and assessment updated following and decision which impact Staff and Patients.	It is expected that if the offer is refused the Ambulance unions will begin a renewed series of industrial action and may well take a harder line on derogation's etc.	As per RA	Identify and agree any actions	Continue to monitor
SR-001	Failure to achieve Operational Performance Standards	The risks will be identified and managed through the specific risk assessments which relate to each area. These are escalated via relevant group/committee and via the BAF is required.	The Trust continues to see hospital hand over delays and patients waiting exceeding pre-COVID levels, which remain a significant risk to performance. EMB recently requested a review of the risk score of the 25 graded risks to determine whether they could be reduced, however, there was no evidence to suggest that a reduction was suitable. The 111-contract was taken over by DHU from 1st March 2023 which has resulted in several staff being TUPED over and the Trust reverting to emergency calls only. Whilst this will seem to have a positive impact on performance, it may take some time for this to be realised. From April 2023 it has been announced that there will be a cessation of all Overtime across the Trust due to the cost saving which must be made (circa £19 Million). An initial risk assessment has been drafted to include risks for each area, which has highlighted several concerns to performance. The RA will be reviewed by EMB on 4th April to determine risk score and further action.	As per RA and associated actions	Identify and agree any actions	Continue to monitor
ORG-003	Failure to complete Serious Incident (SI) Investigations within timescales resulting in	There are currently 76 investigations sitting with WMAS. 0 SI's are currently over the time frame.	Although the current figures are positive there continues to be a risk of High work volumes. Because of the recent cessation of overtime	As per RA and associated actions	Identify and agree any actions	Agree reduction of risk score

	reduced learning, complaints, litigation delay of update to CCG and potential further patient safety concerns	65 SI's were reviewed for closure during March, with 4 being reviewed so far during April. These are now either going through or awaiting further review at SIRG. 6 SI's are currently awaiting review prior to closure request. The Lead ICB reviewed and closed 28 SI's during February, and 37 during March. Serious Incident Review Group meetings continue to be arranged, to review SI's. The total for 2022/23 was 453 (203 solely related to delayed responses. Clinical themes: management of choking, management of cardiac arrest, inappropriate discharge). For the same period in 2021/22 there were 204 SI's reported. 523 potential SIs have been reviewed since 01.04.22. 5 cases currently sit in the potential SI files. 0 are currently awaiting director response. 0 need registering on StEIS as SI's. 0 have been reviewed and all are awaiting more information (call audits/patient outcome). All SI's have been allocated to an IO. The EOC delayed response SI's have been registered on StEIS and have been allocated an Investigation Officer to undertake DoC. There are ongoing thematic reviews of this group of SI's, with a single RCA encompassing all incidents. There will be a single Investigation report, which will include evidence of all the SI cases DoC, and a list of each SI will be listed as appendices and evidence. This approach was agreed with and continues to have the support of the CCG. Discussions are taking place with the CCG to attempt to streamline the process of the thematic reviews further. This is with the aim to obtain maximum efficiency whilst still adhering to the Serious Incident Framework 2015. A meeting took place on 20th March 2023 where an agreement was reached. The Lead ICB will liaise with the Trust and create a new process for the management of the delayed ambulance response thematic reviews. This process will then be submitted as part of the governance arrangements for both the Lead ICB and The Trust prior to implementation. The second thematic review for delayed response to STEMI patients has started with 9 currently sitting within this investigation. The previous STEMI thematic totalled 16 cases.	combined with staff returning to Operations will lead to slippage on RCA dates, timely completion of SI's and timely review and closure of SI's. Following a meeting on Friday 4th October 2022, the ICB have requested a copy of the business case. Pir Shah (Regional Clinical Lead, for NHS England for Integrated Urgent & Emergency Care) states that he would like to review the case with a view to speaking with associate commissioners, asking for further funding. The business case has now been forwarded. Confirmation has now been received that no further funding is available.			
PTS-041	Shortage of staff in all NEOCs as a result of unfilled vacancies and a freeze on recruitment	PTS operates through four separate NEOCs based across the region, in Coventry, Frankley, Tollgate and Warrington	There are significant staffing issues within each of these, which has been caused by various issues such as, difficulties in recruiting, better	As per RA and associated actions	Identify and agree any actions	Continue to monitor

	leading to risk to performance, workload, patient delay and possible harm,		conditions in other roles and now a freeze on recruitment.			
ORG-056	Continuity of Business as a result of global supply chain issues, resulting in the inability to source supplies, increase in costs and the impact on patient care and meeting regulatory requirements	Extensive workstreams have been implemented since the last review including a robust policy for all staff to follow - "Management of Drugs, POMs, Uniform, Medical Equipment and Supplies Shortages Policy" which has improved the issues identified within the risk. Weekly stock figures for Central Stores are reported to Operational Director and Consultant Paramedic for assurance, who can intervene and provide details of any alternatives where required, to communicate for frontline ops, and added to weekly brief. Given the reduction of issues and insignificance of shortages, this risk has been reduced.	N/A	As per RA and associated actions	Identify and agree any actions	Agree to reduce and remove from BAF
EOC-003	Clinical validation for Cat 3 and Cat 4 incidents	Risk reviewed and likelihood reduced based on reduction of cases and an initial belief that the risk impact would be greater than realised.	Actions extended and a further action created to review against the updated position to ensure mitigating actions remain relevant or need updating to manage and reduce risk greater.	As per RA and associated actions	Identify and agree any actions	Agree risk score reduction
EOC-022	Clinical validation for Cat 2 999 Calls impacting patient safety and performance	Patient Safety have reviewed all cases in relation to this risk and suggest the likelihood is reduced to possible. There is however a concern around C2 CVT and a possible delay when resources are available. The team will continue to monitor and report when required. IEUC review have strengthened existing controls, added an additional control regarding potential update to how C2 calls are validated, discussed at SMT but no action as yet. Risk score reduced as suggested by Patient Safety team on the basis that incidents have not been likely.	N/A	As per RA and associated actions	Identify and agree any actions	Agree risk score reduction
EOC-023	Failed clinical contacts within IEUC resulting in delay to adequate treatment, patient deterioration, non-compliance with policy and potential litigation/complaints	All evidence reviewed including Trend reports and SI's and no issues have been identified therefore the reviewing team have agreed that the Likelihood can reduce. However, the action will remain that all evidence is continually reviewed and if cases occur, then an immediate review will be initiated.	N/A	As per RA and associated actions	Identify and agree any actions	Agree risk score reduction
EOC-027	Consideration for Category 2 IEUC Closing Instructions impacting patient safety, performance and staff wellbeing	All evidence reviewed including Trend reports and SI's and no issues have been identified therefore the reviewing team have agreed that the Likelihood can reduce. However, the action will remain that all evidence is continually reviewed and if cases occur, then an immediate review will be initiated.	N/A	As per RA and associated actions	Identify and agree any actions	Agree risk score reduction
ORG-093	Utilisation of surge contingency as a result of COVID-19 and increased demand, and its impact on 2021/22 resourcing, training, finance and ultimately performance and potential patient delays and harm	Risk assessment reviewed as part of discussion at HSREG in March regarding COVID-19 Risks.	Risk Assessment forwarded to IEUC Director to determine actions – which will include change of title and appropriate evidence regarding surge enactment and demand impacts.	As per RA and associated actions	Identify and agree any actions	Continue to monitor
ORG-130	Failure to complete the closure process on	Review completed as part of Task and Finish Group to determine where forms could be closed and where further review and action was	N/A	As per RA and associated	Identify and agree	Continue to

	Patient Safety ER54's resulting in possible failure to manage incidents appropriately and delaying learning by failure to implement possible actions	required. The review initiated an Action plan for Paramedic Practice & Patient Safety Director, to implement recommendations, which are in hand. Additional controls completed and a number added as part of the Recommendations. Risk will be reviewed at the end of May with view to archive if all relevant actions completed.		actions	any actions	monitor
ORG-140	Impact of the removal of overtime availability on abstractions, performance, quality and achievement of mandatory workstreams resulting in failure of specific targets.	Recent discussions at Board and EMB have identified that a financial plan for 2023/24 was currently predicated on presenting a draft budget with a forecast deficit of £63m.	The deficit was primarily arising from the impact of reductions in income for Covid, the challenge of matching income lost due to cessation of the 111 contracts with equivalent reductions in costs, and a range of inflationary costs pressures. Work was required to reduce the deficit and EMB would allocate time to addressing the financial plan for 2023/24. One of the actions advised is a blanket removal of all overtime across the Organisation in a bid to recoup costs and ensure that moving forward, this does not continue to impact the Trust financially. However, it is believed that due to increasing and ongoing demands because of COVID-19, hospital delays, operational pressures and workloads in other areas of the organisation, this may have a detrimental impact on the quality and achievement of key workstreams, which in fact rely on overtime to be completed	As per RA and associated actions	Identify and agree any actions	Continue to monitor

Strategic Objective 2 :A great place to work for all
Lead Director: Carla Beechey

	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*

Strategic Objective 3 :Effective Planning and use of resources
Lead Director: Paul Jarvis

	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*

Strategic Objective 4 : Innovation and Transformation 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*
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)	None given – still awaiting update	Awaiting update from Strategy and Engagement Director			N/A
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.	None given – still awaiting update	Awaiting update from Strategy and Engagement Director			N/A

Strategic Objective 5 : Collaboration and Engagement Lead Director: Carla Beechey						
	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	None given – still awaiting update	Awaiting update from Strategy and Engagement Director			N/A

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 09 MONTH: JULY 2023 PAPER NUMBER: 07

Freedom To Speak Up Update	
Sponsoring Director	Vivek Khashu, Strategy and Engagement Director
Author(s)/Presenter	Pippa Wall, Head of Strategic Planning, FTSU Guardian
Purpose	To provide an update on the action plans and the updated strategy
Previously Considered by	
Report Approved By	Strategy and Engagement Director

Executive Summary

This paper provides an update in respect of workstreams to support the development of Freedom to Speak Up within the Trust and includes:

- Updates to Strategy
- Updates to Action Plans
- FTSU Guardian Vacancy
- Reflection and Planning Tool
- New Quarterly Newsletter
- Speak Up Month
- NGO Guardian Survey
- Ambassadors' Annual Declarations

Related Trust Objectives To meeting which of the Trust's objectives does the proposal contribute:	Please tick relevant objective
SO1 – Safety Quality and Excellence (our commitment to provide the best care for patients)	✓
SO2 – A great place to work for all (Creating the best environment for all staff to flourish)	✓
SO3 - Effective Planning and Use of Resources (continued efficiency of operational and financial control)	✓
SO4 - Innovation and Transformation (Developing the best technology and services to support patient care)	
SO 5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care)	✓

Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☒	Inclusivity	☒
	Accountability	☒		
Risk and Assurance	The actions and communications contained within the documents referred to, comprise the Trust's response to the recommendations by the National Guardian's Office, thereby reducing risk and building assurance that the service provided to staff is compliant with best practice and incorporates recommendations for further development			

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 09 MONTH: JULY 2023 PAPER NUMBER: 07

Legal implications/ regulatory requirements	The Trust's arrangements for Freedom to Speak Up form part of any regulatory inspection. The involvement of NHS England in the development of our action plans and supporting documents provides assurance of the quality and compliance of our arrangements for future inspections.
Financial Implications	The Business Case that has been prepared following the National Guardian's Office Review seeks funding for 1 whole time equivalent Guardian
Workforce & Training Implications	The FTSU arrangements are built upon the expanding network of Ambassadors, who require time for development sessions (meetings are arranged each quarter), and flexibility to support staff and attend promotional events locally, where required. The National Guardian's Office online training content has been incorporated into the Trust's Learning Portal, and the approach to disseminating the training requirements among staff, student and volunteer groups has been agreed and published.
Communications Issues	A Communications Plan has been developed and approved by the Board of Directors
Diversity & Inclusivity Implications	Freedom To Speak Up provides fundamental principles to ensure that the Trust supports and encourages all staff, students and volunteers, irrespective of protected characteristic. In order to have a positive effect on as many of the protected characteristics as possible, the following are key to making our approach successful: • Ambassador network - From April 2023, all reports will incorporate an update on the gender and race mix of the Ambassador Team. Further recruitment exercises will encourage expressions of interest from people representing any of the protected characteristics. • Regular discussion with Chairs of Staff networks to support integrated practice and mutual support • Mutual support with the development of the network of equality champions and mental health champions • Regular updates and signposting with the SALS network (some FTSU Ambassadors are also SALS Advisors) • Participation in Health and Wellbeing Roadshows to promote FTSU to all staff
Quality Impact Assessment	Not required
Data Quality	Supporting documentation and information is maintained by the FTSU Guardian.
Action required Members of the Board of Directors are requested to note the contents of the paper Board members are asked to review and approve the updated FTSU strategy attached.	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: MONTH: JULY 2023 PAPER NUMBER:

Updates to Strategy

As part of ongoing collaboration with NHS England, since the approval of the updated FTSU Strategy by the Board of Directors in January 2023, further amendments that were proposed by NHS England were communicated to the Board of Directors in May 2023, a copy of the amendments are highlighted in the strategy which is attached to this paper. These changes will now be updated in the version of the strategy that is accessible on PolicyStat.

Updates to Action Plans

The action plans that were presented at the March meeting of the Board of Directors have been updated to reflect progress to date and work planned within the next quarter. This takes account of the comments received from NHS England in respect of the Strategy.

Business Case

Following the National Guardian's Office review, a business case was approved for one whole time equivalent Guardian. This post was advertised with a closing date of 13 July 2023 and the interviews will be held week commencing 31/7/2023.

Reflection and Planning Tool

To support the Trust's improvement journey, the Board of Directors invited the National Guardian's Office and NHS England to carry out a development session. This interactive session took place on 10 May 2023 and enabled discussion on matters including perceived barriers to speaking up, managing conflicts and opportunities for improvement within WMAS. The outcomes from the session will be reflected in the Trust's Reflection and Planning tool which will be presented at the meeting of the Board of Directors in October 2023, this is consistent with the requirement for Boards to receive by 31 January 2024:

- Results of the Trust's assessment of its FTSU arrangements against the revised guidance.
- Assurance that the Trust is on track with its FTSU improvement plan.

Quarterly Newsletter

First quarterly newsletter is currently being drafted and will be published based upon data and news from April to June 2023. The first article will include:

- Introduction to the team (Directors, Guardian and Ambassadors)
- Overview of FTSU and how to raise a concern
- Summary of concerns during Quarter 1
- Promotion of Speak Up Month

Speak Up Month

The National Guardian's Office have published the theme for Speak Up Month 2023, which relates to identification and breaking of barriers to raising concerns. Our FTSU team across the organisation will be developing ideas to promote this key message across the Trust as we approach October.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: **MONTH: JULY 2023** **PAPER NUMBER:**

NGO Guardian Survey

The National Guardian's Office has published the results from a survey of Guardians. The results demonstrate some key positives including that 84% said their organisaiton was taking action to tackle barriers to speaking up, and 75% said that retaliation as a result of speaking up was not tolerated. However, there was an increase of 8% to 66% in those that identified the concern that 'nothing would be done' being a barrier to workers. This put feelings of futility on a par with fear of detriment. These will be key topics to focus on during Speak Up Month and in our new Quarterly Newsletter.

Ambassadors

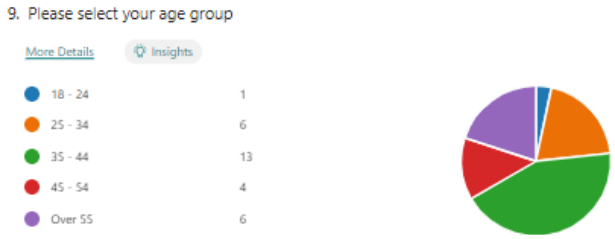
Our team of Ambassadors have been asked to submit their annual declarations, which included confirmation that:

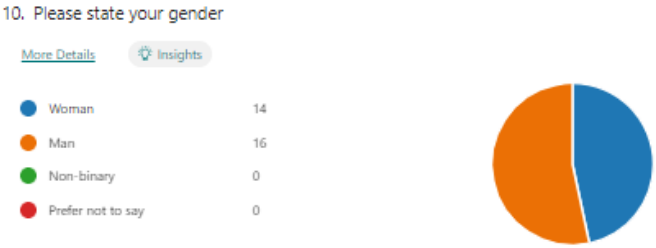
- they are not currently the subject of an investigation
- they have no interest to declare
- they understand the need for complete confidentiality regarding all FTSU concerns that are disclosed to them
- they understand the process for raising a concern on behalf of a staff member
- they wish to continue in their role as FTSU Ambassador
- they welcome a conversation with the Guardian
- they would welcome further development for this role

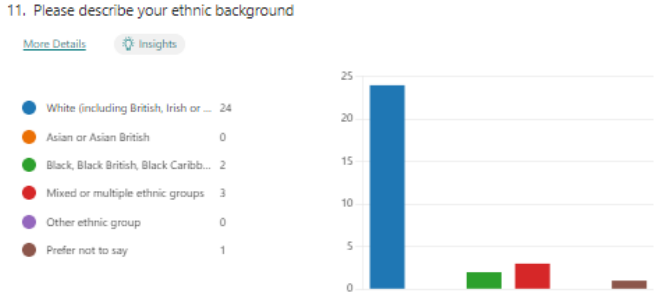
At the current time, 30 Ambassadors have returned their declarations, and the responses indicate:

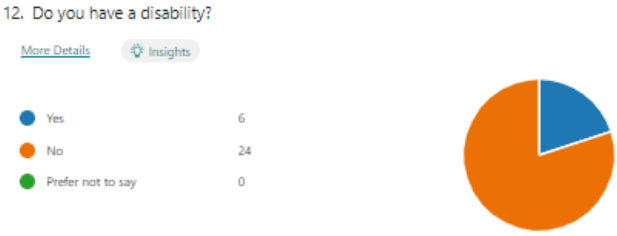
- 77% of Ambassadors stated they would welcome a conversation with the Guardian. This will be achieved through planned, regular one to one conversations and site visits.
- 83% stated they would welcome further development for the role. This is encouraging, indicating that the Ambassadors are keen to do more to support their colleagues. A development plan will be discussed with our Organisational Development team.

The diversity of those Ambassadors who have responded reflects the following:









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There remain some responses to be submitted, and expressions of interest have been received from staff who wish to become Ambassadors. These will be processed so that all potential Ambassadors are on board in time for Speak Up Month. Future expressions of interest will be encouraged by staff, students and volunteers from black and minority ethnicities.

FREEDOM TO SPEAK UP

IMPROVEMENT STRATEGY

DATE APPROVED:	
APPROVED BY:	
IMPLEMENTATION DATE:	
REVIEW DATE:	
LEAD DIRECTOR:	**Strategy & Engagement Director**
IMPACT ASSESSMENT STATEMENT:	**Impact Assessments to be carried out for specific areas of the delivery plan**

Policy Reference Number:

Change Control

Document Number	
Document	
Version	6
Owner	Strategy & Engagement Director
Distribution list	All
Issue Date	
Next Review Date	
Impact Assessment	No Adverse Impact
Author	Strategy & Engagement Director

Change History

Date	Change	Authorised by
20/9/2022	Updated prior to EMB review	Comments received from Medical Director before meeting
20/9/2022	Updated following EMB review	
January 2023	Amended to reflect discussion at Board of Directors	
May 2023	Amendments suggested by NHS England	Changes communicated to Board of Directors
July 2023		Full copy of updated strategy presented to Board of Directors

CONTENTS

1 Purpose

West Midlands Ambulance Service University NHS Foundation Trust (the Trust) is committed to delivering an efficient, high quality health care service which fully integrates all the threads of clinical quality, performance and governance as detailed in the Trust's values, which can be found on our website here: Our Strategy – West Midlands Ambulance Service University NHS Foundation Trust (wmas.nhs.uk)

The Trust's approach to Freedom to Speak Up supports our whole commitment to communication and engagement throughout the organisation, in which we seek to encourage open and transparent communication, and a culture of accountability, where improvements need to be made.

This Strategy sets out the steps for continued development and improvement of the way in which staff and volunteers are supported and encouraged to raise concerns in the most appropriate way for them. Through it, we will demonstrate our commitment to the Trust Vision:

Delivering the right patient care, in the right place, at the right time through a skilled and committed workforce in partnership with Health Economies

2 Drivers for the Strategy

The NHS Constitution places a duty on NHS organisations to aspire to the highest standards of excellence and professionalism, keeping patients at the heart of everything that they do, working across organisational boundaries to provide cost effective healthcare. Having effective and efficient communications and engagement methods will only help the Trust to achieve that duty. WMAS' Five-Year Strategic Plan outlines the strategic context and key drivers which affect the Trust's overall strategy, which can be found on the Trust website here.

Following the Francis Inquiry, a report published in 2015 recommended a package of principles, actions and measures to create the right conditions to ensure NHS Staff would feel free to speak up about patient safety concerns. As a result, all NHS organisations must have in post a Freedom To Speak Up Guardian, with appropriate supporting arrangements that span the whole organisation.

In the foreword to the Department of Health publication 'The Communicating Organisation', it says: "Our vision of improving quality relies on everyone who works in the NHS playing their part in communicating with colleagues, patients and their communities".

Research by the Cabinet Office showed that engaged staff are 43% more productive, perform up to 20% more effectively and take an average of 3.5 fewer sick days per year than disengaged staff.

Given these statements, the ability for everyone to speak up when there are practices, process or individual behaviour which do not support our Trust values must be widely understood and supported at all levels to ensure that the vision, values and objectives can be taken forward in the most efficient and supportive way possible. Freedom to Speak Up is embedded within the organisation, and this strategy identifies processes to ensure continued governance and improvement.

This Strategy should be read in connection with other Trust Strategies which support the Trust to achieve its Vision and deliver services to meet the requirements of patients.

The Board of Directors will be accountable for delivering the Strategy.

3 Current Position

In accordance with the recommendations from the Francis Inquiry, the existing FTSU arrangements ensure that identified senior leads have responsibility governance and ensuring that the processes provide an honest and open culture.

Staff are encouraged to raise concerns and are supported by a team of Ambassadors throughout the organisation, who are on hand to provide advice and support in confidence.

Regular communication takes place between the Guardian and members of the Board with specific responsibilities for FTSU. The Chief Executive and Chairman take a key interest in the progress of FTSU, and the Board of Directors are regularly briefed. The Guardian makes contact with the team of Ambassadors regularly and they have protected time for development sessions each year. The Guardian briefs key groups and committees on a regular basis to ensure, whilst maintaining confidentiality, that the key messages identified are shared and form the basis of learning and future development.

This strategy builds upon the strong foundations, which are already in place, and identifies actions for further development and improvement.

4 Objectives

Given the above, the Trust will look to use the Strategy to achieve the following:

- Informed and accountable leadership creates and develops an environment which actively supports and encourages staff, students and volunteers to speak up in a manner in which they feel comfortable
- An integrated approach to identification of potential concerns and discussion of key trends across the organisation, to ensure that any concerns for the safety of patients are quickly escalated
- Regular engagement and communication with staff, students and volunteers ensures the process for raising concerns is widely understood, and staff feel able to do so comfortably and without fear of detriment
- A proactive approach to learning and continuous improvement

Appendix A identifies the planned actions to support the delivery of these objectives.

5 Who are the Key Audiences

It is vital that the Trust understands who the key audiences are so that suitable and often different communication and engagement methods can be put in place so that messages can be passed and received. The main target audiences for the Trust include:

- Staff
- Board Members – Executive and Non-executive
- Foundation Trust Governors and members
- Staff side union representatives
- Staff 'champions' such as Freedom to Speak Up, Health & Wellbeing, Staff Advice and Liaison Service volunteers
- Volunteers such as community first responders, ambulance car drivers and voluntary immediate care governance responder (ICCG) schemes
- Our regulators such as the Care Quality Commission and NHS England
- The National Guardian's Office

6 What is Necessary for the Strategy to Work

Achieving a culture in which all staff and volunteers feel safe and comfortable to raise concerns requires:

- effective communications and engagement throughout the organisation with strong, open and approachable leadership.

- Clear, concise policies, procedures and strategies, which provide effective processes and support arrangements to ensure the safety and wellbeing of both staff and patients, some of the most applicable policies, procedures and strategies include those within:
    - People Directorate, including those which set out to support the workforce
    - Clinical Directorate, including those which ensure the provision of the highest quality patient care
    - Operations, including those which provide the structure in which the front line staff work
    - Communications and Engagement, including those which set out our aims and processes for communicating with staff and stakeholders

- A thorough understanding of the background and importance of Freedom to Speak Up

- Availability of, and joint planning with, other support arrangements and channels of communication

- Learning from experiences, whether positive or negative

As already specified, communication is not just a top-down process; it is vital that managers listen to the views of staff so that feedback can be received and concerns listened to and acted upon. Several processes are in place to assist with communication and triangulation of information

- The National Staff Survey
- Partnership Working with Staff side
- Board Buddy Scheme
- Day in the Life Scheme
- *Friends and Family Test*
- *Quarterly Pulse Surveys*
- *Staff Development Programmes*
- *Freedom to Speak Up Scheme*
- *All staff Briefings*

7 Core Principles

As a Trust we will aim to build confidence in the organisation by following these principles:

- Transparency in all that we do
- Openness and honesty and respect
- Inclusivity and accessibility
- Proactively and responsibly promote the Trust's reputation
- Demonstrate and encourage innovation and support best practice
- Good communications is embedded in all that we do
- Work with other directorates to create a climate where everyone feels that they can make a positive difference, and raise concerns where they feel it is required
- Consistency of message
- Positivity and enthusiasm
- Assist in ensuring WMAS is recognised as a good employer and the public are interested in working for us
- Maintain public confidence in the service

8 Risks

A number of risks have been identified in the delivery of this strategy. These include:

- The ability to effectively engage with staff due to the mobile nature of the workforce. This can be mitigated by expanding our team of Ambassadors, and encouraging them to work proactively with staff
- Capacity to deliver effective engagement and communications across a wide area with current level of resourcing within the team. The Ambassadors provide a vital role in increasing capacity for communication across the organisation.
- The necessity for all Directorates to work together to ensure that good communications is embedded within the organisation as a key priority. The Trust benefits from established arrangements to support staff in multiple ways, including SALS and Health and Wellbeing advocates. These arrangements provide the opportunity to enhance communication and support for staff with respect to Freedom to Speak Up.

9 Monitoring and Evaluation

To achieve the intended outcomes of this strategy, all staff within the Trust need to be aware of the importance of communications and engagement, which are fundamental to being able to confidently raise concerns. There need to be clear lines of responsibility and appropriate escalation of concerns, when raised.

The FTSU Guardian and Strategy & Engagement Director will monitor the delivery of this strategy, based upon the actions identified in Appendix A, and report on progress though the Trust governance structure, and through regular briefings with the Chief Executive, and Chair Non-Executive Lead. Exception reports will be established and escalated to the Chief Executive and Board of Directors as appropriate.

10 Appendices

A. FTSU Development Plan
A concise overview of the objectives within the strategy and how they are supported by key actions

B. Strategy on a Page
An overview of the purpose of the strategy, and its key objectives, supported by intended outcomes and key areas that fall within the scope of the document.

C. Strategic Framework
An overview of the Vision and Strategic Objectives of the Trust and the governance arrangements associated with the enabling strategies

Appendix A Freedom To Speak Up Development Plan

Objective	Actions	Timescale
Informed and accountable leadership creates and develops an environment which actively supports and encourages staff, students and volunteers to speak up in a manner in which they feel comfortable	Review the practice of maintaining regular updates with the Chief Executive, Executive and Non-Executive Leads for FTSU	March 2023
	Review the content and frequency of updates to Board of Directors to ensure members are fully briefed on FTSU developments	March 2023
	Leaders actively shape the speaking up culture through strategy discussions and triangulation with key informatic trends	September 2024
	Attendance at Senior Management Team Meetings to brief on trends in concerns and to ensure best practice in response in encouraging staff to raise concerns and consistency in response when they do	September 2023 and ongoing
	Communications Plan to include plans for promoting FTSU to all staff in line with national guidance and best practice.	September 2024
	Development plan with Organisational Development Team to ensure leadership courses include updates in respect of all routes to raising concerns	March 2024
An integrated approach to identification of potential concerns and discussion of key trends across the organisation, to ensure that any concerns for the safety of patients are quickly escalated	The FTSU Guardian reviews processes to utilise applicable sources of data to enable triangulation to identify potential concerns.	March 2023
	Learning from patient safety concerns are shared, documented and actioned as appropriate	As required
	Development of dashboard to include: • Trends in cases, including types, location, resolution • Reference to any areas of targeted communication or promotion • Triangulation with concerns raised through other routes	March 2024 and ongoing
Regular engagement and communication with staff, students and volunteers ensures the process for raising concerns is widely understood, and staff feel able to do so comfortably and without fear of detriment	Review communication to ensure staff in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process	March 2023
	Review and increase the number of active Freedom to Speak Up Ambassadors to more adequately reflect the representation of staff and the wider community	September 2023
	Establish collaborative practices with other support services, such as SALS / health and wellbeing services to remove barriers and further encourage staff to speak up and communicate with trusted colleagues	October 2023
	Increased engagement, innovation and openness within the team of Ambassadors to provide the best support for each other and their staff groups	October 2023
	Implement routine pulse surveys and other engagement activities to record experience of detriment.	October 2023 and annually

		thereafter
	Action is taken to address where staff have been victimised as a result of speaking up, regardless of seniority.	As required
A proactive approach to learning and continuous improvement	- Completion of Speak Up Training: All staff, CFRs and Students – complete as part of mandatory training - Completion of Speak Up and Listen Up Training – All Managers, FTSU Ambassadors, Governors - Completion of Speak Up, Listen Up and Follow Up Training – All Board Members and All Band 8c and Above	March 2024 April 2023 March 2023
	A diverse range of staff views are sought, heard and acted upon to shape the culture of the Trust.	October 2023
	Increased reflective practice and discussion amongst the team of Ambassadors, to ensure learning from experience and continuous improvement	October 2023
	Lessons learnt are shared widely both within relevant service areas and across the Trust.	As required
	The speaking up culture and the handling of concerns is subject to audit, both internally and externally, to ensure compliance, best practice and continuous learning	As required
	Regular reports and triangulation of data reported through the governance structure, with regular reports made either confidentially or publicly as required. Key Performance Indicators to be consistent with best practice and to meet the requirements of National Guardian's Office and NHS England	According to frequency agreed within the Committee Structure

Appendix B Strategy on a Page

Vision
Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce; in partnership with local health economies

Freedom To Speak Up Improvement Strategy On a Page				
Purpose	To support the delivery of high-quality patient care through a culture of openness and transparency, responsive to feedback and focused on learning and continuous improvement by using data that is regularly triangulated and reported on			
Objectives	Informed and accountable leadership creates and develops an environment which actively supports and encourages staff, students and volunteers to speak up in a manner in which they feel comfortable	An integrated approach to identification of potential concerns and discussion of key trends across the organisation, to ensure that any concerns for the safety of patients are quickly escalated	Regular engagement and communication with staff, students and volunteers ensures the process for raising concerns is widely understood, and staff feel able to do so comfortably and without fear of detriment	A proactive approach to learning and continuous improvement
Outcomes	• Staff, students and volunteers are knowledgeable about Freedom To Speak Up • Those who feel the need to speak up feel safe to do so without the fear of detriment • All patient safety concerns are escalated, acted upon, and learned from • A growing team of FTSU Ambassadors who are known and trusted in their engagement role • Demonstrable developments, with ongoing learning and improvements in the FTSU process and outcomes •			
Key Areas	Leadership	National Organisations and Regulators	Staff, students and volunteers	Patient Safety

VALUES	World Class Service	Patient Centred	Dignity & Respect	Skilled Workforce	Teamwork	Effective Communication	Environmental Sustainability

Appendix C Strategic Overview

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10C DATE: JULY 2023 PAPER NUMBER: 08B

Emergency Services Operations Delivery Director Report MONTHS: Quarter 1/ June 2023	
Sponsoring Director	Emergency Services Operations Delivery Director
Author(s)/Presenter	Nathan Hudson, Emergency Services Operations Delivery Director
Purpose	This report provides an update from the Emergency Services Operations Delivery Director and covers the year-to-date position up to and including June 2023.
Previously Considered by	Not applicable
Report Approved By	Emergency Services Operations Delivery Director

This report covers the first quarter of 2023.

Overview

From previous months and quarters this has been a better response to patients than previous quarters, although it's important to note that May and June were challenged with performance compared with April.

There has however been a good progress on PDRs, mandatory training, MWB, Clinical mentoring in the form of CS1 shifts. Absenteeism has decreased along with attrition rates for the quarter, and that has continued for June, with a similar picture for July.

Overall incident demand has been down also with low conveyance trend continuing.

Performance

Performance continually challenged with the operational output, hospital delays and productivity the route course.

Despite lower activity, & lower hospital delays from May 2023, performance has deteriorated in June. The main reason for this is the reduction in the operational output. May saw 181,603 operational hours, June was 174,041 operational hours. With a combination of planned overtime suspensions, high training abstractions with 400 staff away at university, and June being the warmest on record have had a massive impact on operational performance, and therefore has put the QTD in a failed position for 30 min, and the YTD in a position now in catch up which no doubt

will bring pressure. Overtime will help, some reduced university abstraction in the following quarter will help.

Cat 2 performance recovery plan is being constructed between me and Jez because more action will be needed for recovery.

Performance for Quarter 1 (June2022)

	Target		Month		QTD		YTD	
Priority	Mean	90%	Mean	90%	Mean	90%	Mean	90%
Category 1	7:00	15:00	8:09	14:13	8:08	14:21	8:08	14:21
Category 1 T	19:00	30:00	9:20	16:38	9:22	16:51	9:22	16:51
Category 2	18:00	40:00	52:11	125:50	47:26	110:36	47:26	110:36
Category 3	60:00	120:00	235:47	664:30	199:12	550:06	199:12	550:06
Category 4	-	180:00	265:50	722:26	236:39	626:19	236:39	626:19
HCP 2hr	-	-	245:16	714:34	206:43	537:19	206:43	537:19
HCP 4hr	-	-	337:23	868:26	302:47	748:41	302:47	748:41

Performance for Quarter 1 (June2023)

	Target		Month		QTD		YTD	
Priority	Mean	90th	Mean	90th	Mean	90th	Mean	90th
Category 1	7:00	15:00	8:18	14:34	8:12	14:29	8:12	14:29
Category 2	18:00	40:00	36:48	82:44	32:18	71:16	32:18	71:16
Category 3	60:00	120:00	167:54	442:59	151:41	386:03	151:41	386:03
Category 4		180:00	210:57	585:39	177:08	454:29	177:08	454:29
HCP 2hr			283:38	737:40	255:53	663:10	255:53	663:10
HCP 4hr			462:47	993:59	407:22	908:41	407:22	908:41

Activity

Activity was less in June than May and that was consistent from the previous year. Emergency activity was down 6% from last year however there is nearly 2,000 incidents down from May 2023.

All Incidents

Cumulative Summary	Current Year	Previous Year	Variation from Previous Year	% Variation from Previous Year
MTD	84277	89165	-4888	-5.5%
QTD	254154	271259	-17105	-6.3%
YTD	254154	271259	-17105	-6.3%

Emergency Incidents

Cumulative Summary	Current Year	Previous Year	Variation from Previous Year	% Variation from Previous Year
MTD	81692	86009	-4317	-5.0%
QTD	246155	261145	-14990	-5.7%
YTD	246155	261145	-14990	-5.7%

Operational Absenteeism Management

Combined sickness year to date for EU operations is 3.19 % with June at 3.14% significantly below the national average and the best in the country from an ambulance service perspective.

Resourcing

Month	Current Year	Previous Year	Variation from Previous Year	% Variation from Previous Year
June 2023/2024	174,041	204,637	(30,596)	-14.95%

Skill mix

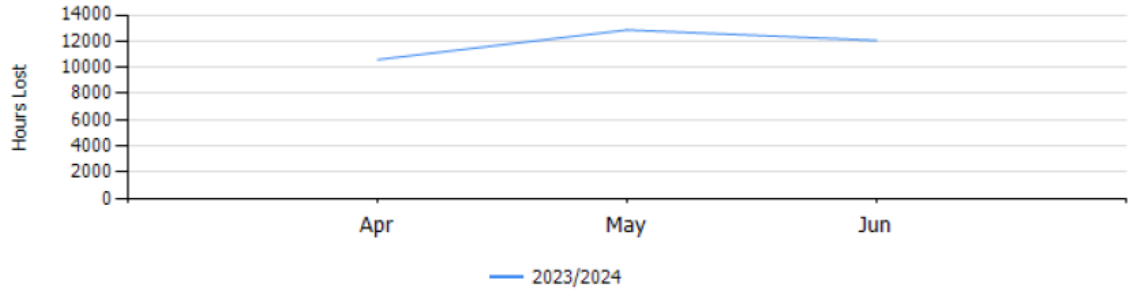
Skill Mix has remained strong with 99.9 % of patients receiving a paramedic on board.

	Apr 23	May 23	Jun 23
Bromsgrove Hub	100.0%	100.0%	99.9%
Coventry Hub	100.0%	100.0%	100.0%
Donnington Hub	100.0%	100.0%	100.0%
Dudley Hub	100.0%	100.0%	100.0%
Erdington Hub	100.0%	100.0%	100.0%
Hereford Hub	100.0%	100.0%	100.0%
Hollymoor Hub	99.9%	100.0%	100.0%
Lichfield Hub	100.0%	100.0%	100.0%
Sandwell Hub	97.6%	99.4%	99.6%
Shrewsbury Hub	100.0%	100.0%	99.6%
Stafford Hub	100.0%	100.0%	100.0%
Stoke Hub	100.0%	100.0%	100.0%
Warwick Hub	100.0%	100.0%	100.0%
Willenhall Hub	100.0%	100.0%	100.0%
Worcester Hub	100.0%	100.0%	100.0%
Total	99.7%	99.9%	99.9%

Hospital delays over 15 min

As mentioned this is some of the best in recent times of hopsital delays, and although still not acceptable, there is some improvments in this area and for patintes for resorce availability.

	April 2023/2024	May 2023/2024	June 2023/2024
2023/2024	10595:04:57	12855:06:21	12058:51:44



Training and PDR update

PDRs	85%
Mandatory day 1	26% all booked
Mandatory day 2	43.30% all booked
MWB	61.61%
CS1 days	65.65%

Attrition

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		Actual Mar-23	Actual Apr-23	Actual May-23	Actual Jun-23
CREWS AVAILABLE					
EMPLOYED STAFF					
Employed FTEs at start of month	FTEs	3,502	3,522	3,529.67	3,506.47
Starters (+)	FTEs	42	24.60	0.90	0.90
Leavers (-)	FTEs	-25	-13.16	-18.10	-14.86
Transfers out of Emergency Services (-)		0	-6.00	-6.00	1.00
Transfers into Emergency Services (+)		3	2.00	0.00	0.00
Net increase / (decrease)	FTEs	20	7.44	-23	-13
Employed FTEs at end of month	FTEs	3,522	3,529.67	3,506.47	3,494

HART

Hart funding agreed.

HART Director Report: June 2023

HART Managers Monthly Summary
- Tom Cheal leaves the Trust. - The Ops team took part in a series of MTA exercises with BTP. - Ant Carswell and Ben Pallante provided support to James Williams for the EPRR submission.

National Ops Group (NOG) & Technical User Group (TUG) Updates	
NOG	- Next meeting (MS Teams) 18/07/23
Workstreams	- NOG Risk Registered reviewed with Matt Brown (new monthly battle rhythm) - Summary of NOG circulated to NH, JW and HART Team Leaders

Operational Deployments								
Month	**HazMat**	**IWO**	**SSO**	**ConSpace**	**SWAH**	**Unstable Terrain**	**Ops Support**	**RRV's Orbit 756**
June	27	15	2	4	9	5	34	345
Previous Month	15	11	1	1	9	4	27	443

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

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National Ops Group (NOG) & Technical User Group (TUG) Updates	
NOG	The next NOG is planned to take place on the 19th of July
The NOG met in May. updates received from the following areas - CBRN TUG (EPD's): Option paper forwarded to James Williams.	

Operational Deployments								
Month	HazMat	IWO	SSO	ConSpace	SWAH	Unstable Terrain	Ops Support	RRV's Orbit 756
June	26	13	1	2	7	2	38	230
Previous Month	28	14	3	3	14	5	29	176

Work Force							
Management WTE	Staffing WTE	Operational Staff	Secondments/ Reservist	LTS/ Maternity	NARU	Vacancies	Reserve Pool
4/4	75.5/75	63.5	5	1	6	0	0

National Position for JUNE 2023 Only

CAT 1

			Response times		
Code	Ambulance Service	Count of Incidents	Total (hours)	Mean (hour: min:sec)	90th centile (hour:min:sec)
Category 1		A8	A24	A25	A26
	England	**77,063**	**11,155**	**8:41**	**15:27**
RX9	East Midlands	7,943	1,168	8:50	15:48
RYC	East of England	8,091	1,221	9:03	17:15
R1F	Isle of Wight	115	18	9:24	17:17
RRU	London	12,698	1,697	8:01	13:36
RX6	North East	3,192	388	7:18	13:04
RX7	North West	8,686	1,212	8:22	14:04
RYE	South Central	3,459	533	9:15	16:27
RYD	South East Coast	4,596	712	9:18	17:00
RYF	South Western	9,884	1,587	9:38	17:59
RYA	West Midlands	9,918	1,373	8:18	14:35
RX8	Yorkshire	8,481	1,246	8:49	15:15

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CAT 1 T

Category 1T		A9	A27	A28	A29
	England	**50,381**	**9,205**	**10:58**	**20:11**
RX9	East Midlands	5,029	1,256	14:59	33:22
RYC	East of England	5,221	1,057	12:09	22:27
R1F	Isle of Wight	79	14	10:17	17:48
RRU	London	8,949	1,754	11:46	20:04
RX6	North East	2,073	283	8:11	14:54
RX7	North West	5,606	958	10:15	17:29
RYE	South Central	2,210	391	10:36	18:57
RYD	South East Coast	2,917	527	10:50	20:18
RYF	South Western	5,938	1,072	10:50	20:15
RYA	West Midlands	6,347	931	8:48	15:47
RX8	Yorkshire	6,012	963	9:37	16:46

CAT 2

Category 2		A10	A30	A31	A32
	England	**367,670**	**225,598**	**36:49**	**1:18:53**
RX9	East Midlands	35,707	23,548	39:34	1:24:48
RYC	East of England	38,034	26,008	41:02	1:28:26
R1F	Isle of Wight	1,229	455	22:14	41:58
RRU	London	51,927	39,570	45:43	1:43:45
RX6	North East	20,065	12,337	36:53	1:16:15
RX7	North West	48,614	21,470	26:30	53:22
RYE	South Central	25,244	14,641	34:48	1:08:26
RYD	South East Coast	32,401	16,817	31:08	1:03:47
RYF	South Western	38,020	27,222	42:58	1:28:36
RYA	West Midlands	40,143	24,638	36:49	1:22:44
RX8	Yorkshire	36,286	18,893	31:14	1:10:43

CAT 3

Category 3 [2]		A11	A33	A34	A35
	England	**124,156**	**260,050**	**2:05:40**	**5:03:18**
RX9	East Midlands	9,854	24,148	2:27:02	5:48:02
RYC	East of England	15,449	31,108	2:00:49	4:53:05
R1F	Isle of Wight	865	814	56:26	2:01:42
RRU	London	13,930	19,805	1:25:18	3:28:43
RX6	North East	6,476	11,163	1:43:26	4:08:55
RX7	North West	15,802	35,615	2:15:14	5:14:06
RYE	South Central	11,804	24,852	2:06:19	4:42:34
RYD	South East Coast	13,565	33,045	2:26:10	5:36:05
RYF	South Western	14,084	27,658	1:57:50	5:10:42
RYA	West Midlands	13,073	37,131	2:50:25	7:27:19
RX8	Yorkshire	9,254	14,711	1:35:23	3:35:20

CAT 4

Category 4		A12	A36	A37	A38
	England	**4,725**	**13,013**	**2:45:15**	**6:39:53**
RX9	East Midlands	270	487	1:48:12	4:26:43
RYC	East of England	346	1,177	3:24:06	9:22:45
R1F	Isle of Wight	57	86	1:30:54	3:29:08
RRU	London	704	1,861	2:38:38	5:55:47
RX6	North East	458	840	1:49:59	4:14:45
RX7	North West	999	3,330	3:19:59	7:24:30
RYE	South Central	607	1,448	2:23:10	5:23:33
RYD	South East Coast	390	1,312	3:21:55	8:22:44
RYF	South Western	284	637	2:14:38	5:50:12
RYA	West Midlands	349	1,310	3:45:16	11:00:35
RX8	Yorkshire	261	524	2:00:31	4:55:30

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10C DATE: JULY 2023 PAPER NUMBER: 08B

RISKS

1. Operational Output/ Productivity.
3. Performance.
4. Hospital delays.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST
REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11A MONTH: JULY PAPER: 09A

Well Led Review (Good Governance Institute) Report, Presentation and Action Plan	
Author(s)/Presenter	Interim Organisational Assurance Director
Purpose	To present the proposal and next steps arising out of the Well Led Review and report of the Good Governance Institute which was presented to the Board prior to its meeting in May 2023.
Previously Considered by	The GGI recommendations report was presented to the Board of Directors prior to its meeting on 31 May 2023. The recommendations draft action plan was shared at the Executive Management Board (EMB) on 27 June 2023 to confirm the recommendation action, Lead and priority status, and the final draft action plan was presented at the Board of Directors Briefing session on 4 July 2023.
Report Approved By	Chief Executive Officer

Executive Summary

To further prepare the Trust pending a possible Care Quality Commission (CQC) visit the EMB agreed, and the Board endorsed a Well Led Review using the 2019 WMAS Well Led Review Report as a benchmark, to identify any areas for review and subsequent learning for reassurance.

Given that the Trust was using the Well Led Review report produced in 2019 by the Good Governance Institute (GGI) as a benchmark and GGI are familiar with the Trust; it was agreed, that subject to an appropriate procurement exercise the GGI should be commissioned to carry out a benchmark review of its 2019 report. The Board agreed to commission the GGI to carry out the Well Led review of the Trust. The final report and salient recommendations from the GGI report was presented to the Board of Directors by the authors prior the Board meeting in May 2023.

After considering the recommendations contained in the report it was agreed that the Interim Organisational Assurance Director would review the report in detail and produce an action plan based on the recommendations contained in the GGI report.

The initial draft action plan has been reviewed by EMB on 27 June 2023 to confirm the recommendation action, the Lead and priority status.

The draft action plan was presented at the Board of Directors Briefing session on 4 July 2023.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST
REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11A MONTH: JULY PAPER: 09A

The final Good Governance report, presentation and resulting action plan (Version 3) is attached for Board members information.	
Related Trust Objectives/ National Standards	The Board of Directors have in place strategic objectives and is currently in the process of reviewing its strategic plan. Given that the Integrated Care Boards (ICB's) have now been placed on a statutory footing, and that the licence conditions require the Trust to collaborate and align its strategy with that of system partners the Well Led Review and Action Plan is timely. The use of the external reviewer is intended to provide assurance to the Trust and the Board.
Risk and Assurance	This is a major element of the Well Led review and makes a number of proposals on a review of the Board Assurance Framework (BAF) and Risk.
Legal implications/ regulatory requirements	Legal advice has not been sought in the preparation of this report. An appropriate Well Led Review at regular intervals of no less than three years is considered good practice. Section C 4.7 of the revised NHSE Code of Governance, which came into force on a comply or explain basis states: *All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.*
Financial Implications	There are no direct financial consequences in relation to this report other than to report that the GGI was commissioned following a procurement exercise and that the total cost of the review was budgeted.
Workforce & Training Implications	This is included within the Well Led review. The Well Led Review will require an assessment of strategy, management and culture. Including engagement with staff.

Communications Issues	Not directly applicable within the context of this report. Communications of course form part of the Well Led Review and the action plan arising.
Diversity & Inclusivity Implications	Diversity & Inclusion forms part of the Well Led Review
Quality Impact Assessment	This has not been completed as part of constructing this report.
Data Quality	The documentation relating to the procurement, process and report are held by the Trust Secretary

Proposals and recommendations:

Board members are requested to note the GGI Final report (Appendix 1), GGI initial feedback to the Board (Appendix 2) and review version 3 of the draft action plan (Appendix 3) which is attached for approval and subsequent action by the relevant Leads.

Learning and reflection of the recommendations and subsequent actions will be undertaken on completion of the action plan and reported back to the Executive Management Board and Board of Directors.

The governance and review process are proposed to be at Executive Board and Board of Director level, as this is a Well Led Board level review.

Good Governance Institute

NHS West Midlands Ambulance Service University NHS Foundation Trust

West Midlands Ambulance Service University NHS Foundation Trust

Developmental well-led review

A **final** report from the Good Governance Institute

May 2023

The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole.

It enables organisations to play their part in building a sustainable, better future for all.

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West Midlands Ambulance Service University NHS Foundation Trust

Developmental well-led review

Document name: Final report

Date: May 2023

Authors: Joanna Watson
Mason Fitzgerald
Mike Weaver

Reviewed by: Professor Andrew Corbett-Nolan
Martin Thomas

Document design: Helen Williams, Designer, @designcreatingbusiness.co.uk

The report has been prepared by GGI Development and Research LLP (GGI) for the board of West Midlands Ambulance Services University NHS Foundation Trust. The report highlights the conclusions drawn from the review and an outline of future suggested actions and improvements to address the identified shortcomings and strengthen the governance structure.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given with regard to the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist. This report is prepared solely for use West Midlands Ambulance Services University NHS Foundation Trust. Details may be made available to specified external agencies, including regulators and external auditors, but otherwise the report should not be quoted or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

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Section 1 – Introduction

The Good Governance Institute (GGI) was appointed by West Midlands Ambulance Service University NHS Foundation Trust (WMAS/the trust) to deliver a developmental well-led governance review using the NHS England well-led framework, taking into account future changes in the way the CQC regulates, with a particular focus on working as part of an integrated care system.

Our analysis uses the eight key lines of enquiry (KLoEs) from the guidance to provide a framework for an assessment of current and future dynamics for well-led development for the trust. Our aim is to provide added value by taking a developmental approach rather than providing a detailed audit of compliance, structures and processes.

The review was undertaken between February and May 2023 and followed GGI's well-established methodology, which is grounded on the triangulation of evidence gathered through meeting observations, interviews, focus groups and documentation review followed by subsequent analysis.

This report sets out the outcomes of this review, and also incorporates the findings of an external stakeholder review which was carried out by GGI over the same period, and for which a separate report has been provided to WMAS. We have also reflected on the findings in this review compared to the findings of the last developmental well-led review in 2019.

The anonymised quotes included throughout the report are taken directly from interviews and focus groups conducted for the review.

Section 2 - Summary of findings and recommendations

WMAS is seen by all those we spoke to as being a great organisation: well run, with strong leadership and a clear focus on operational delivery. We saw much that was very good, and the areas for improvement that we have identified need to be seen in that context.

Since the last well-led review in 2019, the trust has had to respond to the pandemic and to the ever-increasing pressures on NHS services, in particular the challenges caused by delays in ambulance handover at hospitals. There have also been significant changes in the NHS, with the Health and Care Act 2022 bringing new challenges and opportunities to work with other organisations across health and care systems.

The trust has a track record of success, which can make it hard to adapt and change. Actions in response to our findings will need to be considered carefully and delivered in a managed way, so as to deliver change and improvement while retaining all that is great about the organisation.

Below is a summary of findings and recommendations by KLoE. Detailed analysis of findings is included in section 4 of this report.

KLoE 1: Leadership

Summary of findings

The chief executive demonstrates strong leadership, is well respected and is both visible and approachable. The executive team is knowledgeable and experienced. There is a flat structure at the top of the organisation, which has implications for the visibility and authority of executives.

Non-executive directors have a good range of skills. As with the executive directors, some are relatively new to the role. The board as a whole would benefit from time spent together in board development.

The trust is operating in a very different setting now, compared to the last well-led review. Working in systems is increasingly important and there is a need for more partnership working. This requires system leadership, both individually and as a board.

Recommendations

- The board should review the executive team structure once the remaining two executive director appointments have been made; it should also maintain the balance of the board between non-executive and executive voting members.
- A board development programme should be developed and rolled out, supported by individual board member coaching for less experienced directors. This should cover areas such as what it means to be a unitary board, how the board gets assurance, and the trust's role in integrated care systems.
- As part of its continued work on succession planning, the trust should review the wider leadership development offer to senior managers in the trust.

KLoE 2: Vision and strategy

Summary of findings

All those we spoke to have a clear understanding of what the organisation stands for. However, the overall strategy is not widely understood. The strategy is currently being refreshed, which provides an opportunity to ensure that it is well understood, and that it reflects the trust's role as a system partner.

Environmental sustainability currently has a low profile at the trust.

Recommendations

- The trust's strategy needs to reflect its role and responsibilities as a system partner. In refreshing the strategy, the trust should take the opportunity to build on its unique role in each system.
- We recommend that the directors spend time together as a board, to plan their involvement in delivering the strategy, and in monitoring and reviewing progress.
- The profile of environmental sustainability should be raised in the trust, including robust governance arrangements, increased accountability and reporting to the board.

KLoE 3: Culture

Summary of findings

The trust is a large and complex organisation with a diverse workforce. It has a culture that is different from other NHS organisations, with fewer tiers and more collaboration and teamwork. Decision-making is considered to be very rapid, which reflects the nature of the services the trust provides and the challenges it faces.

One of those challenges is engaging with the trust's predominantly mobile workforce. The organisation uses a variety of communication channels to do this. The trust is committed to creating an open and honest culture where staff feel comfortable speaking up, by focusing on communication and collaboration and by investing in freedom to speak up (FTSU) capacity.

The trust is concerned about who isn't speaking up. This is a challenge that many organisations face, but it is important to make sure that everyone's voice is heard. The trust is committed to creating a positive and inclusive work environment for all staff, and to embedding equality and inclusion in all aspects of its work.

Recommendations

While recognising the evident progress the trust has made in relation to equality, diversity and inclusion (EDI), the trust board should ensure EDI remains a strategic priority so it can be assured that progress continues to improve the lives of all its staff and service users.

The trust is taking action to create a more open and supportive culture where staff feel safe to speak up about concerns. We recommend the trust ensures there is specific focus on:

- Encouraging staff to speak up about concerns and providing them with the support they need to do so.
- Addressing the underlying causes of staff concerns – this could include

addressing workload, staffing levels, and the availability of resources.

- Recognising and valuing staff for their work through regular feedback, performance reviews, and opportunities for professional development.

By taking these steps, the trust can create a more positive and supportive working environment, which will lead to improved patient care.

KLoE 4: Governance

Summary of findings

The trust has a desire to be open and transparent in governance and in sharing information, but this has led to a high number of meetings and lengthy papers. Board and committee meetings tend to be unduly operational, with little discussion of strategic issues, and there is very limited use of assurance reports, with reports regularly going to more than one meeting in the same form.

By improving the effectiveness of meetings, much better use could be made of time spent in meetings and in preparing for them. Increased resourcing of governance support is needed to facilitate this.

Recommendations

- The trust should focus on increasing the effectiveness of meetings, including:
  - reducing the length of papers, taking out unnecessary detail.
  - increasing the use of assurance reports from board committee to board, and from management groups to executive management board.
  - tightening up on reports going to more than one committee, to minimise duplication of discussions.
  - using the board assurance framework (BAF) to help set the board agenda, so as to have a strategic, risk-based focus.
- The policy group should be renamed and its objectives reviewed. The trust should consider forming a separate group with oversight of policies to provide assurance that policies are being managed and updated appropriately.
- To improve resilience and support improvement, we recommend increasing the size of the central governance team.

KLoE 5: Management of risks, issues and performance

Summary of findings

The trust is making progress in improving its risk management process. It is working to improve the risk identification process and to make it easier for people to report risks.

We believe that the current BAF does not adequately reflect the trust's strategic risks, as the board has not identified risks relating to all of its strategic objectives, and there are too many risks included, many of which are very operational and detailed. We heard that the BAF has evolved into a top risk register over the past three years, focusing on operational risks. It does not include wider risks, such as those posed by partners in the system, or risks relating to the workforce, such as staff wellbeing.

There are plans to develop a new clinical supervision model in the trust that will focus on patient safety and patient outcomes. It is hoped that this new approach to clinical supervision will be valued by staff and embedded in the culture of the organisation.

Recommendations	The trust should revise the BAF to include a smaller number of strategic risks, ensuring that risks in relation to each of the strategic objectives have been considered. This should then be used to shape the agenda and the discussions that take place at the board and its committees, so that the board's focus is on strategic issues.

KLoE 6: Information management

Summary of findings	The trust has a culture that values the importance of good information and has systems in place that enable staff to do their job. However, as reflected in our findings above, too much data is being presented to board and committee meetings, with duplication and a lack of clear purpose. Effective data visualisation methods (i.e. SPC charts) are used sporadically and much of the data presented is difficult to read and digest.
Recommendations	The trust should: • Adopt the 'hierarchy of data visualisation' and work with staff to ensure that all data presented supports intelligent decision-making. • Review and update the information available to the public about the performance of the trust (via the website).

KLoE 7: Service users, staff and external partner engagement

Summary of findings	Operating across six integrated care systems (ICSs), with more limited patient engagement time than other NHS service providers, and with staff spread over such a vast geography, the WMAS stakeholder context has huge challenges. We observed lots of good practice, particularly around staff and patient engagement, and there is evidence that the trust is attentive to continually developing and improving. In its engagement with staff there are good systems in place and evidence of engagement on service improvement and culture development. There are, however, some cultural challenges and issues around inclusivity. When it comes to partners, the trust is good at communicating its decisions, operates transparently and is good at information sharing. The main area for improvement is around engagement and input, especially at a strategic level, with the integrated care systems it operates in and with how key partners are involved in trust decision-making.
Recommendations	• The board should look at the culture in the organisation and its impact on engagement. • More needs to be done to increase executive and non-executive visibility with staff. • The board should review and increase the resourcing and support for staff networks and provide them with greater opportunities to engage with the board. • The trust should think about ways it can collaborate with partners (other

providers, Healthwatch) on patient engagement around service quality and experience.

- The trust should review its ICS engagement and involvement and do more to contribute strategically to the systems in which it operates, especially in the Black Country ICS as host, to develop the trust's sphere of influence.
- The trust should do more to engage and involve partners in the decision-making process and should review/ develop its process for doing so.
- The trust should look at how it can support and create more opportunities for governors to engage with staff, even if this must be virtual due to operational constraints.

KLoE 8: Learning, continuous improvement and innovation

Summary of findings

We saw and heard much that was positive about the trust's approach to learning and innovation. There is, however, a disconnect between the results of the latest staff survey and information we received from frontline staff, which requires further exploration.

Stakeholders perceive the trust as having a strong learning and improvement culture. There is more of a mixed view about the trust's appetite for innovation but some great examples were shared. There is a general feeling that the trust could do more in this space, such as leading on more research and conducting more collaborative learning and improvement exercises with partners.

Recommendations

The trust should:

- Review the results of the staff survey in detail to consider the disconnect in staff experience of improvement, and develop plans to make improvements in this area.
- Consider how learning, improvement and innovation can be done collaboratively with partners at place and system level.

Section 3 – Context, acknowledgements and limitations

Context

West Midlands Ambulance Service serves a population of 5.6 million people covering an area made up of Shropshire, Herefordshire and Worcestershire, Staffordshire and Stoke-on-Trent, Coventry and Warwickshire, Birmingham and Solihull, and the Black Country conurbation, which are six separate integrated care systems.

The trust responds to around 4,000 999 calls each day, employing approximately 7,000 staff and operating from 15 hubs across the region. The trust also provides non-emergency patient transport services across some parts of the region and beyond.

The trust has been rated 'outstanding' by the Care Quality Commission (CQC) for several years; the most recent CQC inspection took place in 2019.

Acknowledgements

The GGI review team would like to thank everyone who made themselves available for interviews and to those who provided project support and documentation for review.

Limitations

The review is limited to the documentation that was provided to GGI during the time period described and confined to the information provided to us by those who we interviewed as part of this process or observed at those meetings we were able to attend. The review was carried out within a relatively short period and this, together with the other limitations, provides a caveat to the report's findings.

Section 4 – Findings and recommendations

KLoE 1: Leadership

KLoE 1: Characteristics of good organisations

- Leaders have the experience, capacity, and integrity to ensure that the strategy can be delivered and risks to performance addressed.
- The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.
- Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.
- Leaders at every level are visible and approachable.

Chief executive (CEO) and the executive team

The chief executive officer (CEO) demonstrates very strong leadership and is very well respected, both within the trust and by its partners. He is visible across the organisation, and more widely across the region, and is considered to be very approachable. He also has national roles in relation to the ambulance service, which enables him to bring insight from all ambulance services in England.

The executive directors are mainly drawn from staff who have been at the trust for many years. The trust has a very flat executive team structure, with 15 individuals in the organisational structure reporting to the CEO. This has potential implications for the workload of the CEO, although we saw no evidence that this is an issue in practice. There are currently two vacancies: the director of nursing retired in March 2023, and the trust has not yet been able to appoint a successor; and the trust is looking to appoint to a new post, director of performance and improvement, in the near future. Once these appointments are in place then it will be appropriate for the trust to review the structure of the executive team.

Non-executive directors (NEDs)

NEDs are from a wide range of backgrounds and experiences, with a good range of skills and experience. Some of the NEDs are working full-time, and all balance the role of NED with other roles and responsibilities. Because of this, the pressures of the number of meetings and the high volume of meeting papers which are outlined in KLoE 4 below are very significant.

For some of the NEDs this is their first experience as an NHS NED and in interviews and meeting observations we noted that NEDs do not all have a full understanding of what it means to be a member of a unitary board, nor about wider issues such as how the board gets assurance.

Board membership

The board is relatively large. The constitution sets out a board comprising the chair, up to six non-executive directors, and up to six executive directors. The trust currently has six NEDs and the structure has five executives. We understand this to be due to one of the current NEDs standing down after 6 years in post and the trust deciding to keep her on the board subject to annual review, in order to ensure a smooth transition and transfer of knowledge to the newly appointed NED. We would recommend maintaining an equal number of voting non-executive and executive directors, to give balance to the board.

In addition to voting directors, the trust has seven non-voting executive directors. This gives rise not just to a large board membership, but more significantly to an increased risk that discussion at board becomes unduly operational.

Visibility of the board

We heard mixed views on the visibility of board members. All executive and non-executive directors are linked to one of the ICSs the trust serves, with the expectation of regular on-site visits. While these have happened in some areas, this is not the case for all, and it is important that the board reflect on this and consider how best to increase the visibility of the board (see also KLoE 7 below).

The flat executive team structure with a large number reporting to the CEO has implications for visibility too, as stakeholders expressed the view that they see individuals who need to 'report back' rather than have the authority to represent the trust.

Development of the board

As noted above, there are both executive and non-executive directors who are relatively new members of NHS boards. In addition, because of the impact of the pandemic and changes in membership, board members had very few opportunities to spend time together. We strongly recommend that the trust procures external board development and ensures that board members spend time exploring the issues we have raised above, so that they share a common understanding of the role. The board may also wish to supplement this with individual coaching for directors, both executive and non-executive, who are relatively new to the role.

The board should also explore, more broadly, the need for the board and its members to work differently as part of integrated care systems, recognising that to be successful in the NHS going forward requires different skills and focus – in particular in relation to system leadership – to what has been valuable in the past. The appointment of a director of strategy and engagement has made a significant difference, creating a clear portfolio on the board for liaising and working with partners. However, the trust's role as a partner is the responsibility of all board members, and this needs to be developed further.

Wider trust leadership

The trust has a team which provides leadership courses internally, although the funding is limited. Support for leadership development should be reviewed as part of the trust's succession planning, where progress has been made but there is still more to do.

Recommendations

- The board should review the executive team structure once the remaining two executive director appointments have been made; it should also ensure it maintains the balance of the board between non-executive and executive voting members.
- A board development programme should be developed and rolled out, supported by individual board member coaching for less experienced directors. This should cover areas such as what it means to be a unitary board, how the board gets assurance, and the trust's role in integrated care systems.
- As part of its continued work on succession planning, the trust should review the wider leadership development offer to senior managers in the trust.

KLoE 2: Vision and Strategy

KLoE 2: Characteristics of good organisations

- There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.
- The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.
- Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.
- The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.
- Progress against the delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

In all of our interactions with the trust and its stakeholders, we found that all had a clear understanding of what the organisation stands for, and the focus on excellent operational performance and quality is clearly understood. We heard from staff how objectives cascade through the organisation.

The overall strategy is, however, not widely understood. This came through in our interviews with directors, our focus groups with staff, and our meetings with stakeholders. There have been many changes to the environment in which the trust operates that need to be reflected, including system working, financial challenges, and unprecedented operational pressures. The current refresh of the strategy provides an opportunity to reinvigorate it, and to find new ways to share and promote it. Given the increased importance of working in systems, this is an opportunity to engage staff and external stakeholders to develop a strategy that is well understood and reflects the trust's unique role in each system in which it works.

The strategic focus of the organisation has been strengthened with the appointment of a director of strategy and engagement. As we set out in KLoE 4 below, the board has a tendency to focus on operational issues rather than strategic. In refreshing the strategy the board should take time together to plan how to ensure that delivery of the strategy and managing the associated risks, using the board assurance framework, are driving their work.

Environmental sustainability

Environmental sustainability has an increasing profile within the NHS, with the target of reaching net zero by 2045. It is one of the eight quality statements in the new CQC assessment framework. Environmental sustainability is included in the trust's vision, focusing on investing in the fleet, using technology to become fully paperless, and increasing recycling.

In line with other NHS organisations, the trust has a green plan which sets out its commitment to achieving net zero. This plan was approved by the board in January 2022. The plan included 21 actions, two of which were complete, five were in progress but the remaining 14 were all 'under review'.

The trust has a health, safety, risk and environmental group responsible for monitoring the implementation of the green plan. This group reports to the quality governance committee, which in turn reports to board. Once a year the quality governance committee reviews progress in delivery of the sustainability strategy.

During our review we saw no evidence that progress in the green plan has been reported to the board. Overall, environmental sustainability appears to have a low profile within the trust.

Recommendations

- The trust's strategy needs to reflect its role and responsibilities as a system partner. In refreshing the strategy, the trust should take the opportunity to build on its unique role in each system.
- We recommend that the directors spend time together as a board, to plan their involvement in delivering the strategy, and in monitoring and reviewing progress.
- The profile of environmental sustainability should be raised in the trust, including robust governance arrangements, increased accountability and reporting to the board.

KLoE 3: Culture

KLoE 3: Characteristics of good organisations

- Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.
- Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.
- There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.
- Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.
- Equality and diversity are actively promoted, and the causes of any workforce inequality are identified, and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.
- There is a culture of collective responsibility between staff and teams, where conflicts are resolved quickly and constructively and responsibly is shared.

The trust's vision and values

We were told that the executive management board (EMB) wanted the trust's values to be seen as everyone's values, not just the organisation's, so they took a collaborative approach to developing and launching them. They engaged staff at all levels through team sessions, anonymous surveys and discussions with networks and trade unions. This helped to ensure that the values were relevant and meaningful to everyone in the organisation. The organisation relaunched its values and behavioural framework following approval by the board.

The trust is taking a very proactive approach to embedding its values into the organisation, including a 'values check' in all decision-making processes – a commendable way to ensure the values are actually being considered when making decisions. The plan to include a values section in all performance reviews will help to ensure that employees are held accountable for living the values.

Freedom to Speak Up

In February 2023 the National Guardian's Office (NGO) for the NHS published a report following a review in response to consistent findings that the speaking up culture in NHS ambulance trusts appeared be more challenged compared to other NHS trust types. The NGO wanted to understand why this was. At the time of the review ambulance services had been under immense pressure for an extended period, with ambulance workers bearing some of the consequences of systemic and operational issues affecting the whole of the NHS.

The trust is committed to creating an open and honest culture where staff feel comfortable speaking up, and it is providing a variety of ways for staff to do this. FTSU concerns are taken seriously and are investigated and followed up as appropriate. FTSU arrangements and emerging themes are regularly discussed at board, and the board has spent time considering the NGO's report. Overall, the trust is taking a positive approach to creating a more open and honest culture. It is hoped the trust's focus on communication and collaboration will be successful in creating a more cohesive and productive work environment.

The trust is taking action to increase the resources given to FTSU, including increasing the number of FTSU ambassadors, promoting their work and bringing forward a business case to expand FTSU capacity. Further recruitment of FTSU ambassadors will focus on ensuring that the team is diverse and inclusive. The trust is concerned about who isn't speaking up. This is a challenge that many organisations face, but it is important to make sure that everyone's voice is heard.

Trust culture

The trust is a large, complex, multifaceted organisation with a diverse workforce. We were told the culture of the trust is very different to that of an acute trust or commissioning organisations and more akin to a police or fire service. Ambulance trusts tend to have fewer tiers, which results in less bureaucracy and a more streamlined decision-making process. There are also fewer 'professional tribes', which results in greater collaboration and teamwork. Unlike other NHS organisations, decision-making in the trust is considered to be very rapid and this reflects the nature of the services provided by the trust and the challenges it faces.

Some staff expressed concerns about the pace of change in the organisation, feeling that things happen too slowly. Others commented on an 'us versus them' mentality between frontline staff and management. We heard that some people see the organisation as arrogant, but it is thought this is a perception that can be changed through better communication. Others see the organisation as well-run and willing to report concerns. Staff told us that there is a good reporting culture for risk and patient safety, and staff are generally open and transparent about these issues.
We were told that the organisation is willing to raise the alarm about issues, even if it means that other organisations will be negatively affected. This willingness to raise the alarm may be seen as arrogance by some, but we see it as a sign of a healthy organisation that is not afraid to challenge the status quo.

Equality, diversity, and inclusion

The trust's equality and inclusion report, dated November 2022, outlines the progress made in the previous two quarters. Key findings from the report are as follows:

- There are robust policies and procedures in place to ensure that all staff are treated fairly and with dignity and respect.
- The trust is aware of its legal equality duties as a public sector employer and provides equality and diversity training to all staff.
- The trust has developed an equality impact assessment (EIA) toolkit and is using it to assess the impact of new policies and procedures on equality.

- A range of equality analysis screenings have been carried out to ensure that the trust is paying due regard to the three aims of the Equality Act 2010.
- The trust has developed a new equality and inclusion strategy, which sets out its vision and goals for equality and inclusion.
- The trust is committed to embedding equality and inclusion in all aspects of its work, including workforce, services, and community engagement.

This report demonstrates the trust's commitment to equality and inclusion and its willingness to take action to improve the lives of its staff and service users.

Annual staff survey

The response rate for the last staff survey was 39%, which is down from 44% in 2021. Of the staff who responded, 179 identified as Black, Asian, or Minority Ethnic (BAME). This is a decrease from 226 in 2021. The trust is ranked sixth out of the seven trusts for the most positive responses received. This means the trust has a lower percentage of staff who are satisfied with their working environment than the other six ambulance trusts. The survey results provide valuable insights into the areas where the trust can improve staff satisfaction.

The survey results show that there has been a significant drop in advocacy, with respondents feeling less safe to speak up about concerns and less confident that the trust would address their concerns if they did. There is also a significant drop in satisfaction with the recognition and value that respondents feel they get for their work. However, there are also some positive results. Personal development is one of the most improved areas, with respondents feeling that they have more opportunities to improve their skills and knowledge. The trust is also doing well in terms of health and wellbeing, with respondents reporting that they are generally healthy and well rested.

The survey results are analysed by the trust's equality and diversity team. The results are shared with all localities, so that staff can see how their trust is performing overall and in comparison to other trusts. The staff survey response action group (SSG) is made up of representatives from across the trust, including staff, managers and clinicians. The SSG builds a trust-wide action plan to address the issues raised in the survey. The action plan is signed off by the executive membership board (EMB) and the board of governors. The data from the survey is triangulated with other data measuring employee engagement to get a more complete picture of employee engagement.

Recommendations

While recognising the evident progress the trust has made in relation to equality, diversity and inclusion (EDI), the trust board should ensure EDI remains a strategic priority so it can be assured that progress continues to improve the lives of all its staff and service users.

The trust is taking action to create a more open and supportive culture where staff feel safe to speak up about concerns. We recommend the trust ensures there is specific focus on:

- Encouraging staff to speak up about concerns and providing them with the support they need to do so
- Addressing the underlying causes of staff concerns – this could include addressing workload, staffing levels, and the availability of resources.
- Recognising and valuing staff for their work through regular feedback, performance reviews, and opportunities for professional development.

By taking these steps, the trust can create a more positive and supportive working environment, which will lead to improved patient care.

KLoE 4: Governance

KLoE 4: Characteristics of good organisations

- Structures, processes, and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.
- The board and other levels of governance in the organisation function effectively and interact with each other appropriately.
- Staff are clear on their roles and accountabilities.

The trust has a culture of openness and transparency in governance and information. In many ways this is to be commended, but this manifests in an approach where the sharing of information and decision-making leads to lengthy meeting papers and a high number of meetings.

Board meetings

The board schedule for the year ending 31 March 2023 was that the board would meet in public five times. Throughout the year, five extraordinary meetings were added, resulting in two board meetings in September 2022 and in March 2023. We understand that in some cases these additional meetings were at times when the board was planning to meet informally in any case. However, this approach to meetings is generating significant additional work for the organisation, for those supporting the meetings and drafting papers, and for board members in preparing for meetings.

While in rare cases there seems to have been good reason for an additional meeting, in other cases it appears to happened because there was more to be discussed than could be covered in the planned cycle of meetings. This also means that the board has fewer opportunities to meet informally, because of the time spent in formal meetings.

It would be better to plan for board meetings six times a year, and then to stick to that plan unless there are exceptional circumstances. We also heard in interviews with NEDs that requests for approval are frequently sent to board members between meetings; this should be done rarely, if at all.

One of the reasons for the high number of meetings would appear to be a focus on operational, rather than strategic, matters. The agendas for board meetings reinforce this tendency, as they are structured as reports from each executive director. There was little discussion of strategic issues or the trust's role in the integrated care systems.

The papers for board meetings are in general lengthy, and longer than most other NHS trusts. The public board papers in 2022/23 averaged 351 pages, added to which there is a trust information pack which averages 85 pages and confidential board papers too. The meeting we observed, on 29 March 2023, had in total 1,123 pages of papers. This was the second meeting in the month and, in addition to the extraordinary meeting two weeks before, the large amount of papers creates a huge burden on directors. These papers were unusually large because the audit committee meeting earlier in the month had not been quorate – but even without this the number of papers would still be excessive.

There were a range of reasons why the papers for the board meeting we observed were long, including:

- Documents which are publicly available, and so could have been shared electronically.
- Reports 'to note', rather than for discussion or decision.
- Reports which had been in full to board committee(s) and which could have been reported to the board in an assurance report.

- More detail in reports than was necessary, which increases the risk that the board is operational in focus, rather than strategic.

In appendix B we have included further details of this board meeting, including commentary on the length of papers.

We heard from both executive and non-executive directors that board papers are not all read by board members, which is unsurprising given the volume, and that this is evident in the discussion at meetings. Because this is the accepted norm for the trust, papers cannot be taken as read, and presenters spend time talking through papers. Board meetings would be much more effective with:

- Shorter papers .
- Fewer reports 'to note'.
- Assurance reports from board committees.
- Use of the BAF to inform the agenda and focus the discussion on high-risk areas.

Board committees

The structure of board committees is typical of an NHS trust, with quality governance, people, and performance committees in addition to the required audit committee and remuneration and nominations committee. As part of our review we observed meetings of the audit, performance, people and quality governance committees. We noted similar themes to those noted at board:

- Long papers, with excessive operational detail.
- Overlap of papers both within committees and across committees.
- Papers were presented in detail rather than taken as read.

The operational nature of the discussion is at least in part because the governance structure includes management groups reporting to board committees. This is, in our view, suboptimal, as it leads to operational groups reporting to board committees, and so increases the likelihood that board committee meetings will be more operational in content and approach. These groups should instead be reporting to the executive management board, which would then consider what should be reported to board committees.

The audit committee we observed was not quorate, and the previous meeting had not been quorate either. While the performance committee we observed was quorate, there were a number of apologies at the meeting we observed, and a NED had to step in as chair at short notice. We noted directors leaving both committee and of board meetings early. Improving the focus of meetings would help reduce the number and length of meetings, which should help attendance levels. Equally, it is important for directors to commit to attending board and committee meetings as a key part of their role. It would be beneficial to explore this in board development sessions.

Executive management board (EMB)

EMB meets two to three times each month. The meetings are well structured, with clear agendas and papers. As with other meetings, the volume of papers is high. At the meeting we observed, the papers totalled 265 pages, some of which were discussed at a meeting of EMB the following day. There was much that was positive about the meeting, including a good level of attendance from executive directors, a focus on the action plan, discussion of what should go to board, and highlighting risks and learning at the end of the meeting. It would have been better if there had been more reporting from management groups to EMB, and less detail at EMB. This would also provide more opportunity for discussion as there was little opportunity for this at the meeting we observed.

Policy group

There was reference at meetings to the trust's policy group. While the group is very much valued by the trust for the work it does in reviewing policies, it is in reality a staff consultation group, with staff-side representation. The objectives for the group include phrases such as 'consult and negotiate', but also 'to ensure policies are appropriately reviewed, updated and maintained', which is not appropriate for a staff consultation group. We heard reference at meetings to the policy group 'approving' policies, which is potentially misleading.

Governance support

The trust is very much reliant on one individual for the support of its governance. Several interviewees commented that they felt more resource was required, and we concur with that view. Increasing the size of the team would not only increase resilience but would also enable focus to be given to improving the effectiveness of the board and its committees.

Recommendations

- The trust should focus on increasing the effectiveness of meetings, including:
  - Reducing the length of papers, taking out unnecessary detail.
  - Increasing the use of assurance reports from board committee to board, and from management groups to executive management board (see example in Appendix C).
  - Tightening up on reports going to more than one committee, to minimise duplication of discussions.
  - Using the board assurance framework (BAF) to help set the board agenda, so as to have a strategic, risk-based focus.
- The policy group should be renamed, and its objectives reviewed. The trust should consider forming a separate group with oversight of policies to provide assurance that policies are being managed and updated appropriately.
- To improve resilience and support improvement, we recommend increasing the size of the central governance team.

KLoE 5: Management of risks, issues & performance

KLoE 5: Characteristics of good organisations

- There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.
- Financial pressures are managed so that they do not compromises the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.
- The organisation has the processes to manage current and future performance.
- Performance issues are escalated to the appropriate committees and the board through clear structures and processes.
- Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve.

The risk management process

The trust's risk management strategy is a clear, concise, document. In addition, the trust has supporting documents that underpin the strategy. These documents include:

- A risk appetite statement policy, which sets out the trust's appetite for risk and its approach to managing risks.

- A risk assessment and management policy, which outlines the trust's approach to identifying, assessing and managing risks
- A competency for completing a risk assessment document, which sets out the skills and knowledge staff need to complete a risk assessment document.

These supporting documents are an important part of the trust's risk management strategy. They help to ensure that the trust is able to identify, assess, and manage risks effectively. The trust organisational committee structure supports delegated risk management systems within the trust.

When speaking to staff we asked them to identify what they considered to be the three top risks faced by the trust. Handover delays were reported to be the top risk. Second was the risk of patient harm resulting from handover delays, and the trust's inability to respond quickly to incoming calls because of capacity being tied up elsewhere was third.

The trust is making progress in improving the knowledge of risk, working to improve the risk identification process, and making it easier to report risks.

The board assurance framework

A board assurance framework (BAF) should bring together all the relevant information about risks to the board's strategic objectives. It is an essential tool for boards but, like all tools, it needs to be used with skill and diligence. Used properly, the BAF should:

- Provide a structure and process for the board to focus on those risks that might compromise the achievement of the organisation's strategic objectives .
- Provide the board with a simplified approach to reporting and prioritisation and drive the board's (and sub-committees') cycle of business.
- Encourage individuals and groups to think proactively about their objectives, with board agendas focused on strategic and reputational risks rather than operational issues.

A BAF is an agreement between the board and the trust's management which summarises:

- The organisation's strategic objectives.
- The risks to achieving these.
- The controls management are to put in place to minimise the likelihood or effect of those risks materialising.
- The assurances the board needs to be confident that the controls are operating effectively.

The BAF should comprise strategic risks as defined by the board: the major risks that could prevent the board from fulfilling objectives in the trust's agreed strategy. In our view, a BAF should contain a small number of risks, ideally only one or two for each strategic objective, so that the board is focused on truly strategic risks. By contrast, the corporate risk register comprises operational risks, mainly identified by services themselves.

The board of directors review the BAF at least four times each year. The format has been revised recently, in response to recommendations made in an internal audit report. In the BAF presented to the board meeting in March 2023 the total risks included were:

Strategic objective 1: safety, quality and excellence	20 risks
Strategic objective 2: a great place to work for all	No risks

Strategic objective 3: effective planning and use of resources	6 risks
Strategic objective 4: innovation and transformation	4 risks
Strategic objective 5: collaboration and engagement	2 risks

All risks rated 20, (consequence 5 x likelihood 4) after applying all mitigating actions were reported in relation to strategic objective one. The risks were:

- Risks associated with extensive hospital breaches, delays and turnaround.
- Stacking of incidents at times of high demand.
- Clinical validation for category-2 999 calls impacting patient safety and performance.
- Consideration for category-2 IEUC closing Instructions impacting patient safety, performance, and staff wellbeing.

We believe that the current BAF does not adequately reflect the trust's strategic risks, as the board has not identified risks relating to all the board's strategic objectives, and there are too many risks included, many of which are very operational and detailed.

Most of the risks identified on the current BAF are related to strategic objective one – safety, quality and excellence – as these risks were thought to be more visible and easier to identify than risks related to other strategic objectives. We heard in interviews that the BAF has evolved into a top-risk register over the past three years, focusing on operational risks. It does not include wider risks, such as those posed by partners in the system, or risks relating to the workforce, such as staff wellbeing.

The BAF should be revised so that it includes the risks of not delivering each of the strategic objectives, and excluding operational risks. This would make it a more effective tool for the board to use in managing risk, which could then be used to shape the agenda and discussions at board meetings.

Managing performance

As a unitary NHS board, all directors are collectively and corporately accountable for organisational performance.

The performance committee is responsible for providing information and making recommendations to the board of directors on financial, investment and operational performance issues and for providing assurance that these are being managed. As noted in KLoE 4 above, governance would be improved by the introduction of assurance reports from committee to board.

Clinical supervision

We were told of plans to develop a new clinical supervision model in the trust that will have a focus on patient safety and patient outcomes. It is expected to support all levels of the organisation, including patient transport services and advanced practitioners. The model of clinical supervision will be role specific, flexible and tailored towards individual learning needs to help staff reflect on and improve their practice. It is hoped this new approach to clinical supervision will be valued by staff and embedded in the culture of the organisation.

Recommendation

The trust should revise the BAF so that it includes a smaller number of strategic risks, ensuring that risks in relation to each of the strategic objectives have been considered. This should then be used to shape the agenda and the discussions at the board and its committees, so that the board's focus is on strategic issues.

KLoE 6: Information management

KLoE 6: Characteristics of good organisations

- Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.
- Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.
- Performance information is used to hold management and staff to account.
- The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.
- Information technology systems are used effectively to monitor and improve the quality of care.
- Data or notifications are consistently submitted to external organisations as required.
- There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

EPR

The trust's electronic patient records systems are viewed as good. There is a positive culture about the use of data in the organisation and data quality is seen as good.

Business intelligence

The trust has put significant effort into its business intelligence systems and staff at all levels report that they have access to the information they need. Governors also reported that they got the information they need to carry out their role.

A number of dashboard systems are in use, which enables staff to monitor their individual and team performance. Regular audits are carried out to monitor quality and performance, and information is fed into the trust's governance framework.

Quality & performance

The quality report submitted to the public board meeting has some good data visualisation, i.e. SPC charts, but also a number of very detailed tables that are unreadable, as well as some that are not accompanied by any narrative explanation. Other information is written in small text, which makes it difficult to read. The paper template reads 'business data that is not intended for public consumption', which seems odd given that it is available for a public board meeting.

The CEO's national role also means that the trust has good awareness of its relative performance. We note, however, that the trust's website section on 'How is WMAS performing' has a link to a dataset that has not been updated since April 2020. The trust should therefore consider how it should make current information about performance accessible to the public.

Reporting

We observed that there are large amounts of data being reported to the trust board and its committees. Some of the issues we identified are:

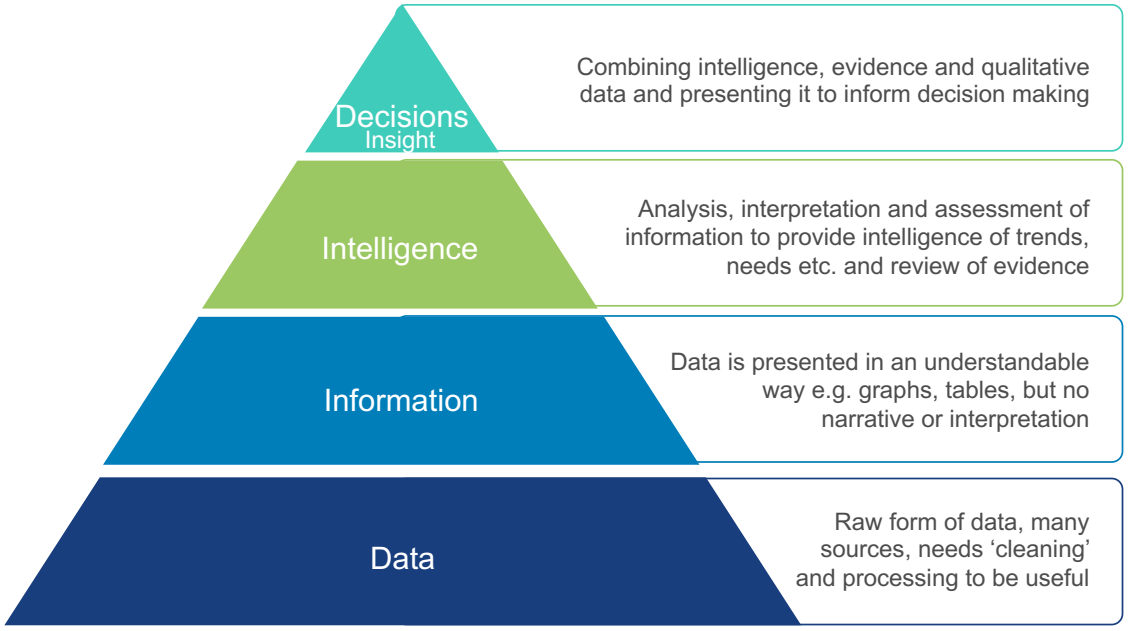
- Duplication across different papers on the agenda

- Lengthy papers (one set of committee minutes was 18 pages long)
- Data presented with no/little narrative
- Data presented in detailed and numerous tables which makes it difficult to identify progress or hotspots etc.
- Redacted versions of papers being presented to the public trust board.

We believe that these issues are inhibiting the levels of challenge at board and committees, as data is not being presented in a way that allows non-executive directors to identify key areas, or to understand the context of the data.

Our concerns were shared with several board members. As one person observed: "We can't see the wood for the trees".

The trust would be wise to review the level of information taken to meetings and consider how it can best be presented. The trust should consider adopting a hierarchy of visual understanding to set standards and monitor compliance in this area.



Recommendations

The trust should:

- Adopt the 'hierarchy of data visualisation' and work with staff to ensure that all data presented supports intelligent decision-making.
- Review and update the information available to the public about the performance of the trust (via the website).

KLoE 7: Service users, staff and external partner engagement

KLoE 7: Characteristics of good organisations

- A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.
- The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.
- The service is transparent, collaborative, and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

Meaningful stakeholder engagement and involvement is critical to good governance and to the effective performance of any organisation. Overall, the review team observed a number of characteristics of stakeholder engagement good practice at the trust, particularly internally, and there is evidence that it is attentive to continually developing and improving.

In the trust's engagement with staff and patients there are good systems in place and evidence of engagement on service improvement and culture development. There are, however, some cultural challenges and issues around inclusivity. When it comes to partners, the trust is good at communicating decisions it has taken, it operates transparently and is good at information sharing. The main area for improvement is around engagement and input, especially at a strategic level, with the integrated care systems it operates in and with how key partners are involved in trust decision-making.

Public

The trust leadership recognises the importance of active public engagement, especially given the nature of the services provided, and resources and attends to it accordingly. Consequently, the trust is very active when it comes to keeping the communities it operates in informed about service delivery. The trust conducts extensive media engagement, answering enquiries and managing relationships with over 60 outlets. It is proactive in sharing information through local, regional and at times national media and its own channels. It has cultivated a large following on social media, primarily through Twitter, and is doing more public engagement through this means, as well as using it increasingly as a tool for gaining new insight and engaging new audiences beyond typical demographics.

The trust has also used television, through shows such as In the Ambulance, to build public understanding of ambulance services and grow its reputation. This has particularly aided recruitment. This public engagement function is led by an experienced director who sits on the board and is well supported by the chair and the chief executive.

In this activity WMAS's leadership is mindful of its reputation and public trust, which is as much of a motivator as the intrinsic purpose of keeping people informed of important service changes or issues. This is prudent, however there have been instances where the trust's public engagement has caused problems for its partner organisations, which has caused relationship strains and damaged trust with those organisations. The trust should be more mindful of how its public communication and engagement reflects on its partners. In the new landscape of integrated care, this is more of a strategic risk than it might previously have been. The trust could also do more across the six systems in which it operates, in conjunction with other partners, to push broader system-wide public health messages and those around appropriate service use.

Staff

We saw and heard a lot about how staff are given a lot of opportunities, through various means, to feed into decision-making, service improvement and innovation and culture change. There are many positive examples of this, such as the design and specification of the service's ambulance fleet. There is a survey group, which works closely with the communications team but is led separately, which coordinates this type of engagement and staff input.

Staff are currently being engaged in this way on culture improvement work and the development of the trust's culture statement. There is also a staff forum, and a number of staff networks – such as the Women's Network, One Network, Proud Network and Disability Carer and Advocates Network – each of which has an executive sponsor and gives staff from protected characteristic groups their own voice forums. Several groups of staff champions have also been created around things like health and wellbeing. Staff are also regularly invited to workshops to feed into various areas of work or decision-making, one recent example being a series of workshops, and engagement via other means, for input on the trust's new values work. Other factors, such as issuing all staff with iPads and the introduction of operations managers roles, have helped improve communication and engagement with staff. The trust has good processes in place for celebrating staff success, including how it showcases compliments.

However, despite all of these measures, the trust still has some issues around the breadth and depth of staff engagement, especially with groups of protected characteristics. This has scored poorly in the annual NHS staff survey around staff engagement and involvement areas and especially for inclusion.

The trust has shown it is regularly reviewing the effectiveness of its means for engaging staff and should continue to test them with staff. These point to some of the cultural challenges, which have been identified and talked through elsewhere. At times the trust's hierarchical, traditional and command-and-control culture, which brings so much value to operational performance, can be a barrier in other aspects of corporate life. The effectiveness of engagement with staff networks should be reviewed, including considering the need for dedicated resource and support, and whether representatives from these groups could be given regular opportunities to discuss staff experience with the board. The existence of an independent staff discussion group on Facebook, in which issues are aired, isn't necessarily a bad thing but could be a symptom of not having the right forums. Also, the psychological safety to input to the group is something for the trust's leadership to be continually mindful of.

The trust leadership is perceptive about the importance of and challenges to staff engagement. One such challenge, which is ongoing, is the visibility of the board to staff. Virtual all staff briefings featuring the chief executive and at times other directors have recently been reinvigorated and are well attended. These include an active Q&A, giving staff direct engagement with directors and a regular platform for expression. There is a broader challenge around the variability of staff communication and engagement across hubs, which the trust is attempting to mitigate by introducing plans for each hub.

Patients

The trust's leadership has an almost zealous focus on patient safety, experience and outcomes, which shapes the culture of the organisation. The trust was praised for taking patient feedback and learning seriously and using it to improve service delivery. The board regularly receives patient stories but in a purposeful way, tied to recent decisions, service changes or serious incidents. In recent years the trust has developed and improved the scale and effectiveness of its patient engagement, and has recently developed a new patient engagement strategy. Patient surveys are carried out and patients are invited to feedback directly and share their stories at events run by the trust.

The appointment of a director of strategy and engagement and the recruitment of a new EDI manager were both praised as having had a significant impact on patient engagement, especially with regard to engaging patients of more diverse backgrounds and ethnicities. We also heard positive things about how

the trust engages with patients when things go wrong, with comments made about the personable and personalised nature of such engagements. The trust was also much praised for the way it amplifies and shares patient stories through its platforms, both publicly and with partners.

That said, several areas where the trust could improve were also identified, such as increasing the diversity of patients invited to share their stories with the board. When asked about the trust's patient engagement, stakeholders were very positive but they were also clear that there would be a significant benefit in WMAS doing more collaborative patient safety and experience-related engagement and learning with partners, particularly hospital trusts.

Partners

"They [WMAS] could be not just an outstanding trust but one of the very best organisations in the entire NHS with just some slight changes to how they work with others"

Our overarching finding from the stakeholder audit is that WMAS is seen as a great organisation – very well run and very effective – but not always a good partner.

WMAS is very highly regarded and respected by key partners for its operational effectiveness and the quality of its operational leadership. Stakeholders unanimously felt the trust was well run, that it has a good board with robust governance systems, is great in a crisis, can be relied on to deliver well, and has a good grip on risk, among other positives.

These strengths, it was felt, are all rooted in a razor-sharp focus on the service's core purpose and delivering against that, patient focus and outcomes, and a culture of being the best. Since 2020, the trust has conducted an annual stakeholder survey. Partners were also engaged in the development of the trust's strategy around the same time. The trust was praised for how effectively it communicates decisions to partners and for its responsiveness and accessibility. It was also praised for its transparency and openness, particularly around performance and its willingness to come to the table for difficult conversations, and for being an active contributor and voice in the specific partner and system forums it does attend, especially through the director of engagement and strategy.

We also heard from stakeholders about areas for improvement. Somewhat paradoxically, the zealous, uncompromising focus on patient outcomes and the trust's own performance, which drives a lot of WMAS's effectiveness, is also often the cause of issues with stakeholder relations and can exacerbate operational problems elsewhere in the system.

The review team heard about several instances where WMAS's means of engagement and/ or the content of their public communications had been damaging to the reputations of and relations with partners. The trust's partners generally feel that WMAS is quite insular, sometimes has an air of 'we know best', hasn't really embraced integrated care and at times the trust's own operational or strategic imperatives see them act or take material decisions that have tangible impact on others without consultation or engagement. Some of these decisions are to the detriment of partners and the wider system.

No organisation is an island. Engagement with key partners has always been important in health and care but in the landscape of integrated care it is essential. WMAS, as with all ambulance trusts, has a specific challenge about the sheer number of its stakeholders – especially operating as it does across several ICSs – but it is one the trust needs to address. However, stakeholders unanimously felt that with a few adjustments to how WMAS works with others, involving partners in decision-making and contributing at a more strategic level with integrated care, it could be not just an excellent high-performing organisation but a good partner and a key contributor to the success of others and the broader systems in which it operates.

Governors

Overall, there are good lines of communication and active engagement between the board and the governors. As a group, the governors feel listened to and involved. We were told that the trust's governors generally feel well equipped to be effective in their role and have good relationships with both the chair and chief executive, who are regarded as being open, accessible and approachable. The governors have regular contact with the trust's executive leadership, particularly through the dedicated time they have with the chief executive every few weeks. There is also a buddying scheme in place between non-executives and governors, which was praised.

The governors felt well informed and praised the supply of information from the board and the trust's communications team, and the responsiveness to enquiries and requests. They also told us they were well sighted and appraised on action and resolutions to issues raised. We also heard that the governors are regularly invited to attend board meetings and although governors don't sit on committees, the committee chairs attend council of governor meetings and NEDs have an open invitation to attend.

Engagement and communication with the rest of the organisation is slightly less effective. The review team were made aware of issues around governor visibility and understanding of governor roles and responsibilities across the workforce, with some confusing governors with union representatives. Covid impacted governor liaison with staff, already made difficult because of the vast geography and dispersed nature of the trust's workforce. This has yet to fully recover. Efforts have been made to raise awareness of who the governors are through posters at each hub and via social media but they acknowledge more could be done to engage staff.

Recommendations

- The board should look at the culture in the organisation and its impact on engagement.
- More needs to be done to increase executive and non-executive visibility with staff.
- The board should review and increase the resourcing and support for staff networks and provide them with greater opportunities to engage with the board.
- The trust should think about ways it can collaborate with partners (other providers, Healthwatch) on patient engagement around service quality and experience.
- The trust should review its ICS engagement and involvement and do more to contribute strategically to the systems in which it operates, especially in the Black Country ICS as host, to develop the trust's sphere of influence.
- The trust should do more to engage and involve partners in decision-making and should review/develop its process for doing so.
- The trust should look at how it can support and create more opportunities for governors to engage with staff, even if this must be virtual due to operational constraints.

KLoE 8: Learning, continuous improvement and innovation

KLoE 8: Characteristics of good organisations

- There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.
- There is knowledge of improvement methods and the skills to use them at all levels of the organisation.
- The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.
- Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.
- There are organisational systems to support improvements and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

Learning

Staff at all levels and external stakeholders saw the trust as a learning organisation, and this is also supported by the staff survey results to an extent (the trust's score is average, but has improved over the last year). Learning from serious incidents (SIs) is identified as a particular strength, although some work has been disrupted. The monthly SI newsletter was stopped during COVID-19 but is being brought back. The numbers of SIs increased markedly as a result of COVID-19 and related service pressures, but the backlog has now been addressed and actions are implemented in a timely manner.

Stakeholders perceive the trust as having a strong learning and improvement culture. There is more of a mixed view about the trust's appetite for innovation but some great examples were shared. There is a general feeling that the trust could do more in this space, leading on more research and conducting more collaborative learning and improvement exercises with partners.

Improvement culture

We saw and heard much that was positive about the trust's approach to learning and innovation. This was particularly voiced by senior leaders in the trust, who felt that the flat hierarchy and the general culture encouraged improvement and innovation. Innovation is also encouraged through an 'all ideas matter' section on the staff intranet. The trust adopts the PDSA (plan, do, study, act) methodology, and improvement projects are identified through a top-down as well as a bottom-up approach.

We did, however, hear a different message from the frontline staff we spoke to, who did not feel that they were involved in decision-making, although they were positive about other forms of learning. These views are supported by the trust's latest staff survey results. The trust scored low (close to worst in the country) for the following statements:

- I am able to make suggestions to improve the work of my team/department.
- I am involved in deciding changes introduced that effect my work area/team/department.
- I am able to make improvements happen in my area of work

Trusts with strong improvement cultures will generally score better in these areas, through empowering staff and equipping them with the skills to bring about changes and improvements. The trust should consider this disconnect in experience and revise its quality improvement strategy and plans to bring about improvements.

Recommendations

The trust should:

- Consider the results of the staff survey in detail to consider the disconnect in staff experience of improvement, and develop plans to make improvement in this area.
- Consider how learning, improvement and innovation can be done collaboratively with partners at place and system level.

Section 5 – Progress made since the last well-led review

The last developmental well-led review was reported in June 2019. Following this, the trust developed an action plan which was reported to the board. All actions were delivered.

The report identified the following areas which needed to be strengthened:

- Articulating a long-term strategy beyond the current dynamics
- Offering clarity about the trust's future role in the integrated health and care system and the wider NHS
- Developing and implementing a trust-wide quality improvement methodology
- Further investing in leadership and management development to drive a long-term capability and succession plan
- Reframing the trust's risk appetite to reflect the approach the trust will take to balancing risk in the context of the system environment in which it works
- Some rebalancing of board time to allow more time and space for strategic over the immediate and tactical
- Ensuring there is a practical impact of the investment being made in supporting diversity and equality
- Developing the trust's sphere of influence through partnerships and deeper joint working with external stakeholders locally and nationally within the health and care setting and beyond both
- Considering a board development programme

It is of note that the themes of this report echo the themes noted in 2019:

- Developing the strategy
- Clarity about the trust's role in integrated care systems, and closer working with external stakeholders
- Rebalancing board time to be more focused on strategic rather than operational issues
- Consideration of a board development programme

This does not mean that actions were not delivered before, but it does indicate that these are areas where the trust is less strong. Since the well-led review in 2019 there have been huge challenges, including the pandemic, unprecedented operational demands, the formation of integrated care boards, and significantly increased financial pressures. This does indicate that, in preparing an action plan in response to this report, the trust needs to ensure that actions taken will be embedded in the organisation.

Appendix A – Methodology and summary of work carried out

Methodology

The review was undertaken using a well-established technique grounded in the triangulation of evidence. This conforms with the standard for well-led reviews set in the NHSI and CQC guidance of June 2017. GGI's review process used a variety of materials, templates and benchmarking tools to guide various review activities, which have included:

- Semi-structured interviews with key staff within WMAS.
- Semi-structured interviews with external stakeholders.
- A review of relevant documentation.
- Interviews with staff focus groups.
- Meeting observations, including of the trust board and assurance committees.

The review team used the NHS England (previously NHS Improvement) well-led framework, structured around eight key lines of enquiry, as the basis for the review:

NHSI: Developmental reviews of leadership and governance using the well-led framework: guidance for NHS Trusts and NHS foundation Trusts, June 2017, p.10

In carrying out this review we have also been mindful of the CQC's new single assessment framework, including eight quality statements, which is expected to be rolled out in 2023.

Interviews

The following is a list of individuals interviewed as part of this well-led review:

Name	Title
Ian Cumming	Chair
Anthony Marsh	CEO
Alison Walker	Executive Medical Director
Mark Docherty	Director of Nursing and Clinical Commissioning
Paul Jarvis	Interim Director of Finance
Karen Rutter	Appointed Director of Finance
Vivek Khashu	Strategy and Engagement Director, FTSU Exec Lead
Carla Beechey	People Director
Nathan Hudson	Emergency Services Operations Delivery Director
Jeremy Brown	Integrated Emergency, Urgent Care and Performance Director
Michelle Brotherton	Non-emergency Services Operations Delivery and Improvement Director
Murray MacGregor	Communications Director
Narinder Kaur Kooner	NED
Mohammed Fessal	NED, People Committee Chair
Wendy Farrington-Chadd	NED
Mushtaq Khan	NED, Performance Committee Chair
Julie Jasper	NED, Audit Committee Chair
Diane Scott	Organisational Assurance Director
Phil Higgins	Governance Director
Pippa Wall	FTSU Guardian
Craig Cook	Environmental sustainability, Estates
Nick Henry	Patient safety director
Tony Yeaman	Legal services & compliance
Matt Brown	Head of risk management

Stakeholder interviews

Name	Title
Mark Axcell	Chief executive, Black Country ICB
Jason Evans	Associate Director West Midlands 999 and NHS 111 Commissioning Team, Black Country ICB
Richard Kirby	Chief executive, Birmingham Community Healthcare NHS Foundation Trust
David Loughton	Chief executive, Royal Wolverhampton NHS Trust & Walsall Healthcare NHS Trust
Richard Beeken	Chief executive, Sandwell and West Birmingham NHS Trust and chair of the ICB urgent and emergency care group
Glen Burley	Chief executive, South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust & the Wye Valley NHS Trust
Sally Roberts	Chief nursing officer, Black Country ICB
Dale Byewater	Executive regional managing director (Midlands and East), NHS Improvement
Tim Davies	Staffordshire University
Sharon Hardwick	Birmingham City University

Peter Gregory	Head of School and Associate Dean, School of Allied Health and Midwifery, University of Wolverhampton
Gareth Robinson	Executive Director of Delivery and Transformation, NHS Shropshire, Telford & Wrekin
Ned Hobbs	Chief Operating Officer, Walsall Healthcare NHS Trust
Gwen Nuttall	Chief Operating Officer, Royal Wolverhampton Hospitals NHS Trust
Simon Trickett	Chief Executive, Herefordshire & Worcestershire Integrated Care Board

Focus groups

In addition, the following focus groups and joint interviews were held:

Focus group	Date of focus group
Corporate and Academy Staff Focus Group	5 April 2023
Operational Staff Focus Group	5 April 2023
Governors Focus Group	20 March 2023
Staff Network Leads and Union Representatives Focus Group	3 April 2023

Meeting observations

The following is a list of meetings observed during the review:

Meeting observed	Date of meeting
Performance Committee Meeting	23 February 2023
People Committee Meeting	27 February 2023
EMB Meeting	7 March 2023
Audit Committee Meeting	14 March 2023
Quality Governance Committee Meeting	22 March 2023
Board Meeting	29 March 2023

Appendix B – Detailed commentary on the board meetings we observed

We observed the public and confidential board meetings held on 29 March 2023, both of which were held remotely.

The papers for the meetings totalled 1,123 pages, made up of:

Public meeting papers	653
Confidential meeting papers	371
Trust information pack (mostly performance information)	99
Total	1,123

Public meeting

The public meeting papers were unusually long as they included 145 pages of papers from the audit committee meeting on 14 March 2023, which had not been quorate, and which were brought to the board for ratification. These papers were:

- Policy and procedures, including amendments to standing financial instructions. These papers did need to be presented to the board in full, given that the audit committee meeting was inquorate.
- The external audit progress report and outline audit plan (19 pages), to provide confirmation of the audit fee. This document did not need to be presented to the board.

Details of other significant papers are set out below, together with our view on the appropriateness of the papers:

- NHS England Delivery plan for recovering urgent and emergency care services (49 pages). This document is available online, so a link could have been shared rather than including the full document in the papers.
- A paper for discussion on the pricing structure for incidents undertaken by WMAS, which included 44 pages of a report produced in 2009. The director who presented the report described it as 'sort of for information, sort of to add to debate outside the board'. In our view, it would have been more appropriate to discuss this in a board development session.
- Freedom To Speak Up (FTSU) action plans, with papers totalling 111 pages. This included:
  - 57-page report by the national FTSU guardian on ambulance trusts in England, which is available online and so a link could have been shared.
  - The completed FTSU reflection and planning tool, which is 30 pages. In our view this is unnecessarily detailed for discussion at the public board.
- The WMAS data security and protection toolkit action plan, which is very detailed and is not a document that is generally discussed at public board meetings. This includes details such as:
  - The trust's ICO registration number.
  - Details of the data protection impact assessment procedure.
  - Specialist data protection training undertaken by staff.

  This was accompanied by a paper outlining the process for the assessment plus a cover sheet (total 23 pages).

  According to the cover sheet this report had previously been considered by:

  - The trust's Senior Information Risk Owner.
  - Health, Safety, Risk and Environment Group.

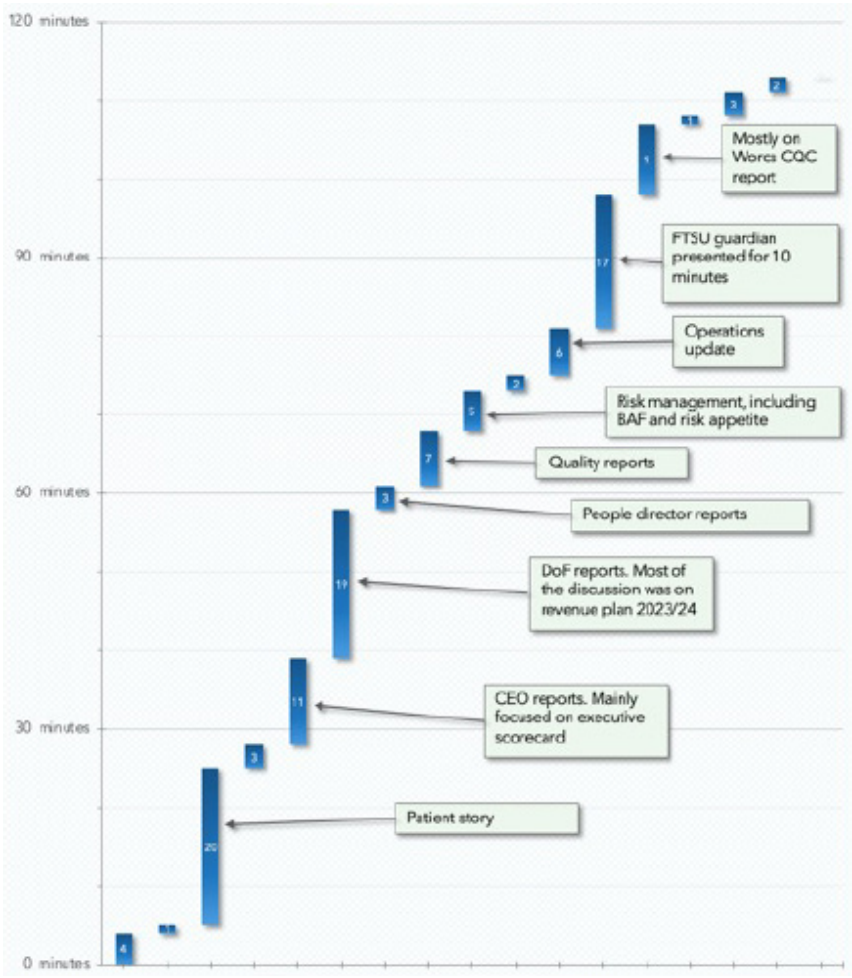
- Audit Committee.
- Executive management board.
- Quality Governance Committee.

In our view the board did not need to see this document.

- A risk appetite policy (16 pages plus cover sheet), which we consider to be unnecessarily long and so is less likely to be used in decision-making.
- Fit and proper persons annual assurance which was a short paper (two pages plus cover sheet) comprising details of the individual checks that had been carried out in relation to each director – effectively, the working paper. All that was required was assurance that the checks had been done, and this could have been dealt with at the people committee rather than at board.

What was clear from the meeting itself, as evidenced in the graph below, is that the trust board did spend an appropriate amount of time on the revenue budget for 2023/24, where there was discussion and there were questions, and where non-executive directors articulated the extent to which the budget had already been discussed in committee. There was very little discussion of the trust's strategy or strategic risks.

Public Board Meeting



Confidential meeting

As with the public papers, these papers were in some cases very detailed and too operational. These included:

- Digital maturity assessment which included the detailed assessment (40 pages) which in our view did not need to be considered by board. There was no discussion of this at the meeting.
- Minutes of EMB meetings which are operational and do not need to be seen by the board (total 116 pages).
- Commercial in confidence papers relating to a contract (total 48 pages) where there was a short discussion and it was agreed that dedicated time was needed, for which there would be a separate meeting.

There was one paper in the confidential board where board members commented that they did appreciate the detail of the report (39 pages). This was a confidential update which was appropriate for the board to discuss in private, and in detail.

Appendix C – Example key issues report

[Insert name] meeting Key issues report (This report should be a maximum of 2 sides of A4 paper)		
Report date:		**Report of:** [insert name]
Date of last meeting:		Membership numbers: [State the number of members in attendance] **Quoracy met** = [For example: 100% attendance including the chair and deputy chair]
1	Agenda	The [committee/group name] continues to meet [add in meeting frequency]. The [committee/group name] considered an agenda which is attached [attach agenda when sending]
2a	Alert	The [committee/group name] wish to alert members of the [add in name of group that your meeting reports to under the governance structure] that: [Provide details of the key 3 or 4 matters you wish the committee or group that you report to under the governance structure to be alerted to and which have been discussed in your meeting].
2b	Assurance	The [committee/group name] wish to assure members of the [add in name of group that your meeting reports to under the governance structure] that: [Provide details of the key 3 or 4 matters you wish the committee or group that you report to under the governance structure to be assured of and which have been discussed in your meeting.]
2c	Advise	The [committee/group name] wish to advise members of the [add in name of group that your meeting reports to under the governance structure] that: [Provide details of the key 3 or 4 matters you wish the committee or group that you report to under the governance structure to be advised of and which have been discussed in your meeting.]
2d	Review of risks	[Provide a brief update on any risk that needs to be escalated, for example if a risk is showing mitigating actions that are outside the agreed timescale or that meet a certain risk score that require their escalation in line with the Trust's risk management policy].
2e	Sharing of learning	[Provide a details of key points of learning that should be shared across the Trust. This may be taken from the sections above, or additional information).
3	Actions to be considered by the [add in name of group to which your meeting reports]	[Provide any additional actions not referenced above that you would like the committee/group that you report, to consider or undertake on your behalf.]
4	Report compiled by: [Name of Chair and officer who compiled the report] Minutes available from: [Name of officer from where the minutes of the meeting may be obtained].	

Appendix D – Stakeholder audit

Executive summary

This appendix paper sets out the findings and recommendations from the stakeholder audit conducted by the Good Governance Institute for West Midlands Ambulance Service University NHS Foundation Trust (WMAS), as part of a broader well-led review, between February and May 2023. It is a supplement to the main well-led report.

The purpose of this paper is to provide an objective assessment of the way WMAS is perceived by stakeholders, both in terms of how it is run and operates internally and also in its engagement and work with partners.

GGI conducted semi-structured interviews with 15 of WMAS's key partners, who were asked questions aligned to the eight Well-led key lines of enquiry, alongside desktop research and document review. The focus was on strategic relationships and the target representatives of partner organisations were the most senior officers. There was an emphasis in the questioning on the effectiveness of the trust's leadership, decision-making, culture and its role in, engagement with and contributions to the integrated care systems in which it operates.

The findings and recommendations are derived from triangulated evaluation of stakeholder feedback referenced against desktop research and document review. The output from the audit fed into the main report and, consequently, there are some areas of crossover with the findings analysis and recommendations but this paper provides further detail, broader emphasis and a more extensive list of suggested areas for improvement in this paper.

Headline findings

"I dread to think where we would have been without them"

"They are doers. They do things, they do them right, they do them well"

The key areas of strength/ good practice identified:

- The trust is very well respected and regarded by partners particularly for its operational effectiveness and for the strength and quality of its leadership, with the chief executive singled out.
- The WMAS board is seen as effective and well-resourced with a good culture of constructive challenge.
- The trust's operational engagement with partners, particularly at management level, where it was commented on, is seen as excellent.
- WMAS was praised as being a problem solver.
- The trust is seen, and much praised for, having a zealously patient-centric focus
- Stakeholders felt that the WMAS board exhibited a good balance of focus and attention across quality, safety and finance.
- The trust is seen as very reliable and dependable, especially in times of crisis.
- Partners generally feel the trust is willing to and does engage where it can though mostly where there is a clear benefit to the trust.
- The trust was praised for how well it communicates decisions with partners.
- Partners also praised the trust for being especially responsive to requests for information.
- The trust was also praised for its openness and accessibility to conversations with partners around key issues.
- Partners feel the trust's leadership have an excellent understanding and oversight of the organisation's risks and communicate them effectively and robustly.
- WMAS is seen as reliable, well-led - though more operationally than strategically - and good in a crisis.

- Partners feel that WMAS has a strong and respected voice and is vocal when it feels it needs to be.

"They can be quite internally minded and focused, quite insular…"

The key areas of challenge/ improvement were:

- Stakeholders generally felt the WMAS leadership were more operationally than strategically focused.
- Generally, the trust is seen as quite insular, both in how it makes decisions and operates and this is increasingly out of sync with new ways of working under integrated care.
- In the partner and system forums where the trust is represented, it is generally felt that while they are active participants and contributors, they don't yet feel like invested partners in the broader system agenda.
- There are certain ways in which the trust communicates, particularly through the press, that are seen as bullish and at times are damaging to the reputation of partners and harmful to relations.
- The trust's engagement with partners is particularly concentrated through a few key roles, chiefly the director of strategy and engagement and the chief nursing officer, the latter of whom has recently left the trust; visibility and involvement beyond them is minimal.
- Although decisions are well communicated, the general feeling was that partners aren't involved or given opportunities to input into the decision-making process even where the decisions have material impact on them.
- The trust is perceived to have been somewhat dismissive of the integrated care agenda and, until recently, not very engaged at a strategic level with the ICSs in which it operates.
- Partners felt that a significant barrier to partnership work and system involvement was the trust's intolerance of anything that might jeopardise its own performance or increase its risks.
- Partners generally felt that although WMAS is always keen to help, and often willing to collaborate, it wants to do so on its own terms, with a focus on benefit to it rather than more broadly across the system, and finance is always the key contingent.
- Partners perceive some of the engagement challenges arise from the trust's minimal structures directly under the board and also in certain key teams such as education and quality.

Recommendations

The summary recommendations for WMAS to consider are:

1. The trust should review its strategic engagement and involvement with all systems but especially the Black Country ICS, with a view of providing more strategic leadership (for instance the chief executive attending the regular Black Country chief executive meetings).
2. The trust should develop an internal strategic stakeholder engagement plan to frame its engagement with partners and the ICSs it operates in, with sections dedicated to each key partner and each system.
3. When the trust conducts its next corporate strategy review it should seek to maximise the involvement and input from key partners and the systems leaders and link to the four key ICS aims.
4. The trust should look at what more it can do to communicate its strategy and strategic objectives to partners and frame decisions it takes against these.
5. The trust should look at how its NEDs can be more visible to and engaged / involved with partner and systems work, particularly in collaboration with other NEDs across the systems.
6. The trust should review is buddying arrangement of NEDs and execs allocated in pairs to each system, to ensure it is being implemented and reflect on its effectiveness.
7. The trust should look at developing the system leadership skills of its board as part of its board development programme.
8. The trust should do more to engage and involve partners in decision-making and should review/ develop its process for doing so.
9. The trust should review the forums it used to run or be part of, especially with the universities it works with,

that would provide platforms for strategic discussions and partner input into trust decision making.

10. The trust should reconsider its approach of sending these formal letters and utilising other means or else reviewing the tone and framing of these letters.
11. Review the trust's use of public communication methods in relation to content which explicitly names and casts partners in a negative light.
12. The trust should review the engagement demands on these areas and re-assess the capacity requirements in light of these demands, especially in its education and quality teams .

It is important to note that these recommendations have been made with the trust's ambition to be the best service provider it can be and its culture of high performance in mind. Many of these points raised as areas for improvement are areas that distinguish the great organisations from the good and the aspects that relate to ICSs are things that most trusts are still working on.

The following report has the supporting detail and analysis.

1 Introduction

West Midlands Ambulance Service University NHS Foundation Trust (WMAS) appointed the Good Governance Institute (GGI) to conduct a well-led review in January 2023. As part of this work, WMAS was keen for GGI to carry out an external stakeholder audit to incorporate the perspectives of key system partners into the review.

WMAS employs around 7,000 staff, spread out across 17 operational hubs over its vast geography, and responds to around 4,000 '999' calls each day. The trust serves a population of more than 5.6 million people over an area of 5,000 square miles across six integrated care systems:

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

Black Country ICS is the WMAS's parent system and the lead commissioner. WMAS are represented on the Board of NHS Black Country Integrated Care Board and is also on the Board of NHS Shropshire, Telford and Wrekin Integrated Care Board. Additionally, it feeds in through various other parts of the Black Country and other systems governance structures. The trust also works with several universities across the Midlands for the training and development of its workforce. Given the vast geography WMAS operates over it has multiple partnerships and stakeholders to manage effectively.

WMAS is rated an outstanding trust by the CQC, the only ambulance trust to be so. GGI was commissioned by WMAS in 2019 to conduct a well-led review, in advance of a CQC inspection. Since GGI's last well-led the trust has had some changes to its leadership with Professor Ian Cumming appointed as chair in April 2020, and several non-executives and executives departing.

The timing of the review is important given the context of acute financial and operational pressures across the NHS and the ongoing impact of the Covid-19 pandemic. WMAS's operational area includes systems and trusts with some of the most acute financial and operational pressures and performance issues. The other key material factor is the continued development of the integrated care systems and the fundamental changes to WMAS's strategic and operational context due to the integrated care reforms.

2 Purpose and value

The purpose of this stakeholder audit was to seek the views and perspectives of WMAS's key system partners on:

- The effectiveness of the Trust's leadership, vision and strategy.
- The trust's engagement with its parent system and other ICSs it works with.
- The trust as a partner and collaborator.

In order to add value to the well-led review by providing:

- An additional evidence base of external perspectives to triangulate and infuse with internal ones to enrich the review and help test, inform and develop the findings and recommendations.
- Building a clear picture of how the trust is perceived by partners both in terms of its internal function and operation and in the places and forums it engages and works with partners.

The purpose of this paper is to provide objective assessment of the way WMAS is perceived by its key stakeholders. Its recommendations are designed to support the development of WMAS's engagement and relations with partners and its role as a key system partner.
There will be value alone for the trust in comparing the perception presented here to that understood by the board as derived from its own stakeholder survey and engagement exercises. There are differences between the two, although this exercise focuses on a more senior level audience. This review does take note of the findings of recent annual stakeholder surveys undertaken by the trust.

3 Methodology

GGI conducted desktop research, document review, and a series of 13 semi-structured interviews via MS Teams, encompassing 14 key stakeholders, to gather a broad range of perspectives and provide a triangulated assessment of the trust as a provider and a partner, particularly within the Black Country ICS.

The stakeholders were selected in collaboration with the trust to ensure they represented a balanced cross-section of the most influential voices in the current place, civic, and systems settings. The trust's company secretary and director of strategy and engagement acted as the client-side liaison, helping to inform and support the delivery of the review. The stakeholders engaged in the process were encouraged to input candidly, supported by the fact that all responses would be anonymised in this report.

The interviews were carried out by Daniel Taylor, a specialist engagement consultant with GGI, and they were designed and delivered to maximise the qualitative output. There was a strong response to the invitation to interview with every one of the targeted stakeholders engaging. Each interview lasted between 30-60 minutes. The following people were interviewed:

- Mark Axcell, chief executive, Black Country Integrated Care Board
- Jason Evans, Associate Director West Midlands 999 and NHS 111 Commissioning Team, Black Country Integrated Care Board
- Richard Kirby, chief executive, Birmingham Community Healthcare NHS Foundation Trust
- David Loughton, chief executive, Royal Wolverhampton NHS Trust & Walsall Healthcare NHS Trust
- Richard Beeken, chief executive, Sandwell and West Birmingham NHS Trust & chair of the Black Country ICB urgent and emergency care group
- Sally Roberts, chief nursing officer, Black Country Integrated Care Board
- Dale Bywater, midlands regional director, NHS England
- Julie Grant, west midlands director, NHS England
- Tim Davies, head of department for midwifery and allied health, Staffordshire University

- Sharon Hardwick, head of operating department practice and paramedic science, Birmingham City University
- Peter Gregory, head of school and associate dean, School of Allied Health and Midwifery, University of Wolverhampton
- Gareth Robinson, executive director of delivery and transformation, NHS Shropshire, Telford & Wrekin
- Ned Hobbs, chief operating officer, Walsall Healthcare NHS Trust
- Gwen Nuttall, chief operating officer, Royal Wolverhampton Hospitals NHS Trust
- Simon Trickett, chief executive, Herefordshire & Worcestershire Integrated Care Board

Below is a list of the high-level questions explored in each interview which were shaped with input from the key WMAS personnel mentioned above:

- What do you think of the leadership of WMAS?
- Do you think they are an effective organisation? Why?
- What do you think they do particularly well? Do you have any examples of good practice?
- What could they do better? Any particular areas of concern?
- Do you feel that the trust is a good partner? Does WMAS support the system's aims and priorities?
- What impact do they have on supporting positive health outcomes in the system?
- What do you think of the trust's vision, values and strategy?
- What should their priorities be for the next five years?
- What do you make of the trust's culture?
- How does the trust engage with you?
- How well do you think it engages with and listens to patients?
- Do you consider WMAS innovative?
- Is there any additional information you'd like to share?

4 Findings

4.1 Overall

"There is clear blue sky between them and any other ambulance provider"

The overarching response to WMAS's leadership and effectiveness as an organisation was really positive. WMAS is very highly regarded and respected by key partners for its operational effectiveness and the quality of its operational leadership. Stakeholders unanimously felt the trust was well run, that it has a good board with robust governance, is great in a crisis, can be relied on to deliver well, and has a good grip on risk, among other positives. There was also a generally positive view of the trust's communication and engagement with partners, particularly at an operational level. The response to WMAS as a partner is more nuanced; a number of areas of good practice were identified but generally the feeling was the trust was still very insular and in its work with partners still in the old mindset that is increasingly out of sync with new ways of working under integrated care.

These strengths, it was felt, are all rooted in a razor-sharp focus on the service's core purpose and delivering against that, as well as patient focus and outcomes, and a culture of being the best. Since 2020, the trust has conducted an annual stakeholder survey. Partners were also engaged in the development of the trust's strategy around the same time. The trust was praised for how effectively it communicates decisions to partners and for its responsiveness and accessibility. It was also praised for its transparency and openness, particularly around performance and its willingness to come to the table for difficult conversations, and for being an active contributor and voice in the specific partner and system forums it does attend, especially through the director of engagement and strategy.

We also heard from stakeholders about areas for improvement. Somewhat paradoxically, the zealous, uncompromising focus on patient outcomes and the trust's own performance, which drives a lot of WMAS's effectiveness, is also often a barrier to genuine investment in shared aims and outcomes and the broader objectives of systems, all of which can cause issues with stakeholder relations and can exacerbate operational problems elsewhere in the system. The review team heard about several instances where WMAS's means of engagement and/ or the content of their public communications had been damaging to the reputations of and relations with partners. The trust's partners generally feel that WMAS is quite insular, sometimes has an air of 'we know best', hasn't really embraced integrated care and at times the trust's own operational or strategic imperatives see them act or take material decisions that have tangible impact on others without consultation or engagement. Some of these decisions are to the detriment of partners and the wider system.

4.2 Analysis

Trust leadership

There was a generally very positive view of the trust's leadership, specifically its executives who are seen as very experienced, responsive, and accessible. NEDs are less visible to partners. The board is seen as having good capacity and a good grip on performance and risk. Some areas for improvement were identified particularly around addressing an over-reliance on the chief executive and cultivating system leadership skills.

Strengths

- Very good operational leadership.
- Board regarded as having a good culture of constructive challenge.
- Very responsive and accessible.
- Strong executive leadership, particularly through the chief executive who is seen as excellent.
- Board seen as having good capability and capacity.
- Board seen as having a good balance in its attention and focus on quality, safety and finance.
- Certain executives very active in system and partner engagement.
- Leadership has a strong, trusted voice.

Weaknesses

- Not as strong strategic leadership as operational.
- Too much reliance on the chief executive.
- NEDs aren't particularly active or visible to partners.
- The board is perceived as lacking in system-leadership skills.
- Very flat structure, minimal senior support under board executives' limits engagement and can cause bottlenecks.
- Executives sitting on partner and system boards and forums often feel disempowered/ unable to act beyond agreed organisational lines.

Clear vision and strategy

Although the trust was praised almost unanimously for the coherence and thoughtfulness of its decision-making, and for the supreme focus of its leadership on delivering on the core purpose of the organisation and achieving excellence performance, almost all stakeholders felt unsighted and unfamiliar with the trust's strategy and strategic plans and to a lesser extent its vision. The leadership is also generally seen as being more operationally than strategically focused.

Strengths

- Partners couldn't necessarily quote the Trust's vision but could pretty accurately interpret it through the trust's actions.
- Stakeholders felt the trust's vision was embodied well by its actions save the last line about in partnership.
- All partners see a clear focus on delivering the trust's core purpose and patient outcomes.
- Decision making feels coherent, logical and well rationalised to stakeholders.

Weaknesses

- Partners aren't well sighted on the Trust's strategy.
- Most stakeholders felt they didn't have enough/ any input in the development of the trust's strategy.
- Most stakeholders felt the Trust had far more of an operational than strategic focus.
- Stakeholders generally felt there was a lack of a clear strategy when it came to the trust's engagement and involvement in systems.

Culture

All stakeholders were asked to summarise the culture in one word. Interestingly most of the words used had both positive and negative connotations (performance-driven, military-esque, command-and-control, hierarchical). The general view was that the trust's culture was typical of ambulance trusts generally but perhaps are the extreme end and while it lent itself to a culture of high and effective performance, it also had some not insignificant limitations especially around inclusivity but also at times in how the trust comes across in its engagement with partners and in its communication. It was felt that the command-and-control type culture could and should be softened in the relevant spaces.

Strengths

- The board was seen to have a very effective culture with good mutual trust, constructive challenge, and teamwork.
- The trust was also generally praised for aspects of its culture which deliver operational performance.
- Stakeholders perceive the driving force of the trust's culture as a focus on high-quality care and patient safety and outcomes.

Weaknesses

- A number of stakeholders raised concerns about the male dominated nature of the culture.
- Concerns were also raised about some of the negative impacts of a highly command-and-control.
- It was commonly remarked on that the trust's culture was insular and closed off and cited that a significant number of senior and executive roles were internal appointments.

Roles, responsibilities, accountabilities

There was a mixed picture among stakeholders of the board roles and responsibilities. Stakeholders felt that the chief executive is an almost single conduit through which all decisions flow and questioned how much authority other executives have. The appointment of a director of strategy and engagement has made a big difference, creating a clear portfolio on the board for liaising and working with partners but non-executives aren't generally well known to partners.

Strengths

- The trust is seen as having a very clear sense of its role and purpose and that this drives and shapes how it operates and the decisions it takes and how it works with partners.
- Partners have a good understanding of the trust's role, its responsibilities and performance accountabilities.
- Stakeholders felt the trust demonstrates excellent ownership of its accountabilities and areas of responsibility with.
- The trust was praised for its openness especially around areas of accountabilities to partners and the system.
- Generally, there was a reasonable sense of executive-level areas of responsibility.

Weaknesses

- A number of comments were made about the trust at times being prickly around responsibilities and accountabilities.
- Lots of stakeholders were unsure of NED roles and responsibilities on the board.
- There is limited understanding of the Trust's approach of allocating a board member and governor to each system and who these people are.
- Too much accountability and responsibility still rests with the chief executive, who is too often used as the main point of contact.
- Some felt that the Trust was reluctant to take any responsibilities or accountabilities for things which weren't entirely in their control .
- Concerns were raised about the intention to reduce the hours of the executive director or nursing and commissioning role.

Effective risk and performance management

The trust was universally praised for the effectiveness of its oversight and management of performance and risk. There were a few areas for improvement identified, especially in relation to how the trust publicly communicates risk and its risk appetite.

Strengths

- The trust's leadership, especially the chief executive, are puritanical about performance and consequently there is very close scrutiny and monitoring of performance.
- The trust was universally praised and is clearly well regarded and respected for the strength of its operational performance.
- The board is seen as having an excellent understanding and effective oversight of risk.
- The trust is seen as being good at communicating to and building the visibility of its risks with partners in the right ways and forums.
- The trust is praised for its themed analysis work around quality improvement.
- The trust is seen to manage clinical risk very prudently and is strong in how they deal with other organisations around things that increase clinical risk .

Weaknesses

- Several stakeholders made the point that the trust's quality team is under-resourced.
- Sometimes the board's low risk appetite in relation to service effectiveness can be a barrier to collaborative improvement/ transformational work (though several notable exceptions were acknowledged).
- The trust can be quite public about risks in a way that is potentially and at times actually quite critical/ damaging to partners and which strains relations.

Information sharing, challenge, and action

The trust is seen as being incredibly responsive, reliable and action-orientated. Stakeholders frequently remarked on the fact that when issues were raised or a need for action evidenced the trust has a fantastic record of responding, and at speed. The trust's board and committees are seen as being well furnished with the information needed to drive decision-making and relevant information is shared with partners, as necessary.

Strengths

- The Trust is regarded as excellent at acting when it needs to especially in a crisis or in the face of clear need.
- WMAS is seen as having a well-supported and informed board with rich Board papers demonstrating good level of scrutiny, oversight and challenge.
- WMAS was praised pretty much universally for how it communicates decisions to partners.
- The trust was also praised strongly for the way it shares information, including around serious incidents, in a very timely manner.
- The trust is seen as being operationally very active and responsive .

Weaknesses

- It was felt that at times WMAS could be prickly towards external challenge.
- Though the trust was generally very good at sharing information and welcoming challenge, a few instances were mentioned when this was not the case and around important decisions.

Engaging stakeholders and involving stakeholder

This was the area in which stakeholders identified the most areas for improvement for the Trust. It was acknowledged that WMAS was good engaging with patients, well represented in system and partner forums but generally had a lot more to do in terms of its engagement and involvement in and with systems, how it communicates with partners and involving stakeholders in decision-making.

Strengths

- The trust was fairly unanimously praised for its engagement with patients.
- In forums the trust is represented on it is generally seen as an active participant and keen contributor.
- The trust was praised for having a strong voice that is respected by partners.
- It was felt that in recent times, owing not insignificantly to the appointment of a director of strategy and engagement, the Trust has been doing a much better job at engaging with partners and being visible and proactive in system and partner forums.

Weaknesses

- Lots of stakeholders felt the Trust's engagement with systems, including the Black Country ICS, was minimal particularly at a strategic level and that ICSs.
- A near universal point was made about WMAS making decisions with material impact on stakeholders without involving those stakeholders in the decision-making process.
- The trust's reputation and performance can at times create a culture of engagement with external partners that seems defensive at best and arrogant/ dismissive at worst.
- Stakeholders observed a dissonance between what they perceived as individual vs corporate views which can cause mismatches between what is vocalized at meetings and what is acted on or decisions that are made.

Learning, improvement and innovation

Stakeholders perceive the trust as having a strong learning and improvement culture. There was more of a mixed view about the trust's appetite for innovation but some great examples were shared. General feeling that the Trust could do more in this space and lead on more research and conduct more collaborative learning and improvement exercises with partners. Barrier to this in stakeholders' eyes is lack of staff resource.

Strengths

- Stakeholders generally felt the Trust has a strong culture of learning and improvement.
- The Trust was commonly seen as having a good appetite for and track record of innovation, particularly where it related to improving key areas of performance such as conveyancing.
- The trust was praised for having engaged in a number of really good learning exercises both local and regional over the past few years.
- Stakeholders commented on a strong learning and innovation culture among clinical staff.
- The trust is seen as having a willingness to explore new solutions and ways of working.
- Stakeholders felt the Trust had put more emphasis and effort into research in recent years but mostly providing data and supporting others not leading themselves.

Weaknesses

- The trust has a very small quality and safety team for an organisation of its size.
- Lack of capacity were repeatedly cited repeatedly as a challenge and barrier.

5 Recommendations

The recommendations in this report are organised into thematic areas. These thematic areas are themselves derived from the analysis of the findings as the key areas where the trust should focus its improvement to have the greatest impact.

The five distinct themes are:

- Strategic approach
- Leadership visibility, involvement and impact
- Decision-making involvement
- Communication approach
- Structures and resourcing

Strategic approach

A common theme from partners was the lack of understanding of the trust's strategy and how it frames key decisions the trust takes. This is particularly an issue where the logic of those decisions is hard for partners to see and where those decisions have a potentially negative impact on other partners.

Another common theme in this area was the lack of a sense of strategic coherence to involvement in partner and systems forums, with certain engagements seeming arbitrary. At the same time another common theme was that the trust's executive representatives on the partner and system forums, although they were active participants, lacked a sense of purpose and strategic framework from which to operate and contribute from. The result of this is that often these representatives come across as disempowered, having to always check before they could commit or agree to anything.

Recommendations

1. The trust should review its strategic engagement and involvement with all systems but especially the Black Country ICS, with a view of providing more strategic leadership (for instance the chief executive attending the regular Black Country chief executive meetings).
2. The trust should develop an internal strategic stakeholder engagement plan to frame its engagement with partners and the ICSs it operates in, with sections dedicated to each key partner and each system.
3. When the trust conducts its next corporate strategy review it should seek to maximise the involvement and input from key partners and the systems leaders and link to the four key ICS aims.
4. The trust should look at what more it can do to communicate its strategy and strategic objectives to partners and frame decisions it takes against these.

Leadership skills and involvement

A significant amount of partner engagement and system involvement is led by the director of strategy and engagement and the chief nursing officer, who has in the course of this review retired. Although partners were very clear that they could get hold of the chair or chief executive when needed, they themselves were quite disengaged from partner and system involvement and yet could add a lot of value. It is understood that there are practical challenges to this given the fact the trust covers so many ICSs. NEDs and a number of executives on the Board were largely unknown and invisible to partners and there are questions about the effectiveness, and implementation, of the trust's ICS buddying approach of assigning a NED and exec to each system.

A number of partners made the observation that the board has been slower than most in acclimatising to some of the skills and requirements of system working implicit to the success of integrated care.

Recommendations

5. The trust should look at how its NEDs can be more visible to and engaged / involved with partner and systems work, particularly in collaboration with other NEDs across the systems.
6. The trust should review is buddying arrangement of NEDs and execs allocated in pairs to each system, to ensure it is being implemented and reflect on its effectiveness.
7. The trust should look at developing the system leadership skills of its board as part of its board development programme.

Decision-making input

An almost universally made point by partners during the audit was the lack of involvement and input into the trust's decision-making. It is quite strongly felt that the trust will actively make unilateral decisions without what partners perceive as their adequate input and involvement, and even where these decisions have a direct and material impact on partners. This can and at times if the cause of relationship strains and a threat to trust. It was understood that at times the trust needed to make operational decisions at speed and input wasn't always possible in these circumstances but more often there was and should be opportunity for the input, input which may actually help improve the trust's decision making by providing different perspectives or information otherwise missed or not considered. This is an issue which will become more acute as ICSs develop.

Recommendations

8. The trust should do more to engage and involve partners in decision-making and should review/ develop its process for doing so.
9. The trust should review the forums it used to run or be part of, especially with the universities it works with, that would provide platforms for strategic discussions and partner input into trust decision-making

Communication approach

One of the areas in which partners were most critical of the trust was about how it communicates at times. Two key issues were raised:

- The trust's habit of sending very formal letters which were often perceived to be quite chastising or patronising in tone to partners over serious issues.
- The trust's habit of using public communication, including through the media, on issues which put partners in a negative light and impacted on their reputations.

It was felt that both were damaging and unnecessary and that softer, more conversational and dialogue-based approaches would be much more effective and help improve relations. It was acknowledged that these harsher communications, ultimately, came from a good place of the trust's well-meaning focus on patient and staff outcomes but were still seen as ill advised.

Recommendations

10. The trust should reconsider the approach of sending these formal letters and utilising other means or else reviewing the tone and framing of these letters.
11. The trust should review its use of public communication methods in relation to content which explicitly names and casts partners in a negative light.

Structures and resourcing

Another common theme in the comments about the trust's resourcing in certain teams having a real impact on engagement purely from a capacity point. The three acute areas were: the education team, quality team and the senior management, band 7s and 8s tier, under the board executives. There is nothing more to this point other than there being a capacity issue with how these areas are resourced which for obvious reasons constrain and slow effective communication and engagement with partners and can have real impacts on partner operations and therefore partner relations.

Recommendations

12. The Trust should review the engagement demands on these areas and re-assess the capacity requirements in light of these demands, especially in its education and quality teams.

These recommendations are linked, some directly, to those in the main report related to KLoE 7.

6 Conclusion

"They [WMAS] could be not just an outstanding trust but one of the very best organisations in the entire NHS with just some slight changes to how they work with others."

The recommendations in this paper are developmental. This paper acknowledges that the trust is already doing a lot of what is considered good, and in some cases best, practice in how it communicates, engages, and works with partners, and instead focuses on the areas it could improve to be even better and address issues or gaps.

Engagement with key partners has always been important in health and care but in the landscape of integrated care it is essential. WMAS, as with all ambulance trusts, has a specific challenge about the sheer number of its stakeholders – especially operating as it does across several ICSs – but it is one the trust needs to address. West Midlands Ambulance Service is an organisation driven by a high-performance culture. At times this culture of uncompromising and totalising focus on the trust's performance and individual purpose and role can impact on partner relationships and broader system performance and health and care outcomes. The trust is not just an ambulance service, it is a mobile provider of care and one which is part of a much broader ecosystem of health and care support beyond just emergency care

pathways. Increasingly, as the integrated care matures, the trust's effectiveness and the impact it can have on patient outcomes and service demand will depend more on its wider role and contribution to the systems it works and the national aims of all systems.

Collectively, stakeholders felt that with a few adjustments to how WMAS works with others, involving partners in decision-making, evolving from the contractor-provider to true collaborator, and contributing at a more strategic level with integrated care, it could be not just an excellent high-performing organisation but a great partner and a key contributor to the success of others and the broader systems in which it operates. By taking forward the recommendations in this report, GGI believes that WMAS would become an even more effective organisation, would improve key relationships and would develop its influence and impact on the systems it operates in, bringing benefits to patients and staff.

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Well-led review: feedback of findings

Andrew Corbett-Nolan, Chief Executive
Joanna Watson, Senior Consultant
31 May 2023

Scope of well-led review

The CQC's 8 key lines of enquiry (KLoEs) were supplemented by three areas which have higher profile in the proposed CQC framework:

- environmental sustainability
- equality, diversity and inclusion
- partnership working

As part of the review we carried out a stakeholder audit, which is included as an appendix to the report.

Work carried out

During the course of the well-led review we:

- Carried out 24 interviews within the trust, and a further 15 interviews as part of the stakeholder audit
- Observed six meetings
- Held four focus groups

This was supplemented by our review of a wide range of documents.

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Overall findings

WMAS is seen by all those we spoke to as being a great organisation, well run, with strong leadership and a clear focus on operational delivery. We saw much that was very good, and the areas for improvement that we have identified need to be seen in that context.

Extraordinary times in the NHS since the last well-led review in 2019:

- Unprecedented range of challenge – pandemic, demand, staffing
- Change brings uncertainty, in particular adapting to collaborative system working
- Post pandemic recovery and adjustment

Headline messages

"They [WMAS] could be not just an outstanding trust but one of the very best organisations in the entire NHS with just some slight changes to how they work with others"

- Overall, comments were positive
  - The interview sandwich
  - Stakeholders keen to talk and engage
- Key strengths:
  - Very strong leadership from the CEO
  - Clear understanding as to the purpose of the organisation
  - Culture of being the best. Huge amount of pride
  - Good use of dashboards and good understanding of relative performance
  - Strong learning culture

Key areas for focus

Leadership

- Board development
- Executive team structure

Being a system partner

- Minority partner, but with the potential to make a significant difference
- Brings a number of challenges, not least capacity
- Range of potential benefits

Key areas for focus

Governance and information

- Culture of sharing, but this impacts on number of meetings and quality/quantity of papers
- Opportunities to make better use of management groups and committees
- Need for additional support

Strategy and risk

- Develop to reflect trust's role as a system partner
- More discussion at board
- Develop the BAF to be more strategic, using it to inform agendas

Key areas for focus

Culture

- Equality, diversity and inclusion – strategic priority
- Developing a more open and supportive culture
- Learning organisation – but disconnect regarding improvement

Looking beyond the well-led framework

Being a high performing board:

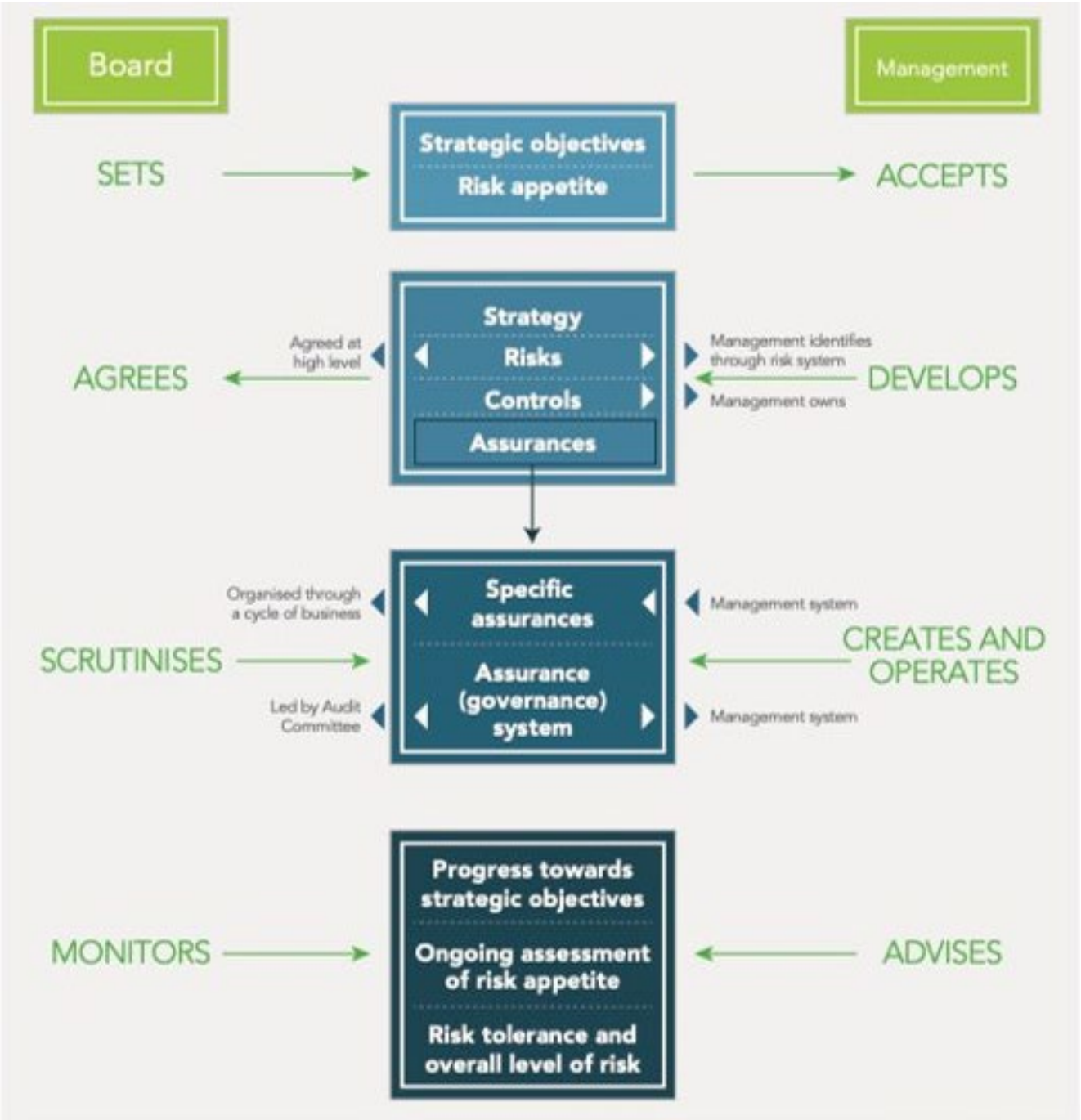
“Good is only good until you find better”

Being strategic

"…the future of the enterprise depends on the board as a whole and therefore the direction in which it is to be led is the unique responsibility of the board."

– *Sir John Harvey Jones*

- The board must be the thinking brain of the organisation as well as its conscience
- Hence the emphasis on strategy, risk and focus



Next steps

- Action plan
  - Strategic rather than transactional
  - Trust's strong track record can make it more challenging to change. Actions need to be considered carefully, and appropriately managed

Thank you for all the support and help we have received during the course of the review.

Thank you

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Developmental well-led review (GGI) May 2023
Recommendations Action Plan

Rec No	Recommendation	Priority	Action required	Lead / Oversight	Date/ RAG
KLoE 1: Leadership - (Pages 8 & 9)					
KL1.1	• The board should review the executive team structure once the remaining two executive director appointments have been made; it should also maintain the balance of the board between non-executive and executive voting members.	H	The appointment process for the 2 x Executive vacancies is being progressed, with the interviews taking place for the Dir P&I 06/07/23 and DoN 20/07/23. On appointment the CEO will update the executive team structure and present to the Rem Co, and to confirm voting arrangements in line with Trust constitution.	ACM/IC BoD	30 Sept' 2023
KL1.2	• A board development programme should be developed and rolled out, supported by individual board member coaching for less experienced directors. This should cover areas such as what it means to be a unitary board, how the board gets assurance, and the trust's role in integrated care systems.	H	Chair and CEO to discuss Board development needs and this may be subject to a procurement exercise to seek external support.	ACM/IC BoD	30 Sept' 2023
KL1.3	• As part of its continued work on succession planning, the trust should review the wider leadership development offer to senior managers in the trust.	M	This work needs to be incorporated into the Trust's Engaging Leaders programme. Also review availability through NHSE and external sources.	CB EMB	31 Dec' 2023
KLoE 2: Vision and strategy - (Pages 10 & 11)					
KL2.1	• The trust's strategy needs to reflect its role and responsibilities as a system partner. In refreshing the strategy, the trust should take the opportunity to build on its unique role in each system.	M	The Strategy and Engagement Director will share the latest iteration of the Strategy at the Board of Directors on 26/06/23. Further engagement with system partners is required to ensure true integration and synergy between strategies.	VK BoD	31 Dec' 2023
KL2.2	• We recommend that the directors spend time together as a board, to plan their involvement in delivering the strategy, and in monitoring and reviewing progress.	M	This links with recommendations KL1.2 and KL2.1.	VK/IC BoD	31 Dec' 2023
KL2.3	• The profile of environmental sustainability should be raised in the trust, including robust governance arrangements, increased accountability and reporting to the board.	M	The Director of Finance is the Executive Director responsible for sustainability.		

			The Green Plan needs progressing to complete the agreed actions, with clear and increased governance arrangements around reporting.	KR BoD	31 Dec' 2023
KLoE 3: Culture - (Pages 11 to 13)					
KL3.1	• Encouraging staff to speak up about concerns and providing them with the support they need to do so.	H	FTSU action plans are in place and promoting staff to speak up, however, this is about the wider culture of the organisation, its policies and staff responsibilities with regards to being open and duty of candour.	VK/PW EMB	30 Sept' 2023
KL3.2	• Addressing the underlying causes of staff concerns – this could include addressing workload, staffing levels, and the availability of resources.	H	Review of our current strategy and operational model and look at what is achievable within financial planning and workforce plan.	VK/PW EMB	30 Sept' 2023
KL3.3	• Recognising and valuing staff for their work through regular feedback, performance reviews, and opportunities for professional development.	M	Review of the 'Flourish' framework to ensure it is fit for purpose, and that it meets the needs of the organisation. Ensure that staff are aware of what opportunities are available to them.	CB EMB	31 Dec' 2023
KLoE 4: Governance - (Pages 14 to 16)					
KL4.1	• The trust should focus on increasing the effectiveness of meetings, including: – reducing the length of papers, taking out unnecessary detail. – increasing the use of assurance reports from board committee to board, and from management groups to executive management board. – tightening up on reports going to more than one committee, to minimise duplication of discussions. – using the board assurance framework (BAF) to help set the board agenda, so as to have a strategic, risk-based focus.	H	Directors and report authors to be reminded of the need for succinct papers, with supporting papers held in a repository. Review of the committee structure, ToRs, frequency and reporting lines. Chair of each committee to provide a brief update to the next appropriate meeting, with approved minutes. As above, to ensure the purpose of the report is clear.	PH/KR BoD PH/KR BoD PH/KR BoD PH/MD BoD	31 Oct' 2023 31 Oct' 2023 31 Oct' 2023 31 Oct' 2023

			The BAF has been reviewed by GGI and Internal Audit and may be subject to a procurement exercise to seek external support. This should link with the ICB's and Trust strategy.	MD BoD	31 Dec' 2023
KL4.2	• The policy group should be renamed and its objectives reviewed. The trust should consider forming a separate group with oversight of policies to provide assurance that policies are being managed and updated appropriately.	M	A review of the current process of how policies are approved should be undertaken, which may result in a major change to the ToRs of the Policy Group. Consultation and engagement are separate to approval.	PH/NH EMB	31 Dec' 2023
KL4.3	• To improve resilience and support improvement, we recommend increasing the size of the central governance team.	H	An audit of the current support workforce to propose new ways of working with centralised corporate and administrative functions.	PH/KR EMB	30 Sept' 2023
KLoE 5: Management of risks, issues and performance – (Pages 16 to 19)					
KL5.1	• The trust should revise the BAF to include a smaller number of strategic risks, ensuring that risks in relation to each of the strategic objectives have been considered. This should then be used to shape the agenda and the discussions that take place at the board and its committees, so that the board's focus is on strategic issues.	H	Links to KL4.1 - The BAF has been reviewed by GGI and Internal Audit and may be subject to a procurement exercise to seek external support. This should link with the ICB's and Trust strategy.	MD BoD	31 Dec' 2023
KLoE 6: Information management - (Pages 19 to 21)					
KL6.1	The trust should: • Adopt the 'hierarchy of data visualisation' and work with staff to ensure that all data presented supports intelligent decision-making.	M	It is unlikely that the Trust will have this knowledge and may be subject to a procurement exercise to seek external support If this is to be pursued.	KR EMB	31 Dec' 2023
KL6.2	• Review and update the information available to the public about the performance of the trust (via the website).	M	A review of the website is required to ensure that key information is available about the Trust.	MM EMB	31 Dec' 2023
KLoE 7: Service users, staff and external partner engagement - (Pages 21 to 24)					
KL7.1	• The board should look at the culture in the organisation and its impact on engagement.	M	Links with KL2.1.	VK BoD	31 Dec' 2023
KL7.2	• More needs to be done to increase executive and non-executive visibility with staff.	H	Chair to refresh the Buddy scheme in line with updated executive appointments.	IC BoD	30 Sept' 2023

KL7.3	• The board should review and increase the resourcing and support for staff networks and provide them with greater opportunities to engage with the board.	M	Consider what the resourcing requirements look like and what they would achieve. If appropriate draft a business case and apply for funding.	CB EMB	31 Dec' 2023
KL7.4	• The trust should think about ways it can collaborate with partners (other providers, Healthwatch) on patient engagement around service quality and experience.	M	Internal and external engagement should be reviewed, with opportunities to improve. This will link with the Trust Engagement Strategy review.	MD/VK EMB	31 Dec' 2023
KL7.5	• The trust should review its ICS engagement and involvement and do more to contribute strategically to the systems in which it operates, especially in the Black Country ICS as host, to develop the trust's sphere of influence.	M	Links to KL2.1. Further engagement with system partners is required to ensure true integration and synergy between strategies.	VK EMB	31 Dec' 2023
KL7.6	• The trust should do more to engage and involve partners in the decision-making process and should review/ develop its process for doing so.	M	Links to KL2.1. Further engagement with system partners is required to ensure true integration and synergy between strategies.	VK EMB	31 Dec' 2023
KL7.7	• The trust should look at how it can support and create more opportunities for governors to engage with staff, even if this must be virtual due to operational constraints.	M	The Membership and Governor Support Officer will review this as part of ongoing engagement with the Council of Governors.	PH CoG/BoD	31 Dec' 2023
KLoE 8: Learning, continuous improvement and innovation - (Pages 24 & 25)					
KL8.1	The trust should: • Review the results of the staff survey in detail to consider the disconnect in staff experience of improvement, and develop plans to make improvements in this area.	H	The People Director will review as part of the current arrangements for improving the staff survey results.	CB EMB	30 Sept' 2023
KL8.2	• Consider how learning, improvement and innovation can be done collaboratively with partners at place and system level.	H	Consider how this can be done.	CB/VK EMB	30 Sept' 2023
Stakeholder Audit (SA) – Annex D (Pages 34 to 42) The summary recommendations for WMAS to consider are:					
Strategic Approach (Page 44)					
SA 01	The trust should review its strategic engagement and involvement with all systems but especially the Black Country ICS, with a view of	M	Review as part of our engagement strategy and the buddying arrangements with ICS and ICB's.	VK EMB	31 Dec' 2023

	providing more strategic leadership (for instance the chief executive attending the regular Black Country chief executive meetings).				
SA 02	The trust should develop an internal strategic stakeholder engagement plan to frame its engagement with partners and the ICSs it operates in, with sections dedicated to each key partner and each system.	H	Linked to SA01 Review as part of our engagement strategy.	VK EMB	30 Sept' 2023
SA 03	When the trust conducts its next corporate strategy review it should seek to maximise the involvement and input from key partners and the systems leaders and link to the four key ICS aims.	H	This is part of the Board Briefing session on 04/07/23. This action will be carried forward to September briefing session and the October Board of Directors meeting.	VK BoD	31 Oct' 2023
SA 04	The trust should look at what more it can do to communicate its strategy and strategic objectives to partners and frame decisions it takes against these.	H	Links to KL4.1 and 5.1 - The BAF has been reviewed by GGI and Internal Audit and may be subject to a procurement exercise to seek external support. This should link with the ICB's and Trust strategy.	VK BoD	30 Sept' 2023
			Leadership skills and involvement – (Page 44)		
SA 05	The trust should look at how its NEDs can be more visible to and engaged / involved with partner and systems work, particularly in collaboration with other NEDs across the systems.	M	Communicate with partner organisations to link NEDs across the system, through Chairs' network meetings.	IC BoD	31 Dec' 2023
SA 06	The trust should review is buddying arrangement of NEDs and execs allocated in pairs to each system, to ensure it is being implemented and reflect on its effectiveness.	H	Linked to KL7.2. Chair to refresh the Buddy scheme in line with updated executive appointments, and review annually in PDR's and to report back to the CoG.	IC BoD	July 2023
SA 07	The trust should look at developing the system leadership skills of its board as part of its board development programme.	H	Linked to KL1.2.	ACM/IC BoD	31 Dec' 2023
			Decision-making input- (Page 44)		
SA 08	The trust should do more to engage and involve partners in decision-making and should review/ develop its process for doing so.	M	Working in consultation with partners in advance of major/strategic changes.	VK EMB	31 Dec' 2023

SA 09	The trust should review the forums it used to run or be part of, especially with the universities it works with, that would provide platforms for strategic discussions and partner input into trust decision making.	M	Linked to SA 08. Review all current arrangements and consolidate to ensure a co-ordinated approach by the Trust.	VK/CB EMB	31 Dec' 2023
			Communication approach – (Page 45)		
SA 10	The trust should reconsider its approach of sending these formal letters and utilising other means or else reviewing the tone and framing of these letters.	M	Linked to SA 08. Working in a more collaborative approach with partner organisations. Consider personal engagement at the appropriate level before formal sending correspondence.	ACM EMB	31 Dec' 2023
SA 11	Review the trust's use of public communication methods in relation to content which explicitly names and casts partners in a negative light.	M	Working more collaboratively with partners.	MM EMB	31 Dec' 2023
			Structures and resourcing – (Page 45)		
SA 12	The trust should review the engagement demands on these areas and re-assess the capacity requirements in light of these demands, especially in its education and quality teams.	M	Review of current resources and arrangements for engagement.	ACM EMB	31 Dec' 2023

Priority timescales	
High (H)	1 to 3 months
Medium (M)	4 to 6 months
Low (L)	7 to 9 months

RAG Rating legend	
Green	Action complete
Amber	Action commenced, but not complete (Ongoing)
Red	Action not commenced

Lead

Initial	Name	Position
IC	Ian Cumming	Chair
ACM	Anthony Marsh	Chief Executive Officer
KR	Karen Rutter	Director of Finance
PW	Pippa Wall	Freedom To Speak Up Guardian / Head of Strategic Planning
CB	Carla Beechey	People Director
VK	Vivek Khashu	Strategy & Engagement Director / FTSU Executive Director
MM	Murray MacGregor	Communications Director
PH	Philip Higgins	Governance Director / Trust Secretary
DJS	Diane Scott	Interim Organisational Assurance Director
NH	Nathan Hudson	Emergency Services Operations Delivery Director
MD	Mark Docherty	Interim Director of Nursing

Governance	
BoD	Board of Directors
EMB	Executive Management Board
CoG	Council of Governors

Agenda item 10a

Minutes of the Audit Committee meeting held on
6 June 2023, 10am, CR1, WMAS HQ, Millennium Point, Brierley Hill/Teams

Present:

Julie Jasper	JJ	Non-Executive Director - Chair
Mushtaq Khan	MK	Non-Executive Director – via Teams
Narinder Kooner	NK	Non-Executive Director – via Teams
Mohammed Fessal	MF	Non-Executive Director – via Teams
Alex Hopkins	AH	Non-Executive Director – via Teams
Karen Rutter	KR	Director of Finance
Ian Geddes	IG	Chief Financial Accountant
Anthony Marsh	ACM	Chief Executive Officer – via Teams
Andy Cardoza	AC	External Audit – KPMG – via Teams
Orapeleng Othibeng	OO	External Audit – KPMG – via Teams
Kristina Woodward	KW	Internal Audit
Chris Kerr	CMK	Head of Security Management
Julie Hill	JH	LCFS
Diane Scott	DJS	Organisational Assurance Director – via Teams
Pippa Wall	PW	Head of Strategic Planning – via Teams
Donna Stevenson	DS	EA to Director of Finance

Section 1 - Approval of the 2022-23 Annual Report and Accounts (ARA)

ITEM	Audit Committee Meeting 6 June 2023	ACTION
	Introduction JJ outlined the format for the meeting and said that the agenda has been split into two parts, therefore, the business of approving the Annual Report and Accounts on behalf of the Board, receiving and noting the LCFS Annual Report, the Internal Audit Annual Report and the Quality Account will take place prior to the normal schedule of Audit Committee business.	
06/23/01	**External Audit** **Draft Auditor's Annual Report 2022-23** AC outlined the draft auditor's annual report and said that this is a public document which summarises the findings from the 2022/23 audit of WMAS' accounts and is prepared in line with national requirements. AC said that in terms of the accounts it is the intention to issue an unqualified opinion. KPMG did not identify any significant inconsistencies and there were no concerns regarding the Value for Money element. **ISA 260** AC outlined the report to the Committee and expressed his thanks to the Finance team for their assistance during the audit. The audit is substantially complete and it is expected that an unqualified opinion on WMAS' financial statements with no significant weaknesses identified will be issued. Any areas that require further input will be discussed with KR, IG and PJ.	

AC pointed out the Audit Findings on page 5 of the report:-

- Expenditure Recognition – all expenditure (non-pay) is appropriate.
- Value of land and buildings (Property, Plant and Equipment) – results of testing was satisfactory and appropriate.
- Management Override of Controls – this is a standard risk across all organisations and is challenged robustly. These were able to be tested and there were no concerns in this area.
- Key accounting estimates – Land and Buildings - overall the valuation estimate of land and buildings is appropriate.

Annual Report and Annual Governance Statement – KPMG has found no inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.

AC pointed out that the Audit Fee was £97,190 and he also confirmed that no non audit work was completed during the year, as this could compromise independence and objectivity.

Whole of Governance accounts – no items of concern noted.

Value for Money – one significant risk noted appertaining to the large deficits and efficiency targets at both Trust and ICS level, together with continued national NHS pressures. Pressures experienced by the Trust include the effects of handover delays, ongoing pressures due to further demand and industrial action. Due to arrangements in place, KPMG has not identified a significant weakness in the arrangements to deliver value for money at the Trust during the year. However, the Trust will still have a challenge going forward.

Recommendations Raised:-

AC said that on page 17 one recommendation was made in year relating to Payroll to ensure that exception reports are run and reviewed every month and the Payroll Manager has already implemented this change.

Page 18 onwards details the previous year's recommendations that have not been implemented and page 19 of the reports on the low-risk recommendations. All other recommendations have been implemented.

Agreement of Balances (NHS Organisations) – AC said that any inconsistencies over £300k have to be reported and these are identified in the report. NK asked for further clarity regarding these variances. AC outlined the variances to the meeting.

JJ thanked AC for the level of detail provided to the Committee. JJ said she was also impressed with the quality of the accounts and thanked both KPMG and the Finance Team for their work.

MK also thanked AC for the level of detail in the report and also extended his thanks to the Finance Team for all their work.

06/23/02	**Review of:** **Annual Report 2022-23, including Annual Governance Statement (AGS)** ACM presented the Draft Annual Report and AGS to the Committee and said that if any members of the Committee had any comments that they could be incorporated into the document if required. ACM said it was pleasing to report that all governance arrangements have remained in place, even during the pandemic, and the Trust has maintained all of these arrangements. ACM thanked DJS for her assistance during this reporting period and for overseeing compliance assurance arrangements. The continuity of NEDs and Executive Directors has also been really important during the period for the Trust. ACM pointed out the PwC review of business cases and the recommendations made. The action plan from this was signed off by the Board of Directors in November 2022 and work is ongoing in this area, i.e., the post implementation review of all business cases and ACM thanked PW for her work in this area. The Trust has a strong system of Internal Control with a robust Board of Directors, Council of Governors, Executive Management Board and the sub committees of the Board which are expertly chaired by the Non-Executive Directors. Internal Audit's ongoing programme of work is also very important to the Trust and it was pleasing to note that Significant assurance has been received from the Head of Internal Audit. Risk Management is the responsibility of both EMB and the Board and was expertly led by Mr M Docherty throughout the reporting period, who will return on a part time basis until a substantive Director of Nursing post is appointed to. Despite a slight back log of SI's ACM was pleased to report that these have now been cleared. The high risks are regularly reviewed and reported to the Board of Directors, along with the risk appetite statement. The Good Governance Institute (GGI) undertook a well led review and the action plan from this will be developed and DJS is the lead Director to take this forward. Some areas identified are to improve and strengthen the BAF. It was pleasing to report that WMAS remains the only "Outstanding" rated Ambulance Service in the Country by the Care Quality Commission. The Board Skills matrix and succession planning is maintained to ensure the Board has the appropriate skills, experience and expertise. Use of Resources – WMAS are currently in segmentation 2 only due to the recognition of the lost hours and handover delays and the Trust looks forward to the support from the ICB in the region in relation to this.	

	ACM also confirmed that he will be presenting the Annual Report, Accounts and AGS to the Annual meeting of the members on 26 July 2023. JJ, on behalf of audit colleagues, thanked ACM for his summary of the AGS. AC said he has reviewed the AGS and congratulated the Trust on a very comprehensive document, he also said it detailed improvements required and improvements that have been made, risk management, internal audit work, and he was pleased that the PwC report and recommendations had been implemented in full. The Committee approved the Annual Report and Annual Governance Statement on behalf of the Board of Directors, as per delegated authority from the Board. **Financial Statements 2022-23** KR said that the review of the accounts has taken place with the Non-Executive Directors and the financial statements have been thoroughly reviewed. The Financial Statements were approved by the Committee on behalf of the Board of Directors. **Board Letter of Representation** This is a standard letter and was approved by the Committee. JJ also pointed out that every member of the Audit Committee has received the Annual Report and Accounts and approved and confirmed them.	
	Resolved: **a) Annual Report and Accounts –** The Annual Report and Accounts were approved by the Committee on behalf of the Board of Directors. **b) Board Letter of Representation –** approved by the Committee on behalf of the Board of Directors.	**DMS/KR** **DMS**
06/23/03	**Internal Audit Annual Report 22-23 including *Head of Internal Audit Opinion*** KW outlined the Internal Audit Annual Report for 2022-23 and for the 12 months ended 31 March 2023, the Head of Internal Audit Opinion for West Midlands Ambulance Service University NHS Foundation Trust is as follows: *"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk. significant assurance was given to the Trust."*	

	KW also pointed out the following:- 18 reports received either optimal (5) or substantial assurance (13) 8 reports required improvement. 5 were advisory reports. JJ thanked KW for her report and delivering the Head of Internal Audit Opinion to the Committee, she also expressed thanks to C Knight who retired on 31 May, for all his work over the years as the Head of Internal Audit.	
	Resolved : **a)** The Committee received and noted the Internal Audit Annual Report and Head of Internal Audit Opinion.	
06/23/04	**LCFS Annual Report**	
	JH said the LCFS Annual report summarises the work undertaken during the year. Fraud risks are identified as part of delivering the proactive work and by undertaking investigations and these are summarised within the report. A total of 95 days were delivered during 2022 to 2023: 16 days on Strategic Governance, 16 days on Inform and Involve, 35 days on Prevent and Deter and 28 days on Hold to Account. JH said that the section relating to the Trust's compliance with the Counter Fraud Functional Standards has been included in the Annual Report in accordance with the CFA guidance and it was pleasing to note the overall score is green (self-assessed). There have been some changes since the previous year in the individual component scores and the number of "amber" ratings overall has increased by one. The following were also noted: Requirement 2 – was Amber now improved to Green. Requirement 3 – unchanged at Amber Requirement 6 – unchanged at Amber - this relates to outcome metrics and the effectiveness of proactive work and how this is measured. Requirement 8 - was Green, changed to Amber. Requirement 12 – was Green changed to Amber. JH said the measurement of staff awareness needs to be determined and work will be carried out in this area in 2023-24. An Action plan for all amber and non-robust green items has been devised. Access to the Toolkit, which is an online portal and a link to the submission was included in the annual report. JJ thanked JH for the LCFS Annual Report and said that this has been signed off by JJ, KR and PJ.	

	NK queried the referral received in May 2022 via the CFA reporting line relating to "false accounting" by WMAS where it is alleged that the budgets for 111 and 999 are not accurate, and asked what safeguards are being put in place to counteract this. JH said this was an anonymous referral from the CFA portal, but merely related to two cost centres being used and there was no case to answer and no subsequent allegations made.	
	Resolved: a) The Committee received and noted the content of the LCFS Annual Report.	
06/23/05	**Quality Account 2022-23** JJ said the Quality Account has already been submitted to the Board of Directors and the Council of Governors. PW said the Quality Account has been through the appropriate route within the Trust. There is no national guidance for Quality Accounts this year, but the documents are still to be created and published by each Trust and whilst there is no updated guidance, it has been clearly stated that there is no requirement for external audit of the document. Anticipating that this will continue in future years, it is suggested that the Quality Account process forms part of the Internal Audit schedule in 2024 in terms of good practice. KW said that this has been included in the Internal Audit Plan for 2023-24. PW also said the final version of the Quality Account will be submitted to EMB.	
	Resolved: a) The Committee received and noted the Quality Account 2022-23 and confirmed that as this is no longer subject to external audit will be reviewed as part of the Internal Audit plan.	
	Section 1 of the meeting closed at 11:15 hours.	

Section 2 – Audit Committee Business

06/23/01	**Apologies and Welcome**	
	Apologies were received from Wendy Farrington-Chadd, Paul Jarvis, Professor Ian Cumming, Matt Brown and Phil Higgins.	
06/23/02	**Minutes of the Last Meeting (14 March 2023)**	
	Resolved: The minutes of the meeting held on 14 March 2023 were agreed as an accurate record.	
06/23/03	**Matters Arising from the last meeting and Action Log**	

	Action Log • Paper required for EMB re Risks (JJ/PH) – action deferred to next meeting. • Internal Audit Plan – this has been through the relevant process but will be reviewed going forward throughout the year. • Terms of Reference – JJ said these will be subject to ongoing review following the GGI Well Led review. • Fraud Sanctions and Fraud Redress Policy and Procedure – DMS to check if these were approved at Board level. • Policy Group Terms of Reference – to be brought back to the next meeting following GGI debriefing. • Declarations of Interests – to be declared for those staff who have financial responsibility over a certain limit. JH said that she is currently undertaking a review of this as well. • **Payroll Procedures –** KR said these are the procedures that have been through Policy Group and are reviewed every three years. These were approved by the Committee. DMS to approve document on 'PolicyStat'.	**JJ/PH** **DMS** **PH** **DMS**
	Resolved: a) Risk paper – deferred to next meeting. b) Fraud Sanctions and Fraud Redress Policy – DS to check that this these were ratified at the Board meeting due to the March Audit Committee meeting being inquorate. c) Policy Group Terms of Reference – to be brought back to the next meeting following GGI debriefing. d) **Payroll Procedures –** the Committee approved the Payroll Procedures. DMS to approve on 'PolicyStat'.	**JJ/PH** **DMS** **PH** **DMS**
06/23/04	**Internal Audit**	
	Internal Audit Workplan 2023-24 KW outlined the plan to the Committee – it is an amended version and changes are mainly around leads due to changes at Board level. The Committee noted the changes to the Internal Audit Plan. MF suggested that any reports that "Requires Improvement" that the actions are listed to ensure that these have been implemented from the previous year's report. ***Internal Audit Progress Report June 2023*** KW said that the reports to consider at this committee are listed below. a) Overtime and Additional Hours – KW said this was finalised recently. • NK queried the timesheets and how procedures can be strengthened. KR said the timesheets are not always submitted or authorised on time and there are a mix of both manual and electronic timesheets. • DJS said she understood the majority would be electronic, but some late submissions may require manual timesheets to be authorised.	

	• MF raised concern that there is still a facility to be able to have paper-based overtime authorised. KR said she would raise these items with Ops colleagues and would report back to the next meeting. • MF also raised the overtime for Band 8 and 9 and asked if this had ceased. JJ said that this item should be reviewed at People Committee, however, a report on overtime for 22-23 will be submitted to the next Audit Committee in line with the NHSE recommendations report. JJ also said that there may be a need for distribution of audit committee reports to relevant committees. NK asked if it would be possible for Internal Audit to be used as a mechanism to look into areas that require more focus. KW said all the audit reports are submitted to EMB in order for all Executive Directors to be aware of the recommendations made. KR said the process could be reviewed for strengthening. • MF queried the overtime with regard to handover delays, KR said this is included within Performance Committee reports. b) Assurance Mapping – this is an advisory piece of follow up work and all actions have been implemented. DJS said one outstanding action went to Board last week and JJ agreed that due to this being signed off at Board this gave sufficient assurance to this report and there was no need for it to be brought back to Audit Committee. c) Procurement Follow Up – Substantial assurance. d) 1596 Secure Email Standard Assessment – this is completed annually as per requirements. e) Q4 Penetration Testing – this is part of the plan for 2023-24. f) DSPT Management Processes – Optimal assurance. g) Stock Management Follow up – Substantial assurance. **Follow up –** the number of outstanding actions is 0, but 46 recommendations are to be actioned on the Aardvark system.	
	Resolved: a) The Committee received and approved the Internal Audit Workplan 23-24. b) The Committee received and noted the Progress Report. c) The Committee received and noted the Full Internal Audit Reports. d) KR to report back to the July meeting regarding electronic and manual timesheet authorisations. e) Distribution of reports to relevant Committees to be reviewed.	**KR**
06/23/05	**Board Assurance Framework (BAF)**	
	Board Assurance Framework and Risk Register DJS pointed out the following on behalf of MB : • 116 Risk assessments have been reviewed and a number removed from the framework. • Two highest risks with a score of 25 noted:– ➢ PS 074 - Hospital delays and turnaround times. ➢ EOC 016 – stacking of incidents at times of high demand. • DJS also said that the BAF will be reviewed and updated in future with regard to best practice and in relation to the GGI review.	

	• JJ said it is important to review and refresh the BAF. • MF said that references to 111 should be removed and the BAF is checked for any errors. The Risk Changes report and the Out of Date Risks Report were noted by the Committee.	
	Resolved: **a)** The Committee reviewed and noted the BAF.	
06/23/06	**Data Security and Protection Toolkit and Action Plan**	
	CMK outlined the report to the meeting. He said the paper has been received at QGC and Health, Safety and Risk meeting prior to this meeting. The key items to note to provide assurance are:- • DSPT is a self-assessment – Internal Audit have examined this process and have received optimal assurance. • Action plan for delivery of the DSPT by the 30 June 2022 deadline. • The updated plan will be circulated to the group following Cyber Security meeting updates.	
	Resolved: a) The Audit Committee received the DSPT report for assurance and recognition of the optimal level of assurance given by internal Audit.	
06/23/07	**LCFS Progress Report** **LCFS Workplan 23-24**	
	<u>LCFS Progress Report</u> JH said the 22-23 table is still included for ease of reference. Two items have been closed, however, one case (8) has been re-opened for this year and work in this area is ongoing. NFI data – data matching process – some sharing of information between organisations has taken place and is in progress. **<u>LCFS Workplan 2023-24</u>** The Work plan has been reviewed by KR. It is broken down by areas – Involve and inform; Prevent and deter; Proactive reviews (still to be determined). The Committee approved the Work plan.	
	Resolved: a) The Committee noted the LCFS Progress Report. b) The Committee approved the LCFS workplan and the number of days in the plan.	

06/23/08	**Terms of Reference**	
	• JJ said the membership of the Committee should be extended to all Non-Executive Directors and has recommended this to the Chairman of the Trust. • JJ said she has also recommended to the Chairman that the Audit Committee should have a Nominated Vice Chair. • The current Terms of Reference were approved by the Committee subject to any amendments from the Well Led Review.	
	Resolved: a) The Terms of Reference were approved subject to any amendments from the Well Led Review.	**PH**
06/23/09	**Any Matters reported to the Chair from other Committees.**	
	• No items reported to the Chair of Audit Committee.	
06/23/10	**Schedule of Business**	
	JJ said that some items originally scheduled for today's meeting have been deferred to the meeting on 18 July 2023.	
	Resolved: Schedule of Business received and noted.	
06/23/11	**Any New Risks Identified**	
	DJS said she noted the following potential risk areas:- • Management of Timesheets and overtime controls. • Distribution and triangulation of documentation (audit reports).	
06/23/12	**Any Other Urgent Business**	
	• MK said that it is important that Teams invites are sent out with meeting invites.	
06/23/13	**Dates of Future Meetings**	
	• 18 July 2023, 10am to 1pm, CR1, MP (apologies from NK) • 7 November 2023, 10am to 1pm, CR1, MP • 25 January 2024, 10am, CR1, MP	
06/23/14	**Meeting of the Audit Committee in the absence of Officers of the Trust**	
	This was held prior to the meeting between JJ and AC.	

The meeting closed at 1230 hours.

Action Points – Audit Committee 6 June 2023 – Section 1

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
06/23/02	• **Annual Report and Accounts –** The Annual Report and Accounts were approved by the Committee on behalf of the Board of Directors. • **Board Letter of Representation –** approved by the Committee on behalf of the Board of Directors.	**KR/DMS** **DMS**	Complete Complete	*Complete and submitted.* *Complete and submitted.*

Action Points – Audit Committee 6 June 2023 – Section 2

06/23/03	• Risk paper – deferred to next meeting.	**PH/JJ**	Complete	**please see below – BAF to be reviewed as per GGI recommendation*
	• Fraud Sanctions and Fraud Redress Policy – DMS to check that this these were ratified at the Board meeting due to the March Audit Committee meeting being inquorate.	**DMS**	Complete	*Ratified at March Board Mtg*
	• Policy Group Terms of Reference – to be brought back to the next meeting following GGI debriefing.	**PH**	Complete	*ToR to be reviewed as per the GGI recommendation. *please see below.*
	• **Payroll Procedures –** the Committee approved the Payroll Procedures. DMS to approve on Policy Stat.	**DMS**	Complete	*Approved on Policy Stat and live*
06/23/04	• KR to report back to the July meeting regarding electronic and manual timesheet authorisations.	**KR**	Complete	*On agenda for verbal update*
06/23/08	• Terms of Reference approved.	**PH**	Complete	*Approved on Policy Stat and live*

Date of next meeting:
18 July 2023, 10am, CR1, Millennium Point

* The GGI Well Led Review Report and Action Log includes the following actions which will be taken forward:

KL4.2	• The policy group should be renamed and its objectives reviewed. The	M	A review of the current process of how policies are approved should be undertaken, which may result	PH/NH	Dec' 2023

	trust should consider forming a separate group with oversight of policies to provide assurance that policies are being managed and updated appropriately.		in a major change to the ToRs of the Policy Group. Consultation and engagement are separate to approval.		
KLoE 5: Management of risks, issues and performance – (Pages 16 to 19)					
KL5.1	• The trust should revise the BAF to include a smaller number of strategic risks, ensuring that risks in relation to each of the strategic objectives have been considered. This should then be used to shape the agenda and the discussions that take place at the board and its committees, so that the board's focus is on strategic issues.	H	Links to KL4.1 - The BAF has been reviewed by GGI and Internal Audit and may be subject to a procurement exercise to seek external support. This should link with the ICB's and Trust strategy.	PH/MD	Sept' 2023

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS MEETING

AGENDA ITEM 12a ii MONTH JULY 2023 PAPER NUMBER 10b

Committee	**Audit Committee**
Chair	Julie Jasper, Non-Executive Director
Executive Director	Karen Rutter - Director of Finance
Meeting Date(s)	18 July 2023
Matters of concern or key risks to escalate	• Internal Audit report - Risk Management and Assurance Framework "requires improvement" • BAF "in need of improvement" – as per GGI report. • Audit Committee attendance.
Major actions commissioned/ work underway	• GGI – review underway
Positive assurances to provide	• Internal Audit reviews - significant assurance: General Ledger & Budgetary Control, Payroll.
Decisions made	• Approval of minutes 6/6 Audit Committee minutes • Approval of the Audit Committee Annual Report • Approval of the revised Internal Audit Plan • Completion and approval of the Audit Committee Self-Assessment toolkit
Chair's comments on the effectiveness of the meeting	The meeting was quorate. But Committee attendance still disappointing Good, detailed discussions, with the quality of the reporting at this committee continually improving.
Any other key points for escalation to the Board	None other than detailed above.

Agenda item 10c

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE FINANCIAL YEAR 2022-23

Introduction

The NHS Audit Committee Handbook includes the requirement for Audit Committees to provide an Annual Report to the Board. The Board is invited to note and comment on the contents of the report and the overall conclusion reached by the Committee in relation to the provision of assurance to the Accounting Officer and the Board.

Membership and Attendance

This Annual Report gives details of the coverage and challenge provided by the Audit Committee of WMAS and the conclusion and opinions reached.

The report covers meetings during the period 1st April 2022 to 31st March 2023.

During the period from 1 April 2022 to 31 March 2023 the membership of the Audit Committee was as follows:

- Wendy Farrington-Chadd – Chair (to 31.12.22), Non-Executive Director
- Narinder Kooner – Non-Executive Director
- Mushtaq Khan – Non-Executive Director
- Julie Jasper – Chair (from 1.1.2023), Non- Executive Director

It is a requirement that at least one of the above will have recent and relevant financial experience. The Chair of the Audit Committee holds an appropriate and current professional accountancy qualification.

A quorum will be two non-executive members.

In addition, the following are invited to attend:

- Director of Finance, West Midlands Ambulance Service University NHS Foundation Trust;
- Internal and External Auditors;
- Local Counter Fraud Specialist; and
- Directors, senior finance staff and managers as requested by the Audit Committee.

The Chair and CEO attend by invitation of the Committee, with the CEO attending annually to present the Annual Governance Statement.

The Audit Committee met five times: 23 May 2022, 19 July 2022, 14 November 2022, 24 January 2023 and 14 March 2023.

Three meetings were quorate and two were not quorate. The Committee spent time with the auditors, and without the presence of management, at 4 out of 5 meetings. The Audit Committee reported its findings at each following Board meeting.

Attendance of voting members was as follows: -

NAME	23.5.22	19.7.22	14.11.22	24.1.23*	14.3.23*
Wendy Farrington-Chadd[1]	✓	✓	✓	☒	☒
Mushtaq Khan	☒	✓	☒	☒	☒
Narinder Kaur Kooner	✓	☒	✓	☒	☒
Julie Jasper[2]			✓	✓	✓

[1]Chair to 31 December 2022

[2]Member of Committee from November 2022 and Chair from January 2023.

*Meeting not quorate

Consideration and proposals

The NHS Audit Committee Handbook recommends that the Audit Committee should prepare an annual report that sets out how the committee has discharged its responsibilities and met its terms of reference. The report is timed to support preparation of the Annual Governance Statement and it should summarise the Audit Committee's work for the past year and present the Audit Committee's opinion regarding:

- The comprehensiveness of assurances in meeting the Board and Accounting Officer's needs;
- The reliability and integrity of these assurances;
- Whether the assurance available is sufficient to support the Board and Accounting Officer in their decision taking and their accountability obligations;
- The implication of these assurances for the overall management of risk;
- Any issues the Audit Committee considers pertinent to the Annual Governance Statement and any long-term issues the Committee thinks the Board and/or Accounting Officer should give attention to;
- Financial reporting for the year;
- The quality of both Internal and External Audit and their approach to their responsibilities; and
- The Audit Committee's view of its own effectiveness, including advice on ways in which it considers it needs to be strengthened or developed.

Quality of assurances

This section provides the Committee's comments and opinions on the comprehensiveness, reliability, integrity and sufficiency of assurances in meeting the needs of the Board and the Accounting Officer.

In setting its forward agenda the Committee considered items currently on the Board Assurance Framework and the associated High Level Risk Register, items of current interest and items raised by the auditors and senior management team. In addition, the Committee followed up risk items previously identified to ensure that it remains informed of progress against previously agreed actions.

The Committee dealt with the following items, during the year:

- Recommendation of approval of the WMAS accounts for 2021-22, to the Board meeting held on 9 June 2022. This meeting also covered:
    - Review of 2021/22 Internal Audit Annual Report incorporating Head of Internal Audit Opinion;
    - The process for external audit from the financial year 2021/22;
- Approval of the Trust's Accounting Policies;
- Any matters reported to the Chair from other Committees raising any areas of concern;
- Review of internal audit reports, including follow up of management actions;
- Review of the following policies/procedures:
    - Anti-fraud, Bribery and Corruption policy
    - Standing Financial Instructions and Scheme of Delegation
    - Finance Procedures
    - Purchasing and Management of Substances Policy
    - Stock Management Policy
    - Contract Management Policy
    - Change to Depreciation Application
    - Cash and Treasury Management Policy
    - Fraud Sanctions and Redress Policy and Fraud Sanctions and Redress Procedure
- Assessment of the applicability of the Going Concern concept to the Trust with respect to production of the 2022/23 accounts and Annual Report;
- Reviewing the Terms of Reference in March 2023, these were subsequently approved at the Audit Committee held in June 2023, and it was recommended that the membership of the Committee

should be extended to all Non-Executive Directors and also that the Audit Committee should have a Nominated Vice Chair;

- Board Assurance Framework and associated Risk Register were reviewed regularly;
- Review of learning from legal claims and Claims and Coroners Report;
- Updates from the external auditors, KPMG;
- Approval of annual plans for External Audit, Internal Audit and Counter Fraud;

- Review of aspects of Local Counter Fraud Specialist Service (LCFS):
  - For 2022-23 the LCFS annual report included evidence of a completed self-assessment against the Government (Cabinet Office) Counter Fraud Functional Fraud Standards (CFFFS). The Overall score for the Trust was rated "green" for the year. The Counter Fraud annual workplan includes actions to support maintaining the individual green scores and improving where possible on any individual scores that were rated "amber".

- Data Security and Protection Toolkit and Action Plan;
- Clinical Audit Programme;
- Insight Reports presented by the Head of Internal Audit at each meeting detailing publications of interest to the Committee;
- Overseeing the Developing Compliant Business Cases and investment process combined action plan; and
- Regular review of the Debtors Report and Action Plan.

The following items were considered over the course of the year:

- Fraud, losses and compensations, waiving of standing orders, hospitality, documents signed under seal, Directors' interests, ex-gratia payments, claims, credit notes in excess of £1k, Procurement workplan (including tenders).

In discharging its responsibilities, the Committee places reliance on the work of Internal and External audit.

The Committee accepts the Annual Opinion provided by Internal Audit expressed in the Head of Internal Audit Opinion 2021/22 as **"significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."**

Overall Management of Risk

The Committee has reviewed the Trust's risk management arrangements. It reviews the Assurance Framework and Risk Register arrangements through its own activities and through receiving relevant reports from the External and Internal Auditors. Risks have been monitored at Executive Management Board (EMB), Audit Committee, the Performance Committee, the People Committee,

and the Quality Governance Committee, with high risks reported to Board. Audit Committee monitoring involves a regular review of the Board Assurance Framework and Risk Register processes. This is in keeping with the 2018 NHS Audit Committee Handbook guidelines that state "... the primary role of the Audit Committee is to continually review the relevance and rigour of the assurance framework and the arrangements surrounding it". The Committee, at each of its meetings, also determines if there are any new or emerging risks which are then escalated to the Board.

Based on this, the Committee is assured that appropriate consideration is being given to risk management and was assured that the steps management is taking to mitigate risks and learn lessons are robust.

Financial Reporting

The Committee reviewed the 2021/22 Annual Report and Accounts at the 23 May 2022 meeting these were subsequently approved by the Board at an extraordinary Board meeting held on 9 June 2022.

Audit Arrangements

This section provides the Committee's opinion on the quality of Internal and External Audit arrangements.

The Public Sector Internal Audit Standards describe internal audit as *'…an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations*. Essentially internal audit works closely with management and the Audit Committee to design and implement risk-based programmes of work. This approach provides assurance on the effectiveness of governance, risk and internal controls across key systems that support the delivery of the objectives and/ or function and duties of the organisation.

The Audit Committee approved the Internal Audit Plan for 2022-23 in July 2022 and has since received a summary of all final reports and agreed management action plans, as shown below with a breakdown of the assurance opinion provided:

Assignment	Findings reported to Audit Committee	Assurance Opinion				
		Optimal	Substantial	Requires Improvement	Insufficient	Advisory
Area 1: Governance						
Complaints Management	March 2023		✓			
Assurance Mapping	June 2023					✓
Risk Management and Assurance Framework	June 2023			✓		
Area 2: Clinical/ Patient Safety						
Medicines Management	November 2022					✓
Medical Devices	November 2022		✓			
Clinical Audit	November 2022			✓		
Infection, Prevention & Control	January 2023	✓				
Area 3: Quality/ Performance						
Data Quality (Emergency & Urgent)	July 2022	✓				
Area 4: Finance						
Application of Payment Protection	November 2022			✓		
Financial Sustainability	November 2022					✓
Purchase Fuel Cards	November 2022			✓		
Procurement Follow Up	June 2023		✓			
Stock Management Follow Up	June 2023		✓			
Overtime/ Additional Hours	June 2023			✓		
General Ledger & Budgetary Control*	July 2023		✓			
Payroll*	July 2023		✓			
CIP Follow Up*	July 2023					✓
Area 5: Information Management and Technology						
Data Security and Protection Toolkit – (2022-23) Management Processes	June 2023	✓				
Sensitive Information	January 2023		✓			
Penetration Testing Q1	November 2022		✓			
Penetration Testing Q2	November 2022		✓			
Penetration Testing Q3	January 2023		✓			
Penetration Testing Q4	June 2023			✓		
Phishing Exercise Q2	November 2022		✓			
Phishing Exercise Q3	March 2023			✓		
NARU IT Asset Management	March 2023			✓		
1596 Assessment	June 2023					✓
Secure Email Standards	July 2022		✓			

Area 6: Workforce						
Education and Training	March 2023		✔			
Learning From Staff Feedback	Expected July 2023					
Area 7: Estates and Facilities						
Violence Prevention and Reduction Standards	November 2022	✔				
Fleet Management	July 2022	✔				
Health and Safety	Expected July 2023					
Total		5	13	8	0	5

As part of the Internal Audit Progress Reports presented to each Audit Committee, any overdue management actions that require follow up are flagged. The Audit Committee has continued to implement the agreed formal protocol whereby, in the light of the results of Internal Audit enquiries on implementation status, the Committee has requested senior management attendance at the Committee to report more fully on the reasons for any apparent difficulties in management action implementation.

The Trust commissioned an independent validation of Internal Audit services in 2020/21 to provide assurance on whether the approach meets the requirements of the International Professional Practices Framework (IPPF) published by the Global Institute of Internal Auditors (IIA) on which Public Sector Internal Audit Standards (PSIAS) are based. The independent validation was carried out by an independent assessor holding the relevant qualifications. The independent review concluded that *"the Audit and Assurance Team at West Midlands Ambulance Service University NHS Foundation Trust are generally in compliance with the PSIAS"* – detailed findings from the review and the agreed action plan were presented to the Audit Committee in July 2021.

The Committee can take assurance from the level of engagement with KPMG and that their experience of other NHS organisations allows them to make a valued contribution to the Committee.

Private meetings are held regularly to encourage informal dialogue with the auditors.

Based on the above the Committee is satisfied with the audit arrangements in place.

Issues for the Annual Governance Statement

The 2021-22 Annual Governance Statement (AGS) was presented to an extraordinary meeting of the Board of Directors on 9 June 2022 meeting. The AGS stated that the Board's review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the West Midlands Ambulance Service University NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. The AGS declared that "***significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."***

Audit Committee Effectiveness

The Audit Committee carried out its annual self-assessment of its Terms of Reference and the operation of the Committee following its May 2022 meeting. The self-assessment for 2022-23 will take place at the July 2023 Audit Committee meeting.

Forward Look – 2023-24

External Audit Contract – a procurement exercise will be undertaken during 2023/24 to secure External Audit provision. This has been notified to the Council of Governors.

The External Audit plan for 2023-24 was accepted by the Committee at the meeting held on 14 March 2023 and the Council of Governors meeting on 5 May 2023.

The Internal Audit plan and charter for 2023/24 was recommended for approval by the Committee at the meeting held in March 2023 (which is embedded within a rolling five-year strategy considered by the Committee annually). The internal audit plan includes coverage of seven key areas of the organisation, including: governance; clinical/patient safety; quality/performance; financial control; information management and technology; workforce; estates and facilities. The plan will be reviewed by the Chair and amendments reported to Committee during the year.

Conclusion

The Committee acknowledges that whilst it is not possible to eliminate risk, it believes that Management are managing risk in a professional and considered way. The Schedule of Business includes a "Risk and Assurance Focused" meeting during the year and these are held in January.

The Audit Committee has placed appropriate and reasonable reliance on the reports and representations referred to above and has concluded that a good system of internal control and risk management is in place.

Wendy Farrington-Chadd
Chair – Audit Committee
to 31.12.22

Julie Jasper
Chair – Audit Committee
from 1.1.23

July 2023

Minutes of the meeting of the Quality Governance Committee held on 24 May 2023

This meeting was convened by electronic means through Microsoft Teams software

Present:

Alexandra Hopkins	(AH)	Non-Executive Director (Chair)
Mohammed Fessal	(MF)	Non-Executive Director
Diane Scott	(DJS)	Interim Organisational Assurance & Clinical Director
Matthew Ward	(MW)	Consultant Paramedic – Head of Clinical Care
Michelle Brotherton	(MB)	Non-Emergency Services Delivery & Improvement Director
Jeremy Brown	(JB)	Integrated Emergency & Urgent Care Director
Vickie Whorton	(VW)	Integrated Emergency & Urgent Care Clinical Commander
Pete Green	(PG)	Staffside Representative

In attendance:

Jenny Lumley-Holmes	(JLH)	Head of Clinical Audit
Matt Brown	(MWB)	Head of Risk
Pippa Wall	(PW)	Head of Strategic Planning
Chris Kerr	(CK)	Head of Governance & Security
John Kelly	(JK)	Head of Security & Safety
Andy Rosser	(AR)	Head of Research & Development

Secretariat:

Nicky Shaw	(NS)	PA to Executive Medical Director

ITEM	Quality Governance Committee (QGC) Meeting 24 May 2023	ACTION
05/23/01	**Apologies and Introductions**	
	Apologies were received from Dr Alison Walker, Executive Medical Director, Nick Henry, Paramedic Practice & Patient Safety Director, Jason Wiles, Consultant Paramedic for Emergency Care, and Stephen Thompson, Staffside Representative. The meeting was quorate. AH introduced herself as the new Chair of the committee and welcomed everyone to the meeting. A final thank you was given to LBP for handing over the meeting in a good position.	
05/23/02	**Minutes of previous meeting – 22 March 2023**	
	The minutes of the meeting held on 22 March 2023 were submitted.	
	Resolved:	
	That the minutes of the meeting held on 22 March 2023 be received and approved as a true and accurate record.	
05/23/03	**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).	

	Resolved:	
	1. In relation to continued minute 03/23/05.1: Executive Medical Director & Executive Nurse Director Summary Report including the Impact and Risks on Hospital Handover Delays Paper AW had emailed Paper 6b – Impact and Risks of Hospital Handover Delays paper to committee members, for information. QGC agreed to discharge this continued minute.	**Discharged**
	2. In relation to continued minute 03/23/05.6: Clinical Supervision Plan In NVH's absence, AH would pick up the action to provide some evaluation and feedback data from the clinical supervision survey to QGC to see what impact clinical supervision is having outside of the meeting.	**AH/NVH**
	3. In relation to continued minute 03/23/05.8: Integrated Emergency & Urgent Care (IEUC) & 111 Assurance Report The Integrated Emergency & Urgent Care (IEUC) & 111 Assurance Report will be discussed as an agenda item. QGC agreed to discharge this continued minute.	**Discharged**
	4. In relation to continued minute 03/23/07.1: Terms of Reference & Committee Self-Assessment (Action Log Nos. 4 & 5) (Action No. 4) The terms of reference had been reviewed and will be discussed as an agenda item. QGC agreed to discharge this continued minute. (Action No. 5) A chaser email had been circulated to remind committee members to complete and return the committee self-assessment form. Several forms have been received and the responses are being collated. AH informed there had been a review of the governance of committee meetings with the organisation in terms of the way in which the committees are working and the Board will be looking at the findings of that review. The term of reference and completed committee self-assessment form will be circulated outside of the meeting.	**Discharged** **NS**
	5. In relation to continued minute 03/23/07.4: Measuring Organisational Learning Report MWB had not had an opportunity to produce a report and put together some examples of standardised learning and requested if this action could be rolled over to the next meeting.	**MWB**
05/23/04	**Chair's Reports from Working Groups**	
	4.1 Learning Review Group (LRG)	
	The Chair's Report from the meetings held on 3 April 2023 and Action Log of 20 February 2023 had been submitted. In NVH's absence, DJS advised the contents Chair's Report and Action Log would be taken 'as read' noting a recent LRG meeting took place on 18 May 2023.	

	The Chair's Report shows the significant amount of work done by LRG in relation to the serious incidents, learning and the number of investigatory reviews which have been done. In terms of the action log, there is some work being done reporting on Coroners and Claims and this is going to the Board next week.	
	Resolved:	
	That the Chair's Report from the meetings held on 3 April 2023 and Action Log of 20 February 2023 be received and noted.	
	4.2 Health, Safety, Risk & Environment (HSRE)	
	The Chair's Report from the meeting held on 13 March 2023 and the Action Log of 8 February 2023 had been circulated. DJS advised the Chair's Report and Action Log submitted should be taken 'as read' as there had been a HSRE meeting held on 15 May 2023 which she had chaired noting there is nothing specific QGC needs to be made aware of from that meeting. MWB added the Chair's report shows there is a lot of workstreams presented together with risks and actions identified.	
	Resolved:	
	That the Chair's Report from the meeting held on 8 February 2023 and the Action Log of 14 November 2022 be received and noted.	
	4.3 Professional Standards Group (PSG)	
	The Chair's Report from the meetings held on 11 April 2023 and 6 March 2023 and Action Logs of 6 March 2023 and 30 January 2023 had been received. MF raised this suite of papers had been circulated late therefore not everyone would have had chance to read through them and normally significant discussions take place which the committee would not be able to do due to receipt of the late papers. AH took these comments on board and in order to make sure that we do not lose the essence of what is being said around managing meetings and the volume of papers, this would be taken back to the Board as a matter under any other business. In terms of assurance, there may be some other ways to manage the logistics as AH was aware colleagues are working hard to produce papers and although there are only 5 QGC meetings each year, the May meeting does seem to have quite a large agenda. MF added the review of the terms of reference and the feedback from the committee self-assessment needs to be included as a wider conversation as this goes a long way to support this meeting going forward in terms of awareness and timeliness of meetings i.e. in relation to the Chair's Reports and being notified another meeting had taken place and the documents not being submitted due to the timings, etc. DJS said all points will be taken on board and highlighted the last few weeks have been challenging with the retirement of the Executive	

	Director of Nursing & Clinical Commissioning at the end of March, the non-attendance of both NVH and AW at this meeting along with the recent directorate changes. AH acknowledged it is unfortunate all of these things have happened and confirmed item 4.3 would be deferred due to the earlier discussion around the late arrival of papers. MF was aware the terms of reference were on the agenda to be reviewed and queried that the current terms of reference states in the quoracy that either AW or the Executive Director of Nursing & Clinical Commissioning needs to be present and whether this would be DJS for this meeting. DJS said as Non-Executives are aware she had been asked by the Chief Executive Officer to step into the clinical part of the Executive Director of Nursing & Clinical Commissioning portfolio for an interim period. The larger part of the portfolio had moved across to NVH's role as Paramedic Practice & Patient Safety Director. AH stated in terms of quoracy DJS has been asked to be that substitute until the Director of Nursing role has been recruited to.	
	Resolved:	
	That the Chair's Report from the meetings held on 11 April 2023 and 6 March 2023 and Action Logs of 6 March 2023 and 30 January 2023 be received and deferred to the next meeting.	
05/23/05	**Care, Quality & Safety**	
	5.1 Executive Medical Director, Paramedic Practice & Patient Safety Director and Interim Organisational Assurance & Clinical Director Integrated Quality Summary Report	
	The Executive Medical Director, Paramedic Practice & Patient Safety Director and Interim Organisational Assurance & Clinical Director Integrated Quality Summary Report had been submitted. DJS advised the report was 'draft' and is due to be presented to the Board next week and is a joint directorate integrated quality report from herself, NVH and AW. The key point to raise from the report is that although patient handover delays have improved and the hours lost is still reducing, there is still significant patient harm and this remains one of the highest risks on the board assurance framework because we know harm is being caused to patients are a result. Also, as a result of the long delays, the number of serious incidents involving serious harm or death is a significant risk and remains at a 25. The number of lost hours relating to patient hospital handover delays remains above the pre-pandemic average of 7,000 and DJS highlighted in April there was 10,000 hours lost and although we have seen an improvement is still not good enough. WMAS attended a meeting with the Integrated Care System (ICS) to focus on improving Cat 2 performance and working to reduce hospital handover delays.	

	There has been lots of work on serious incidents investigations and the number reported during the month of April has reduced and is a direct correlation with hospital handover delays even though delays are the highest trend for these investigations and the patient safety team are still completing serious incident investigations in good time. In terms of the patient safety reporting issues, there has been a lot of work with the recovery plan as it was discovered the ER54s were not being closed and this was dealt with over a period of a few weeks. For those that were overdue or unclosed these are now being completed and there is a process in place to prevent this happening again in the future and the system is constantly being monitored. It was noted the Care Quality Commission (CQC) and the Commissioners were informed of the issue and the learning has been shared with them. The Trust is working with the Integrated Care Board (ICBs) to improve mental health services by providing 5 mental health cars, additional staff in EOC within the clinical validation team and mental health educators but this is all dependant on confirmation of funding from the ICB. The next few pages of the report show tables of data for hospital handover delays which are decreasing slightly, patient conveyance, patient safety incidents, learning from deaths, safeguarding, medicines management. With regards to patient experience, it was noted 24 formal complaints had been received during April compared to 55 for the same month last year which is a good decrease of 31 as these would have been around delayed response. 144 PALS concerns have been received compared to 177 for April last year. It was noted a lot of this data had been through other committees/groups before being presented to QGC. The remainder of the report provides a summary of Clinical Director activity. MB added in terms of hospital handover delays in the month of April we did see a decrease to 10,000 lost hours which includes cohorts of anything over 15 minutes, therefore, it is pleasing on one hand to note improvement which is correlated to performance which is back down to 2019-20 performance. This will be monitored going forward to this year noting the trajectory above 10,000 this month is down to 3 main Acute hospitals who are outliers and MB wanted to give assurance they are focusing on reducing the delays. MF said it was good to hear these numbers are coming down from the peak and hopefully will further reduce with the 3 main outliers focusing on reducing delays. It was highlighted there is a lot of information in this paper which is repeated again in other papers. MF sought clarification whether the Trust was awaiting funding for the expansion of the mental health services or whether it relates to the previous funding applied for, around mental health provision which has still not been paid. Therefore, do we see this as a reality or something good to do but the money might not follow.	

	MWB advised there is some work currently being undertaken with the Health and Wellbeing Leads around mental health funding which was removed in the Black Country and impacted a large number of staff which is part of the work mentioned at the People Committee around moral injury and physiology injury which is the current concern. JB added work in underway as NVH has picked this up at pace and there is an ongoing business case which had been presented to the Executive Management Board (EMB) and includes the funding to be made available for mental health clinicians, mental health care, etc but this requires further work and will be resubmitted to EMB. It was agreed a detailed paper outlining what mental health provision is being provided together with details of the fundings will be presented to QGC once the paper has been agreed through the EMB. MF asked whether the reduction in conveyance from the Trust is leading to a greater number of incidents and are the issues around handover delays influencing the decisions made by staff which is resulting in lower conveyance because as a Board, we need assurance this is not the case. AH said this is a critical question in terms of correlation with capacity and it has been mentioned when discussing cost pressures that capacity has been impacted therefore, we need to ask this fundamental question at Board as well as there needs to be a flow in and out of the Board. MW confirmed there is a lot of triangulation for patients discharged at scene as we have seen some of the concerns raised in clinical audits and a decrease in clinical performance and there have been actions put in place to improve patient safety. There has been work done on ACS with patients being discharged on scene with chest pain and this has been triangulated with the clinical audits, patient safety incidents, etc and we are looking at a similar process of the introduction of check lists and guidance to support making a decision through a more governed and robust process. MF added it was important to look at the different areas of business triangulation and see if we can improve somewhere else and externally as there are 2 pieces of other work going on. The first relates to the change to the national governance guidelines for Naloxone, recommending supplying to patients discharged at scene, but MF had not seen that conversation discussed further and if the Trust is not doing this what is the rationale; or if they are what is the plan. The second relates to the local authorities in this area asking for discharge on scene data relating to Naloxone and drugs and MF was unsure who is responsible for facilitating that. AH said this is a really important question as it should be discussed at the appropriate management meeting before it comes to QGC and sought clarification as to where this would be. MW said this would be the Medicines Management Group who reports directly into PSG. Naloxone has been discussed by the Medicines Management Group and the Senior Clinical Leads Group as well but there are some issues with the ICBs around funding therefore further	

	work which is ongoing as there is not a current final resolution. MF was the Lead on this for the country and said funding might be less of an issue and was happy to facilitate, offer support and assist with engagement with the ICBs as this encompasses performance, research, regular repeat callers and greater integration with other providers might lead to resolve some of the issues around verbal abuse, etc. AH suggested the offer is taken up and asked MW to work with MF on this specific issue as it appears we have gone down the expected route given the change in policy but have come to a standstill so this is an opportunity to see what the other alternatives might be. MW would pass this onto JW, who is the lead for medicines in normal practice and in terms of links with alcoholism this is covered in the HEE programme as MW is the author of the alcohol use guidelines for JRCALC so that clinicians have advice on as this is not covered in previous paramedic education but further work is needed on that. AH gave thanks to DJS for presenting the report in NVH and AW's absence.	
	Resolved:	
	a) That the contents of the Executive Medical Director, Paramedic Practice & Patient Safety Director and Interim Organisational Assurance & Clinical Director Integrated Quality Summary Report. b) That a detailed paper outlining what mental health provision is being provided together with details of the fundings will be presented to QGC once the paper has been agreed through the Executive Management Board. c) That the question is raised at Board around whether the reduction in conveyance from the Trust is leading to a greater number of incidents and are the issues around handover delays influencing the decisions made by staff which is resulting in lower conveyance as assurance is needed that this is not the case.	**NVH** **AH/MF**
	5.2 Trust Board Reporting – Clinical Performance	
	The Clinical Performance Report for April 2023 had been circulated. JLH advised the report is submitted to several governance groups i.e. Clinical Audit & Research Group (CARPG) and PSG and then onto QGC and it is also reported at the Board and provides an overview of clinical performance against the Ambulance Quality Indicators (AQIs). The report is reviewed at CARPG and PSG where there are discussions to identify any actions to support performance or if there are any barriers, if there are no barriers, we expand the quality initiatives. The good news story is that STEMI and Stroke performance is really improving as 18 months ago it had dropped dramatically as we were unsure if it was the effect of introducing EPR2. The data quality screen was introduced as a prompt to clinicians if they complete the impressions within the care bundle i.e. administer aspirin or a reminder to complete 2 pain scores, etc. The clinical record cannot be locked down so clinicians are able to move past the prompt if they want to.	

	STEMI performance has increased from 71% to over 94% in April and Stroke is the same as we are finding the quality initiatives to keep on top of this. JLH said 'for information' there is a new AQI around elderly fallers on scene and we are currently doing a pilot on this as we will have to put quite a lot of quality initiatives in place to improve the performance. MW said there has been excellent success from NHS England proving funding for the Paramedic who has been focusing on running initiatives i.e. cardiac arrest days externally funding by medical product companies, workshops on Hubs as there has been lots of interest and engagement from staff and you can see all the different elements combined have improved performance and some of this is what we are looking to do for a number of different areas. AH was aware there had been an increase in the development of the Public Health role within the service with Public Health education being conducted by ourselves. MF was pleased to see hear and receive the papers showing the improvements on STEMI and Stroke performance which had seen a decline during COVID and some of this had been attributed to the IT digital side of things as the IT and systems have picked up a lot of that slack. It was acknowledged the Cardiac Arrest is work in progress and during the last 18-24 months it appeared the rationale for the poor performance was that PPE was the barrier to getting the results but was it really that much of the issue. Also, MF had noticed the cardiac arrest data did not provide a station breakdown as this would identify if there was any variance in our region. MB informed a paper is due to be submitted to the EMB by the Head of IP&C around PPE as the PPE levels donned during the pandemic for cardiac arrests have been relaxed and NHS England have asked Trusts to make their own dynamic risk assessment as to whether PPE will be continued to be worn, currently WMAS are continuing to wear Level 2 PPE (mask and gloves). It was noted some hospitals have withdrawn PPE as a mandatory requirement and this will form part of the recommendations being presented to EMB next week. JB said regarding Hub level response targets, these are available in Orbit reports and other papers and it was agreed this data would be shared with the committee. MW explained a cardiac arrest is such a dynamic situation and linking this directly to individual Hubs did not provide such useful data as there are too many confounders to be considered. For example when did the cardiac arrest occur, did the patient receive bystander CPR, therefore, MW felt the data would be best looked at through a heat mapping system so we can see how patients do in which areas rather than immediately isolating the Hubs. There are a large number of Community First Responders (CFRs) that reach the patient first and the public have access to defibrillators so the patient might have received 1 or 2 shocks and been conscious before the crew arrived on scene therefore, we do not want to isolate one Hub performing as being worse than another	

	because of the Hub location differences. JLH said it might be worth looking at the data based on the clinical EPR rather than response times which is currently being worked on. There is a dynamic report, this being the Cardiac Arrest Annual Report which was done last year and can be done quarterly through the year and does include a heat map and key insights using the digital data rather than just having Hub level based data. This is currently being worked on and will be made available to QGC as this should be done by the end of June 2023. In response, AH said this was most reassuring and asked would the report reach QGC before the end of the operating year. JLH replied the annual report will be for 2022-23 so what we are hoping to do is produce the full year data and then provide the data quarterly to QGC. MF raised data limitations on the individual hubs, and because the cardiac arrest data at this level for a considerable amount of time, there are other key things this committee could be looking at for example looking at the correlation across the region in terms of the geography for CFRs and AEDs and are there less in one area which will need to work on to bring performance up as the data currently shows performance is extremely low.	
	Resolved:	
	a) That the contents of the Clinical Performance Indicator Report for April 2023 be received and noted. b) That the Cardiac Annual Report 2022-23 is presented to QGC and then cardiac arrest data will be provided quarterly to QGC.	**JLH**
	5.3 Clinical Supervision Plan	
	The Clinical Supervision Plan had been received. In NVH's absence, MB advised the report was 'as read' and in terms of providing assurance provided an update to the committee as follows: • from an E&U perspective 100% of staff have had their CS1 day with their named Clinical Team Mentor (CTM) in an operation setting. • Conflict resolution training is at 98%. • Mandatory workbook is 99%. • PDR's is 98%. • Mandatory training (part 1) which is the e-learning element is at 98%. • Mandatory training (part 2) which is the face to face life support training is 99%. MB stated any discrepancies will be picked up in the return to work meetings for those staff who may be on long term sickness or maternity leave. The report also covers progress to date on this year's clinical supervision plan.	
	Resolved:	
	That the contents of the Clinical Supervision Plan be received and noted.	

	5.4 Integrated Emergency & Urgent Care (IEUC) Assurance Report	
	The Integrated Emergency & Urgent Care (IEUC) Assurance Report including the IEUC Audit Programme and Category 2 Segmentation – Learning Event had been submitted. VW advised the first paper is the 111 assurance paper which outlines the position of where we where before the service transferred across to the new provider and can be taken 'as read'. MF said it was good to see sight of the paper which needs to be part of the Board conversation around the wider 111 including finance, etc. AH replied this is still on the agenda for the Board but we need confirmation from the Trust Secretary as to which meeting this will be discussed so we can pick up any concerns and include this paper. AH would speak to the Trust Secretary to confirm which meeting this is an agenda item. VW said the second report provides an oversight of the IEUC clinical audit programme and the salient points to raise are: • The trust has achieved 16.6% for hear and treat during April. • 61% of all calls when triaged had a hear and treat outcome and the outcomes are detailed within the report. • Cat 2 segmentation has seen a reduction in the main resource availability as this works differently to Cat 3 and Cat 4 calls. • Clinical audits remain strong and the figures in the report are good with only a failure rate of 8 for the month of April. VW said these figures will be shown as percentages going forward to align with the rest of the report. • There has been a decrease in the number of prescribing clinicians following the separation from 111 but it is envisaged this will increase moving forward as more prescribers are signed off. • Recontact rates where patients have been reassessed within a 48 hour period was 9.3% for April which is really positive. JB said this is a really good positive and referred back to the point raised around frequent callers and confirmed this data had been included. The recontact data is more around when patients have gone down the wrong pathway route rather than them deteriorating, or they are calling back as their symptoms are still persistent 2 days later and want to be treated by a clinician because the care they received previously was good and they would rather come directly to WMAS than go to primary care. MF agreed patients' would ring the organisation because we provide a good service even if this is not the natural home for these calls therefore do we need to open the opportunity when looking at the expansion of primary care because there have been discussions around Paramedic roles and the patient could come to WMAS rather than go to their GP. This also ties into our strategy in terms of what we can provide and fill the gap when looking a wider NHS alternatives to pick up primary care and perhaps this is something for the ambulance sector as also being prescribers, the staff have the skills and the confidence of the public.	

	JB said a strategy is being developed and we do need to be more dynamic because we can promote the fact that WMAS has a Paramedic on every ambulance, we have moved on from that slightly due to COVID. AH asked where would this go, is there a group looking at development of the Paramedic roles such as the People Committee. MF said it sits more naturally with QGC in terms of quality and governance although the People Committee does cover aspects of people, training and development. MW advised this comes across into advanced practice and stated the Health Education England (HEE) project he has been involved in has been completed and would share the finding with the committee once these have been received. Undergraduate practice manages a wider range of systems and access to more patients and this forms part of a national report to HEE for that. MW informed WMAS is the only ambulance service in the UK who have prescribing in the 999 environment as it is normally either in 111 or separate primary care and there are lots of eyes looking at the Trust as to how this works from a benefit and safety perspective. There are 6 non-medical prescribers working within IEUC and there are 26 trainee advanced practice practitioners who are developing those skills and being supported by an Advanced Nurse Practitioner (JK) within the Clinical Validation Team (CVT) who is a designated Non-Medical Prescribing Supervisor. MW referred back to MF's point in terms of getting the balance right and not attracting the wrong patients in terms of drug seeking behaviour or who want repeat prescriptions who are able to access other services, as there were some concerns around this whilst operating the 111 service. The 999 prescribing will be a huge benefit to patients in the future and JB and VW should be really proud of what has been achieved. AH endorsed what MW had said and acknowledged the work that had been done with HEE and expanding the roles. AH asked if there were any specific requirements from the Health and Care Professions Council and MW replied there are no requirements for specialist, advanced or consultant role but there is a programme of recognition for advanced practitioners and MW has set up an Advanced Practitioners Governing Group within the Trust who are looking at the development and skills of staff in a safe and governed manner to take further in the Trust. A draft Advanced Clinical Practitioners & Consultant Practitioners Policy and Advanced Clinical Practice Strategy had been written and will be discussed by the Advancing Practice Governing Group on 1 June 2023 and then these documents will come back to this committee. JB referred to the final paper relating to the Cat 2 segmentation learning event, stating essentially WMAS along with London Ambulance Service are the early adopters of the Cat 2 segmentation process. Initial feedback is positive as those patients identified as needing an immediate response are being reached quicker than other Cat 2 calls and JB stated to date there have been no patient safety risks.	

	It was noted the process had been put together because there is a need and requirement to undertake this work due to the sheer volume of patients being let down and if there were there more resources and funding available, we would not have to do this. There are a number of different initiatives being undertaken to prevent harm to some of those patients sitting in the Cat 3 stack and being able to move them up into the Cat 2 category and this part of the process has been reviewed by the Coroners. JB said one of the main drivers is to try to reduce all categories where we can and to provide a clinically sound basis to be able to move more activity into the Cat 3 stack. It was noted there is a new piece of work around building in a small buffer of time so patients who are identified for clinical validation are not dispatched for 5 minutes to enable the clinical reviewer to review the case and potentially take a little more activity out of the Cat 2 stack and the results have been really positive. JB said it is an accolade to the Trust to be leading on this nationally because it has the experienced clinicians, a proven track record of delivering a safe project as well as being good at collating data. AH highlighted the findings from both the pilot groups have been similar considering they are serving different communities and something we need to consider is the capacity for the clinical navigator as we move forward with this mechanism. JB said himself and VW recognise capacity can be gained by way of efficiencies within the clinical validation team to get more productivity out of those clinicians.	
	Resolved:	
	That the contents of the Integrated Emergency & Urgent Care (IEUC) Assurance Report including the IEUC Audit Programme and Category 2 Segmentation – Learning Event be received and noted.	
	5.7 Update from the Health Education England (HEE) Lead on Non-Medical Prescribing and Advanced Clinical Practice	
	MW stated the main points for this item had been covered off in the IEUC assurance report discussion. In response to a question raised by MF around supervision for the Non-Medical Prescribing roles, MW confirmed there are designated prescribing practitioners which includes himself and the advanced nurse practitioner in the clinical validation team who are providing this. The supervision is taking place and in development as MW has created a TEAMS site which has been shared with the advanced practitioners across the Trust to discuss and share best practice. It was noted there are a number of advanced practitioners who have HEE funding attached to them in terms of rotating through advanced practice placements and the face to face element of seeing and monitoring patients.	
	Resolved:	
	That the verbal update from the Health Education England (HEE) Lead on	

	Non-Medical Prescribing & Advanced Practice be received and noted.	
05/23/06	**Risk**	
	6.1 Board Assurance Framework (BAF)	
	The Board Assurance Framework (BAF) had been received. MWB stated the paper was 'as read' and a number of risks have been reduced and removed from the BAF because they scored lower than a 12, these include a number of EOC risks and the business continuity as a result of global supply chain issues. The risk in relation to the cessation of overtime and shortage of staff in PTS NEOC have been reviewed and these are the main points of note. It was noted it is useful to know a number of these risks are covered from the Chair's Reports i.e. serious incidents, clinical audits, etc and form part of the agenda at other meetings.	
	Resolved:	
	That the contents of the Board Assurance Framework be received and noted.	
05/23/07	**Governance/Compliance and Regulation**	
	7.1 Terms of Reference	
	The Terms of Reference had been circulated. The terms of reference were approved noting the minor amendments being made to job titles, etc to reflect the recent directorate changes. MF referred to a conversation relating to Non-Executive Director Membership at committees with the initial proposal being 3 Non-Executive Directors as this will enable at least 2 to attend therefore the terms of reference might need to be amended following the outcome of that conversation. AH agreed with MF's comments noting that a change to one committee can impact on another and this will need to be included in the wider conversation. It was agreed QGC would accept the changes noting the greater discussion with Board and would be brought back if there are any ensuing changes.	
	Resolved:	
	a) That the contents of the Terms of Reference be received and approved. b) That the approval of the Terms of Reference is included in the Chair's Report.	**AH**
	7.2 Quarterly review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones	
	The Quarterly review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones had been circulated. The standard report monitoring the agreed milestones for each of the strategies aligned to QGC was presented.	

	PW highlighted there are a few AMBERS in the report which means they are either at risk of falling behind or not being achieved, these being: • **Communications** – this relates to the annual survey to stakeholders but there is no strict agreement a survey has to be done in every financial year. The survey questions have been reviewed along with the distribution list in light of the changes to the ICBs in readiness to be send out. • **Risk Management** – relates to the safety culture survey. MWB confirmed the survey had been completed and an action plan drawn up with a number of actions implemented. The AMBER relates to the longer timescales for implementation of some of the actions. As MWB is part of the staff survey group it is the intention to incorporate some of the actions from the staff survey into the safety culture survey in terms of triangulation of information. • **Sustainability** – this relates to the capacity of the sustainability lead and the outstanding VAR to recruit to the vacant role which means the department are struggling to keep on top of some of the workstreams. PW stated everything else is included in the report. AH asked in relation to those risks which are being rolled over into quarter 1 or 2 of this year how do we make sure we do not lose sight of them. In response, PW said the Trust strategy was reviewed in January and is due a refresh soon therefore this is when we will ensure all the current and outstanding actions are included in that review.	
	Resolved:	
	That the contents of the Quarterly review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones be received and noted.	
	7.3 Serious Incident Report	
	The Serious Incident Report had been circulated. DJS said the report was 'as read' and the key points of note are: • In April 2024, 24 serious incidents were registered. • The serious incident review group continues to review the serious incident investigatory reports. • The total number of serious incidents reported for 2022-23 was 453 compared to 204 last year which is a significant increase. • Of the 453 serious incidents, 203 were solely related to delayed responses. Clinical themes include management of choking, management of cardiac arrest and inappropriate discharge. A summary of the serious incident dashboard is referred to on Page 3 and shows how many have been received and completed, etc. The good news story is there are no overdue recommendation actions, and the patient safety team are working well to achieve within the timescales compared to a few months ago.	
	Resolved:	
	That the contents of the Serious Incident Report be received and noted.	

	7.4 Data Sharing & Protection Toolkit (DSPT) Report	
	The Data Sharing & Protection Toolkit (DSPT) Report had been submitted. The paper was taken 'as read' and CK wanted to draw attention to the fact the DSPT is a self-assessment therefore the process is key which is captured on the first 2 pages of the report. The internal audit response regarding the process is outlined on page 3 which is 'optimal' assurance. The report has been considered by the Health, Safety, Risk & Environment Group on 15 May as part of the governance process. The DSPT is presented to QGC for assurance on the progress for submission which is on 30 June 2023. DJS noted this is a piece of work which takes a small team a lot of time and to achieve 'optimal' assurance from internal audit is great news.	
	Resolved:	
	That the contents of the Data Sharing & Protection Toolkit (DS&PT) Report be received and noted.	
	7.5 Learning from Deaths Quarter 4 Report	
	The Learning from Deaths Quarter 4 Report had been circulated. MW presented the report which was 'as read' highlighting the LFD agenda not only looks at those patients who die in our care, but this continues for the next 24 hours where there might be concerns raised by family members, clinicians or carers where they want to raise a review; noting this is a lot work by a small team. The report reflects the triangulation of some of the elements identified and actions from serious incidents, patient safety incidents, etc which are either in place or have already been done. The areas identified are: • failure in the management of cardiac arrest which led to a change in education and the life support training being delivered face to face in quarter 1. • Delays – repeated concerns and the cause of some patient deaths. • Discharge at scene – some cases have the incorrect diagnosis reached or the incorrect follow-up occurred. The other thing to note is whilst we look at death negatively, the service is called to a number of patients who are at the end of life and the excellence of care in terms of supporting families and the patient at that point in their care is recognised and there are good news stories coming out of that.	
	Resolved:	
	That the contents of the Learning from Deaths Quarter 4 Report be received and noted.	
	7.6 Security Monthly Report	
	The Security Monthly Report had been circulated.	

	JK advised the monthly report for April and is 'as read' with the salient point of note is that overall there has been an increase in all categories (V&A, physical, security and near misses). On a positive note there has been an increase in the body worn camera activation to support ER54's which has increased slightly from 12% to 19% but there is still a lot of work to be done. JK said that included in the monthly report is the number of CCTV activations for the rear of the vehicles, which is circulated to the Senior Management Teams so they have sight of the figures and encourage staff to activate the cameras. In terms of the conflict resolution training, there is a meeting between JK, Training School and STAND 2 to review the training content and see if any improvements are needed in terms of situation awareness, because there is evidence from the ER54s staff are putting themselves in situations they should not be. They are using some of their training to restrain people which is quite clear is the result of a build up in some of these situations which they should avoid. AH commented although the increase in figures is quite shocking this is being accepted because there is a rationale as to why, but there does need to be more focus on recording these incidents and asked JK if he felt things were getting worse. JK replied yes, as we have not seen a reduction year on year and what we are seeing is the increased numbers is that one third of incidents are either drugs, alcohol or mental health related. There is also the concern around the Police not attending certain types of the incidents due to lack of resources, etc and this is something WMAS are working on because by the time the Police do arrive the patient is in such an agitated state, they end up assaulting the Police Officer as well. Therefore, as an organisation, we are looking at ways of preventing our staff getting into those situations in the first place and avoiding those issues. MF acknowledged the year on year increase in figures and hoped some of this might reduce by working in partnership with organisations in terms of identifying the actual needs of these patient group and more collaboration in this area might help. MF added although there has been an improvement there is still limited usage of the body worn camera by staff and he was aware there have been talks about conducting an evaluation on the impact and financial value but raised whether the Trust has considered having a public consultation to obtain their views and whether some of this is linked to the crews' perception or assumption of what the public might think when seeing them wearing a body camera, as this might provide some validation. AH asked if there was any sense of how much footage is being taken by the public using mobile phones at incidents. JK replied from reviewing the ER54s, the incident is seen from the eyes of the staff and could not recollect an incident where there has been any mention where the public have been recording the incident. CK felt to have a public consultation was a very good point as the body	

	worn camera is very staff focused and would take this back to NHS England as to whether we can have a national approach to obtain feedback. CK would also take on board the comments made around mobile phone footage. CK raised the fact that the Trust is having to chase the Police to take receipt of our body worn camera and the vehicle CCTV footage to take forward which is a strange approach to try to push for convictions because we do get convictions from them receiving the good evidence we actually hold. MWB referred back to the comment around working with our partnerships and the impact of hospital handover days, informing QGC there have been 2 cases this week where patients who have been delayed at hospital have absconded from the vehicle because it has made the patient feel awkward. Therefore, we do not fully consider the impact of hospital handover delays on patients being confined in the back of an ambulance particularly if they are going through a mental health episode which results in staff and hospital staff being assaulted. AH stated it is obvious from the presentation of the paper and the discussion by the committee, that this situation is not going away.	
	Resolved:	
	That the contents of the Security Monthly Report be received and noted.	
	7.7 Clinical Audit Programme 6-Monthly Report	
	The Clinical Audit Programme 6-Monthly Report had been submitted. JLH explained the clinical audit programme is a 2-year rolling programme which is presented at CARPG and PSG monthly and comes to QGC and Audit Committee on a quarterly basis. The progress of the clinical audit reports is summarised into 3 main themes, these being: • Drug Administration • Locally Identified Concerns • NICE & National Audits The report outlines any learning from the clinical audits, the clinical audit assurance levels and progress against the action plans. It was noted the 2 delayed audits; Management of Overdose Patients and Patient Group Direction (PGD) have been submitted to CARPG and PSG and the report will be updated at the next meeting to show all is on track. MF raised the results from the clinical audits are incredibly concerning are a risk to the organisation therefore are these risks on the risk register. Most of the clinical audits are 'insufficient' and there is a lot of work being done to improve the outcomes in a various number of areas and we need to consider that can been challenging to staff because how much can an individual take on board.	

	Previously it was felt the increase in the number of serious incidents was the next biggest concern after the hospital handover delays but MF thought this was now the clinical audits as there appears to be so many actions which needs to be addressed and this can be overwhelming to staff as they do not have the time to take everything on board. AH stated what has been put on the table is what people are thinking about but was not sure what the next step might be in terms of further consideration of this and did colleagues have any ideas where this important question might be considered apart from QGC as it is relevant to other groups and committees. MW said clinical supervision is being reviewed as there does need to be some consideration around delivering the right clinical supervision for the all the clinicians within the organisation as not all of them are frontline. There is some triangulation around what our staff need to support them as well and agreed with MF's comments around the need to consider what is reasonable for staff to understand. All staff are supplied with the JRCALC guidance which are widely accepted and it is acceptable for crews to refer to specific guidelines whilst with a patient for example with a head injury to go through all the red flags, checklist, etc because it is around ensuring the decision making is make easier for our clinicians. For STEMI and Stroke there is a checklist of what needs to be documented and these clinical audits are based on the clinician record of the clinician who might be doing everything appropriately, but it is not being recorded. Therefore, there is a need to make this process easier for them or implement a checklist but you can become a bit checklist blind so what we are asking the clinicians to do is a safe and important thing in order for them to make an important decision. MF was a champion of clinical informatics as it is not about checklists but where there is ability to change the IT system to support and reduce demand on the resources you have. Most of the work has been on primary and secondary care by having bespoke templates to support the person on the group as they cannot recall all of the knowledge at the time, as they might be experiencing abuse from the patient, therefore there needs to be prompt implementation so as not to miss that data, which means it could be more standardised, accurate and provides more assurance. MW said JLH has done a lot of work with informatics which we have seen with Stroke and STEMI as the checklist is part of the process and patient documentation as we did not want to make it a burden but part of the job without taking away the perceived autonomy and we can see it is working with Stroke and STEMI and will work for other areas in the future. JLH agreed it was around balance and not trying to look down on staff for example with drug administration it is making sure the drug administered, presentation and batch number have all been completed before they lock down the system. It has been made clear this is a medical not an audit record but is helping with clinical care as it identifies what clinicians have or have not done and it is out there as there in the kit bag there is a link to the clinical dashboard so they can access their own clinical data.	

	Clinicians have been advised this information is for themselves to be able to reflect on, identify training needs, see what interventions they have or have not done, what cases they have attended as we want the dashboard to be more about developing learning and giving the ownership of the own data back to them. Staff are using the EPR and IT systems we currently have and this is being done in a phased approach and they have to record an impression again we are making sure it is not an audit tool but a medical tool to help their clinical care and improve patient care. MF highlighted that AW had touched on the clinician dashboard at the last meeting and suggested a demonstration is given to the committee at a future meeting to see what it looks like. JLH was happy to provide a demonstration. MF referred to digital informatics and felt until much more of that is done the assurance around the clinical audits will continue for a while. A discussion for another time is a wider board discussion around digital informatics and front-loading improvements comes down the line and this investment is not cheap and comes back to the strategy as to where can we go to improve performance when demand is up and resources are down. These are conversations that have not been touched on in-depth and there needs to be a bigger conversation how to progress and plan for the future using technology. AH said this goes back to the conversation around the strategic plan refresh item and forms part of that wider discussion. MWB referred back to MF comments about information load and changes, stating we are not expecting clinicians to change their way of working by just doing these things. We are involving staff who work on the road in the work being done around the changes and how we do the policies, procedures, etc and how the changes can be implemented on the job. JLH added there are specific champion groups such as the EPR where staff test everything that is changed in the system before it is rolled out on the road. There are digital and data champions and both groups feed into the dashboard and provide feedback which is taken on board to adapt it to what they want. There is also a digital transformation oversight group and a digital data transformation group who meet weekly and the Digital Transformation Lead is going out to departments to get ideas from staff to improve different processes and move forward on these.	
	Resolved:	
	a) That the contents of the Clinical Audit Programme 6-Monthly Report be received and noted. b) That a demonstration of the clinician dashboard is given to the committee at a future meeting.	**JLH**
	7.8 Research & Development Programme 6-Monthly Report	
	The Clinical Audit Programme 6-Monthly Report had been circulated. AR gave brief outline for the report which summaries the year's work, which has been a success in recruiting 609 participants across 10 studies.	

	The report shows a table of where WMAS sits amongst the larger hospital trusts and provides an overview of each of the studies the organisation is taking part in. In response to MF's question around whether there had been a study done on the impact of COVID on staff, AR confirmed there was a national study sponsored by the College of Paramedics which is currently in the final write up phase and very close to publication. The 5-year research strategy is in draft format and it was started with LBP and there was one catch up before it got postponed due to COVID and AR was happy if anyone wanted to be involved taking this forward. MF was happy to support AR with the strategy. MF informed one of the areas the People Committee are looking at is really promoting diversity across all the areas of the Trust's business and asked if AR was working with the organisational development team to promote and give those opportunities for those wanting to engage with research. AR stated there are currently 2 BME members of staff were being supported to undertake a Masters by Research with Coventry. Everything we do covers full diversity of our staff. AH welcomed the development of a 5-year strategy but said there would need some clarification as the framework is different for research in higher education as this is driven by the Research Assessment Exercise and we should look for opportunities with HE partners when they arise as there are stringent set of rules associated with the RAE but there are also benefits and AH could supply the rules information at any time.	
	Resolved:	
	That the contents of the Research & Development Programme 6-Monthly Report be received and noted.	
	7.9 Maternity Services Action Plan	
	The Maternity Services Action Plan had been received. AH requested the maternity services action plan is deferred to the next meeting given the sensitivity around maternity and hospital services but noted some of the actions from the last year had not been completed and would like to discuss the rationale for this in more detail.	
	Resolved:	
	That the Maternity Services Action Plan is deferred to the next meeting.	
05/23/08	**Documents for Approval/Discussion**	
	8.1 Quality Account & Departmental Annual Reports	
	The Quality Account & Departmental Annual Reports had been circulated. • CD Accountable Officer & Medicines Management • Infection Prevention & Control • Maternity Services • Patient Experience • Patient Safety • Health & Safety • Clinical Audit • Research • Learning from Deaths • Making Every Contact Count • Emergency Preparedness	

	• Safeguarding • Security Management • Diversity & Equality PW advised the paper is in two parts, the first part is the Quality Account which is the final draft being submitted for review and approval prior to submission to the Board next week. This is a substantial paper and has had significant input from each of the Leads, noting there had been some minor additions/amendments since it had been circulated. On that basis, PW was asking QGC to accept the Quality Account in order for it to go to Board with the caveat that the correct version of the maternity action plan would be included following the discussion earlier in the meeting. AH requested the updated maternity action plan is re-circulated to the committee to be able to provide a response (which might have to be verbal) back to the Board on the day noting the Quality Account will have already been shared and in the public domain. PW explained although it is the Board responsibility to approve Quality Account, it does require QGC approval beforehand and next week the Board will be asked to give delegated authority to the Executive Management Board to sign off the final version on 13 June to accommodate receipt of any further external stakeholder comments, final formatting and any graphics added before the document is published. AH thanked each of the Leads for the contributions made and to PW for providing an oversight and presenting the document. The second part of the report is the Departmental Annual Reports and again there has been a lot of work done by each of the Heads of Departments in producing these documents. PW clarified it had been previously agreed the suite of annual reports would be collated as an addendum to the Quality Account and although there may be some repetitions, they provide a broader view of what the organisation is doing. It was noted some annual reports are required by law and the others it was felt are good to have available. PW advised the Maternity and Making Every Contact Count annual reports had been circulated electronically to PSG for approval requesting comments back by the end of the week. These will then be circulated to the committee if any updates or comments are received. All the other annual reports listed have been approved by the appropriate groups as stated except for the DSPT and the Diversity & Equality annual reports which be submitted later because of the national timescales. The Emergency Preparedness annual report is currently being finalised and will go through the Operational Management Team and the Executive Management Board for approval. In response to a question raised by MF, it was confirmed NVH is the Trust's Controlled Drugs Accountable Officer and both NVH and JW were undergoing the appropriate training today.	

	In relation to the Safeguarding annual report, MF suggested to include the data for the different levels of safeguarding training as it might be useful to know how many staff have undergone which level of training. PW would take this comment back to JW consider. Another suggestion made by MF was for the Clinical Audit annual report to have a priority around learning from clinical audit outcomes and JLH would update the annual report to reflect this. PW highlighted the date on the Controlled Drugs & Medicines Management annual report needs to be amended to reflect 2022-23 as this is an end of year report. AH confirmed QGC approved the Quality Account and Departmental Annual Reports for onward approval by the Board.	
	Resolved:	
	a) That the contents of the Quality Account and Departmental Annual Reports be received and approved. b) That the maternity services action plan is updated and re-circulated to the committee for review and approval. c) That the suggestion to include the data for the different levels of safeguarding training in the Safeguarding annual report would be taken back to JW to consider. d) That the Clinical Audit annual report is updated to reflect a new priority around learning from clinical audit outcomes. e) That the Controlled Drugs & Medicines Management annual report is updated to reflect 2022-23. f) That the approval of the Quality Account and Departmental Annual Reports is included in the Chair's Report.	**JW** **PW/JW** **JLH** **SC** **AH**
05/23/09	**Schedule of Business**	
	The Schedule of Business had been received. AH noted following a review of the governance of the Trust's committees, a report is being shared with the Board of Directors and this does give the committee chance to look at the Schedule of Business to ensure the pressures faced by individuals and the committee are as minimal as possible in terms of the flow of work.	
	Resolved:	
	That the Schedule of Business be received and noted.	
05/23/10	**Any Other Urgent Business**	
	Quality Impact Assessments (QIAs) for the Cost Improvement Programmes (CIPs) PW said normally the completed QIAs come through to the committee by March but due to the timescales with the financial arrangements for this year and agreeing the CIPs, this is late being done but has not been forgotten. On that basis, the relevant Leads have been asked to complete the QIA paperwork by the end of May and PW had advised the Efficiency Group the QIA's normally come through QGC who were meeting today. Due to	

	the timeliness of the QGC meetings and not to hold up the work further, PW was seeking agreement from QGC to receive all of the paperwork electronically for comment, which can be summarised at the next meeting. AH confirmed QGC agreed to this recommendation.	
05/23/11	**New or Increased Risks highlighted from the meeting**	
	The following new/increased risks were highlighted at the meeting. 1. Lateness of Papers for Committees – this will be picked up via discussion related to the publication of the governance report to Board and is around the number of papers which are submitted and managers and service leaders capacity to complete papers. 2. Mental Health Services and removal of funding – further mental health provision papers being submitted to EMB. 3. Conveyance of Patients - is reduction of conveyance of patients leading to more incidents and influencing decision making. 4. LFD's – discharge on scene work being done as picking up other areas. There is some positive work around end of life and the level of care provided. 5. Violence and Aggression cases – concerns around body worn camera usage, public perception/opinion, mental health, hospital delays impact and the need for partnership support and triangulation of information. 6. Clinical Audit risks and performance - IT Development to assist findings from audit – includes cognitive load reduction, checklists, and other tools. AH gave thanks to colleagues for attending the meeting today and for all the teams for the work that has gone into producing and presenting the reports to the committee today. There has been generous and kind explanations and an excellence quality of debate and as the first opportunity to chair this meeting, AH had felt privileged and humbled. There being no further business, the Chair declared the meeting closed at 13.55 pm.	
05/23/12	**Date and Time of the next meeting**	
	Wednesday 19 July 2023 at 11.00 am via Microsoft TEAMS	

These minutes were agreed as an accurate record on Wednesday 19 July 2023.